A meeting of the **Clackmannanshire and Stirling Integration Joint Board** will be held on
Wednesday 13 June 2018 at **2pm - 4pm**,
in **Boardroom, Forth Valley College, Alloa**

Please notify apologies for absence to
cs.integration@nhs.net

LUNCH 12 noon – 12.30pm

IJB Development Session – 12.30pm – 13.45pm
Self-directed Support
Caroline Cherry/Jim Robb

AGENDA

1.	**NOTIFICATION OF APOLOGIES**	For Noting
2.	**NOTIFICATION OF SUBSTITUTES**	For Noting
3.	**DECLARATION(S) OF INTEREST**	For Noting
4.	**URGENT BUSINESS BROUGHT FORWARD BY CHAIRPERSON**	
5.	**MINUTE OF THE CLACKMANNANSHIRE & STIRLING INTEGRATION JOINT BOARD MEETING HELD ON 28 MARCH 2018**	For Approval
6.	**MATTERS ARISING**	
7.	**TRANSFORMING CARE**	
7.1	**TRANSFORMING CARE END OF YEAR REPORT** (Paper presented by Stephanie McNairney & Janice Young)	For Noting
7.2	**PRIMARY CARE IMPROVEMENT PLAN** (Paper Presented by Stuart Cumming)	For Approval
7.3	**MENTAL HEALTH REDESIGN: DAY SERVICES & UPDATE** (Paper Presented by Jim Robb)	For Approval
7.4	**LEARNING DISABILITY REDESIGN: DAY SERVICES & UPDATE** (Paper Presented by Jim Robb)	For Approval
7.5	**CHIEF OFFICER REPORT** (Paper presented by Shiona Strachan)	For Noting & Approval

7.6 SET ASIDE BUDGET FOR LARGE HOSPITAL SERVICES: SELF ASSESSMENT — For Noting
(Paper presented by Ewan Murray)

8. PERFORMANCE

8.1 PERFORMANCE REPORT — For Noting & Approval
(Paper Presented by Carol Johnson)

8.2 DRAFT ANNUAL PERFORMANCE REPORT — For Approval
(Paper Presented by Carol Johnson) To follow

9. FINANCE

9.1 FINANCIAL REPORT FOR YEAR ENDED 31 MARCH 2018 — For Noting & Approval
(Paper Presented by Ewan Murray)

9.2 2018/19 BUDGET UPDATE — For Noting & Approval
(Paper Presented by Ewan Murray)

10. GOVERNANCE

10.1 DELEGATION OF SERVICES: OPERATIONAL MANAGEMENT OF STIRLING COUNCIL ADULT SERVICES — For Noting
(Paper Presented by Marie Valente)

10.2 INTEGRATION UPDATE — For Noting
(Paper Presented by Cathie Cowan)

10.3 CLINICAL & CARE GOVERNANCE — For Approval
(Paper presented by Marie Valente)

11. CARERS ACT IMPLEMENTATION — For Approval
(Paper presented by Caroline Cherry)

12. NATIONAL HEALTH & SOCIAL CARE STANDARDS: MY SUPPORT, MY LIFE — For Noting

13. DOUNE HEALTH CENTRE NEW BUILD FULL BUSINESS CASE — For Noting

14. STRATEGIC PLANNING GROUP MINUTES (16/05/18) — For Noting
(None approved at present)

15. EXEMPT ITEM

15.1 CARE HOME UPDATE — For Noting
(Verbal presented by Caroline Cherry)

16. ANY OTHER COMPETENT BUSINESS

17. DATE OF NEXT MEETING
Wednesday 26 September 2018
Kildean Suite, Forth Valley College, Stirling Campus
Lunch 12noon – 12:30pm, Development Session 12:30pm – 1:45pm,
Integration Joint Board Meeting 2:00pm - 4:00pm

DRAFT

Clackmannanshire & Stirling Health and Social Care Partnership
Integration Joint Board

13 June 2018

This report relates to
Item 5 on the agenda

Draft Minute of the Clackmannanshire & Stirling Integration Joint Board Meeting held on 28 March 2018

(Paper presented by Shiona Strachan)

For Approval

Approved for Submission by:	Shiona Strachan, Chief Officer
Author:	
Date:	13 June 2018
List of Background Papers / Appendices:	
The papers that may be referred to within the report or previous papers on the same or related subjects.	

Draft Minute of the Clackmannanshire & Stirling Integration Joint Board meeting held on Wednesday 28 March 2018, at 2:00pm in the Kildean Suite, Forth Valley College, Stirling Campus.

Councillor Farmer welcomed all members to the meeting. He also welcomed Winnie Burke and Linda Connolly from the Care Inspectorate. Councillor Farmer also welcomed Robert Clark, Employee Director, NHS Forth Valley who is Tom Hart's replacement.

Present:

VOTING MEMBERS

Councillor Scott Farmer (Chair), Stirling Council
John Ford (Vice Chair), NHS Forth Valley
Councillor Dave Clark, Clackmannanshire Council
Cathie Cowan, Chief Executive, NHS Forth Valley
Councillor Ellen Forson, Clackmannanshire Council
Dr Graham Foster, Executive Board Member, NHS Forth Valley
Fiona Gavine, Non Executive Board Member, NHS Forth Valley
Councillor Graham Houston, Stirling Council
Councillor Susan McGill, Stirling Council
Councillor Bill Mason, Clackmannanshire Council

NON-VOTING MEMBERS

Robert Clark, Employee Director, NHS Forth Valley
Anthea Coulter, Business Manager, Clackmannanshire Third Sector Interface
Teresa McNally, Service User Representative for Clackmannanshire
Morag Mason, Service User Representative for Stirling
Natalie Masterton, Third Sector Representative for Stirling
Paul Mooney, Third Sector Representative, Clackmannanshire
Elizabeth Ramsay, Unpaid Carers Representative, Clackmannanshire
Abigail Robertson, Joint Trade Union Committee Representative for Stirling
Wendy Sharp, Forth Valley Advocacy
Marie Valente, CSWO, Advisor to the IJB (Chief Social Work Officer, Stirling Council)
Professor Angela Wallace, Director of Nursing, NHS Forth Valley

Ewan Murray, Chief Finance Officer, Clackmannanshire & Stirling HSCP
Shiona Strachan, Chief Officer, Clackmannanshire & Stirling HSCP

Substitute:

Nikki Bridle, Assistant Chief Executive, Clackmannanshire Council attending on behalf of Elaine McPherson, Chief Executive, Clackmannanshire Council
Alan Milliken, Senior Manager, Communities & People, Stirling Council attending on behalf of Stewart Carruth, Chief Executive, Stirling Council

In Attendance:

Jim Boyle, Chief Finance Officer, Stirling Council
Elsbeth Campbell, Head of Communications, NHS Forth Valley
Caroline Cherry, Service Manager, Adult Assessment & Partnership, Stirling Council

Stephanie McNairney, Integrated Care Funds Manager, Clackmannanshire & Stirling HSCP
Kathy O'Neill, General Manager, Community Services Directorate
Jim Robb, Service Manager, Integrated Mental Health & Learning Disabilities, Clackmannanshire & Stirling HSCP
Margaret Robbie, PA to Chief Officer
Lindsay Thomson, Standards Officer, Integration Joint Board
Elaine Vanhegan, Head of Performance & Governance, NHS Forth Valley
Julie Wilson, Communications, NHS Forth Valley
Janice Young, Interim Service Manager, Clackmannanshire & Stirling HSCP
Karen Campbell, HSCP Administrator (minute taker)

Inspection Team:

Winnie Burke (Observing), Lead Inspector, Care Inspectorate
Linda Connolly (Observing), Strategic Inspector, Care Inspectorate

Members of the Public:

Henk Berits
Daniel Lafferty

1. APOLOGIES FOR ABSENCE

Apologies for absence were intimated on behalf of:

Joanne Chisholm, Non Executive Board Member, NHS Forth Valley
Alex Linkston, Chairman, NHS Forth Valley
Stewart Carruth, Chief Executive, Stirling Council
Lesley Fulford, Programme Manager, Clackmannanshire & Stirling HSCP
Celia Gray, Chief Social Work Officer, Clackmannanshire Council
Shubhanna Hussain-Ahmed, Unpaid Carers Representative for Stirling
Elaine McPherson, Chief Executive, Clackmannanshire Council
Andrew Murray, Medical Director, NHS Forth Valley
Pamela Robertson, Chair, Joint Staff Forum
Dr Scott Williams, NHS Forth Valley

2. NOTIFICATION OF SUBSTITUTES

None for Integration Joint Board Members.

3. DECLARATIONS OF INTEREST

Elizabeth Ramsay declared an interest in item 13.2.

4. URGENT BUSINESS BROUGHT FORWARD BY CHAIRPERSON

There was no urgent business brought forward.

DRAFT

5. MINUTE OF THE CLACKMANNANSHIRE & STIRLING INTEGRATION JOINT BOARD MEETING HELD ON 13 DECEMBER 2017

The minutes of the meeting held on 13 December 2017 were approved as an accurate record. The minutes were proposed by Councillor Susan McGill and seconded by John Ford.

6. MATTERS ARISING

Teresa McNally pointed out under item 9.5 that papers should be issued 5 working days before the Integration Joint Board meeting and that this does not always happen.

Shiona Strachan advised item 12.1, 'Revised Integration Scheme' had been removed from the agenda as this is incorporated within the Performance Report.

7. TRANSFORMING CARE

7.1 CHIEF OFFICER REPORT

Shiona Strachan presented this report which provided a summary of the work being taken forward within the Health and Social Care Partnership and to raise awareness of any national issues affecting the Partnership.

The Integration Joint Board:

- Noted that the work which had taken place to develop and deliver an initial development session for the Integration Joint Board.
- Approved a second development session for the full Board (section 4).
- Approved the next steps in the development of a Partnership identity (section 5).
- Noted that the MSG indicators now form part of the Performance Report (section 6).
- Noted the progress of the Strategic Inspection (section 7).
- Noted the work taking place to review the Over Sight Group and establish full Partnership arrangements in respect of Clinical & Care Governance and that a full report will be brought forward to the June meeting of the Integration Joint Board for consideration of the outcome of the review (section 8).
- Noted the progress of work taking place in Stirling Council in respect of delegation of services (section 9).
- Noted the work taking place in respect of delegation of services in respect of NHS Forth Valley, which are also the subject of a separate report

on this agenda (section 9).

- Noted that an update will be provided in June 2018 in relation to the funding and contract management arrangements for services in respect of adult support and protection, including domestic abuse and addictions services delivered by the third sector in the Clackmannanshire Council area (section 9).

- Noted the progress of the Transforming Care work streams and in particular the proposed establishment of a Partnership Joint Staff Forum and the review of the roll out of iMatter (section 10).

- Noted the progress of the General Medical Services (GMS) contract and the work taking place in respect of the development of the Primary Care Improvement Plan for the end of July 2018 and sustainability (section 11).

- Noted the likely development of a national Power of Attorney campaign and approved the involvement of the Partnership in this work (section 12).

- Noted the delay to the completion of the Equalities Mainstreaming Progress Report and to approve the delegation of the completion and publication of the required Report (in draft form) by the end of April 2018 to the Chief Officer and the equalities leads within the constituent authorities, with a report and the final draft brought forward for approval by this Board in June 2018 (section 13).

- Noted the ongoing work to support the Implementation of the Carers Act (section 14).

7.2 MENTAL HEALTH REDESIGN

Jim Robb presented this paper. The purpose of this paper was to inform the Integration Joint Board (IJB) on the progress of the redesign of Mental Health services across the Clackmannanshire and Stirling Partnership. The redesign work is part of the Transforming Care programme for the Partnership, which is regularly reported to the Board through the Chief Officer report.

The Integration Joint Board:

- Noted that the delegated authority to the Service Manager Learning Disability/Mental Health will continue with the redesign of the Mental Health service across the Health and Social Care Partnership.

- Noted the progress and timescales for implementation of the different elements of the proposed redesign. Specifically:

  - Redesign of the management structure across health and social care services and development of operational delivery services

consistent with a single integrated service. The timescale for implementation being July/August 2018.

- The implementation of the joint commissioning plan across health and social care services for mental health services.

- Redesign of internal day services. Initial redesigned services to be in place for October 2018.

- Approved the proposed reduction of budget allocation to care packages of an assumed minimum of 10% via the Self-directed Support Resource Allocation System (RAS) during the financial year 2018/19. All cases will be subject to professional overview in order to assess risk of implementation.

- Approved the proposal to present the full business case for day services to the Integration Joint Board at the next meeting on 13 June 2018.

7.3 LEARNING DISABILITY REDESIGN

Jim Robb presented this paper. The purpose of this paper is to inform the Integration Joint Board (IJB) on the progress of the redesign of Learning Disability Services across the Clackmannanshire and Stirling Partnership. The re design work is part of the Transforming Care programme for the Partnership, which is regularly reported to the Board through the Chief Officer report.

The Integration Joint Board:

- Agreed to delegate authority to the Service Manager Learning Disability/Mental Health to continue with the redesign of the Learning Disability service across the Health and Social Care Partnership.

- Noted the work to date and the progress and timescales for implementation of the different proposed elements of the redesign. Specifically:

  - It was noted that the redesign of the management structure across health and social care services and development of operational delivery services consistent with a single integrated service. Timescale for implementation being July/August 2018.

  - It was approved the implementation of the joint commissioning plan across health and social care for Learning Disability Services.

  - Approved the redesign of internally provided day services, with full implementation for October 2018.

- Approved the proposed reduction in spend for in-house day services of 7.5% per annum for the financial years 2018/19 and 2019/20.

- Approved the proposed reduction of budget allocation to care packages of an assumed minimum of 10% via the Self-directed Support Resource Allocation System (RAS) during the financial year 2018/19. All cases will be subject to professional overview in order to assess risk of implementation.

- Approved the proposal to present an updated report including a full business case to the Integration Joint Board on 13 June 2018 in respect of day support services.

8. PERFORMANCE

8.1 PERFORMANCE REPORT

Elaine Vanhegan presented this report. As set out in the approved Performance Management Framework, the Integration Joint Board has a responsibility to ensure effective monitoring and reporting on the delivery of services and relevant targets and measures included in the Integration Functions, and as set out in the Strategic Plan.

The content of the report mainly focused on the Ministerial Strategic Group for the Health and Community Care (MSG) indicators around delivering unscheduled care inclusive of delayed discharges and social work areas of performance measurement.

The Integration Joint Board:

- Noted the content of the performance report (Appendix 1).

- Noted that appropriate management actions continue to be taken to address the issues identified through the performance reports.

- Approved the submission to the Ministerial Strategic Group with agreed targets around unscheduled care (Appendix 5).

- Noted the recommendations arising from the recent Internal Audit Review of Performance Management and Reporting and the intention to develop an improvement plan to be monitored via the Audit Committee were noted.

9. FINANCE

9.1 FINANCIAL REPORT

Ewan Murray, Chief Finance Officer presented this paper. This report was prepared based on information supplied by the finance teams from the constituent authorities including financial projections.

DRAFT

The Integration Joint Board:

- Noted that, based on financial performance 31 January 2018 and known issues, an overspend of £2.721m on the Partnership Budget (17/18) is projected.

- Noted the changes to the Partnership Budget.

- Noted the significant variances and financial pressures within the Partnership Budget.

- Noted that the projected residual overspend after application of useable reserves of the Integration Joint Board and,

- Approve the utilisation of these reserves to partially meet the projected overspend.

- Noted that the agreement in principle in how the residual 2017/18 financial risk will be managed, subject to any further governance agreement required by the constituent authorities.

9.2 BUDGET FOR 2018/2019

Ewan Murray, Chief Finance Officer presented this paper. The purpose of this report is to present the Integration Joint Board budget for 2018/19, along with related issues and risks, for approval.

The report should be read alongside the papers on Partnership Planning Approach, Partnership Funding and Governance including the proposal to establish a Finance Committee.

The Integration Joint Board:

- Noted the General Economic Update.

- Noted the proposed payments from Clackmannanshire and Stirling Councils and NHS Forth Valley and proposed Set-Aside budget for Large Hospital Services subject to approval of NHS Forth Valley's financial plan.

- Noted that the proposed payments and Set-Aside budget for Large Hospital Services are fair and proportionate given the overall settlements to the constituent authorities.

- Approved the Partnership Budget for 2018/19 and the measures detailed in summary form within Table 4 to achieve financial balance in 2018/19.

- Agreed to delegate to the Chief Officer and Chief Finance Officer, in consultation with the Deputy Chief Executive of Clackmannanshire Council and Chief Finance Officer of Stirling Council, and within the

resources set out in this report the authority to set agree contract rates for 2018/19.

- Approved the completion of a Post Due Diligence review.
- Noted that the progress on developing medium term financial planning and strategy included linkage to the Partnership Planning Approach.
- Noted the approach to Directions including national work to establish best practice and approve the issuing of initial directions for 2018/19.
- Approved the Audit Committee's recommendation that the Reserves Policy and Strategy remains unchanged for 2018/19.
- Noted that the Partnership remains at high risk of overspend in 2018/19 taking account of the issues set out in this report.
- The significant risks set out in Section 15.4 of this report were noted and approved the update to the Strategic Risk Register to reflect these risks.

9.3 PARTNERSHIP FUNDING

Alan Milliken presented this paper, which provided the Board with an update to the paper brought to the December 2017 meeting with regards the review of funded projects.

The Integration Joint Board:

- Noted the work to date in relation to ensuring robust project documentation including reporting framework is in place.
- Noted the areas earmarked for service redesign or realignment in sections 6.6 to 6.8.
- Approved the funding recommendations for 2018/19 as set out in Appendix 1 of the report.

10. PLANNING

10.1 PARTNERSHIP PLANNING APPROACH

Shiona Strachan, Chief Officer presented this paper. The purpose of this paper is to provide the Integration Joint Board with an overview of the activities required to deliver a Strategic Plan for 2019-2022 and how this will be achieved.

The Integration Joint Board:

- Approved a replacement Strategic Plan is required for 2019 - 2022.

- Approved the Strategic Plan Working Group review the Partnership progress against its Delivery Plan at its meeting in March 2018 and formally report this to the Strategic Planning Group meeting in April 2018 and the Integration Joint Board in June 2018 for their scrutiny and challenge.

- Noted the areas to be considered for the Strategic Plan for 2019- 2022.

- Noted the work required to refresh the Strategic Needs Assessment and replace the Strategic Plan and the associated timescales.

- Agreed to consider and challenge the care groupings proposed.

- Noted the Locality based discussions at the Strategic Planning Group.

- Approved the new planning approach and that the Integration Joint Board will receive regular updates on progress.

10.2 UPDATE REPORT: DEVELOPMENT OF AN INTEGRATED STRUCTURE (TO FOLLOW)

This agenda item was removed from the Agenda by Shiona Strachan, Chief Officer.

11. GOVERNANCE

11.1 CHANGE OF CHAIRPERSON AND VICECHAIRPERSON OF THE INTEGRATION JOINT BOARD, AUDIT COMMITTEE CHAIRPERSON AND PROPOSAL TO ESTABLISH A FINANCE COMMITTEE

Elaine Vanhegan presented this paper.

The Integration Joint Board's Standing Orders set out the arrangements for Chairperson and Vice Chairperson of the Integration Joint Board. From 1 April 2018 the Chairperson of the Integration Joint Board shall be nominated by NHS Forth Valley for a period of two years.

Given that the terms of reference of the Audit Committee states that the Chairperson of the Integration Joint Board should not normally be a member of the Audit Committee there is also a requirement to consider the appointment of Chairperson of the Audit Committee at the same time.

Discussions with voting members in November 2017 and February 2018 in relation to the Integration Joint Board budget have highlighted the merits of formally establishing a Finance Committee of the Integration Joint Board.

The Integration Joint Board:

- Approved the nomination of John Ford, NHS Forth Valley for Chairperson of the Integration Joint Board for the period 1 April 2018 to 31 March 2020.

- Approved the nomination of Councillor Les Sharp, Clackmannanshire Council for Vice Chairperson of the Integration Joint Board for the period of 1 April 2018 to 31 March 2019.

- Approved the appointment of Councillor Dave Clark for Chairperson and Councillor Graham Houston for Vice Chairperson of the Integration Joint Board Audit Committee.

- Approved the establishment of a Finance Committee, with Councillor Scott Farmer, Stirling Council as Chairperson and Joanne Chisolm, NHS Forth Valley Vice Chairperson of the Finance Committee, and approve**d** the draft terms of reference. Further nominations are required from the constituent authorities to fulfil the membership of the committee. Clackmannanshire Council nominated Councillor Ellen Forson and Councillor Dave Clark. Stirling Council and NHS Forth Valley will advise of their nominations.

11.2 THE GENERAL DATA PROTECTION REGULATION (GDPR)

This paper was presented by Shiona Strachan. From 25 May 2018, the existing Data Protection Act 1998 will be replaced by the General Data Protection Regulation (GDPR). There will also be a new Data Protection Act in the UK.

The Integration Joint Board:

- Noted the requirements of new data protection legislation, and its significance for the work of the IJB.

- Approved Deirdre Coyle, Head of Information Governance, NHS Forth Valley as the Data Protection Officer for the Clackmannanshire & Stirling Integration Joint Board.

- Noted that further work will be required by the Integration Joint Board to review arrangements for processing of personal data by the Integration Joint Board, to check that processes are compliant with GDPR.

- Noted that the Integration Joint Board must document its arrangements for processing personal data, and make the documentation available publicly, in line with the requirements of GDPR in relation to transparency and accountability.

12. PAPERS FOR NOTING

12.1 REVISED INTEGRATION SCHEME

The Integration Joint Board:

- Noted that the contents of this report and the revision to the Integration Scheme.

12.2 LOCAL OUTCOME IMPLEMENTATION PLAN – CLACKMANNANSHIRE

The Integration Joint Board:

- Noted the Clackmannanshire's Local Outcome Improvement Plan for 2017/2027.

12.3 CLACKMANNANSHIRE & STIRLING INTEGRATION JOINT BOARD AUDIT COMMITTEE MINUTES OF MEETING 14/09/17

The Integration Joint Board:

- Noted the Clackmannanshire & Stirling Integration Joint Board Audit Committee Minutes of meeting held on 14/09/17.

12.4 JOINT STAFF FORUM MINUTES OF MEETING 03/08/17, 05/10/17 AND 07/12/17

The Integration Joint Board:

- Noted the Joint Staff Forum minutes of meetings held on 03/08/17, 05/10/17 and 07/12/17.

12.5 STRATEGIC PLANNING GROUP MINUTES OF MEETING 07/11/17

The Integration Joint Board:

- Noted the Strategic Planning Group minutes of meeting held on 07/11/17.

13. EXEMPT ITEMS

Under section 50A (4) of the Local Government (Scotland) Act 1973, the public should be excluded from the meeting for this item on the grounds that it involved the likely disclosure of exempt information.

13.1 COMMISSIONED SOCIAL CARE SERVICES RATE INCREASES 2017/18

Paper presented by Caroline Cherry, Service Manager, Adult Assessment & Partnership.

The Integration Joint Board:

- Noted the paper presented by Caroline Cherry.

DRAFT

13.2 CARE HOMES

A verbal report was given by Caroline Cherry, Service Manager, Adult Assessment & Partnership.

The Integration Joint Board:

- Noted the content of the verbal report presented.

14. ANY OTHER COMPETENT BUSINESS

John Ford thanked Councillor Scott Farmer for his role as Chair and commitment to the Board.

15. DATE OF NEXT MEETING

Wednesday 13 June 2018
Lunch - 12 noon – 12:30pm
Development Session - Self directed Support, 12:30pm – 1:45pm
Integration Joint Board, 2:00pm – 4:00pm
Boardroom, Forth Valley College, Alloa Campus

DRAFT

Clackmannanshire & Stirling
Integration Joint Board

13 June 2018

This report relates to
Item 7.1 on the agenda

Transforming Care End of Year Report

Paper presented by
Stephanie McNairney & Janice Young

For Noting

Approved for Submission by	Shiona Strachan, Chief Officer
Authors	Janice Young Jim Robb Linda Melville Caroline Cherry Lesley Middlemiss Stephanie McNairney
Date:	13 June 2018
List of Background Papers / Appendices:	

Title/Subject: **Transforming Care End of Year Report**

Meeting: **Clackmannanshire & Stirling Integration Joint Board**

Date: **13 June 2018**

Submitted By: **Stephanie McNairney/Janice Young**

Action: **For Noting**

1. Introduction

1.1. The purpose of this paper is to update the Integration Joint Board on progress against a number of the key work streams underway across the Partnership area, as progress towards the delivery of strategic priorities as set out in the Strategic Plan.

2. Executive Summary

2.1. This report sets out the work undertaken within each of the key work streams and enablers over the last year, and accomplishments achieved towards the delivery of the core strategic priorities.

2.2. The work is over seen by the Transformational Care Group with exception reporting to the Joint Management Team.

2.3. The work streams considered in this report are:

- Intermediate Care
- Day Services
- Mental Health
- Learning Disability
- Self-directed Support
- Delayed Discharge
- Stirling Health and Care Village
- Model of Neighbourhood Care
- Primary Care Transformation
- High Health Gain

2.4. The enablers are:

- Strategic Needs Assessment
- Technology Enabled Care
- Information & Directories
- Housing Contribution
- Data Sharing & Shared Assessment
- Commissioning - Market Position & Providers
- Workforce

- Financial
- Outcomes - Framework & Improvement Objectives

3. Recommendations

The Integration Joint Board is asked to:

3.1. Note the progress of key work streams over the last year towards delivery of the core strategic priorities.

4. Background

4.1. Following the development of the Strategic Plan 2016-2019, a programme of transforming care activities were commenced to deliver the strategic priorities of the Strategic Plan.

4.2. Significant work has been undertaken to deliver these key service developments.

5. Intermediate Care

What Did You Set Out To Do?

5.1 Approval was provided at the April 2017 Integration Joint Board [JB] meeting to review the model of service delivery under the umbrella of Intermediate Care as part of the “step into” the Health and Care Village, covering bed based intermediate care and the supporting intermediate care at home services.

- It was agreed that to ensure a cohesive approach across the Health and Social Care Partnership [HSCP], the review of models of service would incorporate both Clackmannanshire and Stirling based services.
- There was also approval provided that a whole systems approach was required to enable re-design activity, which sought to align teams and services appropriately to maximise outcomes and efficiency. This would also support further integration of teams.

5.2 Within the HSCP intermediate care services are largely focused on supporting older people and are provided as Intermediate Care at Home and Bed Based Intermediate Care. There are a number of challenges identified in the current models of service.

- There is no single model of Reablement or Intermediate Care at Home, with 5 overlapping service delivery models. All have a focus on early intervention and prevention and were developed at various times to respond to local needs or utilise resources more effectively. The 5 models are – Clackmannanshire Reablement, Stirling Home Care Assessment

and Reablement Team (HART), Stirling: the Rural Partnership, Stirling: the North West Rural Partnership and, Stirling: Rapid Response.

- There is also bed based Intermediate Care within residential care homes owned by the local authorities. The units currently used for this purpose in Stirling will step into the Care Village when it is completed in autumn 2018, while the service in Clackmannanshire requires to be reviewed in line with this to ensure consistency across the Partnership.

What Have You Achieved?

5.3 Additional support was sought by the Partnership from iHub [the national improvement service] to guide the evaluation of these services, while providing 'critical friend' support.

5.4 For the step up/step down bed based services, this support has been sourced from the Strategic Commissioning Support Unit of iHub. This work has focussed upon:-

- Evidence search of efficacy and range of Intermediate Care models
- User led engagement to support articulation of model of care
- Critical friend support
- Support in conversation with Care Inspectorate
- Support for Third Sector engagement

5.5 This guidance has largely focussed upon Stirling Health and Care Village, but has also provided an approach which can be replicated when taking forward the development of other service areas.

5.6 For the Reablement service, which is a care at home service, the Living Well in Communities section of iHub have supported the development of a logic model to evaluate the range of models currently in place, and will guide the Partnership in deciding on a preferred model for future service delivery. Meanwhile, the range of models has reduced over the past year, with Clackmannanshire Reablement being rationalised, while the service areas in the rural locality of Stirling are being evaluated alongside the continued development of the Neighbourhood Model of Care.

How Has This Helped Partnership Performance?

5.7 It is expected that with the conclusion of the evaluations expected in June 2018, this help overall performance of Intermediate Care services, as there will be clearly defined models of service which are fully integrated and support the delivery of the Strategic Plan priorities. In having a well articulated model of step up/step down bed provision, the Partnership will be ready to move into the Bellfield Centre on the Stirling Health and Care Village site by November 2018. Meanwhile, the definition of the Partnership's approach to Reablement will be able to be implemented across all localities in line with the transition of all in-scope services in the autumn of 2018.

What Has Been The Impact on Outcomes?

5.8 The clear definition of services across the Partnership is necessary to support workforce planning as well as communicating with users of services, unpaid carers and other professionals. The Intermediate Care Services within the Partnership have a strong outcomes focus with a positive impact on supporting people to live well in their communities. However, it was clear that there has been duplication of effort, with multiple and potentially confusing models of service delivery which were not well defined across the Partnership. This evaluation work, along with greater scrutiny of performance outcomes will provide the Partnership with reassurance that there is equity of access to services.

Summary of Next Steps

5.9 The project will enter an implementation stage from June 2018. The definition of Reablement will allow the integration of multi-skilled teams across the Partnership, which will support a community front door to services. This will also align with Models of Neighbourhood Care, Enhanced Care Team services and models of support for Overnight Care.

5.10 Meanwhile, the Partnership will 'step into' the Stirling Health and Care Village in November 2018, when the integrated model of care and support will be fully concluded. This is described further in section 11 of this report.

5.11 It is then expected that further analysis of the model of care provided within Clackmannanshire Community Health Centre's services will then be carried out so that the services there can be aligned to those of the Bellfield Centre. Opportunities to shift towards greater preventative approaches, avoiding acute services will be pursued.

Status

Intermediate Care		
Reablement [Care at Home]	June 2018	
Bed Based Intermediate Care	Nov 2018	

6. Day Services [Older People]

What Did You Set Out To Do?

6.1 A management review of Day Services has been undertaken with the aim of identifying how a more responsive and cost effective service could be developed. This work has focussed on service provision within the Clackmannanshire.

6.2 There are currently traditional models of day supports provided within Ludgate House Day Service for older people, and The Whins Resource Centre for adults with physical disabilities. Meanwhile, therapeutic day care is also provided within Clackmannanshire Community Healthcare Centre, for both physical disability and old age psychiatry services.

6.3 There is a need to re-design and align these models of service to modernise current practice, and ensure equity of access to services which meet the priorities of the Strategic Plan as well as to fit with Self-directed Support opportunities.

6.4 The growing older population, along with the drive for people to be supported to live in their own homes means that there is a requirement for services to be able to respond in different ways to promote successful ageing wherever possible. However, it is also recognised that for some older people, additional support may be required to both support themselves and their carers when living with long term or life limiting conditions. The key issues are:

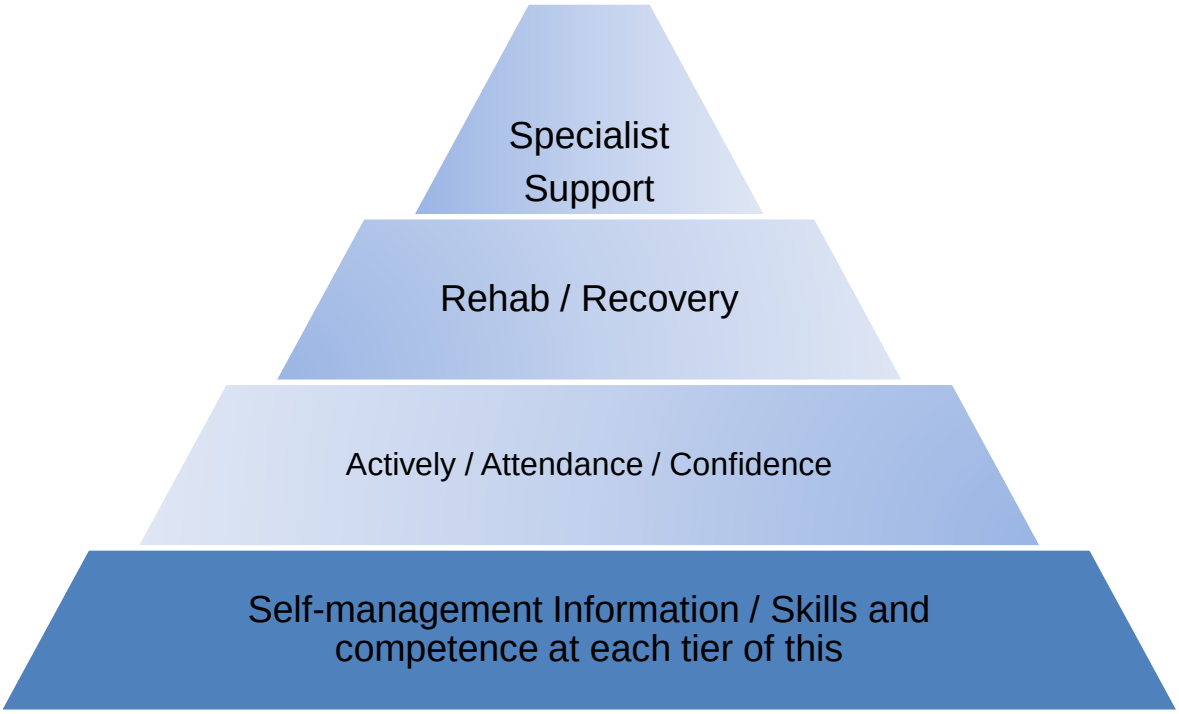
- Growing older population (by 2033, 1 in 4 people in Clackmannanshire will be over 65)
- Focus on rehabilitation, recovery and living well in later life
- Appropriate and timely pathways for high resource users of health and social care services
- The challenge to meet budget priorities
- Supporting carers
- Promoting choice and control over the types of services which individuals wish to access in planning their own care support

<u>What Have You Achieved?</u>

6.5 A short life working group was established during 2017, to scope out existing service models and provide a level of scrutiny on the outcomes being achieved within these services. Consideration was also given to other Health and Social Care Partnership areas and the range and types of services available in other areas. It was identified that there was an on-going need for 4 different types of service provision:

- Specialist Support
- Short Term service based upon rehabilitation and recovery
- Maintenance programmes to support benefits of rehabilitation programmes or to continue with long-term outcomes
- Long-term day respite for users and unpaid carers

6.6 A workshop with colleagues from old age psychiatry services was held in September 2017 to consider the needs of people living with dementia, with similar views on the types and range of day supports required, with these being described within a pyramid of need, with service user numbers expected to be smaller as the pyramid narrows:



6.7 Work commenced in February 2018 with Clackmannanshire Third Sector Interface to consider the range and types of services which could support place based, community supports, and a public engagement event has been planned for May 2018, to further identify how people wish to be supported in their communities.

How Has This Helped Partnership Performance?

6.8 There is inconsistent and potentially inequitable access to day supports across the Partnership. Meanwhile, there is a budget pressure within Clackmannanshire resulting from previous Making Clackmannanshire Better projects, meaning that the current range of services are not affordable and have reducing outcomes due to diminishing numbers of attendees. The evaluation of day supports and the plan to prioritise service delivery to those of highest need will improve performance and budget management over the next 12 months.

6.9 In working collaboratively with the Third Sector, there is opportunity to co-design services which seek to support those who can self-managed in a more pro-active and preventative way.

What Has Been The Impact on Outcomes?

6.10 The approach to evaluate existing services while seeking to rationalise buildings, and define an approach to day supports has the intention of delivering transformational change which has been co-produced by staff, users and carers.

Summary of Next Steps

6.11 Following the Third Sector event planned for May 2018, it is intended that:

- Service innovation of place based community supports will be taken forward by the Third Sector Interface
- Continued engagement with the public will be facilitated by CTSi and the Partnership to ensure that services are designed in line with identified needs
- Opportunities to use Clackmannanshire Community Healthcare Centre's Day Therapy Unit will be explored further. This venue will be taken forward as the key location to support people with High Health Gain needs
- Ludgate House will be re-defined as a Third sector resource within the Partnership, while retaining core community based services including respite, reablement and technology enabled care.

Day Services [Older People]		
Review of the current day care services in Clackmannanshire	June 2018	
Development work with the third sector for community based alternatives	Oct 2018	

7. Mental Health

What Did You Set Out to Do?

7.1 The Mental Health services across the Partnership are presently subject to review. The planned benefits of the review are consistent with the national Mental Health Review (Scottish Government) and spans a variety of issues from general Human Rights to the development of services consistent with Self Directed Support, innovative commissioning of services and day supports for those with profound and mental health issues.

7.2 The Mental Health Service is required to evidence how it implements local, operational priorities:

- Change from traditional single agency services to integrated services at operational level across the NHS and the 2 councils.
- Redesign of traditional day services to personal outcome services, 5/7 shift work etc. In house or commissioned the service specification should be the same.
- The development of a commissioning plan that focuses on the development financially sustainable, alternative services to long term hospital care, external high cost residential care and the development of supported living opportunities , care and home and day services that are

developed local where possible and are outcomes focussed and consistent with best practice.

What Have You Achieved?

7.3 Redesign of management structures and operational services:

There is a clear commitment to developing, where practical, a service based on a single integrated management structure operating from a pooled budget and which is co-located. The proposals were agreed at the IJB meeting of 28 March 2018 and have agreed with staff and Trade Unions/Staff representatives. The job evaluation and recruitment process for the new Team Leader posts is now in progress with a view to having the posts in place and managing both community nursing and social work posts within an integrated team by October 2018.

7.4 Commissioning and recommissioning of services.

The Joint Commissioning Plan was signed off by the Integration Joint Board on 28 March 2018 and provides the basis of a plan for the next 3 years and will proceed on the following basis:

- Commission services within the Partnership's geographical area and / or the NHS Forth Valley area where possible.
- Commission services that promote choice and innovation and focus on personal outcomes.
- Commission independent living services as a direct alternative to low/medium dependency residential care (note it is accepted that alternative to high dependency, specialist residential nursing care will create a challenge in developing alternative local services).

7.5 Redesign of in house Day Services

The projected benefits of the redesign of in-house day services are the provision development of flexible and innovative community based services consistent with the principles of client specific outcomes and Self Directed Support operating seven day per week including the option of providing opportunities during evenings and weekends.

The Alloa based, Integrated Mental Health Team presently operates within this model and services within the Stirling locality are commissioned from the Third sector likewise. However, further review of the service is being progressed in order to meet the requirements of a consistent approach across the Partnership area that also meets the requirements of the agreed Eligibility Criteria and complements the redesign of community mental health services that are managed by the NHS Board. Timescale: October 2018

7.6 Projected full year gross financial efficiency of £262,130 identified via the development of an integrated team and management structures and efficiencies generated from the redesign of the Community Outreach service

in Clackmannanshire as reported to the IJB in March. Figure subject to some staff taking Voluntary Severance or being successfully redeployed to other

How Has This Helped Partnership Performance?

7.7 The models being developed are designed to move towards a more fully integrated team and supporting management structure, which should help reduce duplication and provide a positive basis for more integrated working across the wider service areas.

7.8 Summary of Next Steps

- The Partnership is now moving towards an integrated operational team for Learning Disability in each locality with Team Managers being appointed to manage the staff groups as a single team. Timescale: October 2018.
- The Partnership has an agreed model of commissioning service in the future that emphasises a move away from traditional, high cost, hospital and residential services to supporting people in the community within supported accommodation in partnership with independent service providers and housing colleagues.
- Financial efficiency of £262,130 (full year costs) confirmed as part of the redesign.
- Review of high cost or complex care provision including any provided out with the area and business case development for alternative options.

Mental Health [Adults]		
Establish a fully integrated management and service structure	Oct 2018	
Commissioning Plan to support commissioning of service in line with needs	June 2018	
Review of high cost or complex care provision and business case for options	Oct 2018	

8. Learning Disability

What Did You Set Out to Do?

8.1 The Learning Disability services across the Partnership are presently subject to review. The planned benefits of the review are consistent with the national "Keys to Life" strategy (Scottish Government 2013) which spans a variety of issues from general Human Rights to the development of services consistent with Self Directed Support, innovative commissioning of services and day supports for those with profound and multiple learning disabilities.

8.2 The Learning Disability Service is required to evidence how it implements local, operational priorities:

- Change from traditional single agency services to integrated services at operational level across the NHS and the 2 councils.
- Redesign of traditional day services to personal outcome services, 5/7 shift work etc. In house or commissioned the service specification should be the same.
- The development of a commissioning plan that focuses on the development financially sustainable, alternative services to long term hospital care, external high cost residential care and the development of supported living opportunities , care and home and day services that are developed local where possible and are outcomes focussed and consistent with best practice.

What Have You Achieved?

8.3 Redesign of management structures and operational services:

There is a clear commitment to developing, where practical, a service based on a single integrated management structure operating from a pooled budget and which is co-located. The proposals were agreed at the IJB meeting of 28 March 2018 and have agreed with staff and Trade Unions/Staff representatives. The job evaluation and recruitment process for the new Team Leader posts is now in progress with a view to having the posts in place and managing both community nursing and social work posts within an integrated team by October 2018.

8.4 Commissioning and recommissioning of services.

The Joint Commissioning Plan was signed off by the Integration Joint Board on 28 March 2018 and provides the basis of a plan for the next 3 years and will proceed on the following basis:

- Commission services within the Partnership's geographical area and / or the NHS Forth Valley area where possible.
- Commission services that promote choice and innovation and focus on personal outcomes.
- Commission independent living services as a direct alternative to low/medium dependency residential care (note it is accepted that alternative to high dependency, specialist residential nursing care will create a challenge in developing alternative local services).

8.5 Redesign of 'in house' Day Services

The projected benefits of the redesign of in-house day services are as follows:

- The development of flexible and innovative community based services consistent with the principles of client specific outcomes and Self Directed

Support operating seven day per week including the option of providing opportunities during evenings and weekends.

- Building based services primarily being used for high dependency service users who require high levels of supervision and personal care as well as their social development including the option of providing opportunities during evenings and weekends.

8.6 An initial assessment of need is subject to further clarification on a case by case basis via detailed planned reviews with service users, their unpaid carers/family and appropriate professionals and support workers. There has been regular engagement with the staff and the Trade Unions on the redesign and this has been supplemented by carer and service user engagement in relation to the proposals and will continue on an ongoing basis.

8.7 The proposed timescale to implement the initial phase of the redesign of in-house services is 1 October 2018. The expectation is that the redesign would be accompanied by a culture of innovation and change that would see the service continues to evolve and innovate in order to meet the needs and ambitions of service users in the future.

8.8 A 7.5% efficiency for the 3 financial years 2017/18, 2018/19 and 2019/20 has been identified as part of the redesign via the combination of authorising voluntary severance requests and deleting vacant posts.

How Has This Helped Partnership Performance?

8.9 The models being developed are designed to move towards a more fully integrated team and supporting management structure, which should help reduce duplication and provide a positive basis for more integrated working across the wider service areas.

8.10 The supporting commissioning strategies and their supporting implementation plans will ensure that the service commissions services on basis of evidence of need and within a transparent commissioning framework.

Summary of Next Steps

8.11 The Partnership is now moving towards an integrated operational team for Learning Disability in each locality with Team Managers being appointed to manage the staff groups as a single team. Timescale: October 2018.

8.12 The Partnership has an agreed model of commissioning service in the future that emphasises a move away from traditional, high cost, hospital and residential services to supporting people in the community within supported accommodation in partnership with independent service providers and housing colleagues.

8.13 The Partnership is in the process of redesigning internal day services with a view to developing innovative community based services as an alternative to traditional building based services where appropriate to assessed need.

Timescale for initial phase of change: October 2018. Financial efficiency of 7.5% per annum achieved for the 3 financial years noted.

Learning Disability		
Establish a fully integrated management and service structure	Oct 2018	
Commissioning Plan to support commissioning of service in line with needs	June 2018	
Review of high cost or complex care provision and business case for options	Oct 2018	
Review of Day Services	Oct 2018	

9. Self-directed Support

What Did You Set Out to Do?

9.1 The programme is part of a ten year strategy (2010-2020) which will implement the Social Care (Self-directed Support) Scotland Act 2013. The Act intends to ensure that care and support is offered, and delivered, in a way that supports choice and control and respects the right to live an independent life and the right to participate in society. The Act applies to adults, children and young people and their families and carers. The legislation enshrines the following principles: participation, dignity, involvement, informed choice and collaboration.

9.2 This work stream operates within in a new Programme Implementation Board with working groups, in each locality, taking forward the next stage of implementation. The Board is chaired by Operational Senior Management and includes representatives from Finance, Strategic Commissioning, Business Support (IT) and Business and Finance. A decision was made to combine the two Stirling and Clackmannanshire Boards during September 2017.

What Have You Achieved?

9.3 Work Strands:

Training of operational staff and Team Managers was completed during the final quarter of 2017 and the first quarter of 2018. This will be an ongoing issue with emphasis put on Team Leaders to be the “champions” for SDS and lead the operational practice issues: Completed in both Stirling and Clackmannanshire Localities.

9.4 A “Test of Change” on the new assessment & care management electronic documents was carried out in both localities involving operational staff. This will be reviewed again during 2018 and thereafter annually: Completed across the Partnership.

9.5 Electronic documents are now updated and ‘live’. Clackmannanshire and Stirling have different client based information systems: Stirling has implemented a new assessment document (16 April 2018) that links into the Resource Allocation System (RAS). This remains outstanding in Clackmannanshire with an expected implementation date of 18 June 2018.

9.6 The RAS is electronic and links outcomes based assessment outcomes to the allocation of finance.

- The Resource Allocation System has 100 points – this is the most any individual can achieve.
- There are 3 Resource Allocation Systems – 1 for Learning Disability, 1 for Mental Health and the other for Adult, Assessment and Partnership. This is because historically care packages for individuals within Learning Disability have been significantly higher than other care categories. (MH and AAP were in line for 17/18 but have had different efficiencies applied in 18/19, hence having different Indicative Budgets). The option of using a single RAS across all care groups will be considered for future years.
- A 10% efficiency has been built into the Mental Health/Learning Disability RAS for 2018/19 given the perceived opportunity for efficiencies and 7. 5% efficiency built into all other care groups
- The RAS was implemented in the Stirling on 16 April and Clackmannanshire is working to the 18 June timescale. The RAS will be reviewed within 3 months of implementation and then 6 monthly for year 1 and thereafter annually.

<u>Summary of Next Steps</u>

9.7 As noted above Clackmannanshire has an implementation date for the electronic documents and the RAS for 18 June 2018.

Operational Social Work staff will require ongoing leadership from Team Managers in order that practice remains consistent with the values of Self – directed Support (choice, empowerment, development of community resources).

Commissioning models to be further developed that both inform staff and service users with the availability of cost effective framework providers and just as importantly a full list of community based alternatives to registered social work services in order that service users and unpaid carers can make informed choices about the revenue available to them

9.8 Team Managers are indicating that social work staff are approaching the assessment/care planning task differently in a manner that encourages a

conversation with service users in relation to their needs, effective use of their allocated revenue and the development of community based alternatives to formal social work services.

9.9 It is too early in the process however to evidence significant change in how services are developed and how cost effective the implementation may be.

Self-directed Support		
Embed the RAS into systems	June 2018	
Review at 3 months	Sept 2018	

10. Delayed Discharge

What Did You Set Out To Do?

10.1. In the HSCP there has been a very focussed approach to the prevention of avoidable Hospital Admissions, as well as more focus on the reasons for people experiencing delays in their discharge.

10.2. The governance and reporting arrangements for all the strands of work is to the Delayed Discharge Steering Group. This Group plays a pivotal role in the process of overseeing the Improvement Plan and agreeing implementation arrangements and timeframes. The group ensures there is a collective ownership of targets and actions for improvement across services.

What Have You Achieved?

10.3 During the last year the Steering Group has:

- Reviewed and updated the Improvement Plan (version 10) on a quarterly basis
- Reviewed and improved the process for people subject to Guardianship
- The Edison system has been successfully replaced, simplifying the recording of Delayed Discharges and the reporting of performance information
- Reviewed and updated the Terms of Reference for the Delayed Discharge Steering Group

How Has This Helped Partnership Performance?

10.4 Overall, the performance of the Partnership has been maintained and in some areas (e.g. occupied bed days) has improved. The impact of this is that

patients are able to move more quickly to their next stage of care. There are also positive benefits in relation to hospital flow.

10.5 Next Steps

- Daily Dynamic Discharge within Community Hospital. Evidence shows this approach has a positive impact on discharges
- Implementation of the frailty collaborative
- Participation in Unscheduled Care Programme Board
- Community Front Door initiative
- Working with Care Homes to improve process of transition from hospital

Unscheduled Care and Delayed Discharge		
Support the work of the Unscheduled Care Programme Board across the wider Forth Valley system	Ongoing	
Maintain and improve responses to delays in discharge in line with the improvement plans	Ongoing	

11. Stirling Health and Care Village

What Did You Set Out To Do?

11.1 Stirling Health and Care Village is a £35m health and care development on the Stirling Community Hospital site which is being taken forward through an innovative partnership between NHS Forth Valley, Stirling Council, the Scottish Ambulance Service, this Board and Forth Valley College.

11.2 The site consists of three main purpose built facilities – the Bellfield Centre which will provide intermediate bed based care; GP/primary care, with two practices moving onto the site from existing premises in Stirling; the Scottish Ambulance facility, which will replace the existing base at Riverside; X ray and Minor Injuries. The existing outpatient facilities will be retained within their current buildings on the wider Stirling Community Hospital site.

11.3 The diagram below provides an overview of the site.

What Have You Achieved?

11.4 The Bellfield Centre will offer bed based intermediate care for older people – essentially a 'step up' for older people at risk of admission to acute hospital or long term care home admission or a 'step down' from hospital. The facility has 84 beds split into smaller units and suites with a total of 116 beds. The lower ground floor will have 16 rooms where care will be provided for people with a diagnosis of mental illness and/or dementia. The ground floor will have 48 rooms which offer intermediate care. The top floor will have a further 16 intermediate care rooms. This floor will also have 32 rooms where care will be provided for individuals with complex health needs. In addition, there will be 4, more generous bedsit style rooms which will support assessment and independent living.

11.5 The model of intermediate care has been developed and delivered over a number of years. Work has been taking place with iHUB to sense check and further develop the model.

11.6 The Bellfield Centre is scheduled to 'go live' in November 2018 and will involve the retraction of services from the existing community hospital wards and from Allan Lodge, which is a residential care home.

Summary of Next Steps

11.7 Work is now taking place to finalise the staffing model, including the key and new integrated posts of Intermediate Care Manager and deputy. Further discussion is planned with the staff side and trade unions at the Joint Staff Forum on 14 June 2018. The staff group will be multi disciplinary and will largely transfer with the existing services.

11.8 Additional work is also taking place in respect of the Allied Health Professional input and overall medical input. It should be noted that services are currently operating from different buildings using the developed model for intermediate care.

11.9 Over the last 12 months a series of work force engagement events have taken place with a focus on the development of the Health and Care Village and the delivery of the strategic priorities described in this report. Specific staff sessions are also being held with members of staff within the community hospital and the community hospital wards. Staff are able to visit the site, with slots available each week. Arrangements are now being made for a series of hosted visits for other key staff groups and for this Board.

11.10 There have been ongoing discussions regarding registration for the Bellfield Centre intermediate care beds. While a standard registration has been applied for there has been focused discussion with the Care Inspectorate to ensure that we are able to proceed and deliver a fully integrated model.

11.11 Construction remains ahead of programme. The choice of names for each building and the internal suites was subject to consultation with members of the public and staff and patient/service user and unpaid carer groups. It is planned that the signage will be in place before occupation of the GP and Minor Injuries Centre and before the occupation of the Bellfield Centre.

11.12 Handover of the building dates are scheduled to take place on a phased basis from the end of June with the first occupation dates from mid August. In terms of the Bellfield Centre the dates are – 24 November to 1 December.

11.13 Relations with neighbours and the local community remain good. It should be noted by the Board that the Robertson's construction site team have achieved Gold in the 'Considerate Constructor Scheme Awards'. This demonstrates a 'beyond compliance' position and is testament to the work of the Senior Project Manager and his team.

11.14 The supporting operational commissioning programme is also on track with the majority of the required equipment now signed off by partners. The legal and financial agreements are also now reaching final stages.

11.15 The buildings offer an opportunity for community space, including a café and this overall space and its use is now an area of focus. Community engagement events have been held, with two out of three potential arts commission briefs advertised on the Creative Scotland Opportunities site and

further work taking place to refine the approach to the green space around the buildings.

11.16 The following photographs show the construction at May 2018.

Stirling Health and Care Village		
Construction and service planning	Ongoing	✓

12. Model of Neighbourhood Care

What Did You Set Out To Do?

12.1 We set out to develop a model of neighbourhood care on a pilot basis in rural southwest Stirling. The model is based on the "Buurtzorg" principles of neighbourhood care, adapted to our local circumstances. The key principle is "putting the person at the centre", with promotion of supported self-management, independence, and active involvement of friends, family & the community. Autonomy for staff is another key principle, with streamlined administration, reduced bureaucracy and self-management supported by a

team coach. The pilot team will consist of staff currently delivering reablement, adult social care and nursing to people in rural southwest Stirling.

What Have You Achieved?

12.2 Over the past year we have achieved significant progress against our planned project milestones. The business case for the project was developed by the project team and signed off by the IJB in June 2017.

12.3 A core "planning group" comprising of managers and team leaders directly involved with the staff of the pilot team has been driving forward the implementation of the pilot. The planning group has engaged in fortnightly meetings to scope out the current operational and governance arrangements for example: referral processes, assessment tools, case recording/ICT systems, pathways, supervision, scheduling and information sharing.

12.4 The group is has worked to develop the arrangements for how these operational processes will work most effectively in the integrated team.

12.5 A data gathering exercise was completed which gives an overview of existing assets, resource and demand in the pilot area.

12.6 A series of engagement session workshops took place with key staff. These sessions were facilitated by the Scottish Social Services Council and Stirling Council Organisational Development. Detailed staff feedback has been captured from these engagements and this feedback has been compiled and analysed in comprehensive reports.

12.7 All in-scope staff from the existing reablement and district nursing teams have been identified and will form the new Neighbourhood Care team from summer 2018. Social Care Officers and Social Workers from the existing Adult Assessment & Partnerships team will be initially aligned to the team on a temporary basis before permanent recruitment to those roles takes place later in 2018.

12.8 The team will be supported by a Coach to develop and function as a fully integrated self-managing team. The team will also include a Resource Worker who will ensure that the team has access to accurate, up to date information about activities and services within the community. The job descriptions for the Coach and Resource worker roles have been created and have undergone job evaluation ahead of being advertised and recruited.

12.9 An accommodation work-stream was developed to specify the accommodation arrangements for the team. Detailed requirements for the team accommodation base were gathered in consultation with the planning group. These requirements were fed in to an ongoing review of the public sector estate in the Balfron area led by the Stirling Council Assets team. This review concluded that a suitable long-term permanent base for the team is not available immediately. It was determined that the Cherry Tree office in

Balfron is the most suitable base for the team on an interim basis. This office offers a central location and adequate space for the team.

12.10 A graduate intern was appointed to work on evaluation of the project. A comprehensive evaluation strategy and plan has been developed. An "outcome focussed" approach is being taken to qualitative analysis of the project. Health Improvement Scotland has provided support from Dr Ailsa Cook, who has worked with the project team and the graduate intern to develop "outcome maps" which can form the basis of the evaluation.

12.11 A community asset survey was undertaken to in order to engage with the rural south west communities and get their views on existing community assets that matter to them. The feedback from this survey was categorised and analysed by our graduate intern.

12.12 The existing Community Reference Group-comprising local people and Third Sector services, has been involved and sighted on project developments. Work with this group has involved preventative work and supporting informal networks. We hope that this reference group will take equal place beside the planning group as key advisors to the team.

12.13 The pilot has remained involved with national learning with the Neighbourhood Care Network.

<u>How Has This Helped Partnership Performance and What Has Been The Impact on Outcomes?</u>

12.14 The success and impact of the project will be measured using an approach that focuses on outcomes. The anticipated outcomes of the project as developed by the project team are as follows:

- Peoples' needs are met by the right person, first time, every time
- People have improved health and wellbeing
- People live at home independently for as long as possible with the right level of support
- Staff are valued, motivated and empowered

12.15 The detailed evaluation strategy will be implemented throughout the first year of the pilot project in order to measure the effectiveness of the project in delivering the project outcomes. It is anticipated that the project will be an enabler for key partnership priorities such as "enabling people to live for longer at home or in homely settings within their community" and "ensure resources including staffing are focused on effective and efficient delivery of services".

<u>Summary of next steps</u>

12.16 The pilot team will begin working together from the end of June 2018. Team members will take part in weekly sessions to develop and shape the model of working for the team. The planning group will increase the frequency of

meetings to weekly and will focus on developing processes, pathways and governance arrangements. The Team Coach and Resource worker will be recruited and join the pilot team.

12.17 Engagement with the community in rural southwest Stirling will continue through the community reference group. Communication with the public will take place via various channels such as social media and local press. A meeting with key stakeholders will take place ahead of the launch of the team. The effectiveness of the project will be measured in line with our evaluation strategy

12.18 This pilot has been subject to revision of the original time scales and work is now on schedule to develop the core team.

Models of Neighbourhood Care		
Pilot team in place	June 2018	

13. Primary Care Transformation

What Did You Set Out To Do?

13.1 After a period of review and primary care consultation, the outline plan for our local approach to implementation and governance of the Primary Care Transformation Programme was approved by Clackmannanshire and Stirling IJB on 30 August 2017. The three strands of the programme being:

- Urgent Care GP Out of Hours Transformation: Implementing the recommendations of the "Report of the Independent Review of Primary Care Out of Hours Services".
- Primary Care Transformation: This strand aims to encourage GP practices to work together in clusters, taking a multi-disciplinary approach to care within practice and the community.
- Mental Health in Primary Care: The investment for mental health services aims to improve access for people with mental health needs to the most appropriate support as quickly as possible, in the most appropriate setting.

What Have You Achieved?

13.2 Since August the following progress has been made:

13.3 Urgent Care Out of Hours

Following a multidisciplinary case review of out of hours care the following aims were confirmed:

- Transform the provision of OOH primary care to a sustainable, multidisciplinary model, that provides care to the highest standard
- Shift the balance of multidisciplinary workforce so that 30% of the current OOH service will be provided by advanced nurse practitioners, Mental Health practitioners and Paramedic Practitioners within 1 year

13.4 Achievements since September 2017 include:

- We have implemented and evaluated a test of change for mental health support between 9pm and 8am: successfully introducing Mental Health nurse practitioners to the OOH service
- We have recruited 5 wte Advanced Nurse Practitioner training posts into the service
- These posts are currently progressing through a bespoke training schedule alongside general practice teams, paediatrics and other skilled ANPs and GPs.
- We have had a poster accepted for the NHS Scotland event in June

13.5 Anticipated Achievements in the next 6 months

- A staff survey is due to be sent in the next month, which will form a baseline for staff satisfaction rates
- A service design and delivery plan will be completed and shared with IJBs
- Plan to develop an improvement approach to Tests Changes to support for care homes that could potentially reduce the number of repeat requests for home visits
- Testing the role of the paramedic practitioner within the service – this has proved difficult to date because of the training time required
- We will see productive shift of service delivery to ANPs from mid July when the first 2 ANP staff members will be joining the OOH rota fully independently

Primary Care Transformation: Multidisciplinary Team Development in Clackmannanshire

13.6 In partnership with the Cluster Quality Lead and Locality Lead GP in Clackmannanshire we have focussed the core of transformational work in this locality. Initial exploration of priorities with all of the practices resulted in a clear set of aims

- To introduce primary care mental health practitioner capacity to all GP practices in Clackmannanshire, offering more than 200 new appointments per week
- To test the model of training a pharmacist in an extended set of skills so they can comprehensively manage diabetic patients within a primary care setting and free up GP capacity
- To provide alternative support model to care homes which will reduce the need for GP call outs to care homes in Clackmannanshire initially for two practices

- To introduce Home Blood Pressure Monitoring to 5 practices and 100 patients

13.7 Achievements since August 2018 include

- We have baseline measures for mental health activity in Clacks practices, identifying 10% of all appointments being for mental health alone and 18% in total including a mental health consultation.
- Recruitment of 3 Primary Care Mental Health Nurses, although this has taken 3 rounds of advertising and due to the need to support pressures from emerging 2C practices we remain one post short and are again recruiting.
- Ongoing pharmacy training and initiation of pharmacy led clinics for pain management and diabetes with 50 pharmacy clinical consultations since February.
- Implementation of nurse led support for care homes for two GP practices for two days per week with immediate positive outcomes for both care homes and GPs. GP visits to care homes have become a rarity and a proposal to scale this up to all GP practices is developed.
- A partnership with Ayrshire and Arran TEC hub has been generated, via a successful national Technology Enabled Care bid, has meant a delay to initiation of Home BP testing, however, the result will be a much simpler process for practices and a faster roll out post initial testing.

- We have also been successful in applications for other national programmes.

    - Securing £50,000 for three years from Scottish Government and £75,000 for one year from the I-HUB improvement fund to test a community support model for people with lower limb arthritis in partnership with Active Clacks as part of a wider “Best in Class” approach to lower limb arthritis and elective surgery.
    - Securing one of four partnership places in the national Practice Administration Staff Collaborative which will see Clackmannanshire and North West Stirling endeavour to meet their aim of reducing administration workflow to GPs by 50% and improving care navigation / signposting at point of contact for assistance.

13.8 Anticipated Achievements in Next Six Months

- 200 additional mental health appointments across the 7 Clacks practices
- All practices and care homes in Clackmannanshire having nurse led primary care support
- Pharmacy clinical role tested and evaluated
- Home Monitoring of Blood Pressure being the norm for diagnosis and medication titration in 5 – 10 practices in Clacks / Stirling
- Enhanced access to Joint Pain Advice and community based wellbeing supports
- Increased Practice Administration efficiency in two clusters

Mental Health in Primary Care

13.9 In addition to the Primary Care Mental Health Nurse practitioner roles in 7 GP practices in Clackmannanshire the focus of the mental health fund was to support the overarching partnership aims of:

- Provide Post Diagnostic Support to all patients diagnosed with Dementia in the first year following diagnosis. Aiming for 80% by March 2019.
- Provide person-centred, joined up support and care for all patients with Dementia.

13.10 Achievements since September 2017 include:

- Multiagency Redesign of Dementia Services scoped and proposed. Now approved by both HSCPs and NHS Forth Valley
- Linking with Health Improvement Scotland, Alzheimer Scotland and Scottish Government innovation support sources (CAN-DO) to develop a second application for innovation funding to explore alternative ways of delivering PDS
- Additional 1.5wte Link Workers have been employed to deliver PDS in Clackmannanshire and Stirling
- Redefined criteria for PDS models, ensuring a matched care approach.
- Working with ISD and collaborating with colleagues nationally around the measurement of PDS performance including standardisation of recording of PDS across the system

Summary of Next Steps

13.11 Anticipated Achievements in the next 6 months

- Agree a structure for the specialist team which will hold PDS
- Recruit Social Workers to the PDS / Dementia Team
- Develop systems of working for the new team to ensure efficient and person centred responses to patient and carer need
- Evidence of improved service to users from investment in PDS link workers and service redesign

13.12 In addition to the core work above, there are many other enabling activities ongoing, including:

- Development of resource and support model to improve post diagnostic support for Autistic Spectrum Disorders
- Advance Practice Training for nurses, District nurses and Physiotherapists
- Cluster based tests of change including the introduction of dermoscopy assessment for potential skin cancers within two GP practices
- Outcome Focussed Communication education and development
  - Developed and facilitated set of workshops with podiatry staff in Clacks
  - Facilitated set of workshops with DN staff in Clacks
  - change idea development following CREATE Signposting for Administration Staff

- Liaison with national Personal Outcomes Network to share practice
- Liaison with NES Practice Manager Education Lead to promote inclusion of signposting/ communication skills on education agenda
- Liaison with NES Psychology department to include MAP: Health Behaviour Change eLearning resource as skill development tool

13.13 Overarching all of this work is the new General Medical Services Contract and the current development of a Primary Care Implementation Plan which will inform the direction of transformation over the next three years. The Plan is the subject of a separate report to this Board.

13.14 On 23 May the Scottish Government requested an implementation plan for Mental Health Services [across all age groups and a range of settings] which is due to be submitted at the end of July 2018. The Plan relates to Action 15 of the Mental Health Strategy and the content of the request is detailed in the Chief Officer's report to this meeting.

Primary Care Transformation		
Primary Care Implementation Plan in place	Ongoing	
Mental Health Implementation Plan	July 2018	

14 High Health Gain

14.1 The focus of work within the High Health Gain work stream over the last year was our innovation work "Supporting full and independent lives through innovative technology approaches". The poster inserted below outlines this work and has been accepted for poster presentation at the NHS Scotland event in June.

14.2 This area of work is linked to the Primary Care Improvement Plan and Technology Enabled Care.

High Health Gains		
Use of new technology to support delivery of health and social care	Ongoing	

Supporting full and independent lives through innovative technology approaches

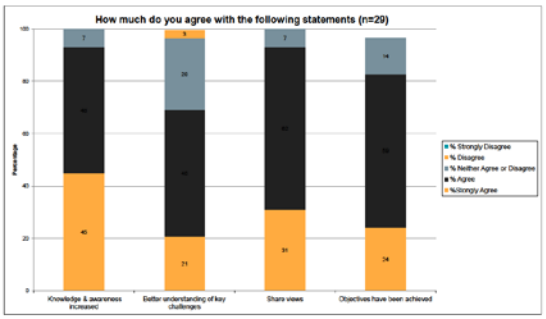
Susan Bishop (NHS Forth Valley), Ann Allison (NHS Forth Valley),
Lesley Middlemiss (Clackmannanshire & Stirling and Falkirk HSCP), Shiona Strachan (Clackmannanshire & Stirling HSCP)

Aim and objectives:
The **aim** was to maximise use of resources to increase the number of people supported to live full and independent lives.
The **objectives** were to:
Increase awareness of technology options/'innovations' already in use elsewhere and how they could be transferred into use locally.
Increase the number of people in the NHS, Health & Social Care Partnerships and Third Sector with creativity and innovation knowledge and skills.

Results and outcomes:
A search identified existing technologies that may be fit for purpose, before moving to look to additional business and community solutions.

The value of each of six technology solutions to increase independent living, self management and Self Directed Support was assessed. This was based on knowledge of the current stage of development ,or use of each of the technologies in Clackmannanshire and Stirling Health and Social Care Partnership , costs , impact and benefit.

The Health and Social Care Partnership refocused on making better use of available technologies and avoided committing resources (min 25K , max £60K) to an additional solution.

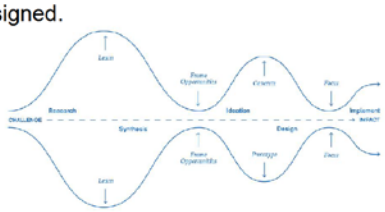


76 people were involved in this creativity and innovation approach.

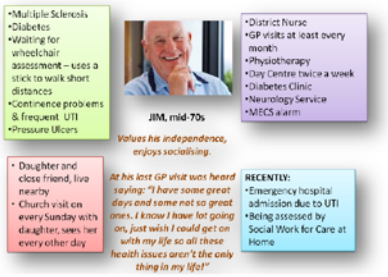
93% of the people providing feedback on the innovation workshop either agreed or strongly agreed with statements about their improved knowledge and understanding of technology/innovation, and being able to share their views of what would be beneficial to the people of Clackmannanshire.

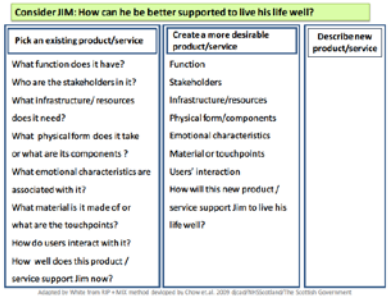
Method:
NHS Forth Valley with two Health and Social Care Partnerships, Third Sector Interface, Community Planning Partnerships, Stirling University and Scottish Care reviewed how to increase capacity for creativity and innovation.

The Nesta/IDEO Designing for Public Services[1] innovation process was adapted for use. A #Clacksinnovate session was designed.



2challenge briefs and personae were used with a Rip and Mix technique to identify concepts to be taken to the next stage. 7 concepts were generated and refined to 5.





A Technology Sharing Session reviewed 6 existing solutions for impact, reach and benefit to the organisation and for individuals. (FLORENCE home and mobile health monitoring, Just Checking and Just Roaming ,Living it Up/ALISS, CM2000's scheduling were in use. Procurement of ADL Smartcare was being considered).

Conclusions:
Increasing creativity and innovation is one way of finding solutions to the challenge of improving outcomes at lower cost. In this case a collaborative, systematic approach was applied to make best use of available resources to support people to live full and independent lives in Clackmannanshire.

References:
1. Kershaw A., Dahl, S., Roberts, I. Designing for Public Services by Nesta, IDEO and Design for Europe, 2017.

15 Enablers

15.1 The areas of activity in this section described as 'enablers' are supporting activities and are long term in nature. For the purposes of this report they do not have an attached progress grid.

16 Strategic Needs Assessment

What Did You Set Out To Do?

16.1 On 1 April 2016 Clackmannanshire & Stirling Health & Social Care Partnership published its first strategic plan to cover the period 2016-2019. The plan set out how the partnership intended to meet the current needs of the population as well as considering projected population changes. A key theme throughout was making the best of resources to deliver efficient and effective health and social care.

What Have You Achieved?

16.2 In order to support the production of the plan a strategic needs assessment was produced to provide an understanding of the health and care needs of the local population. The needs assessment was extensive and covered a wide range of topics including demographics, life circumstances, risk factors, population health and service provision. Many of the data sources will have been updated but the key messages will remain relevant given only a short period of time has passed. With that in mind this iteration of the needs assessment is designed to be a more focussed update to sit a long side the original document to support the next iteration of the strategic plan. The agreed areas of focus included gaps from the first iteration as well as refreshing the following areas: Population, Unscheduled Care, Delayed Discharges, Care at Home, Residential Care and Respite Care

16.3 In order for the Partnership to produce a detailed Strategic Plan that best meets the needs of its local population we require a clear understanding of the health and care needs of the population. The needs assessment, alongside the first iteration, aims to bring together the available data in order to describe the current pattern and level of supply of services.

16.4 Some emerging findings have recently been presented to the Strategic Planning Group and a draft to support the priority setting for the next Strategic Plan is now being worked on.

Summary of Next Steps

16.5 Needs assessment is an ongoing process and it is likely that there will be new areas of focus identified over the coming months. The next step after

completion of the needs assessment will be to update locality profiles to support the development of the localities.

17 Technology Enabled Care

What Did You Set Out To Do?

17.1 Clackmannanshire and Stirling Health and Social Care Partnership have been awarded £212,000 from the Scottish Government Technology Enabled Care Fund to support the expansion of Telecare for people living in the community. The aim of the project is to successfully support people to live full and positive lives within supportive communities.

17.2 Technology Enabled Care (TEC) can be used successfully to support people with care needs and those that care for them, to have greater choice and control over their own lives; and enable them to live well in their own homes for longer with greater independence and safety, while reducing the need for unplanned or over care.

17.3 The approach of the Clackmannanshire TEC Service MECS (Mobile Emergency Care Service) is to have a TEC first approach to all assessments, with the service evaluating well when benchmarked with similar services in Scotland.

What Have You Achieved?

17.4 To date, the project has seen a net increase across the HSCP in people accessing technology to support them with their care needs, with key achievements of:-

- Increased provision of basic Telecare community alarm units.
- Increased provision of monitoring equipment such as falls monitors, smoke and heat detection, front door contacts etc.
- Testing of digital technologies such as Doro smart phones.
- Increased use and awareness of GPS technologies to support people living with dementia to remain safe in their own homes.
- The service has worked collaboratively with Police Scotland to contribute to the development of a Missing Persons Protocol for Scotland.
- Improved referral pathways have been developed with Scottish Fire and Rescue Service to promote access to Home Safety Visits, including information sharing to support people to keep safe.
- Testing of improved referral pathways with Scottish Ambulance Service to support the care needs of uninjured fallers in the community.
- Contributed to national work in the development of core datasets for Technology Enabled Care.
- The introduction of improved home monitoring systems, working in collaboration with Just Checking. This system supports the assessment of individuals through the use of discreet monitoring in the home which provides data on service user movements, and actions, helping to identify

risks and care needs. This system has been used successfully to support the assessment of people with learning disabilities and their assessment of need over a 24 hour period, and has had very positive outcomes for a number of service users.

- A further project utilising Just Checking to support the assessment of older people accessing Reablement Services.
- These initiatives have been accelerated through accessing funds from the Scottish Government TEC Programme, but have not been wholly reliant upon this.

Summary of Next Steps?

17.5 It is expected that analogue phone lines will be replaced with digital technologies by 2025. This will have a significant impact on Telecare Services, which are currently reliant upon analogue phone lines. To address this, the Scottish Government TEC Programme and Digital Office have developed a work stream specific to the needs of Telehealthcare Services, which is using an Agile approach to identify new and innovative ways in which digital technology could support people to live well in their communities.

17.6 Small tests of change are currently being carried out with the limited number of suppliers available to us to examine how digital Telecare could function, and the service is currently testing 2 types of equipment –

- Doro Smartphones which have the functionality of any android smart phone, with the additionality of an assistance button on the back of the device as well as the possible addition of a wrist worn pendant.
- Doro Telecare unit which performs in the same way as an analogue system but has the additionality of a sim card.

17.7 Full opportunities for digital technologies will only come with what is described as “end-to-end” systems ie when the Alarm Receiving Centre operates on a superfast broadband network as well as the base equipment used by the service user. Currently, Clackmannanshire Council have a Service Level Agreement with Stirling Council’s Alarm Receiving Centre, and this service is about to go out to tender to replace their operating system with a digitally ready solution. When in place, this will open up huge opportunities to improve communication with service users via video calling, use of existing technologies in the home (eg smart TV’s, Amazon Alexa etc), and widen access via mobile phone networks.

17.8 Work is also being progressed with Primary Care to develop innovative approaches to supporting people to live well at home. This includes the introduction of Home and Mobile Health Monitoring systems such as Florence which operates via a system of text alerts to someone’s mobile device to prompt them to test their own health condition and send in readings to be analysed remotely by nursing staff. This system has been used successfully in other areas of Scotland to improve people’s independence in managing conditions such as diabetes, Chronic Obstructive Pulmonary Disease, and for

weight management programmes, and is about to be rolled out in a number of primary care practices across the HSCP.

18 Information and Directories

What Did You Set Out To Do?

18.1 Stirling Council is partnering with Frog Systems Ltd to become the first local authority in the UK to launch Frog.net. This is a cost effective solution for our digital care requirements. Frog.net is a website which directly connects people geographically via a single, UK wide platform to health and wellbeing providers, local groups and community activities, care and support services available in their immediate locality. This supports the principles of choice and independence, for individuals, by providing easy accessibility to information on resources in their own particular locality.

What Have You Achieved?

18.2 Stirling Council have worked closely with Frog Systems Ltd over the last year to shape the directory into a 'Minimum Viable Product' ready to launch across the UK.

18.3 This included facilitating consultation with Providers and service users to help review and feedback on the directory, as well as arranging a number of local and national presentations on the platform.

18.4 This culminated in the directory having a 'soft' launch with local businesses, charities, providers and services in March 2018.

How Has This Helped Partnership Performance?

18.5 The launch of Frog.net supports the principles of choice and independence by providing easy accessibility to information on resources. There is a recognised need that community assets will be increasingly required to support people with self-management and to meet some of their individual outcomes, and the new Outcome Focussed Assessment has a focus on informal support.

What Has Been The Impact of Outcomes?

18.6 Although at an early stage of business development, Frog Systems Ltd was shortlisted to the top 3 Business to Customer (B2C) companies in Scotland for Frog.net at the Scotland IS Digital Tech Awards 2018. This was in recognition of the innovation of the product and the potential impact for citizens in Scotland.

Summary of Next Steps

18.7 Stirling Council is now actively promoting the directory with local providers, charities, services and groups to help prepare stirling.frog.net for use by citizens. An official launch will take place later this Summer.

18.8 Work has been carried out within Clackmannanshire via the third sector to develop local directories of services including community activities. Further discussion is required on how this approach can be rolled out further and feed into a digital platform.

18.9 At national level NSS have begun to develop a national platform for local directories. The Partnership will engage with and support this work.

19 Housing Contribution

What did you set out to do?

19.1 The rebranded 'Housing and Social Care Group' set out to develop a distinct Action Plan for the group that would establish a framework to allow priority objectives to be delivered. This Action Plan focuses on four key areas relating to housing that will be developed going forward. These are: Governance, Homelessness, Mental Health and Older People.

What have you achieved?

19.2 *Governance* – New Group structure and terms of reference have been agreed. This is informed by the Action Plan.

19.3 *Homelessness* – Stirling Council are currently working with Forth Housing Association to develop a 'Housing First' pilot for the area for homeless clients with complex support needs. This will provide an alternative to standard temporary accommodation, and assist with meeting the aims for the Scottish Government's ambitions for repaid rehousing of homeless people.

19.4 *Mental Health* – Strong links have been developed with colleagues in Social Work to ensure a greater understanding of different client groups with mental health issues/learning disabilities etc. This closer working has helped planning for new affordable housing, to ensure that specific client needs can be incorporated into the design of homes from an early stage.

19.5 *Older People* – Stirling Council are currently looking to employ a housing-specific occupational therapist to ensure that applications for medical assessments are processed efficiently. It is hoped that introducing this distinct role will enable medical assessments to be undertaken almost immediately, as opposed to a waiting period of several weeks – meaning clients will have access to appropriate housing, adaptations and support as soon as it is required.

19.6 Work is ongoing in respect of housing with care options for the Clackmannanshire area.

How has this helped Partnership Performance?

19.7 The work of the Housing and Social Care Group is still developing, and as a result, it is too early to full assess the impact and outcomes derived from these projects. However, it is envisaged that the areas being developed will help to promote independent living across the partnership area by ensuring that all people have the necessary housing and support services available to meet their needs in perpetuity.

Summary of Next Steps

19.8 The reconvened group is due to meet on 14th June 2018, with quarterly meetings planned thereafter. The group will work to develop the existing action plan and undertake specific tasks to help achieve partnership priorities relating to housing. These include: developing the next Housing Contribution Statements (for Stirling & Clackmannanshire); exploring accommodation and support models to assist homeless clients with complex needs; improve strategic planning for future housing that is appropriate for the expanding elderly population across the partnership area; developing adaptations services; and exploring options for delivering OT services (relating to housing) to ensure that all residents across the partnership area receive a high quality service.

20 Data Sharing and Shared Assessment

What did you set out to do?

20.1 The Forth Valley Data Sharing Partnership identified priorities for 17/18;

- Delayed Discharge (Edison Replacement)
- Single Shared Assessment (SSA)
- Health and Social Care Information Sharing Portal
- File Share (ensuring that operational staff within the Partnership can work effectively in a range of locations within and between all 3 of the constituent authorities)

What have you achieved?

20.2 Edison Replacement - This new NHS FV system has been built and became operational in early 2018. Edison is no longer being used, and the new system is now reporting data formally to Information Services Division of NSS. Relevant staff across the Partnerhsip has access to the web-browser based system. This is now complete.

20.3 Single Shared Assessment - NHS staff are using the agreed SSA paperwork when referring to Social Care in Stirling Council and Clackmannanshire Council. At this point it is a paper based process and electronic developments are linked with the Information Sharing Portal. It is early days in this process with further progress expected throughout 18/19 and beyond.

20.4 Information Sharing Portal – There has been support elements put in place to take forward this project within 17/18, although progress has been delayed because all of the constituent authorities are going through core system renewals over the next couple of years.

20.5 File Share – Integrated teams and co-located staff are being developed in connection with the Health & Care Village, and Models of Neighbourhood Care both within Stirling Council areas. Systems have been tested to ensure that access is available to both NHS and Stirling Council systems in these two locations. As these projects move into operational phases the demands to ensure access will become more tangible. At present the Partnership is not looking for integrated systems, where necessary staff will use two devices to access local authority or NHS systems. This is level 4 (lowest) within the Partnership scoping document, with level 1 being fully integrated systems. At present Partnership staff now connect to guest wifi established in key buildings used by the Partnership to access host systems. This is early days and this initial workaround is available to only a small number of Integration staff using mobile devices to maintain system access across the Partnership.

How has this helped Partnership performance?

20.6 Being the only Health and Social Care Partnership comprised of two local authorities creates an extra layer of complexity within the 'Body Corporate' model. Staff remain hosted within their constituent authority and access those systems. Very few staff at present access all constituent authority systems. It is therefore fundamental to efficient and effective working that staff are able to continue to access their system whilst physically located in other organisations buildings. Without level 4 basic access the Partnership could not function for those growing members of staff who will increasingly require to use it.

Summary of next steps

20.7 It is very early days in the development of suitable technologies and information sharing processes within the Partnership. Much of the work will require additional financial resources.

21 Commissioning – Market Position and Providers

What did you set out to do?

21.1 The Market Position Statement for Clackmannanshire and Stirling (2017) was presented and approved by the IJB in June 2017. The Market Position Statement was revised in November 2017 and was published in March 2018. It sets out key pressures, summarises current supply and expected demand and provides key messages about future priorities. Included in the Market Position Statement is the Market Facilitation Statement which sets out how the partnership will work with providers to deliver high quality, person-centred

and cost effective services and supports. There was full consultation on the Market Position Statement.

21.2 The key messages set out in our Market Position Statement demonstrate a holistic approach, with a balance between prompting health and wellbeing, early intervention and prevention and more intensive care and support. We have set out the key messages for providers and areas for anticipated future developments in service design and delivery. This is evidenced by the work that has taken place with Care at Home Providers, where a shared approach to supporting reduced delayed discharges and unplanned admissions has been successful to both the indicators, the quality of the care and to building relationships

What have you achieved?

21.3 The Market Position Statement was fully consulted on and is a clear point of reference for any current and future providers who may want to enter the market.

21.4 We are holding regular Provider Forums for both Older People and Learning Disability and Mental Health, as well as one to one meetings with our Providers. The discussions within the Forums are around sharing ideas and practice on how we can work collaboratively on provision of support which meets the principles of choice and control, individual outcomes, innovation and creativity and supporting people to access training, volunteer and employment opportunities.

21.5 We are working on revision of the Service Specification part of the Contract and our Contract Monitoring Tool to ensure that we are monitoring quality based on the vision, objectives and principles of the HSCP.

21.6 We have written the Commissioning Strategies for Learning Disability and Mental Health and are supporting the Implementation of these. We are hosting some Open Space events over the next three months to ask Stakeholders what they would like services, across the HSCP, to look like to support Mental Health and Wellbeing. Service user engagement is now an integral part of everything we do.

How Has This Helped Partnership Performance?

21.7 Commissioned services are critical to ensuring that we meet the shared vision of the HSCP, national and local indicators. Provider monitoring has been introduced and gives clarity around performance and quality. This gives the opportunity for providers to evidence good practice and positive outcomes for citizens. We hope to roll out a formal Contract Management tool that will provide management information on how services are performing and delivering on customer need. What has been the impact, outcomes?

21.8 We have received feedback from Providers that they feel more informed about the expectations from the HSCP, they are working more collaboratively and

are receiving information on areas like technology enabled care, social enterprises and independent travel schemes.

Summary of Next Steps

21.9 We would like to plan for the Market Position Statement to be reviewed regularly, to continue the Provider Forums, however to support these to be more Provider lead, to develop robust Engagement strategies to inform our Commissioning Strategies.

22 Workforce

What Did You Set Out To Do?

22.1 Our workforce continues to plays a key and valued role in the delivery of our priorities and our aims are to ensure the availability of a flexible, responsive Partnership workforce with the right skills, in the right place and at the right time, confident and competent, to help ensure that our service users get the right level of support early enough to deliver on our strategic outcomes.

What Have You Achieved?

22.2 We have continued to deliver on our *'Caring Together'*, our Integrated Workforce Plan (2016/19) focusing on the following key areas:

- Workforce Information, Demographics and Role Development
- Organisational Design and Processes
- Workforce Engagement and Support
- Leadership and Management Development
- Workforce Learning, Training and Development

22.3 We have continued to collaborate and engage staff using the Communication and Engagement Protocol for staff integration – delivering effective communication and a Partnership Participation and Engagement Strategy and helping us make sure any initiatives are aligned to our strategic priorities.

22.4 As the Partnership deliverables have moved into implementation phases, organisational development plans, service designs and transformations have started to be co-produced with staff, Joint Staff Forum representatives and Partnership agencies including those for the Bellfield Centre as part of the Stirling Health and Care Village for example, all of which have been supported by a number of staff and stakeholder events.

22.5 The promotion of working in integrated ways has also been supported by the introduction of quarterly "Big Team Meetings" for health and social care staff which have seen over 150 staff from health and social care attending a number of networking involving and engaging staff in topics including National Health and Care Standards, Neighbourhood Models of Care, Stirling Health

and Care Village, Technology Enabled Care, Mental Health Services and Carer's (Scotland) Act 2016 to name a few.

22.6 In November 2017, we carried out a survey of staff within the social care services using an adapted form of iMatter (survey that NHS currently uses) The response to the survey has been encouraging with most responses indicating a positive level of commitment from the workforce and staff and managers have since worked together through Big Team Meetings to identify improvements to be delivered in 2018/2019.

22.7 Some of the many other things we have achieved this year include:

- Co-produced the Workforce Model for the Bellfield Centre that blends health, social care and 3rd sector workforces (Workforce Information, Demographics and Role Development).

- Sought opportunities to share and combine learning and development across the Partnership to deliver on all strategic outcomes including (workforce learning, training and development):

    - Good (personal outcomes) Conversations training attended by health and social care staff and supported the training of four additional Good Conversations trainers/facilitators across the Partnership who with a fifth has formed Forth Valley Personal Outcome Network, to support a robust and sustainable approach to learning/training in outcome focused practice
    - Playlists for Life train the trainer programme shared with Local Authority and independent sector care homes
    - Parkinson's training shared with staff and carers of people with Parkinson's
    - Partnership delivery of Anticipatory Care Planning learning events to enhance integrated ways of working in terms of future planning for people
    - Partnership delivery of Carer's Act learning and consultation events with health and social care staff

- Worked with SSSC to:

    - Start to engage and involve staff in the Neighbourhood Care Team
    - Introduce 23 Digital Things; learning to support staff with digital capabilities
    - Contribute to the review of Dementia Ambassador learning and support as part of a national review group
    - Become an Open Badge Issuer as a Partnership that means we will be able to create digital recognition for learning or recognise skills, knowledge, behaviours and competence across the Partnership

- Continued to develop the Promoting Excellence in Dementia Care programme, involving Dementia Services Development Centre as a partner in

delivery and continuing to increase the number of Dementia Ambassadors and Champions across the Partnership

- Continued to work with FV Regional College in a number of ways including supporting young people undertaking Foundation Apprenticeship placements in our health and social care settings

Summary of Next Steps

22.8 2018/2019 will see the next iteration of the Integrated Workforce Plan that will make clear our aspirations for the next stages of our journey in blending health, care and third sector workforces to deliver on our outcomes and support sustainable workforce solutions, including our aspirations in relation to workforce digital capabilities and confidence to enhance our ability to deliver on improving and increasing our support in relation to technology enabled care.

22.9 As well as supporting and developing the Workforce through the implementation OD plans, 2018/2019 will also see us:

- Work with staff and stakeholders, including NES, SSSC and Forth Valley College, to review and design integrated health and care worker roles for the future (Workforce Information, Demographics and Role Development).

- Strengthen our approach to supporting the digital capabilities of the workforce to meet the needs of supporting 21st Century health and care services (Workforce Information, Demographics and Role Development)

- Implement iMatters across the Health and Social Care workforce in the Partnership to support continuous learning and improvement and to enhance staff engagement

- Continue to deliver and learn from quarterly Big Team Meeting events with staff leading on the themes and involved in the delivery of the events, working with partners including i-Hub, SSSC and NES to do so. (Staff Engagement and Support)

- Review and implementation of leadership development for key Partnership Managers to continue to strengthen our shared leadership approaches across the Partnership (Leadership and Management)

- Continuing to seek every opportunity to join and combine learning and development across the Partnership to deliver on all strategic outcomes including (workforce learning, training and development):

  - Continuing to build on the Promoting Excellence in dementia care delivery programme; joining learning across health and third sector workforces starting with the pilot of a Masterclass study day in July 2018 for 40 skilled level practitioners.

- Developing the FV Personal Outcome Network to increase and enhance integrated learning resources for outcome focused practice and conversations to put people and carers at the heart of their care.

- Work with SSSC to develop and launch a suite of Open Badges for the Partnership, to include induction into the Bellfield Centre.

- Continue to support staff involvement in transformation and service design in relation to the key priorities including supporting agreed ways of working (policies and procedures) including supervision. (Organisational Design and Processes)

23 Financial Plan

23.1 The Integration Joint Board approved the financial plan for 2017/18 at its meeting on 29 March 2017 which highlighted a level of financial risk which triggered the requirement to develop a budget recovery plan for the Boards approval. The Integration Joint Board also received a financial report at each of its meetings during the year, each of which included financial projections taking account of the projected impact of corrective actions taken. It was not possible to fully recover the financial position in year and a risk sharing agreement was agreed between the Integration Joint Board and the constituent authorities for 2017/18 Financial Year only.

24 Outcomes – Framework and Improvement Objectives

What Did You Set Out To Do?

24.1 Over the last year the Partnership has statutory deadlines to meet in relation to reporting progress against core integration indicators and national outcomes, as well as formal reporting of agreed targets and improvement objectives on Unscheduled Care.

What Have You Achieved?

24.2 The Partnership published the first Annual Performance Report in July 2017 (within very tight statutory timescales), and is currently working on the second annual report. Performance reports are tied to local outcomes and improvement objectives, and are a standing item on every IJB. Further layers of operational performance reporting have been developed to inform Joint Management Team and Social Care services. Improvement objectives around Unscheduled Care are a collaborative effort across Health and Social Care. The Partnership is a member of the Programme Board which operates across Forth Valley. A range of ‘tests of change’ have been put in place, and data reporting is provided by the Partnership.

How Has This Helped Partnership Performance?

24.3 Performance reporting is developing into a multi-layered systematic process with exceptions escalating appropriately. This allows services to be informed of progress or otherwise, and holds them accountable. It is early days in integrating performance data but as more services are delegated to the Partnership this will develop.

Summary of Next Steps

24.4 Further work is required around alignment of metric methodologies across health and social care, along with an improvement in data validation. This will progress along with service redesign over the coming year and beyond. Work around the use of Pentana to provide real time information to managers will progress as indicators are finalised and embedded within performance reporting.

25 Conclusions

25.1 The Partnership is involved in an ambitious programme of change. As described throughout this report, significant work has been undertaken over the last year, across a varied range of transforming care change activates and in line with the Strategic Plan priorities. This work is being delivered in a challenging resource environment.

25.2 Work will continue over the coming months, when it is anticipated that a number of these priority areas will become fully embedded.

25.3 As some of these improvement areas become embedded, attention will turn to new areas of focus. These areas will form the basis of the forthcoming revised Strategic Plan.

26 Resource Implications

26.1 During periods of significant redesign, there is a demand on staff capacity. This is the case for each of the work streams.

26.2 Associated financial implications vary markedly across the key work stream areas, with the delivery of Stirling Health and Care Village in particular being a substantial investment.

26.3 Finances are monitored by each work stream, and are reported as part of the overall Partnership financial planning and monitoring arrangements.

27 Impact on Strategic Plan Priorities and Outcomes

27.1 This report and associated recommendations, relates to the following Clackmannanshire & Stirling Health and Social Care Partnership local outcomes and Strategic Plan priorities (please select as appropriate):

Fit with Local Outcomes	
Self Management	☒
Community Focussed Supports	☒
Safety	☐
Decision Making	☒
Experience	☐

Fit with Our Priorities 'we will...'	
Further develop systems to enable front line staff to access and share information	☐
Support more co-location of staff from across professions and organisations	☒
Develop single care pathways	☒
Further develop anticipatory and planned care services	☒
Provide more single points of entry to services	☒
Deliver the Stirling Care Village	☒
Develop seven-day access to appropriate services	☒
Take further steps to reduce the number of unplanned admissions to hospital and acute services	☒

28 Legal & Risk Implications

28.1 Consideration to legal implications, and risk assessments as appropriate are undertaken as part of the activity of each work stream

29 Consultation

29.1 Consultation as appropriate in relation to staff, service users and carers, Trade Unions and Staff Representatives and Community representatives, is undertaken as part of the activity of each work stream.

30 Equality and Human Rights Impact Assessment

30.1 The contents of this report do not require an EQIA because each of the component transformational change work streams will have undertaken.

31 Data Protection Impact Assessment

31.1 The contents of this report do not require a DPIA.

Clackmannanshire & Stirling
Integration Joint Board

13 June 2018

This report relates to
Item 7.2 on the agenda

Primary Care Improvement Plan – Delivering the New 2018 General Medical Services Contract

Paper presented by
Stuart Cumming, Associate Medical Director

For Approval

Approved for Submission by	Stuart Cumming, Associate Medical Director
Author	Janette Fraser, Head of Planning
Date:	13 June 2018
List of Background Papers / Appendices:	
Background Papers: • New GMS Contract 2018 • Memorandum of Understanding between Scottish Government, British Medical Association, Integration Authorities and NHS Boards **Appendices:** Appendix 1 – Primary Care Transformation End of Year Report 2017/18 Appendix 2 - Scottish Government – Primary Care Improvement Fund: Annual Funding Letter 23 May 2018	

Title/Subject: **Primary Care Improvement Plan - Delivering the New 2018 General Medical Services Contract**

Meeting: **Clackmannanshire & Stirling Integration Joint Board**

Date: **13 June 2018**

Submitted By: **Janette Fraser**

Action: **For Approval**

1. Introduction

The purpose of this paper is to update the Integration Joint Board on progress with developing the Forth Valley Primary Care Improvement Plan for delivering the new 2018 General Medical Services Contract and sets out the principles and priorities which will be included in the draft plan.

2. Recommendations

The Integration Joint Board is asked to:

2.1 Note the progress with developing the Forth Valley Primary Care Improvement Plan. The draft plan requires to be submitted to the Scottish Government by 1July 2018.

2.2 The Primary Care Improvement fund element of the wider primary care fund is to be used by Integration Authorities to commission primary care services and allocated on an NRAC basis through NHS Boards to Integration Authorities. NRAC is the NHS national funding formula.

2.3 Delegate authority for signing off the Draft Primary Care Improvement Plan for submission to Scottish Government, to the Chief Officer and the NHS Board Chief Executive and reported to the September IJB.

2.4 Approve a Forth Valley wide approach to develop a single plan. The Clackmannanshire and Stirling NRAC allocation should be clearly set out in the plan.

3. Background

3.1. This paper outlines the requirement for all Integration Authorities to produce a Primary Care Improvement Plan in response to new General Medical Services Contract, which was introduced in January 2018 and progress with preparing the Primary Care Improvement Plan for Forth Valley.

4. New General Medical Services Contract for Scotland 2018

4.1. The new 2018 General Medical Services Contract for Scotland describes a number of benefits for patients to help people have access to the right person, at the right place, at the right time in line with the Scottish Government Primary Care Vision and Outcomes. In particular this will be achieved through:

- Maintaining and improving access.
- Introducing a wide range of health and social care professional to support the Expert Generalist (GP).
- Enabling more time with the GP for patients when it is really needed.
- Providing more information and support for patients.

4.2. The benefits of the proposals in the new contract for the profession are:

- A refocusing of the GP role and improve on being a GP.
- Sustainable funding and practice income, including new minimum earning expectation from April 2019.
- Manageable workload – additional Primary Care staff to work alongside and support GPs and practice staff to reduce GP workload and improve patient care.
- Improving infrastructure and reducing risk, including management/ ownership of premises, shared responsibility as data controller for information sharing and responsibilities for new staff.
- Improve recruitment and retention.

4.3. As an Expert Medical Generalist, the GP will focus on:

- Undifferentiated presentations.
- Complex care.
- Local and whole system quality improvement.
- Local clinical leadership for the delivery of general medical services under GMS contracts.

4.4. Expert Medical Generalists will strive to ensure robust interface arrangements, connection to and coherence with other parts of the wider primary care team e.g. nurses, pharmacists and physiotherapists, the health and social care community based services and with acute services when required. They will be supported by a multi-disciplinary team and the contribution of clinical and non-clinical staff in medicine, allied health professional, links workers, practice management, administration and others will be maximised.

4.5. The Memorandum of Understanding between the Scottish Government, the British Medical Association, Integration Authorities and NHS Boards builds on these arrangements and represents a landmark statement of intent. It recognises the statutory role of the Integration Authorities in commissioning primary care services and service redesign and of NHS Boards in service delivery, employers and partners to General Medical Service contracts.

4.6. The development of primary care service redesign should be in the context of delivery of the new GMS contract and should accord with seven key principles:

- Safe
- Person Centred
- Equitable
- Outcome Focussed
- Effective
- Sustainable
- Affordability and Value for Money.

4.7. The Memorandum of Understanding identified key priorities which should be included in the health and social care Primary Care Improvement Plans:

- Vaccination Transformation Programme
- Pharmacotherapy Services
- Community Treatment and Care Services
- Urgent Care (advanced practitioners)
- Additional Professional Roles
- Community Link Worker

5. Development of a Primary Care Improvement Plan

5.1. The Primary Care Improvement Plan Working Group has been working to produce a single Primary Care Improvement Plan for Forth Valley. The Improvement Plan will identify how additional funds are implemented in line with the Contract Framework and will outline how services will be introduced until March 2021, to establish an effective multi-disciplinary team model at Practice and Cluster level.

5.2. A Primary Care Improvement Plan Working Group has been established with representation as below:

- NHS Forth Valley Chief Executive
- Chief Officers, Clackmannanshire & Stirling and Falkirk Health and Social Care Partnerships
- Medical Director
- Associate Medical Director, Primary Care
- 7 GP representatives
- Senior representatives from Planning, HR, Finance, Estates & Facilities, Community Nursing, Pharmacy, AHPs and General Management

5.3. The Plan is being developed in collaboration with local GPs and others, including the GP Sub-Committee, Local Medical Committee and Area Partnership Forum. A GP Information Evening on the new GMS Contract, including a workshop on the Improvement Plan took place on 9 May and a

CREATE session explored the Improvement Plan options in greater depth on 23 May.

5.4. The Board are asked to agree Forth Valley approach to develop a single plan. There should be consideration given to ensuring the Falkirk NRAC allocation is clearly set out in the plan.

5.5. Whilst it is expected that Integration Authorities will prepare a 3 year Primary Care Improvement Plan, for the period 2018 to 2021, in reality it is likely that implementing the new models of care will not be fully in place by 2021 and will continue to be implemented beyond this date. The main reasons for this are the scale and complexity of the changes required, the availability of additional people to take on the new roles and the time it will take to develop the right skills and competencies in the existing and additional workforce.

6. Primary Care Sustainability

6.1. The development of the Primary Care Improvement Plan in Forth Valley requires to be viewed in the context of continuing challenges with sustaining GP practices in the area. This issue is recognised in the NHS Forth Valley Board Corporate Risk Register and more specific practice issues are reflected in the Primary Care Risk Register.

6.2. The move towards a new GMS Contract is set against a background of ongoing sustainability issues recognising that less doctors are choosing to become GPs and over 50% of our current GPs in Forth Valley are over 50 with 23-25% aiming to retire or significantly reduce their clinical commitment in the next 3-5 years.

6.3. While Forth Valley issues in relation to GP recruitment and retention are mirrored nationally, the scale and potential impact of the local problem is recognised currently to be very significant. It is estimated nationally that 25% of GP practices are experiencing recruitment difficulties. These challenges also bring additional risks of destabilising neighbouring practices.

6.4. Kersiebank, Bannockburn, Slamannan and Hallpark practices are currently managed by the NHS Board and operating through a multi-professional primary work model. These Practices continue to carry vacancies despite a continuous rolling recruitment programme.

6.5. Emerging sustainability issues are also being reported in respect of a number of practices. An option appraisal process to manage individual practice circumstances is established and is led by the Associate Medical Director of Primary Care.

6.6. All Forth Valley practices are required to complete the Primary Care Sustainability Framework Tool as part of the Whole System Working Project for 2018/19 to help identify sustainability challenges and needs for support at an early stage.

7. Transformation Programme

7.1. The Primary Care Transformation programme was initiated to test new ways of working in advance of the new General Medical Services Contract. As indicated in this paper, implementation of this contract will see a significant change in the model of general practice in Scotland. This will enable GPs to be expert generalists, develop a multidisciplinary primary care team approach and reduce non essential GP workload.

7.2. The attached end of year report 2017-18 (Appendix 1) provides an overview of the Primary Care Transformation Programme in the Falkirk and Clackmannanshire and Stirling Partnerships which is focused on 3 areas:

- Urgent GP Out of hours transformation
- Primary care transformation – working collaboratively in clusters of GP practices
- Mental Health in Primary Care.

8. Primary Care Improvement Plan Priorities

8.1. Six priority areas were identified in the Memorandum of Understanding for improvement, and these will form the basis of the 3 year plan for Forth Valley.

8.2. <u>Vaccination Transformation Programme</u>

The Vaccination Transformation Programme was announced in March 2017 to review and transform vaccine delivery in light of the increasing complexity of vaccination programmes in recent years, and to reflect the changing roles of those, principally GPs, tasked historically with delivering vaccinations.

8.3. In the period to 2021 change will be delivered in a phased way as part of the Primary Care Improvement Plan to meet a number of nationally determined outcomes including shifting work to other appropriate professionals and away from GPs. This has already happened in Forth Valley for school-aged childhood immunisation and vaccinations. It is expected that this change will be managed, ensuring a safe and sustainable model and delivering the highest levels of immunisation and vaccination uptake. There may be geographical or other limitations to the extent of any service redesign.

8.4. In Forth Valley the following phased implementation is proposed:

2018/19 - Travel vaccination moves from GP practice to NHS service
Pilot pre-school vaccination programme.

2019/20 - Implement NHS managed pre-school vaccination programme.

2020/21 - Implement NHS managed vaccination programme for older adults and vulnerable groups.

8.5. Other Priorities

It is proposed to implement the other 5 improvement priorities on a phased basis, with each GP cluster gaining at least 1 new NHS provided service in 2018/19. Each priority will then be rolled out to the other clusters, over the 3 year period of the Improvement Plan.

8.6. This phased approach recognises that there will be the need to recruit additional staff and to train and develop people to take on new roles, over this 3 year period and beyond. The approach also recognises the requirement to ensure that the new models which are being introduced, deliver the desired outcomes.

8.7. The priority areas outlined below will require new and innovative ways of working and therefore alongside implementation of these priorities will be significant work to test the models and adapt these to local circumstances. Further scoping will be required during 2018/19 to ensure that these are effective and efficient and offer best value.

8.8. Implementation of the Plan will also take into consideration any local requirements or developments, in shaping how the priorities will be implemented in each Practice and Cluster. For example, development of the new services needs to acknowledge and complement the wider work taking place in the Partnerships such as “place based care” and further integration of health and social care teams.

8.9. Pharmacotherapy Services

Pharmacotherapy services are in three tiers, divided into core and additional activities, to be implemented in a phased approach.

8.10. By 2021, phase one will include activities at a general level of pharmacy practice including acute and repeat prescribing and medication management activities and will be a priority for delivery in the first stages of the Primary Care Improvement Plan. This is to be followed by phases two (advanced) and phase three (specialist) which are additional services and describe a progressively advanced specialist clinical pharmacist role. However in order to ensure successful recruitment and retention of staff, roles will require to include a balance of activities, between providing the most appropriate service model to support practices and making roles suitably attractive.

8.11. Community Care and Treatment

These services include, but are not limited to, basic disease data collection and biometrics (such as blood pressure), chronic disease monitoring, the management of minor injuries and dressings, phlebotomy, ear syringing, suture removal, and some types of minor surgery as locally determined as being appropriate. Phlebotomy will be delivered as a priority in the first stage of the Primary Care Improvement Plan.

8.12. This change needs to be managed to ensure, by 2021, a safe and sustainable service delivery model, based on appropriate local service design.

8.13. Urgent Care (Advanced Practitioners)

These services provide support for urgent unscheduled care within primary care, such as providing advance practitioner resources e.g. nurse or paramedic for GP clusters and practices as first response for home visits, and responding to urgent call outs for patients, working with practices to provide appropriate care to patients, allowing GPs to better manage and free up their time.

8.14. By 2021, it is expected that there will be a sustainable advance practitioner provision in both Partnership areas, based on appropriate local service design. These practitioners will be available to assess and treat urgent or unscheduled care presentations and home visits within an agreed local model or system of care.

8.15. Additional Professional Roles

Additional professional roles will provide services for groups of patients with specific needs that can be delivered by other professionals as first point of contact in the practice and/or community setting (as part of the wider MDT). For example, but not limited to:

- Musculoskeletal focussed physiotherapy services.
- Community clinical mental health professionals (e.g. nurses, occupational therapists) based in general practice.

8.16. By 2021 specialist professionals will work within the local MDT to see patients at the first point of contact, as well as assessing, diagnosing and delivering treatment, as agreed with GPs and within an agreed model or system of care. Service configuration may vary dependent upon local geography, demographics and demand.

8.17. Community Link Worker

Community Link Worker (CLW) is a generalist practitioner based in or aligned to a GP practice or Cluster who works directly with patients to help them navigate and engage with wider services, often serving a socio-economically deprived community or assisting patients who need support because of (for example) the complexity of their conditions or rurality. As part of the Primary Care Improvement Plan, Health and Social Care Partnerships are expected to develop CLW roles in line with the Scottish Government's manifesto commitment to deliver 250 CLWs over the life of the Parliament. The roles of the CLWs will be consistent with assessed local need and priorities and function as part of the local models/systems of care and support.

9. Resources

9.1. The funding available to the Partnerships to implement the Primary Care Improvement Plan in the Forth Valley area has just been announced by the Scottish Government (23 May 2018). This is attached at Appendix 2 for information.

9.2. The Primary Care Improvement fund element of the wider primary care fund is to be used by Integration Authorities to commission primary care services and allocated on an NRAC basis through NHS Boards to Integration Authorities. NRAC is the NHS national funding formula.

9.3 The overall figure for Forth Valley in 2018/19 is £2,479,354. However this amount includes funding for services already in place, as per previous Scottish Government directions and therefore the actual amount available to Forth Valley for investment in Primary Care Improvement in 2018/19 is around £1,800,000. This amount will **not** be sufficient to fund all of the improvements identified against the 6 priority areas for 2018/19.

9.4 An assessment of the improvements identified for each of the priority areas for 2018/19 will be made against the available funding and any gaps will be identified and highlighted in the draft plan and will be reported to the IJB.

10. Infrastructure, Enablers and Workforce

10.1. The Primary Care Improvement Plan will also consider the impact of the new GMS contract on the infrastructure, including premises, enabling factors and workforce.

10.2. The National Code of Practice for GP Premises sets out how the Scottish government will support a shift, over 25 years, to a new model for GP premises in which GPs will no longer be expected to provide their own premises. The measures outlined in the Code represent a significant transfer in risk of owning premises away from individual GPs to the Scottish Government. Therefore, premises and location of the workforce are an important component on the 3 year Improvement Plan for Forth Valley.

10.3. A detailed review of current Primary Care premises will be undertaken, once further direction is received from Scottish Government, in order to identify the current condition and use, future suitability for use and any changes required to create positive environments for patients and staff (investment, vacation etc.).

10.4. An understanding of other suitable community based premises is also required in order make best use of facilities, for example to establish locality/ cluster treatment hubs and resource centres. Opportunities to use the premises of partner organisations should be considered.

10.5. The National Health and Social Care Workforce Plan Part 3 – Improving Workforce Planning for Primary Care in Scotland was published in April 2018. This Plan sets out recommendations and the next steps that will improve primary care workforce planning in Scotland. These complement the recommendations in parts one and two and, taken together, will form the basis of the integrated workforce plan in 2018. The recommendations set out how the expansion and up-skilling of the primary care workforce will be enabled, the national facilitators to support this, and how this will complement local workforce planning.

10.6. An assessment of the current Primary Care workforce in Forth Valley is underway and will inform the workforce plan which will form part of the Primary Care Improvement Plan. Areas of development already underway include a review of recruitment with the aim of making Forth Valley an attractive place to work in and early recruitment to key posts.

10.7. The availability of additional suitably skilled and trained staff to recruit is a significant risk factor in implementing the Primary Care Improvement Plan in Forth Valley. All Health systems in Scotland will also be seeking to expand their multi-disciplinary workforce to support Primary Care services at the same time, and therefore the ability to recruit staff will be a major concern.

11. Conclusions

This report provides an overview of the New GMS Contract and specifically work in progress to prepare a Primary Care Improvement Plan for the Forth Valley area. The draft Primary Care Improvement Plan will be finalised in June and submitted in draft form to the Scottish Government in July.

12. Resource Implications

Over the period of implementation (2018-2021), the Scottish Government has advised that £250M of new funds will be invested to support General Practice. In 2018/19 it is indicated that £110M will be allocated nationally to support Primary Care Improvement in line with the Memorandum of Understanding. Clarification of the funding available to Partnerships is expected from Scottish Government imminently, however it is not expected that the level of funding allocated will be sufficient to meet all of the local improvement priorities this year. An assessment of the improvement priorities for 2018/19 against the available funding of around £1,800,000 for Forth Valley will be made and any gaps will be identified.

13. Impact on Strategic Plan Priorities and Outcomes

13.1 This report and associated recommendations, relates to the following Clackmannanshire & Stirling Health and Social Care Partnership local outcomes and Strategic Plan priorities:

Fit with Local Outcomes	
Self Management	☒
Community Focussed Supports	☒
Safety	☒
Decision Making	☒
Experience	☐

Fit with Our Priorities 'we will...'	
Further develop systems to enable front line staff to access and share information	☒
Support more co-location of staff from across professions and organisations	☒
Develop single care pathways	☒
Further develop anticipatory and planned care services	☒
Provide more single points of entry to services	☐
Deliver the Stirling Care Village	☐
Develop seven-day access to appropriate services	☐
Take further steps to reduce the number of unplanned admissions to hospital and acute services	☒

14. Legal & Risk Implications

As noted in sections above.

15. Consultation

Consultation and engagement with GPs has included an Information Evening, CREATE session and formal meetings. This will continue as the development and implementation of the Plan progresses.

16. Equality and Human Rights Impact Assessment

16.1 The contents of this report do not require an EQIA because the Primary Care Improvement Plan puts in place actions to deliver the nationally agreed new General Medical Services Contract.

17. Data Protection Impact Assessment

17.1 The contents of this report do not require a DPIA.

18. Appendices

Appendix 1 – Primary Care Transformation End of Year Report 2017/18
Appendix 2 - Scottish Government – Primary Care Improvement Fund: Annual Funding Letter 23 May 2018

APPENDIX 1

Primary Care Transformation Group
May 2018

Primary Care Transformation
End Of Year Update

Lesley Middlemiss, Programme Manager Primary Care Transformation

Author	Lesley Middlemiss
Date:	15 May 2018
List of Background Papers / Appendices:	

Title/Subject: **Primary Care Transformation**

Date: **24 May 2018**

Submitted By: **Lesley Middlemiss, Programme Manager Primary Care Transformation Fund**

Action:

1. Introduction

1.1. The attached paper gives an overview of the progress made through the primary care transformation fund since the programme was approved by both Integration Joint Boards in august 2018.

2. Executive Summary

2.1. There has been much progress within the three core work streams of the primary care transformation programme since the programme was approved at IJB in August 201. The three work streams consist of Urgent GP Out of Hours, Primary Care Sustainability and mental health in primary care. This paper outlines the highlights from each work stream and anticipated achievements for the next six months.

3. Recommendations

The Primary Care Transformation Group is asked to:

3.1. Note the progress of the Primary Care Transformation Fund.

3.2. Note that the future transformation work will be driven by a new Primary Care Improvement Plan which is currently under development and will support the implementation of the General Medical Services Contract

4. Background

The Primary Care Transformation programme was initiated to test new ways of working in advance of the new General Medical Services Contract, which has now been agreed. Implementation of this contract will see a significant change in the model of general practice in Scotland. This will enable GPs to be expert generalists, develop a multidisciplinary primary care team approach and reduce non essential GP workload.

5. Main Body Of The Report

5.1 After a period of review and primary care consultation, the outline plan for our local approach to implementation and governance of the Primary Care Transformation Programme was approved by both Falkirk and Clackmannanshire and Stirling IJBs in August 2017. The three strands of the programme being:

- Urgent Care GP Out of Hours Transformation: Implementing the recommendations of the "Report of the Independent Review of Primary Care Out of Hours Services".
- Primary Care Transformation: This strand aims to encourage GP practices to work together in clusters, taking a multi-disciplinary approach to care within practice and the community.
- Mental Health in Primary Care: The investment for mental health services aims to improve access for people with mental health needs to the most appropriate support as quickly as possible, in the most appropriate setting.

Since August the following progress has been made:

5.2. <u>Urgent Care Out of Hours</u>

Following a multidisciplinary case review of out of hours care the following aims were confirmed:

- Transform the provision of OOH primary care to a sustainable, multidisciplinary model, that provides care to the highest standard.
- Shift the balance of multidisciplinary workforce so that 30% of the current OOH service will be provided by advanced nurse practitioners, Mental Health practitioners and Paramedic Practitioners within 1 year.

Achievements since September 2017 include:

- We have implemented and evaluated a test of change for mental health support between 9pm and 8am: successfully introducing Mental Health nurse practitioners to the OOH service.
- We have recruited 5 wte Advanced Nurse Practitioner training posts into the service.
- These posts are currently progressing through a bespoke training schedule alongside general practice teams, paediatrics and other skilled ANPs and GPs.
- We have had a poster accepted for the NHS Scotland event in June.

Anticipated Achievements in the next 6 months:

- A staff survey is due to be sent in the next month, which will form a baseline for staff satisfaction rates**.**
- A service design and delivery plan will be completed and shared with IJBs.

- Plan to develop an improvement approach to Tests Changes to support for care homes that could potentially reduce the number of repeat requests for home visits.
- Testing the role of the paramedic practitioner within the service – this has proved difficult to date because of the training time required.
- We will see productive shift of service delivery to ANPs from mid July when the first 2 ANP staff members will be joining the OOH rota fully independently .

5.3. Primary Care Transformation: Multidisciplinary Team Development

In partnership with the Cluster Quality Lead and Locality Lead GP in Clackmannanshire and West Falkirk Clusters we have focussed the core of transformational work in this locality. Initial exploration of priorities with all of the practices resulted in a clear set of aims:-

- To introduce primary care mental health practitioner capacity to 7 GP practices in, offering more than 400 new appointments per week.
- To test the model of training a pharmacist in an extended set of skills so they can comprehensively manage diabetic patients within a primary care setting and free up GP capacity.
- To provide alternative support model to care homes which will reduce the need for GP call outs to care homes in Clackmannanshire initially for two practices.
- To introduce Home Blood Pressure Monitoring to 5 practices and 100 patients.

Achievements since August 2018 include:

- We have baseline measures for mental health activity in Clacks and Denny/Bonnybridge practices, identifying 10% of all appointments being for mental health alone and 18% in total including a mental health consultation.
- Recruitment of 5 of 7 Primary Care Mental Health Nurses, although this has taken 3 rounds of advertising, late withdrawal of 2 people from an initial recruitment of 7 and one post prioritised to support pressures from emerging 2C practices. We remain 3 post short and are again recruiting although recruiting to temporary posts remains challenging.
- Ongoing pharmacy training and initiation of pharmacy led clinics for pain management and diabetes with 50 pharmacy clinical consultations since February.
- Implementation of nurse led support for care homes for two GP practices for two days per week with immediate positive outcomes for both care homes and GPs. GP visits to care homes have become a rarity and a proposal to scale this up to all GP practices is developed.
- A partnership with Ayrshire and Arran TEC hub has been generated, via a successful national Technology Enabled Care bid, has meant a delay to initiation of Home BP testing, however, the result will be a much simpler process for practices and a faster roll out post initial testing.

- We have also been successful in applications for other national programmes.
    - Securing £50,000 for three years from Scottish Government and £75,000 for one year from the I-HUB improvement fund to test a community support model for people with lower limb arthritis in partnership with Active Clacks as part of a wider “Best in Class” approach to lower limb arthritis across Forth Valley and elective surgery.
    - Securing one of four partnership places in the national Practice Administration Staff Collaborative which will see Clackmannanshire, Polmont and the Braes and North West Stirling endeavour to meet their aim of reducing administration workflow to GPs by 50% and improving care navigation / signposting at point of contact for assistance.

Anticipated Achievements in Next Six Months:

- 400 additional mental health appointments across the 14 GP practices.
- All practices and care homes in Clackmannanshire having nurse led primary care support. Similar model in a Falkirk locality to be initiated.
- Pharmacy clinical role tested and evaluated.
- Home Monitoring of Blood Pressure being the norm for diagnosis and medication titration in 10-15 practices across both partnerships.
- Enhanced access to Joint Pain Advice and community based wellbeing supports.
- Increased Practice Administration efficiency in three clusters.

5.4 Mental Health in Primary Care

In addition to the Primary Care Mental Health Nurse practitioner roles the focus of the mental health fund was to support the overarching partnership aims of:

- Provide Post Diagnostic Support to all patients diagnosed with Dementia in the first year following diagnosis. Aiming for 80% by March 2019.
- Provide person-centred, joined up support and care for all patients with Dementia.

Achievements since September 2017 include:

- Multi-agency Redesign of Dementia Services scoped and proposed. Now approved by both HSCPs and NHS Forth Valley.
- Linking with Health Improvement Scotland, Alzheimer Scotland and Scottish Government innovation support sources (CAN-DO) to develop a second application for innovation funding to explore alternative ways of delivering PDS.
- Additional 1.5wte Link Workers have been employed to deliver PDS in Clackmannanshire and Stirling.
- Redefined criteria for PDS models, ensuring a matched care approach.

- Working with ISD and collaborating with colleagues nationally around the measurement of PDS performance including standardisation of recording of PDS across the system.

Anticipated Achievements in the next 6 months:

- Agree a structure for the specialist team which will hold PDS.
- Recruit Social Workers to the PDS / Dementia Team.
- Develop systems of working for the new team to ensure efficient and person centred responses to patient and carer need**.**
- Evidence of improved service to users from investment in PDS link workers and service redesign.

5.5 Enablers

In addition to the core work above, there are many other enabling activities ongoing, including:

- Development of resource and support model to improve post diagnostic support for Autistic Spectrum Disorders.
- Advance Practice Training for nurses, District nurses and Physiotherapists.
- Cluster based tests of change including the introduction of dermoscopy assessment for potential skin cancers within two GP practices.
- Outcome Focussed Communication education and development.
    - Developed and facilitated set of workshops with podiatry staff in Clacks.
    - Facilitated set of workshops with DN staff in Clacks.
    - change idea development following CREATE Signposting for Administration Staff.
    - Liaison with national Personal Outcomes Network to share practice.
    - Liaison with NES Practice Manager Education Lead to promote inclusion of signposting/ communication skills on education agenda.
    - Liaison with NES Psychology department to include MAP: Health Behaviour Change eLearning resource as skill development tool.

6. Resource Implications

An overview of Primary Care Transformation Fund Spend is outlined in a separate paper.

Appendix 2

Directorate for Population Health
Primary Care Division
T: 0131 244 2305

E: Richard.Foggo@gov.scot

Integration Authority Chief Officers
NHS Board Chief Executives

23 May 2018

Dear Colleagues,

PRIMARY CARE IMPROVEMENT FUND: ANNUAL FUNDING LETTER 2018-19

I am writing to confirm the 2018-19 funding allocations for the Primary Care Improvement Fund element of the wider Primary Care Fund, which will be used by Integration Authorities to commission primary care services, and allocated on an NRAC basis through Health Boards to Integration Authorities (IAs).

This letter should be read in close conjunction with two other letters due to issue, which will set out additional ring-fenced resources being made available to IAs in 2018-19:

- A second letter from my Division covering the allocation and use of an additional £5 million for Out of Hours primary care; and
- A letter from Penny Curtis, Deputy Director Mental Health Division, regarding funding of 'Action 15' of the Mental Health Strategy. Action 15 is a four-year commitment to deliver 800 more mental health workers in a range of settings, including primary care, and £11 million is being made available to IAs for this in the first year[1].

Background

Last year we brought together the Out of Hours, Primary Care Transformation Fund and Mental Health Funds into a single funding allocation, referred to as the Primary Care Transformation Fund (PCTF). My colleagues Penny Curtis and Linda Gregson wrote to you on 9 August 2017 to set out the 2017-18 allocation in your area and associated deliverables. An End of Year template for your completion is at Annex F.

[1] Note: for the avoidance of doubt, SG is also continuing to fund the development of primary care mental health services, in a similar way to previous years. This funding for primary care mental health now forms part of the Primary Care Improvement Fund. The £11m Action 15 funding referenced in the section above is additional to it.

