PERTH AND KINROSS INTEGRATION JOINT BOARD

Council Building
2 High Street
Perth
PH1 5PH

31 October 2019

A meeting of the **Perth and Kinross Integration Joint Board** will be held in **the Council Chamber, 2 High Street, Perth, PH1 5PH** on **Wednesday, 06 November 2019** at **09:30**.

If you have any queries please contact Scott Hendry on (01738) 475126 or email Committee@pkc.gov.uk.

Gordon Paterson
Chief Officer/Director – Integrated Health & Social Care

Please note that the meeting will be recorded and will be publicly available on the Integration Joint Board pages of the Perth and Kinross Council website following the meeting.

Voting Members
Councillor Eric Drysdale, Perth and Kinross Council (Chair)
Councillor Colin Stewart, Perth and Kinross Council
Councillor Xander McDade, Perth and Kinross Council
Councillor Callum Purves, Perth and Kinross Council
Bob Benson, Tayside NHS Board (Vice-Chair)
Pat Kilpatrick, Tayside NHS Board
Jenny Alexander, Tayside NHS Board
Dr Norman Pratt, Tayside NHS Board

Non-Voting Members
Gordon Paterson, Chief Officer, Perth and Kinross Integration Joint Board
Jacquie Pepper, Chief Social Work Officer, Perth and Kinross Council
Jane Smith, Chief Financial Officer, Perth and Kinross Integration Joint Board
Dr Douglas Lowden, NHS Tayside
Sandra Gourlay, NHS Tayside

Stakeholder Members
Bernie Campbell, Carer Public Partner
Allan Drummond, Staff Representative, NHS Tayside
Stuart Hope, Staff Representative, Perth and Kinross Council
Sandy Watts, Third Sector Forum
Linda Lennie, Service User Public Partner
Lynn Blair, Scottish Care

Perth and Kinross Integration Joint Board

Wednesday, 06 November 2019

AGENDA

1	**WELCOME AND APOLOGIES**	
2	**DECLARATIONS OF INTEREST** Members are reminded of their obligation to declare any financial or non-financial interest which they may have in any item on this agenda in accordance with the Perth and Kinross Integration Joint Board Code of Conduct.	
3	**ANDY'S MAN CLUB** Presentation	
4	**UPDATE ON REDESIGN OF COMMUNITY MENTAL HEALTH SERVICES AND SUPPORTS IN PERTH AND KINROSS** Report by Head of Health (copy herewith G/19/171)	**5 - 26**
5	**MINUTE OF MEETING OF THE PERTH & KINROSS INTEGRATION JOINT BOARD OF 27 SEPTEMBER 2019** (copy herewith)	**27 - 38**
6	**ACTION POINTS UPDATE** (copy herewith)	**39 - 40**
7	**MATTERS ARISING**	
8	**MEMBERSHIP UPDATE** Verbal Update by Clerk	
9	**FINANCE AND GOVERNANCE**	
9.1	**2019/20 FINANCIAL POSITION** Report by Chief Financial Officer (G/19/173)	**41 - 46**
10	**DEVELOPING STRATEGIC OBJECTIVES**	
10.1	**CHIEF OFFICER STRATEGIC UPDATE** Report by Chief Officer/Director - Integrated Health & Social Care (copy herewith G/19/176)	**47 - 50**
11	**CARERS AND YOUNG CARERS STRATEGY FOR 2019-2022** Report by Head of Adult Social Work and Social Care (copy herewith G/19/174)	**51 - 136**

12 WINTER PLANNING 2019/2020 **137 - 198**
Report by Chief Officer/Director - Integrated Health & Social Care (copy herewith G/19/175)

13 FUTURE IJB MEETING DATE 2019
Wednesday 11 December 2019 at 2.00pm

14 PROPOSED IJB MEETING DATES 2020 (1.00PM - 4.00PM UNLESS OTHERWISE STATED)
Wednesday 4 March 2020
Wednesday 29 April 2020
Wednesday 24 June 2020
Wednesday 23 September 2020 (2.00pm - 4.00pm)
Wednesday 9 December 2020

