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A&B HSCP Transforming Together

Argyll & Bute Health & Social Care Partnership

13 September 2022

NOTICE OF MEETING

A meeting of the **ARGYLL AND BUTE HSCP INTEGRATION JOINT BOARD (IJB)** will be held **BY MICROSOFT TEAMS** on **WEDNESDAY, 21 SEPTEMBER 2022** at **1:00 PM**, which you are requested to attend.

BUSINESS

1. **APOLOGIES FOR ABSENCE**

2. **DECLARATIONS OF INTEREST (IF ANY)**

3. **MINUTES** (Pages 3 - 8)

   Argyll and Bute Integration Joint Board held on 24 August 2022

4. **MINUTES OF COMMITTEES**

   (a) Strategic Planning Group held on 8 September 2022 - to follow

   (b) Strategic Planning Group held on 8 September 2022 - Link to Argyll and Bute Community Directory

   https://abcd.scot

   (c) Audit and Risk Committee held on 13 September 2022 (Pages 9 - 12)

5. **CHIEF OFFICER'S REPORT** (Pages 13 - 18)

   Report by Chief Officer

6. **FINANCE**

   Reports by Head of Finance and Transformation

   (a) Budget Monitoring - 4 Months to 31 July 2022 (Pages 19 - 34)

7. **HEALTH CARE FRAMEWORK FOR ADULTS LIVING IN CARE HOMES** (Pages 35 - 102)

   Report by Lead Nurse for Care Homes and Care at Home

8. **ARGYLL AND BUTE CHILD POVERTY ACTION PLAN REVIEW 2021-2022** (Pages 103 - 110)

   Report by Head of Children, Families and Justice (review document to follow)

9. **YEAR 2 (2021/22) ANNUAL REVIEW OF THE CHILDREN AND YOUNG PEOPLE'S SERVICES PLAN 2020 - 2023** (Pages 111 - 126)

   Report by Head of Children, Families and Justice

10. PUBLIC HEALTH ANNUAL REPORT 2021-2022 AND LIVING WELL MID STRATEGY REPORT 2019-2022 (Pages 127 - 132)

Report by Interim Associate Director of Public Health

11. GUARDIAN SERVICE ANNUAL REPORT - TO FOLLOW

Report by Director of People and Culture

12. NATIONAL CARE SERVICE CONSULTATION RESPONSE (Pages 133 - 140)

Report by Business Improvement Manager

13. DATE OF NEXT MEETING

Wednesday 23 November 2022

E1 **14. ACQUISITION OF KINTYRE CARE CENTRE** (Pages 141 - 172)

Report by Head of Finance and Transformation

The Board will be asked to pass a resolution in terms of Section 50(A)(4) of the Local Government (Scotland) Act 1973 to exclude the public for items of business with an “E” on the grounds that it is likely to involve the disclosure of exempt information as defined in the appropriate paragraph of Part I of Schedule 7a to the Local Government (Scotland) Act 1973.

The appropriate paragraphs are:-

E1 **Paragraph 6** Information relating to the financial or business affairs of any particular person (other than the authority).
Paragraph 9 Any terms proposed or to be proposed by or to the authority in the course of negotiations for a contract for the acquisition or disposal of property or the supply of goods or services.

Argyll and Bute HSCP Integration Joint Board (IJB)

Contact: Hazel MacInnes Tel: 01546 604269

MINUTES of MEETING of ARGYLL AND BUTE HSCP INTEGRATION JOINT BOARD (IJB) held in the BY MICROSOFT TEAMS on WEDNESDAY, 24 AUGUST 2022

Present: Sarah Compton-Bishop, NHS Highland Non-Executive Board Member (Chair)
Councillor Amanda Hampsey, Argyll and Bute Council (Vice Chair)
Councillor Kieron Green, Argyll and Bute Council
Councillor Dougie Philand, Argyll and Bute Council
Jean Boardman, NHS Highland Non-Executive Board Member
Graham Bell, NHS Highland Non-Executive Board Member
Susan Ringwood, NHS Highland Non-Executive Board Member

Attending: Fiona Davies, Chief Officer, Argyll and Bute HSCP
Fiona Broderick, Staffside Lead, Argyll and Bute HSCP (Health)
Linda Currie, Lead AHP, NHS Highland
James Gow, Head of Finance and Transformation, Argyll and Bute HSCP
Elizabeth Higgins, Lead Nurse, NHS Highland
Kenny Mathieson, Public Representative
Julie Hodges, Independent Sector Representative
Alison McGrory, Interim Associate Director of Public Health, Argyll and Bute HSCP
Kevin McIntosh, Staffside Lead, Argyll and Bute HSCP (Council)
Betty Rhodick, Public Representative
Kirstie Reid, Carers Representative, NHS Highland
Takki Sulaiman, Chief Executive, Argyll and Bute Third Sector Interface
John Stevens, Carers Representative, NHS Highland
Fiona Thomson, Lead Pharmacist, NHS Highland
Evan Beswick, Head of Primary Care, Argyll and Bute HSCP
Caroline Cherry, Head of Adult Services, Argyll and Bute HSCP
Charlotte Craig, Business Improvement Manager, Argyll and Bute HSCP
Lorna Jordan, Principal Accountant, Argyll and Bute Council
Geraldine Collier, HR People Partner, Argyll and Bute HSCP
Hazel MacInnes, Committee Services Officer, Argyll and Bute Council
David Ritchie, Communications Manager, Argyll and Bute HSCP
Jillian Torrens, Head of Adult Services, Argyll and Bute HSCP
Stephen Whiston, Head of Strategic Planning and Performance, HSCP

1. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor Gary Mulvaney, David Gibson, Dr Rebecca Helliwell, Margaret McGowan and Angus MacTaggart.

2. DECLARATIONS OF INTEREST

There were no declarations of interest intimated.

3. MINUTES

The Minutes of the meeting of the Argyll and Bute Integration Joint Board held on 25 May 2022 were approved as a correct record.

4. MINUTES OF COMMITTEES

(a) Finance and Policy Committee held on 27 May 2022

The Minutes of the meeting of the Finance and Policy Committee held on 27 May 2022 were noted.

(b) Strategic Planning Group held on 9 June 2022

The Minutes of the meeting of the Strategic Planning Group held on 9 June 2022 were noted.

(c) Audit and Risk Committee held on 28 June 2022

The Minutes of the meeting of the Audit and Risk Committee held on 28 June 2022 were noted.

(d) Finance and Policy Committee held on 5 August 2022

The Minutes of the meeting of the Finance and Policy Committee held on 5 August 2022 were noted.

5. CHIEF OFFICER REPORT

The Board gave consideration to a new format of Chief Officer report which had been updated to fully reflect the wide range of activity taking place both in Argyll & Bute and nationally. The report highlighted the formal launch of the Strategic Plan; Ministerial thanks for the work undertaken by staff every day; and a report back from the NHS Scotland Event that had taken place from 21-22 June 2022 in Aberdeen. It also included updates under the headings HSCP Updates; Change to Senior Management Responsibilities within Adult Care; Service Updates; Operational Challenges; National Updates; Good News and New Colleagues.

The Chief Officer welcomed Alison McGrory to her new role as Interim Associate Director of Public Health.

Decision

The Integration Joint Board noted the report from the Chief Officer.

(Reference: Report by Chief Officer dated 24 August 2022, submitted)

6. NATIONAL CARE SERVICE (SCOTLAND) BILL

The Board gave consideration to a report providing information on the National Care Service (Scotland) Bill which had been introduced on 20 June 2022. The report advised that the Bill was currently at Stage 1 which allowed the Scottish Parliament to debate and consult publicly on the general principles of the Bill.

The Chief Officer advised verbally that following publication of the report a call to respond had been received from the Parliamentary Committee.

Decision

The Integration Joint Board –

1. Noted the proposed Bill and timeline.

2. Noted the formation of an operational working group.

(Reference: Report by Chief Officer dated 24 August 2022, submitted)

7. PUBLIC HEALTH UPDATE

The Board gave consideration to a report outlining Public Health activity in relation to Covid-19 prevalence in Scotland. The report also included details on new legislation for smoke free hospital grounds, and deaths statistics related to alcohol, drugs and suicide.

Decision

The Integration Joint Board noted –

1. The latest Covid-19 issues, in terms of:
   - Distribution of infection rates
   - The success of the Covid-19 testing programmes
   - The autumn vaccination programme

2. The new legislation on smoke free hospital grounds.

3. The latest statistics on deaths related to suicide, alcohol and drugs and work being undertaken.

(Reference: Report by Interim Associate Director of Public Health dated 24 August 2022, submitted)

8. PRIMARY CARE MODERNISATION PLAN UPDATE

The Board gave consideration to a report providing a high level summary noting the progress of the Primary Care Modernisation Plan. The report noted the internal governance, progress in key areas and management of risk in the current operating environment. The report reflected the focus of delivery of the General Medical Services Contract in Scotland 2018 in line with the needs of a diversely populated urban, remote and island area with a range of needs.

Decision

The Integration Joint Board noted progress in the delivery of the Primary Care Modernisation Plan.

(Reference: Report by Head of Primary Care dated 24 August 2022, submitted)

9. STAFF GOVERNANCE REPORT FOR FINANCIAL QUARTER 1 (2022/23)

The Board gave consideration to a report on staff governance covering financial quarter 1 (April – June 2022) and highlighting the activities of Human Resources and Organisational Development Teams.

The People Partner advised verbally that the June figure had been omitted from paragraph 3.3.8 of the submitted report and should have read 5.6%, which was higher than anticipated.

Decision

The Integration Joint Board –

1. Noted the content of the quarterly report on the staff governance performance in the HSCP.

2. Took the opportunity to ask any questions on people issues that may be of interest or concern.

3. Endorsed the overall direction of travel, including future topics that they would like further information on.

(Reference: Report by HR People Partner dated 24 August 2022, submitted)

10. INTEGRATION JOINT BOARD - PERFORMANCE REPORT

The Board gave consideration to a report detailing performance for August 2022 with regards to the Health and Social Care Partnership and NHS Highland.

Decision

The Integration Joint Board –

1. Acknowledged the introduction of new Key Performance Indicators to improve long waiting times across Scotland and the move away from previous Remobilisation performance reporting.

2. Acknowledged Long Waiting Time Performance (over 26 weeks) with regards to the New Outpatient Waiting List by main speciality.

3. Noted the Integrated Performance Management Framework- progress update.

4. Acknowledged the Treatment Time Guarantee (TTG) performance with regards to the Inpatient/Day Case Waiting List.

(Reference: Report by Head of Strategic Planning Performance and Technology dated 24 August 2022, submitted)

11. FINANCE

(a) Budget Monitoring - 3 months to 30 June 2022

The Board gave consideration to a report providing a summary of the financial position of the Health and Social Care Partnership as at 30 June 2022 and which provided an early forecast for the year.

Decision

The Integration Joint Board –

1. Noted that the transition to a new ledger system within the Council had had an impact on the Quarter 1 financial reporting as transaction processing had been prioritised.

2. Noted that the current position was a small overspend in respect of NHS budgets.

3. Noted that there was a small forecast revenue overspend of £346k as at 30 June 2021 and that it was anticipated that the HSCP would operate within budget in the current year.

4. Noted the summary of financial risks.

5. Noted progress with the savings programme and confirmation of £3.5m in savings delivered, 42% of target.

6. Noted that earmarked reserves of £2.6m had been committed to date for spend in 2022/23.

(Reference: Report by Head of Finance and Transformation dated 24 August 2022, submitted)

(b) **Medium Term Financial Plan 2023-2026**

The Board gave consideration to a report providing the current medium term financial plan for the Health and Social Care Partnership covering 2023/24 to 2025/26. The report provided the basis for detailed financial planning and would be used to inform the savings target for 2023/24.

Decision

The Integration Joint Board –

1. Noted the draft Financial Plan and budget outlook for 2023-24 to 2025-26.

2. Noted the risks and uncertainties regarding the Financial Plan.

3. Noted the forecast budget gap and endorsed the proposal that the HSCP seeks to develop a Value for Money and Savings Strategy aimed at addressing the budget gap.

(Reference: Report by Head of Finance and Transformation dated 24 August 2022, submitted)

12. ARGYLL AND BUTE HSCP COMMITTEES ANNUAL REPORTS 2021/22

(a) **Audit and Risk Committee Annual Report 2021-22**

A report providing a summary of the work of the Audit and Risk Committee during 2021/22, the auditors and an evaluation by the Chair, was before the Board for noting.

Decision

The Integration Joint Board noted the annual report.

(Reference: Report by Chair of the Audit and Risk Committee dated 24 August 2022, submitted)

(b) **Clinical and Care Governance Committee Annual Report 2021-22**

A report providing a summary of the work of the Clinical and Care Governance Committee during 2021/22 was before the Board for noting.

Decision

The Integration Joint Board noted the annual report.

(Reference: Report by Chair of the Clinical and Care Governance Committee dated 24 August 2022, submitted)

(c) **Finance and Policy Committee Annual Report 2021-22**

A report providing a summary of the work of the Finance and Policy Committee during 2021/22 was before the Board for noting.

Decision

The Integration Joint Board noted the annual report.

(Reference: Report by Chair of the Audit and Risk Committee dated 24 August 2022, submitted)

13. DATE OF NEXT MEETING

The date of the next meeting was noted as Wednesday 21 September 2022.

Agenda Item 4c

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

MINUTES of MEETING of ARGYLL AND BUTE HSCP AUDIT AND RISK COMMITTEE held BY MICROSOFT TEAMS on TUESDAY, 13 SEPTEMBER 2022

Present: Councillor Kieron Green (Chair)

Susan Ringwood
Councillor Douglas Philand

Attending:
James Gow, Head of Finance and Transformation, Argyll and Bute HSCP
Paul MacAskill, Chief Internal Auditor, Argyll and Bute Council
Charlotte Craig, Business Improvement Manager, Argyll and Bute HSCP
Mhairi Weldon, Senior Audit Assistant, Argyll and Bute Council
Lynsey Innis, Senior Committee Assistant, Argyll and Bute Council
Kyle McAulay, Audit Scotland

1. APOLOGIES FOR ABSENCE

Apologies for absence were intimated on behalf of Sarah Compton-Bishop and Fiona Davies.

2. DECLARATIONS OF INTEREST (IF ANY)

There were no declarations of interest intimated.

3. MINUTES

The Minute of the previous meeting of the Argyll and Bute HSCP Audit and Risk Committee held on 28 July 2022, was approved as a correct record.

4. BEST VALUE IN INTEGRATION JOINT BOARDS

Having previously been advised that Audit Scotland had indicated that they intended to roll out formal Best Value Audits to the IJB/HSCP sector, the Committee gave consideration to a report which advised of Audit Scotland's recent decision not to progress this, largely as a result of the implementation of the National Care Service. The report also highlighted that value for money and Best Value in respect of the Argyll and Bute HSCP is reported in the Annual Report and Accounts and that progress in relation to the Saving's Plan is routinely reported to the Finance and Policy Committee and the IJB.

Decision

The Audit and Risk Committee noted that Audit Scotland have decided not to progress with formal Best Value Audits in the IJB sector.

(Reference: Report by Head of Finance and Transformation, dated 13 September 2022, submitted)

5. AUDIT SCOTLAND PUBLICATIONS

Consideration was given to a report which highlighted a number of Audit Scotland's recently published reports and provided a brief summary of some of the key points contained within them.

Discussion was had in relation to the National Fraud Initiative and the possibility of an update on local implications being provided as part of a future IJB development session.

Decision

The Audit and Risk Committee noted that Audit Scotland had recently published a number of reports that may be of interest to members of the Audit and Risk Committee.

(Reference: Report by Head of Finance and Transformation, dated 13 September 2022, submitted)

6. AUDIT SCOTLAND IJB FINANCIAL ANALYSIS 2020/21

Consideration was given to a report which presented Audit Scotland's Financial Analysis for 2020/21 and outlined the key messages contained within.

Decision

The Audit and Risk Committee noted the Audit Scotland Financial Analysis Report for the year ended 31 March 2021, published in June 2022.

(Reference: Report by Head of Finance and Transformation, dated 13 September 2022, submitted)

7. INTERNAL AUDIT UPDATE

The Committee gave consideration to a report which provided an update on the work carried out by Argyll and Bute Council's Internal Audit Team on audits which are of operational relevance to the Committee. The report also provided an update on the actions from audit reports already presented to the Committee which were still open as at June 2022.

Decision

The Audit and Risk Committee reviewed and considered the progress on completion of the internal audit plan and recommendations.

(Reference: Report by Chief Internal Auditor, dated 13 September 2022, submitted)

8. DATE OF NEXT MEETING

The Audit and Risk Committee noted that a Special Meeting would be held on Wednesday, 9 November 2022 for consideration of the Audited Annual Accounts and the next full meeting of the Committee would take place on Tuesday, 13 December 2022.

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Integration Joint Board **Agenda item:**

Date of Meeting: 21 September 2022

Title of Report: Chief Officer Report

Presented by: Fiona Davies, Chief Officer

The Integration Joint Board is asked to: • Note the following report from the Chief Officer

Introduction

It was with sadness that we received the news of the death of her Majesty the Queen. The following statement was issued on behalf of IJB members and the HSCP by Sarah Compton-Bishop (IJB Chair), Councillor Amanda Hampsey (IJB Vice-Chair) and myself through our social media.

"We would like to express our sadness on the announcement of the death of Her Majesty the Queen.

"Her Majesty's life was one of dedicated public service and devotion to our nation and the Commonwealth. We were privileged to welcome Queen Elizabeth II and Prince Philip, Duke of Edinburgh to Argyll and Bute to mark the official opening of Lorn and Islands Hospital in 1995.

"We join together in mourning and extend our condolences and compassion to the Royal Family as the whole country comes to terms with this news and mourns her passing."

This month within my report I have also included an update on the recent Cabinet Secretary visit to Bute where the Minister met with HSCP staff as well as residents and patients at some of our health and social care facilities on the island. I am very grateful that the Minister took up my invitation to visit Argyll and Bute. It was a really valuable day and he had an opportunity to meet some really amazing staff and members of the public and see for himself the innovative work carried out by the teams on the island both from the HSCP and our partners.

I have also included in the report an update on the HSCP's vaccination programme and I would encourage everyone to take up the opportunity to get vaccinated if they are invited to do so. This will help protect our local communities.

It is also important that I highlight in my report some of the operational challenges that we are facing as an organisation and this month I have highlighted that we are currently managing directly a number of GP Practices and our Primary Care team is actively marketing these vacant GP contracts. In the meantime they have arranged locum GPs for the Practices concerned to ensure continuity of care for patients.

In the last section of my report I have included some staffing updates and it's a real pleasure to see colleagues who have worked for us for a number of years being successful in applying for more senior roles. This is a testament to the breadth of talent we have as an organisation and I wish them all well.

HSCP Updates

Helensburgh and Lomond Carers – We would like to congratulate Helensburgh and Lomond Carers who were recently awarded the Excellence for Carers Award by the Carers Trust. This award is well deserved and highlights the enormous amount of work that the organisation is doing for the local community. A motion has also been lodged in the Scottish Parliament to highlight their achievement and you can view it here.

Ministerial visit to Bute - Humza Yousaf, the Cabinet Secretary for Health and Social Care, visited Bute on Friday 19 August. This followed on from an invitation from the Chief Officer to the Cabinet Secretary earlier this year to visit Argyll and Bute. During his visit he met with the Chief Officer, health and social care staff both from the local hospital and the community, GPs and staff at Bute Medical Practice, residents and staff at Thomson Court Care Home and the Phoenix Centre as well as meeting with local home care providers and representatives from the Lade Centre (local health and wellbeing hub) and the resettlement team on the island. There is also a short video of the visit (available here) where you can view some of the highlights from the day.

National Care Service - A response to the National Care Service consultation from the Integration Joint Board was submitted on the 2 September. A copy of the response is included in the papers for this month's meeting.

Glad to Care Awareness Week - This is a national campaign, which ran this year from 20-24 June, and is an opportunity to highlight, and show appreciation for, the work that care at home and care home staff do every day for the people who receive care.

The HSCP promoted the Awareness Week through our social media pages and we would like to thank the many staff from the HSCP and our partners who volunteered to participate in the campaign by providing their own personal messages as to why they were 'Glad to Care'.

Service Updates

Outpatient appointments - Throughout the coming weeks and months patients in Argyll and Bute who have been referred for outpatient treatment may be offered opportunities to be seen in other areas of NHS Highland and within NHS Greater

Glasgow and Clyde. This is in line with national policy and will enable patients to be seen sooner, helping to bring waiting times down.

HSCP Vaccination Programme - Vaccinations in Argyll and Bute began on Monday 5 September starting with Care Homes, housebound people and Health and Social Care staff.

COVID-19 and flu vaccines are being delivered by dedicated HSCP vaccination teams, except on Coll, Colonsay, Jura, Tiree, Bute, & Islay. GPs practices are delivering in these locations.

It is vital that you take up the offer of vaccination when invited - it protects you and those you support against serious COVID-19 infection.

If you're eligible for both the COVID-19 and flu vaccine this winter, they will be given at the same time where possible. Getting both together is safe and will deliver maximum protection over the winter months.

Operational Challenges

GP services

Due to a number of GPs having resigned from their Practice, or intimated their intention to do so, the HSCP is currently managing a number of GP Practices across Argyll and Bute. These are Carradale, Kilcreggan and from 1 October it will also include Garelochhead. This is in addition to the three practices which comprise Kintyre Medical Group, which the HSCP has managed for some years.

The contracts for the newly vacant Practices are being actively marketed through the British Medical Journal and we remain hopeful that replacement GP partners can be contracted in the near future.

In the meantime the Primary Care team have arranged for locum GPs to cover the Practices concerned to ensure there is continuity of care for patients and the locums will work alongside the Practice staff until replacement GP partners are recruited. The 'marketplace' for locums is becoming increasingly challenging and this increases both clinical risk (i.e. around lack of cover) and financial risk (i.e. increasing cost of locum cover). We will continue to monitor this.

Care at Home Services

The HSCP is continuing to face significant recruitment and retention challenges in providing sustainable care at home services across Argyll and Bute (care at home is provided both in-house and by independently commissioned providers). We are working closely with our independent providers to help them sustain their services. Our care at home team also communicates directly with clients and their families if there are any changes made to the providers who are delivering care at home services.

The HSCP has also developed a dedicated Facebook page which promotes vacancies across the care at home sector in Argyll and Bute both from providers

and also in-house HSCP posts. Funding has also been sourced to recruit an HR resource to help with recruitment in this area and this post is currently out to advert.

National Updates

Winter vaccines programme begins

Older people resident in care homes are among the first to receive COVID-19 and flu vaccines as the winter vaccine programme got underway from 5 September. More than two million people in Scotland will be offered vaccines over the next three months - helping protect the public and relieving pressure on the NHS. Invitations will have been sent to all over 65s by the end of the first week. Further information is available here.

Facemasks no longer recommended in social care

Social care staff and visitors are no longer being advised to wear facemasks at all times under new guidance published today (7 September).

The recommendation has been lifted due to a sharp drop in coronavirus infections and a reduction in severity of illness, which has been driven by Scotland's successful vaccination programme which has so far seen more than 12 million Covid-19 vaccine doses administered in Scotland. Further information is available here.

Smoking banned near hospital buildings

Patients and healthcare staff will no longer face second-hand smoke at hospital doors as a nationwide ban came into effect on Monday 5 September. The new legislation means anyone found lighting up within fifteen metres of a hospital building could face a fixed penalty notice of £50 or a fine of up to £1,000 if the case goes to court.

This is the latest step in the Scottish Government's plan to create a tobacco free Scotland by 2034 and supports the voluntary smoke-free hospital grounds policy introduced in 2015. The new law will apply to NHS hospital settings used for the treatment and care of patients and includes a ban on lighting up beneath overhanging structures. Further information is available here.

Retiring NHS staff helped to return to workplace

New national guidelines will make it easier for retiring NHS staff to return to support the NHS as it continues to recover from the pandemic. The arrangement for 'Retire and Return' streamlines the process to let experienced staff take up a part-time post while drawing their pension. It was developed in partnership with employers and trade unions following calls for a simpler process. Further information is available here.

National Care Service Update

The Scottish Government lodged a Bill in Parliament on 21 June 2022 in relation to their plans for a National Care Service (NCS) for Scotland and further details of this Bill are available on the Scottish Government website here.

A further update on the NCS is included in the papers for this month's meeting.

Good News

Musculoskeletal Physiotherapy (MSK) Services

Due to increasing demand and the impact of COVID-19 the waiting lists for MSK Physiotherapy services are longer than we would like. As a result, we are going to offer everyone currently waiting for a physiotherapy appointment access to a new service called PHIO. PHIO is a chat-bot based triage and self-management tool which can be accessed via a smartphone, tablet or computer and will ensure we can support and monitor how patients are doing whilst they wait for an appointment.

Whilst some people will still need an appointment, PHIO will help many of those waiting to self-manage and avoid a deterioration in their condition and will help some to get better without needing to see a physiotherapist at all. We are just finalising the details for the implementation of the service and are hopeful that it will go live by the end of September.

Understanding Autism Course

Congratulations to Katy Watson, Janice Beasley and Gordon Planck from the Phoenix Centre on Bute who have all successfully passed the Training Qualifications UK (TQUK) level 2 certificate in understanding autism. Katy is the Senior Support Worker and Janice and Gordon are Support Workers.

The team work with adults with learning and physical disabilities in day support plus a younger group of adults with autism who require support for their autism in order to live a fully inclusive life. Our prime objective is to support individuals to move on to more or full independence in their lives, so this better understanding of the complexities of autism supports us to reach this outcome.

Staffing Updates

Podiatry Team Lead

We would like to congratulate, Lynn Dalrymple from the Helensburgh team, who has taken up post as the Podiatry Team Lead/Professional Lead for the HSCP. Lynn will initially be starting in this role in a development capacity and colleagues from across the organisation are looking forward to working with her.

Interim Area Management Changes

Finola Owen, the Area Manager for Kintyre and Islay, has been successful in gaining the Interim Area Manager post for Cowal (for 6 months) to cover long-term absence, whilst Emma King-Venables, Physiotherapy Team Lead Mid Argyll, will step into the Kintyre and Islay post for six months. We wish both Finola and Emma congratulations and best wishes.

Head of NHS Finance

Morven Moir has been appointed to the role of Head of NHS Finance. Morven brings with her a wide range of skills and experience from her previous role as Finance Manager for the HSCP and we wish her well in her new role.

Agenda Item 6a

Integration Joint Board

Date of Meeting: **21 September 2022**

Title of Report: **Budget Monitoring – 4 months to 31 July 2022**

Presented by: **James Gow, Head of Finance and Transformation**

The Integration Joint Board is asked to:

- Note that there is a small forecast revenue overspend of £575k as at 31 July 2022 and that it is anticipated that the HSCP will be able operate within budget in the current year.
- Note progress with the savings programme and confirmation of £2.8m in savings delivered, 46% of target.
- Note that earmarked reserves of £3m has been committed for spend in 2022/23.
- Note that at the time of writing the net cost of the revised local authority pay offer is not known but is expected to add a further cost pressure to Social Work Budgets.

1. EXECUTIVE SUMMARY

1.1 This report provides a summary of the financial position of the Health and Social Care Partnership as at 31 July 2022 and provides a forecast for the year. It also updates on the delivery of the savings programme and utilisation of reserves.

1.2 The forecast is a small overspend of £575k, it is anticipated that this can be managed as the year progresses. The forecast is based on a number of assumptions and therefore there are risks associated with it. These are outlined in the Financial Risks report, inflation and pay settlements are key risks. It is assumed in the forecast that any nationally agreed pay settlement within the NHS will be fully funded. The implications of the local authority pay offer and in particular how it is being funded were not confirmed at the time of writing.

1.3 The HSCP is still experiencing challenges in filling posts and as a result there remains some slippage in spend against specific allocations aimed at easing pressures within the sector. It continues to be under pressure to maintain and increase capacity where possible in advance of the winter period.

2. INTRODUCTION

2.1 This report provides a summary of the financial position of the Health and Social Care Partnership as at 31 July 2022. Information is provided in respect of the year to date position and the forecast outturn. Summary information is provided with further analysis in the appendices.

3. DETAIL OF REPORT

3.1 Year to 31 July 2022

The table below summarises the position for the first 4 months of the year. The year to date position is still slightly distorted by the temporary issues associated with the implementation of the new ledger system within the Council although good progress is now being made and this will be addressed fully in the period 5 reporting cycle. The NHS position is a small reported overspend of £228k (0.3% of the NHS budget). For Council services the year to date figure is reported on a cash basis whereas the Health figures are on an accruals basis. Appendix 1 provides an analysis of the variances against budget by service.

Service	Actual £000	Budget £000	Variance £000	% Variance
COUNCIL SERVICES TOTAL	22,295	24,363	2,068	8.5%
HEALTH SERVICES TOTAL	74,677	74,449	-228	-0.3%
GRAND TOTAL	**96,972**	**98,812**	**1,840**	**1.9%**

3.1.1 For Social Work budgets the favourable variance is not representative of the actual position. As with any major ICT related project, there have been some difficulties encountered with the transition to the new ledger system and the focus has been on ensuring transaction systems and processes transitioned smoothly. Budget monitoring processes have taken place but are not fully reflected in the ledger system, this will be fully corrected in the month 5 reporting. The main area of concern with the Social Work budgets relates to high demand and spend on the Learning Disability budget and the implications of the local government pay offer.

3.1.2 For Health Service budgets, a small overspend of £228k is reported. The main drivers of the year to date overspend are agency medical staffing costs particularly in Lorne & Islands Hospital and Oban, out of hours services, and agency nursing costs across a number of our hospitals. Additionally, inflation and supply chain issues are having an impact, particularly in respect of prescribing budgets and slippage with delivering savings in this area.

3.2 Forecast Outturn

3.2.1 The forecast outturn position is summarised below and a small overspend is forecast on the revenue position (0.2% of budget). Further detail is provided in appendix 2.

Service	Annual Budget £000	Forecast Outturn £000	Variance £000	% Variance
COUNCIL SERVICES TOTAL	88,170	88,245	-75	0.1%
HEALTH SERVICES TOTAL	235,650	236,150	-500	-0.2%
GRAND TOTAL	**323,820**	**324,395**	**-575**	**-0.2%**

The small forecast adverse variance is not in itself a concern at this stage in the year and it is anticipated that spend will be managed within budget. Additionally, the HSCP has significant reserves available and it is anticipated that additional funding for winter pressures will be allocated by Government in the coming weeks. However, the impact of increasing inflation and the costs and funding of the local authority pay settlement have the potential to place increased pressures on service budgets. The main focus in respect of budget management at present is delivery of the exiting savings programme.

3.2.2 Within Social Work there are two areas of concern:

1. Learning Disability Budget - an overspend of £1.5m is reported in the period 4 figures although further analysis has reduced this slightly. This is due to increasing demand and costs of care packages and is now the subject of a detailed analysis to better understand the drivers. Additional funding was allocated in the 2022/23 budget and some previous savings target had also been cancelled.
2. Local Authority Pay Increases – the cost of the revised offer is estimated at an increase of £1.4m on established posts, this is over and above the public pay policy assumption made at the time the budget was prepared. The funding arrangements for the improved pay offer are uncertain at the time of writing. It is likely that there will be a gap between the additional cost and the funding allocations to HSCPs. This is not incorporated in the month 4 report.

The overall forecast position for Social Work recognises that there are non-recurring vacancy savings and slippage on spend programmes and the current forecast is a small overspend.

3.2.3 The forecast for Health budgets is a small overspend totalling £500k. Appendix 2 provides details on a service level basis. The main area of concern at present relates to spend on Community and Hospital Services. Overspending here is at £1m with some of this being offset by underspending and slippage on other spend programmes. The main driver of the overspend relates to the steps that are having to be taken to stabilise medical staffing at Lorne and Islands Hospital. Recruitment continues to be a challenge, however, given the level of pressure on services nationally we are accepting that increased spend is required to maintain services and avoid increasing pressures elsewhere in the system. It is anticipated that additional resources will be allocated by Government via NHS Highland in the coming months, although at a reduced level in comparison with recent years.

3.2.4 The forecast takes account of anticipated shortfalls against recurring savings targets and emerging cost pressures with an expectation that these will be largely, but not fully, offset by non-recurring savings and underspends. It is assumed within the forecast that all additional costs associated with our direct response to Covid-19 and for both the Covid Booster & Flu Vaccination Programmes will be fully funded from IJB held Covid reserves and not additional funding allocations.