Several key developments have taken place since then. These include:

- Scottish Government and BMA agreement to proceed with the 2018 General Medical Services contact following a poll of the GP profession – January 2018[2].
- Publication of the Memorandum of Understanding (MoU) between Scottish Government, British Medical Association, Integration Authorities and NHS Boards – draft published November 2017 and finalised 19 April 2018[3]. This determines the priorities of Integration Authorities over the next period and should be read in conjunction with this funding letter.
- Primary Care National Workforce Plan – published 30 April 2018[4].
- Passing of Scottish Government Budget Bill in February 2018 confirming increase in Primary Care Fund from £72m in 2017-18 to £110m in 2018-19.
- Wider contextual developments (e.g. the new Oral Health Action Plan and ongoing work by the Health and Justice Collaboration Improvement Board to further develop 'Action 15' of the Mental Health Strategy, which committed to 800 new mental health workers in health and justice settings).

Taken together, these set the terms of the main deliverables we expect in 2018-19 and beyond. Further information on them is at Annex C.

2018-19 approach

The Scottish Government is investing a total of £115.5 million in the Primary Care Fund (PCF) in 2018-19. There are a number of elements to the overall Primary Care Fund:

- Primary Care Improvement Fund (the subject of this letter);
- General Medical Services;
- National Boards; and
- Wider Primary Care Support including Out of Hours Fund.

These are described in more detail in Annex B.

Primary Care Improvement Fund (PCIF)

An in-year NRAC allocation to IAs (via Heath Boards) will comprise £45.750 million of the £115.5 million Primary Care Fund. This in-year allocation is hereafter referred to as the *Primary Care Improvement Fund*.

---

[2] British Medical Association and Scottish Government (2017), *The 2018 GMS Contract in Scotland* http://www.gov.scot/Resource/0052/00527530.pdf

[3] *Memorandum of Understanding between Scottish Government, British Medical Association, Integration Authorities and NHS Boards - GMS Contract Implementation in the context of Primary Care Service Redesign*, published in draft 13 November 2017 and published as final 19 April 2018: http://www.gov.scot/Resource/0053/00534343.pdf

[4] http://www.gov.scot/Publications/2018/04/3662

Primary Care Improvement Plans should set out how this additional funding will be used and the timescale for the reconfiguration of services. Further information is at Annexes D and E.

Total PCIF allocation by Board area

The 2018-19 funding allocation for the PCIF is £45.750 million.

Allocation of the fund, by Health Board and IA, is shown in Annex A. All figures are calculated using NRAC. The money must be used by IAs for the purposes described in this letter. The PCIF (including £7.800 million baselined GP pharmacy funding being treated as PCIF) is not subject to any general savings requirements and must not be used to address any wider funding pressures.

The fund must be delegated in its entirety to IAs. We do not anticipate any adjustment to these figures locally except in two circumstances:

- Marginal changes may be made with the agreement of the Health Board and Integration Authorities to reflect local arrangements, for example in relation to management arrangements within and between Integration Authorities.
- Health Boards and IAs may work collaboratively within their area to jointly resource pre-existing commitments which clearly fall within the scope of the MoU. An example of this would be early adopter link workers who are already in post in areas of higher socio-economic deprivation. This joint working to deliver the overall commitment to links workers (or other MoU related area(s)) can be appropriately reflected in PCIPs for all the IAs concerned. Such a joint approach should be considered especially where it is considered that continuation of such a service in an IA could disproportionately impact on funding available for other activities under the MoU.

Integration Authorities should set out their plans on the basis that the full funds will be made available and will be spent by them within financial year 2018-19. In this initial year of funding, the funding will issue in two tranches starting with allocation of 70% of the funding in June 2018. A high level report on how spending has been profiled must be submitted to SG by the start of September and, subject to confirmation via this report that IAs are able to spend their full 100% allocation in-year, the remaining 30% of funding will be allocated in November 2018. An outline template for making the start-September report is at Annex G. A final template will be issued before September.

I look forward to continuing to work with you in this pivotal year for primary care transformation.

Yours faithfully,

RICHARD FOGGO
Deputy Director and Head of Primary Care Division

Copy: Local Authority Chief Executives
COSLA Chief Executive
Integration Authority Chief Finance Officers
Health Board Directors of Finance
Health Board Directors of Pharmacy
Health Board Directors of Planning and Policy
Health Board Medical Directors
Primary Care Leads
Health Board Out of Hours Clinical Leads
Scottish Executive Nurse Directors (SEND)
Health Board AHP Directors
Health Board Directors of Public Health

ANNEX A

PRIMARY CARE IMPROVEMENT FUND: ALLOCATION BY BOARD AND INTEGRATION AUTHORITY

Allocation By Territorial Health Board

Allocations by Territorial Board 2018-19				
	2018-19 Target share	**2018-19 NRAC Share**	**2017-18 Allocation now in 18-19 Baseline**	**2018-19 Allocation**
NHS Ayrshire and Arran	7.41%	£3,389,685	£569,300	£2,820,385
NHS Borders	2.10%	£962,647	£161,300	£801,347
NHS Dumfries and Galloway	2.98%	£1,363,090	£229,100	£1,133,990
NHS Fife	6.81%	£3,113,646	£521,800	£2,591,846
NHS Forth Valley	5.42%	£2,479,354	£415,000	£2,064,354
NHS Grampian	9.87%	£4,516,701	£755,400	£3,761,301
NHS Greater Glasgow & Clyde	22.34%	£10,219,379	£1,718,200	£8,501,179
NHS Highland	6.44%	£2,947,380	£494,100	£2,453,280
NHS Lanarkshire	12.35%	£5,648,985	£947,700	£4,701,285
NHS Lothian	14.80%	£6,772,970	£1,132,000	£5,640,970
NHS Orkney	0.48%	£220,754	£75,000	£145,754
NHS Shetland	0.49%	£224,204	£76,200	£148,004
NHS Tayside	7.85%	£3,590,567	£601,900	£2,988,667
NHS Western Isles	0.66%	£300,639	£103,000	£197,639
Total	100.00%	£45,750,000	£7,800,000	£37,950,000

**Pharmacists in GP Practices funding was a recurring allocation in 2017-18 and will be included in Boards' 2018-19 baseline funding.*

Allocation by Integration Authority: overview of full £45.750 breakdown

Total Bundle £45.750m			
NHS Board	**2018-19 NRAC Share**	**IA Name**	**IA Share**
Ayrshire & Arran	3,389,685	East Ayrshire	1,111,935
		North Ayrshire	1,245,806
		South Ayrshire	1,031,944
Borders	962,647	Scottish Borders	962,647
Dumfries & Galloway	1,363,090	Dumfries and Galloway	1,363,090
Fife	3,113,646	Fife	3,113,646
Forth Valley	2,479,354	Clackmannanshire and Sti	1,166,827
		Falkirk	1,312,527
Grampian	4,516,701	Aberdeen City	1,793,412
		Aberdeenshire	1,935,573
		Moray	787,716
Greater Glasgow	10,219,379	East Dunbartonshire	830,888
& Clyde		East Renfrewshire	713,977
		Glasgow City	5,529,498
		Inverclyde	754,813
		Renfrewshire	1,553,435
		West Dunbartonshire	836,768
Highland	2,947,380	Argyll and Bute	847,966
		Highland	2,099,414
Lanarkshire	5,648,985	North Lanarkshire	2,939,438
		South Lanarkshire	2,709,546
Lothian	6,772,970	East Lothian	839,311
		Edinburgh	3,806,420
		Midlothian	720,229
		West Lothian	1,407,010
Orkney	220,754	Orkney Islands	220,754
Shetland	224,204	Shetland Islands	224,204
Tayside	3,590,567	Angus	985,878
		Dundee City	1,355,476
		Perth and Kinross	1,249,213
Western Isles	300,639	Eilean Siar (Western Isles	300,639
Total	**45,750,000**		**45,750,000**

Allocation by Integration Authority: IA share of £7.8m baselined funding[5]

£7.8m from Boards' Baseline Funding			
NHS Board	**Baselined funding**	**IA Name**	**IA Share**
Ayrshire & Arran	569,300	East Ayrshire	186,750
		North Ayrshire	209,234
		South Ayrshire	173,316
Borders	161,300	Scottish Borders	161,300
Dumfries & Galloway	229,100	Dumfries and Galloway	229,100
Fife	521,800	Fife	521,800
Forth Valley	415,000	Clackmannanshire and S	195,306
		Falkirk	219,694
Grampian	755,400	Aberdeen City	299,941
		Aberdeenshire	323,717
		Moray	131,742
Greater Glasgow	1,718,200	East Dunbartonshire	139,698
& Clyde		East Renfrewshire	120,042
		Glasgow City	929,683
		Inverclyde	126,908
		Renfrewshire	261,181
		West Dunbartonshire	140,687
Highland	494,100	Argyll and Bute	142,153
		Highland	351,947
Lanarkshire	947,700	North Lanarkshire	493,134
		South Lanarkshire	454,566
Lothian	1,132,000	East Lothian	140,278
		Edinburgh	636,186
		Midlothian	120,376
		West Lothian	235,161
Orkney	75,000	Orkney Islands	75,000
Shetland	76,200	Shetland Islands	76,200
Tayside	601,900	Angus	165,266
		Dundee City	227,223
		Perth and Kinross	209,410
Western Isles	103,000	Eilean Siar (Western Isle	103,000
Total	**7,800,000**		**7,800,000**

[5] Being treated as part of the PCIF. Note that there is no difference between the use for PCIP purposes of the baselined £7.8 million and the remainder of the PCIF this year.

Allocation by Integration Authority: tranche 1 and tranche 2 of £37.950 million in-year allocation[6]

£37.95m split into Tranche 1 and Tranche 2							
NHS Board	**2018-19 Board Allocation**	**Tranche 1 (70%)**	**Tranche 2 (30%)**	**IA Name**	**IA Share**	**Tranche 1 (70%)**	**Tranche 2 (30%)**
Ayrshire & Arran	2,820,385	1,974,270	846,116	East Ayrshire	925,185	647,629	277,555
				North Ayrshire	1,036,572	725,600	310,972
				South Ayrshire	858,629	601,040	257,589
Borders	801,347	560,943	240,404	Scottish Borders	801,347	560,943	240,404
Dumfries & Galloway	1,133,990	793,793	340,197	Dumfries and Galloway	1,133,990	793,793	340,197
Fife	2,591,846	1,814,292	777,554	Fife	2,591,846	1,814,292	777,554
Forth Valley	2,064,354	1,445,048	619,306	Clackmannanshire and Stirling	971,521	680,065	291,456
				Falkirk	1,092,833	764,983	327,850
Grampian	3,761,301	2,632,910	1,128,390	Aberdeen City	1,493,471	1,045,429	448,041
				Aberdeenshire	1,611,857	1,128,300	483,557
				Moray	655,973	459,181	196,792
Greater Glasgow & Clyde	8,501,179	5,950,825	2,550,354	East Dunbartonshire	691,189	483,832	207,357
				East Renfrewshire	593,935	415,754	178,180
				Glasgow City	4,599,815	3,219,871	1,379,945
				Inverclyde	627,905	439,534	188,372
				Renfrewshire	1,292,253	904,577	387,676
				West Dunbartonshire	696,081	487,257	208,824
Highland	2,453,280	1,717,296	735,984	Argyll and Bute	705,813	494,069	211,744
				Highland	1,747,467	1,223,227	524,240
Lanarkshire	4,701,285	3,290,899	1,410,385	North Lanarkshire	2,446,305	1,712,413	733,891
				South Lanarkshire	2,254,980	1,578,486	676,494
Lothian	5,640,970	3,948,679	1,692,291	East Lothian	699,032	489,323	209,710
				Edinburgh	3,170,234	2,219,164	951,070
				Midlothian	599,854	419,898	179,956
				West Lothian	1,171,850	820,295	351,555
Orkney	145,754	102,028	43,726	Orkney Islands	145,754	102,028	43,726
Shetland	148,004	103,603	44,401	Shetland Islands	148,004	103,603	44,401
Tayside	2,988,667	2,092,067	896,600	Angus	820,612	574,428	246,184
				Dundee City	1,128,253	789,777	338,476
				Perth and Kinross	1,039,803	727,862	311,941
Western Isles	197,639	138,347	59,292	Eilean Siar (Western Isles)	197,639	138,347	59,292
Total	**37,950,000**	**26,565,000**	**11,385,000**		**37,950,000**	**26,565,000**	**11,385,000**

[6] Total PCIF minus the £7.8 million baselined amount. Note that there is no difference between the use for PCIP purposes of the baselined £7.8 million and the remainder of the PCIF this year.

ANNEX B

OVERVIEW OF NATIONAL PRIMARY CARE FUNDING ARRANGEMENTS

Primary Care Fund 2018-19

The Scottish Government is investing a total of £115.5 million in the Primary Care Fund (PCF) in 2018-19. There are a number of elements to the overall Fund:

- Primary Care Improvement Fund;
- General Medical Services;
- National Boards; and
- Wider Primary Care Support including Out of Hours.

The full Primary Care Fund breakdown is below.

Primary Care Fund £m	2018-19	Notes
Primary Care Improvement Fund: Service redesign through Primary Care Improvement Plans	**45.750**	Wider MDT development across 6 priority areas in the GMS contract/ MoU, including Pharmacy, CLW, Vaccination Transformation Programme, primary care mental health and Pharmacy First.
GMS: Income & Expenses Guarantee Professional Time Activities Rural package GP Additional support GP clusters (PQLs) **GMS Total**	 23.000 2.500 2.000 3.075 5.000 **35.575**	Additional support includes oxygen, occ health, parental leave, sickness, appraisal and GP retainers scheme
National Boards	**16.569**	Cluster support (HIS and LIST), SAS Strategy/national board transformation, practice nurse training
Wider Primary Care Support: National Support Primary Care Infrastructure Out of Hours GP Recruitment and Retention **Wider Primary Care Support Total**	 5.606 2.000* 5.000 5.000 **17.642**	National support includes primary care development, GP sustainability reccs, community eyecare review, evaluation
Total: Primary Care Fund *£10m Premises Fund available in 2018-19 from a separate funding source	**115.500**	

The table above demonstrates the allocation of the entirety of the Primary Care Fund. A separate letter will be prepared and copied to IAs in due course providing a

breakdown of which elements of the Primary Care Fund are in direct support of General Practice, contributing to the Scottish Government's commitment to invest an additional £250 million in direct support of General Practice by the end of this Parliament.

Primary Care Improvement Fund

An in-year NRAC allocation to IAs (via Heath Boards) will comprise £45.750 million of that £115.5 million Primary Care Fund. This in-year allocation is hereby referred to as the Primary Care Improvement Fund (PCIF). Primary Care Improvement Plans should set out how this additional funding will be used and the timescale for the reconfiguration of services.

In 2018-19, for the PCIF, we are continuing the process of radical simplification we began last year. As agreed with the *Scottish Government – Chief Officer Advisory Group on Primary Care*, we are making a single broad allocation, to provide maximum flexibility to local systems to deliver key outcomes. This is a successor fund to activities previously funded including:

- Pharmacy teams in General Practice
- Vaccination Transformation Programme
- Primary Care Transformation Fund
- Community Links Workers
- Mental Health Primary Care Fund
- Pharmacy First

Primary Medical Services

A separate Primary Medical Services (PMS) revenue allocation letter will issue in due course, which will include the elements of the Primary Care Fund that relate to General Medical Services (GMS) such as the £23 million income guarantee associated with the new GMS contract.

National NHS Boards will also receive letters setting out the outcomes associated with their funding allocations.

Out of Hours Fund

IAs will be expected to maintain and develop a resilient out of hours service that builds on the recommendations set out in Sir Lewis Ritchie's report *Pulling Together*, building effective links and interface between in and out of hours GP services.

Therefore, IAs will receive an in-year NRAC allocation *additional* to the Primary Care Improvement Fund of £5 million for investment in Out of Hours.

A separate letter will set out further detail before the end of May on the allocation and use of the £5 million.

Wider Elements of Primary Care Fund

Funding from the Primary Care Fund outwith the IA-led allocation includes:

- Support to GP sustainability recommendations and national evaluation;
- Support to GP Recruitment and Retention; and
- Funding for National Boards to support primary care transformation.

Future funding profile

To aid in preparation of the Primary Care Improvement Plans, IAs and Health Boards should note that the Primary Care Fund is expected to increase substantially over the next three years. The Scottish Government has announced its commitment to increase the overall PCF to £250 million by 2021-22. The detail of the funding breakdown within that is a matter for Ministers and the annual Parliamentary budgeting process.

However – *strictly as a planning assumption, and subject to amendment by Ministers without notice* – IAs may wish to note our expectation that the Primary Care Improvement Fund will increase to approximately £55 million in 2019-20, £110 million in 2020-21, and £155 million in 2021-22. This will, as this year, be distributed on an NRAC basis.

All PCIF in-year allocations should be considered as *earmarked recurring* funding. It should be assumed therefore that staff may be recruited on a permanent basis to meet the requirements set out in the MoU. We will engage with IAs and others on any plans to baseline these funds.

Linked non-Primary Care Fund funding

Linked funding from outwith the Primary Care Fund in 2018-19 includes:

- The £10 million annual Premises Fund to fund interest-free secured loans to GP contractors who own their premises, as set out in the National Code of Practice for GP Premises.
- The £11 million Mental Health 'Action 15' fund, which will be the subject of a separate letter this month from Penny Curtis.

National trends in funding for primary care

In March 2017 the Cabinet Secretary for Health and Sport announced that in addition to the funding for the provision of general medical services, funding in direct support of general practice will increase annually by £250 million by the end 2021-22. In 2017-18 £71.6 million was committed through the Primary Care Fund in direct support of general practice. Further investment will see this increase over the three financial years from 1 April 2018 to £250 million in 2021-22.

This forms part of the commitment during this Parliament to extra investment of £500 million per year for Primary Care funding. This will raise the primary care budget from 7.7% of the total NHS frontline budget in 2016-17 to 11% by 2021-22.

ANNEX C

SUMMARY OF KEY POLICY DEVELOPMENTS IN PRIMARY CARE 2017-18

GMS contract offer: key elements

The contract offer to GPs[7], jointly negotiated by the BMA and the Scottish Government, sets out a refocused role for GPs as Expert Medical Generalists (EMGs) and recognises the GP as the senior clinical decision maker in the community. This role builds on the core strengths and values of general practice, involves a focus on undifferentiated presentation, complex care, and whole system quality improvement and leadership.

This refocusing of the GP role will require some tasks currently carried out by GPs to be carried out by members of a wider primary care multi-disciplinary team – where it is safe, appropriate, and improves patient care. Integration Authorities, the Scottish GP Committee (SGPC) of the British Medical Association (BMA), NHS Boards and the Scottish Government have agreed priorities for transformative service redesign in primary care in Scotland over a three year planned transition period. These priorities include vaccination services, pharmacotherapy services, community treatment and care services, urgent care services and additional professional services including acute musculoskeletal physiotherapy services, community mental health services and community link worker services. GPs will retain a professional role in these services in their capacity as expert medical generalists. The contract offer also sets out new opportunities for GP-employed practice staff.

The contract improves the formula used to determine GP funding, and proposals for the next phase of pay reform, and proposes significant new arrangements for GP premises, GP information technology and information sharing. The effect of these arrangements will be a substantial reduction in risk for GP partners in Scotland, and a substantial increase in practice sustainability.

Practice core hours will be maintained at 8am-6.30pm (or as previously agreed through local negotiation). Online services for patients will be improved, and online appointment booking and repeat prescription ordering will be made available where the practice has the functionality to implement online services safely.

The contract sets out how analytical support from Information Services Division of NHS National Services Scotland will be further embedded. Practices will supply information on practice workforce and on demand for services to support quality improvement and practice sustainability.

Memorandum of Understanding

The Memorandum of Understanding (MoU) with Integration Authorities, the British Medical Association, NHS Boards and the Scottish Government[8] set out the

---

[7] British Medical Association and Scottish Government (2017), *The 2018 GMS Contract in Scotland* http://www.gov.scot/Resource/0052/00527530.pdf

[8] http://www.gov.scot/Resource/0053/00534343.pdf

principles underpinning primary care in Scotland, including respective roles and responsibilities.

The seven key principles for service redesign in the document are:

- Safe
- Person-Centred
- Equitable
- Outcome focused
- Effective
- Sustainable
- Affordability and value for money

The MoU provided the basis for the development by IAs, as part of their statutory Strategic Planning responsibilities, of clear IA Primary Care Improvement Plans, setting out how allocated funding will be used and the timescales for the reconfiguration of some of the key services currently delivered under GMS contracts.

The MoU underpins the new Scottish GMS contract; and enables the move towards a new model for primary care that is consistent with the principles, aims and direction set by the Scottish Government's National Clinical Strategy (NCS) and the Health and Social Care Delivery Plan.

Workforce Plan

The third section of the National Workforce Plan[9] was published on 30 April 2018.

Scottish Ministers have committed to a significant expansion of the wider Multi-Disciplinary Team (MDT), including the training of an additional 500 advanced nurse practitioners, 250 Community Links Workers to be in place by 2021 in practices serving our poorest populations, and 1,000 paramedics to work in the community. General Practice will further be supported by ensuring all practices are given access to a pharmacist by the end of this parliamentary period. An additional investment of £6.9 million will be made in nursing in primary care, particularly general practice nursing and district nursing.

The publication of *National Health and Social Care Workforce Plan: Part 1 – a framework for improving workforce planning across NHS Scotland*[10] last June signalled the beginning of a process to further improve workforce planning across health and social care. It set out new approaches to workforce planning across Scotland, within a framework for wider reform of our health and care systems. Part 2 of the Workforce Plan – *A framework for improving workforce planning for social care in Scotland*[11] – published jointly by the Scottish Government and COSLA, set out a whole system, complementary approach to local and national social care workforce planning, recognising our new integrated landscape.

[9] http://www.gov.scot/Publications/2018/04/3662
[10] http://www.gov.scot/Resource/0052/00521803.pdf
[11] http://www.gov.scot/Resource/0052/00529319.pdf

Part 3, the primary care workforce plan, marks an important further step in that journey. It addresses the following main issues:

- how primary care services are in a strong position to respond to the changing and growing needs of our population, alongside the evidence of the significant benefits that will be delivered through focusing our workforce on prevention and self-management.
- The shape of the existing primary care workforce, including recent trends in workforce numbers
- The anticipated changes in the way services will be reconfigured to meet population need
- How the MDT will be strengthened to deliver an enhanced and sustainable workforce
- Our approach to recruiting 800 more doctors into general practice over the next decade and supporting and retaining the existing workforce
- How we will work with partners to ensure that better quality and more timely data is developed to drive effective local and national workforce planning.
- A commitment to work alongside partners including the RCN to understand the requirements for sustaining and expanding the district nursing workforce. By September 2018 we will better understand the requirements and investment needed to grow this workforce.

Other key policy developments

GP Clusters

The approach to quality which began with the move away from the Quality and Outcomes Framework introduced in the 2004 GMS contract will continue. Following the publication of *Improving Together: A National Framework for Quality and GP Clusters in Scotland*[12] in January 2017, work is now underway to continue to develop the collaborative learning role of GP clusters, to help identify and improve the quality of services in their locality. Healthcare Improvement Scotland and National Services Scotland, through Local Intelligence Support Teams (LIST) will continue to support clusters to gather intelligence to establish what these priorities are, and how to collect and evaluate data to determine what action is needed. Work is now underway to further refine the National Framework, with input from Integration Authorities, and this work will continue in 2018/19. Support should be made available from Public Health locally to help identify suitable cluster outcomes for improvement.

Community Eyecare

As indicated in last year's letter, the Community Eyecare Services Review[13] required Integration Authorities to consider the full eyecare needs of their communities when planning and commissioning services. Work is now underway in taking forward the recommendations, particularly around revising the General Ophthalmic Services Regulations. We would expect Integration Authorities to continue to work with

[12] https://beta.gov.scot/publications/improving-together-national-framework-quality-gp-clusters-scotland/documents/00512739.pdf?inline=true
[13] http://www.gov.scot/Publications/2017/04/7983

optometrists and NHS Board Optometric Advisers in considering how eyecare services can be delivered more effectively in their area, as work to implement further recommendations around clinical and quality improvement will continue in 2018/19.

Oral Health

On 24 January 2018, the Scottish Government published the *Oral Health Improvement Plan* (OHIP)[14]. The OHIP sets the direction of travel for oral health improvement and NHS dentistry for the next generation, and has a strong focus on preventing oral health disease, meeting the needs of the ageing population and reducing oral health inequalities. This does not form part of the PCIF, but appropriate links should be identified where possible.

Pharmacy

Our strategy 'Achieving Excellence in Pharmaceutical Care'[15]. was published in August 2017, and sets out the priorities, commitments and actions for improving and integrating NHS pharmaceutical care in Scotland over the next five years. It is driven by two main priorities: Improving NHS Pharmaceutical Care and Enabling NHS Pharmaceutical Care Transformation.

Achieving Excellence emphasises the important role the pharmacy team in NHS Scotland has to play as part of the workforce, making best use of their specialist skills and much needed expertise in medicines. It describes how we see pharmaceutical care evolving in Scotland along with the crucial contribution of pharmacists and pharmacy technicians, working together with other health and social care practitioners, to improve the health of the population, especially for those with multiple long term and complex conditions.

[14] http://www.gov.scot/Publications/2018/01/9275
[15] http://www.gov.scot/Resource/0052/00523589.pdf

ANNEX D

CORE REQUIREMENTS OF PRIMARY CARE IMPROVEMENT PLANS REQUIREMENT 1: PREPARATION OF PRIMARY CARE IMPROVEMENT PLANS (PCIPS)

The MoU requires IAs to:

1. Develop three-year Primary Care Improvement Plans (PCIPs), consulting NHS Boards and other partners. These must be agreed with the local GP Subcommittee of the Area Medical Committee, with the arrangements for delivering the new GMS contract being agreed with the Local Medical Committee (LMC),and
2. Through the Plans, commission, deliver and resource (including staff resources) the six priority services identified in the MOU and the Contract document ("Blue Book") in support of the new GP contract.

Process

Initial Plans, with evidence of appropriate local consultation and agreements, will be completed by 1 July 2018 and shared with the National Oversight Group by the end of that month. They should be kept under review and updated at least annually.

The Plans are to be developed collaboratively with advice and support from GPs; and explicitly agreed with the local GP Subcommittee of the Area Medical Committee (and, in the context of the arrangements for delivering the new GMS contract, explicitly agreed with the Local Medical Committee).

Key partners and stakeholders (including patients, carers, and representatives of service providers such as the third sector) should be as engaged as possible in the preparation, publication and regular review of the Plans. There will also be a need for appropriate engagement with specific professionals and groups. For example, on the pharmacotherapy service, Directors of Pharmacy and others such as area pharmaceutical committees (or area clinical forums) and local pharmacy contractors committees will have a strong need for engagement on its implementation locally.

We appreciate that achieving full engagement within the challenging initial timescale for the PCIP may be difficult, and some of the more detailed dialogue may take place after the plans are submitted. They will be living documents, and regularly reviewed and updated.

Content

The transfer of services in the six priority areas (detailed under Requirement 2 below) will be a major component of PCIPs, and we expect that PCIPs will show a funding profile for each area.

Good communications and understanding across the wider health and social care interfaces with both services and professional groups (e.g. primary/secondary, community health and social care services, district nursing, out of hours services,

mental health services) will also be required to address direct patient care issues, such as prescribing, referrals, discharges, follow up of results and signposting. An important principle here is that each part of the system respects the time and resources of the other parts. There should not be an assumption that patient needs or work identified in one part of the service must be met by another without due discussion and agreement. This should ensure that patients do not fall through gaps in the health and care system.

Wider spending on those services should form part of IAs' broader strategic planning and commissioning role, and it would be helpful if PCIPs could reference how these services will work together.

IAs, in preparing PCIPs, should also consider the underpinning need for strong collective leadership from all parts of the local system, and how best to support it. Measures to build the leadership capability of GP Sub-Committees, and Cluster Quality Leads, as well as wider capability and capacity, should form a key part of Plans. NHS Education for Scotland is likely to be a key partner for IAs in delivering programmes to support that capacity-building. PCIPs may also address practical support to the programmes of work, such as coordination or programme management.

Wider considerations

Connection to Action 15 of the Mental Health Strategy

Primary Care Improvement Plans should show clear connections to the plans being prepared under Action 15 of the Mental Health Strategy for delivery of 800 more mental health staff in general practice, Accident and Emergency, prisons and police custody suites over the next three years. Penny Curtis will be writing to you separately on this matter.

Some of the same staff may be counted both as part of the MOU delivery (for example as part of the development of primary care mental health and/or the work on links workers) and the delivery of the general practice element of the 800. This is acceptable, and Penny Curtis's letter will set out how we expect additionality to be accounted for in terms of the 800. It would be helpful to see any cross-over clearly articulated in both PCIPs and existing plans (or those in development) regarding Action 15 of the Mental Health Strategy.

Inequalities

Whilst we recognise that the key determinants of health inequality lie outside general practice services and health care generally, there remain opportunities to strengthen the role of general practice and primary care in mitigating inequality. All PCIPs should include a section on how the services will contribute to tackling health inequalities. The community links worker service will be one aspect of this, as will the developing quality improvement role of GP Clusters, but IAs will wish to consider what more can be done to ensure there is parity of access for all groups, and that the workload of GPs in the most deprived areas is manageable.

IAs are also subject to the new Fairer Scotland Duty which came into force from April 2018. Guidance on the new duty is available on the SG website[16]. The duty aims to ensure that public bodies take every opportunity to reduce inequalities of outcome, caused by socio-economic disadvantage, when making strategic decisions. We would therefore strongly encourage IAs to consider how they can meet their obligations under the duty as they develop their PCIPs. In particular, all IAs should have completed an inequalities assessment, and make reference to this in their PCIP.

Sustainability

All IAs should also consider the sustainability of general practices in their area including the recruitment and retention of local GPs. Where there are specific sustainability issues, these should be discussed with GP representatives, and consideration given to how the PCIP can best support the sustainability of general practice locally.

National support will continue to be made available through the multi-partner Improving General Practice Sustainability Advisory Group which, over the past year, has made significant progress in delivering the practically focused recommendations for reducing workload pressures, including actions to improve interface working and improved signposting of patients to appropriate primary care services and to self-care. During 2018 the Group will focus on supporting local partners to address local sustainability issues.

Rural, remote and island communities

The needs of rural, remote and island communities should be addressed in PCIPs if they form part of the IA area.

The expectation is that the contract workload reduction measures and new services must be made available to *every* practice where it is reasonably practical, effective and safe to do so.

The service redesign requires practices to be involved via their GP clusters, so they have a say in how services will work locally.

Governance

A new National Oversight Group with representatives from the Scottish Government, the SGPC, Integration Authorities and NHS Boards will oversee implementation by NHS Boards of the GMS contract in Scotland and the IA Primary Care Improvement Plans, including clear milestones for the redistribution of GP workload and the development of effective MDT working, including with non-clinical staff.

At local level, Integration Authorities will hold Health Boards and Councils to account for delivery of the milestones set out in the Plan, in line with the directions provided

[16] http://www.gov.scot/Publications/2018/03/6918

to the Health Board and Council by the Integration Authority for the delivery of Strategic Plans.

Directors of Pharmacy will be leading on the implementation of the pharmacotherapy services during the three year trajectory, to ensure governance arrangements are in place, workforce planning and capacity issues are addressed, and the initial momentum is maintained. This will be taken forward through the recently established Pharmacotherapy Service Implementation Group which will form part of the governance arrangements under the new National Oversight Group.

The Vaccination Transformation Programme is overseen by a Programme Board with representatives from the Scottish Government, SGPC, Trade Unions, Health Protection Scotland, Health Boards, and Directors of Nursing. It is responsible for realising the benefits of vaccination transformation nationally, and managing, monitoring and evaluating progress made by each Health Board. The Vaccination Transformation Programme Board links into the National Oversight Group by reporting to the Primary Care Programme Board.

Other stakeholder groups such as dentistry and optometry should also be engaged with.

Evaluation

At local level, all PCIPs should include consideration of how the changes will be evaluated locally.

Healthcare Improvement Scotland and LIST analysts from National Services Scotland will work with IAs to provide support and learning in development of the new services.

At the national level, the Scottish Government plans to publish a 10-year Primary Care Monitoring and Evaluation Strategy in June 2018, setting out our overarching approach to evaluating primary care reform.

We will also publish a Primary Care Outcomes Framework before then, which maps out planned actions and priorities against the changes we are working towards. The Framework was co-produced by the Primary Care Evidence Collaborative, which includes NHS Health Scotland, the Scottish School of Primary Care, Healthcare Improvement Scotland, NHS Education for Scotland, National Services Scotland, the Alliance, and the Scottish Government.

ANNEX E

CORE REQUIREMENTS FOR PRIMARY CARE IMPROVEMENT PLANS 2018-21
REQUIREMENT 2 – SERVICE TRANSFER

The MoU requires IAs to:

1. Develop three-year Primary Care Improvement Plans (PCIPs), consulting NHS Boards and other partners. These must be agreed with the local GP Subcommittee of the Area Medical Committee, with the arrangements for delivering the new GMS contract being agreed with the Local Medical Committee (LMC),and

2. Through the Plans, commission, deliver and resource (including staff resources) the six priority services identified in the MOU and the Contract document ("Blue Book") in support of the new GP contract.

This Annex sets out the six core requirements for service transfer in PCIPs over the three year period.

IAs should work with a range of professionals in NHS Boards and practices, reflecting the service priority areas, to plan and manage service transfers in a way that ensures patient safety and maximises benefits to patient care. The nature and speed of delivery at a local level will vary based on local factors such as the extent to which comparable services are already in place, upon local geography, and prioritisation based on local demographics and demand. The new services should be provided within GP practices or clusters of practices, or be closely located.

Delivery of the Vaccination Transformation Programme, pharmacotherapy service and community treatment and care service (and within that, specifically phlebotomy) have been identified as the key immediate priorities, in that responsibility for these services will be fully transferred to IAs by the end of the transition period in April 2021. However, the other aspects of service transfer should also be considered urgent, and requiring of significant progress over the three years of Plan to deliver the arrangements set out in the MOU and the new GMS contract document.

Service 1) Vaccination Transfer Programme

High level deliverable: All services to be Board run by 2021.

By 2021, vaccinations will have moved away from a model based on GP delivery, to one based on NHS Board delivery through dedicated teams.

The Vaccination Transformation Programme can be divided into different work streams:
1. pre-school programme
2. school based programme
3. travel vaccinations and travel health advice
4. influenza programme
5. at risk and age group programmes (shingles, pneumococcal, hepatitis B)

We expect IAs and NHS Boards to have all five of these programmes in place by April 2021. The order and rate at which IAs and NHS Boards make the transition may vary but progress is expected to be delivered against locally agreed milestones in each of the 3 years, including significant early developments in financial year 2018-19.

The Vaccination Transformation Programme includes all vaccination work in primary care, whether previously delivered by IAs or not. For the avoidance of doubt, this includes childhood immunisations in every case.

Governance and oversight

The Vaccination Transformation Programme is overseen by a Programme Board with representatives from the Scottish Government, SGPC, Trade Unions, Health Protection Scotland, Health Boards, and Directors of Nursing. It is responsible for realising the benefits of vaccination transformation nationally, and managing, monitoring and evaluating progress made by each Health Board. The Vaccination Transformation Programme Board links into the National Oversight Group by reporting to the Primary Care Programme Board.

Service 2) Pharmacotherapy services

High level deliverable: Pharmacotherapy Service to the patients of every practice by 2021.

The GP contract includes an agreement that every GP practice will have access to a pharmacotherapy service. To date, investment from the GP Pharmacy Fund has meant that we have exceeded the initial target to recruit 140 wte pharmacists, together with a number of wte pharmacy technicians. The combined skill mix of these pharmacists and technicians are supporting over one third of GP practices across Scotland. An outturn exercise will be completed shortly confirming the total recruitment figures over the three year period up to the end of March 2018.

The PCIP should set out a three year trajectory from April 2018 to April 2021, to establish a sustainable pharmacotherapy service which includes pharmacist and pharmacy technician support to the patients of every practice. Pharmacists and pharmacy technicians will become embedded members of core practice clinical teams and, while not employed directly by practices, the day-to-day work of pharmacists and pharmacy technicians, will be co-ordinated by practices and targeted at local clinical priorities. Implementation of the pharmacotherapy service will be led by Directors of Pharmacy during the three year trajectory period through the Pharmacotherapy Service Implementation Group.

Pharmacists and pharmacy technicians will take on responsibility for:

a) Core elements of the service, including: acute and repeat prescribing, medicines reconciliation, monitoring high risk medicines
b) Additional elements of the service, including: medication and polypharmacy reviews and specialist clinics (e.g. chronic pain)

By the end of the three year period, PCIPs should be able to demonstrate appropriate delivery of both the core and additional elements of the service in response to local needs.

There will be an increase in pharmacist training places to support this work.

<u>Chronic Medication Service</u>

In addition, PCIPs should also take into account the contribution of the Chronic Medication Service (CMS) available in all local community pharmacies, and ensure the appropriate links between the pharmacotherapy service and CMS are embedded to make best use of total capacity.

Under this centrally funded service, community pharmacists can carry out an annual medication review, as well as regular monitoring and feedback to the practice for patients registered for this service. Involving community pharmacists in the medication review of people with a stable long term condition will support pharmacists in GP practices and GPs to concentrate on more complex care. Making full use of the clinical capacity within community pharmacy can improve the pace and efficiency of delivery of the pharmacotherapy service in GP practices.

Other Centrally Funded Community Pharmacy Services

GP practice teams should also make full use of the other NHS services available through local community pharmacies as part of local triaging arrangements.

Community pharmacists can provide self-care advice on a range of common (uncomplicated) clinical conditions. Children, the elderly, people with medical exceptions, and those on low incomes can also make full use of the Minor Ailment Service (MAS). We will be looking to see how we can develop the MAS on a national basis, based on the outcomes of the extended MAS pilot in Inverclyde.

Smoking cessation support and sexual health advice (including access to Emergency Hormonal Contraception) are also available through the community pharmacy Public Health Service.

Pharmacy First

Also included in your 2018-19 funding allocation are monies to support the continuation of the Pharmacy First service introduced in community pharmacies across Scotland from winter 2017-18.

Linked to the MAS, Pharmacy First allows community pharmacists to treat uncomplicated urinary tract infections in women and impetigo in children without the need for a GP appointment or prescription, opening access to treatment both in and out-of-hours.

Taken together, the NHS Services available through the network of community pharmacies at both local and national levels builds on the role of pharmacists as part of the multidisciplinary team in primary care, making the best use of their clinical skills and providing convenient routes of access to appropriate primary care.

Service 3) Community Treatment and Care Services

High level deliverable: A service in every area, by 2021, starting with phlebotomy.

These services include, but are not limited to, basic disease data collection and biometrics (such as blood pressure), chronic disease monitoring, the management of minor injuries and dressings, phlebotomy, ear syringing, suture removal, and some types of minor surgery as locally determined as being appropriate.

Phlebotomy should be delivered as a priority in the first stage of the PCIP.

There will be a three year transition period to allow the responsibility for providing these services to pass from GP practices to IAs. By April 2021, these services will be commissioned by IAs, and delivered in collaboration with NHS Boards that will employ and manage appropriate nursing and healthcare assistant staff.

Community treatment and care services should be prioritised for use by primary care. They should also be available for secondary care referrals if they would otherwise have been workload for GPs (i.e. if such use means they are directly lifting workload from GPs). It is essential that the new funding in direct support of General Practice is only used to relieve workload from General Practice. Work from secondary care sources should be funded from other streams.

IAs should consider how this service might best be aligned with wider community treatment and care services used by secondary care.

Service 4) Urgent care (advanced practitioners)

High level deliverable: A sustainable advanced practitioner service for urgent unscheduled care as part of the practice or cluster based team, based on local needs and local service design.

The MoU sets out the benefits of utilising advanced practitioners to respond to urgent unscheduled care within primary care, including being the first response to a home visit or responding to urgent call outs, freeing up GPs to focus on their role as expert medical generalists. These practitioners will be available to assess and treat urgent or unscheduled care presentations and home visits within an agreed local model or system of care.

Where service models are sufficiently developed, advanced practitioners may also directly support GPs' expert medical generalist work by carrying out routine assessments and monitoring of chronic conditions for vulnerable patients at home, or living in care homes. These advanced practitioners may be advanced paramedics or advanced nurse practitioners. It is for the IAs, in collaboration with GP clusters, to determine the best provision for their locality.

By 2021, there should be a sustainable advanced practitioner provision in all IA areas, based on appropriate local service design.

Service 5) Additional Professional roles

High level deliverable: In most areas, the addition of new members of the MDT such as physiotherapists or mental health workers acting as the first point of contact.

By 2021 specialist professionals should be working within the local MDT to see patients as the first point of contact, as well as assessing, diagnosing and delivering treatment, as agreed with GPs and within an agreed model or system of care. Service configuration may vary dependent upon local geography, demographics and demand.

Physiotherapy services focused on musculoskeletal conditions

IAs may wish to develop models to embed a musculoskeletal service within practice teams to support practice workload. In order to provide a realistic alternative for patients, access times must be comparable to those of general practice. Priority for the service, such as focusing on elderly care, will be determined by local needs as part of the PCIP.

Mental health

As indicated in last year's letter, the Mental Health Strategy 2017-27[17] commits to action 23, "test and evaluate the most effective and sustainable models of supporting mental health in primary care, by 2019". It describes the primary care transformation that will improve this - up skilling of all Primary Care team members on mental health issues, the roles of clinical and non-clinical staff, and the increased involvement of patients in their own care and treatment through better information and technology use.

In previous years, nearly £10m was invested via the Primary Care Mental Health Fund (PCMHF) to encourage the development of new models of care to ensure that people with mental health problems get the right treatment, in the right place, at the right time. In 2018-19, further mental health funding is included within the £45.750 million for IAs, and Primary Care Improvement Plans must demonstrate how this is being used to re-design primary care services through a multi-disciplinary approach, in conjunction with how other mental health allocations are being managed (including that of Action 15 within the Mental Health Strategy).

Action 15 of the Mental Health Strategy 2017-2027 is to increase the workforce to give access to dedicated mental health professionals to all A&Es, all GP practices, every police station custody suite, and to our prisons. Over the next 5 years we have committed to additional investment which will rise to £35 million in the final year for 800 additional mental health workers in those key settings. The first tranche of funding for Action 15 is set at £11 million in 2018-19. Following detailed consideration of this matter by the Health and Justice Collaboration Improvement Board, a separate letter will be issued to you regarding funding for Action 15, which should be read in conjunction with this letter. It will include a requirement to count

[17] http://www.gov.scot/Publications/2017/03/1750

and monitor the number of additional mental health workers needed to deliver this commitment.

Others

A link could be made, if wished, with community pharmacy as part of Pharmacy First and in support of the GP Sustainability report actions.

Service 6) Community Link Workers

High level deliverable: Non-clinical staff, totalling at least 250 nationally, supporting patients who need it, starting with those in deprived areas.

Community link workers are based in or aligned to a GP practice or cluster and work directly with patients to help them navigate and engage with wider services, often serving a socio-economically deprived community or assisting patients who need support because of (for example) the complexity of their conditions, rurality, or a need for assistance with welfare issues.

As part their PCIP, IAs should assess local need and develop link worker roles in every area, in line with the Scottish Government's manifesto commitment to deliver 250 link workers over the life of the Parliament. The roles of the link workers will be consistent with assessed local need and priorities, and function as part of the local models/systems of care and support. However, the primary intention of this work is to act as one of the ways in which local systems can tackle health inequalities, and therefore the expectation is that the first priority for link workers will be more deprived areas.

It is essential that IAs work together to ensure that they have identified a **national trajectory towards 250 additionally-provided staff** (which could include upskilled staff or those receiving new contracts) by the end of the period. It will be for the national Oversight Group to maintain oversight of this national trajectory.

The 53 'early adopter' link workers who are already in post in areas of higher socio-economic deprivation are the foundation of the build-up towards 250, and continuation of these posts should be considered to be a priority. It is, however, entirely for IAs to decide whether any changes to the scope, oversight, employer or lead responsibility for these posts are required in the light of emerging learning and the developing PCIPs.

The 'early adopter' posts were not initially distributed on an NRAC basis, so Health Boards and IAs should, where necessary, work collaboratively within their area to jointly resource early adopter link workers. This is also the case for additional link workers that may in future be specifically jointly targeted by IAs on areas of the highest deprivation within a Health Board.

This joint working in support of the overall commitment to link workers can be reflected in PCIPs for all the IAs concerned, and will be welcomed.

Such a joint approach should be considered especially where it is considered that continuation of the early adopter service in an IA could disproportionately impact on funding available in that IA for other activities under the MoU.

Support for this work is available to IAs from ScotPHN (Kate Burton) who can support IA work to develop and implement the role of link workers during 2018-19; and from NHS Health Scotland on the development of local evaluation and learning.

ANNEX F

END YEAR REPORT

We would be grateful for a high level report on spend, impact and plans for any carry forward for your overall spending from the Primary Care Transformation Fund in 2017-18. This should include a high level breakdown of the outcomes achieved in 2017-18 across in hours, out of hours and mental health funded by your 2017-18 Primary Care Transformation Fund allocation. When responding, it would also be helpful if this could also include an explanation of how any underspend from 2016-17 that your Integration Authorities were able to carry forward into 2017-18 was spent.

A template for your use is below.

Test of Change Summary Table		
IA Name		
Primary Care Outcome[18]	*Select from the table of primary care outcomes that best fits your test of change*	
Primary Care Outcome	*add a secondary outcome if appropriate.*	
Section 1: 2017-18 actual spend		
Funding allocated to this test of change in 2017-18		£
High level breakdown of actual spend incurred:		
Actual spend		£
Total underspend carried forward to 2018-19		£
Plans for use of the underspend in support of Primary Care Improvement Plans:		
Impact & key learning points:		

[18] Primary Care Outcomes:

1 We are more informed and empowered when using primary care

2 Our primary care services better contribute to improving population health

3 Our experience as patients in primary care is enhanced

4 Our primary care workforce is expanded, more integrated and better co-ordinated with community and secondary care

5 Our primary care infrastructure – physical and digital – is improved

6 Primary care better addresses health inequalities

ANNEX G

OUTLINE 2018-19 INTEGRATION AUTHORITY FINANCIAL REPORTING TEMPLATE, DUE FOR RETURN BY SEPTEMBER 2018

IA area

Confirmation that PCIP, agreed with the local GP Subcommittee of the Area Medical Committee, is **in place (date submitted)**

Summary of agreed spending breakdown for 2018-19 by service area, with anticipated monthly phasing

Actual spending to date against profile, by month, by service area

Remaining spend to end 2018-19, by month, by service area

Projected under/ over spend by end 2018-19

Is it expected that the full second tranche will be required in 2018-19?

Please return to:

Laura Cregan
Primary Care Division
1ER, St Andrew's House, Regent Road, Edinburgh EH1 3DG

Or by email to:
Laura.cregan@gov.scot

Clackmannanshire & Stirling Health and Social Care Partnership
Integration Joint Board

13 June 2018

This report relates to
Item 7.3 on the agenda

Mental Health Redesign: Day Services & Update

Paper presented by Jim Robb Service Manager Learning Disability/Mental Health

For Approval

Approved for Submission by	Shiona Strachan, Chief Officer
Author	Jim Robb, Service Manager Learning Disability/Mental Health
Date:	15 May 2018
List of Background Papers / Appendices: • IJB Report: Redesign of Learning Disability & Mental Health Services December 2017. • IJB Report: Mental Health Redesign: Progress Report: March 2018 • Scottish Government 2017 National Mental Health Strategy 2017-2027 Appendix 1**:** Business Case: Integration of Operational Services Appendix 2: Integrated operational structure diagrams	

Title/Subject: **Mental Health Redesign: Day Services & Update**

Meeting: **Clackmannanshire & Stirling Integration Joint Board**

Date: **13 June 2018**

Submitted By: **Jim Robb, Service Manager, Learning Disability/Mental Health**

Action: **For Approval**

1. Introduction

1.1 The purpose of this paper is to update the Integration Joint Board (IJB) on the progress of the redesign of Mental Health Day Services across the Clackmannanshire and Stirling Partnership and a general update on the integration of operational services. The redesign work is part of the Transforming Care programme for the Partnership, which is regularly reported to the Board through the Chief Officer report.

2. Executive Summary

2.1 The Mental Health services across the Partnership are presently subject to review. The review and recommendations are consistent with the national Mental Health Strategy, 2017-27 (Scottish Government 2017).

2.2 The outcome priorities of the Partnership's Strategic Plan 2016-19 are consistent with the themes noted. The focus of the review is as follows:

- Redesign of day services.
- Development of a joint commissioning plan across health & social care services with the focus being on the development of local services in partnership with Housing and Third Sector colleagues with a reduction in the use of long term hospital beds and high cost, externally commissioned residential and nursing beds.
- Redesign of the management structure across health and social care services as presented to the March 2018 IJB. (see Appendix 2b for agreed integrated structure).

2.3 The Full Business Case specific to the redesign is attached in see appendix 1.

3. Recommendations

The Integration Joint Board is asked to:

3.1. Approve the Full Business Case specific to the redesign of Mental Health Services as noted in appendix 1.

3.2. Delegate authority to the Service Manager Learning Disability/Mental Health to continue with the redesign of the Mental Health service across the Health and Social Care Partnership.

3.3. Note the models of day services being developed across the range of integrated health and social care services as detailed in section 5.3.

3.4. Note that the Clackmannanshire based community outreach day service (Integrated Mental Health Team) is subject to further review and that an updated report will be presented during October 2018.

4. Background

4.1. The redesign of Mental Health services are specifically identified as priorities for transformation within the Partnership's Strategic Plan for the period 2017-19.

4.2 The Mental Health Service is required to evidence how it implements local, operational priorities:

- Change from traditional single agency services to integrated services at operational level across the NHS and the 2 Local Authorities.
- Develop services consistent with the national strategy for Mental Health, Mental Health Strategy, and 2017-27.
- Design and deliver services that operate within the available resources.

5. Main Body Of The Report

5.1 National Strategic Policy, Mental Health Strategy, 2017-27 highlights 40 key priorities for health and social care services under 4 general headings:

- Prevention & Early Intervention.
- Access to treatment and joined up accessible services.
- The physical wellbeing of people with mental health problems.
- Rights. Information use and planning & Data Measurement .

5.1.1 Within the context of the national strategy the mental health redesign groups have focussed on three specific issues of which first two noted are considered in this report:

- Redesigned management structures across health and social care services and development of operational delivery services consistent with a single integrated service.

- Redesign of internal day services in the Clackmannanshire locality.

- The development of a commissioning plan that focuses on the development of alternative services to long term hospital care, external high cost residential care and the development of supported living opportunities , care and home and day services that are developed local where possible and are outcomes focussed.

5.2 Redesign of management structures and operational services:

5.2.1 Previously agreed by the Integration Joint Board on March 2018 and outlined in appendix 2b.

5.2.2 At this time, the community outreach team, Integrated Mental Health Team, based at Marshill, Alloa will continue to be based there given its central location and early intervention and community focus.

5.2.3 The new Integrated Team Management Posts are presently subject to job evaluation by the partners organisations.

5.2.4 While the co location of health and social services staff is already in place within the Stirling base at Livilands Resource Centre the options relating to the Clackmannanshire locality continue to be subject to discussion including the co location at the Clackmannanshire Community Health Care Centre where the NHS Community Team is based.

5.2.5 Staff engagement sessions relating to this matter took place during February 2018. Staff have indicated their support in moving to a model of integrated team and single integrated management. There will be further meetings with staff as we move to implementation including specific training and development sessions.

5.3 Redesign of In-House Community Outreach Service:

5.3.1 The redesign of the mental health day services are outlined within the business case and re-designed operational structure in appendix 2b. This is specific to Clackmannanshire as services are commissioned via the Third Sector in Stirling.

5.3.2 Services based at Marshill House, Alloa (Integrated Mental Health Service):

The Phoenix Centre:

- The team provides mental health assessment and support for people with common but significant and enduring mental health such as depression and anxiety. This team received 326 referrals in 2017/18, constituting 20% of total referrals. Using a Cognitive Behaviour approach, the team (3.3 fte) work with this vulnerable group to develop better coping strategies and improve resilience and functioning. The team work within a recovery model, using a range of approaches from direct access courses (Stress Control course), Guided Self Help, individual and group support providing education, understanding and coping strategies.

- The team ethos is to empower individuals by building resilience, regaining control of their lives and promoting self management. This team has evolved over the last 6 years, changing approach and delivery to meet identified local and national need for prevention, early intervention and the importance of self management. Clackmannanshire experiences relatively higher levels of mental health issues and poor resilience to adverse life events and although not classified as mental illness, this significantly impacts on the functioning and life opportunities for individuals.

- Over the last year the service has redesigned provision by building stronger relationships with partners and aligning referral meetings. High Intensity Cognitive Behavioural Therapy [CBT] is now being appropriately provided by Psychological Therapies. This approach has supported the Phoenix Centre to focus on the care group as noted above. The plan is to consolidate this approach across the Partnership by redesigning services across localities, making best use of our available resources including staffing and reviewing overall commissioning across the area to build on the good work developed.

- The Board approved the Joint Commissioning Strategy at the meeting in March 2018. The implementation plan which formed part of the Commissioning Strategy highlighted the work now moving forward to commission services which provide a consistent ‘offer’ and standard of service across the Health and Social Care Partnership area. As part of the re design the lower intensity and resilience work will be re commissioned. A consultation process will progress over the summer with communities, service users, unpaid carers, staff and partners to inform this development.

The Community Access Team:

- The Community Access Team supports individuals with mental illness or more complex/entrenched mental health problems to link into community supports; supported employment, education, volunteering, leisure & recreation. The team mainly work one-to-one, linking individuals to mainstream community resources, but also deliver two in-house social support groups for more complex individuals. The team has a great deal of experience in supporting people with mental health problems, a wealth of knowledge on available activities and are trained in promoting social inclusion. From a historical team caseload of 93, only 15 individuals actually attend the longer term Social Groups, evidencing to social Inclusion remit of team.

- The Team also staff a weekly 'Well-being Outreach' in the Speirs Centre and we are currently looking at a partnership approach with CTSi to further develop this approach. In line with previous decisions the specialist Supported Employment element of this team has recently been discontinued and the core elements of an employability pathway provided by the wider team and we are forming links with the new Fair Start Scotland employment programme which started in April 2018.

- This model of service delivery promotes true social inclusion, wellbeing, community involvement and belonging and has evidenced of decreasing dependence on services. The learning from this model is currently being shared with the Learning Disability Service with a view to developing a single Adult Care Community Outreach service covering the Mental Health, Learning Disability and Physical Disability care groups that have historically been managed as separate services. This ambition is to develop this service across the partnership localities while the initial redesign will focus on the Clackmannanshire locality.

5.3.3 Community Health Services:

Livilands Resource Centre (Stirling) & Mental Health Resource Centre (Alloa):

- Both Resource Centres comprise of Consultant Psychiatrists, Community Psychiatric Nurses, Community Staff Nurses, Occupational Therapist, Psychologists, and Art Therapist. The Resource Centre provides assessment and interventions for patients who experience moderate to severe and or complex mental health problems, aged 18-65; this is provided on an individual, out-patient or group basis, within the Resource Centre or within the home environment and wider community.

- Many patients in our care of have complex, severe and enduring mental health problems such as schizophrenia and bi-polar disorder. These patients will establish and maintain contact with the service, often developing a longer term therapeutic relationships with staff.

- The services provide ongoing specialist care for those patients subject to interventions under the Mental Health (Care and Treatment) (Scotland) Act 2003 who live in the community.

- Priority will be given to individuals who have severe, enduring and complex mental health problems such as schizophrenia, bi-polar disorder and borderline personality disorder.

- Individuals who have been identified as having moderate mental health problem that is not likely to improve without assessment or treatment from specialist services.

5.3.4 The integration of the management of the social care and health service day services within a single locality management structure will provide the opportunity for not just joint working in a consistent manner but a further opportunity to plan and develop services in a strategic manner across health, local authority and Third Sector social care services. Perceived benefits will include clarity in service pathways, reduction in duplication, provide a cost efficient management structure and maximise the capacity of the service in providing a service consistent with the national Mental Health Strategy

6. Conclusions

6.1 The Mental Health services across the Partnership are presently subject to review. The perceived benefits of the review are consistent with the national Mental Health Strategy, 2017-27which focuses on improved outcomes for people across health and social care services and generally within the community. The specific element of the review referred to in this report is as follows:

- Redesign of the management structure across health and social care, including existing day services, and the development of operational delivery services consistent with a single integrated service. Timescale for implementation being by the end of the first quarter of 2018/19.

7. Resource Implications

7.1 Projected full year gross financial efficiency of £262,220. (11.7% of total budget via the development of an integrated team and management structures and efficiencies generated from the redesign of the Community Outreach service in Clackmannanshire. (see appendix 1 Full Business Case)

Figure subject to some staff taking Voluntary Severance or being successfully redeployed to other posts.

8. Impact on Strategic Plan Priorities and Outcomes

8.1. This report and associated recommendations, relates to the following Clackmannanshire & Stirling Health and Social Care Partnership local outcomes and Strategic Plan priorities (please select as appropriate):

Fit with Local Outcomes	
Self Management	☐
Community Focussed Supports	☒
Safety	☐
Decision Making	☒
Experience	☐

Fit with Our Priorities 'we will...'	
Further develop systems to enable front line staff to access and share information	☐
Support more co-location of staff from across professions and organisations	☒
Develop single care pathways	☒
Further develop anticipatory and planned care services	☐
Provide more single points of entry to services	☐
Deliver the Stirling Care Village	☐
Develop seven-day access to appropriate services	☒
Take further steps to reduce the number of unplanned admissions to hospital and acute services	☐

9. Legal & Risk Implications

9.1. Not applicable at this stage of the review.

10. Consultation

10.1. As noted in the body of the report in relation to staff, service users and carers, Trade Unions and Staff Representatives and Community representatives.

11. Equality and Human Rights Impact Assessment

11.1. An EQIA has been completed for the proposals contained in this paper on the basis that this is a significant change in the way operational services are organised and delivered across the Partnership.

12. Data Protection Impact Assessment

The contents of this report do not require a DPIA.

13. Appendices

Appendix 1: Business Case: Integration of Operational Services
Appendix 2: Appendix 2a & b: Integrated operational structure diagram

Clackmannanshire Council

Stirling Council

NHS Forth Valley

Appendix 1
15 May 2018

Business Case

Document Owner(s)
Name: Jim Robb

Revision History			
By	**Reason**	**Date**	**Version**
Jim Robb	Service Review	15 May 2018	v1

Document Distribution		
Name	**Date**	**Version**
Shiona Strachan	16 May 2018	v1

Document Approvals			
Name	**Title**	**Date**	**Version**

Contents

1. Executive Summary.....12
2. Background.....13
3.1 Scope.....15
3.2 Out of Scope 15
4. Business Needs and Priorities.....15
7. Recommendation.....16
8. Benefits Matrix.....16
9. Benefits Tracker.....18
10. Risks.....22
11. Timeline.....22
12. Governance.....22
13. Project Management Plan Checklist 23
14. Dependencies 23

A. Appendix 1 – Pilot Area Data Summary..... **Error! Bookmark not defined.**

Project Name	Integration of Mental Health Community, Nursing, Mental Health Officer and Community Outreach Service
Proposed By	Jim Robb, Service Manager, LD/MH

1. Executive Summary

Background:

The Mental Health services across the Partnership are presently subject to review. The perceived benefits of the review are consistent with the national Mental Health Strategy, 2017-27 (Scottish Government 2017) which highlights 5 key themes:

- Prevention & Early Intervention
- Access to treatment and joined up accessible services
- The physical wellbeing of people with mental health problems
- Rights. Information use and planning
- Data Measurement

The outcome priorities of the Partnership's Strategic Plan 2016-19 are consistent with the themes noted. The focus of the review is as follows:

- Redesign of the management structure across health and social care services, including the community outreach service, and the development of operational delivery services consistent with a single integrated service.

Scope:

- Mental Health Officer services in the Clackmannanshire & Stirling
- Community Mental Health Nursing services managed within the HSCP
- Community Outreach services in the Clackmannanshire Locality.

Business Needs and Priorities:

- Services required to operate within available budget.
- Integration Joint Board's Strategic Plan 2016-19
- Services developed in a manner consistent with agreed eligibility framework, Critical & Substantial Risk

Benefits:

Benefits of Integrating operational services:

High Level:

- Efficient management structures & cost effective.
- Consistent approach to service planning and workforce planning.
- Consistent approach to service delivery and agreed priorities.

Operational:

- Cost effective single management system providing consistency of approach to service delivery.
- Single door access to services across health & social care and reduction in duplication of task such as information giving.
- Consistency of approach across health and social care professionals and the development of an integrated single care pathway.

2. Background

Proposal:

It is evident that within both service groups that there is a clear commitment to developing, where practical, a service based on a single integrated management structure operating from a pooled budget and which is co-located. The benefits of an integrated team and management structure as follows:

- Cost effective single management system providing consistency of approach to service delivery
- Single door access to services across health & social care and reduction in duplication of task such as information giving and assessment
- Consistency of approach across health and social care professionals and the development of a consistent approach to service delivery.
- Consistent approach to service planning and workforce planning

At this time, the community outreach team, Integrated Mental Health Team, based at Marshill, Alloa will continue to be based there given its central location and early intervention/community focus. The service is subject to further review and an updated report will be provided by October 2018. The Team Manager's remit will be expanded in order to take the operational overview of community mental health services commissioned from the Third Sector in the Stirling Locality.

Key Principles:

- Single/Integrated Management.

  The Team Manager manages the integrated Social Work and Community Nursing team in one locality on a daily basis while being part of the partnership management team across the partnership as required. The Team Manager is a key post in providing professional/clinical management as per a matrix management approach to management that covers both operational and professional management requirements. Consequently, one of the Team Managers will be from an NHS professional background and the other a Social Work professional background.

- Pooled Budget.

- Co Location. While co location in Stirling has been achieved the matter is outstanding in the Clackmannanshire Locality.

The proposed structure is attached as Appendix 2b of the covering report.

Efficiencies:

- Deletion of Assistant Team Manager for Mental Health Officers. Post is presently vacant and would provide a gross efficiency of £52,000. (Vacant post).

- Reduction of one Mental Health Officer (MHO) post in Clackmannanshire. Gross efficiency of £52,000. Proposal is to supplement the core MHO Teams by a combination of training and recruiting MHO posts throughout the totality of the Social Work service in order to increase the total number of MHO's.

- Deletion of Assistant Team Manager of the Integrated Mental Health Team in Clackmannanshire (Phoenix Centre). Proposal is to retain £6,442 within the service, and provide a gross efficiency of £34,973. (Employee presently in post and options relating to redeployment/voluntary severance (VS) being progressed via the agreed corporate process).

- Deletion of Supported Employment Worker (0.6fte). Gross efficiency of £20,257. (Employee presently in post and options relating to redeployment/voluntary severance (VS) being progressed via the agreed corporate process).

- Deletion of Local Area Coordinators x 2 (Stirling). Capacity can be developed required in partnership with the Third Sector as required. Gross efficiency of £102,990. (Employees presently in post and options relating to redeployment/VS being progressed via the agreed corporate process.)

Note:

Combined Budget: £2,240,364

- Total gross full year efficiency identified £262,220. (11.7% of total budget) Full efficiency subject to the conclusion of the VS and redeployment processes and therefore will not be achieved in full until 2019/20.

- The new Integrated Team Management Posts are presently subject to job evaluation by the partners organisations and will be recruited thereafter.

3. Scope

- Direct provision of Mental Health Officer services across the Clackmannanshire & Stirling Localities.
- Direct provision of community Mental Health Nursing services managed with the HSCP across the Clackmannanshire and Stirling localities.
- The community outreach team, Integrated Mental Health Team, based at Marshill, Alloa. The service is subject to further review and an updated report will be provided by October 2018.

4. Out of Scope

- Community Mental Health Nursing services managed on a NHS Forth Valley Board basis.
- Community Outreach services commissioned from the Independent and Voluntary sectors.

5. Business Needs and Priorities

The Mental Health Service is required to evidence how it implements local, operational priorities. Specifically:

- Integration of operational teams across community Mental Health Nurses, Allied Health Professionals (AHP) and Mental health Officers via a single management structure, including the community outreach service, and the development of operational delivery services consistent with a single integrated service.
- Develop services consistent with the principles of the Self Directed Support Legislation In line with the national Self-directed Support Strategy [2010] and the recent report by Audit Scotland support the embedding of Self-directed support as a means of ensuring that services are being provided in a cost effective manner, with equitable access to the available resources.
- Service to operate within available revenue.

<u>Priorities:</u>

To develop services consistent with the principles of:

- Established best practice for clinical care
- Minimum statutory intervention and promotion of independence
- Development of community alternatives to statutory social work intervention and service delivery
- Promoting empowerment and choice for service users and their families both in the

design of social care support and when it can be delivered.

- Operate with available revenue and making efficiencies of 7.5% per annum for the financial years 2017/18, 2018/19 and 2019/20.

6. Recommendation

1. Approve the integration of Mental Health services as presented in Appendix 2b of the covering report.

2. Approve the financial efficiencies identified for the financial year 2018/19, gross full year efficiency of £262,220. (11.7% of total budget) Full efficiency subject to the conclusion of the VS and redeployment processes and therefore will not be achieved in full until 2019/20.

3. Approve that a further a further 7.5% efficiency will be achieved during the financial year 2019/20.

4. Note that the Clackmannanshire based community outreach day service (Integrated Mental Health Team) is subject to further review and that an updated report will be presented during October 2018.

7. Benefits Matrix

Improvement in efficiency/effectiveness:

- Efficient management structures & cost effective.
- Consistent approach to service planning and workforce planning.
- Consistent approach to service delivery and agreed priorities.

Compliance:
Consistent with national policy and legislation and the HSCP priorities.

- The Keys to Life, Scottish Government 2014.
- Self-directed Support Strategy [2010] and the recent report by Audit Scotland support the embedding of Self-directed support as a means of ensuring that services are being provided in a cost effective manner, with equitable access to the available resources.
- Partnership's Strategic Plan and priorities 2017-19.

User Value:

- Single management system providing consistency of approach to service delivery.

Wider public/organisational value:

- Promotes the integration of people with disabilities within the wider community and lessens the dependency on statutory services.

• Single door access to services across health & social care and reduction in duplication of task such as information giving. • Consistency of approach across health and social care professionals and the development of an integrated single care pathway.	• Develops services that are consistent with national policy and best practice both in terms of value for money and outcomes for service users. • Improves reputation of the Health & Social Care Partnership in terms of providing services consistent with national policy and best value.

8. Benefits Tracker

Benefit	Category	Owner	Who Benefits?	Indicators	Baseline Metric	Target Metric	Progress Narrative (RAG)
Efficient management structures & cost effective that combines: • a consistent approach to service planning and workforce planning • a consistent approach to service delivery and agreed priorities.	Improvement in Efficiency & Effectiveness.	Service Manager & Integrated Team Leaders.	Cost effective management structure assists the HSCP to operate within available resources.	Develop-ment of integrated management structure within existing pool of revenue.	Existing Budget: £2,2240,364	Efficiencies Identified for 2018/19: £262,220. (11.7%)	**Green.** Proposals on tracks via vacancies and planned recurring efficiencies via the deletion of posts.
More efficient use of buildings.	Improvement in Efficiency & Effectiveness.	Service Manager & Integrated Team Leaders.	Cost effective use of buildings assists the HSCPl to operate within available resources.	Reduction in number of buildings used in the Clacks Locality.	Services in the Stirling Locality are presently co-located. Separate Council and NHS buildings in Clacks Locality.	Co location in Clacks.	**Amber.** Co location in Clacks Locality presently subject to negotiation.

Consistent with national policy and legislation. Mental Health Strategy 2017-27 (Scottish Government)	Compliance.	Service Manager / Integrated Team Managers.	Cost effective use of community services and development of person centred & innovative services that reduce the financial dependency on the HSCP while promoting service user independence.	Service users being provided with services consistent with the Mental Health Strategy.	40 Actions within the Strategy.	HSCP to evidence progress against the 40 Actions within the Strategy.	**Amber.** Implementation of Actions is being led on a NHS Board wide basis and subject to update.
Self-directed Support Strategy [2010] and the recent report by Audit Scotland support the embedding of Self-directed support as a means of ensuring that services are being provided in a cost effective manner, with equitable access to the available resources.	Compliance.	Service Manager / Integrated Team Managers.	Cost effective use of community services and development of person centred & innovative services that reduce the financial dependency on the HSCP while promoting service user independence.	Higher numbers of service users being provided with services consistent Self Directed Support.	Limited evidence of all service users being assessed/reviewed using the principles of SDS.	Evidence of all service users being assessed/ reviewed using the principles of SDS within the financial years 2018/19 and 2019/20.	**Amber** Detailed reporting systems in place – programme to be monitored via joint finance meetings

Partnership's Strategic Plan and priorities for 2017-2019.	Compliance.	Service Manager.	Cost effective use of community services and development of person centred & innovative services that reduce the financial dependency on the HSCP while promoting service user independence.	Integration of operational services across NHS and Social Work.	Services managed within single agency model.	Services managed within integrated model.	**Green.** Proposals on track for October 2018.
Promotes the integration of people with disabilities within the wider community and lessens the dependency on statutory services. • Develops services that are consistent with national policy and best practice both in terms of value for money and outcomes for service users. • Improves reputation of the Health & Social Care Partnership in terms of providing services consistent with national policy and best practice.	Wider public/ organisational value.	Service Manager.	Cost effective use of community services reduces the financial dependency on the HSCP while promoting service user independence.	Higher numbers of people using community based services, education, employment, leisure & recreation as an alternative to social work services.	Tbc.	Tbc.	**Red.** Reporting indicators as yet to be confirmed.

Single management system providing consistency of approach to service delivery. Single door access to services across health & social care and reduction in duplication of task such as information giving. Consistency of approach across health and social care professionals and the development of an integrated single care pathway.	User Value.	Service Manager.	Service Users & Carers.	Increasing Numbers of Service Users/ Carers providing positive feedback on services.	National Outcomes Framework provides service indicators.	Improved performance for the financial year 2018/19.	**Amber.** New social care outcomes focussed assessment/ review documents to routinely provide the opportunity for service user/carer feedback that will be reported quarterly/annually once in place. (October 2018). This will supplement existing service user/carer/patient feedback.

9. Risks

Risk	Impact H/M/L	Probability H/M/L	Action to Mitigate Risk
Lack of engagement with/from Trade Unions and Staff side	H	L	Regular meetings have been in place with Trade Unions since August 2017 in relation to the development of proposals. Proposals are also discussed within the Joint Staff Forum
Lack of engagement with staff	H	L	There were staff engagements sessions relating to this matter during February. Staff have indicated their support in moving to a model of integrated team and single integrated management. There will be further meetings with staff as we move to implementation.
Lack of engagement with patients/service users and unpaid carers	H	M	Engagement started during February 2018 and ongoing every 6-8 weeks.
Lack of community engagement. Strategic Planning Group / Public Partnership Forum.	H	L	Engagement proceeded during February/March 2018.

10. Timeline

	Milestone	Planned Date
1	Options drafted for the design of day services. Signed off at IJB meeting March 2018.	March 2018
2	Full Business Case to be presented to IJB during June 2018	June 2018
3	Implementation of redesigned day services beginning October 2018	1st October 2018
4		
5		
6		
7		
8		
9		
10		

11. Governance

Report to Joint Management Team and to the Clackmannanshire & Stirling Integration Joint Board.

12. Project Management Plan Checklist

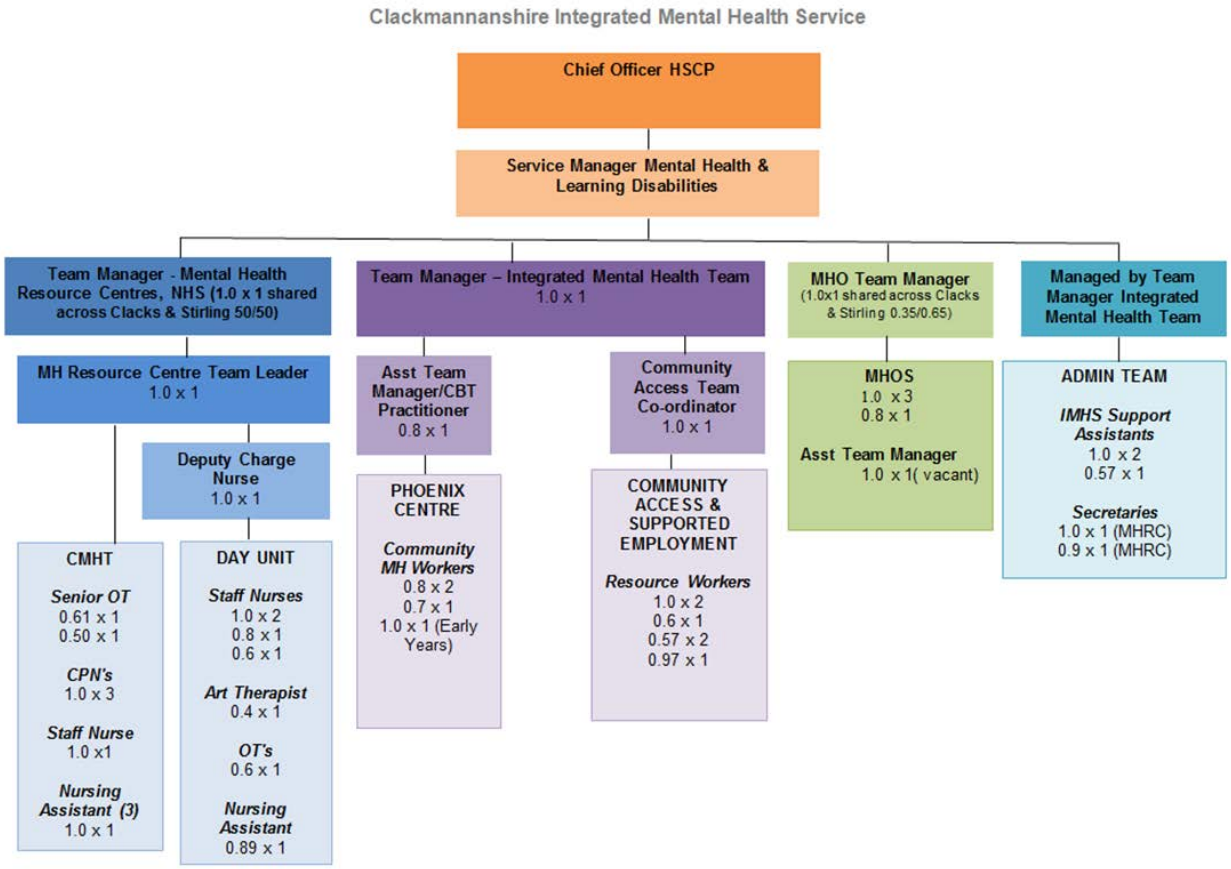
Project Tool	Function	Status	Sponsor Sign off

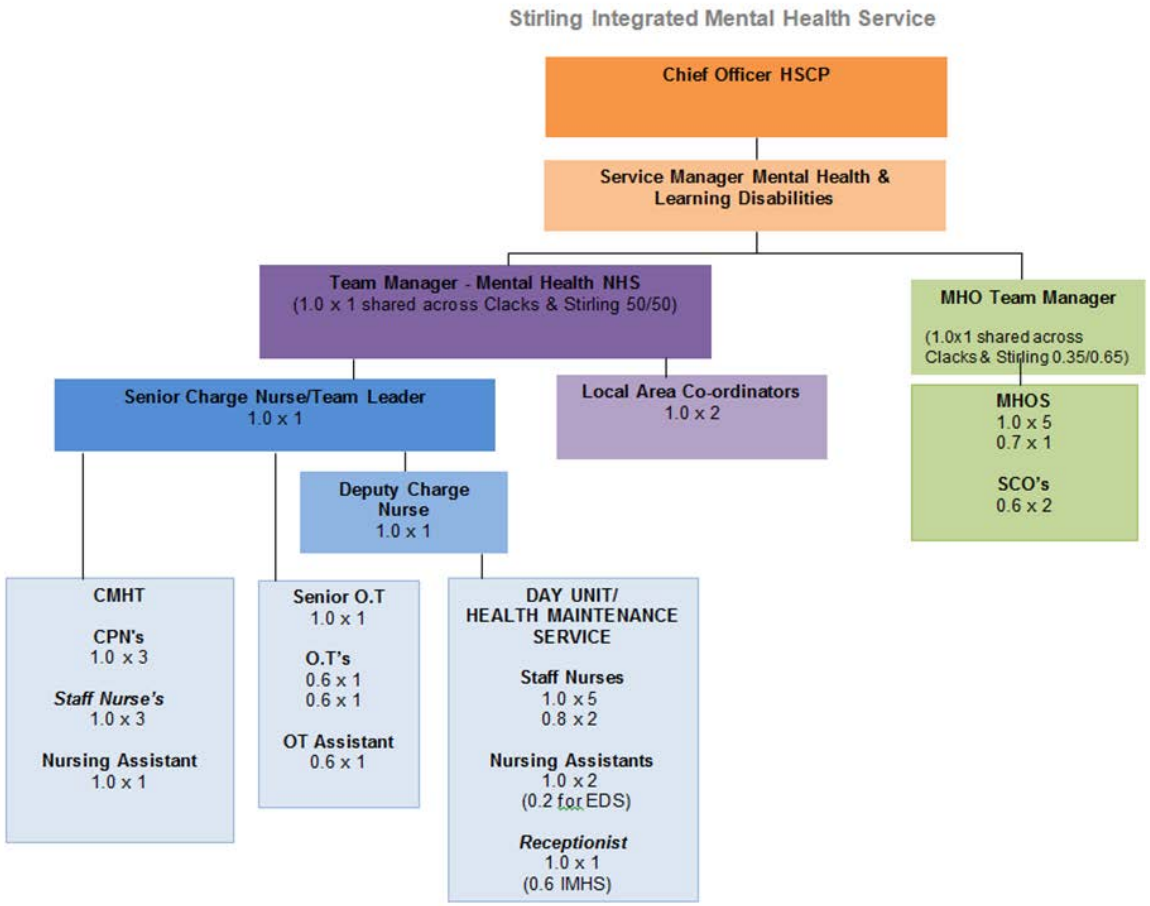
13. Dependencies

Project or Initiative Name / Ref	Reason	Managed By

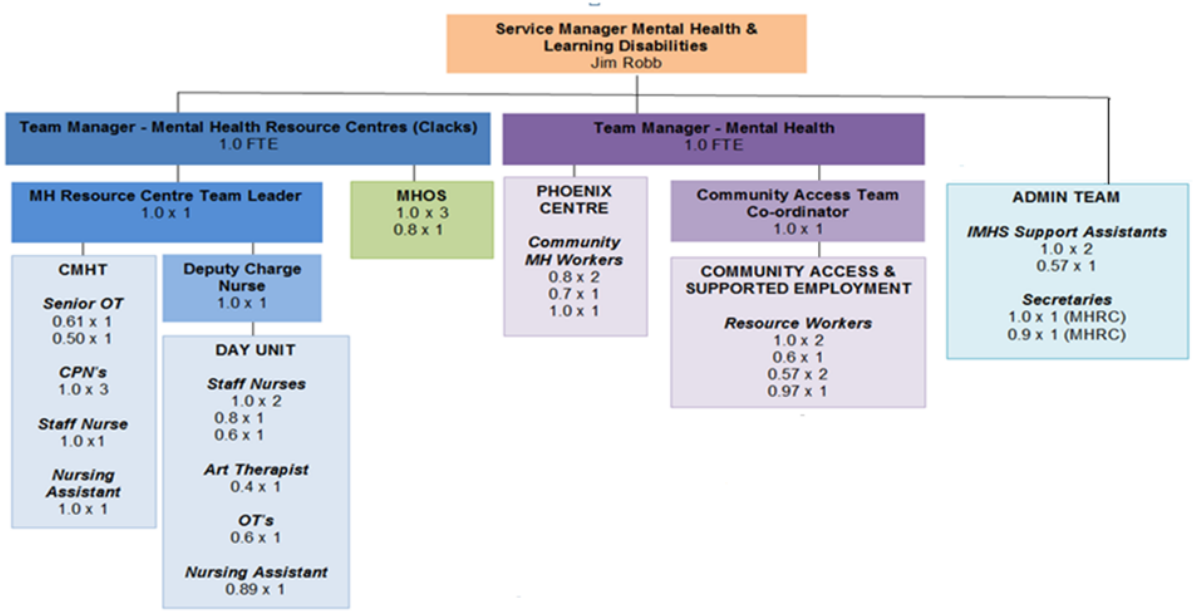
Present Operational Management Arrangements

Appendix 2a


Clackmannanshire Integrated Mental Health Service
Chief Officer HSCP
Service Manager Mental Health & Learning Disabilities
Team Manager - Mental Health Resource Centres, NHS (1.0 x 1 shared across Clacks & Stirling 50/50)
MH Resource Centre Team Leader 1.0 x 1
Deputy Charge Nurse 1.0 x 1
CMHT
Senior OT
0.61 x 1
0.50 x 1
CPN's
1.0 x 3
Staff Nurse
1.0 x1
Nursing Assistant (3)
1.0 x 1
DAY UNIT
Staff Nurses
1.0 x 2
0.8 x 1
0.6 x 1
Art Therapist
0.4 x 1
OT's
0.6 x 1
Nursing Assistant
0.89 x 1
Team Manager – Integrated Mental Health Team 1.0 x 1
Asst Team Manager/CBT Practitioner 0.8 x 1
PHOENIX CENTRE
Community MH Workers
0.8 x 2
0.7 x 1
1.0 x 1 (Early Years)
Community Access Team Co-ordinator 1.0 x 1
COMMUNITY ACCESS & SUPPORTED EMPLOYMENT
Resource Workers
1.0 x 2
0.6 x 1
0.57 x 2
0.97 x 1
MHO Team Manager (1.0x1 shared across Clacks & Stirling 0.35/0.65)
MHOS
1.0 x 3
0.8 x 1
Asst Team Manager
1.0 x 1(vacant)
Managed by Team Manager Integrated Mental Health Team
ADMIN TEAM
IMHS Support Assistants
1.0 x 2
0.57 x 1
Secretaries
1.0 x 1 (MHRC)
0.9 x 1 (MHRC)


Stirling Integrated Mental Health Service
Chief Officer HSCP
Service Manager Mental Health & Learning Disabilities
Team Manager - Mental Health NHS
(1.0 x 1 shared across Clacks & Stirling 50/50)
MHO Team Manager
(1.0x1 shared across Clacks & Stirling 0.35/0.65)
Senior Charge Nurse/Team Leader
1.0 x 1
Local Area Co-ordinators
1.0 x 2
MHOS
1.0 x 5
0.7 x 1
SCO's
0.6 x 2
Deputy Charge Nurse
1.0 x 1
CMHT
CPN's
1.0 x 3
Staff Nurse's
1.0 x 3
Nursing Assistant
1.0 x 1
Senior O.T
1.0 x 1
O.T's
0.6 x 1
0.6 x 1
OT Assistant
0.6 x 1
DAY UNIT/ HEALTH MAINTENANCE SERVICE
Staff Nurses
1.0 x 5
0.8 x 2
Nursing Assistants
1.0 x 2
(0.2 for EDS)
Receptionist
1.0 x 1
(0.6 IMHS)

Appendix 2b Proposed Clackmannanshire Integrated Mental Health Service



OPTION 4 (Clacks)

Clackmannanshire & Stirling Health and Social Care Partnership
Integration Joint Board

13 June 2018

This report relates to
Item 7.4 on the agenda

Learning Disability Redesign: Day Services & Update

(Paper presented by Jim Robb)

For Approval

Approved for Submission by	Shiona Strachan, Chief Officer
Author	Jim Robb, Service Manager Learning Disability/Mental Health
Date:	13 June 2018
List of Background Papers / Appendices:	
• IJB Report: Redesign of Learning Disability & Mental Health Services December 2017 • IJB Report: Learning Disability Redesign. March 2018. Appendix 1: Business Case: Integration of Operational Services Appendix 2a & b **:** Integrated operational structure diagram Appendix 3: Business Case: Review of directly provided Day Services	

Title/Subject: **Learning Disability Redesign: Day Services & Update**

Meeting: **Clackmannanshire & Stirling Integration Joint Board**

Date: **13 June 2018**

Submitted By: **Jim Robb, Service Manager, Learning Disability/Mental Health**

Action: **For Approval**

1. Introduction

1.1 The purpose of this paper is to update the Integration Joint Board (IJB) on the progress of the redesign of the Learning Disability (LD) Day Services across the Clackmannanshire and Stirling Health and Social Care Partnership and a general update on the integration of operational services. The re design work is part of the Transforming Care programme for the Partnership, which is regularly reported to the Board through the Chief Officer report.

2. Executive Summary

2.1 The Learning Disability services across the Partnership are presently subject to review. The planned benefits of the review are consistent with the national "Keys to Life" strategy (Scottish Government 2013) which spans a variety of issues from general Human Rights to the development of services consistent with Self-directed Support, innovative commissioning of services and day supports for those with profound and multiple learning disabilities.

2.2 The outcome priorities of the Partnership's Strategic Plan 2016-19 are consistent with the themes noted. The focus of the review is as follows:

- Redesign of the management structure across health and social care services and development of operational delivery services consistent with a single integrated service. Timescale for implementation being September 2018 subject to a successful recruitment process (see appendix 2b for new integrated structure).

- Redesign of day services and day support. Initial redesign of service to be in place by October 2018 with the understanding that redesign opportunities will continue thereafter in a manner consistent with service user outcomes.

- The Full Business Case specific to the redesign is attached in appendix 1.

2.3 The following graphic highlights the different areas and levels of service which form part of the community support services.

3. Recommendations

The Integration Joint Board is asked to:

3.1 Approve the Business Case for the redesign of operational services across the Partnership incorporating the development of integrated teams in Clackmannanshire and Stirling (appendix 1).

3.2 Delegate authority to the Service Manager Learning Disability and Mental Health to continue with the redesign of the Learning Disability service across the Health and Social Care Partnership.

3.3 Note the update on the model of in-house day services being developed across the Partnership.

4. Background

4.1. The redesign of Learning Disability services are specifically identified as priorities for transformation within the Partnership's Strategic Plan for the period 2017-19.

4.2. The Learning Disability Service is required to evidence how it implements local, operational priorities:

- Change from traditional single agency services to integrated services at operational level across the NHS and the 2 councils.
- Redesign of traditional day services to personal outcome services, 5/7 shift work etc. Whether services are provided directly by the Partnership or externally commissioned the service specification should be the same.
- Develop services consistent with the national strategy for Learning Disability, “The Keys to Life”.
- Services that operate in an outcomes framework and are delivered within the available resources.

5. Main Body of the Report.

5.1 Within the context of the national strategy the Learning Disability Redesign groups have focussed on the following:

- Redesigned management structures across health and social care services and development of operational delivery services consistent with a single integrated service.
- Redesign of internal day services.

5.2 <u>Redesign of management structures and operational delivery</u>:

5.2.1 Appendix 2b outlines the proposed integrated operational structure which was noted by the Integration Joint Board in March 2018.

5.2.2 The Integrated Team Management Posts are presently subject to job evaluation by the constituent partner organisations.

5.2.3 While the co location of health and social services staff is already in place within Stirling the options relating to Clackmannanshire continue to be subject to discussion including the co location at the Clackmannanshire Community Health Care Centre where the NHS Community Team is based.

5.2.4 Staff engagements sessions relating to this matter took place during February 2018. Staff have indicated their support in moving to a model of integrated team and single integrated management. There will be further meetings with staff as we move to implementation including specific training and development sessions for all staff.

5.3 Redesign of In-house Day Services:

5.3.1 The projected benefits of the redesign of in-house day services are as follows:

- The development of flexible and innovative community based services consistent with the principles of client specific outcomes and Self-directed Support, operating seven day per week including the option of providing opportunities during evenings and weekends.

- Building based services focused primarily on the provision of services for high dependency service users who require high levels of supervision and personal care as well as their social development including the option of providing opportunities during evenings and weekends.

5.4 Clackmannanshire:

- In Clackmannanshire a similar exercise is being progressed with the Physical Disability (PD) service users attending the Whins with a view to combining the staff group and the service where it is appropriate to do so. It is proposed that the building based service is managed by the same group of managers while retaining separate services within this single building base.

- It is proposed that a new community outreach, non- building based service, is developed for both LD & PD client groups supported through an integrated management team and work force. Initial proposals are also being considered in order that existing community outreach Mental Health services will be considered as part of the redesign in order to create services that are managed through a single integrated structure.

- The current Learning Disability service is primarily a building based service across 4 sites for 57 service users with an average attendance of 35 service users per day over the period Monday to Friday and excludes evening work. As reported to the March IJB, an initial assessment developed by Day Services staff is that the redesign should conclude with a single building to serve between 15-20 high dependency service users (present and future over the next 10 years) with a remaining 31 service users being supported in the community. An additional 14 service users would be supported to access a range of employment, education, leisure and recreation opportunities and to reduce dependency on day services.

- Individual care reviews are presently progressing with priority given to those service users where a change in service is proposed whether it be a move from a building based services to a community outreach service or supporting service users out of the service and into employment, education, leisure activities. A similar exercise is presently progressing for the Physical Disability service users.

- There are bi monthly meeting with unpaid carers in relation to the development of future services and the model of care. In the absence of an existing community outreach model in Clackmannanshire many unpaid carers continue to have concerns relating to the development of an alternative model of care and perceived risks. There will be ongoing engagement using both group discussions and individual care reviews where the detail of what community opportunities can be developed in order to meet the needs and ambitions of individual service users will be further explored.

- There are bi monthly meetings with staff in relation to the future staffing requirements for the combination of a community based and building based service. Trade Union representatives have attended the recent meetings and we are now at the stage of moving to more formal negotiations around the detailed requirements of the service.

5.5 Stirling:

- In Stirling the service is a combination of a building based service at Riverbank and a non building based, community support service named "Streets Ahead". Both operate over Monday to Friday and exclude evening and weekend working.

- As reported to the March IJB, Riverbank presently supports 24 service users with a maximum attendance of 16 per day. The initial assessment developed by Day Services staff is that the redesign should conclude with Riverbank providing services for 16 high dependency service users and provision for an additional 3 places for future growth making 19 places in total. It is proposed that 9 of the existing group of service users would be more appropriately supported via the Streets Ahead service.

- Streets Ahead presently supports 32 service users with a maximum of 20 per day. The initial assessment concluded that 29 existing service users would continue to use the service with an additional 9 transferring from the Riverbank service as noted. An additional 4 service users have been initially assessed as having the potential to be supported out of the service completely into a range of employment, education, leisure and recreation opportunities by October 2018.

- There are bi monthly meeting with unpaid carers in relation to the development of future services and the model of care. Given the existence of the Streets Ahead service in Stirling, carers have a clearer idea of how a community outreach model might support their family members, although there is concern that this may be limited to Monday-Friday daytime given the additional cost of evening and weekend work. Carers note that they believe there is some contradiction in being encouraged to be innovative in their approach to service development if there is a disadvantage in the provision in the number of hours provided in doing so. As in Clackmannanshire the unpaid carers have expressed concerns relating to the development of an alternative model of care and perceived

risks. There will be ongoing engagement both within groups and individual care reviews where the detail of what community opportunities can be developed in order to meet the needs and ambitions of individual service users will also be further explored.

- There are bi monthly meetings with staff in relation to the future staffing requirements for the combination of a community based and building based service. Trade Union representatives have attended some of the meetings and we are now at the stage of moving to more formal negotiations around the detailed requirements for the service.

5.6 In both Clackmannanshire and Stirling there is an identified 7.5% efficiency for the years 2017/18, 2018/19 and 2019/20. It is expected that the efficiencies will be achieved by the reorganisation of services that support a planned reduction in staffing via the combination of the deletion of staff vacancies and authorising voluntary severance requests where appropriate.

5.7 The proposed timescale to implement the initial phase of the redesign of in-house services is 1st October 2018.The expectation is that the redesign would be accompanied by a culture of innovation and change that would see the service continue to develop in order to meet the needs and ambitions of service users in the future.

6. Conclusions

6.1 The Learning Disability services across the Partnership are presently subject to review. The perceived benefits of the review are consistent with the national "Keys to Life" strategy (Scottish Government 2013) which focuses on improved outcomes for people across health and social care services and generally within the community. The specific elements of the review are as follows:

- Redesign of the management structure across health and social care services and development of operational delivery services consistent with a single integrated service. Timescale for implementation being by the end of the first quarter of 2018/19.

- Redesign of internal day services. Initial redesign of services to be in place for October 2018.

7 Resource Implications

7.1 7.5% reduction per annum in the in house day services within both localities for the financial years 2017/18, 2018/19 and 2019/20.

8 Impact on Strategic Plan Priorities and Outcomes

8.1 This report and associated recommendations, relates to the following Clackmannanshire & Stirling Health and Social Care Partnership local outcomes and Strategic Plan priorities (please select as appropriate):

Fit with Local Outcomes	
Self Management	☐
Community Focussed Supports	☒
Safety	☐
Decision Making	☒
Experience	☐

Fit with Our Priorities 'we will...'	
Further develop systems to enable front line staff to access and share information	☐
Support more co-location of staff from across professions and organisations	☒
Develop single care pathways	☒
Further develop anticipatory and planned care services	☐
Provide more single points of entry to services	☐
Deliver the Stirling Care Village	☐
Develop seven-day access to appropriate services	☒
Take further steps to reduce the number of unplanned admissions to hospital and acute services	☐

9 Legal & Risk Implications

9.1 Not applicable at this stage of the review.

10 Consultation

10.1 As noted in the body of the report in relation to staff, service users and carers, Trade Unions and Staff Representatives and Community representatives.

11 Equality and Human Rights Impact Assessment

11.1 An EQIA has been completed for the proposals contained in this paper on the basis that this is a significant change in the way operational services are organised and delivered across the Partnership.

12. Data Protection Impact Assessment

The contents of this report do not require a DPIA.

Appendix 1: **Business Case: Integration of Operational Services**

Appendix 2a & 2b: **Integrated Operational Structure Diagram**

Appendix 3: **Business Case: Review of Directly Provided Day Services**

APPENDIX 1 - BUSINESS CASE

Integration of Operational Services

Business Case

Document Owner(s)
Name: Jim Robb

Revision History			
By	**Reason**	**Date**	**Version**
Jim Robb	Service Review	15th May 2018	v1

Document Approvals			
Name	**Title**	**Date**	**Version**

Contents

1. Executive Summary....13
2. Background....14
3.1 Scope....16
3.2 Out of Scope....16
4. Business Needs and Priorities....16
7. Recommendation....17
8. Benefits Matrix....17
9. Benefits Tracker....19
10. Risks....24
11. Timeline....24
12. Governance....24
13. Project Management Plan Checklist....**Error! Bookmark not defined.**
14. Dependencies....**Error! Bookmark not defined.**
A. Appendix 1 – Pilot Area Data Summary....**Error! Bookmark not defined.**

Project Name	Integration of Operational Services: Review of Learning Disability & Physical Disability Day Services. Direct Provision
Proposed By	Jim Robb, Service Manager, LD/MH

1. Executive Summary

Background:

The Learning Disability service across the Partnership is presently subject to review. The perceived benefits of the review are consistent with the national *Keys to Life* Strategy (Scottish Government 2013) which spans a variety of issues from general Human Rights to the development of services consistent with Self-directed Support, innovative commissioning of services and day supports for those with profound and multiple learning disabilities.

The outcome priorities of the Partnership's Strategic Plan 2016-19 are consistent with the themes noted. The focus of the review is as follows:

- Redesign of the management structure across health and social care services, including the community outreach service, and the development of operational delivery services consistent with a single integrated service.

Scope:

- Social care staff operating within the Learning Disability Teams across the Partnership areas.
- Community Learning Disability Nursing and Allied Health Professionals (AHP) operating within the Partnership

Business Needs and Priorities:

- Services are required to operate within available budget.
- Integration Joint Board Strategic Plan 2016-19
- Services developed in a manner consistent with agreed eligibility framework, which is operating at the levels of Critical & Substantial Risk

Benefits:

Benefits of Integrating operational services:

<u>High Level:</u>

- Efficient management structures & cost effective.

- Consistent approach to service planning and workforce planning.
- Consistent approach to service delivery and agreed priorities.

Operational:

- Cost effective single management system providing consistency of approach to service delivery.
- Single door access to services across health & social care and reduction in duplication of tasks such as information giving.
- Consistency of approach across health and social care professionals and the development of an integrated single care pathway.

2. Background

Proposal:

It is evident that within both service groups that there is a clear commitment to developing, where practical, a service based on a single integrated management structure operating from a pooled budget and which is co-located. The benefits of an integrated team and management structure as follows:

- Cost effective single management system providing consistency of approach to service delivery.
- Single door access to services across health & social care and reduction in duplication of tasks such as information giving and assessment.
- Consistency of approach across health and social care professionals and the development of a consistent approach to service delivery.
- Consistent approach to service planning and workforce planning.

Key Principles:

- Single/Integrated Management:

  The Team Manager manages the integrated Social Work and Community Nursing team in one locality on a daily basis while being part of the partnership management team across the partnership as required. The Team Manager is a key post in providing professional/clinical management as per a matrix management approach to management that covers both operational and professional management requirements. Consequently, one of the Team Managers will be from an NHS professional background and the other a Social Work professional background.

- Pooled Budget.

- Co Location:

  While co location in Stirling has been achieved the options for co location in Clackmannanshire require to be developed.

Proposed Structure:

Clackmannanshire:

The locality option combines Operational Management (0.5 management), of a relatively small group of staff, with the provision of 0.5WTE Nursing Clinical Care (Band 7 grade).

This combined model already exists within the NHS and is considered a viable option recognising that the 50/50 split of roles and responsibilities will vary on a day to day basis depending upon the specific circumstances of that day.

The Integrated Team Manager (ITM) will be created from the following revenue: 0.35 from Social Care Team manager post and the vacant Band 5 Nursing Post. This will then be divided by 0.5 Management time 0.5 clinical time. The remaining budget for the band 5 post will be recruited to as 0.4wte band 5, therefore no reduction in clinical posts.

The ITM post will manage:

2 Social Workers/Care Managers.
1 Band 6 Nurse.
1.4 Band 5 Nurses.

Stirling:

The Integrated Team Manager (SW Qualified) would be created by combining the following revenue :0.65 from the Social Work Team Manager vacancy and 0.35 from a Social Worker vacancy

This means a reduction in the team of a 0.5 WTE social care but a 'gain' of a full time locality manager to provide daily, visible management with the expected outcome being a full integrated and efficient service that should offset the 0.5 reduction through greater efficiency.

The ITM post will manage:

4 Social Workers/Care Managers.
2 Social Care Officers.
2 Band 6 Nurses.
1.8 Band 5 Nurses .

Note: The proposed structure is attached as Appendix 2 of the main cover report.

The 2 Integrated Team Managers will report directly to the Service Manager LD/MH with a clear view that the three posts are part of a single, integrated management team for LD services with strong links to the relevant professional leads in Local Authority and Health and a clear clinical and care governance framework.

The Team Managers will be responsible for the direct line management of the Nursing staff, Social Worker/Care Managers & Social Care Officers in their locality and all of the operational management therein. Cross professional support will be arranged as required in relation to clinical and professional support specific to professional development and registration requirements.

The proposed model requires the Clackmannanshire Integrated Team Manager to be either Nurse or AHP qualified given that 50% of the post is clinical provision.

The proposed model requires a Social Work manager to be in place to manage the professional development and registration requirements of Social Care staff across the 2 localities. It is therefore proposed that the Stirling Team Manager will be registered Social Worker.

Efficiencies:

The proposal is cost neutral and within the available revenue with no efficiencies identified.

Note: The new Integrated Team Management Posts are presently subject to job evaluation by the constituent partner organisations and will be recruited thereafter.

3. Scope

- Direct provision of operational Social Care /Care Management services within the Learning Disability Teams across the Partnership

- Direct provision of community Learning Disability Nursing and Allied Health Professional (AHP) services where there is delegated management to Integrated Team Managers across the Partnership

4. Out of Scope

- Community Learning Disability Nursing services operationally delivered and managed on a NHS Forth Valley Board basis.
- Allied Health Professional operationally delivered and managed on a NHS Forth Valley Board basis.

5. Business Needs and Priorities

The Learning Disability Service is required to evidence how it implements local, operational priorities. Specifically:

- Integration of operational teams across community Learning Disability Nurses, AHP staff working in the HSCP Localities and Social Workers/Care Managers & Social Care Officers via a single management structure.

- Develop services consistent with the national “Keys to Life Strategy” (2014).

- Develop services consistent with the principles of the Self -directed Support legislation In line with the national Self-directed Support Strategy [2010] and the recent report by Audit Scotland support the embedding of Self-directed Support as a means of ensuring that services are being provided in a cost effective manner, with equitable access to the available resources and with a strong outcomes focus.

- Service to operate within available revenue.

Priorities:

To develop services consistent with the principles of

- Established best practice for clinical care

- Minimum statutory intervention and promotion of independence

- Development of community alternatives to statutory social work intervention and service delivery

- Promoting empowerment and choice for service users and their families/unpaid carers

- Services that are delivered within available resources

6. Recommendation

- Approve the proposed model of an integrated operational service including Community Nursing, delegated AHP and Social Care services across the Health & Social Care Partnership area.

7. Benefits Matrix

Improvement in efficiency/effectiveness:	**Compliance:**
• Efficient management structures & cost effective.	Consistent with national policy and legislation and the HSCP priorities. • *The Keys to Life*, Scottish

• Consistent approach to service planning and workforce planning. • Consistent approach to service delivery and agreed priorities.	Government 2014. • Self-directed Support Strategy [2010] and the recent report by Audit Scotland support the embedding of Self-directed support as a means of ensuring that services are being provided in a cost effective manner, with equitable access to the available resources. • Partnership's Strategic Plan and priorities for 2017-2019 .
User Value • Single management system providing consistency of approach to service delivery. • Single door access to services across health & social care and reduction in duplication of task such as information giving. • Consistency of approach across health and social care professionals and the development of an integrated single care pathway.	**Wider public/organisational value;** • Promotes the integration of people with disabilities within the wider community and lessens the dependency on statutory services. • Develops services that are consistent with national policy and best practice both in terms of value for money and outcomes for service users. • Improves reputation of the Health & Social Care Partnership in terms of providing services consistent with national policy and best value.

8. Benefits Tracker							
Benefit	**Category**	**Owner**	**Who Benefits?**	**Indicators**	**Baseline Metric**	**Target Metric**	**Progress Narrative (RAG)**
Efficient management structures & cost effective that combines: 1. a consistent approach to service planning and workforce planning. 2. and a consistent approach to service delivery and agreed priorities.	Improvement in Efficiency & Effectiveness.	Service Manager & Integrated Team Leaders.	Cost effective management structure assists the HSCP to operate within available resources.	Development of integrated management structure within existing pool of revenue.	£735,823	£735,823	**Green.** Proposal operates within existing pooled revenue.
More efficient use of buildings	Improvement in Efficiency & Effectiveness.	Service Manager & Integrated Team Leaders.	Cost effective use of buildings assists the HSCPl to operate within available resources.	Reduction in number of buildings used in the Clacks Locality.	Services in the Stirling Locality are presently co-located. Separate Council and NHS buildings in Clacks	Co location on Clacks Locality.	**Amber.** Co location in Clacks Locality presently subject to negotiation.

					Locality.		
Consistent with national policy and legislation and the HSCP priorities. • The Keys to Life, Scottish Government 2014.	Compliance.	Service Manager / Integrated Team Managers.	Cost effective use of community services and development of person centred & innovative services that reduce the financial dependency on the HSCP while promoting service user independence.	Service users being provided with services consistent with Keys to Life.	52 Recommendations with Keys to Life.	HSCP to evidence progress against the 52 Recommendations within keys to Life	**Amber.** Implementation of recommendations is ongoing and subject to update.
Self-directed Support Strategy [2010] and the recent report by Audit Scotland support the embedding of Self-directed support as a means of ensuring that services are being provided in a cost effective manner, with	Compliance.	Service Manager / Integrated Team Managers.	Cost effective use of community services and development of person centred & innovative	Higher numbers of service users being provided with services	Limited evidence of all service users being assessed /reviewed	Evidence of all service users being assessed /reviewed using the	**Amber.** Review work on track – further development of the detailed reporting systems required

equitable access to the available resources.			services that reduce the financial dependency on the HSCP while promoting service user independence.	consistent Self Directed Support.	using the principles of SDS.	principles of SDS within the financial year 2018/19 and 2019/20.	
Partnership's Strategic Plan and priorities for 2017-2019.	Compliance.	Service Manager.	Cost effective use of community services and development of person centred & innovative services that reduce the financial dependency on the HSCP while promoting service user independence.	Integration of operational services across NHS and Social Work.	Services managed within single agency model.	Services managed within integrated model.	**Green.** Proposals on track for October 2018.

• Promotes the integration of people with disabilities within the wider community and lessens the dependency on statutory services. • Develops services that are consistent with national policy and best practice both in terms of value for money and outcomes for service users. • Improves reputation of the Health & Social Care Partnership in terms of providing services consistent with national policy and best value.	Wider public/ organisational value.	Service Manager.	Cost effective use of community services and development of person centred & innovative services that reduce the financial dependency on the HSCP while promoting service user independence.	Higher numbers of service users being provided with services consistent with *Keys to Life* and Self-directed Support.	Tbc.	Tbc.	**Red.** Reporting indicators as yet to be confirmed.
Single management system providing consistency of approach to service delivery. Single door access to services across health & social care and reduction in duplication of task such as	User Value.	Service Manager.	Service Users & Carers.	Increasing Numbers of Service Users/ Carers providing	National Outcomes Framework provides service indicators	Improved Perform-ance for the financial year 2018/19.	**Amber.** New outcomes focussed assessment /review documents to routinely provide

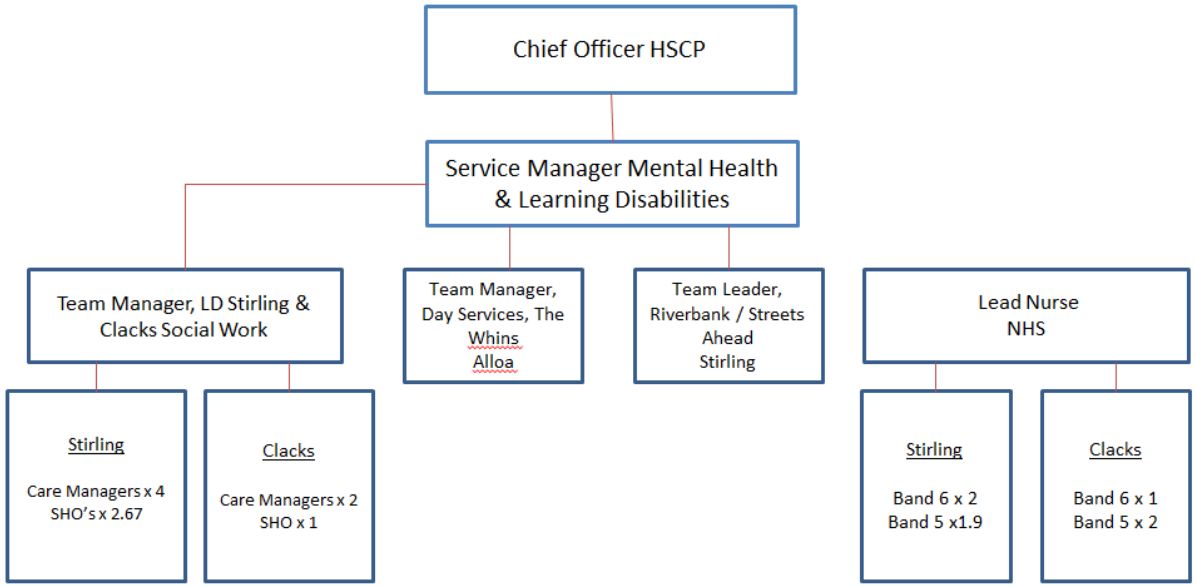
information giving. Consistency of approach across health and social care professionals and the development of an integrated single care pathway.				positive feedback on services.	.		the opportunity for service user/carer feedback that will be reported quarterly/annually once in place (October 2018).

9. Risks			
Risk	**Impact H/M/L**	**Probability H/M/L**	**Action to Mitigate Risk**
Lack of engagement with/from Trade Unions and Staff Side .	H	L	Regular meetings have been in place with Trade Unions since August 2017 in relation to the development of proposals. Proposals are also discussed more formally within the Joint Staff Forum arrangements which are currently being refreshed to meet the developing needs of the Partnership
Lack of engagement with staff.	H	L	There were staff engagements sessions relating to this matter during February. Staff have indicated their support in moving to a model of integrated team and single integrated management. There will be further meetings with staff as we move to implementation.
Lack of community engagement. Strategic Planning Group / Public Partnership Forum.	H	L	Engagement proceeded during February/March 2018

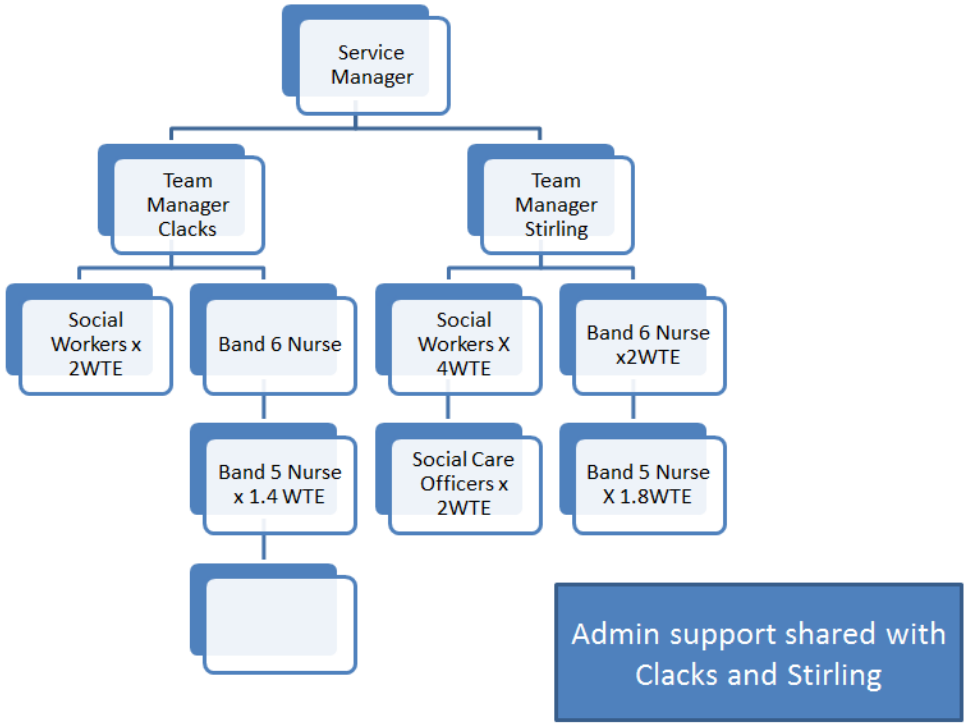
10.Timeline		
	Milestone	**Planned Date**
1	Options drafted for the design of day services. Signed off at IJB meeting March 2018.	March 2018
2	Full Business Case to be presented to IJB during June 2018	June 2018
3	Implementation of redesigned day services beginning October 2018	1st October 2018

11.Governance
Report to Joint Management Team and to the Clackmannanshire & Stirling Integration Joint Board.

Appendix 2a:Present Operational Structure



Appendix 2b: Proposed Operational Structure



APPENDIX 3 - BUSINESS CASE

Review of Directly Provided Day Services

Appendix 1: Business Case: Review of Learning Disability & Physical Disability Day Services. Direct Provision

Appendix 2a: Current Operational Structure

Appendix 2b: Proposed Integrated Structure

Appendix 3: Business Case: Review of Directly Provided Day Services

Business Case

Document Owner(s)
Name: Jim Robb

Revision History			
By	**Reason**	**Date**	**Version**
Jim Robb	Service Review	15th May 2018	v1

Document Approvals			
Name	**Title**	**Date**	**Version**

Contents

1. Executive Summary 13
2. Background 14
3.1 Scope 16
3.2 Out of Scope 16
4. Business Needs and Priorities 16
7. Recommendation 17
8. Benefits Matrix 17
9. Benefits Tracker 19
10. Risks 24
11. Timeline 24
12. Governance 24
13. Project Management Plan Checklist ..... **Error! Bookmark not defined.**
14. Dependencies ..... **Error! Bookmark not defined.**
A. Appendix 1 – Pilot Area Data Summary ..... **Error! Bookmark not defined.**

Project Name	Review of Directly Provided Day Services: Review of Learning Disability & Physical Disability Day Services. Direct Provision
Proposed By	Jim Robb, Service Manager, LD/MH

1. Executive Summary

Background:

The Learning Disability Service is required to evidence how it implements local, operational priorities. Specifically:

- Redesign of traditional day services to personal outcome services, 5/7 shift work etc. In house or commissioned the service specification should be the same.
- Develop services consistent with the national strategy for Learning Disability; "The Keys to Life".
- Develop services consistent with the principles of the Self Directed Support Legislation.
- Service to operate within available revenue.

Note: While there is no specific national document relating to Physical Disability Day Services the same principles apply.

Scope:

Directly provided Learning Disability and Physical Disability day services in the Clackmannanshire.

Directly provided Learning Disability day services in Stirling.

Business Needs and Priorities:

- Services required to operate within budget and achieve 7.5% efficiencies for the financial years 2017/18, 2018/19 and 2019/20.
- Integration Joint Board's Strategic Plan 2016-19
- Services developed in a manner consistent with agreed eligibility framework,

Critical & Substantial Risk

Benefits:

Proposal is consistent with the principles of:

- Minimum statutory intervention and promotion of independence
- Development of community alternatives to statutory social work intervention and service delivery.
- Promotes empowerment and choice for service users and their families both in the design of social care support and when they can be delivered.
- Develops a cost effective model of service delivery.

2. Background

Proposal:

Clackmannanshire :

In Clackmannanshire the Learning Disability service is primarily a building based service across 4 sites for 57 service users with an average attendance of 35 service users per day.

The initial assessment developed by Day Services staff is that the redesign should conclude with a single building to serve between 15-20 high dependency service users (present and future over the next 10 years) with the remaining 31 service users being supported in the community by the service. An additional 14 service users would be supported out of the service completely into a range of employment, education and leisure and recreation opportunities.

The proposed timescale to implement the redesign of internal Learning Disability day services is 1st October 2018.

<u>Physical Disability:</u>

Staff within The Whins Resource Centre carried out an exercise in April 2018 to identify service user dependency, similar to that carried out by Centre Space staff for Learning Disability services. Following this exercise it is proposed that the service move to a model of service that would provide a building based service for service users who have assessed complex care needs and for whom it would not be practical or appropriate for their needs to be met within community resources.

The service would also be provided Monday to Friday between 9a.m. and 4p.m.

with consideration being given to the possibility of evening and weekend provision at a later date should this be an identified need following review. Following the exercise to identify service user dependency it is proposed that a building based service is required for 18 service users daily with provision for existing service users and young people who are due to come to the service from school via the transition process in 2018, and new referrals from Locality and Reach teams. It is considered that this element of service be given priority over community based service delivery. Note: these numbers are subject to change dependent upon individual care reviews.

Redesign Proposal:

The proposal is to combine the Learning Disability and Physical Disability Day services.

Combined Budget: £1,219,110 (2018/19)

The model would be the combination of the following:

- A single based building based service, using the Whins, for those service users with significant levels of disability, that require high levels of supervision and personal care as well as their developmental requirements. The two services would be managed separately with the building design and layout amended as required.

Proposed Staff Structure for LD Building based service:

1 Senior Resource Worker
8.36 FTE Support Assistants
0.51 Driver / Attendant
0.51 Escort / Attendant

Proposed Staff Structure for Physical Disability Building based service:

1 Senior Resource Workers
4 FTE Support Assistants
0.51 Driver / Attendant
0.51 Escort / Attendant

- A community outreach model of service delivery with focus being on supported education, employment, development of social skills and leisure in the community and at home within the principles of Self Directed Support legislation which focuses on personal outcomes and the maximisation of independence. It is proposed that this is delivered and managed as a single service for people with disabilities.

Proposed Staff Structure for combined LD/PD Community Based service:

2 FTE Senior Resource Worker

6.49 FTE Support Assistants.

Note: 1FTE Team Manager to manage the totality of the combined service supported by the 4FTE Senior Resource Workers as noted.

Note: The final number of hours allocated to the community based service will be dependent on the remaining budget once the building based area of service has been resourced. It is considered that the building based service should be prioritised due to the high dependency levels of the service users. The service will need to meet the requirements of the Care Inspectorate and the provision of a safe and sustainable service to high dependency service users.

Proposed Financial Efficiencies for Clackmannanshire Locality:

2017/18: 7.5%. This was achieved via vacancy management

2018/19: 7.5%.£91,433

2019/20 : 7.5% :£84,575

Total Efficiency Target for 2018/19 & 2019/20: £176,008:

Proposed to combine the efficiencies for 2018/19 and 2019/20 into a single efficiency via the combination of deleting posts and authorising VS requests. At present there are enough VS requests to allow the efficiency to be made.

The efficiency will combine a reduction in:

- Senior Resource Workers being reduced by 3.1fte :£124,279
- Reduction in Support Assistants reduced by 1.8fte : £ 51,729

Total Efficiency Proposed for Clackmannanshire : £176,008

Note: It is envisaged that the combined 2 year efficiency will be achieved during the financial year 2018/19 via a combination of vacancy management and the proposed VS /Deletion of posts proposals.

Stirling Locality:

Riverbank Centre is a purpose built building which is currently the only operational base for the following services:

- Riverbank Centre – building based service.
- Streets Ahead – community based support
- Community Resource – which includes various stakeholders

accessing/booking rooms in the building, e.g. NHS colleagues, various care providers and the local community, registered with Changing Places (as per *The Keys to Life*) and the café is open to the public. Riverbank Centre is currently in the process of becoming a demonstrator site for Telecare/MECS.

There is recognition that the review of our services is an on-going process, and that there are a number of service users with profound and complex care needs will continue to require a building based service.

Riverbank Centre and Streets Ahead currently have 2 separate registrations with the Care Inspectorate and 2 Cost Centres, therefore for the purpose of this paper, will be looked at separately. However after further discussion with staff, then service users, parents/unpaid carers, we would hope to discuss with the Care Inspectorate moving to one single registration.

The summary of savings will be looked at jointly, due to the overlap on both services regarding the future development of the services.

Riverbank Centre – Current Total Operating Budget £566,170 (17/18)

Building Based Service - Core Service & Community Resource:

Currently 24 service users access the service at Riverbank Centre.

Having carried out an exercise to identify service users' care needs, it is proposed that we continue to provide the current model of day support for service users who have complex care needs and for whom it would not be practical or appropriate to meet their needs in wider community resources, e.g. lack of personal care changing facilities in the local area.

The service would continue to be provided Monday to Friday from 0930 hrs to 1530 hrs, with consideration being given to the possibility of evening and weekend provision (subject to review of personal outcomes).

An initial high level assessment was carried out by the management team at Riverbank Centre and it is proposed that 8 service users require to be reviewed to decide if a building based service is required. During these reviews, it will be determined if the Streets Ahead Service would support these 8 service users meet their outcomes in a more risk enabling manner.

It is proposed that a building based service is required for 16 service users and provision for existing service users and young people who are due to access the service from school via the transition process in 2018. An additional 3 places will be provided to create capacity for growth, making 19 places in total. It is considered that this element of service be given priority to continue to be provided in the current manner, whereas the Streets Ahead Service (Community Based).

Streets Ahead Service – Current Total Operating Budget £370,940

Currently 31 service users access Streets Ahead Service.

Streets Ahead Service is a well-established community based service. There are no building overhead costs applicable to this service. There is a charge for the use of Bridge of Allan Church Hall regarding the coffee morning (£20 per week), but the profits generated from the Coffee Morning cover this cost. Service users are supported to participate in mainstream activities in the local community.

An initial high level assessment was carried out by the management team at Streets Ahead Service. It is anticipated that 4 of these service users will exit the service by 01.10.18, subject to the outcomes of the review process which will explore other options for these individuals.

Proposed Staff Structure for LD Riverbank:

2 FTE Day Service Officers
8. FTE Social Care Assistants
2 FTE General Assistants

Proposed Staff Structure for LD Streets Ahead:

2 FTE Day Service Officers
13 FTE Support Partners

1FTE Team Manager to manage the combined service supported by the 4 FTE Day Service Officers as noted.

Proposed Financial Efficiencies for Stirling Locality

Combined Riverbank/Streets Ahead Budget: £937,110

2017/18: 7.5%: This was achieved via vacancy management

2018/19: 7.5%: £70,283.

The Assistant Manager post to be deleted. Presently vacancy: £44090
One Day Services Officer post to be deleted, presently vacant: £34,365

Total confirmed efficiency for 2018/19 : £78,455

2019/20: 7.5%:£ £65,012.

To be achieved by a reduction of the equivalent of 2.5 staff from the Social Care Assistant/ Support Partners staff groups (dropping from 20.8fte to 18.3fte). This can be achieved via the deletion of existing vacancies.

Total Efficiency Target for 2018/19 & 2019/20: £135,295

Proposed to combine the efficiencies for 2018/19 and 2019/20 into a single efficiency via the deletion of existing vacancies.