PROPOSED IJB BRIEFING/DEVELOPMENT SESSION DATES 2020 (1.00PM - 4.00PM)
Wednesday 8 April 2020
Wednesday 13 May 2020
Wednesday 19 August 2020
Wednesday 28 October 2020

Perth & Kinross Integration Joint Board

6 November 2019

Update on Redesign of Community Mental Health Services and Supports in Perth and Kinross

Report by Head of Health (Report No. G/19/171)

PURPOSE OF REPORT

To provide an update on the review of community mental health services and supports in Perth and Kinross.

1. RECOMMENDATION(S)

It is recommended that the IJB:

- Consider the content of this report and the progress of the review of community mental health services and supports.
- Commit the Chief Officer to present to the IJB the Community Mental Health Strategy once produced.

2. BACKGROUND

The strategic drive in Perth and Kinross is to support people with mental health issues to remain at home in their own communities with the same life chances and opportunities as wider society. Over the past two decades there has been a shift away from institutional care and a wide range of community based service and supports have been made available for people with mental health issues and their carers in Perth and Kinross. However, there is a need to review and further development the range of services and supports available to people with mental health issues and this work, which will support the redesign of inpatient services in Tayside, is now underway.

2.1 Aim

The aim of this review is to scope existing community services and supports for people with mental health issues in Perth and Kinross and to identify any gaps and areas for improvement. It will also identify any redesign necessary to support the review of the inpatient bed base in Tayside. The findings from this review will contribute to a new Community Mental Health Strategy and Implementation Plan for Perth and Kinross.

The six strategic aims identified in Perth and Kinross HSCP's Strategic Plan will underpin this review and the new strategy;

- Prevention and early intervention
- Person-centred healthcare and support
- Working with communities
- Reducing health inequalities and promoting health living
- Making the best use of available facilities, people and resources
- Keeping people safe

2.2 Objectives

The objectives of the review are to

- Ensure personalised support is available at the right time for individuals throughout Perth and Kinross to maximise their recovery and independence
- Embed multi-disciplinary teams and inter-agency working at the heart of 'seamless' care pathways and support for people
- Implement a high quality model of care that is financially sustainable
- Ensure there is a focus on health promotion and early intervention and prevention, including supporting young people as they transition to adulthood.

3. PROGRESS TO DATE

3.1 Mental Health and Wellbeing Strategy Group

The Mental Health and Wellbeing Strategy Group have been refreshed and is now meeting again regularly. The Strategy Group will lead the review of community mental health services and support in Perth and Kinross and will develop the Improvement Plan. The Strategy Group will also make recommendations on how any new monies, including Action 15 monies, are spent and any plans for decommissioning current services.

3.2 Tayside Mental Health Alliance

The Tayside Mental Health Alliance has been established to bring together NHS Tayside and the three Health and Social Care Partnerships responsible for delivering or commissioning mental health services. The Alliance will

operate at a strategic level to identify the opportunities for developing and improving mental health services on a 'once for Tayside' basis. This will ensure that all elements of care and treatment are joined up and consistent irrespective of where in Tayside the person lives or what age they are.

The Alliance is now meeting regularly and the Perth and Kinross representatives are the Head of Health and the Head of Adult Social Work and Social Care.

3.3 Tayside Public Health Information Network (TAYPHIN)

Perth and Kinross HSCP now has representatives on TAYPHIN. Part of this group's remit is to collect and analyse data relating to mental health across Tayside to benchmark with other areas, identify gaps in provision and inform service development.

3.4 Mental Health Needs Analysis

A needs analysis for mental health in Perth and Kinross is being conducted. Information and data from a range of sources has been considered to inform understanding of; prevalence rates; hospital admissions; detentions and compulsory treatment orders, suicide rates and treatment diagnoses. This information is being analysed to identify key issues/themes in Perth and Kinross to inform the development of the strategy and improvement actions.