	Annual Budget (£'000)	Forecast Outturn (£'000)	Forecast Variance (£'000)	Explanation
Health Services	235,650	236,150	(500)	Hospital staffing, inflation and expected slippage with savings.

With eight months of the financial year remaining, there is sufficient scope for to address the modest forecast year-end overspend and deliver a break-even outturn position. The intention is to continue to ensure that the HSCP operates within budget, delivers on the savings programme and increases capacity where it can within its growth funding.

3.3 Savings Delivery

3.3.1 The Service Improvement Team and the Project Management Office, co-ordinated by NHS Highland, continue to work with managers to progress, monitor and report progress on savings projects. This is done in conjunction with the management accounting teams. As at the end of July, £2.8m (46%) of the £6m target has been achieved and declared, an increase of £276k In July:

2022/23 Savings	Target £' 000	Year to 31 July 2022 Achievement £' 000	Balance £' 000	%
Fully Achieved	2,313	2,313	0	
Remaining Programme	3,689	463	3,226	
Total	**6,002**	**2,776**	**3,226**	**46%**

3.3.2 Appendix 3a lists the projects that have been fully delivered and declared. The projects which are declared on a non-recurring basis will be addressed as part of the capital project at Cowal Community Hospital. Appendix 3b provides further detail in respect of the remaining balance of £3.2m, risk rated per below:

Savings Perceived as Low Risk	£578k	
Savings anticipated to be difficult to achieve in full in 2022/23	£2,157k	
Savings unlikely to be deliverable in 2022/23	£491k	

3.3.3 It is not proposed that the IJB are asked to consider the removal of projects from the plan at present. The appendix provides a brief explanation on progress and detailed service deep dive reports to the Finance & Policy Committee provide further detail.

3.3.4 One of the biggest challenges relates to the Cowal Community Hospital project, this is being project managed by NHS Highland and is subject to delay and additional costs. If the funding issue is resolved quickly then the best outcome available will be for construction work to start in December for March completion. Engagement with the local community also needs to be progressed in the coming months. We are also in the process of seeking to bring in additional resource to support the work on catering, cleaning and hotel services, some slippage with these projects is expected to continue.

3.3.5 The medical staffing structure at LIH in Oban is not stable at present, work is on-going, with support from NHS Highland to stabilise the situation and establish a stable staffing model which is compliant with the medical staff training requirements, there is no possibility that plans to deliver additional services can be implemented in the current year.

3.3.6 Overall good progress has been made in delivering savings, however, slippage will require to be covered by non-recurring savings as the year progresses, the forecasts now take this into account.

3.4 Earmarked Reserves

3.4.1 The IJB carried forward earmarked reserves of £21.2m at the end of financial year 2022/23. During the first four months, £3m has been allocated to specific project costs. Plans are in place in respect of an estimated further £12.5m of spend. Appendix 4 provides a summary of the firm commitments to the end of period 4. This is now part of the monthly financial reporting process as there is an increasing risk that resource will be lost to the Argyll and Bute area as a consequence of unspent reserves.

4 RELEVANT DATA AND INDICATORS

4.1 Information is derived from the financial systems of Argyll and Bute Council and NHS Highland.

5 CONTRIBUTION TO STRATEGIC PRIORITIES

5.1 The Integration Joint Board has a responsibility to set a balanced budget which is aligned to the Strategic Plan. It is required to ensure that financial decisions are in line with Strategic Priorities.

6 GOVERNANCE IMPLICATIONS

6.1 Financial Impact – the forecast outturn positon is an overspend of £575k. It is anticipated that the HSCP will be able to manage this during the year. It is noted that it has carried forward substantial levels of reserves.

6.2 Staff Governance – None directly from this report but there is a strong link between HR management and delivering a balanced financial position.

6.3 Clinical Governance – None.

7. PROFESSIONAL ADVISORY

7.1 Professional Leads have been consulted with in respect of the implications of the budget and savings programme.

8. EQUALITY AND DIVERSITY IMPLICATIONS

8.1 None directly from this report.

9. GENERAL DATA PROTECTION PRINCIPLES COMPLIANCE

9.1 None.

10 RISK ASSESSMENT

10.1 There are a number of financial risks which may impact on the forecast. These are reviewed and reported separately. There is an increasing risk that funding streams will be reduced whilst significant reserves are held. NHS Highland also continue to experience a particularly challenging financial situation in 2022/23.

11. PUBLIC AND USER INVOLVEMENT AND ENGAGEMENT

11.1 None directly from this report, engagement on activities relating to savings and transformation forms part of the project plans where appropriate.

12. CONCLUSIONS

12.1 This report provides a summary of the financial position as at the end of Month 4. A small overspend against budget is forecast, however it is anticipated that the position can be managed during the remainder of the year. On-going high levels of demand for services and the additional costs associated with agency and locum cover are contributing to budget pressures. Increasing inflation and the implications of the increased pay offer to local authority staff are expected to put further pressure on the management of the budget in the current year.

12.2 Good progress has been made in delivering 46% of the savings programme although some challenges have been identified. Additionally, efforts are on-going to ensure that progress with allocating reserves continues as there is a risk that in-year allocations will be reduced until reserves are utilised. Continued action to address delayed discharges, the autumn covid vaccination programme and efforts to increase capacity in advance of the winter are likely to add to financial pressures and spend later in the year.

13. DIRECTIONS

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

APPENDICES:

Appendix 1 – Year to Date Position
Appendix 2 – Forecast Outturn for 2022-23
Appendix 3a – Fully Achieved Savings
Appendix 3b – Live Savings Programme
Appendix 4 – Earmarked Reserves

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ARGYLL AND BUTE HEALTH AND SOCIAL CARE PARTNERSHIP **APPENDIX 1**
REVENUE BUDGET MONITORING SUMMARY - YEAR TO DATE POSITION AS AT 31 JULY 2022

Reporting Criteria: +/- £50k or +/- 10%

For information:
The Council don't do monthly based accrual accounting, whereas Health do.
On the Council side, there may be a mismatch between year to date actual and budgets, due to timing differences as to when invoices are paid.
Health do monthly based accrual accounting, therefore, you should see a correlation in the year to date position and the year end outturn position.

Service	Actual £000	Budget £000	Variance £000	% Variance	Explanation
COUNCIL SERVICES:					
Chief Officer	388	695	307	44.2%	Variance due to underspends on centrally held funds.
Service Development	138	123	(15)	(12.2%)	Variance due to overspends on staff costs combined with timing of income receipt.
Looked After Children	2,081	2,318	237	10.2%	The underspend relates to Adoption and Fostering due to demand levels for these services.
Child Protection	803	890	87	9.8%	The YTD underspend is due to underspends on payments to other bodies combined with additional one off unbudgeted income receipt for NearMe from the Scottish Government.
Children with a Disability	229	295	66	22.4%	The variance is as a result of budget profiling for payments to other bodies. This needs to be adjusted in line with planned expenditure.
Criminal Justice	56	1	(55)	(5500.0%)	The variance is as a result of timing of income receipt for the S27 grant funding partially offset by underspends on staff costs.
Children and Families Central Management Costs	812	958	146	15.2%	The variance is as a result of staff vacancies which have yet to be transferred to vacancy savings combined with timing of expenditure on rental costs and payments to other bodies.
Older People	11,081	12,299	1,218	9.9%	The YTD variance is as a result of staff vacancies in the Assessment and Care Management Teams, timing of payments across Homecare and the availability of Scottish Government funding.
Physical Disability	1,119	1,129	10	0.9%	Outwith reporting criteria.
Learning Disability	4,585	4,489	(96)	(2.1%)	The Overspend is due to demand for services within Supported Living.
Mental Health	822	967	145	15.0%	The variance is as a result of staff vacancies in the Assessment and Care Management Teams, combined with underspends on payments to other bodies.
Adult Services Central Management Costs	181	199	18	9.0%	Outwith reporting criteria.
COUNCIL SERVICES TOTAL	**22,295**	**24,363**	**2,068**	**8.5%**	
HEALTH SERVICES:					**Explanation**
Community & Hospital Services	20,070	19,400	(670)	(3.5%)	Overspending due to agency staffing costs and unachieved savings
Mental Health and Learning Disability	4,782	4,993	211	4.2%	Vacancies
Children & Families Services	2,564	2,680	116	4.3%	Vacancies
Commissioned Services - NHS GG&C	22,986	23,007	20	0.1%	Outwith reporting criteria.
Commissioned Services - Other	1,457	1,386	(71)	(5.1%)	Overspend due to emergency ICU patient admitted to Aberdeen Royal Infirmary
Primary Care Services inc Dental	8,076	8,174	98	1.2%	Vacancies mainly within dental services
Other Primary Care Services	4,108	4,108	0	0.0%	The YTD variance is outwith reporting criteria.
Prescribing	6,878	6,746	(131)	(1.9%)	Unachieved savings & short supply of specific drugs
Public Health	758	777	19	2.5%	Outwith reporting criteria.

Service	Actual £000	Budget £000	Variance £000	% Variance	Explanation
Lead Nurse	501	531	30	5.7%	Outwith reporting criteria.
Management Service	(593)	(596)	(3)	0.5%	Outwith reporting criteria.
Planning & Performance	911	822	(89)	(10.8%)	Overspend due to unachieved savings
Budget Reserves	0	160	160	0.0%	
Income	(796)	(596)	200	(33.6%)	Favourable variance is due to increased number of visitors requiring emergency hospital treatment
Estates	2,976	2,857	(119)	(4.2%)	Overspend is due to further increases in cost of utilities and PFI charges
HEALTH SERVICES TOTAL	**74,677**	**74,449**	**(228)**	**(0.3%)**	
GRAND TOTAL	**96,972**	**98,812**	**1,840**	**1.9%**	

ARGYLL AND BUTE HEALTH AND SOCIAL CARE PARTNERSHIP **APPENDIX 2**

REVENUE BUDGET MONITORING FORECAST OUTTURN - AS AT 31 JULY 2022

Reporting Criteria: +/- £50k or +/- 10%

Service	Annual Budget £000	Forecast Outturn £000	Variance £000	% Variance	Explanation
COUNCIL SERVICES:					
Chief Officer	4,296	3,235	1,061	24.7%	Forecast underspends on centrally held funds (£1.021m) and non recurring savings.
Service Development	448	440	8	1.8%	Outwith reporting criteria.
Looked After Children	7,688	7,326	362	4.7%	Forecast underspend reflects demand for Fostering and Adoption services as well as over-recovery of income across Supporting Young People Leaving Care for UASC activity from the Home Office. This is partially offset by overspends in the Children's Houses on payroll costs.
Child Protection	3,297	3,273	24	0.7%	Outwith reporting criteria.
Children with a Disability	921	899	22	2.4%	Outwith reporting criteria.
Criminal Justice	88	78	10	11.4%	Underspend is due to staff vacancies.
Children and Families Central Management Costs	3,276	3,288	(12)	(0.4%)	The forecast variance is outwith reporting criteria.
Older People	43,607	43,385	222	0.5%	The forecast underspend is due to current known demand and capacity in Homecare (£808k) and higher than budgeted income for fees and charges in the Residential Units and Telecare. These are partially offset by demand for Care Home Placements (£677k).
Physical Disability	3,449	3,574	(125)	(3.6%)	Overspend is due to higher than budgeted demand for Support Living (£23k) and Residential Placements (£103k).
Learning Disability	17,393	18,943	(1,550)	(8.9%)	The forecast overspend reflects higher than budgeted demand for services in Supported Living (£1.009m) and Joint Residential care(£546k). This is subject to on-going further analysis.
Mental Health	3,260	3,365	(105)	(3.2%)	Overspend reflects higher than budgeted demand for Residential Placements (£169k) partially offset by underspends in the Assessment & Care Management Teams and Supported Living.
Adult Services Central Management Costs	447	439	8	1.8%	Outwith reporting criteria.
COUNCIL SERVICES TOTAL	**88,170**	**88,245**	**(75)**	**(0.1%)**	
HEALTH SERVICES:					**Explanation**
Community & Hospital Services	58,101	59,183	(1,082)	(1.8%)	Agency staffing costs and unachieved savings
Mental Health and Learning Disability	15,341	15,207	134	0.9%	Vacancies
Children & Families Services	8,403	8,153	250	3.1%	Vacancies
Commissioned Services - NHS GG&C	69,020	69,020	0	0.0%	The forecast variance is outwith reporting criteria.

Service	Annual Budget £000	Forecast Outturn £000	Variance £000	% Variance	Explanation
Commissioned Services - Other	4,156	4,174	(18)	(0.4%)	The forecast variance is outwith reporting criteria.
Primary Care Services inc Dental	24,684	24,556	128	0.5%	Vacancies mainly within dental services
Other Primary Care Services	12,254	12,254	0	0.0%	The forecast variance is outwith reporting criteria.
Prescribing	20,904	21,080	(176)	(0.8%)	Unachieved savings
Public Health	2,043	1,983	60	3.0%	The forecast variance is outwith reporting criteria.
Lead Nurse	1,616	1,542	74	4.8%	Vacancies
Management Service	800	800	0	0.0%	The forecast variance is outwith reporting criteria.
Planning & Performance	2,452	2,660	(208)	(7.8%)	Unachieved savings
Budget Reserves	8,728	8,228	500	6.1%	Anticipated slippage on inyear SG allocations
Income	(1,788)	(1,888)	100	(5.3%)	Increase in number of visitors requiring emergency hospital treatment
Estates	8,936	9,198	(262)	(2.8%)	Increases in cost of utilities and PFI charges
HEALTH SERVICES TOTAL	**235,650**	**236,150**	**(500)**	**(0.2%)**	
GRAND TOTAL	**323,820**	**324,395**	**(575)**	**(0.2%)**	

Appendix 3a - 2022/23 Fully Complete Savings

Ref.	Savings Description	Target £' 000
Social Work		
2122-01	C &F Align business model for staffing for the 3 children's homes	6
2122-03	C&F - Do not replace independent chair of panel	2
2223-22	Older Adults - Remove current year underspend and anticipated unfunded growth from budget.	390
2223-23	Older Adults - Funding to cover care home contract uplift.	193
2223-11	MH - Reduction in value of 3rd Party Contract	10
2223-12	C&F Shift the balance of care across fostering, kinship and out of area residential placements.	100
2223-13	C&F - Redesign and review of Justice services to become fully funded by specific grant.	60
2223-15	C&F - Printer and Paper cost reduction	4
2223-20	LD&PD Transport costs - Day Services.	12
2223-21	Corp - Hold programme manager post vacant.	76
2223-10	Corp - Additional non-recurring vacancy savings to be removed from budget in year as they arise.	250
Health		
2122-10	Redirect Oban Integrated Care Funding to pay for day responder service as in other areas	14
2223-3	MH - Review of specific high cost care packages.	115
2223-4	Ensure that funding for pay rate uplifts are passed through to Health Budgets	50
2223-24	Primary Care -Ensure national funding is fully utilised to cover eligible costs - Denistry.	22
2223-26	Public Health - Review of Living Well grants	18
2223-6	Estates - Reduce Energy Usage	60
2122-37	Campbeltown hospital catering	2
2223-2	Corp - Additional non-recurring vacancy savings to be removed from budget in year as they arise.	750
2223-25	Public Health -Reduce specific engagement budget which is now subsumed into mainstream PH activities	9
Declared on non-recurring basis at present:		
1920-35	Bed reduction savings : Cowal Community Hospital	150
2021-29	Dunoon Gum clinic - underspend	20
		2,313

Total Savings Programme	**6,002**
% Fully Complete	**39%**

Appendix 3b - LIVE SAVINGS PROGRAMME

Ref.	Savings Description	Target £' 000	Declared M4 £' 000	Remaining £' 000	RISK	NOTES
Social Work						
2122-11	Remove funding for all lunch clubs	29		29		Saving declared last year non-recurring, expect to declare in 2022/23
2021-7b	Review of provisioning of day services and remodel considering options of greater third sector involvement aiming for 10% reduction in cost, several targets under this project have been amalgamated.	145		145		Restructuring complete - no further action required
2021-32	Review housing support services and remove where not required for LD and PD clients - several targets under this project have been amalgamated.	86	4	82		Expect to declare in 2022/23
1819-19b	Review and Redesign of Learning Disability Services - Sleepovers and Technology Argyll Wide	50		50		Member of staff now appointed to progress
2223-16	Day Services - Internal Staffing	20		20		Restructuring complete - no further action required
2122-15b	End grants paid to link clubs, some of which are no longer providing services	2		2		
2223-18	Increased utilisation of new housing capacity for service users.	31		31		Dunbeg project complete, full savings target unlikely to be realised due to changes in care & support needs
1819-33	Catering, Cleaning and other Ancillary Services	71		71		Catering related project - proposal to work with Argyll & Bute Council under development
TBC	MH/LD/PD	225		225		Specific projects still to be developed
2223-17	Reduce the number of individual sleepovers and utilise TEC	78		78		Project underway - Expecting half of target to be declared in Q3
2223-19	Implement reviews of care packages to ensure these are equitable across the area and transition to older adult care packages were appropriate	80		80		Project delayed as staffing resource has been deployed to assist with severe service pressure and unmet need in Oban area
2122-02	Carry out hostel review to achieve best value in admin and catering	23		23		Changes to contracts to be phased in to reduce term time contracted weeks - expect saving to be delivered by August 2023 per SLT decision to phase contract changes.
Health						
2021-1	Mental Health redesign of dementia services	200	100	100		Declared on a non-recurring basis last year, structure to be confirmed and expect to declare in 22/23.
2122-35	Mid Argyll hospital removal of surplus budgets on hotel services £20k, comms £4.3k; GMS out of hours £2k; equipment £1.5k	4		4		Small balance to be declared
2122-33	centralise lab ordering £20k and theatre stock ordering £5 along with North Highland	20		20		Expect to declare in 22/23
2122-43	Oban Patient travel £25k; staff travel £10k	10		10		Expect to declare in 22/23
2122-60	Planning & Performance team - reduce budget for travel & printing £3k; Consultant Travel £10k	10	5	5		Expect to declare in 22/23
2122-36	Campbeltown hospital patients travel £30k	30		30		Expect to declare in 22/23
2122-38	Campbeltown hospital sundry underspends comms £6k; portering £1; pharmacy £6k; general management discretionary £5k, transport £2k; GMS out of hours £1.5k	13		13		Expect to declare in 22/23
2122-42	Islay: saving on local outreach clinics and accommodation through more remote clinics	15		15		Expect to declare in 22/23
2223-27	Children & families	130	112	18		Plan in place for balance of saving, low risk
1819-44	Advanced Nurse Practitioners - Oban	14		14		Complete
1920-38b	Lorne & Islands Hospital staffing	21		21		Complete
1819-32	Catering & cleaning review	20		20		Catering related project - proposal to work with Argyll & Bute Council under development
2021-2	Standardise procurement of food across all sites and expansion in conjunction with Council for early years	69		69		Catering related project - proposal to work with Argyll & Bute Council under development
2021-19	Redesign of hotel services to reflect reduction in inpatient numbers	99		99		Catering related project - proposal to work with Argyll & Bute Council under development
2021-23	Catering & domestic - spending below budgets	30		30		Catering related project - proposal to work with Argyll & Bute Council under development
2122-32	1% general efficiency requirement across all hospital budgets	186	116	70		Carried forward saving - work on-going
2122-46	Helensburgh outreach clinics £8k; casualty payments £14k,	14		14		Negotiations underway - requires variation to GP contract
2122-30	Introduce more re-use of walking frames and improved procurement of musculo-skeletal supplies	20		20		Work underway to develop project
2021-4a	Admin & clerical general productivity / efficiency enhancement via shift to digital working in 2020/21 and 2021/22	100		100		Project underway
2021-4b	Right size admin budgets Mid Argyll and LIH	27		27		Project underway
2021-20	Centralised booking of medical records - reduction in admin costs	97		97		Project underway
2223-7	Transfer Switchboard Services to Highland Health Board from Glasgow.	54		54		Project underway but delay with transfer to NHS Highland
2223-1	Management and review of prescribing processes and products to ensure best value is being achieved.	589	70	519		Work on-going - saving challenging due to on-going supply chain disruption - £360k of savings identified to date.
1920-4	Review of Service Contracts	20		20		Specific savings to be identified as part of contract management processes
2223-5	Ensure that all staff are deployed to substantive roles within the HSCP staffing structure.	129		129		HR now providing support to progress.
2223-8	1% reduction in hospital budgets.	470	56	414		Approximately half of the target has been identified to date
2021-64	Review of Forensic Medical Examiner Costs - Bute & Cowal and Out of hours	50		50		Negotiations underway - dependent upon Dunoon contract
2223-9	Reduction in Forensic Service Contract costs.	20		20		Negotiations underway
2122-66	Savings from building rationalisation following increase in home working	72		72		Saving is subject to Cowal Community Hospital Capital Project - This has not yet been formally signed off and completion is now March 2023 at best
1920-22	Dunoon Medical Services (see also 2021-16)	100		100		As Above
2021-3	AHP - carry out workforce planning and establishment setting to find efficiencies in posts and realign services provided to match	86		86		Workforce Establishment Setting Underway - this is not now expected to result in a net saving
2021-16	Rationalisation of medical services for Dunoon (adds to 1920-22)	20		20		Subject to Dunoon GMS procurement and capital project
2122-04	Bring back urology services from NHS Greater Glasgow & Clyde and offer from Oban Hospital instead	110		110		Unable to progress as Medical Staffing in LIH is not stable at present.
		3,689	**463**	**3,226**		

Target	Declared M4	Remaining	RISK	NOTES
799	221	578		Saving perceived as low risk
2,399	242	2,157		Saving anticipated to be challenging to deliver in full within year
491	0	491		Saving now considered unlikely to be deliverable in 2022/23

Appendix 4 - Earmarked Reserves

	Reserves Balance 31 March 22 £	Reserves Allocated to 31 July £	Balance 31 July 2022 £
Primary Care Improvement fund	3,061,992	265,400	2,796,592
Other Primary Care Projects	74,521		74,521
Action 15 of the Mental Health Strategy 2017-27	289,661		289,661
Technology Enabled Care (Near Me)	142,230		142,230
Additional ADP Funding	185,238		185,238
Best Start - Maternity Services (Board re-provision)	86,000		86,000
Supporting Improvements to GP Premises	178,441		178,441
Scotgem Funding	20,701		20,701
Covid-19 support	10,489,150	1,840,112	8,649,038
Childrens Mental Health Services (CAHMS)	645,170		645,170
Community Living Change Fund	300,000		300,000
ACT Aros Residences Upgrade	184,200	64,200	120,000
Primary Care OOH Funding	231,870		231,870
Insulin Pumps correction including VAT	70,220		70,220
ASC Nurse Director Support IPC	61,066		61,066
Trauma Network Tranche 1 (70%) / Tranche 2 (30%)	62,525		62,525
PFG School Nursing Tranche 2	166,783		166,783
District Nurse Posts	127,015		127,015
E-health Strategy Funding	72,400		72,400
Perinatal MH Funding	160,679		160,679
Mental Health Officer Training	28,221		28,221
Type 2 Diebetes Framework (70%) & (30%)	31,803	22,600	9,203
Trauma Training Programme	69,444	5,250	64,194
Wellbeing Funding	85,028		85,028
Oban Accomodation	145,000		145,000
Primary Care Education Fund	250,000		250,000
Fleet Decarbonisation	86,520		86,520
Additional Band 2-4 Staffing	258,971	93,000	165,971
Nursing Support for Care Homes	151,386		151,386
Remobilisation of Dental Services	89,604	37,700	51,904
Mental Health Facilities	285,284		285,284
Diabetic Technologies	205,114		205,114
Waiting Times Funding	497,183	282,100	215,083
Interface Care Programme	133,032		133,032
Medical Assisted Treatment Standards	114,114	86,000	28,114
Psychological Therapies	55,923		55,923
Inequalities Project	26,369	26,369	-
Dementia Post Diagnostic Support	66,566		66,566
Mental Health Funding for Pharmacology	17,869		17,869
Medical Equipment	128,885	37,700	91,185
Eating Disorders	69,238	10,000	59,238
Ventilation Improvement	81,900	5,800	76,100
Mental Health Recovery Services	38,931		38,931
Whole Family Wellbeing Fund	39,000		39,000
Care at Home Funding	287,913		287,913
Multi Disciplinary Teams	213,946		213,946
Interim Care	447,402	90,410	356,992
General Reserves - Service Transformation	681,528	97,452	584,076
Total	**21,196,036**	**2,964,093**	**18,231,943**

Agenda Item 7

Integration Joint Board

Date of Meeting: 21st September 2022

Title of Report: Scottish Government Health Care Framework for Adults Living in Care Homes

Presented by: Jaime Smith – Lead Nurse for Care Homes and Care @ Home, NHS Highland

The IJB is asked to:
▪ Note the publication of the Health Care Framework for adults living in care homes (June 2022). ▪ Discuss the planned approach to response to Healthcare Framework for adults living in care homes by the Care Home Oversight function.

1. EXECUTIVE SUMMARY

1.1 This paper provides an introduction to the NHS Highland response to the recently published framework. NHS Highland co-ordinate the Care Home Oversight function that links directly with the multi-agency Care Home Assurance function within Argyll and Bute.

2. INTRODUCTION

The Healthcare framework for adults living in care homes. My Health – My Care – My Home, was published June 2022 by the Scottish Government. A link is attached to the framework at **Appendix 1**.

The framework seeks to examine how the health and health care of those living in care homes should be optimised, supported and delivered. Providing high quality, personalised care that is consistent, safe and meaningful is top priority for Scotland's health and social care services.

The Public Health Care Home Census (Dec 2021) reports that there are 33,000 people living in 1,069 care homes for adults across Scotland. 64% are living with dementia and the mean age of care home residents is 82. There are an additional 157 care homes for people with learning disabilities and 52 for people with mental health conditions, 36 for people with physical and sensory impairment and 15 for those with acquired brain injury, alcohol and drug misuse.

The framework was developed following active engagement across the sector – including those with lived experienced and their families, Care Home providers, staff, HSCP teams, academics and policymakers. The programme of engagement included 29 engagement events, 674 stakeholders invited, 44 residents and families, 6 focus groups, 508 online survey responses and 73 good practice returns. NHS Highland (North?) submitted a good practice return.

3. DETAIL OF REPORT

3.1 The Health Care Framework has seven aims.

- Examine how health and care should be supported and delivered.
- Enhance the health of people living within a care home
- Improve the way we assess, monitor and respond to the health care needs.
- Work with health care and social care professionals, HSCP and care home providers.
- Promote a consistent approach to support people to remain as healthy as possible.
- Challenge professionals, services and systems to work effectively.
- Enable provision of seamless, personalised care at all times.

There 8 framework areas (Nurturing environment, The Multi-disciplinary team, Preventative Recommendations, Anticipatory Care – self management and early intervention, Urgent and Emergency care, Palliative and End of Life care, Sustainable and skilled workforce, Data, digital and technology) have been developed with a total of 78 recommendations. 33 of these have been identified as priority areas for NHS Highland which incorporates Argyll and Bute HSCP.

The Care Home Oversight Group agreed a pan Highland in response to the Healthcare Framework Recommendations.

The first workshop was held on the 1st September at 9am with the objectives of – reviewing the framework, creating work streams, agreeing work stream leads and actions. Upon establishing work streams we will be able to develop key performance indicators.

4. RELEVANT DATA AND INDICATORS

Emergency department attendances, hospital admissions, delayed discharges figures, unscheduled care contacts, ACP data will provide indicators for impact of the framework.

5. CONTRIBUTION TO STRATEGIC PRIORITIES

The implementation of the framework will ensure that we provide high quality, person centred care for adults living in care homes. This will seek to maximise their health and wellbeing. A direct result of this could be a reduction in avoidable admissions as well as avoidance of delayed or poor quality discharges.

6. GOVERNANCE IMPLICATIONS

6.1 Financial Impact

Scottish Government funding for oversight arrangements and allocations for nursing support for adult social care were provided to the Board in March 2022 at a flat rate of £368 per bed. This funding was allocated across the NHS Highland board area with the provision of dedicated staff within Argyll and Bute. The funding allocation runs until March 2023, at present it remains unclear if this funding will be recurring.

6.2 Staff Governance

Any issues will be raised through the work stream development.

6.3 Clinical Governance

Professional leadership are involved and will ensure that any issues relating to governance are dealt with in according with the Clinical and Care Governance Framework of both NHS Highland and Argyll and Bute Integration Joint Board.

7. PROFESSIONAL ADVISORY

Professional leads are involved in the core group identified to support this work.

8. EQUALITY & DIVERSITY IMPLICATIONS

The implementation of the framework recommendations will seek to standardise health care provision for those living within care homes and ensure peoples' rights and dignity are maintained. .

9. GENERAL DATA PROTECTION PRINCIPLES COMPLIANCE

None identified currently.

10. RISK ASSESSMENT

N/A at present**.**

11. PUBLIC & USER INVOLVEMENT & ENGAGEMENT

Significant engagement by Scottish Government prior to development of the framework. A communication plan needs to be developed to facilitate the sharing of information regarding response to the framework and ensuring that the voice of those with lived experience is heard**.** Key stakeholders also include care home managers and these staff are connected in Argyll and Bute through a Care Home managers' forum and the Care Home Task Force.

12. CONCLUSIONS

This paper has provided a brief overview at this early stage, updates as this work progress will be provided at appropriate forums, the Older Adult Strategy Group for Argyll and Bute and the Care Home Oversight Group (pan Highland).

13. DIRECTIONS

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

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Appendix 1:

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Scottish Government

Healthcare framework for adults living in care homes

My Health – My Care – My Home

June 2022

Healthier Scotland
Scottish Government

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Making This Happen

Glossary

Ministerial Foreword

As the Cabinet Secretary for Health and Social Care and the Minister for Mental Wellbeing and Social Care, we are proud to announce this new healthcare framework, which seeks to strengthen the continuity and increase access to healthcare for people living in care homes.

This framework is a bold and ambitious document which aims to provide information, assurance and direction to all those involved in and affected by the provision of health and care in care homes. This includes people living in care homes and their family and friends, health and social care teams, care home providers and sector leaders across Scotland.

The framework is important for those living in care homes, as well as the wider health and social care system. However, it also plays a critical part as we recover and rebuild from COVID-19. As the sector emerges from the pandemic, it is essential that we learn from these experiences. We must expand the excellent advances in transformational change, integrated working, and relationship-building which have arisen over the last few years. We are also aware of the many good practices and innovation that the care home sector has exhibited and continued to show over the last couple of years against a very difficult background. The number of good practice examples that were collected as part of the development of the framework is testimony to that. We would like to take this opportunity to thank the workforce and wider social care sector for the commitment and hard work it has shown over the course of the pandemic. The professionalism and dedication of staff has been exceptional and we thank you on behalf of the Government and population of Scotland.

The recent Independent Review of Adult Social Care (2021) re-emphasised the importance of professionals working together across the traditional boundaries of health and social care to ensure that people living in care homes receive the same access to healthcare as people living in their own homes. As part of the Care Home Clinical and Professional Advisory Group pandemic response (CPAG), a Clinical Models of Care sub-group of stakeholders from across Health and Social care was established. The ask of the group was to review the current model of healthcare for care homes in Scotland and to set out recommendations for enhanced ways of working in order to fully meet the holistic needs of people living in care homes. As a result, in 2020, the Scottish Government tasked CPAG with developing a healthcare framework for adults living in care homes in Scotland. This was part of the delivery phase for the Adult social care – winter preparedness plan: 2021-22.

It is also part of a wider approach to improving the national healthcare model by seeking to fully integrate the Health and Social care system in Scotland. It is a pivotal building block in improving outcomes as we move towards the establishment of the National Care Service (NCS). Importantly, it also strongly aligns with other key Government policies, including; our development of a Health and Social Care Strategy for Older People; the framework for community health and social care integrated services; the health and social care standards; Promoting Excellence 2021 (Dementia framework); the Preventative and Proactive Programme Charter; the Rehabilitation Framework; A Fairer Scotland for Older People framework; the transformation of Primary Care; and, our commitment and approach to a new national strategy for palliative and end of life care.

Following a period of extensive engagement, this framework has been produced in collaboration with those living and working in the health and social care sector. From this engagement, responses included: that there is a strong need for everyone in the sector to work together in a supportive way to enable better health outcomes for individuals living in care homes; the importance of informed decision-making; good communication; that healthcare should be more than medicine.