Note: It is envisaged that the combined 2 year efficiency will be achieved during the financial year 2018/19 via a combination of vacancy management and the proposed deletion of existing vacancies.

Engagement:

Staff Engagement:

There has been a high level of staff engagement with the Learning Disability Day services staff in the development of the initial proposals noted. This has taken the form of between 2-4 workshops per service during which staff have presented the options noted including a high level of debate and discussion as to the potential employment implications for staff. To date there have been four workshops in each of the localities and there will be ongoing engagement with staff on a bi monthly basis as part of the redesign process.

Service User/Unpaid Carer Engagement:

Service user and unpaid carer engagement sessions began in February 2018 and this will be an ongoing process every 6-8 weeks for the foreseeable future. Initial response has combined concerns that the process is being financially driven, general concerns relating to change with recognition, particularly in Clackmannanshire of moving to a service that combines a building based service with a community outreach service should be considered. As noted, general engagement on the redesign issues will be followed by service user specific care reviews at which the detail of individual care packages will be agreed.

Engagement with Trade Union/ NHS Staff Side:

There have been monthly meetings with a core group of senior Trade Union and NHS Staff Side following the initial meeting on 31st August 2017. The meetings have involved a combination and discussion relating to the issues highlighted in the report. Trade Union and Staff Side representatives have also participated in a number of the working groups in the development of the integrated team proposals and have also attended some of the staff development sessions within the day services. The focus is now on the steps required for implementation in conjunction with H.R representatives from each constituent partner agency.

Community Engagement:

Engagement with the Public Partnership Forum proceeded during February as did a presentation to the Strategic Planning Group. All 3 aspects of the review were considered and feedback was generally positive and in line with progressing a partnership and innovative approach to service delivery that will have a positive

impact on service delivery.

3. Scope

- Direct provision of social care day services for service users with a Learning Disability across the Partnership
- Direct provision of social care day services for service users with a Physical Disability in Clackmannanshire

4. Out of Scope

- Externally commissioned social care day services for service users with a Learning Disability.
- Externally commissioned social care day services for service users with a Physical Disability.

5. Business Needs and Priorities

The Learning Disability Service is required to evidence how it implements local, operational priorities. Specifically:

- Redesign of traditional day services to personal outcome services, 5/7 shift work etc. In house or commissioned the service specification should be the same.
- Develop services consistent with the national strategy for Learning Disability, “The Keys to Life”.
- Develop services consistent with the principles of the Self -directed Support legislation In line with the national Self-directed Support Strategy [2010] and the recent report by Audit Scotland support the embedding of Self-directed support as a means of ensuring that services are being provided in a cost effective manner, with equitable access to the available resources.
- Service to operate within available resources
- Provision of services subject to the agreed Eligibility Criteria, services at priority levels 1(Critical Risk) and 2(Substantial Risk) and on a needs led individual review basis.

Note: While there is no specific national document relating to Physical Disability Day Services the same principles apply.

Priorities:

To develop services consistent with the principles of:

- Minimum statutory intervention and promotion of independence.
- Development of community alternatives to statutory social work intervention and service delivery.
- Promoting empowerment and choice for service users and their families both in the design of social Care support and when they can be delivered.
- Operate with available revenue and making efficiencies of 7.5% per annum for the financial years 2017/18, 2018/19 and 2019/20.

6. Recommendation

- Develop a single building based service, using the Whins, in Clackmannanshire for those service users with significant levels of disability, that require high levels of supervision and personal care as well as their developmental requirements. The two services would be managed by a single management group while retaining care group specific services within the building.
- Develop a community outreach model of service delivery in Clackmannanshire for service users with disabilities (serving Learning & Physical Disability) to supplement the building based service, with focus being on supported education, employment, development of social skills and leisure in the community and at home within the principles of Self -directed Support legislation which focuses on personal outcomes and the maximisation of independence. It is proposed that this is delivered and managed as a single service for people with disabilities.
- Further redesign Learning Disability Day services in Stirling on the basis of high dependency service users being supported in the Riverbank Building based service with those service users with greater potential for independent living being served by the Streets Ahead service with focus on community and at home within the principles of Self -directed Support focused on personal outcomes and the maximisation of independence. It is proposed that this is delivered and managed as a single service for people with disabilities.

- Approve the identified efficiencies for the financial years 2018/19 and 2019/20.

Clackmannanshire Locality;

2018/19: 7.5%: £89,205

2019/20 : 7.5%: £82,514

Total Efficiency Proposed for Clackmannanshire: £174,066

Proposed to combine the efficiencies for 2018/19 and 2019/20 into a single efficiency during the financial year 2018/19 via a combination of vacancy management and the proposed VS /Deletion of posts proposals.

Stirling:

2018/19: 7.5%: £70,283.

2019/20: 7.5%: ££65,012.

Total Efficiency Target for 2018/19 & 2019/20: £135,295

Proposed to combine the efficiencies for 2018/19 and 2019/20 into a single efficiency during the financial year 2018/19 via the deletion of existing vacancies as noted.

7. Benefits Matrix

Improvement in efficiency/effectiveness:

- More efficient management structure.
- More efficient use of buildings.
- Reduced dependence of statutory social services and greater use of existing community supports including employment, education, leisure & recreation.

Compliance:

Consistent with national policy and legislation and the HSCP priorities.

- *The Keys to Life*, Scottish Government 2014.
- Self-directed Support Strategy [2010] and the recent report by Audit Scotland support the embedding of Self-directed support as a means of ensuring that services are being provided in a cost effective manner, with equitable access to the available resources.
- Partnership's Strategic Plan and

	priorities for 2017-2019
User Value: Benefits consistent with: • Promoting independence. • Choice /Empowerment for service user. • Greater innovation in developing services that are service user specific and outcomes focussed.	**Wider public/organisational value:** • Promotes the integration of people with disabilities within the wider community and lessens the dependency on statutory services. • Develops services that are consistent with national policy and best practice both in terms of value for money and outcomes for service users. • Improves reputation of the Health & Social Care Partnership in terms of providing services consistent with national policy and best value.

8. Benefits Tracker							
Benefit	**Category**	**Owner**	**Who Benefits?**	**Indicators**	**Baseline Metric**	**Target Metric**	**Progress Narrative (RAG)**
More efficient management structure.	Improvement in Efficiency & /Effectiveness.	Service Manager.	Cost effective management structure assists the HSCP to operate within available resources.	Reduction in spend on managements structure.	Allocated budget for 2018/19.	7.5% efficiency confirmed for 2018/19 & 2019/20.	**Green.** Proposals on tracks via vacancies and planned recurring efficiencies via the deletion of posts.
More efficient use of buildings.	Improvement in Efficiency & Effectiveness.	Day Service Team Manager Clacks.	Cost effective use of buildings assists the Council to operate within available resources.	Reduction in number of buildings used in the Clacks Locality.	4 buildings.	1 building.	**Amber.** Detail dependent upon the conclusion of care reviews in the period April-August 2018.
Reduced dependence on statutory social services and greater use of existing community supports including employment, education, leisure & recreation.	Improvement in Efficiency & Effectiveness.	Day Service Team Managers.	Cost effective use of community services reduces the	Higher numbers of people using community based	Tbc.	Tbc.	**Amber.** Services have been developed to some degree in the Stirling locality however this

Creation of choice for service users.			financial dependency on the HSCP while promoting service user independence.	services, education, employment, leisure & recreation as an alternative to social work services.			requires a significant level of development across the HSCP area in the short medium and long term. Staff have been deployed specifically to progress this agenda. Baseline figures for April 2018 to be confirmed.
Consistent with national policy and legislation and the HSCP priorities. The Keys to Life, Scottish Government 2014.	Compliance.	Service Manger/ Team Manager Day Services.	Cost effective use of community services and development of person centred & innovative services that reduce the financial dependency on the HSCP while promoting	Service users being provided with services consistent with Keys to Life.	52 Recommendations with Keys to Life.	HSCP to evidence progress against the 52 Recommendations within keys to Life.	**Amber.** Implementation of recommendations is ongoing and subject to update.

			service user independence.				
Self-directed Support Strategy [2010] and the recent report by Audit Scotland support the embedding of Self-directed support as a means of ensuring that services are being provided in a cost effective manner, with equitable access to the available resources.	Compliance.	Service Manger/ Team Manager Day Services.	Cost effective use of community services and development of person centred & innovative services that reduce the financial dependency on the HSCP while promoting service user independence.	Higher numbers of service users being provided with services consistent Self Directed Support.	Limited evidence of all service users being assessed/ reviewed using the principles of SDS.	Evidence of all service users being assessed/reviewed using the principles of SDS within the financial years 2018/19 & 2019/20.	**Amber.** Review work on track – further development of the detailed reporting systems required
Partnership's Strategic Plan and priorities for 2017-2019.	Compliance.	Service Manager.	Cost effective use of community services and	Review of directly provided Day Services	Day services provided in building based,	Day Services provided via a combination of	**Green.** Proposals on track for October 2018.

			development of person centred & innovative services that reduce the financial dependency on the HSCP while promoting service user independence.		traditional models of service delivery.	building based services for high dependency service users and alternative community based services that service users attend either independently or with minimum support.	
Promotes the integration of people with disabilities within the wider community and lessens the dependency on statutory services. Develops services that are consistent with national policy and best practice both in terms	Wider public/ organisational value.	Service Manager	Cost effective use of community services and development of person centred &	Higher numbers of service users being provided with services consistent	Tbc.	Tbc.	**Red.** Reporting indicators as yet to be confirmed.

of value for money and outcomes for service users. Improves reputation of the Health & Social Care Partnership in terms of providing services consistent with national policy and best value.			innovative services that reduce the financial dependency on the HSCP while promoting service user independence.	with Keys to Life and Self - directed Support.			
Promoting independence. Choice /Empowerment for service user. Greater innovation in developing services that are service user specific and outcomes focussed.	User Value.	Service Manager.	Service Users & Carers.	Increasing Numbers of Service Users/Carers providing positive feedback on services.	National Outcomes Framework provides service indicators.	Improved Performance for the financial year 2018/19.	**Amber:** New outcomes focussed assessment /review documents to routinely provide the opportunity for service user/carer feedback that will be reported quarterly/annually once in place (October 2018).

9. Risks			
Risk	**Impact H/M/L**	**Probability H/M/L**	**Action to Mitigate Risk**
Lack of engagement with/from Trade Unions and Staff Side.	H	L	Regular meetings have been in place with Trade Unions since August 2017 in relation to the development of proposals. The Joint Staff Forum arrangement is currently being refreshed to meet the developing need of the Partnership and support more focused discussions.
Lack of engagement with staff.	H	L	Regular engagement has taken place with Day Services staff as part of the redesign process. More limited engagement sessions have taken place with staff to discuss general principles of operational management structure. Further engagement required on specific proposals during January/February 2018.
Lack of engagement with service users and carers	H	M	Engagement started during February 2018 and run every 4-6 weeks and ongoing. However, to date, only 60% of carers have attended engagement meetings.
Lack of community engagement. Strategic Planning Group / Public Partnership Forum.	H	L	Engagement proceeded during February/March 2018.
Inability to provide services during evenings and weekends in the Clackmannanshire.	H	L	Clackmannanshire Council presently working on potential changes to conditions of service.
Inability to provide services during evenings and weekends in Stirling Locality.	H	H	Stirling Council's conditions of service include additional pay rates for evening and weekend work the outcome of which being that evening/weekend work is not cost effective.

10. Timeline		
	Milestone	**Planned Date**
1	Options drafted for the design of day services. Signed off at IJB meeting March 2018.	March 2018
2	Full Business Case to be presented to IJB during June 2018.	June 2018
3	Implementation of redesigned day services beginning October 2018.	1st October 2018

11. Governance
Report to the Joint Management Team and the Clackmannanshire & Stirling Integration Joint Board

Clackmannanshire & Stirling Health and Social Care Partnership
Integration Joint Board

13 June 2018

This report relates to
Item 7.5 on the agenda

Chief Officer Report

(Paper presented by Shiona Strachan)

For Noting & Approval

Approved for Submission by	Shiona Strachan, Chief Officer
Author	Shiona Strachan, Chief Officer
Date:	13 June 2018
List of Background Papers / Appendices:	
Background Papers; Integration Joint Board [December 2017] Update Report: Development of the Integrated Structure **Appendices:** Appendix 1 – Beyond Boundaries Newsletter Appendix 2 – letter 23 May 2018 - 23 May 2018- Action 15 Mental Health Strategy	

Title/Subject: **Chief Officer Report**

Meeting: **Clackmannanshire & Stirling Integration Joint Board**

Date: **13 June 2018**

Submitted By: **Shiona Strachan**

Action: **For Noting & Approval**

1. Introduction

1.1. This report provides a summary of the work being taken forward within the Health and Social Care Partnership (HSCP) and raises awareness of any regional and national issues affecting the Partnership.

2. Executive Summary

2.1. This paper provides the Board members with information on the following areas outlined within the recommendations.

2.2. The report will not address the Transforming Care programme which is addressed through a separate report to this Board meeting.

3. Recommendations

The Integration Joint Board is asked to consider the recommendations under each heading:

- to note the work taking place to prepare for the Development Session in September 2018. [section 3.1]
- to note the ongoing work and next steps in the development of a Partnership visual identity, which will come forward for consideration at the September 2018 meeting.[section 3.2]
- to note the process to recruit the non voting service users representation for the Strategic Planning Group and the Integration Joint Board.[section 3.3]
- to note the continued progress of the Strategic Inspection.[section 4]
- to note the outstanding work in relation to Equalities Mainstreaming.[section 7].
- to note the changes to the Joint Staff Forum [section 8]
- note the development of the Data Protection Impact Assessment tool for the Partnership and the proposed review of the Board paper templates [section 9]
- to note the work taking place as part of the Unscheduled Care Programme Board across Forth Valley and at Regional level [section 12]
- to note the ongoing work in relation to the development of regional planning [section 13]
- to note the content of the letter at appendix 2 of this report and
- to approve the delegation to the Chief Officer to work with partners to develop the content of the required draft Plan for action 15 and submit as draft to the

Scottish Government by the required timescale of 31 July 2018. The draft plan is subject to the full approval of the Board in September 2018.[section 14]

- to note the requirement for the development and lodging of a Records Management Plan by March 2019 with the Keeper of Records for Scotland [section 15].

3.1. Integration Joint Board Development - Second Workshop

Work is now underway on the preparation work for the second workshop as part of the ongoing development of the Integration Joint Board.

In line with the approval of the Board at the meeting in March 2018 three focus group sessions were planned as follows:

1. Professional advisory members
2. Staff representatives
3. Service user, unpaid carer and service user representatives

The first two focus group sessions have now taken place with, at the time of writing, the third due to take place on 31 May 2018. Where members of the Integration Joint Board are unable to attend the group sessions follow up telephone calls have been arranged.

The date for the development session is now being planned for 6 September, 2018.

The Integration Joint Board is asked to note the work taking place to prepare for the Development Session in September 2018.

3.2. Partnership Visual Identity

Following the March 2018 meeting of the Board work has been taken forward by the communications leads for the partners, with the survey launched and completed in April. The information from the survey will now be used to inform the development of the visual identity.

This work will take place over the summer months and an options paper brought forward for Board consideration at the meeting on 29 September 2018.

The Integration Joint Board is asked to note the ongoing work and next steps in the development of a Partnership visual identity, which will come forward for consideration at the September 2018 meeting.

3.3. Integration Joint Board and Strategic Planning Group Membership – Service User Representation

The current service user representatives for the Integration Joint Board and for the Strategic Planning Group were appointed in October 2015 for a period of three years, in line with the Integration Scheme. The current representatives are –

- Strategic Planning Group - Helen Maguire [Clackmannanshire]; Eileen Wallace [Stirling]

- Integration Joint Board - Teresa McNally [Clackmannanshire]; Morag Mason [Stirling]

Using the previously agreed selection process to support the recruitment of non voting membership for the Integration Joint Board and the Strategic Planning Group applications for the roles have been advertised through the PPF, the Community Councils and through social media sites for NHS Forth Valley, Clackmannanshire Council and Stirling Council.

In addition four information sessions have been hosted by the PPF for any potential applicants to find out more about the role, with applications closing on 25 May 2018. Two meetings will be hosted by the PPF [one in each Local Authority area] in June to select the representatives through a vote.

The Integration Joint Board is asked to note the process to recruit the non voting service users representation for the Strategic Planning Group and the Integration Joint Board.

4. Strategic Inspection

As noted at the meeting in March 2018 the strategic inspection, Joint Inspection [Adults] of the Effectiveness of Strategic Planning, had commenced. The periods of fieldwork are now complete and an initial verbal feedback session with the management teams has taken place, with a further meeting planned for 8 June 2018, which will include the draft report.

The areas of focus for the inspection are the following Quality Indicators –

What key outcomes have we achieved?	How good is our management of whole systems in the partnership?	How good is our leadership?
1. Key performance outcomes	6. Policy development and plans to support improvement in service.	9. Leadership and direction that promotes partnership.
1.1 Improvements in partnership performance in both healthcare and social care.	6.1 Operational and strategic planning arrangements. 6.5 Commissioning arrangements.	9.1 Vision, values and culture across the partnership. 9.2 Leadership of strategy and direction.

Quality Indicator 9 will not be fully evaluated – that is, this area will not be given a formal grading in the final inspection report but will be subject of some commentary.

The Integration Joint Board is asked to note the continued progress of the Strategic Inspection.

5. Clinical and Care Governance

A full report on the Clinical and Care Governance arrangements for this Partnership is contained in a detailed report at 10.3 of the agenda for this meeting of the Integration Joint Board.

6. Delegation of Services – Operational Management Arrangements

The Board were advised of the work taking place across both Stirling Council and NHS Forth Valley in respect of developing more integrated structures to support the delivery of services at the meetings in December 2017 and in March 2018.

Full progress reports on the work taking place form part of the agenda of this meeting at 10.1 and 10.2.

The papers describe the services 'in scope' as defined within the Partnership's own Integration Scheme, which is the legal agreement between the constituent parties and the steps being taken to, -

- For Stirling Council, transfer the operational responsibility for the adult social care services in Stirling on or before the 1 September 2018.
- For NHS Forth Valley, a phased implementation plan to support further operational delegation across two phases to be agreed and completed by March 2019, with phase one completed by September 2018. The paper sets out the core principles being applied to any hosting arrangements for services. It is proposed within the paper that NHS Forth Valley should continue to operationally manage Primary Care including the Out of Hours services with a review in 18 months. Further work will take place over this financial year to clarify any hosting arrangements for services which operate across Forth Valley such as complex care and the larger groupings of Allied Health Professionals working out with hospital based services and in mental health services.

As highlighted previously to the Board there is an increasing expectation of planning activity, response to consultations etc., and the support to the Board itself. At present there is a mixed approach of support drawn from the constituent authorities and limited, dedicated resources to support this wide range of activity. Further delegation of services will help to consolidate some of the capacity required in terms of direct service management but there is a key requirement to address the outstanding support services agreement. Support services include legal; governance; equalities; performance management; human resources; management and corporate accounting support to the Chief Finance Officer; information management and technology; risk management, property and facilities management and communications services. It is essential

that this is addressed in line with the delegation of the operational management arrangements and that the arrangements support the day to day operation of the services and the development of the Board itself.

As part of the movement of operational management of services to the Chief Officer work is now progressing on the development of the first stage locality management arrangements.

7. Equalities Mainstreaming

At the March meeting the delay in the completion of the Equalities Mainstreaming Progress Report was highlighted with agreement that the report should be brought forward to this meeting. We have been unable to take this work forward due resourcing issues arising from absence and at the time of writing we are still trying to identify capacity to take this area of work forward.

The Integration Joint Board is asked to note the outstanding work in relation to Equalities Mainstreaming. .

8. Joint Staff Forum

The Joint Staff Forum has met across Forth Valley on a regular basis since the 'shadow year' and has a formal Constitution. The Joint Staff Forum is intended to provide a forum to enable effective joint discussions between employer and employee representatives, on employment issues, relating to the effective implementation of Health and Social Care Integration. Approved minutes are provided to the Integration Joint Board.

At the meeting on 26 February 2018 it was agreed that given the stage of development of the two Partnerships the Forum should move from a Forth Valley wide forum to one for each Partnership, with an option to bring together membership across the two as required.

The next scheduled meeting of the Forum is on 14 June 2018, with meetings in August, October and December. Chairing will continue to be joint and it is anticipated that the Clackmannanshire and Stirling Joint Staff Forum will adopt a slightly amended version of the current Constitution to reflect the single Partnership approach and a clearer focus on the issues and development opportunities for this Partnership.

The Integration Joint Board is asked to note the change to the Joint Staff Forum.

9. General Data Protection Regulation [GDPR] & Integration Joint Board Reports

The Board received a report on the provisions of the GDPR legislation which came into force on 25 May 2018. The legislation imposes new responsibilities on all organisations who process [or control the processing of] personal data. The Board has limited processing of personal data but work is ongoing alongside the constituent authorities to ensure compliance in all areas of activity.

In addition to the appointment of Deirdre Coyle as the Data Protection Officer for the Integration Joint Board work has been carried out on the development of the screening tools to support reporting to this Board and service development work. A DPIA or Data Protection Impact Assessment is required at the start of any new projects, initiatives including new technology which uses personal data.

Due to the size and volume of reports for the Board papers for this cycle have not included the EQIA and DPIA tools. It is proposed that they are held on file for access should they be required or requested and that further work is done to streamline the report format for the Board which is repetitive in nature.

The Integration Joint Board is asked to note the development of the Data Protection Impact Assessment tool for the Partnership and the proposed review of the Board paper templates.

10. Transforming Care Work Stream Updates

The end of year statement on the Transforming Care work streams is contained within the report at 7.1 of this meeting.

11. General Medical Services [GMS] – Primary Care Improvement Plan

The Board were provided with an updated on the proposed General Medical Services contract at their meeting in December 2017 and the required Primary Care Improvement Plan and supporting information is provided in detail at 7.2 of this agenda..

An initial meeting to discuss funding to support the delivery of Unscheduled Care and the 4 Hour Emergency Access target will be held on 8 June 2018. The purpose of the meeting is to better align the local Partnership and regional priorities – and to support whole systems approaches. The refreshed approach will include -

- more proactive information analytics
- greater focus on discharge over seven days, with locally agreed targets and monitoring at ward, site and HB level

- continued focus on shifting the discharge curve through Daily Dynamic Discharge approaches rolled out across acute and community, with locally agreed targets and monitoring at ward, site and HB level
- achieving specialty in - out balance monitored by nurse and medical directors
- focus on flow through the ED and assessment units
- review of acute assessment units
- alignment of scheduled and unscheduled care
- greater engagement across acute, social and primary care
- implementation of key recommendations from the Public Holiday Review and the National Out of Hours Review

12. The Unscheduled Care Programme Board and Frailty at the Front Door Collaborative

The Partnership is part of the Unscheduled Care Programme Board which operates across forth Valley and is chaired by Andrew Murray, Medical Director. The purpose of the Unscheduled Care Programme Board [USC] is to

- Oversee system wide activities, initiatives, actions and performance around unscheduled care.
- Seek to streamline approaches and activity across the system where possible
- Co-ordinate action to ensure delivery of targets
- Ensure appropriate escalation to enable swift decision making if any significant redesign is required

Membership of the group reflects the whole systems approach required to address the range of issues, challenges and opportunities relating to unscheduled care and in particular address the 6 essential actions.

- Medical Director
- General Manager – Medicine
- General Manager – Community Services
- Chief Officer for Falkirk IJB
- Chief Officer for Clackmannanshire and Stirling IJB
- Head of Planning
- Head of Performance and Governance/Deputy
- General Practitioner
- Lead Nurse – Community Services
- Associate Medical Director - Medicine
- Senior Nurse - Medicine
- Head of Efficiency, Improvement and Innovation
- Information Analysts x2 (LIST & NHS)

A meeting is scheduled for 8 June for the inaugural regional funding discussions with a focus on the following areas –

- enhanced management and leadership going from triumvirate to quadrumvirate, including Chief Officers
- more proactive information analytics
- greater focus on discharge over seven days, with locally agreed targets and monitoring at ward, site and HB level
- continued focus on shifting the discharge curve through Daily Dynamic Discharge approaches rolled out across acute and community, with locally agreed targets and monitoring at ward, site and HB level
- achieving specialty in - out balance monitored by nurse and medical directors
- focus on flow through the ED and assessment units
- review of acute assessment units
- alignment of scheduled and unscheduled care
- greater engagement across acute, social and primary care
- implementation of key recommendations from the Public Holiday Review and the National Out of Hours Review

As part of this work the Partnership is involved in the Frailty at the Front Door Collaborative. There is compelling evidence to support the benefits of early and effective comprehensive geriatric assessment, reablement and intermediate care for people living with frailty. However, optimal outcomes are only achieved when community health and social care services and hospital systems are fully aligned, well-coordinated, and care and support are attuned to the specific needs of people living with frailty.

The aim of the Frailty at the Front Door Collaborative is to improve the processes of identifying frailty and coordinating care to deliver better experiences and outcomes for people living with frailty. While this specific work is focused on the front door of acute care, it is driven by an approach that recognises the importance of thinking about flow across the whole system. Getting the care pathway right for older people and people living with frailty in acute care has a wider impact on the whole system – including our rates of admission and reduction of bed days lost due to delays in discharge. .

Five NHS boards across Scotland will be taking part in the Frailty at the Front Door Collaborative. The collaborative will work alongside the iHub's Living Well in Communities portfolio, Scottish Government's National Unscheduled Care Team and Integration Authorities to support improvements across the pathway.

Within Forth Valley we have established a multi disciplinary Project Team to drive this work forward, which reports into the Unscheduled Care Programme Board.

The objectives of the Team are –

- To develop a system whereby older people presenting to front door services at FVRH will be rapidly and reliably screened for frailty

- To develop a system which ensures the initiation of Comprehensive Geriatric Assessment (CGA) by an adequately skilled multi-disciplinary team within 24 hours of admission for patients presenting with a frailty syndrome

CGA is defined as a "multidimensional interdisciplinary diagnostic process focused on determining a frail older person's medical, psychological and functional capability in order to develop a coordinated and integrated plan for treatment and long term follow up."

- To promote and facilitate the development of a system whereby alternatives to admission are available and considered, with a focus on providing coordinated care and support as close to home as possible in a timely manner

- To evolve systems and processes to ensure that when admission to specialist in-patient care is considered the correct option for an older person with frailty then access to these specialty areas is coordinated and occurs within 24 hours to ensure the individual receives the right care at the right time, in the right place, every time

- To improve patient experience by providing a person centred, coordinated and dynamic approach to supporting individuals with a frailty syndrome using clearly defined pathways

- Improved interface, collaboration and integrated working between health and social care

The Integration Joint Board is asked to note the work taking place as part of the Unscheduled Care Programme Board across Forth Valley and at Regional level.

13. Regional Planning

A further engagement event was held in May 2018 for the Integration joint Board members and key staff groups and work is continuing within the work streams to develop the Regional Plans.

A newsletter is now being produced for staff and a copy of this is attached at appendix 1 and provides good and easy access information on the current focus of work.

The Integration Joint Board is asked to note the ongoing work in relation to the development of regional planning.

14. National Mental Health Strategy – action 15 - Planning and Funding from 2018/19

On 23 May 2018 received notification of a request for an initial plan to be submitted to the Scottish Government no later than 31 July 2018 in respect of the allocated funding to meet the commitments in relation to action 15 of the Mental Health Strategy – at national level this is the commitment to support the employment of additional mental health workers to improve access in key settings such as Accident and Emergency, GP Practices, police stations and custody suites.

The funding will be available from this year (£12 million, of which £11 million is the subject of the letter attached at appendix 2) and will rise to £35 million in 2021-22. For this Partnership this is £280, 549 moving to £816,141 by 21/22. For Forth Valley this is £596, 129 moving to just over £1.7 million by 2012-22.

The actions required link into the work already taking place through the Primary Care Improvement Fund and as indicated in the correspondence there will need to be some clear linkages and read across for this plan.

Work is now taking place at Forth Valley level to form the core content of the initial draft plan which will be based on the work already in place both in relation to the primary care work and to the mental health strategy where there has already been a consultation and development event. It should be noted that not all of the service areas described within the action are in scope for this Board.

The current focus for the planning teams across the area has been on the completion of the Primary Care Improvement Plan which forms part of the agenda for todays meeting. At the point of writing more time is required to develop a cohesive plan for this and the Board is asked to delegate responsibility to the Chief Officer to work with partners, including the Chief Executives, practitioners, clinician's, service users and carers across the system to develop a draft plan for submission within the time scales requested by the Scottish Government. This will mean that the September meeting of the Board will require to consider the draft plan [post submission] and if appropriate approve the content.

The Integration Joint Board is asked to note the content of the letter at appendix 2 of this report and to approve the delegation to the Chief Officer to work with partners to develop the content of the required draft Plan for action 15 and submit as draft to the Scottish Government by the required timescale of 31 July 2018. The draft plan is subject to the full approval of the Board in September 2018.

15. Public Records (Scotland) Act 2011

Under the requirements laid down in Part 1 of the Public Records (Scotland) Act 2011, the Integration Authority will be required to prepare a Records

Management Plan [RMP] setting out arrangements for the management of the Authority's records. We will be required to submit this plan by March 2019 to the Keeper of the Records of Scotland for their agreement. There is a model RMP and supporting guidance which will be used to develop the Plan.

The Integration joint Board is asked to note the requirement for the development and lodging of a Records Management Plan by March 2019.

16. Resource Implications

As noted in previous reports to the Board sustainability remains a risk in terms of the current arrangement for service management and the Board, with now 2 committees to be supported.

The steps now being taken to move to delegate the operational management of services will assist in the medium term but there is considerable work taking place across the system to support a safe, effective transfer including the proposed development of locality services supported by three locality managers for this Partnership area. .

The Clackmannanshire services continue to be managed through an interim arrangement of service managers and 0.25FTE of the Chief Officer. In addition, the support service agreement is outstanding – and while it makes sense to include this within the delegation arrangements the growing levels of demand on the Integration Authority and services are leading to increased level of pressure on all areas and a struggle to maintain momentum.

The current issues include

- a time and resource intensive inspection process – while the fieldwork section is now at an end there is further work required to respond to any recommendations in the report which will be published in the Autumn
- Transformation programmes – Partnership; Stirling Council; Clackmannanshire Council and NHS Forth Valley
- Growing regional planning requirements
- GMS contract implementation requirements for the wider team
- Carers Act implementation in which the provisions of the Act are now being embedded at service level
- Development and Publication of the second Annual Performance Report
- The development of locality planning and the work required for the second Strategic Plan
- Support of the two committees

There is a need to step up the pace of the joint areas for service re design such as those relating to the frailty pathway, the day support and reablement/intermediate care to help us address the growing budget pressures and to deliver sustainable services within the available resource envelope.

17. Impact on Strategic Plan Priorities and Outcomes

17.1. This report and associated recommendations, relates to the following Clackmannanshire & Stirling Health and Social Care Partnership local outcomes and Strategic Plan priorities (please select as appropriate):

Fit with Local Outcomes	
Self Management	☒
Community Focussed Supports	☒
Safety	☒
Decision Making	☒
Experience	☒

Fit with Our Priorities 'we will...'	
Further develop systems to enable front line staff to access and share information	☒
Support more co-location of staff from across professions and organisations	☒
Develop single care pathways	☒
Further develop anticipatory and planned care services	☒
Provide more single points of entry to services	☒
Deliver the Stirling Care Village	☒
Develop seven-day access to appropriate services	☒
Take further steps to reduce the number of unplanned admissions to hospital and acute services	☒

17.2. This report covers a range of topics which link back directly to our local outcomes and priorities.

18. Legal & Risk Implications

18.1. This report covers a range of topics and areas and specific legal and risk implications are noted throughout the paper where identified.

19. Equality and Human Rights Impact Assessment

19.1 The contents of this report do not require an EQIA because it provides updates on a range of activities which will have equality impact assessments completed as required.

20. Data Protection Impact Assessment

The contents of this report do not require a DPIA.

21. Exempt Reports

Not exempt.

22. Appendices

Appendix 1 – Beyond Boundaries Newsletter
Appendix 2 – letter 23 May 2018 - 23 May 2018- Action 15 Mental Health

West of Scotland region

Connecting beyond boundaries

Developing a new regional plan for the West of Scotland

Information for staff

May 2018 Issue two

The launch of the Health and Social Care Delivery Plan in December 2016 set out an ambition to look across boundaries and to plan and deliver services that would meet the triple aim of:

- improving the patient experience of care;
- improving the health of populations; and
- reducing the cost of health care.

In the West of Scotland we have added to this by stating that the fourth aim should be about staff value. Since the publication of the plan, we have seen the regional planning arrangements across Scotland evolve. This newsletter provides the second update to staff across the West of Scotland about the work being taken forward.

In the West of Scotland we have been working across our Health Boards and Integration Joint Boards to establish a common purpose to our planning that respects the importance of local and locality planning:

- improving health and wellbeing;
- increasing care and quality;
- better workplace with a focus on staff; and
- delivering best value.

West of Scotland region

The West of Scotland has a population of around 2.7 million people, and covers approximately 8,777 square miles. There is a combination of urban, rural and island communities.

A range of organisations have responsibilities for health and care services across the West of Scotland, including the five territorial Health Boards, 15 Integration Joint Boards and 16 local authorities.

The vast majority of care in the West of Scotland is provided local to people's homes.

For the period 2012/2013 to 2016/2017, activity within the hospital setting grew at an average rate of just under one per cent each year - with the growth much greater among those aged 65 years and over. Activity within the hospital setting in the West of Scotland is higher than would be expected (once age, sex and deprivation are accounted for) when compared to the rest of Scotland.

John Burns, Chief Executive of NHS Ayrshire & Arran, and Regional Implementation Lead for the West of Scotland, comments:

"In the 70 years since the NHS was established – and indeed in the 50 years since the Social Work (Scotland) Act was signed – the West of Scotland has seen great changes in what, how and where care is delivered. These changes have been made possible for lots of reasons – not least of which have been the considerable advances in knowledge and technology. However, they have also been driven by often bold leadership and a collective appreciation that improvement requires change. We have made considerable strides in improving quality of care, and today we can and should take pride in the many examples of excellent care available. However, we also know that we can and need to do more to prevent and address the high levels of ill-health and care needs that blight the lives of too many individuals, families and communities.

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

"In the West of Scotland we have a strong track record of delivering new models and effective regional services. These achievements have demonstrated that it is possible to overcome challenges and deliver safer, higher quality services, but only if we get the process right and genuinely challenge ourselves. For example, in 2009 we set up regional cardiology services. Nearly ten years on, we need to be planning how to meet the challenges of the next 20 years. And given the scale of challenges, our transformation ambition needs to be greater than ever.

"We have developed a draft regional position and discussion document that describes the collective ambition of the West of Scotland Boards to improve the health and care of the 2.7 million people who live within our communities. We will do this by providing care to and with individuals and their carers that fosters independence; is sustainable; and is safe, effective, equitable and proportionate to their needs. Working across and connecting beyond our traditional boundaries - across health and social care; across professions and disciplines; across settings; across specialties; and across organisations - will be critical to building a person-centred and sustainable service that is fit for the 21st century.

"This is an ongoing journey that will build on the engagement to date to create a more involving approach, as we look to develop and successfully implement improvements for the West of Scotland. We understand that in looking to take this bold agenda forward – whether at regional, health board, Integration Joint Board/Community Planning Partnership or locality level – there will need to be:

- celebrating of, learning from and scaling up of good practice within the region;
- co-production with individuals and communities; and across staff, services and organisations;
- fostering of support for improvement from within local communities;
- leadership for improvement at national, regional and local levels; and
- action at a "once for Scotland" level - across the three regions, and with the National Boards."

Our vision

We will ensure that wherever you live in the West of Scotland that you are in control of your wellbeing and care, by respecting your wishes and empowering you to live independently.

Our priority is that you will get the care you need in the right place, at the right time, every time.

You will:

- **be at the heart of decisions that affect you.**

We will tailor our approach so that we provide integrated care organised around your needs and the needs of your carer.

- **be empowered.**

We will provide support that enables you to take greater responsibility for your own health and wellbeing. This will include innovative ways of working to help you live a healthy life in your own home.

- **receive safe and high quality care.**

Wherever you receive your care and whoever is providing it, we will ensure services are safe and effective.

- **receive care in the most appropriate place for you.**

We will provide care that is both convenient and of a high quality. We will do this by reducing unnecessary trips to health centres and hospitals and ensuring you get the most out of the visits you make.

- **experience compassionate care no matter where you live.**

Wherever possible, care will be provided as close to your home as possible and reflect your care needs and personal circumstances.

Sharon Adamson, Director of Regional Planning for the West of Scotland, comments:

"Regional partners have been developing an over-arching model of care that reflects our aspiration to deliver both the National Health and Social Care Delivery Plan and the National Clinical Strategy; and reinforce the conditions for delivering Realistic Medicine and Care.

"With the empowered individual at its heart, the model emphasises the importance of strengthening and increasing informed self-care and self-management; supportive and connected communities; integrated health and care services; and networked clinical services.

"Fundamentally, the model of care reflects an understanding that getting the basics right is likely to be much more important than any single tool or care management approach; and that our systems have to encourage and strengthen our approach to prevention by encouraging individuals to manage their own health and be responsible for personal wellbeing.

"All of this work is underpinned by the recognition that:

- many of the same functions and interventions will be provided within different settings;
- wherever a function or intervention is delivered - or indeed by whom - that it will be done to the same high standard;
- individuals will frequently receive care and support in different settings as part of the same package of care/care episode;
- in order to provide as much support and services as close to people's homes as possible, ensure consistent quality and reduce the number of journeys that people have to make to receive care, services and staff may have to operate as part of a structured network;
- staff may operate across different settings and be part of multi-disciplinary teams in doing so;
- the contribution of unpaid carers needs to be properly appreciated and that they require to be supported appropriately; and
- the individual and their care needs should be at the heart of all decision-making, with and for them."

Next steps

The development of the West of Scotland delivery plan is ongoing, with communication and engagement being two important aspects of our work going forward.

Over the coming months we will continue our engagement to refine the regional position and discussion document across our five local Health Boards; and our 15 Integration Joint Boards. We will also further engage with local authorities; and strengthen our engagement across professional disciplines and with other important stakeholders, including staff side and the third sector.

As we progress our work we look forward to working with as many colleagues as possible to shape the future of services across our region. Look out for details on how you can get involved.

Further information

As our plans progress, we will be issuing further staff briefings so that you are kept up-to-date with what's going on across the West of Scotland.

For more information about how we are sharing updates on the regional delivery plan, contact your local communications lead.

NHS Ayrshire & Arran

Miriam Porte, Regional Communications Lead

miriam.porte@aapct.scot.nhs.uk

NHS Dumfries & Galloway

dgcommunications@nhs.net

NHS Forth Valley

Elsbeth Campbell

elsbeth.campbell@nhs.net

NHS Greater Glasgow and Clyde

Ally McLaws

Ally.McLaws@ggc.scot.nhs.uk

Sandra Bustillo

Sandra.Bustillo@ggc.scot.nhs.uk

NHS Lanarkshire

Calvin Brown

Calvin.Brown@lanarkshire.scot.nhs.uk

Golden Jubilee National Hospital

Sandie Scott

Sandie.Scott@gjnh.scot.nhs.uk

Population Health Directorate
Mental Health and Protection of Rights Division

T: 0131-244 07119 F: 0131-244 2846
E: Pat.McAuley@gov.scot

Chief Officers, Integration Authorities

cc: Chief Executives, NHS Boards
Directors of Finance, NHS Boards
Chief Executives, Local Authorities
Angiolina Foster, Chief Executive, NHS24
Caroline Lamb**,** Chief Executive, NES
Colin McKay, Chief Executive, MWC
Health & Justice Collaboration Improvement Board

Your ref:
Our ref:

23 May 2018

Dear Colleague

ACTION 15 OF THE MENTAL HEALTH STRATEGY – PLANNING AND FUNDING FROM 2018/19

As part of the Mental Health Strategy 2017-2027, Scottish Government Ministers made a commitment to provide funding to support the employment of 800 additional mental health workers to improve access in key settings such as Accident and Emergency departments, GP practices, police station custody suites and prisons. The detail is set out in Action 15 of the Mental Health Strategy. The funding will be available from this year (£12 million, of which £11 million is the subject of this letter) and will rise to £35 million in 2021-22.

Background

You will know that last year, Ministers established the *Health & Justice Collaboration Improvement Board* (HJCIB). The Board draws together some of the most senior leaders from Health, Justice and Local Government. Its purpose is to lead the creation of a much more integrated service response to people whose needs draw upon the work of our Health and Justice services. As you might expect, our mutual response to people who suffer mental illness and distress is a significant theme in the Board's interests. Membership of the Board is set out an Annex A.

Ministers asked the Board to consider how our commitment to additional mental health workers might best be delivered.

National test of change

The Board has subsequently set out an approach that will test improvements in national arrangements for service delivery. This involves the Ambulance Service, NHS24 and Police Scotland, and £1 million has been set aside for this initiative. The current thinking on these ideas is set out at Annex B.

Local improvements

The Board has also adopted some broad principles (helpfully informed by a Short Life Working Group with membership from Integration Authorities, Health Boards, justice and local government) that it believes are likely to inform credible local improvements. These include recognition that:

- the application of additional resources should result in additional services commensurate with the commitment in the Mental Health Strategy to provide 800 additional mental health workers by 2021-22;

- the nature of the additional capacity will be very broad ranging – including roles such as peer and support workers;

- prospective improvements may include the provision of services through digital platforms or telephone support;

- improvement may include development for staff who are not currently working in the field of mental health.

Links to the Primary Care Improvement Fund

Richard Foggo has written to Integration Authority Chief Officers and NHS Chief Executives today regarding the Primary Care Improvement Fund (PCIF) allocation for 2018-19. His correspondence should be read in conjunction with this letter.

As outlined in Richard's letter, nearly £10 million was invested during 2016-18 via the Primary Care Mental Health Fund (PCMHF) to encourage the development of new models of care to ensure that people with mental health problems get the right treatment, in the right place, at the right time. In 2018-19, the Primary Care Improvement Fund (£45.750 million) is a single allocation to provide maximum flexibility to local systems to deliver key outcomes.

The PCIF includes recurring funding for mental health services, building on the funding for primary care mental health previously provided. Although it is separate to this funding line, there is likely to be close cross-over between the services, particularly in general practice settings, and in some cases the staff may be the same individuals.

As set out in the letter, Primary Care Improvement Plans should demonstrate how this funding is being used to re-design primary care services through a multi-disciplinary approach, including mental health services.

PCIPs should also show how wider services, including the mental health services which are the subject of this letter, integrate with those new primary care services.

Planning and Partnerships for Delivery of 800 Mental Health Workers

We want to ensure that IAs are able to utilise the additional resources for 800 mental health workers and the PCIF flexibly to support sustainable mental health and primary care service redesign. As far as possible we want to ensure that the planning processes, governance and evaluation processes are aligned.

Planning: by 31 July

We are asking that Integration Authorities each develop a plan by 31 July that sets out goals for improving capacity in the settings outlined in Action 15 of the Mental Health Strategy. We would like the plan from each Authority to set out:

- How it contributes to the broad principles set out under *Local Improvements* on page 2;
- How it takes account of the views of local Justice and other Health partners in the area about what improvements should be introduced
- How it fits with other local plans currently in development.
- Initial scoping of potential staffing changes over the next four years as a result of this additional funding, towards the committed 800.

Our reason for asking you to do this is that it will help the H&JCIB to shape discussions around future collaboration – including further consideration of national proposals. We will let you know about our thinking as consequence of these discussions over the summer.

This should include demonstrating additionality of the new workforce, such as information about the numbers of additional staff being recruited, existing staff being up-skilled (who are currently not working within mental health services) and the settings which will allow the Scottish Government to demonstrate progress against the national commitment. If it is possible, this could be through a supplementary to your Primary Care Improvement Plans or it could be through a linked document

In the longer term, we anticipate that Primary Care Improvement Plans might start to allow an increasingly integrated approach to mental health planning and delivery of the 800 mental health worker commitment. As set out in Richard Foggo's letter, it is important that the PCIPs from the outset show links with broader community developments, and the 800 mental health worker commitment. Over time, we anticipate that this may develop into a single statement of the approaches being developed.

Consultation and Engagement

The H&JCIB recognises that redesigning services to meet people's needs across health and justice settings is complex and that it will require collaborative partnership working across organisational boundaries.

We recognise that this is a complex area that involves many partners, but it will be essential that your emerging plans demonstrate how Justice and Health partners (both Health Boards and GPs) have been consulted and included in preparation of the plan. If that is not possible to deliver fully in the timescales, an indication of consultation and engagement plans would be very helpful.

Governance

Giving primacy to Integration Authorities to deliver the national commitment for 800 mental health workers in the Primary Care Improvement Plans simplifies local governance arrangements. At local level, Integration Authorities will hold NHS Boards and councils to account for delivery of the milestones set out in their plans, in line with the directions provided to the NHS Board and Council by the Integration Authority for the delivery of Strategic Plans.

At national level, we will consider how we can ensure that Ministers have the necessary assurances about delivery of the overall 800 staff over four years.

Monitoring and Evaluation

You will need to plan for and demonstrate a clear trajectory towards 800 additional mental health workers under the funding for this commitment over the next four years, and we will consider what national oversight arrangements should be in place to offer assurance on that point.

The plans should also include consideration of how the changes will be evaluated locally.

Allocation methodology and future funding

IAs have delegated responsibilities for adult Mental Health services therefore we are asking you to work with Health and Justice partners to deliver a holistic perspective on the additional mental health requirements in key settings (including but not restricted to A&E, GP practices, prisons and police custody suites).

The Scottish Government therefore plans to allocate funding for local improvements to Integration Authorities (via their associated NHS Health Board). National tests of change will continue to be funded centrally.

The expected allocation of additional funds over the next period in total and to each Integration Authority is set out at Annex C. The funding should be considered as *earmarked recurring* funding. It should be assumed therefore that staff may be recruited on a permanent basis to meet the requirements of the commitment. We will engage with IAs and others on any plans to baseline these funds beyond 2021/22 subject to Parliamentary approval of the budget.

This is intended to guide your thinking about the future in terms of the funding over the next four years under this commitment. In broad terms, the distribution presumes a local share of the funding based on National Resource Allocation Committee (NRAC) principles and we would encourage partnership working across IA

boundaries, as per the statutory duty on IAs to work together particularly within Health Board areas[1].

In this initial year of funding, the funding will issue in two tranches starting with allocation of 70% of the funding in June 2018. A high level report on how spending has been profiled must be submitted to SG by the start of September and, subject to confirmation via this report that IAs are able to spend their full 100% allocation in-year, the remaining 30% of funding will be allocated in November 2018. An outline template for making the start-September report is at Annex D. A final template will be issued before September.

We understand that the detail of these plans will take some time to develop and that your ideas about what is necessary will change as the extent and depth of understanding and service response improve over time. We also know that tackling these issues in a more effective way over time will do a lot to improve the help that we provide to communities. We are grateful to Chief Officers and to partners for your commitment to prioritising delivery of this commitment in keeping with the ambition in the Mental Health Strategy.

Please share your plans with Pat.McAuley@gov.scot If you have questions about the process or require further information, please contact Pat on 0131 244 0719.

Penny Curtis
Head of Mental Health and Protection of Rights Division

[1] Given Action 15 of the Mental Health Strategy explicitly specifies prison settings, a population NRAC does not take account of, it is requested that the plans of those partners hosting significant prisons populations include outlines of additional funding requirements they might have based on any available need assessments.

ANNEX A

Membership of the Health and Justice Collaboration Improvement Board

Paul Johnston (co-chair)	DG Education, Communities & Justice
Paul Gray (co-chair)	DG Health and Social Care
Iain Livingstone	Police Scotland
Alasdair Hay	Scottish Fire and Rescue Service
Pauline Howe	Scottish Ambulance Service
Colin McConnell	Scottish Prison Service
Karyn McCluskey	Community Justice Scotland
David Harvie	Crown Office and Procurator Fiscal Service
Robbie Pearson	Healthcare Improvement Scotland
Jane Grant	NHS GG&C
Cathie Curran	NHS Forth Valley
David Williams	IA Chief Officers Group
Shiona Strachan	Clackmannanshire & Stirling IJB
Sally Louden	COSLA
Joyce White	SOLACE
Andrew Scott	Scottish Government
Neil Rennick	Scottish Government
Gillian Russell	Scottish Government

ANNEX B

NHS24 / Police Scotland / Scottish Ambulance Service Collaboration Project

IMPROVING THE MANAGEMENT OF, AND RESPONSE TO, MENTAL HEALTH CRISIS AND DISTRESS FOR THOSE PRESENTING TO SCOTTISH AMBULANCE SERVICE & POLICE SCOTLAND

What are we trying to accomplish?

To support the realisation of Action 15 – Mental Health Strategy (Scotland) 2017-2027, this project (test of change) will improve the care pathway for people suffering from mental illness / mental distress and poor mental well-being who are being supported by Police Scotland and/or the Scottish Ambulance Service.

This initial (draft) proposal has been shared with senior colleagues across all three partner agencies. To date we have received a positive response to the overarching principles of the First Response Test of Change concept, which is aligned to:

Integration with strategic priorities across all service providers.
Integration and facilitation of a joint co-productive / collaborative approach to future service development and delivery.

The project will initially be implemented across a specified geographical area, and delivered within a "test and learn" environment.

The project aim is:

To improve the care pathway for people suffering from mental illness / mental distress and poor mental well-being presenting to Police Scotland and / or Scottish Ambulance Service. By increasing access for Police Scotland and Scottish Ambulance Control Room and Frontline Staff to designated mental health professionals within NHS 24, working closely with locality based care and support services, to provide an appropriate and enhanced mental health triage and assessment of need service.

The project will also aim to (1) Reduce deployment of frontline Police Scotland and Scottish Ambulance Service staff to manage patients in mental distress/ suffering from poor mental health or mental well-being, and (2) Reduce demand placed on locality based Emergency services to manage individuals in mental health crisis / mental distress.

The current service provision for patients who contact Police Scotland / Scottish Ambulance Service requiring mental health care and support is described in Appendix 1.

Significant analysis of the demand placed on NHS 24, Scottish Ambulance Service, Police Scotland and NHS Emergency Departments to manage the mental health and

well-being of the population has been gathered and this will be used to determine outcome measures and key performance indicators for the test of change. Key findings from this work have identified:

People with a Mental Health Problem are three times more likely than the general population to attend the Emergency Department.
The peak presentation time to the Emergency Department is after 11pm, and this patient group are five times more likely to be admitted in the out of hours period.
Frequent callers to emergency services are more likely to be already known and supported by locality based mental health services.

The benefits of an improved care pathway (Appendix 2) for individuals contacting in mental distress / with poor mental health are:

The ability to provide the level of support required to reduce distress and safely manage the needs of the individual effectively either via telephone support or ongoing referral to appropriate locality based services.
Reduction in the need for people to be transferred by / to emergency services.
Reduction in unnecessary demand being placed on Emergency Departments

Project (service) outcomes will be reviewed and reported on monthly, and project activities will be coordinated to ensure that changes tested and implemented successfully within the "test and learn" environment are, if appropriate and feasible, spread across the wider service.

How will we know that a change is an improvement?

A framework of evaluation will be developed in consultation with all partners, including the locality based integrated joint board supporting the "test and learn" phase. This framework will include both quantitative and qualitative measures. Qualitative data will also be used, to gain insights and feedback from individuals utilising the service, staff, partners and wider stakeholders.

Qualitative Outcome measures – across the triumvirate model

Individual experience in relation to outcomes, satisfaction levels, and any follow up action
Partner experience in relation to appropriateness of contacts received, and any follow up/re-triage required at a local level
Staff experience – NHS 24 / Police Scotland / Scottish Ambulance Service

Quantitative Outcome measures – across the triumvirate model

Number of mental health calls managed within the test & learn environment.
Number of mental health calls resulting in a final disposition of self care and our web based content
Numbers of mental health calls across the range of possible outcomes
Reduction in demand to emergency services including ED attendance
Number of contacts signposted to community based services

The project team have had the opportunity to liaise with other service providers who have implemented a first response service to manage the mental health needs of the population they serve. This service model incorporates mental health professionals working across a number of service areas, including Police Control Centres.

Data from Cambridgeshire and Peterborough Crisis Care Concordant (comparing 6 months pre intervention, 8 months post intervention) showed:

ED attendance for any "mental health" need – down 25%
Admission to Acute Trust for MH patients from ED – down 19%
Mental Health Ambulance Conveyances – down 26%
111 Calls and OOH GP appointments – down 45% and 39%

What changes can we make that will result in improvement?

The timetable below highlights the key milestones of the initial test of change proposal:

TIMESCALE	OUTCOME
To Month 3	Briefing Paper re ToC to sponsor Identification of ToC Geographical Area Establish Programme Board / Governance and Assurance Structure. Recruitment of Frontline Mental Health Professionals Recruitment of project staff Establish Shared Outcome Measures across all partner agencies. Planning and preparation; Process, Operations, Technology and Information
Month 3 – Month 6	Training and Locality Pathway Development. Phase One of Implementation of TOC.
Month 6 – Month 9	Evaluation of Phase One Implementation. Phase 2 / Whole System Implementation.
Month 9 – Month 12	Project Evaluation. Development Proposal for further / future upscaling of model – national learning and implementation plan

Project Team

The Project Team will compromise of three distinct groupings, all of which will be aligned to the current Service Transformation Plans in place across NHS 24 / Police Scotland and the Scottish Ambulance Service:

Programme Board (Quarterly Meetings)

Programme Lead(s) – PS / SAS / NHS24
Communication and Engagement Lead
Evaluation Lead
Locality Representative(s)
Project Manager (NHS 24)
Executive Leadership Representation from PS / NHS24 / SAS
Executive Sponsor : Scottish Government Mental Health Division

Implementation Group (Monthly Meetings)

Programme Leads
Project Manager
Data Analyst
Locality Representatives – including service users.
Frontline Police Scotland & Scottish Ambulance Service Representatives
Communication and Engagement Lead

Project (Service) Delivery Team (Daily / Weekly Meetings)

Project Manager
Communication & Engagement
Team Leader(s)
Mental Health Support Workers
Mental Health Advisors
Mental Health Specialist Practitioners
Learning & Development Advisor

Financial Implications

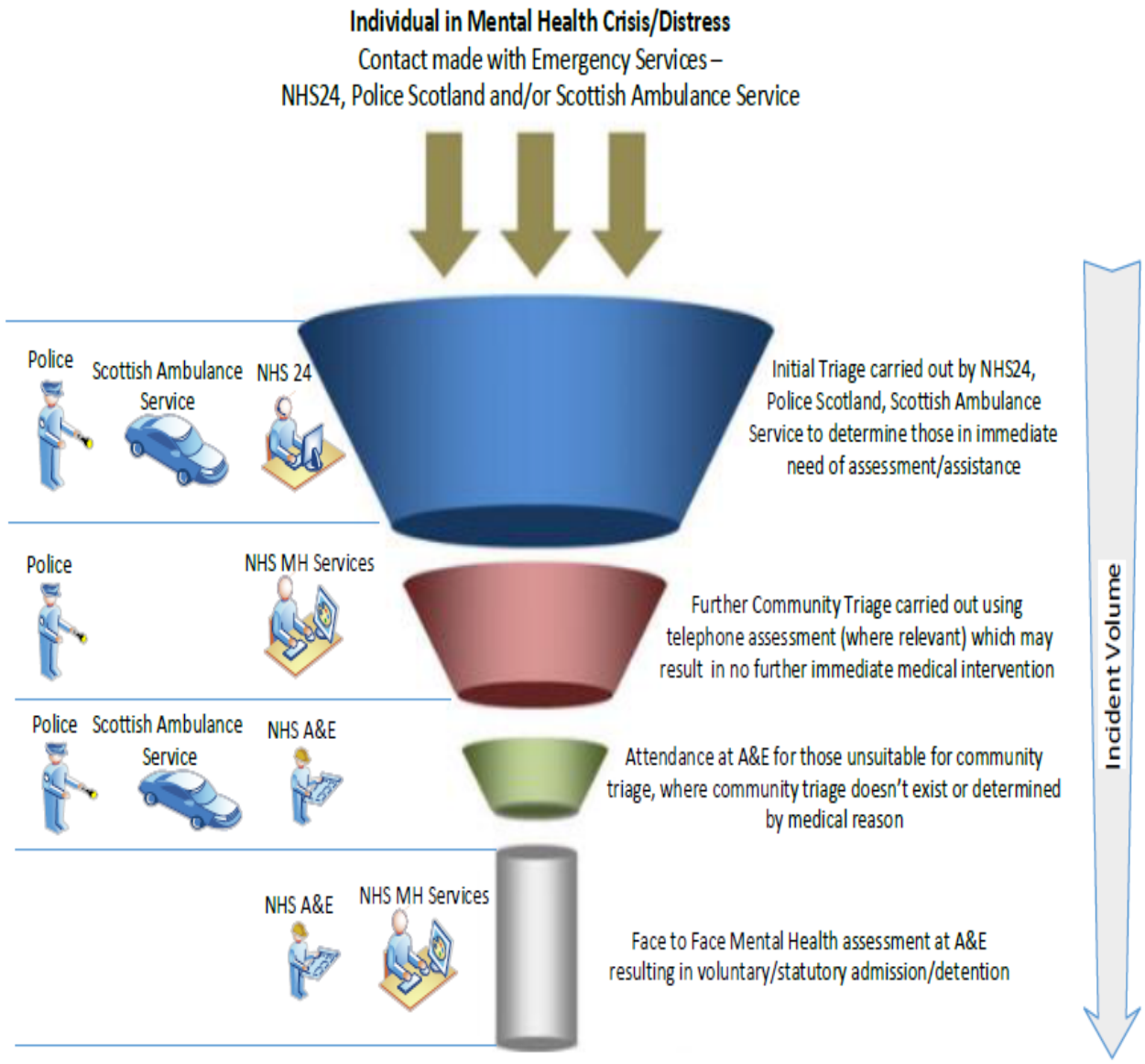
The final budget required to deliver this proposed test of change model is dependant on the needs and demand of the agreed geographical area where the pilot will be implemented. The table below details a workable draft budget, with reference given to particular roles and responsibilities required to ensure a smooth delivery of the project across all three partner areas. Several of these roles will straddle across all three components of the project.

Details	Amount
Infrastructure, Development & Implementation of Model - Senior Programme Leadership - Communication and Engagement - Learning & Education - Technology / Systems Upgrade	£117,144
Service Delivery Staffing - Mental Health Clinical Service Manager (1xWTE Band 8a) - Mental Health Team Leaders (2x WTE Band 7) - Mental Health Call Operators (5x WTE Band 3) - Mental Health and Well-being Advisors (4x WTE Band 4) - Mental Health Specialist Practitioner (4x WTE Band 6) *** This would ensure at least 16 new Mental Health Professionals being recruited to support direct patient care***	£669,288
Evaluation and Programme Management Project Administrator Data Analyst / Researcher	£81,582

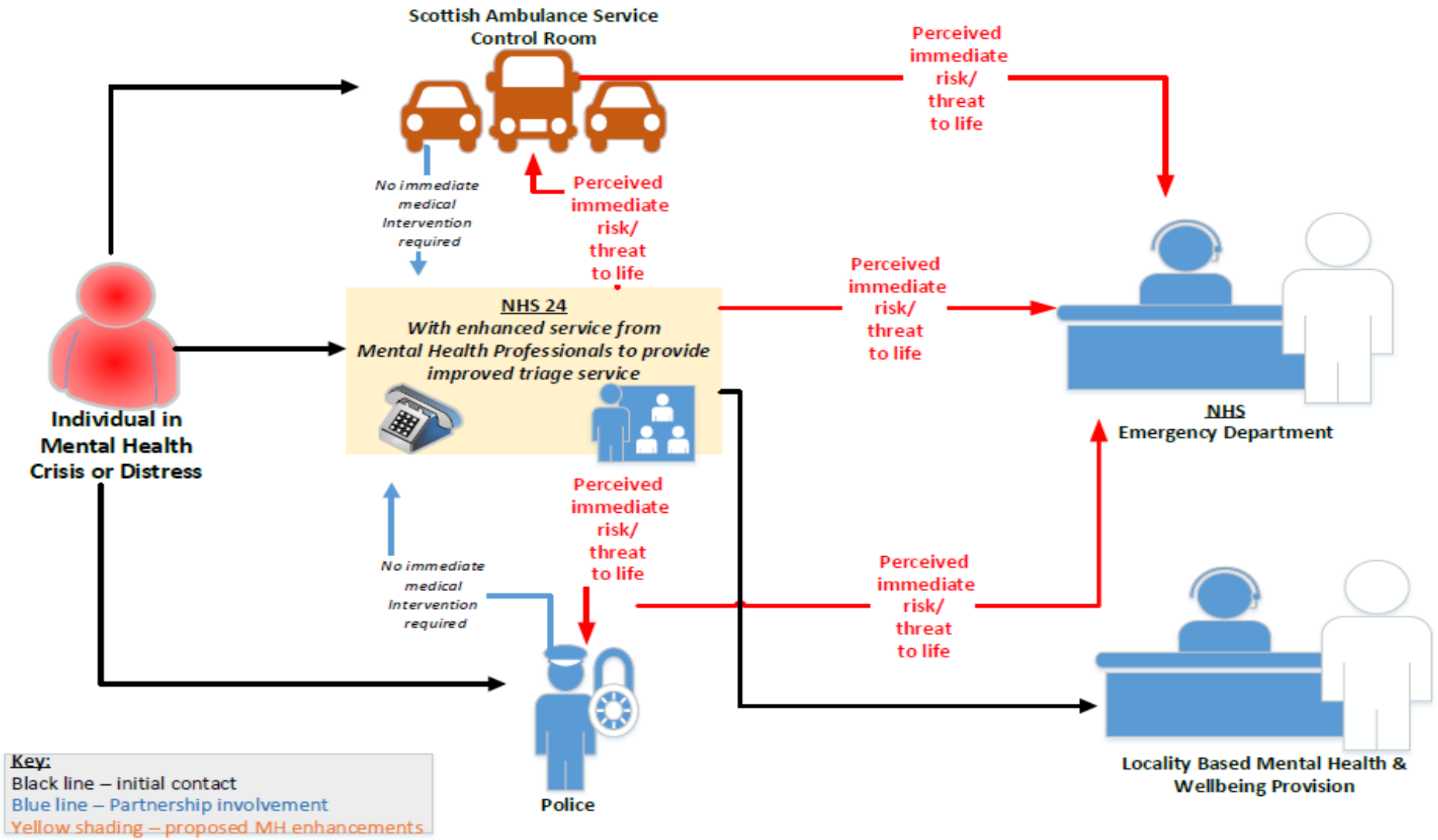
The proposed draft budget for year 1 would be **£868,014.**

Appendix 1: Current Service provision

Appendix 1



Appendix 2 – Proposed Enhanced Mental Health Pathways First Response



ANNEX C

Breakdown of funding

Please note - these figures are only provided as a guide using the NRAC formula calculator for 2018/19. [2] The formula changes only very slightly each year therefore it is not possible to provide an exact figure over the next 4 years.

Allocations by Territorial Board – 2018/2019 £11 Million		
NHS Board	**Target Share**	**NRAC Share**
NHS Ayrshire and Arran	7.409%	£815,006
NHS Borders	2.104%	£231,456
NHS Dumfries and Galloway	2.979%	£327,738
NHS Fife	6.806%	£748,636
NHS Forth Valley	5.419%	£596,129
NHS Grampian	9.873%	£1,085,983
NHS Greater Glasgow & Clyde	22.337%	£2,457,118
NHS Highland	6.442%	£708,660
NHS Lanarkshire	12.348%	£1,358,226
NHS Lothian	14.80 4%	£1,628,474
NHS Orkney	0.483%	£53,077
NHS Shetland	0.490%	£53,907
NHS Tayside	7.848%	£863,306
NHS Western Isles	0.657%	£72,285

Breakdown of estimated allocation per IJB - 2018/2019 £11 Million					
NHS Board	**NRAC Share %**	**NRAC Share £**	**HSCP Name**	**HSCP NRAC Share %**	**NRAC Share £**
Ayrshire & Arran	7.41%	815,006	East Ayrshire	2.43%	£267,351
			North Ayrshire	2.72%	£299,538
			South Ayrshire	2.26%	£248,118
Borders	2.10%	231,456	Scottish Borders	2.10%	£231,456
Dumfries & Galloway	2.98%	327,738	Dumfries and Galloway	2.98%	£327,738
Fife	6.81%	748,636	Fife	6.81%	£748,636
Forth Valley	5.42%	596,129	Clackmannanshire and Stirling	2.55%	£280,549
			Falkirk	2.87%	£315,580
Grampian	9.87%	1,085,983	Aberdeen City	3.92%	£431,203

[2] As per the footnote on page 5, Action 15 of the Mental Health Strategy explicitly specifies prison settings, a population NRAC does not take account of, it is requested that the plans of those partners hosting significant prisons populations include outlines of additional funding requirements they might have based on any available need assessments.

			Aberdeenshire	4.23%	£465,384
			Moray	1.72%	£189,396
Greater Glasgow & Clyde	22.34%	2,457,118	East Dunbartonshire	1.82%	£199,776
			East Renfrewshire	1.56%	£171,667
			Glasgow City	12.09%	£1,329,497
			Inverclyde	1.65%	£181,485
			Renfrewshire	3.40%	£373,503
			West Dunbartonshire	1.83%	£201,190
Highland	6.44%	708,660	Argyll and Bute	1.85%	£203,883
			Highland	4.59%	£504,777
Lanarkshire	12.35%	1,358,226	North Lanarkshire	6.43%	£706,750
			South Lanarkshire	5.92%	£651,476
Lothian	14.80%	1,628,474	East Lothian	1.83%	£201,801
			Edinburgh	8.32%	£915,205
			Midlothian	1.57%	£173,170
			West Lothian	3.08%	£338,298
Orkney	0.48%	53,077	Orkney Islands	0.48%	£53,077
Shetland	0.49%	53,907	Shetland Islands	0.49%	£53,907
Tayside	7.85%	863,306	Angus	2.15%	£237,042
			Dundee City	2.96%	£325,907
			Perth and Kinross	2.73%	£300,357
Western Isles	0.66%	72,285	Eilean Siar (Western Isles)	0.66%	£72,285

Allocations by Territorial Board – 2019/2020 £17 million		
NHS Board	**Target Share**	**NRAC Share**
NHS Ayrshire and Arran	7.409%	£1,259,555
NHS Borders	2.104%	£357,705
NHS Dumfries and Galloway	2.979%	£506,503
NHS Fife	6.806%	£1,156,983
NHS Forth Valley	5.419%	£921,290
NHS Grampian	9.873%	£1,678,337
NHS Greater Glasgow & Clyde	22.337%	£3,797,365
NHS Highland	6.442%	£1,095,201
NHS Lanarkshire	12.348%	£2,099,076
NHS Lothian	14.804%	£2,516,732
NHS Orkney	0.483%	£82,029
NHS Shetland	0.490%	£83,311
NHS Tayside	7.848%	£1,334,200
NHS Western Isles	0.657%	£111,713

Breakdown of estimated allocation per IJB - 2019/2020 17 Million					
NHS Board	**NRAC Share %**	**NRAC Share £**	**HSCP Name**	**HSCP NRAC Share %**	**NRAC Share £**
Ayrshire & Arran	7.41%	1,259,555	East Ayrshire	2.43%	£413,178
			North Ayrshire	2.72%	£462,922
			South Ayrshire	2.26%	£383,455
Borders	2.10%	357,705	Scottish Borders	2.10%	£357,705
Dumfries & Galloway	2.98%	506,503	Dumfries and Galloway	2.98%	£506,503
Fife	6.81%	1,156,983	Fife	6.81%	£1,156,983
Forth Valley	5.42%	921,290	Clackmannanshire and Stirling	2.55%	£433,575
			Falkirk	2.87%	£487,715
Grampian	9.87%	1,678,337	Aberdeen City	3.92%	£666,404
			Aberdeenshire	4.23%	£719,229
			Moray	1.72%	£292,703
Greater Glasgow & Clyde	22.34%	3,797,365	East Dunbartonshire	1.82%	£308,745
			East Renfrewshire	1.56%	£265,303
			Glasgow City	12.09%	£2,054,677
			Inverclyde	1.65%	£280,477
			Renfrewshire	3.40%	£577,233
			West Dunbartonshire	1.83%	£310,930
Highland	6.44%	1,095,201	Argyll and Bute	1.85%	£315,091
			Highland	4.59%	£780,110
Lanarkshire	12.35%	2,099,076	North Lanarkshire	6.43%	£1,092,250
			South Lanarkshire	5.92%	£1,006,826
Lothian	14.80%	2,516,732	East Lothian	1.83%	£311,875
			Edinburgh	8.32%	£1,414,407
			Midlothian	1.57%	£267,626
			West Lothian	3.08%	£522,823
Orkney	0.48%	82,029	Orkney Islands	0.48%	£82,029
Shetland	0.49%	83,311	Shetland Islands	0.49%	£83,311
Tayside	7.85%	1,334,200	Angus	2.15%	£366,337
			Dundee City	2.96%	£503,674
			Perth and Kinross	2.73%	£464,188
Western Isles	0.66%	111,713	Eilean Siar (Western Isles)	0.66%	£111,713

Allocations by Territorial Board – 2020/2021 £24 million		
NHS Board	**Target Share**	**NRAC Share**
NHS Ayrshire and Arran	7.409%	£1,778,196
NHS Borders	2.104%	£504,995

NHS Dumfries and Galloway	2.979%	£715,064
NHS Fife	6.806%	£1,633,388
NHS Forth Valley	5.419%	£1,300,645
NHS Grampian	9.873%	£2,369,417
NHS Greater Glasgow & Clyde	22.337%	£5,360,986
NHS Highland	6.442%	£1,546,166
NHS Lanarkshire	12.348%	£2,963,402
NHS Lothian	14.804%	£3,553,033
NHS Orkney	0.483%	£115,805
NHS Shetland	0.490%	£117,615
NHS Tayside	7.848%	£1,883,576
NHS Western Isles	0.657%	£157,712

Breakdown of estimated allocation per IJB - 2020/2021
24 Million

NHS Board	NRAC Share %	NRAC Share £	HSCP Name	HSCP NRAC Share %	NRAC Share £
Ayrshire & Arran	7.41%	1,778,196	East Ayrshire	2.43%	£583,310
			North Ayrshire	2.72%	£653,537
			South Ayrshire	2.26%	£541,348
Borders	2.10%	504,995	Scottish Borders	2.10%	£504,995
Dumfries & Galloway	2.98%	715,064	Dumfries and Galloway	2.98%	£715,064
Fife	6.81%	1,633,388	Fife	6.81%	£1,633,388
Forth Valley	5.42%	1,300,645	Clackmannanshire and Stirling	2.55%	£612,106
			Falkirk	2.87%	£688,539
Grampian	9.87%	2,369,417	Aberdeen City	3.92%	£940,806
			Aberdeenshire	4.23%	£1,015,383
			Moray	1.72%	£413,228
Greater Glasgow & Clyde	22.34%	5,360,986	East Dunbartonshire	1.82%	£435,875
			East Renfrewshire	1.56%	£374,545
			Glasgow City	12.09%	£2,900,720
			Inverclyde	1.65%	£395,968
			Renfrewshire	3.40%	£814,917
			West Dunbartonshire	1.83%	£438,960
Highland	6.44%	1,546,166	Argyll and Bute	1.85%	£444,835
			Highland	4.59%	£1,101,332
Lanarkshire	12.35%	2,963,402	North Lanarkshire	6.43%	£1,542,000
			South Lanarkshire	5.92%	£1,421,401
Lothian	14.80%	3,553,033	East Lothian	1.83%	£440,294
			Edinburgh	8.32%	£1,996,810
			Midlothian	1.57%	£377,825
			West Lothian	3.08%	£738,104

Orkney	0.48%	115,805	Orkney Islands	0.48%	£115,805
Shetland	0.49%	117,615	Shetland Islands	0.49%	£117,615
Tayside	7.85%	1,883,576	Angus	2.15%	£517,182
			Dundee City	2.96%	£711,069
			Perth and Kinross	2.73%	£655,325
Western Isles	0.66%	157,712	Eilean Siar (Western Isles)	0.66%	£157,712

Allocations by Territorial Board – 2021/2022 £32 million		
NHS Board	**Target Share**	**NRAC Share**
NHS Ayrshire and Arran	7.409%	£2,370,927
NHS Borders	2.104%	£673,327
NHS Dumfries and Galloway	2.979%	£953,418
NHS Fife	6.806%	£2,177,851
NHS Forth Valley	5.419%	£1,734,193
NHS Grampian	9.873%	£3,159,222
NHS Greater Glasgow & Clyde	22.337%	£7,147,981
NHS Highland	6.442%	£2,061,555
NHS Lanarkshire	12.348%	£3,951,202
NHS Lothian	14.804%	£4,737,378
NHS Orkney	0.483%	£154,407
NHS Shetland	0.490%	£156,821
NHS Tayside	7.848%	£2,511,435
NHS Western Isles	0.657%	£210,283

Breakdown of estimated allocation per IJB - 2021/2022 £32 Million					
NHS Board	**NRAC Share %**	**NRAC Share £**	**HSCP Name**	**HSCP NRAC Share %**	**NRAC Share £**
Ayrshire & Arran	7.41%	2,370,927	East Ayrshire	2.43%	£777,747
			North Ayrshire	2.72%	£871,383
			South Ayrshire	2.26%	£721,797
Borders	2.10%	673,327	Scottish Borders	2.10%	£673,327
Dumfries & Galloway	2.98%	953,418	Dumfries and Galloway	2.98%	£953,418
Fife	6.81%	2,177,851	Fife	6.81%	£2,177,851
Forth Valley	5.42%	1,734,193	Clackmannanshire and Stirling	2.55%	£816,141
			Falkirk	2.87%	£918,051
Grampian	9.87%	3,159,222	Aberdeen City	3.92%	£1,254,408
			Aberdeenshire	4.23%	£1,353,844
			Moray	1.72%	£550,970
Greater Glasgow &	22.34%	7,147,981	East Dunbartonshire	1.82%	£581,167

Clyde					
			East Renfrewshire	1.56%	£499,394
			Glasgow City	12.09%	£3,867,627
			Inverclyde	1.65%	£527,957
			Renfrewshire	3.40%	£1,086,555
			West Dunbartonshire	1.83%	£585,280
Highland	6.44%	2,061,555	Argyll and Bute	1.85%	£593,113
			Highland	4.59%	£1,468,442
Lanarkshire	12.35%	3,951,202	North Lanarkshire	6.43%	£2,056,001
			South Lanarkshire	5.92%	£1,895,202
Lothian	14.80%	4,737,378	East Lothian	1.83%	£587,059
			Edinburgh	8.32%	£2,662,414
			Midlothian	1.57%	£503,767
			West Lothian	3.08%	£984,138
Orkney	0.48%	154,407	Orkney Islands	0.48%	£154,407
Shetland	0.49%	156,821	Shetland Islands	0.49%	£156,821
Tayside	7.85%	2,511,435	Angus	2.15%	£689,576
			Dundee City	2.96%	£948,093
			Perth and Kinross	2.73%	£873,766
Western Isles	0.66%	210,283	Eilean Siar (Western Isles)	0.63%	£210,283

ANNEX D

ACTION 15 - OUTLINE 2018-19 INTEGRATION AUTHORITY FINANCIAL REPORTING TEMPLATE, DUE FOR RETURN BY SEPTEMBER 2018

IA area

Summary of agreed spending breakdown for 2018-19 with anticipated monthly phasing

Actual spending to date against profile, by month

Remaining spend to end 2018-19, by month

Projected under/ over spend by end 2018-19

Is it expected that the full second tranche will be required in 2018-19?

Please return to:

Pat McAuley
3ER, St Andrew's House, Regent Road, Edinburgh EH1 3DG

Or by email to:
Pat.McAuley@gov.scot

Clackmannanshire & Stirling
Integration Joint Board

13 June 2018

This report relates to
Item 7.6 on the agenda

Set Aside Budget for Large Hospital Services: Self Assessment

Paper presented by Ewan C. Murray

For Noting

Approved for Submission by	Shiona Strachan
Author	Ewan C. Murray, Chief Finance Officer
Date:	30 May 2018
List of Background Papers / Appendices:	
Public Bodies (Joint Working) (Scotland) Act 2014 Clackmannanshire and Stirling Health and Social Care Partnership Integration Scheme Appendix 2 – Letter from Scottish Government Appendix 3 – Pan Forth Valley response to Scottish Government	

Title/Subject: **Set Aside Budget for Large Hospital Services: Self Assessment**

Meeting: **Clackmannanshire & Stirling Integration Joint Board**

Date: **13 June 2018**

Submitted By: **Ewan C. Murray**

Action: **For Noting**

1. Introduction

1.1. The Public Bodies (Joint Working) (Scotland) Act 2014 section 14(3), supporting guidance to the legislation and the Clackmannanshire and Stirling Health and Social Care Partnership Integration Scheme set out the responsibilities and arrangements for the Set Aside Budget for Large Hospital Services.

2. Recommendations

The Integration Joint Board is asked to:

2.1. Note the content of the letter from the Scottish Government and the agreed pan Forth Valley response submitted by the Chief Executive of NHS Forth Valley.

2.2. Note that further updates will be provided to the Board in due course.

3. Background and Considerations

3.1. A letter to Health Board Chief Executives and Integration Authority Chief Officers was received from Director of Health Finance, Scottish Government on 12 April 2018 requiring a response by 18 May 2018 in the form of a self assessment of progress in relation to the Set Aside Budget for Large Hospitals Services. [Appendix 1] The response was developed and agreed on a pan Forth Valley basis and submitted by NHS Forth Valley's Chief Executive on 18 May 2018. [Appendix 2]

3.2. Large Hospital Services are defined as hospitals serving the population of more than one Local Authority area.

3.3. The Set Aside budget for Large Hospital services was calculated in the extant budget model based on national finance guidance and assurance was given to the Integration Joint Board that the process was sound as part of the due

diligence process. The need to revisit the model, taking account of more up to date information and trends, has previously been acknowledged. There is a need to consider this as part of service planning and performance management linked to the work of the Unscheduled Care Programme Board and not as a financial process in isolation.

4. Resource Implications

4.1. As detailed in the response.

5. Impact on Strategic Plan Priorities and Outcomes

5.1. This report and associated recommendations, relates to the following Clackmannanshire & Stirling Health and Social Care Partnership local outcomes and Strategic Plan priorities (please select as appropriate):

Fit with Local Outcomes	
Self Management	☐
Community Focussed Supports	☒
Safety	☐
Decision Making	☒
Experience	☒

Fit with Our Priorities 'we will...'	
Further develop systems to enable front line staff to access and share information	☐
Support more co-location of staff from across professions and organisations	☐
Develop single care pathways	☒
Further develop anticipatory and planned care services	☐
Provide more single points of entry to services	☐
Deliver the Stirling Care Village	☐
Develop seven-day access to appropriate services	☐
Take further steps to reduce the number of unplanned admissions to hospital and acute services	☒

5.2. The Set Aside Budget for Large Hospital Services relates to the Partnership populations usage of Unscheduled Care Services delivered through Forth Valley Royal Hospital, Bellsdyke (Mental Health) and Lochview (Learning Disabilities) facilities.

6. Legal & Risk Implications

6.1. The development of an accountability framework on risk sharing for the Set Aside budget has financial risks for the Integration Joint Board which will require to be considered as part alongside development of Medium Term Financial Planning and Integration Authority Strategic Commissioning Plans for 2019-2022.

7. Consultation

7.1. No consultation requirements identified.

8. Equality and Human Rights Impact Assessment

8.1. The contents of this report do not require an EQIA because no impacts on equalities or human rights are identified at this point.

9. Data Protection Impact Assessment

9.1. The contents of this report do not require a DPIA.

10. Exempt reports

10.1. Not exempt.

11. Appendices

11.1. Appendix 1 – Letter from Scottish Government

11.2. Appendix 2 – Pan Forth Valley response to Scottish Government

Health Finance Directorate
Christine McLaughlin, Director

Scottish Government
Riaghaltas na h-Alba
gov.scot

T: 0131-244 3464
E: christine.mclaughlin@gov.scot

Integration Authority Chief Officers
Health Board Chief Executives

Cc Local Authority Chief Executives
Integration Authority Chief Finance Officers
Health Board Directors of Finance

12 April 2018

Dear Colleagues

Progress establishing set aside arrangements – integrated budgets

As you will be aware, a Finance Development Group (FDG) has been established to support implementation of the financial aspects of the health and social care integration legislation and associated guidance. The FDG includes representation from NHS Boards, Integration Authorities, local authorities, Audit Scotland, CIPFA, COSLA and Scottish Government. At the most recent meeting, the group agreed that there was a need to understand the progress that is being made towards planning across the full pathway of care, including the acute hospital component and the way in which the statutory guidance on the use of delegated hospital budgets is being applied in practice.

The statutory guidance sets out six key steps for implementing the arrangements, as follows:

1. A group should be established comprising the hospital sector director and finance leads, and the Chief Officers and Chief Finance Officers of the Integration Authorities, whose populations use the hospital services, including those with a material level of cross boundary flow. The purpose of the group is to develop an understanding of the baseline bed capacity used by Integration Authority residents in the delegated specialties and the resource affected; to develop projections and agree a plan for the capacity that will be needed in future; and to monitor implementation of the plan.

2. The baseline bed days used by Integration Authority residents in the ten specialties should be quantified and the relevant budgets mapped to the bed capacity. The resulting amounts would then be the baseline sum set aside.

3. A method should be agreed for quantifying how the sum set aside will change with projected changes in bed capacity. This should be at two levels of detail: one allowing for the development of outline plans, giving an initial indication of the potential resource implications; and a more comprehensive analysis of agreed changes in capacity, that takes into account cost behaviour and timing of resource changes. Although ultimately left to local decision, the guidance recommends that a similar process to the one successfully used for Learning Disability Same As You (LDSAY) should be used for the more detailed modelling.

INVESTOR IN PEOPLE
POSITIVE ABOUT DISABLED PEOPLE

4. A plan should be developed and agreed that sets out the capacity levels required by each Integration Authority (taking into account both the impact of redesign and of demographic change) and the resource changes entailed by the capacity changes.

5. Regular information should be provided to the group to monitor performance against the plan.

6. As the plan for hospital capacity is a joint risk held by the Integration Authorities and the Health Board an accountability framework should be agreed that clarifies relevant risk sharing arrangements.

I am writing to you in my role as Chair of the FDG to request information on the development of your local arrangements for this key part of the legislation. I would be grateful if you could provide a response, agreed by both the Integration Authority and NHS Board. which sets out your assessment of your partnership's progress in implementing these six recommendations and plans for this financial year 2018/19. It would be helpful if you could identify any areas that would support further progress when responding.

Responses should be sent to Eilidh.love@gov.scot on completion, by close on 18th May. Please let me know if this timescale presents any practical difficulties.

Yours sincerely

Christine McLaughlin

CHRISTINE MCLAUGHLIN

INVESTOR IN PEOPLE
POSITIVE ABOUT DISABLED PEOPLE

NHS Forth Valley

Carseview House
Castle Business Park
Stirling
FK9 4SW

Telephone: 01786 463031
Fax: 01786 451474

Christine McLaughlin
Director
Health Finance Directorate
The Scottish Government
St Andrew's House
Regent Road
Edinburgh
EH1 3DG

Date 18 May 2018

Enquiries to Cathie Cowan
Extension 210
Direct Line 01786 457210
Email cathiecowan@nhs.net

Dear Christine

Progress establishing set aside arrangements – integrated budgets

I write with reference to your correspondence of 12 April 2018 on the above. This is submitted as a collective response from the Chief Officers of both Falkirk and Clackmannanshire and Stirling Integration Authorities, and the Chief Executive of NHS Forth Valley.

In preparation for the establishment of the two integration authorities in Forth Valley, significant work took place to identify those operational and set aside budgets in scope, and to construct a financial model to allocate in scope budget shares to the two Health and Social Care Partnerships.

Within the financial model, the sum for set aside is based on financial values for in-scope services, aggregated from service and ward level budgets. These budgets formed part of the model which then allocated the budgets across the two partnerships, using Integrated Framework (IRF) statistics, as provided by the Information Services Division. The model and the methodology used were subject to a due diligence exercise undertaken by internal auditors and assurance was given to the Integration Joint Boards. The requirement to revisit and further develop these arrangements has been acknowledged.

Regarding the six steps as set out in the statutory guidance we would respond as follows:

1 To update work previously undertaken on set aside, a group will be established, with appropriate Terms of Reference. It is envisaged that this group will include Chief Officers and their finance support, together with Hospital General Management and Planning and Project support. The group will report progress to the Unscheduled Care Programme Board.

2 The work done on the previous model will be reviewed and updated to take account of the most recently available data from SOURCE to establish an updated budget and activity baseline by specialty.

3 Once the baseline model is reviewed and updated and has been subject to appropriate due diligence scrutiny, it will be available to be used to model the impact of development plans which might propose an alternative utilisation of the current bed complement. As advised, the Learning Disability Same as You methodology will be reviewed for modelling purposes.

4 In order to identify the likely capacity levels required by each Integration Authority, it is envisaged that planning assumptions including those informed by new models of care, the General Register Office population statistics, local intelligence through Joint Strategic Need Assessments and activity information via SOURCE will be used, and aligned to current work on medium and longer term financial planning. It will be important to align assumptions with those developed for the West of Scotland Strategic Resource Framework.

5 As set out above, the reporting route will flow through the Falkirk IJB Leaderships Group, the Clackmannanshire and Stirling IJB Leadership Group and through the Unscheduled Care Programme Board, and will occur on a regular basis. A project plan will be established and performance against that will be monitored. Progress will also be reported as appropriate through the Integration Joint Boards, including committee structures to ensure visibility and understanding of relevant accountabilities.

6 The establishment of a robust accountability framework on risk share to manage proposed services and budget changes will be developed and agreed with Integration Joint Boards and NHS Board. This will aim to ensure that operational and financial turbulence is minimised.

In summary, we will establish an expert group to review work previously done on Set Aside and update for the most recent SOURCE information to update the current baseline. This model will then be available to understand capacity and resource usage by the Integration Authorities and give a platform to plan and manage change.

Yours sincerely

Cathie Cowan
Chief Executive
NHS Forth Valley

cc Patricia Cassidy, Chief Officer, Falkirk Integration Joint Board
Shiona Strachan, Chief Officer, Clackmannanshire & Stirling Integration Joint Board

Clackmannanshire & Stirling Health and Social Care Partnership
Integration Joint Board

13 June 2018

This report relates to
Item 8.1 on the agenda

Performance Report

Paper presented by Shiona Strachan

For Noting and Approval

Approved for Submission by	Shiona Strachan, Chief Officer
Author	Viv Meldrum, Carol Johnson
Date:	25 May 2018
List of Background Papers / Appendices:	
Appendix 1. Performance Summary, key performance areas 2. Glossary 3. MSG submission	

Title/Subject: **Performance Report**

Meeting: **Clackmannanshire & Stirling Integration Joint Board**

Date: **13 June 2018**

Submitted By: **Chief Officer**

Action: **For Noting**

1. Introduction

1.1 As set out in the approved Performance Management Framework, the Integration Joint Board has a responsibility to ensure effective monitoring and reporting on the delivery of services and relevant targets and measures included in the Integration Functions, and as set out in the Strategic Plan.

1.2 The approach to performance reporting and management continues to develop across the Partnership.

2. Executive Summary

2.1 The report has been prepared in partnership. The reporting style continues to develop to support the Board to carry out its scrutiny functions and in line with previous Board decisions is in an exceptions reporting format.

2.2 The report has been formatted around some of the 6 themes required by the Scottish Government's MSG indicators which aim at promoting a whole system approach to the delivery of unscheduled care within the scope of and in partnership with the IJB.

2.3 The Strategic Risk Register was considered by the Audit Committee on 21 February 2018 and will be reviewed by the Joint Management Team on 20 June 2018. There are 10 high level risks, 4 of which have been scored high. The next Audit Committee is on 27 June 2018 when the risk register will be considered in depth.

2.4 In conjunction with the Unscheduled Care Programme Board, targets have been agreed for 11 key indicators across health and social care that are associated with MSG Unscheduled Care. This has enabled further development of operational target setting which is monitored at the Joint Management Team (JMT) and reported to the Unscheduled Care Programme Board. Baselines have been set to allow comparison with performance before the Partnership was established.

2.5 Locality based performance reporting is being further developed and it is proposed that in line with the wider Partnership performance is monitored by both the Joint Management Team and the multi agency Strategic Planning

Group (SPG). Locality level data was provided to the May SPG which helped inform discussion around locality planning.

2.6 This report also contains information on Social Care services core activity and community supports. It is recognised that there needs to be further development of the social care information presented to the Integration Joint Board and this work will take place in advance of the next Board meeting.

2.7 Appendix 1 of this report provides an 'at a glance 'summary of performance [section 1], an outline of the key performance areas for consideration [section 2] and a summary of linked performance areas under the local outcomes.

3 Recommendations

The Integration Joint Board is asked to:

3.1 Note the content of the performance report.

3.2 Note that appropriate management actions continue to be taken to address the issues identified through these performance reports.

4 Background

4.1 The purpose of this report is to ensure the Integration Joint Board fulfils its ongoing responsibility to ensure effective monitoring and reporting on the delivery of services and relevant targets and measures included in the Integration Functions, and as set out in the Strategic Plan.

4.2 Annual performance against the core integration indicators associated with the National Health and Wellbeing Outcomes is reported in an accompanying paper to this Board.

4.3 Since the last paper was presented to the Board, underpinning scorecards for the Clackmannanshire locality and Stirling Adult Social Care have been developed with further work ongoing across the other core areas of service.

4.4 The Joint Management Team for the Partnership also considers key operational and strategic performance measures, informing the Annual Performance Report and future performance reports to this Board.

4.5 The content of the report is monitored and actively managed on an ongoing basis and the information also supports wider planning and delivery in areas such as the developing locality planning and the review of the Strategic Plan.

5 Approach

5.1 As described in previous Integration Joint Board Performance reports, a Strategy Map has been created to ensure there is a direct link back from performance to the outcomes of the Strategic Plan. The Strategy Map will be refreshed in line with the development of the next Strategic Plan.

5.2 This report contains information on some of the 6 themes of the MSG Indicators relating to unscheduled care, using local data items within the main body of the report in order to provide more up to date information.

The six MSG themes are:

- Unplanned Admissions
- Occupied Bed Days for Unscheduled Care
- Emergency Department Performance
- Delayed Discharges
- End of life care
- Balance of care

5.3 Appendix 3 provides a summary of progress using data provided by Information Services Division [ISD] as at February 2018. The purpose of these indicators as stated by the Scottish Government is to provide a strategic framework for the planning and delivery of health and social care services allowing decisions to be made on the best use of resources. The Unscheduled Care Programme Board review this data in depth quarterly.

5.4 The Pentana performance reporting system has been used to prepare the majority of this report. Within Pentana a variance range is required to be set for indicators. This defines the acceptable or tolerable spread between the numbers in a data set and red and amber RAG statuses.

5.5 Where possible this report is reflecting on the data over 17/18 and dovetails with the core data provided in the accompanying Annual Performance Report.

5.6 A glossary has also been provided [Appendix 2] to give explanation and context to abbreviations and areas contained within this report.

6 Report Structure

6.1 Section 1 of the Performance provides an ‘at glance performance summary’ of the key areas of performance. Work is required in terms of developing a Balanced Scorecard to provide a broader range of measures and build upon qualitative improvement and assurance. The IJB focus is across the five local outcomes with work to support a balanced approach to measurement and reporting.

6.2 Section 2 provides a summary of key performance areas for consideration by the Board. The areas highlighted include:

- Emergency Department (ED) Performance against the 4 hour Standard
- Rate of ED Attendance
- Delayed Discharges
- Adult Support and Protection
- Social Care activity

6.3 Overall there has been an improvement in most of the indicators for the Partnership, especially around the outcomes of safety, decision making and experience. Due to lack of historical data it was not possible to assess the Community Based Support outcome.

6.4 Indicators around Delayed Discharge showed an improvement on the previous year. Unscheduled Care and especially attendance at Emergency Department and being seen within 4 hours continue to present a challenge across the whole system and a significant amount of work is taking place via the Unscheduled Care Programme Board to address these areas.

6.5 Indicators within Social Care demonstrate a growing demand over the year, with an increase in supporting people to live at home in the community. Dementia and frailty put a strain on both health and social care which is a focus for improvement work across the Partnership and Forth Valley, in order to meet the needs of people and their unpaid carers more appropriately and to ensure that services are delivered in a way that helps to address the predicated continued demographic growth in the number of older people living in our communities.

6.6 Section 3 offers additional detail with regard to the indicators described above as well as detail in respect of a number of other linked indicators relating to Unscheduled Care.

7 Conclusion

7.1 The Integration Joint Board is responsible for effective monitoring and reporting on the delivery of services and relevant targets and measures included in the Integration Functions, and as set out in the Strategic Plan. This report represents the process in terms of presenting a formal performance report to the Board.

7.2 Performance reports are used across the service areas to inform planning, priorities and management actions.

7.3 As noted above further work is required in respect of the social care information and the reporting style of this report.

8 Resource Implications

8.1 The management of performance is critical to managing the overall budget of the Integration Joint Board. The resource requirements to ensure the effective

development of performance management and performance reporting are under review.

8 Impact on Strategic Plan Priorities and Outcomes

8.1 This report and associated recommendations, relates to the following Clackmannanshire & Stirling Health and Social Care Partnership local outcomes and Strategic Plan priorities (please select as appropriate):

Fit with Local Outcomes	
Self Management	☒
Community Focussed Supports	☒
Safety	☒
Decision Making	☒
Experience	☒

Fit with Our Priorities 'we will...'	
Further develop systems to enable front line staff to access and share information	☐
Support more co-location of staff from across professions and organisations	☐
Develop single care pathways	☐
Further develop anticipatory and planned care services	☐
Provide more single points of entry to services	☒
Deliver the Stirling Care Village	☐
Develop seven-day access to appropriate services	☐
Take further steps to reduce the number of unplanned admissions to hospital and acute services	☒

8.2 Only by managing performance can the delivery of the Integration Joint Board outcomes and priorities be truly assessed providing a sound basis from which to make decisions regarding investment and service change.

9 Legal & Risk Implications

9.1 Performance management is a legal requirement as defined in the Integration Joint Board's Integration Scheme.

10 Consultation

10.1 Approach defined in the approved Performance Management Framework..

11 Equality and Human Rights Impact Assessment

12.1 The contents of this report do not require an EQIA. The content of the report is derived from national indicators.

12 Data Protection Impact Assessment

13.1 The contents of this report do not require a DPIA.

13 Exempt reports

14.1 Not exempt

14 Appendices

- Appendix 1 Performance Summary
- Appendix 2 Glossary
- Appendix 3 MSG summary

Appendix 1 - Performance Summary Report

Section 1: At a Glance Performance Summary

The Partnership focus is across the five Local Outcomes with work on-going to support a balanced approach to measurement and reporting. It should be noted that work is required in terms of developing a Balanced Scorecard to provide a broader range of measures and build upon qualitative and quantitative data which will enable and support quality improvement and assurance.

Key:

Direction of travel relates to previously reported position	
▲	Improvement in period
◄►	Position maintained
▼	Deterioration in period
—	No comparative data

The table highlights local data for the year to date position; April to March 2018, compared with the previous full year 16/17. Data for the baseline year 15/16 is also included. The Delayed Discharge position is reported at the March 18 census. Performance data pertains to adults aged 18 and over.

Local Outcomes	Partnership Indicator	Clackmannanshire & Stirling			
Self Management	Emergency department 4 hour wait Forth Valley	2015/16	2016/17	2017/18	
		93.4%	93.2%	88.0%	▼
	Emergency department 4 hour wait Clackmannanshire & Stirling	2015/16	2016/17	2017/18	
		93.9%	94.3%	88.9%	▼
	Emergency department attendances per 100,000 Forth Valley population	2015/16	2016/17	2017/18	
		1,731	1,747	1,774	▼
	Emergency department attendances per 100,000 Clackmannanshire & Stirling	2015/16	2016/17	2017/18	
		1,145	1,166	1,211	▼

Local Outcomes	Partnership Indicator	Clackmannanshire & Stirling (C&S)			
Safety	Readmission rate within 28 days per 1000 Forth Valley population	2015/16	2016/17	2017/18	
		1.84	1.24	0.68	▲
	Readmission rate within 28 days per 1000 C&S population	2015/16	2016/17	2017/18	
		1.57	1.09	0.56	▲
	Readmission rate within 28 days per 1000 C&S +75 population	2015/16	2016/17	2017/18	
		1.42	1.12	1.13	▲
	Adult Support and Protection referrals	2015/16	2016/17	2017/18	
		513	719	805	▲
	Adult Support and Protection investigations	2015/16	2016/17	2017/18	
		85	52	147	▲
	Emergency bed days rate per 1,000 Forth Valley population	2015/16	2016/17	2017/18	
		767	637	784	▼
	Emergency bed days rate per 1,000 C&S population	2015/16	2016/17	2017/18	
		707	712	701	▲

Local Outcomes	Partnership Indicator	Clackmannanshire & Stirling (C&S)			
Decision Making	Emergency admission rate per 100,000 Forth Valley population	2015/16	2016/17	2017/18	
		1,007	1,007	968	▲
	Emergency admission rate per 100,000 C&S population	2015/16	2016/17	2017/18	
		865	865	831	▲

Local Outcomes	Partnership Indicator	Clackmannanshire & Stirling (C&S)			
Experience	Snapshot census standard delayed discharges (total for year)	2015/16	2016/17	2017/18	
		145	200	160	▲
	Snapshot census delayed discharges over 2 weeks (total for year)	2015/16	2016/17		2017/18
		54	82	51	▲
	Number of code 9 delays (total for year)	2015/16	2016/17	2017/18	
		132	145	69	▲
	Monthly total bed days occupied by delayed discharges (total for year)	2015/16	2016/17	2017/18	
		5805	7160	6331	▲

Local Outcomes	Partnership Indicator	Clackmannanshire & Stirling (C&S)			
Community Based Support	Number of patients with an Anticipatory Care Plan in Forth Valley	2015/16	2016/17	2017/18	
		n/a	n/a	15,522	—
	Number of patients with an Anticipatory Care Plan in C&S	2015/16	2016/17	2017/18	
		n/a	n/a	8,315	—
	Key Information Summary as a percentage of the Board List size for Forth Valley	2015/16	2016/17	2017/18	
		n/a	n/a	4.9%	—
	Key Information Summary as a percentage of the Board List size for C&S	2015/16	2016/17	2017/18	
		n/a	n/a	5.7%	—
	Number of Social Care referrals	2015/16	2016/17	2017/18	
		n/a	n/a	4,921	
	Number of Social Care assessments	2015/16	2016/17	2017/18	
		n/a	n/a	7,105	
	Number or care home residents aged 65+	2015/16	2016/17	2017/18	
		701	n/a	634	

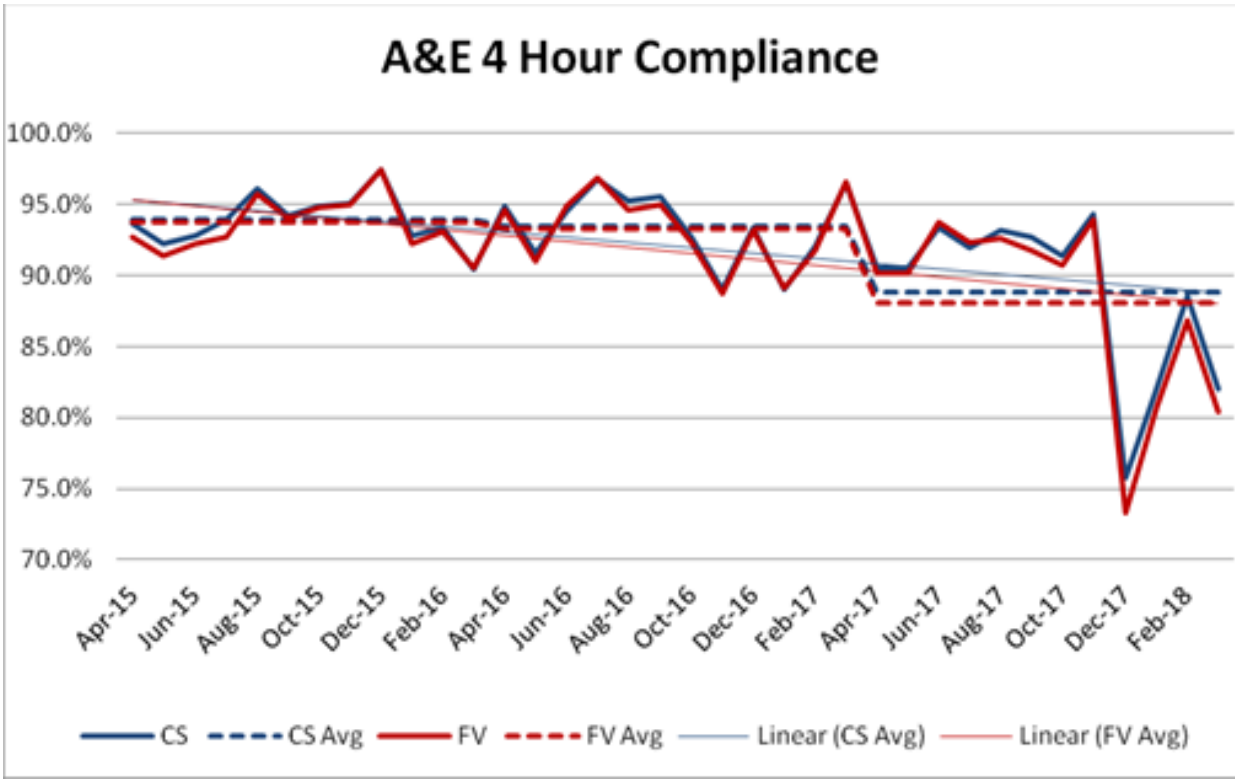
Appendix 1 - Section 2: Summary of Linked Performance Issues

Local Outcome – Self Management

- **Individuals, Carers and families are enabled to manage their own health, care and wellbeing**

Measure	Emergency Department Performance against the 4 Hour standard (includes Minor Injuries Unit). This is a 95% target.
C&S Partnership Performance	Average monthly performance in 2017/18 = 88.9%
Forth Valley Performance	Average monthly performance 2017/18 = 88.0%

Chart 1: Emergency Department (ED) 4 Hour Compliance



Commentary

This indicator relates to residents of the Partnership who make new or unplanned return attendances to the Emergency Department (ED) at Forth Valley Royal Hospital in Larbert or the Minor Injuries Unit in Stirling. The waiting time is calculated as the time of arrival until the time of leaving the Emergency Department via either admission transfer or discharge. The national standard is within four hours.

As described in chart 1 above, performance against the 4 hour ED target throughout Forth Valley has declined since the baseline year of 2015/16 by approximately 6%. Analysis shows compliance is lowest in the 85 years plus age range at 78%. This is down 9% from 86.7% in 2015/16.

50% of delays are attributed to 'Wait for First Assessment' which is most prevalent in all age ranges with the exception of those aged over 85 years where 37% of delays are caused by a 'Wait for a bed'.

Action:

The Unscheduled Care Programme Board (UCPB), is led by the Medical Director and comprises of Chief Officers, General Managers, Unscheduled Care Teams, LIST and Information Services analysts. The Board continually monitor ED performance against the MSG indicators and the six essential actions prescribed by the Scottish Government. Bed usage is audited via the Day of Care Audit to ensure acute and community hospital beds are occupied appropriately and to take action where necessary to have patients relocated to a facility which best addresses their care needs.

A number of key improvement processes and actions are in place with NHS Forth Valley and the Partnerships working with the Scottish Government around the 6 Essential Actions and to ensure a whole systems approach.

- Essential Actions 1-4 are about changes needed to the way hospital services are designed and provided. These includes strengthening clinical leadership and ownership of patient pathways, analysing and planning hour by hour to check that patients are on the right pathway and in the right place on their pathway, holding safety briefings and escalating and resolving issues quickly, providing assessment, diagnosis and treatments as soon as possible to support people to return home or to most suitable place of care earlier rather than later in the day.

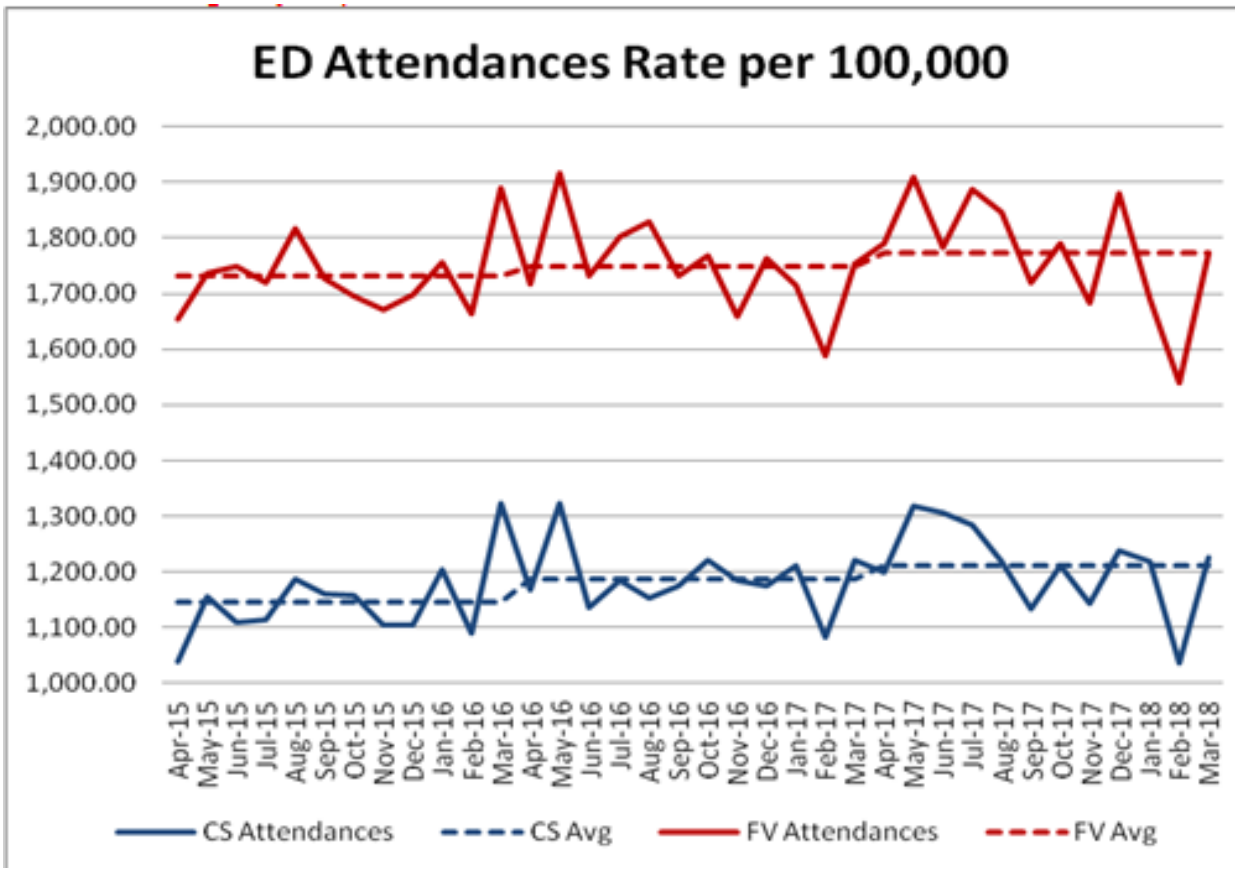
- Essential Action 5 focuses on provision of services such as phlebotomy, diagnostics and medicines over seven days.

- Essential Action 6 *Ensuring Patients Are Cared For In Their Own Homes* is about avoiding attendance, avoiding admission, short and reduced length of stay. It is delivered through the initiatives and core provision mentioned elsewhere, rather than being a separate stream of work.

The Partnership continually works towards developing services and responses to ensure residents receive appropriate support and treatment within the community in order to reduce the number of un necessary A&E attendances and subsequent admissions to hospital.

Measure	C&S Unscheduled Care – Emergency Department Attendance Rate per 100,000 population
C&S Partnership Performance	Average monthly performance 2017/18 = 1,211 per 100,000 population
Forth Valley Performance	Average monthly performance 2017/18 = 1,774 per 100,000 population

Chart 2: Emergency Department Attendance Rate



Commentary

As noted above there is a considerable level of work taking place via the Unscheduled Care Programme Board to deliver whole systems improvements. Through developing Health and Social Care initiatives the aim is to meet the Scottish Government's 2020 vision to deliver the highest standard of care which is preventative, anticipatory and promoting self management. Through signposting to more appropriate services it may no longer be necessary for patients to present directly to ED, the anticipated benefit being to reduce how long patients are waiting to be seen and facilitate more efficient hospital flow to improving the overall patient experience.

The average monthly Emergency Department attendance rate in Forth Valley has increased from 1731 per 100,000 population in the baseline year to 1774 per

100,000 population in 2017/18 to date. This is highlighted as a 2.5% increase.

This Partnership has seen a rise of 5.7% in 2017/18 to an average 1,211 per 100,000 population, from 1145 per 100,000 population in 2015/16. A breakdown by age group in the Partnership area shows a 16.4% rise in attendances in the 75-84 years age.

Action:

Closer to Home (C2H)/ Enhanced Community Team & GP Fellows.

The number of referrals to Closer to Home has steadily increased each month since June 2017. Since 15th Feb, phone referrals to the team have been picked up by Advice Line For You (ALFY). It is very early days but initial improvements are that a broader range of options are available to referrer; and that some clinical staff time is freed up.

Work with night nursing is ongoing to ensure a more equitable response both in and out of hours.

Social Care – services have seen an increase in use of C2H to facilitate discharge due to the lack of quick access to commissioned care at home across the area.

Allan Lodge, Beech Gardens, Strathendrick and Ludgate House have all facilitated direct access to bed based intermediate care 24/7 and C2H have continued to support some patients in this service.

Scottish Ambulance Service (SAS) referrals – falls pathway : Closer to Home Team continue to take referrals from Scottish Ambulance Service for unwell, uninjured falls patients as part of a national initiative to reduce the number of falls patients being conveyed to hospital following a fall. This is being rolled out further as part of implementation plan.

SAS referrals – COPD: the criteria for this is being revisited as there have been no referrals so far. GP Fellows to work with a small GP Practice to ID suitable parameters for COPD referrals to C2H.

The use of a RAG system as an outcome measure has been shown to be helpful in identifying positive outcomes from interventions. Work with FVRH pharmacy department to develop a domiciliary IV antibiotic pathway is ongoing.

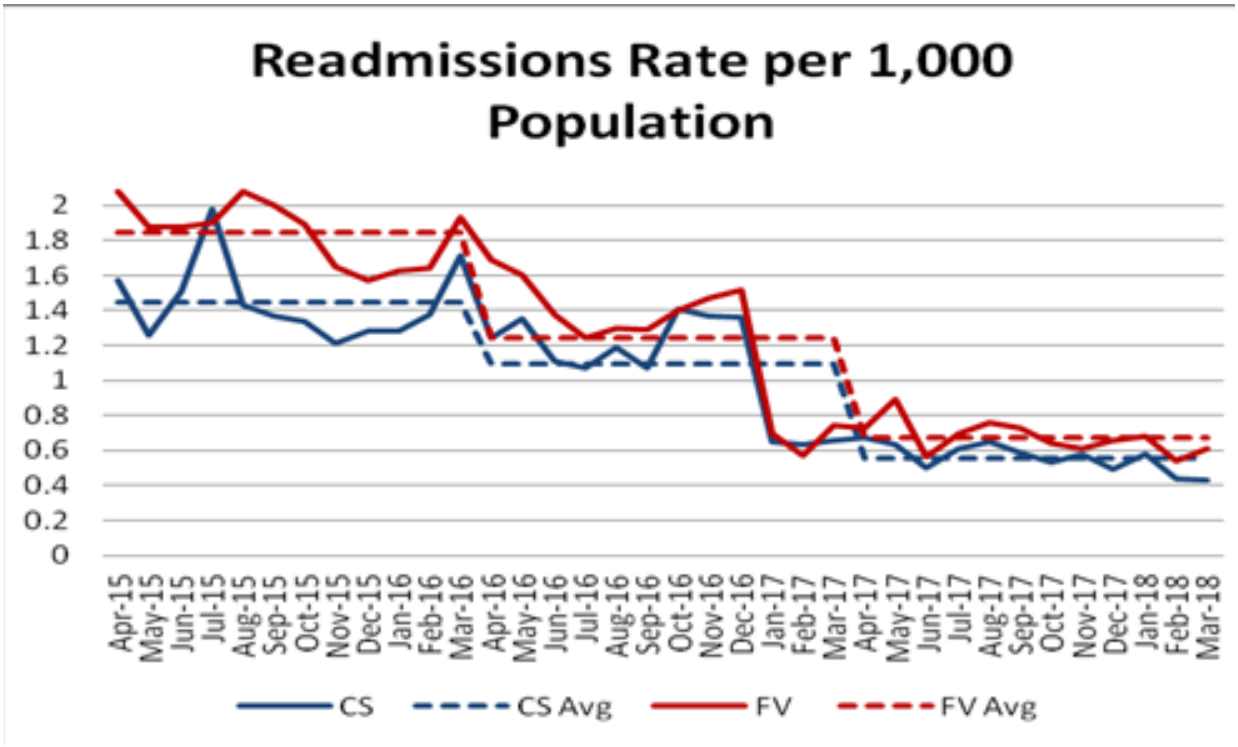
Other service pressures over the last year also relate to palliative care, supporting people to live at home.

Local Outcome - Safety

- **Health & Social Care support systems are in place, to help keep people safe and live well for longer**

Measure	C&S Unscheduled Care - Rate of Readmissions per 1,000 population
C&S Partnership Performance	Average Monthly Rate 2017/18 = 0.56 per 1,000 population
Forth Valley Performance	Average Monthly Rate 2017/18 = 0.68 per 1,000 population

Chart 3: Emergency Readmissions Rate



Commentary

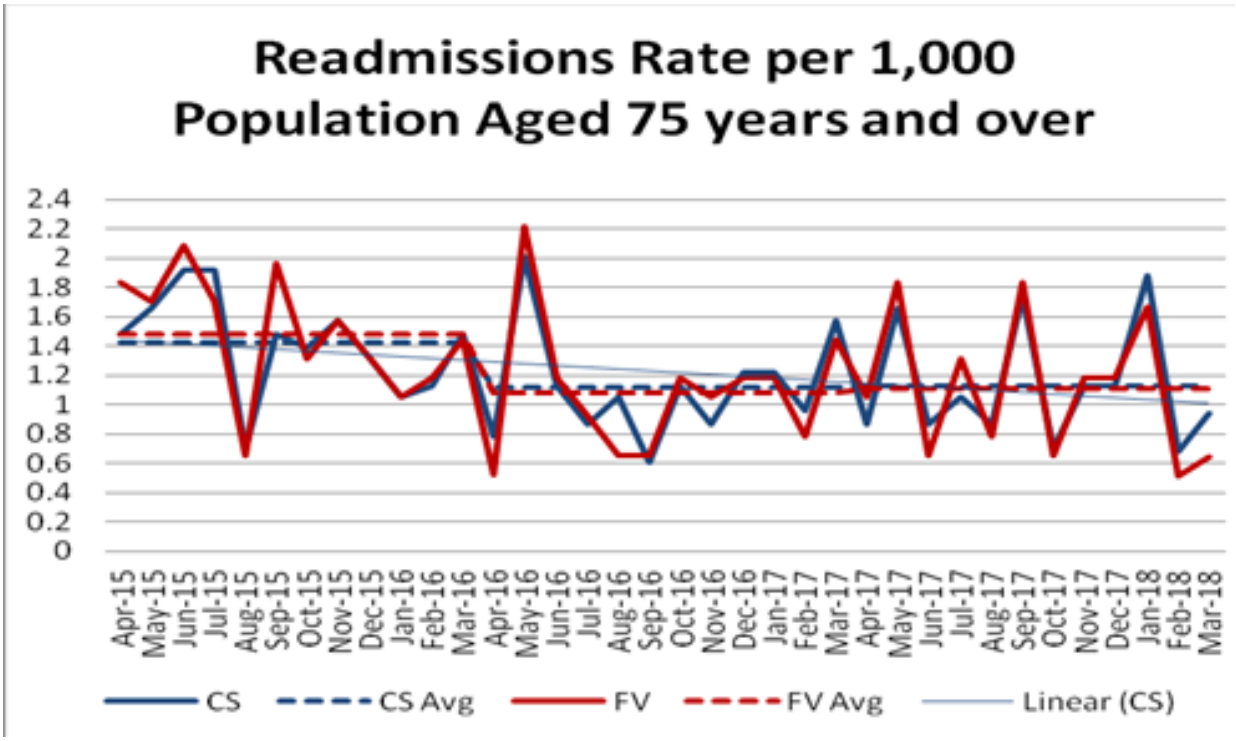
Within Forth Valley the readmissions data are standardised by specialty and condition at readmission. This means that if a patient was admitted to a medical specialty initially with a respiratory condition and is readmitted with a broken leg, this is not categorised as a readmission as it is not relevant to the initial presentation at hospital. If however the patient is readmitted to the same specialty then this is classed as a readmission. In this way it enables targeting in areas that may require improvement.

It should be noted that this differs from national publications that report the crude

rate of readmissions which is any readmission within 28 days to any health board regardless of the reason for this readmission.

Chart 4 highlights a decrease in the rate of readmissions across Forth Valley from 1.84 per 1000 population in 2015/16 to 0.68 per 1000 population in 2017/18 year to date. This decreasing trend is mirrored within the C&S Partnership with a decrease from 1.44 per 1000 population in 2015/16 to 0.56 per 1000 population in 2017/18 year to date.

Chart 4: Emergency Readmission Rate Aged 75 years and Over



Readmissions for those aged 75 and over have also decreased Forth Valley and Partnership wide. Forth Valley has decreased to 1.11 rate per 1000 from 1.48 in 2015/16. C&S has seen a similar reduction from the baseline year from 1.42 in to 1.13 2017/18.

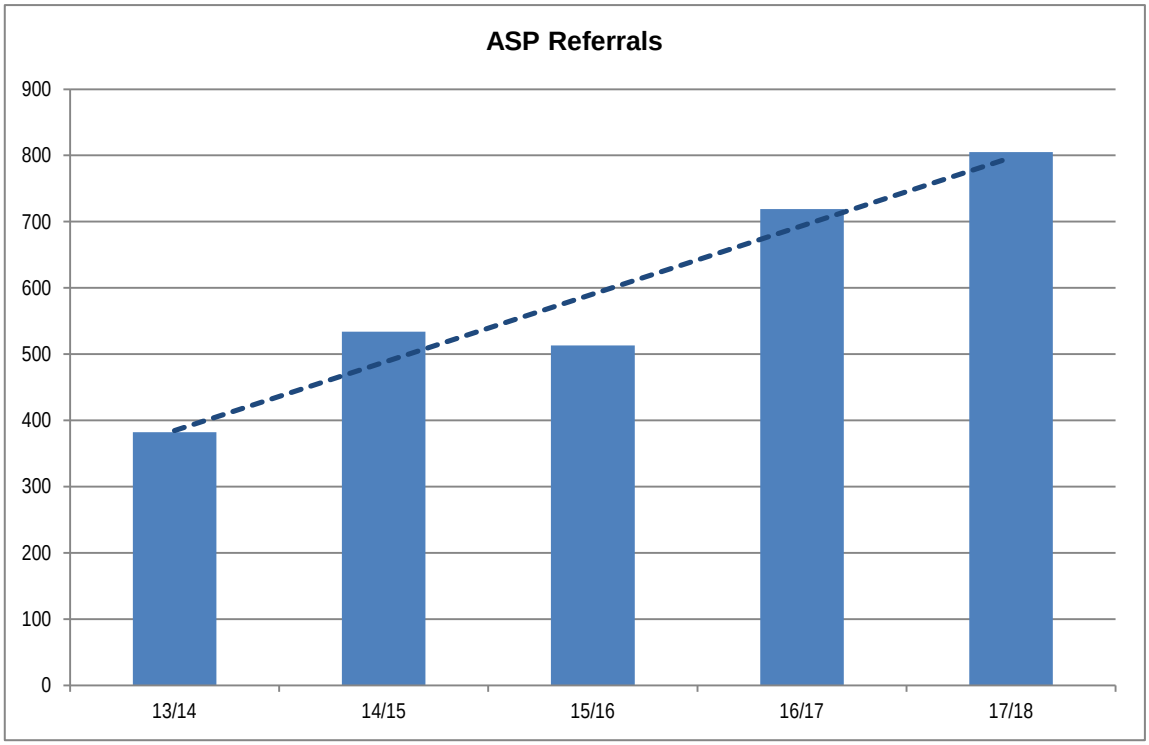
Action:

Pilot schemes across parts of the Partnership are assessing community focussed supports in a bid to see patients being treated at home or in a homely setting where appropriate.

Routine monitoring is to be adopted by the UCPB, and lead by the Medical Director.