A robust Performance Framework will also be developed to determine the impact of community based services and supports for people with mental health issues in Perth and Kinross. This local Performance Framework will align to the Tayside wide Performance Framework being developed by the Tayside Mental Health Alliance.

3.5 Action 15 monies

The Scottish Government has awarded funding to HSCPs to improve support for people with mental health issues. Due to timescales to secure the money, decisions had to be made regarding how to use the first tranche of funding before this review of community services could be completed. The following themes were used to inform decisions;

- **Improving Access to Services:** Six nurses have been recruited and aligned to GP Practices to provide triage, initial assessment and support and ongoing referral/signposting as required for people presenting at GP Practices with mental health issues. A nurse has also been recruited to the Access Team (adult social work intake team) to provide the same role for people presenting there. Three mental health support workers have been funded to provide support with self-management, symptom control and to provide wellbeing advice. Funding for a coordinator for the 'It's Good to Talk' service has been provided so that this service is now available in every GP Practice. Funding has been awarded to Mindspace to increase the number of

counselling sessions, to reduce waiting times and increase availability in rural areas.

- **Support for people in crisis/distress:** Funding has been awarded for a co-ordinator for the 'Lighthouse Project' which will provide support for people 'in distress' out with office hours. This is a jointly funded project between mental health and substance use.

- **Prison Healthcare:** Two CBT Therapists and 1.6 (whole time equivalent) OTs are being recruited to support people with mental health issues in Perth Prison. A part-time specialist doctor, part-time Advanced Nurse Practitioner and 1.5 Non-Medical Prescribers are also being recruited to support prisoners with substance misuse issues using funding provided by the Alcohol and Drug Partnership.

3.6 Scoping of Current Services and Supports

Current services and supports for people with mental health issues in Perth and Kinross have been scoped and aligned to one of five pathways (see appendix 1):

- Self-Referral and Community Based Prevention and Early Intervention Support
- Wider mental health support and wellbeing
- Community based specialist mental health support
- In patient services
- Crisis response and Out of Hours

The pathways provide a summary of the various services and supports available in pictorial form. This helps to identify any gaps or areas of duplication and these will be updated regularly. Information has also been collated detailing the support each organisation/service on the pathway provides (see appendix 2).

3.7 Consultation and Engagement

A workshop has been held with professional stakeholders from the statutory and independent sectors, where the above pathways were discussed. The aim of this was to 'sense check' the pathways to ensure they are correct and add any missing services and supports. Groups also discussed any issues and ideas for improving the pathways. Discussions highlighted that a lot of the organisations on the pathways weren't aware of other supports available in Perth and Kinross and one proposal for the future is to have regular network meetings to improve communication and ensure people are accessing the most appropriate support at the appropriate time.

A consultation with the public is currently underway using the PKC Consultation Hub to obtain feedback on community mental health services and supports in Perth and Kinross.

A second survey for HSCP staff is also underway seeking views and opinions of the mental health supports being provided, which will supplement the views from the professionals' workshop.

A further workshop is planned with professionals and service user and carer representatives to analyse the findings from the first workshop and the consultation.

3.8 Community Police Triage

Funding has been identified to continue to support the Community Police Triage pilot in Perth and Kinross. The involves mental health nurses providing joint assessments and/or advice to police officers who are dealing with people who are presenting in crisis and/or experiencing mental illness in the community. The nurses also assist with ongoing referrals and signposting, as required. This helps ensure people receive appropriate support when they require it and reduces the risk of them ending up in custody.

3.9 Emerging Issues

Although the review of community health services and supports is still ongoing a number of issues and themes are emerging.

- Accessibility of services, especially in rural areas, needs to be investigated.

- More community-based supports, especially in Perth City, are needed to reduce the requirement for statutory supports at a later date and there is a need for increased Social Prescribing capacity to help people access them.