We wish to take this opportunity to express our gratitude to those who took part in the engagement events. Your frank, open and honest views have been invaluable, and helped to develop this framework. Some examples of your feedback can be read in quotes throughout this document.

To address the comments reflected, this new and transformative framework sets out a series of recommendations to improve the outcomes for people living in care homes. It has a strong focus on multi-disciplinary team (MDT) working, with a need to place the person living in the care home at the centre of the MDT. It is important that the individual is integral to this and they should be able to make an informed decision on their own care, which should be supported by a MDT. To enable this, there should be regular meetings and good communication between those professionals providing constant and regular input and the person living in the care home. It aims to meet the needs of all people living in care homes by enhancing not only their health, but also their wellbeing. By working in a collaborative and coordinated way, we can enhance the health and wellbeing of those living in care homes, and therefore, improve outcomes.

As we move forward to implement these recommendations, we will continue to be committed to supporting this work and expect the same commitment from all partners. We must be ambitious and bold in our aspirations to transform the healthcare that people living in care homes receive. True multi-disciplinary and multi-agency working must commence now, with people living in care homes, their families and carers firmly at the centre of what we do.

Humza Yousaf
Cabinet Secretary for Health and Social Care

Kevin Stewart
Minister for Mental Wellbeing and Social Care

About This Framework

This framework will examine how the health and healthcare of people living in care homes should be optimised, supported, and delivered. It will also enhance the assessment, monitoring and response to the forever-changing health and healthcare needs of people who live in care homes.

It is clear, however, that a person's health is enabled by both our 'social care' and our 'healthcare' workforce. Therefore, throughout this document, the term healthcare refers to the health needs of the individual in their broadest sense. It will be made clear where there is an intention to specifically refer to the healthcare or social care workforce.

Through active engagement and participation, this framework and its recommendations has been developed in collaboration with various key stakeholders from across the sector. This includes people who live in care homes and their families, care home providers, representatives and staff, Health and Social Care Partnerships (HSCPs), our health and social care workforce, academics, and policymakers.

The recommendations draw on the diverse experience and feedback shared during the engagement and consultation process aiming to ensure consistent high-level healthcare for everyone who is living in a care home.

Aims

The majority of people in care homes are living with more than one significant long term medical condition which may not improve and will often be progressive. Provision of a consistent and enhanced approach to care will enable people to remain as healthy as possible, therefore encouraging them to live their best life. It challenges professionals, services and systems to work effectively to support this, and therefore provide seamless, personalised care at all times.

With this in mind, a key element of this framework is to ensure a proactive focus on the fundamental components of what we need to live well. For example, by ensuring that our fundamental needs of fluid, nutrition and movement are met, we can reduce or delay the need for wound care. Similarly, by ensuring a person has the opportunity and support to connect, engage and express their needs, we can alleviate distress and anxiety.

The wider determinants of health and wellbeing have also been examined and explored. This, coupled with our extensive programme of engagement, has helped to centre the framework around the following six core elements:

1. nurturing environment
2. the multi-disciplinary team
3. prevention
4. anticipatory care, supporting self-management and early intervention
5. urgent and emergency care
6. palliative and end of life care

Importantly, the core elements are underpinned by both 'a sustainable and skilled workforce' and effective use of 'data, digital and technology'. These areas are seen as key enablers that will help the sector to implement the recommendations within this framework. Other enablers are realistic medicine and ethical commissioning:

Practising and applying the six principles of Realistic Medicine will ensure decisions about healthcare are made in partnership with people and their families and will deliver care of greatest value to them. These six principles are:

- shared decision making
- personalised approach to care
- managing risk better
- reducing harm and waste
- reducing unwarranted variation
- innovating and improving

These take account of an individual's approach to risk and their decisions about the care they feel is right for them. In addition, when practising Realistic Medicine, we strive to reduce waste, harm and unwarranted variation in pathways of care, enabling optimal use of our precious health and social care resources. We call this value-based healthcare. Value-based healthcare is not focused on saving money or delivering efficiencies. It is about working with people to consider whether a treatment or an investigation is going to be of value, based on what matters to them.

In March 2021, the Scottish Government and COSLA issued a joint statement of intent outlining how they would work together to deliver the key foundation pillars set out in the Independent Review of Adult Social Care in Scotland. This will lead to shared ethical commissioning principles and establishment of core requirements for ethical commissioning which will ensure that going forward, fair work requirements and principles are met and delivered consistently across Scotland. Ethical commissioning and procurement standards will allow the Scottish Government to focus on those important issues that will affect how care is planned, designed, sourced, delivered, and monitored. Components in the commissioning cycle that are important to achieving the vision in this framework. It will also allow the Scottish Government to spotlight critical areas were we have limited legislative levers to take action through NCS accountability and governance structures. By taking action now to embed ethical commissioning and procurement principles, the Scottish Government can help public bodies and providers to fully engage in the new and changing responsibilities for a NCS.

The remaining chapters of the framework will describe what we have heard from those living and working in the sector, and our recommendations for the future. This is a pivotal building block in improving outcomes as we move towards the establishment of the National Care Service.

Introduction

Providing high-quality, personalised care that is consistent, safe, and meaningful, is the top priority for our health and social care services in Scotland today. This framework aims to provide direction and vision that will maximise the health and wellbeing of people living in care homes. It aims to ensure that people living in care homes experience this wherever they are living in Scotland. Therefore, the framework, and its recommendations, are aligned to the Health and Social Care Standards and takes a human rights based approach. In order to fully implement this framework, it will be necessary to ensure that workforce and other resources are in place to address local needs and circumstances.

Scotland's population is now at its highest level and is also growing steadily older. This is true of both people living in care homes and the workforce that provides healthcare. It is undoubtedly positive that people are living longer, however, some are living with increasingly complex health and care needs which may necessitate residing within a care home.

The care home sector in Scotland provides care for adults and older people, individuals with learning and physical disabilities, neurological illness, mental health conditions and brain injury. Some care homes also provide intermediate care and respite services for people on a temporary basis. Across each of these groups the healthcare needs of those living in care homes is becoming more complex and requires more specialist interventions.

The latest Public Health Scotland Care Home Census for Adults in Scotland (published December 2021) reports that there are 33,000 people living in 1,069 care homes for adults in Scotland. Of these, 91% are living in a care home for older people, and 64% are living with dementia (either medically or non-medically diagnosed). The mean age at admission into a care home for older people is 82 years.

The 2021 census also reports there are 157 care homes for people with learning disabilities, 52 for people with mental health conditions, and 36 for people with physical and sensory impairment. The remaining 15 care homes for adults in Scotland included those for acquired brain injury, alcohol and drug misuse, and blood-borne virus.

The requirements of those living in care homes go beyond physical health, and include social, psychological and spiritual care needs.

> **Importance of retaining community links, relationships, family and friendships. The importance of this in helping to maintain good health cannot be understated.**

The COVID-19 pandemic has undoubtedly had a significant impact on people who live and work in care homes, and their friends and families. Older people, individuals with a weakened immune system, and those living with long term medical conditions were all more vulnerable to severe illness from the infection.

There have also been historical factors pre-pandemic which have challenged the care home sector. These issues are well documented in the Independent review of adult social care in Scotland report (2021). It is essential that we learn from these experiences and build on some of the excellent innovative practice, integrated working and relationship-building which have arisen in parts of the country during the course of the pandemic.

Care homes are where people live and call home. They should expect the same level of involvement, choice and support for their health and wellbeing as they would if they were living elsewhere in the community. This can only be achieved through a whole-system, collaborative approach.

All parts of the system working together to review the true cause of the presenting issue.

People have a range of health and wellbeing needs that extend across relationships with family and friends. These include psychological and social needs, in addition to environmental needs and basic biological needs. The Wheel of wellbeing diagram (below) helps us to visualise the range of needs, that when fulfilled, contribute to good experiences of wellbeing. All five of the segments within the wheel must be in place to enable optimal health. If one or more of the segments are missing, it can result in a decline in physical or mental health.

Figure 1 The biopsychosocial components within the 'Wheel of wellbeing'

The deliberate focus on people, and their health and care, is in recognition of the increasing number and complexity of long term conditions that individuals in a care home are living with. It is also in recognition of the fragmented or reactive healthcare that is often experienced, rather than preventative and planned healthcare.

This new framework specifically seeks to strengthen the continuity and access to healthcare, both from within and outwith the care home. It is about ensuring that people living in care homes have all of their needs met, and are supported to live their best life possible. The first step to achieve this was to have a diverse programme of engagement that encouraged active participation with various stakeholders including those living and working in care homes and their families.

What We've Heard

Our programme of engagement, most of which took place online between November 2021 and April 2022, involved the following:

Whilst the opportunity for face-to-face engagement was limited by the Omicron wave of the COVID-19 pandemic, it was possible to engage directly with 25 people living in care homes. People were encouraged to share their views on living in the care home, and their experiences of accessing healthcare. We also wanted to know what was important to them. Some of this feedback was collected using postcards (see page 11).

We also engaged directly with 19 family members. However, many stakeholders attending other engagement sessions in a professional capacity also gave views on their personal experiences of family members living in care homes.

We have also used social media, surveys and focus groups to hear from a wide range of stakeholders. These included care home providers and staff, the Care Inspectorate, Healthcare Improvement Scotland (HIS), the 'third' and independent sector and numerous other professionals from across the system who plan, provide and deliver care. We are extremely grateful to everyone who provided their thoughts, insights and suggestions.

A consistent comment emanating from our engagement was the need to do work 'with' the care home community rather than doing things 'to' them. There was a strong desire for everyone to work together in a supportive way to enable better health outcomes for people living in care homes.

An online survey was developed and sent to all care homes across Scotland. There was an overwhelming view from respondents (93%) that healthcare for people living in care homes could be improved.

All the various comments, stories, experiences, opinions and suggestions from our engagement activities have been used to shape the framework and inform the recommendations. Engagement is not a one-off exercise and must continue as we start implementing the various recommendations within this report. More information on implementation can be found in the 'Making This Happen' section.

Resident Engagement Sessions – Fife

In 2021, Abbotsford Care, the Care Home Hub from Fife Health and Social Care Partnership collaborated to develop the 'Hear My Voice and Return to Sender' initiative as a means of exploring new methods of engagement with people living in care homes. The immediate aim was to influence this framework but the group has longer-term aims to develop methodology utilising an activities-based approach to supporting and prioritising the voices of people living in care homes throughout Scotland.

The focus of this initiative centred around a creative approach, using fun and activities in focus group sessions to begin conversations and support the generation of feedback in a comfortable environment. Using person-centred activities, participants engaged in a number of activities; for example, they were asked to assign a colour scale to a set of emotive questions, create a shape to reflect their feelings representing their experiences, discuss and sharing a mind map of all the support services who have helped them, and detail their personal experiences on a postcard which centres around a performative moment for residents and staff to engage in.

The importance of being well-cared-for was emphasised, as was the sense of living and enjoying life. While some residents expressed a preference to be able to live independently at home, others highlighted that they felt safe in the care home. Individual preferences for company and solace were shared. Some spoke of their enjoyment of activities within the home, shared with staff and other residents. The negative impact of restrictions on access to family, opportunities for leaving the home and going outside were noted, with residents looking forward to greater opportunities now restrictions have eased. Connectedness and relationships with families and care staff were shared.

What was noted as one of the most positive outcomes from this initiative was the direct opportunities for Care Home Liaison nurses from the Health and Social Care Partnership to spend time with those living in Care Homes and to learn more about their experiences. A further 1,000 postcards have been distributed to people living in care homes across Scotland which will be used to inform the roll-out and implementation of the framework.

1. Nurturing Environment

The health and wellbeing of someone is greatly influenced by the immediate environment, activities, and those providing day-to-day care.

During the COVID-19 pandemic, restrictions were imposed on many of the activities that people living in care homes were allowed to participate in. This had a significant and detrimental impact on their health and wellbeing, and also that of their friends and families.

Health and healthcare is much more than medicines and clinical diagnoses. Provision of a safe, homely and stimulating environment with meaningful activities, good nutrition and social connection are essential and fundamental components of good healthcare that also support positive wellbeing.

There should be daily opportunities to do things that are important or meaningful to the individual; such as connecting with families and friends, music, art, exercise, gardening, animal therapy and spiritual time.

As such, health and wellbeing is represented by the largest section of the diagram below (figure 2) as it is greatly influenced by the local environment, the community living in the care home, professional carers, families and friends.

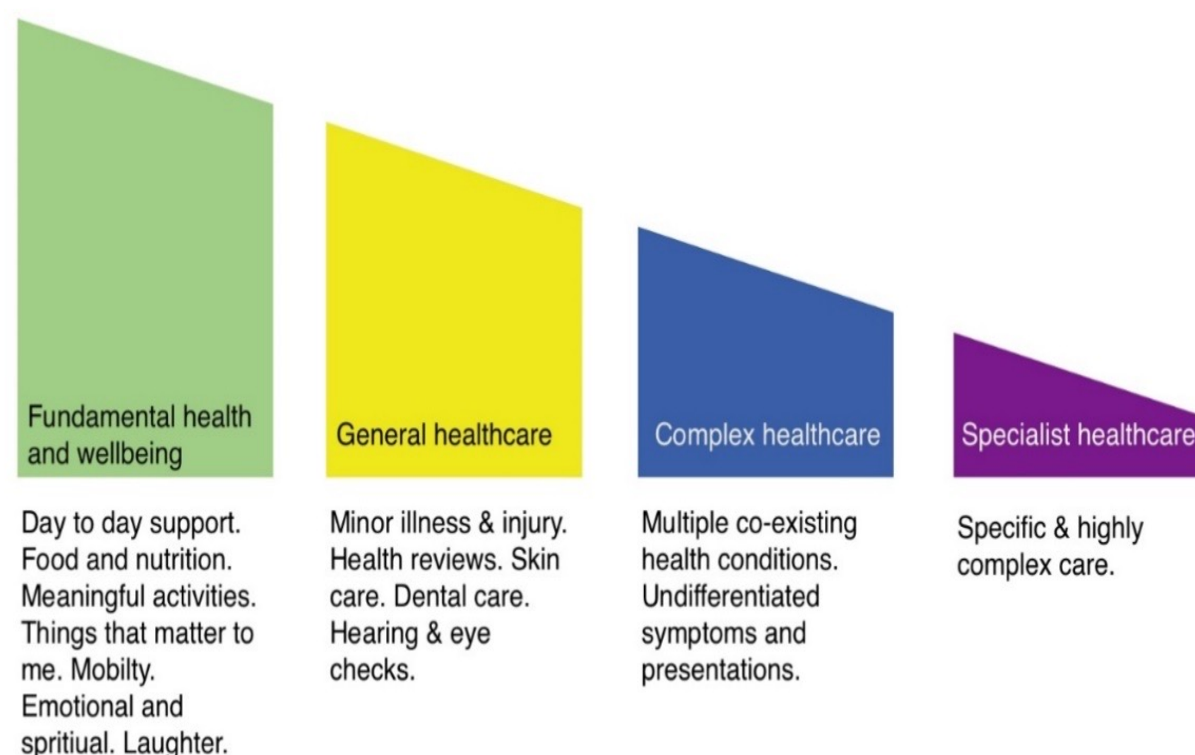

Figure 2 The healthcare needs of people living in care homes

As we come through the pandemic, the importance of day-to-day activities and social interactions has never been clearer and we rely on our skilled and dedicated care home staff to enable this to happen. It is often through these routine daily contacts that social care staff are able to detect that 'something is not quite right'. This comes from knowing the person in the care home well, recognising different patterns of behaviour and spotting changes that are indicative of illness.

It is essential that the important role of care home staff in improving health and wellbeing is both recognised and valued in our society. The care home team should continue to play the leading role in the healthcare of people living in care homes, with a keyworker who co-ordinates the day-to-day care of the individual.

Contact and engagement with families and friends greatly enhances health and wellbeing. Based on feedback from stakeholders and families, the Scottish Government considers that Anne's Law should provide people who live in adult care homes with the right to see and spend time with a named visitor or visitors at all times. They will have the same access rights to care homes as staff, while following infection, prevention and control procedures. Anne's Law will be incorporated into primary legislation in the National Care Service Bill, due to be introduced by the end of this parliamentary year.

The Health and Social Care Standards set out what people should expect when receiving health and social care in Scotland. Two new standards were introduced in March 2022 to ensure that people living in care homes have their right to maintain contact with people important to them in their care and support upheld.

Other healthcare provision (as outlined in figure 2) can be categorised as general, complex and specialist. However, health and wellbeing must not become over-medicalised as care homes are where people live and call home, they are not, and should not become clinical wards. Health and social care professionals must work together to address these healthcare needs within the nurturing environment of the care home.

Nurses working in care homes play a leading role in supporting people living in care homes to live the best life possible. They also lead many aspects of 'general healthcare' such as managing minor illness and infections supporting the more complex care needs that people have.

Everyone living in a care home should have access to nursing care. These nurses may either be employed by the care home, or, if employed externally, should have expertise in care homes. It is important that there is also responsive access to wider community and specialist nursing, allied health professionals and advanced practitioners for healthcare.

The General Practitioner, as the 'expert medical generalist', has a particularly important role within the multi-disciplinary community team in managing people with complex and multiple medical problems and making sense of 'undifferentiated presentations'. This is illustrated in the 'complex healthcare' section of figure 2.

The requirement for someone to be living in a care home indicates a level of complexity in their care. However, some people have very specific and *highly* complex healthcare needs which may have previously required inpatient hospital care, or specialist input within a community hospital or a complex care ward. These individuals must be able to access appropriate specialist assessment and regular specialist review when living in a care home where that is required.

Recommendations

1.1 We must recognise and value the important role of all staff working in the care home in improving health and wellbeing of people living in care homes.

1.2 The care home team should continue to play a leading role in the healthcare of people living in care homes, alongside a keyworker who co-ordinates the day-to-day care of the individual.

1.3 Health and social care professionals must work together to address any healthcare needs within the nurturing environment of the care home and ensure that people living in care homes are not over-medicalised.

1.4 Everyone living in a care home should have access to nursing care. These nurses may either be employed by the care home, or, if employed externally, should have expertise in care homes.

2. The Multi-Disciplinary Team

A multi-disciplinary approach allows people to benefit from the combined skills and expertise of health and social care professionals who are working together to optimise health and care outcomes.

A constant desire emanating from our programme of engagement is the need to adopt a multi-disciplinary team (MDT) approach to healthcare.

This is where a group of healthcare and social care professionals, who are members of different disciplines, with different skills and expertise (e.g. care workers, social workers, podiatrists, dentists, nurses and doctors), work together to enable the best outcome for the person living in the care home.

The MDT

There are many different individuals and professionals who support the health and wellbeing of an individual living in a care home, and these can be represented by concentric wheels around the person (figure 3).

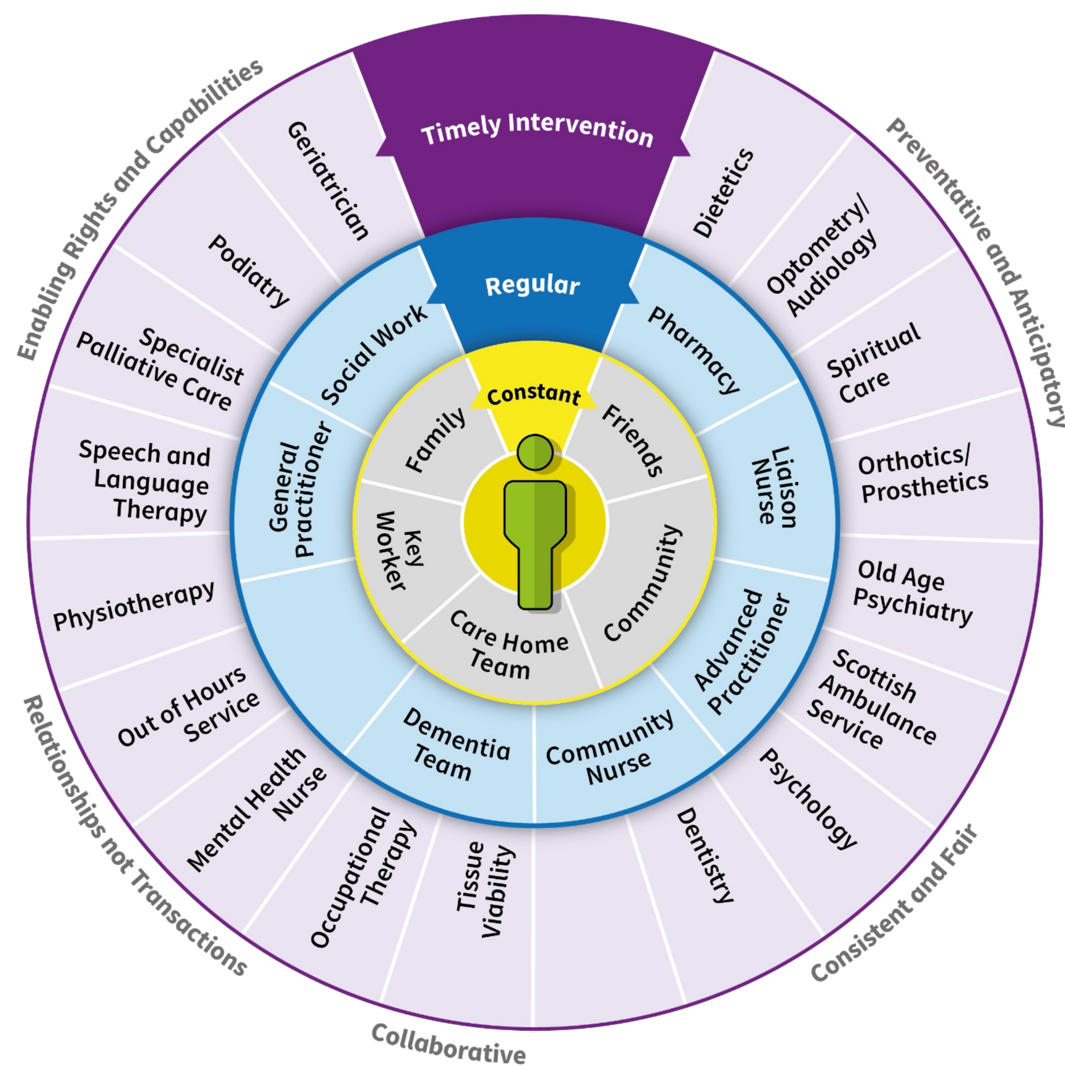

Figure 3 The multi-disciplinary team around the person living in a care home

The people that will normally have the largest impact on health and wellbeing, and who are likely to be a constant presence in the life of the individual in a care home, are listed in the inner wheel. These include friends and family, the community and the care home team. All members of the care home team have an important role in promoting a person's health and wellbeing; for example, catering staff supporting nutritional care, domestic staff engaging in day-to-day conversation and promoting mental wellbeing, and gardening staff who can promote outdoor physical activity by creating a safe and stimulating outdoor environment. There is a particularly important role for the registered nurse within this team. They possess an in-depth knowledge of long term health conditions associated with ageing and skills in the management of complex multiple morbidities and frailty.

Nurses working in care homes require leadership skills and will often have management responsibilities for others within the care team. They are also a key link with the professionals working within the middle and outer wheels.

The people listed in the middle wheel may not be involved on a daily basis, but will often be providing regular healthcare advice and reviews over many weeks, months and sometimes years. They will work closely with those in the inner wheel. Those in this wheel may change depending on the needs of the individual. For example, someone recovering from an illness or injury may require a proactive rehabilitative or enablement approach led by a physiotherapist or an occupational therapist. The role of advanced practitioners within the middle wheel, providing regular professional input is increasing. These advanced practitioners may be specialist nurses or Allied Health Professionals. Social workers hold legal duties under the Social Work (Scotland) Act 1968 to assess needs and make arrangements for care and support. They have an important role in 'protection and monitoring', and also provide assessment of needs and finance when making arrangements for people to go into care homes. Approaches based on human-rights enabling and person-centred strengths should drive the support delivered, but also challenge it where it is not. Social workers have a statutory duty to ensure this happens.

The outer wheel represents a range of other health and care professionals who will provide proactive timely interventions to support the individual. This may be through offering advice and guidance to those in the inner or middle wheel.

It is likely that the individual will not require input from everyone within these concentric wheels, and for some people there will be more focused involvement than for others.

The blank boxes within the diagram signify that other professionals who are not listed, may become part of the MDT for an individual, and that professionals may move between the outer and inner wheels.

Someone living in a care home may need the time-limited and focused support from specific members of the MDT. For example, someone with swallowing problems may require increased input from those professionals highlighted in green within figure 4.

It should be clear to the key worker and care home team how to access all members of the MDT, with a clear understanding of how and when to obtain help. Professional to professional support should be available without having to go through the GP, whenever it is clinically appropriate to do so.

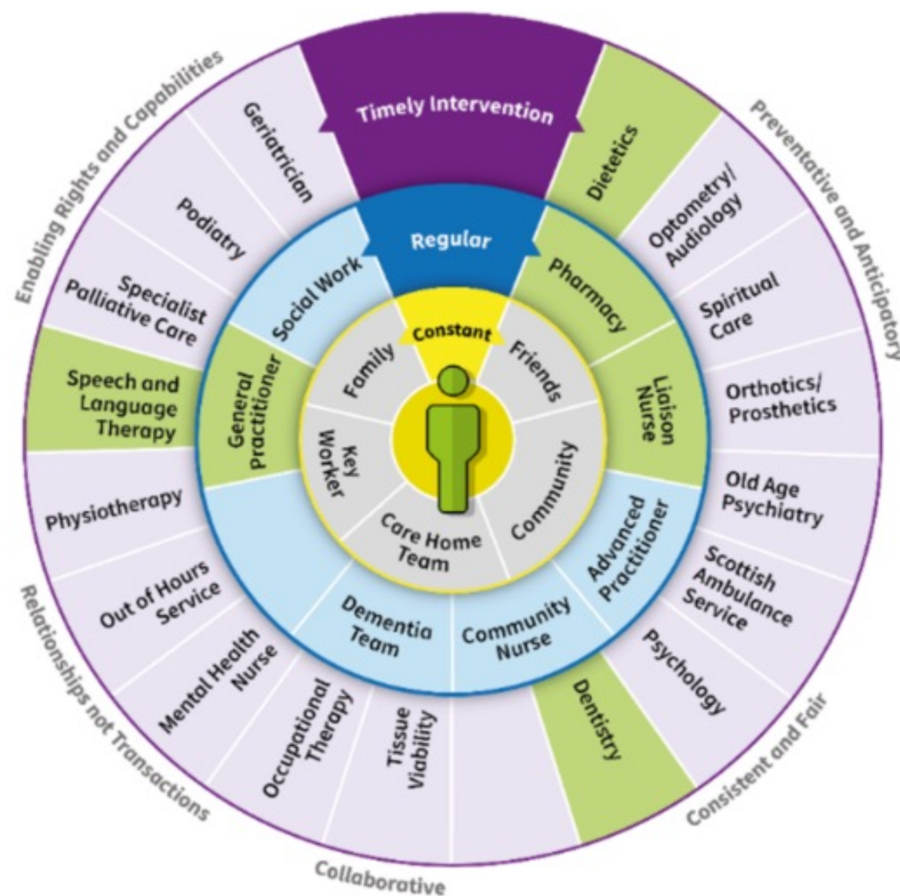

Figure 4 An example showing an individual with swallowing problems

MDT meetings

The MDT must take a proactive and anticipatory approach to the care of those living within the care home. To enable this to happen there should be regular meetings and good communication between those professionals providing constant and regular input (the inner two wheels in figures 3 and 4) and the person living in the care home. Other professionals highlighted as part of a person's care team (for example those in green in figure 4) should be invited to contribute to MDT meetings as and when required. This could be in person, or by providing a report or update ahead of the MDT meeting. Allied Health Professionals can make a significant contribution to discussions by shifting the focus onto prevention, rehabilitation and reablement. These MDT meetings will allow professionals to share information, discuss and plan care for the individual. All members of the team (including families and the person) will have the opportunity to highlight people that should be discussed at the MDT meeting.

For practical reasons meetings may take place virtually using video technology, and should happen as frequently as is necessary. However, this is likely to be dependent on the person and/or the care home. Smaller care homes may wish meetings to take place monthly whereas larger care homes may need to meet more frequently. The 2018 General Medical Services (GMS) contract describes how GPs should provide senior clinical leadership to the MDT, and so with the implementation of Primary Care Improvement Plans, it is a strong recommendation that there is GP representation at these meetings.

MDT meetings will require some administrative support to ensure that they take place and that the appropriate people are invited. This role should be co-ordinated between the HSCP and the care home. Discussions during these meetings should be led by the most appropriate members of the MDT. During any subsequent planned review, people living in care homes should have the opportunity to involve a family member or any legally appointed welfare guardian or attorney. If required, Chief Social

Work Officers can act as legal welfare guardians, making decisions (Adults with Incapacity (Scotland) Act 2000) if there are no other suitable people in a person's life to undertake this role.

As MDTs form and develop, opportunities for shared learning should be explored to develop the knowledge, skills and experience required to provide the best possible care.

Some health boards are already looking at this multi-disciplinary way of working. NHS Tayside have developed a set of principles for developing the MDT and for how General Practice should work with care homes.

Communication between different agencies needs to be improved for a co-ordinated and enhanced MDT approach to work. There must be better access to relevant care and clinical information, with sharing of relevant assessments, care plans and treatment decisions. This theme is explored more in the Data, Digital and Technology section.

Alignment of GP practices with care homes

Some care homes look after people who are registered across multiple GP practices, and similarly some GP practices look after people residing in multiple different care homes. This can be challenging for all involved.

Care home staff and community MDTs report difficulties when dealing with several GP practices who each have different ways for requesting advice, visits and prescriptions. It is also inefficient for staff in the same GP practice to visit multiple care homes on the same day. There is evidence of better outcomes (better satisfaction amongst all professionals, fewer medication-related problems, reduced inappropriate admissions to hospital, agreement over the optimal healthcare management plan) when care homes are either aligned or work more closely with specific GP practices. Optimal NHS service delivery to care homes

It is a strong recommendation that each care home should be linked with a named GP practice that will play a lead role with that home. This will allow closer and stronger working relationships to develop between the GP practice team and the care home. It will also provide clarity over which GP practice should be supporting the MDT.

We are lucky as our district nursing teams and GP practice work excellently alongside us to benefit the resident.

HSCPs should work within localities to have, wherever possible, a single lead GP practice, working in close partnership within an extended MDT for each care home. Very large care homes may require input from more than one GP practice. Where there are exceptional circumstances making linkage of care home and GP practice impossible, HSCPs should work with the local care homes and GP practices to establish safe and reliable alternative arrangements that enable effective MDT working.

There may be someone living in the care home who chooses to remain registered with a GP practice which is not the lead practice for that home, but is still within the practice boundary. This request should be accommodated whenever possible, but the individual should be aware of the advantages of being registered with the lead GP practice for their care home and that they are able to make a decision that best suits their needs.

Most health boards in Scotland offer GP practices 'local enhanced services' (LES) in relation to care homes. These provide additional funding to supplement services already offered within the core GP contract. GP practices can decide whether or not to participate in a LES. Many of the LES relating to care homes have not been revised since the introduction of the GP contract in 2018. Health Boards should review their existing LES that relate to care homes and revise them in line with the aspirations of the 2018 GP contract and the ambitions of this framework.

Specialist provision for those with the most complex care needs

Care home staff have a wealth of experience and expertise in caring for frail older people, people living with dementia and within palliative and end of life care. However, there should still be clear pathways to access and obtain support from specialist services. There should be a proactive system in place for reviewing people living with the most complex of healthcare needs.

Some care homes have established dedicated facilities for people living with very specific and complex health conditions (e.g. homes for people with advanced Huntington's disease or severe brain injury). The healthcare needs of these people go beyond the scope of General Practice, and so HSCPs have a responsibility to ensure that there is the appropriate specialist provision available when commissioning such services from the care home sector. These specialist services must maintain close links with the care home and be responsive to the specialist needs of the unit, as well as with the GP practice and MDT. This includes having clear contact details, referral routes and communication channels for when specialist advice and support is required.

Getting It Right For Everyone (GIRFE)

The Scottish Government's National Care Service consultation consulted on a National Practice Model: Getting It Right For Everyone. A proposed multi-agency approach of support and services from young adulthood to end of life care.

GIRFE will help define the adult's journey through individualised support and services, and will respect the role that everyone involved has in providing support planning and support. Too often, adults and their families are excluded from assessment and support processes by complex bureaucracy.