Measure	Adult Support and Protection referrals to Social Care
C&S Partnership Performance	Annual total 2017/18 =805.

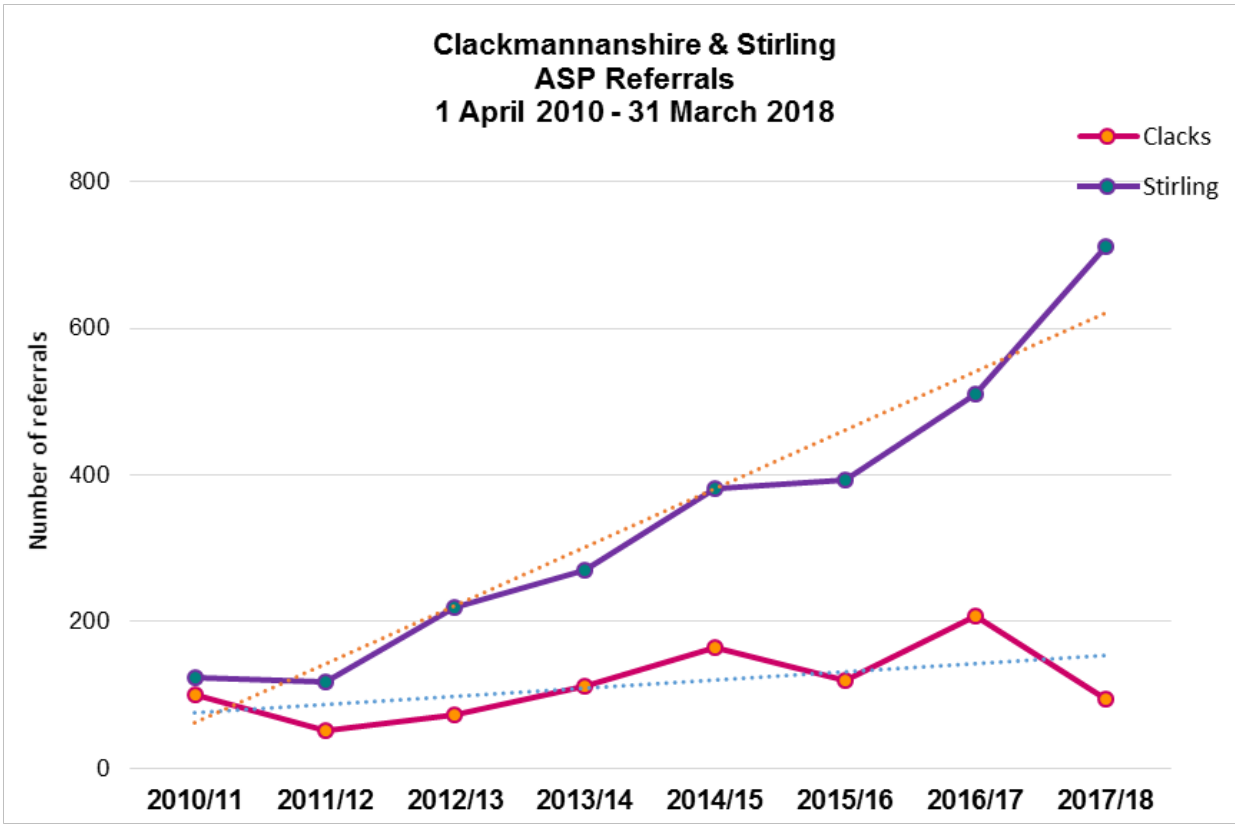
Chart 5 ASP Referrals



Commentary

Adult Support and Protection referral rates within the Partnership show a long term rising trend. However activity across the area does show some difference - in Clackmannanshire the numbers more than halved (55%) in comparison with the previous year. Conversely the referral rate in Stirling saw an increase of 39%., which relates to some of the provider related issues previously highlighted to the Board. Work has taken place with providers through the forums and training sessions on using referral guidance appropriately and seeking advice and support at the point of referral.

Chart 6



Referalls by source:

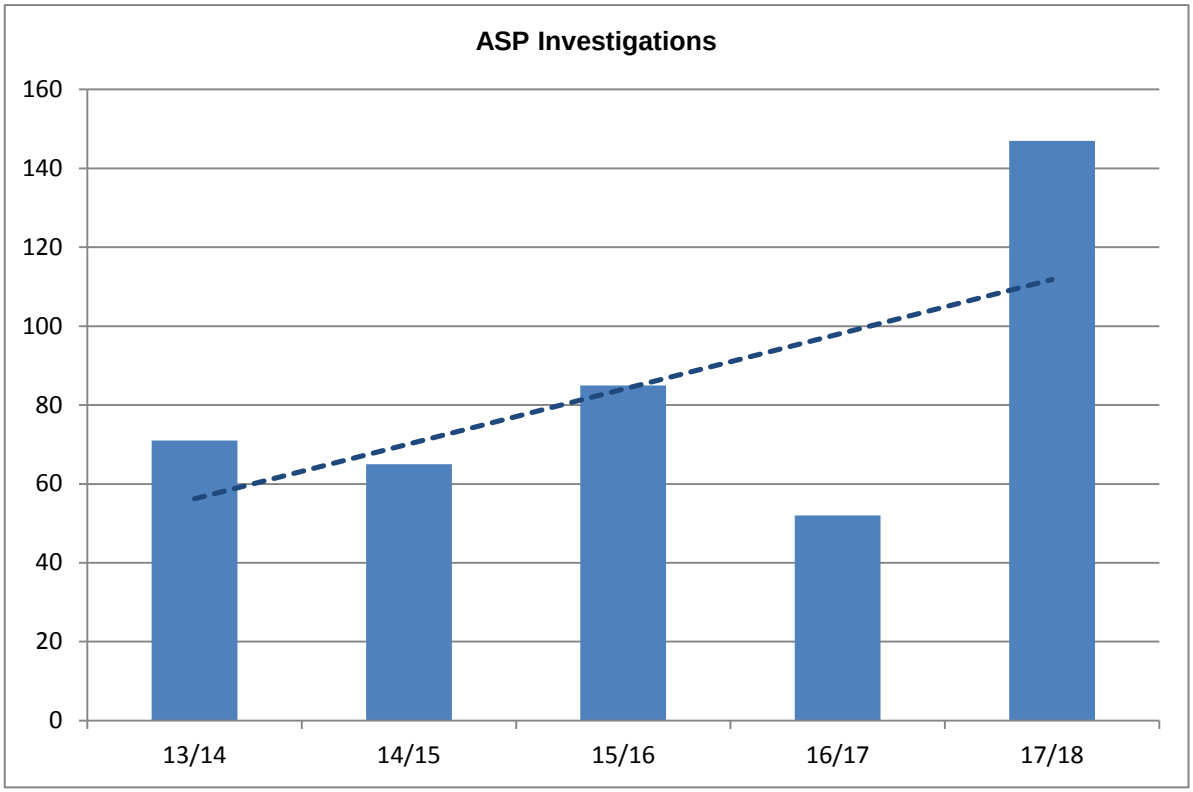
- Adult Support and Protection referrals from an NHS source increased by 233% (3 to 10) in Clackmannanshire and 41% in Stirling (22 to 31), these figures do not include GP practices.
- ASP referrals from the Police were down 80% (20 to 4) in Clackmannanshire, however remained the same in Stirling (22) in comparison with the previous year.
- Referrals from the Fire & Rescue Service were down two thirds in Clackmannanshire (3 to 1) and a third in Stirling (12 to 8)
- The Scottish Government Annual return categories referrals from care homes, professional care providers, housing and banks as 'other organisations'. The referral rate in this category increased by 93% (15 to 29) in Clackmannanshire and 49% (370 to 553) in Stirling over the past year.

Action:

147 of the 805 referrals resulted in an investigation (18%). Of the remainder, 49 cases did not meet the 3 point test, 169 cases were actioned but not under Adult Protection, 258 cases had no further action, and 182 cases were recorded as ongoing, which indicates that further data cleansing is required. .

Measure	Adult Support and Protection investigations by Social Care
C&S Partnership Performance	Annual total 2017/18 =147

Chart 7 ASP Investigations



Commentary

Adult Support and Protection investigations within the Partnership show a long term rising trend. The number of ASP investigations increased in both local authorities up 317% (6 to 25) in Clackmannanshire and 165% (46 to 122) in Stirling. The proportion of referrals leading to investigation also increased, in Clackmannanshire 27% of referrals led to an investigation compared with 3% the previous year. In Stirling 17% of referrals led to an investigation compared to 9% the previous year.

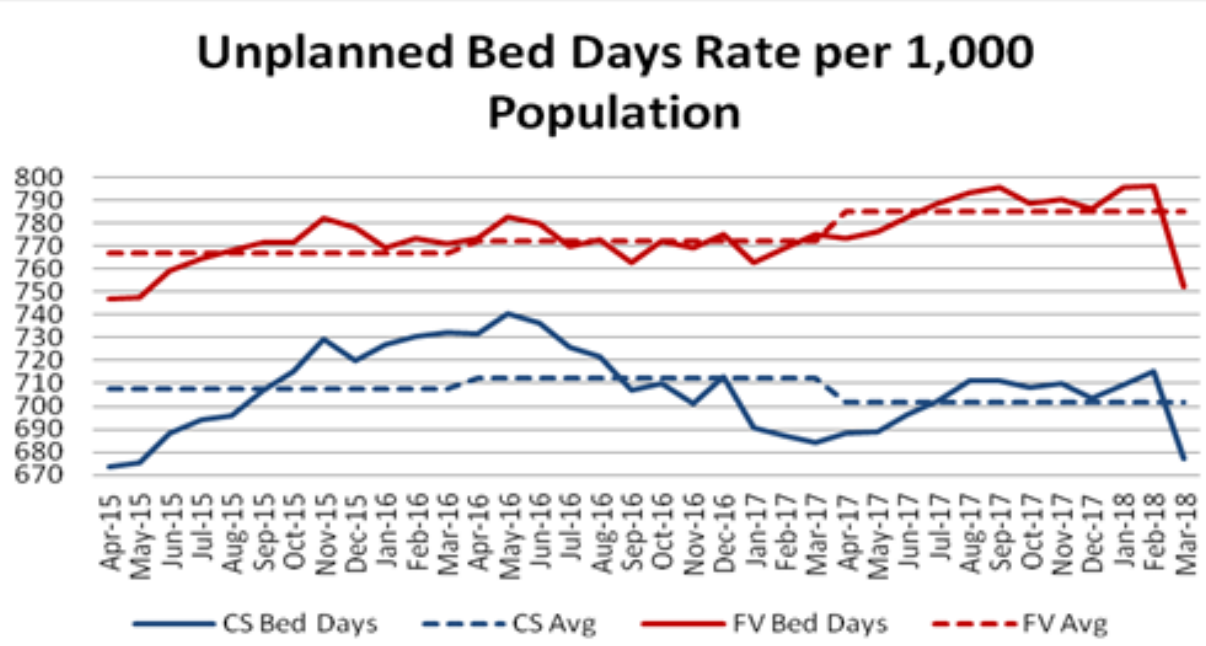
The differential in statistics is largely attributable to better understanding of ASP and in particular the distinction between an inquiry and an investigation. A small number of referrals led to full Case Conferences – 9 or 6%.

Action:

Further training and development work is being carried out led by the Adult Protection Committee.

Unscheduled Care	C&S Unscheduled Care - Rate of Unplanned Bed Days Rate per 1000
C&S Partnership Performance	Average Monthly Rate 2017/18 = 701.8 per 1,000 population
Forth Valley Performance	Average Monthly Rate 2017/18 = 784.8 per 1,000 population

Chart 8 Unplanned Bed Days



Commentary

In 2015/16 the average monthly rate in terms of unplanned bed days for Forth Valley was 767 per 1000 population compared to 784 per 1000 population in 2017/18 at the end of the financial year. This highlights a 2.3% increase. The rate per 1,000 of patients pertaining to the Clackmannanshire and Stirling local authority areas has decreased by 0.8% from 707per 1000 population in 2015/16 to 701 per 1000 population in 2017/18.

Further analysis shows a rise on all age groups in the C&S Local Authority area. However there is a significant decrease in the number of bed days occupied of 9% in the 75-84 age group.

Action:

Bed usage continues to be monitored via the Day of Care Audit. The May 2018 update is as follows:

Within the Community hospital setting there have been nine surveys so far. The first survey found that 52% of patients did not meet the inpatient criteria. The latest

survey in April 2018 has demonstrated that this is now 44% (84 patients).

The current plan is to continue repeating the Community Hospital survey monthly in order to continue the improvement work. .

Next Steps

- The Day of Care survey will be carried out on a Friday afternoon instead of a Thursday morning. This will capture patients identified as not meeting in-patient criteria at the weekend and may highlight different reasons for remaining in hospital;

- The community hospital Day of Care survey continues and the process now appears to be settled and embedded;

- The Discharge team, social work and 24/7 meet daily to discuss patients who have been identified as waiting for a community hospital bed and package of care to allow the most appropriate patients to be moved;

- Pilot of the daily dynamic discharge in the 2 community hospital wards continues with plans to roll out to the rest of the community hospitals and wards. This has been part of the initiatives promoted through the Unscheduled Care Programme Board.

Chart 9 % of Patients identified as not meeting the acute inpatient criteria

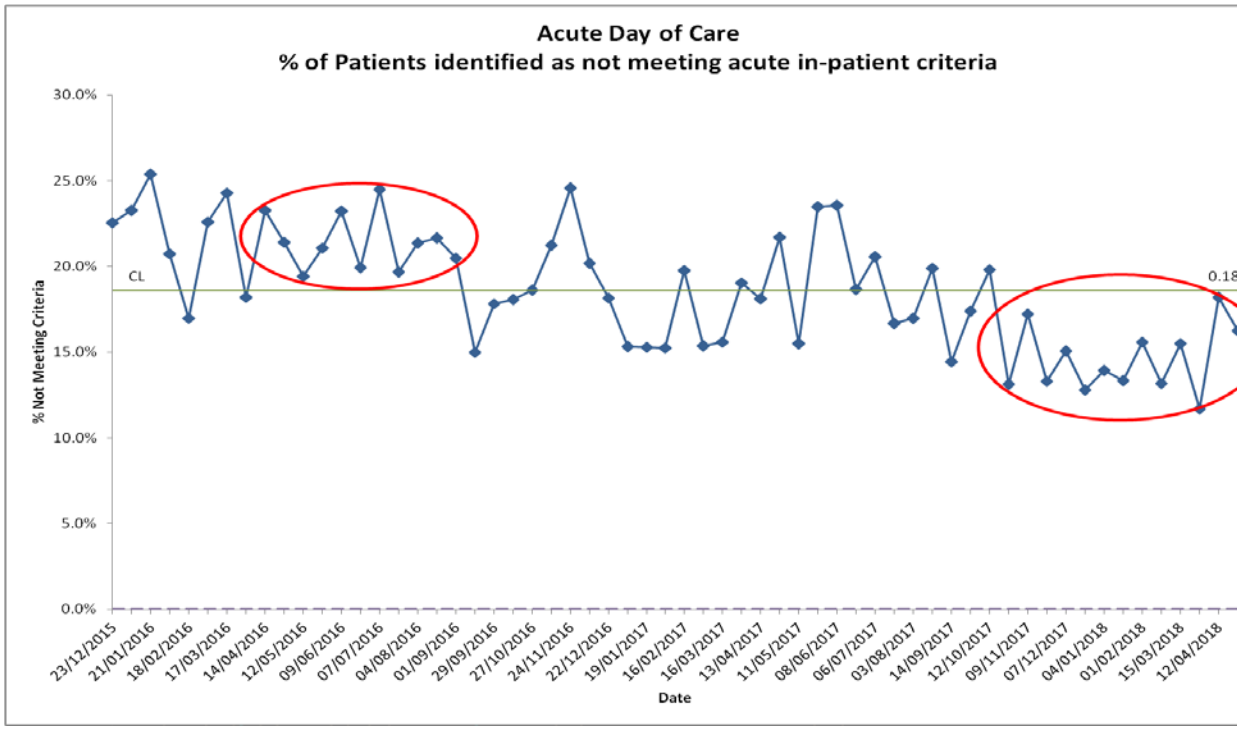
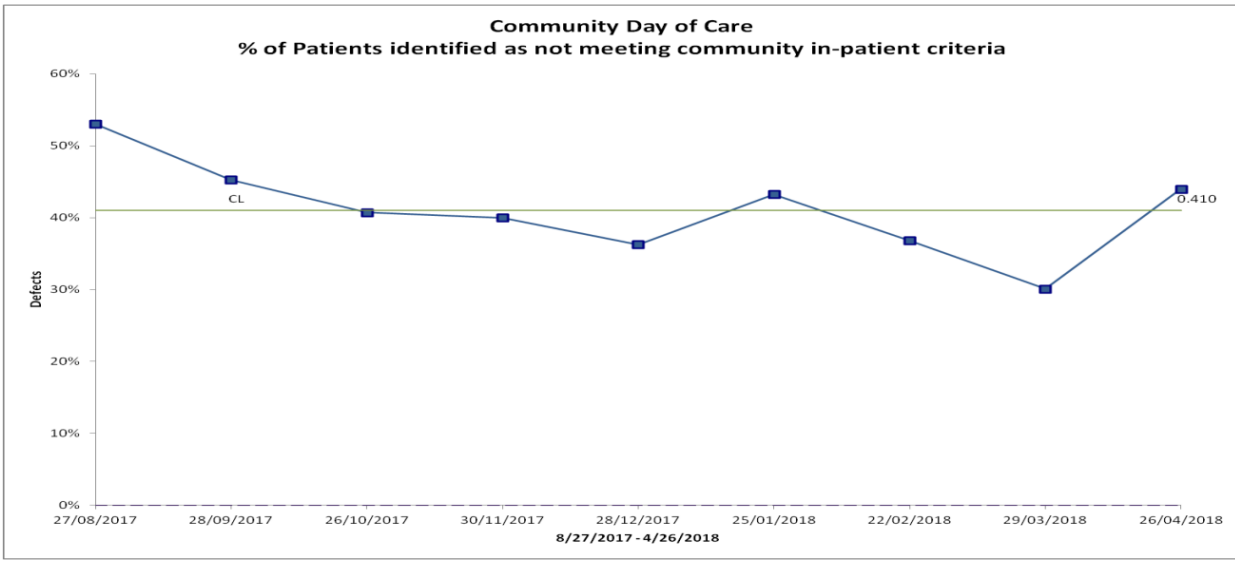


Chart 10 % of Patients identified as not meeting the community inpatient criteria

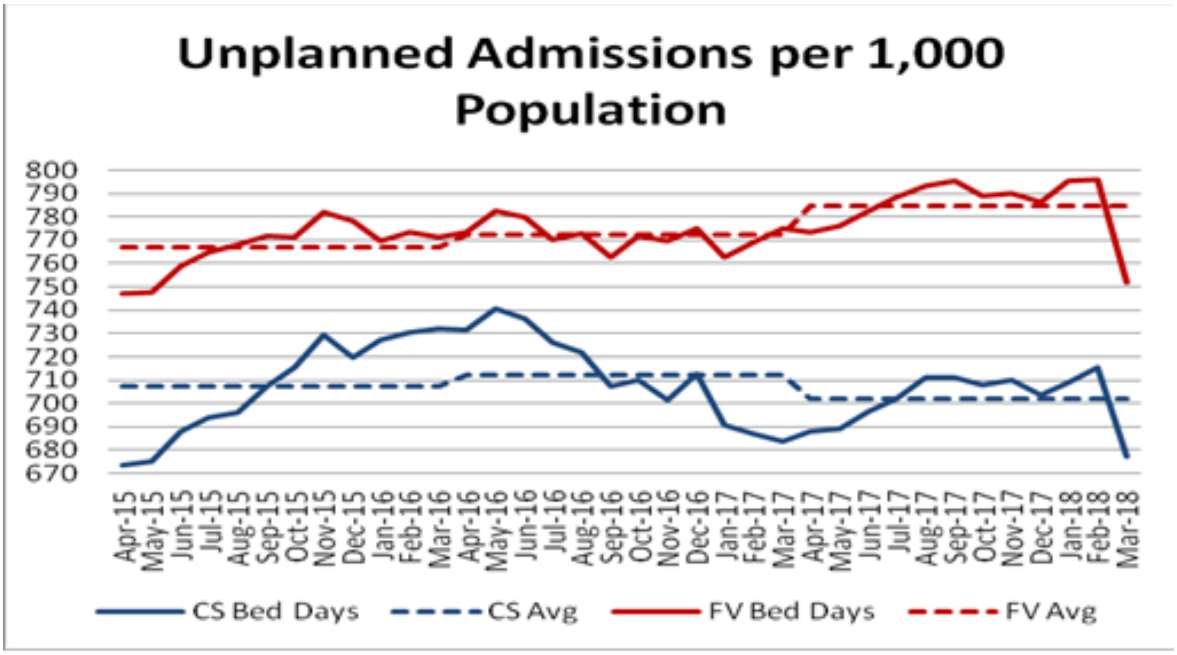


Local Outcome – Community Based Support

- **Informal supports are in place, which enable people, where possible, to live well for longer at home or in homely settings within their community**

Unscheduled Care C&S Partnership Performance	C&S Unscheduled Care - Rate of Hospital Emergency Admissions per 100,000 population Average Monthly Rate 2017/18 = 831 per 100,000 pop
Forth Valley Performance	Average Monthly Rate 2017/18 = 968 per 100,000 pop

Chart 11: Unplanned Admissions



Commentary

Despite the rise in Emergency Department attendance the average unplanned admission rate for both C&S and Forth Valley in 2017/18 has reduced. The admission rate for the financial year 2015/16 in Forth Valley is down by 6.7%, from 1,038 per 100,000 per population to 968 per 100,000 per population this year to date.

C&S admissions remain below the Forth Valley average with a further decrease from 914 per 100,000 per population to 831 per 100,000 per population from 2015/16 to the end of the financial year 2017/18.

Local Outcome –Experience

- **People have a fair and positive experience of health and social care**

Measure	Unscheduled Care – Delayed Discharges • Standard Delayed Discharges • Bed days lost attributed to delayed discharge • Code 9 and Code 100 delays
C&S Partnership Performance	Standard delayed discharges total 2018 = 160
Forth Valley Performance	Standard delayed discharges total 2018 = 538

Commentary

The monthly graphs highlight seasonal fluctuations in demand, however overall the number of standard delays reduced compared to the previous year. There is a long term reducing trend for the Partnership.

Chart 12: Delayed Discharges – Standard Delays

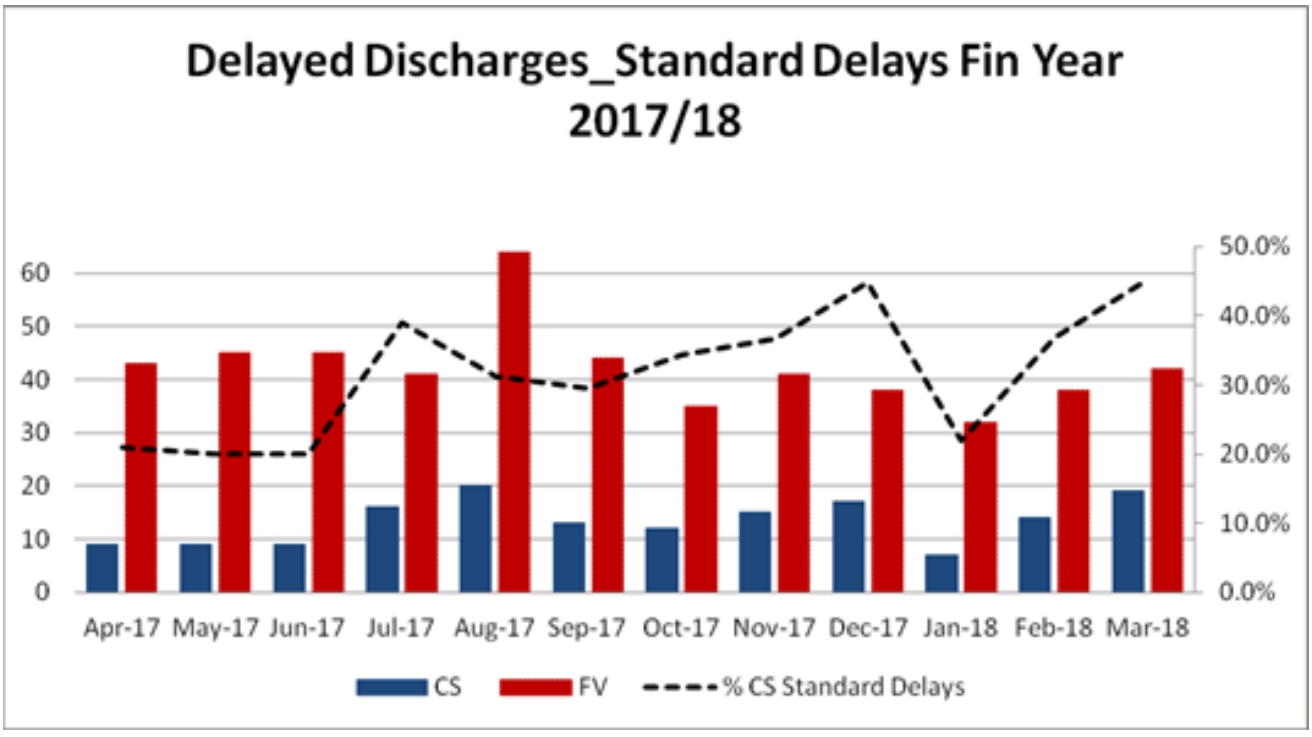
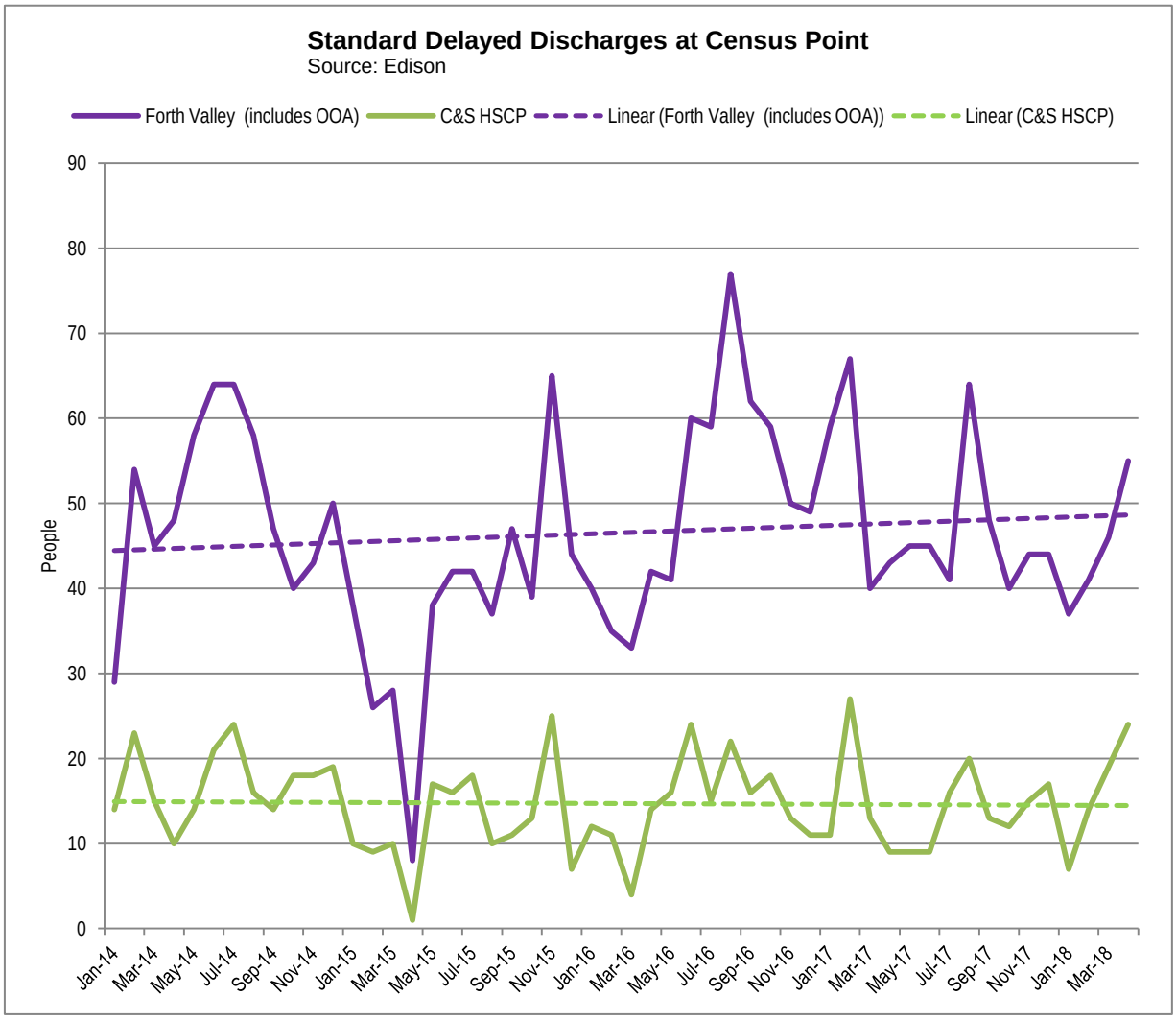


Chart 13 Number of standard delayed discharges



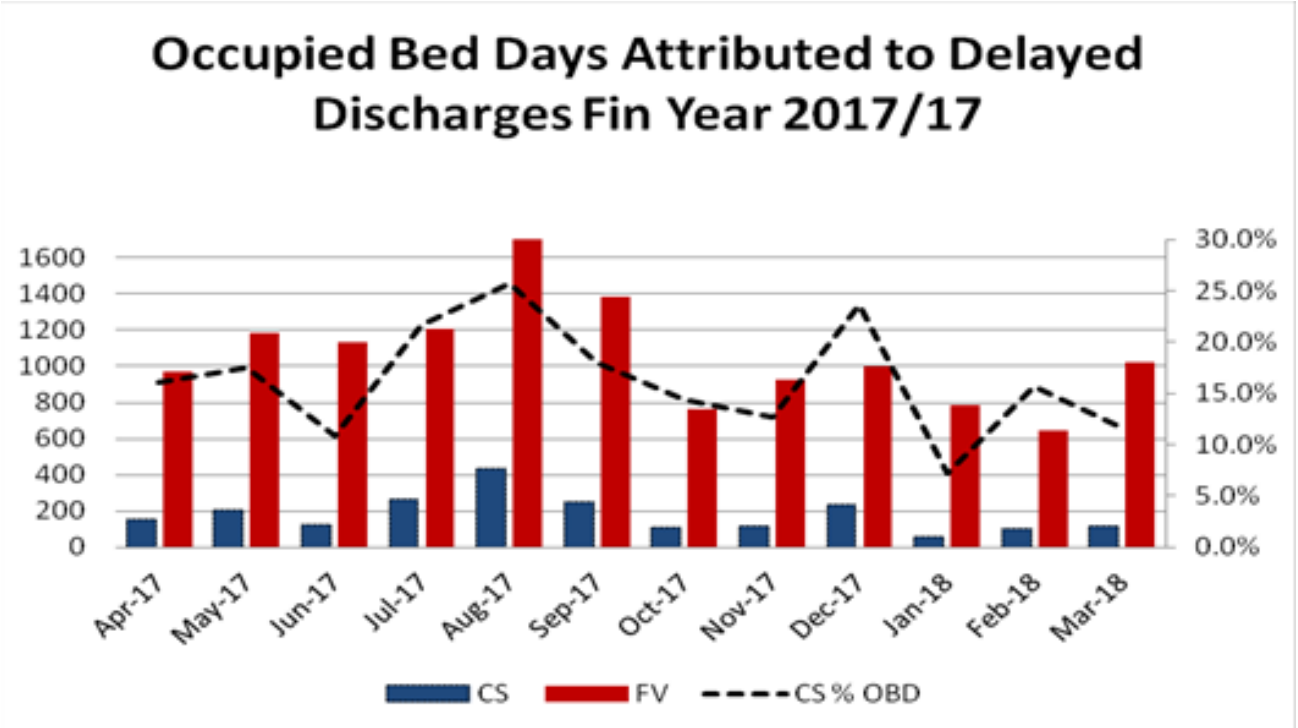
In March 2018 the number of standard delays for Forth Valley is 42. Clackmannanshire and Stirling accounts for 19 or 45.2% of all standard delays. The March 18 position for C&S Partnership figure is a 35% increase from February 2018. 15% (3/19) C&S delays are waiting to over 2 weeks at the January census point. These C&S patients account for 18% (3/16) of Forth Valley waits over 2 weeks.

Table 1 shows the total number of standard delays April 2017 to March 2018.

Table 1

	Apr 17	May 17	Jun 17	Jul 17	Aug-17	Sep-17	Oct-17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
Total delays at census point	9	9	9	16	20	13	12	15	17	7	14	19
Total number 2 weeks	2	3	2	8	8	5	2	2	9	1	3	3

Chart 14: Occupied Bed Days Attributed to Delayed Discharges



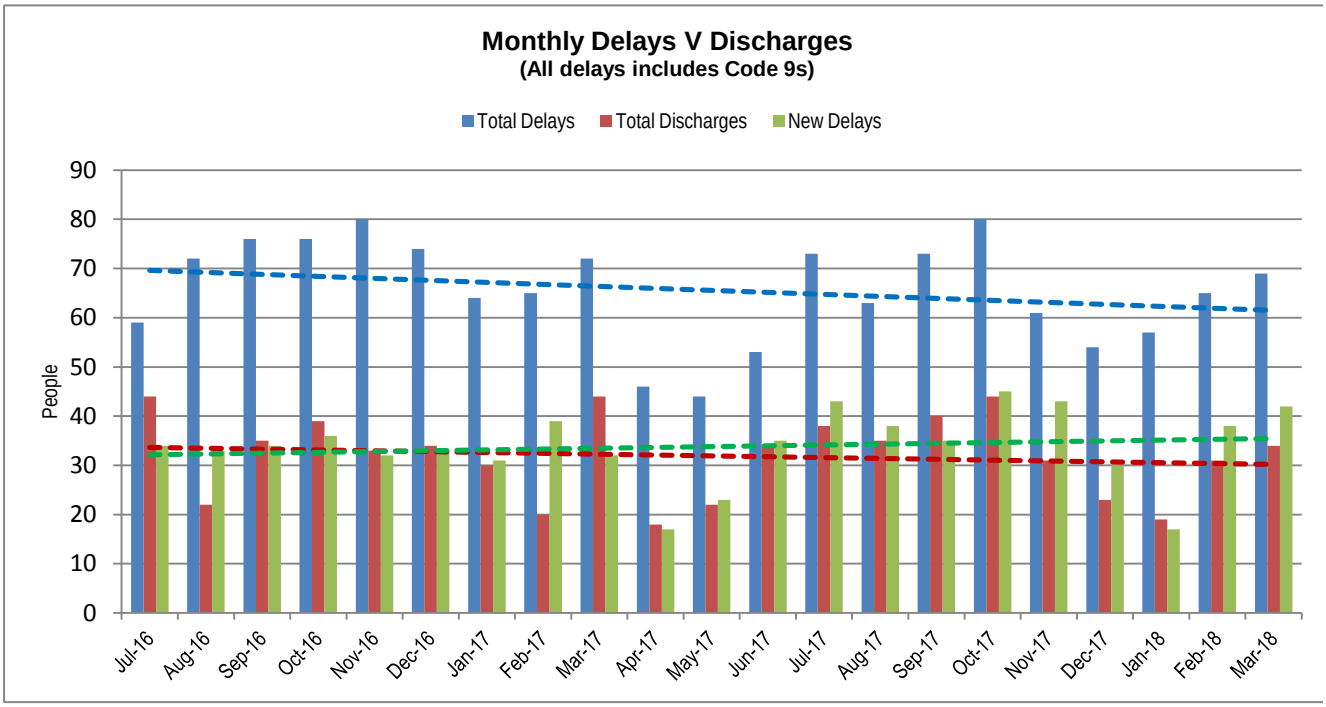
Across Forth Valley there has been an increase in the number of occupied bed days attributed to delayed discharges with the number at the March 18 census 1025 compared with 645 in February 2018.

The C&S Partnership position at the March 2018 census was 119 occupied bed days attributed to delayed discharges. This is 11% (119/1025) of the occupied bed days within Forth Valley attributed to delayed discharges.

Chart 15 below shows total activity over the month and not just at the census snapshot. The data includes all delays (standard and code 9) reflecting more of the work undertaken by health and social care within a monthly period. It shows the relationship between those entering hospital (new delays) and those leaving (discharges).

Although the overall numbers (total delays) are reducing, the numbers of new admissions continue to be higher than the number of people being discharged.

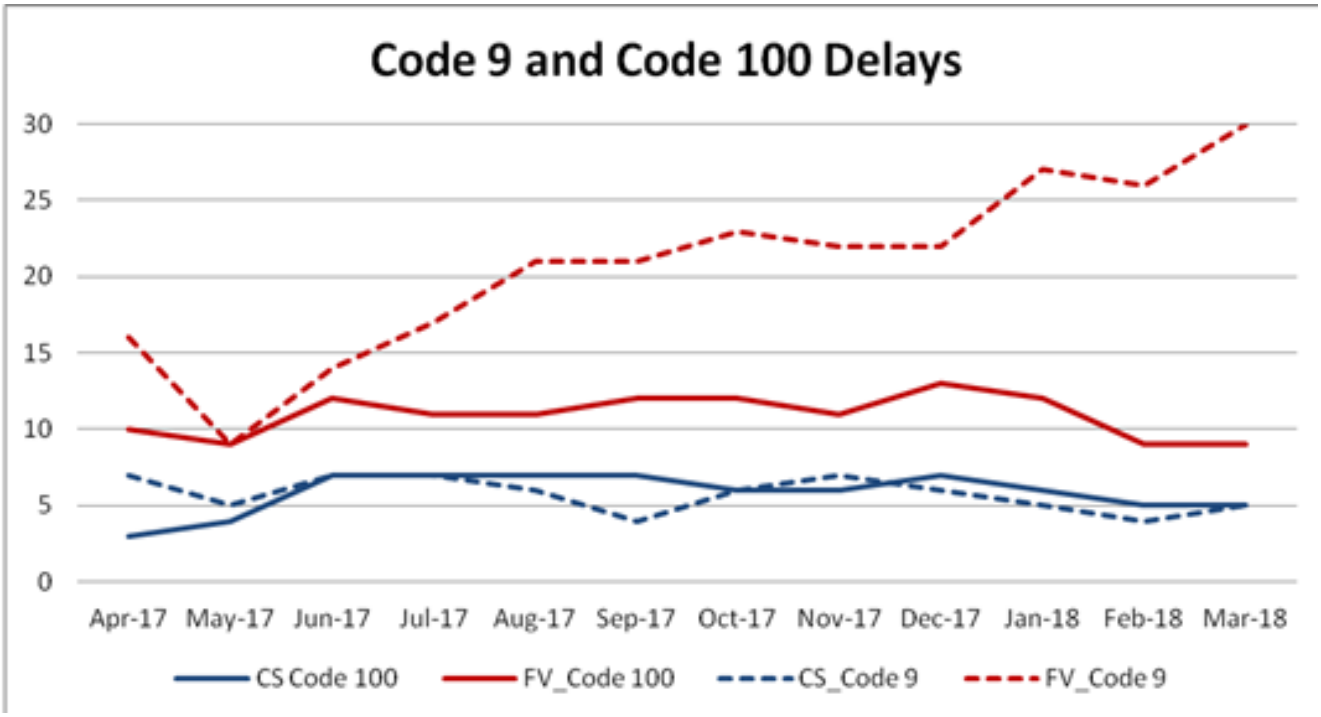
Chart 15 Monthly Activity



Action:

Work being done through the Unscheduled Care Programme Board 6 Essential actions plan at a Forth Valley level, and the HSCP Discharge Improvement Plan monitored by the Delayed Discharge Steering Group aims to reduce the number of new admissions (new delays) and speed up the number leaving hospital (discharges) through a range of interventions and tests of change. There is good anecdotal evidence of improvements from 'Tests of change' around Daily Dynamic Discharge.

Chart 16: Code 9 and Code 100 Delays



There has been an increase in the number of Code 9 and Code 100 delays across Forth Valley. Across the C&S Partnership the position at the March 18 census is 5, Code 9 delays, in keeping with the average to date and 6 Code 100 delays which is in keeping with the average since April17.

Chart 17 Discharge Destinations

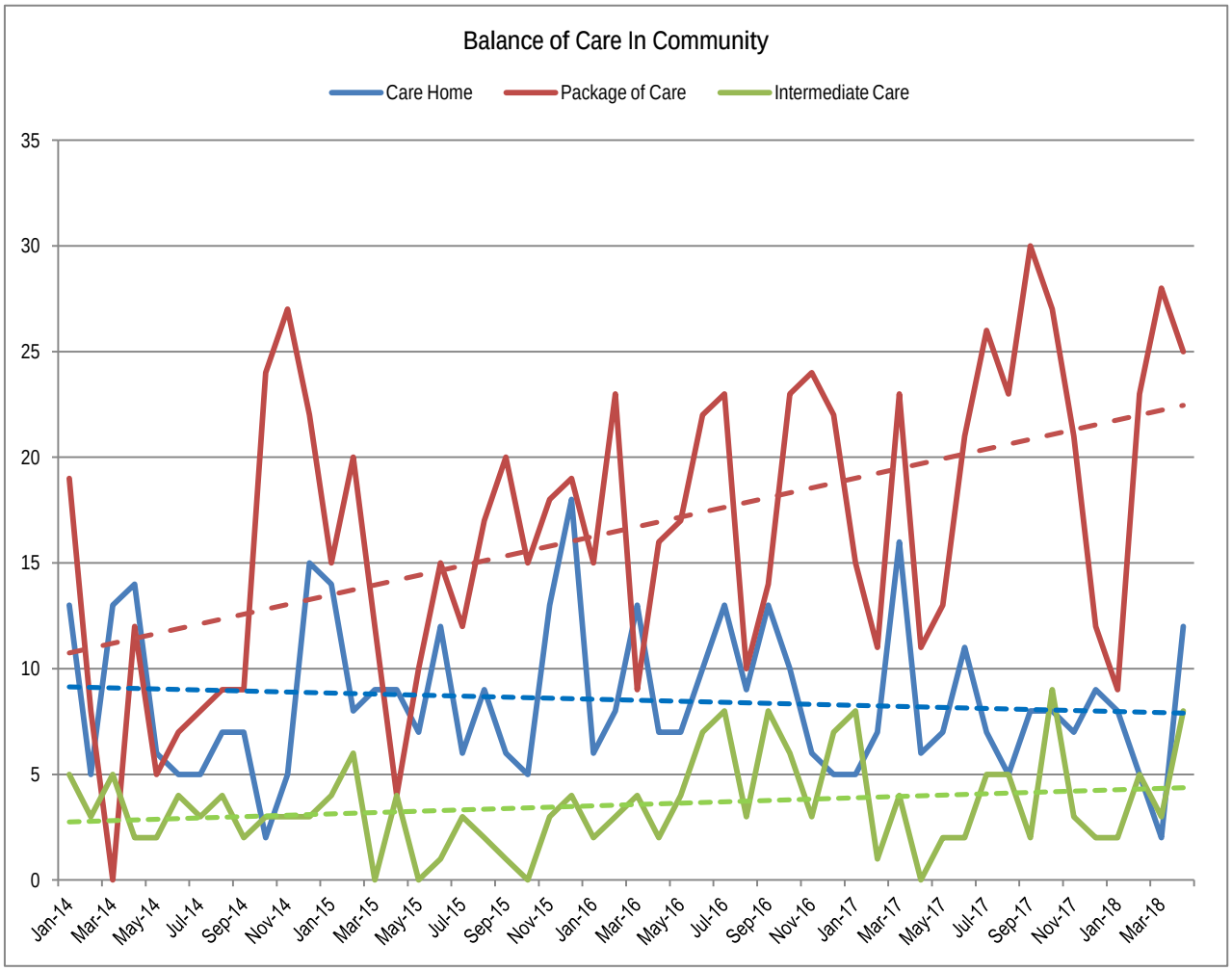
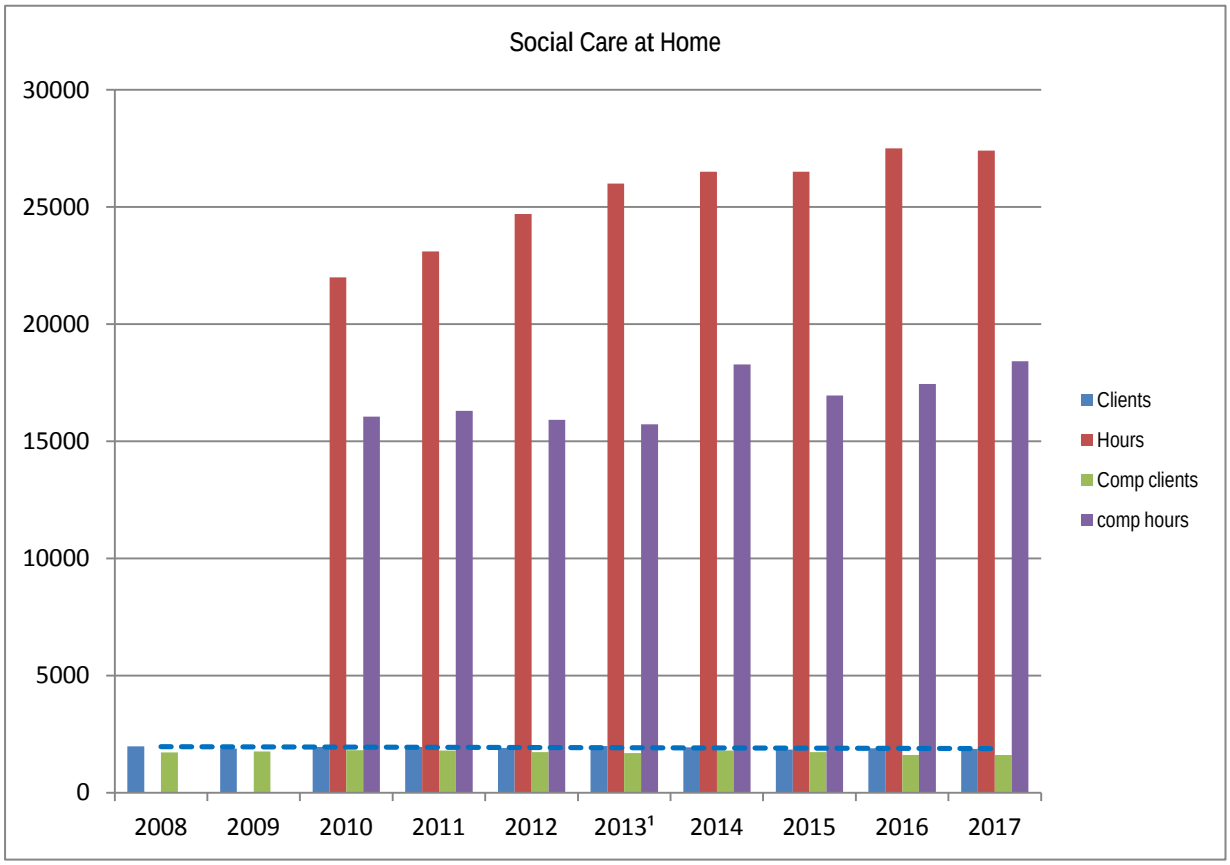


Chart 17 above shows long term trends around those Delayed Discharge patients who leave hospital, and the increasing use of those patients returning home with packages of care.

Community Hospitals, Intermediate Care Capacity and Care at Home

- The Partnership has a total of 41 Intermediate Care beds located within the community, 4 beds within the Clackmannanshire locality, 7 beds within the Stirling Rural locality and 30 beds within the Stirling City locality.
- The development of the Stirling Health and Care Village will change the way existing community hospital and intermediate care services are delivered within Health and Social Care. This will hopefully have an impact on performance around Delayed Discharges and occupied bed days.

Chart 18 Living at home with support trends



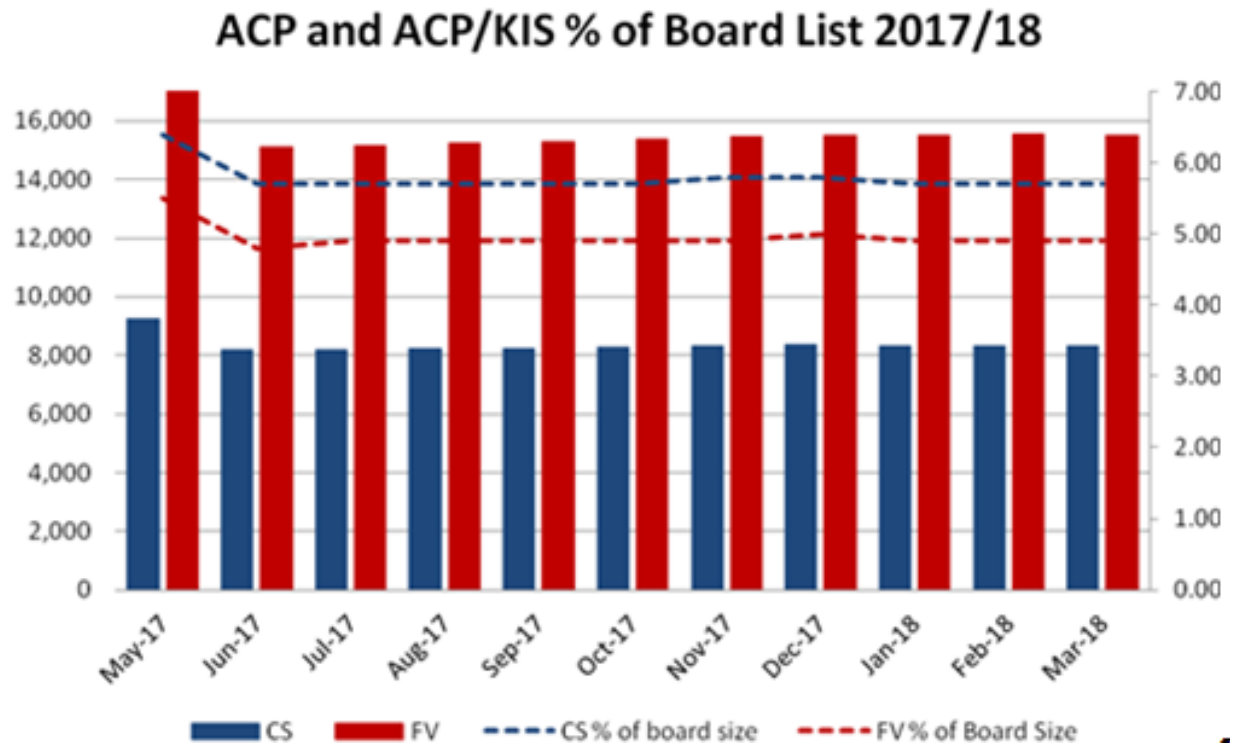
The data from chart 18 above comes from the published Social Care survey. The rising trend of number of hours provided is similar to national trends, and the number of clients is similar to our peers (comp). However the number of actual hours is much higher than other similar Partnerships. This may be reflecting in some part the 'balance of care' within the Partnership which is above average for the % of the population living in the community with support.

Action:

The more recent reablement approach adopted within Social Care which aims to provide targeted time limited person centred support, to ensure long term independence, may reflect the slight drop in hours in 2017 and going forward.

Unscheduled Care C&S	C&S Unscheduled Care - Anticipatory Care Plans as percentage of Forth Valley Health Board List
Partnership Performance	Number 2017/18 = 8,339 (5.7%)
Forth Valley Performance	Number 2017/18 = 15,513 (4.9%)

Chart 19: Anticipatory Care Plans



Commentary

Anticipatory Care Planning (ACP) has been identified nationally as a priority to support the delivery of the 2020 vision and the Health and Wellbeing Outcomes linked with the Health & Social Care Integration agenda as highlighted in the recent Audit Scotland Report on Integration.

Figures above are supplied by ISD. The drop in number from circa 17,000 plans produced in 2017 is a result of ISD culling records for those patients who have since died or moved out with the area. The position of 15,522 accounts for 4.9% of Forth Valley residents and exceeds the target of 4,500 or 1.5%. 8,315 (5.7%) of the C&S population are in receipt of an ACP or Key Information Summary (KIS).

Action:

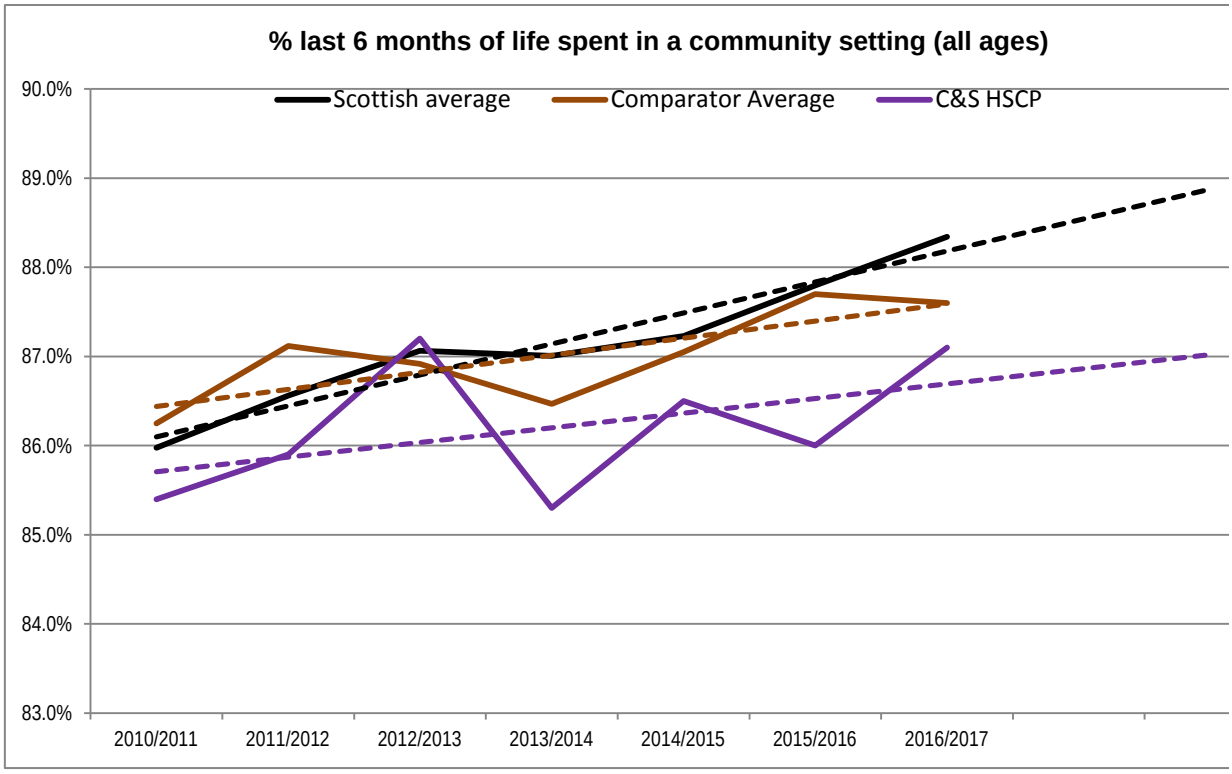
The impact of the Anticipatory Care Plans on patient care is ongoing. Deliberations need to be made via robust studies to assess at which stage in the patient journey referral for an ACP should be made determining the best use of current resource and

identify areas for development.

End of Life and Palliative Care

A proxy measure for looking at 'end of life' is the % of the last six months of life spent in a community setting. The graph below shows a rising trend for the Partnership but still less than national average or similar sized partnerships. The Partnership is aiming to achieve 90% by the end of 2019.

Chart 20



Action:

In addition to core funded Out of Hours Palliative Care and Cancer Helplines, initiatives include the Hospice at Home Project, night time MECS and nurse wound support. The End of Life (EoL) and Palliative Care Transformation Group is exploring the need for redesign of EoL patient pathways, workforce and communication.

Measure	Referrals and Assessments for Social Care
C&S Partnership Performance	Total number of referrals 2017/18 = 4,921 Total number of assessments 2017/18 = 7,105

Chart 21

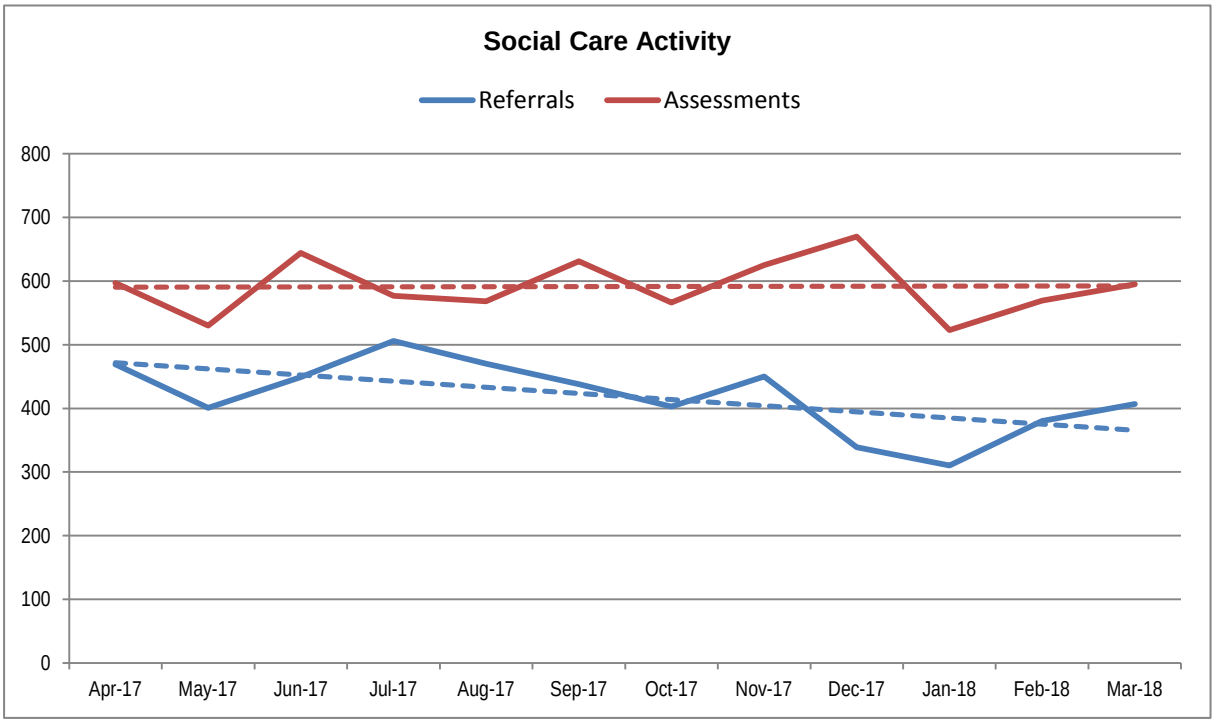
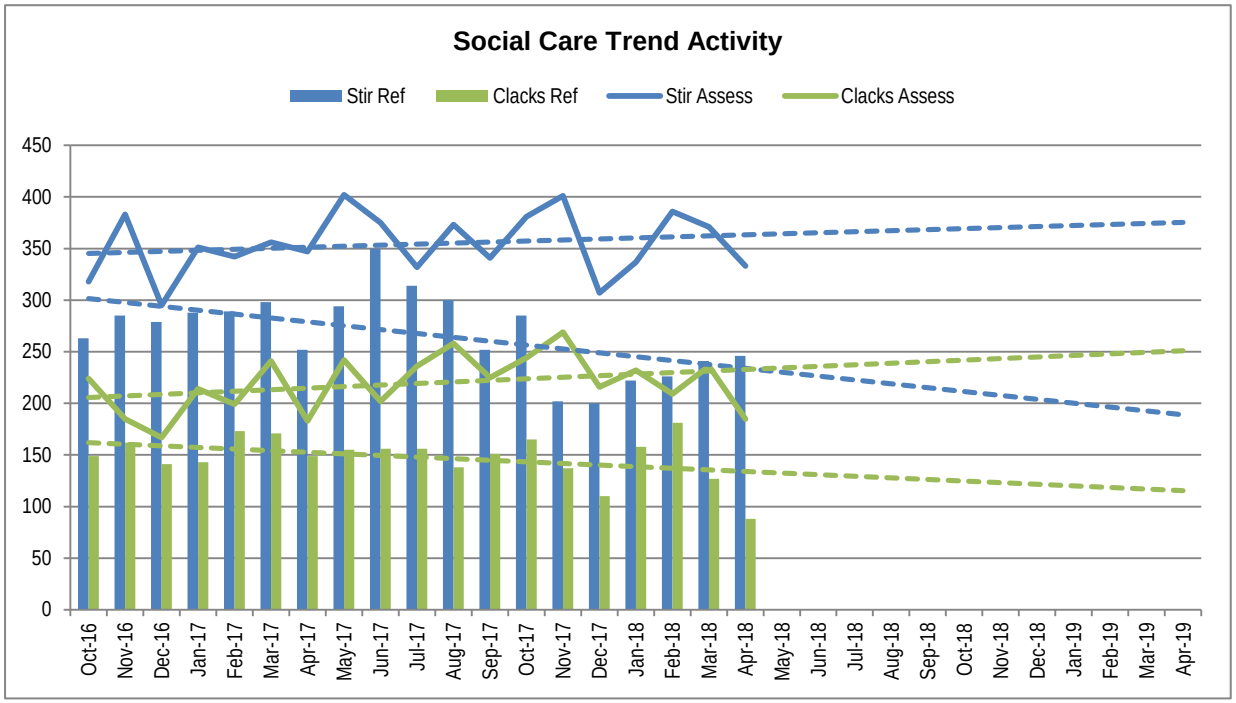


Chart 22



Commentary

17/18 - the graph above (and indeed the Adult Support and Protection data) demonstrates a growing demand on the service.

Although the trendline for referrals is a reducing one, the number of assessments undertaken continues to increase. This suggests that most of the referrals are appropriate requests for service, however further work will need to be done to analyse the outcome of the referrals. Especially those that are considered inappropriate or do not meet the eligibility criteria.

Action:

Service redesign across the Partnership will look at ensuring a better fit between demand and resources.

Measure	Older residents aged 65+ in Care Homes
C&S Partnership Performance	Number at end March 18 = 634

Chart 23

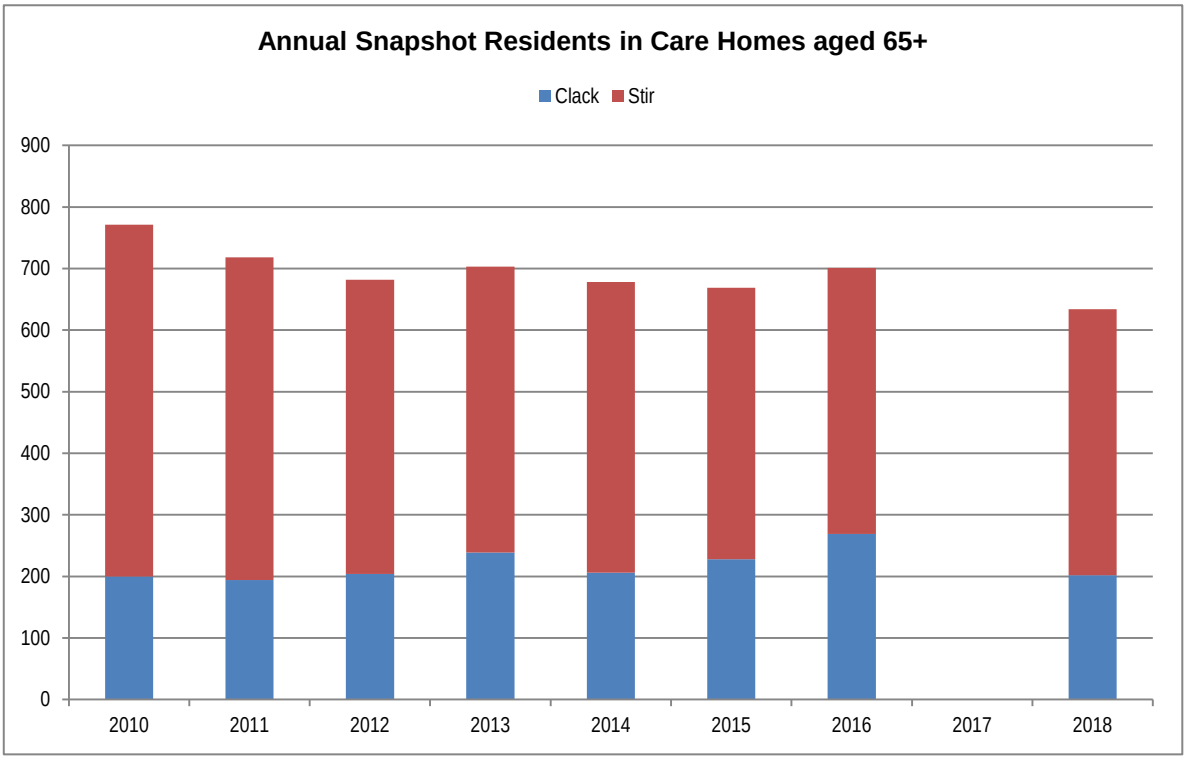
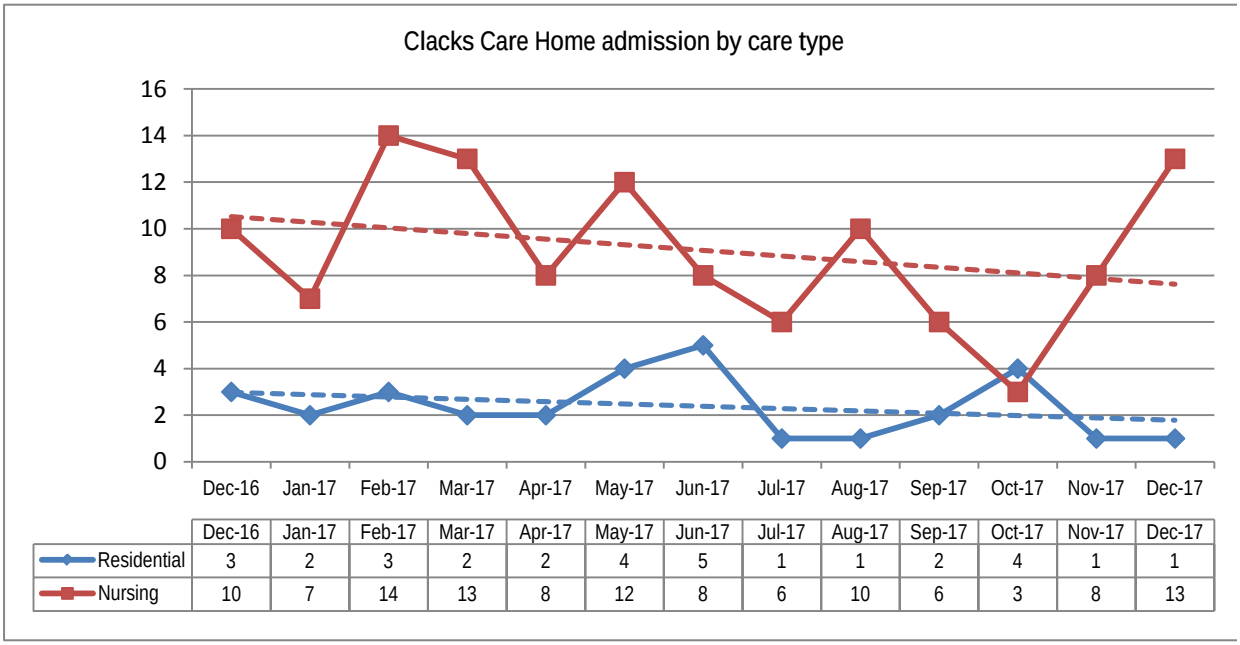


Chart 24



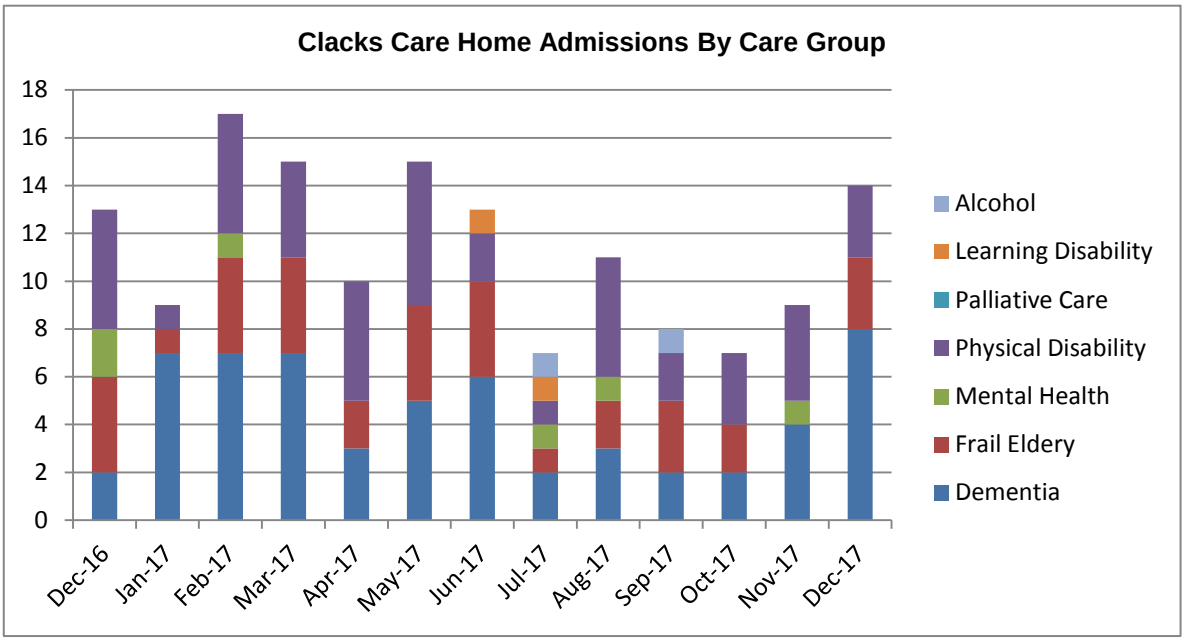
	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
Residential	3	2	3	2	2	4	5	1	1	2	4	1	1
Nursing	10	7	14	13	8	12	8	6	10	6	3	8	13

Commentary/Action

There is a long term reducing trend for the Partnership, which reflects the above average number of older residents supported in the community. Although the number of care home residents are reducing over time the level of support and cost in this area is challenging for the Partnership.

Analysis of placements undertaken for the 17/18 Winter Plan, was undertaken in the Clackmannanshire locality which showed the higher proportion of placements requiring a more specialised and resource intensive level of nursing care. Dementia focussed highly in the care groups of admissions over the period. We know that the proportion of the older population will continue to grow within the Partnership, and community supports around frailty and increasing demands around conditions such dementia put pressures on all health and social care sectors.

Chart 25



Action:

Dementia

Clinical, social work and Third Sector representatives have been working to redesign the Dementia Outreach Team to ensure more effective pathways across Forth Valley for people with dementia to access the right support at the right time. This ongoing group will look at the piloting of a multi-disciplinary specialist team with clear locality links. This is part of a wider requirement to look at service and community based redesign of supports for people with dementia across Forth Valley in line with the new national dementia strategy and reflects the success of local dementia friendly communities across the Partnership in offering a range of community based approaches.

The broad network of groups and services supporting people with dementia, met in January 2018 to look at the commitments contained in the national strategy and where the leadership of these commitments should lie. There are clear links with locality approaches, the Model of Neighbourhood Care and greater emphasis on the needs of carers.

The network will meet again in August to confirm agreed actions and look to work over the next year on refreshing the overarching vision for dementia supports and services.

Frailty

The aim of the Frailty at the Front Door Collaborative is to improve the processes of identifying frailty and coordinating care to deliver better experiences and outcomes for people living with frailty. While this specific work is focused on the front door of acute care, it is driven by an approach that recognises the importance of thinking

about flow across the whole system. Getting the care pathway right for older people and people living with frailty in acute care has a wider impact on the whole system.

Forth Valley is one of five NHS boards across Scotland taking part. The collaborative will work in synergy with the iHub's Living Well in Communities portfolio, Scottish Government's National Unscheduled Care Team and Integration Authorities to support improvements across the pathway.

Appendix 2

Glossary

- **Accident & Emergency (A&E) Services** - Collectively the term Accident and Emergency (A&E) Services includes the following site types: Emergency Departments; Minor Injury Units, community A&Es or community casualty departments that are GP or nurse led.

- **Admission** - Admission to a hospital bed in the same NHS hospital following an attendance at an ED service.

- **Admission rate** - the number of admissions attributed to a group or region divided by the number of people in that group (the population).

- **ALFY** – A service, supported by NHS Forth Valley and its Council Partners, introduced across Forth Valley to help support older people to remain well at home. The service, which consists of a round-the-clock advice line known as ALFY (Advice Line For You), is available to everyone aged 65 or over as well as family members and other people who may care for them. The dedicated advice line 01324 567247 is operated by experienced nurses. Support could range from; providing general health advice & re-assurance, arranging a nurse assessment and organising a home visit day or night, organising certain equipment to be provided to support people at home, providing access to general or specialist medical advice or review as required; arranging a referral to the Community ReACH Service (Rehabilitation Service), co-ordinating multiple actions required to support people to remain well at home, prioritising access to social care services determined by need, signposting to voluntary organisations and other locally based services.

- **Anticipatory Care Plan (ACP)** - The measure is the number of patients who have a Key Information Summary or Electronic Palliative Care Summary uploaded to the Emergency Care Summary. The Emergency Care Summary provides up to date information about allergies and GP prescribed medications for authorised healthcare professionals at NHS24, Out of Hours services and accident and emergency.

- **Attendance** - The presence of a patient in an A&E service seeking medical attention.

- **Attendance rate** - The number of attendances attributed to a group or region divided by the number of residents in that group (the population).

- **Circa** - means about or approximately.

- **COPD** - Chronic obstructive pulmonary disease is a common lung disease. . There are two main forms of COPD: Chronic bronchitis, which involves a long-term cough with mucus. Emphysema, which involves damage to the lungs over time.

- **Delayed Discharge -** A delayed discharge is experienced by a hospital inpatient who is clinically ready to move on to a more appropriate care setting but is prevented from doing so for various reasons. Delays can occur for a variety of reasons, but are usually due to a lack of appropriate care or services available within the community. For example, there may not be a place available in a local care home, or a person's house may need altered to help them get around. The date on which the patient is clinically ready to move on to the next stage of care is the ready-for-discharge date which is determined by the consultant/GP responsible for the inpatient care in consultation with all agencies involved in planning the patient's discharge, both NHS and non-NHS (Multi-Disciplinary Team). Thus the patient is ready-for-discharge, but the discharge is delayed due to: Social care reasons, Healthcare reasons, Patient/Carer/Family-related reasons. A **Code 9** delay and its various secondary codes, are used by partnerships that are unable, for reasons beyond their control, to secure a patient's safe, timely and appropriate discharge from hospital; The patient is delayed awaiting availability of a place in a specialist facility, where no facilities exist and an interim move would not be appropriate i.e. no other suitable facility available. Patients for whom an interim move is not possible or reasonable. The patient lacks capacity, is going through a Guardianship process. However some patients destined to undergo a change in care setting should not be classified as delayed discharges and can be categorised as **Code 100**. Such as; long-term hospital in-patients whose medical status has changed over a prolonged period of treatment and discharge planning such that their care needs can now be properly met in non-hospital settings. Patients awaiting a 'reprovisioning' programme where there is a formal (funded) agreement between the relevant health and/or social work agencies. Information on patients recorded as code 100 is not published but details are made available to the Scottish Government.

- **Emergency Department (ED)** – The department of a hospital responsible for the provision of medical and surgical care to patients arriving at the hospital in need of immediate care. **4 hour wait standard** - since 2007 the national standard for ED waiting times is that new and unplanned return attendances at an ED service should be seen and then admitted, transferred or discharged within four hours. This standard applies to all areas of emergency care such as EDs, assessment units, minor injury units, community hospitals, anywhere where emergency care type activity takes place. **Frequent attenders** - Have been defined as patients who attend a health care facility repeatedly. The frequency of attendance has been variously defined between 3 and 12 attendances per annum.

- **MECS** – Mobile Emergency Care Service.

- **MSG -** Ministerial Strategic Group for Health and Community Care agreed an initial framework for measuring progress against national priorities January 2017. Following a national review of the initial MSG framework, the extent of the data to be reported on was refined and Guidance was issued to Partnerships asking for a new submission to be sent by 31st January 2018. In response to this request a draft (second) submission was made and subsequently amended (slightly) and approved by the FV Unscheduled Care Programme Board in February 2018.

- **Pentana –** formerly known as Covalent is a web based performance monitoring tool that enables controlled access to a range of relevant data. The three main organisations within the Partnership have this tool which has the potential to automate, group and share information in a systematic and coordinated way. NHS FV host a Partnership Portal on their Pentana where indicators and data relevant to the Partnership from all three organisations is held.

- **RAG** – Is a quick visual way of identifying areas or concern or progress that is good, not so good, or poor. It refers to the use of colours RED AMBER GREEN.

- **Readmission -** This indicator measures the percentage of admissions of people who returned to hospital as an emergency within 30 days of the last time they left hospital after a stay. This indicator aims to measure the success of the NHS and the Partnership in helping people to recover effectively from illnesses or injuries. If a person does not recover well, it is more likely that they will require hospital treatment again within the 30 days following their previous admission. Thus, readmissions are widely used as an indicator of the success of health and social care.

- **SAS** – Scottish Ambulance Service.

- **Scottish Index of Multiple Deprivation** - The area based measurement of multiple deprivation ranking areas based on 38 indicators spanning 7 dimensions of deprivation; employment, income, health, education, housing, geographic access to services and crime**.**

- **Unscheduled Care -** is “NHS care which cannot reasonably be foreseen or planned in advance of contact with the relevant healthcare professional, or is care which, unavoidably, is out with the core working period of NHS Scotland. It relates to aim of reducing the number of patients and the amount of time they spend in hospital where it is not planned e.g. operation. Shorter lengths of stay results in better outcomes for patients, reduced risk of healthcare acquired infections, and improved patient flow through hospital systems.

- **Variance Range -** Variance is a measurement of the spread between numbers in a data set. The range is the difference between the high and low values. Tolerance limits define the range of data that fall within a specified percentage with a specified level of confidence.

Appendix 3 – MSG UPDATE SUMMARY – as at February 2018 (data provided by ISD)

<table>
<tr><th>Clackmannanshire & Stirling</th><th>Emergency admissions into acute (18+)</th><th>Unscheduled hospital bed days (18+)</th><th>A&E attendances (18+)</th><th>Delayed discharge bed days (18+)</th><th>Last 6 months of life (all ages)</th><th>Balance of Care (75+)</th></tr>
<tr>
<td rowspan="3">Objective

Baseline 15/16
Actual 16/17
Actual 17/18
Expected 17/18
Expected 18/19

Updated 16/3/18 following approval at USCPB 17/05/18 cj</td>
<td rowspan="3">Change 5% reduction on baseline by March 2019.
Baseline 11,134
Expected this means reduce by 557 admissions.
<table><tr><td>From</td><td>11,134</td><td>15/16</td></tr><tr><td>Feb 18</td><td>10,843</td><td>17/18</td></tr><tr><td>To</td><td>10,577</td><td>18/19</td></tr></table>
17/18 figure is 11 month total to Feb 18 - average 986 p/m would take us above target by year end 17/18. Therefore more reduction expected18/19 to meet target.

Source: ISD SMR01</td>
<td>Acute specialities (SMR01)
Change 6% reduction on baseline by March 2019.
Baseline 94,450
Expected this means reduce by 5,667 bed days.
<table><tr><td>From</td><td>94,450</td><td>15/16</td></tr><tr><td>Feb 18</td><td>79,399</td><td>17/18</td></tr><tr><td>To</td><td>88,783</td><td>18/19</td></tr></table></td>
<td>Number attendances
Change maintain baseline to March 2019
Baseline 26,585
Expected this means
<table><tr><td>From</td><td>26,585</td><td>15/16</td></tr><tr><td>Feb 18</td><td>25,933</td><td>17/18</td></tr><tr><td>To</td><td>26,585</td><td>18/19</td></tr></table>11 month total to Feb 18 – average 2,358 p/m. More reduction expected18/19 to meet target</td>
<td rowspan="3">All reasons.
Change maintain baseline to March 2019
Baseline 10,069
Expected this means reduce by 1,782 bed days.
<table><tr><td>From</td><td>10,069</td><td>15/16</td></tr><tr><td>Feb 18</td><td>7,440</td><td>17/18</td></tr><tr><td>To</td><td>10,069</td><td>18/19</td></tr></table>11 month total to Feb 18 – average 676 p/m</td>
<td rowspan="3">Community setting
Change 4% increase to 90% and maintain to March 2019
Baseline 86%
Expected this means an increase of 4%.
<table><tr><td>From</td><td>86%</td><td>15/16</td></tr><tr><td>To</td><td>90%</td><td>18/19</td></tr></table>No 17/18 data</td>
<td>Home unsupported
Change 1% increase to 85% and maintain to March 2019
Baseline 84.1%
Expected this means an increase of 0.9%
<table><tr><td>From</td><td>84.1%</td><td>15/16</td></tr><tr><td>To</td><td>85%</td><td>18/19</td></tr></table>No 17/18 data</td>
</tr>
<tr>
<td>Geriatric long stay (SMR01E)
Change 18% reduction on baseline by March 2019.
Baseline 18,109
Expected this means reduce by 3225 bed days.
<table><tr><td>From</td><td>9,4450</td><td>15/16</td></tr><tr><td>Dec 17</td><td>10,321</td><td>17/18</td></tr><tr><td>To</td><td>14,884</td><td>18/19</td></tr></table>Three quarter total to Dect 17 –10,321 (average 1,147 p/m)</td>
<td>% seen within 4 hours
Change 1% increase to 95% and maintain to March 2019
Baseline 94%
Expected this means
<table><tr><td>From</td><td>94%</td><td>15/16</td></tr><tr><td>Feb 18</td><td>89.8%</td><td>17/18</td></tr><tr><td>To</td><td>95%</td><td>18/19</td></tr></table>11month average to Feb 18.</td>
<td>Home with support
Change reduce to 9% and maintain to March 2019
Baseline 9.5%
Expected this means a reduction of 0.5%
<table><tr><td>From</td><td>9.5%</td><td>15/16</td></tr><tr><td>To</td><td>9%</td><td>18/19</td></tr></table>No 17/18 data</td>
</tr>
<tr>
<td>Mental health (SMR04)
Change maintain baseline to March 2019. Baseline 24,754
Expected this means
<table><tr><td>From</td><td>24,754</td><td>15/16</td></tr><tr><td>Dec 17</td><td>20,186</td><td>17/18</td></tr><tr><td>To</td><td>24,754</td><td>18/19</td></tr></table>Quarterly recording, average 6,729 per quarter. More reduction expected18/19 to meet target</td>
<td>Care home
Change reduce to 4% and maintain to March 2019
Baseline 4.4%
Expected this means a reduction of 0.4%
<table><tr><td>From</td><td>4.4%</td><td>15/16</td></tr><tr><td>To</td><td>4%</td><td>18/19</td></tr></table>No 17/18 data</td>
</tr>
</table>

Clackmannanshire & Stirling Health and Social Care Partnership
Integration Joint Board

13 June 2018

This report relates to
Item 8.2 on the agenda

Annual Performance Report 2017-18

Paper presented by Shiona Strachan

For Approval

Approved for Submission by	Shiona Strachan, Chief Officer, Clackmannanshire & Stirling Health & Social Care Partnership
Author	Carol Johnson, Principal Information Analyst
Date:	13 June 2018
List of Background Papers / Appendices:	
Appendix 1 – Annual Performance Report	

Title/Subject: **Annual Performance Report 2017-18**

Meeting: **Clackmannanshire & Stirling Integration Joint Board**

Date: **13 June 2018**

Submitted By: **Carol Johnson/Shiona Strachan**

Action: **For Approval**

1. Introduction

1.1. This report outlines the statutory requirement for the Partnership to deliver and publish an Annual Performance Report before the end of July 2018 and presents the draft Annual Performance Report for approval.

2. Executive Summary

2.1. The Public Bodies (Joint Working) (Scotland) Act 2014, along with the Regulations compiled to implement the Act, provides the legislative framework for the integration of health and social care services in Scotland. This includes the requirement to publish an Annual Performance Report.

2.2. A draft Annual Performance Report has been drawn up with input from colleagues across the Partnership. The Annual Performance Report sets out the Partnership's performance against the National Outcomes and Indicators, (as required by the legislation) and highlights our achievements and progress made throughout the year, with comparison where possible with the previous year.

2.3. The Partnership has improved its performance against the core suite of integration indictors, performing positively in 15 of the 19, an increase on last year.

2.4. Further work is required to design and format the report for publication. It should be noted by the Integration Joint Board that the format has been retained for this year to ensure consistency with the 2016-2017 Annual Performance Report and a clear visual link the existing Strategic Plan.

3. Recommendations

The Integration Joint Board is asked to:

3.1. Note that the Annual Performance Report is in draft form and that work will be ongoing to refine the content and presentation ahead of publication by the end of July 2018.

3.2. Approve the content of the draft Annual Performance Report for 2017-18, included in Appendix 1.

3.3. Approve the delegation of the final formatting and design to the Chief Officer. This is in line with the approach taken to the last Annual Performance Report.

3.4. Instruct the Chief Officer to provide copies of the Annual Performance Report to the constituent authorities, Clackmannanshire Council, NHS Forth Valley, and Stirling Council.

3.5. Note that the formatted report should be published on the Partnership Integration page of NHS Forth Valley by 31st July 2018.

4. Background

4.1. The Public Bodies (Joint Working) (Scotland) Act 2014 provides the legislative framework for the integration of health and social care services in Scotland. Section 42 of the Act requires that Performance Reports are prepared by the Integration Authority. To ensure that performance is open and accountable, the 2014 Act requires Health and Social Care Partnerships to publish an Annual Performance Report setting out an assessment of performance in planning and carrying out the integration functions for which they are responsible.

4.2. A suite of guidance documents has been provided by the Scottish Government to assist with the production of the Annual Performance Report (APR). The guidance states that the purpose of the APR is to provide an overview of performance and it is produced for "the benefit of Partnerships and their communities".

4.3. The required content of the Annual Performance Report is set out in The Public Bodies (Joint Working) (Content of Performance Reports) (Scotland) Regulations 2014. The regulations and associated guidance sets out the minimum expectations on the content of these reports, with particular reference to the reporting off the Core Integration Indicators to support assessment of performance in relation to the National Health and Wellbeing Outcomes.

4.4. The outcomes and supporting indicators are presented within the annual Performance Report. The report for 2017-18 is required to be published no later than 31 July 2018. That is, a period of no more than 4 months from the end of the financial year.

4.5. The Annual Performance Report will also be reported to the NHS Forth Valley Board, Clackmannanshire Council and Stirling Council as a key part of the monitoring arrangements for the Partnership.

4.6. It is for Partnerships to decide the layout of their Annual Performance Reports, other than the requirement to include the specified National Indicator Data. The Regulations require Partnerships to assess performance in relation to the National Health and Wellbeing Outcomes which have been developed to measure the experiences and quality of services for service users. Performance must also be set out in the context of the strategic plan and financial statement.

4.7. Data should be included for both the year which the report covers and the preceding 5 years, or for all previous years if less than 5. The first performance report to include the full set of historical information will be 2021/22.

5. Annual Performance Report 2017-18

5.1. The draft Annual Performance Report for 2017-18, included in Appendix 1, has been compiled with input from colleagues across the Partnership. The Annual Performance Report reflects the Partnership activity in relation to the Strategic Plan and the core delivery priorities agreed as part of the Delivery Plan. Where possible this report also provides a comparator with 2016/17 data to help track the impact of the work taking place.

5.2. The focus for the presentation of the Annual Performance Report is to make it an interesting and easy to read document, written in plain English and making use of charts, diagrams, photographs and graphics as much as possible. This iteration is not the final design but allows an overview of the narrative and performance.

5.3. Timescales have been challenging, particularly as the timeframe coincides with production of the annual accounts and verified data from the Information Services Division (ISD) and social care systems is not fully available during the drafting period for the Annual Performance Report. The timing is a national issue and has been raised with the Scottish Government. However, the deadline of the end of July is statutory and therefore the best information available is utilised. It is acknowledged that annual performance reporting, involving joint working across several disciplines and recording systems will develop further over the coming years.

5.4. This is an opportunity to highlight the many milestones achieved and successes we have had over the Partnership's second year of operation. There will always be areas for improvement, and we also highlight our plans for delivering the transformational change set out in the Strategic Plan.

5.5. The indicators for each outcome are reported both in summary format in the table on page 25 and in detail in the following sections. The information includes a benchmark against the Scottish average and one for a small group of similar Partnerships in terms of population, geography and key indicators such as deprivation.

5.6. The Partnership performs positively in 15 out of a total of 19 relevant indicators covering areas such as; service user experience, good health, independence, inequalities, and effective use of resources.

6. Conclusions

6.1. The Partnership's second Annual Performance Report is an opportunity to reflect on the wide and varied activities and improvements that have been achieved over the year and consider how well we are moving towards delivering the Partnership's Strategic Plan outcomes. It also allows some comparison with the previous year's performance and highlight emerging trends for the Partnership.

7. Resource Implications

7.1. There are no resource implications arising specifically from this report. The Annual Performance Report includes information on the use of the Partnership budget and funding streams.

8. Impact on Strategic Plan Priorities and Outcomes

8.1. This report and associated recommendations, relates to the following Clackmannanshire & Stirling Health and Social Care Partnership local outcomes and Strategic Plan priorities (please select as appropriate):

Fit with Local Outcomes	
Self Management	☒
Community Focussed Supports	☒
Safety	☒
Decision Making	☒
Experience	☒

Fit with Our Priorities 'we will...'	
Further develop systems to enable front line staff to access and share information	☒
Support more co-location of staff from across professions and organisations	☒
Develop single care pathways	☒
Further develop anticipatory and planned care services	☒
Provide more single points of entry to services	☒
Deliver the Stirling Care Village	☒
Develop seven-day access to appropriate services	☒
Take further steps to reduce the number of unplanned admissions to hospital and acute services	☒

8.2. The Annual Performance Report will help to measure the impact on the Strategic Plan outcomes and Partnership priorities.

9. Legal & Risk Implications

9.1. The Annual Performance Report is a statutory requirement. There is a risk that the Annual Performance Report does not fully illustrate the achievements of the Partnership to date.

9.2. There is a risk that the Integration Joint Board and the services it directs fail to meet the required outcomes.

9.3. The report seeks to ensure that the Partnership meets its statutory obligations in terms of publication of the Annual Performance Report by 31 July 2017 and illustrates our performance against our local and national outcomes.

10. Consultation

10.1. Significant consultation has taken place throughout the year and this has already informed the position taken by the Partnership when considering policies and projects which make up the core business of the Partnership and which are referred to in the Annual Performance Report.

11. Equality and Human Rights Impact Assessment

11.1. The Annual Performance Report is a review of the previous year of Partnership activity. As such there is no requirement to carry out an EHRIA. Any required assessments will have been carried out on individual Partnership Projects or policies adopted by the IJB.

12. Data Protection Impact Assessment

12.1 The content of this report does not require a DPIA.

13. Exempt reports

13.1. This report is not exempt.

14. Appendices

14.1. Appendix 1 – Annual Performance Report

Clackmannanshire & Stirling Health & Social Care Partnership Annual Performance Report 2017 - 2018

"Our vision is to enable people in Clackmannanshire and Stirling to live full and positive lives in supportive communities"

Clackmannanshire Council

Stirling Council

NHS Forth Valley

Contents

Our Second Year 1

Section 1 About Us 3
Background 3
Our Strategic Plan and Partnership Priorities 4
Localities 5

Section 2 Transforming Care: Delivery Priorities 17-19 7
Models of Neighbourhood Care 7
Learning Disability and Mental Health 8
Intermediate Care, Day Support & Care Homes 8
Stirling Health & Care Village 11
High Health Gains 14
Delayed Discharge 16

Section 3 Transforming Care: The Enablers 17
Strategic Needs Assessment 17
Technology Enabled Care 17
Housing Contribution 18
Data Sharing and Shared Assessments 18
Commissioning: Market Position Statement & Providers 18
Workforce 19
Financial Plan 20

Section 4 Outcomes: Our Performance 23
National Outcomes and our Local Framework 23
Performance Under Integration 24
Our Performance: A Summary 25
Our Performance: In Detail 27
Inspections 33
Inspection Recommendations 34

Section 5 Next Steps 36

Section 6 Glossary 38

Our Second Year

Welcome to our second Annual Performance Report which gives us the opportunity to reflect on our progress together as a Partnership since it was fully established on 1 April 2016. We are the only Health and Social Care Partnership in Scotland incorporating two Local Authorities and one Health Board – and this provides us with some unique opportunities to work together to improve our services and the outcomes for the communities across Clackmannanshire and Stirling.

Our vision for the Partnership is 'to enable people in the Clackmannanshire and Stirling Health and Social Care Partnership area to live full and positive lives within supportive communities.'

Our Strategic Plan and the underpinning Delivery Plan sets out how we are working together to achieve this vision.

The Partnership is changing the way we deliver health and social care services locally by placing people and their outcomes at the centre of our activity and some of our key achievements over the past year include:

- Delivering a range of integrated bed based and care at home health and social care services
- Engaging our workforce, stakeholders and communities in service transformation and redesign, including preparation for Stirling Health and Care Village
- Continuing to reduce delays in discharge from acute services
- Supporting primary care services to develop a cluster based locality approach
- Achieving our Technology Enabled Care Programme objectives with 1,226 new users of telecare over a 2 year period
- Working with communities to develop a model of neighbourhood care based upon the Buurtzorg principles.
- Working to change the way we respond to unpaid carers

In common with other Health and Social Care Partnerships across Scotland, we are working together to meet the challenge of growing levels of demand across services and a challenging financial environment.

We are maintaining an overall good performance against the national Health and Wellbeing Outcomes, with the Partnership performing above or in line with the national average in most of the core indicators.

To gain objective insight into how well we are performing, we requested that an Internal Audit Review was carried out. This looked at Performance Management and Reporting and has provided substantial assurance, based on testing, that arrangements in respect of performance management and reporting are appropriate and are operating effectively.

We are undertaking a range of reviews of services to ensure they offer best value in terms of both effectiveness and are efficient to help us live within the available resources.

We have also sought to collaborate with organisations such as Healthcare Improvement Scotland's, Improvement Hub [iHub], Scottish Health Council and Glasgow Caledonian University to explore and develop how we operate to improve and evaluate personal outcomes.

To help drive improvement and change the Joint Management Team is also reviewing its approach to performance reporting and data gathering to achieve a more consistent approach to the gathering and reporting of activity measures such as referrals, assessments, complaints and interventions including adult support and protection.

We have established quarterly 'big team' meetings within the social care services to support engagement and information sharing and we plan to develop this approach further over 2018.

During 2018 the Partnership has taken part in a strategic inspection of our performance and planning led by the Care Inspectorate and Healthcare Improvement Scotland. We await the outcome of the Inspection.

Special thanks also go to the service users and carers who have been willing to share their story with us as case studies throughout this report.

During 2017/18 we have sought to develop services which are place based, meeting the aspirations of local communities. To this end, we are engaged with the Community Planning Partnership in Stirling and the Clackmannanshire Alliance, and will work together to deliver for our communities.

Models of Neighbourhood Care approach in Stirling has taken a ground up approach to developing a community based service, with the development work supported by a community reference group.

At a wider Partnership level we are involved with the emerging regional planning for health and social care services.

Finally, I would like to take the opportunity to thank the Chair of the Integration Joint Board during 2017/2018, Councillor Scott Farmer, the Vice Chair John Ford and the members of the Integration Joint Board for their work and support over this year.

Further thanks also go to the members of the Strategic Planning Group and to our partners and their staff, and not least to the many people who use our service, as well as their unpaid carers, family and friends and local communities for their willing engagement, ideas and energy.

Shiona Strachan, Chief Officer

1. About Us

Background

Clackmannanshire and Stirling Integration Authority and its governing Integration Joint Board is a separate legal body which became responsible for the strategic planning and delivery of community based health and social care services to adults and older people from April 2016.

The Integration Joint Board, often referred to as the IJB, has 12 voting members: 6 are NHS Forth Valley Board and 6 are Elected Members from the two Councils [3 from Clackmannanshire Council and 3 from Stirling Council]. There are also 7 non voting members, including representatives from service user, patient and unpaid carer groups and from the third sector. The Board is supported in its work by the Strategic Planning Group which has membership drawn from across the services. These include the third and independent sector, carers' organisations, the local Hospice and palliative care services, service users/patients and carers.

Our Strategic Plan and Partnership Priorities

The Strategic Plan [2016-2019] established the Partnership vision and outlined the local and national outcomes [the basis for the performance framework], a high level approach to locality planning and the eight local priorities. Work is ongoing through 18/19 to review and update the Strategic Plan.

The high level priorities, expressed as a series of ***'we will'*** statements, in the Strategic Plan are –

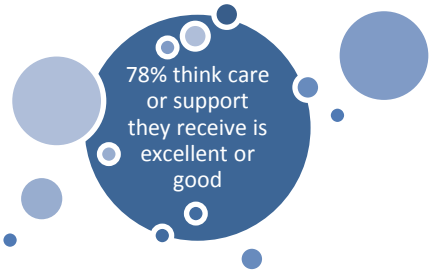
- Further develop systems to enable front line staff to access and share information
- Support more co location of staff from across professions and organisations
- Develop single care pathways
- Further develop anticipatory and planned care services
- Provide more single points of entry to services
- Deliver the Stirling Health & Care Village
- Develop seven day access to appropriate services
- Take further steps to reduce the number of unplanned admissions to hospital and acute services

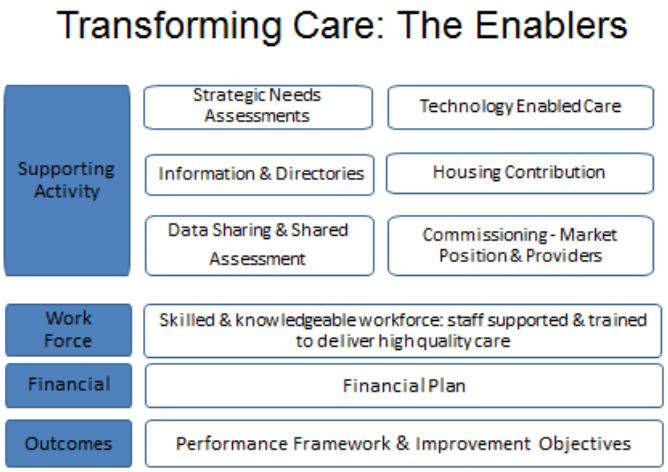
The Partnership Annual Audit Report (Audit Scotland), published in September 2017, highlighted:

- IJB open and transparent in the way it conducts business – public can attend meetings and access agendas and meeting papers
- The IJB has appropriate governance arrangements in place that support scrutiny of the Board.

The following diagrams represent the core Partnership delivery priorities for 2017-2019 and the underpinning enablers, which also involve redesign activity. Together they make up the content of the Partnership's Transforming Care Programme.

These delivery priorities do not cover the entire activity taking place within and between services and partners but focus on the actions the Partnership can take together to strengthen and develop the building blocks for community based services.





The enablers are a set of activities which support the development and delivery of the priorities.

Work is ongoing in each of these workstreams, to suppport the core delivery priorities and deliver the required progress and performance reporting to the Board.

Localities

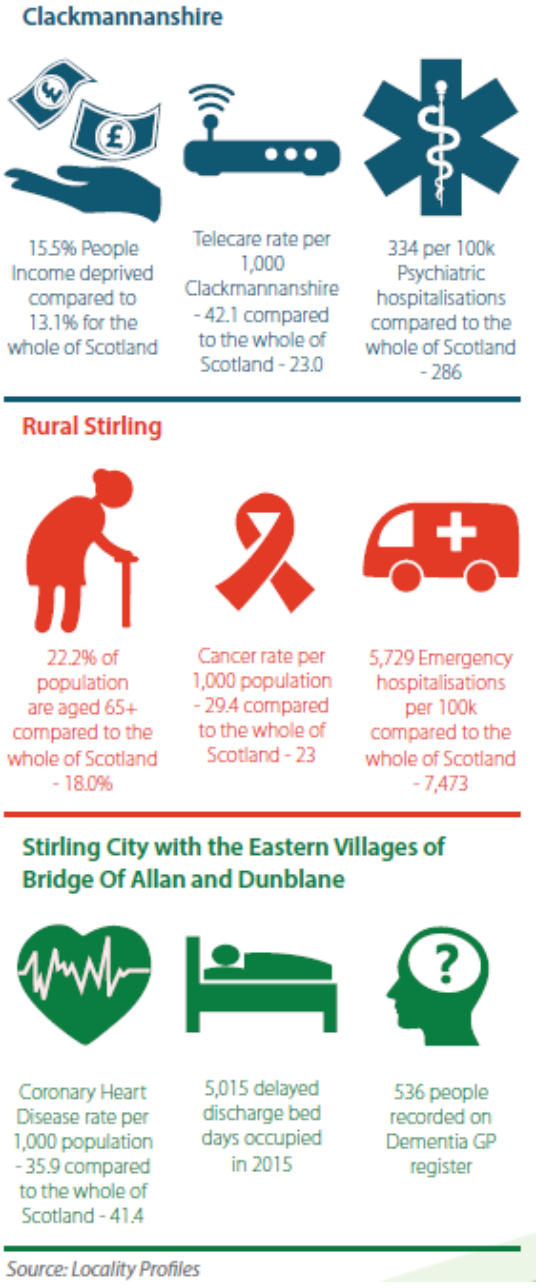
The Strategic Plan identified the planning localities for the Health and Social Care Partnership, which were agreed in October 2015.

The population of the Partnership area is estimated at 142,770, with 64% of the population residing in Stirling and 36% in Clackmannanshire. The age profile of the population is similar to that of Scotland as a whole - with growing numbers of older people.

Locality profiles were established last year and work is ongoing at a national and local level to provide data for the 3 designated zones within the Partnership.

As part of the over arching programme we have work-streams which are specific to each of the Localities and reflect the priorities of these Localities. A considerable amount of work has been carried out with our communities, building on the work already taking place by the Local Authorities and the third sector.

The Strategic Planning Group oversees locality performance and planning and this will develop over 18/19.



Clackmannanshire Locality

- Attendance at A&E is forecast to rise, and the rate of unplanned admission and readmission to hospital are highest in the Partnership.
- Rising proportion of older people.
- Clackmannanshire has some of the most deprived areas in Scotland with associated health challenges. Life expectancy is lower for a wide range of the population, especially females.

- Locality Work Stream - as a Partnership we have strong investment in the development and delivery of intermediate care – both bed based and care at home (reablement) services, which support people in their recovery from ill health, and are key to the Partnership's approach to supporting effective discharge from hospital and preventing readmission. We have been reviewing the pathways and service delivery model in Clackmannanshire
- Locality Work Stream -

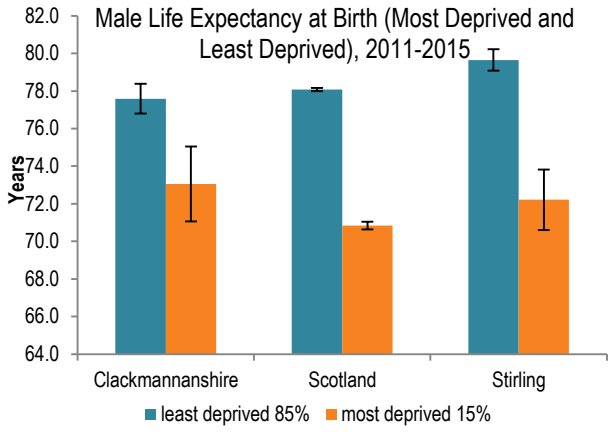
Stirling City & Eastern Villages Locality

- Locality with the highest density and number of individuals in Partnership.
- Rising trend of attendances at A&E and admissions from there.
- Stirling has areas of marked contrast in terms of inequalities with some of the least deprived areas in Scotland sitting alongside some of the most deprived.
- In more deprived areas of the City and eastern villages, levels of heart disease, cancer, stroke, emergency admissions and other conditions are much higher.
- Locality Work Stream - we are currently working with iHub to further develop our integrated model of care for the Stirling Health and Care Village and in particular the services which will be provided from the Bellfield Centre for older people.

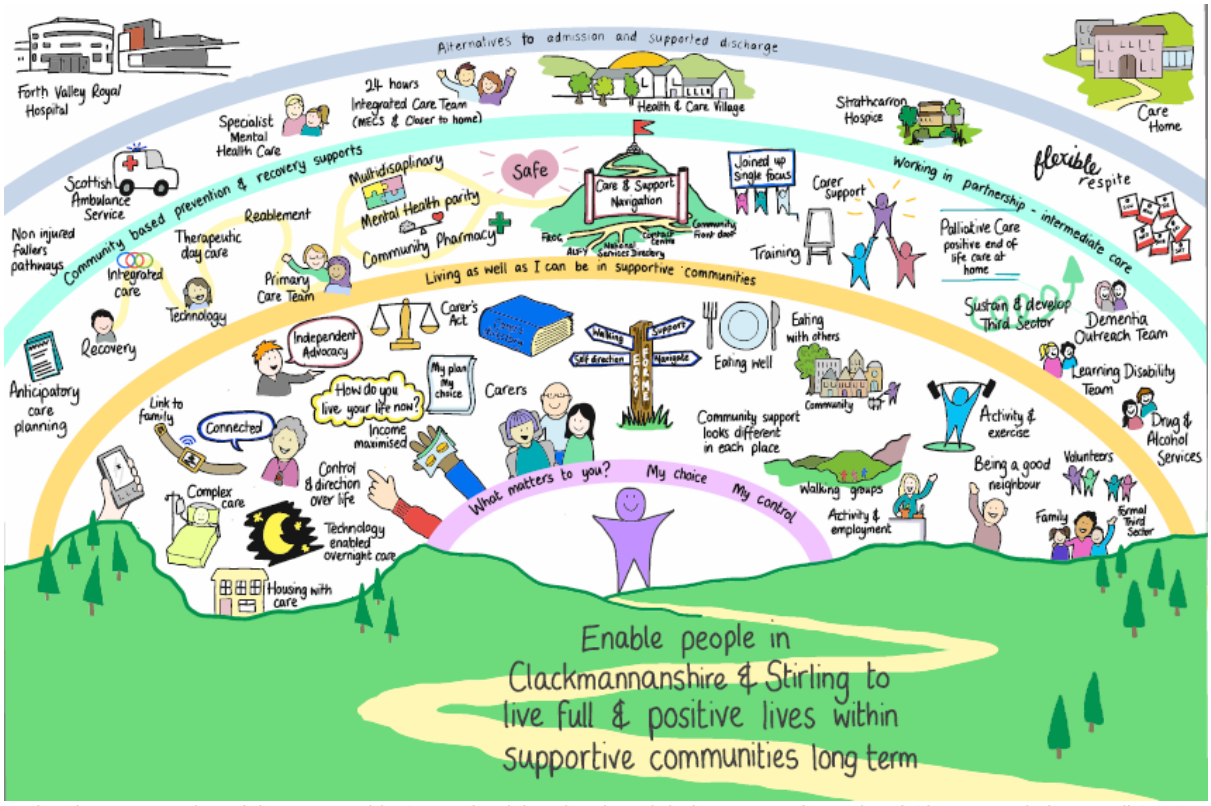
Rural Stirling Locality

- Least populated area in the Partnership.
- Most of the northern part of Stirling's rural area lies within the most deprived 5% nationally for accessibility. This is calculated using drive times and public transport travel times to facilities such as GPs, shops, post offices and schools.
- Health in the rural area is generally better than the Stirling and Scotland averages. Where deprivation and older populations are more prevalent rurally, there are greater incidences and early deaths from coronary heart disease and cancer.
- Trend of rising emergency admissions to hospital.
- Locality Work Stream - the work on the Models of Neighbourhood Care within the Stirling Rural locality will see the operational development of place based services through a Locality planning agenda. Changing the way services are delivered to suit the needs identified within a locality and ensure a better fit.

Inequalities



2. Transforming Care: Core Delivery Priorities 2017/19



Visual representation of the Partnership Strategic Vision developed during a Transformational Change workshop April 2018.

This section highlights some of the work taking place across the Partnership to drive forward the delivery of our Transformating Care Programme.

Models of Neighbourhood Care

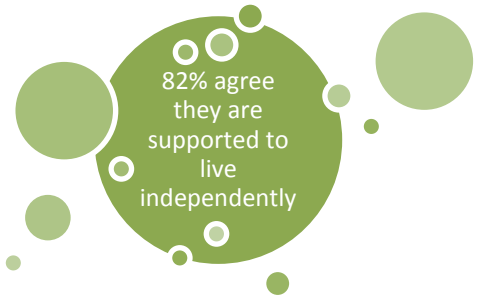
The community of rural south west of Stirling have identified the care of older people as a priority. We have been working together to develop a new and innovative model of neighbourhood care based on the Buurtzorg principles. This will **change the way health & social care services are provided in the locality**. The multi disciplinary, place based services are scheduled to commence in 2018.

Staff engagements sessions have been taking place with key staff and have been facilitated by Scottish Social Services Council & Organisational Development.

The pilot team will consist of staff currently delivering reablement, adult social care and nursing.

The success and impact of the pilot will be measured using an approach that focuses on the following outcomes:

- Peoples' needs are met by the right person, first time, every time.
- People have improved health and wellbeing.
- People live at home independently for as long as possible with the right level of support.
- Staff are valued, motivated and empowered.



Learning Disability & Mental Health

The Learning Disability Service and community adult Mental Health Services have been integrated for some time. These services offer a range of assessment, support and intervention services.

Work is ongoing to redesign the community services provided across Clackmannanshire and Stirling to **ensure Best Value and consistency of service** across the Partnership. This includes the re design of day services and the wider use of Self-directed Support to support service users and their unpaid carers to exercise choice and control over their care.

In addition there are other enabling activities ongoing, including development of an information resource to improve post diagnostic support for Autistic Spectrum Disorders.

Intermediate Care

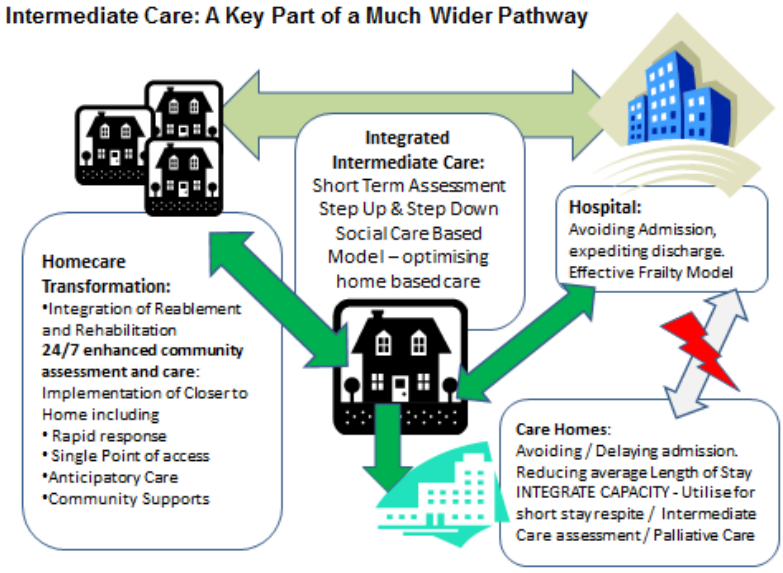
The Partnership has developed a range of intermediate care services for older people all operating within the national framework.

Work is currently taking place [supported by iHub] to develop our approach to intermediate care both in terms of our bed based models and our reablement care at home models. This work is linked to the Stirling Health & Care Village and over the coming year to work in relation to the Clackmannanshire Community Health Care Centre. It will also feed into the Commissioning Strategy for older peoples services.

An average of 484 hours of reablement support per week was arranged in 2017-18 by Social Care for people living in the community in Clackmannanshire and Stirling.

We have carried out positive work in areas such as mental health and dementia services, including the development of post diagnostic support and supporting communities to become Dementia enabled.

Redesign of dementia services is taking place in line with Scotland's National Dementia Strategy [2017-20]. Services are working together to ensure **more effective pathways** across Forth Valley for people with dementia supporting **access to the right support at the right time**. This is part of a wider requirement to look at appropriate supports for people with dementia and reflects the success of local dementia friendly communities work across the Partnership, offering a range of community based approaches with clear links to unpaid carers.



The rising trend of the number of care at home hours provided is similar to national trends, and the number of clients is similar to our peers. However the number of actual hours is much higher than other similar partnerships. This may be reflecting in some part the 'balance of care' within the Partnership which is above average for the % of the population living in the community with support.

Intermediate Care at Home

This provides people with rapid access to assessment, rehabilitation and support at home in order to promote independence and prevent crisis situations. It is usually provided by a mix of health and social care professionals.

This model is often referred to as reablement. Reablement has a positive impact on effective discharge from hospital and supports people to regain their confidence.

Case Study

Mrs P was referred for a short stay assessment to step down from acute hospital after a period of ill health. Her daughter had expressed that her mother may require long term care.

The Intermediate Care Team:

* Developed an exercise programme
* Supported Mrs P's personal care
* Provided Mrs P with confidence building on stairs
* Increased confidence and independence in managing medication

Mrs P was able to return to her home in the community with a package of homecare, three times daily

The service

* Worked collaboratively with Mrs P and her daughter, involving them in all aspects of care and support
* Used the skills of all professionals to maximise Mrs P's potential

Bed Based Intermediate Care

Similar to Intermediate Care at Home, this is a time limited episode of care currently provided in dedicated care homes across the Partnership. It often provides an alternative to admission to hospital [step-up] or to provide further assessment and rehabilitation, following discharge from hospital [step-down].

Clackmannanshire Bed Based Care services celebrated 21 years of accreditation to BS EN ISO 9001standard this year.

2016 - 2018	Total People Discharged From Intermediate Care Service		Home with package of care		Care home admission		Hospital re-admission		Death	
	16/17	17/18	16/17	17/18	16/17	17/18	16/17	17/18	16/17	17/18
Clackmannanshire	26	25	27%	40%	46%	32%	23%	8%	4%	4%
Stirling	97	133	55%	35%	25%	25%	17%	17%	3%	4%
Partnership	123	158								

Approval was granted April 2017 to review the model of service delivery to:

- Ensure a fit to re ablement care at home and the use of all of our bed based facilities across the Partnership
- Support the step into the Bellfield Centre on the Stirling Health and Care Village site by November

2018 with an integrated model of care and support

This work will inform and support the further integration of multi disciplinary teams across the Partnership area including the model of neighbourhood care which forms the basis for the locality teams; the Enhanced Care Team and our Overnight Care and Out of Hours services.

Over the coming year further, detailed work will take place in Clackmannanshire to further develop our bed based and community integrated care and support services.

Stirling Health & Care Village

Stirling Health and Care Village is a £35m health and care development on the Stirling Community Hospital site which has been taken forward through an innovative partnership between NHS Forth Valley, Stirling Council, the Scottish Ambulance Service, Forth Valley College and the Health and Social Care Partnership.

The focus for the services which will be delivered from the site is to support people to live full and positive lives within supportive communities. For many older people this will mean having appropriate services built around a model of rehabilitation and reablement.

Work is underway, with the iHub supporting conversations on the service and staffing models required for this new provision, while providing 'critical friend' support on areas including, capacity modelling data collection and third sector involvement.

158 people were discharged from Intermediate Care in 17/18

The site consists of three main purpose-built new facilities – the Bellfield Centre which will provide intermediate bed based care; GP/primary care, with two Practices moving onto the site from older premises within Stirling; the Scottish Ambulance facility, which will replace the existing facility in Riverside; X-ray and Minor Injuries. The existing outpatient facilities will be retained within their current buildings on the wider Stirling Community Hospital site.

A community engagement event was held February 2018, to bring together the local community, third sector and staff across both NHS Forth Valley and the Health and Social Care Partnership and consult on the ways in which the public spaces can be used, the activities they might like to see, and the activities that local organisations might be able to offer.

Considerable work has been carried out in preparation for moving services into the Bellfield Centre to ensure the integration of the workforce for the maximum benefit of service users and their carers. Care will be delivered in a comfortable homely environment for older adults to help them recover, regain their independence and, where possible, return to their own homes.

A work force group has been established for the Health & Care Village to focus on issues for staff and to support the development and implementation of the model of care.

Over the past 12 months, a series of workforce engagement events have taken place with a focus on the development of the identity of the Bellfield Centre in delivery of the strategic priorities of the Partnership.

Day Support

The growing older population, along with the drive for people to be supported to live in their own homes means that there is a requirement for services to be able to respond in different ways. It is also acknowledged that there is an inconsistent and potentially inequitable access to day supports across the Partnership.

A short life working group has been working to scope out the existing resources and the individual service user ad unpaid carer outcomes being achieved within these services. It identified that there was an on-going need for 4 different types of service provision:

- Specialist Support
- Short Term service based upon rehabilitation and recovery
- Long-term day respite for users and unpaid carers and,
- Maintenance programmes to support benefits of rehabilitation programmes or to continue with long-term outcomes

Work commenced in February 2018 with Clackmannanshire Third Sector Interface to consider the range and types of services which could support place based, community supports, and a public engagement event took place in May 2018, to further identify how people wish to be supported in their communities.

The consultation will carry on throughout the summer of 2018, to identify the most appropriate supports to reduce isolation and loneliness across Clackmannanshire's older population.

67% are supported at home with intensive care needs

Care Homes

We are one of 8 Partnerships across Scotland who are currently engaged with the Care Inspectorate's improvement initiative, **Care About Physical Activity**. 10 services across internal and commissioned care homes have been very active in adopting the improvement tools and resources promoted.

It was anticipated that participation in this programme would be a positive opportunity to promote transformational change in the way services are delivered to enable people to live successful lives in a care setting.

It was hoped that the programme would also **improve outcomes for people living in care homes** who may otherwise be excluded from community based opportunities.

The impacts noted by local care homes have been significant and incredibly positive. Locally, this has included:-

- Outdoor mobility & exercise groups
- Improved personal care skills
- Greater links with local community groups
- Inter-generational projects with local schools
- Improved communication and self-esteem of residents
- Improved sleeping patterns
- Improved mental health of residents who may have otherwise felt excluded
- Secondary impacts have also been noted such as improved physical activity within staff groups, and communication between care homes and their communities
- Links with Care at Home services [where possible]

The programme has also supported a greater level of communication between the Partnership and commissioned services. For instance, the Partnership were able to resource Playlist for Life training for all local care homes over 2 learning events. This is an important initiative which **supports the therapeutic care of people living with dementia** through the use of music which is meaningful to them. There has been a commitment to develop a networking group for those services who wish to pursue this further. The Partnership has also sourced end of life care training via MacMillan for all local care homes.

While the improvement programme came to an end with the final learning event in May 2018, this carried a theme of sustainability, with the Partnership committing to continuing to work closely with our care homes to build opportunities with groups and communities. This approach will also be rolled out to Care at Home services at a greater scale.

The community nursing support to care homes for two GP practices has already demonstrated significant benefits. This model will be scaled up over this year to provide support over the full week for all of the Clackmannanshire care homes and practices

87% spend their last 6 months at home or community setting

High Health Gains

It is notable that a small percentage of people, with complex and intensive needs, account for half the total health expenditure in the local area.

For 16/17, there were 1,077 individuals in Clackmannanshire and 1,783 in Stirling who accounted for 50% of health expenditure in their areas. This was a slight drop on the previous year.

It is therefore important that the Partnership focusses on this group to ensure that services are as efficient and effective as they can be and that people's experience of services is positive, with their outcomes met as far as possible.

The focus over the last year was our innovation work **"Supporting full and independent lives through innovative technology approaches"**. We have worked with people to get access to equipment that meets their needs.

Within Clackmannanshire , working with the GP practices, 4 new mental health primary care nurses have been recruited, as well as community nursing support to care homes and additional pharmacy sessions. Baseline data has been collected with 10% of GP appointments found to be for mental health support alone. A further 10% of consultations include a mental health component presented alongside other complaints.

Exploring New Models for General Practice

We have three strands to our Primary Care Transformation Programme:

- Urgent Care GP Out of Hours Transformation. Introduction of 5 Advanced Nurse Practitioner training posts, Paramedic Specialists and improved integration with other over night supports.
- Primary Care Transformation: GPs in practices are working together in clusters, taking a multi-disciplinary approach to care within practice and the community.
- Mental Health in Primary Care: The investment for mental health services includes Mental Health Nurse Practitioner posts and aims to improve access for people with mental health needs to the most appropriate support as quickly as possible, in the most appropriate setting.

We are now working on a comprehensive Primary Care Implementation Plan to support services to deliver within local communities.

Hospital At Home - Enhanced Community Team

The Enhanced Community Team covers 'Closer To Home' (C2H) and GP Fellows. It aims to support people at home, avoiding preventable hospital attendance and/or admission. The Team provides an urgent response 24 hours a day, 7 days a week, using a dedicated enhanced nursing, Allied Health Professional and carer workforce support people to remain at home during the day and overnight.