- The pathway for people with a Personality Disorder needs to be reviewed to ensure timeous access to appropriate support.

- Links between mental health and substance use services need to be improved especially for younger adults; integrated funding needs to be investigated and pathways need to be developed.

- A review of support to reduce the risk of people completing suicide is required, especially in Perth City.

- To reduce hospital admissions the support for people in crisis needs to be improved, including the development of A and E Liaison Service and improved Anticipatory Care Planning.

- The reasons for people being readmitted to hospital need to be investigated to identify approaches that reduce the incidence of this.

- Investigation and benchmarking is required to identify the reason(s) for the rising number of people from Perth and Kinross being compulsorily detained.

- The potential of Advanced Mental Health Nurse Practitioners needs to be explored as a role that can developed to support people with complex mental health needs to remain in the community.

4. CONCLUSION

Once completed, information from the needs analysis, the workshops, the consultations, the scoping/gap analysis and evaluation of action 15 monies spend to date will be collated and analysed along with data and information from other sources including the Independent Inquiry into Mental Health Services in Tayside and the Perth Plus Survey on 'Acute Mental Health Bed Centralisation in NHS Tayside for 16-65 year olds.'

This will then be used to inform the development of the new Community Mental Health and Wellbeing Strategy and Implementation Plan for Perth and Kinross, which will be presented to the IJB for approval in the new year.

Author(s)

Name	Designation	Contact Details
Evelyn Devine Diane Fraser	Head of Health Head of ASWSC	evelyn.devine@nhs.net dfraser@pkc.gov.uk

NOTE: No background papers, as defined by Section 50D of the Local Government (Scotland) Act 1973 (other than any containing confidential or exempt information), were relied on to any material extent in preparing this report.

ANNEX

1. IMPLICATIONS, ASSESSMENTS, CONSULTATION AND COMMUNICATION

Strategic Implications	**Yes / None**
HSCP Strategic Commissioning Plan	**Yes**
Transformation Programme	**n/a**
Resource Implications	
Financial	**Yes**
Workforce	**Yes**
Assessments	
Equality Impact Assessment	**n/a**
Risk	**Yes**
Other assessments (enter here from para 3.3)	
Consultation	
External	**Yes**
Internal	**Yes**
Legal & Governance	
Legal	**No**
Clinical/Care/Professional Governance	**Yes**
Corporate Governance	**No**
Directions	**No**
Communication	
Communications Plan	**Yes**

1. Strategic Implications

1.1 Strategic Commissioning Plan

The proposals contribute to all the key themes of the HSCP's Strategic Plan.

2. Resource Implications

2.1 Financial

This redesign will need to take place within existing budgets but include the allocation of the Action 15 monies provided by the Scottish Government over a four year funding period.

Funding has been provided with a remit to increase the workforce to give access to dedicated mental health professionals and for Perth & Kinross, the requirement is to create a minimum of 21.8 new positions by the March 2022. The Action 15 funding allocation for Perth & Kinross totals £2,293,420 and is due as follows:

- 2018/19 - £300,141
- 2019/20 - £464,188
- 2020/21 - £655,325
- 2021/22 - £873,766

2.2 Workforce

HR and Professional Leads have been consulted as required.

3. Assessments

3.1 Equality Impact Assessment

Not applicable

3.2 Risk

Any risks will be managed and escalated when necessary to the Mental Health and Wellbeing Board.

3.3 Other assessments

Any further assessments will be completed as required.

4. Consultation – Patient/Service User first priority

On line consultation in progress, one workshop has happened and another is being arranged.

5. Legal and Governance

The redesign project reports to the Mental Health and Wellbeing Board.

6. Directions

There are no Directions with this paper.

7. Communication

A Communications Plan is being developed.

8. BACKGROUND PAPERS/REFERENCES

Not applicable.

9. APPENDICES

This paper contains two appendices applicable to the content. Both of these documents are working versions and will evolve as the project progresses.