GIRFE is about providing an easier way to access help and support when it is needed – placing the person at the centre of the decision-making process to achieve the best outcomes, with a joined-up, coherent and consistent multi-agency approach regardless of the support needed at any stage of life.

Principles:

- **Focused on individual care needs**
  ensures that every person is at the centre of informed multi-disciplinary decision making and the support available to them.
- **People treated as equal partners**
  share decisions about treatment options so people are supported to make an informed choice about what's right for them.
- **Based on an understanding of the wellbeing of individuals**
  adopts a person centred approach to ensure that a person's needs are taken into account while acknowledging that their needs will vary over time.
- **Based on early intervention**
  aims to ensure individual needs are identified through meaningful and ongoing conversation, and appropriate support provided, as early as possible.
- **Requires joined-up working/information sharing**
  is about people and their care teams working together in a co-ordinated way to meet specific needs, provide care they really value and improve their wellbeing.
- **Requires an evidence-based approach**,
  where professional judgment, the best available evidence and people's preferences converge to ensure we provide better value care for the people we care for and for the system, and in turn help to reduce waste and potential harm.
- **Based on a human rights approach**
  about ensuring that both the standards and the principles of human rights are integrated into policymaking as well as the day-to-day running of organisations. Everyone has the right to be involved in decisions about their treatment and care.

Recommendations

2.1 Regular MDT meetings (face-to-face, virtual or hybrid) should take place involving the care home team, the GP practice and relevant other professionals to co-ordinate and plan healthcare.

2.2 The administration and support of MDT meetings should be co-ordinated between the HSCP and the care home.

2.3 People living in care homes should have the opportunity to involve a family member or any legally appointed welfare guardian or attorney during consultations with members of the MDT.

2.4 As MDTs form and develop, opportunities for shared learning should be explored, to develop the knowledge, skills and experience required to provide the best possible care.

2.5 Wherever possible, each care home should be linked with a named GP practice that will play a lead role with that home. Where this is not possible, HSCPs should work with the local care homes and GP practices to establish safe and reliable alternative arrangements that enable effective MDT working.

2.6 People living in care homes should be made aware of the benefits of being registered with the GP practice that is linked to the care home that they live in, however they should not be forced to change GP practice.

2.7 Health Boards should review Local Enhanced Services (LES) that relate to care homes and revise them in line with the aspirations of the 2018 GP contract and the ambitions of this framework.

2.8 HSCPs must ensure that there is access to appropriate specialist provision when commissioning with the care home sector to provide specific services for people with highly complex care needs.

2.9 Care home teams must be provided with contact details and referral routes for all members of the MDT. Where these are not clear, the HSCP should work with the care home to obtain these.

3. Prevention

Preventing deterioration in health and wellbeing through good nutrition, hydration continence, movement and activity, cognitive stimulation and social connections.

Prevention can stop the onset of illness through early positive interventions. It can also reverse, stop or delay the progression and impact of a pre-existing condition. Put simply, it involves proactively keeping people well, and maximising their independence to thrive in the most appropriate care setting for their needs. This involves an asset based approach, focusing on what a person can and likes to do rather than where their difficulties are.

People living in care homes must be supported to access any relevant age-specific public health programmes, for example screening for bowel cancer or immunisations against flu, COVID-19, pneumococcal and shingles infections. They should have the opportunity to make an informed decision about whether to take part in these programmes with appropriate information that is tailored to their needs.

Preventing the spread of infections has always been important within care homes, and has been even more apparent during the COVID-19 pandemic. Care homes are not and should not become sterile 'clinical' settings, but they must remain safe environments for people to live in.

The Healthcare Improvement Scotland (HIS) Infection Prevention and Control (IPC) standards are a requisite for safe, high-quality care in all settings. They must be supported by access to relevant IPC guidance, advice, education/training and guidance.

By applying best practice, infections such as respiratory tract, gastrointestinal or wound infections, may be prevented. It is essential that this is part of routine compassionate care in a homely environment. IPC plays a part but so does hydration, mobility and medicines management.

A regularly reviewed personal plan can support a preventative approach to care, and is therefore essential that everyone living in a care home has one. The health and social care standards define a personal plan as:

> *'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.'*

Personal plans are currently being produced, often at a very good standard, across the country. However, there is a variation in how they are being written and utilised, particularly in respect to the development and use of online resources. There should be consistency in the approach taken when developing these personal plans, as recommended within the Care Inspectorate's Guide for providers on personal planning.

The views and wishes of the resident should be sought, considered and implemented to support them to live their lives to the fulfilment.

Preventative care involves a collaborative approach where professionals focus on their knowledge and understanding of the individual to do what is right for them. MyHomeLife Scotland is an initiative to promote quality of life for those living, dying, visiting and working in care homes for older people through relationship-centred and evidence based practice. Together in Dementia Everyday (TIDE) acknowledges and values the experience and skills of carers, and gives them a voice across many aspects of care, including prevention.

Restoring Relationships: The Recovery of Love, Connection and Family

As the COVID-19 pandemic took hold families felt a physical and emotional separation from their relatives living in care homes. Care home staff and managers have also experienced a huge range of emotions, loss and change whilst ensuring the safety of the people they care for.

In response TIDE (Together In Dementia Everyday) have created two Recovering Relationships toolkits, one for families and friends and one for care home staff and managers. These toolkits are for anyone who knows someone living in a care home in Scotland or for anyone who works with care providers in Scotland. Relationships initiative

These toolkits focus on different areas of communication and relationships with lots of practical hints and tips designed to support you to take the first steps to improve and renew your relationships.

Prevention also covers many other aspects of healthcare, including:

Medicines management

Prevention of deterioration or of harm also involves the proactive management of long term health conditions and regular, structured polypharmacy reviews. It has been estimated that 25% to 40% of hospital admissions of older people are related to harm caused by medication errors. In residential care facilities, falls occur at a much higher rate and progress to more severe complications in the presence of polypharmacy and/or inappropriate prescriptions.

The person centred medication review, using the 7-step approach should be initiated by a pharmacist and take place when someone first moves into a care home, and then at least annually thereafter. Certain high-risk drugs, such as antipsychotics, will require more frequent monitoring and review. The aim should be to optimise benefits from medication, and minimise medication related harm.

Figure 5 The 7 steps to appropriate polypharmacy

A suite of prescribing safety indicators are available to help address unwarranted variation and support improvement. In addition, several tools are available to ensure that people and their families are involved in shared decision making at the point of prescribing.

Oral health

Good oral health is crucial to overall wellbeing and helps to promote adequate nutrition and hydration. People living in care homes are at greater risk of oral conditions because of a variety of factors including high levels of dependency, the effects of medication, physical disabilities and cognitive impairment. However, many people are now keeping their natural teeth for much longer than before and so, it is essential that they receive good oral care.

The national Caring for Smiles programme offers training to care staff in oral health. Whilst it is a national programme, there have been some local adaptations. Further useful information can also be found in the Care Inspectorate's 'Supporting better oral care in care homes' quality illustration. This includes details of the oral health programme Open Wide for younger adults with additional care needs who may need support with daily oral care.

Routine and regular dental reviews should continue to be part of an individual's personal care plan when they move to live in a care home. There should be a named dentist / dental practitioner for each care home.

Hearing and eye care

The monitoring and maintenance and proper use of hearing aids, glasses and low vision aids are an important part of preventative care. Uncorrected poor eyesight or poor hearing can significantly impact a person's ability to engage. Low vision or poor hearing impacts on holistic wellbeing and on undertaking the functions of daily living such as eating, dressing, or basic hygiene.

For a person to participate fully within their environment and community, they must be able to see and hear as well as possible. This is particularly important for a person with a cognitive impairment, and can help to reduce distress and prevent falls. With effect from 1st April 2023, a new national low vision service will roll out across Scotland, which will provide support to those who have low vision or are sight impaired. This service will operate in both practice premises and domiciliary locations, which will include care homes.

Routine sight and hearing reviews should continue to be part of an individual's personal care plan when they move to live in a care home. This is one of the recommendations in the Scottish Government/COSLA See Hear strategy.

Particular attention should be paid to the needs of residents who have both sight and hearing loss (deafblindness). Deafblindness is a unique disability, with prevalence rates increasing sharply from age 70.

Nutrition and hydration

Nutrition and hydration is a part of our everyday life. What and how much we eat and drink has a direct impact on our health and wellbeing. Building nutrition and hydration into everyday practice is important, and should include the proactive identification of anything that might prevent good intake. This includes the ability to see well, ability to hold cutlery and ability to chew food. Dietary choices extend beyond just vegetarianism and veganism. Around 10% of the total UK population may have special dietary requirements because of the beliefs that they hold. These should be respected and supported when someone moves into a care home. An all-party parliamentary group has produced Respect for religious and philosophical beliefs while eating in care with recommendations.

Malnutrition affects every system in the body and results in increased vulnerability to illness and complications, for example, increased risk of chest infections, falls, anxiety and depression or the ability to fight off infection. The Malnutrition universal screening tool (MUST) should be used to identify those at risk. Good hydration is vital for many elements of healthcare for example in the prevention of UTIs; tissue viability and clarity of cognition. A helpful resource about eating and drinking well can be found on the Care Inspectorate website. Further helpful information to support nutrition and hydration can be found on the Royal College of Psychiatrists website and the Scottish palliative care guidelines.

Continence promotion and bowel care

Loss of continence can produce marked reduction of self-esteem and independence. It may be associated with physical problems such as skin breakdown, falls, urine infection and catheter associated urinary tract infection which in turn often causes confusion that in itself can result in injuries that require an acute hospital admission.

Therefore, proactive continence promotion can have multiple benefits for an individual and forms an important part of a person's health and wellbeing. The Care Inspectorate provides a helpful resource for promoting continence for people living with dementia and long term conditions.

Tissue Viability and Wound Care

Tissue viability and wound care is closely connected with hydration, nutrition, continence and mobility. Prevention and early intervention when required are vital as is support from a range of people in a person's care team.

There are a number of resources which can help, for example, the tissue viability toolkit from Health Improvement Scotland. NHS Lothian has a dedicated Care Home Tissue Viability Team who deliver educational packages that build on care home staff's knowledge, skills, and confidence.

Mobility and meaningful activity

Maintaining independence and being engaged in meaningful activity is core to enabling a person to live their best life. Mobility may be how a person moves around. It can be classed as aided (e.g. with a Zimmer frame), or unaided. Being active is how we all help prevent ill health or deterioration. It also has a positive impact on a person's self-esteem, independence, respiratory care, joint pain and tissue viability.

Activity does not have to be a formal exercise or activity programme; it also includes recognising the opportunities to make every moment count throughout a person's day. CAPA Resources | care about physical activity can be used to support physical activity in different ways. Allied Health Professionals may be an important part of a person's care team to help with this area of their wellbeing. For example, a physiotherapist can help an individual maintain their mobility, enabling them to independently engage in their daily activities.

Psychological wellbeing and spiritual support

Upholding people's psychological wellbeing and connections to a spiritual life are fundamental principles of person-centred care. Knowing 'what makes life worth living' and facilitating support for everyone's right to live according to their beliefs and fulfil their emotional, psychological and spiritual needs start from confident conversations with the person and those close to them. Their wishes should be reflected and upheld and regularly reviewed via their plan.

Spiritual care is an integrating aspect of holistic, person-centred care; affirming that fear, anxiety, loss and sadness are all part of the normal range of human experience within health and social care. By supporting individuals to explore challenging questions relating to change, mortality, meaning, purpose and identity we can help individuals to (re)discover core values and

beliefs. When such matters are expressed, identified and addressed, people living in care homes can experience a greater sense of enablement, personal wellbeing and resilience in the context of illness, disease and life-changing or other social issues.

Low mood, anxiety and depression

Admission to a care home can be associated with multiple losses and represents a major life transition. It is important to distinguish between the transitory low mood and sadness that may be related to a change in circumstances, compared with enduring depressive disorders.

Agitation is a physical sign of anxiety and can manifest in shouting or other displays of stress and distress, particularly for people living with dementia. Loneliness is a factor in low mood, which is why it is so important to understand what and who are important to a person, and to plan their care and days collaboratively. Low mood and depressive disorders often precede development of dementia and symptoms can be difficult to tell apart. Management begins with a careful assessment to determine cause, followed by a range of therapies which may include activity based interventions, psychological or pharmacological interventions.

Cognitive stimulation and connections with the wider community

Across the sector there are some great examples of cognitive stimulation and active connections within the community, but these do not consistently happen everywhere. The result of this is that for some people, their experiences are limited to 'traditional' activities that may exclude those with declining cognitive health or may not take into account a person's individual preference. Being mindful of a person's life before they have moved into the care home and what connects them to their community should always be part of their care plan. Understanding what matters to the person, whether that be maintaining a spiritual life, family and intergenerational connections or a passion for music is a vital starting point.

In July 2021, Scotland launched a strategy for promoting brain health and dementia research, with the ambition of translating this into health and social care practice. One of the key aims of the strategy is to develop brain health and dementia boards within each NHS board area that will look at dementia research. In addition the Brain health Scotland initiative was developed in partnership with Alzheimer Scotland and funded by the Scottish Government. This initiative provides advice about brain health research and policy, supports the provision of personalised prevention plans and promotes positive brain health in collaboration with Public Health Scotland and other partners.

Communication equipment and support

People who have difficulty speaking and who can be assisted by communication equipment have the right to get the equipment and support they need to use it, when they need it, whoever they are and wherever they live in Scotland, enabling them to participate in their communities and be fully included in society.

Communication equipment, and support in using it, can make a real difference to people's lives and makes sure they have a voice to be heard. From 19 March 2018, NHS boards in Scotland have a duty to provide communication equipment and support to use that equipment.

This duty applies to children and adults, from all care groups who have lost their voice or have difficulty speaking. Health Boards deliver this duty, in the main, through Speech and Language Therapists.

Recommendations

3.1 People living in care homes must be supported to access any relevant age-specific public health programmes with appropriate information to allow an informed decision.

3.2 Application of IPC standards in care homes should be supported by access to relevant IPC advice, education and guidance.

3.3 Everyone living in a care home will have a regularly reviewed personal plan.

3.4 Ensure there are effective systems in place to deliver a consistent approach to the development and implementation of proactive, personal plans.

3.5 A person centred medication review, using the 7-step approach should be initiated by a pharmacist when someone first moves into a care home, and then at least annually thereafter. Certain high-risk drugs, such as antipsychotics, will require more frequent monitoring and review.

3.6 Routine dental, sight, and hearing reviews should continue to be part of an individual's personal care plan when they move to live in a care home.

3.7 There should be a named dentist / dental practitioner for each care home and contracts with local optometry and hearing services.

3.8 There should be a proactive approach to hydration, nutrition, continence promotion, meaningful activity and mobility using appropriate resources and should be considered with the same degree of importance as reactive healthcare.

3.9 Religious and philosophical beliefs in relation to food and diet should be enquired about and catered for.

3.10 Psychological and spiritual aspects of healthcare should be assessed and regularly reviewed within care plans.

3.11 Individuals should be supported to maintain links in their local community which enables cognitive stimulation, mobility, independence and communication.

4. Anticipatory Care, Self-Management And Early Intervention

Helping people to think and plan ahead according to their wishes, helping people to be involved in their own health and wellbeing, and managing any existing health conditions at an early stage to reduce deterioration.

Anticipatory Care Planning

Anticipatory care planning is an approach where people living in care homes are supported to have meaningful discussions about '*What Matters to Me*' in the context of their health and care. This can then progress to a conversation about '*Let's Think and Plan Ahead*'.

Effective conversations should help people (including family members) to understand what living well with their physical and mental health conditions means for them, both now and in the future. People should be supported to 'think ahead' and be as fully involved as they are able to be in the management and planning of their care.

Whenever possible, anticipatory care planning should commence long before the person moves into a care home and should continue at regular intervals with the various people and professionals who are involved in providing care throughout their time in the care home. Social workers provide initial identification of the outcomes that people have expressed as important to them, covering their daily lives and their emotional and spiritual needs. This is the foundation for the personal plan developed by the care staff delivering day-to-day care over many conversations.

People living in care homes should have the opportunity to be supported by their family when thinking and planning ahead, including any registered welfare power of attorney where the person lacks capacity to make these decisions.

Some elements of anticipatory care planning require a more detailed understanding of how the health of an individual is likely to change in the future, and the various treatment options that may be appropriate should that happen. It is often helpful to consider and plan what to do following a sudden deterioration such as a collapse, swallowing difficulty, or a severe infection in the context of existing health conditions. Where someone has a complex health condition or when there are a variety of different treatment options, a senior clinician such as GP should be involved in discussions.

It is not the sole responsibility of any particular professional group to lead these conversations, but those who do must be suitably trained and equipped to do so. All health and social care staff must be provided with support and training in communication to improve confidence and skills in conducting these meaningful conversations. The 6-step RED-MAP framework offers a helpful model to guide health and care professionals having care planning conversations.

Once an anticipatory care plan (ACP) has been agreed with the person and any registered welfare power of attorney, it must be available and accessible to the various health and social care professionals involved in providing care.

Although 'What Matters to Me' conversations are taking place within care homes across Scotland, they are often not reviewed as frequently as they should be. Sometimes these discussions are not used to 'Think and Plan Ahead' and to create a proactive ACP. The MDT should be consulted to check that every person living in the care home has had the opportunity to develop an ACP and that it is up to date. Where this has not happened there should be a discussion and agreement about who is the most appropriate person to take a lead.

ACPs must also be visible to all that need to see them. Work must continue to develop a national shared clinical and care record onto which ACPs can be stored, seen and used to inform decisions around treatment and care. Until such an integrated health and care record is developed, the Key Information Summary (KIS) remains the best way to share elements of an ACP between different healthcare providers. It is therefore recommended that everyone living in a care home has the opportunity to have a KIS created incorporating their ACP. It can be helpful for the care home staff to hold a paper copy of the KIS, but as this will not be a 'live' document it will require regular updating. Practical advice and guidance on ways to keep the KIS up to date has been published by Healthcare Improvement Scotland (HIS).

A comprehensive ACP toolkit comprising resources that can be used in different situations (e.g. for people with dementia or neurological conditions) has been developed by Healthcare Improvement Scotland, with the aim of supporting the development of holistic and person-centred ACPs.

We know that a whole systems approach to ACP is possible and leads to better outcomes for individuals. Edinburgh Health and Social Care Partnership has demonstrated through their 7 steps to ACP programme that where there is a shared understanding of an individual's health and care. Care home staff, including social care workers, can be supported to have ACP conversations effectively with appropriate tools and an appropriate process.

There is growing interest in the use of the ReSPECT process for developing person-centred plans around emergency care and treatment. NHS Forth Valley are adopting a digital ReSPECT approach to support the development of ACPs with care homes. Formal evaluation of their pilot is not yet complete, but several other health boards in Scotland are also exploring the use of the ReSPECT process and documentation.

It is recommended that all health boards agree and adopt a robust approach (such as those referenced above) when conducting ACP discussions.

Supporting self-management

Supporting self-management describes a way of working which aims to support, empower and enable people living in care homes to manage aspects of their health and wellbeing so that they can live the best life possible. When people first move into a care home it is particularly important that their lifetime habits and self-management actions continue, building on and maintaining what a person can do for themselves (e.g. brushing their teeth, applying a prosthesis etc.)

Health and social care professionals who adopt self-management approaches are 'facilitators' not 'fixers', who support people to identify their own health and wellbeing outcomes. Supporting self-management should be achieved through a shared agenda that uses a person's motivation to make changes that can improve health and wellbeing.

Some people living with learning disabilities may need to stay in a care home because they are unable to live independently elsewhere in the community. However, with support and supervision from families and social care staff, they should be able to manage many aspects of their care themselves. By promoting a shift from 'doing to' to 'doing with', people can greatly enhance their confidence, self-esteem and feelings of self-worth.

People living with frailty can be supported to manage many aspects of their health and care by allowing them more time to undertake daily tasks (e.g. when washing, dressing, moving around the home). Supporting self-management is more challenging when people lose capacity through cognitive impairment and dementia. However, social care staff can and do achieve this through the encouragement of meaningful activities, regular routines and prompting. Occupational Therapists have specialist knowledge and can help the care home team if this becomes difficult.

It is recommended that community-based supporting self-management programmes are established to consider how best to support care home teams to adopt self-management approaches.

Planned healthcare

'Supporting self-management' can also be used to enable people to play an active role in the planned management of their existing health conditions. Having the opportunity to be involved in the management of known medical conditions in the context of everyday life is empowering and can lead to better health outcomes.

There should be regular proactive review of medical conditions such as hypertension, diabetes and heart disease. People living in a care home should not be denied regular check-ups and 'chronic disease management' reviews that other people receive from their GP and Primary healthcare teams. However, there is a significant risk of over-medicalisation if standard tests such as cholesterol checks are taken without considering personalised priorities. 'Realistic Medicine' principles should be adopted. We must work with people living in care homes and their families to agree the goals for management of long term health conditions, and reduce unnecessary investigations and treatment.

Planned healthcare should be delivered as part of general medical services provided by a General Practice to its registered population, with additional services provided to many care homes through funded Local Enhanced Services. These planned healthcare services include the proactive management of people living with long term medical conditions, regular review of medication, and the development of proactive and person-centred anticipatory care plans.

The OPTIMAL study (2017) looking at Optimal NHS service delivery to care homes demonstrated that regular patterns of GP working (e.g. through regular clinics, or a regular MDT) were associated with higher levels of care home staff satisfaction and fewer medication related problems. This was particularly true when there were opportunities to discuss care provision across the care home and not just individual patient's healthcare.

Some people living in care homes may be able to attend their GP practice for such reviews, however for many these will be more appropriately undertaken in the care home. GP practice teams must ensure that adequate arrangements are made for these to happen.

Through 'Primary Care Improvement Plans', pharmacists are integral members of the multi-disciplinary team with expertise and responsibilities for reviewing medication, monitoring high-risk drugs, and considering the impact of polypharmacy. Further investment in pharmacists and pharmacy technicians across Scotland is required to enable provision of level 2 and level 3 pharmacotherapy services.

Everyone living in a care home taking prescribed medication should have an annual medication review using a person centred '7-step approach' as outlined in the Prevention section.

Early intervention

Early intervention to maintain health and reduce deterioration is another important area of focus. For example, through the early detection of hearing loss and access to appropriate assessment and hearing aids, someone living in a care home will be supported to remain engaged and involved in the life of the care home, reducing the risk of withdrawal, isolation and depression. Early identification of cognitive changes is important to ensure that care home residents access the same standard of dementia care as those living in the community, from prediagnostic to post diagnostic support. This may include differential diagnosis of reversible or non progressive causes of cognitive impairment, or multidisciplinary dementia care, including intervention for distress or timely palliative care. Currently access to cognitive assessments and post diagnostic support is very variable, and many people with

dementia will not receive a formal diagnosis once they are living in a care home. Having the right support and understanding can make a huge impact on the quality of life and independence for someone experiencing cognitive challenges.

People with complex medical conditions may require a planned review from specialist services. They should be supported to attend hospital-based clinics where this is possible and will not cause distress. Where this is not possible, specialist input into the care of the person living in a care home should be adapted to the situation. This may be by telephone, video consultation or by visiting the care home.

Recommendations

4.1 'What Matters to Me' and 'Thinking Ahead' ACP conversations should take place at the earliest opportunity, ideally prior to entering the care home, and at regular intervals throughout the individual's stay.

4.2 Where someone has a complex health condition, or there are a variety of different treatment options, a senior clinician, such as GP should be involved in discussions.

4.3 All health and social care staff must be provided with support and training in communication to improve confidence and skills in conducting these meaningful conversations.

4.4 Everyone living in a care home should have the opportunity to develop an Anticipatory Care Plan.

4.5 All health boards should seek to agree and adopt a robust approach (such as the HIS ACP Toolkit, Lothian 7 Steps, ReSPECT) to conducting ACP discussions.

4.6 Anticipatory Care Plans should be shared with everyone involved in providing the individual's care, and a summary should be included in the Key Information Summary (KIS).

4.7 Establish community-based supporting self-management programmes to consider how best to support care home teams to adopt self-management approaches.

4.8 People living in a care home should continue to have regular assessments of their long term conditions, as appropriate, from their Primary Healthcare Teams.

4.9 Realistic Medicine principles should be adopted to reduce unnecessary or inappropriate investigations and treatment.

4.10 Where possible, people with complex medical conditions should be supported to attend hospital-based clinics. Where this is not possible, specialist input into the care of the person living in a care home should be adapted to the situation. This may be by telephone, video consultation or by visiting the care home.

4.11 Changes to mood or cognition should be identified at an early stage and discussed with members of the MDT to determine whether referral is indicated for specialist mental health services for assessment and intervention.

5. Urgent And Emergency Care

Accessing appropriate urgent and emergency care in a safe and timely way is extremely important. This is particularly so at weekends and during the out of hours period.

Equity of access to urgent care services

People living in care homes can become unexpectedly unwell, requiring urgent care and attention. However, it is more difficult for people living in care homes to access some services that have been set up for urgent care (e.g. an urgent optometry or dental appointment, a community pharmacy or a hospital minor injuries unit). Many of the urgent care services developed as part of the GP contract, such as advanced practitioners, will only see people who are able to attend the GP surgery.

During our programme of engagement, we learned that when urgent and emergency care can be accessed in a responsive way, with consideration of ACPs and using a 'Realistic Medicine' approach, experiences were good. However, inappropriate admissions to hospital were more likely to happen where that preventative planning was not in place or professionals did not have the relevant access to an ACP.

Urgent and emergency care services perform a critical role in keeping the population healthy. People living in care homes should receive the right care, in the right place, at the right time. Care home staff are pivotal in providing this on a day-to-day basis, but there are circumstances when they may need more support to empower them to have confidence in their decisions, and there may be situations where additional services are required to meet the needs of the person.

Urgent/emergency care can be very sporadic as residents are deemed to be in a place of safety therefore not a priority for out of hours services.

People living in care homes should have timely and equitable access to a member of the primary care multi-disciplinary team when this is required. Several HSCPs have already set up dedicated care home teams comprising of Advanced Practitioners (nurses, paramedics and physiotherapists) who can respond quickly and visit people requiring urgent unscheduled assessments, with support and advice being available from the GP by phone. The development of these local care home teams has many potential benefits and should be considered within every HSCP covering weekdays and weekends.

Supporting good communication between professional staff

Social care staff and health care staff must be able to communicate the needs of an individual in a way that is clear and concise. By implementing an SBAR (Situation, Background, Assessment, Recommendation) tool care home staff have described increased confidence in being able to focus on their observations, reflect on the person experiencing care and their care needs. Healthcare staff also found that the use of SBAR aided communication, as it provided them with the appropriate information in a concise way. It is therefore recommended that both care home staff and healthcare staff are familiar with the SBAR format when discussing urgent or emergency care and consider using a structured proforma for these conversations.

RESTORE2 is a physical deterioration and escalation tool for care homes. It is designed to support homes and health professionals to:

- recognise when someone may be deteriorating or at risk of physical deterioration
- act appropriately according to the person's care plan
- obtain a set of physical observations to inform escalation and conversations with health professionals
- speak with the most appropriate health professional in a timely way to get the right support
- provide a concise escalation history to health professionals to support their professional decision making

During the COVID-19 pandemic, the development of a Care Home Assessment Tool (CHAT) was led by Technology Enabled Care, working with care homes and GP practices in Glasgow and Lanarkshire. This digital tool used the components of RESTORE 2 to enable care homes to share assessments of people who had symptoms of COVID-19 or other serious infection quickly with their GP practice.

Access to services out of hours can be challenging for care home staff and response times may be lengthy. This was echoed in the responses to our survey of care homes. There are many different ways to obtain urgent and emergency care across Scotland outwith normal working hours (out of hours services, professional lines, NHS 24 / 111, or 999), many of which do not provide an immediate service for vulnerable people living in care homes. A consistent approach is needed.

Staff can be on the phone an hour before getting connected.

A multi-disciplinary approach of professionals working together is required. The sector has made clear their desire for direct professional to professional communication channels, such as dedicated phone lines, to ensure staff in care homes have 24/7 support in making decisions for a person who has become unwell. Having direct access to help during the out of hours period will aid seamless and timely access to health and care support and response 24/7. This is particularly important in managing symptom control for people approaching the end of life.

Providing urgent and emergency care within the care home

There are advances in near patient and point of care testing that allow medical tests and investigations to be undertaken outwith hospitals or other healthcare facilities. It is important to explore how these could be used to benefit the care of people in care homes and aid decision making regarding treatment. It is felt that simple tests such as the ability to measure oxygen saturations would be useful in the decision relating to need for hospital admission. However, this needs to be balanced with the concern of inappropriate investigations and remembering that care homes should not become clinical settings. Just because it is possible to do an investigation or test remotely, does not mean that the test should be done. Realistic Medicine principles should be considered when determining the best course of action for an individual. As part of the implementation process further exploratory work should be done to investigate this field and also how near patient and point of care testing could link in with Hospital at Home services.

Alternatives to hospital admission including community facing specialty teams (e.g. hospital@home) should be considered to allow individuals to receive hospital level care within the care home when appropriate. All health boards should develop Hospital@Home type services that enable people living in care homes to receive hospital-level care within the care home.

Hospital at Home (H@H)

H@H is a short-term, targeted intervention that provides a level of acute hospital care in an individual's own home which is equivalent to that provided within a hospital. A hospital specialist acts as senior decision maker and responsible medical officer, sometimes with the help of other grades of medical staff. Care is delivered by multi-disciplinary teams of healthcare professionals complying with current acute standards of care. It complements other community-based health and care initiatives which support patients to remain in their own homes. It provides a different level of interventions, such as access to intravenous fluids and oxygen. It has been in existence in a number of countries across the world for 25 years. The first hospital at home service was introduced in Scotland in 2011.

HIS have established a programme to support the implementation of H@H, including work with a mixture of NHS boards and Health and Social Care Partnerships. A total of 20 HSCP areas across the country are supported.

The programme includes a system to share learning and good practice, building on the experience of the established services in NHS Lanarkshire, NHS Fife and NHS Lothian. It tends to work best when it is part of an integrated acute and community-based service model to meet local population need.

The Urgent and Unscheduled Care Team are leading on the development of virtual capacity pathways with a number of stakeholders. Outpatient Parenteral Antimicrobial Therapy (OPAT) and Respiratory pathways are currently in place with others in the development phase.

Treating urgent medical conditions within the care home will often require prompt access to appropriate medication. The relationship between care homes and pharmacy services is varied across the country. One of the main challenges the sector faces is how medicines can be obtained out of hours. Visiting out of hours GPs only carry a limited supply of medicines, and care homes are not permitted to hold stocks of prescription-only drugs unless they are for a specific named individual. It is a constant challenge for staff to access medicine when their local pharmacy is closed. This can sometimes lead to attendances / admission to hospital if medication is not available. During the pandemic, temporary changes in legislation were allowed for care homes to repurpose medicines for another person if they had stocks in the care home. Further work is required within this area.

Hospital transfers and admissions

People living in care homes are at risk of developing delirium and deconditioning from an admission to hospital. A shared decision should be made about whether transfer to hospital is appropriate, taking into account the individual's care plan, carer and relatives' wishes and clinical assessment. However, people should never be denied admission to hospital solely on account of living in a care home.

There are often delays in transferring people living in care homes to and from hospitals, often as a result of wider system pressures. It is important that ambulance staff and other stakeholders work closely together, optimise safe travel routes and utilise all options of transport available.

Upon arrival at hospital it is vital that people living in care homes have equitable access to specialist care and they should, wherever possible, be assessed by a senior clinical decision maker. We know that older people living in care homes are often frail, and unless clinically inappropriate (e.g. if they have an acute stroke), their care should be in a specialist area for frail, older adults. They should have early access to comprehensive geriatric assessment, with nurses and AHPs trained and experienced in caring for this vulnerable group. This can enable faster recovery and earlier discharge back to the care home.

Acute and Emergency Care

It is recognised that when care home patients are admitted to hospital they are at risk of adverse events. It is important that the hospital team are aware of the wealth of information that would be available from the carers usually looking after them and that there are ways to mitigate the risk of adverse events. The following infographic is available to download from the Scottish Government website, and was developed to assist in assessing and managing older adults being admitted from their care home.