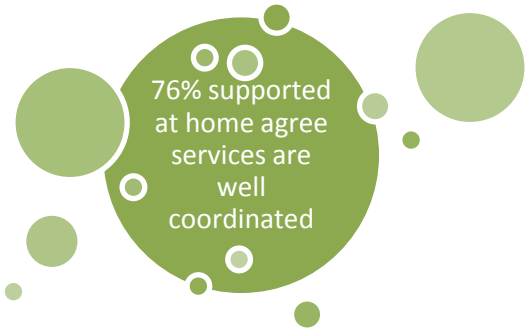
At the moment, the team's work falls mainly into these categories:

- Assessment of unwell patient (diagnosis has been made but the patient has additional needs or is deteriorating and is at risk of hospital admission)
- Rapid assessment of an uninjured faller
- Discharge facilitation
- Working on "acutely unwell adult" pathway where there is no diagnosis, using the GP fellows to provide the medical input.

Since February 2018, phone referrals to the team have been picked up by Advice Line For You (ALFY). It is very early days but initial improvements are that a **broader range of options are available to referrer**; and that some clinical staff time is freed up.

Work with night nursing is ongoing to ensure a more equitable response both in and out of hours.
A direct access pathway for the Enhanced Community Team to care homes have helped to support hospital discharges and Forth Valley Royal Hospital.

The Closer to Home Team continue to take direct referrals from the Scottish Ambulance Service for unwell, uninjured falls patients as part of a national initiative to **reduce the number of falls patients being conveyed to hospital following a fall**. This is being rolled out further as part of implementation plan.



Case Study - Closer To Home

MrsT had recently been in hospital following treatment for an infection. She had a number of other conditions which left her vulnerable to further admission, but had expressed a wish to avoid a return to hospital. When she developed a cough and further signs of infection, she was visited by the Closer To Home Team who were able to provide her with appropriate medication as well as an oxygen concentrator.

Heath Care Support Workers visited Mrs T for a short period and a Telecare [MECS] alarm was installed. Mrs T was discharged from the Closer to Home service after 7 days.

In 17/18 people aged 75+ spent less days in hospital waiting to be discharged

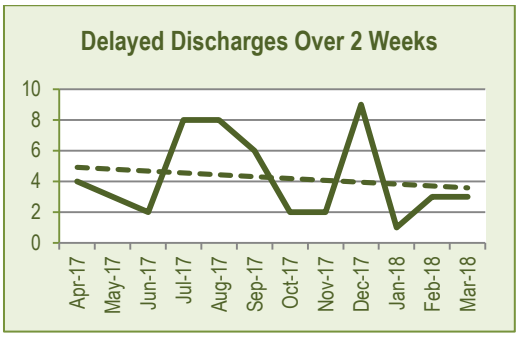
In 17/18 we spent 22% of our budget on emergency hospital stays

Delayed Discharge & Unscheduled Care

We continue to work together to reduce our delays to discharge and redesign our services to support avoidance of unnecessary admission.

This work is driven by the Unscheduled Care Programme Board and Delayed Discharge Steering Group, regular performance management reports, and a discharge improvement plan. We are working together around the whole systems 6 Essential Actions Plan.

'Daily Dynamic Discharge' is a 'Test of Change' ongoing within Stirling Community Hospital where there are daily and weekly meetings between Health and Social Care staff. It is early days but staff feel that patient flow and discharge appears to have been quicker since implementation.



Source: FV NHS 17/18

At the end of 2017/18 our performance for all delayed discharges continues to be in the second highest quartile nationally. Our performance in the graph shows some peaks and troughs but there continues to be a positive general downward trend for 17/18.

The Partnership is well below comparators and national average when looking at all delays in the table below.

As at March 18	Number of all delayed discharges			
	16/17	17/18		
Partnership	23	24	Benchmark	✓
Comparators	34	33		
Scotland	41	43		

Source: ISD 17/18

Trends are also improving for:

- Patients are spending less time in hospital waiting to move back to community.
- The number of days is reducing for patients who are admitted to hospital as an emergency.
- Especially for those who are older or frail.

These indicators form part of the key targets agreed with Ministerial Strategic Group for Health and Community Care.

3. Transforming Care: The Enablers

This section of the Annual Performance Report outlines the supporting activities (the underpinning Enablers) which involves re design activity, but is also about information, research, or planning work that help us to understand our population and services.

Strategic Needs Assessment

The existing needs assessment informed our Strategic Plan, and we are currently refreshing this information focussing on key priority areas.

- We know that both Clackmannanshire and Stirling have an ageing population.

> The number, and proportion, of older adults across Clackmannanshire and Stirling is projected to double, and our area will have growing numbers of individuals living with long term conditions, multiple conditions and complex needs.

We need to continue to work together to redesign our services to meet the needs of our population.

- We know that there are **inequalities**. There is a difference in life expectancy of men and women in the most and least deprived areas.
- Life expectancy in Stirling is higher than in Scotland in both the most and least deprived areas.
- There are a high proportion of women who face additional inequalities through disability and/or unpaid caring responsibilities in Clackmannanshire.

Technology Enabled Care

The Partnership secured grant funding from the Scottish Government's Technology Enabled Care (TEC) programme, and focussed on increasing users of telecare. The target of 500 more users over 16/17 and 17/18 was exceeded with a total of 1,226 new users by March 2018.

Increasing the use of technology has played a key role in supporting people with more complex needs to remain safely at home:

- Technology such as 'Just Checking' is now used regularly to support

reablement and home care assessment.

- Technology supports have also been central to reshaping overnight care and enabling independence.
- Improved relationships with other partners such as Scottish Fire and Rescue Service and Scottish Ambulance Service have been developed

Case Study

Fraser lives with a significant brain injury following a serious fall, and had previously used our Reablement and TEC services when he was discharged from hospital to stay with his parents. However, Fraser had expressed a wish to return to his own home, and so the service worked with him and his family to identify the appropriate personal outcomes to make this happen.

the TEC service installed Just Checking as an environmental monitoring tool, following assessment and input from the Reablement team. This helped to build a picture of Fraser's daily routine, and reduced concerns raised by his mother.

By working together, the service was able to support Fraser to improve his confidence, reduce his risks and build his self esteem and relationships with care providers. This also supported his family to make this transition for his future.

Housing and Social Care Contribution

The population projections raise questions about current local housing provision and the capacity of housing support services to ensure effective delivery for older people. The multi-agency Housing and Social Care Group ensures joint working around key areas.

Older people living in the community who are vulnerable, often with complex medical conditions are a priority area for Local Housing Strategies.

Homelessness affects a small proportion, of households in the area, but the impact on lives including health and support issues can be high.

Data Sharing & Shared Assessments

We work within the Forth Valley Data Sharing Partnership to take forward the following priorities:

- Single Shared Assessment
- Information Sharing Portal
- File Sharing

Data sharing and shared assessment processes such as our single, shared assessment have the potential to reduce duplication and improve service user and carer experience.

Commissioning: Market Postion & Providers

We recognise that commissioning, procurement and contract monitoring can act as drivers for transformational change, and challenge existing models of service delivery.

Our Market Position Statement sets out key pressures, and messages about future priorities. The Statement and Market Facilitation Plan describes how we will work with providers to deliver high quality, person-centred and cost effective services and supports.

We used the Action Learning Set method facilitated by the Improvement Hub. Working with a range of staff and a local provider, to provide a shared understanding, greater ownership, and more joined up processes around overnight care.

Commissioning Plans are now in place for Learning Disability and Mental Health Services.

Joint Provider Forums are also in place to ensure dialogue and information sharing.

We are now working on the Commissioning Plan for Older People's services.

Workforce

Our workforce plays a key role in the delivery of our priorities. We have agreed and developed:

- Integrated Workforce Plan (2016-19)
- Partnership Development and Training
- Communication and Engagement Protocol & Engagement Strategy

Our Workforce Plan shapes the approach to planning for capacity and skills and is key to the delivery and re design of services. Work is ongoing to refresh the Workforce Plan to reflect the changing patterns, needs, and skills.

A Transforming Nursing Group has been established to future proof community nursing in the Partnership.

During 17/18 staff engagement events have begun to focus more on the detail of the operational delivery of some of the key elements of the Transforming Care programme reflecting the current stage of our journey – this has included sessions relating to:

- Clackmannanshire Service Planning
- Neighbourhood Care Team
- Health & Care Village – Bellfield Centre
- Innovation events in Clackmannanshire

We carried out a survey of social care staff using an adapted form of iMatter with a view to full roll out of iMatter across health and social care services next year. The response to the survey was encouraging with most responses indicating a positive level of commitment from the workforce.

Over 60% of Social Care staff were very or fairly satisfied with their job.

Unpaid Carers

Health and Social Care Partnerships have been identified as having the lead role in the effective implementation of the Carers (Scotland) Act 2016 for adults. We worked together with Carers Centres to prepare for implementation of the Act from April 2018, and will continue this work over the next year.

Carers Centres play an essential role in implementing the Act. Over the next year we will commission a review of the services within the Partnership.

- Identification of carers and awareness of supports remains a challenge particularly with some groups of carers.
- Further work is required to scope the elements required in acute NHS services including the duty to involve carers in discharge planning.

Financial Plan

We will continue to utilise current Partnership funding plans, including the Integrated Care Fund (ICF), Delayed Discharge Funds, Technology Enabled Care, Out of Hours and the Primary Care and Mental Health Transformation Funds to support our Transforming Care Programme, aligned to the Strategic Plan priorities.

The Partnership has been working with a Glasgow Caledonian University research programme funded by the Chief Scientists Office of the Scottish Government Health and Social Care Directorate to develop the first framework for making difficult social and healthcare decisions which integrates economics, decision-analysis, ethics and law to be applied in this new context of shifting the balance of care.

Financial Performance

The funding available to the Integration Joint Board to support the delivery of the Strategic Plan comes from payments from the constituent authorities (Clackmannanshire and Stirling Councils and NHS Forth Valley), the Set Aside budget for Large Hospital Services and partnership funding allocated from Scottish Government.

The Integration Joint Board then issues directions to the constituent authorities to utilise the funding available to deliver and/or commission services across the partnership on it's behalf to deliver the priorities of the Strategic Plan.

For the financial year ended 31 March 2018 a balanced financial position is reported. However, it is important to understand that this position has been achieved through a combination of budget recovery actions, utilisation of £1.145m of reserves of the Integration Joint Board and additional non-recurrent contributions for 2017/18 only from the constituent authorities on an agreed risk share basis. The Partnership's underlying financial position is a net deficit of £2.746m which requires to be addressed, along with other pressures in 2018/19 to achieve financial balance.

The expenditure of the Integration Joint Board for year ended 31 March 2018 is detailed in tabular form below. These figures are subject to statutory audit.

Service Area	£'000
Set Aside Budget for Large Hospital Services (Note 1)	19,985
Adult Social Care: Clackmannanshire Locality	16,539

Adult Social Care: Urban and Rural Stirling Localities	32,383
Health Services under Operational Responsibility of Integration Joint Board	33,543
Universal Family Health Services including Primary Care Prescribing	67,034
Integration (Social) Care Fund	8,860
Shared Partnership Posts	262
Transformation	3,086
TOTAL EXPENDITURE	**181,692**

Note 1. Relates to Large Hospital Services Delivered in the Acute Sector for which the IJB is responsible for Strategic Planning but not Operational Delivery.

Best Value

Clackmannanshire Council and Stirling Council and NHS Forth Valley (the constituent authorities) delegate budgets, referred to as payments, to the Integration Joint Board which decides how to use these resources to achieve the objectives of the Strategic Plan. The Board then directs the partnership through the constituent authorities to deliver services in line with this plan.

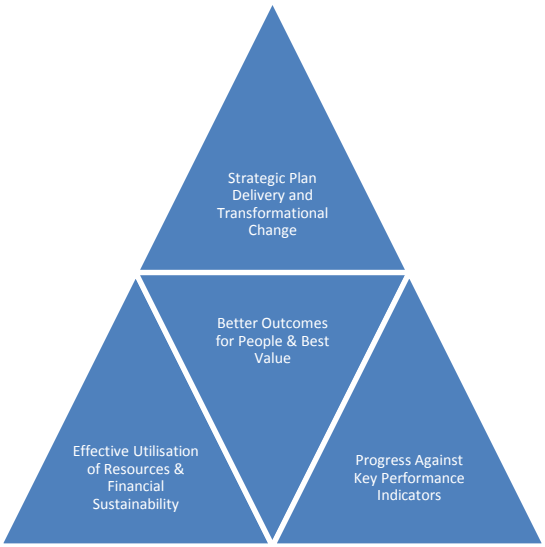
We are working to improve our evidence based approach to decision making in relation to investment and disinvestment priorities and have been working alongside the Scottish Government lead on commissioning as part of a national research programme led by Glasgow Caledonian University on the impact of a decision making framework in health and social care services.

The governance framework is the rules, policies and procedures by which the Integration Joint Board ensures that decision making is accountable, transparent and carried out with integrity. The Integration Joint Board has legal responsibilities and obligations to its stakeholders, staff and residents of Clackmannanshire and Stirling Council areas.

Clackmannanshire and Stirling Integration Joint Board ensures proper administration of its financial affairs by having a Chief Financial Officer (section 95 of the Local Government (Scotland) Act 1973).

The Integration Joint Board has also reviewed its committee structure in 2017/18. It has an established Audit Committee and has approved the establishment of a Finance Committee to improve scrutiny and financial governance.

As part of governance arrangements to oversee the change programme the Chief Officer chairs both a Senior Leadership Group and Joint Management Team to oversee the change programme.



The Partnership views the triangulation of key performance indicators, measureable progress in delivering the priorities of the strategic plan, and financial performance as forming the cornerstone of demonstrating best value. Therefore the evidence of best value can be observed through:

- The Performance Management Framework and Performance Reports
- Financial Reporting
- Reporting on Strategic Plan through both the Chief Officer's reports to the Integration Joint Board and topic specific reports.

This approach is visually represented in the Best Value Diagram above.

"All performance reports clearly state that, in order to ensure a sound basis for decision making and prioritisation, performance information should be read alongside financial reports to give a rounded view of the overall performance, best value and financial sustainability of the Partnership."

Internal Audit Review - Performance Management and Reporting

Financial Reporting on Localities

The 2017/18 financial information is not split into localities. Locality level financial reporting will be a key focus for development in 2018/19.

Integrated Care Fund

The Partnership received £2,480,000 from the Integrated Care Fund (ICF) from Scottish Government during 2017/18. The spending priority was to support our strategic priorities.

Funding was allocated under the following areas:

- Test and Deliver action to ensure a responsive 24/7 Health & Social Care Model
- Develop and Extend intermediate care model to all adults – particularly implement a dementia intermediate care pathway
- Embedding a range of person centred anticipatory and prevention planning – across areas of poverty and high multi morbidity
- Extending Community Based Supports
- Direct Support to Carers
- Communications, Navigation/Way Finding
- Targeted Resource to Support Lifestyle Change
- Enablers for Transformational Change
- Bridging to Stirling Care Village

To ensure Partnership investment is providing good value, and that projects are sustainable, further reviews have been carried out and will continue to be revisited regularly throughout the duration of the programme. Work is ongoing to identify linkages and collaborative working in order to improve service delivery and ensure financial efficiencies.

We are working with Glasgow Caledonian University as part of a national programme to develop ways funded projects and services are monitored and reviewed. We will continue to develop this approach during 18/19.

4. Outcomes: Our Performance

National Outcomes & Our Local Framework

Integration Joint Boards are responsible for effective monitoring and reporting on the delivery of services and relevant targets and measures, included in the Integration Functions and as set out in Strategic Plans.

The Scottish Government has developed National Health and Wellbeing Outcomes, supported by a Core Suite of Integration Indicators to provide a framework for Partnerships to develop their performance management arrangements to help them understand how well services are meeting the individual outcomes of people using services and for communities.

The national outcomes are-

- **Outcome 1:**People are able to look after and improve their own health and wellbeing and live in good health for longer
- **Outcome 2:** People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting
- **Outcome 3:** People who use health and social care services have positive experiences of those services, and have their dignity respected
- **Outcome 4:** Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services
- **Outcome 5:** Health and social care services contribute to reducing inequalities
- **Outcome 6:** People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being
- **Outcome 7:** People using health and social care services are safe from harm
- **Outcome 8:** People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide
- **Outcome 9:** Resources are used effectively and efficiently in the provision of health and social care services

To support the delivery of the national priorities Partnerships were invited to set out local improvement objectives and agree targets for the following supporting key areas:

Performance Measures & Improvement Objectives

- Accident & Emergency Performance
- Unplanned Admissions
- Bed Days Unscheduled Care
- Delayed Discharges
- Care In Community For Age 75+

The progress around these measures is overseen by the Forth Valley Unscheduled Care Programme Board. Partnership and some locality data is being provided by national sources.

We have developed a Strategy Map which helps us to clearly link the outcomes to the Strategic Plan, and will review this map over the 18/19 period.

The Outcomes are supported by a Core Suite of Integration Indicators. This data is provided nationally by the Information Services Division of the Scottish Government to each Partnership. The unique nature of our Partnership means that sometimes our data may be provided at local authority level only. However there has been progress over the last year in receiving national data at a Partnership level, and performance reporting to the Integration Joint Board is now provided from this perspective.

We will continue to refer to historical data at local authority level where appropriate because historical trend information for the two areas is very useful to help inform locality planning.

Some local data is now being extracted at locality level and this will increase over the 18/19 period, to inform the Strategic Planning Group (who over see Locality Planning within the Partnership).

We will continue to benchmark against similar Partnerships to give a context around progress.

The Local Outcomes come directly from the Strategic Plan and were created to address the key challenges highlighted in the Strategic Needs Assessment to ensure that the outcomes are consistent with the views of people who use services, their unpaid carers and communities.

Our Performance: A Summary

Indicators 1-9 of the core indicators draw on questions from the Health & Care Experience Survey. The Partnership set baseline data in the first annual report, due to publication timescales this was the most current data available at the time of production.

Core Suite of Integration Indicators - Annual Performance (as at June 18)

	Indicator	Title	Partnership	Comparator Average	Scotland
Outcome indicators	NI - 1	Percentage of adults able to look after their health very well or quite well	94%	94%	93%
	NI - 2	Percentage of adults supported at home who agreed that they are supported to live as independently as possible	82%	80%	81%
	NI - 3	Percentage of adults supported at home who agreed that they had a say in how their help, care, or support was provided	74%	74%	76%
	NI - 4	Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated	76%	74%	74%
	NI - 5	Total % of adults receiving any care or support who rated it as excellent or good	78%	80%	80%
	NI - 6	Percentage of people with positive experience of the care provided by their GP practice	87%	82%	83%
	NI - 7	Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life	79%	79%	80%
	NI - 8	Total combined % carers who feel supported to continue in their caring role	38%	37%	37%
	NI - 9	Percentage of adults supported at home who agreed they felt safe	86%	83%	83%
	NI - 10	Percentage of staff who say they would recommend their workplace as a good place to work	NA	NA	NA

Core Suite of Integration Indicators - Annual Performance (as at June 18)

	Indicator	Title	Partnership			Comparator Average	Scotland
			Baseline	Current			
			15/16	16/17	17/18		
Data indicators	NI - 11	Premature mortality rate per 100,000 persons aged under 75 years	425	389	NA	401	440
	NI - 12	Emergency admission rate (per 100,000 adult population)	10,367	10,010	10,699	11,762	11,959
	NI - 13	Emergency bed day rate (per 100,000 population)	118,775	111,969	109,934	118,993	115,518
	NI - 14	Readmission to hospital within 28 days (per 1,000 population)	103	105	104	103	97
	NI - 15	Proportion of last 6 months of life spent at home or in a community setting	86%	87%	87%	88%	88%
	NI - 16	Falls rate per 1,000 population aged 65+	18	16	20	20	22
	NI - 17	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	82%	86%	94%	86%	83%
	NI - 18	Percentage of adults with intensive care needs receiving care at home	69%	67%	NA	62%	62%
	NI - 19	Number of days people aged 75+ spend in hospital when they are ready to be discharged (per 1,000 population)	640	723	516	793	772
	NI - 20	Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	23%	22%	22%	25%	23%
	NI - 21	Percentage of people admitted to hospital from home during the year, who are discharged to a care home	NA	NA	NA	NA	NA
	NI - 22	Percentage of people who are discharged from hospital within 72 hours of being ready	NA	NA	NA	NA	NA
	NI - 23	Expenditure on end of life care, cost in last 6 months per death	NA	NA	NA	NA	NA

Source: ISD are still developing these indicators and NA defines where no data is available yet. Comparators: South Ayrshire, East Lothian, Angus, Moray, Perth & Kinross, Falkirk. Figures as at May 2018

Our Performance : In Detail

This section outlines the Partnership's performance in each of the national Health and Wellbeing Outcomes where national data is available.

Outcome 1

People are able to look after and improve their own health and wellbeing and live in good health for longer.

NI 1	% of adults able to look after their health very well or quite well	
	15/16	17/18
Partnership	94%	94%
Comparators	95%	94%
Scotland	94%	93%

Source ISD 17/18

The percentage reflects a positive position and is similar to national and comparator average. The vast majority of those surveyed reporting that they are **able to look after their own health and wellbeing** and did not have any limiting illness or disability.

Outcome 2

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

NI 2	% of adults supported at home who agree that they are supported to live as independently as possible	
	15/16	17/18
Partnership	85%	82%
Comparators	83%	80%
Scotland	84%	81%

Source ISD 17/18

This indicator reflects whether people who need support feel that it helps them maintain their independence as much as possible. **This is a positive reflection of the support provided by the Partnership to those living in the community.**

Table Symbols			
	Benchmark		Survey
	Achieved		More work required

Outcome 2 cont'd

This is an area prioritised through the Integrated Care Fund to support the development of services such as bed based intermediate care and reablement care at home. **Other improvements being made are through outcome focussed assessments which are supporting the embedding of Self-directed Support**.

NI 18	% of adults aged 18+ with intensive care needs receiving care at home	
	15/16	16/17
Partnership	69%	67%
Comparators	62%	62%
Scotland	62%	62%

Source ISD 16/17

The figure for the Partnership is a positive position. This indicator reflects the **work to shift care from hospitals and care homes to the community**.

The rising trend of care at home hours is similar to national trends, and the number of clients is similar to our peers. However the number of actual hours is much higher than similar partnerships. This may be reflecting in some part the **above average for the % of the population living in the community with support**.

NI 15	Proportion of last 6 months of life spent at home or in a community setting	
	16/17	17/18
Partnership	87%	87%
Comparators	87%	88%
Scotland	87%	88%

Source ISD 17/18

The 17/18 figure for the Partnership reflects a positive position, overall this is a rising trend and the Partnership is aiming to achieve 90% by the end of 2019.

We are doing this through core funded Out of Hours Palliative Care and Cancer Helplines, and initiatives include the Hospice at Home Project, night time MECS and nurse wound support.

The End of Life and Palliative Care Transformation Group is exploring the need for redesign of this patient pathway, workforce and communication.

The development of the Health and Care Village may impact this figure when it moves to a full community based model. This will **better support the delivery of more effective, person centred end of life care for residents** of the Partnership.

Outcome 3

People who use health & social care services have positive experiences of those services, and have their dignity respected

NI 3	% of adults supported at home who agree that they had a say in how their help, care or support was provided	
	15/16	17/18
Partnership	79%	74%
Comparators	79%	74%
Scotland	79%	76%

Source ISD 17/18

The figure has reduced since the last survey reflecting national trends. We have further work to do to **more fully embed choice and control.**

NI 6	% of people with positive experience of the care provided by their GP practice	
	15/16	17/18
Partnership	87%	87%
Comparators	87%	82%
Scotland	87%	83%

Source ISD 17/18

The figure for the Partnership reflects a positive position. **GP services are central to the delivery of community based health and social care services** and the Partnership continues to work together to support Primary Care services through, for example, investment of the Primary Care Transformation Fund and the developing cluster and Locality work.

NI 5	% of adults receiving any care or support who rate it as excellent or good.	
	15/16	17/18
Partnership	80%	78%
Comparators	82%	80%
Scotland	81%	80%

Source ISD 17/18

The figure for the Partnership reflects a positive position and is only slightly less than national. **Services are provided by a range of organisations and are guided by the Partnership's commissioning strategies and most are regulated by the Care Inspectorate** [NI17]. For those services directly provided by the Partnership, a proactive approach is taken in regard to complaints and learning from them to make improvements.

Outcome 4

Health and social care services are centred on helping to maintain or improve the quality of life of service users.

NI 7	% of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life	
	15/16	17/18
Partnership	77%	79%
Comparators	85%	79%
Scotland	84%	80%

Source ISD 17/18

The figure for the Partnership is a positive one and similar to the national average. Within the Neighbourhood Model of Care work we have developed an **outcomes focussed framework, which will be rolled out across the Partnership** area. The Partnership will review and identify any areas for further development.

NI 12	Emergency Hospital Admission Rate per 100,000 adult persons	
	16/17	17/18
Partnership	10,005	10,699
Comparators	11,456	11,762
Scotland	12,294	11,959

Source ISD 17/18

The NI 12 rate is a positive position in comparison to national and comparator figures. Although the rate of admissions in 17/18 has risen on the previous year, along with other similar Partnerships, this may reflect the rise in emergency admissions around the winter months (Nov-Jan) when Flu admissions were challenging.

It is important to note, that **although more people were admitted in 17/18 the length of time they are staying in hospital is reducing** [NI13].

The Partnership is aiming to achieve a 5% baseline reduction on admissions by 2019.

NI 13	Emergency bed day rate per 100,000 adult persons	
	16/17	17/18
Partnership	111,969	109,934
Comparators	128,090	118,993
Scotland	125,634	115,518

Source ISD 17/18

The NI 13 figure is less than the previous year and lower than national and comparator average. **This means that people are not staying as long when they are admitted to hospital in an emergency.**

Bed usage is monitored in hospitals through the Day of Care Audit, and the community hospital audit is showing a reduction for those who are still in hospital but don't medically need to be there. Pilot work called the 'daily dynamic discharge' continues in the 2 community hospital wards.

NI 14	Readmission to hospital rate within 28 days per 1,000 persons	
	16/17	17/18
Partnership	105	104
Comparators	106	103
Scotland	100	97

Source ISD 17/18

The NI14 rate has improved on the previous year and similar to our comparators. This is a crude measurement that does not consider the reason for the readmission which might be different to the original admission.

Within Forth Valley the readmissions data is standardised by specialty and condition at readmission. This means that it only counts those who return to the same speciality within 28 days. This local figure shows a reducing trend in readmissions for the Partnership.

NI 16	Falls rate per 1,000 population aged 65+ who were admitted to hospital as an emergency	
	16/17	17/18
Partnership	16	20
Comparators	23	20
Scotland	22	22

Source ISD 17/18

The 17/18 figure for the Partnership reflects a positive position. Although higher than the previous year it is within tolerance. **Examples of work in this area are the development of the Falls Pathway and expanded Technology Enabled Care services such as personal alarms and responder services.**

NI 17	Proportion of care services graded 'good' (4) or better in Care Inspectorate Inspections	
	16/17	17/18
Partnership	86%	94%
Comparators	80%	86%
Scotland	84%	83%

Source Care Inspectorate/ISD 17/18

The NI 17 figure reflects a positive position and is higher than the national and comparator average. This indicator includes all services registered within the Partnership provided by third, independent and local authorities.

Partnership commissioners work closely with the Care Inspectorate. Quarterly liaison meetings take place to share local knowledge and best practice as an early intervention mechanism to identify and act upon any intelligence gathered.

Outcome 5

Health &social care services contribute to reducing health inequalities

NI 11	Premature mortality rate per 100,000 persons aged under 75 years old	
	15/16	16/17
Partnership	425	389
Comparators	387	401
Scotland	441	440

Source ISD 2016

The Partnership figure is lower than our comparators and national average. This is a positive figure. The refresh of the Partnership Strategic Needs Analysis will give further insight in 18/19. In the meantime, the Partnership will **continue to explore and address inequalities through locality planning and communities collaboration.**

Outcome 6

People who provide unpaid care are supported to reduce the potential impact of their caring role on their own health and well-being.

NI 8	% of carers who feel supported to continue in their caring role	
	15/16	17/18
Partnership	34%	38%
Comparators	43%	37%
Scotland	41%	37%

Source ISD 17/18

This indicator highlights a need to continue to work closely with unpaid carers and our local carer organisations to develop our services in line with the provisions of the Carers (Scotland) Act 2016 and to focus on the way we gather local feedback on the experiences of unpaid carers. Improvement work around Self-directed Support and the Dementia pathways will ensure resources are outcome based and available within the community.

Outcome 7

People who use health and social care services are safe from harm.

NI 9	% of adults supported at home who feel safe	
	15/16	17/18
Partnership	82%	86%
Comparators	85%	83%
Scotland	84%	83%

Source ISD 17/18

The figure has improved on the last survey and is positive for the Partnership. It reflects the joint work **with the Adult Support and Protection Committee and the Lead Officer to improve our responses**.

The Social Care staff survey reported that over 80% of staff within the Partnership agreed that the service their team provides is successful in helping people to remain safe from harm.

Adult Support and Protection activity has increased throughout the year. With 806 referrals, 147 investigations, and 22 case conferences.

Outcome 8

People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.

NI 10	% of staff who say they would recommend their workplace as a good place to work
Partnership	N/A
Comparators	N/A
Scotland	N/A

Source ISD 15/16

Although there is no national data available, in a Social Care staff survey across the Partnership in 2017, **just over half of the staff said they would recommend their organisation as a good place to work.**

There are a number of pieces of work carried out locally that support this outcome; iMatters is the staff experience continuous improvement tool designed with NHS Scotland to help individuals, teams and Partnerships understand and improve staff experience. It is hoped that by 2019 we will be able to use this tool across all of the health and social care Partnership.

Outcome 9

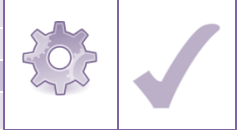
Resources are used effectively in the provision of health and social care services, without waste.

NI 4	% of adults supported at home who agree that their health and care services seemed to be well co-ordinated	
	15/16	17/18
Partnership	74%	76%
Comparators	78%	74%
Scotland	75%	74%

Source ISD 17/18

This is a positive figure for the Partnership. In terms of service examples, work carried out in relation to the use of single shared assessment, Anticipatory Care Plans, and the development of the model of neighbourhood care will provide further opportunity **to develop community based integrated responses.**

NI 19	Number of days people aged 75+ spend in hospital when they are ready to be discharged per 1,000 population	
	16/17	17/18
Partnership	723	516
Comparators	964	793
Scotland	842	772



Source ISD 17/18

The 17/18 Partnership figure reflects a positive position and is much lower than last year. Reflecting the positive work being done in both Unscheduled Care and Delayed Discharge.

NI 20	% of Health & Social Care spend on hospital stays where the patient was admitted in an emergency			
	16/17	17/18		
Partnership	22%	22%		
Comparators	26%	25%		
Scotland	25%	23%		

Source ISD 17/18

The time spent in hospital wards following emergency admission has reduced in 17/18

The 17/18 Partnership figure reflects a positive position and the rate is lower than comparator average. It reflects the reduction in delayed discharges, admissions, and the shift to receiving support within the community.

The time delays for those clincally ready to leave hospital has reduced in 17/18

Inspections

The Care Inspectorate undertook both scheduled and unscheduled inspections across 9 services during 2017/18. The quality of care and support was assessed as 'good' or 'better' in 89% of these inspections. This is a reduction in performance from last year and is due to an 'adequate' environmental rating in Menstrie House. There were 3 mandatory requirements and a number of recommendations made by Inspectors, which have all been actioned by staff. Additional information and full detail on inspections can be found at the Care Inspectorates website www.careinspectorate.com

Unit	Date Inspection Completed	Quality Theme Care Grades (out of 6)				Number of recommendations	Number of requirements
		Care and Support	Environment	Staffing	Management & Leadership		
Allan Lodge	02/06/17	5	N/A	N/A	5	1	1
Beech Gardens	09/01/18	5	N/A	N/A	5	0	0
Clacks Reablement and TEC Service	19/01/18	5	N/A	5	N/A	0	0
Stirling Reablement and TEC Service	20/11/17	5	N/A	4	N/A	2	0
Ludgate House Resource Centre	12/01/18	6	5	N/A	N/A	0	0
Menstrie House	25/10/17	4	3	N/A	N/A	5	2
Strathendrick Care Home	19/02/18	5	N/A	5	N/A	0	0
Streets Ahead	02/05/17	5	N/A	5	N/A	1	0
Whins Resource Centre	26/01/18	5	N/A	5	N/A	0	0

Source

Key to grading:
1. Unsatifactory
2. Weak
3. Adequate
4. Good
5. Very Good
6. Excellent

Rec - A recommendation sets out actions that a provider should take to improve or develop service quality, but where failure to do so would not directly result in enforcement.

Req - A requirement sets out what a care service must do to improve outcomes for people who use services and must be linked to a breach in statutory requirements. Requirements are enforceable in law.

Inspection Requirements and Recommendations

Unit	Action
Allan Lodge	
Requirement - To ensure the safety and well-being of people the provider must ensure that the Care Inspectorate are notified within 24 hours of any unforeseen event including accidents and incidents resulting in harm or injury to a person using the service which results in: - a GP visit - a visit or referral to hospital - an injury reportable under Reporting of Injuries, **Timescale: Immediate**	Senior and Admin Staff to have training on the Care Inspectorate website/eforms. This will enable them to notify the Care Inspectorate of any events including accidents and incidents. Senior and Admin Staff will now notify Care Inspectorate as part of the Allan Lodge reporting accident incident procedure. Timescale: Immediate - This action is complete
Recommendation - It is recommended that the manager works with staff to improve the quality of care planning evaluation to make sure known needs and risks are clearly identified with guidance on how they should be managed or minimised. Care plans should be subject to robust evaluation, to establish the effectiveness of the care being delivered for the benefits of those using the service.	Allan Lodge Care Plan Audit documentation to be reviewed. Audit documentation to be more meaningful and include an evaluation process which clearly establishes the effectiveness of the care being delivered to service users. Timescale: Immediate - This action is complete.
Stirling Reablement and TEC Service	
Recommendation - Six-monthly reviews of people's support needs should be planned and consistent. Review visits should evidence discussion of service user's support, if it continued to meet their needs, future needs and include any points of discussion with service users or their representative.	An alert will be added to our new schedule system to inform Care Coordinator a 6th monthly review is due. This involves approximately 8 people at this time. The Service will ensure discussions with the Service user and/or with their representative, will be clearly recorded and will reflect any discussions and any changes to their care needs. The service will work alongside Adult assessment to ensure any changes to their care needs are updated on their support plan. Timescale: March 2018 This action is complete
Recommendation - The service will ensure that supervision is a priority for all staff as a key aspect of their learning. Use of management practices such as supervision, appraisal, observed practice and care audits should be further developed to guide staff and support the services quality assurance practices.	A rolling programme for one to one and group supervision is in place. Team leader and Care Co-ordinators will observe group supervisions to ensure these are around good reflective practice and sharing information. All Seniors and Care Co-ordinators have or are in the process of completing PDA in Supervision. Staff participation group will be further established to ensure all staff are involved in service development and learning. Team leader and Care Co-ordinators will ensure supervision is a priority for the team, this is non-noticeable. The Team Leader and Care Co-ordinators are aware of the importance one to one and group supervision and will strive to ensure they are maintained. Care audits and any other quality assurance audits will be continued to be developed and ensure recordings are appropriate and any actions are completed. Timescale: June 2018 - Actions are complete.
Menstrie House	
Requirement - The provider must ensure that people who use the service have access to a reliable and efficient room alarm system. When a person cannot operate the room alarm system then a risk assessment should be completed and incorporated into the care plan. Timescale: To be in place by 31 March 2018	Capital bid previously submitted to the senior management team for upgrade /replacement of existing call system prior to inspection. Meetings have already taken place with suppliers and costings being sought for the appropriate call system that will be in place by 31st March 18. In the event of the call system breaking down staff will provide regular checks to residents throughout the day and night. Where there is a risk of a resident being unable to operate the room alarm system there are risk assessments in each care plan to identify the risk and there are regular checks carried out throughout the day and night. Timescale: 31st March 2018 This action is complete

Unit	Action
Menstrie House	
Requirement - The home should be maintained and decorated to a good standard. Maintenance to bathrooms, bathing equipment and communal toilets should be rectified without unnecessary delays. Timescale: To be completed by 31 March 2018.	Meetings have taken place with facilities management to identify work that needs carried out, costings sought and manager currently seeking to identify funding for maintenance required for upgrade of areas highlighted in this report. Timescale: 31st March 2018 This action is complete
Recommendation - Cleaning records should evidence the required frequency of cleaning in the specified areas has been carried out.	Facilities Management manage the domestic staff within Menstrie House. The manager of Menstrie House has arranged a monthly meeting between Facilities management and their staff to discuss cleaning schedule throughout the month. During the meeting the supervisor and manager of Menstrie House will check cleaning schedules to ensure all areas have been cleaned and signed by staff. Timescale: within 1 month / Dec 17 - Actions are complete.
Recommendation - Regular maintenance checks should be evidenced and carried out for profiling beds and window restictors within the recommended frequencies.	The property maintenance team have provided the service with a copy of all relevant paperwork regarding regular maintenance checks. A monthly check list for window restrictors was put in place by the end of October 17. The property maintenance team have been instructed to arrange a yearly contract with Arjo for testing of Profiling beds. Timescale: March 2018 This action is complete
Recommendation - The recording of daily oral health for residents should be implemented and advice and support sought where necessary.	Email sent to NHS re caring for smiles. Awaiting response. Staff are already reviewing caring for smiles and residents care plans are being developed to include good oral hygiene. Timescale: 3 months - Actions are complete.
Recommendation - The recording of cream applications for residents should improve so that it is evidenced the frequency of administering is in accordance with the prescribed instructions.	All Mar charts to be checked at the change of each shift by seniors to ensure creams administered are signed in accordance with prescribed instructions. Timescale: 3 months - Actions are complete.
Recommendation - Care should be taken with the recording of medicated adhesive patches so that it is clear and legible when these have been applied, removed and observed to be in place and that guidance is followed as to where in the body these are applied.	Small workshops will be arranged to discuss protocol and guidance for the recording of medicated adhesive patches. Timescale: 3 months - Actions are complete.
Streets Ahead	
Recommendation –The service provider should ensure that plans of support are signed by the person, or where appropriate, their representative.	6 monthly care provider review will be recorded in new format that welcomes feedback from parents/carers and other provider's as well as service users. Timescale: 3 months – Action complete.
Source Care Inspectorate	

5 Next Steps

This Annual Performance Report highlights the range of activity taking place within and between services as part of the Transforming Care programme. The focus of the activity in this second year has been to jointly work on the actions the Partnership can take together to strengthen and develop the building blocks for community based services.

- We are currently working with iHub to develop our services further and support the step into the Health & Care Village late 2018. The work will feed into the refresh of our Older People's Commissioning Strategy and inform our organisational development plans.

- Work has been taking place to delegate further services from NHS Forth Valley and Stirling Council into a more integrated delivery structure by Autumn 2018.

- We will continue to work with others including housing services to develop opportunities for co-location of services by better use of our joint estate and alternatives to long term care for people such as 'housing with care' in local communities as scoped out within the Strategic Needs Assessment supporting our Housing Contribution Statements.

- We will continue to develop our services and whole systems approaches to support people to be discharged timeously from hospital and to develop our early intervention approaches including the avoidance of unnecessary admission to hospital through, for example, the more recent iHub supported Falls Pathway and Frailty review work across Forth Valley.

- We are currently working on a refresh of our approach to Self- directed Support and will continue to work to embed a culture of services which promote an enabling approach and help us to better manage the available resources in an equitable, transparent manner.

- In Clackmannanshire we are reviewing our day support services for all care groups with a view to establishing integrated day assessment services and are working closely with Primary Care to support new ways of working. Initial work has also taken place to consider options for an integrated front door approach for health and social care services.

- Over the next year we will develop our the next Strategic Plan 2019 – 2022 which will include updating the Strategic Needs Assessment and horizon scanning to assess the impact of key developments such as the Carers Act.

- We will continue to develop the areas identified within our Delivery Plan and work together across all service areas to ensure greater understanding of the impact of our services on individual patients/ service users and their unpaid carers.

- We will review or develop the following key strategic plans:
  - Partnership Carers Strategy
  - Participation & Engagement Strategy
  - Older People's Commissioning Strategy
  - Primary Care Improvement Plan
  - Inspection Improvement Plan
  - Mid-term Financial Plan
  - Workforce Plan

- Implement new national Health and Social Care standards. These Standards set out what we should expect when using health, social care or social work services in Scotland. The objectives of the Standards are to drive improvement, promote flexibility and encourage innovation in how people are cared for and supported.

- The FV Dementia group will look at the piloting of a multi-disciplinary specialist team with clear locality links. This is part of a wider requirement to look at service and community based redesign of supports for people with dementia across Forth Valley in line with the new national dementia strategy. The broad network of groups and services supporting people with dementia, met in January 2018 to look at the commitments contained in the national strategy and where the leadership of these commitments should lie. There are clear links with locality approaches, the neighbourhood models of care and greater emphasis on the needs of carers. The network will meet again in August 2018 to confirm agreed actions and look to work over the next year on refreshing the overarching vision for dementia supports and services.

- Develop our approach to digital health and care services in response to Scotland's Digital Health & Care Strategy.

- Embed appropriate processes to support unpaid carers. As well as completing a commissioning review of services to support unpaid carers.

- Review opportunities to develop housing with care models across the Partnership and care groups

6. Glossary and Abbreviations

Accident & Emergency (A&E or ED) Services	Collectively the term includes for this Partnership: Emergency Departments (Forth Valley Royal Hospital Larbert); Minor Injury Units (Stirling Community Hospital), community A&Es or community casualty departments that are GP or nurse led. See also Emergency Department.
Acute services	A branch of 'secondary' health care where a patient receives short-term treatment for a severe injury or episode of illness, an urgent medical condition, or during recovery from surgery. In medical terms, it is the opposite of chronic or longer term care.
Admission	Admission to a hospital bed in the same NHS hospital following an attendance at an Emergency Department service.
Admission rate	The standardised figure representing the number of admissions attributed to a group or region divided by the number of people in that group (the population).
AHP	Allied Health Professionals are a range of professionals who provide preventative interventions in such areas as supported self-management, diagnostic, therapeutic, rehabilitation and enablement services to support people to live healthy, active and independent lives. They can include; Dietitian, Occupational therapist, Physiotherapist, etc. More information can be found in this link http://www.gov.scot/Topics/Health/NHS-Workforce/Allied-Health-Professionals.
ALFY	A service, supported by NHS Forth Valley and Health & Social Care Partnerships, introduced across Forth Valley to help support older people to remain well at home. The service, which consists of a round-the-clock advice line known as ALFY (Advice Line For You), is available to everyone aged 65 or over as well as family members and other people who may care for them. The dedicated advice line 01324 567247 is operated by experienced nurses.
Anticipatory Care Plan (ACP)	For individuals, particularly those with long term conditions, to plan ahead and understand their health to help have more control and to manage any changes in their health and wellbeing. It's about knowing how to use services better, helping people make choices about their future care.
Attendance	The presence of a patient in an A&E service seeking medical attention.
Attendance rate	The number of attendances attributed to a group or region divided by the number of residents in that group (the population).
Balance of Care	Shifting the Balance of Care describes changes at different levels across health and care systems, all of which are intended to bring about better health outcomes for people, provide services which reduce health inequalities, promote independence and are quicker, more personal and closer to home.
Benchmark	A benchmark is a standard or point of reference against which other things can be compared.
Census	An agreed date to take a snapshot count to measure agreed information e.g. Annual Care Home Census on 31 March and the monthly Delayed Discharge Census on the last Thursday of every month.
Circa	Means about or approximately.
Code 9	This is a very limited category for measuring reasons for delayed discharge from hospital where it has not been possible to secure a patient's safe, timely and appropriate discharge.
Comparator	A group of Partnerships who share agreed similarities. The group is then used to compare performance against. Comparator Partnerships are; Angus, East Lothian, Moray, Perth & Kinross, Falkirk, South Ayrshire.
COPD	Chronic obstructive pulmonary disease is a common lung disease.
Delayed Discharge	A delayed discharge is experienced by a hospital inpatient who is clinically ready to move on to a more appropriate care setting but is prevented from doing so for various reasons.
Discharge to Assess	'Discharge to Assess' approach supporting people to leave hospital, when safe and appropriate to do so, and continuing their longer term care and assessment out of hospital.
Emergency Department (ED)	The department of a hospital responsible for the provision of medical and surgical care to patients arriving at the hospital in need of immediate care. 4 hour wait standard - is that new and unplanned return attendances at an ED service should be seen and then admitted, transferred or discharged within four hours. This standard applies to all areas of emergency care.
Enablers	These are people or things that help to make something happen.
GP Cluster	A grouping of GP practices who work together to discuss the quality of care provided to patients in the locality. Each GP cluster will have a GP designated as a Cluster Quality Lead who will have a coordinating role within the cluster.
GP Fellows	A trial project which aims to develop the skills and experience of recently qualified GPs in caring for older

	people. The doctors, known as GP Fellows, will provide support to a number of local GP Practices, develop strong links with staff in community hospitals and assess patients referred to the Frailty Unit at Forth Valley Royal Hospital.
High Health Gain	The term used for the group of people who collectively account for 50% of the total health expenditure of their local area during the financial year.
Holistic	A holistic approach looks at the "whole" person, not just individual parts.
ICF	Integrated Care Fund. Additional resources available to health and social care partnerships to support delivery of improved outcomes from integration, help drive the shift towards prevention and tackling inequalities. http://www.gov.scot/Resource/0046/00460952.pdf
iHub	Healthcare Improvement Scotland's Improvement Hub (iHub), supports health and social care organisations to redesign and continuously improve services. https://ihub.scot/about/who-we-are/
In Scope	Services that are delegated to the Partnership https://nhsforthvalley.com/wp-content/uploads/2015/04/Clackmannanshire-Stirling-Integration-Scheme.pdf
Integration Joint Board (IJB)	A legal body established under the Public Bodies (Joint Working) (Scotland) Act 2014. The Parties to our IJB are Clackmannanshire and Stirling Councils and NHS Forth Valley. The Parties agreed the Integration Scheme for our Health and Social Care Partnership, which sets out the delegation of functions by the Parties to the IJB.
Intermediate Care/STA	An umbrella term used to describe services which provide a bridge between health and social care with the aim of supporting people to live in their own homes, or in a homely setting, reducing dependence on acute hospital facilities.
iMatter	A staff experience continuous improvement tool http://www.staffgovernance.scot.nhs.uk/monitoring-employee-experience/imatter/
ISD	The Information Services Division (ISD) is a division of National Services Scotland, part of NHS Scotland and provides health information, statistical services and advice to support the NHS in progressing quality planning and improvement in health and care. http://www.isdscotland.org/
Locality Planning	A locality is defined in legislation as a smaller area within the borders of an Integration Authority – their purpose is to provide an organisational mechanism for local leadership of service planning.
MECS	Mobile Emergency Care Service https://www.clacks.gov.uk/social/mecs/ https://my.stirling.gov.uk/services/housing/adapting-homes/telecare
MSG	Ministerial Strategic Group for Health and Community Care agreed an initial framework for measuring progress against national priorities. http://www.gov.scot/Publications/2016/03/4544/5
NI	National Indicator. In this case, the suite of National Core Integration Indicators set by the Scottish Government to help measure performance. http://www.gov.scot/Resource/0047/00473516.pdf
Palliative Care	For people with an illness that can't be cured, palliative care makes them as comfortable as possible, by managing pain and other distressing symptoms. It also involves psychological, social and spiritual support for the person and their family or carers.
Primary Care	The first point of contact for health care for most people, mainly provided by GPs (general practitioners) but community pharmacists, opticians and dentists are also primary healthcare providers.
RAG	Is a quick visual way of identifying areas or concern or progress that is good, not so good, or poor. It refers to the use of colours Red Amber Green.
Reablement	Services for people with poor physical or mental health to help them accommodate their illness, by learning or re-learning the skills necessary for daily living.
Readmission	This indicator measures the percentage of admissions of people who returned to hospital as an emergency within 30 days of the last time they left hospital after a stay.
SAS	Scottish Ambulance Service
Self Directed Support (SDS)	This gives people choice and control over their individual budget which helps to buy services, such as help with dressing and personal care, to help meet agreed health and social care outcomes.
SIMD	Scottish Index of Multiple Deprivation - The area based measurement of multiple deprivation ranking areas. http://www.gov.scot/Topics/Statistics/SIMD
SSSC	The Scottish Social Services Council (SSSC) is the regulator for the social service workforce in Scotland.
Technology Enabled Care (TEC)	Technologies which have the potential to transform the way people engage in and control their own healthcare, empowering them to manage it in a way that is right for them.
Telecare	Telecare is technology to help people to stay living independently at home for longer.
Third Sector	An umbrella term for a range of organisations belonging to neither the public nor private sectors (e.g. voluntary sector or non-profit organisations). http://ctsi.org.uk/
Transformation Care Fund	Primary Care Transformation Fund - allocated over three years to GP practices to prototype the new vision for the GP contract, including those wishing to use new ways of working to address current demand. This work will inform the design of primary care in the future. https://news.gov.scot/news/primary-care-investment
Unscheduled Care	NHS care which is not planned in advance of contact with the relevant healthcare professional, or is care

	which, unavoidably, is out with the core working period of NHS Scotland. Shorter lengths of stay results in better outcomes for patients, reduced risk of healthcare acquired infections, and improved patient flow through hospital systems.

Clackmannanshire & Stirling
Integration Joint Board

13 June 2018

This report relates to
Item 9.1 on the agenda

Financial Report for Year Ended 31 March 2018

Paper presented by
Ewan C. Murray, Chief Finance Officer

For Noting and Approval

Approved for Submission by	Shiona Strachan, Chief Officer
Author	Ewan C. Murray, Chief Finance Officer
Date:	29 May 2018
List of Background Papers / Appendices:	
2017/18 Partnership Budget and Previous Finance Reports	

Title/Subject: **Financial Report for Year Ended 31 March 2018**

Meeting: **Clackmannanshire & Stirling Integration Joint Board**

Date: **29 May 2018**

Submitted By: **Ewan C. Murray, Chief Finance Officer**

Action: **For Noting and Approval**

1. Introduction

1.1. The purpose of this report is to provide the Integration Joint Board with an overview of the financial position for the partnership for the year ended 31 March 2018.

2. Recommendations

The Integration Joint Board is asked to:

2.1. Note the financial position for year ended 31 March 2018, subject to statutory audit.

2.2. Note the resultant reserves position.

2.3. Note the significant variances and financial pressures.

2.4. Approve the issuing of final directions for 2017/18 as appended to this report.

3. Background

3.1. The Integration Joint Board agreed the initial budget for the Partnership for 2017/18, at the special meeting of the Integration Joint Board of 29 March 2017.

3.2. Given the level of financial risk apparent at budget setting the requirement to develop, approve and monitor and budget recovery plan was agreed. Subsequently each financial report to the Integration Joint Board included updated projections including detail on budget recovery actions and the estimated impact of budget recovery measures.

3.3. At this point initial directions were issued to the constituent organisations requiring them to deliver the delegated functions within the defined resource envelopes and in line with the approved Strategic Plan. Constituent authorities are required to report on the use of these delegated resources which is then consolidated to produce financial reports to the Integration Joint Board.

3.4. The financial position detailed in this report was considered by the Integration Joint Board Finance Committee on 28 May 2018.

4. Financial Report for Year Ended 31 March 2018

Summary of Financial Position for Year Ended 31 March 2018

4.1. The financial position is summarised in the table below:

Gross Overspend Before Utilisation of Reserves and Risk Shares	£m
Adult Social Care: Clackmannanshire Locality	1.198
Adult Social Care: Urban and Rural Stirling Localities	0.779
Operational and Universal Health Services	0.624
Gross Overspend	**2.601**
Utilisation of Reserves and Partnership Funding	
General Reserves	0.688
Integration (Social Care) Earmarked Reserves	0.457
Partnership Funding	0.302
Sub-Total	**1.447**
Remaining Overspend Met by Constituent Authorities on Agreed Risk Sharing Basis	**1.154**
Clackmannanshire Council (25%)	0.289
Stirling Council (25%)	0.289
NHS Forth Valley (50%)	0.577
Total Additional Non Recurrent Contributions for 2017/18 Only	**1.154**

4.2. Whilst, after taking account of the additional non-recurrent contributions made by the constituent authorities on the agreed risk share basis for 2017/18 only the partnership will have a balanced budget position, it is important to view this in the context of:

4.2.1. The underlying recurrent budget overspend of £2.746m consisting of the 2017/18 gross overspend and £0.145m of non-recurrent savings within the Operational and Universal Health Services budget in 2017/18 as part of the budget recovery plan. This assumes, on the basis of prudence, that the costs of a number ordinary residence claims currently in dispute are an ongoing cost to the partnership budget at current levels. This may or not be the case and if liability for ongoing costs is established the care packages will be subject to review as is routine professional practice.

4.2.2. The level of reserves utilised in 2017/18.

4.3. The Integration Joint Board accounts for 2017/18 will report a deficit of £1.053m being the overall movement in reserves for the year through the Comprehensive Income and Expenditure Statement (CIES).

4.4. A summary of the overall position as it affects the constituent authorities of the partnership is attached as Appendix 4 to this report.

Significant Variances and Financial Pressures

4.5. The significant cost pressures across the partnership budget have been documented through financial reports to the Integration Joint Board during the financial year.

4.6. The most significant variances and areas of financial pressure are:

4.6.1. In relation to Operational and Universal Health Services

- Family Health Service Prescribing which was overspent by £1.086m
- Community Hospitals which was overspent by £0.195m
- Complex Care which was overspent by £0.272m
- These overspends were partially offset by underspends in District Nursing, Community Allied Health Professionals, Community Mental Health Teams and services provided to promote public health.

4.6.2. In relation to Adult Social Care Budgets:

- The overspend in the Clackmannanshire locality has reduced from a previous projection of £1.373m to an outturn of £1.198m. This outturn includes provision for the ordinary residence claims detailed elsewhere in this report on a 'without prejudice basis' to the outcome of the due process. The significant areas of overspend within these budgets relate to Care at Home, Residential Care in both residential and nursing homes, and Respite Care. The underlying financial position improved considerably at the year end and further work is required on a continuous improvement basis to improve information quality and forecasting. A fuller analysis of budget movements is being prepared to better understand the impact on underlying cost trends. The Internal Audit review in relation to this area is being finalised and is due to be considered by the Audit Committee in June 2018.
- The overspend in the Urban and Rural Stirling localities increased from a previous projection of £0.703m to an outturn of £0.779m overspend. The increase in costs of an ordinary residence case and higher than anticipated costs associated with Stirling Care Village drove the increase in the overspend. The significant areas of overspend within

these budgets relate to Care and Support at Home, Staffing and Respite Care.

4.7. The financial risk associated with the Set Aside budget for Large Hospital Services is currently managed by NHS Forth Valley but is a strategic financial risk for the Partnership as joint accountability frameworks are developed linked to medium term planning. This budget is reporting a £0.842m overspend for financial year 2017/18 based on the extant budget model. The main areas of cost and service pressure within this budget relate to Accident and Emergency Services and Geriatric Medicine and Mental Health Inpatient Services.

Reserves Position

4.8. The IJB Revenue Budget 2017/18 considered by the IJB on 29 March 2017 indicated the intention to use the IJBs financial regime to establish various reserves. The outturn for the financial year has had an impact on the levels of reserves held.

4.9. In line with the position approved by the Integration Joint Board to manage, in part, the overspend for financial year 2017/18 the following reserves have been utilised.

- General Reserves £0.688m
- Integration Fund (Social Care) Earmarked Reserve £0.457m

4.10. The utilisation of resources released through the Partnership Funding Review taken along with expenditure in year has also resulted in a reduction in the earmarked Partnership Funding reserve of £0.298m. The balance of the Partnership Funding reserve has previously been approved by the Board to be earmarked to meet bridging costs for the care model for Stirling Care Village in 2018/19. This will therefore be fully exhausted in year.

4.11. Taken together this means the Integration Joint board has no general reserves remaining to assist in managing financial risk and/or unforeseen events with a financial implication in the coming year, and given ongoing service and financial pressures it will be extremely challenging to generate such reserves in the near future. Whilst it was not envisaged at establishment that the Integration Joint Board would hold significant general reserves our extant reserves strategy and policy supports the generation and holding of a level of general reserves as part of prudent financial management. It is proposed to reconsider this matter linked to medium term financial planning.

4.12. All of the reserves at 31 March 2018 are usable and all are earmarked reserves for a specific purpose. The main purpose of these earmarked reserves is managing differences in timing between allocation of funding for specific purposes from Scottish Government and timing of expenditure to achieve maximum benefit and best value from resources available.

4.13. Appendix 5 to this report details the Movements in Reserves from 1 April 2017 to 31 March 2018.

Directions

4.14. Final Directions for 2017/18 have been prepared and are appended to this report.

4.15 These directions ensure sufficient resources are directed to the constituent authorities, after additional contributions on the agreed risk sharing basis for 2017/18, to meet expenditure incurred.

5. Conclusions

5.1. Whilst this report illustrates a moderately improved outturn for the Partnership for financial year 2017/178 than had been forecast there remains a significant underlying recurrent deficit to address alongside the savings and efficiency plans required to deliver financial balance.

5.2. As detailed in the 2018/19 revenue budget paper the risk of overspending in 2018/19 remains high at this point in time. Efforts to agree and implement savings and efficiency programmes therefore requires to continue at pace.

5.3. The Partnership requires to plan and deliver services in an integrated and financially sustainable basis going forward taking into account the agreed Strategic Plan priorities and demand and cost pressures faced. This will require effective, collegiate and collaborative working across the Partnership to exploit the potential of integration and achieve best value from the resources available.

6. Resource Implications

6.1. The resource implications are detailed in the body of this report.

7. Impact on Strategic Plan Priorities and Outcomes

7.1. This report and associated recommendations, relates to the following Clackmannanshire & Stirling Health and Social Care Partnership local outcomes and Strategic Plan priorities as the Partnership budget represents the total resource envelope available to be deployed in pursuance of the Strategic Plan Priorities and Outcomes.

Fit with Local Outcomes	
Self Management	☒
Community Focussed Supports	☒
Safety	☒
Decision Making	☒
Experience	☒

Fit with Our Priorities 'we will...'	
Further develop systems to enable front line staff to access and share information	☒
Support more co-location of staff from across professions and organisations	☒
Develop single care pathways	☒
Further develop anticipatory and planned care services	☒
Provide more single points of entry to services	☒
Deliver the Stirling Care Village	☒
Develop seven-day access to appropriate services	☒
Take further steps to reduce the number of unplanned admissions to hospital and acute services	☒

8. Legal & Risk Implications

8.1. The report highlights the risks associated with the financial position of the partnership and the utilisation of reserves in 2017/18.

9. Consultation

9.1. No consultation implications have been identified through this report.

10. Equality and Human Rights Impact Assessment

10.1. The contents of this report do not require an EQIA because no direct impact on equality and human rights has been established.

11. Data Protection Impact Assessment

11.1. The contents of this report do not require a DPIA, as demonstrated by the completed screening tool in Appendix 1.

12. Exempt reports

12.1. Not exempt.

13. Appendices

13.1. Appendix 1 – Data Protection Screening Tool

13.2. Appendices 2,3 and 4 – Final 2017/18 Directions to Clackmannanshire Council, Stirling Council and NHS Forth Valley

13.3. Appendix 5- Tabular Summary of Financial Position Across Constituent Authorities

13.4. Appendix 6- Movement in Reserves 2017/18

Appendix 1

Are you unsure whether you need to carry out a data protection impact assessment -'DPIA'- previously referred to as a privacy impact assessment 'PIA'? Then complete the questions below.

What is a project?
In the screening questions below, the term 'project' includes projects, plans, proposals, policies, new developments and any significant business changes which use personal information.

What do I need to do next?
Keep a record of your answers to the questions with the documentation accompanying your 'project' so that you can demonstrate you considered the need for a DPIA.

If you answer 'yes' to any of the questions then you need to complete a DPIA template. When you complete the DPIA template you will be asked to consider another set of questions. These will tell you whether or not your DPIA is a legal obligation.

	QUESTION	**RESPONSE YES/NO**
1.	Will the project involve the collection of new information about individuals?	No
2.	Will the project change the method of handling/processing information about individuals (e.g. change from a manual to electronic process)?	No
3.	Will the project compel individuals to provide information about themselves?	No
4.	Will information about individuals be disclosed to organisations or people who have not previously had routine access to the information?	No
5.	Are you using information about individuals for a purpose it is not currently used for, or in a way it is not currently used?	No
6.	Does the project involve you using new technology which might be perceived as being privacy intrusive? For example, the use of biometrics or facial recognition.	No
7.	Will the project result in you making decisions or taking action against individuals in ways which can have a significant impact on them?	No
8.	Is the information about individuals of a kind particularly likely to raise privacy concerns or expectations? For example, health records, criminal records or other information that people would consider to be particularly private.	No
9.	Will the project require you to contact individuals in ways which they may find intrusive?	N

CONCLUSIONS/ RECOMMENDATIONS:			
DPIA not required.			
APPROVED BY:		**DATE:**	

Appendix 2

Final 2017/18 Direction

Clackmannanshire Council
13 June 2018

Dear Mrs Nikki Bridle, Interim Chief Executive

Direction from the Clackmannanshire & Stirling Integration Joint Board
Service Delivery and Discharge of Statutory Functions from 1 April 2017

This letter hereby constitutes a Direction under Section 26(1) of the Public Bodies (Joint Working) (Scotland) Act 2014 from the Integration Joint Board to your authority, Clackmannanshire Council.

Clackmannanshire Council is hereby directed by the Clackmannanshire & Stirling Integration Joint Board (**IJB**) from 1 April 2017, to continue to deliver the integrated services and to discharge the statutory functions delegated to the IJB under the Integration Scheme (between Clackmannanshire Council, NHS Forth Valley and Stirling Council approved by Scottish Ministers on or around 17 September 2015) in line with operational practice immediately prior to 1 April 2017. Namely, those functions provided for at Annex 2 Part 1 and those services detailed at Annex 2 Part 2.

Such continuation of delivery of in-scope services and discharge of in-scope statutory functions by your authority, Clackmannanshire Council, is hereby deemed to be subject to the following:

1. In-scope statutory functions are to be delivered within the relevant budget of £16.539m prescribed by the Integration Joint Board within the Financial Statement in the IJB's Strategic Plan [as approved by the IJB on 29 March 2017]; and in a manner consistent with the IJB's Strategic Plan approved on 22 March 2016;

2. The prescribed budget(s) at 1 above shall be used by Clackmannanshire Council to enable it to continue to deliver in-scope services and discharge in-scope statutory functions in accordance with this Direction;

3. Any significant decisions as to in-scope service delivery or discharge of any in-scope statutory function after 1 April 2017 being referred back to the IJB for its consideration prior to implementation; and

4. Any future Direction by the IJB as to the in-scope service to be delivered or the in-scope statutory function to be discharged by Clackmannanshire Council.

Yours sincerely

Shiona Strachan
Chief Officer, Clackmannanshire & Stirling Integration Joint Board

Final 2017/18 Direction **Appendix 3**

Stirling Council
13 June 2018

Dear Mr Stewart Carruth, Chief Executive, Stirling Council

Direction from the Clackmannanshire & Stirling Integration Joint Board
Service Delivery and Discharge of Statutory Functions from 1 April 2017

This letter hereby constitutes a Direction under Section 26(1) of the Public Bodies (Joint Working) (Scotland) Act 2014 from the Integration Joint Board to your authority, Stirling Council.

Stirling Council is hereby directed by the Clackmannanshire & Stirling Integration Joint Board (**IJB**) from 1 April 2017, to continue to deliver the integrated services and to discharge the statutory functions delegated to the IJB under the Integration Scheme (between Clackmannanshire Council, NHS Forth Valley and Stirling Council approved by Scottish Ministers on or around 17 September 2015) in line with operational practice immediately prior to 1 April 2017. Namely, those functions provided for at Annex 2 Part 1 and those services detailed at Annex 2 Part 2.

Such continuation of delivery of in-scope services and discharge of in-scope statutory functions by your authority, Stirling Council, is hereby deemed to be subject to the following:

1. In-scope statutory functions are to be delivered within the relevant budget of£32.383m prescribed by the Integration Joint Board within the Financial Statement in the IJB's Strategic Plan [as approved by the IJB on 30 March 2017]; and in a manner consistent with the IJB's Strategic Plan approved on 22 March 2016;

2. The prescribed budget(s) at 1 above shall be used by Stirling Council to enable it to continue to deliver in-scope services and discharge in-scope statutory functions in accordance with this Direction;

3. Any significant decisions as to in-scope service delivery or discharge of any in-scope statutory function after 1 April 2017 being referred back to the IJB for its consideration prior to implementation; and

4. Any future Direction by the IJB as to the in-scope service to be delivered or the in-scope statutory function to be discharged by Stirling Council.

Yours sincerely

Shiona Strachan
Chief Officer, Clackmannanshire & Stirling Integration Joint Board

Final 2017/18 Direction **Appendix 4**

Forth Valley Health Board
13 June 2018

Dear Mrs Cathie Cowan, Chief Executive,

Direction from the Clackmannanshire & Stirling Integration Joint Board
Service Delivery and Discharge of Statutory Functions from 1 April 2017

This letter hereby constitutes a Direction under Section 26(1) of the Public Bodies (Joint Working) (Scotland) Act 2014 from the Integration Joint Board to your authority, Forth Valley Health Board.

Forth Valley Health Board is hereby directed by the Clackmannanshire & Stirling Integration Joint Board (**IJB**) from 1 April 2017, to continue to deliver the integrated services and to discharge the statutory functions delegated to the IJB under the Integration Scheme (between Clackmannanshire Council, NHS Forth Valley and Stirling Council approved by Scottish Ministers on or around 17 September 2015) in line with operational practice immediately prior to 1 April 2017. Namely, those functions provided for at Annex 1 Part 1 and those services detailed at Annex 1 Part 2.

Such continuation of delivery of in-scope services and discharge of in-scope statutory functions by your authority, Forth Valley Health Board is hereby deemed to be subject to the following:

1. In-scope statutory functions are to be delivered within the relevant budget of £112.523m prescribed by the Integration Joint Board within the Financial Statement in the IJB's Strategic Plan [as approved by the IJB on 29 March 2017]; and in a manner consistent with the IJB's Strategic Plan approved on 22 March 2016;

2. The prescribed budget(s) at 1 above shall be used by Forth Valley Health Board to enable it to continue to deliver in-scope services and discharge in-scope statutory functions in accordance with this Direction;

3. Forth Valley Health Board will make use of £19.985m set aside in relation to Large Hospital Services;

4. Any significant decisions as to in-scope service delivery or discharge of any in-scope statutory function after 1 April 2017 being referred back to the IJB for its consideration prior to implementation; and

5. Any future Direction by the IJB as to the in-scope service to be delivered or the in-scope statutory function to be discharged by Forth Valley Health Board.

Yours sincerely

Shiona Strachan
Chief Officer, Clackmannanshire & Stirling Integration Joint Board

APPENDIX 5

Clackmannanshire & Stirling Integration Joint Board : Financial Year 2017/18

Financial Position for Year Ended 31 March 2018

NHS Forth Valley		Notes
Nature	**Expected Value (full year) £'000**	
Set Aside Budget for Large Hospital Services	**19,985**	1
Set Aside Expenditure	**19,985**	
Expenditure		
Operational and Universal Services	112,523	
Share of Costs of Partnership Posts	136	
Total Expenditure	**112,659**	
Income		
Payment	112,461	
Contribution to Partnership Posts	136	
Non Recurrent Additional Contribution on Risk Sharing Agreement	577	
Total Income	**113,174**	
Clackmannanshire Council		
Expenditure		
Total Expenditure on IJB functions	16,539	
Share of Costs of Partnership Posts	63	
Total Expenditure	**16,602**	
Income		
Payment	15,341	
Contribution to Partnership Posts	63	
Non Recurrent Additional Contribution on Risk Sharing Agreement	289	
Total Income	**15,693**	
Stirling Council		
Expenditure		
Total Expenditure on IJB functions	32,383	
Share of Costs of Partnership Posts	63	
Total Expenditure	**32,446**	
Income		
Payment	31,435	
Share of Costs of Partnership Posts	63	
Non Recurrent Additional Contribution on Risk Sharing Agreement	289	
Total Income	**31,787**	

Summary (Excluding Set Aside)	**£'000**
Total Expenditure	161,707
Total Income	160,654
Rounding Adjustment	0
Net Reduction in IJB Reserves via CIES	**(1,053)**

Notes:

1 Set Aside Treated in line with previous year (expenditure adjusted to allocation)
Financial Risk Currently Managed by NHS Forth Valley

2 Final Directions will be issued post 13 June IJB to direct sufficient resources to constituent authorities to cover expenditure incurred taking account of risk shares.

Appendix 6

Clackmannanshire & Stirling IJB Closing Reserves Financial Year 2017/18

	Originating Constituent Authority	Opening Balance £'000	Movement in Reserves £'000	Closing Balance £'000
General Reserves				
General Reserve	NHS FV	663	(663)	0
General Reserve	Stirling Council	25	(25)	0
TOTAL GENERAL RESERVES		**688**	**(688)**	**0**
Earmarked Reserves				
Integration Fund (Social Care) Balance	NHS FV	457	(457)	0
Partnership Funding (ICF/ Delayed Discharge)	NHS FV	863	(298)	565
Primary Care & Mental Health Transformation Funds	NHS FV	306	266	572
Transforming Urgent Care Fund	NHS FV	169	140	309
Pharmacy First	NHS FV	0	1	1
Mental Health Innovation Fund	NHS FV	0	100	100
GP Cluster Model	NHS FV	0	52	52
Autism Strategy	Stirling Council	18	6	24
Dementia Friendly Monies	Stirling Council	18	(18)	0
National Care Home Contract	Stirling Council	39	(39)	0
Drug & Alcohol Recovery Support	Stirling Council	803	(112)	691
Substance Development Worker	Stirling Council	0	0	0
Substance Forum	Stirling Council	0	0	0
See Hear Funding	Stirling Council	34	0	34
Sensory Impairment	Stirling Council	17	(6)	11
TOTAL EARMARKED RESERVES		**2,724**	**(365)**	**2,359**
TOTAL CLOSING RESERVES		**3,412**	**(1,053)**	**2,359**

Clackmannanshire & Stirling
Integration Joint Board

13 June 2018

This report relates to
Item 9.2 on the agenda

2018/19 Budget Update

Paper presented by
Ewan C. Murray, Chief Finance Officer

For Noting and Approval

Approved for Submission by	Shiona Strachan, Chief Officer
Author	Ewan C. Murray, Chief Finance Officer
Date:	23 May 2018
List of Background Papers:	
28 March 2018 -2018/19 Integration Joint Board Budget 28 March 2018 – Partnership Planning Approach	

Title/Subject: **2018/19 Budget Update**

Meeting: **Clackmannanshire & Stirling Integration Joint Board**

Date: **13 June 2018**

Submitted By: **Ewan C. Murray, Chief Finance Officer**

Action: **For Noting and Approval**

1. Introduction

1.1. The purpose of this report is to provide the Integration Joint Board with an update on the 2018/19 Budget including the impact of the draft outturn for 2017/18 and the Savings and Efficiency Programmes required to deliver a balanced financial position.

2. Executive Summary

2.1. The Integration Joint Board approved the 2018/19 initial budget on 28 March 2018.

2.2. Whilst a balanced budget was presented the level of service and financial pressures and risks associated with delivery was such that the Board were asked to note that the partnership remained at high risk of overspending in 2018/19.

2.3. The issues covered in this report were considered by the Integration Joint Board Finance Committee on 28 May 2018. The Finance Committee discussions focussed on the need for urgent action to be taken to accelerate delivery of savings and efficiency programmes and develop and agree further measures to deliver financial balance over both the short and medium term.

3. Recommendations

The Integration Joint Board is asked to:

3.1. Note the update on the 2018/19 Budget.

3.2. Note the update on Savings and Efficiency Programmes and Updated Risk Assessment.

3.3. Note the significant financial risks facing the Partnership.

3.4. Approve the proposed monitoring arrangements for the Savings and Efficiency Programmes on a pan Partnership basis through the Transformational Change Group.

3.5. Note the update on developing Medium Term Financial Planning.

3.6. Agree that further updates on Savings and Efficiency Programmes and options for further measures to deliver financial balance will be considered by the Integration Joint Board Finance Committee at its next meeting on 24 August 2018. Meantime efforts to mitigate the risk of overspend require to continue with urgency.

4. 2018/19 Budget Update

4.1. The initial 2018/19 Partnership budget totals £180.805m including the payments from the constituent authorities, set aside budget for large hospital services and partnership funding allocated to Integration Authorities via NHS Boards.

4.2. The 2018/19 payments from the constituent authorities were agreed to be 'fair and proportionate' given the overall settlements to the constituent authorities.

4.3. Given the proximity of the Integration Joint Boards budget setting to NHS Forth Valleys, the table at that point in time included an assumption that savings plans in relation to operational and universal NHS services. The table has now been updated to reflect savings plans in place split by Family Health Services Prescribing and Non-Prescribing. Further detail on savings plans in relation to Operational and Universal NHS services is provided later within the risk assessment of savings delivery appended to this report.

4.4. The partnership budget approved in March set out a summary of the cost and service pressures, additional resources and existing savings plans and proposals for addressing the resultant financial gap.

Table 1 below summarises the comparative position at budget setting illustrating the requirement for savings to be delivered to meet the net difference between estimated cost and service pressures and additional resources available.

Table 1		
	At Budget Setting £m	Current Position £m
COST AND SERVICE PRESSURES		
Recurrent Overspend from 2017/18	2.937	2.746
Unachieved Savings and Additional Savings Targets	0.899	0.899
Estimated Pay and Non Pay Inflation (Including Contracts)	2.380	2.380
Service Pressures And Additional Spending Committments		
Demand Growth (including Transistions)	1.311	1.311
Learning Disability Discharge Programme	0.426	0.426
Prescribing Cost and Volume Growth	1.518	1.518
Carers Act	0.421	0.421
War Pensions and Guaranteed Income	0.128	0.128
TOTAL COST AND SERVICE PRESSURES	**10.020**	**9.829**
ADDITIONAL RESOURCES		
Inflation Allowances in Payments from Constituent Authorities	1.620	1.620
War Pensions and Guaranteed Income	0.128	0.128
Share of NHS Budget Uplifts	1.461	1.461
Shares of £66m Social Care Pressures from Settlement	1.570	1.570
Demand Pressures Funding	0.150	0.150
TOTAL ADDITIONAL RESOURCES	**4.929**	**4.929**
BALANCE REQUIRING TO BE MET BY SAVINGS	**5.091**	**4.900**

5. Update on Savings and Efficiency Programmes

5.1. Taking into account the impact of the 2017/18 outturn on the recurrent financial position of the partnership the quantum of estimated savings requirements totals £4.9m.

5.2. The risk assessment on the savings and efficiency programme has been updated to incorporate the savings plans relating to Operational and Universal Health Services and reviewed based on information currently available. Progress and risk assessments will be further reviewed by the Transformational Change Group in June 2018 and alongside Quarter 1 financial reports in July 2018.

5.3. The savings plans have been risk assessed on a RAG (Red/Amber/Green) rating. At the current point in time the quanta of savings plans by risk rating is summarised in the table below:

Totals by Risk Rating	£m
Red	2.365
Amber	2.040
Green	0.947
Totals	**5.352**

5.4. The level of plans assessed as Red or Amber in terms of delivery supports the conclusion that the partnership remains at high risk of continuing to overspend at this point in time. Urgent focus is therefore required to accelerate delivery of savings, mitigate risk and identify corrective actions or alternative options where less than full savings delivery is anticipated.

5.5. Delivery of savings and efficiency programmes is, of course, only one element of financial management regimes. The budget made a range of assumptions in relation to cost, demand and service pressures. Whilst there is no specific intelligence that any of these will be materially wrong at this point in time these also require to be closely monitored over the year to inform projections and requirements for further corrective action.

5.6. A full initial projection will be prepared with Quarter 1 financial monitoring reports. However, early indications are of significant financial pressure across the Partnership budget which will require urgent focus to mitigate.

5.7. Further detail of the savings plans and risk assessment is attached to this report at Appendix 2.

6. Significant Financial Risks

6.1. The 2018/19 Budget approved by the Integration Joint Board in March 2018 set out the significant financial risks for the Partnership. Aside from the risks around delivery of the efficiency and savings programmes the following significant risks remain.

6.1.1. Pay Inflation: The risk that 2018/19 settlements may be in excess of provisions made.

6.1.2. Contract Inflation: A process is in train for negotiation and agreement of contract rates for 2018/19 including the effect of the Scottish Living Wage increase. Whilst the financial provisions made are still regarded as reasonable there remains a risk until negotiations are concluded.

6.1.3. Activity Assumptions: The risk that assumptions made, based on best information available at the time, prove to be materially wrong e.g. an unforeseen surge in demand for services.

6.1.4. Unforeseen Events: The risk that one or more unforeseen event with material financial consequences occurs. This risk is compounded by the lack of general reserves currently held by the partnership.

6.1.5. Capacity to Manage Change Programme: As set out in the Chief Officers report the near term delivery priorities along with changes in operational delegation, managing financial recovery and development of and consultation on the 2019-2022 Strategic Commissioning Plan pose a significant challenge to management capacity.

6.2. The Strategic Risk Register is being updated to reflect these risks and will be reviewed by the Integration Joint Board Audit Committee in June 2018.

6.3. Measures to bring the Partnership into financial balance will also place an ongoing risk to the Partnership in terms of Performance against key indicators including delayed discharge which requires to be monitored on an ongoing basis.

7. Proposed Monitoring Arrangements for Savings and Efficiency Programmes

7.1. There is an identified requirement to effectively and efficiently monitor delivery of savings and efficiency based on the Partnership Planning Approach approved by the Integration Joint Board in March 2018. These arrangements aimed to more closely align strategic, operational and financial planning going forward.

7.2. In terms of financial reporting developments are ongoing to support development of financial reporting particularly at locality level. A monthly reporting timetable has been set for 2018/19 from quarter 1 which requires a suite of information on expenditure, forecast projections and savings monitoring.

7.3. It is proposed to amend the function of the existing Transformational Change Group to collate and monitor progress on delivery of savings and efficiency programmes and budget recovery proposals and actions using a pan partnership savings tracker which clearly identifies accountable officers and key support staff (including Finance Officer and other professional support) for each element of the programme. The Chief Finance Officer and Integrated Care Funds Manager will support this group. There are also some changes to the membership of the group being made to ensure key accountable officers form the core membership.

7.4. The savings tracker is currently being updated to incorporate the savings plans in relation to Operational and Universal Health Services and will be incorporated into the next reports to the Finance Committee and Integration Joint Board.

7.5. The Transformational Change Group reports to the Joint Management Team which fulfils the function of a the Programme Board for the Transformational Change Programme and a clear reporting line to the Integration Joint Board via the Chief Officer and Chief Finance Officer.

8. Development of Medium Term Financial Planning

8.1. Work is ongoing in developing Medium Term Financial Planning and this work will also be informed by the refresh of the Joint Strategic Needs Assessment

whether specific account requires to be taken of significant changes such as the introduction of Free Personal Care for <65s.

8.2. The Scottish Government is due to publish a 5 year financial strategy imminently and it is logical to align our planning to the national approach.

8.3. Locally there is a need to approach medium term planning in a relatively consistent manner across the two Health and Social Care Partnerships within Forth Valley to take account of a single acute hospital site and wider Regional Planning. It is envisaged that a significant part of this work will be undertaken during the summer of 2018 and a fuller update will be considered at the next Integration Joint Board Finance Committee before reporting progress to the Integration Joint Board.

9. Conclusions

9.1. Whilst the 2017/18 outturn was moderately improved outturn for the Partnership there remains a significant underlying recurrent deficit to address alongside the savings and efficiency plans required to deliver financial balance.

9.2. As detailed in the 2018/19 revenue budget paper and the reports to this committee the risk of overspending in 2018/19 remains high at this point in time. Efforts to agree and implement sufficient savings and efficiency programmes therefore require to continue urgently to mitigate the risk of the Partnership continuing to overspend.

9.3. The Partnership requires to plan and deliver services in an integrated and financially sustainable basis going forward taking into account the agreed Strategic Plan Priorities, National Outcomes and demand and cost pressures faced. This will continue to require effective, collegiate and collaborative working across the Partnership to exploit the potential of integration and achieve best value from the resources available.

10. Resource Implications

10.1. The resource implications are detailed in the body of this report.

11. Impact on Strategic Plan Priorities and Outcomes

11.1. The Integration Joint Board's budget represents the resources available to deliver the priorities of the Strategic Plan.

12. Legal & Risk Implications

12.1. The report highlights the risks associated with the financial position of the partnership.

13. Consultation

13.1. No consultation implications have been identified through this report.

14. Equality and Human Rights Impact Assessment

14.1. No equality and human rights issues arising directly in relation to this report. An assessment was presented as part of the budget considerations in March 2018. Further measures to bring to Partnership into financial balance will be subject to Equalities and Human Rights Assessments.

15. Data Protection Impact Assessment

15.1. The contents of this report do not require a DPIA, as demonstrated by the completed screening tool in Appendix 1.

16. Exempt reports

16.1. Not exempt.

Appendix 1

Are you unsure whether you need to carry out a data protection impact assessment -'DPIA'- previously referred to as a privacy impact assessment 'PIA'? Then complete the questions below.

What is a project?
In the screening questions below, the term 'project' includes projects, plans, proposals, policies, new developments and any significant business changes which use personal information.

What do I need to do next?
Keep a record of your answers to the questions with the documentation accompanying your 'project' so that you can demonstrate you considered the need for a DPIA.

If you answer 'yes' to any of the questions then you need to complete a DPIA template. When you complete the DPIA template you will be asked to consider another set of questions. These will tell you whether or not your DPIA is a legal obligation.

	QUESTION	**RESPONSE YES/NO**
1.	Will the project involve the collection of new information about individuals?	No
2.	Will the project change the method of handling/processing information about individuals (e.g. change from a manual to electronic process)?	No
3.	Will the project compel individuals to provide information about themselves?	No
4.	Will information about individuals be disclosed to organisations or people who have not previously had routine access to the information?	No
5.	Are you using information about individuals for a purpose it is not currently used for, or in a way it is not currently used?	No
6.	Does the project involve you using new technology which might be perceived as being privacy intrusive? For example, the use of biometrics or facial recognition.	No
7.	Will the project result in you making decisions or taking action against individuals in ways which can have a significant impact on them?	No
8.	Is the information about individuals of a kind particularly likely to raise privacy concerns or expectations? For example, health records, criminal records or other information that people would consider to be particularly private.	No
9.	Will the project require you to contact individuals in ways which they may find intrusive?	No

CONCLUSIONS/ RECOMMENDATIONS:			
No requirement for DPIA identified.			
APPROVED BY:		**DATE:**	

APPENDIX 2

Clackmannanshire Health And Social Care Partnership
Further Detail and Risk Analysis on Savings Plan

Proposal	Brief Description	Savings Theme	Estimated Savings £m	Risk Rating (RAG)	Estimated Number of Service Users / Patients	Quarter of Financial Year Savings Anticipated From	Notes
Adult Social Care: Clackmannanshire Locality							
Integrated Mental Health Team Management Efficiency and Redesign	Changes to Staffing Structure	Establishing Single Partnership Management Structures	0.055	G	n/a	Q1	
Mental Health Care @ Home - Reviews and Eligibility Criteria Using Self Directed Support Framework	Application Using Resource Allocation System with Built in Efficiencies	Rapid Implementation of Self Directed Support	0.038	A	per LD and MH business cases	Q2	Updates presented to June IJB
Mental Health Officers Staffing Restructure	Changes to Staffing Structure	Establishing Single Partnership Management Structures	0.104	G	n/a	Q1	
Learning Disability Care @ Home - Reviews and Eligibility Criteria Using SDS Framework	Application Using Resource Allocation System with Built in Efficiencies	Rapid Implementation of Self Directed Support	0.119	A	per LD and MH business cases	Q3	Updates presented to June IJB
Learning Disability - Day Service (Centrespace)	Single Service Based for Maximum for 20 Clients	Implementation of New Models of Care	0.040	A	per LD and MH business cases	Q2	Updates presented to June IJB
Mental Health Residential - Restrict Levels of Placements to Funded Levels	Limit service to defined affordable capacity level using waiting lists etc.	Access to Services	0.049	R	1	TBA	Challenging to Practically Implement within eligibility criteria. Risk of legal challenge. Risk to partnership performance including delayed discharges.
Assessment and Care Management Restructure	Changes to Staffing Structure	Establishing Single Partnership Management Structures	0.080	G	n/a	Q1	
Procurement and Other Measures	Revised Equipment Contract	Market Testing and Procurement	0.003	G	n/a	Q1	
Menstrie House	Review of Rotas, Improving Absence Management and Reducing Agency Use	Management Actions	0.048	G	n/a	Q1	Requires ongoing management and monitoring.
Reablement - Review of Staffing Structure	Changes to Staffing Structure Implemented	Service Change and Redesign	0.023	G	n/a	Q1	
Meals on Wheels	Disinvestment in Current Model of Service Provision	Service Change and Redesign	0.020	A	67	Q3	Engagement event on 22 May. Current service users being reviewed over next 3 months.
Social Care: Urban and Rural Stirling Localities							
Roll out of Reablement for Under 65s	Service Redesign	Implementation of New Models of Care	0.150	A	36	Q3	
Redesign of Learning Disability Services	Links to Implementation of SDS and Review Activity	Service Change and Redesign	0.350	R	per LD and MH business cases	TBA	Highly Unlikely To be Achievable from LD alone. Ongoing discussion re alternatives across budgets.
Reducing Demand for Long Term Care	Longer term impact of Care at Home, Reablement and Audit of Placements	Service Change and Redesign	0.117	A	3	Q2-3	Impact of Ongoing Audit of Long Term Care Placements Based on Trends
Remodelling of Physical Disability Services	Service Redesign	Service Change and Redesign	0.100	A	14-16	Q2-3	Estimated impact of Review Activity
Partnership Funding							
Non-Recurrent Support from Disinvestment in Partnership Funding Commitments	Full Year Effect of Review in 2018/19	Service Change and Redesign	0.546	G	n/a	Q1	
Operational and Universal Health Budget (Outwith FHS Prescribing)							
Dietetics : Home enteral feeding contract discount	Contract Discount	Market Testing and Procurement	0.018	G	n/a	Q1	
Dietetics : Use of electronic resources for education		Service Modernisation and Digitalisation	0.003	A	n/a	TBA	
Dietetics : Use of existing staff to progress time limited projects	Realignment of Staff Deployment	Management Actions	0.002	A	n/a	TBA	

Service Redesign : Outpatient Parenteral Antimicroial Therapy, Specialist Rehab provision, Day Hospital review, Frailty	Various Service Change Proposals in Medical Directorate	Service Modernisation and Digitalisation	0.338	R	TBA	TBA	Update on progress anticipated June 2018
Quetiapine prescriptions	Review Prescribing of Antipsychotics	Prescribing	0.062	A	TBA	TBA	
Specialist Mental Health : Redesign of Community Rehabilitation Teams	Repositioning of Core Remit of Community Rehab Team to Community Mental Team Team and Reviewing Roles of IHTT, Crisis Service and CMHTs	Service Modernisation and Digitalisation	0.090	R	22	TBA	Update on progress anticipated June 2018
Specialist Mental Health : Cap non-core staffing	Reducing Nurse Bank Usage	Management Actions	0.020	A	n/a	TBA	Requirement to Maintain Safe Staffing Levels
Hope House Bed Income	Make excess capacity available to neighbouring areas	Income Maximisation	0.089	R	n/a	TBA	Dependant on Local Demand and Appetite for Utilisation if Excess Capacity Available
Adult Speech and Language Therapy Review of service to voice patients/ information group sessions	Service review.	Service Modernisation and Digitalisation	0.009	R	TBA	TBA	Update on progress anticipated June 2018
Allied Health Professionals, Mental Health Learning Disability and Old Age Psychiary Care Group - various skill mix changes	Review of Skill Mix across services	Management Actions	0.032	R	n/a	TBA	Update on progress anticipated June 2018
Operational and Universal Health Budget (FHS Prescribing)							
Part 7 tariff reductions - full year effect	National drug tariff arrangements	Prescribing	0.014	G	n/a	Q1	
Full year effect prior of year technical switches		Prescribing	0.031	G	n/a	Q1	
Childhood immunisations		Prescribing	0.005	G	n/a	Q1	
18-19 part 7 tariff reductions/off patent benefits	National drug tariff arrangements	Prescribing	0.120	R	n/a	TBA	Highly uncertain at this point. Linked to national tariff and contractor remuneration arrangements.
Technical switch: switch to edoxaban as first line choice	Technical Switches with same therapeutic effect	Prescribing	0.085	R	TBA	TBA	Prescribing information approximately 2 months in arrears. Impact will be reassessed as current year information emerges.
Technical switch: Aminosalicylates - technical switch from asacol to Octasa	Technical Switches with same therapeutic effect	Prescribing	0.007	A	TBA	TBA	Prescribing information approximately 2 months in arrears. Impact will be reassessed as current year information emerges.
Technical switch: mucolytics - switch from carbocysteine to aceylcysteine	Technical Switches with same therapeutic effect	Prescribing	0.076	A	TBA	TBA	Prescribing information approximately 2 months in arrears. Impact will be reassessed as current year information emerges.
Technical switch: Antimuscarincs - switch of device of remaining tiotropium patients to Braltus at annual review.	Technical Switches with same therapeutic effect	Prescribing	0.054	A	TBA	TBA	Prescribing information approximately 2 months in arrears. Impact will be reassessed as current year information emerges.
Non steroidal antiinflammatory drugs - dose optimisation of mefenamic acid	Technical Switches with same therapeutic effect	Prescribing	0.008	A	TBA	TBA	Prescribing information approximately 2 months in arrears. Impact will be reassessed as current year information emerges.
Over-ordering/waste	Reduction in Wastage	Prescribing	0.575	A	TBA	TBA	Significant ongoing focus required including work with professionals, carers and general public.
Changes in Melatonin protocol	Revision of Prescribing Protocols	Prescribing	0.020	G		Q1	
Further Measures to Achieve Financial Balance							
Accelerated Implementation of Self Directed Support Using a Resource Allocation System	Application Using Resource Allocation System with Built in Efficiencies	Rapid Implementation of Self Directed Support	0.650	A	TBQ	Q2-3	Includes other care groups in additional to Learning Disabilities and Mental Health
Service Modernisation and Digitalisation	Roll of Real Time Monitoring Using CM2000 system	Service Modernisation and Digitalisation	0.150	R	n/a	Q3-4	Pilot Only in Place. Requires Scaling based if pilot evidence positive. Evidence of savings from other Health and Social Care Partnerships who have implemented same or similar systems.
Commisioning and Market Testing	Re-tendering of External Contracts in Substance Misuse and Care at Home.	Market Testing and Procurement	0.250	R	n/a	Q4	Significant preparatory work and lead in times. Unlikely substance misuse retendering will be concluded till early 2019.
Restriction in Capacity in Social Care to Affordable Levels	Use of Waiting List and Define Service Capacity Levels in Long Term Care and Care at Home on 2:1 Ratio	Access to Services	0.803	R	41	TBA	Challenging to Practically Implement within eligibility criteria. Risk of legal challenge. Risk to partnership performance including delayed discharges.

Total Quantum of Savings Proposals	5.352
Total Savings Requirement	4.900

Totals by Risk Rating	
Red	2.365
Amber	2.040
Green	0.947
Totals	**5.352**

Risk Rating Definitions
Red: Significantly Off Track/ High Risk of No or Limited Savings
Amber: Moderately Off Track or Delays in Implementation / Risk of Less than Full Savings Delivery either in total or in year
Green: On Track / Full Savings Anticipated

Clackmannanshire Council

Stirling Council

NHS Forth Valley

Clackmannanshire & Stirling
Integration Joint Board

13 June 2018

This report relates to
Item 10.1 on the agenda

Delegation of Services: Operational Management of Stirling Council Adult Services

(Paper presented by Marie Valente, Chief Social Work Officer, Stirling Council)

For Noting

Approved for Submission by	Shiona Strachan, Chief Officer
Author	Marie Valente, Chief Social Work Officer, Stirling Council Caroline Cherry, Service Manager, Adult Assessment and Partnerships/Augmented Care, Stirling Council
Date:	13th June 2018
List of Appendices: Appendix 1-Services in scope Appendix 2: Structure charts Appendix 3: Key Functions Appendix 4: IJB Budget	

Title/Subject:	**Delegation of Services: Operational Management of Stirling Council Adult Services**
Meeting:	**Clackmannanshire & Stirling Integration Joint Board**
Date:	**13th June 2018**
Submitted By:	**Marie Valente/Caroline Cherry**
Action:	**For Noting**

1. Introduction

1.1 The aim of this paper is to present the Integration Joint Board with details on the transfer of operational management of Stirling Council adult services to the Chief Officer following the strategic delegation of services on the 1 April 2016.

1.2 In October 2017, Stirling Council presented an approved operational management transfer plan to the Integration Joint Board setting out the services that were in scope to be transferred to the operational management of the Chief Officer. The transition period was to allow Stirling Council to ensure:

- operating models of care are clarified
- a robust, resilient workforce is in place
- appropriate commissioning arrangements are fully examined
- areas of out-dated practice are minimised
- superfluous costs are reduced

1.3 Stirling Council has been addressing these challenges and focusing on making sure that the services and staff who will be managed under the Chief Officer are in as good a shape as possible. The priority has been to deliver high quality, safe services to adults within the context of changing operational management arrangements.

1.4 This report now sets out for the Integration Joint Board, the full scope of the services that will be operationally managed by the Chief Officer with a confirmed date of transfer on or before the 1 September 2018.

2 Executive Summary

2.1 The Clackmannanshire & Stirling Health and Social Care Partnership has been in operation since April 2016 which has included the strategic delegation of adult services in Stirling Council.

2.2 The Public Bodies (Joint Working) (Prescribed Local Authority Functions etc.) (Scotland) Regulations 2014 sets out the list of functions that must be delegated by Local Authorities. Appendices 1 and 2 detail the services in scope and functions already delegated by Stirling Council.

2.3 The detail of support services from Stirling Council for the Partnership is not the purpose of this paper. This will be the subject of a separate paper by Stirling Council to the Integration Joint Board.

3 Recommendations

The Integration Joint Board is asked to:

3.1 Note that Stirling Council will transfer operational responsibility of all adult services to the Chief Officer on or before the 1 September 2018.

4 Background

4.1 The Public Bodies (Joint Working) (Scotland) Act 2014 requires Health Boards and Local Authorities to integrate planning for, and delivery of, certain Adult and Social Care Services.

4.2 The Clackmannanshire & Stirling Health & Social Care Partnership has been in operation since 2016 and has strategic delegation not operational management of Stirling Council adult care services.

4.3 In October 2017, Stirling Council presented a proposed operational management transfer plan to the Integration Joint Board setting out the proposal to show how full operational management responsibility of Stirling Council adult social care services would be delegated to the Chief Officer in a way that would minimise risk to service users and ensure a seamless transition for staff.

4.4 Since October 2017, Stirling Council has set up a Transition Board, attended by the Chief Officer of the Partnership and Senior Managers of Stirling Council. The key purpose of the group is to oversee the strategic planning required to manage a smooth and effective transition of operational management responsibilities.

4.5 An operational working group has also been established which is chaired by the Service Manager, Adult Assessment and Partnerships. This group is attended by key operational staff as well as representatives from support services. The Operational Group has developed a detailed plan and work streams to ensure that the services and staff who will be managed under the Health and Social Care Partnership are in as good a shape a possible when they transfer.

4.6 It is now confirmed that the date to transfer operational responsibility of service and staff from Stirling Council to the Chief Officer will be on or before the 1 September 2018. The transfer plan for autumn 2018 was supported by Stirling Council at the Social Care and Health Committee in October 2017.

5 Transition of Services

5.1 Given that planning is well underway to ensure the smooth transition of services, a scoping exercise has also been carried out to clearly set out the detail of the services that will be delegated by Stirling Council.

5.2 The services in scope from Stirling Council are set out in Appendix 1. Whilst the staff structures and operational detail are described in Appendices 2 and 3.

5.3 Appendix 4 shows the IJB budget covering Stirling Council Services.

5.4 Clackmannanshire & Stirling Health and Social Care Integration Scheme states that the relevant parties will identify any corporate services required to allow the Integration Joint Board to discharge its functions and will agree (a) how any or all of those will be provided to the Integration Joint Board to support it to discharge is duties under the Act and (b) how this resource will be funded. The Integration Scheme further states that the provision of such support will be reviewed annually.

5.5 Support services which may be relevant include – finance, legal/governance, commissioning, equalities, performance management, human resources, risk management, information technology, property management, communication services.

5.6 A further paper will be prepared setting out how support services will be provided.

6 Conclusions

6.1 Stirling Council is making good progress to ensure that all services and staff are ready to transfer to the operational responsibility of the Chief Officer on or before the 1 September 2018.

7 Resource Implications

7.1 Budget for services already sits with the Partnership.

8 Impact on Strategic Plan Priorities and Outcomes

8.1 This report and associated recommendations, relates to the following Clackmannanshire & Stirling Health and Social Care Partnership local outcomes and Strategic Plan priorities:

Fit with Local Outcomes	
Self Management	☐
Community Focussed Supports	☐
Safety	☐
Decision Making	☐
Experience	☐

Fit with Our Priorities 'we will...'	
Further develop systems to enable front line staff to access and share information	☒
Support more co-location of staff from across professions and organisations	☒
Develop single care pathways	☐
Further develop anticipatory and planned care services	☐
Provide more single points of entry to services	☐
Deliver the Stirling Health and Care Village	☐
Develop seven-day access to appropriate services	☐
Take further steps to reduce the number of unplanned admissions to hospital and acute services	☐

8.2 The transfer of adult social care services to the Partnership will enable progression of co-located health and social care services and staff.

9 Legal & Risk Implications

9.1 Legally, Stirling Council will still be discharging its statutory functions under direction of the Partnership.

10 Consultation

10.1 Chief Executive, Stirling Council, Depute Chief Executive, Stirling Council, Chief Officer, Health and Social Care Partnership.

11 Equality and Human Rights Impact Assessment

11.1 The contents of this report do not require an EQIA because it is a progress report on the planning for the transition or operational management functions from Stirling Council to the Health and Social Care Partnership. There will be no change in service delivery.

12 Data Protection Impact Assessment

12.1 The content of this report does not require a DPIA.

13 Exempt Reports

13.1 Not exempt.

14 Appendices

14.1 Appendix 1-Services in Scope and Delegated

14.2 Appendix 2 – Structure Charts of the Core Adult Social Care/Augmented Care Functions Transferring

14.3 Appendix 3 – Summary of Services/Key Functions in Stirling Council

14.4 Appendix 4 – IJB Budget

Services in Scope*

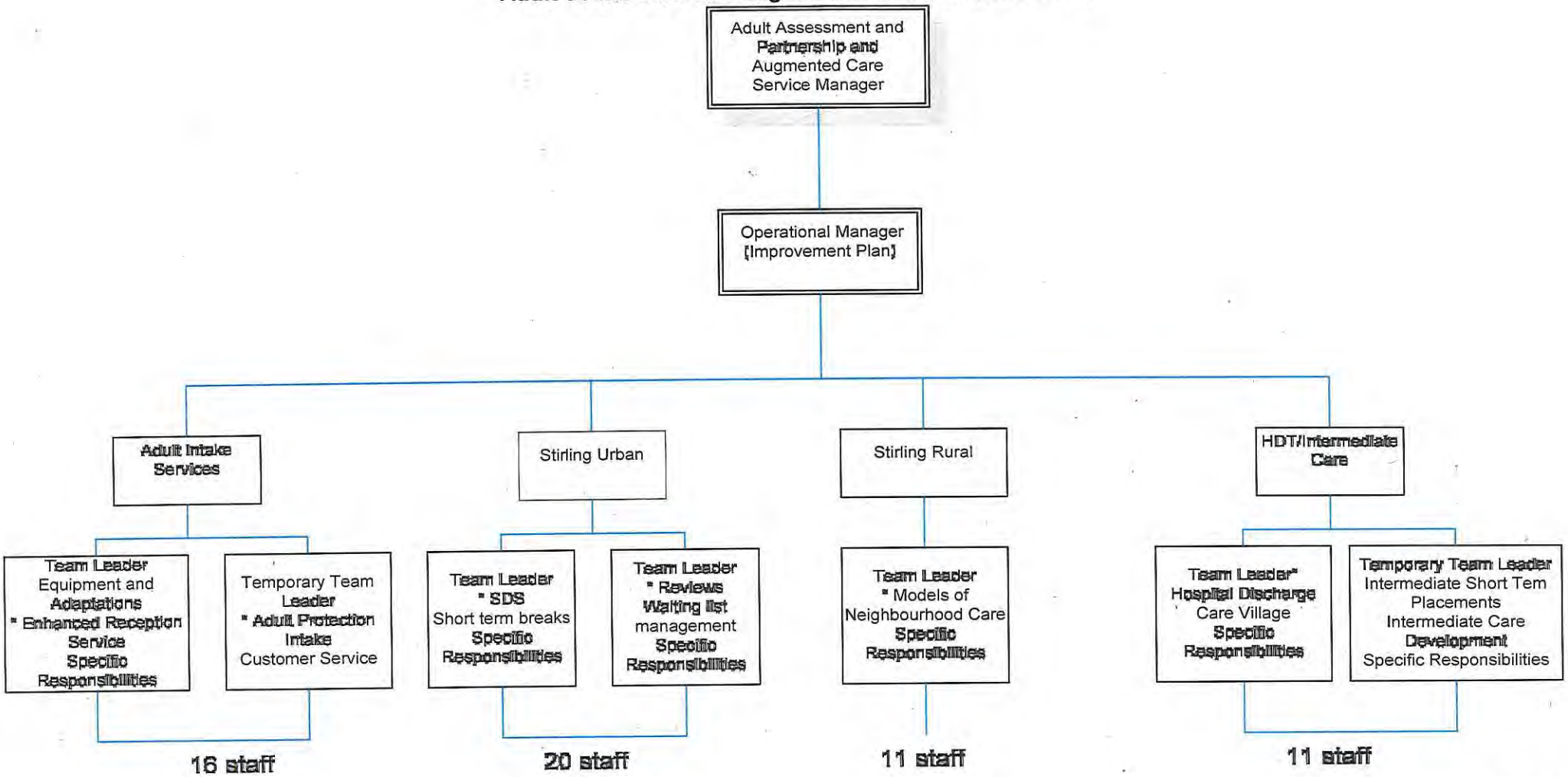
- Social work services/community care services – including assessment and care management and directly provided and commissioned
- Older Peoples Services
- Drug and alcohol
- Physical Disability
- Adult Services
- Direct provision & commissioned:
  - Care home;
  - Care at home;
  - Adult placement;
  - Day services;
  - Short breaks/respite;
  - Reablement/intermediate care: bed based & care at home.

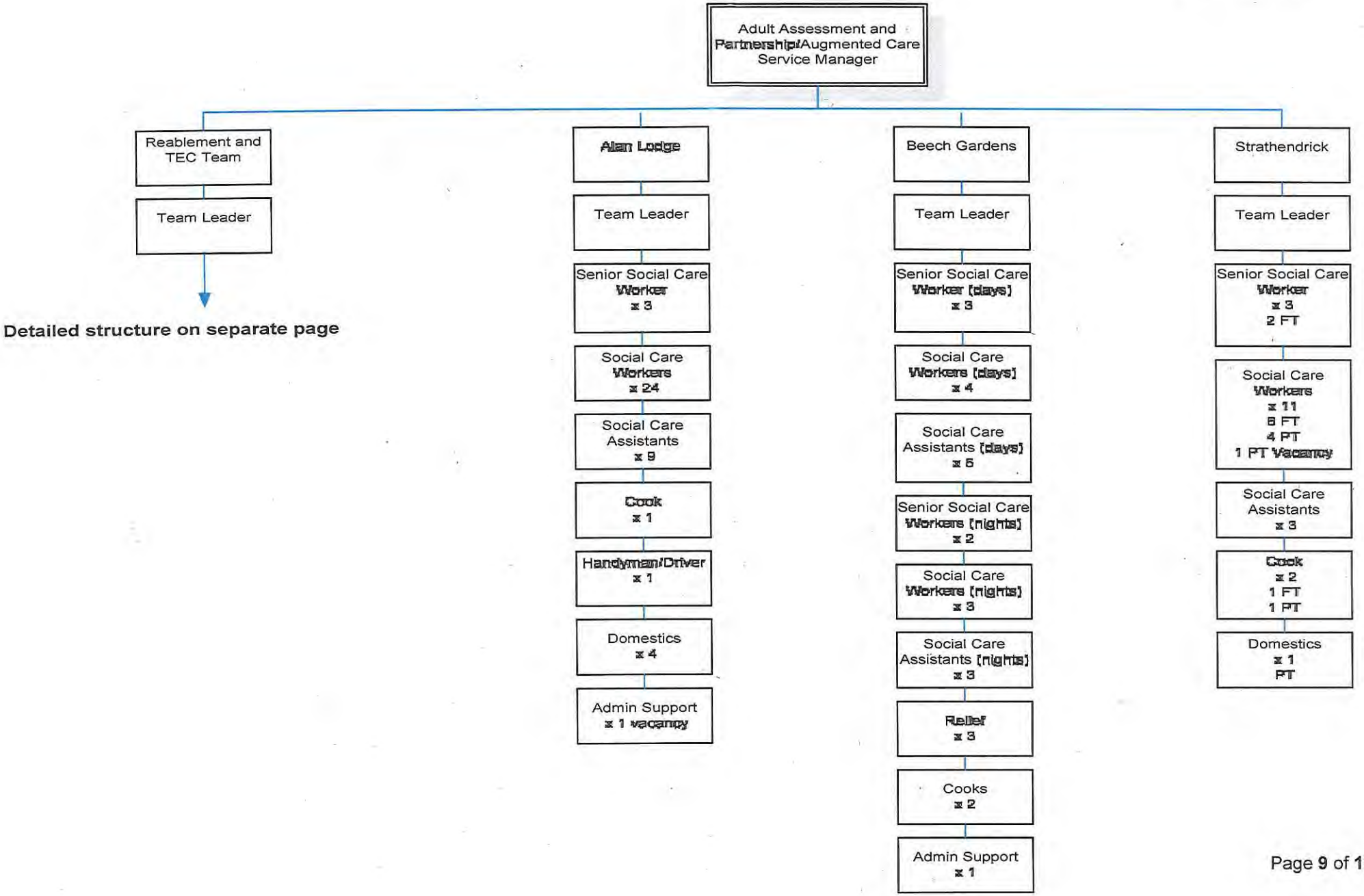
- Mental Health
- Learning Disability
- Health Improvement Services
- Adult Protection & Support including domestic abuse/services to women
- Carer Support services
- Support services – general duty
- Local area co ordination

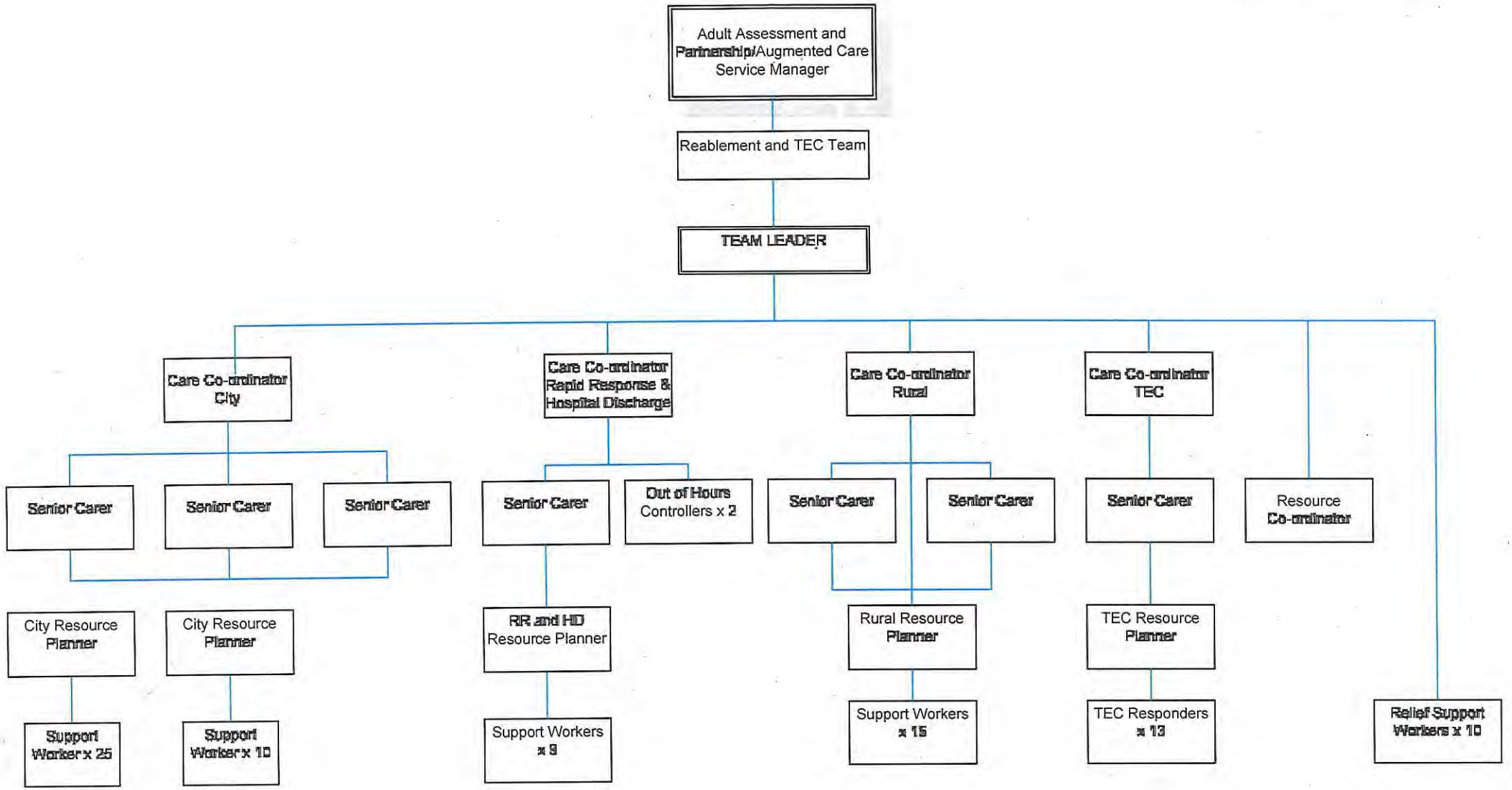
* Source: Integration Scheme for C&S HSCP

Structure Charts of the Core Adult Social Care/Augmented Care Functions Transferring

Adult Social Care and Augmented Care Structure Chart




Adult Assessment and Partnership/Augmented Care Service Manager
Reablement and TEC Team
Team Leader
Detailed structure on separate page
Alan Lodge
Team Leader
Senior Social Care Worker x 3
Social Care Workers x 24
Social Care Assistants x 9
Cook x 1
Handyman/Driver x 1
Domestics x 4
Admin Support x 1 vacancy
Beech Gardens
Team Leader
Senior Social Care Worker (days) x 3
Social Care Workers (days) x 4
Social Care Assistants (days) x 5
Senior Social Care Workers (nights) x 2
Social Care Workers (nights) x 3
Social Care Assistants (nights) x 3
Relief x 3
Cooks x 2
Admin Support x 1
Strathendrick
Team Leader
Senior Social Care Worker x 3 2 FT
Social Care Workers x 11 8 FT 4 PT 1 PT Vacancy
Social Care Assistants x 3
Cook x 2 1 FT 1 PT
Domestics x 1 PT



Total number of staff = 101 + 6 FTE vacancies

Appendix 3

SUMMARY OF SERVICES THAT ARE BEING DELEGATED BY STIRLING COUNCIL:

(Excluding Mental Health and Learning Disability Services which have already transferred to the Partnership):

Adult Social Care/Augmented Care Key Functions

- All front facing Adult Social Care Services focused on older adults/adults with physical disability inclusive of:
  - the Enhanced Reception Service (funding arrangements to be confirmed beyond March 2019)
  - Adult Intake
  - Hospital Discharge/Intermediate Care
- Locality Teams split into Stirling Urban and Stirling Rural.
- Services supporting sensory impairment based at the Sensory Service (including rental of space; assessment; rehabilitation and support).
- Reablement Service (including Mecs/Telecare/Telehealth).
- Intermediate Care Services.
- Budgets to support delivery inclusive of Care at Home/Care Home including respite care.
- Aids, Equipment and Adaptations budgets.- budgets are already delegated and operational responsibility would be split between adult social care services and housing services in recognition that this area covers varying types of adaptions
- Drug and Alcohol services for adults are already included in IJB budget. Operational management will transfer from Economic Development and Regeneration to Adult Social Care.
- Grass Cutting Services are already included in IJB budget, within the Housing, aids and adaptions, however not detailed above in the organisational charts. The service will continue to be managed centrally by Land Services in recognition this is this part of a wider service, providing grass cutting to a variety of Stirling Council residents.
- Services to Women are already included in the IJB budget, operational management for the service will initially remain within housing services.

Appendix 4

IJB (Stirling) Budget 2018/19

Budget Area	Total Budget 18/19
	£'000
Long Term Care	16,160
Housing, Aids and Adaptations*	784
Voluntary Organisations/3rd Sector Payments	638

Sensory Services	210
Daycare	1,814
JLES	217
Equipment	165
Mecs/Telecare/Telehealth	652
Respite	310
Carers	0
Adult Support and Protection	26
Care and support at home	18,935
Transport	180
Drug and Alcohol Services	124
Resource Transfer	(5,122)
Integration Fund	(5,442)
Staffing	2,997
Total	**32,650**

Clackmannanshire & Stirling Health and Social Care Partnership
Integration Joint Board

13 June 2018

This report relates to
Item 10.2 on the agenda

Integration Update

(Paper presented by Cathie Cowan)

For Noting

Approved for Submission by	Title and Organisation
Author	Cathie Cowan, Chief Executive, NHS Forth Valley
Date:	25 May 2018
List of Background Papers / Appendices:	
None	

Title/Subject: **Integration Update**

Meeting: **Clackmannanshire & Stirling Integration Joint Board**

Date: **13 June 2018**

Submitted By: **Cathie Cowan, Chief Executive, NHS Forth Valley**

Action: **For Noting**

1. Introduction

1.1. The purpose of this paper is to provide assurance regarding the ongoing NHS commitment to integration and the progress being made to implement the operational arrangements for those NHS functions in-scope as determined by the approved Integration Scheme.

2. Recommendations

The Integration Joint Board is asked to:

2.1 **Note** the significant and ongoing work to develop the integrated management arrangements to support the delegation of functions.

3. Background

3.1 The purpose of integration is to create Health and Social Care Partnerships that deliver integrated services for the local population. Integration means that over the next few years GPs, hospitals, health workers, social care staff and others will increasingly work side by side to share information and take a more coordinated approach to the way services are delivered to improve outcomes.

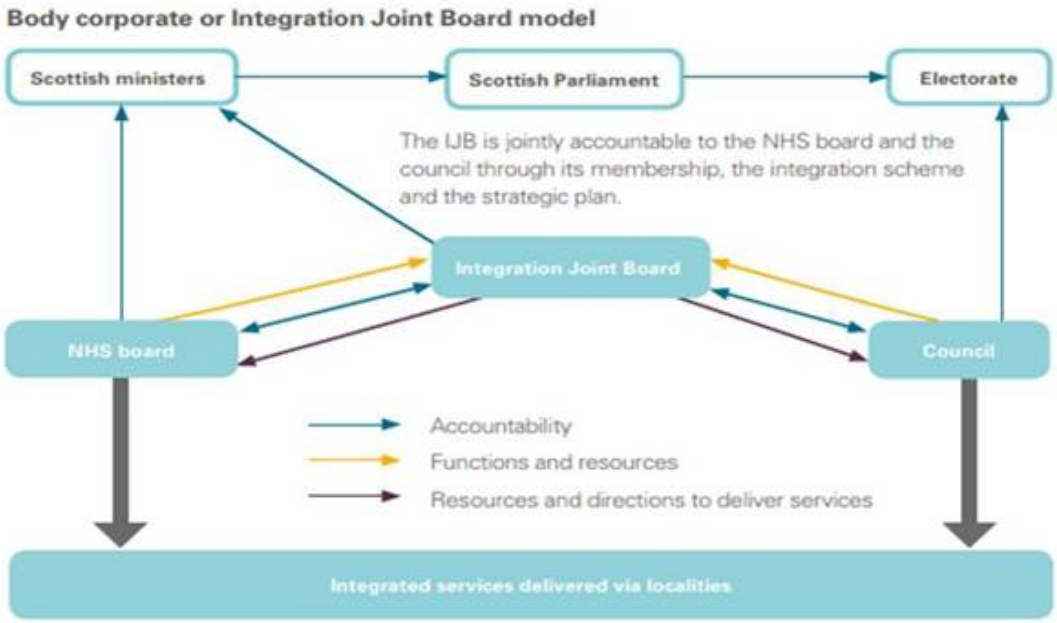
3.2 In 2016, NHS Forth Valley and the Local Authorities delegated the integration functions as set out in the Integration Scheme for each of the Integration Joint Boards (IJBs) in accordance with the Public Bodies (Scotland) Act 2014. At the stage of agreeing the Scheme in 2015 the scope of the health services that would be operationally managed by the Chief Officers within the health and social care partnerships had not been agreed.

3.3 This paper sets out NHS Forth Valley's ongoing commitment to integration and to further implement the operational arrangements to support the delivery of health and social care within our established Partnerships.

4. Integration Process

4.1 By way of context, the Integration Joint Board (IJB) sets the strategic direction of the delegated functions (through the Strategic Plan), directs the Health

Board/Local Authority to provide services as per the Strategic Plan and allocates budget. The IJB in its oversight role for the Health and Social Care Partnership reviews performance against the Strategic Plan and has the ability to issue directions to the Health Board and Local Authority that drive delivery of the priorities as outlined in this Plan. As a statutory body distinct from the constituent authorities, the IJBs have a role in monitoring and reporting on how the Health Board and the Local Authorities account for delivery of the delegated functions. This is illustrated in Diagram 1 below:



IJBs are not expected to directly employ staff, operating only as strategic commissioning bodies. There is no change anticipated but the Act allows for IJBs to employ staff. However, this would need Scottish Ministers approval rather than being decided locally. A Chief Officer and Chief Finance Officer provide support for the IJB, but they are employed by either the Local Authority or NHS Board and seconded to the IJB. Corporate support to the IJBs will be shared by the NHS Board and Local Authorities to avoid duplication and/or additional costs.

4.2 The Chief Officer has a dual role. The Chief Officer reports to the Chief Executives of each of the Partners and is responsible for the delivery of integrated services in line with the relevant policies and procedures of the Local Authority and NHS Board. They are also directly accountable to the IJB for all of its responsibilities. These include strategic planning, establishing the strategic planning group, producing the annual performance report, ensuring directions are being carried out and recommending changes and reviewing the strategic plan in line with legislation.

4.3 The Chief Officer will be responsible for some of the NHS services in their operational role as an officer of the Health Board. Where the Chief Officer does not have an operational role, the Integration Scheme requires that they are given the support and 'line of sight' to provide assurance to the IJB that

the Health Board is delivering services appropriately in accordance with Directions and the Strategic Plan. The Chief Officers are members of the Senior Leadership Team within NHS Forth Valley. Line of sight will be achieved through the Chief Officer being a member of NHS Forth Valley's Senior Leadership Team and through the Performance Report prepared by the NHS Board to assure each of the Integration Joint Boards.

4.4 The Chief Finance Officer under the terms of Section 95 of the Local Government (Scotland) Act 1973 has formal responsibilities for the financial affairs of the IJB.

4.5 In regard to functions within health legislation, functions of Health Boards are generally described very broadly. The same statutory function may provide a legal basis for a wide range of services (including acute, tertiary and community services, in some cases). The Integration Schemes for each of the Partnerships therefore include a list of the health services to which integration applies, rather than just the functions. The Integration Schemes approved by Scottish Ministers refer to the 'Functions delegated by the Health Board to the Integration Joint Board'. The Scheme refers to a number of Acts and those functions to be delegated except for those functions listed. For example:

<u>National Health Service (Scotland) Act 1978:</u>

Section 17C (type of primary care contract for the provision of primary care medical services) – is not delegated to the IJB whilst services provided by General Practitioners are delegated but the contracting function under Section 17C cannot be delegated. Similarly, the same applies to General Ophthalmic, General Dental and The National Health Service (Pharmaceutical Services) (Scotland) Regulations 2009/183 and The National Health Service (Free Prescription and Charges for Drugs and Appliances) (Scotland) Regulations 2011/55 – these are not delegated to the IJB. As with the other services, these regulations relate to practical arrangements such as contracting, payment and standards.

4.6 NHS Forth Valley has agreed with the three Local Authorities to a phased implementation plan to support further operational management delegation, this is being developed by the Chief Executives of the Partners supported by Chief Officers and key senior managers including HR and Finance from both the Health and Local Authorities.