Appendix 1 – Perth & Kinross Mental Health Pathway
The attached document shows, in summary, the five levels within the pathway and the supports for each.

Appendix 2 – Perth & Kinross Mental Health
The attached document provides more detailed information about the supports within the overall mental health pathway.

Appendix 1

Mental Health Pathway

Entry Routes	Therapeutic Intervention	
GP Referral / Agency Referral /	**Level 1:** Self-Referral and Community Based Prevention & Early Intervention Support	1.1 Beating the Blues 1.2 Books on Prescription 1.3 Breathing Space 1.4 Healthy Minds Book List 1.5 Live Active Compass Membership / GP Referral 1.6 Money Worries Crisis App 1.7 Moodjuice 1.8 MoveAhead 1.9 NHS Living Life 1.10 Suicide Help App / Website
Self-Referral / Social Prescriber / Interagency Referral Social Work / MHO / GP	**Level 2:** Wider Mental Health Support & Wellbeing	2.1 Adult Psychological Therapies Service Primary Care 2.2 Andy's Man Club 2.3 Access Team 2.4 Employment Support Teams 2.5 Mindspace 2.6 North, South, Perth City Social Work 2.7 Perth Six Circle Project 2.8 Perthshire Women's Aid 2.9 PKAVS Mental Health and Wellbeing Hub 2.10 Rape and Sexual Abuse Centre 2.11 Social Prescribers 2.12 Suicide and Self-Harm Support Group 2.13 Support in Mind 2.14 Tayside Council on Alcohol 2.15 Victim Support 2.16 Wellbeing Support Team 2.17 OWLS 2.18 Barnardo's 2.19 Floating Housing Support 2.20 CATH 2.21 College Student Support 2.22 Perth Creative Community Collaborative 2.23 Listening Service, NHS Tayside / Do you need to Talk? 2.24 Men's Shed
GP Referral / All Statutory Services MH Nurses	**Level 3:** Community based Specialist	3.1 CAMHS 3.2 Clinical Psychology to General Adult Psychology CMHT 3.3 Perth and Kinross Adult Community Mental Health Team 3.4 Perth & Kinross Intensive Home Treatment Team 3.5 Older Peoples CMHT 3.6 Psychological Therapies Service 3.7 Primary Care Mental Health Nurses
GP / MHO Assessment	**Level 4:** In Patient	4.1 Amulree Rehabilitation ward 4.2 Forensic MHO and Social Work services – Rohallion 4.3 Mental Health Officer Input 4.4 POA – Inpatients 4.5 GAP – Inpatients 4.6 Learning Disabilities – Inpatients
?	**Level 5:** Crisis and Out of Hours	5.1 Crisis Response Service, Carseview 5.2 Out of Hours Social Work 5.3 Samaritans 5.4 Street Pastors