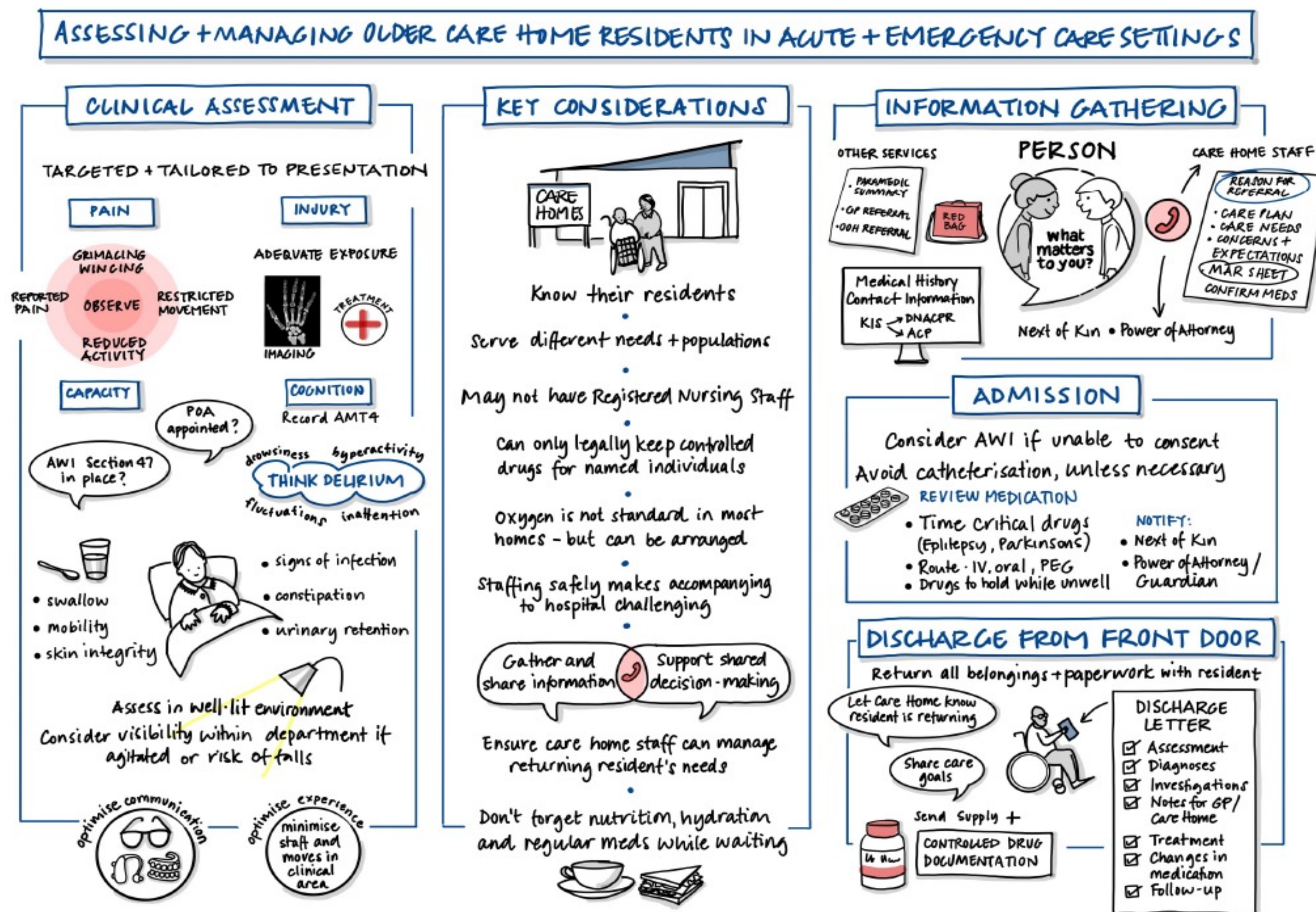

Figure 6 Looking after people from a care home infographic

Timely access to someone's health records is also vital. The Key Information Summary (KIS) and ACP information should be readily available to all parts of the system. On transfer back to the care home, clinical information and outcomes should be shared with the care home to allow the care home records to be updated. Sharing details of any previous discussions and decisions regarding capacity and DNACPR (Do Not Attempt Cardio Pulmonary Resuscitation) can be helpful both for people being admitted but also on discharge back to the care home.

There is currently no national data on the frequency by which people living in care homes use urgent and emergency care. NHS 24 have put measures in place to fulfil the desire for this metric by asking callers if they are calling from a care home.

Recommendations

5.1 Support and empower care home staff by providing and encouraging participation in training opportunities and enabling all staff to have the tools to assess and communicate in acute and emergency situations using the SBAR format.

5.2 People living in care homes should have timely access to members of their MDT, 24/7 when urgent or unscheduled care is required.

5.3 HSCPs should consider developing dedicated community healthcare teams comprising advanced practitioners who can respond quickly and visit people in care homes requiring urgent unscheduled assessments, with support and advice being easily available from the GP by phone. These services should cover both weekdays and weekends.

5.4 Both care home staff and healthcare staff should be familiar with the SBAR format when discussing urgent or emergency care, and consider using a structured proforma for these conversations.

5.5 Care home staff should be able to contact healthcare professionals during an urgent or emergency situation in a consistent and timely manner – this includes exploring possibilities for dedicated professional to professional communication channels.

5.6 Scoping work should take place to explore the use of near patient and point of care testing within care homes, taking into account Realistic Medicine principles.

5.7 Health boards should develop Hospital@Home services that support people living in care homes to receive hospital-level care within the care home.

5.8 Further work is required across Scotland to improve the accessibility and provision of medicines during an urgent situation. This includes exploring mechanisms to enable care homes to hold a stock of certain drugs within the home.

5.9 People living in care homes should never be denied admission to hospital solely on the basis of living in a care home, and at point of admission older people should be assessed by a senior clinical decision maker with experience in caring for frail older adults.

5.10 Timely and safe transfers to and from hospital for older people in care homes should be optimised.

5.11 Digital access to an individual's health records, and clinical outcomes should be timely and accessible to all parts of the system.

6. Palliative And End Of Life Care

Enabling a person-centred and holistic approach to health and care when curative treatments are no longer possible and length of remaining life is reducing.

Palliative care supports people to have a good quality of life even when faced with serious, irreversible and progressive health conditions. Effective palliative care can prevent and relieve suffering through the early identification, accurate assessment and management of pain and other problems, whether physical, psychosocial or spiritual.

'End of life care' is also an important part of palliative care which addresses the physical, social, emotional, spiritual and accommodation needs of people who are approaching death.

Provision of palliative care

Many adults and most older people living in care homes will benefit from a palliative approach to their care. This can be enabled and provided by members of the individual's family and community, and all the health and social care professionals who have responsibilities for the person's care.

Social care staff working within care homes have a wealth of experience and expertise in adopting a palliative approach to care, and supporting someone who is nearing the end of their life. However, there may still be occasions when advice and support is required from Primary Care and specialist palliative care services. Health and Social Care Partnerships have responsibility to ensure that these specialist services are in place and available to people living in care homes.

Identification of those who need palliative care

It is important to be able to identify individuals whose health is at risk of deterioration at an early stage. This will allow early and proactive assessment and delivery of the most appropriate care. Healthcare Improvement Scotland (HIS) has published various tools which have enabled earlier identification of those who may benefit from a palliative approach to their care. The SPICT (Supportive and Palliative Care Indicators Tool) and PPS (Palliative Performance Scale v2) have both been adopted successfully within some care homes in Scotland for this purpose. Glasgow City's Riverside Care Home used the PPS along with a Supportive Palliative Action Register to assist staff in identifying any change or decline within people living in their care home. Care home staff should consider how they can incorporate such tools and assessments within normal practice to help identify people that may be at risk of deterioration.

Assessing symptoms/needs and planning

Assessing symptoms can be particularly difficult where there is associated cognitive impairment, such as in the context of delirium or dementia. There is a risk of diagnostic overshadowing, whereby physical symptoms such as pain are not recognised and instead changes in behaviours are incorrectly attributed to dementia. Families, friends and the care home team are key to recognising distress, from their knowledge of the person and their normal patterns of behaviour. Other health and social care staff, who do not know the individual as well, must listen to the concerns of those that are closest to the person. Training in the use of appropriate symptom assessment tools (e.g. Doloplus-2 or the Abbey Pain Scale), and early involvement of dementia link workers can help ensure that those living with dementia receive the care and treatment they require.

Distress and suffering is not just about pain and other physical symptoms. Careful consideration must be given to all 4 domains of palliative care, including any psychological, spiritual and social factors which may be contributing to distress. Adopting a

holistic approach to assessment and care is of prime importance, and can be aided by tools such as the HOPE approach to spiritual assessment.

A co-ordinated MDT approach to care is important at the end of life. Anticipatory Care Plans should be reviewed to ensure they are firmly rooted in a clear understanding of the values, beliefs and preferences of the individual. This may include the discontinuation of unnecessary medication and a review of treatment goals, including sensitive discussion around cardiopulmonary resuscitation (CPR).

Figure 7 The four domains of palliative care (image Hazel White Design)

What skills and knowledge are needed to provide palliative care?

Scottish Social Services Council and NHS Education for Scotland has published 'Enriching and improving experience', a framework to support the learning and development needs of the health and social service workforce in Scotland. They have identified five domains which reflect the core knowledge and skills considered integral to the delivery of high-quality palliative and end of life care. Each domain presents four levels of knowledge, skills and experience that outline what health and care workers need to know and do. People working in care homes and their employers should use this framework to identify learning needs in relation to palliative and end of life care.

The Scottish Palliative Care Guidelines have been developed by a multi-disciplinary group of professionals and provide practical, evidence-based or best-practice guidance on a range of symptoms and other palliative care issues. These include guidance on assessing pain in people living with cognitive impairment.

Accessing specialist palliative care services when required

Most of the care for someone who is approaching the end of their life can be provided with compassion, skill and knowledge by the care home team. However, sometimes symptoms will be more troublesome, or there may be other complex factors involved in providing care. In these circumstances the wider MDT should be involved, including timely intervention from specialists in palliative care as required.

There is wide variation in access to specialist palliative care across Scotland. HSCPs and NHS boards should ensure that specialist palliative care services are available for the care homes in their area, as set out in the advice note on Strategic Commissioning of Palliative and End of Life Care by Integration Authorities. A named individual, team or service from the specialist palliative care should be easily accessible and provide timely support to the MDT and care home. They should foster close "co-working" and "shared learning" relationships with the care homes in their area.

Some care homes have found it extremely helpful to participate in Project ECHO. These multi-site videoconferencing meetings with an emphasis on shared learning and peer support have often focused on palliative and end of life care issues, with input from the local specialist palliative care team. Project ECHO is described in more detail within the data, digital and technology section of the framework.

Responding promptly to change

There may be times when an unexpected change occurs with an individual's symptoms or condition, and so prompt access to assessments, advice and support from the Primary Care and MDT is essential. Many areas of Scotland have a dedicated out of hours palliative care line, allowing direct and fast access to community nursing staff for people who are nearing the end of life. It is recommended that all HSCPs ensure that there are arrangements to allow prompt access to nursing and medical staff throughout the 24-hour period.

Very difficult to get in touch with health care professionals.

People should also have timely access to appropriate medication, equipment such as pressure relieving mattresses and syringe pumps, and to community nursing (particularly where there are no registered nurses in the care home).

'Just in case medication', as recommended in the Scottish Palliative Care Guidelines should be available for everyone who is assessed to be in their last weeks of life. Further work needs to be undertaken to explore the legislative and contractual barriers to requisitioning and holding a stock supply of medicines in care homes in Scotland.

Families and friends

It is particularly important that families and friends are kept informed, involved and supported as their loved one is approaching the end of their life. Clear compassionate communication and unrestricted visiting are key to achieving this. Care home staff are best placed to lead in this area, as they have established relationships with the people that are close to the individual. However, the GP and other members of the MDT should be available to support the care home staff and speak with family and friends when required.

Dealing with loss

Those who work or live in care homes describe the strong bonds and connections that develop between staff and those living in the care home, and so the death of an individual can have a profound effect on everyone. Care home staff will often have to break the news that someone has died whilst they are still coming to terms with the information themselves.

Scotland's first bereavement charter was published in April 2020. This describes what good bereavement support and care looks like. This bereavement charter is particularly pertinent to people who live and work within care homes and should be used to guide the support that is offered to those who are bereaved.

Recommendations

6.1 Care homes should consider how they can incorporate identification tools and assessments within normal practice to help identify people who may require a palliative approach to their care, and support the individual as their health needs change.

6.2 Provide training in the use of appropriate symptom assessment tools, and enable early involvement of dementia link workers to ensure that those living with dementia receive the care and treatment they require.

6.3 Anticipatory Care Plans should be reviewed as people are nearing the end of life to ensure they are firmly rooted in a clear understanding of the values, beliefs and preferences of the individual.

6.4 Care home providers should use the 'enriching and improving experience' framework to identify need and plan the learning and development of their employed staff in relation to palliative and end of life care.

6.5 HSCPs and NHS boards should ensure that there is a specialist palliative care service available and easily accessible to the MDT, and these services should foster close "co-working" and "shared learning" relationships.

6.6 Care home providers and specialist palliative care teams should work together to explore shared learning and peer support opportunities, through initiatives such as Project ECHO.

6.7 GPs and other members of the MDT should be available to support the care home staff with end of life care, and speak with relatives when required.

6.8 Dedicated out of hours palliative care lines, allowing direct and fast access to community nursing and medical staff for people who are nearing the end of life, should be available in all HSCPs.

6.9 There should be prompt access to appropriate medication (including anticipatory 'just in case medication' and oxygen) and equipment, such as syringe pumps and pressure relieving mattresses.

6.10 Scotland's bereavement charter should be adopted by all those working in and with care homes and used to guide the support that is offered to those who are bereaved.

7. A Sustainable And Skilled Workforce

The vision of this framework – that the health and wellbeing needs of people living in care homes are met so that they can live their best life – will only be fully achieved by a sustainable and skilled workforce.

The care home workforce demonstrate care, compassion, professionalism, and a broad range of skills in working with people living in care homes, their families, and the multi-disciplinary team to deliver personalised, relationship-based services which not only keep people safe, but also preserve their identity and promote their independence.

During the COVID-19 pandemic care home staff have had to take on additional responsibilities in relation to testing and adherence to IPC guidance. They have supported individuals, families, and colleagues through the very particular and emotional challenges of the pandemic. They have had to work through their own experiences of grief and bereavement. This has all been within the context of long-standing pressures within care homes with regards to attracting, recruiting, and retaining staff, exacerbated by the combined impacts of the withdrawal from the EU and the pandemic itself.

In December 2021, the Care Inspectorate and the Scottish Social Services Council (SSSC) published their vacancies report which confirmed that care homes for older people in Scotland had 55% of services reporting staff vacancies and 38% of services reporting nursing vacancies.

There is also the need to strengthen the healthcare workforce. GPs, Community Nurses, and Primary Care teams are under considerable pressure to meet the increasing demand that is associated with the ageing Scottish population.

The Health and Social Care: National Workforce Strategy makes clear the need to grow the workforce. The Five Pillars of Workforce: Plan, Attract, Train, Employ and Nurture, are key to the strategy and to how the vision of a 'sustainable, skilled workforce with attractive career choices where all are respected and valued for the work they do' can be achieved. This section of the framework focuses on this vision and identifies the necessary conditions to sustain and further develop the care home workforce.

The care home workforce

The Multi-Disciplinary Team section uses concentric wheels to describe how the MDT is made up of individuals and professionals and how they work together in the direct provision of care. The effectiveness and impact of the MDT will be influenced by the availability of a skilled and sustainable workforce.

The Adults' services workforce table published by the SSSC informs that as of 2020, 46,340 staff were employed in care homes for older people in Scotland. Additionally SSSC's 2020 report on workforce data (August 2021) informs of 52,920 (41,390 WTE) people working in all adult care homes in Scotland.

Analysis of the latter indicates that 75% of all staff are reported as care staff providing direct care, support or clinical assessment. Data relating to the nursing workforce is limited as they are categorised along with others who are responsible for assessment of care needs, for example Social Workers and Occupational Therapists. However, this group account for only 11% of this direct care and support function in care homes, with care home managers accounting for 2% of the total workforce. The data available, along with the time lag in it becoming available, not only makes robust workforce planning challenging, but adds concern regarding the provision of clinical and professional leadership to support the increasing levels of dependency and complexity that now exist.

Care home workforce skills

As described in the introduction to the framework, Scotland's population is ageing and as people are living longer, some are living with increasingly complex health and care needs. This demographic change is also reflected across the care home population impacting on the current and future skills needs of the care home workforce. The SSSC's Workforce Skills report (2021) highlights that over 90% of care home managers felt existing qualifications are fit for purpose. However, 72% believed new skills needs will develop over the next five years that existing qualifications won't address. Particular areas of skills needs that were highlighted were Infection, Prevention and Control, and Digital skills. Survey respondents to the consultation on this framework also identified the value in developing care home workforce skills in preventative asset based approaches and some basic clinical procedures for example, wound dressing.

Care home managers

The responsibilities of the care home manager are all encompassing. In short, they are responsible for the overall management, development and quality assurance of care and support provided in a care home service, including the supervision of staff and the management of resources.

Care home managers are dedicated and caring, they are motivated to meeting the needs of people. Studies on job satisfaction inform that care home managers cite the provision of good quality care, their use and development of skills in their work, working with capable staff, having a good reputation in the care home sector and opportunity for career development as essential. Investment in the development of care home managers, which should include leadership training is required to enable this.

Challenges to be overcome in dispensing these responsibilities are described throughout this framework. Changes to regulation, legislation, policy, challenging recruitment and retention of workforce, fragmented care and communication systems and not least the impact of the financial climate.

Registered Nurses

The NHS Education for Scotland Post-registration Career Development Framework for Nurses, Midwives and AHPs defines four pillars of practice (clinical practice, facilitation of learning, leadership, evidence, research and development). These are core components of education and development which support the development of Registered Nurses to increase their knowledge and skills to work across levels of practice from Newly Qualified Practitioner, Senior/Specialist to Advanced Nurse Practitioner and Consultant Nurse. These are demonstrated in page 5 of the Chief Nursing Officer Directorate, Transforming Roles, Paper 5: Transforming education and career development in nursing.

Whilst Registered Nurses work across these levels of practice, fundamentally they have the skills, knowledge and experience required to undertake assessment of an individual's needs, ensuring that appropriate response to their findings is taken leading to the best outcomes for the individual. At Level 5 of practice (newly qualified practitioner), some examples of responsibilities and roles defined within the four pillars of practice are provided on page 8 of the CNOD: Transforming Nursing, Midwifery and health Professions (NMaHP) Roles; pushing the boundaries to meet health and social care needs in Scotland.

The CNOD Transforming Roles paper: Advanced Nursing Practice set out the core competencies, education priorities and supervision requirements for ANP roles in Scotland. The paper defines Advanced Nurse Practitioners (ANPs) as *'experienced and highly educated registered nurses who manage the complete clinical care of their patients, not focusing on any sole condition.'*

In working with, and as part of, the care home team, all four pillars of practice will be utilised in meeting the needs of the person. However, the attributes, skills and knowledge as leaders that the Registered Nurse brings to the team is key. They bring leadership and co-ordination to the team – they are critical to managing and overseeing infection, prevention and control practices, food, fluid and nutritional care and safe medicines management. Using mentorship and a coaching ethos they oversee and support the wider care and support team. Provision of registered nurses is required, as there is a well reported correlation between provision of Registered Nurses and high-quality, safe and effective care.

Regulation and registration

The Health and Care (Staffing) (Scotland) Act explicitly states that staffing is to provide safe and high-quality services and to ensure the best health care or care outcomes for people experiencing care. Once enacted, it places a statutory duty on care home providers to ensure that, at all times, suitably qualified and competent individuals are working in such numbers as are appropriate for the health, wellbeing and safety of people using the service, and the provision of high-quality care. Providers are also required to ensure staff are appropriately trained for the work they perform. The Care Inspectorate's Guidance for providers on the assessment of staffing levels has been designed to support care home and other care service providers in assessing and providing staffing levels to best meet the needs of people in their care.

Statutory regulation of the health and social care professions serves to protect the public from the risk of harm associated with the provision of health and social care services. There are 9 regulators of healthcare professionals in the UK, overseen by the Professional Standards Authority (PSA), regulating 34 professions, which all must be registered with their professional regulatory body by law. The regulators maintain and hold the register of those qualified to practise in each regulated profession they oversee; they set the education and training requirements for entering a profession; set the standards of conduct and competence needed to continue to practise and take action where concerns are raised about a registered professional.

There is some variation in the mechanisms for maintenance of registration across the professions. However, it is the individual responsibility of the registrant to maintain registration, providing and demonstrating evidence of practice, maintenance of skills and knowledge together with evidence of ongoing learning and development. Employers have a duty to regularly check the registration status of their healthcare professional staff, however, it is the individual responsibility of the registrant to maintain registration.

Care home workforce registration

All care staff and managers within care homes for adults require to be registered with the SSSC, if not already registered with another regulatory body. There are four register parts related to working within care homes for adults. To register individuals must satisfy the criteria for registration, this includes gaining employment in a relevant role and holding or agreeing to work towards the appropriate qualifications for their role, usually within a 5-year period. Individuals working in Social Care, who are registered with one of the 9 Healthcare Professional Regulators, are not required to register with the SSSC; for example, Nurses. Social care employers have a legal responsibility to make sure all their staff are correctly registered within six months of their start date.

The SSSC Code of Practice for Social Service Employers sets out the responsibilities of employers in the regulation of social service workers, which states "As a social service employer, you must provide learning and development opportunities to enable social service workers to strengthen and develop their skills and knowledge". The Care Inspectorate take the Codes of Practice into account during inspection of services and may take action to support improvement or require change if providers don't meet the required standards.

Recruitment, retention and wellbeing

There are difficulties with staff recruitment and retention throughout the health and social care workforce which have been present for a number of years, with many care homes experiencing high turnover of staff. The workforce data reported by SSSC informs of a decrease in workforce in care homes between 2011 and 2020 (-2.3%). In addition, many staff move between care homes so they take their skills, knowledge and experience attained through training and education with them. This puts additional pressure on the current workforce and impacts their own personal wellbeing. Recruitment and retention are key to providing adequate care, along with sustaining and improving resilience of the care home team.

The National Workforce Strategy for Health and Social Care in Scotland acknowledges these significant pressures that care home staff, and the wider workforce are facing and emphasises that sustained actions are required from planning for and attracting into the workforce through to support and development of our workforce, and supporting and delivering Recovery, Growth and Transformation of our workforce. Care home staff and wider workforce should experience wellbeing support, meaningful work and attractive terms and conditions, which reflect modern society; all helping to deliver the high-quality care that citizens expect.

There is a need to look at recruitment of workforce and career opportunities around it, including the implementation of training. Placing a focus more on values than experience when recruiting may assist to grow, nurture and sustain the workforce. Exploring opportunities for people leaving school and ways we can link in with schools and the school curriculum, as well as advertising such opportunities also need to be considered.

The health and wellbeing of those working in care homes is of equal importance to that of those living in care homes. The needs of staff should be addressed and they should feel supported as they deal with difficult and traumatic experiences. The range of supports put in place in Lanarkshire are captured in this recent video by the CH Wellbeing Group. NHS Greater Glasgow and Clyde have introduced short care space sessions.

NHS Greater Glasgow and Clyde 20 minute care space sessions

With the increasing pressure on care home staff during the pandemic NHS Greater Glasgow and Clyde developed weekly 20 minute care space sessions to provide a space for self-care through facilitated connection and support. It is an experiential, reflective learning based exercise aimed at providing support to busy healthcare staff. Sessions are hosted by the Senior Principal Clinical Psychologist and have been co-facilitated by previous Trainee Clinical Psychologists and currently, by an Assistant Psychologist.

A number of sessions have been delivered since the programme's inception and staff feedback has been wholly positive in increasing their awareness of self-care and building connections with their colleagues. The programme also has the support from the Care Inspectorate.

Leadership

Effective leadership at all levels is in integral to ensuring that the health and wellbeing outcomes of people living in care are met. As part of our online survey just under half (48%) of respondents highlighted the value in having good leadership but this was counteracted by 41% suggesting that leadership in care homes could be better.

The Scottish Government recognises that having a strong leadership in place within the Health, Social Work and Social Care workforce can improve the culture and the wellbeing of staff and also lead to better care and outcomes for the people who use services. That is why in August 2022, we are launching a National Leadership Development Programme (NLDP), which will build on the work of Project Lift, and complement existing leadership development and support on offer within health, social work and social care workplaces. The Programme will be focused on developing compassionate, collaborative and inclusive leadership at all levels across the health, social work and social care system.

A range of Leadership support programmes and resources across Scotland are available to care home staff and managers via the SSSC's Step into Leadership website.

Pre-employment

There are different open access resources that introduce people to a career in social care, including care homes, and include tools that help people identify their existing skills and knowledge. The SSSC's Right values, right people: recruitment toolkit offers a range of pre-employment tools both for employers and people interested in working in social care. The College Development Network has launched the Introduction to a Career in Care programme and SSSC has created a mechanism for employers, including care home providers to share employment opportunities directly with local colleges and course participants. The SSSC's network of Careers Ambassadors are supported to work with social care staff, schools, colleges and employability providers, to promote life changing careers in social care.

Induction training

Good induction training is essential to prepare all members of the care home team for their duties and help them to immediately feel valued and supported in their role, which in turn may lead to better staff retention.

Whilst care homes will provide induction training for all new staff, outwith statutory training requirements this can be variable across the sector as it is adapted to the individual requirements of each care home. In addition, previous education and training is not always accepted as being transferable when an employee moves between care homes.

The SSSC and NES have worked in partnership with Scottish Government and employers to deliver a National Induction Framework for adult social care which provides a single point of access to existing NES/SSSC learning materials relevant to adult social care induction as a complement to the induction learning already provided by care home providers. It includes a learning assessment tool and Open Badges that support care home workers work with their managers to plan, record and reflect on their induction. Implementation and widespread consistent use of this induction framework across the sector is recommended.

Education and Career Development Pathway for the integrated community nursing team

The Education and Career Development Pathway for the integrated community nursing team was introduced as part of the Chief Nursing Officer's Transforming roles programme. This supports nurses from care home, district nursing, prison health and general practice nursing teams to develop skills and knowledge to practise confidently and competently from levels 5 to 8 of the NES NMAHP Development Framework and aims to develop a responsive, flexible, community nursing workforce.

Care homes should strive for consistency in providing mandatory training for all staff which addresses the core elements required to deliver safe care, covering a wide range of duties that will increase their knowledge, experience and skill-set. There should also be opportunities for staff to undertake continued professional development and pursue meaningful learning and development and to allow career progression.

Continuous Professional Learning

A requirement of SSSC registration is that individuals either hold or agree to work towards achieving, an approved qualification, usually a SVQ, within a 5-year period. The qualifications are designed from the National Occupation Standards for social care. Both SSSC and registered healthcare professionals are also required to evidence Continuous Professional Development (CPD) to maintain their ongoing registration. It is not unusual for staff to move or change roles during the 5-year period and therefore it can be a challenge to maintain a consistent level of education standards within the workforce. Response to the SSSC's A register for the future consultation have demonstrated an overwhelming support to making qualifications more flexible so people can move more easily to work in different kinds of services.

Although individuals have a professional responsibility to maintain their own training as part of their professional registration, employers have a responsibility to ensure that people living in care homes have suitably trained and qualified staff supporting them. This means that they need to identify relevant general and specialist training and ensure that their care home team delivers safe and effective care in line with all relevant legislation, guidance and best practice.

During our engagement sessions it was evident that there is an abundance of care, compassion, skills and knowledge within the care home team and wider workforce. However, over three quarters (79%) of our online survey responses from care home team members highlighted a lack of protected time for staff to undertake training and practice development. Building on the expertise within the current workforce is essential. Planning protected time, as well as providing opportunities to support the learning and development of the team is required. Everyone in the team should feel supported and valued in their roles, thus, encouraging new people to enter the workforce and experience working in a physical and social environment where they can truthfully say they are satisfied with their role and feel valued.

It is important to support staff and enable them to remain flexible to allow transferability of skills, which will help retain a diverse workforce with different skill sets that all work together to provide the full range of care required.

Availability of training courses, resources and programmes

Lifelong or continuous learning occurs in many different ways. Some high level examples are provided here, but are not exhaustive.

The Scottish Social Services Council have developed digital certificates called 'Open Badges' that help social care staff recognise continuous and informal learning that would otherwise go unrecorded. When applying for an Open Badge, staff need to give evidence of their learning and reflection on practice. Many badges also require endorsement of that evidence by a supervisor or line manager.

The SSSC's Learning Zone and NES TURAS Learn are online platforms where all health and social care staff can access health, wellbeing and social care tools and learning resources. Care home staff can select from a wide range of relevant tools and resources developed specifically to meet the education and training needs of those working in the care home environment. These resources support informal learning, specialist training, induction of new staff and the delivery of learning programmes by employers and critically the formal qualifications required for SSSC registration.

Training and education for Registered Nurses and AHPs is also available online through independent and private education providers, with Health Boards also providing training for their employees. Higher Education Institutes provide pre-degree and postgraduate programmes. Many of these support the recommendations of the Chief Nursing Officers Transforming Roles work, in particular the wider role of nurses working in community settings. Following the pandemic, Transforming Roles is being reviewed, with decisions on what shape this will take in the future awaited.

A training package has been developed for pharmacists, doctors and other healthcare professionals to undertake an in-depth review of prescribed medications. This can be accessed on TURAS and is available for anyone who wishes to complete it.

Much of the training takes place online and there is a desire from those we spoke to whilst developing the framework for the sector to introduce more practical support tools, with education and training that is meaningful, consistent, and fit for purpose, to better equip staff and empower them to feel confident in doing their job.

Most training is now done online however not all of our carers feel confident using computers. This is definitely putting some of them off doing it.

It is recognised that online training solutions can save time, but there needs to be an investment in time to train individuals in digital technology. This is a challenge for an already strained workforce, but it is key that staff have a basic level of digital education to enable access to these resources and opportunities as well as those that are provided face-to-face.

Many areas have successfully developed a HSCP based 'Care Home Liaison Service'. This is a multi-disciplinary team who work alongside the care home team to build competence and confidence in meeting the needs of the people living in the home. This may include focused study sessions on topics such as falls prevention, pressure area care and prevention, use of feeding tubes and palliative care. This should be explored for wider implementation across care homes in Scotland. NHS Lanarkshire for example has developed and built a Care Home Liaison Service over a 20 year period to cover all care homes for older people within the Lanarkshire area.

Evidence from the OPTIMAL study shows that when training includes all members of the care home team (e.g. catering, care and domiciliary team members) there is more likely to be organisational engagement and sustained improvements. This may not always be appropriate as there will be different levels of training required for different roles, where possible this should be encouraged.

There are numerous learning and development opportunities offered via various websites, providers and institutions, in various modes. This can make it difficult to keep track of what is available, relevant and what has been completed. There are also examples of good approaches taking place throughout care homes in Scotland that others are not aware of but could benefit from adapting to use within their own areas. It would therefore be beneficial to explore opportunities to develop and introduce a one-stop repository for tools and resources that everyone can access, which includes courses available as well as highlighting these good approaches for others to draw from.

A single record of education and training for all staff would not only assist to evidence statutory and mandatory training undertaken and promote transferability of learning, it would also help identify educational gaps for an individual. Better promotion of the training resources already available would help staff to know what is available to them and would improve take-up.

As we move forward

The Care Inspectorate have developed new approaches to scrutiny, with the Health and Social Care Standards used in conjunction with the Quality Framework for Care Homes for Adults. The importance of and ability for care homes to self-assess and be subject to scrutiny on the quality and experience of care they provide, to take actions required for improvement or maintenance is required to assure the care provided and experiences of people living in the home. However, it can also add to workforce pressures and capacity.

This framework is not intended to replace these standards, rather to support how care home teams and the wider MDT can meet them. Additionally, in its ambition for a sustainable and skilled care home workforce, the framework echoes the Workforce Strategy's vision and outcomes and aligns its recommendations to the five pillars of the workforce journey.

To meet the direct and indirect care requirements, the care home team is critical, in sufficient numbers, with the right skills and knowledge and the right supports to nurture and retain them. For this, the team requires good leadership and oversight. The roles of the care home manager and the registered nurse are key to this leadership provision.