4.7 The delegated operational management responsibilities will be aligned wherever possible to co-produced Locality Structures of each Partnership. These will be considered and approved in due course by the NHS Board, Local Authorities and IJBs.

5. Delegation of NHS Functions to each of the Integration Joint Boards

5.1 NHS Forth Valley is determined to deliver integration for our local population and will delegate operational service delivery of appropriate services to Health and Social Care Partnerships. This will build on the successful delegation of operational responsibilities for Community Mental Health and Learning Disability functions. This was completed in February 2017. By delegating further operational responsibility for health functions to the Health and Social Care Partnerships, we will, with partners, develop an integrated system for local joint strategic commissioning of health and social care services. This will be informed by the needs of patients and service users with a focus on preventative and anticipatory, community-based, whole system redesign.

5.2 Delegation of operational management including workforce and management resources will be informed and agreed by all Partners. This will be phased over this financial year. Appendix 1 describes those functions to be delegated, the line management support and the budgets which will be operationally managed by the Chief Officers from September 2018. These are functions which already work closely in partnership to deliver local priorities and where resources are already broadly aligned with the Health and Social Care Partnership areas.

5.3 There are exceptions where services are configured on a Forth Valley wide basis. Agreement will be required to ensure optimal operational delivery for these services. Arrangements for these will be informed by the principles outlined in appendix 2.

5.4 This work will be incorporated into phase 2. Delegation of these functions will take place after phase 1 (those arrangements described in appendix 1) and will be completed within this financial year (i.e. March 2019). Primary care including Public Dental Services will be hosted by the NHS Board, and similar to Unscheduled Care, the Chief Officers will have a line of sight through the Programme Board structure to fulfil their oversight role and will receive regular performance reports. A review of this arrangement will take place in 18 months; this will enable the NHS Board to oversee the new General Medical Services (GMS) contract implementation in partnership with the IJBs. Similarly, Public Health/Health Improvement will remain within the NHS Board aligned to the priorities set by localities and community planning partners. This will be reviewed after publication of the recommendations of the Public Health Reform Oversight Board.

5.5 Health and Social Care Partnerships are expected to develop locality based health and social care models of care. Where it is not in the best interests of service users, impacts adversely on protecting or improving the safety for service users and/or fails to make best use of available resources, then the services will be maintained on a Forth Valley wide basis to support access to equitable, integrated NHS services. It is intended that, for those services that are likely to be ‘hosted’ clinical staff, supported by line managers will inform a stakeholder event on the preferred model of service delivery to further inform

delegation decisions as part of a phased approach. A stakeholder event is currently being developed for June.

5.6 For functions not to be delegated it is expected that both Health and Social Care Partnerships will in partnership with the Health Board be responsible for the strategic planning six Partnership Objectives around Unscheduled Care contributing to the delivery of the 4 hour access target and reduction in avoidable admissions and reductions in occupied bed days. This work led by the Medical Director is part of the NHS Board's Unscheduled Care Programme of work.

5.7 Alongside the work of the Unscheduled Care Programme Board will be a review that supports improvements in Acute Services. This work, led by the NHS Chief Executive will review the future scope of the acute hospital footprint as part of a whole system review and utilisation of the Health Board's current overall estate. This work will involve members of the Health Board's Senior Leadership Team.

5.8 Following the principles described in paragraph 5.3, it has been agreed that the Health Board will be responsible for the operational management of the Out of Hours Service given the current service sustainability issues in Primary Care Services. The Health Board is supporting a number of salaried practices and will, given the risks, retain operational management for these services at this time. This decision will be reviewed in 18 months. Responsibility for the management and maintenance of the Primary Medical Services Performers Lists will remain a Health Board function in line with the Board's contractual duties.

6. Corporate Support to the Integration Joint Boards

6.1 NHS Forth Valley will continue to prepare a joint performance report (bringing together Local Authority and NHS Board information for the nationally agreed six integration measures). The assurance report will compare over time performance and benchmark each of the IJBs against national data. The Chief Officer in this regard will be expected in presenting the report to provide assurance and/or interventions to improve performance.

6.2 In addition to the above the NHS Board has agreed to provide 'Data Protection Officer' support through the NHS Board's Head of Information Governance to the Integration Joint Board in response to the General Data Protection Regulation legislation.

6.3 The Chief Executive is also in discussion with the Chief Officer to further inform corporate support to the Integration Joint Board and Partnership.

6.4 Ongoing financial support to the Chief Finance Officer will continue, directed by the Director of Finance.

7. Conclusions

7.1 It is intended that the paper provides assurance to the Health Board and to each of the Integration Joint Boards on the commitment to support the Health and Social Care Partnerships deliver community-based, integrated services that provide best value, best care and best experience for the people of Forth Valley.

7.2 Work is underway by the Senior Leadership Team to meet the commitment to delegate operational management for Phase 1 by 1 September 2018 and to complete Phase 2 by the end of March 2019. Chief Officers will be supported during this transition to ensure a smooth transfer of operational management.

7.3 The Integration Joint Board should also note the significant and ongoing work to develop the integrated management arrangements to support the delegation of services. This will include staff side engagement. Staff side engagement through the NHS will continue to be led by the Chief Executive with regular updates through the Area Partnership Forum and each Joint Staff Forum.

7.4 A further update on progress including project arrangements and a detailed Implementation Plan will be shared at subsequent meetings.

8. Resource Implications

8.1 The paper proposes no additional budget allocation as staff will continue to operate in their current roles aligned wherever possible to the co-produced Locality Structures of each Partnership.

9. Impact on Strategic Plan Priorities and Outcomes

9.1 Developing operational management arrangements for services in-scope is core to transforming health and social care.

10. Legal & Risk Implications

10.1 A risk assessment will be included as part of the development of arrangements.

11. Consultation

11.1 The phased implementation plan to support the further operational management delegation has been developed by the Chief Executives of the NHS, supported by Chief Officers and key senior managers, including HR and Finance from both the Health Board and Local Authorities. A weekly meeting chaired by the Chief Executive will support this transition. The Group met on

Friday 1 June and a note will be circulated to IJB members outwith meeting cycles to demonstrate progress.

Staff side engagement will continue to be led by the Chief Executive with regular updates through the Area Partnership Forum and each Joint Staff Forum.

12. Equality and Human Rights Impact Assessment

12.1 Due regards will be given to the Equality Act 2010 and compliance with the three aims of the Equality Duty as part of the decision making process.

13. Appendices

14.1 Appendix 1 – Delegation Summary Service Profiles
14.2 Appendix 2 – Principle for Hosting

PHASE 1: DELEGATION SUMMARY SERVICE PROFILES

1. DISTRICT NURSING
    a. DESCRIPTOR
    b. MANAGEMENT ARRANGEMENTS
    c. BUDGET

2. COMMUNITY HOSPITALS

3. ReACH

4. LEARNING DISABILITIES / COMMUNITY RESIDENTIAL RESOURCES

5. COMMUNITY MENTAL HEALTH FOR OLDER PEOPLE

Summary Service Profile – District Nursing

1. Description of Service

The District Nursing Service plays a crucial role within the primary healthcare team. They visit people within their own homes or in residential care homes, providing increasingly complex care for patients and supporting family members.

District Nurses support people to remain in their own home by

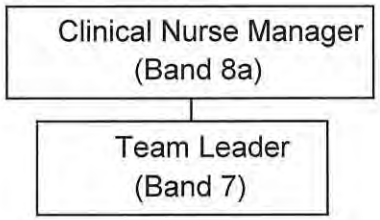
- Utilising collaborative, holistic assessment processes, educating and supporting patients/ carers in self care and management
- Using asset based approaches to service development, which recognises resources within the community
- Focussing on re-ablement, rehabilitation and recovery
- Providing open and accessible communication pathways
- By working in partnership with local authority to enable more adults to remain in their own homes
- Identifying individuals with LTC that are more likely to require hospital admission and anticipating and mitigating against this by use of ACP approaches
- Increased support during times of crisis, acute illness and end of life care in collaboration with partners, including third sector
- Contribute to the development of effective IT systems that will enable the sharing of appropriate information across services
- Work to develop a single point of access/ referral for service users to prevent duplication and maximise effective use of resource

The District Nursing Team provides a 7 day service which includes a separate Night Nursing team which operates as a single Forth Valley Wide Team.

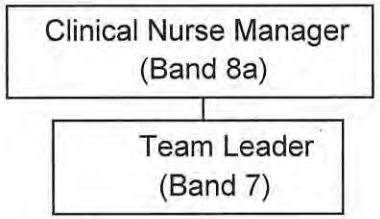
The Closer to Home Enhanced Community Team operates as a single Forth Valley wide service currently funded through Partnership Funds by both Integration Joint Boards.

2. Current Operational Management Arrangements

Falkirk



Clackmannanshire & Stirling



3. Budgets & Workforce

Service	Future Year Annual Budget Total IJB £	Future Year Annual Budget C/S IJB £	Future Year Annual Budget F IJB £	Future Year WTE Establishment Total IJB	Future Year WTE Establishment C/S IJB	Future Year WTE Establishment F IJB
District Nursing Services	7,462,167	3,473,759	3,988,408	163.74	74.18	89.56

Summary Service Profile – Community Mental Health Nursing Services (Older Adult)

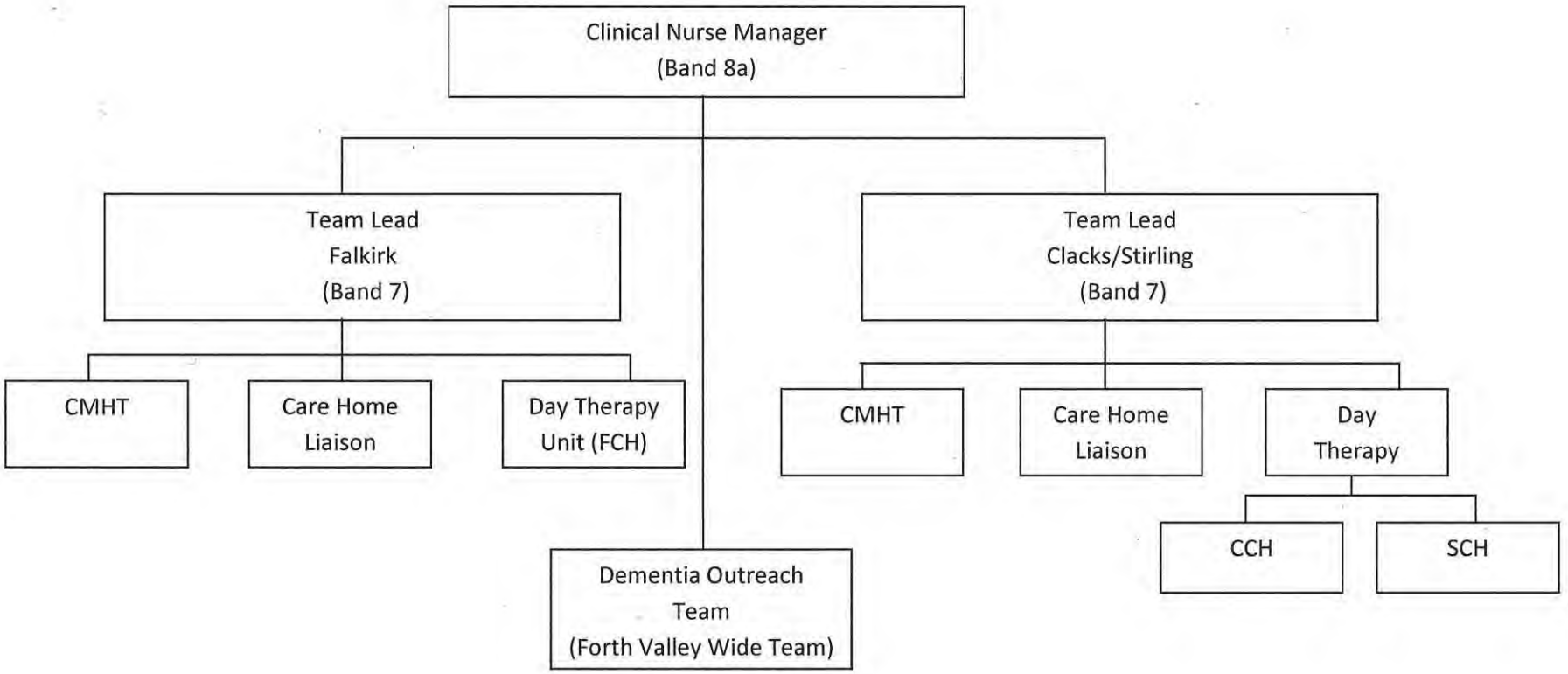
1. Description of Service

The Community Mental Health Team for Older Adults (CMHT(OA)) provide specialist mental health assessment, diagnosis and treatment interventions for people over 65 years and for people under 65 years with memory impairment. Assessments are provided in the patient's own home, out-patient clinics, Day Therapy Unit and other community settings including care homes. A range of disciplines work within the team, including medical staff, occupational therapists, psychologists and nursing staff including CPN's, Healthcare Support Workers, Dementia specialist nurses, CBT nurse therapist and care home liaison nurse. The service has close links with and accepts referrals from local authority partners, third sector providers, GP's, Acute and Community Hospitals, REACH and district nursing. There is a strong history of successful partnership working with these services.

The service is based at Falkirk Community Hospital, Stirling Community Hospital and Clackmannan Community Healthcare Centre. CPN's, Occupational Therapists, Day Therapy Unit and Consultant Psychiatry are co –located in each of the team locations. CPN's work in sectorised teams aligned to specific GP practices.

The Dementia Outreach Team is a specialist crisis response team which operates as a Forth Valley Wide Service.

2. Current Operational Management Arrangements



3. Budgets & Workforce

Service	Future Year Annual Budget Total IJB £	Future Year Annual Budget C/S IJB £	Future Year Annual Budget F IJB £	Future Year WTE Establishment Total IJB	Future Year WTE Establishment C/S IJB	Future Year WTE Establishment F IJB
Community Mental Health for Older People	1,906,817	804,981	1,101,836	46.11	18.96	27.15

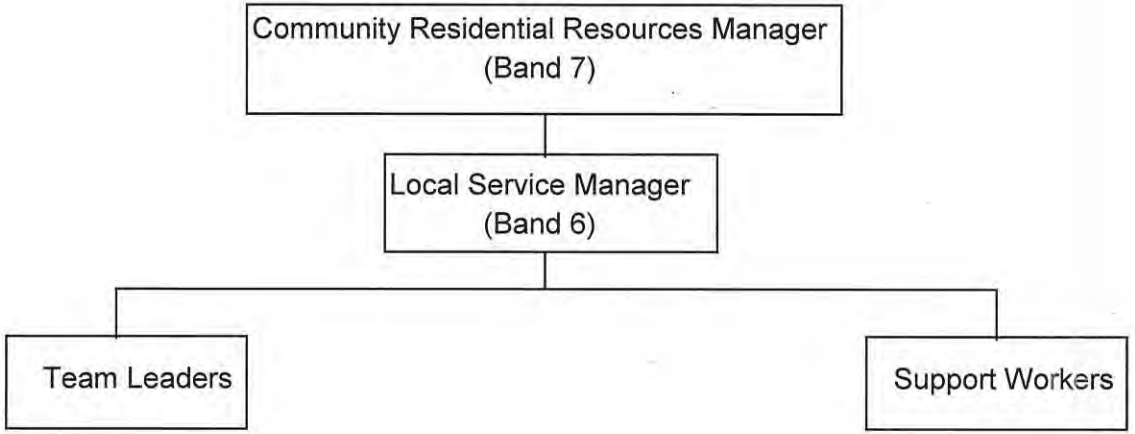
Summary Service Profile – Learning Disability Community Residential Resources

1. Description of Service

The Community Residential Resources provide accommodation and support across five locations as follows:-

Service Name	Type of service provision	No of service users
Ercall Road (2A + 2B) Falkirk	Care Home	8
Alanmor (2 + 2A) Falkirk	Housing Support	7
Arnothill (14 + 14A) Falkirk	Housing Support	5
Randolph Road Stirling	Housing Support	5
St.Blane's Stirling	Housing Support	4

2. Current Operational Management Arrangements



3. Budgets & Workforce

Service	Future Year Annual Budget Total IJB £	Future Year Annual Budget C/S IJB £	Future Year Annual Budget F IJB £	Future Year WTE Establishment Total IJB	Future Year WTE Establishment C/S IJB	Future Year WTE Establishment F IJB
Community Learning Disability Residential Resources	980,153	477,409	502,744	57.39	27.95	29.44

Summary Service Profile – Rehabilitation Care Group

1. Description of Service

The care group provides a range of services:

1. Community Rehabilitation

- ReACH South(Falkirk) and ReACH North(Stirling/Clacks) provide:
  - Multidisciplinary community rehabilitation to predominantly but not exclusively, older adults
  - Domicillary Physiotherapy and some uni-disciplinary Occupational Therapy input to specific patient groups
- ReACH Forth Valley provides specialist, mainly neurological multidisciplinary rehabilitation, to adults. It includes early supported discharge service for stroke, spasticity management service as well as vocational rehabilitation and technology solutions, including environmental control service
- ReACH teams also provide both inpatient rehabilitation within Falkirk, Stirling and Clacks Community Hospitals and specialist inpatient rehabilitation within brain injury ward FCH
- ReACH also provides generalist rehab to patients and specialist neurological outpatient service as part of Rehab centre, FVRH
- Community Weekend Service

2. Integrated Intermediate Care Services

- Reablement services
- Rehab at home
- Intermediate care beds
- Therapeutic day care

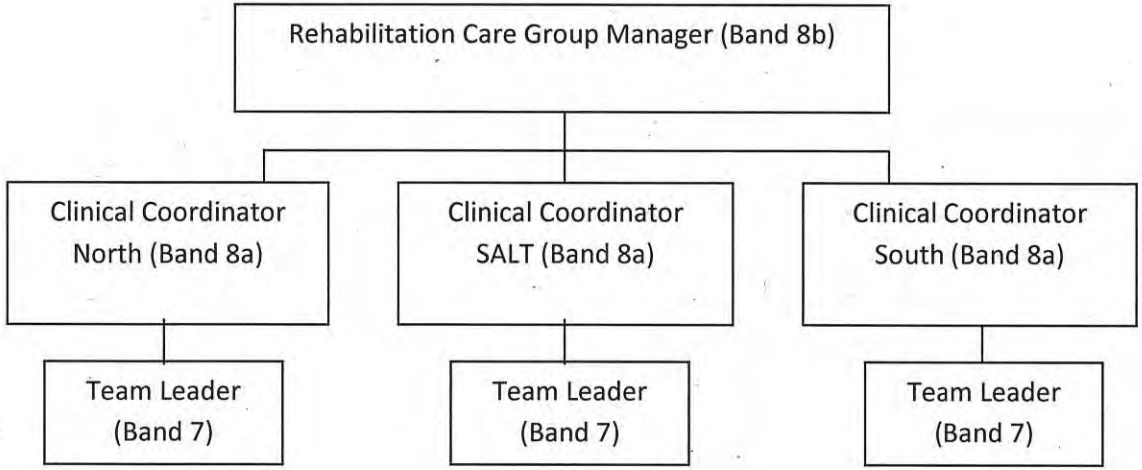
3. Rehabilitation Element Within Other Services

- Enhanced community team, as part of Closer to Home
- Rapid Access Frailty Clinic
- Physiotherapy On call within the Acute Care Group

4. **Speech and Language Therapy** - Forth Valley wide adult service (Acute inpatients including neonatal, community hospital inpatient, community and outpatients) delivered as a single service.

5. **Services that are Out of Scope for Health and Social Care Integration**
   - Working Health Services and Fit for Work

2. Current Operational Management Arrangements



Note that some of the Clinical Co-ordinator team leader roles are part-time

3. Budgets & Workforce

Service	Future Year Annual Budget Total IJB £	Future Year Annual Budget C/S IJB £	Future Year Annual Budget F IJB £	Future Year WTE Establishment Total IJB	Future Year WTE Establishment C/S IJB	Future Year WTE Establishment F IJB
ReACH	2,800,085	1,321,396	1,478,689	69.95	33.01	36.94

Summary Service Profile – Community Hospital Inpatient Service

1. Description of Service

All Community Hospitals operate on a Forth Valley wide basis as part of a whole system integrated approach. In particular Stroke Rehabilitation has been provided from SCH and Specialist Neuro Rehabilitation from FCH. In practice patients with a postcode have, where possible, been transferred from FVRH to the hospital closest to their home and social networks, it is intended that this continues.

All four Community Hospitals provide a range of services mainly to older people, people with long term conditions, physical and/or mental frailty (cognitive impairment). This includes palliative care, Hospital based long term complex care, rehabilitation. Medical support to the inpatient services is provided through a mix of Advanced Nurse Practitioners, GP mainstream services and Portfolio GPs.

The medical staffing profile and budget for the inpatient services is held by the Community Services Directorate.

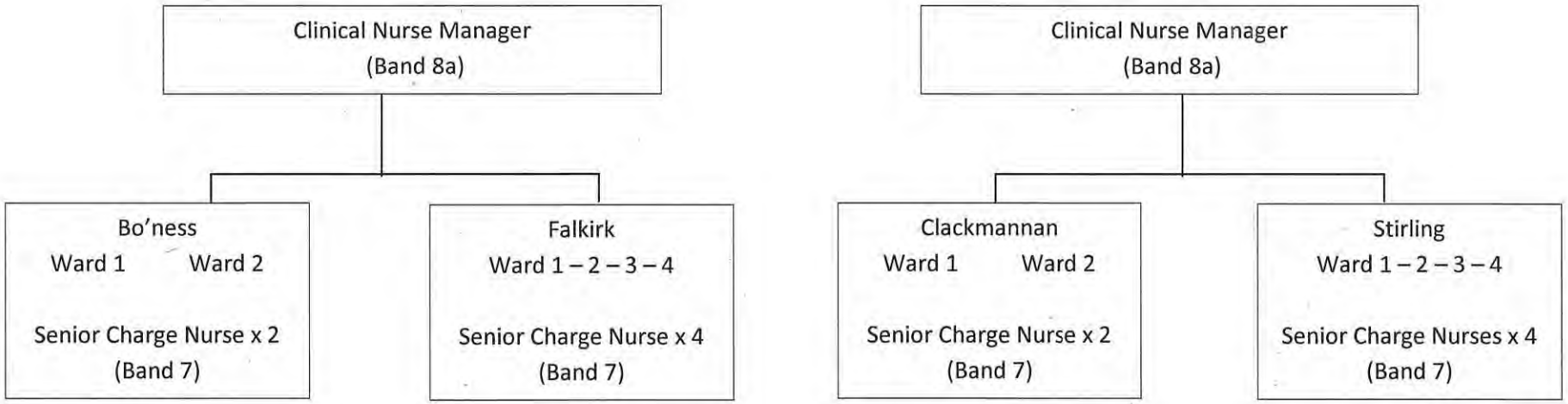
Three of the four Community Hospitals, excluding Bo'ness, have access to on site Physio and OT provided by assistants and qualified staff. All other services including pharmacy are provided on either a referral eg dietetics, or by timetabled visits such as pharmacy.

Work is underway to revisit the acute hospital footprint as part of wider estates review to support a growing demand in acute/hospital services, this review will take into account how we utilise community hospitals to support integrated pathways of care that take account of the six essential actions described in the unscheduled care programme led by the Medical Director.

Table 1 **Community Hospital Service Profile**

Site	Ward	Bed Numbers	Function
Clackmannan Community Campus	1 2	25 20	Frail Elderly/Rehab Old Age Psychiatry
Stirling Community Hospital	1 2 3 4	12 18 25 26	General Function Old Age Psychiatry Rehab/Stroke Rehab
Falkirk Community Hospital	1 2 3 4	24 24 24 16	Rehab/Neurology Rehab Rehab Cognitive Impairment
Bo'ness Community Hospital	1 2	20 16	General Function Old Age Psychiatry

2. Current Operational Management Arrangements



3. Budgets & Workforce

Service	Future Year Annual Budget Total IJB £	Future Year Annual Budget C/S IJB £	Future Year Annual Budget F IJB £	Future Year WTE Establishment Total IJB	Future Year WTE Establishment C/S IJB	Future Year WTE Establishment F IJB
Community Hospital (inpatient services)	**10,857,289**	**5,295,517**	**5,561,772**	**295.33**	**148.13**	**147.20**

PRINCIPLES FOR HOSTING:

- INTERESTS OF SERVICE USERS
- PROTECTS AND IMPROVES SAFETY / QUALITY
- MAKES BEST USE OF RESOURCES
- MAINTAINS SERVICE SUSTAINABILITY
- ATTRACTIVE TO RECRUITMENT/ RETENTION
- MIXED CHILDREN / ADULT SERVICE
- SIZE OF SERVICE (economies of scale)
- FORTH VALLEY IDENTITY – DIFFERENT MODELS; DIFFERENT OUTCOMES
- WHERE SERVICES ARE SUBJECT TO NATIONAL TARGETS

Clackmannanshire & Stirling
Integration Joint Board

13 June 2018

This report relates to
Item 10.3 on the Agenda

Clinical & Care Governance

For Approval

Approved for Submission by	Shiona Strachan, Chief Officer
Authors	Andrew Murray, Medical Director, Marie Valente, CSWO, Stirling Council; Celia Gray, CSWO, Clackmannanshire Council
Date:	13 June 2018
List of Background Papers/Appendices:	
Appendix 1 – Draft Clinical and Care Governance Framework for IJB	

Title/Subject: **Clinical & Care Governance – Partnership Group**

Meeting: **Clackmannanshire & Stirling, C&CG**

Date: **13 June 2018**

Submitted By: **Andrew Murray, Medical Director; Marie Valente, Chief Social Work Officer, Stirling Council; Celia Gray, Chief Social Work Officer, Clackmannanshire Council**

Action: **For Discussion**

1. Introduction

1.1. The purpose of this paper is to inform the Integration Joint Board of the proposed update to the Framework for development of a Partnership approach to Clinical and Care Governance.

2. Executive Summary

2.1. To inform the discussion the updated Framework is attached in appendix 1, which outlines the membership, purpose and structure.

2.2. The original Framework was approved in 2016 and was Forth Valley-wide. This Framework applies only to the Clackmannanshire & Stirling Integration Joint Board and the Partnership arrangements for Clinical and Care Governance.

3. Recommendations

3.1. The Integration Joint Board is asked to review and approve the updated Framework.

4. Background

The original Framework was approved in 2016 with agreement at that time that as the operational and strategic arrangements for service integration progressed the Framework would be reviewed. This paper and appendix 1 outlines the outcome of the review for consideration by the Integration Joint Board.

5. Conclusion

This paper presents the outcome of the review of the Clinical and Care Governance arrangements for the Partnership carried out by the Clinical and Care Governance leads.

6. Resource Implications

6.1 Services are provided within existing resources.

7. Impact on Integration Joint Board Outcomes, Priorities and Outcomes

7.1. The actions outlined in this report contribute to the delivery of the National and Local outcomes set out in the Strategic Plan.

8. Legal & Risk Implications

8.1. N/A

9. Consultation

9.1. N/A

10. Equality and Human Rights Impact Assessment

10.1. The contents of this report do not require an EQIA. The author can confirm that due regard has been give to the Equality Act 2010 and compliance with the three aims of the Equality Duty as part of the decision making process.

11. Data Protection Impact Assessment

11.1 The contents of this report do not require a DPIA**.**

12. Exempt reports

12.1. No.

CLACKMANNANSHIRE & STIRLING NHS FORTH VALLEY CLINICAL AND CARE GOVERNANCE FRAMEWORK

The Scottish Government, National Health and Wellbeing Outcomes: A framework for improving the planning and delivery of integrated health and social care services:

"Health and social care services should focus on the needs of the individual to promote their health and wellbeing, and in particular, to enable people to live healthier lives in their community. Key to this is that people's experience of health and social care services and their impact is positive; that they are able to shape the care and support that they receive; and that people using services, whether health or social care, can expect a quality service regardless of where they live."

Public Bodies (Joint Working) (Scotland) Act 2014

20 April 2018

1. INTRODUCTION **3**
2. PURPOSE OF THE FRAMEWORK **3**
3. DEFINITION OF CLINICAL AND CARE GOVERNANCE **4**
4. ROLE OF A CLINICAL AND CARE GOVERNANCE COMMITTEE IN MONITORING AND ASSURING THE QUALITY AND CARE OF SERVICES **5**
5. ROLES AND RESPONSIBILITIES **6**
CHAIRS, COUNCIL LEADERS, NHS NON-EXECUTIVE DIRECTORS & ELECTED MEMBERS 6
CHIEF EXECUTIVES, CHIEF OFFICERS, DIRECTORS OR EQUIVALENT 7
6. PROFESSIONAL LEADERSHIP **8**
NHS MEDICAL DIRECTOR 8
NHS NURSING DIRECTOR 8
CHIEF SOCIAL WORK OFFICER 9
ALL THOSE PROVIDING CARE & SERVICES 9
7. REPORTING ARRANGEMENTS **10**
8. INFORMATION, GOVERNANCE AND SHARING **10**

DRAFT

1. Introduction

The main purpose of the integration of health, social work and social care services in Scotland is to improve the wellbeing of people who use such services, in particular those whose needs are complex and who require services and support from both health and social care.

Integration Schemes, drawn up for the Clackmannanshire and Stirling and NHS Forth Valley Integration Joint Board (IJB) are intended to arrange services that can deliver better outcomes for people requiring support services. Services will be set up to deliver the national health and wellbeing outcomes that are prescribed by Scottish Ministers in Regulations under Section 5(1) of the Public Bodies (Joint Working) (Scotland) Act 2014[1].

The national health and wellbeing outcomes apply across all integrated health and social care services, and ensure that Health Boards, Local Authorities and Integration Joint Boards are clear about responsibility and accountability for the delivery of shared priorities. Scottish Ministers will also bring together performance management arrangements for health and social care. National health and wellbeing outcomes, together with the integration planning and delivery principles, are grounded in a human rights based and social justice approach.

2. Purpose of the framework

The context in which the clinical and care governance framework for the Integration Joint Board (IJB) will be implemented is one of a developing legislative framework with a wide range of policy drivers. Partner organisations across Clackmannanshire & Stirling and NHS Forth Valley will work to deliver services that are responsive, integrated and coordinated to meet the needs of individuals and communities in line with the strategic intentions expressed in law and policy.

Improved outcomes and effective services for service users and their unpaid carers require alignment of culture, values and language. This framework is intended to empower clinical and care staff to contribute to the improvement of quality of care, to make care safer, more effective and person centred – by making sure that there is a strong voice of the people and communities who use services.

The clinical and care governance arrangements described in this framework are designed to assure the Integration Joint Board, NHS Forth Valley and Clackmannanshire Council and Stirling Council, that the quality and safety of services delivered by staff, and the outcomes achieved from delivery of those services, are the best possible and make a positive difference. The diagram at Figure 1 illustrates lines of accountability.

[1] Power to prescribe national outcomes Public Bodies (Joint Working) (Scotland) Act 2014

It is acknowledged that this framework will be updated to reflect experience of joint working and as local requirements for services are better understood and evolve.

In addition, the framework will evolve as service delivery models change and the workforce become more integrated and changes to regulation occur.

3. Definition of Clinical and Care Governance

The Scottish Government's National Framework, to guide Health and Social Care Partnerships on the setting up of their clinical and care governance arrangements has served as a useful foundation document for the Clackmannanshire & Stirling IJB Framework.

3.1. Annex C of the National Clinical and Care Governance Framework sets out in some detail the working definition to be applied to Integrated Health and Social Care Services in Scotland. This working definition is as follows:

a) Clinical and care governance is the process by which accountability for the quality of health and social care is monitored and assured, building on existing governance systems. It should create a culture where delivery of the highest quality of care and support is understood to be the responsibility of everyone working in the organisation – built upon partnership and collaboration within teams and between health and social care professionals and managers.

b) It is the way by which structures and processes assure Integration Joint Boards, Health Boards and Local Authorities that this is happening – whilst at the same time empowering clinical and care staff to contribute to the improvement of quality – making sure that there is a strong voice of the people and communities who use services, their unpaid carers and their families.

c) Clinical and Care Governance should have a high profile, to ensure that quality of care is given the highest priority at every level within integrated services. Effective clinical and care governance will provide assurance to patients, service users, unpaid carers, clinical and care staff, managers, and members of the Integration Joint Board on the following:

- Quality of care, safety of service users, effectiveness and efficiency drive decision making about the planning, provision, organisation and management of services.
- The planning and delivery of services take full account of the perspective of patients, service users, unpaid carers, and their families.
- Unacceptable clinical and care practice will be detected and addressed.

d) Effective Clinical and Care Governance is not the sum of all these activities; rather it is the means by which these activities are brought

together into this structured framework and linked to the corporate agenda of Integration Authorities, NHS Boards and Local Authorities.

e) An important element of clinical and care governance is to support staff in continuously improving the quality and safety of care. However, it will also ensure that wherever possible poor performance is identified and addressed.

f) Clinical and care governance issues may relate to the organisation and management of services rather than to individual decisions. All aspects of the work of Integration Authorities, Health Boards and Local Authorities should be driven by and designed to support efforts to deliver the best possible quality of health and social care. Clinical and care governance is principally concerned with those activities which directly affect the care, treatment, protection and support people receive whether delivered by individuals or teams.

4. Role of a Clinical and Care Governance Group in monitoring and assuring the quality of care and services

The priorities of the IJB will be outlined in the Strategic Plan. This will link closely with Clackmannanshire Alliance and Stirling's Community Planning Partnership arrangements and delivery plans. Successful strategic planning will result in partnership working to deliver and plan services that focus on people and their outcomes. The IJB will have a plan that sets out its arrangements for integrated health and social care and how those arrangements will lead to the improvement of the outcomes for the communities it serves.

The quality of care provided within the Health and Social Care Partnership will be overseen by a Clinical and Care Governance Group (CCGG) reporting to the Integration Joint Board. This will provide assurance to the IJB, NHS Forth Valley and respective Councils that clinical and care governance as part of the planning and delivery of services is being delivered effectively.

To maintain their independence, the statutory responsibility for Mental Health Officers with regard to practice standards (including Adults with Incapacity and Guardianship responsibilities) will remain the responsibility of the respective Councils exercised through the role of the Chief Social Work Officer.

The members of the Clinical Care Governance Group will include:

- Chief Officer
- Chief Social Work Officer (Co-chair)
- Professional Lead – GP*
- Professional Lead – Nurse/AHP*

  * the Medical Director and Director of Nursing will provide support and advice as Clinical Leads to the professional leads and initially co-chair
- Independent Sector Representative
- Reelvant senior adult social care or locality managers

- Head of Clinical Governance

This membership will be reviewed after 12 months and reconfigured as guided by learning throughout the year. The role of the CCGG will be to ensure that there is effective clinical and care governance within the Partnership that provides assurance to patients, service users, unpaid carers and their families, clinical and care staff, managers, and members of the IJB.

The CCGG will be responsible for ensuring that the five key principles outlined in the National Framework of clinical and care governance is delivered by the IJB:

1. The Partnership has clearly defined governance functions and roles are performed effectively.

2. Values of openness and accountability are promoted and demonstrated through actions.

3. Informed and transparent decisions are taken to ensure continuous quality improvement.

4. Staff are supported and developed.

5. All actions are focused on the provision of high quality, safe, effective and person-centred services underpinned by a human rights based ethos.

DRAFT

The basis for the work of each CCGG is set out as five process steps in the National Framework:

1. Information on the safety and quality of care is received
2. Information is scrutinised to identify areas for action
3. Actions arising from scrutiny and review of information are documented
4. The impact of actions is monitored, measured and reported
5. Information on impact is reported against agreed principles.

This will include review and scrutiny as appropriate of key information including that relating to:

- The National Health and Wellbeing outcomes
- The National Health and Care Standards
- The quality and safety of integrated health and social care services, including health and safety issues
- Service user and unpaid carer engagement
- Thematic analysis of adverse event data including complaints and Duty of Candour as it relates to the Partnership services
- Significant adverse events including significant case reviews
- Impact assessment and learning from external publications (including policies, guidelines, inquiries, monitoring and standards)
- Professional regulation and fitness to practice
- Responses to external scrutiny and internal investigation
- The quality of decision making by Mental Health Officers
- The quality of practice in relation to Adults with Incapacity, Adult Support & Protection and the Mental Health Care and Treatment statutory framework
- Clear delineation of responsibility/accountability around the roles and interdependencies of the Chief Officer and the Chief Social Work Officers.

The CCGG will establish an information sharing and strategic relationship with the Chief Officers Public Protection Group.

5. Roles and Responsibilities

The National Framework identifies clear roles for members of the IJB and how they fulfil these.

<u>Chairs, Council Leaders, NHS Non-Executive Directors & Elected Members will:</u>

- Create an organisational culture that promotes human rights and social justice, values partnership working through example; affirms the contribution of staff through the application of best practice including learning and development; is transparent and open to innovation, continues learning and improvement.

DRAFT

- Establish that integrated clinical and care governance policies are developed and regularly monitor their effective implementation.

- Seek reassurance that practice and standards related to public protection are robust.

- Require that rights, experience, expertise, interests and concerns of service users, unpaid carers and communities inform and are central to the planning, governance and decision-making that informs quality of care.

- Ensure that transparency and candour are demonstrated in policy, procedure and practice.

- Seek assurance that effective arrangements are in place to enable relevant Health and Social Care professionals to be accountable for standards of care including services provided by the third and independent sector.

- Require that there is effective engagement with all communities and partners to ensure that local needs and expectations for health and care services and improved health and wellbeing outcomes are being met.

- Ensure that clear robust, accurate and timely information on the quality of service performance is effectively scrutinised and that this informs improvement priorities. This should include consideration of how partnership with the third and independent sector supports continuous improvement in the quality of health and social care service planning and delivery.

- Seek assurance on effective systems that demonstrate clear learning and improvements in care processes and outcomes.

- Seek assurance that staff are supported when they raise concerns in relation to practice that endangers the safety of service users and other wrong doing in line with local policies for whistleblowing and regulatory requirements.

<u>Chief Executives, Chief Officers, Directors or Equivalent will:</u>

- Embed a positive, sharing and open organisational culture that creates an environment where partnership working, openness and communication is valued, staff supported and innovation promoted.

- Provide a clear link between the organisational and operational priorities of NHS Forth Valley, Clackmannanshire Council and Stirling

DRAFT

Council; objectives and personal learning and development plans, ensuring staff have access to necessary support and education.

- Implement quality monitoring and governance arrangements that include compliance with professional codes, legislation, standards, guidance and that these are regularly open to scrutiny. This must include details of how the needs of the most vulnerable people in communities are being met.

- Implement systems and processes to ensure a workforce with the appropriate knowledge and skills to meet the needs of the local population.

- Implement effective internal systems that provide and publish clear, robust, accurate and timely information on the quality of service performance.

- Develop systems to support the structured, systematic monitoring, assessment and management of risk.

- Implement a coordinated risk management, complaints, feedback and adverse events/incident system, ensuring that this focuses on learning, assurance and improvement.

- Lead improvement and learning in areas of challenge or risk that are identified through local governance mechanisms and external scrutiny.

- Develop mechanisms that encourage effective and open engagement with staff on the design, delivery, monitoring and improvement of the quality of care and services.

- Promote planned and strategic approaches to learning, improvement, innovation and development, supporting an effective organisational learning culture.

- Ensure compliance with professional standards, codes of practice and performance requirements and alignment of activities with organisational objectives and service user outcomes.

- Promote learning from good practice, adverse incidents, complaints and risks.

- Create an environment that supports the contribution of staff, their safety and professional development as well as supporting and enabling innovation.

- Establish clear lines of communication and professional accountability from point of care to Executive Directors and Chief Professional Officers/Leads accountable for clinical and care governance:

DRAFT

- This will include a relationship of accountability between the Adult Support and Protection Committee; the Child Protection Committee; the MAPPA Strategic Oversight Group; the Alcohol and Drugs Partnership; and, the Gender Based Violence. It is expected that the Public Protection Chief Officers Group would undertake this function.

- It is expected that this will include articulation of the mechanisms for taking account of the training environment for all health and social care professionals training (in order to be compliant with all professionals' regulatory requirements).

6. Professional Leadership

The Chief Social Work Officers, the NHS Medical Director and the NHS Nursing Director (together, "the CCG Leads") will take the lead role in relation to Clinical and Care Governance. The NHS Medical and Nursing Directors will have arrangements in place for co-ordinating these functions across clinical groups. The Chief Social Work Officers will have arrangements in place for co-ordinating these functions across social care groups.

NHS Medical Director

The NHS Medical Director is the individual appointed by NHS Forth Valley to provide the professional leadership for medical services and appointed by the Scottish Ministers as an Executive Board Member of NHS Forth Valley.

NHS Nursing Director

The NHS Nursing Director is the individual appointed by NHS Forth Valley to provide the professional leadership for nursing and midwifery services and appointed by the Scottish Ministers as an Executive Board Member of NHS Forth Valley.

Chief Social Work Officers

The role of the Chief Social Work Officers (CSWO) is to provide professional advice on the provision of social work services which assists authorities in understanding many of the complexities which are inherent across social work services. The principal functions relate to governance, management of risk, protection and the deprivation of liberty. The CSWOs are 'proper officers' in relation to the social work function: an officer given particular responsibility on behalf of a local authority, where the law requires the function to be discharged by a specified post holder. The CSWOs have responsibility to advise on the specification, quality and standards of services commissioned.

The Medical Director and the Chief Social Work Officers will be responsible for providing professional advice to the IJB and the Chief Officer including any risks inherent in relation to any proposed actions.

All those providing care & services

Each individual professional is expected to ensure that their professional practice and continuing educational development is evidence based with a focus on regulatory and continuous professional development requirements and standards therefore they will:

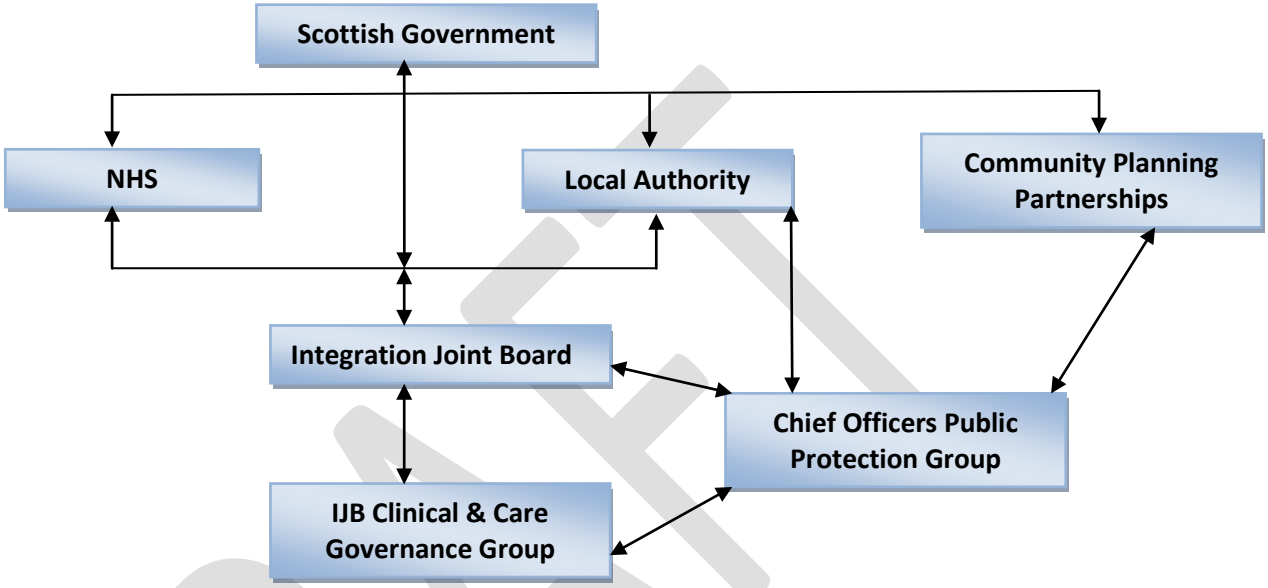
- Practice in accordance with their professional standards, codes of conduct and organisational values.
- Be responsible for upholding professional and ethical standards in their practice and for continuous development and learning that should be applied to the benefit of the public.
- Understand their responsibilities relating to Public Protection.
- Have the necessary policies and procedures in place to report and manage incidents of suspected, witnessed or actual harm.
- Ensure the best possible care and treatment experience for service users and families.
- Provide accurate information on quality of care and highlight areas of concern and risk as required.
- Work in partnership with management, service users, unpaid carers and other key stakeholders in the designing, monitoring and improvement of the quality of care and services.
- Speak up when they see practice that compromises the safety of patients or service users in line with local whistleblowing policy and regulatory requirements.
- Engage with colleagues, patients, service users, unpaid carers, communities and partners to ensure that local needs and expectations for safe and high quality health and care services, improved wellbeing and wider outcomes are being met.

DRAFT

Reporting Arrangements

The diagram below illustrates probable lines of accountability and reporting. Reports will be sent directly to the NHS Forth Valley Clinical and Care Governance Group and to the respective Council's Scrutiny Committees responsible for overseeing the quality of social work and social care services.

Figure 1



8. Information, Governance and Sharing

Existing information management and data sharing protocols will continue to be applied, and the standing principles that pertain to information governance will remain.

June 2018

DRAFT

Clackmannanshire & Stirling
Integration Joint Board

13 June 2018

This report relates to
Item 11 on the agenda

Carers Act Implementation

Paper presented by Caroline Cherry

For Approval

Approved for Submission by	Shiona Strachan, Chief Officer
Author	Caroline Cherry, Service Manager
Date:	13 June 2018
List of Background Papers: N/A	
Background: Carers (Scotland) Act 2016 and associated Regulations Previous reports to the Integration Joint Board **Appendices:** Appendix 1 Carers Act Regulations and Guidance Status February 2018 Appendix 2 Carers Act Implementation Sub Group Remit Appendix 3 Adult Carer Support Plan incorporating the local Eligibility Criteria Appendix 4 Proposed Carers Strategy Priorities 2018-2023	

Title: **Carers Act Implementation**

Meeting: **Clackmannanshire & Stirling Integration Joint Board**

Date: **13 June 2018**

Submitted By: **Caroline Cherry**

Action: **For Approval**

1. Introduction

1.1 This paper will provide an update on the implementation of the Carers (Scotland) Act 2016. The Carers Act Implementation Sub-Group is a sub group reporting to the Strategic Planning Group operating across the Health and Social Care Partnership developed to oversee and co-ordinate implementation until 2019. Members are asked to note and discuss the scope, progress and challenges of implementation.

1.2 The Carers Act National Steering Group has been established to oversee the process. They have produced an outline timeline, initiated a series of work streams, including pilots, and identified key areas that have been taken forward during 2017/18. An update on the legislative and regulatory programme is attached. (Appendix 1)

1.3 Health and Social Care Partnerships have been identified as having the lead role in the effective implementation of the Act at a local level for adults. A Carers Act Implementation Group was established to take forward preparations for implementation of the Carers Act from April 2018 in the Clackmannanshire and Stirling Partnership area.

1.4 It is proposed that this group continues to operate on a Partnership level for the next year with a clear remit as a formal sub group of the Strategic Planning Group. The revised remit is attached at appendix 2.

1.5 Each Local Authority has to publish eligibility criteria from the 1 April 2018 The Partnership covering the two Local Authorities for adults, agreed to follow the national guidance on eligibility criteria, which is attached at appendix 3. Critical and substantial needs are recommended to be met by statutory authorities. This was made available to the public on the 1 April 2018 as a draft but requires to be formally approved by the Board.

2. Executive Summary

2.1 The Implementation Sub-Group reviewed the Carers Act requirements based on the national programme and identified the main areas that are being taken forward locally. The outputs of the group will be supported by a timeline.

2.2 The Carers (Scotland) Act 2018, referred to as "the Act" came into force on the 1 April 2018. The Implementation sub-group has responsibility for the overview and co-ordination of the Act and a revised remit for the group is proposed. Membership is inclusive of children's service representation to allow for clear transition between children and adult carers. Duties and Powers remain with Local Authorities and one duty lies with the NHS.

2.3 Carers Centres will play an essential role implementing the Act. The IJB recommended extending existing funding to the Stirling Carers Centre and Central Carers Association (Falkirk and Clackmannanshire) pending a commissioning review of the services across the Health and Social Care Partnership area during the coming year. Business cases are now being progressed.

2.4 Over the past few months the priority of the sub group has been to develop operational guidance for adult social care staff in partnership with Carers Centres, operational guidance and pathways between adult services and the centres. Operational Guidance has had legal overview and staff involvement in the process and were finalised at the end of May 2018.

2.5 Challenges remain in terms of utilising the various strands of carers funding to underpin the implementation of the Act by developing business cases across the Partnership; deliver on a statement and funding around short breaks (by December 2018) and develop a carers strategy (by March 2019). The waiving of charges section of the Act is currently subject to further Scottish Government and COSLA review. Data collection is also required. Membership of the group will be refreshed to ensure it is fit for purpose.

2.6 Identification of carers and awareness of supports remains a challenge particularly with some groups of unpaid carers.

2.7 Initial anecdotal evidence suggests the greatest uptake since the Act came into force are young carer's statements.

2.8 Further work is required to scope the elements required in acute services including the duty to involve carers in discharge planning.

3. Recommendations

The Integration Joint Board is asked to approve:

3.1. The extension of the existing service level agreements (SLA) of the Carers Centre Contracts for 2018/19 to allow services to continue during the first phase for the Carers Act, pending service re-design across the Health & Social Care Partnership area in respect of:

- Stirling Carers Centre.
- Central Carers Association (Falkirk and Clackmannanshire).

3.2. Delegation of authority to the Chief Officer and Chief Finance Officer to agree proposed business case for additional funding, within the approved budget allocation, to the Stirling Carers Centre and the Central Carers Association (Falkirk and Clackmannanshire) to meet additional identified demand for carers' services in 2018/19 under the Carers (Scotland) Act 2016. This funding is pending service re-design across the Health & Social Care Partnership area.

3.4. Eligibility criteria outlined within the documentation in appendix 3

3.5. Priorities identified for inclusion in the Partnership Carers Strategy in appendix 4 which requires to be in place by March 2019.

4. Background

4.1. The Carers Act places significant duties and responsibilities on public bodies, which are described in a comprehensive range of regulations and statutory guidance which is currently being developed nationally. Commencement of the Carers (Scotland) Act 2016 took place on the 1 April 2018 with further implementation of sections of the Act planned.

5. Main Body Of The Report

5.1 The Act has a range of new provisions to identify, assess and support carers, the definition of a carer is also widened from someone carrying out regular or substantial care to the focus on the individual receiving community care services. The main delivery areas subject to guidance and regulation and current status are summarised in the table below.

Area	Status	Local Action	Timeline
Local Eligibility Criteria Guidance	Published	Draft Local Eligibility Criteria and guidance produced	In Place
Carers Census Data Guidance	Published	Being incorporated into assessment.	In Place
Supporting documentation to be produced (Strategy, LEC, ACSP, YCS).	Underway	Draft documentation produced	In Place
Regulations and supporting national guidance	Regulations due to be laid before Parliament.	Reflected in local operational guidance.	Statutory Guidance in place. Operational guidance almost complete.

5.2 Guidance on Local Eligibility Criteria has been published by the Scottish Government which has been adapted, after stakeholder engagement and incorporated into local processes for the production of Adult Carer Support Plans and Young Carer Statements. The eligibility framework is adapted to five categories based on potential impact:

- caring has no impact
- caring has low impact
- caring has moderate impact
- caring has substantial impact
- caring has critical impact

5.3 These categories are used to measure the impact of caring on seven key aspects of a carer's life including:

- health and wellbeing
- relationships
- living environment
- employment and training
- finance
- life balance
- future planning

5.4 We have incorporated this framework into guidance notes along with the development of a draft Adult Carers Support Action Plan detailed in Appendix 3.

5.5 The proposed business model for delivering the Carers Act is described in the guidance notes and involves identification and referral of unpaid carers to the Carers Centres to undergo initial screening at the Carers Centres and potential referral to statutory services if they meet the criteria for substantial or critical impact.

5.6 The intention is that the Carers Centres will provide an initial assessment and development of Adult Carers Support Plan and Young Carers Statement (if requested), information and advice to the majority of carers in the Partnership area. There are some differences in approach between the two localities but consistent standards of practice will be maintained. As 2018/19 is expected to be the transition year it will provide an opportunity to redesign the services provided to carers in a consistent way across the Partnership.

5.7 A national launch is currently being prepared and local arrangements, briefing arrangements and materials for staff and the public are currently under development.

6. Conclusions

6.1. Progress has been made taking a co-production approach to implementation with statutory services and carers organisations. The pace of implementation and level of complexity presents challenges particularly financially.

6.2. The development of an integrated approach within the partnership area requires agencies to work together and produce an approach which builds on existing good practice and takes advantage of mechanisms that are already in place.

6.3 The environment for delivering this agenda remains challenging with significant pieces of guidance and associated documentation still to be published along with greater confirmation of available resources.

6.4 A programmed approach is required to co-ordinate a series of clear processes, good practice and a consistent approach across all agencies.

7. Resource Implications

7.1. The total current spend on SLAs with the carers centres in 2018/19 is:-

- Stirling Carers Centre - £84,744;
- Central Carers Association (Falkirk and Clackmannanshire) £54,644.

7.2 A sum of £0.421m was allocated in the Integration Joint Board 2018/19 budget to support implementation of the Carers (Scotland) Act 2016 in line with the financial memorandum which underpins the legislation.

8. Impact on Strategic Plan Priorities and Outcomes

8.1. If the recommendation to extend the existing contracts for the Carers Centres is refused there is a risk that the Partnership will not be able to implement the Carers Act as there is not suitable resources available within the local authorities to provide.

8.2. There is a risk that potential services may challenge any decision to extend the existing agreements as this does not comply with procurement legislation or the Contract Standing Orders in Clackmannanshire Council and Stirling Council. This risk can be mitigated by minimising the duration of any extension period and developing a clear strategy for procuring services following appropriate service re-design. As this is non-compliant with Clackmannanshire Council or Stirling Council Contract Standing Orders the relevant officer will need to approve and sign an exception report on behalf of Clackmannanshire Council and a waiver report on behalf of Stirling Council to allow contracts/agreements to be continued.

Fit with Local Outcomes

Self Management	☒
Community Focussed Supports	☒
Safety	☐
Decision Making	☒
Experience	☒

Fit with Our Priorities 'we will...'	
Further develop systems to enable front line staff to access and share information	☒
Support more co-location of staff from across professions and organisations	☒
Develop single care pathways	☒
Further develop anticipatory and planned care services	☒
Provide more single points of entry to services	☒
Deliver the Stirling Care Village	☐
Develop seven-day access to appropriate services	☒
Take further steps to reduce the number of unplanned admissions to hospital and acute services	☒

9. Legal & Risk Implications

9.1. Given the nature of the changing timescales for detailed regulations, the Partnership may find it challenging to implement all aspects of the Carers Act and there may not be suitable resources available within the local authorities to provide services to meet need.

9.2. There is a risk that potential services may challenge any decision to extend the existing agreements as this does not comply with procurement legislation or the Contract Standing Orders in Clackmannanshire Council and Stirling Council. This risk can be mitigated by minimising the duration of any extension period and developing a clear strategy for procuring services following appropriate service re-design.

10. Consultation

10.1. Implementation of the Act is taking place across a multi agency partnership basis.

11. Equality and Human Rights Impact Assessment

11.1 An EQIA has been completed in respect of this paper.

12. Data Protection Impact Assessment

12.1 The content of this report does not require a DPIA.

13. Exempt reports

13.1. None

Appendix 1 Carers Act Regulations and Guidance Status June 2018

Regulations

The following summary table provides an update on the status of the secondary legislation being prepared for Carers Act implementation.

Those statutory instruments yet to be made will be scheduled in time to take effect on 1 April 2018. The only exception to this is the regulations setting timescales for adult carer support plans and young carer statements for carers of terminally ill persons. A study is currently underway to inform the development of these regulations later in 2018. Work continues at national level on refinement as outlined below.

Scottish Statutory Instrument	Purpose	Status
The Carers (Scotland) Act 2016 (Commencement No.1) Regulations 2017	Brings into effect consequential amendments to update legal references in the Public Bodies (Joint Working) (Scotland) Act 2014.	Passed
The Carers (Scotland) Act 2016 (Commencement No. 2 and Savings Provision) Regulations 2017	Brings into effect remaining provisions of the Carers Act in time for local eligibility criteria to be set from 1 October 2017; and for guidance and regulations to be made before the main provisions of the Act to come into effect on 1 April 2018.	Passed
The Carers (Scotland) Act 2016 (Agreements of a Specified Kind) Regulations 2017	Ensures that a kinship carer agreement with a local authority does not exclude someone from being seen as a carer under the Act (as long as they meet the other requirements of the definition).	Passed
The Public Bodies (Joint Working) (Prescribed Local Authority Functions etc.) (Scotland) Amendment Regulations 2017	Adds the responsibility for setting local eligibility criteria to the list of functions that must be delegated to Integrated Joint Boards.	Passed
The Carers (Scotland) Act 2016 (Prescribed Days) Regulations 2017	Sets 1 October 2017 as the start of the 6 month period for setting local eligibility criteria and sets the period for their first review at three years after	Passed

Scottish Statutory Instrument	Purpose	Status
	publication.	
The Public Bodies (Joint Working) (Prescribed Local Authority Functions etc.) (Scotland) Amendment (No.2) Regulations 2017	Lists the remaining Local Authority functions under the Act that must be delegated to Integration Joint Boards	Passed
The Public Bodies (Joint Working) (Prescribed Health Board Functions etc.) (Scotland) Amendment Regulations 2017	Lists further Health Board functions under the Act that may be delegated to Integration Joint Boards.	Passed
The Carers (Scotland) Act 2016 (Review of Adult Carer Support Plans and Young Carer Statements) Regulations 2018	To set out those circumstances which must always lead to a review of Adult Carer Support Plans and Young Carer Statements.	All before Parliament Current discussion with COSLA/SG
The Carers (Scotland) Act 2016 (Short Breaks Services Statements) Regulations 2018	To require certain information to be included n short breaks services statements, and to set out when and how the statements are to be published and reviewed.	
The Carers (Scotland) Act 2016 (Transitional Provisions) Regulations 2018	To set out how the duties under the Carers Act should apply to carers already assessed and receiving support.	
The Carers (Waiving of Charges for Support) (Scotland) Amendment Regulations 2018	Technical - To update the legal references in the Carers (Waiving of charges for support) (Scotland) Regulations 2014 to take account of the Carers Act.	
The Self-directed Support (Direct Payments (Scotland) Amendment Regulations 2018	Technical - To update the legal references in the Self-directed Support (Direct Payments) (Scotland) Regulations 2014 to take account of the Carers Act.	

Scottish Statutory Instrument	Purpose	Status
Carers of terminally ill person's regulations.	To set timescales for the preparation of adult carer support plans and young carer statements for carers of terminally ill persons.	To be developed. Late 2018.

Appendix 2 Clackmannanshire and Stirling Health and Social Care Partnership Carers Act 2016 Implementation Sub Group

Remit of Carers Act 2016 Implementation Sub Group

The overall remit of the Clackmannanshire and Stirling Health and Social Care Partnership Carers Act 2016 Implementation Sub Group is to work at a partnership level until 2019 and to act as a formal sub group to the Strategic Planning Group.

The group will co-ordinate the work required for the implementation of the Carers Act from April 2018 across the Clackmannanshire and Stirling Health and Social Care Partnership. Work will be progressed and monitored via a clear action plan.

The role of the Group is to develop the guidance, tools and training required to ensure that staff are able to support adults and in accordance with the agreed Local Eligibility Criteria.

The group is responsible for ensuring that systems are in place to gather and submit the data to the Scottish Government in accordance with the Act.

The group is also responsible for an overview of the required processes to monitor the performance of services to carers in the Clackmannanshire and Stirling Health and Social Care Partnership area and to identify good-practice, trends and gaps in service delivery. The aim is to inform the strategic commissioning of a range of services for carers and make recommendations to the Strategic Planning Group.

The provision of services to young carers sits within the governance of each Local Authority however this group will have an overview of young carers work in order to ensure transition planning is in place.

Membership of the group includes:

- Clackmannanshire and Falkirk Carers Centre
- Stirling Carers Centre
- Adult Services in Clackmannanshire and Stirling Council areas
- Children's Services in Clackmannanshire and Stirling Council areas
- Education Services in Clackmannanshire and Stirling Council areas
- Commissioning Services in Clackmannanshire and Stirling Council areas
- Business and Information Team in Stirling
- Performance and Quality Assurance Teams across Clackmannanshire and Stirling Council areas
- NHS Forth Valley

The group meets monthly to consider potential risks and to review and agree action points assigned to members of the group according to the timescales set

Clackmannanshire and Stirling Health and Social Care Partnership

GUIDANCE NOTES / OUTCOME FRAMEWORK

ADULT CARER SUPPORT PLANS

Background

There are around 12,958 people in the Clackmannanshire and Stirling Partnership area who identify themselves as unpaid carers (2011 census). However, the true figure is estimated to be around 23,000 (Scottish Health Survey, 2013), as many people do not recognise themselves as unpaid carers and are therefore not known to local services. Unpaid carers are one of the largest group of care providers in our area and should be recognised as equal partners in providing care and support.

The intention of the Scottish Government, through the enactment of the Carers (Scotland) Act 2016 is that Scotland's adult and young carers are better supported in terms of their health and wellbeing, and are better supported to continue in their caring role, if that is their wish.
The Act puts a duty on Clackmannanshire and Stirling Health and Social Care Partnership, Clackmannanshire Council and Stirling Council to provide support to carers, where identified needs meet agreed eligibility criteria. To achieve this, a framework of **eligibility criteria** has been developed covering two aspects:

1. The definition of levels and types of need for support
2. The thresholds that must be met to be eligible for support

The framework of eligibility criteria creates a fair and transparent system for determining eligibility and to ensure that support is provided to carers in different caring situations across a whole range of life circumstances. It will ensure that the limited public resources available are used to target those carers at their identified level of need.

Definition of a ‘carer’

With regards to the Carers (Scotland) Act 2016, a ‘carer’ is defined as someone who provides or intends to provide unpaid care for another individual (the ‘cared for person’).

This would exclude individuals who are providing care under or by virtue of a contract, or as voluntary work. This would also exclude individuals who are caring for a child under 18 years old and are only providing the care that would be required by virtue of the person’s age. This is to ensure that not all parents are regarded as carers for the purposes of the Act, except where they are caring for that child for a reason other than the child’s age. Therefore, parents of disabled children will be regarded as ‘carers’.

A young carer is a carer who is under 18 years old. It also includes carers who are 18 years old and are still in school.
An adult carer is a carer who is at least 18 years old and not still in school.

Adult Carer Support Plans (ACSP)

The Act introduces the right to all adult carers to an Adult Carer Support Plan based on a preventative model and approach to identify every carer's personal outcomes and needs for support. This is intended to improve access to support without there being any prerequisite that they are providing, or intend to provide, care on a regular or substantial basis. The Act will ensure that carers are recognised in their own right, and are treated as equal partners. The Adult Carer Support Plan will ensure meaningful conversations with individual carers to understand their personal needs and outcomes.
The Carers (Scotland) Act 2016 requires the Adult Carer Support Plan to set out:

- An adult carer's identified personal outcomes
- An adult carer's identified needs (if any): and
- The support (if any) to be provided by the responsible local authority to an adult carer to meet those needs

In Clackmannanshire and Stirling Health and Social Care Partnership, our approach to supporting carers will be underpinned by a strong commitment to preventative support and early intervention. This will ensure that carers feel supported to have a good quality of life and are able to continue in their caring role, should they wish to do so.

The ACSP will identify personal outcomes for the carer and include contingency plans should the situation change. Information and advice will also be provided at this stage, including carers' rights and income maximisation.

Staff will work jointly with carers to complete a personal Adult Carer Support Plan which will identify the carer's individual needs and personal outcomes. These will then be assessed in line with the agreed local eligibility criteria to ensure that the right level of support is delivered at the right time.

The Process

The Carers (Scotland) Act 2016 requires all authorities such as Clackmannanshire and Stirling Health and Social Care Partnership to set out local eligibility criteria and to have a duty to support carers who meet the eligibility criteria framework. The process of how this will happen can be broken down into four steps:

Step 1: If an adult carer wishes to access support, they should request an Adult Carer Support Plan (from their carers centre or social worker). This will involve conversations between the carer and practitioner to jointly assess the individual's caring situation and needs, and to also work out how the personal outcomes identified by the carer can be best achieved. The conversations between the carer and practitioner will focus on the impact of caring across eight key indicators (domains) of a carer's life:

- Physical health and well-being

- Emotional / mental health and well-being
- Life balance
- Finances
- Relationships
- Living environment
- Employment / Training
- Emergency planning/ Future planning

A carer may have an **eligible need** across one or more of the 8 domains, or may not have an eligible need across any of the domains. Regardless of whether a carer has an eligible need or not, they should have access to universal and or preventative services. Carers may also be signposted to relevant information and advice services, Carers Centres, or projects in the local area that provide services which meet their personal outcomes.

Step 2: When an Adult Carer Support Plan is complete and the carer's outcomes and actions are identified, then the carer's level of support and eligibility for services will be decided in terms of impact and risk of their caring role across the 8 key domains. There are five categories of impact and risk:

No Impact	This indicates that there are no quality of life issues as a result of a caring role and at this moment no need for support of advice
Low Impact	This indicates that there may be some quality of life issues resulting from a caring role but low risk to the carer's capacity for independence or health and wellbeing. There may be some need for universal and/or preventative support or advice.
Moderate Impact	This indicates that there is some risk to a carer's capacity for independent living and health and wellbeing. This may call for provision of some health and social care services.
Substantial Impact	This indicates that there is a major risk to a carer's capacity for independent living and health and wellbeing. It is likely to require urgent provision or health and social care services.
Critical Impact	This indicates that there are significant risks to a carer's capacity for independent living and health and wellbeing. It is likely to require immediate provision or social care services.

The impact and risk of the caring role will be assessed across each of the 8 domains. In determining a carer's risk or impact, it is important to recognise that the 8 domains will not always exist in isolation from one another. It is appropriate and advisable that the domains should be explored in relation to one another, as there may be a 'multiplier' effect when two or more domains overlap or interact. Similarly, some domains may be overarching, such as the ability to have a life alongside caring, which may be affected by the cumulative impact of the caring role in several areas of a carer's life.

	No Impact	Low Impact	Moderate Impact	Substantial Impact	Critical Impact
Finances	The carer's caring role is such that it is not causing financial hardship e.g. The carer can afford housing and utility costs	The carer's caring role is such that it is causing a risk of financial hardship e.g. some difficulty meeting housing and utility costs	The carer's caring role is such that it is causing some detrimental impact on finances e.g. difficulty meeting either housing costs OR utilities	The carer's role is such that it is having a significant impact on finances e.g. difficulty meeting housing costs AND utilities	The carer's caring role is such that it is causing severe hardship e.g. carer cannot afford household essentials and utilities, not meeting housing payments
Relationships	The carer has a good relationship with the person they care for and is able to maintain relationships with other key people in their life	The carer has some concerns about their relationship with the person they care for and/or their ability to maintain relationships with other key people in their life	The carer has identified issues with their relationship with the person they care for that need to be addressed and/or they find it difficult to maintain relationships with other key people in their life	The carer's relationship with the person they care for is in danger of breaking down and/ or they no longer are able to maintain relationships with other key people in their life.	The carer's relationship with the person they care for has broken down and their caring role is no longer sustainable and/or they have lost touch with other key people in their life
Living Environment	The carer's living environment is suitable and posing no risk to the physical health and safety of the carer or cared for person	The carer's living environment is mostly suitable but could pose a risk to the health and safety of the carer and cared for person in the longer term.	The carer's living environment is unsuitable but poses no immediate risk	The carer's living environment is unsuitable and poses an imminent risk to the health and safety of the carer and/or cared for person	The carer's living environment is unsuitable and there is immediate and critical risks to the health and safety of the carer and/ or the cared for person.

	No Impact	Low Impact	Moderate Impact	Substantial Impact	Critical Impact
Employment/Training	The carer's caring role is such that they have no difficulty in managing caring and employment and/or education/ training. The carer does not want to be in paid work or education	The carer's caring role is such that they have some difficulty managing caring and employment and there is a risk to sustaining employment and/or training/education. The carer is not in paid work or education/training but would like to be in the long term.	The carer has difficulty managing caring and employment/training/ education and there is a risk to sustaining this in the medium term. The carer is not in paid work or education/training but would like to be in the medium term.	The carer has significant difficulty managing their caring role and employment/training/ education in the short term. The carer is not in paid work or education/ training but would like to be soon.	The carer has significant difficulty managing caring and employment/training/ education and there is an imminent risk of giving up work/ education/training. The carer is not in paid work/education/ training but would like to be now.
Emergency/Future Planning	The carer is confident about emergency planning and planning for the future and has no concerns about managing their caring role	The carer is largely confident about emergency planning and planning for the future but has minor concerns about managing their caring role.	The carer is not confident about emergency planning and planning for the future, and has some concerns about managing their caring role.	The carer is anxious about emergency planning and planning for the future and has significant concerns about managing their caring role.	The carer is very anxious about emergency planning and planning for the future, and has severe concerns about managing their caring role.

Determining Impact of Caring Role and Associated Risk

The following table details the impact that the caring role has on each of the domains listed above:

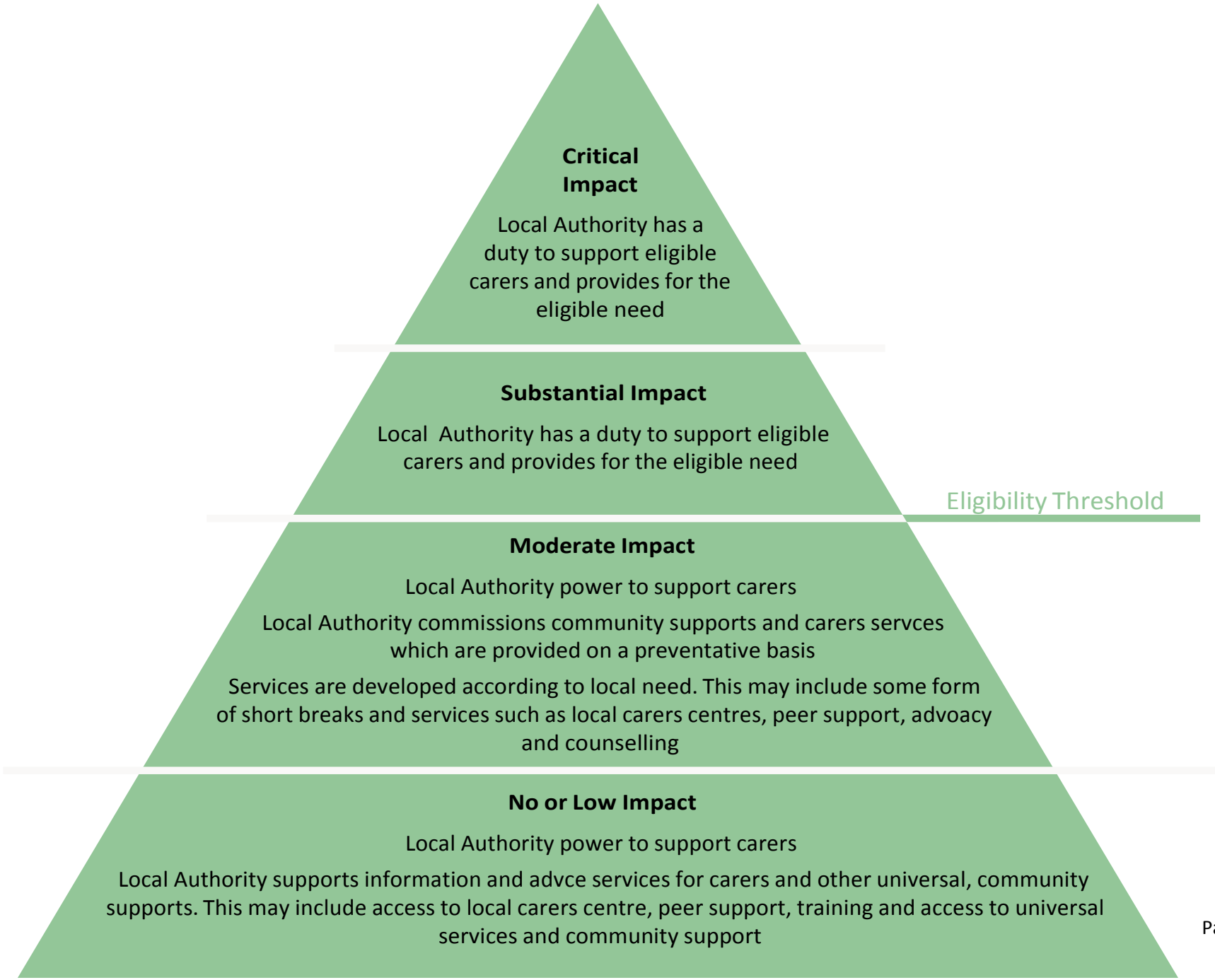
	No Impact	Low Impact	Moderate Impact	Substantial Impact	Critical Impact
Physical Health and Wellbeing	The carer's caring role has no impact on their physical health and they keep in good health.	The carer's caring role is beginning to have a minor impact on their physical health	The carer's caring role is having a negative impact on their physical health and their health is becoming at risk without intervention	The carer's caring role is having a considerable negative impact on their physical health and they are at high risk without urgent attention	The carer's caring role has impacted so much on their physical health it is breaking/has broken down and crisis point has been reached
Emotional / Mental Health and Wellbeing	The carer's caring role has no impact on their emotional/mental health, they keep in good health	The carer's caring role is beginning to have an impact on their emotional/mental health	The carer's caring role is having a negative impact on their emotional/ mental health and it is becoming at risk without intervention	The carer's caring role is having a considerable negative impact on their emotional/mental health and requires urgent attention	The carer's caring role has impacted so much on their emotional/ mental health it is breaking/has broken down and crisis point has been reached
Life Balance	The carer's caring role is such that they have regular opportunities to achieve the balance they want in life.	The carer's caring role is such that they have some opportunities to achieve the balance they want in their life	Due to the caring role, the carer has limited opportunities to achieve the balance they want in life	Due to their caring role, the carer has few and irregular opportunities to achieve the balance they want in life	Due to their caring role, the carer has no opportunities to achieve the balance they want in life

Step 3: The framework for eligibility criteria will be used to identify the carer's level of support. Under the Act there is no national eligibility threshold for support. The diagram on the next page shows the local eligibility threshold in relation to the impact of caring and where the triggers are that places the duty to provide support.

If the caring role is considered to have substantial or critical impact across one or more of the 8 domains, then the carer will be deemed to have an eligible need(s). The local authority would then have a duty to support the carer to meet their eligible need(s). The diagram also illustrates the role of preventative and universal services in supporting carers who do not meet the eligibility thresholds.

Step 4: Once the level of support is agreed, the carer will decide how they would prefer to arrange their support and choose from one of the four self-directed support options. A review date will also be set at this point. However, if the carer requires a review to happen sooner than the date set, then they have the right to request this.

Carers will be kept informed throughout the process and will be involved as much as they want in each of the four stages and in the decision making.

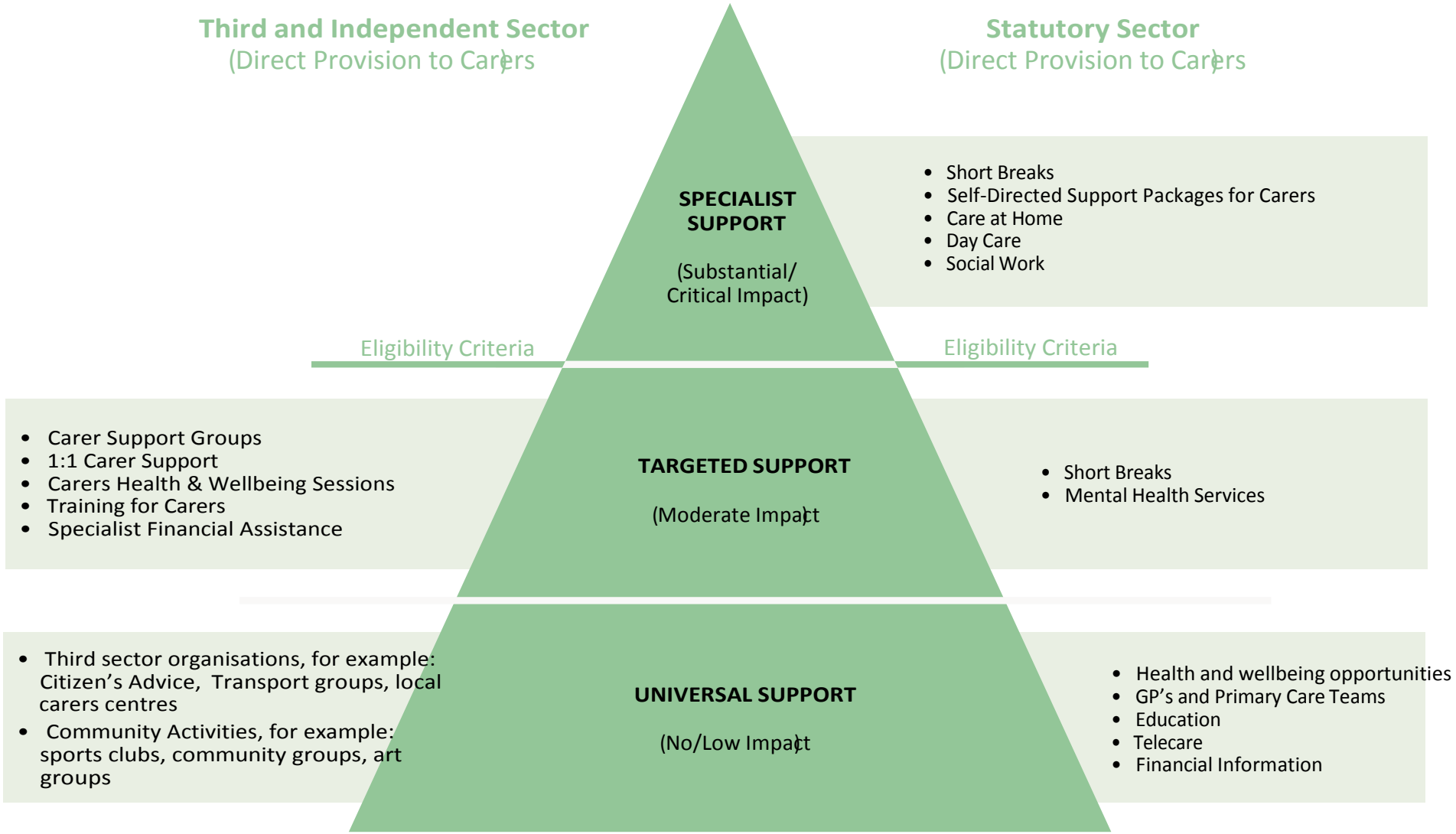

Critical Impact
Local Authority has a duty to support eligible carers and provides for the eligible need
Substantial Impact
Local Authority has a duty to support eligible carers and provides for the eligible need
Eligibility Threshold
Moderate Impact
Local Authority power to support carers
Local Authority commissions community supports and carers servces which are provided on a preventative basis
Services are developed according to local need. This may include some form of short breaks and services such as local carers centres, peer support, advoacy and counselling
No or Low Impact
Local Authority power to support carers
Local Authority supports information and advce services for carers and other universal, community supports. This may include access to local carers centre, peer support, training and access to universal services and community support

What Support Services Are Available?

- **Short breaks or respite:** Where arrangements are put in place that allow the carer to have a break from their normal routine and their caring responsibilities. This can be during the day or overnight, for a few hours, a few days or longer, and for the carer, cared-for person or both together.
- **Information and advice:** Where the carer receives information/advice on their caring role, particularly where they are new to caring or there are changes to the caring situation.
- **Practical support:** This may be providing practical support in the form of transport, equipment, aids/adaptations
- **Counselling/emotional support:** Providing or enabling access to emotional support to help the carer to cope with the demands of caring. This can be in the form of one-to-one discussion, peer support groups and training sessions, or passing on contact details for support services such as psychological services.
- **Training or learning:** Activities intended to improve the carer's knowledge, skills, mental health and ability to cope with their caring responsibilities.
- **Advocacy services:** Where a person independent from the local authority/NHS/service provider provides assistance through helping to safeguard the carer's rights, access information and making sure that the carer's voice is heard.
- **Help with financial issues:** This may include checks on benefit entitlements (such as the Carers Allowance); help with filling out forms for benefits, grants and allowances, and direction towards relevant financial and advice services.
- **Carer's payment:** A scheme operated by some agencies whereby eligible carers may apply for a small payment to assist their caring role; also selfdirected support may be used to provide support to carers.

The diagram on the following page shows where the different forms of support may sit in relation to the Impact Model shown earlier, however the support will be tailored to meet the carer's personal outcomes and could be a combination of support from all the areas in the diagram. To access the specialist supports, a carer will have to have identified above the eligibility criteria and be in the position where the risk to them or the cared for person is critical, and the risk of them not meeting their identified outcomes is critical.

Adult Carers Triangle of Support



FORM 3

Clackmannanshire & Stirling Health & Social Care Partnership

ADULT CARER SUPPORT ACTION PLAN

Carer Name: **Date:**

Life Outside Caring	Conversation Notes	Impact of Caring Role		
		None/Low	Moderate	Substantial/Critical
Physical Health				
Mental & Emotional Well-being				
Life Balance				
Finances				
Feeling Valued				
Relationships				
Living Environment				
Employment / Training				

Future/Emergency Planning		Would like help?		
		Yes	No	Don't Know
Emergency Plan				
Future Plan				

Continuing to Care		Able / willing to continue caring?		
		Yes	No	Don't Know
Ability to Care				
Willingness to Care				

Goals & Aspirations	Actions	Who will do this?

Signed by Carer: **Date:**

Carer Support from Social Work

If Action Plan indicates that the support required needs to be provided by Social Work Services:

Does carer consent to Carers Centre making referral to Social Work Services? Yes ☐ No ☐

Does carer consent to Carers Centre sharing Adult Carer Support Plan with Social Work Services? Yes ☐ No ☐

Signature of carer confirming consent: **Date of consent:**

Date for Action Plan Review:

Appendix 4 Clackmannanshire-Stirling Carers Strategy Priorities 2018-23

Requirements for implementation of the Carers Act:

- Strategic Commissioning Review to consider what services will be required moving forward.
- Commission services to meet the requirements of the Act over the period of the strategy
- Develop a range of flexible respite and short break services for carers
- Develop a range of advice, information and support services based on carers experiences
- Develop a short breaks statement with carers
- Involve carers in service planning and service delivery
- Involve carers in hospital discharge planning
- Information Management systems to take account of Carers Data Census.
- Performance Management system that takes account personnel outcomes approach and implementation of the Act
- Further develop carer involvement mechanisms in the Partnership
- Workforce development and awareness
- Review and update the Carers Strategy on an annual basis.
- Develop the provision of greater involvement support for carers during hospital discharge.

- **Support for carers:**

    - Ensure the delivery of a range of advice, support and information services
    - Support development and provision of specialist welfare benefits and money advice for unpaid carers.
    - Development of transitional and ongoing support for carers.
    - Support young carers who are more likely to be living in poverty/deprivation and with poor mental health and well being.

- **Training and education, information:**

    - Continue to disseminate information resources and training for carers, young carers and professionals.
    - Produce operating procedures for all staff to ensure carers are sign posted to the most appropriate level of support
    - Continue to develop the programme of training for carers across Clackmannanshire and Stirling
    - Continue the delivery of workforce training and raising awareness of unpaid carers issues across Forth Valley
    - Provide specific young carer awareness training for professionals from health, education and social services.

- Increase workforce training and development increasing equality and accessibility for rural and remote living young carers.

- **Raising awareness:**

  - Develop carer friendly materials on what the Carers Act means and where to access support advice and information
  - Continue to promote the uptake of carer's assessments.
  - Ensure the continued involvement of carers that ensures carers and their needs are represented at a strategic and operational planning levels
  - Ensure carers are engaged in the development and delivery of support and services to meet their needs.

- **Improving performance and quality:**

  - Introduce a performance management process that reflects the Carers Census Data requirements
  - Ensure carers needs inform the development of the Falkirk Partnership Carers Strategy.
  - Improve performance management and quality improvement processes in relation to delivering the carers agenda.

Health and Social Care Integration Directorate
Care, Support and Rights

Scottish Government
Riaghaltas na h-Alba
gov.scot

T: 0131-244-6935
E: peter.stapleton@gov.scot

To:
Chief Officers, Integration Authorities,
Chief Executives, Local Authorities,
Chief Finance Officers, Integration Authorities,
NHS Board, Chief Executives,
NHS Board, Directors of Finance,
Chief Social Work Officers,
COSLA,
Social Work Scotland

Copy to: Carers lead officers

27 December 2017

Dear colleagues,

Please find attached the near-final draft guidance for the Carers (Scotland) Act 2016.

The draft guidance is still subject to editing but we are circulating the draft now, to enable local organisations to prepare for implementation of the remaining provisions of the Act from April. The draft does not include guidance on transitional provisions but we intend to circulate that separately in the new year.

The guidance needs to include advice on regulations, including those which are not scheduled to have passed through Parliament until March. Therefore it cannot be finalised and published as statutory guidance until that time.

Kind regards,

Peter Stapleton
Carers Policy Branch

INVESTOR IN PEOPLE
POSITIVE ABOUT DISABLED PEOPLE

Carers (Scotland) Act 2016
Statutory Guidance
Draft

Table of Contents

Introduction 3

Part 1: Key Definitions

Chapter 1: Meaning of “carer”, “young carer” and “adult care” 5

Part 2: Adult Carer Support Plans and Young Carer Statements

Chapter 1 – Adult Carer Support Plans 11

Chapter 2 – Young Carer Statements 28

Part 3: Provision of support to carers

Chapter 1 – Local Eligibility Criteria – Existing Statutory Guidance 50

Chapter 2 – Duty to provide support to carers 51

Chapter 3 – Waiving of Charges & Replacement Care 67

Part 4: Carer involvement

Chapter 1 – Carer Involvement In Services and Service Planning 74

Chapter 2 – Carer Involvement In Hospital Discharge 79

Part 5: Local Carer Strategies

Chapter 1 – Local Carer Strategies 90

Part 6: Information and advice for carers, including short breaks services statements

Chapter 1 – Information and Advice for carers 100

Chapter 2 –Short Breaks Services Statement 108

Part 7: Delegation of functions 113

Glossary 116

Annexes

Annex A – Support to carer or cared-for person 119

Annex B – Carers who are also service users (adults or children with support needs) 122

Annex C – Short Breaks –definition by Shared Care Scotland 124

Annex D – Carer Identification 126

Introduction

Background

This is statutory guidance for local authorities, health boards and integration authorities. It will also be of interest to other organisations working alongside statutory bodies to deliver carer support, as well as the directing authorities of independent or grant aided schools responsible for young carer statements. It is designed to provide guidance on effective implementation of the provisions of the **Carers (Scotland) Act 2016** ("the Act"). Also, it includes links to legislation and policy documents, which are clearly set out in each part of the guidance.

It is the intention of the Scottish Government that Scotland's estimated 789,000 adult carers including 44,000 young carers are better supported on a more consistent basis so that they can continue to care, if they so wish, in good health and wellbeing, allowing them to have a life alongside caring.

The overriding intention for young carers is that they should have a childhood similar to their non-carer peers. We want to ensure that young carers are enabled to be children and young people first and foremost and relieved of any inappropriate caring roles to allow them to have a quality of life.

The Act makes real this ambition by furthering the rights of both adult and young carers.

Provisions and intentions

The Act introduces the right to a new Adult Carer Support Plan or Young Carer Statement based on the preventative approach to identify each carer's personal outcomes and needs for support. This will improve access to support for adult and young carers without any requirement that that they are providing, or intend to provide, care on a substantial and regular basis.

The Adult Carer Support Plan and Young Carer Statement will encourage meaningful conversations with individual carers to understand personal needs and outcomes. Engaging effectively with carers as equal partners will help empower them with more useful information about the support that may be available to them. This is also reflected in the requirements to involve carers in hospital discharge processes.

The Act introduces a duty to set local eligibility criteria frameworks in each local authority area. These frameworks will help local authorities determine the level of support to provide to carers based on their identified needs

By ensuring more personalised and effective delivery of support to carers, the Act seeks to address the issues that may reduce or impede the wellbeing and positive outcomes for Scotland's carers. Improving the physical and emotional wellbeing of carers also benefits those being cared for and can help to sustain good caring relationships.

Across Scotland, there will be local carer strategies developed which will set out the provision of services to adult and young carers in each integration authority. These carer strategies will also set out plans for how carers are identified and how they receive information about local support in their area.

A cornerstone of the Act is the provision of information and advice services to carers, which must be accessible and proportionate to the needs of carers who use these services. The third sector is well placed in helping to deliver information and advice services to carers.

There is also a requirement for carers and carer representatives to be involved in the preparation of short breaks services statements and planning of carer services, sharing their caring experiences and knowledge with those responsible for providing these services.

A separate carers' charter will be published setting out the rights of carers as provided for under the Act.

Preparation of guidance

This statutory guidance to accompany the Act is published following collaboration and consultation with a number of key interests, including: adult and young carers; carer organisations; local authorities; health boards; health and social care partnerships; third-sector organisations; COSLA; Social Work Scotland; NES; SSSC and others.

We thank all of our partners in helping to inform this document.

Using this guidance

The Scottish Government encourages those who are responsible for delivering good quality support which benefits carers, and through supporting the needs and personal outcomes of carers, to use this guidance in the spirit of the Act itself, and with the intention of delivering preventative, personalised support which will empower carers through improved choice and control.

It is also important that local authorities, health boards, integration authorities, and others continue to share learning and good practice, helping to ensure successful implementation of new frameworks across the country. Establishing and maintaining good partnerships with third sector organisations will also play an important part in delivering effective local personalised support to carers, which meets their personal outcomes and helps them continue in their caring role.

Part 1

Meaning of "carer", "young carer" and "adult carer"

Summary

Section 1(1) and **1(2)** defines "carer".

Section 1(3) provides a regulation-making power for Scottish Ministers to specify certain exceptions in relation to care provided under a contract or as voluntary work.

Section 2 defines "young carer".

Section 3 defines "adult carer".

Meaning of "carer"

1.1.1. **Section 1(1)** defines a carer as an individual who provides or intends to provide care for another individual ("the cared-for person").

1.1.2. Where the Act refers to "carers" it means both adult and young carers of the cared-for person.

Intention to provide care

1.1.3. "Intending to provide" care would encompass situations where, for example, a previously healthy person is about to be discharged from hospital and will require care, which a relative or friend is willing and able to provide. This person will be the carer.

1.1.4. It may also be the case that the cared-for person requires a fluctuating level of care due to their condition, and so the carer would not always be providing care but rather intending to do so should the need arise.

1.1.5. There is a duty on authorities to offer an ACSP or YCS in respect of an identified carer and to prepare one if that offer is accepted. The duty to prepare an ACSP or YCS also applies in circumstances where a carer has requested one. These duties are considered in Part 2 of this guidance.

Situations involving more than one carer or cared-for person

1.1.6. A carer can be caring for one or more cared-for persons. A cared-for person can have one or more carers. They do not need to live together in the same household.

Removal of 'regular and substantial test'

1.1.7. The definition of carer is not limited to individuals who provide or intend to provide a substantial amount of care on a regular basis. This represents a change from previous legislation on duties to carry out a "carer's assessment".

1.1.8. It is expected that people who are being neighbourly to their elderly neighbours (for example, doing the shopping now and again, a spot of gardening, clearing the snow from the path) will not be seen as carers. The expectation is that such people will, for the most part, continue to see themselves as neighbourly volunteers. However, the situation could change if these neighbourly acts become more frequent. In these circumstances, the person might become a carer.

Exclusions – parents of dependent children

1.1.9. **Section 1(2)(a)** states that a person is not a carer "in the case of a cared-for person under 18 years old, to the extent that the care is or would be provided by virtue of the person's age".

1.1.10. This will avoid all parents of dependent children automatically being "carers" within the Act. But parents of dependent children with additional care and support needs can still be "carers" to the extent that the care is or would be provided by virtue of something other than the child's age.

1.1.11. This does not mean that a child has to meet the definition of "disabled child" in **section 23(2) of the Children (Scotland) Act 1995**[1] (chronically sick or disabled or having a mental disorder) in order for the parent to be a "carer".

1.1.12. A parent would not be viewed as a carer if their child exhibited problematic behaviour which was not due to a condition. The parent might instead be signposted to appropriate parenting support services. It is important to recognise that problematic behaviour may be due to a condition that has not yet been diagnosed. The lack of a formal diagnosis should not prevent parents being recognised as carers and receiving the support they need. This will depend on the relevant multidisciplinary professionals working together with the parent(s) to consider the circumstances of the particular case, to determine whether the parent is in fact a carer and to identify any subsequent support needs.

Exclusions – voluntary work

1.1.13. Under **section 1(2)(b)(ii),** if the care is or would be provided as voluntary work, then the person undertaking that voluntary work is not seen as a carer.

Exclusions – paid care workers

1.1.14. Paid care workers are excluded from the meaning of carer. This is because under **section 1(2)(b)(i),** if the care is or would be provided under or by virtue of a

[1] http://www.legislati on.gov.uk/ukpga/1995/36/section/23

contract, then, to the extent that the care is provided under the contract, the person providing the care is not a carer.

Exclusions - foster carers (care under or by virtue of a contract)

1.1.15. The exclusion in **section 1(2)(b)(i)** also means that foster carers do not fall within the definition of 'carers' under the Act. The vast majority of foster carers are registered as being self-employed and their fostering agreement with a local authority entitles them to a fee or reward element for the care they undertake.

Regulation making power – contract and /or voluntary work

1.1.16. Under **section 1(3)(b)**, Scottish Ministers may make regulations to permit a relevant authority to disregard **section 1(2)(b)** where the authority considers that the relationship between the carer and the cared-for person is such that it would be appropriate to do so. This would enable people who would otherwise be excluded from the definition to be considered carers.

1.1.17. This allows Scottish Ministers to make regulations to allow a local authority to support carers who provide care by way of a contract or through voluntary work to be classed as 'carers'. **This is especially relevant in the case of carers who provide care both on a paid and unpaid basis to same family member**. As the **Social Care (Self-directed Support) (Scotland) Act 2013** ("the 2013 Act") becomes even more widely used, it is likely that direct payments under the 2013 Act will mean that the number of "mixed carers" who provide both paid care, by way of a contract with the person they care for, and unpaid care are likely to rise. This power allows legislation to take account of the possible rise in the different types of these caring situations.

1.1.18. Scottish Ministers are not using this regulation-making power at the present time. The exclusion under section 1(2)(b) only applies **to the extent** that care is provided under a contract or as voluntary work. So it would already be possible for a mixed carer to be considered a "carer" in relation to the unpaid care they provide outwith the contract. On that basis, local authorities will be able to support mixed carers in relation to the unpaid care they provide and will be able to establish how best to do this based on professional judgment and carer involvement without the need for regulations at this stage.

Regulations to place kinship carers[2] on the same footing as parents of dependent children

1.1.19. Kinship carers often find themselves undertaking a caring role after a family member has fallen into crisis, with the only alternative being that the child is taken into formal care arrangements. No payment is received for the caring kinship carers

[2] Kinship carer is a term that is used to define someone who is looking after another individual's child because they are unable to do so. The individual must either be:

- a person who is related to the child; or
- a person who is known to the child and with whom the child has a pre-existing relationship.

There are a number of recognised "types" of kinship carer and situations will differ depending on the family's circumstances .

undertake but the caring role can be formalised in a written agreement with the local authority.

1.1.20. **The Carers (Scotland) Act 2016 (Agreements of a Specified Kind) Regulations 2017 (SSI 2017/257)**[3] ensure that kinship carers who care for children can be classed as carers for the purpose of the Act, regardless of whether they have a formal written agreement with the local authority or receive a kinship carers allowance. The regulations achieve this by specifying that a written agreement with the local authority[4] cannot be considered a "contract" and so would not exclude a kinship carer from the definition of "carer" under the Act. This places kinship carers on the same footing as parents of dependent children as considered above.

Meaning of "young carer"

1.1.21. **Section 2** defines young carer as a carer who –
(a) is under 18 years old, or
(b) has attained the age of 18 years while a pupil at a school, and has since attaining that age remained a pupil at that or another school.

1.1.22. Any carer who is under 18 will be a young carer, whether or not they are still at school. Older young carers may continue their studies after leaving school. Post school, until they are aged 18 years old, the young person would still be considered a young carer and may have a young carer statement in place. In addition a carer who turns 18 while a school pupil will remain a young carer until leaving school. There is therefore no absolute cut-off age at which a young carer would cease to be a young carer.

1.1.23. There is no lower age limit for being a "young carer." It would be arbitrary to create a lower age limit thus excluding access to the young carer statement and support to younger age groups. In most instances, the expectation would be to remove or lessen the caring responsibilities of the relatively few very young carers and to put in place more services for the cared-for person. The responsible authority[5] will also be alert to any child protection concerns.

Meaning of "adult carer"

1.1.24. **Section 3** defines "adult carer". Adult carers must be at least 18 years old and cannot also be not young carers. So if a carer is aged 18 but still at school, they will remain a young carer until they leave school.

Young adult carers

1.1.25. The only age distinction in the Act is between young and adult carers. The Act does not make any specific provisions for "young adult carers" (normally understood to mean carers aged 16 to 25); instead the individuals will be either "young carers" or "adult carers".

[3] http://www.legislation.gov.uk/ssi/2017/257/made?view=plain
[4] Under regulation 12 of the Looked After Children (Scotland) Regulations 2009 (SSI 2009/210) http://www.legislation.gov.uk/ssi/2009/210/part/V/made
[5] The body responsible for preparing the young carer statement – as defined in section 41 of the Act.

1.1.26. The 16 to 25 age group is often characterised by transitions that may change the caring role and/or the need for support such as the transition to college, university and work; living away from home; or wanting to reduce the caring role/ not wanting to be a carer at all. These can be reflected in the carer's adult carer support plan or young carer statement. Part 2 of this guidance contains more information on the links and transitions between ACSP and YCS.

Person caring for someone in residential care

1.1.27. When an adult is in full-time residential care such as a care home, nursing home or secure unit, there is a question as to whether the person who cared for them prior to them being admitted into residential care is still the carer.

1.1.28. The person in residential care is being provided with accommodation, meals, personal and health care. Nevertheless, some people still consider themselves to be a carer. This may be due to continuing with some caring tasks such as shopping, emotional support, personal care, dealing with personal affairs, and taking their loved one on days out. There is also the emotional impact on the carer of the person being in residential care. Other people do not consider themselves to be carers in this situation.

1.1.29. When a cared-for person is first admitted full-time to residential care, the person who was the carer may continue to have caring responsibilities in the initial settling-in period. This then may diminish over time.

1.1.30. In the circumstances of the cared-for person being in full-time residential care, then the responsible local authority[6] should decide on a case-by-case basis if the person is providing or intending to provide care for the individual. If the responsible local authority recognises that the person is providing or intending to provide care then an adult carer support plan or young carer statement should be offered. Such a person may themselves request an adult carer support plan or young carer statement. Their request should be granted if they are providing or intending to provide care.

1.1.31. In practice, because there is no definition of "care" in the Carers Act and because a carer can provide low-level care, then in many cases the person who cared for the cared-for person prior to them moving to residential care may continue to be considered a carer rather than a visitor.

1.1.32. With regard to "forensic carers" who support people in forensic mental health services, the carers can have significant caring responsibilities, especially at certain times, for example, support required when the cared-for person moves between secure services or is admitted from prison or general psychiatric services.

[6] Defined in the glossary.

1.1.33. With regard to children, it is clear that the parent of the child in residential settings[7] or NHS care is a carer, since the care they would be providing goes beyond that which is just because of the child's age as at **section 1(2)(a)** of the Act[8].

Meaning of "cared-for person"

1.1.34. The term "cared-for person" is not defined in the Act but should be commonly understood. There is no requirement for a cared-for person to be someone receiving social care support. The cared-for person might have health needs only. They might have refused community care services. The care needs of the cared-for person may be permanent or temporary.

1.1.35. A carer therefore might have identified needs which meet the local eligibility criteria whilst the cared-for person is not eligible for services and vice versa.

Meaning of "care"

1.1.36. The term "care" in the definition of carer is not defined in the Act and so has its ordinary meaning. It therefore means the provision of what is necessary to the cared-for person in order to support their physical and mental health and wellbeing. This can encompass:

a) medical or nursing care, such as helping someone to take medication or applying dressings;
b) personal care, such as helping to wash, dress or eat;
c) practical support, such as taking a person shopping or to medical appointments, cleaning or accompanying them to social events; and
d) emotional support.

1.1.37. The focus is on the impact of care on the carer. As such, the definition of carer does not include any threshold for the level of care provided. In every situation, a proportionate approach to the preparation of the adult carer support plan or young carer statement should be adopted, taking into account the impact of the caring role on the carer. Part 2 of this guidance deals with the preparation of the ACSP and YCS.

[7] Exceptions would include where the child has been removed from the care of the parent or guardian and placed in a residential setting by the Children's Reporter, it would be unlikely that they would be undertaking the role of an unpaid carer.
[8] A Supreme Court decision in July 2015 highlighted the care provided by parents to a disabled child during a long-stay in hospital: https://www.supremecourt.uk/cases/docs/uksc-2014-0166-press-summary.pdf.

Part 2, Chapter 1

Adult carer support plans

Summary

Part 2, Chapter 1 of the Act covers adult carer support plans.

Section 6 sets out the duty to prepare an adult carer support plan.

Section 7 deals with adult carers of terminally ill cared-for persons.

Section 8 deals with the identification of outcomes and needs for support of adult carers.

Section 9 sets out the minimum information that an adult carer support plan must contain.

Section 10 deals with the review of adult carer support plans.

Section 11 addresses the provision of information to the carer about their adult carer support plan.

The duty under **section 6** is delegated to integration joint boards under the **Public Bodies (Joint Working) (Prescribed Local Authority Functions Etc.) (Scotland) Amendment (No. 2) Regulations 2017**[9].

For the purpose of this chapter the terminology "responsible local authority" will continue to be used in place of integration joint boards or integration authorities.

Purpose of adult carer support plans

2.1.1. The adult carer support plan (ACSP) provides a framework for identification of personal outcomes and individual needs for support of adult carers. This then links to the duty and power of the responsible local authority to provide substantive support to meet those identified needs. These duties and powers are considered in Part 3 of this guidance.

2.1.2. The preparation of an ACSP is intended to ensure that adult carers are valued as equal partners in the provision of care to the cared-for person and that their knowledge, experience and views are taken into account when a support plan is developed with them.

2.1.3. The ACSP is also intended to help to increase the numbers of carers identified and having their needs properly considered (when compared to the numbers previously receiving a carers assessment).

Duty to prepare adult carer support plan

[9] Insert hyperlink when regulation has been published

2.1.4. **Section 6** requires a responsible local authority to offer an ACSP in respect of an identified adult carer and to prepare one if that offer is accepted. The duty to prepare an ACSP also applies where an adult carer has requested one.

2.1.5. The duties to offer and prepare an ACSP still apply, even if the carer's identified needs do not meet local eligibility criteria. In these circumstances, the ACSP can include signposting and access to any relevant supports, for example, universal or community-based services.

2.1.6. **Section 6(1)(a)** to **(c)** requires an ACSP to set out:

- an adult carer's identified personal outcomes;
- an adult carer's identified needs (if any); and
- the support (if any) to be provided by the responsible local authority to an adult carer to meet those needs.

2.1.7. Further guidance on each of these elements is set out below.

2.1.8. The ACSP is therefore the mechanism through which needs for support are monitored and support is managed.

Responsible Local Authority

2.1.9. As at **section 6(6)** the 'responsible local authority' in relation to an adult carer support plan, means the local authority for the area in which the cared-for person resides.

Approach to adult carer support plans

Third sector role

2.1.10. Responsible local authorities are encouraged to work collaboratively with the third sector in developing their models for preparing ACSPs. It would be up to the responsible local authority to decide whether it wishes to commission third sector partners to undertake the function of preparing individual ACSPs.

Learning from ACSP pilots
During the pilots for this aspect of implementation of the Act, one Health and Social Care Partnership found that developing their adult carer support plan collaboratively with their local carer centre ensured that an outcomes focused perspective was taken by both partners.

This also allowed both the carer centre and the Health and Social Care Partnership to test out some of the draft adult carer support plans with carers.

Not all carers required a service following on from having an ACSP, but they valued the experience of being involved and having their voices heard on the issues they face including emergency planning.

Information for Carers about ACSPs

2.1.11. Carers will need to know what to expect when they request or accept the offer of an ACSP. It is recommended that this information be jargon free, published and provided through carer information and advice services as part of the ACSP offer. This could take the form of a leaflet that is freely available both online and in printed format. Further information about the duties to provide information and advice is set out in Part 6 of this guidance.

Equal opportunity requirements

2.1.12. **Section 6(5)** requires the responsible local authority to exercise its functions when preparing an ACSP in a manner which encourages equal opportunities, in particular the observance of the equal opportunity requirements (within the meaning of **section L2 of Part 2 of schedule 5 of the Scotland Act 1998**).

Online approaches

2.1.13. Responsible local authorities covering remote rural areas may wish to consider the option of an ACSP being undertaken through an online platform such as a video call. It is recommended that if this option is pursued, its development would benefit from the involvement of carers and carer representatives from local carer support organisations. It is recommended that responsible local authorities have an option to undertake an ACSP in person for those carers who are uncomfortable with or unable to access the online alternative.

Self-evaluation approaches

2.1.14. Responsible local authorities may also wish to consider providing for a self-evaluation approach through which carers identify their own needs if they are willing and able to do so. Carers can provide certain aspects of the information required for the ACSP. It would still require the responsible local authority to check the completed self-evaluation with the carer; ensure all required information has been considered and recorded; and make decisions about carer support, based on the carer's identified needs and personal outcomes. It is therefore strongly recommended that there is always a conversation, preferably in person with the carer as part of the process in order to allow information to be checked and so that it can be determined to what extent the carer's identified needs meet the local eligibility criteria.

2.1.15. It is recommended that the responsible local authority follows the same outcomes focused approach to the preparation and formation of an ACSP using good conversations to aid the process regardless of whether the carer undertakes a self-evaluation or not.

2.1.16. Before offering a self-evaluation, the responsible local authority can take steps to try to determine that a carer has the ability to fully assess and reflect their own needs. Where responsible local authorities have concerns that a carer may experience substantial difficulty in understanding, retaining and using the relevant information in relation to their self-evaluation, they could offer support and advice. It may be worth considering using an independent advocate or another member of the carer's family or support network to assist the carer with their self-evaluation.

Outcomes-focused approach

2.1.17. It is recommended that responsible local authorities take account of the national outcomes for Integration and in particular, National Outcome 6, which states "People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing."

2.1.18. There are several useful practice approaches for responsible local authorities to make use of when undertaking an ACSP. These include using a conversational approach, an outcomes approach and an assets based approach to assessment. There are several models of assessment but the exchange model is particularly well suited to an outcomes focused approach.

2.1.19. A conversational approach to assessment such as the exchange model[10] could be considered by responsible local authorities when undertaking an ACSP. In this context, the approach involves practitioners and carers working together to develop outcomes into individual stories and coproduce their collaborative plans.

2.1.20. An outcomes approach[11] supports the exchange model where the carer's strengths and aspirations are fundamental, and a process of negotiation involving the knowledge and skills of each participant. This aligns well with an assets based approach to wellbeing, whereby the focus is on what the carer wants to change in their life and the resources and strengths they bring to realise the intended changes. The Talking Points personal outcomes approach[12] is a valuable evidence-based framework that summarises the outcomes important to adults and carers living in the community who use health and social care services.

Proportionate Approach

2.1.21. When preparing the ACSP, the responsible local authority is recommended to take a proportionate approach, taking into account what issues are raised through the conversation with the carer and which issues need to be raised with the carer.

2.1.22. In carrying out a proportionate approach to an ACSP, authorities will have regard to the carer's wishes, preferences and personal outcomes. For example, a carer who cares for someone who pays for their own care may wish to receive some support from the authority with accessing a particular service, but may not wish the same interaction with the authority as a carer for someone who wants greater support.

Low and Fluctuating Need

2.1.23. It is recommended that responsible local authorities consider the potential fluctuation of the carer and/or the cared-for person's needs. For example where the responsible local authority is aware that the cared-for person's needs fluctuate over time due to a mental health condition, the ACSP carried out at a particular moment may take into account the cared-for person's history to establish a complete picture of the cared-for person's needs and the impact these fluctuating needs have on the caring situation.

[10] https://www.scie.org.uk/publications/guides/guide18/teaching/howtaught.asp
[11] http://arcuk.org.uk/scotland/files/2011/08/JIT-Good-conversations.pdf
[12] https://personaloutcomes.files.wordpress.com/2014/04/talk_about_outcomes_01.pdf

2.1.24. It is recommended that low level needs and the support to meet those needs are considered as part of the ACSP process. This process will be based on the identification of personal outcomes, needs and risks. It would be worth considering whether a carer's identified needs can be met by the local information and advice service or general services in the community.

Signposting to universal support where carer refuses an ACSP

2.1.25. Not all adult carers will want to accept the offer of an ACSP. In these cases the responsible local authority may consider signposting the carer to a carer centre or similar support provider.

Learning from ACSP Pilots
During the pilots for this aspect of implementation of the Act, a Health and Social Care Partnership took a coproduction approach to developing their ACSP. This found that

- it made sense to allow carers to have access to universal supports without having to undertake an ACSP;
- more information and communication was required to allow carers to know what is available in their area and what choices they can make;
- any forms used need to be as simple, accessible and as user friendly as possible.

Tensions between carer and cared-for person

2.1.26. There may be tensions between the carer and the cared-for person. Carers can often find their caring role stressful and difficult in a range of different ways. The cared-for person may not be coping well with their condition or a deterioration of their health. This can put tremendous strain on the relationship between the carer and the person that they care for. Responsible local authorities need to take account of this and be sensitive to it when undertaking an ACSP. The authority could consider working with both parties to try and seek a resolution to the situation if possible. In situations where the caring situation has become completely unmanageable or has a harmful impact on the carer's wellbeing or that of the cared-for person, it may be necessary to raise an adult protection[13] concern in line with their local multi-agency adult protection guidelines.

Content of adult carer support plan

2.1.27. **Section 9** outlines what information must be contained in an ACSP.

Carer's personal circumstances

2.1.28. **Section 9(1)(a)** requires information about the carer's personal circumstances when the ACSP is being undertaken. This must include information about the nature and extent of care provided or to be provided by the carer and information about the impact of caring on the adult carer's wellbeing and day-to-day life.

[13] http://www.gov.scot/Topics/Health/Support-Social-Care/Adult-Support-Protection

2.1.29. In practice, a good conversational approach would be important to determine a picture of the types of care and the intensity of the care being provided by the carer. This might include emotional support and practical care such as assistance with toileting and bathing.

2.1.30. The responsible local authority will also need to understand the impact on the carer from undertaking their caring role. This would include the impact on the carer's wellbeing and ability to have a life of their own. Negative impacts could include high levels of emotional distress, regular physical strain and acute social isolation.

2.1.31. When undertaking the ACSP, the responsible local authority must also consider the carer's daily activities beyond their caring responsibilities, and the impact of caring upon these activities. This includes considering the impact of caring duties on a carer's desire and ability to undertake paid work, to participate in education, training or recreational activities, such as having time to themselves. It is recommended that authorities consider both short-term and longer term cumulative impacts of caring responsibilities.

Able and willing to provide care

2.1.32. **Section 9(1)(b)** requires information about the extent to which the adult carer is able and willing to provide care for the cared-for person. It is recommended not to make any assumptions about a carer's willingness or ability to care. For example, the carer may indicate that they are willing and able to care in order to facilitate the discharge of the cared-for person from hospital, while in reality they are unable to sustain the caring role in the community without adequate support. This is partly due to the anxiety that many carers have that a statutory involvement may lead to a loss of control over the care of the cared-for person.

2.1.33. Ability and willingness to care can be closely linked to a carer's opportunities to have some time away from caring and to recover. A break from caring can help the carer to recharge and continue in their caring role. There is therefore a link between this aspect of the ACSP and the support provided to meet the carer's needs (as considered in Part 3 of this guidance). Some carers may not be able to sustain the caring role even with support in the form of breaks from caring. There could be many reasons for this, including mental exhaustion or physical deterioration. In these circumstances, it may be more appropriate to explore longer term alternative care and accommodation options for the cared-for person. See also the discussion of ability and willingness to care in Chapter 3 of Part 3.

2.1.34. The willingness and ability of the carer to continue to provide care to a cared-for person may be closely linked to the support provided to the cared-for person following other assessments. It is therefore recommended that the responsible local authority takes into account the outcomes of any prior community care assessment or assessment of a disabled child's needs in relation to the cared-for person. This may help to establish whether the carer is able and willing to continue to provide care to the cared-for person. The Act also requires the ASCP to be taken into account when carrying out assessments under other legislation, as considered below.

Link to SDS plans, Community Care assessments and assessment of disabled child's needs

2.1.35. **Section 30** of the Act amends **section 12A of the Social Work (Scotland) Act 1968**, which sets out the duty of local authorities to assess needs in relation to community care. The effect of the amendments is to require the responsible local authority to take account of the care provided by the carer as set out in the ACSP when making decisions about the provision of services to meet the cared-for person's needs. The responsible local authority is also required to take account of the views of the carer in so far as it is reasonable and practicable to do so.

2.1.36. **Section 30** of the Act makes similar amendments to **section 23 of the Children (Scotland) Act 1995,** which sets out the duty of the local authority to assess the needs of children affected by disability. The effect of the amendments is to require the responsible local authority to take account of the care provided by the carer as set out in the ACSP when making decisions about the provision of services to meet the needs of the cared-for child. The responsible local authority is also required to take account of the views of the carer in so far as it is reasonable and practicable to do so.

2.1.37. Responsible local authorities may consider preparing an ACSP at the same it undertakes an adult cared-for person's self-directed support plan/ community care assessment or the assessment of a disabled child's needs.

Emergency care plans for cared–for persons

2.1.38. **Section 9(1)(c)** requires information about whether the adult carer has arrangements in place for the care of the cared-for person in an emergency.

2.1.39. Emergency planning (sometimes called contingency planning) includes planning for events such as the carer not being able to care due to illness or adverse weather preventing the carer from accompanying the cared-for person to medical appointments.

2.1.40. Some responsible local authorities already offer carers emergency plans or discuss emergency planning with them, whilst other areas offer carers an emergency card which lets the emergency services or social care services know that a person is a carer. Encouraging carers to carry the card at all times can help services to put other support in place in a crisis.

2.1.41. ENABLE Scotland has a suite of resources about emergency planning which applies in all caring situations, including caring for children and adults with learning disabilities[14]. Responsible local authorities are encouraged to make use of these resources or direct adult carers to the ENABLE emergency planning resources.

Learning from ACSP pilots
During the pilots for this aspect of implementation of the Act, a Health and Social Care Partnership introduced the ENABLE emergency planning toolkit

[14] http://www.enable.org.uk/families/Pages/Emergency-Planning.aspx

through a conversation with the carer as part of preparing the ACSP. They found this helped to establish what would be required to be done in an emergency situation. There was very positive feedback from carers about the introduction of emergency planning as part of their ACSP.

Future care plans for cared-for persons

2.1.42. **Section 9(1)(d)** requires the ACSP to include information about whether the adult carer has arrangements in place for the future care of the person that they care for. If the carer identifies future care planning through discussion on their personal outcomes or identified needs as part of the ACSP process, they could be provided with support to put such plans in place.

2.1.43. Where carers appear to have a significant need for support with future care planning, this would be considered as part of the ACSP and the identification of needs; and if this identified need meets local eligibility criteria, the responsible local authority will be under the duty to provide support (see separate guidance chapter on duty to provide support to carers).

2.1.44. Information and advice services for carers are covered in Part 6 of this guidance. These services can signpost to or be designed in partnership between a carer centre and specialist, professional, independent services to offer future planning services. Such services could include making wills, trusts and longer term financial planning if appropriate to an adult carer's situation. Responsible local authorities may also consider the provision of carer advocacy services and make reference to the Scottish Government's guidance on carer advocacy in Scotland[15].

Example – Information and advice on future care planning
VOCAL Carer Centre in Edinburgh offers free surgeries to carers to access future planning services. Working in partnership with a solicitor, VOCAL offers carers short consultations, for information and advice about key issues such as wills, trusts and guardianship. They also offer long term care financial advice surgeries via a chartered financial advisor who explores options with carers who are concerned about paying for care home fees, how much they will have to pay and what happens to the property.

Link to anticipatory care planning

2.1.45. In terms of future care arrangements, the ACSP is well placed to link to an anticipatory care plan[16] This is a dynamic record that can be developed over time through an evolving conversation, collaborative interactions and shared decision making. It is a summary of the discussions between the cared-for person, their carer and the practitioner. Carers themselves may find it useful to have their own anticipatory care plan which can be kept updated and shared using technology such as the associated app.[17]

[15] http://www.gov.scot/Publications/2016/03/5362
[16] http://ihub.scot/anticipatory-care-planning-toolkit/
[17] http://ihub.scot/anticipatory-care-planning-toolkit/

2.1.46. Anticipatory care planning is more commonly applied to support those living with a long term condition to plan for an expected change in health or social status. It also incorporates health improvement and staying well. Completion of a common document called an anticipatory care plan is suggested for both long term conditions and in palliative care. Future care arrangements will also be relevant when the cared–for person is receiving end of life care. Advance care planning is the term most commonly referred to in end of life care, although it does incorporate the writing of wills or "Living Wills" now known as advance directives or advance decisions which can be done by the cared-for person early on in life to plan for what may happen at the end of life.

Personal outcomes

2.1.47. It is recognised that caring for another person is likely to impact on a carer physically, emotionally and on the way in which that carer lives his/her day to day life. The policy intention of the Act is to maximise opportunities and minimise negative impacts so as to allow the carer to have a life alongside caring. Consequently, the ACSP seeks to support carers not just in relation to the substantive care that they provide to the cared-for person, but also by putting measures in place that will help a carer to live their own life and to achieve their own goals and aspirations. These day to day goals and longer term aspirations are to be documented within the ACSP as the carer's "personal outcomes".

2.1.48. **Section 9(1)(e)** requires the ACSP to contain information about the identification of the adult carer's personal outcomes and what those outcomes are.

Definition and approach to identifying personal outcomes

2.1.49. The term 'personal outcomes' is defined at **section 4** of the Act. It includes outcomes, which if achieved would enable carers to provide or continue to provide care for the cared-for person(s).

2.1.50. **Section 4(2)** allows Scottish Ministers to make further provision in regulations about personal outcomes while **section 8(1)** allows Scottish Ministers to make provision in regulations about the way in which personal outcomes and needs for support are to be identified. No such regulations have been made for the commencement of the Act.

Evidence on personal outcomes
The review paper *Review of evidence on personal outcomes relevant to the Carers (Scotland) Act 2016*, Emma Miller (2017), University of Strathclyde[18] is a valuable source of information on domestic and international practice in the literature to evaluate personal outcomes; their use, efficacy and integration with existing processes and procedures.

2.1.51. In terms of approach to identification of the adult carer's personal outcomes, the discussion can be focused on the adult carer's wellbeing needs, and consider how coordinated services or support can impact on their wellbeing. The outcomes

[18] http://www.gov.scot/Topics/Health/Support-Social-Care/Unpaid-Carers/Implementation/UsefulResources

must be specific to the carer and their circumstances and may have a short or longer term focus as required.

Consideration of equalities when identifying outcomes

2.1.52. **Section 8(2)** requires that in identifying an adult carer's personal outcomes and needs for support, the responsible local authority must take into account any impact that having one or more protected characteristics (within the meaning of **section 149(7) of the Equality Act 2010**) has on the adult carer.

Equalities Examples

Sensory loss & deafblindness

Where an adult carer has dual sensory loss or is deafblind, responsible local authorities could have an appropriately skilled professional involved in the ACSP or consider a specialist assessment undertaken by a professional with dedicated skills in understanding the impact that deafblindness or dual sensory loss can have on an individual person and their family.

English not a 1st language

When planning to undertake an ACSP, it is identified that English is not the carer's first language. In this situation, it is recommended that the responsible local authority would offer an interpreting and translation service when undertaking the preparation of the ACSP.

Older carers

Older carers may have to manage their own long-term conditions and frailty which may impact considerably on their ability to provide care. Other factors to consider are whether or not the carer also requires their own community care assessment alongside their ACSP and to the level at which they may reach eligibility for services as undertaking a smaller caring role may have a much greater impact on an older carer than other carers.

Carers with a learning disability

In the case of adult carers who have a learning disability, responsible local authorities may consider who is best placed to undertake the ACSP. The carer may have barriers to participate in their ACSP. Consideration of the use of an independent advocate alongside the carer may help the carer to express their views and opinions on what their needs and personal outcomes are.