Independent Advocacy Plus Perth

Appendix 2

Mental Health and Wellbeing Care Programme

Mental Health Pathways Redesign Project

Detailed Pathways Information

Working document

Version 3

Self-Referral and Community Based Prevention and Early Intervention Support – Level 1	How is the service accessed?	What are the criteria for services?	Number of Service Users? Are there waiting lists?	Can service respond to a crisis?	Hours of Operation	What happens if a person refused or cannot be seen?
1.1 **Beating the Blues -** Computerised CBT for people experiencing anxiety or low mood, this website can help people make the link between how they think and how this influences feelings and behaviours	GP Referral	People with depression and/or anxiety.	N/A	N/A	Available 24/7	N/A
1.2 **Books on Prescription -** Self-help books available to borrow in Perth and Kinross libraries.	General Practitioners (GPs) and other NHS professionals can prescribe the books.	Requires prescription – can respond to people on: Stress, Low mood / Depression, Anxiety, Panic, Sleep problems, Parenting, Anger, Relaxation.	N/A	N/A	N/A	N/A
1.3 **Breathing Space -** Support people who may experience difficulty and unhappiness, mental health problems and emotional distress. A free, confidential, phone service for anyone in Scotland.	'First stop' phone service.	Emotional difficulties			Monday - Thursday 6pm to 2am Friday 6pm - Monday 6am	Signposts to GP/111/Samaritans out of hours or if feeling very unwell
1.4 **Healthy Minds Book List -** Encourages people to use books instead of, or alongside, medication and therapy services. Books recommended by NHS mental health professionals.	Open to all library members	No criteria	N/A	N/A	N/A	N/A
1.5 **Live Active Compass Membership/GP Referral -** The Compass Membership offers free and reduced cost access to Live Active Leisure services for priority target groups who are socially or economically disadvantaged.	Agency or GP referral. Must be directly supported by the referring agency at the time of referral.	Physically inactive. Underlying health problems/long term condition. In receipt of benefits, allowances, on work based training or a student.	N/A	N/A	N/A	N/A
1.6 **Money Worries Crisis App -** Free mobile App signposting to appropriate sources of help and a support in a crisis, including money, benefits, housing, work and emotional crisis.	Anyone can access info on app	No criteria	N/A	N/A	N/A	N/A
1.7 **Moodjuice -** A website that encourages individuals to think about emotional problems and work towards solving them.	N/A	N/A	N/A	N/A	N/A	N/A
~~**1.8**~~					-	
1.9 **NHS Living Life 24** - free Cognitive Behavioural Therapy (CBT) telephone service	GP Referral	Anyone over the age of 16 who is suffering from low mood, mild to moderate depression and/or anxiety.	N/A	N/A	Monday to Friday: 1pm - 9pm	N/A
1.10 **Suicide Help App/Website -** Help for someone with suicidal thoughts is always available through the app – search for Suicide? Help! in your app store.	Anyone can access info on app or website	Targets people with suicidal feelings and their supporters	N/A	N/A	N/A	N/A
1.11 **Scotland All Strong - [Description]**						

Wider Mental Health and Wellbeing Support – Level 2	How is the service accessed?	What are the criteria for services?	Number of Service Users? Are there waiting lists?	Can service respond to a crisis?	Hours of Operation	What happens if a person refused or cannot be seen?
2.1 Adult Psychological Therapies Service Primary Care	Primary referrers are GPs but referrals also accepted from CMHT, Primary Mental Health and Well-being Nurses, Physical Health clinicians (including maternity services)	**ELIGIBLE:** Individuals in age range 18-64 years (also 16 and 17 year olds who have left school) with diagnosed mild to moderate psychological disorders likely to respond to a brief time-limited period of psychological treatment e.g. anxiety disorders, PTSD & OCD not previously treated, mild to moderate depressive disorders, bulimia with no physical complications, functional neurological disorders. APTS offers routine appointment only. Referrals will be prioritised in line with the National Armed Forces Covenant and the peri-natal pathway. Individuals must be motivated to engage in treatment. **NOT ELIGIBLE:** Individuals with presenting problems which are **primarily:-** • severe or enduring mental illness • not a diagnosable psychological disorder • current input from other specialist services (e.g. CMHT, Substance Misuse) • where psychological disorder is central to offending behaviour/ recent contact with Criminal Justice System • personality disorders • acquired brain injury • associated with a physical health condition • primary addiction problems • anorexia nervosa • psychosexual disorders • due to social factors • anger management	Currently the primary care service meets the Scottish Government 18 week referral to treatment target. Most are contacted within 3-4 weeks of referral and the average wait from time of referral is around 11 weeks. Referrals in to the service average around 100 a month	No – there is no crisis provision within primary care. When a crisis presents liaison is required with the CMHT or Crisis service or GP.	Monday – Friday 9am – 5pm	Very few cases referred to the service are not accepted. Majority are seen and around 10% will be directed to other, more appropriate services eg Mindspace, Clinical Health Psychology, etc
2.2 **Andy's Man Club -** A space for men to talk about their problems without judgement or feeling like a burden. A safe place for men to talk about their mental health and hear other people's stories.	Self-referral	Men who want support from peers	Club operates a closed Facebook group where members can post if they are struggling and get peer support.	our guys within the closed group if available will if available respond to messages and in the past they have attended hospital, Kinnoull Hill etc but this is not an official service so couldn't really advertise it as one.	Monday 7pm Officially AMC is a Monday night peer support group but has additional support online if in the closed group	To date we haven't refused anyone entry to AMC and it's down to the person to access the group under their own steam. We can meet prior to the meeting in the car park or at our unofficial meet in Costa's at St. Catherine's retail park from 5.30ish to 6.30pm