Care home staff and wider workforce should experience wellbeing support, meaningful work and attractive terms and conditions, which reflect modern society; all helping to deliver the high-quality care that citizens expect.

Recommendations

7.1 Seek to improve the timeous availability of workforce data to support robust workforce planning, recruitment and retention in line with requirements of The Health and Care (Staffing) (Scotland) Act 2019.

7.2 Invest in the development of care home managers and consider access to enhanced leadership training, mentoring and leadership networks.

7.3 Plan and ensure clinical and professional leadership through the provision of registered nurses as key members of the care home team.

7.4 Explore opportunities for recruitment within the community, by placing a greater emphasis on values rather than experience.

7.5 Organisations should take steps to ensure the emotional wellbeing of their staff, and provide access to support and signposting to the range of resources currently available to them.

7.6 Ensure workforce plans include dedicated time for staff to undertake recommended and required education and training.

7.7 Explore opportunities for career and development pathways for support workers, ensuring consistency and transferability of skills and knowledge across the sector.

7.8 When complete, implement the Induction Framework, developed by NES, SSSC & Scottish Government, across the sector in a 'Once for Scotland' approach.

7.9 Identify the mandatory and core elements of training for care staff to ensure the essential knowledge and practical skills are readily available for use in the care home.

7.10 Have meaningful and consistent education and training that is fit for purpose, includes more practical support tools, and is supplemented by online training.

7.11 'Care Home Liaison Service' models should be explored, whereby multi-disciplinary teams work alongside the care home team to build competence and confidence in meeting the needs of the people living in the home.

7.12 Explore opportunities to develop and introduce a one-stop repository for tools and resources, that everyone can access and that will highlight and share good practice already happening for others to draw from.

7.13 Encourage interdisciplinary multi-sector learning and development to develop the skills required to support people living in care homes.

8. Data, Digital And Technology

For the framework to succeed, we must fully embrace the digital world and use data and technology appropriately to enable people to live well. The current digital landscape across care homes in Scotland is diverse. Many care homes use digital care planning systems and electronic medication management, and provide Wi-Fi access throughout the home for use by people living in the care home and any families or visitors. Other homes lack both accessible devices and connectivity, with significant implications for all.

Improving the use of data to support people living in care homes

Care homes are data-rich environments, collecting and collating detailed records of people's needs, plans and activities. They also provide data to inform the requirements of their regulator, contract monitoring with Partnerships, and intelligence to support national statistics on care home services – such as the Care home census. During the pandemic, the Safety Huddle Tool was developed to provide real-time data to inform the pandemic response, with respect to outbreaks, staffing and hospital use. It has been necessary to collect this data from care homes directly as it is not possible to identify the whole of the adult care home population using so-called 'routinely collected' health data in Scotland. This challenge limits our ability to use our national data to understand the needs of those living in care homes. This includes having reliable data on vaccination uptake and effectiveness, understanding patterns of hospital use, exploring pathways into care homes and their use to provide temporary care and support (e.g. respite and intermediate care services). Furthermore, there is inconsistency across the health system in what is considered to be a care home, with care home mortality statistics being based on alternative codes and definitions than those used by the Care Inspectorate as care regulator. Such inconsistencies mean we have a poor understanding of vital events and make existing and historical data difficult to compare.

Improving care home data in Scotland has the potential both to better understand the needs of those living in care homes and the staff who support them, but also to evaluate the implementation of this framework and generate evidence from practice around the most effective models of support. However, this will require specific work to improve the reliability of the data which NHS services collect on those living in care homes and routine systems to identify who lives in a care home, even on a temporary basis, so data are inclusive of the whole care home population. Joint working must take place between national bodies such as Public Health Scotland, National Records of Scotland and the Care Inspectorate, with improvements to NHS digital systems in Scotland. The National Care Service identifies the need for improved data about those receiving any social care, including those living in care homes. It is essential that there is both a review of the existing care home data landscape and work with key stakeholders which establishes the core data which should be collected and the specific purposes for collection, to ensure it is used to benefit those living in care homes.

Scottish Government analysts will shortly commence a review of care home data. The aims of the review are to ensure a coherent suite of data collections, reduce requests on data providers and more comprehensively understand and meet the existing and emerging needs of data users.

This Care Home data review will form one strand of a wider review of the entire social care data landscape. It will provide an important stock-take as we move towards the National Care Service. It will also support us to meet the recommendations set out in the Independent Review of Adult Social Care and reports from the Office for Statistics Regulation. It is envisaged that this will enable the monitoring of future approaches to the delivery of care, such as this healthcare framework.

Sharing information electronically

The importance of being able to share confidential information about the health of an individual, between the healthcare and social care workforce, was a common theme arising through the engagement sessions. We heard from healthcare professionals working in hospitals who did not have access to personal plans or ACPs when treating someone from a care home. Care home staff told us that they would often not receive adequate information at the time of hospital discharge to enable them to provide appropriate care.

It is important that when different professionals or organisations become involved in the provision of care to an individual, that relevant and appropriate personal information is shared between them and that data entries are understood to mean the same thing. The latter could be achieved by introducing and adhering to data standards and should enable professionals and organisations to deliver co-ordinated, effective and seamless services to the person living in a care home.

The Scottish Information Sharing Toolkit enables service-providing organisations directly concerned with the safeguarding, welfare and protection of the wider public to share personal information between them in a lawful and intelligent way. The Sharing Toolkit should be used to help organisations sharing or handling NHS Scotland's data to take the necessary steps to confidently share and use health data.

Digital technology for the individual

Being mindful of a person's life before they have moved into the care home and maintaining connections with the wider community is important and can be aided through the use of technology. This can enable the continued participation in faith or wider community activities.

During the COVID-19 pandemic there were strict restrictions on what people living in care homes were allowed to do, and who were allowed to visit them. Video calls allowed continued connection with family and friends who were not able to visit. They also enabled people to join church services, weddings and funerals in a virtual manner from the care home. Opportunities to use technology in this way must continue whenever it benefits the individual living in a care home.

However, this depends upon good Wi-Fi or broadband connectivity, access to appropriate phones, tablets, or laptops and staff with the time to help those who need it. It is therefore essential that this is available in all care homes in Scotland.

Digital technology to support the MDT approach to care

Increasingly videoconferencing technology has been used by healthcare teams to assess and review people rather than bringing them to hospital. This was particularly important during the COVID-19 pandemic as it allowed people to have healthcare interventions without the risks associated with attending a clinical environment such as a clinic or hospital.

As we move through the COVID-19 pandemic, the use of videoconferencing technology for consultations will continue to be important. Whilst face-to-face assessments must still take place when they are necessary and clinically appropriate, the use of photos and video-consultations can allow quicker access to advice and treatment for some health conditions (e.g. an unusual rash, or advice on wound-care) and can reduce the need for unnecessary travel. This is particularly important for people with mobility issues, or for people with cognitive decline. NHS Near Me is the platform that is currently used for video-consultations with healthcare professionals, and so staff working in care homes must be familiar with this, and be able to support people living in care homes to use it.

Videoconferencing technology must also be available to health and social care teams to enable the MDT to function. All care homes must have access to appropriate laptops or tablets to support videoconferences and have Wi-Fi and broadband connectivity that is sufficient to host these systems.

Near Me

Near Me is a secure form of video consulting that is widely used across NHS Scotland for health and care appointments. In 2021, a case study examined the use of Near Me to reduce the backlog of health reviews in Glasgow. Conducting the care home reviews via Near Me allowed staff and professionals to come together in a single call. Further benefits of Near Me include:

- Reduced travel to appointments: time, cost, convenience
- Reduced time away from home
- Easier to attend if you usually need someone to take you to appointments
- Enables you to have someone with you for support at your appointment (either with you or joining the consultation by video from another location, even from abroad)
- Better for the environment
- Reduces spread of infectious diseases

Digital approaches in care homes

The uptake and use of digital technology across the care home sector is a source of significant variation. Reducing this variation and ensuring people living in care homes can benefit from digital technologies to facilitate and support healthcare is key as we move forwards. This will not be without challenges – it requires investment of resource, addressing governance issues, establishing clear data sharing pathways and supporting the development of a digitally-skilled workforce.

The Connecting People Connecting Services Action Plan responds to the current and emerging needs of people living in care homes to realise the benefits of digital technologies. It provides a wider view on the scope of the digital issues and how to address them. The plan sets out key aspirations for enhancing Scotland's care homes' digital capacity to be able to fully embrace the potential for supporting people living in care homes and enabling new care management processes through the use of digital technology. Initial work took place during the COVID-19 pandemic, when the programme that supports the action plan equipped all interested care homes with tablets and dongles for connectivity. This saw people living in care homes being able to connect with outside services and loved ones during the periods of lockdown. Crucially, since November 2020 a number of digital training opportunities have been made available for care home staff with the goal of helping staff gain confidence and key skills to navigate day-to-day digital tasks to support those that they care for. The digital action plan for care homes will continue to be delivered and evolve through engagement with care home staff and managers. Information about current work and opportunities to participate in training and programme development sessions can be found on the Technology Enabled Care website.

Technology Enabled Care (TEC)

Technology Enabled Care (TEC) is a programme within Scottish Government which focuses on citizen facing digital solutions. It has a number of online digital resources that are designed for care homes, and include resources on device security, training resources and information on digital champions. All care home staff can potentially play the role of a digital champion, and can help colleagues and those living in the home to build their confidence and skills to get online.

Technology to support learning and development: Project ECHO

Project ECHO enables collaborative learning and the development of 'communities of practice' via multi-site videoconferencing. These meetings have often focused on palliative and end of life care issues, with input from the local specialist palliative care team. Highland Hospice is a super-hub and has helped establish and train eight other hubs across Scotland.

It is a recommendation that more care homes across Scotland have the opportunity to take part in Project ECHO.

Project ECHO

Project ECHO (Extension for Community Healthcare Outcomes) is an internationally recognised collaborative model of health education and care management that empowers health and social care professionals everywhere to provide better care to more people where they live and enhance their skills, confidence and build relationships with other professionals.

The ECHO model is guided by four main principles:

1. Amplification – using technology to leverage scarce resources
2. Best practice – to reduce disparity
3. Case based learning – to master complexity
4. Capturing data – Monitoring outcomes

There are a series of 'hubs' established across the UK, which have their own knowledge networks based on needs identified by the community itself.

Recommendations

8.1 Undertake a review of the existing care home data landscape to ensure it is used to benefit those living in care homes.

8.2 Data standards should be introduced, so that data entries from different organisations are understood to mean the same thing.

8.3 The Information Sharing Toolkit should be used to help organisations sharing or handling NHS Scotland's data to take the necessary steps to confidently share and use health data.

8.4 People living in care homes should have opportunities and support to use technology to connect with the world outside the care home, including access to good Wi-Fi and broadband connections.

8.5 There should be access and support for people living in care homes to use NHS Near Me for video-consultations with healthcare professionals.

8.6 There must be appropriate technology within every care home to support virtual MDT meetings.

8.7 The actions listed within Connecting People Connecting Services should be implemented.

8.8 All care home staff should have access to resources that build and strengthen their digital skills, such as those developed by Technology Enabled Care.

8.9 Digital initiatives that support learning, such as Project ECHO should be explored.

Table Of Recommendations

Framework Chapter	Recommendation	
Nurturing Environment	1.1	We must recognise and value the important role of all staff working in the care home in improving health and wellbeing of people living in care homes.
	1.2	The care home team should continue to play a leading role in the healthcare of people living in care homes, alongside a keyworker who co-ordinates the day-to-day care of the individual.
	1.3	Health and social care professionals must work together to address any healthcare needs within the nurturing environment of the care home and ensure that people living in care homes are not over-medicalised.
	1.4	Everyone living in a care home should have access to nursing care. These nurses may either be employed by the care home, or, if employed externally, should have expertise in care homes.
The Multi-Disciplinary Team	2.1	Regular MDT meetings (face-to-face, virtual or hybrid) should take place involving the care home team, the GP practice and relevant other professionals to co-ordinate and plan healthcare.
	2.2	The administration and support of MDT meetings should be co-ordinated between the HSCP and the care home.
	2.3	People living in care homes should have the opportunity to involve a family member or any legally appointed welfare guardian or attorney during consultations with members of the MDT.
	2.4	As MDTs form and develop, opportunities for shared learning should be explored, to develop the knowledge, skills and experience required to provide the best possible care.
	2.5	Wherever possible, each care home should be linked with a named GP practice that will play a lead role with that home. Where this is not possible, HSCPs should work with the local care homes and GP practices to establish safe and reliable alternative arrangements that enable effective MDT working.
	2.6	People living in care homes should be made aware of the benefits of being registered with the GP practice that is linked to the care home that they live in, however they should not be forced to change GP practice.
	2.7	Health Boards should review Local Enhanced Services (LES) that relate to care homes and revise them in line with the aspirations of the 2018 GP contract and the ambitions of this framework.
	2.8	HSCPs must ensure that there is access to appropriate specialist provision when commissioning with the care home sector to provide specific services for people with highly complex care needs.
	2.9	Care home teams must be provided with contact details and referral routes for all members of the MDT. Where these are not clear, the HSCP should work with the care home to obtain these.

Framework Chapter	Recommendation	
Prevention	3.1	People living in care homes must be supported to access any relevant age-specific public health programmes with appropriate information to allow an informed decision.
	3.2	Application of IPC standards in care homes should be supported by access to relevant IPC advice, education and guidance.
	3.3	Everyone living in a care home will have a regularly reviewed personal plan.
	3.4	Ensure there are effective systems in place to deliver a consistent approach to the development and implementation of proactive, personal plans.
	3.5	A person centred medication review, using the 7-step approach should be initiated by a pharmacist when someone first moves into a care home, and then at least annually thereafter. Certain high-risk drugs, such as antipsychotics, will require more frequent monitoring and review.
	3.6	Routine dental, sight, and hearing reviews should continue to be part of an individual's personal care plan when they move to live in a care home.
	3.7	There should be a named dentist / dental practitioner for each care home and contracts with local optometry and hearing services.
	3.8	There should be a proactive approach to hydration, nutrition, continence promotion, meaningful activity and mobility using appropriate resources and should be considered with the same degree of importance as reactive healthcare.
	3.9	Religious and philosophical beliefs in relation to food and diet should be enquired about and catered for.
	3.10	Psychological and spiritual aspects of healthcare should be assessed and regularly reviewed within care plans.
	3.11	Individuals should be supported to maintain links in their local community which enables cognitive stimulation, mobility, independence and communication.

Framework Chapter	Recommendation	
Anticipatory Care, Self-Management And Early Intervention	4.1	‘What Matters to Me’ and ‘Thinking Ahead’ ACP conversations should take place at the earliest opportunity, ideally prior to entering the care home, and at regular intervals throughout the individual’s stay.
	4.2	Where someone has a complex health condition, or there are a variety of different treatment options, a senior clinician, such as GP should be involved in discussions.
	4.3	All health and social care staff must be provided with support and training in communication to improve confidence and skills in conducting these meaningful conversations.
	4.4	Everyone living in a care home should have the opportunity to develop an Anticipatory Care Plan.
	4.5	All health boards should seek to agree and adopt a robust approach (such as the HIS ACP Toolkit, Lothian 7 Steps, ReSPECT) to conducting ACP discussions.
	4.6	Anticipatory Care Plans should be shared with everyone involved in providing the individual’s care, and a summary should be included in the Key Information Summary (KIS).
	4.7	Establish community-based supporting self-management programmes to consider how best to support care home teams to adopt self-management approaches.
	4.8	People living in a care home should continue to have regular assessments of their long term conditions, as appropriate, from their Primary Healthcare Teams.
	4.9	Realistic Medicine principles should be adopted to reduce unnecessary or inappropriate investigations and treatment.
	4.10	Where possible, people with complex medical conditions should be supported to attend hospital-based clinics. Where this is not possible, specialist input into the care of the person living in a care home should be adapted to the situation. This may be by telephone, video consultation or by visiting the care home.
	4.11	Changes to mood or cognition should be identified at an early stage and discussed with members of the MDT to determine whether referral is indicated for specialist mental health services for assessment and intervention.

Framework Chapter	Recommendation	
Urgent / Emergency Care	5.1	Support and empower care home staff by providing and encouraging participation in training opportunities and enabling all staff to have the tools to assess and communicate in acute and emergency situations using the SBAR format.
	5.2	People living in care homes should have timely access to members of their MDT, 24/7 when urgent or unscheduled care is required.
	5.3	HSCPs should consider developing dedicated community healthcare teams comprising advanced practitioners who can respond quickly and visit people in care homes requiring urgent unscheduled assessments, with support and advice being easily available from the GP by phone. These services should cover both weekdays and weekends.
	5.4	Both care home staff and healthcare staff should be familiar with the SBAR format when discussing urgent or emergency care, and consider using a structured proforma for these conversations.
	5.5	Care home staff should be able to contact healthcare professionals during an urgent or emergency situation in a consistent and timely manner – this includes exploring possibilities for dedicated professional to professional communication channels.
	5.6	Scoping work should take place to explore the use of near patient and point of care testing within care homes, taking into account Realistic Medicine principles.
	5.7	Health boards should develop Hospital@Home services that support people living in care homes to receive hospital-level care within the care home.
	5.8	Further work is required across Scotland to improve the accessibility and provision of medicines during an urgent situation. This includes exploring mechanisms to enable care homes to hold a stock of certain drugs within the home.
	5.9	People living in care homes should never be denied admission to hospital solely on the basis of living in a care home, and at point of admission older people should be assessed by a senior clinical decision maker with experience in caring for frail older adults.
	5.10	Timely and safe transfers to and from hospital for older people in care homes should be optimised.
	5.11	Digital access to an individual's health records, and clinical outcomes should be timely and accessible to all parts of the system.

Framework Chapter	Recommendation	
Palliative and End of Life Care	6.1	Care homes should consider how they can incorporate identification tools and assessments within normal practice to help identify people who may require a palliative approach to their care, and support the individual as their health needs change.
	6.2	Provide training in the use of appropriate symptom assessment tools, and enable early involvement of dementia link workers to ensure that those living with dementia receive the care and treatment they require.
	6.3	Anticipatory Care Plans should be reviewed as people are nearing the end of life to ensure they are firmly rooted in a clear understanding of the values, beliefs and preferences of the individual.
	6.4	Care home providers should use the 'enriching and improving experience' framework to identify need and plan the learning and development of their employed staff in relation to palliative and end of life care.
	6.5	HSCPs and NHS boards should ensure that there is a specialist palliative care service available and easily accessible to the MDT, and these services should foster close "co-working" and "shared learning" relationships.
	6.6	Care home providers and specialist palliative care teams should work together to explore shared learning and peer support opportunities, through initiatives such as Project ECHO.
	6.7	GPs and other members of the MDT should be available to support the care home staff with end of life care, and speak with relatives when required.
	6.8	Dedicated out of hours palliative care lines, allowing direct and fast access to community nursing and medical staff for people who are nearing the end of life, should be available in all HSCPs.
	6.9	There should be prompt access to appropriate medication (including anticipatory 'just in case medication' and oxygen) and equipment, such as syringe pumps and pressure relieving mattresses.
	6.10	Scotland's bereavement charter should be adopted by all those working in and with care homes and used to guide the support that is offered to those who are bereaved.

Framework Chapter	Recommendation	
A Sustainable and Skilled Workforce	7.1	Seek to improve the timeous availability of workforce data to support robust workforce planning, recruitment and retention in line with requirements of The Health and Care (Staffing) (Scotland) Act 2019.
	7.2	Invest in the development of care home managers and consider access to enhanced leadership training, mentoring and leadership networks.
	7.3	Plan and ensure clinical and professional leadership through the provision of registered nurses as key members of the care home team.
	7.4	Explore opportunities for recruitment within the community, by placing a greater emphasis on values rather than experience.
	7.5	Organisations should take steps to ensure the emotional wellbeing of their staff, and provide access to support and signposting to the range of resources currently available to them.
	7.6	Ensure workforce plans include dedicated time for staff to undertake recommended and required education and training.
	7.7	Explore opportunities for career and development pathways for support workers, ensuring consistency and transferability of skills and knowledge across the sector.
	7.8	When complete, implement the Induction Framework, developed by NES, SSSC & Scottish Government, across the sector in a 'Once for Scotland' approach.
	7.9	Identify the mandatory and core elements of training for care staff to ensure the essential knowledge and practical skills are readily available for use in the care home.
	7.10	Have meaningful and consistent education and training that is fit for purpose, includes more practical support tools, and is supplemented by online training.
	7.11	'Care Home Liaison Service' models should be explored, whereby multi-disciplinary teams work alongside the care home team to build competence and confidence in meeting the needs of the people living in the home.
	7.12	Explore opportunities to develop and introduce a one-stop repository for tools and resources, that everyone can access and that will highlight and share good practice already happening for others to draw from.
	7.13	Encourage interdisciplinary multi-sector learning and development to develop the skills required to support people living in care homes.

Framework Chapter	Recommendation	
Data, Digital & Technology	8.1	Undertake a review of the existing care home data landscape to ensure it is used to benefit those living in care homes.
	8.2	Data standards should be introduced, so that data entries from different organisations are understood to mean the same thing.
	8.3	The Information Sharing Toolkit should be used to help organisations sharing or handling NHS Scotland's data to take the necessary steps to confidently share and use health data.
	8.4	People living in care homes should have opportunities and support to use technology to connect with the world outside the care home, including access to good Wi-Fi and broadband connections.
	8.5	There should be access and support for people living in care homes to use NHS Near Me for video-consultations with healthcare professionals.
	8.6	There must be appropriate technology within every care home to support virtual MDT meetings.
	8.7	The actions listed within Connecting People Connecting Services should be implemented.
	8.8	All care home staff should have access to resources that build and strengthen their digital skills, such as those developed by Technology Enabled Care.
	8.9	Digital initiatives that support learning, such as Project ECHO should be explored.

Making This Happen

Following publication of this framework we will embark on a period of engagement and collaboration with key stakeholders from across the sector to effectively implement and deliver the recommendations outlined in the framework.

Moving forward it is essential that we ensure we are aligned with individual policies across the health and social care system so we can build on the many good practices that are already in place and are able to influence the levers that will allow the recommendations to happen. We recognise this will not transpire immediately and implementation will be ongoing and require a collaborative approach across the system.

To enable us to do this we will:

- establish an 'implementation oversight group' with members from all areas of health and social care as well as people living in care homes and their families.
- consider at a Directorate Health and Care level the most effective means on achieving the recommendations by ensuring we are aligned to broader programmes and priorities such as the care and wellbeing portfolio and urgent and emergency care collaborative, and in doing so, ensure we can adequately resource the recommendations.
- work with the Care Inspectorate, Health Improvement Scotland, Public Health Scotland and academic and policy colleagues to develop a set of metrics to monitor and evaluate success and provide a robust platform for quality improvement.
- work with the sector on a number of improvement projects to understand how we can embed the vision, and in doing so, ensure we understand the opportunities and challenges to achieve the recommendations at scale across the sector.
- produce an annual review of progress against the framework's recommendations.

Glossary

Advanced Practitioner	A healthcare professional with developed skills and knowledge allowing them to take on expanded roles and scope of practice caring for patients. These come from a range of professional backgrounds such as nursing, pharmacy, paramedics, physiotherapists and occupational therapy.
Allied Health Professional (AHP)	Someone other than a physician, registered nurse, or dentist, trained to provide system-wide care to assess, treat, diagnose and discharge patients. Includes, chiropodists/podiatrists, dietitians, occupational therapists, paramedics, physiotherapists, and speech and language therapists.
Anticipatory Care Planning	An approach where people are supported to have meaningful discussions about 'What Matters to Me' in the context of their health and care, providing person-centred, co-ordinated care, focusing on goals and preferences, whilst offering opportunities to consider realistic treatment and care options.
Care homes	Care homes providing care for adults in Scotland including care homes for older people (aged 65+), adults with learning disabilities, mental health problems, physical and sensory impairment, acquired brain injury, alcohol and drug misuse, and blood-borne virus.
Care Home Liaison Nurse	A registered nurse working alongside the care home to provide specialist support, advice, education and support interventions to the Care Home staff.
Care Home Liaison Service	A multi-disciplinary team who work alongside the care home team to build competence and confidence in meeting the needs of the people living in the home.
Community nursing	Nursing care provided outside of a hospital to people in their own homes, care homes, or close to where they live, in clinics and GP practices across every village, town and city in the country.
COSLA	A councillor-led, cross-party organisation who champions councils' vital work to secure the resources and powers they need. They also work on councils' behalf to focus on the challenges and opportunities they face, and to engage positively with governments and others on policy, funding and legislation.
Early Intervention	Identifying and providing effective early support to people who are at risk of poor outcomes, to prevent problems occurring, or to tackle them head-on when they do, before problems get worse.
Health and Social Care Partnership (HSCP)	A compact of health and social care providers responsible for adult social care, adult primary health care and unscheduled adult hospital care working towards a set of national health and wellbeing outcomes.
Health Board	NHS Scotland consists of 14 regional NHS Boards responsible for the protection and the improvement of their population's health and for the delivery of frontline healthcare services. There are also 7 Special NHS Boards and 1 public health body who support the regional NHS Boards by providing a range of important specialist and national services.
Health and Social Care Standards	Standards applicable to the NHS and services registered with the Care Inspectorate and Healthcare Improvement Scotland, setting out what people should expect when using health, social care or social work services in Scotland.

Term	Definition
Health care	Health care or healthcare is the maintenance or improvement of health via the prevention, diagnosis, and treatment of disease, illness, injury, and other physical and mental impairments in people. Health care is delivered by health professionals in allied health fields.
Healthcare Improvement Scotland (HIS)	The purpose of Healthcare Improvement Scotland is to enable the people of Scotland to experience the best quality of health and social care. Their broad work programme supports health and social care services to improve.
Local Enhanced Services (LES)	Services that provide additional funding to supplement services already offered within the core GMS (General Medical Services) contract.
Multi-disciplinary Team (MDT)	A group of healthcare and social care professionals, who are members of different disciplines with different skills and expertise (e.g. care workers, podiatrists, dentists, nurses and doctors) that work together to enable the best outcome for the person living in a care home.
National Care Service	The establishment of a National Care Service (NCS), accountable to Scottish Ministers, to create comprehensive community health and social care service that supports people of all ages which is rights-based and people powered.
Near patient/point of care testing	An investigation taken at the time of consultation with instant availability of results to make immediate and informed decisions about patient care.
Out Of Hours (OOH) service	A fundamental part of the healthcare service in Scotland providing support to those who require medical assistance outwith normal GP surgery hours. The out-of-hours period is from 6:30pm to 8am on weekdays and 24 hours at weekends and on bank holidays.
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.
Prevention	Preventing deterioration in health and wellbeing through good nutrition, hydration continence, movement and activity, cognitive stimulation and social connections.
Primary care	The first point of contact with the NHS. This includes community based services provided by general practitioners (GPs), community nurses, dentists, dental nurses, optometrists, dispensing opticians, pharmacists and pharmacy technicians. It can also be with allied health professionals such as physiotherapists and occupational therapists, midwives and pharmacists.
Realistic medicine	An approach that puts the person at the centre of decisions made about their care, with shared decision making and a personalised approach to care. It also aims to reduce harm, waste and unwarranted variation, whilst acknowledging and managing the inherent risks associated with all healthcare, and championing innovation and improvement.
Scottish Social Services Council (SSSC)	The regulator for the social service workforce in Scotland.
Social care	A wide range of non-medical services provided by local authorities and independent bodies, including from the voluntary sector, to support the social needs of individuals, especially older adults, the vulnerable or those with special needs, to improve their quality of life.

Social worker	Social worker is a statutory role which involves assessing need, managing risk and promoting the wellbeing of individuals and communities.
Stakeholders	Stakeholders are individuals, groups or organisations that are affected by the work or activity of an organisation or service.
Tissue viability	A speciality that primarily considers all aspects of skin and soft tissue wounds including acute surgical wounds, pressure ulcers and leg ulceration.

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Agenda Item 8

Integration Joint Board

Date of Meeting: 15/08/2022

Title of Report: Argyll and Bute Child Poverty Action Plan Review 2021-2022

Presented by: David Gibson, Head of Children & Families and Justice.

The IJB is asked to:
▪ Note the review

1. EXECUTIVE SUMMARY

The Argyll and Bute Child Poverty Action Plan Review 2021-2022 is the third review of the Child Poverty Action Plan first published in 2019. It is a requirement under the 2017 Child Poverty (Scotland) Act that local authorities and health boards jointly produce and publish an annual review of their plan, setting out work being undertaken to tackle child poverty in their region. This action is required up until 2030 and includes key target years of 2023 and 2030 for particular levels of progress to be achieved.

The Argyll and Bute Child Poverty Action Group, led by Fiona Davies (Chief Officer; Argyll & Bute Health and Social Care Partnership) have produced this year's review to reflect the work of its members and others working to tackle child poverty across the region. It reflects a strong children's rights approach and the vision shared vision that:

We want an Argyll and Bute where no-one lives in poverty. Everyone should be able to achieve their potential and feel healthy, happy and valued. We want to be a place where everyone understands that tackling poverty is a shared responsibility. We believe that if we act locally, and in partnership, we can make a difference.

A child friendly SWAY version of the plan has been created for engaging with children and young people. It is hoped that this will be developed into a One Page Plan, graphic version that will also be of real value in working with children and also adults who might prefer this presentation to reading a long report.

Current Child Friendly SWAY

https://sway.office.com/od2HbGIr940R2j3u?ref=Link

2. INTRODUCTION

In 2017 the Child Poverty (Scotland) Act came into force as an attempt to put in place measures that would reduce the concerning increase in child poverty,

both on a national and local level. The Act introduced a new requirement for local authorities and each relevant Health Board to jointly prepare a Local Child Poverty Action Report and to review it on an annual basis until 2030. The Scottish Government publishes a national child poverty report, "Every Child Every Chance" which sets out the national measures taken to address the issue and this too is reviewed annually. In 2022 a second delivery plan was published" Best Start, Bright Futures: Tackling Child Poverty Delivery Plan 2022-202".

Of particular relevance to the duties under the Child Poverty (Scotland) Act are Parts 1 and 3 of the Children and Young People (Scotland) Act 2014. Part 1 requires public authorities to publish, as soon as practicable after the end of each 3 year period, a report of what steps it has taken in that period to secure better or further effect within its areas of responsibility of the UNCRC requirements. Of particular relevance to the issue of child poverty are the following articles:

- Article 3 (best interests of the child)
- Article 6 (life, survival and development)
- Article 12 (respect for the views of the child)
- Article 26 (social security)
- Article 27 (adequate standard of living)

The Child Poverty Action Plan and the Children's Rights Report are closely linked and should in turn be linked to key Council and Health Board strategies and plans, for example the Children and Young People's Service Plan 2020 – 2023. It should be noted that child poverty and children's rights are issues not limited to Children's Services or the HSCP but are a wider responsibility that Council departments and partners need to be cited on.

The Plans also link to the Fairer Scotland Duty. This is an overarching strategic duty on public bodies. It has interactions with the Equality Act 2010 and Scotland Act 2016; and came into force on 1 April 2018. The Duty requires that: "An authority to which this section applies must, when making decisions of a strategic nature about how to exercise its functions, have due regard to the desirability of exercising them in a way that is designed to reduce the inequalities of outcome which result from socio-economic disadvantage." In ensuring that this obligation is met, Equality and Socio-Economic Impact Assessments (EQSEIA's) must be carried out when new plans and strategies are being developed. Children's rights obligations call for a similar process to be carried out and Child Rights and Wellbeing Impact Assessments (CRWIA's) to be completed. Work is currently taking place in Argyll and Bute to integrate these two assessment documents into one process.

The 2017 Act set four targets relating to ending child poverty, which the Scottish Government committed to trying to achieve by 2030. The targets for children living in households in Scotland are that:

- less than 10% of children live in relative poverty (relative poverty is less than 60% of average household income for the year taking account of the size and composition of the household);
- less than 5% of children live in absolute poverty (absolute poverty is less than 60% of average household income for the financial year beginning 1 April 2010);

- less than 5% of children live in combined low income and material deprivation (low income is defined as less than 70% of average household income for the year, material deprivation is when families are unable to afford three or more items out of a list of basic necessities);
- less than 5% of children live in persistent poverty (persistent poverty is where a child has lived in relative poverty for three out of the last four years). These are all measured after housing costs are deducted.

The Act also sets out interim targets which are to be met in the financial year beginning 1 April 2023. These are all measured after housing costs are deducted.