Identified needs

2.1.53. **Section 9(1)(f)** requires the ACSP to contain information about the identification of the carer's needs for support, including what these needs are. "Identified needs" are defined in **section 5** of the Act as the needs for support which are identified in order to meet the carer's identified personal outcomes. These support needs could include a broad range including the carer's physical needs, emotional needs, relationship needs, health needs, economic needs and physical environment needs. Identified needs must be recorded in the ACSP. If a carer has no identified needs for support, this must also be recorded.

2.1.54. In considering what the carer needs to meet their personal outcomes, responsible local authorities are recommended to consider the carer's strengths and capabilities, and what support might be available from their wider support network or within the community. Suggestions that support could be available from other family and friends could be considered in light of their willingness and ability to provide any additional support and the impact on them of doing so.

Whole family approach

2.1.55. Consideration of what other support may be available through the carer's networks and the wider community, allows for a whole family approach and for the responsible local authority to build a more holistic view of the needs of the carer and the person they care for.

2.1.56. In considering the impact of the cared-for person's needs on those around them, the responsible local authority may consider whether additional information and advice would be beneficial to those people identified. Alongside the main carer there may be others undertaking a caring role. For example where a carer has children, one of whom has additional care needs, there may be other children who are young carers, which allows the offer of a young carer statement to be made.

Support available locally

2.1.57. **Section 9(1)(g)** requires information about the support available to adult carers and cared-for persons in the responsible local authority's area to be contained in the ACSP. It is recommended that this information is tailored to the specific identified personal outcomes and needs of the adult carer and the person that they care for.

Carers living in other areas from the cared-for person

2.1.58. **Section 9(1)(h)** requires that if an adult carer does not reside in the responsible local authority's area, information must be provided about the support available to them, in the area where they live. The 'responsible local authority' in relation to an adult carer, means the local authority for the area in which the cared-for person resides.

2.1.59. It is recommended that the responsible local authority who has identified a carer in their area who resides in a different local authority area, but cares for someone in their own local authority area, liaise with the other local authority to ensure that they can provide appropriate information about the support available to them, in the area where they live.

2.1.60. This information may for example, take the format of a leaflet or a carer information pack. It may also include contact details of the information and advice service of the other local authority area or carer centre and instructions on relevant online information. It could include information on universal support in that area or more intensive support such as respite which would be outlined in the short break services statement of that area.

Adult carers caring for people in more than one local authority area

2.1.61. There may be occasions where an adult carer is caring for more than one person across different local authority areas. In these circumstances, both local authorities where the cared-for persons are living have responsibility to offer and if that offer is accepted undertake an ACSP. Following that, they would provide support to the carer (dependent on the two local authorities' potentially different eligibility criteria) which might involve providing support to the cared-for person.

2.1.62. We encourage each local authority in these circumstances to work together, so that they can jointly:

a) achieve an outcomes focus for the individual carer;
b) minimise the need for the carer to provide the same information twice;
c)can make decisions on support and eligibility based on a shared understanding of the total impact of the carer's caring responsibilities; and;
d) avoid duplication of effort.

2.1.63. Whilst each local authority's eligibility criteria would be relevant in its own decision making about support, we recommend collaboration between each area in that decision making process.

Case Study – Carer caring for two people in different areas
An adult carer is caring for their daughter, a child who has a long term condition, whilst also providing care to their elderly mother, in her seventies with dementia. The carer and her daughter both live in Dundee (the same local authority) but the grandmother (second person being cared-for) lives in Perth and Kinross (another local authority).

The 'responsible local authority' in relation to an adult carer, means *the local authority for the area in which the cared-for person resides*. The responsible local authority would therefore be Dundee for the first caring situation and Perth and Kinross for the second caring situation.

Therefore the duty to undertake the ACSP and provide support if the carer's identified needs meet the local eligibility criteria for the Dundee caring situation would sit with Dundee as the responsible local authority. For the other caring situation, it would be Perth and Kinross as the responsible local authority.

However, Dundee as the responsible local authority who have identified a carer in their area who also cares for someone who resides in a different local authority area (Perth and Kinross), could liaise with that local authority and make a referral (with consent) to ensure that the carer has access to an ACSP and any requisite support that would benefit them and to which they are entitled.

Carer who resides in Scotland caring for someone outwith Scotland

2.1.64. The Carers (Scotland) Act 2016 does not create a duty to offer an ACSP to a carer in this situation, or provide subsequent support as the cared-for person

resides outwith Scotland. However, carers are still able to access local carer support such as: carer centre services; citizens advice bureau; advice shops and local authorities' information and advice services.

2.1.65. A carer living in Scotland who cares for someone outwith Scotland may be eligible for support from the local authority in which the cared-for person resides. In these instances, it would be a matter for the relevant local authority in England or Wales, or the Health and Social Care (HSC) Trust in Northern Ireland to make decisions as set out under legislation in those countries. (See Part 3, Chapter 2 on duty to provide support.)

Carer resides outwith Scotland, caring for someone in Scotland

2.1.66. Instances where a carer outwith Scotland is caring for someone residing in Scotland may also occur. For example, a 'distance caring' relationship where a carer looks after:

a) a frail parent and provides emotional support, liaises with statutory services, and arranges other help from a distance, and visits regularly to provide hands-on assistance; or

b) someone nearby, just over the border.

2.1.67. For adult carers, the Scottish local authority where the cared-for person lives has a duty to offer an adult carer support plan and to support the carer under the Act where their identified needs meet local eligibility criteria.

Support to be provided

2.1.68. Once the responsible local authority is satisfied that the ACSP has accurately captured the carers identified needs, the authority must come to a view on the carer's eligibility for support. This process is detailed in **Part 3** of this guidance.

2.1.69. Although the responsible local authority and the carer are working jointly to ascertain needs and eligibility, the final decision regarding eligibility will rest with the responsible local authority. In all cases, the responsible local authority must inform the carer of their eligibility judgement and why it has reached the eligibility determination that it has. Where a carer is identified as having eligible needs for support, it must discuss what these eligible needs are and outline how these might be met including via the four options of self-directed support (Please refer to guidance on local eligibility criteria and duty to support carers).

2.1.70. **Section 9(1)(i)** requires the ACSP to provide information about the support which the responsible local authority provides or intends to provide to the adult carer to meet their identified needs if those needs meet the local eligibility criteria.

2.1.71. At this support planning stage, if the carer's identified needs meet the threshold of the local eligibility criteria, the responsible local authority must offer the four options (see table 1 below) of self-directed support[19] to the carer based on their indicative budget or relevant amount.

Table 1
The four options of Self-directed Support are:

[19] http://www.gov.scot/Topics/Health/Support-Social-Care/Support/Self-Directed-Support

Option 1: a Direct Payment (a cash payment);
Option 2: funding allocated to a provider of your choice (sometimes called an individual service fund, where the council holds the budget but the person is in charge of how it is spent);
Option 3: the local authority can arrange a service for you; or
Option 4: you can choose a mix of these options for different types of support.

2.1.72. There is no single approach to resource allocation prescribed on the face of the **Social Care (Self-directed Support) (Scotland) Act 2013**, nor any single method recommended by the Scottish Government. The authority may wish to adopt an equivalence model where they determine the cost of the service to be arranged and then provide the equivalent amount as a budget for the supported person or carer to control. Alternatively, it may wish to adopt a resource allocation system whereby the authority gathers information about the person's outcomes allocates points to those outcomes and then allocates a level of funding. In addition, decisions about budgets may be made on a case by case basis. It is recommended to make reference to the statutory guidance to accompany the **Social Care (Self-directed Support) (Scotland) Act 2013**[20].

2.1.73. The responsible local authority may decide to offer one holistic budget that extends to meet both the eligible needs and personal outcomes of the adult carer and the eligible needs and personal outcomes of the cared-for person. If budgets are combined, it is important that the focus is not just on the cared-for person but also acknowledges the carer's health and wellbeing. Carers also require choices and their support personalised.

2.1.74. **Section 9(1)(j)** requires that where the adult carer's identified needs do not meet the local eligibility criteria, information about any support which the responsible local authority nevertheless agree to provide must be included in the ACSP. Responsible local authorities can choose to provide individualised support to the carer on a discretionary basis using their powers rather than duties to provide support. This could include making a referral or signposting carers to universal or community based services, for example a local carers centre or a citizens advice service.

2.1.75. If the carer's needs do not meet the local eligibility criteria, then it is recommended that other preventative supports in the community still be considered by the responsible local authority.

Example
Carer centres can offer a wide range of preventative support to carers including advice and information, emotional support, carer training, short breaks and welfare benefits checks to maximise income. Carer centres are often third sector organisations who specialise in carer support.

Breaks from caring

[20] http://www.gov.scot/Resource/0044/00446933.pdf

2.1.76. **Section 9(1)(k)** requires the ACSP to include information about whether the support should include breaks from caring. Part 3 of this guidance contains more information about breaks from caring .

Review of ACSP

2.1.77. **Section (9)(1)(l)** requires the ACSP to contain information about the circumstances in which it is to be reviewed.

2.1.78. The Scottish Government intends to bring forward regulations under **section 10** of the Act specifying circumstances in which ACSPs must be reviewed. Proposals have been subject to consultation and the final regulations will be taken into account in the final version of this guidance.

2.1.79. Responsible local authorities may also consider what other circumstances will be relevant to trigger a review in individual cases, such as:

a) a stated period of time;
b) deterioration in the health of the carer or cared-for person;
c) the cared-for person being discharged from hospital.

Effectiveness of support provided under previous adult carer support plan

2.1.80. After an initial ACSP has been prepared, **Section 9(2)** requires each subsequent ACSP to contain information about the extent to which any support provided under a previous plan has assisted in the achievement of the adult carer's identified personal outcomes.

Additional information

2.1.81. The responsible local authority can decide what additional content to include in the ACSP, over and above the minimum requirements set out in the legislation. This could be information tailored to individual ACSPs or general information. An example could be a risk assessment in relation to tasks undertaken by the carer such as bathing the person that they care for or assistance with mobility.

Timescales for preparing an adult carer support plan

2.1.82. There are no timescales set out in the Act for preparing and completing individual adult carer support plans and young carer statements. There will be timescales prescribed in relation to carers of terminally-ill cared-for persons, as outlined below.

2.1.83. **Section 31(2)(h)** requires the local carer strategy to set out the intended timescales for preparing adult carer support plans and young carer statements. Part 5 of this guidance deals with local carer strategies. The intention of **section 31(2)(h)** is to give carers collectively an indication of how long, on average, they are likely wait for an adult carer support plan. It is fully expected that some will take less time and some will take longer than those indicated time periods for valid reasons

2.1.84. There may be different timescales for completion of individual adult carer support plans. ACSPs ought to be prepared within reasonable timescales taking into account the urgency of needs for support and any fluctuation in those needs. Responsible local authorities may have guidance for timescales based on urgency or risk. There may be valid reasons for a plan taking longer to complete than perhaps anticipated, for example, where the carer's needs are complex and require more than one contact to prepare and complete the plan and/or where support required is specialised and not readily available. Responsible authorities are encouraged to focus on achieving the right outcomes for the carer rather than allowing set timescales to become a *de facto* target or input measure.

2.1.85. Responsible local authorities are advised to inform the individual carer of an indicative timescale over which their assessment will be conducted and keep the carer informed throughout the assessment process. Some responsible local authorities also, as a matter of good practice and courtesy, advise individual carers of any delays and the reasons for the delays.

Timescales for ASCPs for carers of terminally ill cared-for persons

2.1.86. **Section 7** requires Scottish Ministers to prescribe timescales in regulations for the preparation of the ACSP in relation to adult carers who are caring for someone who is terminally ill. Research is currently underway to consider what timescales would be appropriate. Regulations will be brought forward in due course once that research is complete and this guidance will be updated accordingly.

2.1.87. The term, 'terminally ill cared-for person' for the purposes of this section and **section 13** of the Act is a person who is terminally ill due to suffering from a progressive disease and death as a consequence of that disease can be reasonably expected within six months.

2.1.88. **Section 9(3)** provides a power to make regulations about other information which an ACSP must or must not contain and the form of the ACSP. Scottish Government do not intend to use this power for commencement of the Act.

Adult carer support plan: provision of information to carer etc.

2.1.89. **Section 11** requires the responsible local authority to provide information contained in the ACSP to the carer to whom the ACSP relates and any other person the carer requests, unless the authority does not consider it appropriate to provide the information. For example, It might not be considered appropriate to provide sensitive medical information about the cared-for person to a third party.

2.1.90. When considering information to be shared and who to share it with, the responsible local authority would have to comply with the common law duty of confidentiality and the requirements of data protection and human rights legislation, in particular, the right to private and family life under Article 8 of the European Convention on Human Rights (ECHR).

2.1.91. **Section 11(4)** states that the information is to be provided as soon as practicable after the plan is prepared or in the case of a revised plan, when the

revised plan is prepared. In terms of good practice, this would mean that the carer is provided with a physical copy of their agreed ACSP within a reasonable timescale by the responsible local authority.

Digital Technology

2.1.92. There is an important role for effective IT systems in sharing agreed information between partners and keeping plans up to date. The Scottish Government through the Health and Social Care Delivery Plan has identified digital technology as key to transforming health and social care services. There has been success through previous eHealth and Technology Enabled Care Strategies in the delivery of many core IT systems required to support efficient service delivery at a local level, and in technology assisted home care to support wellbeing, self-management and safer living at home or in community settings. However, there is a need for even better use of digital technology, data and research in order to achieve this transformation agenda. [Our new Digital Health and Social Care Strategy, being published in early 2018 and produced alongside COSLA, will recognise this as a key aim.]

Part 2, Chapter 2

Young carer statements

Summary

Section 12 places a duty on responsible authorities to offer a young carer statement to all identified young carers and prepare a young carer statement for those that take up this offer, as well as for any young carer who requests one.

Section 13 states that Scottish Ministers must, by regulations, prescribe timescales for the preparation of young carer statements for young carers of terminally ill cared-for persons.

Section 14 makes reference to the duty on the responsible authority to take into account any impact that having one or more protected characteristic (within the meaning of **section 149(7) of the Equality Act 2010**) has on the young carer.

Section 15 details the information that must be contained within a young carer statement.

Section 16 allows Scottish Ministers to make provision about the review of young carer statements through regulations.

Section 17 details under which circumstances and with whom the responsible authority must provide the information contained in the young carer statement with.

Section 18 makes provision for the continuation of a young carer statement.

Section 19 details the meaning of "responsible authority" in relation to young carers.

Section 20 details where there may be "special cases" in relation to the responsible authority and young carers.

The duties at **Chapter 2** apply to responsible authorities. Depending on the area, these functions may either sit with children's services or be delegated to the integration joint boards under the **Public Bodies (Joint Working) (Scotland) Act 2014**. It would be expected that in cases where the functions are not delegated to integration schemes, there would be a level of joint working.

For the purpose of this chapter the terminology "relevant authority" will be used in place of children's services, local authorities or integration joint boards.

Purpose of young carer statements

2.2.1. The young carer statement (YCS) provides a framework for identification of the personal outcomes and individual needs for support of young carers by the responsible authority and the substantive provision of support by the responsible local authority to meet those identified needs.

2.2.2. The YCS is intended to ensure that young carers are seen as children and young people first and foremost and are protected from undertaking caring responsibilities and tasks which are inappropriate having regard to their age and maturity.

2.2.3. The policy intention is that the YCS will help and empower young carers, provide them with confidence and assist the child or young person recognise their own needs and identify personal outcomes which are important to them. Responsible authorities must offer a young carer statement to an identified young carer and to prepare one if that offer is accepted.

2.2.4. The YCS provides young carers who request or who are offered and accept a young carer statement, a record of their identified needs and personal outcomes. This document becomes a record which they will receive a copy of and can choose to share this information with any other person that the young carer requests to do so.

2.2.5. In order to promote effective planning for transitions, the YCS ensures that even when a young carer has attained the age of 18 years, any young carer statement prepared in relation to that carer continues to have effect until the carer is provided with an adult carer support plan.

Duty to prepare young carer statements

2.2.6. **Section 12** requires a responsible authority to offer an YCS in respect of an identified young carer and to prepare one if that offer is accepted. The duty to prepare an YCS also applies where a young carer has requested one.

2.2.7. **Section 12(1)(a)** to **(c)** requires a YCS to set out:

- a young carer's identified personal outcomes;
- a young carer's identified needs (if any); and
- the support (if any) to be provided by the responsible local authority to a young carer to meet those needs.

2.2.8. Each of these elements is considered in more detail below.

2.2.9. The YCS is therefore the mechanism through which needs for support are assessed and monitored and support is managed.

2.2.10. The duty under **section 12** to offer and prepare a YCS still apply even if the young carer's identified needs are not or do not seem likely to be deemed eligible for the provision of support (according to local eligibility criteria). In this context, it is also recommended that the responsible authority provides the young carer with preventative support through the information and advice service which must be provided under the Act (see Part 6 of this guidance) and signpost them to any community based services that may be available universally or from a local carer centre.

Responsible authority

2.2.11. The provisions about the responsible authority are different for young carers compared to adult carers. Under **section 19**, the **responsible authority** for the majority of young carers will be the local authority of the area where the young carer resides. For pre-school young carers it will be the health board for the area where the young carer resides.; and. **Under section 20** the responsible authority for those young carers who attend a grant aided or independent school will be the directing authority of that school. Section 20 also makes provision about special cases where the responsible authority may be different. These are considered in more detail later in this chapter.

2.2.12. The duty to prepare a YCS could come under the delegated responsibilities of integration authorities. Some integration authorities will have responsibility for children's services and others won't. However, under integration duties placed on local authorities, responsibility for young carer support could be a delegated function of the integration authority, unless it is being retained by the local authority as part of children's (social care) services or retained by the health board in terms of children's health services. Part 7 of this guidance provides more information about delegation of functions under the Act.

2.2.13. **Section 12(2)** requires the responsible authority to offer a YCS to any child or young person they identify as a young carer.

Example – carer identification through awareness raising

Edinburgh Young Carers Project deliver a 'schools awareness raising campaign' in Edinburgh.

This involves carer support workers from the young carer centre speaking at school assemblies, classroom sessions and at continuing professional development sessions to teaching staff on young carer issues.

2.2.14. **Section 12(3)** requires the responsible authority to prepare a YCS for:

- anyone who accepts an offer under **section 12(2)**; and
- anyone who requests a YCS and appears to the responsible authority to be a young carer.

2.2.15. This duty applies whether or not the young carer also requires a child's plan in accordance with **section 33 of the Children and Young People (Scotland) Act 2014** (see **section 12(5)** of the Act).

2.2.16. **Section 12(6)** deals with cases where the responsible authority (i.e. the authority responsible for preparing a YCS under section 19 and 20) is different from the responsible local authority (defined in **section 12(8)** as the authority where the cared-for person resides). In such cases the responsible authority must not provide the YCS to the young carer without the approval of the responsible local authority. In practice, this would involve liaison and agreement between the responsible authority and the responsible local authority on the content of the YCS and on provision of support (if any) to the young carer.

2.2.17. **Section 12(7)** requires that in preparing the YCS, the responsible authority must exercise its functions under this section in a manner which encourages equal opportunities and in particular the observance of the equal opportunity requirements (within the meaning of section L2 of Part 2 of schedule 5 of the Scotland Act 1998).

Approach to YCS

2.2.18. A YCS must combine the identification of a young carer's personal outcomes, and an assessment of their needs for support to help them achieve those identified personal outcomes along with the preparation of a support plan to monitor the needs and the support managed. See **Section 5** of the Act and Chapter 1 of Part 2 of this guidance for the definition of identified personal outcomes and identified needs.

Outcomes-focused approach

2.2.19. Some responsible authorities may wish to approach the preparation of the YCS in a single event following a face-to-face visit and outcomes-focused conversation with the young carer. Other areas may prefer an approach which requires more than one visit and facilitates more time to have an outcomes-focused conversation with the young carer in order to complete the support planning and then finalise the YCS.

2.2.20. At a local level, clear procedures for how and when a YCS will be undertaken and by whom require to be established and understood by the relevant staff groups. Young carers will need to know what to expect when they request, or accept the offer of a YCS and it is recommended that this information is made freely available.

2.2.21. It is recommended that responsible authorities be mindful that where a young person is preparing for school exams or otherwise focusing on their education, that the preparation and review of the YCS does not interfere with the young carer's studies.

2.2.22. When undertaking the outcomes-focused conversation with the young carer to prepare the YCS the responsible authority is encouraged to be respectful of the young person's wishes, opinions and boundaries. It is suggested that when undertaking the conversation with a young carer, responsible authorities make use of coproduction and child-centred approaches, active listening, use of empathy and any other relevant skills.

2.2.23. The approach to an outcomes focused conversation with a young carer would benefit from a solid understanding of children's rights and for practitioners to promote and respect those rights. The United Nations Convention on the Rights of the Child (UNCRC) is an international law which sets out the rights of children and young people. The UNCRC underpins Getting it right for every child, Scotland's approach to improving outcomes for children and young people. There is useful guidance on the UNCRC and the foundation of Getting it right for every child[21].

[21] http://www.gov.scot/Resource/0041/00417256.pdf

2.2.24. Responsible authorities would benefit from taking into account the UNCRC when preparing a YCS. All of the rights are of equal importance and all are underpinned by four general principles:

- all of the rights must be available to all children without discrimination (Article 2)
- the best interests of the child must be a primary consideration in all actions concerning children (Article 3)
- that every child has the right to life, survival and development (Article 6)
- that the child's view must be considered and taken into account in all matters affecting them (Article 12)

Who can prepare the young carer statement?

2.2.25. We would expect responsible authorities to give consideration to who is best placed to prepare the YCS, e.g. the local authority, a health professional or someone else who is suitably qualified to do so. This may be someone who has an existing relationship with the young carer and their family.

2.2.26. This function could be undertaken by a third sector organisation such as a young carer support provider or a carers centre, as their staff may have the necessary skills and experience to undertake YCSs. Responsible authorities are encouraged to work collaboratively with the third sector in developing their models for preparing YCSs.

2.2.27. It is for the responsible authority to decide how it carries out the function and whether or not it wishes to commission third sector partners to undertake the function of preparing individual YCSs. There will remain a role for the responsible authority to oversee the delivery and quality of these assessments in practice. Some authorities in Scotland already delegate the assessment function of young carers to the third sector and have contracts in place.

Learning from YCS pilots

During the pilots for implementing this aspect of the Act, it was found that there was potential for further integration of third sector provision when undertaking the YCS. It was found that a strong partnership approach between third sector and statutory services worked best to support young carers.

The pilots also found that young carers felt that they ought to be able to choose who helps them prepare a YCS, including teachers, sports coaches or others.

Example – Third sector role in assessment
Quarriers, a third sector organisation are contracted by Moray Council to provide services to young people (aged 18 years and under) who provide care to family members.

They are also contracted by Moray Alcohol and Drug Partnership to specifically identify and support young people caring for family members who misuse alcohol or drugs.

Services offered include undertaking carers assessments; supporting young carers to participate in existing recreational facilities in their community and offering age appropriate information, training and advice.

Potential conflict of interest

2.2.28. There could be a potential conflict of interest where the body carrying out the YCS assessment is also a provider of young carer support. This could happen if the responsible authority commissions the YCS function to an external third sector provider, for example a young carers centre, which also provides support. The conflict could arise because any identified needs of the young carer which meet the local eligibility criteria threshold will trigger the duty to support the young carer and as such could have funding implications for both the responsible authority and the young carer support provider.

2.2.29. This need not prevent delegation of assessment functions to 3rd sector providers. If the young carers centre is also a provider of carer support, it would need to be careful about how it manages offering choice and control to the young carer to meet their eligible needs and personal outcomes. This could be achieved through offering the young carer a range of support options as required under the Social Care (Self-directed Support) (Scotland) Act 2013. Those options may not necessarily provided by the young carers centre who undertook the YCS.

2.2.30. To mitigate the risks arising from any potential conflicts of interest, it is recommended that the responsible authority have monitoring processes and checks built into any contract with a third sector provider, so that they can audit case files against YCSs prepared and see how decisions were reached and budgets allocated appropriately.

Links to other plans and strategies for children and young people

Local carer strategy

2.2.31. In preparing a local carer strategy, **section 32** of the Act requires the local authority and the relevant health board to have regard to any plans for the provision of services relevant to young carers which are set out in the children's services plan prepared for the area of the local authority under section 8 of the 2014 Act. See Part 5 of this guidance for further information on local carer strategies.

Child's plan

2.2.32. While **Part 5 of the Children and Young People (Scotland) Act 2014** has not yet been commenced, a number of authorities may provide an integrated planning framework for children and young people on a policy basis (the child's plan). Where a child's plan is in place for a young carer, it would be good practice to consider and agree with the child and other relevant persons how the YCS sits alongside the child's plan and forms part of it. Where possible it would be of merit to

reduce the number of separate meetings for different plans and to coordinate these plans into one meeting. This would help to ensure a coherent approach to planning.

Considerations for children's services and/or education colleagues

2.2.33. The responsible authority will be aware of when a young carer in an educational setting has a co-ordinated support plan (CSP).

2.2.34. Education authorities and other agencies have duties under the **Education (Additional Support for Learning) (Scotland) Act 2004** (as amended) ("the 2004 Act") to identify, provide for and review the additional support needs of their pupils. An additional support need can arise for any reason and be of short or long term duration. Additional support may be required to overcome needs arising from learning environment; health or disability; family circumstances or social and emotional factors.

2.2.35. Education authorities can ask other agencies (including social work services, health boards and Skills Development Scotland) for help in carrying out their duties under the 2004 Act. Other agencies must respond to the request within a specific timescale (but there are exceptions to these timescales).

2.2.36. Children and young people's needs are met through planning for their learning and support, usually through an individualised educational programme (this may have another name such as an Additional Support Plan) which sets out targets for learning and the support to be provided (usually termly). For children and young people who have complex or multiple needs which require significant support from education and another agency or agencies a co-ordinated support plan may be required. The purpose of the CSP is to support co-ordinated planning to meet pupils' needs. The plan lasts for up to a year.

2.2.37. A young carer can be eligible for a CSP if the education authority agrees that they have additional support needs which meet the criteria for a co-ordinated support plan. To meet the criteria for a co-ordinated support plan, the support required must be significant and from more than one agency in addition to the education authority and for more than a year. This might include family circumstances relevant to caring acting as a barrier to the learning outcomes of a young carer

2.2.38. There are a range of dispute resolution mechanisms available; including independent mediation and adjudication, and referral to the Additional Support Needs Tribunals for Scotland. The Tribunals hear references involving children and young people who either have, or are potentially entitled to have, a CSP, certain placing requests and transitional arrangements.

Barriers to learning

2.2.39. The statutory code of practice[22] which provides guidance on the 2004 Act makes clear that young carers may experience barriers to their learning and additional support needs should be identified, provided for and reviewed in line with the requirements of the 2004 Act.

[22] http://www.gov.scot/Publications/2011/04/04090720/0

2.2.40. Further, the guidance on Attendance in Scottish Schools, "*Included, Engaged and Involved: Part 1*"[23] makes clear that education authorities should recognise the impact that caring responsibilities may have on school attendance. The guidance makes clear the need to follow up on changes in patterns of attendance or increased absence to ensure that appropriate support is provided if necessary.

Signposting, information and advice if young carer refuses offer of YCS

2.2.41. Not all young carers will accept the responsible authority's offer of a YCS. It is a choice for the young carer to decide to accept this offer of a YCS. Where a young carer declines the offer of a YCS, the responsible authority could consider signposting the young carer, if they agree and with consent to a young carer centre or similar support provider. Also some young carers may of their own accord approach a young carer centre or support provider for information, advice and support.

Low and fluctuating needs

2.2.42. It is recommended that responsible authorities consider the potential fluctuation of the young carer and/or the cared-for person's needs. For example where the responsible authority is aware that the cared-for person's needs fluctuate over time due to a mental health condition, the YCS carried out at a particular moment may take into account the cared-for person's history to establish a complete picture of the cared-for person's needs and the impact these fluctuating needs have on the caring situation.

2.2.43. Low level needs and the support to meet those identified needs will be considered as part of the YCS process. This process will be based on the identification of personal outcomes, needs and risks. It is recommended that consideration be given to whether a young carer's identified needs can be met by the local information and advice service or general services in the community.

Tensions between young carer and cared-for person

2.2.44. There can be circumstances where there are tensions between the young carers and the cared-for person. The caring role can be stressful and the cared-for person may not be coping well with their condition. This can put a tremendous strain on the relationship between the young carer and the cared-for person. The responsible authority will need to take this into account when preparing a YCS. Where the caring situation becomes unmanageable or has a detrimental impact on the young carer's wellbeing or that of the cared-for person, it is recommended that the professionals working with the young carer seek advice from the appropriate professionals within the responsible authority.

2.2.45. This could include, if necessary, raising a child protection[24] concern or an adult protection[25] concern in line with either their local multi-agency child protection guidelines (in accordance with the **Children (Scotland) Act 1995** and other relevant

[23] http://www.gov.scot/Publications/2007/12/05100056/0
[24] http://www.gov.scot/Publications/2014/05/3052/0
[25] http://www.gov.scot/Topics/Health/Support-Social-Care/Adult-Support-Protection

legislation) or their local multi-agency adult protection guidelines (in accordance with the **Adult Support and Protection (Scotland) Act 2007**)

Content of young carer statement

2.2.46. **Section 15** outlines what information must be contained in a YCS.

Young carer's personal circumstances

2.2.47. **Section 15(1)(a)** requires the YCS to include information about the young carer's personal circumstances at the time when the YCS is being undertaken. This must include information about the nature and extent of care provided or to be provided and information about the impact of caring on the young carer's wellbeing and day-to-day life.

2.2.48. When considering the impact of caring on the young carer's wellbeing and day to day life, **section 15(3)** requires the responsible authority to assess the wellbeing of a young carer by reference to the extent to which the matters listed in section 96(2) of the Children and Young People (Scotland) Act 2014 are or, as the case may be, would be satisfied in relation to the young carer. In doing so, the responsible authority is to have regard to the guidance issued under section 96(3) of the 2014 Act. This ensures that the eight wellbeing indicators (also known as the SHANARRI indicators) of the national Getting it right for every child approach[26] must be used when considering the child's personal circumstances.

Able and willing to care

2.2.49. **Section 15(1)(b)** requires the YCS to contain information about the extent to which the young carer is able and willing to provide care for the cared-for person. When considering whether the young carer is able and willing to provide care, it is recommended to take account of the age and maturity of the young carer along with the nature of the caring role and any associated risks.

Appropriateness of caring role

2.2.50. **Section 15(1)(c)** requires information about the extent to which the responsible authority considers that the nature and extent of the care provided by the young carer is appropriate.

2.2.51. It is necessary to ensure that young carers are seen as children and young people first and foremost and that they are protected from undertaking caring responsibilities and tasks which are inappropriate having regard to their age and maturity.

2.2.52. For example, the responsible authority might consider that any personal, intimate care provided by a young carer is not appropriate. They might consider that the young carer is engaged in caring during too many hours per week and have concerns on the impact that this has on their wellbeing. They might consider that the young carer, particularly a very young child, is too young to be carrying out any caring role. In this context, the responsible authority, must consider whether the caring situation of the young carer is appropriate and take any required steps as necessary.

[26] http://www.gov.scot/Topics/People/Young-People/gettingitright/publications/revised-draft-guidance

2.2.53. There is a relatively small number of very young carers, where there is a very young child (whether pre-school or in the early years of primary school) caring for a family member, There may be some scope for a young child to make a small contribution to the care of their parents, but this has to be set at the very lowest level, taking account of the child's age and maturity amongst other factors. It is strongly recommended that support provided ought to be directed towards removing them from their caring role through enhanced support for the person that they care for.

Link to SDS Plans, Community Care assessments and assessment of disabled child's needs

2.2.54. The willingness and ability of the young carer to continue to provide care to a cared-for person may be closely linked to the support provided to the cared-for person following other assessments. It is therefore recommended that the responsible local authority takes into account the outcomes of any prior community care assessment or assessment of a disabled child's needs in relation to the cared-for person. This may help to establish whether the young carer is able and willing to continue to provide care to the cared-for person. Amendments under section 30 of the Act also require the YCS and the views of the young carer to be taken into account when carrying out assessments under other legislation, as considered below.

2.2.55. **Section 30** of the Act amends **section 12A of the Social Work (Scotland) Act 1968**, which sets out the duty of local authorities to assess needs in relation to community care. The effect of the amendments is to require the responsible local authority to take account of the care provided by the young carer as set out in the YCS when making decisions about the provision of services to meet the cared-for person's needs. The responsible local authority is also required to take account of the views of the young carer in so far as it is reasonable and practicable to do so.

2.2.56. **Section 30** of the Act makes similar amendments to **section 23 of the Children (Scotland) Act 1995,** which sets out the duty of the local authority to assess the needs of children affected by disability. The effect of the amendments is to require the responsible local authority to take account of the care provided by the young carer as set out in the YCS when making decisions about the provision of services to meet the needs of the cared-for child. The responsible local authority is also required to take account of the views of the young carer in so far as it is reasonable and practicable to do so.

2.2.57. Responsible local authorities may consider preparing a YCS at the same time it undertakes an adult cared-for person's self-directed support plan/ community care assessment or the assessment of a disabled child's needs.

Emergency plans for the cared-for person

2.2.58. **Section 15(1)(d)** requires information about whether the young carer has arrangements in place for the care of the cared-for person in an emergency.

2.2.59. Emergency planning (sometimes called contingency planning) includes planning for events such as the young carer not being able to care due to the carer's illness and unable to support the cared-for person taking their daily medication. There may also be adverse weather or transport problems which prevent the young carer from accompanying the person they are caring for to a doctor's appointment or

an outpatient clinic. (See guidance in Chapter 2 of Part 4 on carer involvement in hospital discharge).

2.2.60. It is recommended that any discussions on emergency planning with the young carer also be thoroughly discussed with the cared-for person who often will be the parent or guardian of the young carer, to ensure that any agreed emergency plan is appropriate and takes into account the age and maturity of the young carer.

2.2.61. Under **section 34(2)** local authorities must establish and maintain an information and advice service for relevant carers including emergency care planning and future care planning for carers.

2.2.62. Some areas already offer young carers emergency plans or discuss emergency planning with them whilst other areas offer young carers an emergency card. An emergency card lets the emergency services or social care services know that a person is a carer. Encouraging young carers to carry the card at all times can help services to put other support in place in a crisis.

Example – Young carers card – use in emergency

Perth and Kinross Association of Voluntary Service (PKAVS) in partnership with NHS Tayside and Perth and Kinross Council offer a young carers card.

It has four sections on the reverse of the card showing medication, diagnosis, prognosis and discharge/care planning. As part of the application process, it is agreed with young carers and their parents what sections the young carer card will have information on.

The card also acts as an alert, for example, if the young carer has an accident their young carer card will allow others to know that there is a cared-for person at home and will need to be updated of this situation and possibly require additional care.

2.2.63. ENABLE Scotland has a suite of resources about emergency planning which applies in all caring situations, including caring for adults with health needs or disabilities[27]. Responsible authorities are encouraged to make use of these resources or direct young carers depending on their age and circumstances to the ENABLE emergency planning resources.

Future care plans for the cared-for person

2.2.64. **Section 15(1)(e)** requires the YCS to contain information about whether the young carer has arrangements in place for the future care of the person that they care for. There may be less stress and anxiety on the young carer if appropriate plans are in place for the future care of the cared-for person.

2.2.65. Future care planning could also be identified in relation to a personal outcome or an identified need later in the YCS process. In that case the authority responsible for supporting the young carer is well placed to consider what support can/is to be provided to meet that need. The information and advice services required under Part 6 of the Act must provide information and advice about emergency care planning and future care planning for carers.

[27] http://www.enable.org.uk/families/Pages/Emergency-Planning.aspx

2.2.66. When any future care plans are developed, it is recommended that they are part of plans applicable to the cared-for person and not the sole responsibility of the young carer. The young carer may have a role in the implementation of any future care arrangements but wouldn't normally be expected to have a lead role unless it is deemed appropriate to do so and in agreement with the cared-for person.

2.2.67. Where the young carer appears to have a significant need for support with future care planning, this would be considered as part of the YCS and the identification of needs; and if this identified need meets local eligibility criteria, the responsible authority will be under the duty to provide support.

2.2.68. Information and advice services for young carers can signpost to or be designed in partnership between a carer centre and specialist, professional, independent services to offer future care planning services such as including making wills, trusts and longer term financial planning if appropriate to a young carer's situation. Responsible authorities may also consider the provision of carer advocacy services and make reference to the Scottish Government's guidance on carer advocacy in Scotland[28].

2.2.69. This would be in line with the requirements under **section 34(2)** around the provision of an information and advice service for relevant carers, particularly on income maximisation for carers, advocacy for carers and emergency care planning and future care planning. Part 6 of this guidance deals with information and advice for carers.

Link to anticipatory care plans

2.2.70. If relevant to the situation of the young carer, information contained in the YCS may aid the preparation of parts of an anticipatory care plan of the cared-for person, if the young carer agrees to share that information. An anticipatory care plan is a dynamic record that can be developed over time through an evolving conversation, collaborative interactions and shared decision making. It is a summary of the discussions between the cared-for person, the young carer (if appropriate) and the practitioner. Chapter 2 of this Part contains more information on anticipatory care planning.

Personal outcomes

2.2.71. It is recognised that caring for another person is likely to impact on a young carer physically, emotionally and on the way in which that carer lives his/her day to day life. The policy intention of the Act is to ensure that young carers are seen as children and young people first and foremost and that they are protected from undertaking caring responsibilities and tasks which are inappropriate having regard to their age and maturity. Consequently, the YCS seeks to support carers by putting measures in place that will help a young carer to live their own life and to achieve their own goals and aspirations. These day to day goals and longer term aspirations are to be documented within the YCS as the carer's "personal outcomes".

2.2.72. **Section 15(1)(f)** requires the YCS to contain information about the identification of the young carer's personal outcomes and what these outcomes are. 'Personal outcomes' is defined at **section 4** of the Act to include outcomes which, if

[28] http://www.gov.scot/Publications/2016/03/5362

achieved, would enable young carers to provide or continue to provide care for the cared-for person(s).

2.2.73. **Section 14(1)** allows Scottish Ministers to make provision in regulations about the identification of personal outcomes and needs for support of young carers. No such regulations have been made.

2.2.74. The young carer's identified personal outcomes should link and support the achievement of the child's potential in relation to the eight wellbeing indicators of the national Getting it right for every child approach. The wellbeing indicators are: safe, healthy, achieving, nurtured, active, respected, responsible, and included.

2.2.75. In terms of approach to identification of the young carer's personal outcomes, the responsible authority may wish to consider how coordinated services or support can impact on the young carer's wellbeing. The personal outcomes will be specific to the young carer and their circumstances and may have a short or longer term focus as required.

Evidence – Personal outcomes
The review paper *Review of evidence on personal outcomes relevant to the Carers (Scotland) Act 2016*, Emma Miller (2017), University of Strathclyde[29] is a valuable source of information on domestic and international practice in the literature to evaluate personal outcomes; their use, efficacy and integration with existing processes and procedures.

Consideration of equalities when identifying personal outcomes

2.2.76. **Section 14(2)** requires that in identifying a young carer's personal outcomes and needs for support, the responsible authority must take into account any impact that having one or more protected characteristic (within the meaning of section 149(7) of the Equality Act 2010) has on the young carer.

Equalities Example – race and sexual orientation
During the preparation of a young carer statement, a South Asian teenager discloses to the responsible authority that he is gay and in his culture this can be very difficult for others to accept, including within his own family. He doesn't want his friends or peers at high school to know that he is gay or a young carer, in case he gets bullied.

Therefore, the responsible authority has established through the identification of a young carer's personal outcomes and needs for support, that there is an impact from two protected characteristics, race and sexual orientation on the young carer. This impact must be taken into account when preparing the YCS including the young carer's personal outcomes and eligible needs for support.

Identified needs

2.2.77. **Section 15(1)(g)** requires the YCS to contain information about the identification of the young carer's identified needs for support and what those needs

[29] http://www.gov.scot/Topics/Health/Support-Social-Care/Unpaid-Carers/Implementation/UsefulResources

are if any. “Identified needs” are defined in **section 5** of the Act as the needs for support which are identified in order to meet the young carer’s identified personal outcomes. These support needs could include a broad range including the young carer’s physical needs, emotional needs, relationship needs, health needs, economic needs and physical environment needs. Identified needs must be recorded in the YCS. If a young carer has no identified needs that must also be recorded. **Section 14(1)** allows Scottish Ministers to make further provision in regulations about the identification of outcomes and needs for support, but no regulations have been made under this power.

2.2.78. All of the matters in **section 15(1)(a) to (m)** must be considered when preparing a YCS and have an appropriate level of information recorded. A proportionate approach may be considered by the responsible authority when doing this, taking into account what issues are raised through the conversation with the young carer and which issues need to be raised with the cared-for person.

Whole family approach

2.2.79. The responsible authority could build a more holistic view of the needs of the young carer and the person they care for by considering what other support may be available through exploring their networks and the wider community, allowing for a whole family approach.

2.2.80. In considering the impact of the cared-for person’s needs on those around them, the responsible authority may wish to consider whether additional information and advice would be beneficial to those people identified. Alongside the main young carer there may be others undertaking a caring role in the family. For example where a young carer has siblings, they also may be young carers, which would lead to the offer of a YCS.

Example – raising awareness of young carers
Action for Children’s Young Carers Project in North Lanarkshire which is supported by the Health and Social Care Partnership raises awareness of young carer issues in various locations and professional teams including hospitals, health centres, schools and mental health teams. The carers project is actively promoted in these locations and during carers week, awareness training sessions to GP’s and practice staff groups were delivered.

Example – supporting young carers in school
Stirling Young Carers Service has worked with all secondary schools in their area so that there is a timetabled dedicated young carers class as part of the curriculum. Young carers are referred to the class through pupil support.

The young carers decide what the topics for study will be, and these are often have a home economics focus. The young carers worker from the service drops in on the classes regularly to provide a link between school and the young carers service, but many of the young carers do not attend the young carers groups offered by the service, feeling that they have adequate support at school.

Information provision

2.2.81. **Section 15(1)(h)** requires information about the support available to young carers and cared-for persons in the responsible local authority's area to be contained in the YCS. It is recommended that this information be tailored to the specific identified personal outcomes and needs of the young carer having regard to the needs of the person that they care for.

Young carers living in different areas from the cared-for person

2.2.82. **Section 15(1)(i)** requires that if a young carer does not reside in the responsible local authority's area (ie the area where the cared-for person lives), information must be provided about the support available to young carers in the area where they live.

2.2.83. This information may for example, take the format of a leaflet or a carer information pack. It may also include contact details of the information and advice service of the other local authority area or carer centre and instructions on relevant online information.

2.2.84. As a matter of best practice, responsible local authorities who have identified a young carer who cares for someone in their area but resides in a different local authority area, are recommended to liaise with the other local authority to ensure that the young carer has access to a YCS (which would be provided by the other local authority). Any requisite support that would benefit the young carer and to which they are entitled to would be provided by the responsible local authority which is the local authority in which the cared-for person resides.

YCS for young carer caring for people in more than one local authority area

2.2.85. In this situation, it would be the responsible authority where the young carer resides who would be responsible for preparing the YCS. For a pre-school child, this responsibility would fall to the health board where the child resides. For a child who is at school to the local authority. It is anticipated that there is likely to be a small number of young carers in this situation. There are also special cases to consider as outlined in **section 20** of the Act.

Case study – young carer to two cared-for people in different areas
A young carer whose parents have separated. Suzie's father has bipolar disorder and her mother has Parkinson's disease. Suzie is aged fifteen and lives with her mother the majority of the time and provides a caring role and also provides a caring role for her father who lives in another local authority area.

The responsible authority where Suzie resides with her mother would be responsible for the preparing the YCS. This is because the responsible authority for a YCS is determined by the young carers' circumstances (rather than those of the cared-for person). In this context, there will only be one responsible authority offering and preparing the YCS.

2.2.86. In these circumstances, the duty (or power if appropriate) to provide support to the young carer, would rest with both local authorities where the cared-for persons are residing.

2.2.87. Similar to adult carers (see Chapter 1 of this Part), each local authority's eligibility criteria would be relevant in its own decision making about support, however we recommend collaboration between each area in that decision making process.

2.2.88. Decisions about sharing the costs of carer support in these circumstances are a matter for the local authorities involved, however it is recommended that a 50:50 split for carer support is a sensible default position. Any additional support required for the cared-for persons would be a matter for their respective local authorities.

2.2.89. If there is one YCS to cover both caring situations, careful consideration would be required by the responsible authority to ensure that information sharing is well managed.

Young carer who resides in Scotland caring for someone outwith Scotland

2.2.90. There may be a limited amount of these situations for responsible authorities. However, when they do arise there would be a responsibility to offer and prepare a YCS by the responsible authority, if that offer is accepted by the young carer.

2.2.91. Scottish local authorities may still have responsibilities to support young carers by virtue of their wider duties or powers to support them as children under the **Children and Young People (Scotland) Act 2014**[30].

2.2.92. A carer living in Scotland who cares for someone outwith Scotland may be eligible for support from the local authority in which the cared-for person resides. In these instances, it would be a matter for the relevant local authority in England or Wales, or the Health and Social Care (HSC) Trust in Northern Ireland to make decisions as set out under legislation in those countries.

2.2.93. **Part 3, chapter 2** of this guidance provides further information about cross-border caring situations.

Case study – 'distance caring' relationship with young carer in Scotland and cared-for person outwith Scotland

Ross is aged seventeen and a young carer, caring for his father who has chronic back pain and lives in England. Ross resides in the Borders with his mother after his parents separated. He visits his father weekly to help provide more practical assistance such as help with a supermarket shop. He also provides his dad with emotional support, liaising with statutory services and arranges other help such as gardening services.

If Ross identifies himself to his local responsible authority in the Borders, they would then be in a position to offer and undertake a YCS. However, in terms of duty to support that would not sit with the local authority where Ross lives, but they may use their powers to provide some support to him.

[30] http://www.legislation.gov.uk/asp/2014/8/contents

Young carer resides outwith Scotland caring for someone in Scotland

2.2.94. There may be a limited number of situations where a young carer who resides outwith Scotland is providing care to someone who resides in Scotland.

2.2.95. For young carers that may be in this situation, the Act has not created a duty for the Scottish local authorities of the cared-for person to offer a young carer statement. This is because the 'responsible authority' for a young carer statement, under **sections 19** and **20**, is determined by the young carer's own circumstances, rather than those of the cared-for person.

2.2.96. As a consequence, because the duty to support young carers under the Act is dependent on the existence of a YCS, there is no duty or power for Scottish local authorities of the cared-for person to support the young carer.

2.2.97. It is recommended that, subject to the normal requirements on consent to sharing of information, the Scottish local authority of the cared-for person makes sure that the local authority where the young carer lives is aware of their circumstances.

2.2.98. **Part 3, chapter 2** of this guidance provides further information about cross-border caring situations.

Case study - 'distance caring' relationship with cared-for person in Scotland and young carer outwith Scotland

Jamal aged fifteen, who lives in Berwick upon Tweed and provides care to his uncle, Saeed who lives in the Scottish Borders. Jamal's uncle has multiple sclerosis and appreciates his regular visits from his nephew who helps him with emotional support and practical tasks in and around his home. Although Jamal is a young carer, he won't have had a YCS undertaken as he resides outwith Scotland.

However, with permission, Scottish Borders local authority, where his uncle lives, has got in touch with Northumberland County Council, to let them know of Jamal's circumstances.

Support to be provided

2.2.99. **Section 15(1)(j)** requires that if the young carer's identified needs meets the local eligibility criteria, the YCS must contain information about the support which the responsible local authority provides or intends to provide to the young carer to meet these eligible needs. In this section, the responsible local authority, in relation to a carer, means the local authority for the area in which the cared-for person resides.

Example – support provided through young carers card

Dumfries and Galloway Carers Centre offer a young carers card to young carers. This helps the young carer to be involved in information sharing, if consent is given about the treatment and condition of the cared-for person, be better involved with medical procedures and kept up to date by professionals.

Locally if the family of the young carer agrees for the Fire and Rescue Service to be informed that a young carer resides in the household then this information is added to the their system. Then in the event of a fire occurring in the home, the Fire and Rescue Service will be aware of a young carer in the home.

The card also allows peace of mind when away from the cared-for person. It can also be presented to other professionals who are involved in their lives and allows an opening for a conversation about their caring role with professionals including with pupil support teachers, school nurses and class teachers.

2.2.100. Part 3, Chapter 2 of this guidance deals with the power and duty to provide support to carers under **section 24**.

2.2.101. At this support planning stage, if any of the young carer's identified needs meets the threshold of the local eligibility criteria, the responsible local authority must offer the four options of Self-directed support[31] to the young carer based on their indicative budget or relevant amount.

2.2.102. There is no single approach to resource allocation prescribed on the face of the **Social Care (Self-directed Support) (Scotland) Act 2013**, nor any single method recommended by the Scottish Government.

2.2.103. The authority may wish to adopt an equivalence model where they determine the cost of the service to be arranged and then provide the equivalent amount as a budget for the supported person or carer to control. Alternatively, it may wish to adopt a resource allocation system whereby the authority gathers information about the person's outcomes, allocates points to those outcomes and then allocates a level of funding. In addition, decisions about budgets may be made on a case by case basis. Reference can also be made to the statutory guidance to accompany the **Social Care (Self-directed Support) (Scotland) Act 2013**[32].

2.2.104. Alternatively, the responsible local authority may decide to offer one holistic budget that extends to meet both the eligible needs and personal outcomes of the young carer and the eligible needs and personal outcomes of the cared-for person.

2.2.105. **Section 15(1)(k)** outlines that if the young carer's identified needs do not meet the local eligibility criteria, information about any support which the responsible local authority nevertheless agrees to provide must be included in the YCS. Responsible local authorities can choose to provide personalised support to the young carer on a discretionary basis using their powers rather than duties to provide support. This could include making a referral or signposting young carers to universal or community based services, for example a young carers centre or a local youth centre.

Preventative approach whether or not needs meet eligibility criteria

2.2.106. Regardless of whether the young carer's identified needs meet the local eligibility criteria, it is recommended that other preventative supports in the

[31] http://www.gov.scot/Topics/Health/Support-Social-Care/Support/Self-Directed-Support
[32] http://www.gov.scot/Resource/0044/00446933.pdf

community are still considered. This for example may include advice and information, emotional support, befriending or a welfare benefits check to maximise family income. Some of these support services may be offered by the local young carer centre or similar resource for children and young people. Some of these identified needs may be met by changes to practices in the school the young carer attends, such as allowing some flexibility in attendance and not penalising the young carer for being late occasionally if this is in relation to caring

Breaks from caring

2.2.107. **Section 15(1)(l)** requires the YCS to include information about whether support should take the form of or include a break from caring. **Part 3, chapter 2** sets out guidance about breaks from caring under **section 25** of the Act.

Circumstances for YCS to be reviewed

2.2.108. **Section 15(1)(m)** requires the YCS to contain information about the circumstances in which it is to be reviewed.

2.2.109. The Scottish Government intends to bring forward regulations under **section 16** listing circumstances in which the YCS must be reviewed. Proposals have been consulted on and regulations will be laid in Parliament in due course. The final version of this guidance will be updated to reflect the review requirements in those regulations.

2.2.110. Responsible authorities may also consider what other circumstances will be relevant to trigger a review in individual cases. These might include:

- a stated period of time;
- deterioration in the health of the carer or cared-for person;
- the cared-for person being discharged from hospital.

Effectiveness of support under previous YCS

2.2.111. After an initial YCS has been prepared**, section 15(2)** requires that after each review, the revised YCS must contain information about the extent to which any support provided under a previous statement has assisted in the achievement of the young carer's personal outcomes.

Inclusion of other information in YCS

2.2.112. The responsible authority can decide what additional content to include in the YCS, over and above the minimum requirements set out in the legislation. This could be information tailored to individual YCSs or general information. An example could be a risk assessment in relation to tasks undertaken by the young carer such as the moving and handling of the person that they care for.

2.2.113. **Section 15(4)** also allows Scottish Ministers to make regulations about other information which a YCS must or must not contain and the form of young carer statements. This power is not currently being used.

Timescales for preparing a young carer statement

2.2.114. There are no timescales set out in the Act for preparing and completing individual adult carer support plans and young carer statements. However, in due course, Scottish Ministers must use the regulation-making power in

section 13 of the Act to prescribe timescales for the preparation of YCSs in relation to carers of terminally-ill cared-for persons.

2.2.115. **Section 31(2)(h)** requires the local carer strategy to set out the intended timescales for preparing young carer statements. The intention of **section 31(2)(h)** is to give young carers collectively an indication of how long, on average, they are likely wait for an YCS. It is fully expected that some will take less time and some will take longer than those indicated time periods for valid reasons

2.2.116. There may be different timescales for completion of individual YCSs. YCSs ought to be prepared within reasonable timescales taking into account the urgency of needs for support and any fluctuation in those needs. Responsible authorities may have guidance for timescales based on urgency or risk. There may be valid reasons for a YCS taking longer to complete than perhaps anticipated, for example, where the young carer's needs are complex and require more than one contact to prepare and complete the statement and/or where support required is specialised and not readily available. Responsible authorities are encouraged to focus on achieving the right outcomes for the young carer rather than allowing set timescales to become a *de facto* target or input measure.

2.2.117. Responsible authorities are advised to inform the individual young carer of an indicative timescale over which their YCS will be conducted and keep the young carer informed throughout the assessment process. Some responsible authorities also, as a matter of good practice and courtesy, advise individual carers of any delays and the reasons for the delays.

Timescales for YCSs for young carers of terminally ill cared-for persons

2.2.118. **Section 13** requires Scottish Ministers to prescribe timescales in regulations for the preparation of the YCS in relation to young carers who are caring for someone who is terminally ill. Research is currently underway to consider what timescales would be appropriate. Regulations will be brought forward in due course once that research is complete and this guidance will be updated accordingly.

2.2.119. The term, 'terminally ill cared-for person' for the purposes of this section is a person who is terminally ill due to suffering from a progressive disease and death as a consequence of that disease can be reasonably expected within six months.

Young carer statement: provision of information to carer etc.

2.2.120. **Section 17** requires the responsible authority to provide information contained in the YCS to the young carer to whom the YCS relates and any other person the young carer requests, unless the authority does not consider it appropriate to provide the information. For example, It might not be considered appropriate to provide sensitive medical information about the cared-for person to a third party.

2.2.121. The responsible authority is well placed to have a discussion with the young carer about how they might wish to use their YCS and who they wish to share it with. Before the YCS is completed and signed off, it is recommended that the responsible authority records who will receive a copy of it.

Learning from pilots
During the pilots for implementing this aspect of the Act, it was found that when integration authorities involved young carers in the design of the YCS process, this helped to understand their needs better and any relevant support.

Young carers who had been involved also felt that they owned the YCS. They reported that this was aided by including a section in the YCS on who the YCS was to be shared with.

2.2.122. It is paramount that the views of the young carer and any other person, to whom the information relates, for example, the cared-for person, must be sought where it is reasonably practicable to do so and the responsible authority must have regard to these views. If information is to be shared in the absence of agreement of the person to whom the information relates, there must be a clear legal basis for sharing this information. It is good practice to retain a record of the reasons for sharing information in the absence of such agreement.

2.2.123. When considering information to be shared and who to share it with, the responsible authority should comply with the common law duty of confidentiality and the requirements of data protection and human rights legislation, in particular the right to private and family life under Article 8 of the European Convention on Human Rights (ECHR).

Case study – support through communication and information sharing
Joe is an isolated young carer in a household caring for both his parents. His father has severe mental health problems and his mother has drug and alcohol issues. He was suffering from anxiety.

The GP and Joe agreed to keep in touch by email. The GP also made a referral to the local young carer centre with Joe's consent. The GP arranged for a room at the medical centre for the worker from the young carer centre to conduct their visits and also kept in email contact with the young carer centre for updates and ways to support.

This resulted in a reduction in Joe's anxiety as he now has support to help care for his parents and they are also getting additional support.

2.2.124. **Section 17(4)** states that the information is to be provided as soon as practicable after the statement is prepared or in the case of a revised statement, when the revised statement is prepared. In terms of good practice, this would mean that the young carer is provided with a physical copy of their agreed YCS within a reasonable timescale by the responsible authority. It is suggested that this information be in a format and language that the young carer can access and readily understand.

Continuation of young carer statement

2.2.125. **Section 18** outlines the circumstances in which there would be a continuation of the YCS. It would be good practice for discussions to be taking place between the young carer and the responsible authority as the young carer nears 18 years old. This would include discussion on whether the young carer wishes to

remain in their caring role and how they undertake the transition into adult carer services and require an adult carer support plan.

2.2.126. If there is a YCS in place for a young carer that YCS will continue to have effect after the young carer reaches their eighteenth birthday until they are provided with an adult carer support plan.

2.2.127. This should not preclude good planning for the young carer, in particular person-centred transition planning to assist young carers moving to adult carer support from young carer support. Early discussions regarding transition reviews can be undertaken by the responsible authority to ensure the young person is prepared and aware in advance of the support that could be in place for them to support them as an adult carer.

2.2.128. It is recommended that these discussions begin about eighteen months to twenty four months in advance of the transition. If transitions are poorly managed and assessments rushed through at the transition point, this could result in care and support that does not appropriately meet the needs of the young carer. This may in turn result in a greater financial implication to the responsible local authority than it would have been if early discussions and planning took place.

Responsible authority: general and special cases

2.2.129. **Section 19** sets out for the purposes of this chapter the meaning of a responsible authority for preparing a young carer statement. The local authority where the cared-for person lives has the duty to substantially provide the agreed support to the young carer, so this is not always the same as the responsible authority which has the function of preparing the YCS. The responsible authority differs according to the circumstances of the young carer:

- where the young carer is a pre-school child, the health board for the area in which the child resides is the responsible authority.
- where the young carer is not a pre-school child, the local authority for the area in which the child resides is the responsible authority.

2.2.130. A responsible local authority may make arrangements for another person to prepare a YCS on its behalf.

2.2.131. **Section 20** outlines where there will be special circumstances which need to be followed when determining the responsible authority for a young carer.

2.2.132. Special cases include the directing authority of schools being the responsible authority where the young carer is a pupil at a grant-aided school or independent school. The term “directing authority” has the same meaning as in **section 45 of the Children and Young People (Scotland) Act 2014**, that is the managers of a grant-aided school or the proprietor of an independent school.

Part 3, Chapter 1

Local Eligibility Criteria – Existing Statutory Guidance

3.1.1 **Section 21** of the Act requires each local authority to set local eligibility criteria. These are the criteria by which the local authority must determine whether it is required to provide support to carers to meet carers' identified needs

3.1.2 Statutory guidance on the duty to set local eligibility criteria issued in November 2017[33]. This guidance will not be amended further while initial local eligibility criteria are being set between now and 1 April 2018.

3.1.3 After that date, the intention is to incorporate local eligibility criteria guidance into the main Carers Act guidance package so that it can be used when reviewing and revising local eligibility criteria under **section 22**.

[33] [Guidance circulated. Insert hyperlink when published on SG website]

Part 3, Chapter 2

Duty to provide support to carers

Summary
Section 24 creates powers and duties to provide support to carers. These fall on the responsible local authority – meaning the local authority for the area in which the cared-for person resides.

Section 25 creates a related duty to consider whether the support provided under section 24(4)(a) (duty to provide support to meet the carer's eligible needs) and under section 24(4)(b) (discretionary power to provide support to meet the carer's other identified needs) should take the form of, or include, a break from caring.

Section 26 makes consequential amendments to the Social Work (Scotland) Act 1968 regarding charging for support provided to carers.

Local authority functions under **sections 24 and 25**, must be delegated to the integration authority, so far as they relate to adults. This requirement arises under the Public Bodies (Joint Working) (Prescribed Local Authority Functions etc.) (Scotland) Amendment Regulations 2017[34] and the Public Bodies (Joint Working) (Prescribed Local Authority Functions etc.) (Scotland) Amendment (No.2) Regulations 2017[35].

Reasons for duty to provide support to carers

3.2.1. The duty to provide support to carers at section **24(4)(a)** is intended to ensure support is provided to carers is in a more consistent way across Scotland. The duty is subject to a carer having eligible needs which meet the local eligibility criteria. Guidance on the duty to set local eligibility criteria is covered in Chapter 1 of this Part.

3.2.2. The power at section **24(4)(b)** to support carers with identified needs which do not meet the local eligibility criteria provides a mechanism for preventative support to this group.[36]

3.2.3. Each carer's identified needs (if any) will be set out in the adult carer support plan or young carer statement as appropriate.

3.2.4. The "carer support pathway" at figure 1 provides a very high level summary of the overall approach set out in more detail in this chapter.

[34] http://www.legislation.gov.uk/ssi/2017/190/contents/made
[35] Hyperlink to be added once regulations are published.
[36] The power and duty to support carers at section 24 replace the power to support adult carers under section 3 of the Social Care (Self-directed Support) (Scotland) Act 2013, which is repealed.

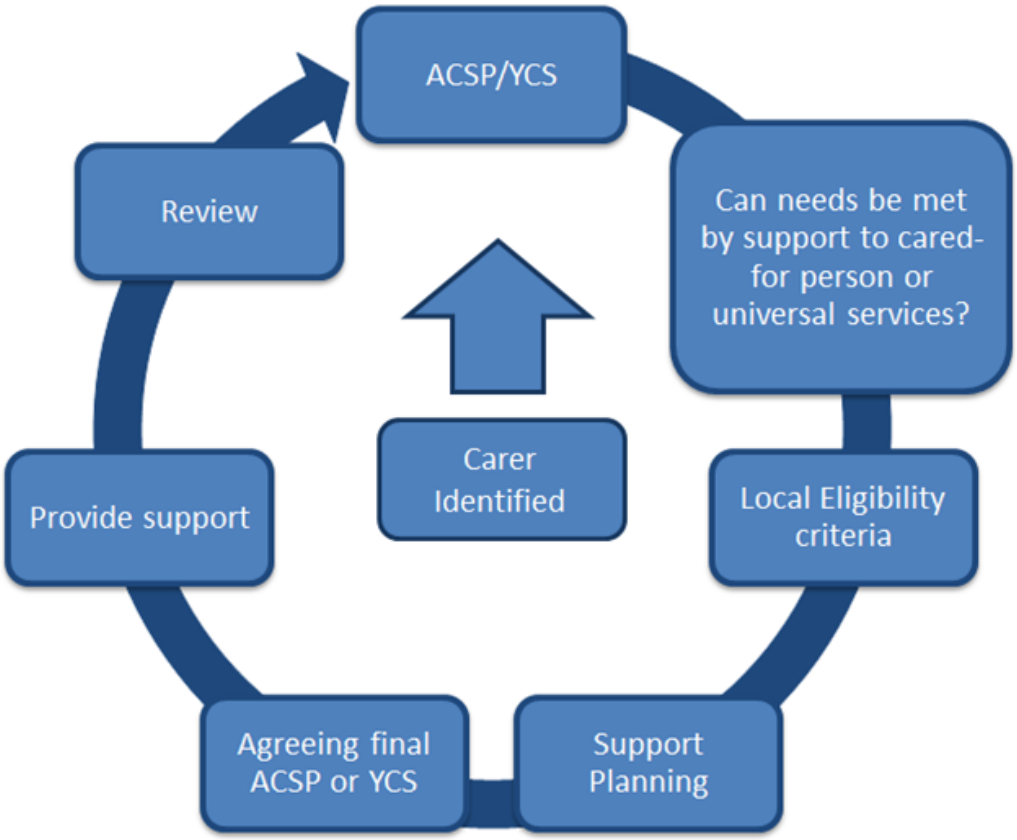


Figure 1: Carer support pathway

Meeting carers' identified needs by provision of services to cared-for person, general services and information and advice

3.2.5. As set out in **section 24(1) (a)** and **(b),** the duty and power to provide support to carers only apply where a carer has identified needs which cannot be met by services or assistance:

- provided to the cared-for person; or
- provided generally to persons in the area of the responsible local authority or, where the carer does not reside in the area of that authority, in the area where the carer resides.

3.2.6. Therefore, the local eligibility criteria for carer support are not relevant insofar as the carer's identified needs in an ACSP or YCS can be met by:

- support to the cared-for person in consequence of a community care assessment or disabled child's assessment;
- universal services or support which the local authority provides to the public at large (e.g. leisure and recreation, adult education, or transport services); and
- support that is available to all carers (e.g. universal services).

3.2.7. Relevant examples of services or assistance to the cared-for person include housing adaptations, Technology Enabled Care (TEC), powered wheelchairs, improved medicine management and care at home. It is possible that support provided to the cared-for person when they are away from the carer might help to achieve the carer's agreed personal outcomes.

3.2.8. Services which are being provided to the cared-for person will often have an impact on the situation of the carer (and sometimes vice versa). In most cases, the provision of services to the cared-for person will mean that the carer has a reduction in caring responsibilities. This could happen where the responsible local authority arranges for a paid care worker to provide assistance to the cared-for person for a particular period in their own home as part of their support plan. **Annex A** provides further guidance where there may be interaction between ACSP/YCS and a community care assessment or an assessment under section 23(3) of the Children (Scotland) Act 1995.

3.2.9. In other cases, the caring responsibilities will remain, but they may be less onerous as a result of a service provided to the cared-for person (for example, the provision of a hoist, housing adaptations or TEC).

3.2.10. It is necessary to consider, and take into account, whether the carer has multiple caring responsibilities.

Example – multiple caring responsibilities
A carer of a child with autism may have other caring responsibilities (such as caring for a parent with dementia which are mainly undertaken when the child is at school).

In this situation, the carer may not be able to have time for themselves and might have eligible needs. This would be identified in the adult carer support plan.

3.2.11. It is also possible that the carer's identified needs might be met by universal services available to the public at large, or by accessing services arranged via a local carer centre (e.g. peer-to-peer support, advocacy, or training).

Duty to provide support to meet eligible needs

3.2.12. **Sections 24(2) to 24(4)** set out the process for determining if carers have identified needs which meet the local eligibility criteria. Where there are eligible needs, the responsible local authority must give the carer the opportunity to choose one of the options for self-directed support unless the authority considers that the carer is ineligible to receive direct payments.

3.2.13. This is set out in **section 7 of the Social Care (Self-directed Support) (Scotland) Act 2013** ("the SDS Act"). The consequential amendments to section 7 of the SDS Act made by paragraph 5 of the schedule to the Act have the effect that any support provided under **section 24 of the Carers Act** must be provided through the option for self-directed support as chosen by the carer.

3.2.14. In the case of young carers under the age of 16, the support to be provided is to "an appropriate person" including parent, guardian, etc., as defined in **section 7(7) of the SDS Act** as inserted by the schedule to the Carers Act.

How do identified needs become eligible needs?

Process

3.2.15. There is a process to be worked through to establish whether a local authority has a duty to provide support to a carer to meet their identified needs. The duty (as opposed to the power) to provide support to a carer depends on the extent

to which a carer's need for support meets the local eligibility criteria. This process is as follows:

(i) establish carer's identified personal outcomes and identified needs (if any) by preparing ACSP or YCS ***(section 6(1)(a) and (b) and section 12(1)(a) and (b))***[37]

(ii) consider which of the identified needs can be met through services or assistance either to the cared-for person (other than "replacement care" to provide a break from caring) or provided generally to persons in the area (i.e. by information and advice, universal services and community support) ***(section 24(1)(a) and (b))***

(iii) if identified needs are met wholly as per (ii), no further action (but keep under review) ***(section 9(1)(l) and section 15(1)(m) re review))***

(iv) if identified needs are met only in part by (ii), or not at all, then apply local eligibility criteria to what are the "outstanding" needs ***(section 24(2) and (3))***

(v) establish whether the outstanding needs meet the local eligibility criteria and therefore engage the legal duty to provide support ***(section 24(4)(a)).***

(vi) if the outstanding needs do not meet the local eligibility criteria, decide whether the discretionary power to provide support should be used ***(section 24(4)(b)).***

(vii) In the case of (v) and (vi), consider whether the support to the carer should include or take the form of a break from caring (including replacement care where required) ***(section 25(1))***

(viii) In the case of (v) and (vi), give the carer the opportunity to choose one of the options for self-directed support (unless ineligible to receive direct payments) ***(Social Care (Self-directed Support) (Scotland) Act 2013)***

Relationship between ACSP/YCS, information and advice, local eligibility criteria and provision of support

3.2.16. Sections 6(1)(c) and 12(1)(c) require the ACSP and YCS to set out the support (if any) to be provided by the responsible (local) authority to an adult or young carer to meet the carer's identified needs.

3.2.17. The assessment process starts from when the local authority begins to collect information about the carer, and will be an integral part of the carer's journey

[37] Part 2 of the guidance on adult carer support plans and young carer statements includes guidance on personal outcomes and needs for support. The ACSP and YCS seek to support carers in relation to the substantive care that they provide to the cared-for person. They also seek to put in place measures that will help a carer to live their own life and to achieve their own goals and aspirations without compromising their responsibilities as a carer. These day-to-day goals and longer-term aspirations are to be documented within the ACSP and YCS as the carer's "personal outcomes" (see glossary).

through the care and support system as their needs change. It should not just be seen as a gateway to care and support, but should be a critical intervention in its own right, which can help carers to understand their own situation and the needs they have, to reduce or delay the onset of greater needs, and to access support when they require it. It can also help carers to understand their strengths and capabilities, and the support available to them in the community and through other networks and services.

3.2.18. Regardless of whether, in fact, the carer is assessed as having any support needs, they should be able to access preventative information and advice services, facilities or resources provided by the local authority or which might otherwise be available in the community. This is because the responsible local authority must provide appropriate information and advice services for all relevant carers, whether or not those carers have an ACSP or YCS in place or any identified needs. This duty is considered further in Part 6.

3.2.19. The ACSP and YCS are both based on an outcomes focused conversation to determine personal outcomes and identify needs. As part of the assessment process, the local authority considers the capacity of the carer to manage their needs or achieve the outcomes which matter to them, and allows for access to preventative support ***before*** a decision is made on whether the carer has eligible needs.

3.2.20. Next, the local authority must apply the local eligibility criteria to decide through a professional judgment which of the identified needs are eligible needs.

3.2.21. The ACSP/YCS and local eligibility criteria provide a framework to identify any level of need for care and support so that responsible local authorities can consider how to provide a proportionate response at the right time, based on the individual's needs and personal outcomes.

3.2.22. Decisions about whether identified needs meet local eligibility criteria depend on the information obtained from the ACSP and YCS (notably information on the nature and extent of care; the impact of caring; and the extent to which the carer is willing and able to provide care). In other words, such decisions, and the completion of the adult carer support plan or young carer statement, are mutually dependent.

3.2.23. Where a carer has some needs that are eligible, and also has some other needs that are not deemed to be eligible, the local authority must provide information and advice on services, facilities or resources that would contribute to preventing, reducing or delaying the needs which are not eligible. This should be aligned and be consistent with the ACSP and YCS. Part 6 of this guidance deals with the duty to provide information and advice.

3.2.24. The ACSP/YCS and eligibility framework provide for ongoing engagement with the carer so that, where they have eligible needs, they are involved in the arrangements put in place to deliver the personal outcomes they want to achieve.

3.2.25. The ACSP/YCS should be person-centred, involving the individual carer, the views of the cared-for person, or any other person they might want involved. A carer

with their own care needs could, for example, ask for their GP or a district nurse to be contacted to provide information relevant to their needs.

Learning from pilots
One of the areas piloting the adult carer support plan and duty to support provisions, has stated that it is essential that carers are engaged with and involved at ***every stage*** as it helps them to take ownership of their ACSP. This will increase the awareness of the caring role, encouraging carers to identify themselves, understand their rights and the supports available for them.

Young carers

3.2.26. The unique needs of young carers should be considered when assessing eligible need and putting support in place. Children and young people should not undertake inappropriate or excessive caring roles that may have an impact on their development. A young carer becomes vulnerable when their caring role risks impacting upon their emotional or physical wellbeing and their prospects in education and life.

3.2.27. A responsible authority may become aware that a child is carrying out a caring role through an assessment or informed through family members or a school. Authorities should consider how supporting the cared-for person can prevent the young carer from undertaking excessive or inappropriate care and support responsibilities. Where a young carer is identified, the responsible authority must undertake a YCS if that offer is accepted.

Prevention

3.2.28. Maintaining and improving support to carers is central to local authority and partnership preventative strategies and is a key priority for health and social care partnerships. Prevention and early intervention are at the heart of the carer support system, and even if a carer has needs that are not eligible at that time, they should still be able to access preventative services including the information and advice services which the local authority is required to provide under the Act. Responsible local authorities are also recommended to consider the carer's own strengths or if any other support might be available in the community to meet their needs.

3.2.29. This means that local authorities need to consider how carers access and benefit from universal services such as education, leisure and transport and the provision of carers' information and advice services, including welfare rights and financial advice. Local authorities also need to consider how community-based support can be further developed to support carers. This includes services provided by carers centres and the wider third sector.

3.2.30. It also means that adult carer support plans and young carer statements need to consider support needs in the round, and not only focus on the more intensive services that may be required by carers where the impact of their caring role and their support needs meet eligibility thresholds.

Non-eligible and eligible needs

3.2.31. **Section 24(4)(a)** of the Act **requires** the responsible local authority to provide support to a carer to meet their "eligible needs". A carer's "eligible needs" are those identified needs for support that cannot be met through support to the cared-for person or through accessing services that are available generally, **and** which meet the threshold for support set by the local eligibility criteria.

3.2.32. **Section 24(4)(b)** gives the responsible local authority a **power** to provide support to meet other identified needs which cannot be met through support to the cared-for person, or services available generally, but which do not meet the threshold for support set by the eligibility criteria (i.e. non "eligible needs").

3.2.33. ***Table 1*** summarises the different ways in which eligible and non-eligible needs can be met, and provides examples of the types of support that can be provided to meet those needs.

Table 1: How to meet a carer's identified needs

Type of support	**Illustrative Examples**
Services or assistance to the cared-for person (other than care provided in order to provide the carer with a break from caring - ie "replacement care").	• care at home • technology enabled care • equipment and adaptations • mental health services • medicine management • support to access activities for disabled children
General services – information and advice.	Information and/or advice on: • carers' rights • education and training (e.g. on support at school, advice on Further and Higher Education) • income maximisation • carer advocacy • health and wellbeing • bereavement support • emergency care planning and future care planning
Other general services – available universally in the community or in particular neighbourhoods.	• leisure centres • libraries • art galleries • community transport • lunch clubs • youth clubs • education services • gardening clubs • walking clubs • local support groups
A carer's identified needs - both **eligible or non-eligible needs** - might be met in	

Type of support	Illustrative Examples
whole or in part by any combination of services or assistance for the cared-for person or general services above. Where they are not, the following applies.	
LA **duty** at section 24(4)(a) to provide support to meet a carers **eligible needs** (explained above). This can be any type of carer support that is not, or cannot be, provided through services for the cared-for person or services that are available generally.	• course on emotional wellbeing • counselling • training on moving and handling • short break (noting LA duty at section 25 to consider whether support to a carer should include a break from caring) • replacement care (care for a cared-for person to allow their carer to take a break) • support to access leisure pursuits
LA **power** at section 24(4)(b) to provide support to meet a carer's **non-eligible needs**. Again, this can be any type of carer support not covered by services for the cared-for person or general services above.	
Under both the duty and power to support carers (at section 24(4)) the responsible local authority must give the carer the opportunity to choose one of the options for Self-directed support (unless the local authority considers that the carer is ineligible to receive direct payments). These options are explained in **Table 3**.	

Options for Self-directed support

3.2.34. As noted earlier in this chapter, where the responsible local authority exercises either its duty to provide support to the carer to meet the carer's eligible needs or its power to meet the carer's other identified needs, the carer must be given the opportunity to choose one of the options for self-directed support (unless the local authority considers that the carer is ineligible to receive direct payments).[38]

3.2.35. Where support services such as general carer training courses, counselling or support groups are openly accessible for carers through a local carers centre (without local eligibility criteria being applied), these universal services are not provided under section 24 of the Carers Act and therefore the requirement to offer options for self-directed support does not apply. A wide range of personal outcomes and identified needs may be met through such preventative carer support services.

3.2.36. Examples of how carers might address their identified needs under options 1-3 of Self-directed support are provided in the statutory guidance which accompanies the Social Care (Self-directed Support) (Scotland) Act 2013.[39] These examples are reproduced (with slight adjustment) in Table 3 below. They show that support to carers can take many forms.

[38] The four options for self-directed support are: **Option 1** – the making of a direct payment by the local authority for the provision of support; **Option 2** - the selection of support by the carer, the making of arrangements for the provision of it by the local authority on behalf of the carer and, where it is provided by someone other than the authority, the payment by the local authority of the relevant amount in respect of the cost of that provision (directing the available support); **Option 3** - the selection of support for the carer by the local authority, the making of arrangements for the provision of it by the authority and, where it is provided by someone other than the authority, the payment by the authority of the relevant amount in respect of the cost of that provision (the local authority arranges support); and **Option 4** - the selection by the carer of Option 1, 2 or 3 for each type of support and, where it is provided by someone other than the authority, the payment by the local authority of the relevant amount in respect of the cost of the support.

[39] http://www.gov.scot/Publications/2014/04/5438/8#table9

Table 3: Examples of support to carers

2013 Act option	Example
Option 1 Direct payment	Example 1 An adult carer who lives in a remote rural area is feeling increasingly isolated and depressed. She has no friends or family living nearby and her nearest carers' centre is miles away. The carer uses a direct payment to pay for the installation of broadband and for a tablet computer. This means she can keep in touch with her family and friends through video-calls and email, particularly her grandchildren who live overseas. She has also made friends with other carers on an online forum and now feels more connected and supported. Example 2 A young carer who cares for his mother expresses that he has not been able to have the same opportunities as his peers. Whilst all his friends are learning to drive, he cannot because his mother cannot afford the cost and because of his caring role he cannot take on a part-time job in order to earn extra money. He thinks that having a driving licence would be useful as the family could get a Motability car, which would help with a lot of the tasks around his caring role such as shopping and taking his mum to places. He also thinks that being able to drive would open up more job opportunities. The young carer uses his direct payment to pay for several driving lessons and the cost of the driving tests. Example 3 A carer lives in a rural area with a cared-for person who attends a day centre twice a week. The carer, who can't drive and isn't on a bus route uses her direct payment for a regular taxi to visit her nearest swimming pool, to make the most of her time away from her caring role.
Option 2 Directing the available support	Example 1 A carer has never had a break from caring. He would like to have a break of an afternoon each week to have a rest where he doesn't have to worry about the safety of the person he cares for. The carer receives a carer's short break voucher and he uses this to purchase a short break. Example 2 The authority arranges for an individual service fund to be set up to support the carer. This carer has always been very house-proud, but her husband has had a stroke and the level of care that she has to provide means that she is falling behind with housework and laundry, which is making her feel increasingly tired and depressed. The carer uses the individual service fund to purchase domestic help from an agency so that someone can come in and help with cleaning, ironing and other domestic tasks. The carer also uses the ISF to pay for a fortnightly visit from a care worker so that she can meet her daughter for lunch and have a break from caring.

2013 Act option	Example
Option 3 Arranged services	Example 1 After the death of his father, a carer is finding caring for his mother, who has dementia, emotionally draining and he is becoming very depressed. He is on a waiting list for NHS counselling services but has been told it may take a long time and his local carers centre does not offer this service. The authority arranges for the carer to attend a private counsellor to help him manage issues of bereavement and caring. Example 2 A carer talks about missing out on making new friends as she never has time because of her caring role. She expresses an interest in attending an art class in a local authority community centre. The authority arranges for the carer to attend the class and arranges replacement care for the person she cares for once a week. **NB:** The art class would be categorised under the Carers Act as general services and enabling the carer to attend this class would be providing general services. The provision of replacement care would be either under the power or duty to support the carer (depending on whether her needs met the local eligibility criteria) and would be non-chargeable.

Special cases: Carers of two people and cross border caring

Adult carers, caring for people in more than one local authority area

3.2.37. There may be instances where an adult carer is caring for more than one person across different local authority areas. For example, where a parent caring for a child with a long-term condition is also providing care for their own parent. In such circumstances both local authorities where the cared-for persons are living have responsibility to:

- offer and conduct an adult carer support plan; and
- provide support to the carer (subject to the two local authorities', potentially different, eligibility criteria) which might involve providing support to cared-for person.

3.2.38. Local authorities in these circumstances are recommended to work together in these circumstances so that they can jointly:

- achieve an outcomes focus for the individual carer;
- minimise the need for the carer to give the same information twice;
- make decisions on support and eligibility based on a shared understanding of the total impact of the carer's caring responsibilities; and
- avoid duplication of effort.

3.2.39. Whilst each local authority's eligibility criteria would be relevant in its own decision making about support, collaboration is recommended between each area in that decision making process.

3.2.40. Decisions about sharing the costs of carer support in these circumstances are a matter for the local authorities involved, however it is recommended that a 50:50 split for carer support is a sensible default position. Any additional support

required for the cared-for persons would be a matter for their respective local authorities.

Young carers, caring for people in more than one local authority area

3.2.41. Situations in which a young carer is caring for more than one person across different local authority areas are not common, however there may be a small number of instances where this occurs. For example, where a child of parents who have separated, and who both have a long term condition or mental health issue.

3.2.42. In such circumstances the duty (or power if appropriate) to provide support to the young carer falls to each of the local authorities where the cared-for persons reside.

3.2.43. Similar to adult carers, each local authority's eligibility criteria would be relevant in its own decision making about support, however we recommend collaboration between each area in that decision making process.

Carer in Scotland caring for someone outwith Scotland

3.2.44. The Carers (Scotland) Act does not create any duty to support the carer where the cared-for person lives outwith Scotland. Carers are still able to access local carer support such as: carer centre services; citizens advice bureaux; advice shops; council helplines; and local authorities' information and advice services.

3.2.45. Scottish local authorities may still have responsibilities to support young carers by virtue of their wider duties or powers to support them as children under the **Children and Young People (Scotland) Act 2014**[40].

3.2.46. A carer living in Scotland who cares for someone outwith Scotland may be eligible for support from the local authority in which the cared-for person resides. In these instances, it would be a matter for the relevant local authority in England or Wales, or the Health and Social Care (HSC) Trust in Northern Ireland to make decisions under the relevant legislation in those countries.

For information - statutory provision for carers in other UK jurisdictions
There is a duty for English local authorities to support an adult carer under **section 20 of the Care Act 2014**[41] where the cared-for person lives in England.

Obligations on Welsh local authorities relevant to carers are set out in **part 3**[42] **and part 4**[43] **of the code of practice** that underpin the **Social Services and Well-being (Wales) Act 2014**[44].

The **Carers and Direct Payments Act (Northern Ireland) 2002**[45] imposes a duty on Health and Social Care (HSC) Trusts to inform carers of their right to an assessment of their needs and to carry out the assessment, if they so wish. This only applies to those carers of individuals whom the HSC Trust would ordinarily provide social care services to (i.e. Northern Ireland residents).

[40] http://www.legislation.gov.uk/asp/2014/8/contents
[41] http://www.legislation.gov.uk/ukpga/2014/23/contents
[42] http://gov.wales/docs/dhss/publications/151218part3en.pdf
[43] http://gov.wales/docs/phhs/publications/160106pt4en.pdf
[44] http://www.legislation.gov.uk/anaw/2014/4/pdfs/anaw_20140004_en.pdf
[45] http://www.legislation.gov.uk/nia/2002/6/contents

Carer outwith Scotland caring for someone in Scotland

3.2.47. Instances where a carer outwith Scotland is caring for someone residing in Scotland may also occur. For example, where:

- a carer looking after a family member or friend provides emotional support, liaises with statutory services, and arranges other help from a distance (who may or may not visit regularly to provide hands-on assistance); or
- a carer looking after a family member or friend nearby, just over the border.

3.2.48. For adult carers, the Scottish local authority where the cared-for person lives has a duty to offer an adult carer support plan and support the carer under the Act, and subject to local eligibility criteria.

3.2.49. For young carers in this situation, the Act has not created a duty for the Scottish local authorities of the cared-for person to offer a young carer statement. This is because the "responsible authority" for a young carer statement, under **sections 19** and **20**, is determined by the young carer's own circumstances, rather than those of the cared-for person.

3.2.50. As a consequence, because the duty to support young carers under the Act is dependent on the existence of a young carer statement, there is no duty or power for Scottish local authorities of the cared-for person to support the young carer.

3.2.51. Subject to the normal requirements on consent to sharing of information, the Scottish local authority of the cared-for person must ensure that the local authority where the young carer lives is aware of their circumstances.

Carers who are also service users

3.2.52. **Annex B** provides guidance on carers who are also service users (adults or children with support needs). This issue is also discussed in Part 3, Chapter 3 – Waiving of charges and replacement care.

Provision of support to carers: breaks from caring

3.2.53. **Section 25(1)** requires a local authority, in determining which support to provide to a carer under **section 24(4)**, to consider whether the support should take the form of or include a break from caring. Under **sections 9(k)** and **15(l)**, the ACSP and YCS must contain information about whether support should be provided in the form of a break from caring.

3.2.54. The intention of these provisions is to ensure local authorities consider breaks tailored to the needs of individual carers as a mainstream form of support.

3.2.55. This requires local authorities to consider with each individual carer if their personal outcomes and needs for support should be met by a break from caring. It does not create a duty to provide a break from caring in every case.

3.2.56. A "**break from caring**" can be any form of support that enables a carer to have time away from their caring responsibilities.

3.2.57. The form of support that enables a break from caring will frequently include provision of "replacement care" for the cared-for person, either on its own or alongside other services that the local authority can provide under **section 24** of the

Act. Other forms of support can include, for example, assistive technology, or short breaks.

3.2.58. A carer might have identified needs which meet the local eligibility criteria, and may be assessed as requiring a break from caring. If the carer cannot take that break without replacement care being provided by the statutory or voluntary sectors rather than by friends, family or neighbours, then the local authority duty under section 24(4)(a) of the Act would include providing or arranging the replacement care, whether or not the cared-for person has eligible social care needs in their own right.

3.2.59. In other words, replacement care is not restricted to cared-for people who meet local social care eligibility. The duties and powers of local authorities under section 24(4) in respect of breaks from caring may as a consequence require replacement care to be provided or arranged for the cared-for person.

Approaches to delivering short breaks as a form of support

3.2.60. Short breaks are one of many forms of support that can enable a carer to realise their personal outcomes. In establishing and maintaining an appropriate range of short breaks services, local authorities are strongly encouraged to consider the following types of short breaks, some of which are already making a real difference to carers and those that they care for. These include, but are not limited to:

- holiday or leisure breaks (with or without the cared-for person);
- sports and activity breaks (with or without the cared-for person);
- breaks at home during the day or overnight (with support from a care at home service); or
- play-schemes or after school clubs for the cared-for person.

3.2.61. Short breaks can be taken with or without the cared-for person. The consideration of delivering short breaks as a form of support offer local authorities an opportunity to provide more holistic services to carers, cared-for persons, and wider family networks if appropriate.

3.2.62. Whilst there is no definition in the Act of what constitutes a short break, local authorities are encouraged to consider the paper provided by Shared Care Scotland attached at **Annex C**. This paper may also be useful for local authorities when preparing the short breaks services statement under **section 35** of the Act. Guidance for short breaks services statements is set out in **Part 6**.

3.2.63. Local authorities are encouraged to foster innovative approaches to provide short breaks that seek to maximise the potential of voluntary and third sector contribution. Community-led approaches could be considered in extending the range and providing a good choice of high-quality short breaks to carers to meet their personal outcomes.

3.2.64. Shared Care Scotland produce “Short Break Stories”[46] which facilitate good practice sharing and learning by hosting case studies from across Scotland. The Learning Exchange[47] also curates examples of good practice.

[46] http://shortbreakstories.org.uk/

Example - Brokerage Model
Brokerage is a way of working that requires a tailored and flexible approach. Brokerage helps carers plan towards the life they want through the development of long-term, sustainable outcomes. The aim is to help carers to resolve any problems that are preventing them having a more balanced life with access to opportunities outside their caring role.

A brokerage support worker can establish with the carer what outcomes they would like to achieve, work out the resources, make a plan, and then help to arrange any services or support that will help achieve these outcomes.

Example - Respitality
Respitality brings together carers centres with the Scottish hospitality sector encouraging relationships to be built between carers centres and local hotels, B&Bs, restaurants and local leisure providers (including local authorities) who provide free shorts breaks to carers. This can include overnight stays, meals out, spa days, or beauty treatments – whatever gift the business chooses to offer.

Hospitality and leisure organisations recognise the benefits of being carer aware, helping to promote their business in communities across Scotland, and helping to promote inclusive growth. This community approach to short breaks means a wider choice of short breaks could be provided much closer to the carer.

3.2.65. **Section 25(2)(a)** allow Scottish Ministers to make regulations about the form of support that may be provided as a break from caring. Scottish Ministers have not used this power for commencement of the Act.

When care for the cared-for person cannot be agreed to enable a break from caring

3.2.66. **Section 25(2)(b)** allows Scottish Ministers to make regulations about the processes required where there may be a disagreement between the carer and the cared-for person about the provision of care for the cared-for person, which would enable the carer to have a break from caring. Scottish Ministers are not using this power at this time but guidance is provided below.

3.2.67. When determining the support to be provided to a carer under **section 24(4)** and **section 25** practitioners need to consider the relationships between the carer and the cared-for person. There may be stress and tension in the relationship. In some cases, the carer and the cared-for person may be unable to agree on the way in which support is provided.

3.2.68. In such circumstances, it is recommended that local authorities:

- take into consideration the perspectives of both the cared-for person and the carer;
- work closely with the cared-for person, the carer and other family members to seek to resolve situations and provide support where the cared-for person

[47] http://lx.iriss.org.uk/sharedcarescotland

does not want an assessment or re-assessment of their needs, or to accept services suggested by the carer's adult carer support plan;

- consider whether the cared-for person has the legal capacity to make the decision to refuse an assessment or services, and if not consider the implications of the Adults with Incapacity (Scotland) Act 2000 for both the carer and the cared-for person;
- remember that services cannot be imposed on the cared-for person if they have the capacity to refuse them;
- consider that the cared-for person's capacity to consent to replacement care being proposed also links with statutory duties to ensure that cared-for persons are supported to be involved in decision making about their own care;
- recognise that tension can arise when either the cared-for person's or carer's ability to communicate is affected by illness, disability or mental health;
- recognise that tension can arise where either the cared-for person's or carer's first language is not English, and one person interprets for the other;
- recognise that the cared-for person must be offered choices in how replacement care is provided via the Self-directed Support legislation;
- provide access to mediation and advocacy services where necessary, which can play and important role in exploring and resolving tensions between the carer and cared-for person;
- provide access to translation and interpretation services where necessary.

3.2.69. There may be situations when it is necessary to identify who is the legal proxy of the adult cared-for person. Local authorities should seek to clarify the circumstances where the cared-for person has a legal proxy, such as a welfare power of attorney or welfare guardian, in addition to where another family member undertakes the main caring role and views themself as the carer of the cared-for person. In this context, local authorities may wish to consider the **Adults with Incapacity (Scotland) Act 2000 Code of Practice for local authorities**[48].

3.2.70. It should be recognised that that any carer who is acting under a power of attorney or a guardianship order under the Adults with Incapacity (Scotland) Act 2000 is also obliged to act under the principles of this legislation. In essence this means that the least restrictive actions are the ones that should be taken and the carer should be ensuring that, as well as involving the cared-for person in decision making, all decisions should reflect the will and preferences of the cared-for person. The principles are set out in the AWIA Code of Practice[49].

3.2.71. There may be circumstances where another person is the cared-for person's "**named person**" under the **Mental Health (Care and Treatment) (Scotland) Act 2003** but another family member undertakes the main caring role. **"The New Mental Health Act: A Guide to Named Persons"**[50] provides useful information for local authorities on the role and responsibilities of named persons

3.2.72. There may be circumstances where there are tensions between the adult carer and the cared-for person, where the cared-for person is a disabled child. Responsible authorities may wish to consider the **National Guidance for Child**

[48] http://www.gov.scot/Publications/2008/03/20114619/0
[49] http://www.gov.scot/Publications/2008/03/20114619/0
[50] http://www.mwcscot.org.uk/media/73341/a_guide_to_named_persons.pdf

Protection in Scotland (2014)[51] where appropriate in addition to following their own child protection procedures.

Planning Breaks from Caring

3.2.73. **Section 25(3)** sets out that a break from caring can be provided on a regular basis or on a temporary basis, and may be provided for varying periods of time. This means that a break from caring can be provided during the day or overnight, and can be a regular or temporary arrangement.

3.2.74. **Section 25(4)** sets out that a local authority must have regard to the desirability of breaks from caring being provided on a planned basis. This means that the consideration of a break from caring is not only in response to a crisis situation.

3.2.75. Breaks from caring are likely to be more effective in meeting a carer's identified needs if they are planned over a longer-term period in order to give the carer some certainty over what will be provided to them. Several breaks planned in advance rather than one-off breaks are likely to lead to enhanced health and wellbeing for the carer and cared-for person.

Example - Short breaks voucher schemes
The use of short break voucher schemes can be a supportive and preventative measure. There is scope to support carers by providing breaks from caring on a preventative basis if the carer does not have eligible needs by using the discretionary power rather than the duty in the Carers Act.

Promoting variety in the market

3.2.76. **Section 25(5)** sets out that section 19(2) of the SDS Act applies in relation to support provided as a break from caring as it applies in relation to any other support.

3.2.77. Section 19(2) of the SDS Act provides for the promotion of options for self-directed support, i.e., promoting variety in the market. The express reference to breaks from caring makes clear that local authorities should promote a variety of options for these types of service provision (both in terms of services provided by the local authority directly, and other service providers). This can be alongside other preventative support for the carer.

3.2.78. By proactively shaping a relevant and diverse market of provision to support carers, local authorities will be able to more effectively deliver breaks from caring that are appropriate and convenient for the carer's individual circumstances, contributing towards a preventative and personal outcomes approach.

[51] http://www.gov.scot/Resource/0045/00450942.pdf

Part 3, Chapter 3

Waiving of charges and replacement care

Background to this guidance

3.3.1. This chapter replaces the "Statutory guidance to accompany section 3 of the Social Care (Self-directed Support) (Scotland) Act 2013 and the Carers (Waiving of Charges for Support) (Scotland) Regulations 2014".

Waiving of charges – legislative framework

3.3.2. Section 87 of the Social Work (Scotland) Act 1968 ("the 1968 Act") allows local authorities to charge for certain care services they provide, but the Carers (Waiving of Charges for Support) (Scotland) Regulations 2014[52] (the "2014 Regulations") then require local authorities to waive these charges in relation to support provided to carers[53].

3.3.3. The 2014 Regulations also amend the Self-directed Support (Direct Payments) (Scotland) Regulations 2014 so that local authorities cannot means test or require a contribution from a carer where carer support is being delivered by way of a direct payment.

3.3.4. Charges cannot be made for support provided to carers either directly by local authorities or commissioned by the local authority through other statutory, independent and third sector bodies. However, if a carer wishes to supplement and pay for carer support above the agreed level they receive through self-directed support, then this is a matter entirely for the individual carer.

Waiving of charges and the Act

3.3.5. Part 3, Chapter 2 of this guidance covers local authorities' duty and power to support carers under section 24 of the Act. These replaced powers to support carers under section 3(4) of the Social Care (Self-directed Support) (Scotland) Act 2013 ("the 2013 Act") and section 22 of the Children (Scotland) Act 1995 (the "1995 Act").

3.3.6. **Section 26** of the Act updates section 87 of the Social Work (Scotland) Act 1968[54]. The Carers (Waiving of Charges for Support) (Scotland) Amendment Regulations 2018[55] [title tbc] update the 2014 Regulations. The Self-directed Support (Direct Payments) (Scotland) Amendment Regulations 2018[56] [title tbc] the Self-directed Support (Direct Payments) (Scotland) Regulations 2014.

---

[52] http://www.legislation.gov.uk/ssi/2014/65/contents/made as amended by The Carers (Waiving of Charges for Support) (Scotland) Amendment Regulations 2018 [title tbc]

[53] See COSLA 'Charges Applying to Non-residential Social Care Services' 2017/18 sections 6.17-6.19 for further information

[54] http://www.legislation.gov.uk/ukpga/1968/49/section/87

[55] [Hyperlink to be added once regulations made.]

[56] [Hyperlink to be added once regulations made.]

3.3.7. These updates ensure that the requirement for local authorities to waive charges for the support provided to carers remains the same but now refers to the power and duty to support carers under section 24(4) of the Act, rather than the previous powers to support carers under the 2013 Act and the 1995 Act.

Examples of carer support

3.3.8. Types of carer support where charges will be waived cover both information/advice and direct practical support. They include, but are not limited, to:

- information and advice, including signposting to other agencies;
- advocacy;
- emotional support and counselling;
- training for carers;
- translation and interpretation services;
- support for the carer with housework or gardening or other similar activity;
- cost of transport to meet the carer's identified needs; and
- breaks from caring.

3.3.9. Most of the types of support are self-explanatory, but further guidance is provided below on household tasks and breaks from caring.

Support unrelated to the caring role

3.3.10. Individuals who are carers may also receive support or services from local authorities for reasons unrelated to their caring responsibilities because of their own social care needs (e.g. due to a disability or mental health issue). Such services are not provided under section 24 of the Act and the local authority's normal financial assessment and charging policies apply. **Annex B** provides guidance on carers who are also service users (adults or children with support needs).

Support with household tasks

3.3.11. Deciding whether support with housework or gardening is support for the cared-for person or support for the carer under section 24 of the Act is not straightforward. These decisions are particularly difficult where the carer and cared-for person live together.

3.3.12. Cared-for persons can be assessed as needing help with household tasks and might be charged, according to the local authority's normal financial assessment and charging policies.

3.3.13. However, many carers have multiple responsibilities over and above their caring role. Where the carer is carrying out a considerable amount of housework and other tasks they may, through their adult carer support plan or young carer statement, have 'identified needs' for assistance with practical aspects of their lives to support their health and wellbeing.

3.3.14. Support with these tasks might be provided to meet the carer's identified needs. Where these are 'identified needs which cannot be met by services provided to the cared-for person' (section 24(1)(a)).

3.3.15. For example, a carer looks after an elderly parent with support needs and is struggling with the volume of household tasks in both the carer's own home and their parent's home. In this case, support with household tasks at the parent's home would be support for the cared-for person and normal local charging policies would apply. However, support with household tasks at the carer's home would be support for the carer under section 24 of the Act and therefore free of charge.

3.3.16. Another example would be where a carer looks after his or her adult daughter who has support needs and lives in the same home. If household tasks have never been the daughter's 'responsibility' due to her disability, assistance with these tasks would be carer support under section 24 of the Act and therefore free of charge.

Waiving of charges - breaks from caring and breaks with the cared-for person

3.3.17. If a local authority decides to provide a break from caring for a carer, it must do so without making a charge.

3.3.18. The charge to be waived will cover the cost of all of the elements of the break that the local authority has decided to provide. Chapter 2 of this part of the guidance covers local authorities' duty to consider breaks from caring as part of their power and duty to support carers. In deciding what to provide, local authorities will wish to consider the component parts of the break and take into account such items as meals, accommodation, travelling expenses, the cost of equipment for classes and so on.

3.3.19. Where the carer and cared-for person have a break together with extra support for the cared-for person, the cost of the break for the carer will be waived. The cost of the break for the cared-for person and the cost of the additional support will not be waived. In these circumstances we would expect that these costs of the additional support could be met by the cared-for person's assessed needs and subsequent support package.

Breaks and replacement care

3.3.20. Where support is provided to a carer, it will often be closely linked to provision of support to the person they care for. This is particularly true when it comes to providing the carer with a break from caring. This is recognised in and built into the Act as a key element when:

- assessing whether the carer has eligible needs, and
- considering how to meet the carer's eligible and other identified needs, including through breaks from caring.

3.3.21. Chapter 2 of this Part also provides guidance on the cared-for person's agreement to provision of care in order to enable the carer to have a break from caring.

3.3.22. Identifying whether provision of care to a cared-for person is provided in order to support the carer or the cared-for person is particularly relevant in the

context of waiving charges for support to carers under the Carers (Waiving of Charges for Support) (Scotland) Regulations 2014[57].

Explaining "Replacement care"

3.3.23. "Replacement care" is not a term used in the Act. It is used in this guidance as a shorthand to cover **care provided to the cared-for person, which replaces care previously given by the carer and which is provided as a form of support to the carer so the carer can have a break from caring**.

3.3.24. However, not all care provided, arranged or funded by a public body which a cared-for person receives will necessarily be "replacement care". It will be necessary to exercise professional judgment and take the circumstances of the individual case into account in order to determine whether care provided to a cared-for person falls into the category of replacement care. It is recognised that this will not always be straightforward.

3.3.25. In making an assessment of whether or not care provided to a cared-for person is replacement care, it may help to ask the following questions, which are considered in more detail below:

Question a: Is the care to be provided to the cared-for person?

Question b: Is the care provided to enable the carer to have a break?
Question b.i: Is the care replacing care previously given by the carer?
Question b.ii: Is the purpose of the care in order for the carer to have a break?
Question b.iii: Aside from the need for a break, is the carer willing and able to continue caring?
Question b.iv: For young carers, aside from the need for a break is it appropriate for them to continue caring?

Question a: Is care being provided to the cared-for person?

3.3.26. This should be self-evident but if the answer is 'no', it cannot be replacement care.

Question b: Is the care provided to enable the carer to have a break?

3.3.27. Various sub-questions may be relevant in considering this question.

Question b.i: Is the care to the cared-for person replacing care usually given by the carer?

3.3.28. Care for the cared-for person may be provided to facilitate a break from caring as a form of support to a carer where it meets the carer's identified needs. In such cases the care will usually replace care normally given by the unpaid carer.

3.3.29. In deciding whether something is "replacement care" it is relevant to consider whether the care to the cared-for person is provided in order to replace care which the carer would otherwise have provided.

[57] http://www.legislation.gov.uk/ssi/2014/65/contents/made as amended by The Carers (Waiving of Charges for Support) (Scotland) Amendment Regulations 2017 [title tbc and hyperlink added once published]

3.3.30. In order to do that it is necessary to understand the caring role. The nature and extent of the care provided or to be provided will be recorded in the ACSP (section 9(1)(a)(i)) or YCS (section 15(1)(a)(i)).

3.3.31. It is not necessary for the care provided to the cared-for person to be a like-for-like replacement for the care usually provided by the unpaid carer. There will be circumstances where the unpaid care usually provided by the carer cannot be exactly replicated by paid care.

Example
An example might be if a carer lived next door to the cared-for person and usually provided a range of regular care (e.g. shopping, emotional support, and checking in regularly with the person during the evenings or at night). It may not be possible to replicate this kind of care while the unpaid carer had a break. Instead the "replacement care" might take another form, such as short term residential care if required. The crucial factor is whether the care is provided to facilitate a break for the carer as a form of support provided under section 24 of the Carers Act, as considered below

Question b.ii: Is the purpose of the care in order for the carer to have a break?

3.3.32. Services for the cared-for person provided primarily in order to meet that person's needs may include day-care to enable their independence and promote life skills and socialisation, play-schemes and out-of-school care provision for disabled children. These services may often deliver ancillary benefits of providing a break for unpaid carers. But they would not constitute "replacement care" where they are primarily intended for the purpose of meeting the cared-for person's needs and not the carer's need for a break.

3.3.33. Breaks for cared-for persons can sometimes be identified within their own care needs assessment and care services can be provided to mainly meet their assessed needs (e.g. to support social opportunities and independent living). Time-off for the carer can be achieved as a welcome consequence of the service. Such breaks for cared-for persons would not constitute "replacement care". If the local authority provides support to enable the carer to enjoy activities to make the most of this time off, this would be support under section 24 of the Act and therefore free of charge.

Question b.iii: Aside from the need for a break, is the carer willing and able to continue caring?

3.3.34. Information about the extent to which the carer is able and willing to provide care for the cared-for person must be included in the ACSP or YCS (under sections 9(1)(b) and 15(1)(b)). (See Part 1, Chapters 1 and 2.)

3.3.35. Care to the cared-for person can only be enabling the carer to have a break if it is replacing care that the carer is otherwise willing and able to provide. In other words, care to the cared-for person is not being provided in order to allow the carer to have a break where that care is needed because the carer is unable or unwilling to provide care. So care would *not* be considered replacement care if, for example, a carer was not willing or able to provide care because:

- the carer is ill, in hospital or recovering at home and alternative care therefore needs to be provided for the cared-for person.
- the carer wishes to work full or part-time and needs to stop providing care or reduce the care they provide when they are in employment. Entering employment is not a form of break. Care provided in these circumstances would be purely to meet the cared-for person's needs (as identified in the assessment of the cared-for person's needs) rather than the carer's needs under the ACSP/YCS.
- the carer is no longer able or willing to provide the same level or type of care for health or other reasons, even with support.

Question b.iv: For young carers, aside from the need for a break, is it appropriate for them to continue caring?

3.3.36. Young carer statements must include information about the extent to which the responsible authority considers that the nature and extent of the care provided by the young carer is appropriate[58].

3.3.37. Care to the cared-for person would not count as being provided in order to allow a young carer to have a break where that care was needed to relieve the young carer of inappropriate caring responsibilities.

3.3.38. This could happen if the care provided by the young carer has been deemed to be inappropriate for reasons such as the age of the young carer, the nature of the care (e.g. personal care in inappropriate circumstances) and the extent of the care (e.g. too many hours of caring impacting adversely on the young carer's health, wellbeing and education).

3.3.39. Although care provided by statutory agencies in these circumstances would be replacing the care which had been provided by the young carer, it would not do so in order to allow the carer to have a break to help sustain that caring situation. Instead it would be provided on a more permanent basis to relieve them of inappropriate caring responsibilities and ensure that the cared-for person's needs are being met.

Replacement care and waiving charges

3.3.40. There are challenges in deciding how certain forms of support, which arguably meet the needs of both the carer and the cared-for person, should be categorised, in order to determine whether the support may be charged for or whether charges should be waived.

3.3.41. In particular, this issue has the potential to arise in the context of "replacement care" which is provided to the cared-for person in order to allow the carer to take a break from caring.

3.3.42. The Carers Act sets out a structured approach to identifying the caring role, outcomes and needs for support in an ACSP/YCS and considering whether those needs for support should be met through a break from caring, which may be facilitated by providing "replacement care".

[58] See Part 2, Chapter 2 on young carer statements, in particular, guidance on section 15(1)(c) and explanation of 'responsible authority'.

3.3.43. This structured approach, together with this guidance, is intended to make it more straightforward for local authorities to determine whether care provided to the cared-for person should be treated as:

- support provided to a carer under the Carers Act in order to facilitate a break from caring; or as
- other care which the cared-for person receives by virtue of their community care assessment.

3.3.44. Where a carer's needs are considered eligible and a break from caring is agreed as an appropriate form of support for the carer, there will be a need to give consideration to the provision of appropriate care for the cared-for person. In some cases, this may be provided by friends, family or other community supports; however, in other cases there may be a need for more formal care - for example, where the cared-for person has complex care needs and requires specialist care provision.

3.3.45. The worked example below illustrates circumstances in which care to the cared-for person is and is not provided for the purposes of giving the carer a break.

Example
The personal outcome agreed in respect of a particular carer might be that she should feel less isolated and more resilient.

The carer will achieve this personal outcome by attending a weekly carer's peer support group on a Saturday afternoon. This form of peer support will enable the carer to continue to provide care for her 20 year-old daughter (the cared-for person).

The daughter's needs are such that she requires the constant presence of another person, and the carer usually provides that care except for when the daughter attends a day-care centre, which she does from 10am to 4pm every weekday. The daughter's day-care placement has been arranged under her community care assessment. It provides the ancillary benefit of giving the carer a break but is not provided for that purpose so does not constitute replacement care.

If the carer needs a paid care worker to look after her daughter for a few hours every Saturday in order that she can attend the peer support group, that replacement care would be support which meets the carer's identified needs and so is provided under section 24. Neither the carer nor the daughter would be charged for the replacement care.

On the other hand, if the peer support group meets at lunchtime on a Wednesday, there would be no requirement for replacement care in order for the carer to attend. The daughter's placement at the day-care on a Wednesday would not become replacement care just because the carer is now attending the peer support group at that time. Therefore, the local authority will still be able to charge the cared-for person for the provision of the day-care placement service according to their own charging policies.

Part 4, Chapter 1

Carer involvement in Services and Service Planning

Summary

Section 27 requires local authorities and health boards to involve carers and persons representative of carers in the carer services they provide. "Carer services" are defined to include both services to carers and services to cared-for persons. "Involvement" is defined to include involvement in considering what needs might call for services, what services might be provided to meet those needs, and how those services might be provided and evaluated. This ensures the involvement of carers at a strategic level in the design and delivery of services.

Sections 29 and 30 amend other legislation so as to require local authorities to involve individual carers in decision making at an individual level.

Section 29 amends section 1 of the Social Care (Self-directed Support) (Scotland) Act 2013. The amendments provide that carers must have as much involvement as they wish in the assessment of their needs and the provision of support under the Carers (Scotland) Act 2016.

Section 30 amends section 12A of the Social Work (Scotland) Act 1968 and section 23 of the Children (Scotland) Act 1995. The amendments require local authorities to take carers' views into account in assessing the needs of the cared-for person and in deciding whether and how to provide services to the cared-for person.

Section 28 deals with carer involvement in hospital discharge of cared-for persons. This is covered in **the next chapter of** this guidance.

The duty under **section 27** applies to local authorities and health boards but is not required to be delegated to integration joint boards as integration joint boards already have responsibilities to ensure carer involvement under the **Public Bodies (Joint Working) (Scotland) Act 2014**.

For the purpose of this chapter the terminology "local authorities" and "health boards" will continue to be used in place of integration joint boards or integration authorities.

Purpose of carer involvement

4.1.1. The Act strengthens the existing commitment to the principle of carer involvement in the development and delivery of services supporting both carers and cared-for persons at both strategic and individual levels. It does this through a combination of free standing duties in the Act and amendment to other relevant legislation.

4.1.2. At an individual level, the expertise and knowledge of carers can be seen as a vital resource to help inform the design and delivery of relevant care and support

services. As such, the principle of carers as equal and expert partners is important. This is especially pertinent in the case of carer groups with particular needs or sensitivities; for example, specific considerations relevant to carers from minority ethnic communities.

4.1.3. The National Carers Strategy 2010-2015[59] articulated Scottish Government policy of carers being viewed as equal partners in care. The established Equal Partners in Care (EPiC) framework states: '*Carers have a unique role in the life of the person they care for. When we are planning and delivering care for that person, it's important that we involve their carer. They have valuable knowledge to contribute and any decision will have an impact on their caring role. Carers, the person they care for and workers from health and social services should work together as partners to achieve better outcomes for all involved.*'

Form of Involvement

4.1.4. Carer involvement can take many forms, including informing carers and carer representatives of relevant information relating to the range and types of carer services available to them. It can also empower carers and carer representatives to make informed decisions, as with the shaping and delivery of any personalised support using the four options of Self-directed Support.

4.1.5. Shared Care Scotland has published a toolkit[60] for consulting and engaging with stakeholders on short breaks that contains a range of different tools with which to seek involvement from carers and people who use services.

4.1.6. Authorities may wish to consider appropriate forums for sharing learning and experiences both between carers and between authorities, including information hubs, Carer Leads meetings and where appropriate, social media.

Duties to involve in carer services

4.1.7. **Section 27** requires local authorities and health boards to take such steps as they consider appropriate to involve carers and such persons and bodies representative of carers in the planning and evaluation of carer services.

4.1.8. "Persons and bodies representative of carers" may include third or voluntary sector organisations. Authorities are strongly recommended to work closely with such organisations in developing services.

4.1.9. Under **section 27(4)** "carer services" are defined as services provided or to be provided by the relevant authority to carers (in relation to the care they provide, or intend to provide), or to cared-for persons (in relation to the care they receive).

4.1.10. Certain services are excluded from the duty to involve carers by virtue of **section 27(5)**, to avoid duplicating existing requirements to involve carers in these cases. These are:

- services which are contained in a children's services plan (within the meaning of section 8 of the Children and Young People (Scotland) Act 2014 if the persons mentioned in **section 27(3)** of the Carers Act have been consulted in relation to the preparation of that plan; and

[59] http://www.gov.scot/Publications/2010/07/23153304/0
[60] https://www.sharedcarescotland.org.uk/resources/tools/consultation-toolkit/

- services provided by virtue of functions which have been delegated under an integration scheme (within the meaning of section 1(3) of the Public Bodies (Joint Working) (Scotland) Act 2014) or which are to be carried out in conjunction with those functions – as integration authorities already have similar responsibilities to involve carers under the 2014 Act.

4.1.11. "Involvement" is defined in **section 27(6)(a) to (d)** to include involvement in considering what needs might call for services, what services might be provided to meet those needs, and how those services might be provided and evaluated. This ensures the involvement of carers at a strategic level in the design and delivery of services.

4.1.12. This includes involvement in the decision making process for the setting of local eligibility criteria.

4.1.13. In looking at what services might be provided, carers would be involved in considering:

- what services or assistance could be provided to cared-for persons other than care for the cared-for person (e.g. equipment and adaptations or mental health services);
- what general services might be provided such as information and advice (under **section 34**); and
- what other general services available universally in the community (e.g. youth clubs or leisure centres).

4.1.14. In looking at how services might be provided, carers would be involved in considering:

- provision through the commissioning process of support services; and
- provision at an individual level in design and delivery of support to the carer and/ or the cared-for person.

4.1.15. Looking at evaluation of services might include carers being involved in considering how evaluation of carer services may form part of a relevant authority or service provider's practice of continuous improvement.

Timing and level of involvement – individual cases

Carer involvement in assessments and support to carers

4.1.16. Section 1 of the Social Care (Self-directed Support) (Scotland) Act 2013 (as amended by section 29 of the Act) requires authorities to have regard to the principles in section 1[61] of that Act when carrying out functions relating to adult carer support plans, young carers statements, eligibility criteria and the duty to provide support to carers. These principles are:

a) a person must have as much involvement as they wish with regard to their needs assessment and support provision;
b) a person must be provided with any reasonable assistance to enable them to express views the person may have about the self-direct support options or make an informed choice about the options; and
c) a local authority must collaborate with a person regarding a person's needs assessment and support provision.

[61] http://www.gov.scot/Publications/2014/04/5438/4

4.1.17. Statutory guidance[62] produced to support the **Social Care (Self-directed Support) (Scotland) Act 2013** elaborates on the core values and principles of care and support in section 1.

4.1.18. This requirement for carer involvement applies to all stages of a carer providing, or intending to provide, care and to all local authorities and health boards.

Carer involvement in assessment and provision of support to cared-for person

4.1.19. **Section 30** of the Act amends both section 12A of the Social Work (Scotland) Act 1968 and section 23 of the Children (Scotland) Act 1995. The amendments require local authorities to take carers' views into account so far as it is reasonable and practicable to do so in assessing the needs of the cared-for person and in deciding whether and how to provide services to the cared-for person

4.1.20. The amendments at **section 30(2)** to **(4)** incorporate the principles of carer involvement into section 12A of the **Social Work (Scotland) Act 1968**[63]. **Section 12A(1B)** of the 1968 Act (as amended) requires that as far as it is reasonable and practical to do so, a local authority must take account of the views of the carer when:

a) assessing the needs of the cared-for person;
b) deciding the need for support; and
c) deciding how any support services are provided.

4.1.21. The amendments at **section 30(5)** to **(7)** incorporate the principles of carer involvement into section 23 of the **Children (Scotland) Act 1995**[64]. Section 23 of the 1995 Act (as amended) requires that as far as it is reasonable and practical to do so, a local authority must take account of the views of the carer when:

a) assessing the needs of the child being cared-for
b) deciding the need for support
c) deciding how any support services are provided to that child.

4.1.22. The level and means of carer involvement in these decisions about the cared-for person can be determined on a case-by-case basis and may require professional judgement from those involved. There may be conflicts between the wishes of the carer and the cared-for person. Sometimes the cared-for person will not accept services to support them, which may in turn place an additional burden back onto the carer.

Involving young carers

4.1.23. The duties to involve carers apply equally for young carers. They apply to strategic planning, particularly for the design and provision of young carer specific services, and to individual assessment and decision making.

4.1.24. Different considerations and approaches will be relevant for the involvement of young carers. In this context, the aim of authorities would be to minimise the impact of their caring role on the young carer's life, and to provide alternative support to the cared-for person that minimises the need for the young carer to act as a carer, taking into account their age and maturity.

[62] http://www.gov.scot/Publications/2014/04/5438/0
[63] http://www.legislation.gov.uk/ukpga/1968/49
[64] http://www.gov.scot/Publications/2004/10/20066/44708

4.1.25. There is a risk that, in supporting young carers in their caring role, authorities could inadvertently perpetuate inappropriate levels of caring by the young person. Young carer input and involvement will be a particular consideration in ensuring this does not happen.

4.1.26. Authorities should recognise that in some situations, young carers may wish to continue to care for someone, but require to be supported sensitively with the aim of minimising the impact of their caring on their wellbeing indicators in line with the Getting it right for every child approach[65].

[65] http://www.gov.scot/Resource/0052/00523204.pdf

Part 4, Chapter 2

Carer involvement in hospital discharge of cared-for persons

The terminology “patient” is used throughout this chapter of the guidance in place of “cared-for person”. This is to place it in the context of the hospital setting. “Cared-for person” will be used only when quoting and paraphrasing the legislation.

This chapter is not intended to provide guidance on all aspects of hospital discharge and other associated processes. Instead, it provides statutory guidance on the key aspects of the duty placed on health boards at **section 28** of the Act along with some suggestions and recommendations on how to meet the duty.

There are many other local and national guidance and best practice documents that comprehensively cover many different aspects of hospital discharge planning, many of which are referenced in this chapter.

Summary

Section 28(1) and (2) requires each health board to involve the carer before a cared-for person is discharged from hospital. It must do so by
(a) taking steps as it considers appropriate to: inform the carer as soon as reasonably practicable of the intention to discharge the cared-for person; and invite the views of carers about the discharge; and
(b) taking account, *so far as it is reasonable and practicable to do so*, of any views given by the carer in making decisions relating to discharge of the cared-for person.

Section 28(3) provides that this duty only applies where:

- the carer of the cared-for person can be identified *without delay*; and
- where it appears to the health board that the cared-for person is likely to require care following discharge.

The duty under **section 28** is subsidiary to any hospital functions delegated to integration joint boards. That means that where hospital functions are delegated to joint boards, the subsidiary duty to involve carers under section 28 will automatically be delegated. In these cases, although the duty applies to health boards and the State Hospital Board for Scotland, in practice it will be implemented by health boards, the State Hospital Board and local authorities working together under the direction of the integration joint boards. This approach will ensure that the functions are exercised in an appropriately integrated way, joining up support for professionals, patients and carers. Where hospital functions are not delegated to joint boards, the subsidiary duty to involve carers under section 28 will not be delegated either.

For the purpose of this chapter, the terminology “health boards” will continue to be used in place of integration joint boards or integration authorities.

Definition of hospital

4.2.1. A hospital in the context of this duty is a "health service hospital" as defined in section 108 of the **National Health Service (Scotland) Act 1978 (as amended)**[66]. The duty is also placed on State Hospital Board for the state hospital in Scotland as defined in section 102 of the 1978 Act[67].

4.2.2. Community hospitals are included within this definition.

4.2.3. This duty does not apply to private hospitals in Scotland unless they are providing NHS treatment to the patient, in which case it is the health board responsible for the patient that has responsibility to ensure the duty is complied with.

Definition of discharge

4.2.4. There is no legal definition of a hospital discharge. Health boards are encouraged by the Scottish Government to prepare an Admission, Transfer and Discharge protocol (ATD). This will be an agreed protocol for use in NHS facilities. The Scottish Government has published a Framework for the Production of Joint Hospital Discharge Protocols[68].

4.2.5. It is recommended to consult the local ATD protocol or seek advice from the relevant health board if unclear about the discharge process in an individual setting or locality.

4.2.6. It is generally understood that when a patient has finished their course of treatment or medication and a doctor has assessed they are fit to leave hospital, they will be clinically ready for discharge.

When this duty applies

4.2.7. The duty applies in situations where:

- Either
  - the identified carer is an adult carer or a young carer (as defined at **section 1** of the Act), or
  - an individual is identified who intends to provide care to a patient post-discharge, or
  - the individual is providing or intends to provide care but does not self-identify as a carer; **and**
- professionals consider it likely that the patient will require care from a carer following discharge; and
- a formal discharge process takes place.

4.2.8. There are settings, such as Assessment Units, in which it can be more ambiguous whether patients require a formal discharge. In such cases no absolute rule should be applied and each case dealt with on an individual basis.

[66] http://www.legislation.gov.uk/ukpga/1978/29/section/108
[67] http://www.legislation.gov.uk/ukpga/1978/29/section/102
[68] http://www.sehd.scot.nhs.uk/publications/CC2003_09.pdf

4.2.9. Neither the nature nor amount of the care estimated to be required following discharge of the patient from hospital should affect whether the hospital involves the carer in the discharge process.

4.2.10. The health board discharging the patient may not be the board for the area where the patient resides. Where this is the case, the health board discharging the patient must still apply this duty.

4.2.11. The duty applies regardless of the patient's discharge destination. It may be the case that a patient is to be discharged to a different place from where they were living before they were admitted to hospital. For example, an individual who had previously been living at home might be discharged to a care home, another NHS facility for further treatment, or to a lower security hospital.