- Less than 18% of children are in relative poverty
- Less than 14% of children are in absolute poverty
- Less than 8% of children are in combined low income and material deprivation
- Less than 8% of children are in persistent poverty.

3. DETAIL OF REPORT

In 2019 the Argyll and Bute Child Poverty Action Group, a multiagency body was set up to oversee the implementation of the local Child Poverty Plan, review it annually and find ways to best use existing resources and develop new initiatives. Following approval and publication there is an obligation for it to be submitted to Scottish Government.

Local Child Poverty Figures

On the 12th of July 2022 the End Child Poverty coalition published the latest local child poverty figures. Their research, covering the period to 2020/21, provides the best available estimates of child poverty at local authority level (below 60% median income after housing costs). Figures for Argyll and Bute are as follows:

2020-2021 - 18.8%; a reduction of 1.8% from the 2014-2015 figure of 20/7%

The current review introduces the challenges the year has brought in terms of food shortages, a cost of living crisis and the war in Ukraine.

It also notes progress as working with The Poverty Alliance, One Parent Families Scotland and The Child Poverty Alliance we put together a broad range of training events for our multi-agency staff group and others. Also noted is our commitment to #KeepingThePromise and our continued development of a trauma informed workforce.

Adding to this is our commitment to train staff in Dyadic Developmental Psychotherapy. Other positives noted include client gain of £10,165,000 from our advice services, engagement in schools, Hermitage Academy becoming the first high school in Argyll and Bute to receive gold accreditation in UNICEF UK's Rights Respecting School programme and the success of the Flexible Food Fund.

It notes that nationally there has been the publication of the Scottish Government's second Tackling Child Poverty Delivery Plan, "Best Start, Bright Futures 2022-2026". We state that we approve that it say the 2030 targets require us to work differently – placing an ever greater focus on families and the

places they live. We make the point that rural, remote and island living can have additional challenges and costs that need to be considered. The high and immediate risks to people in Argyll and Bute due to fuel poverty are emphasized as are the mental and physical health costs of poverty.

Reasons for this Child Poverty Review

It is noted that the 2017 the Child Poverty (Scotland) Act introduced a new requirement for local authorities and each relevant Health Board to jointly prepare a Local Child Poverty Action Report and to review it on an annual basis until 2030.

Pupil Voice on Childhood Poverty

The report includes a reflection from a variety of school age young people giving their views and feelings of pupils, these were collected by schools in engagement exercises.

Children's Rights

The report notes that Children's rights are fundamental to all work tackling child poverty and should be reflected in the principles and objectives of all services that support children. This means not only direct services such as education, health and social care but also our political, social and economic infrastructures. When we look at a Strategic Children and Young People's Service Plan from a Health and Social Care Partnerships (HSCP) we expect to see needs and children's rights identified and considered. Local Authorities also need to show that is happening, for example, when a road is planned, street lighting changed or a Commissioning Strategy developed.

The Promise

A key consideration when looking at our work on tackling child poverty in Argyll and Bute must be keeping The Promise. The Promise, launched by the Scottish Government in Autumn 2020 originates in the findings of The Care Review and makes a commitment to care experienced infants, children, young people, adults and families, that every child grows up loved, safe and respected, able to realise their full potential. It demands a multi-agency approach to support shifts in policy, practice and culture across Scotland and make the difference that is required. In Argyll and Bute a strong, multi-agency commitment has been made to delivering on The Promise and that work has continued, despite the considerable barriers raised by the Covid-19 pandemic, EU exit and the current cost of living crisis.

Our Challenge

This area notes the particular challenges faced by Argyll and Bute, with regards to areas such as fuel poverty, the economy, infrastructure and demographics. It includes statistical data. Under sustainability it notes work being carried out in connection with the UK Community Renewal Fund, Island Community Hall Connectivity Project and Rural Growth Deal. Also noted here is work on school clothing banks, free period products and the Food Forum.

Training

One of our commitments for the year 2021 – 2022 was to deliver training, related to understanding and tackling child poverty, for a wide range of staff groups across Argyll and Bute. This was made possible by monies from the Flexible Fund which enabled us to commission the Poverty Alliance, Child Poverty Action Group and One Parent Scotland to work with us. A number of training packages were developed and delivered on multiple occasions. The nature and impact of this training is noted.

Key Areas of the Plan:

This section notes key areas of work undertaken in relation to child poverty; they are recorded under the 3 Drivers of Poverty, helping families in other ways and planned future work.

A. **Increasing Income from Employment and Earnings**

Employability; The Scottish Government's Islands Programme (IP); Skills Development Scotland; Learning HUBS; Council Apprenticeships; Education; Early Years; UHI Argyll and University of the Highlands and Islands.

B. **Increasing Income through Benefits**

Flexible Food Fund; Client Gain through Advice Activity.

C. **Cost of Living**

Housing; Fuel Poverty; Social Security Scotland; Free School Meals and holiday Provision; Argyll and Bute Community Food Forum; Good Food Nation and Food Strategy; Bute Advice Service; Free Period Products; School Clothing Banks; The GRAB Trust (Group for Recycling in Argyll and Bute); ReStyle Argyll; LORI; Kintyre Recycling; Re-Jig.

D. **Helping Families in Other Ways**

Infant and Perinatal Mental Health Services; Youth Work Education Recovery Learning Programme; What are Carers Centres and MAYDS doing to support Young Carers in Argyll & Bute?; Transforming Responses to Violence against Women and Girls; Free School Meals Delivered by Drones; Universal Pathway Quality Improvement Collaborative Financial Inclusion Practicum (UPQIC); Flexible Fund.

E. **Other Planned Work**

Rural Growth Deal; Local Authority Covid Economic Recovery Fund (LACER); Child Poverty Group.

4. RELEVANT DATA AND INDICATORS

On the 12th of July 2022 the End Child Poverty coalition published the latest local child poverty figures. Their research, covering the period to 2020/21, provides the best available estimates of child poverty at local authority level (below 60% median income after housing costs). Figures for Argyll and Bute are as follows:

Date	Number of Children in Poverty	Percentage of Children in Poverty	Percentage Point Change
2014 - 2015	**2808**	**20.7%**	
2020 - 2021	**2325**	**18.9%**	**-1.8%**

This positive change reflects the Scottish Government investment in the new Scottish child payment, other Social Security payments and a range of other measures. It also reflects the impact of a range of local measures taken to tackle

child poverty and its impacts, which are noted in this report. Scotland has the lowest rate of child poverty amongst countries of the UK at 21%, followed by England at 29% and Wales at 34%.

Whilst this is positive, particularly given the cost of living crisis; Argyll and Bute does have some significant challenges. Although it has a lower percentage of workless households than the national average (14.7% opposed to 18.1% - Jan-Dec 2020), average gross weekly pay rates are lower (553.6 opposed to the national average of 595). Hence the numbers of children in low income families remains a concern.

Children in Low Income Families

	Argyll and Bute	Scotland
2017 - 2018	17.3%	18.6%
2018 - 2019	16.7%	16.5%
2019 - 2020	17.2%	16.8%

In addition the level and nature of fuel poverty in Argyll and Bute makes families particularly vulnerable at the moment given the rises in fuel costs. Recently, revised Scottish Government figures show that fuel poverty is now estimated to be 43% higher than in 2019. This means that in the Argyll & Bute and Highland regions, fuel poverty is likely to be approaching 50% and extreme fuel poverty, probably almost 30% of all households – and further significant price increases seem likely yet to come. Particular local innovations, such as the Flexible Food Fund, are attempting to tackle this, offering grants and client advice.

Fuel poverty is not equally distributed throughout Argyll and Bute but rather more marked in some housing market areas. For example Figure 1 shows that Bute has 41-50% of the population in fuel poverty whereas Cowal has less than 20% in fuel poverty.

Work is being carried out nationally to look at improving data looking at child poverty in rural places. Workshops have taken place led by the Improvement Service and some of the suggestions for taking this forward include:

- Establish a multi-disciplinary working group on Tackling Child Poverty through Innovation in Data and Intelligence, chaired by IS/COSLA/academic partners to include, for example, relevant local authorities and health boards, relevant academics (Scottish Public Policy Exchange, SPIRU, Codeclan, Data Lab, Research Data Scotland, SPIRU), representatives of the Information Commissioner and those with insight/expertise as to private sector use of data sharing legislation. Local government representatives should include those in leadership roles (SOLACE etc.) those with data and analytical expertise, GIS professionals and child poverty policy and delivery leads.

5. CONTRIBUTION TO STRATEGIC PRIORITIES

This review fulfils the obligation, from The Child Poverty (Scotland) Act 2017, for local authorities and health boards to deliver jointly an annual review of their Child Poverty Action Plan. Links with other local authority reporting

duties on tackling child poverty include: Fairer Scotland Duty, Islands (Scotland) Act 2018; Children and Young People (Scotland) Act 2014; Education Act 2016; Community Empowerment (Scotland) Act 2015.
This Child Poverty Action Plan links to: the Local Outcome Improvement Plan, Children and Young People's Services Plan and the Children's Rights Plan. Overarching this, children's rights and tackling child poverty should be a consideration in every Council plan and strategy.

6. GOVERNANCE IMPLICATIONS

6.1 Financial Impact

The report notes a forecast financial impact on families and wellbeing and may risk a subsequent financial impact on organisations as the wider and longer term impacts of poverty are felt.

6.2 Staff Governance

No issues specific to this paper.

6.3 Clinical and Care Governance

This report is governed through a multi-agency strategic group seeking to work together to deliver national policy and alleviate poverty. This report is submitted to the IJB for note and to the Council for approval.

7. PROFESSIONAL ADVISORY

This is supported through the strategic group.

8. EQUALITY & DIVERSITY IMPLICATIONS

An EQSEIA and a CRWIA have been carried out in relation to this Child Poverty Action Plan Review. No negative impacts were noted and positive impacts seen in terms of the work noted in this review.

9. GENERAL DATA PROTECTION PRINCIPLES COMPLIANCE

Data protection principles have been adhered to.

10. RISK ASSESSMENT

The reviewed plan shows a range of planned work to address child poverty; it is noted that the latest child poverty figures for Argyll and Bute show a reduction of 1.8% to 18.9% (below 60% median income after housing costs). However recent events such as the impacts of EU Exit, the war in Ukraine and the cost of living crisis have placed more families into financial crisis and made it less likely that the Scottish Government's child poverty reduction targets for 2023 and 2030 will be met.

11. PUBLIC & USER INVOLVEMENT & ENGAGEMENT

The Child Poverty Action Group has a Communications and Engagement Subgroup which looks to inform and consult on issues relating to child poverty. Group members share information regarding work in the area of child poverty and also what resources and supports are available for people requiring them. A range of networks and media sites are used to achieve this. Key events, such as Challenge Poverty Week are used to raise awareness of child poverty

and the work going on to tackle it. Engagement with children and young people is being developed via schools, youth groups and young carers groups.

12. CONCLUSIONS

The current Child Poverty Action Plan Review 2020 – 2021 sets out the current situation in terms of child poverty in Argyll and Bute and makes particular reference to areas such as children's rights, sustainability and the challenges facing our island communities. The plan sets out work that has been happening to address child poverty in Argyll and Bute and some Page 5 4 plans for actions going forward. This will be led by Fiona Davies and the CPAG group; training, engagement and data analysis are key issues for the coming year.

13. DIRECTIONS

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

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 Agenda Item 9

Argyll & Bute Health & Social Care Partnership

Integration Joint Board **Agenda item :**

Date of Meeting: 21st September 2022

Title of Report: Year 2 (2021/22) Annual Review of the Children and Young People's Services Plan 2020 – 2023

Presented by: Patricia Renfrew

The Integration Joint Board is asked to :
• Note that both NHS Highland and Argyll and Bute Council are jointly and equally responsible for children's services planning • Note Argyll and Bute's Children and Young People's Services Plan 2020-2023 Year 2 review for the period 2021/22 • Note the submission of the Children and Young People's Services Plan Year 2 review to Scottish Government as per the legislative requirement.

1. EXECUTIVE SUMMARY

1.1 The Children and Young People's Service Plan 2020-2023 was approved at the Integrated Joint Board and Community Services Committee in November 2020 https://argyll-bute-girfec.com/wp-content/uploads/2020/12/cysp-2020-14th-dec-digital-version.pdf.

1.2 There is a requirement in Part 3 of the Children and Young People (Scotland) Act 2014 to review the report annually and report on the performance and progress to date in delivering the outcomes set out in the plan.

1.3 This review considers updates on 2021/22 progress and areas for improvement, provides information on key developments that have taken place since the plan was published and sets out key plans for the year ahead.

2. INTRODUCTION

This is the first annual review of the Children and Young People's Service Plan 2020-2023. https://argyll-bute-girfec.com/wp-content/uploads/2020/12/cysp-2020-14th-dec-digital-version.pdf. In this review we will report on our performance and progress to date in delivering the outcomes we set out to achieve.

1.2 The review will consider:

- Updates on 2021/22 24 month progress
- Provide information on developments since the plan was published
- Set out key plans for the year ahead

3. DETAIL OF REPORT

The Children and Young People's Service Plan (CYPSP 2020/23) approved in November 2020 by the Integrated Joint Board and Argyll and Bute Council and is set within the context of four strategic priorities and aligned to the eight well-being indicators (SHANARRI). By adopting the Quality Improvement methodology we are able to evidence improvements in practice supporting us to achieve our aim of improving outcomes for children and young people.

.

3.1 Improvement and Progress Update Summary

We have made good progress with the short-term outcomes expected at 24 months.

Tables 1 - 4 (pages 3 – 13) provide updates on the 2021/22 Performance Measures under each of the Strategic Priorities.

Quality Improvement projects are still live, however due to COVID and a number of staff changes updates are not currently available for the Year 2 2021/22 report.

Strategic Priority 1 - Getting it Right for Every Child (GIRFEC) Leadership

To help improve the visibility of the Children's Services Strategic Leadership Group, member Profiles have been developed and circulated to all staff groups.

Table 1	
Outcomes expected at 24 months (2021/22)	**Progress update**
1. Evidence of improvements in GIRFEC practice and delivery of services are embedded in children's services	1. The improvement work generated through the Argyll and Bute Children and Young People's Improvement Faculty has resulted in improvements in the partnership approach to service delivery leading to better outcomes for children, young people and their families.
2. Streamlined systems and process result in partners having the 'One Child, One Assessment and One Plan' approach to service delivery	2. The replacement of the current Carefirst System with the Eclipse system will provide a fully integrated web-based Care Management system for Children, Families and Social Justice. Eclipse will reduce bureaucracy and support an integrated (HSCP) Child's Plan in practice.
3. Feedback on successes and what is not working	3. Gathering the views of children, young people, parents/families is fundamental and underpins the values and principles of GIRFEC. Staff capacity and COVID have resulted in additional scaling up of the 'What Matters to Me' (WMTM) form allows staff to gather the views parents at Child's Plan meetings. This will be scaled up across all localities throughout Year 3 (2022/23).

Getting it Right for Every Child (GIRFEC) Leadership Quality Improvement work

Table 1.1		
24 months (2021-22)	**Quality Improvement Aims**	**Quality Improvement Projects**
Partners work collectively to review current systems and processes and reduce bureaucracy	• By 31st August 2021, 75% of audited Child's Plans prepared by multi-agency partners after October 2020 will contain a clear set of SMART outcomes for the young person, based on an up-to-date assessment of risk and analysis of need. • By end of May 2021, 95% of Initial child plans where Health Visitors are Lead Professional, will include parent/carer views of their child's plan and they will score 4 or above on a 1- 5 rating scale of how engaged and involved they felt in the process"	Improving the quality of Child's Plans ***Some Quality Improvement projects have been delayed due to staff changes, it is anticipated this will improve in Year 3 of the Plan.***

Strategic Priority 2 - Early Help and Support

Table 2	
Outcomes expected at 24 months (2021-22)	**2021-22 Progress update**
1. Ensure early help and support is put in place. Use the Model for Improvement to develop tests of change and ideas to promote and improve child development 2. Deliver on key priorities identified in the Child Poverty Strategy	1. Data indicates we have maintained above 90% of children having assessments completed at: 13 – 15 months - 93.6% 27 – 30 months - 92.6% Due to COVID restrictions P1 developmental milestone data has not be obtained 2. The benefits of partnership working have been evident with an increase in client engagement through collaborative working. Where agencies are able to bring their skills and expertise together to provide a holistic approach, vulnerable families are also less likely to be missed. Referrals and support from Health Visitors help with those who would falter at the point of making an appointment. Feedback from advisors ensures that clients who don't engage can be supported to re-engage often at a point of difficult circumstances or crisis. The personal

	connections made between staff are beneficial ensuring good communication which is vital in delivering a high standard service. Bute Advice Centre has close working relationship with Health Visitors in the Bute & Cowal area and hope to roll out this service across Argyll.
3. Children and young people feel more positive about their health, wellbeing and developing relationships	3. In the school year 21/22, Health, Education and local 3rd Sector organisations worked in partnership to provide the health improvement programmes Smoke Free Me for P7's and You are Not Alone for S3. The drama productions were presented by video rather than a live play, due to the restrictions of Covid 19. However, these video's were presented in person by a selection of professionals from health improvement, education, school nursing and 3rd sector partners. **Smoke Free** - 100% of primary schools were offered the Smoke Free video complete with additional lesson plans, many were also provided with materials that pupils could take way, to supplement what was taught in school. All, teachers who provided feedback said the lesson plans, music and video access were excellent for their students. Not all schools were able to show the drama due to Covid-19 isolation guidance, but all those who did found it very beneficial and relevant. **S3 Health Drama -** 100% of Argyll and Bute Council secondary schools had access to the S3 Health Drama You Are Not Alone by video and all but one high school took advantage of having a showing supported by professionals who provide services for young people. All pupils had the option of asking any questions remotely and in private and feedback was taken on the structure and content of the drama from teachers, partners and pupils. All who fed back were very supportive and felt the content was appropriate and would welcome being part of the work ongoing.
4. Ensure breast feeding rates are improved and sustained	4. 2021 Breastfeeding rates at 6 – 8 weeks reached 46.8% in one quarter and remained stable at 44% throughout the year, breastfeeding still remains high with the Scottish average at 6 – 8 weeks sitting at 32.5%. Key workers and Infant feeding support workers continue to work to promote the benefits of breastfeeding across all agencies.
5. Children and young people are supported to make good choices with respect to maintaining a healthy weight	5. Limited progress in 2021/22this was in part due to Covid and also some resource issues. An App has been commissioned and is currently being tested. Plans to increase staff hours to re-establish delivery of virtual group treatment sessions which will work alongside the App.

Early Help and Support Quality Improvement Progress

Table 2.1		
24 months (2021-22)	**Quality Improvement Aims**	**Quality Improvement Projects**
Ensuring relevant assessments at key ages and stages are carried out	Creating communication friendly Early years settings in Bute (Aim in development)	The UPQIC financial improvement project AHP Forum - Improve our universal and targeted offer National “Sharing the Ambition” project Breast feeding Communication Friendly early years settings Supporting vulnerable 2’s ***Some Quality Improvement projects have been delayed due to staff changes, it is anticipated this will improve in Year 3 of the Plan***
Ensure the Child Poverty Strategy is rolled out across the partnership	Increased uptake of financial support following Universal Health Visiting Pathway contacts **Aim -** By Sept 2021, Health Visitor’s (HV) in Argyll and Bute will have a financial discussion with parents at 80% of contacts on the HV pathway and where a need is identified 100% will receive the requested money advice and benefit support Data relating to money advice conversations carried out at routine Health Visitor visits in the Bute & Cowal area was gathered to ascertain % of money advice conversations at routine pathway contacts for period Jan to Sept 2021. Data for the same period was also captured which looked at time to the initial money advice prep appointment. (Table was produced and is available). Data notes a sustained improvement with regards to money advice conversations carried out at routine Health Visitor visits in the Bute & Cowal area. Analysis of the data with regards to the total number of visits across the 8 month period notes - 41% achieved the 100% target and 52% at 90% or above. Against the median target wait of 3 days, the data shows that 47% or referrals waited 3 days or less and 53% of referrals waited more than 3 days, the longest wait was14 days.	

Children and young people have a better understanding of what safe and healthy relationships look like	Children, Young people and their families feel supported to adopt healthy lifestyle choices Aim in development)	
Children and young people are able to make informed choices about their dietary needs	Children, young people and their families feel supported to adopt healthy lifestyle choices - AHP Forum (Aim in development)	

Strategic Priority 3 - Mental Health and Well-being

Table 3	
Outcomes expected at 24 months (2021-22)	**2021-22 Progress update**
1. Access and support for early help is available and easily accessible for children and young people	1. Development of the Peri-natal and Infant Mental Health Pathway **Peri-natal and Infant Mental Health** promotes knowledge and skills in understanding Infant Mental Health and parent-infant relationships. Infant mental health services are aimed at giving every child the best start in life by promoting the wellbeing of infants in the first three years of their development. The Infant Mental Health Pathway relies on the dedication and commitment of a large number of frontline practitioners such as midwives, health visitors and early years practitioners.. **The Perinatal Mental Health Service** has been live since December 2021. This service consists of one Trainee Advanced Nurse Practitioner working across Argyll and Bute offering consultation, triage and training. Embedding lived experience into service development to create a new service across Argyll and Bute. Working closely with services in Greater Glasgow and Clyde including the Mother and Baby unit. **Infant Mental Health (IMH**) - A short life working group has been established involving multi-agency staff, partners and agencies from across Argyll and Bute.

The group was formed to develop and input into the IMH referral pathway, which has been taken to the PNIMH pathway.

Our children, their nurturing education (OCTNE) has continued to progress successfully with 33% of schools now engaged with this programme. Through engagement with training and use of a bespoke accreditation framework 23 schools have already achieved bronze accreditation (nurture committed), 1 silver accreditation (nurture aware) and 2 gold accreditation (nurture informed). With the addition of two Nurture Teachers (September 2021), the strategy has expanded and is able to offer increased support to education establishments. This expansion is supporting schools to establish targeted nurture interventions for groups of pupils (trauma skilled) and supporting the team around our most distressed young people who are at risk of educational placement breakdown (trauma enhanced). The role of the Nurture Teacher is focused on providing intensive but time-limited support through coaching, consultation and building capacity in staff and schools to make this targeted provision sustainable.

The School Counselling Service provided for children and young people age 10 years and over has continued to progress very positively. The service started on February 8th 2021 with 7.5 fte counsellors and a team leader. Over the last year there have been some changes to staffing as well as short term enhancement through Council COVID Recovery Funding with the current staffing compliment being 8.5fte. Since the start of the service in February 2021 over 500 referrals have been received with an acceptance rate of over 99%. Analysis of referral information shows:

The most common reasons for referral include Anxiety (44%), Depression (25%), Relationships (with parents, carers and peers, 23%), Emotional or Behavioural Difficulties (21%), and Self-Harm (16%)

60% of young people accessing the service report they are female, 34% report they are male and less than 6% describe themselves in another way

72% of referrals come from a professional (including Education, Health and Social

	Work). 24% come directly from young people through self-referrals The average age of someone accessing counselling is 14 and the majority of referrals come from S2-S4 Of those referred, 7.3% Care experienced, 19% receive free school meals, 7.3% Young Carers, 17% with recorded additional support need and 41% with current or previous involvement from an agency beyond education There has been engagement with young people identifying as LGBTQ+ to consider access and support for early help particular through the school setting. Feedback has included the following: **What support would you like to be available?** 'Need to be patient and listen. Lanyards are OK but it depends on the person. Don't say "I understand" because you don't.' 'More obvious things around the school e.g. information posters and FAQs.' 'Some departments have a good ethos, not particularly about LGBTQ+ but kindness in general'. **Have you found it easy to access other support?** 'Teachers – some teachers I would trust with my life. Accessed a counsellor but she was not very good. Would struggle speaking with guidance but this is to do with whether the person is seen as trustworthy.' 'Pupils need a clear pathway that is made explicit. Told to go to go to Head of House. Better to say: "go to an adult that you trust" this could be anybody. Need them to listen well and also to remember.' **2. Trauma Service -** Argyll and Bute has continue to progress developments as one

2. Partners feel confident in understanding trauma and how it affects children and young people's lives	of three National Trauma Training pilot areas. A number of significant successes have been noted including: • Strong multiagency commitment, leadership and ownership including the 3rd sector • Investment of time in ensuring leadership and strategic buy in to support engagement over time • Strategy built on existing strengths ensuring developments are coordinated with local practice and training including the GIRFEC practice model, existing work o • Adverse Childhood Experiences and Our Children Their Nurturing Education (OCTNE) in schools • Building awareness of trauma in to existing training such Child Protection, OCTNE and the PATHS curriculum • Inclusion of the voice of lived experience • Flexibility in responding to the impact of the pandemic and moving training online with significant update across services • Over 83% of all staff working within our schools completed the e-learning modules at the appropriate levels • High uptake of facilitated on-line trauma skilled training sessions by social work children's services staff • Strong, consistent communication and update of materials • A widening focus on staff wellbeing and increasing shared focus on responding to the impact of trauma • Presentations on progress delivered to national groups including to the Deputy First Minister. Based on review and evaluation of current progress, the Trauma Strategy group, initially in place to support the delivering of the trauma training programme has been reinvigorated to support the next stage of this work. It is centrally important that staff are not merely trauma informed, but that services, teams and individuals modify practice to ensure the work in ways that are trauma responsive. Multiagency consideration of the key objectives from the CYPSP 2020 - 23 identified core areas for development as we move from delivering training to identifying changes to practice, policy and guidance that will make a real difference to children and young people. With support from the national Children and Young People's Improvement Collaborative (CYPIC), approaches within the Model for Improvement have been

3. Implement the standards and pathways of care **4.** Children and young people are routinely using advocacy services	used to identify areas where practice change can be implemented and evaluated. These include: • Our Children Their Nurturing Education, exploring the impact of changes to understanding and practice on outcomes for children, young people and families • Trauma Enhanced Dyadic Developmental Practice (DDP) training which has continued to be delivered for relevant specialist staff across agencies • Engagement of young people regarding how they would like to give their views around Children's Meetings to ensure they can appropriately influence matters that impact their lives. As a result of this engagement the current Have your say approach is being discontinued and a new approached is being co-produced with young people which will be evaluated moving forward • An A&B Trauma champion has been appointed. 3 **Neurodevelopmental Pathway** - The Scottish Government Neurodevelopmental Pathway is now available and is being used to shape pathways in Argyll and Bute through considering the effectiveness of current processes including the robust multiagency approach to autism diagnosis. The Child and Adolescent Mental Health Service (CAMHS) are working towards implementing the Scottish Government CAMHS Service Specification. The Scottish Government Neurodevelopmental Service Specification has now been published and colleagues across the agencies are working together to look at how we implement this 4. Who Cares? Scotland continues to provide advocacy to our care experienced children and young people. In 2020/21: • 90 young people engaged with advocacy workers • 52 young people accepted the offer of advocacy support (UPDATED FIGURES FOR 2021/22 have been requested from Who Cares? Scotland) • The service has now expanded to be available to support those attending Hearings • Independent advocacy continues to be offered to all children on the Child Protection Register over the age of 5 years

Mental Health and Well-being Quality Improvement Progress

Table 3.1		
24 months (2021-22)	**Quality Improvement Aims**	**Quality Improvement Projects**
Trauma training is rolled out across the partnership	1. Impact of Trauma informed practice (Aim in development) 2. Perinatal mental health	1. Early Years - Adults responses to children 2. Play pedagogy 3. Impact of Trauma informed practice 4. Trauma informed practice in schools through Our Children Their Nurturing Education

Strategic Priority 4 - Children and Young People's Voice

Table 4	
Outcomes expected at 24 months (2021 - 22)	**2021-22 Progress update**
1. Methods to engage children and young people are designed and tested by the Away Team and the Young People's Advisory Group	1. By October 2021, 85% of S3 pupils in Oban high will demonstrate an understanding of Argyll and Bute's Children's Service plan and can explain why it matters to them which identifies the improvement in meeting attendance needed to create the right conditions to secure improvements with regards to S3 pupil awareness of the A&B Children's Service Plan. With regards to the baseline question "Do You know about the C&YPSP" analysis notes (another table has been produced) a significant improvement in the understanding of the plan against the baseline score taken ahead of each of the four sessions. The baseline median score pre-session (0%) above 4, this is offset against a significant improvement in post-session median scores above 4 (50.25%) Conclusion: Against the target of 85% the data noted that 71% of S3 pupil reported a rating of 3 which meant that they knew about the Argyll and Bute CYPSP but I would "need help explaining it". Alongside this 90% of S3 pupil also noted that they could "give one reason why the plan matters to young people".

2. Invite the Young Peoples Advisory Group to present progress at the Community Planning Partnership	2. A presentation on the work of the Young People's Advisory Panel has been delivered to Argyll & Bute's Children Strategic Group and can be delivered to the CCP in year 3
3. The findings of the Independent Care Review are embedded in practice across the partnership	3. 3.1) The 2021-24 Corporate Parenting Plan has been updated to ensure that key themes from The Promise are prioritised 3.2) Multi agency review of all admission to care supported and consideration of findings by the Adult Protection and Child Protection Committees and the Corporate Parenting Board (CPB) led to a joint Promise Partnership bid for an innovative project, across adult and children's services. It is anticipated this will support development of new practice model for supporting families affected by parental mental health and substance misuse 3.3) Adoption of a lexicon of institutional language our young people have asked us to stop using and multiagency work to remove these words and phrases 3.4) Recruitment of a care experienced co-chair for the CPB 3.5) Additional funding for a one-year participation co-ordinator for care experienced children and young people 3.6) Continuing roll out of trauma training to develop a Trauma informed children's workforce and carers

Children and Young People's Voice Quality Improvement Progress

Table 4.1		
24 months (2021-22)	**Quality Improvement Aims**	**Quality Improvement Projects**
Young People's Advisory Panel is created	• By October 2021, 85% of S3 pupils in Oban high will demonstrate an understanding of Argyll and Bute's Children's Service plan and can explain why it matters to them • Visibility of Parent/Child's Voice in Child's Plan (Aim under development)	1. Engagement in CSP 2. "What matters to you?" Parent/child voice

3 The focus for year 3 long term performance outcomes include:

Getting it Right for Every Child (GIRFEC) Leadership

- Providing evidence of improvements and embedding the refreshed GIRFEC guidance
- Implementation of the Eclipse system to facilitate more streamlined systems and processes across the HSCP to ensure there is a 'One Child, One Assessment and One Plan' approach to service delivery

Early Help and Support

- Further use of the Model for Improvement to develop tests of change and ideas to improve child development, ensuring early help and support in place
- Supporting families to support a reduction in the number of children and young people affected by poverty
- Developing specific programmes and ideas helps support us to ensure Children and young people feel more positive about their health, wellbeing and developing relationships
- The development of an App to promote healthy eating and assist Children and young people to make good choices with respect to maintaining a healthy weight

Mental Health and Wellbeing

- Children and young people report they are able to access mental health and wellbeing support
- All partners are trauma informed and can demonstrate this in the actions taken to support children and young people
- Standards are improved and robust pathways are in place for children and young people with neuro-developmental conditions
- Children and young people report they are benefitting from accessing advocacy services

Children and Young People's Voice

- Children and young people are engaged and co-designing the next CYPS Plan (2023/27)
- Children and young people are involved in creating the new 2023 – 27 CYPS Plan
- The lives of care experienced children are improved

4 Key developments and alignment to National Policy

Work is underway to ensure children and young people understand their rights as laid out in the United Nations Convention on the Rights of the Child (UNCRC) which has now been incorporated into Scots Law

The Promise made to care experienced infants, children, young people, adults and their families - that every child grows up loved, safe and respected, able to realise their full potential. It is responsible for driving forward the findings of the Independent Care Review and works with organisations to support shifts in policy, practice and culture so Scotland can **#KeepThePromise.** Key themes from **The Promise** have been prioritised in the Argyll and Bute's 2021-24 Corporate Parenting Plan

5. Conclusion

The year 2 review of the 2020 – 23 CYPSP has highlighted progress to date and some of the quality improvement projects that require to be scaled up throughout year 3. The Quality Improvement faculty requires to be re-established to ensure this work continues throughout 2023/23, further improvements and run chart evidence will be realised in the year 3 report (2022/23) under long-term outcomes.

6.0 GOVERNANCE IMPLICATIONS

6.1 Financial Impact

There are no additional resource implications with the delivery of the plan.

Staff Governance

None at this time.

6.3 Clinical Governance

The Council and NHS Highland are required to report on the progress of the Children and Young People's Services plan as directed within the Children and Young People (Scotland) Act 2014, set out within the supporting Statutory Guidance published in December 2016.

7. EQUALITY & DIVERSITY IMPLICATIONS

The Children and Young People's Services Plan identifies how health and social care services contribute to reducing inequalities, including health and education inequality.

8. RISK ASSESSMENT

There are potential reputational implications for the Health and Social Care Partnership should they fail to deliver the full legislative requirements set out within the Children and Young People (Scotland) Act 2014, Statutory Guidance of December 2016.

9. PUBLIC & USER INVOLVEMENT & ENGAGEMENT

The Children and Young People's Services Plan informs our young people, parents, carers, volunteers and practitioners of the outcomes and actions that all partner agencies have committed to deliver in order to ensure that children and young people living in Argyll and Bute get the possible start in life.

NEXT STEPS

To present the 2020 - 2023 Children and Young People's Service Plan Year 3 report

Patricia Renfrew
Senior Manager Child Health and CAMHS

David Gibson
Head of Service Children, Families and Justice and CSWO
Argyll and Bute HSCP

19th August 2022

Agenda Item 10

Integration Joint Board

Date of Meeting: **21 September 2022**

Title of Report **Public Health Team Annual Report 2021-22 and Living Well Mid-Strategy Report 2012-22/Prevention approach**

Presented by: **Alison McGrory, Interim Associate Director of Public Health**

The Integrated Joint Board/Committee is asked to:

- Note the reports on Living Well 2019 – 2022 and Public Health Team activity in 2021-2022
- Note the strategic approach to prevention in Argyll and Bute
- Endorse the role of the IJB in providing leadership to prevent health and social care problems from arising

1. EXECUTIVE SUMMARY

This paper outlines public health activity in Argyll and Bute to prevent ill-health and improve health and wellbeing outcomes for the population. The detail of the paper covers the following three areas:

- Public Health Team Annual Report for 2021-2022
- Living Well Mid-strategy Report for 2019 – 2022
- Update on the strategic approach to prevention in the HSCP

Full reports are available to view here:

https://bit.ly/ABPublicHealthAnnualReport-2021-22
https://www.ablivingwell.org/s/Final-Living-Well-interim-report-rr66.pdf

2. INTRODUCTION

Argyll and Bute Health and Social Care Partnership (HSCP) has a Public Health Team that works towards improving the health and wellbeing outcomes of the population of Argyll and Bute. This team is part of a wider NHS Highland directorate. The steer for this Public Health work comes from different directions, for example: national strategy; national Public Health priorities; HSCP strategic

priorities; and community led aspirations. The Christie Commission of 2011 estimated that 40% of public sector spending is on problems that could be avoided given earlier intervention.

Prevention of health problems can take place at three levels:

- **Primary** – population wide health improvement and laying the foundations of good health
- **Secondary** – targeting health improvement to those at risk of ill-health
- **Tertiary** – directed activity with people already experiencing ill-health to minimise escalating problems

3. DETAIL OF REPORT

3.1 Public Health Team Annual Report for 2021-2022

The Public Health Team in Argyll and Bute includes health improvement, health intelligence/data analysis and the Alcohol and Drug Partnership support team. An annual work plan sets out the work of the team and this is reported at the end of each year.

Throughout 2021 – 2022 there were ongoing demands on the team to support the pandemic response; however there was an active remobilisation of core work and recognition of the important contribution the team makes to pandemic recovery as well as addressing the social determinants of health and prevention. The full report provides detail on the range of activity delivered; highlights of this work include:

- Overseeing the commissioning of Community Links Workers in primary care
- Cool2Talk online support for young people
- Smoking cessation
- Smoke free education in primary and secondary schools
- Contribution to strategic priorities such as Suicide Prevention action plan, the Child Poverty plan and the Social Mitigation strategy
- Screening inequalities research
- Youth mental health first aid training
- Health behaviour change training
- Income maximisation and child poverty work
- Type 2 diabetes, physical activity and health weight work
- Covid-19 health surveillance, testing and vaccination activity
- Pathway for residential rehabilitation for people with drug problems
- Implementation of treatment pathways for people with drug problems
- Naloxone training for those at risk of drug overdose

3.2 Living Well Mid-strategy Report for 2019 – 2021

The Living Well Strategy was launched by Argyll and Bute's IJB in September 2019 as a strategic approach to preventing long term health conditions and enabling people to live well, and also supporting people already living with a long term health diagnosis. At the time a strategic approach to long term health conditions was considered to achieve the following:

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

The intentions of the Living Well strategy include:

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

There is a compelling case to prevent ill-health - both to improve quality of life for individuals and to ensure the sustainability of health and social care services. Long term health conditions are very common and increase with age. The Scottish Health Survey 2020[1] estimates 47% of people in Scotland are living with a diagnosis, for example 18% have cardiovascular disease and 6% have diabetes.

Since September 2019, a multi-disciplinary steering group has met to oversee the delivery of a Living Well action plan and it is notable that this work continued throughout the pandemic. The Living Well Strategy covers a 5-year period to 2024 and this paper provides a mid-term progress report of the outputs of Living Well activity.

Highlights of this work include:

- An active multi-disciplinary steering group that meets regularly and reports to the Prevention Programme Board and in turn to the Transformational Programme Board. Members of the steering group comprise health improvement staff, wider health and social care staff e.g. allied health professionals, Third Sector Interface and community representatives, key partners such as Live Argyll and Versus Arthritis.
- A dynamic action plan that includes key priorities that are agreed in partnership and is responsive to the needs of communities and involves effective engagement. An example of this includes the mental health engagement and signposting activity that took place from autumn 2020 to autumn 2021.

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[1] Scottish Health Survey – telephone survey – August/September 2020: main report - gov.scot (www.gov.scot)

- Capacity building with communities and across the health and social care system to widen the range of people with an interest in preventing the problems that arise from long term health conditions. Examples of this work include health behaviour change training and small grants to the third sector.

3.3 Wider Prevention Activity

In 2021 the HSCP developed a clearer strategic response to preventing health and social care problems. This response recognises that although there is a wider societal aspect to health and wellbeing, the HSCP is a key stakeholder both as a provider and a commissioner of health and social care services. A multi-disciplinary Prevention Programme Board has formed to review the approach and this in turn reports to the Transformation Programme Board. The group looks inwards to how services can support prevention and outwards to how people can live healthy lives within their local communities – both via commissioning and via co-production. The prevention action plan is also closely aligned to the Strategic Plan and the Commissioning Plan. Current activity of the group includes:

- Co-production workshop in June 2022 attended by more than 30 people to review approaches to working alongside communities to support the delivery and sustainability of community based health and wellbeing services.
- Mapping of how existing contracts include prevention in their key performance indicators.
- Mapping of core community based services that support the prevention of health problems and a gap analysis of where there is disparity. Examples include signposting to community support; support for carers; debt advice; peer support groups e.g. for mental health; and opportunities for physical activity.
- A physical activity workstream to increase physical activity rates and improve opportunities for physical activity.
- Joint working with the Third Sector Interface to promote the new Argyll and Bute Community Directory.
- A multi-agency engagement plan to develop local design solutions co - produced with Macmillan, Live Argyll, Argyll &Bute Council, HSCP and TSI initiative. This will link with existing structures such as Locality Planning Groups and Living Well networks.

4. RELEVANT DATA AND INDICATORS

Full details of the outputs of Public Health activity is published in the reports.

5. CONTRIBUTION TO STRATEGIC PRIORITIES

The work of the Public Health Team is linked to:

The Strategic Plan

- Promote health and wellbeing across our communities and age groups

The Commissioning Plan

- Prevention, early intervention and enablement
- Living Well and active citizenship
- Community Co-production

6. GOVERNANCE IMPLICATIONS

6.1 Financial Impact

The Public Health Team is resourced from core HSCP funds and in-year Scottish Government allocations to the sum of approximately £1.5 million. This paper is not asking for additional investment in Public Health. However, it is a topic for debate to consider early upstream intervention can avoid the need for downstream service delivery.

6.2 Staff Governance

No issues in this paper.

6.3 Clinical Governance

No issues in this paper.

7. PROFESSIONAL ADVISORY

No issues in this paper. The Associate Director of Public Health works closely with the other professional advisors, in particular the Associate Director for Allied Health Professions

8. EQUALITY & DIVERSITY IMPLICATIONS

No issues in this paper. Equality and diversity are key principles of Public Health work and interventions and strategies are designed to ensure those most in need will benefit the most. This is with the intention of reducing the gap between the most well off and the worst off in our communities.

9. GENERAL DATA PROTECTION PRINCIPLES COMPLIANCE

No issues in this paper.

10. RISK ASSESSMENT

No immediate risks in this paper although there are risks to the sustainability of health and social care service from rising demand.

11. PUBLIC & USER INVOLVEMENT & ENGAGEMENT

Community engagement is a core principle of Public Health and interventions and programmes always include engagement to ensure effectiveness and suitability. The Living Well strategy was developed following comprehensive community and stakeholder engagement.

12. CONCLUSIONS

The paper provides an update on ongoing wellbeing and prevention activity overseen and delivered by the Public Health Team in Argyll and Bute. There is a compelling need to prevent health and social care problems before they arise.

The HSCP is well placed to both continue and expand upon the recent successes outlined in the detail of this report.

DIRECTIONS

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

REPORT AUTHOR AND CONTACT

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Response ID ANON-Z1FZ-UJ24-G

Submitted to National Care Service (Scotland) Bill (Detailed)
Submitted on 2022-09-02 15:59:58

About you

Please read the privacy notice below and tick the box below to show that you understand how the data you provide will be used as set out in the policy.

I have read and understood how the personal data I provide will be used.

How your response will be published

I would like my response to be published in its entirety

What is your name?

Name:
Charlotte Craig

What is your email address?

Email:
charlotte.craig@argyll-bute.gov.uk

Are you responding as an individual or on behalf of an organisation?

Organisation

Organisation :
Argyll & Bute Integration Joint Board

Please tell us a little more about your connection to care services. Which of the following options best describes you. (Tick all that apply)

Other (please specify in the box below)

If you selected 'Other' please provide more information in the box provided.:
Integration Joint Board

Would you like to be involved in future engagement work?

Yes, I would like to be involved in future engagement work and agreed to be contacted by the Committee in the future.

Organisation details

What is your job role?

Please provide answer in box provided:
Business Improvement Manager

Information about your organisation

Please add information about your organisation in the box below:

The Integration Joint Board (IJB) is the Governance Board of the Health and Social Care Partnership and has responsibility for the planning, resourcing and overseeing of the operational delivery of integrated services. Membership of the IJB comprises elected councillors from Argyll and Bute Council, NHS Highland Board members and individuals from a range of sectors and stakeholder groups including the Third Sector, Independent Sector, patients/service users, Trade Unions, staff and carers.

General questions about the Bill

The Policy Memorandum accompanying the Bill describes its purpose as being “to improve the quality and consistency of social work and social care services in Scotland”. Will the Bill, as introduced, be successful in achieving this purpose? If not, why not?

Please provide your response in the box provided.:

The Bill does not provide sufficient detail to enable the Argyll & Bute HSCP/IJB to respond to this question.
The Bill does not confirm the scope and geographical remit of the new Board which will have responsibility for ensuring that the quality and consistency

of services are improved for the communities it will serve.
We have a strong view that there should be a distinct Board serving the Argyll and Bute area (as defined within the current council boundary). This will ensure that the very specific needs of the rural and Island communities we currently serve are understood and met.
We do acknowledge that there is scope for improvement in respect of the integration and co-production and collaboration of services delivered in the area with our stakeholders and partners and across boundaries into Greater Glasgow and Clyde.
The Argyll and Bute HSCP is of the view that the implementation of the NCS has the potential to achieve the stated purposes and is optimistic that it will do so if it is properly resourced and the way in which it is structured is appropriate for the area. These resources should include capital funding and the transfer of property including equipment and IT. The structure, governance and accountability arrangements require to be sufficiently local to enable this to work effectively.
As one of only two IJB's with all health and social care services delegated we would recommend maintenance of the status quo of delegated services – specifically children, families and justice during any interim arrangements.
The Bill references in principle standards for community health, social care and social work but provides not information on the achievement and review of training, potential for developed and integrated roles or cognisance of the time it would take to feel an impact on a cultural change in approach. It presents the bill in an environment of 'status quo' and risks negating gains made in practice through current integration arrangements.

Is the Bill the best way to improve the quality and consistency of social work and social care services? If not, what alternative approach should be taken?

Please provide your response in the box provided.:

As above, the Bill in itself does not provide sufficient detail on structures local or centralised, services or resourcing to enable a view to be taken.
It should be recognised that the costs of implementing the NCS are substantial. Resources that could have been allocated to service delivery within the existing model will be invested in significant structural change which will take many years to deliver benefits to service users.
The impact on employment terms as staff transfer to the new board could also prove to be extremely disruptive and costly.
Throughout the Bill there is recognition of the crucial involvement of people with lived experience and unpaid carers. The involvement of front line staff with a wealth of experience needs to be heard and engaged in order to improve the quality of consistency of service. At the heart of most of the social care and social work challenges are financial and workforce challenges both within HSCPs and with externally commissioned providers. Morale of the sector is low, harnessing front line staff knowledge and engaging effectively with this group is essential to the success of the NCS.
A review of opportunities and support into professions and available roles and training are integral to the development of the service and little mention is made of a supporting structure for this on the measuring of standards as an output.

Are there any specific aspects of the Bill which you disagree with or that you would like to see amended?

Please provide your response in the box provided.:

There are some concerns that the unpaid carer right to a short break involves the removal of any eligibility criteria. Whilst we fully recognise the role of unpaid carers the resources to offer short breaks with no funding limitations is concerning, this needs clarified. It is not clear if legislation will be amended.
Given the IRASC had a focus on social care, the detail on the social work function and the identification of this crucial role is light. Social work and social care need to be identified as distinct and unique roles. The lack of certainty on employment also creates unease for all potentially affected staff when workforce presents a strategic risk nationally.

Is there anything additional you would like to see included in the Bill and is anything missing?

Please provide your response in the box provided.:

The Bill has actually raised more questions than it answers and the lack of detail leaves huge uncertainty. As such the Bill could be detrimental to service development and continuity.
Consideration for Children, Families & Justice Services which are currently integrated (as in in Argyll & Bute). As noted previously we would make a recommendation of maintaining the status quo during any interim arrangements to minimise disruption.

Future secondary legislation

Please provide your response in the box provided:

The commitment to local accountability and decision making is welcome, however, intentions around the number of Boards, their governance structures and geographical coverage should have been outlined at this stage to enable better informed consultation on the primary legislation. The HSCP would like to see this started or the process to be adopted included in primary legislation with a timescale to better inform the public during consultation.
The Bill gives the minister a wide range of new powers but this in itself does not enable an understanding of if or how these powers are intended to be used or the evidence base for decision making. This potentially results in less scrutiny at later stages and presents an increased risk of unintended local consequences.
The legislation goes further than to recommend a national care service as an abstract entity but not far enough to reflect what that would look like at national and local levels. It takes no account of the public duties currently assigned or assigned through participation in partnership to HSCP's/IJB's and partners which would be impacted.

Transfer of services to the National Care Service

Please provide your response in the box provided:

The priority should be to ensure that the way in which the National Care Service operates and the powers transferred promote further integration of services and do not unintentionally undo progress that has been made to date.
There should also be some scope for local and rural variation and flexibility where this makes sense in the overall framework of integrated health and social care provision (without undermining the consistency objective). This is particularly relevant in rural and island communities which will often require tailored and pragmatic approaches to service delivery which can be very different to the way in which services are delivered and governed in urban areas.
Responsibility and funding for assets and infrastructure should be passed to the new Care Boards, noting that any transfer of assets may require funding to address existing estate issues.
A capital investment funding model requires to be a priority and should be based on the condition and suitability of the current infrastructure in each area. This is critical in ensuring that a single organisation has responsibility for both the services it provides and the physical assets and infrastructure used to provide those services.
The bill segregates community, acute and primary care provision taking no cognisance of the interdependent relationship, the agenda for preventative care in this context and the benefits gained in rural integrated care both in general working and in the support of clinical and care practice.
We believe local accountability is essential to meet the needs and priorities of the communities across Scotland. In our original response to the NCS consultation a hybrid model was proposed with clear lines of dual accountability. This model remains our preferred approach.
It is our view that Government should build on the success of IJBs, empowering them to operate independently. The Chief Officer role should be changed to that of a Chief Executive Officer. A directly funded and empowered IJB led by a CEO who would be accountable for the local delivery of social care. Working with the community to determine local priorities and the required investment.
Scottish Ministers would then hold the accountability for national decisions made which impact/influence the delivery of social care.

Do you have any general comments on financial implications of the Bill and the proposed creation of a National Care Service for the long-term funding of social care, social work and community healthcare?

Please provide your response in the box provided.:

The Social Care sector in particular has been underfunded for many years. Within Argyll and Bute specifically there has been a significant lack of capital investment. This requires to be addressed by the NCS as a priority.
The development of a new, equitable funding model which takes cognisance of rurality, deprivation, demographics and the inherited asset base must be a priority if the NCS is to deliver on its objectives within a reasonable time horizon. Funding to the sector will require to be above the level it is at currently.
The implementation of the Bill will result in significant disruption and structural change, the scale of this is not yet clear. It is evidenced that this scale of change will likely result in increased governance and management costs so risks and impact can be effectively mitigated. This needs to be funded in addition to increased funding for service pressures and capital investment. Again the nature of the new Care Boards and the geographical areas they cover will have an impact on the scale and cost associated with the change.
There is a concern that local long standing partnerships will come under pressure whilst the NCS is created and that this in turn could result in additional local costs and challenges which are unforeseen in the context of the drafting of the legislation.
HSCPs in particular should be allocated relatively modest specific additional funding as soon as possible to fund the programme and project management of this significant management of change programme.
Health and Social Care services and systems are under considerable pressure and HSCPs should not be expected to begin this planning process from within existing resources. Change management lessons from other recent public sector reform process should be carefully considered.
No cognisance has been taken of the prolonged period of change in establishing integrated care services and a proposed period of further change within the bill. The unpicking of services whilst facing significant workforce and workforce planning pressures is poorly timed and may impede any potential benefit of a national approach.

Impact assessments

Please provide your response in the box provided.:

The EQIA reflects where public bodies require to meet the duties currently and identifies no group covered under the PSED would be adversely affected by the legislation. It further notes the disparate picture in respect of the integration of children's services. The interim EQIA fails to look at the wider societal picture of meeting the needs of communities within their communities, existence of communities of interest and infrastructures for supporting a truly equal approach to service provision outwith a metropolitan/urban environment. We would welcome a review of this document to better reflect the complexity of non-urban and mixed environments and consideration of where identity and lifelong conditions can result in direct or indirect discrimination.
Business and Regulatory impact assessment
Financial resources which are available may not necessarily lead to need being met e.g. the reference to short break to unpaid carers. Without the resolution of longer term workforce issues including infrastructure and affordable we would be unable to fulfil the policy directive.
Trade Unions have noted they will offer direct responses but note numerous issues in relation to structures, terms and conditions and ethical commissioning of services and private sector provision.
Child rights and wellbeing impact assessment
Integration of Children's services has offered a the potential for a whole system approach supporting links from pre-birth through to transitions and continuity if adult care is required. At this stage of integration relevant authorities may only be starting to see the benefit and capacity available in delivering a planned approach which encompasses other key services such as Education, policing and third sector in supporting families.
Data protection impact assessment
The HSCP welcomes the creation of a nationally-consistent, integrated and accessible electronic social care and health record and recognises the importance and value and need for data protection. We welcome the DPIA noting that the data strategy focuses on 3 key areas as below:
Personal Data Stores- Personal web spaces, on our phones, breaking down data silo's, able to access own health data , remove duplication of data, "a single version of the truth" remove the need to repeat the same information to different professionals involved in their care, within both social and health care effective use of "Application Programming Interface"
Managing Public Health- learn from pandemic response- public accessing data regarding Covid 19, future dashboard design
Data From Wearables- use of technology phones ,watches etc- BP monitoring, steps, blood O2, sleep, heart rate, mood –how we effectively use this

personal data to support health and wellbeing
Fairer Scotland duty assessment
Unpaid Carers in a remote and island environment are often isolated through their caring role and have a burden of further isolation due to infrastructure , impact of weather conditions, unemployment or underemployment due to lack of opportunities. The Carers Act states the rights of carers and any potential move to an improved position requires to review the underpinning features of rural life to enable those rights to be exercised. There is no focus on the additional issues which are experienced in geographical areas with diverse community need.
The proposed National Care Service does not appear to recognise the part played by the unpaid carer in the overall provision of social care. The unpaid carer is a vital element of the overall provision of care in the community and without the unpaid carer a significant extra burden and cost would be placed on the overall provision of social care in all areas. There is a significant lack of understanding in the role provided by the unpaid carer and the responsibility the carer undertakes in respect of their cared for person. There is no easy way of defining the role of the unpaid carer, each case is different with a unique level of responsibility, commitment and stress. It is also a fact that in some cases becoming an unpaid carer is a life changing situation for the carer that may last for several years, while in other situations it is a short-lived experience. In many cases the unpaid carer has a 24 hour seven days a week commitment without any form of relief. Without the opportunity to have regular breaks the health of the carer can be impaired, which in turn impose an additional burden upon the health services. Overall the responsibilities undertaken by the unpaid carer reduces the demand on the social care and health services.
Island communities impact assessment
Do you have any comments on the contents and conclusions of these impact assessments or about the potential impact of the Bill on specific groups or sectors?
The island communities' impact assessment lacks any intelligence on the reality of accessing health and social care services and the models of delivery especially in small communities with small health and social care infrastructures permanently on the island. Health and social care staff can have interchangeable roles at a certain level ensuring the safety of the most vulnerable. Whilst it is understood that a proportionate service should be offered with a safe and cohesive pathway to accessing acute care
As noted during online engagement sessions the impact assessments are currently very 'light' with particular reference to Island Communities. Response so far is that there will be an opportunity to develop this further – it would be more effective for parliament to review the principle of the Bill with a wider scope of information to fully evaluate the impact of the proposed change. It notes very little on the details of a potentially centralised service and the economic impact rurally further compounding access to a working age population and de-population in Argyll & Bute. In effect then we see no reference to the fulfilling rural growth and the maintenance of the infrastructure which supports a healthy workforce and promotes health equality.

Questions about the Financial Memorandum

Did you take part in any consultation exercise preceding the Bill and, if so, did you comment on the financial assumptions made?

Please provide your response in the box provided.:

Yes, the Argyll & Bute HSCP and IJB took part in the consultation process and made high level comment on the financial implications only as the consultation did not provide any financial detail at that time.

If applicable, do you believe your comments on the financial assumptions have been accurately reflected in the financial memorandum (FM)?

Please provide your response in the box provided.:

To a degree, however there is insufficient information, particularly relating to the number of new Care Boards and geography. It is also unclear which corporate or overhead costs would sit with the NCS centrally or would sit with the new Boards. This is important and provides an opportunity to develop a new joined up digital infrastructure for example could reduce local costs.

No – insufficient detail and time has been provided to enable a well considered response to be developed. The change being outlined is significant and will have many unintended consequences throughout Scotland due to the complex nature of existing and proposed future structures and service delivery models.

Did you have sufficient time to contribute to the consultation exercise?

No

If the Bill has any financial implications for you or your organisation, do you believe that they have been accurately reflected in the FM? If not, please provide details.

Please provide your response in the box provided. :

The bill will have financial implications for Health & Social Care services in Argyll & Bute. These are described in the Financial Memorandum in high level indicative terms only. Again the number of new Boards is important as is the range of corporate functions each one will need to support. It is critical that a new funding model which takes appropriate cognisance of the additional costs and inherent relative inefficiency of service delivery in remote and rural areas is absolutely essential if the objectives are to be met in our area. Again additional capital investment must also be a priority where investment in infrastructure has been lacking.

Do you consider that the estimated costs and savings set out in the FM are reasonable and accurate?

Please provide your response in the box provided. :

It is difficult to provide comments on this as the costs are in wide ranges and based on very high level assumptions. It is also unclear the extent to which the operation of the new Boards would be supported by central services and ICT systems and infrastructure. Overall the financial estimates appear

broadly reasonable in this context. However, achieving savings will be particularly difficult in the transitional stages as it appears envisaged that costs (and therefore people, contracts, assets and services) will transfer from Local Authorities to the new Boards. This process is likely to be challenging and has the potential to result in additional costs and duplication rather than savings if existing partnership and co-location models start to break down during the transition process. It also has the potential to destabilise local authorities financially. Additionally the figures will require to be uplifted for higher than forecast inflation. Affordability should be reconsidered in the context of the challenges now facing public finances, these have clearly increased in recent weeks.

If applicable, are you content that your organisation can meet any financial costs that it might incur as a result of the Bill? If not, how do you think these costs should be met?

Please provide your response in the box provided. :

No. Specific central funding is required to enable IJB's to transition into the NCS arrangements. This is recognised in the financial memorandum but difficult to quantify more accurately until there is further clarity. It is important that early resourcing is provided to enable the development of local project planning methodologies. The scale of the change and managing the impact on existing partnerships are critical to the overall project and this needs to be resourced as a relatively short term priority, the success of the project depends on this.
Technical issues such as those relating to VAT also need to be addressed and additional funding provided if necessary.

Does the FM accurately reflect the margins of uncertainty associated with the Bill's estimated costs and with the timescales over which they would be expected to arise?

Please provide your response in the box provided. :

Earlier funding to IJB's and more detail is required to accurately comment. Availability of workforce to manage and implement the change and practical transitional issues are likely to make it difficult to achieve the timescales and are likely to result in higher than anticipated costs (e.g. transitioning digital systems, contracts, direct and indirect staff, policies, procedures etc.). These costs and difficulties will vary depending on how closely the new Care Boards align with existing IJB's.

National Care Service principles (Section 1)

Please provide your comments on the National Care Service principles in the box provided.

Use text box provided:

The implication that the new Boards will be public bodies and not able to hold or generate reserves for investment could present a significant issue if they are also not able to borrow and there is insufficient capital funding available to enable current investment plans to progress.
The opportunity cost of the project could be substantial and will divert valuable management resource away from service delivery and transformation, this is particularly important in the context of the levels of service demand and workforce pressures currently being experienced.

Accountability to Scottish Ministers (Sections 2 and 3)

Please provide your comments on Scottish Ministers' overarching responsibilities for the National Care Service in the box provided.

Text box provided below:

We believe local accountability is essential to meet the needs and priorities of the communities across Scotland. In our original response to the NCS consultation a hybrid model was proposed with clear lines of dual accountability. This model remains our preferred approach.
It is our view that Government should build on the success of IJBs, empowering them to operate independently. The Chief Officer role should be changed to that of a Chief Executive Officer. A directly funded and empowered IJB led by a CEO who would be accountable for the local delivery of social care. Working with the community to determine local priorities and the required investment.
Scottish Ministers would then hold the accountability for national decisions made which impact/influence the delivery of social care.

Establishment and abolition of care boards (Sections 4 and 5 / Schedules 1 and 2)

Please provide your comments on these sections of the Bill in the box provided.

use text box below:

The implementation of the Bill will result in significant disruption and structural change, the scale of this is not yet clear. It is evidenced that this scale of change will likely result in increased governance and management costs so risks and impact can be effectively mitigated. This needs to be funded in addition to increased funding for service pressures and capital investment. Again the nature of the new Care Boards and the geographical areas they cover will have an impact on the scale and cost associated with the change.

We believe local accountability is essential to meet the needs and priorities of the communities across Scotland. In our original response to the NCS consultation a hybrid model was proposed with clear lines of dual accountability. This model remains our preferred approach.
It is our view that Government should build on the success of IJBs, empowering them to operate independently. The Chief Officer role should be changed to that of a Chief Executive Officer. A directly funded and empowered IJB led by a CEO who would be accountable for the local delivery of social care. Working with the community to determine local priorities and the required investment.

Strategic planning and ethical commissioning (Chapter 2)

Please provide your comments on this part of the Bill in the box provided.

use text box below:

This reflects current Strategic Planning and commissioning approach within the IJB. We would see to ensure we take a best practice and ethical approach to commissioning working with communities.

National Care Service Charter (Sections 11 and 12)

Please provide your comments on these sections of the Bill in the box provided.

Text box:

Supported

Independent advocacy (Section 13)

Please provide your comments on this section of the Bill in the box provided.

text box below:

Supported

Complaints (Sections 14 and 15)

Please provide your comments on these sections of the Bill in the box provided.

use text box:

The current complaints system does not lend well to the integrated approach and an episode of care may straddle both health and social care services. Any effort to streamline the approach to complaints and ensuring it is easier for complainants to resolve any issues. However complaints are often better resolved closer to the operational source where the issues occurred and indeed where they can be addressed, learned from and rectified.

Ministers’ powers to intervene (Chapter 4)

Please provide your comments on these sections of the Bill in the box provided.

text box:

The Bill references both structural reform to improve on the ground services and a centralised and supervised approach by ministers to intervene as required. This response references the importance of local accountability, financial accountability and indeed this is reflected further in the submission from Chief Financial Officers. Ministerial oversight may bring benefit in setting a direction for change and enabling this but may do little to change the ongoing risks held by IJB's which are consistent across Scotland in respect of infrastructure, affordable housing and workforce availability.

Connected functions (research, training, other activities and compulsory purchase (Chapter 5)

Please provide your comments on these sections of the Bill in the box provided.

text box below:

Response is reflected in relation to the financial memorandum in terms of powers delegated to the proposed Care Boards

Transfer of functions, including scope of services (Chapter 6 and Schedule 3)

Please provide your comments on these sections of the Bill in the box provided.

text box:

The Bill provides little detail beyond the establishment of powers with little cognisance taken on the breadth of the current structure in place through integration schemes.

Argyll & Bute has all health and social care services delegated within its scheme of delegation and there is a recommendation that during interim arrangements the status quo of the scheme can be upheld.

As noted previously responsibility and funding for assets and infrastructure should be passed to the new Care Boards, noting that any transfer of assets may require funding to address existing issues.

A capital investment funding model requires to be a priority and should be based on the condition and suitability of the current infrastructure in each area. This is critical in ensuring that a single organisation has responsibility for both the services it provides and the physical assets and infrastructure used to provide those services.

The Bill does not make reference to supporting services of which the IJB as a non-employing body has none.

Inclusion of children's services and justice services (Section 30)

Please provide your comments on this section of the Bill in the box provided.

text box:

Integration of Children's services has offered the potential for a whole system approach supporting links from pre-birth through to transitions and continuity if adult care is required. At this stage of integration relevant authorities may only be starting to see the benefit and capacity available in delivering a planned approach which encompasses other key services such as Education, policing and third sector in supporting families.

As a fully integrated IJB there are forecast impacts in not considering childrens services and justice and this response has noted a recommendation to maintain the status quo if the bill consults separately on this matter.

Consequential modifications / Interpretation of Part 1 (Chapter 7 and Schedule 4)

Please provide your comments on these sections of the Bill in the box provided.

text box:

Health and social care information (Part 2)

Please provide your comments on this section of the Bill in the box provided.

text box:

A shared approach would bring significant benefit to both staff and people using services. Any interim arrangement would require to take cognisance of a very complex landscape of supporting systems and the importance of cyber resilience.

Right to breaks for carers (Sections 38 and 39)

Please provide your comments on these sections of the Bill in the box provided.

text box:

There are some concerns that the unpaid carer right to a short break involves the removal of any eligibility criteria. Whilst we fully recognise the role of unpaid carers the resources to offer short breaks with no funding limitations is concerning, this needs clarified. It is not clear if legislation will be amended.

Implementation of Anne's Law (Section 40)

Please provide your comments on these sections of the Bill in the box provided.

text box:

Supported

Reserved right to participate in certain contracts (Section 41)

Please provide comments on this section of the Bill in the box provided.

text box:

Implications of this aspect of the Bill should potentially be explored further. Centralised contracting can be problematic for remote and rural communities.

Regulation of social services (Sections 42 and 43)

Please provide comments on these sections of the Bill in the box provided.

text box:

The IJB recognise the need for development and support, social care reform and investment but the Bill does not specify how it will achieve this beyond the stated vision and principles.

Final provisions (Part 4)

Please provide comments on this part of the Bill in the box provided.

text box:

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of Schedule 7A of the Local Government(Scotland) Act 1973

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