Exceptions - Outpatients and A&E

4.2.12. The duty does not apply if the patient is an outpatient or is attending A&E.

Mental Health

4.2.13. In relation to mental health, the duty does not apply if the patient has a suspension of detention or has received conditional discharge under the **Mental Health (Care and Treatment) Act 2003 (the "2003 Act").**

4.2.14. It is not necessary for the section 28 duty to apply here because there is already a separate duty to have regard to carers views under section 1 of the **2003 Act**. This requires any person undertaking a function under the 2003 Act, to have regard to relevant views of any carer about that function. For discharge, this includes suspension of detention or conditional discharge. The Code of Practice Volume 1 for the 2003 Act goes into further detail on the requirement to take consideration of the carers' situation and needs, "*so far as is practical and reasonable".*[69]

For information
Suspension of detention can apply to individuals who are detained in hospital under the **Mental Health (Care and Treatment) Act 2003**. It enables the Responsible Medical Officer (RMO) to suspend a person's detention, to allow greater freedom and a better quality of life, while still providing the care and treatment he or she needs. Generally, suspension of detention must be authorised by the RMO for any time a detained patient spends outside the hospital grounds.

Conditional discharge allows a period of formal supervision of a patient in the community by closely monitoring his/her mental health and behaviour for any indicators of increased risk to others so that steps can be taken to assist him/her and protect the public. It also allows a period of assessment of the patient in the community before a final decision is taken on whether to remove the safeguards and control imposed by the restriction order by means of an absolute discharge.

[69] https://www.legislation.gov.uk/asp/2003/13/contents

Why involve carers?

4.2.15. There is evidence to suggest that there has been a significant increase in recent years of post-discharge care being provided by unpaid carers[70]. It is believed that if the hospital discharge is handled in a positive way and involves the carer, this can help with patient recovery and improved outcomes as well as preparing the carer for the care provision to be transitioned back into the community[71].

4.2.16. Professionals involved in discharge planning may not be aware of all aspects of a patient's requirements and wishes. Carers often have detailed knowledge of the patient's medical and social care history as well as an understanding of other relevant issues and personal beliefs. This knowledge can aid professionals who are making decisions around discharge and appropriate after-care and support arrangements.

4.2.17. Evidence shows that the involvement of carers in hospital discharge planning can reduce the risk of delayed discharge and readmission[72]. There is a large cost attached to the provision of additional, perhaps unnecessary, support to someone who has been readmitted to hospital or whose discharge has been delayed.

4.2.18. It is important that the carer feels prepared for the hospital discharge of the patient. Being informed and involved in the process can reduce the risk of negative impacts on the carer's health and wellbeing and produce better outcomes for the carer overall.

4.2.19. Through the involvement of the carer in the hospital discharge process, carers are likely to be better supported through signposting to and awareness of appropriate support and services available to both themselves and the patient.

Workforce readiness

4.2.20. Health boards are encouraged to ensure their local guidance is up to date in relation to the new duty. It will be the responsibility of the health board to ensure that professionals are aware of the duty and have the required training to allow them to meet it.

4.2.21. The Equal Partners in Care[73] (EPiC) national framework contains an online learning resource which can be used by all professionals to develop their skills and

[70] Dellasega C & Nolan M (1997) Admission to care: facilitating role transition amongst family carers, *Journal of Clinical Nursing 6*, 443–451; Shepperd S, Parkes J, McClaran J & Phillips C (2004) Discharge planning from hospital to home, *Cochrane Database of Systematic Reviews* 1, 1–38; Goodwin V & Happell B (2006) Conflicting agendas between consumers and carers: the perspectives of carers and nurses, *International Journal of Mental Health Nursing* 15, 135–143.
[71] The Princess Royal Trust for Carers, *Out of Hospital' Project – Learning from the Pilot Projects Final Report*, May 2010: http://www.static.carers.org/files/out-of-hospital-final-report-6-may-2010-5221.pdf
[72] https://www.nice.org.uk/guidance/qs136/chapter/Quality-statement-5-Involving-carers-in-discharge-planning
[73] http://www.knowledge.scot.nhs.uk/home/portals-and-topics/equal-partners-in-care/about-equal-partners-in-care.aspx

knowledge to enable them to actively involve carers in the care of the cared-for person at all stages of the planning and decision making process.

4.2.22. Although the duty is placed on health boards, it would be expected that health, social care and third sector professionals would work together to ensure that patients and carers are supported.

Involving the carer

4.2.23. The health board must take "*such steps as it considers appropriate*" to meet the duty at section 28. As such, professionals will be required to exercise judgement in certain cases, including where concerns in relation to the carer about child or adult protection have been raised.

4.2.24. In order to involve the carer, it would be expected that a discussion would take place between professionals, the patient and the carer if possible. Professionals may wish to provide information to the carer on what they might reasonably expect to happen during the hospital discharge process and how they should be involved.

Example
The Triangle of Care[74] model of carer involvement has been developed by Carers Trust Scotland, particularly for use in mental health settings, but is a transferable tool. Its aim is to encourage improved engagement and collaboration between service user, carer and professional. The Triangle of Care details six key standards that are required to achieve better collaboration and partnership with carers in planning for the patient's care. These are:
1) Carers and the essential role they play are identified at first contact or as soon as possible thereafter;
2) Staff are 'carer aware' and trained in carer engagement strategies;
3) Policy and practice protocols relating to confidentiality and information sharing are in place;
4) Defined posts responsible for carers are in place;
5) A carer introduction to the service and staff is available, with relevant range of information across the care pathway;
6) A range of carer support services is available.

Planned and unplanned admissions

4.2.25. In cases where hospital admission is planned, such as pre-planned operations, the involvement of the carer in hospital discharge may have begun before the patient is admitted to hospital. Discussions with GPs and other professionals in order to plan for the admission may include the carer where appropriate. This is likely to include an element of anticipatory care planning[75]. It may be useful for professionals in the hospital setting to identify if any such plans have been produced when they begin to involve the carer in the discharge planning process.

[74] Carers Trust Scotland, *The Triangle of Care: Carers Included: A Guide to Best Practice in Mental Health Care in Scotland*, 2013: http://www.mwcscot.org.uk/media/140311/triangle_of_care_-_final.pdf.
[75] http://ihub.scot/anticipatory-care-planning-toolkit/

4.2.26. It would be helpful for professionals to identify whether an emergency plan is in place where the patient's hospital admission is not planned. This may have been produced in conjunction with the carer and detail useful information.

Who is the carer?

4.2.27. If a patient has more than one carer all identified carers must be involved in the discharge process. If for whatever reason it has not been possible to identify all carers of a patient where it is known that a patient has more than one, then the duty is intended only to apply in respect of the carer(s) identified "*without delay*".

4.2.28. Professionals must not assume that the most frequent visitor, the next of kin or a patient's welfare guardian have a caring role for the patient. It would be expected that introductory conversations with family and friends would seek to identify whether or not there are any caring responsibilities without making any prior assumptions.

Specific Considerations

4.2.29. There will be specific considerations for the health board to take into account in certain situations in order to meet the duty. In rural and remote areas this might include consideration of whether carers may be unable to travel to the hospital to visit the patient. Where the carer is a young carer they may not be available during school hours.

Identifying the carer "without delay"

4.2.30. **Section 28** of the Act only applies when:

- the carer can be identified "*without delay*" ; and
- where the patient is likely to require care following discharge. This applies in circumstances including where the care need has increased, decreased or stayed the same or if the nature of care required has changed.

4.2.31. It is expected that professionals would take steps as early as possible after a patient's admission to identify whether they have a carer if this is not already known. In doing so, professionals may wish to consider the most appropriate approach.

Example
Professionals may wish to ask the patient if they have a carer or when speaking to patient visitors, ask whether they or someone they know undertakes caring responsibilities.

4.2.32. A family member or friend may have been providing care for a period of time prior to the patient's hospitalisation however does not self-identify as a carer. This could be for a number of reasons[76], including because they do not recognise the term as being relevant to their situation or they are unsure of its meaning. In this case, the individual may not respond positively to professionals using certain terminology and language.

[76] Carers UK, *Missing Out: The Identification Challenge* November 2016 provides an overview of some of the reasons for and challenges of carer identification.

4.2.33. Professionals should be aware that using alternative language may help with identifying whether or not they have a caring role. For example: "*do you look after…*" or "*do you provide any support to…*"

4.2.34. Professionals should not place pressure on the individual to self-identify as a carer however professionals may wish to signpost them to further information and support.

4.2.35. There may be situations where it is not possible to identify a carer. For example, where communication between health professionals and the patient is difficult, or where the patient has been living independently prior to admission and does not therefore have a carer.

Informing the carer

Timing

4.2.36. The carer must be informed "*as soon as reasonably practicable*" of the intention to discharge the patient. This means the carer should be informed of the intention to discharge the patient as soon as possible when they are considered clinically ready to be discharged. That might be soon after the patient's admission or it might be later during the hospital stay but will vary depending on the individual situation.

Method

4.2.37. Appropriate methods of informing carers about the discharge of the patient will be a decision for the health board however the method of doing so is likely to depend on the individual situation. It is good practice to give consideration to the carer's circumstances when identifying the most appropriate way to inform the carer.

Example
If a carer is often present on the ward, the most appropriate method may be for professionals to approach them to make them aware of the intention to discharge, or alternatively scheduling a phone call to inform the carer if they are at home.

Inviting the carer to give views about the discharge of the cared-for person

4.2.38. Identified carers must be invited by professionals to give their views about the discharge of the patient. Professionals may prompt the carer to provide these views at an appropriate time. This is likely to take place before the patient is declared medically fit for discharge.

4.2.39. Professionals are encouraged to be mindful of how a carer may be feeling as a result of the patient being admitted to hospital and be sensitive in their approach to seeking views.

4.2.40. The method for obtaining the views of the carer will be dependent on the individual situation.

Example
The carer may be invited to the hospital to give their views, however a discussion over the telephone may suffice.

4.2.41. Professionals should be aware that carers will have different levels of understanding of the medical treatment (medicines, special diets, aides and adaptations etc.) the patient is receiving. Treatment may have changed during the patient's stay in hospital. It is important that carers are fully informed of the patient's updated medical situation before taking their views as this may impact on a number of things, including suitability of the discharge destination and their willingness and ability to care.

4.2.42. It may be that a carer has been identified at an earlier stage and views about the hospital discharge have already been provided prior to the patient being clinically ready for discharge. In this case, it would be good practice to revisit any views given at an earlier stage prior to the discharge, especially if the patient or carer situation has altered.

Example
Health boards may wish to consider using the **exchange model**[77], an approach to conversation often used by social workers that recognises people are "an expert in themselves". If the carer is unsure about the sort of views or information that might be appropriate to share in relation to hospital discharge, professionals may wish to prompt them with questions.

Taking account of any views given by the carer

4.2.43. The health board must take account of the carer's views "so far as it is reasonable and practicable to do so". There will be circumstances where it may not be reasonable and practical to take account of their views. This might happen if the carer is out of the country and staff are unable to get in contact with them by the time the patient is clinically ready for discharge.

4.2.44. Where there is more than one identified carer invited to give views and these views are contradictory, it would be expected that professionals will work together, having taken both sets of views into account, so far as it is reasonable and practicable to do so, to identify the most appropriate course of action for the patient.

4.2.45. Professionals are expected to work towards meeting the target of discharging the patient within 72 hours of being clinically ready.

4.2.46. As is current practice, the health and safety of the patient will be the primary consideration when taking account of the views of the carer. Health and social care professionals will be expected to use their professional judgement by asking the primary eligibility question for discharge; "*can this individual's care needs be properly met in any other setting than hospital*?"

[77] http://arcuk.org.uk/scotland/files/2011/08/JIT-Good-conversations.pdf

4.2.47. If a carer is unhappy about a decision made regarding the patient's discharge after having given their views, it may be considered appropriate to have a conversation with the carer to explain the reasoning behind the decision. It might be helpful to provide information to the carer on any additional support for themselves or the patient to enable them to care for the patient post discharge.

Young carers

4.2.48. The intention of the Act is that young carers are able to be children and young people first and foremost and are protected from undertaking inappropriate caring responsibilities.

For Information

Professionals may wish to consider the following when the carer is a child:

- whether the young carer understands what hospital discharge means and the process which will follow;
- whether the patient understands that the child has a caring role at home, and what it is;
- there may be differences in accounts given by the young carer and the patient about the level of caring already being undertaken at home;
- whether the young carer may need an advocate to confidently present their case during the discharge process; and
- what impact the condition of the patient at time of discharge is likely to have on any children in the family and arrange for appropriate referral for support.

Patient is an adult with incapacity

4.2.49. The involvement of carers in situations where the patient is an adult with incapacity[78] is likely to require sensitive handling by professionals. Professionals may wish to refer to the tool "Good Practice Guide: Discharging patients who may lack capacity[79]" for guidance on the matter.

4.2.50. The final decision as to whether or not to involve the carer will be that of the professional, using their professional judgement, having sought the views of the welfare attorney or guardian where possible.

Patient is a child

4.2.51. Standard codes of practice apply when providing consent for information to be shared when the patient is a child (under the age of 18). These are issued by the Information Commissioners Office.[80]

Recording of information

[78] As defined in section 1(6) of the Adults with Incapacity (Scotland) Act 2000 http://www.legislation.gov.uk/asp/2000/4/section/1

[79] http://www.gov.scot/Resource/0045/00454245.pdf; For a learning resource that captures wider issues around patient incapacity, please see the learning resource "Think Capacity, Think Consent", http://www.nes.scot.nhs.uk/media/1557644/capacity_and_consent-interactive.pdf

[80] See ICO statement to local authorities health boards and Police Scotland on Information Sharing - 15 September 2016: http://www.gov.scot/Resource/0050/00507298.pdf

4.2.52. A multi-disciplinary approach is often required to treat patients in hospital, sharing information between professionals regarding carer involvement will be necessary.

4.2.53. It is recommended that health boards establish a method of recording actions taken by professionals under **section 28.** This might include information on attempts made to identify the carer as well as a record of how and when the carer was informed of the intention to discharge and any views that may be given regarding the discharge of the cared-for person.

4.2.54. Recording this information may help to avoid any communication duplication and ensure a joined-up approach, allowing information to be easily shared and could be used as a reference point in the future. This might be recorded as part of the patient's notes or separately.

Patient information and consent to share

4.2.55. Professionals will be aware of the various legal requirements around confidentiality and the sharing of patient information in cases where the patient declines to have a carer informed of the intention to discharge. Patient rights, including the right to privacy and confidentiality, are also enshrined in the **Patient Rights (Scotland) Act 2011**[81] and information on confidentiality in relation to patient information can be found in the General Medical Council's explanatory guidance "Confidentiality: Good Practice in Handling Patient Information[82]". Each health board will have a Data Protection Officer who will be able to provide advice on data protection and confidentiality in their locality. Some health boards will have their own information and guidance on what patient confidentiality means for carers

4.2.56. There may be a number of reasons for a patient to withhold consent for the sharing of their personal information with the carer. A patient may also withhold consent for the sharing of patient identifiable information with a carer and may not want the carer to know they have been admitted to hospital. In these situations, it would be expected that each case would be looked at individually and normal codes and standards of practice regarding information sharing would be applied by professionals[83].

4.2.57. Where consent has been withheld and professionals believe it to be appropriate, it is encouraged that an attempt be made to negotiate with the patient around the sharing of information. This might be achieved by laying out the benefits of doing so for the carer or the patient. Pressure should not be placed on the patient to change their mind if they are not comfortable. It may be that the patient is content for the carer to be informed of the discharge but does not want any further information shared.

4.2.58. If the situation allows, good practice would see professionals supporting and signposting the carer to relevant support.

[81] http://www.legislation.gov.uk/asp/2011/5/contents
[82] http://www.gmc-uk.org/guidance/ethical_guidance/30605.asp
[83] http://www.wdhscp.org.uk/media/1256/revised-code-of-confidentiality-final.pdf

Signposting and support for the carer

4.2.59. Through the process of involving the carer in the hospital discharge of the patient, it would be good practice for professionals to ascertain whether the carer has an adult carer support plan or young carer statement. If not, with the carer's consent, professionals may wish to notify the relevant authority which must offer one (as at **sections 6(1) & (2)** and **12(1) & (2)** of the Act).

4.2.60. If this is not appropriate, professionals may advise the carer of their right to request an adult carer support plan or young carer statement (as at **section 6(4)** and **12(4)** of the Act).

4.2.61. It may be the case that professionals within the hospital have responsibility for the preparation of an adult carer support plan or young carer statement, in which case the offer should be made to each identified carer.

4.2.62. Professionals are encouraged to make themselves aware of local and national carer support services. Many health boards will already have relationships with local carers centres, general community support services and provide resources on support available to carers.

4.2.63. Professionals are recommended to make carers aware of the local information and advice service for carers under section 34 of the Act. See **chapter 6** on information and advice for carers.

4.2.64. If considered necessary, a professional might make a referral to a social work team or carer support worker in the hospital.

Part 5

Local Carer Strategies

Summary

Section 31 requires each local authority and relevant health board to prepare a local carer strategy and provides for what that strategy must set out.

Section 32 requires the local authority and relevant health board to have regard to a non-exhaustive list of factors when preparing their local carer strategy.

Section 33 deals with the publication and review of the local carer strategy.

The duty under **section 31** applies to local authorities and relevant health boards but is delegated to integration joint boards under the **Public Bodies (Joint Working) (Prescribed Local Authority Functions Etc.) (Scotland) Amendment (No. 2) Regulations 2017**[84] and the **Public Bodies (Joint Working) (Prescribed Health Board Functions) (Scotland) Amendment Regulations 2017**[85]. As **sections 32** and **33** are subsidiary functions of **section 31**, these will also fall under the delegation of integration joint boards.

For the purpose of this chapter the terminology “local authorities” and “relevant health boards” will continue to be used in place of integration joint boards or integration authorities.

Statutory local carer strategy

5.1.1. A local carer strategy which deals specifically with the exercise of all functions relating to carers will allow matters to be dealt with more comprehensively than can be the case in the integration strategic plan or children’s services plan.It will also allow issues relating to the needs of both adult and young carers to be planned in one exercise. This in itself will support planning for the transition of individuals from being young carers to adult carers.

5.1.3. The requirement to prepare a local carer strategy is intended to help deliver consistency of approach. Each local authority and relevant health board must prepare and have regard to the same factors when preparing a strategy (**section 32)** and each strategy must contain information about the same things (**section 31)**. This will ensure a consistent approach while allowing the content and presentation of local carer strategies to reflect different local circumstances in the planning and delivery of support to carers.

5.1.4. It is a matter for each local authority and relevant health board to consider whether they wish to include further information in the local carer strategy over and above that required by **section 31**.

[84] http://www.legislation.gov.uk/ssi/2017/449/contents/made
[85] http://www.legislation.gov.uk/ssi/2017/381/contents/made

5.1.5. The duty under **section 27** to involve carers and persons and bodies representative of carers in carer services applies to the preparation of a local carer strategy. Authorities and health boards are strongly recommended to work closely and collaboratively with carers and with the third sector in preparing strategies.

Duty to prepare local carer strategy

Local authority and relevant health board

5.1.6. **Section 31(1)** provides that each local authority and relevant health board must jointly prepare a local carer strategy.

5.1.7. **Section 31(5)** defines "relevant carers", who should be covered by the local carer strategy. Relevant carers include both (a) carers who reside in the area of the local authority (whether or not they provide or intend to provide care for cared-for persons in that area) and (b) carers who do not reside in the authority's area but who provide or intend to provide care to cared-for persons in that area.

5.1.8. This means that the local carer strategy must cover carers:

- living and caring in the local authority area;
- living in the local authority area and caring for people living elsewhere;
- not living in the local authority area but caring for a person or people who live in the local authority area.

5.1.9. **Section 31(6)** sets out the meaning of "relevant health board". It means a health board with a coterminous boundary with the local authority or the health board within whose area the area of the local authority falls.

5.1.10. Where functions have not been delegated, in particular children's services in some areas, the requirement for health boards and local authorities to work closely together to prepare the local carer strategy still applies.

5.1.11. **Section 31(2)** sets out what the local carer strategy is and what information it must contain.

Joint working – two or more local authorities and health boards

5.1.12. There may be some local authorities and health boards which will work together to prepare a joint local carer strategy covering two or more local authority areas. Given that the duty is on each local authority and relevant health board to ensure that it has prepared a local carer strategy applicable to its area, the duty will equally be discharged by working together with another authority to have one local carer strategy which applies to each area.

Content of strategy

Carer Identification

5.1.13. **Section 31(2)(a)** requires the local carer strategy to set out plans for identifying relevant carers and obtaining information about the care they provide or intend to provide to cared-for persons in the local authority and relevant health board area.

5.1.14. It will only be possible for the local authority and relevant health board to plan for the delivery of the Act's functions by taking steps to identify carers and

determine the extent of caring responsibilities. Local authorities and health boards may already know the number of existing identified carers in their areas. They may also use Scottish Government statistical data obtained through surveys such as the Scottish Health Survey[86] and the Census[87] to obtain carer number data.

5.1.15. The plans for identifying relevant carers will be particular to each area but might include identification by different parts of the statutory workforce as well as by the third sector in a number of different ways set out in **Annex D**.

Assessment of demand for support

5.1.16. **Section 31(2)(b)** states that the local carer strategy must include an assessment of the demand for support to relevant carers[88].

5.1.17. It is recognised that assessing current and future demand is not an exact science. The caring population is fluid and carers are constantly moving in and out of the caring role. Many factors will determine demand including:

- the extent to which carers are identified;
- the changing national demographics with the growth in the older population, more adults with complex and multiple care needs and more children with complex needs surviving into adulthood;
- local demographics – age profile and socio-economic make-up of the local population;
- the impact of local publicity and communications regarding support for carers; and
- the extent to which carers are supported by family, friends and neighbours rather than by statutory services.

5.1.18. It should be noted that factors such as complex caring situations and intensive caring in areas of deprivation can exacerbate ill-health and result in increased demand.

Evidence
47% of carers in the most deprived areas care for 35 hours a week or more which is almost double the level in the least deprived areas where 24% of carers care for 35 hours a week or more[89].

5.1.19. There is evidence of lessening demand from the Community Led Support (CLS) Programme in selected areas of Scotland, England and Wales where CLS assists organisations to work collaboratively with their communities and their staff teams to redesign a service that works for everyone[90].

[86] http://www.gov.scot/Topics/Statistics/Browse/Health/scottish-health-survey
[87] http://www.scotlandscensus.gov.uk/
[88] Professor John Bolton, *Predicting and Managing Demand in Social Care, Discussion Paper*, Institute of Public Care, Oxford Brookes University, 2016 - https://ipc.brookes.ac.uk/docs/John_Bolton_Predicting_and_managing_demand_in_social_care-IPC_discussion_paper_April_2016.pdf
[89] http://www.gov.scot/Publications/2015/03/1081
[90] https://www.ndti.org.uk/our-work/our-projects/community-led-support

5.1.20. An assessment of the demand for both preventative support and support for those with eligible needs will help local authorities with the relevant health board to plan for meeting current and future needs, including unmet need.

Support available to carers

5.1.21. **Section 31(2)(c)** requires the local carer strategy to set out the support available to relevant carers in the authority's area from: **(i)** the authority, **(ii)** the relevant health board, **(iii)** such other persons and bodies as the authority and relevant health board consider appropriate.

5.1.22. The purpose of this section is for the local carer strategy to set out the support available at the time when the local carer strategy is being prepared.

5.1.23. "Such other persons and bodies" as at **section 31(2)(c)(iii)** may include support from the third and independent sectors. The support available across all sectors could include community-based assets such as leisure and recreational facilities, gardening clubs, libraries etc and people assets and expertise. It may also include support from educational bodies.

Unmet demand

5.1.24. **Section 31(2)(d)** requires the local carer strategy to set out an assessment of the extent to which demand for support to relevant carers is currently not being met. This means that having set out the support available to relevant carers; the next step is to set out an assessment of whether this is sufficient to meet the need.

Plans for supporting relevant carers

5.1.25. **Section 31(2)(e)** requires the local carer strategy to set out plans for supporting relevant carers. Having assessed demand, considered the existing support available and then assessed the extent to which demand for support is not being met, the final step in this process is to set out the plans for supporting carers.

Emergency planning

5.1.26. **Section 31(2)(f)** requires the local carer strategy to set out plans for helping relevant carers put arrangements in place for the provision of care to cared-for persons in emergencies.

5.1.27. There is separate provision in **sections 9(1)(c)** and **15(1)(d)** of the Act about emergency planning at an individual level. These sections require ACSPs and YCSs to contain information about whether the adult or young carer themselves have arrangements in place for the care of the cared-for person in an emergency.

5.1.28. **Section 31(2)(f)** is intended to be more strategic, reflecting the importance of emergency planning to provide carers with an agreed plan and peace of mind. Emergency planning (sometimes called contingency planning) includes planning for unplanned emergencies. For example a carer not being able to care due to:

- ill health;
- a family emergency; or
- the impact of adverse weather conditions (heavy snow, flooding, etc.)

5.1.29. Some areas already use resources[91] to offer carers emergency plans or discuss emergency planning with them whilst other areas offer carers an emergency card.

5.1.30. An emergency card lets the emergency services or social care services know that a person is a carer. Carrying the card at all times can help services to put other support in place in a crisis.

Reduce impact of caring on health and wellbeing

5.1.31. **Section 31(2)(g)** requires the local carer strategy to set out an assessment of the extent to which plans for supporting relevant carers may reduce any impact of caring on relevant carers' health and wellbeing.

5.1.32. This reinforces the preventative approach underpinning the Act. This requires the local authority and the relevant health board to assess how effective their plans for supporting carers are on a preventative basis.

5.1.33. This provision means that the local authority and the relevant health board will assess the extent to which support may meet carers identified needs in order to achieve their personal outcomes. It also means authorities and health boards will assess the extent to which preventative support may prevent, delay or reduce carers' needs, or potential needs, for support.

5.1.34. There are Audit Scotland reports which focus on the need for transformation in health and social care to take forward preventative approaches to supporting people, including carers, in order to reduce costs and promote health and wellbeing[92].

Examples of preventative support to carers:

- proactive and comprehensive use of the information and advice service for carers, ensuring that carers are provided with the right information and advice at the right time and in the right way;
- providing early support such as a short break to carers who have moderate needs but whose needs might become substantial without such support;
- promoting carers' resilience; and
- carers' health checks.

Intended timescales for preparing adult carer support plans and young carer statements

5.1.35. **Section 31(2)(h)** requires the local carer strategy to set out the intended timescales for preparing ACSPs and YCSs.

5.1.36. There are no set timescales in the Act for preparing these but in due course, Scottish Ministers will use the regulation-making powers in **sections 7** and **13** to prescribe timescales for preparing ACSPs and YCSs for carers of terminally-ill

[91] https://www.enable.org.uk/get-support-information/families-carers/future-planning/

[92] *Social Work in Scotland*, December 2016 (www.audit-scotland.gov.uk/report/social-work-in-scotland); *Changing Models of Health and Social Care*, March 2016 (www.audit-scotland.gov.uk/report/changing-models-of-health-and-social-care); *Health and Social Care Integration*, December 2015 (www.audit-scotland.gov.uk/report/health-and-social-care-integration)

cared-for persons. Part 2 of this guidance provides more information on the timescales for preparing and completing individual ACSPs and YCSs.

5.1.37. The intention of **section 31(2)(h)** is to give carers an indication of the maximum time for preparation of the ACSP or YCS.

5.1.38. There may be different timescales for completion of ACSPs and YCSs. Local authorities may have their own guidance for timescales based on urgency or risk. There may also be factors in individual cases which can result in ACSPs and YCSs taking longer to complete. For example where the carer's needs are complex and require more than one contact to prepare and complete the ACSP or YCS or where support required is specialised and not readily available.

5.1.39. Local authorities are recommended to prepare each ACSP or YCS as quickly as possible and without delay but to focus on achieving the right outcomes for the carer rather than allowing set timescales to become a *de facto* target.

Other information

5.1.40. **Section 31(2)(i)** also allows a local carer strategy to include such other information as each local authority and relevant health board consider appropriate. This enables each local carer strategy to reflect and take into account local circumstances.

5.1.41. This would enable a local authority and health board to include information about, for example:

- achievements and successes from previous non-statutory local carer strategies; or
- an overview of caring situations in relation to different types of conditions of cared-for persons.

Financial Information

5.1.42. Section 31(2)(i) would also allow the strategy to include relevant financial information about how money will be spent in the area on supporting adult and young carers. It will be a matter for the local authority and relevant health board to decide if they wish to include financial information.

5.1.43. It is recognised that carers can be supported indirectly by services put in place for cared-for persons. For various reasons, it may be challenging to identify the total resource supporting carers indirectly[93]. Self-directed support has also made it more difficult to disaggregate individual budgets.

5.1.44. The performance management framework for integration authorities under the **Public Bodies (Joint Working) (Scotland) Act 2014** requires integration authorities to publish certain financial information on an annual basis. The detail of this is set out in **The Public Bodies (Joint Working) (Content of Performance Reports) (Scotland) Regulations 2014**[94]. Regulation 4(1), read with regulation

[93] Indirect support is services put in place for the cared-for person which are of benefit to the carer and include technology enabled care, day care, support for disabled children, medicine management and social care services.

[94] http://www.legislation.gov.uk/ssi/2014/326/contents/made

4(2)(d) of those regulations requires an integration authority to publish, in an Annual Financial Statement, the total amount and proportion of funds which have been spent in each reporting year on 'social care services provided in pursuance of integration functions to support unpaid carers in relation to needs arising from their caring role'.

5.1.45. The figure in the integration performance report may well be different from that which might be included in the local carer strategy at the discretion of the local authority and relevant health board for the following reasons:

- it will be a retrospective account of sums actually spent rather than potentially a projection of sums to be spent;
- it may not cover exactly the same services - in particular if the local authority has chosen not to include the function of supporting young carers in the integration scheme; and
- the performance management obligation relates specifically to money that the integration authority has spent, and so would not cover funding from charitable or other sources.

Young carers

5.1.46. **Section 31(3)** requires a local carer strategy to contain information relating to the particular needs and circumstances of young carers as defined at **section 2** of the Act. This information must include in relation to young carers all the issues covered by section **31(2)(a)** to **31(2)(i)** of the Act.

5.1.47. The Act does not specify how this information is to be included in the local carer strategy. There is therefore local discretion on whether such information is contained in a single local carer strategy document covering both adult carers and young carers or whether a the local carer strategy consists of two documents, one in relation to adult carers and a separate document covering young carers.

Consultation before preparing strategy

5.1.48. Before preparing a local carer strategy, **section 31(4)** requires the local authority and the relevant health board to jointly **(a)** consult such persons and bodies representative of carers as they consider appropriate and **(b)** take such steps as they consider appropriate to involve relevant carers.

5.1.49. Persons and bodies representative of carers may include, for example:

- local adult and young carer organisations;
- condition-specific organisations which work with carers;
- disability or age-focused organisations which do not support carers directly but who have an interest in issues such as short breaks; and
- education bodies.

5.1.50. In order to involve relevant carers, it will be important to consult with carers in different caring situations and with those carers with whom agencies cannot easily interact. Carers centres, young carer projects and other local carer services may be able to help support this engagement with carers.

Links between local carer strategy and other plans and strategies

5.1.51. In preparing a local carer strategy, **section 32** requires local authorities and relevant health boards to take account of a range of statutory criteria and planning obligations, including under integration and children's services planning.

Children's Services Plans

5.1.52. **Section 32(a)** requires the local authority and the relevant health board to have regard to any plans for the provision of services relevant to young carers which are set out in the children's services plan prepared for area of the local authority under section 8 of the Children and Young People (Scotland) Act 2014. **Section 32(b)** also requires the local authority and relevant health board to have regard to the aims of children's services plans under section 9 of the 2014 Act.

5.1.53. Statutory guidance on **Part 3 (Children's Services Planning) of the Children and Young People (Scotland) Act 2014** was published in December 2016[95]. Paragraphs 205 to 208 of that guidance refer to the local carer strategy and to supporting young carers.

Wellbeing of children

5.1.54. **Section 32(c)** requires the local authority and the relevant health board to have regard to the criteria for assessing the wellbeing of children and young people set out in section 96 of the Children and Young People (Scotland) Act 2014.

5.1.55. This means that the wellbeing indicators set out in section 96[96] of the 2014 Act must be used in considering the particular circumstances of young carers in the area.

For Information
The wellbeing indicators are:
Safe, **H**ealthy, **A**chieving, **N**urtured, **A**ctive, **R**espected, **R**esponsible and **I**ncluded.

National Health and Wellbeing Outcomes

5.1.56. **Section 32(d)** requires the local authority and the relevant health board to have regard to any national health and wellbeing outcomes prescribed under **section 5 of the Public Bodies (Joint Working) (Scotland) Act 2014**[97].

5.1.57. These prescribed outcomes include the following as outcome 6:
"People who provide unpaid care are supported to look after their own health and wellbeing, including reducing any negative impact of their caring role on their own health and wellbeing."

5.1.58. There are a number of questions in the Scottish Health and Care Experience Survey[98] which provide evidence in support of this outcome. This survey is run every two years and the results are published by individual Health and Social Care Partnerships as well as for Scotland as a whole. It would be useful to consider these results when preparing the local carer strategy, alongside any local data collections, such as local indicators, and to consider the change every two years.

[95] http://www.gov.scot/Publications/2016/12/8683
[96] http://www.legislation.gov.uk/asp/2014/8/section/96/enacted
[97] http://www.legislation.gov.uk/ssi/2014/343/contents/made
[98] http://www.gov.scot/Topics/Statistics/Browse/Health/GPPatientExperienceSurvey/HACE2015-16

Integration functions in Strategic Plan

5.1.59. **Section 32(e)** requires the local authority and the relevant health board to have regard to any arrangements for the carrying out of integration functions relevant to carers which are set out in the strategic plan prepared for the area of the local authority under section 29 of the **Public Bodies (Joint Working) (Scotland) Act 2014**.

Other local or national plans

5.1.60. **Section 32(f)** requires the local authority and the relevant health board to have regard to any other local or national plans relating to the provision of social work services and health services as the authority and relevant health board consider appropriate.

5.1.61. The local authority and relevant health board may consider it appropriate to take into account the National Health and Social Care Standards: "My support, my life"[99]. These aim to ensure that people across Scotland receive the same high standard of care and support, delivered in a way which reflects their own personal needs and circumstances. The Standards sit beneath five overarching principles (dignity and respect; compassion; included; responsive care and support; and wellbeing). They set out what people should experience every time they use health and/or social care services.

5.1.62. In terms of local plans there are likely to be other, non-statutory, planning processes in the area which may be relevant to assessing the needs of carers and the support to be provided to them. An integration authority may, for example, have detailed planning processes in relation to dementia, mental health, learning disabilities, autism, sensory impairment, augmentative and alternative communication and/or substance misuse. Where such planning processes exist, they may be taken into account when preparing the local carer strategy.

Publication and Review of Local Carer Strategy

5.1.63. **Sections 33** sets requirements for publication and review of the local carer strategy.

Publication

5.1.64. **Section 33(1)** requires each local authority and relevant health board to jointly publish their local carer strategy. There is no statutory provision for the form or method of publication. This could however be on websites and/or made public in other ways. The Scottish Government would however find it useful to have notification of publication and a link to any web based local carer strategy.

Timescales

5.1.65. **Sections 33(2)** requires the first local carer strategy to be published by the date by which the integration authority relevant to the local authority in question must publish its next strategic plan under the **Public Bodies (Joint Working) (Scotland) Act 2014**.

---

[99] *Health and Social Care Standards: My support, my life*. (2017). Produced by the Scottish Government.
http://www.gov.scot/Publications/2017/06/1327

5.1.66. Before preparing a local carer strategy, the local authority and the relevant health board must carry out consultation under **section 31(4),** as outlined above. Because of these statutory consultation requirements, it is not expected that the first statutory local carer strategy would be in place in April 2018.

5.1.67. The timing of local carer strategies and integration strategic plans may not synchronise with that of children's services plans under **Part 3 of the Children and Young People (Scotland) Act 2014**. Under section 8 of that Act, the local authority and health board must prepare a children's services plan in respect of each 3 year period. The first 3 year period will start on 1 April 2017 and subsequent periods will start on each 3 year anniversary of that date. Secondary legislation on Part 3 came into force on 7 October 2016 and requires that a children's services plan, prepared in accordance with the provisions of Part 3 of that Act, should be in place by 1 April 2017. This date will apply consistently to all local authorities and health boards across Scotland.

5.1.68. **Section 32(a) and (b)** of the Act is intended to ensure that, although timescales may not synchronise, the local carer strategy is prepared in a way which takes proper account of children's services plans. Likewise the guidance in relation to children's services planning takes account of local carer strategies as highlighted above.

Review

5.1.69. **Section 33(3) and (4)** requires the local authority and relevant health board jointly to review their statutory local carer strategy at least every three years. This should enable local authorities and relevant health boards to keep the review of their statutory local carer strategy in line with the integration strategic plans if they wish to do so, or to allow the statutory local carer strategy to run for a full 3 years even if the integration strategic plan is reviewed sooner if they feel that is more appropriate.

5.1.70. In conducting the review, **section 33(5)** requires the local authority and relevant health board to comply with the consultation requirements in section 31(4) Guidance on these requirements is set out above.

5.1.71. Following the review, **section 33(6) and (7)** requires the local authority and relevant health board to revise and publish the revised strategy or to publish a statement that they have not revised it. **Section 33(7)** also requires the local authority to comply with section 32 (duty to have regard to other statutory plans, aims, criteria and outcomes) into account in preparing a revised strategy. Guidance on section 32 is set out above.

Part 6, Chapter 1

Information and advice for carers

Summary

Section 34 requires each local authority to establish and maintain an information and advice service, covering a range of mandatory areas for carers either resident in that local authority area, or caring for someone in that local authority area.

Section 35 requires each local authority to prepare and publish a short breaks services statement.

Section 36 requires Scottish Ministers to prepare a carers' charter, setting out the rights of carers as provided for in or under the Carers (Scotland) Act.

The duties under **sections 34** and **35** are delegated to integration joint bodies under the **Public Bodies (Joint Working) (Prescribed Local Authority Functions etc.) (Scotland) Amendment Regulations 2017**[100] and the **Public Bodies (Joint Working) (Prescribed Local Authority Functions etc.) (Scotland) Amendment (No.2) Regulations 2017**[101].

For the purpose of this chapter the terminology "local authorities" will continue to be used in place of integration joint boards or integration authorities.

Reasons for information and advice for carers

6.1.1. Providing good quality, appropriate, and timely information and advice to carers has dual benefits of improving the health and wellbeing of carers, and the cared-for person, reducing the potential need for, and costs of, crisis management.

6.1.2. The aim of information and advice services for carers is to enable them to access independent and comprehensive information and advice, to assist them with decision making in relation to their caring role and to have a life alongside caring.

6.1.3. Signposting to services alone is often ineffective at providing people with the support they need[102]. A proactive approach following early identification of the carer that goes beyond signposting and starts the conversation between carers and identified services is therefore recommended as good practice. Initially this may include arranging introductions to services/ direct referrals, rather than solely signposting to services to help reduce barriers that exist between information and advice provision to carers and support uptake.

6.1.4. This helps mitigate risks around carers not accessing appropriate advice or services, and the long-term wellbeing benefits and cost savings this may have. This research also recommends that carers are meaningfully involved in the design of support systems to ensure their effectiveness.

---

[100] http://www.legislation.gov.uk/ssi/2017/190/contents/made

[101] Hyperlink to be added once regulations are published.

[102] *Creating a stronger information, advice and advocacy system for older people.* (2009) John Rowntree Foundation. https://www.jrf.org.uk/report/creating-stronger-information-advice-and-advocacy-system-older-people

6.1.5. As part of information and advice to carers, short breaks services statements are expected to set out the range of different short breaks services and support that is available to carers in a local authority area and nationally.

6.1.6. It is well recognised that short breaks can be of great benefit to a carer's wellbeing, and drawing relevant information together in one place will help carers to make decisions on the support they receive.

6.1.7. A major barrier for carers' access to short breaks is the lack of information and advice surrounding local provision, with 43% of carers citing a lack of knowledge of how to access services[103].

Duty to provide information and advice services

6.1.8. **Section 34(1)** requires local authorities to ensure that relevant carers have access to quality, comprehensive and consistent information and advice services that allow carers to be aware of support available. Relevant carers are defined in **section 31(5)** of the Act to include both: **a)** carers who reside in that local authority area, and **b)** carers who provide or intend to provide care for someone in that local area.

Timing and targeting of information and advice according to need

6.1.9. The intention is that information and advice services should be provided in an appropriately timely manner. Information and advice will be most effective where it takes account of individual carer's needs and is provided at an appropriate time. For instance, a raft of information and advice received at the onset of a caring role may be overwhelming and may not be the best way to fulfil the carer's needs. A carer may require time to come to terms with the pressures of the caring role.

6.1.10. There are differing information and advice needs associated with different caring roles. It is recommended that, in providing information and advice services, local authorities are mindful of the potentially changing nature of the caring role. Caring roles broadly differ across each of three main axes:

- the specific stage of a carers' journey (e.g. new to caring, caring long term, ending a caring role);
- the specific condition(s) of the cared-for person (e.g. physical disability, mental illness, dementia); and
- the specific circumstances of the carer (e.g. young carer, older carer, rural carer, minority ethnic carer).

6.1.11. Where a carer already has an ACSP or YCS, it is recommended that their identified needs and personal outcomes should be considered when providing appropriate information and advice. However, information and advice provision can also play an important preventative role and need not wait until an initial ACSP or YCS has been prepared.

Reviewing and building on existing provision

[103] *Rest Assured? A Study of Unpaid Carers Experiences of Short Breaks*. (2012). Produced by the Institute for Research and Innovation in Social Services (Iriss), in partnership Shared Care Scotland, the Coalition of Carers in Scotland & MECOPP https://www.iriss.org.uk/sites/default/files/2016-03/iriss-rest-assured-full-report-2012-07.pdf

6.1.12. Local authorities may provide information and advice services as appropriate in their area in line with existing services, local demand and other considerations.

6.1.13. It is recommended that information and advice services should build on the existing networks of carers centres and other local information and advice providers. This approach will ensure that local knowledge and experience is retained and embedded in any system that is developed.

6.1.14. Carer Information Strategies (CIS) have been an important lever to drive forward improved outcomes for adult carers and young carers. It is recommended that local authorities use existing CIS health and social care networks to ensure that local knowledge and experience is retained and embedded in any information and advice service that is developed. This may include, for example, carer centres, young carer projects, and appropriate training to meet the needs of carers in their area.

6.1.15. Conducting a review of existing provision and mapping this out may assist local authorities and their partners to determine whether services are robust enough to cover a range of carer needs, whether any new services are required, and where additional resources can be best targeted and a co-ordinated approach developed.

6.1.16. Local authorities may wish to approach such a review from a carer journey perspective using the carer voice as a guide, which would also consider the linkages between parts of a service and equity of services across that authority area

6.1.17. Consideration of workforce capability and capacity would form an important part of a review, as would the system-wide outcome measures to be able to evaluate the efficacy of the services provided. .

6.1.18. In addition to specific information and advice services for carers (for instance those provided by local carers centres), other sources of information and advice may be relevant, such as:- Citizens Advice Scotland; local authority run Advice Shops; Jobcentre Plus; Royal National Institute of Blind People; Macmillan Cancer Information and Support Centres.

6.1.19. Particularly for universal services it will be important to consider resource allocations, and therefore capacity, alongside the sources of information and advice themselves. Informal information and advice provided by friends and family can be beneficial to some carers but may be difficult to capture in a review of information and advice sources

Collaboration and partnership working

6.1.20. Local partnership working is strongly encouraged when developing information and advice services, including by working closely with health boards and third sector organisations (including carer centres) to design and deliver these information and advice services to ensure effective integration and minimise duplication.

6.1.21. A local authority's duty to provide information and advice services may be discharged through these partners at the discretion of the local authority.

General principles for quality advice provision

6.1.22. As part of its review of its support to existing advice services, the Scottish Government has developed a set of principles for advice services in order to address inequalities across Scotland, treat people with dignity and respect, and deliver

services in a holistic way focusing on the individual. Local authorities may wish to draw on these principles during the design and delivery of local information and advice services as required by the Act. The principles are:

- **Responsiveness**: that people are able to access information and advice at a time and place that fits their needs;
- **Integration**: that providers of information and advice services work in partnership with other local and national organisations to ensure holistic service provision;
- **Professionalism**: that people receive high quality information and advice services; and
- **Inclusivity**: that additional access needs are supported and steps are taken to ensure vulnerable and socially isolated people are reached with the services and support.

6.1.23. Scottish Government supported services are expected to achieve the relevant quality framework accreditation (e.g. Scottish National Standards for Advice and Information Providers). This may be an approach that local authorities wish to replicate to ensure they support high quality service provision.

Scope of information and advice provision

6.1.24. The scope of information and advice provided is at the discretion of the responsible local authority or integration authority (where these functions have been delegated). As a minimum, it must cover the areas set out in **Section 34(2)**:

- carers' rights, including those set out in the carers' charter;
- income maximisation for carers;
- education and training for carers;
- advocacy for carers;
- health and wellbeing (including counselling) for carers;
- bereavement support services for carers following the death of a cared-for person; and
- emergency care planning and future care planning for carers.

Carers' Rights

6.1.25. **Section 34(2)(a)** requires services to cover carers' rights, including those in the carers' charter. It is important carers are made aware of the carers' charter. This will be prepared and published separately by Scottish Ministers, as required under **section 36** of the Act.

Income Maximisation

6.1.26. **Section 34(2)(b)** requires local authorities to provide information and advice on income maximisation for carers.

Evidence
Research shows that around one third of carers report financial difficulties[104]. According to the Scottish Index of Multiple Deprivation (which includes income and employment factors) in the 2011 census, 47% of carers in the most deprived areas

[104] *Carers, Employment and Services in Scotland: focus on East Ayrshire, Falkirk and Highland* (2007) Yeandle, S. Bennett, C., Buckner, L., Fry, G. and Price, C., Leeds: Carers UK and University of Leeds http://circle.leeds.ac.uk/publications/carers-employment-and-services-reports/

provide on average 35+ hours a week, compared to just 24% is the least deprived areas[105]. This indicates a positive correlation between financial security and the amount of care that a carer provides.

6.1.27. Information and advice services may aid the reduction of this inequality and financial stress by facilitating carers to maximise their available income and sustain employment.

6.1.28. Local authorities are encouraged to consider relevant information and advice which helps to prevent or mitigate financial hardship through early financial planning, including assessing the balance between work and care, residential care costs, guardianship for funds.

6.1.29. Providing the appropriate information and advice to carers to support them to sustain employment alongside their caring role, should they wish, is also important in income maximisation.

Example
The **Carer Positive**[106] scheme encourages organisations to establish and maintain flexible and carer friendly practices for their employees. This includes employers in the public, private, and third sectors. We would encourage local authorities to consider Carer Positive when developing their information and advice service (and local carer strategy if appropriate).

6.1.30. The devolution of social security powers to Scotland is expected to bring some changes to the benefits carers may be eligible for. The new Scottish social security agency, being created to administer devolved benefits, will provide information to people on their entitlements. This will be accessible through a number of channels including an enhanced digital and phone service and locally, where possible, in places where people already visit, to provide one-to-one claims advice and support when required.

Example
Carers Trust Scotland provides an **online benefits calculator**[107] that may be an appropriate first step for carers. Local information and advice sources, including carer centres, other third sector organisations and local authorities will form an important part of provision alongside national sources, such as the **Citizen Advice Bureaus and Citizens Advice Direct**[108] of **Citizens Advice Scotland**[109].

6.1.31. Local authorities may wish to raise carer awareness of the relevance of total household income to benefits or charges calculations relating to the carer and/or cared-for person, particularly if both the carer and the cared-for person are in the same household.

Education and training for carers

6.1.32. **Sections 34(2)(c)** requires information and advice on training and education available to carers. This can include both universal opportunities and those that

[105] Scotland's Carers: An Official Statistics Publication for Scotland. (2015) Scottish Government. http://www.gov.scot/Resource/0047/00473691.pdf
[106] http://www.carerpositive.org/
[107] https://carers.org/benefits-calculator
[108] 0808 800 9060 between 9am - 8pm Monday to Friday and 10am - 2pm on Saturday
[109] https://www.citizensadvice.org.uk/scotland/benefits/

specifically for carers. Consideration of carers' personal outcomes as agreed in their ACSP/YCS will be important to provide appropriate information and advice.

Advocacy for carers

6.1.33. **Section 34(2)(d)** requires information and advice on advocacy services available to carers. This covers provision of information and advice about available advocacy services. Unlike section 259 of Mental Health (Care and Treatment)(Scotland) Act 2003[110], this does not require the provision of independent advocacy services themselves.

Evidence
Research by the Joseph Rowntree Foundation states, "information is what you need or want to know; advice is being guided as to how to go about things; advocacy is a way of acting on that information and advice to get your due[111]" This connects information, advice and advocacy in a continuum in terms of the services and support a carer might receive.

6.1.34. It is recommended that local authorities and integration authorities consider Scottish Government guidance on carer advocacy[112]. **The Scottish Independent Advocacy Alliance** website[113] provides information on independent advocacy services nationally. Local authorities may wish to consider what local sources of advocacy currently exist and if there are potential gaps in relation to advocacy services for carers.

6.1.35. Local authorities have an separate duty under the **Social Care (Self-directed Support) (Scotland) Act 2013** ("SDS Act") to provide assistance on Self-directed Support services to those who would benefit, which could include carers, young carers or cared-for persons where they have an eligible need. There is separate guidance for assistance relating to the SDS Act[114].

Health and wellbeing

6.1.36. **Section 34(2)(e)** requires information and advice for carers about their own health and wellbeing. This may take the form of counselling, peer mentoring or other peer support groups, all of which may be of value to a carer and help empower them to manage the emotional impact of a caring role[115]. Maintaining good physical health can also help a carer build good emotional resilience. The content of an ACSP/YCS may include details of personal outcomes related to the health and wellbeing of the carer which can best be met through this type of support.

Bereavement support

6.1.37. **Section 34(2)(f)** requires information and advice on bereavement support services for carers in the event of the death of a cared-for person.

---

[110] http://www.legislation.gov.uk/asp/2003/13/pdfs/asp_20030013_en.pdf
[111] *Information, advice and advocacy for older people: Defining and developing services*. John Rowntree Foundation https://www.jrf.org.uk/report/information-advice-and-advocacy-older-people-defining-and-developing-services
[112] http://www.gov.scot/Publications/2016/03/5362
[113] The Scottish Independent Advocacy Alliance: http://www.siaa.org.uk/ https://www.siaa.org.uk/find-advocate/
[114] http://www.gov.scot/Publications/2014/04/5438/6
[115] https://www.nhsinform.scot/healthy-living/mental-wellbeing/therapy-and-counselling/benefits-of-talking-therapy

6.1.38. If a carer anticipates a need for bereavement support, in advance of the death of a cared-for person, this can be considered as part of the ACSP/YCS process. This may allow for the carer to prepare for that eventuality, and be in a better position to provide care prior to that point.

For Information
There is existing information available about bereavement support services, including but not limited to:
Carers Scotland; which has comprehensive information and advice about coping with bereavement[116];
Bereavement Zone (NHS Inform, which offers practical advice after a death;
Breathing Space; a free, confidential phone and web based service for people in Scotland;
Cruse Bereavement Care Scotland; a charity providing face-to-face and remote bereavement services nationally;
When someone has died information pack, which is widely used across NHS Scotland to help people through the first few days of a bereavement[117]; and
What to do after a death in Scotland, the Scottish Government publication which includes the steps that have to be taken following a death[118].

6.1.39. Some of these services offer specific advice for children or young people, which young carers may find particularly helpful.

6.1.40. A carer may be eligible for a Funeral Payment[119] or Bereavement Support Payment[120] following the death of the cared-for person. Local authorities may wish to provide this specific information and support to carers in this position.

Emergency care planning and future care planning

6.1.41. **Section 34(2)(g)** requires information and advice on emergency care planning and future care planning for carers. This links to the requirements elsewhere in the Act for individual ACSPs/YCSs to contain information about emergency care planning and future care planning (see Part 2 of this guidance) and for local carer strategies to set out plans to help carers put emergency care plans in place (see Part 5 of this guidance).

6.1.42. It would therefore be good practice for services to include information and advice about how and when local authorities will ensure care for the cared-for person during an emergency situation. This may go on to form a part of an emergency care plan that a carer can themselves be supported to create.

6.1.43. Information and advice about future care planning may also be required when a carer wishes to enter employment or education. It would be relevant where a carer is no longer willing or able to carry out a caring role in the same capacity. It may also be relevant where the cared-for person may require an increased amount

[116] http://www.carersuk.org/help-and-advice/practical-support/when-caring-ends/bereavement
[117] *When someone has died.* (2016) NHS Scotland. http://www.nhs24.com/~/media/nhsinform/bereavement%20zone/when%20someone%20has%20died%202016.ashx
[118] *What to do after a death in Scotland*. (2017) One Scotland, Scottish Government. http://www.gov.scot/Resource/0051/00510301.pdf
[119] https://www.gov.uk/funeral-payments
[120] https://www.gov.uk/bereavement-support-payment

of care. It may be appropriate for carers to be provided with information and advice about the different legal status' they may have, e.g. power of attorney or guardianship.

Other information and advice – transitions from young carer to adult carer

6.1.44. Specific information and advice may be necessary when a carer transitions from being a young carer to being an adult carer. This transition may involve a change in circumstance and eligibility for support (e.g. children's services) relating to, for example: leaving school; starting further or higher education; starting work; any potential relocation; and other situations. Guidance on the transition from a YCS to an ACSP can be found in **Part 2**.

Accessibility, proportionality and equalities

6.1.45. **Section 34(3)** requires information and advice to be accessible to carers. This will include, among other factors, consideration of their:

- digital competence and equipment;
- mobility;
- rurality;
- level of understanding (including any cultural or language barriers); or
- opportunities to access services in light on their caring role.

6.1.46. **Section 34(3)** also requires information and advice to be proportionate to the needs of the carer. At an individual level, these needs will be stated in the ACSP/YCS and when conducting the conversation, responsible authorities should be flexible when determining any bespoke support needs the individual carer may have.

6.1.47. **Section 34(4)** requires information and advice services to identify information which is likely to be particularly relevant to people with one or more protected characteristic as set out in **section 149(7) of the Equality Act 2010**. These protected characteristics are:

- age;
- disability;
- gender reassignment;
- marriage and civil partnership;
- pregnancy and maternity;
- race;
- religion and belief;
- sex; and sexual orientation.

6.1.48. A person with one or more protected characteristics may also have specific accessibility needs for information and advice services which deserve consideration. Local authorities may wish to consider the impact of rurality and isolation in particular when designing or procuring their information and advice services.

Part 6, Chapter 2

Short breaks services statements

Duty to prepare short break services statement

6.2.1. **Section 35** requires local authorities to prepare and publish a statement setting out information about short breaks services available for local carers and cared-for persons. To provide this information local authorities will need to consider how a break from caring fits within the context of the duty to provide support (set out in **Part 3, chapter 2**) and how this information can help empower carers' choices, including the use of Self-directed Support.

Evidence
Research shows that carers can lack the information to access short breaks services, can feel that they receive insufficient provision to cope with the pressures of caring[121] or feel that shorts breaks are increasingly being used to respond to crisis situations rather than in a preventative or planned capacity[122].

Content of statement

6.2.2. **Section 35(2)** defines a short break services statement as a statement of information about the short breaks services available in Scotland to carers and cared-for persons. This will cover both short breaks services which may be provided as a form of support where a carer's identified needs in a ACSP or YCS meet the local eligibility criteria and also short break services that are available to all (universal services).

6.2.3. Whilst there is no definition of what constitutes a short break, local authorities are encouraged to consider the paper provided by Shared Care Scotland attached at **Annex C.**

6.2.4. **Section 35(3)** requires information in the statement to be proportionate to the needs of local carers. This is the same requirement as for **section 34(3),** which is considered in Chapter 1 of this Part.

6.2.5. It is recommended that short breaks services statements have an emphasis on local provision, as well as including relevant information about provision which may be available outwith the local authority area. Local authorities can provide support towards, and signpost carers to appropriate services from a variety of sources (universal, specialist, local authority operated, third sector etc.). This could include, for example, community cafes offering the carer with an opportunity to socialise and relax on a regular basis, or a national residential service supporting people with long-term conditions or complex needs and their carers.

[121] http://www.carersuk.org/for-professionals/policy/policy-library/state-of-caring-report-2017
[122] *It always comes down to the money*. (2013). Kirsten Stalker (University of Strathclyde) et al. for Scotland's Commissioner for Children & Young People. http://lx.iriss.org.uk/sites/default/files/resources/it-always-comes-down-to-money.pdf

6.2.6. Local authorities are encouraged to include relevant statistics on local provision as part of the statement. This could include, for example, total local provision of short breaks broken down into different categories of service provision, or the number of carers supported by a particular service. This will help carers better understand the local short breaks landscape, and enable local authorities to consider any gaps in service provision, and in planning for future local demand of short breaks.

6.2.7. Some carers have made it clear that it would be useful for short breaks services statements to contain information about any criteria that needs to be met in order to access short breaks services. This would enable carers to have exercise more choice and control. Local authorities are encouraged to consider this as part of their preparation and content.

6.2.8. Local authorities are encouraged to use the statement as a way of sharing information and good practice in order to meet the needs of local carers and to plan for future demand. This is important where, for example, short breaks provision in a neighbouring local authority would meet the eligible needs of the carer.

For Information
There are also several national directories for information relating to short break services provided, which may be useful for identifying the sufficiency of local markets as well as for signposting purposes, including:
Short Break Services Directory[123] – a national directory of short break providers catering for different care needs and conditions (Shared Care Scotland);
Short Breaks Funding Directory[124] – a directory of national and local sources of funds that individuals can apply to help with a short break (Shared Care Scotland);
Euan's Guide[125], a national disabled access guide;
ALISS (A Local Information Service for Scotland)[126], links to a range of local community supports that can support health and wellbeing;
Short Break Stories[127], examples of voluntary sector Short Break provision in Scotland (Shared Care Scotland);
Autism Society Directory[128]; and
Care Inspectorate[129], a directory of care services that are registered with and inspected by the Care Inspectorate.

6.2.9. The principles of Self-directed Support (choice, control, flexibility, outcomes) apply to the provision of short breaks. Implications of the Social Care (Self-directed Support) (Scotland) Act 2013 for carers are set out in the Self-Directed Support: a guide for carers guidance[130] and in **Part 3** of this guidance.

[123] https://www.sharedcarescotland.org.uk/directory/?action=search
[124] https://www.sharedcarescotland.org.uk/funding-your-break/funding-directory/
[125] https://www.euansguide.com/
[126] https://www.aliss.org/
[127] http://shortbreakstories.org.uk/
[128] http://www.autism.org.uk/directory.aspx
[129] http://www.careinspectorate.com/index.php/care-services
[130] http://www.gov.scot/Resource/0045/00455705.pdf Note: this guidance was written before the passing of the Carers (Scotland) Act 2016.

Consultation

6.2.10. **Section 35(4)** allows Scottish Ministers to make regulations about the preparation, publication and review of short break services statements by local authorities. [**The [insert name of regulations] 2018** have been made under this power. This Part of the guidance will be updated once such regulations are made.]

6.2.11. These regulations require local authorities to consider the views of carers and carer representatives in the preparation and review of the statement. This is intended to ensure that the statement remains fit for purpose and appropriate to the needs of local carers. Local authorities may also wish to involve short break service providers when preparing the first publication of the statement.

Approaches to preparation

6.2.12. There are a number of different approaches used across the UK to disseminate information on short breaks that local authorities may wish to consider when preparing their own short breaks statements, some are described below.

6.2.13. Some Scottish local authorities have produced similar documents alongside referencing short break services in usual reporting documents. As an example, Midlothian Council produced a short breaks strategy (2010-2013) that stated the context and approach of the council to short breaks[131].

6.2.14. The different legal requirements and circumstances in England require English local authorities to meet certain criteria for their statements in order to meet the needs of families with disabled children[132].

6.2.15. Shared Care Scotland established a time-limited action learning project in 2017, with the purpose of helping to develop good quality short breaks services statements. This will comprise of representatives from local authorities, integration authorities, and others who may be responsible for the publication of short breaks services statements. Local authorities are encouraged to consider the outcomes from this project as they emerge.

For Information
Enfield Council publishes a good example of a short breaks statement for families with disabled children[133]. Supporting documents from Enfield council, rather than the statement itself, provide the specific detail of local short break options that would be expected of Scottish local authorities.

[131] *Midlothian Short Break Strategy 2010–2013: Enhancing support systems for carers*. Midlothian Council http://www2.midlothian.gov.uk/Council/Meetings/Public/Cabinet/20100504/CM_CA_20100504_11_2.pdf

[132] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/245580/Short_Breaks_for_Carers_of_Disabled_Children.pdf

[133] *Short Breaks Statement*. Enfield Joint Service for Disabled Children, Enfield Council https://new.enfield.gov.uk/services/children-and-education/local-offer/short-breaks-and-activities/short-breaks/local-offer-information-short-breaks-statement.pdf

Kent County Council also publishes a good short breaks statement for parents and carers of disabled children and young people[134]. It includes useful case studies of the different forms short breaks can take to meet individual needs, and whether these are universal, targeted, or specialist support services.

Format

6.2.16. It is for local authorities to determine who prepares the short break statement. The format and exact content of the statement will be for local authorities to decide, as long as it meets the requirements set out in regulations. The short breaks services statement is to be a useable product for carers forming part of the information and advice service provided to them, and empowering them to take their own decisions regarding the support they need.

6.2.17. Local authorities may want to consider whether their short breaks services statement is prepared as a single piece that is relevant to both adult carers and young carers, or if separate and distinct publications are produced to meet local needs.

6.2.18. **Section 35(3)** requires the statement to be in a readily accessible format. A recommended approach for the short breaks services statement is to publish the statement online in an easily searchable location alongside supplementary locations (e.g. physical copies in GP surgeries, carers centres, community centres, youth projects, schools and colleges).

For Information
Include Us All[135] provides resources for making information accessible. This national inclusive communication hub has been developed by the Scottish Accessible Information Forum (SAIF) and the Scottish Disability Equality Forum (SDEF).

Publication

6.2.19. Local authorities are to publish their first short breaks services statement by 31 December 2018. This is to allow local authorities to fully consider how best to source and present the information to be contained in their short breaks services statements. This will ensure good quality statements are produced, providing carers with accurate and up-to-date information they require to build an appropriate package of support in light of changes resulting from the commencement of the Act.

6.2.20. **Section 35(4)** allows Scottish Ministers to make regulations about the preparation, publication and review of short break services statements by local authorities. [**The Carers (Scotland) Act 2016 (Short Breaks Services Statements) Regulations 2018** (title tbc) have been made under this power. This Part of the guidance will be updated once such regulations are made.]

---

[134] *Short Breaks Statement for Parents and Carers of Disabled Children and Young People in Kent*. Kent County Council https://shareweb.kent.gov.uk/Documents/childrens-social-services/disabled-children/short-breaks-statement.pdf

[135] http://includeusall.org.uk/

Review

6.2.21. It is the responsibility of each local authority to review and update their short breaks services statement as and when required, whilst giving regard to changes such as, for example: new short breaks services that become available locally or nationally; or short breaks services that are no longer available.

6.2.22. Local authorities must consider the views of carers and carer representatives in the review of the statement.

Part 7

Delegation of Functions in the Carers Act

Summary

Each chapter of this guidance describes the different Carers Act functions of 'local authorities' and 'health boards' using those terms, as they appear in the Act.

References in the Carers Act guidance to 'local authorities' and 'health boards' will be understood to refer to the integration authorities of health and social care partnerships for all adult services and children's services where these have been delegated.

Purpose of this chapter

7.1.1. This chapter provides guidance on the health and social care integration context for the Act as a whole, taking account of the variation in approaches to integration for adults and children across different localities.

7.1.2. There was an overlap in the passage of the **Public Bodies (Joint Working) (Scotland) Act 2014** (the "2014 Act") with the preparation of the Carers Act. This created uncertainty regarding final provisions of the 2014 Act so the Carers Act does not refer to the terminology of integration. This chapter therefore explains how bodies given responsibilities and powers under the Carers Act operate within health and social care integration.

7.1.3. The **2014 Act** sets out the legal framework for the integration of health and social care. Regulations under that Act set out those functions which must be delegated to integration authorities (such as adult social care) and those which may be delegated to integration authorities (such as children's social care)[136].

Integration models

7.1.4. There are two distinct models of integration in operation across Scotland. Within these two forms there is further flexibility and variation between local authority areas as to the detail of what these integration models entail. Therefore the exact implications of integration will vary between local authority areas.

7.1.5. The 'Corporate Body Model' has been adopted widely across Scotland. In this model the pattern for delegation is for:

- all adult social care to be delegated to integration authorities, as part of the minimum delegated functions[137]; and

[136] http://www.gov.scot/Topics/Health/Policy/Health-Social-Care-Integration/Statutory-Guidance-Advice/HSCFuncNote

[137] Pg. 3 for minimum delegation requirements http://www.gov.scot/Topics/Health/Policy/Health-Social-Care-Integration/Statutory-Guidance-Advice/HSCFuncNote

- Children's social care can also be delegated to integration authorities.

7.1.6. In integration models where children's social care is not delegated, the local authority retains responsibility for those relevant children's services.

7.1.7. The 'Lead Agency Model' is in operation in Highland. This is an alternative integration model in which all health and social care functions relating to adults and children are transferred to particular authorities separately. In the case of Highland this means:

- NHS Highland is responsible for all adult health and social care; and
- Highland Council responsible for all children's health and social care.

7.1.8. It is worth noting that a young carer, as defined in **section 2** of the Carers Act, is a carer who is under the age of 18 or a carer over the age of 18 if they remain in school. The transition between children and adult social care services typically occurs from age 16 to 18. There will, therefore, be some instances where a young carer can be over 18.

Carers Act functions

7.1.9. Each chapter of this guidance describes the different Carers Act functions of 'local authorities' and 'health boards' using those terms, as they appear in the Act. (The terms 'responsible authority' and 'responsible local authority' are also used and defined.)

7.1.10. Local authority functions which must be delegated to the integration authority are identified in the **Public Bodies (Joint Working) (Prescribed Local Authority Functions etc.) (Scotland) Amendment Regulations 2017**[138] and the **Public Bodies (Joint Working) (Prescribed Local Authority Functions etc.) (Scotland) Amendment (No. 2) Regulations 2017**[139]:

- **Section 6** – Duty to prepare adult carer support plan (and associated responsibilities to review and provide information);
- **Section 21** - Duty to set local eligibility criteria (and associated responsibilities to publish and review);
- **Section 24** – Duty to provide support
- **Section 25** - Provision of support to carers: breaks from caring
- **Section 31** - Duty to prepare local carer strategy (and associated responsibilities to publish and review)
- **Section 34** - Information and advice service for carers
- **Section 35** - Short breaks services statements

7.1.11. In line with the approach noted at **paragraph 3** above, the requirement to delegate the above functions only extends to adult social care. Delegation of these functions with respect to children's social care remains a matter for local decision.

[138] http://www.legislation.gov.uk/ssi/2017/190/contents/made
[139] Hyperlink to be added when regulations are made.

7.1.12. Local authority functions under **section 12** – duty to prepare young carer statement (and associated responsibilities to publish and review) may also be delegated.

7.1.13. Health board functions which may be delegated to the integration authority are identified in **The Public Bodies (Joint Working) (Prescribed Health Board Functions) (Scotland) Amendment Regulations 2017**[140]:

- **Section 12** – Duty to prepare young carer statement (and associated responsibilities to publish and review)
- **Section 31** - Duty to prepare local carer strategy (and associated responsibilities to publish and review)

7.1.14. Health board functions under **section 28** of the Carers Act (Carer involvement in hospital discharge of cared-for persons) are subsidiary to any hospital functions delegated to integration authorities and will therefore automatically be delegated with those functions. (See expanded explanation of this point in Part 4, Chapter 2 – carer involvement in hospital discharge of cared-for persons.)

7.1.15. Local authority and health board functions under **section 27** (Duty to involve carers in carer services) are not required to be delegated as integration authorities already have responsibilities to ensure carer involvement under the **Public Bodies (Joint Working) (Scotland) Act 2014**.

[140] http://www.legislation.gov.uk/ssi/2017/381/contents/made

GLOSSARY

the Act

- The Carers (Scotland) Act 2016

ACSP

- Adult carer support plan

adult carer (defined in section 3 of the Act)

- A carer who is at least 18 years old and not a young carer.

adult carer support plan (defined in section 6)

- Replaces the "Carer's Assessment" for adult carers and sets out a carer's identified personal outcomes, identified needs for support (if any), and any other support that the responsible local authority is to provide to the carer.

break from caring

- Any form of support that enables a carer to have time away from their caring responsibilities. Support can include, for example, a short break or care for the cared-for person that enables the carer to have a break.

care for the cared-for person

- This is care provided to the cared-for person, which replaces care previously given by the carer, and which is provided as a form of support to the carer so the carer can have a break from caring. This may include "replacement care".

carer (defined in section 1)

- Someone who provides (or intends to provide) care for a cared-for person, but not:
    - only by virtue of the cared-for person's age if they are under 18 years old;
    - if the care provided is under contract; or
    - if the care provided is voluntary work.

eligible needs (defined in section 24(3))

- These are the needs for support identified in the adult carer support plan or young carer statement, to enable a carer to achieve their personal outcomes which:
    - cannot be met through services available to the cared-for person, or through services generally available to people in the area of the responsible local authority or where the carer lives;
    - and also meet the local eligibility criteria.

identified needs (defined in section 5)

- These are the needs for support identified in the adult carer support plan or young carer statement, to enable a carer to achieve their personal outcomes. Carers whose identified needs do not meet local eligibility criteria may still have access to other forms of support including, for example, information and advice services. Responsible local authorities have a power to provide

support to meet carers' identified needs which do not meet local eligibility criteria.

information and advice service (required under section 34)

- A service in each local authority area, providing information and advice on a range of mandatory topics relevant to carers. It should be accessible to carers who are resident in that local authority area, or caring for someone in that local authority area.

integration authority

- Established between the local authority and health board, an integration authority is responsible for directing the execution of various local authority and health board functions that have been delegated to it. These arrangements are detailed in a local Integration Scheme and must include adult social care, adult primary health care and unscheduled adult hospital care. They may also include children's care and criminal justice social work.

kinship carer

- A relative or close friend looking after a child in place of the child's parents. In some cases they will have a kinship carer agreement with the local authority.

local eligibility criteria (defined in section 21(2))

- The criteria to be set and published by each local authority, which are to be used to determine whether the local authority is required to provide support to meet an individual carer's identified needs.

personal outcomes (defined in section 4)

- These include outcomes which, if achieved, would enable a carer to provide, or continue to provide, care for the cared-for person. They should be outcomes that matter to an individual carer, which could include outcomes around having a life alongside caring and looking after the carer's own health and wellbeing.

responsible authority (defined in section 41)

- The body responsible for preparing a young carer statement. This can be either a health board, local authority, or the directing authority of a grant-aided or independent school.

responsible local authority (defined in section 41)

- The local authority for the area in which the cared-for person lives. Many of the duties under the Carers (Scotland) Act 2016 are for local authorities to exercise.

short break

- A short break is a form of support that can enable a break from caring. They can be taken with or without the cared-for person, and normally involve a leisure pursuit, holiday break, or other type of informal activity.

short breaks services statement (defined in section 35(3))

- A publication in each local authority area setting out information about short breaks services available in Scotland for carers and cared-for persons.

young carer (defined in section 2)

- A carer who is under 18 years old, or is 18 or over and still attending school.

young carer statement (defined in section 12)

- A new document for young carers, prepared by the responsible authority which sets out a young carer's identified personal outcomes, identified needs for support (if any) and any other support that the responsible local authority is to provide to the young carer.

YCS

- Young carer statement

Annex A

Support to carer or cared-for person

1. There are various reasons why it is important to be clear about whether a decision to provide a particular service is being taken in relation to the cared-for person or the carer:

- if support is provided as a result of a section 12A community care assessment[141] to the cared-for person, then it is clear from sections 5, 6 and 11(2) of the SDS Act that it is for that person to decide whether the support should be provided and how it should be delivered;
- the cared-for person might not wish to receive particular services and so they may not be delivered in practice even though the local authority has decided they have an eligible need through the community care assessment;
- as set out above, different eligibility criteria might apply in assessing whether the needs of the cared-for person call for the provision of community care services or the carer for support;
- the rules in relation to whether a charge can be made in respect of the support or services will be different if it is provided for the carer or the cared-for person.

2. Section 12A of the **Social Work (Scotland) Act 1968** and section 8 of the **Disabled Persons (Services, Consultation and Representation) Act 1986** make provision for community care assessments to take into account the care provided by a carer and the carer's ability to continue to provide that care. These provisions are intended to ensure that the local authority is fully informed about the level of care that a carer is willing and able to provide.

3. Section 12A(1)(b)(ii) of the 1968 Act also expressly requires the local authority to take into account any views which the carer wishes and is able to express, so far as it is reasonable and practicable to do so.

4. As such, the two assessments should dovetail. For example, if a cared-for person requires 24/7 care and the carer is willing and able to provide that care for 8 hours a day, the community care assessment should cover the cared-for person's needs for the remaining 16 hours a day.

5. If there is already a community care assessment in place at the point where an ACSP or YCS is being prepared, and if services are being delivered in accordance with that assessment, then the services provided by the local authority to the cared-for person should be reflected in the part of the ACSP or YCS which sets out the nature and extent of the caring role.

6. The local authority would be required to consider the extent to which the carer's needs are not already being met by the provision of services to the cared-for person, and apply its eligibility criteria to those remaining needs.

[141] Whilst the term "community care assessment" still has currency, "social care assessment" is the term that is increasingly being used in practice.

7. Additional services that might be suitable or needed for the cared-for person could be identified in the context of the ACSP or YCS and not the community care assessment. This might happen where the carer does not agree with the services provided to the cared-for person, either because the situation has changed since the last community care assessment; because the cared-for person wants more support from the carer than the carer wishes; or because the carer feels that the decisions already made are not good decisions and make too many assumptions about the carer's willingness to care. This sort of concern may well be raised during the ACSP or YCS process and the Scottish Government would expect them to be taken seriously. If it was agreed that the concerns were valid, there might be agreement to revisit the community care assessment to see what could be done to resolve matters.

8. Guidance on the Community Care and Health (Scotland) Act 2002[142] makes clear that carers and cared-for persons should have the opportunity to discuss their needs individually without the other person being present.

9. As and when the community care assessment is reviewed, that might result in additional services being put in place for the cared-for person which would in turn change the needs which are identified under the ACSP or YCS. However, until any change to the community care assessment had been made, the local authority would still be under a duty to meet those needs identified in the ACSP which meet the eligibility criteria. This could not be through a change in services to the cared-for person without their community care assessment having been reviewed and so the local authority would have to consider other options available which would provide support to the carer.

10. As a matter of good practice, a revision to the community care assessment done quickly would enable a final decision on how to meet the carer's needs could be met once changes to the cared-for person's support had taken effect. However, there may well be cases where it takes time for any new services to be available and put in place, so completion of the ACSP or YCS should not be conditional on the community care assessment having been reviewed.

11. **Therefore, each of the community care assessment and ACSP or YCS processes include a requirement on the person conducting the process to have regard to what is decided from time to time under the other process**. If the duty to provide tailored support to the carer then operates by reference to the needs which are still existing when both general services and indirect services provided to the cared-for person are taken into account, this will give the correct result.

12. A similar analysis applies in relation to the interaction between ACSP/YCS and an assessment under section 23(3) of the Children (Scotland) Act 1995 where the carer cares for a disabled child. The assessments may be easier to bring together in practice where the carer is a parent of a disabled child, since the carer will often be responsible for agreeing to the services to be provided to the child in their capacity as parent. This means that there is a smaller risk of conflict about what is required to be provided to the child than in the case of a cared-for adult. However, the general principles about the interaction between the two processes should apply equally to considering how far support provided to a disabled child in accordance with a section 23(3) assessment impacts on the needs of their carer.

[142] Scottish Executive Circular CCD 2/2003 - http://www.sehd.scot.nhs.uk/publications/cc2003_02full.pdf

13. In situations where the cared-for person does not have a community care assessment, the carer may still have identified needs which meet the local eligibility criteria. In such circumstances, the carer may have identified needs which might be met by services or assistance provided to the cared-for person but which are not provided via a community care assessment, for example, the provision of additional health services to the cared-for person. This should be recorded in the ACSP/YCS.

Annex B

Carers who are also service users (adults or children with support needs)

1. Carers might also have support needs themselves due to their own illness or disability. Section 24(5)(a) and (b) of the Carers Act (application of duty to support carer to meet the carer's eligible needs) applies where a carer's eligible needs might also be met through community care services *provided to the carer* and assessed under section 12A of the Social Work (Scotland) Act 1968 or services for children and their families provided to the carer under section 22 of the Children (Scotland) Act 1995. If the carer's needs meet the eligibility criteria for carer support, then the duty to provide support to the carer in subsection (4)(a) applies even if those eligible needs for support also in themselves call for the provision of community care services under the 1968 or 1995 Acts.

2. This means a carer can have needs themselves as a disabled or ill person and have those needs met by community care services delivered to them. If they have eligible needs as a carer in their caring role, then the duty to provide support applies.

3. Where carers have support needs themselves, for example, each member of an elderly couple in a mutually dependent relationship, the responsible local authority will have to make decisions about whether the need arises because of the caring (eg depression due to challenges of caring) or because of other factors (e.g. depression due to isolation or which pre-existed the beginning of caring). This may result in artificial distinctions having to be drawn but the responsible local authority will need to exercise their judgment in determining whether the needs relate to the person's caring role. The distinction should however be clear enough.

4. If it is impossible for a local authority to isolate a person's needs as a carer from that same person's needs as a user of services, the local authority may be in a position where there are potentially two sets of eligibility criteria which are relevant. (There is no statutory obligation to have eligibility criteria in respect of the decision about whether needs identified in community care assessments 'call for' the provision of services in terms of section 12A of the Social Work (Scotland) Act 1968, but the Scottish Ministers issued guidance in 2009 suggesting that local authorities should do so for older people (with relevance to adults with support needs too). In such a case, the duty to provide the support to the person as a carer takes precedence when the local eligibility criteria are met, regardless of whether the local authority also decides (or would have decided) that the needs call for the provision of services under section 12A of the 1968 Act.

5. In summary, and to offer pragmatic examples, a carer could have:

- support needs as a carer, some or all of which might be eligible needs - *and could receive, for example, emotional support at the carers' centre (because the caring situation is causing the carer stress and anxiety) and a short break;* and

- concurrent support needs with regard to their own social care needs, some or all of which might be eligible needs - *and could receive, for example, telehealth, (a health monitoring kit) because they have diabetes and this kit helps them to monitor and self-manage their condition at home.*

6. In other instances, as noted above, the distinction between a carer having eligible needs as a carer and as an adult with needs for community care services could be less clear. For example, it may be difficult to distinguish if the mental ill health of the carer is due to their caring role or not, but it is apparent that a certain type of support will help the carer's mental health. In this circumstance, the local authority must decide for itself which eligibility criteria framework to use and do so quickly so that timely support is provided.

ANNEX C

Short Breaks –definition by Shared Care Scotland

Definition

1. A short break is any form of service or assistance which enables the carer(s) to have periods away from their caring routines or responsibilities.

Purpose

2. The purpose is to support the caring relationship and promote the health and well-being of the carer, the supported person, and other family members affected by the caring situation.

Description

3. Breaks from caring may:
    - be for short or extended periods
    - take place during the day or overnight
    - involve the person with support needs having a break away from home allowing the carer time for themselves
    - allow the carer a break away with replacement care, if required, in place
    - take the form of the carer and the person they care for having a break together, with assistance if necessary, providing a break from the demands of their daily caring routines

Rationale

4. Due to the intensity of their caring role, carers are often only able to get the rest and relaxation which are essential to their health, well-being and continuing capacity to care with the help of a short break, including replacement care if appropriate.

Provisos

5. Services or assistance enabling carers to be in employment are not a 'respite' break because the right to work is a universal human right. Such services or assistance are vital to many carers, but in addition carers, like any employed person, have a right to time for themselves for rest, leisure and to pursue wider interests. Equally however, such services or assistance are a form of replacement care to enable the carer to work rather than to have a short break.

6. Cover for carers when they are unwell should be deemed as an emergency break. Again, this cover or services and assistance is a form of replacement care but not to enable the carer to have a short break.

Choice and Flexibility

7. Whichever form the break takes, choice, flexibility and personalisation are key to achieving successful outcomes all round with the needs of everyone in the caring relationship carefully considered and balanced.

Planning

8. Carers and those they care for should be offered assistance to weigh up the different options and to plan ahead for their breaks. This will help them feel more confident about the service or support being provided, to make

necessary arrangements and have time to plan what they want to do to make the most of their break.

Examples

9. In order to meet these different needs a diverse range of short break opportunities should be available locally. These could include:
    - a choice of specialist services such as:
        - hospice care
        - residential accommodation with nursing or personal care support
    - generic or condition specific short break services
    - community flats with care support
    - building-based day centre provision
    - services which offer breaks in the home of another individual or family
    - breaks at home through the day or overnight provided through a care at home service
    - a range of accessible and inclusive community-based activities and groups
    - holiday breaks using mainstream or specialist holiday providers, with or without the carer
    - specialist play schemes and after school clubs
    - befriending schemes where volunteers help facilitate the short breaks
    - peer support groups

Self-directed support

10. The further expansion of self-directed support will allow carers and supported people to explore a range of different short break options tailored to their personal outcomes and to purchase equipment to enable a short break to take place. For example, they may use their agreed budget to:
    - employ a personal assistant to accompany the supported person on leisure breaks, with or without the carer
    - hire or purchase equipment that helps facilitate breaks for the carer, the supported person or both
    - receive time flexible vouchers that can be exchanged for assistance from registered care providers/agencies
    - purchase membership of leisure facilities

Emergency Breaks

11. It is also important for people to have access to emergency support if they need replacement care at short notice, due to the unexpected ill health of the carer; deterioration in the health of the person they are looking after; or in response to a crisis such as bereavement.

12. Emergency services may need to be available at short notice, with the duration unknown, but limited.

13. To minimise the levels of stress that can be generated by these events, an emergency plan should be prepared in advance that includes any options for emergency respite cover. This will be particularly important for any carers that are at increased risk due to their own health or caring circumstances.

Annex D

Carer identification

1. Carer identification can be carried out by, amongst others:
    - health and social care and children's services professionals when carrying out assessments with cared-for persons.
    - health and social care professionals during anticipatory care planning;
    - health and social care professionals in hospital settings;
    - district nurse teams;
    - occupational therapists;
    - community care assistants;
    - GP Link Workers;
    - guidance and teaching staff in schools and staff in colleges and universities;
    - providers of care and support services;
    - housing staff;
    - third sector and independent organisations;
    - employers (including those who are *Carer Positive);*[143]
    - multilingual groups; and
    - outreach with gypsy traveller communities and by those working with Black and Minority Ethnic (BME) communities;

2. The potential barriers to carer identification include:
    - identifying with the term 'carer' – both because of confusion with care workers being referred to as carers and because they see themselves primarily as a 'mother', 'daughter' etc
    - the view that caring is a legitimate domain of family responsibility;
    - resisting access to support in order to protect a person's identity;
    - pride in self-sufficiency and a sense of shame in asking for, or being offered, support;
    - lack of family contact with social work departments;
    - fear of societal stigma if caring for someone with substance misuse or mental ill health;
    - self-management by people with long-term conditions but the caring role becomes more intense over time as people's health deteriorates;
    - with respect to young carers, fear of family break-up or being treated differently to friends who are not carers since young people like a group identity;

[143] Carer Positive is the Scottish Government's accreditation scheme which recognises employers who support carers in the workplace. It is operated by Carers Scotland on behalf of the Scottish Government.
http://www.carerpositive.org/

- language barriers and lack of translation services, for example, there is no word for ‘carer’ in Punjabi and Urdu;
- lack of training with some GPs and other healthcare professionals;
- a need to fully consider the personal outcomes of the carer in the family dynamic; and
- the visibility of services to support carers in some ‘hard-to–reach’ communities, such as in rural and remote areas and in BME communities

3. Examples of good practice in identifying carers include:
    - link workers in GP and hospital settings;
    - employers with carer registers and websites on carers in employment
    - sensitive young carer identification in schools via awareness raising, small group exercises and teacher training and continuous professional development with links to Getting it Right for Every Child
    - carer awareness raising in colleges and universities via carer campaigns and carer policies
    - local publicity and communications
    - training of health and social care professionals.

Clackmannanshire & Stirling
Integration Joint Board

13 June 2018

This report relates to
Item 12 on the agenda

Health and Social Care Standards: My Support, My Life

For Noting

Approved for Submission by	Shiona Strachan, Chief Officer
Author	Janice Young, Acting Service Manager, Clackmannanshire Council
Date:	13 June 2018
List of Background Papers / Appendices:	
Appendix 1 – Health and Social Care Standards: My Support, My Life http://www.gov.scot/Resource/0052/00520693.pdf	

Title/Subject: **Health and Social Care Standards: My Support, My Life**

Meeting: **Clackmannanshire & Stirling Integration Joint Board**

Date: **13 June 2018**

Submitted By: **Janice Young, Acting Service Manager**

Action: **For Noting**

1. Introduction

1.1. The purpose of this report is to provide the Integration Joint Board with information on the publication of the new Health and Social Care Standards which replace the previous National Care Standards. This is a document which outlines the care and support expectations of users of all health and social care services in Scotland and from the 1 April 2018, has become the tool from which both the Care Inspectorate and Healthcare Improvement Scotland will inspect services.

2. Recommendations

The Integration Joint Board is asked to:

2.1. Note the publication of the Health and Social Care Standards and the impact these will have in services provided across the Partnership.

3. Background

3.1 Previously, the Care Inspectorate regulated all registered social care services under a suite of 23 separate National Care Standards dependent on the type of service being provided. These Standards have been revised, and rationalised into a single document, the Health and Social Care Standards: My Support, My Life (the Standards), and will be used by both the Care Inspectorate and Healthcare Improvement Scotland when inspecting all health and care services from April 2018.

3.2 The standards and outcomes set out in the Standards are published in exercise of the Scottish Ministers' powers under section 50 of the Public Services Reform (Scotland) Act 2010 and National Health Service (Scotland) Act 1978. They do not replace outcomes already published in section 10H of the National Health Service (Scotland) Act 1978.

3.3 The Standards (Appendix 1) are designed for everyone who uses a health or care service to ensure that the same high quality of care experience is available to all people in Scotland. They will be used by the scrutiny bodies to guide inspection activity and to support services in making improvements.

4. What the Standards Say

4.1 The objectives of the Standards are to support and guide improvement across the health and social care sector in Scotland and have 5 key principles: dignity and respect, compassion, be included, responsive care and support and wellbeing. These principles reflect how people should feel about the service they receive, and underpin a further set of 5 Standards.

4.2 The Standards are:

4.2.1 I experience high quality care and support that is right for me.
4.2.1 I am fully involved in all decisions about my care and support.
4.2.3 I have confidence in the people who support and care for me.
4.2.4 I have confidence in the organisation providing my care and support.
4.2.5 I experience a high quality environment if the organisation provides the premises.

4.3 These Standard statements are then supported with a suite of outcomes on how they should be met and have been built on a human rights approach which is person-led, and not guided by care settings.

5. Implementation of the Standards

5.1 In the Partnership, the Standards have been recognised as an important tool for services to implement, and that this is a major change to how services are regulated and inspected.

5.2 With this in mind, awareness to all commissioned services has been promoted via Provider Forums over the past few months, to ensure that organisations are familiar with them.

5.3 The Partnership has also promoted the Standards internally through Big Team Meetings with staff, inviting Healthcare Improvement Scotland and the Care Inspectorate to meet with teams and explain the implications of the Standards. This offer has also been made available to commissioned services.

5.4 Sessions involving service users and unpaid carers have taken place with commissioned services, which have been looking at innovative ways of introducing the Standards to people through group and social activities.

5.5 It is noted that the publication of the Standards coincides with a shift in approach from regulatory bodies to one of improvement rather than scrutiny. This will assist services in embedding a culture of continuous improvement.

6. Conclusion

6.1. The introduction of the new Health and Social Care Standards is welcomed by the Health and Social Care Partnership as it seeks to work with both internal

and external providers of care and support to innovatively provide services which are both person-led and outcome focussed.

7. Resource Implications

7.1. None.

8. Impact on Strategic Plan Priorities and Outcomes

8.1. The objectives of the Standards are consistent with the vision and priorities of the Strategic Plan and the National Health and Well-being Outcomes.

9. Legal & Risk Implications

9.1. The Partnership requires to comply with the Standards for all regulated and inspected health and care services.

10. Consultation

10.1 The Standards were widely consulted on by Scottish Government bodies.

11. Equality and Human Rights Impact Assessment

11.1. Not applicable – adheres to Scottish Government publication.

12. Data Protection Impact Assessment

12.1 The contents of this report do not require a DPIA.

13. Exempt reports

13.1. Not exempt.

Health and Social Care Standards
My support, my life.

Health and Social Care Standards

My support, my life

Scottish Government
Riaghaltas na h-Alba
gov.scot

I am delighted to be able to introduce the new Health and Social Care Standards and commend all of the hard work that has gone into creating these new, human rights based Standards.

The new Standards are wide reaching, flexible and focussed on the experience of people using services and supporting their outcomes. One of the major changes to these Standards is that they will now be applicable to the NHS, as well as services registered with the Care Inspectorate and Healthcare Improvement Scotland.

Everyone is entitled to high quality care and support tailored towards their particular needs and choices. This might be in a hospital; a care home; a children's nursery; or within their own home. Each and every one of us at some point in our lives will use or know someone who uses a health or social care service. These Standards are therefore hugely important to ensure that everyone in Scotland receives the care and support that is right for them.

I would like to thank everyone across the health and social care sectors involved in creating these Standards. You have worked hard to make them innovative and aspirational. Contributions from professional bodies, people who use services, service providers, private and third sector organisations, have created Standards that are applicable to a wide range of health and social care services.

Moving forward, there is still work to be done to ensure that the Standards are implemented successfully. We will support health and care providers, commissioners of services and inspection agencies to ensure a full understanding of what is required to meet the Standards and improve levels of care and support in Scotland.

Shona Robison MSP
Cabinet Secretary for Health and Sport

Introduction

These Health and Social Care Standards (the Standards) set out what we should expect when using health, social care or social work services in Scotland. They seek to provide better outcomes for everyone; to ensure that individuals are treated with respect and dignity, and that the basic human rights we are all entitled to are upheld.

The objectives of the Standards are to drive improvement, promote flexibility and encourage innovation in how people are cared for and supported. All services and support organisations, whether registered or not, should use the Standards as a guideline for how to achieve high quality care.

Why have these Standards been developed?

The standards and outcomes set out in the Standards are published in exercise of the Scottish Ministers' powers under section 50 of the Public Services Reform (Scotland) Act 2010 and section 10H of the National Health Service (Scotland) Act 1978. They do not replace previous standards and outcomes relating to healthcare that have already been produced under section 10H of the National Health Service (Scotland) Act 1978 but they will replace the National Care Standards, published in 2002 under section 5 of the Regulation of Care (Scotland) Act 2001.

From 1 April 2018 the Standards will be taken into account by the Care Inspectorate, Healthcare Improvement Scotland and other scrutiny bodies in relation to inspections, and registration, of health and care services.

What are the Standards?

Throughout this document, 'standards' is used as a collective term to describe both the headline outcomes, and the descriptive statements which set out the standard of care a person can expect. The headline outcomes are:

1: I experience high quality care and support that is right for me.
2: I am fully involved in all decisions about my care and support.
3: I have confidence in the people who support and care for me.
4: I have confidence in the organisation providing my care and support.
5: I experience a high quality environment if the organisation provides the premises.

The descriptive statements, set out after each headline outcome, explain what achieving the outcome looks like in practice. Not every descriptor will apply to every service.

The Standards are underpinned by five principles: dignity and respect, compassion, be included, responsive care, and support and wellbeing. The principles themselves are not standards or outcomes but rather reflect the way that everyone should expect to be treated.

Who are these Standards for?

The Standards are for everyone. Irrespective of age or ability, we are all entitled to the same high quality care and support. The Care Inspectorate and Healthcare Improvement Scotland will take into account the Standards when carrying out their inspections and quality assurance functions, and when making decisions about care and health services which are, or are applying to be, registered. Our aim is that non-registered services also use the Standards as a guideline for how to achieve high quality care. The Standards can be applied to a diverse range of services from child-minding and daycare for children in their early years, housing support and care at home for adults, to hospitals, clinics and care homes.

The Standards do not replace or remove the need to comply with legislation which sets out requirements for the provision of services. Health and care services will continue to follow existing legislative requirements and best practice guidance which apply to their particular service or sector, in addition to applying the Standards. The Standards should be used to complement the relevant legislation and best practice that support health and care services to ensure high quality care and continuous improvement. Current best practice guidance can be found on the Care Inspectorate and Healthcare Improvement Scotland websites.

Principles

Dignity and respect

- My human rights are respected and promoted.
- I am respected and treated with dignity as an individual.
- I am treated fairly and do not experience discrimination.
- My privacy is respected.

Compassion

- I experience warm, compassionate and nurturing care and support.
- My care is provided by people who understand and are sensitive to my needs and my wishes.

Be included

- I receive the right information, at the right time and in a way that I can understand.
- I am supported to make informed choices, so that I can control my care and support.
- I am included in wider decisions about the way the service is provided, and my suggestions, feedback and concerns are considered.
- I am supported to participate fully and actively in my community.

Responsive care and support

- My health and social care needs are assessed and reviewed to ensure I receive the right support and care at the right time.
- My care and support adapts when my needs, choices and decisions change.
- I experience consistency in who provides my care and support and in how it is provided.
- If I make a complaint it is acted on.

Wellbeing

- I am asked about my lifestyle preferences and aspirations and I am supported to achieve these.
- I am encouraged and helped to achieve my full potential.
- I am supported to make informed choices, even if this means I might be taking personal risks.
- I feel safe and I am protected from neglect, abuse or avoidable harm.

1: I experience high quality care and support that is right for me

Dignity and respect

1.1 I am accepted and valued whatever my needs, ability, gender, age, faith, mental health status, race, background or sexual orientation.

1.2 My human rights are protected and promoted and I experience no discrimination.

1.3 If my independence, control and choice are restricted, this complies with relevant legislation and any restrictions are justified, kept to a minimum and carried out sensitively.

1.4 If I require intimate personal care, this is carried out in a dignified way, with my privacy and personal preferences respected.

1.5 If I am supported and cared for in the community, this is done discreetly and with respect.

Compassion

1.6 I get the most out of life because the people and organisation who support and care for me have an enabling attitude and believe in my potential.

1.7 I am supported to discuss significant changes in my life, including death or dying, and this is handled sensitively.

1.8 If I experience care and support in a group, the overall size and composition of that group is right for me.

Be included

1.9 I am recognised as an expert in my own experiences, needs and wishes.

1.10 I am supported to participate fully as a citizen in my local community in the way that I want.

1.11 I can be with my peers, including other people who use my service, unless this is unsafe and I have been involved in reaching this decision.

Responsive care and support

Assessing my care and support needs

1.12 I am fully involved in assessing my emotional, psychological, social and physical needs at an early stage, regularly and when my needs change.

1.13 I am assessed by a qualified person, who involves other people and professionals as required.

1.14 My future care and support needs are anticipated as part of my assessment.

1.15 My personal plan (sometimes referred to as a care plan) is right for me because it sets out how my needs will be met, as well as my wishes and choices.

1.16 As a child or young person needing permanent alternative care, I experience this without unnecessary delay.

Choosing my care and support

1.17 I can choose from as wide a range of services and providers as possible, which have been planned, commissioned and procured to meet my needs.

1.18 I have time and any necessary assistance to understand the planned care, support, therapy or intervention I will receive, including any costs, before deciding what is right for me.

Experiencing my care and support

1.19 My care and support meets my needs and is right for me.

1.20 I am in the right place to experience the care and support I need and want.

1.21 I am enabled to live in my own home if I want this and it is possible.

1.22 I can be independent and have more control of my own health and wellbeing by using technology and other specialist equipment.

1.23 My needs, as agreed in my personal plan, are fully met, and my wishes and choices are respected.

1.24 Any treatment or intervention that I experience is safe and effective.

Wellbeing

1.25 I can choose to have an active life and participate in a range of recreational, social, creative, physical and learning activities every day, both indoors and outdoors.

1.26 I can choose to spend time alone.

1.27 I am supported to achieve my potential in education and employment if this is right for me.

1.28 I am supported to make informed lifestyle choices affecting my health and wellbeing, and I am helped to use relevant screening and healthcare services.

1.29 I am supported to be emotionally resilient, have a strong sense of my own identity and wellbeing, and address any experiences of trauma or neglect.

1.30 As a child, I have fun as I develop my skills in understanding, thinking, investigation and problem solving, including through imaginative play and storytelling.

1.31 As a child, my social and physical skills, confidence, self-esteem and creativity are developed through a balance of organised and freely chosen extended play, including using open ended and natural materials.

1.32 As a child, I play outdoors every day and regularly explore a natural environment.

Eating and drinking

1.33 I can choose suitably presented and healthy meals and snacks, including fresh fruit and vegetables, and participate in menu planning.

1.34 If I need help with eating and drinking, this is carried out in a dignified way and my personal preferences are respected.

1.35 I can enjoy unhurried snack and meal times in as relaxed an atmosphere as possible.

1.36 If I wish, I can share snacks and meals alongside other people using and working in the service if appropriate.

1.37 My meals and snacks meet my cultural and dietary needs, beliefs and preferences.

1.38 If appropriate, I can choose to make my own meals, snacks and drinks, with support if I need it, and can choose to grow, cook and eat my own food where possible.

1.39 I can drink fresh water at all times.

2: I am fully involved in all decisions about my care and support

Dignity and respect

2.1 I can control my own care and support if this is what I want.

2.2 I am empowered and enabled to be as independent and as in control of my life as I want and can be.

2.3 I am supported to understand and uphold my rights.

2.4 I am supported to use independent advocacy if I want or need this.

2.5 If I need help managing my money and personal affairs, I am able to have as much control as possible and my interests are safeguarded.

2.6 I am as involved as I can be in agreeing and reviewing any restrictions to my independence, control and choice.

2.7 My rights are protected by ensuring that any surveillance or monitoring device that I or the organisation use is necessary and proportionate, and I am involved in deciding how it is used.

Compassion

2.8 I am supported to communicate in a way that is right for me, at my own pace, by people who are sensitive to me and my needs.

Be included

2.9 I receive and understand information and advice in a format or language that is right for me.

2.10 I can access translation services and communication tools where necessary and I am supported to use these.

2.11 My views will always be sought and my choices respected, including when I have reduced capacity to fully make my own decisions.

2.12 If I am unable to make my own decisions at any time, the views of those who know my wishes, such as my carer, independent advocate, formal or informal representative, are sought and taken into account.

2.13 If a decision is taken against my wishes, I am supported to understand why.

2.14 I am fully informed about what information is shared with others about me.

2.15 I am enabled to resolve conflict, agree rules and build positive relationships with other people as much as I can.

2.16 If I am fostered, my foster family is supported to fully include me in family life.

Responsive care and support

2.17 I am fully involved in developing and reviewing my personal plan, which is always available to me.

2.18 I am supported to manage my relationships with my family, friends or partner in a way that suits my wellbeing.

2.19 I am encouraged and supported to make and keep friendships, including with people my own age.

2.20 If I need or want to move on and start using another service, I will be fully involved in this decision and properly supported throughout this change.

Wellbeing

2.21 I take part in daily routines, such as setting up activities and mealtimes, if this is what I want.

2.22 I can maintain and develop my interests, activities and what matters to me in the way that I like.

2.23 If I need help with medication, I am able to have as much control as possible.

2.24 I make informed choices and decisions about the risks I take in my daily life and am encouraged to take positive risks which enhance the quality of my life.

2.25 I am helped to understand the impact and consequences of risky and unsafe behaviour and decisions.

2.26 I know how different organisations can support my health and wellbeing and I am helped to contact them if I wish.

2.27 As a child, I can direct my own play and activities in the way that I choose, and freely access a wide range of experiences and resources suitable for my age and stage, which stimulate my natural curiosity, learning and creativity.

3: I have confidence in the people who support and care for me

Dignity and respect

3.1 I experience people speaking and listening to me in a way that is courteous and respectful, with my care and support being the main focus of people's attention.

3.2 If I experience care and support where I live, people respect this as my home.

3.3 I have agreed clear expectations with people about how we behave towards each other, and these are respected.

3.4 I am confident that the right people are fully informed about my past, including my health and care experience, and any impact this has on me.

3.5 As a child or young person, I am helped to develop a positive view of myself and to form and sustain trusting and secure relationships.

Compassion

3.6 I feel at ease because I am greeted warmly by people and they introduce themselves.

3.7 I experience a warm atmosphere because people have good working relationships.

3.8 I can build a trusting relationship with the person supporting and caring for me in a way that we both feel comfortable with.

3.9 I experience warmth, kindness and compassion in how I am supported and cared for, including physical comfort when appropriate for me and the person supporting and caring for me.

3.10 As a child or young person I feel valued, loved and secure.

Be included

3.11 I know who provides my care and support on a day to day basis and what they are expected to do. If possible, I can have a say on who provides my care and support.

3.12 I can understand the people who support and care for me when they communicate with me.

3.13 I am treated as an individual by people who respect my needs, choices and wishes, and anyone making a decision about my future care and support knows me.

Responsive care and support

3.14 I have confidence in people because they are trained, competent and skilled, are able to reflect on their practice and follow their professional and organisational codes.

3.15 My needs are met by the right number of people.

3.16 People have time to support and care for me and to speak with me.

3.17 I am confident that people respond promptly, including when I ask for help.

3.18 I am supported and cared for sensitively by people who anticipate issues and are aware of and plan for any known vulnerability or frailty.

3.19 My care and support is consistent and stable because people work together well.

Wellbeing

3.20 I am protected from harm, neglect, abuse, bullying and exploitation by people who have a clear understanding of their responsibilities.

3.21 I am protected from harm because people are alert and respond to signs of significant deterioration in my health and wellbeing, that I may be unhappy or may be at risk of harm.

3.22 I am listened to and taken seriously if I have a concern about the protection and safety of myself or others, with appropriate assessments and referrals made.

3.23 If I go missing, people take urgent action, including looking for me and liaising with the police, other agencies and people who are important to me.

3.24 If I might harm myself or others, I know that people have a duty to protect me and others, which may involve contacting relevant agencies.

3.25 I am helped to feel safe and secure in my local community.

4: I have confidence in the organisation providing my care and support

Dignity and respect

4.1 My human rights are central to the organisations that support and care for me.

4.2 The organisations that support and care for me help tackle health and social inequalities.

Compassion

4.3 I experience care and support where all people are respected and valued.

4.4 I receive an apology if things go wrong with my care and support or my human rights are not respected, and the organisation takes responsibility for its actions.

Be included

4.5 If possible, I can visit services and meet the people who would provide my care and support before deciding if it is right for me.

4.6 I can be meaningfully involved in how the organisations that support and care for me work and develop.

4.7 I am actively encouraged to be involved in improving the service I use, in a spirit of genuine partnership.

4.8 I am supported to give regular feedback on how I experience my care and support and the organisation uses learning from this to improve.

4.9 I can take part in recruiting and training people if possible.

4.10 As a child or young person unable to live with my immediate family, I can live with wider family members alongside my brothers and sisters if I want this and where it is possible and safe.

Responsive care and support

4.11 I experience high quality care and support based on relevant evidence, guidance and best practice.

4.12 I receive proper notice and I am involved in finding an alternative if the service I use plans to close or can no longer meet my needs and wishes.

4.13 I have enough time and support to plan any move to a new service.

4.14 My care and support is provided in a planned and safe way, including if there is an emergency or unexpected event.

4.15 I experience stability in my care and support from people who know my needs, choices and wishes, even if there are changes in the service or organisation.

4.16 I am supported and cared for by people I know so that I experience consistency and continuity.

4.17 If I am supported and cared for by a team or more than one organisation, this is well co-ordinated so that I experience consistency and continuity.

4.18 I benefit from different organisations working together and sharing information about me promptly where appropriate, and I understand how my privacy and confidentiality are respected.

4.19 I benefit from a culture of continuous improvement, with the organisation having robust and transparent quality assurance processes.

4.20 I know how, and can be helped, to make a complaint or raise a concern about my care and support.

4.21 If I have a concern or complaint, this will be discussed with me and acted on without negative consequences for me.

4.22 If the care and support that I need is not available or delayed, people explain the reasons for this and help me to find a suitable alternative.

Wellbeing

4.23 I use a service and organisation that are well led and managed.

4.24 I am confident that people who support and care for me have been appropriately and safely recruited.

4.25 I am confident that people are encouraged to be innovative in the way they support and care for me.

4.26 If I have a carer, their needs are assessed and support provided.

4.27 I experience high quality care and support because people have the necessary information and resources.

5: I experience a high quality environment if the organisation provides the premises

Dignity and respect

5.1 I can use an appropriate mix of private and communal areas, including accessible outdoor space, because the premises have been designed or adapted for high quality care and support.

5.2 I can easily access a toilet from the rooms I use and can use this when I need to.

5.3 I have an accessible, secure place to keep my belongings.

5.4 If I require intimate personal care, there is a suitable area for this, including a sink if needed.

Compassion

5.5 I experience a service that is the right size for me.

5.6 If I experience care and support in a group, I experience a homely environment and can use a comfortable area with soft furnishings to relax.

5.7 If I live in a care home the premises are designed and organised so that I can experience small group living, including access to a kitchen, where possible.

Be included

5.8 I experience a service as near as possible to people who are important to me and my home area if I want this and if it is safe.

5.9 I experience care and support free from isolation because the location and type of premises enable me to be an active member of the local community if this is appropriate.

5.10 If I experience 24 hour care, I am connected, including access to a telephone, radio, TV and the internet.

5.11 I can independently access the parts of the premises I use and the environment has been designed to promote this.

5.12 If I live in a care home, I can control the lighting, ventilation, heating and security of my bedroom.

5.13 If I live in a care home, I can decide on the decoration, furnishing and layout of my bedroom, including bringing my own furniture and fittings where possible.

5.14 If I live in a care home and there are separate facilities for people who support and care for me, these are in keeping with the homely environment.

5.15 If I am an adult living in a care home I can choose to see visitors in private and plan for a friend, family member or my partner to sometimes stay over.

Responsive care and support

5.16 The premises have been adapted, equipped and furnished to meet my needs and wishes.

Wellbeing

5.17 My environment is secure and safe.

5.18 My environment is relaxed, welcoming, peaceful and free from avoidable and intrusive noise and smells.

5.19 My environment has plenty of natural light and fresh air, and the lighting, ventilation and heating can be adjusted to meet my needs and wishes.

5.20 I have enough physical space to meet my needs and wishes.

5.21 I am able to access a range of good quality equipment and furnishings to meet my needs, wishes and choices.

5.22 I experience an environment that is well looked after with clean, tidy and well maintained premises, furnishings and equipment.

5.23 If I live in a care home, I can use a private garden.

5.24 If I live in a care home and want to keep a pet, the service will try to support this to happen.

5.25 As a child or young person living in a care home, I might need or want to share my bedroom with someone else and I am involved in this decision.

5.26 As an adult living in a care home, I have my own bedroom that meets my needs but can choose to live with and share a bedroom with my partner, relative or close friend.

5.27 As an adult living in a care home, I have enough space for me to sit comfortably with a visitor in my bedroom.

5.28 As an adult living in a care home, I have ensuite facilities with a shower and can choose to use a bath if I want. If I live in a small care home that has not been purpose built, I might need to share a bathroom with other people.

Glossary

Below is a list of terms and phrases commonly used across health, social work and social care sectors, along with a description of how these apply for the purposes of the Standards.

Term	Description
24 hour care	Where people are cared for and supported throughout the day and night.
advocacy/advocate	Independent advocacy ensures that people know and better understand their rights, their situation and systems. Independent advocates help people to speak up for themselves and speak for those who need it. An independent advocate is someone who helps build confidence and empowers people to assert themselves and express their needs, wishes and desires. Collective advocacy happens when groups of people with a shared agenda, identity or experience come together to influence legislation, policy or services.
assessment	A health, social work or social care assessment will find out what help and support a person needs, such as healthcare, medication, advocacy, equipment, care at home, housing support or a care home.
capacity	Capacity refers to an individual's ability to make decisions about their care and support. This may change over time and may be different in particular aspects of their life. For people who have been medically assessed as having incapacity there is legislation to protect them.
care home	A care service providing 24 hour care and support with premises, usually as someone's permanent home. See also 'small care home' below.
care plan	See 'personal plan' below.
carer	A carer is someone of any age who looks after or supports a family member, partner, friend or neighbour in need of help because they are ill, frail, have a disability or are vulnerable in some way. A carer does not have to live with the person being cared for and will be unpaid.
child	Although legal definitions vary, for these Standards a child is aged 0 to 16 years.
communal areas	An area in a care service such as a living or dining room, activity room, hairdresser, library, café, garden or quiet area that everyone can use.

Term	Description
communication tools	These help people to communicate in a range of ways. For example, visual prompts, talking mats (system of simple picture symbols) or mobile phone apps.
confidentiality	This means that information that is kept about someone by an organisation will not be shared with anyone else unless the person gives their consent for it to be shared. Confidentiality may only be broken if it avoids or reduces the risk of harm to a person.
creativity	Includes artistic activities, such as arts, crafts, music, drama and dance.
emergency or unexpected event	This is an incident or emergency that could require immediate action, such as the premises being evacuated.
emotionally resilient	Someone's ability to cope with, or adapt to, stressful situations or crises.
evidence, guidance and best practice	Written guidelines for agreed ways to provide care, support or carry out treatment. Often these are put together by professionals based on the best available evidence at the time. These guidelines often change so that they remain up to date.
human rights	Human rights are based on the principle of respect for the individual and they are the rights and freedoms that belong to every person, at every age. They are set out in international human rights treaties and are enshrined in UK law by the Human Rights Act 1998.
intimate personal care	This relates to activities which most people usually carry out for themselves, such as washing, brushing teeth, going to the toilet, dressing or eating.
open ended materials	Open ended materials (also called loose parts) are play materials that can be used in numerous ways indoors and outdoors by children. They can be moved, carried, combined and redesigned in any way the child decides.
permanent alternative care	Care provided to children to ensure they have stable, secure, nurturing relationships, normally within a family setting, that continues to adulthood.
personal plan	A plan of how care and support will be provided, as agreed in writing between an individual and the service provider. The plan will set out how an individual's assessed needs will be met, as well as their wishes and choices.
planned care	The term used to describe care, support or treatment which is carried out as detailed in someone's personal plan (see above).

Term	Description
positive risks	Positive risks means making balanced decisions about risks; it is the taking of calculated and reasoned risks, which recognises that there are benefits as well as potential harm from taking risks in day to day life.
premises	When an organisation providing care and support also provides premises, such as a nursery, hospital or care home. It does not apply when someone using a service is responsible for the premises, including housing support or care at home.
professional and organisational codes	These codes set out standards of conduct and competence, as well as the personal values, which people working and volunteering in health and care services are expected to follow.
representative	This may include someone appointed to have power of attorney, a guardian, family member, friend, neighbour or an agreed person who can speak on the individual's behalf. A representative may be formal or not formal.
restrictions to my independence, control and choice	Involves any restriction to independent movement or freedom of choice, such as a physical barrier. In some exceptional circumstances, this could involve searches and physical or chemical restraint. If physical detention, restraint or searching is used, the individual concerned will usually be subject to a formal legal order authorising this.
small care home	A care home for 6 people or less.
small group living	Small groups, usually numbering fewer than ten people, provided with their own lounge and dining facilities for their own group use in a homely environment. Small group living sometimes takes place within a larger care service such as a care home or hospital.
technology and other specialist equipment	Specialised equipment that helps people in their day to day life, such as telecare, telehealth or telemedicine, alarm call system, remote support and advice or mobility aids.
therapy	A specialised treatment or intervention, such as physiotherapy, occupational therapy, speech and language therapy, counselling and talking therapies.
young person	For these Standards, a young person is aged 16 to 21 years. And anyone over 21 will also be a young person for these Standards while they are being provided with continuing care by a local authority if they have been looked after by the local authority between the ages of 16 and 19.

© Crown copyright 2017

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit **nationalarchives.gov.uk/doc/open-government-licence/version/3** or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: **psi@nationalarchives.gsi.gov.uk**.

Where we have identified any third party copyright information you will need to obtain permission from the copyright holders concerned.

This publication is available at **www.gov.scot**

Any enquiries regarding this publication should be sent to us at
The Scottish Government
St Andrew's House
Edinburgh
EH1 3DG

ISBN: 978-1-78851-015-8

Published by The Scottish Government, June 2017

Produced for The Scottish Government by APS Group Scotland, 21 Tennant Street, Edinburgh EH6 5NA
PPDAS265732 (06/17)

Clackmannanshire & Stirling
Integration Joint Board

13 June 2018

This report relates to
13 on the agenda

Doune Health Centre
New Build
Full Business Case

For Noting

Approved for Submission by	Shiona Strachan, Chief Officer
Author	Morag Farquhar, Programme Director NHS FV
Date:	31 May 2018
List of Background Papers / Appendices:	
Doune Health Centre Proposed New Build presented at meeting 26 January 2016	

Title/Subject: **DOUNE HEALTH CENTRE NEW BUILD, FULL BUSINESS CASE**

Meeting: **Clackmannanshire & Stirling Integration Joint Board**

Date: **13 June 2018**

Submitted By: **Morag Farquhar, NHS Forth Valley**

Action: **For Noting**

1. Introduction

1.1. The purpose of this paper is to provide the Integration Joint Board with an update on the progress and governance of this development, relative to the provision of a replacement health centre in Doune and advise of the current position and next steps

2. Recommendations

2.1. The Integration Joint Board is asked to note the progress to date in preparation of the Full Business Case for the new Doune Health Centre; its submission to Scottish Government Capital Investment Group and its subsequent approval by them at their meeting on 22 May 2018.

3. Background

3.1. This investment in Doune is an important element of a larger programme of work to design and deliver healthcare services fit for the future consistent with NHS Forth Valley's Healthcare Strategy. Investment in facilities in Doune has been identified as a priority.

3.2. The project is being procured through NHS allocated capital and delivered via the hub initiative with Hub East Central Scotland Limited (hubco).

3.3. The project is subject to the NHS Scotland Scottish Capital Investment Manual and is following the business case route as advised by the Scottish Government Health & Social Care Directorates' Capital Investment Group. The Outline Business Case for the new Doune Health Centre was approved by the NHS Board in January 2016 and was submitted to the Scottish Government Health & Social Care Directorates Capital Investment Group thereafter. The Outline Business Case was also considered by the IJB at the meeting held on 26 January 2016. Subsequent to that, there has been ongoing development of the Outline Business Case in line with feedback from the Capital Investment Group over a protracted period until its re-submission in November 2017, which was followed by the approval of Outline Business Case in December 2017 with permission granted to proceed to Full Business Case.

3.4. In terms of timescale, consideration of the Full Business Case by the Capital Investment Group at their meeting on 22 May 2018 was achieved, which with approval following, will allow for Financial Close to be reached soon facilitating a start on site in the Summer of 2018, with completion of construction in Spring 2019.

4. Main Body Of The Report

4.1. Since approval of the Outline Business Case in December 2017, work has continued on the design and specification of the new building, in liaison with Hub East Central Scotland and Stage 2 of the hub process completed, aligned to the development of the Full Business Case. The procurement of the project is NHS Forth Valley capital (from the formula allocation) and implementation via a hub Design & Build Development Agreement.

4.2. Full Planning Permission was obtained in December 2017 and the Building Warrant application was submitted to Stirling Council in early March 2018.

4.3. The Full Business Case was approved by the Capital Investment Group on 22 May, this will now allow Financial Close to be reached soon and a start on site achieved in the summer, with completion of construction in spring of 2019. There are some risks associated with this i.e. obtaining Building Warrant approval and completion of the Design & Build Development Agreement contract, all in line with the programme.

4.4. It was with the programme in mind that a paper was submitted to the NHS Board and considered at their meeting in March 2018. Delegated authority was given to the Performance & Resources Committee to approve the Full Business Case on behalf of NHS Forth Valley for submission to the Capital Investment Group.

4.5. The governance structure of the project has been reviewed since the Outline Business Case and the detail is included in the Full Business Case. The Steering Group has been established and engaged in the development of the Full Business Case.

4.6. Of note is that agreement in principle has been reached with the Rural Stirling Housing Association, who are developing housing nearby, for them/their tenants to utilise the road into the health centre and through to their site. This benefits the Housing Association in facilitating their Planning Permission but also NHS Forth Valley in terms of a capital contribution to the construction of the access road and its ongoing maintenance. This is not reflected in the Full Business Case as yet, as confirmation of the ‘heads of terms’ is awaited.

4.7. Also of note, are that two items of external ‘assurance’ have been actioned. The Value for Money Scorecard has been reviewed by the Scottish Futures Trust and the outcome and the final version of the Scorecard is included in the Full Business Case. The National Design Assessment Process Full Business Case stage has been undertaken and the outcome is with the Project Team/Hubco for review. The assessment has shown a ‘Supported’ status, there are several recommendations within the National Design Assessment

Process outcome which require to be assessed and resolved and it is anticipated that this can be done within the project budget.

5. Conclusions

5.1. Significant progress has been made with the proposed development of the new health centre in Doune, culminating in the most recent approval of the Full Business Case and permission to move to Financial Close of the Design and Build contract.

6. Resource Implications

6.1. Indicative capital and net additional revenue costs of £2.68m and £0.087m respectively have been identified in the Full Business Case document. This represents an increase in revenue costs of £0.016m (23%) compared to the estimated additional recurring revenue costs at Outline Business Case. It should be noted that NHS Forth Valley have provided for the additional revenue implications.

6.2. There are no workforce implications associated with the new health centre development, other than time input from the various governance and implementation groups.

7. Impact on Strategic Plan Priorities and Outcomes

7.1. The project reflects the focus in NHS Forth Valley's Healthcare Strategy away from the acute setting to primary and community care and is in line with the Board's Property & Asset Management Strategy (PAMS). There is considerable detail within the Full Business Case document in relation to the Strategic Case for the proposed development. The service scope of the project has not changed since Outline Business Case stage and much of the detail remains the same. The Full Business Case reflects the updated Scottish Capital Investment Manual format and where appropriate; facts and figures have also been updated from the Outline Business Case. By supporting and enabling the delivery of a wider range of health and social care services to the rural community of Doune, it also supports the Clackmannanshire and Stirling Health and Social Care Partnership Strategic Plan specifically the development of locality and place based services.

7.2. This report and associated recommendations, relates to the following Clackmannanshire & Stirling Health and Social Care Partnership local outcomes and Strategic Plan priorities (please select as appropriate):

Fit with Local Outcomes	
Self Management	☒
Community Focussed Supports	☒
Safety	☒
Decision Making	☒
Experience	☒

Fit with Our Priorities 'we will...'	
Further develop systems to enable front line staff to access and share information	☒
Support more co-location of staff from across professions and organisations	☒
Develop single care pathways	☒
Further develop anticipatory and planned care services	☒
Provide more single points of entry to services	☒
Deliver the Stirling Care Village	☐
Develop seven-day access to appropriate services	☐
Take further steps to reduce the number of unplanned admissions to hospital and acute services	☒

7.3. The new health centre will be adequately sized and functionally suitable, better facilitating the provision of current services and allowing the development of others.

8. Legal & Risk Implications

8.1. A project Risk Register has been utilised since inception of the project and detail included within an appendix to the Full Business Case. At this time, timely approval of the Building Warrant are risks which could impact on the project programme and potentially its costs. Successful closing out of the National Design Assessment Process is also a risk at this time, though assessed to be minimal.

9. Consultation

9.1. Consultation has taken place throughout the development of the project to date with key internal and external stakeholders. This has included: the GP Practice and others who will be providing services within the building; Estates & Facilities, Health & Safety, Finance, Community Services and other NHS Forth Valley Directorates; the local community e.g. Community Council; the Stirling Area Access Panel; Health Facilities Scotland; Architecture & Design Scotland. The Steering Group for the project has also inputted to the Full Business Case document, with comments received being incorporated into the draft.

The Integration Joint Board has supported the development of the new Health Centre, endorsing the Outline Business Case.

9.2. As a development that has been ongoing for some time, it is not considered necessary for the proposal to be ratified through the Regional Planning process.

10. Equality and Human Rights Impact Assessment

10.1. The contents of this report do not require an EQIA because the author can confirm that due regard has been given to the Equality Act 2010 and compliance with the three aims of the Equality Duty as part of the decision making process.

10.2. Further to an evaluation it is noted that: The paper is not relevant to Equality and Diversity.

11. Data Protection Impact Assessment

11.1. The contents of this report do not require a DPIA.

12. Exempt reports

12.1. None.

13. Appendices

13.1. None.