Wider Mental Health and Wellbeing Support – Level 2	How is the service accessed?	What are the criteria for services?	Number of Service Users? Are there waiting lists?	Can service respond to a crisis?	Hours of Operation	What happens if a person refused or cannot be seen?
2.3 **Access Team -** First point of contact for people who need access to health and social care services. People are given information and re-directed as appropriate. Aims to signpost, provides HART (Reablement ethos) care and early assessment and review to minimise longer term needs. Crisis intervention work + responding to VPRs from Police, Bereaved by suicide support and suicide prevention work.	First point of contact for all SW enquiries. Contact can be from anyone with a concern or community care need over the age of 16 years regardless of difficulty or disability. They can call into the office, call, email.	Service users aged 16 Up - all areas of Adult Care	This can change on an hourly basis as all contacts are initially screened by our duty team and only put over for a manager to screen & allocate if required. This is where a waiting list sits in each locality within the Access Team.	Yes and we do on a daily basis. We have a duty team each day and other operational staff to support if required.	8.45 – 17.00 Mon – Fri Delayed opening 11.00am 1st Thursday of each month. (Open all year apart from statutory bank holidays). OOHs team take over 17.00 – 8.45am (365 days yearly)	Never known this to happen.
2.4 Employment Support Teams - Offers employability related support to people with to prepare for, find and maintain paid employment.	Self-referral Signposted by other agency or referrer.	Severe and enduring mental health conditions	N/A	Yes	Office hours only (Nights and Weekends by arrangement)	Agreement and signposting to others services and Case Closure document signed off.
2.5 **Mindspace** - Offers counselling to people who are facing difficulties or challenges. The Recovery College works with people with mental health needs, their carers, families, friends etc. They provide information, advice, learning opportunities and a safe environment to develop new skills. Peer Support is also available.	Self-referral Signposted by other agency or referrer.	Counselling - ages 11+ (Anyone with severe mental health difficulties, or needing addiction support would be signposted elsewhere) **Recovery College:** Any adult (16+) who has mental ill health, carer, friends, professionals **Peer Support:** Age 16 +	Counselling - 3-6 months. Peer Support – 2 months. 2018-2019 - 216 people attended Recovery Courses 140 counselling sessions per week - April 19 **Recovery College:** We run courses on a weekly basis; each course can usually accommodate 10 attendees, although this can vary according to the type of course being run. We gather information on demand, so we can respond to which courses are being asked for.	Counselling – doesn't operate a crisis service **Recovery College:** We are not a crisis service **Peer Support:** No	Daytime office hours. Some evening counselling appointments. **Recovery College:** We mainly run a weekly daytime service, however we are testing out some evening courses.	Counselling – client signposted and/or supported to access more appropriate service. **Recovery College:** We will signpost/or supported to access more appropriate service **Peer Support:** -Signposted / supported to access appropriate support
2.6 **North, South, Perth City Social Work Teams -** Team members are trained in ASIST, SMHFA etc and support clients they work with around mental health and wellbeing.	If you require social work input as a matter of urgency during office hours please contact the Perth City Team duty number 01738 476811 / 01738 475671 or perthcitysocialwork@pkc.gov.uk. Alternatively, if it is an emergency situation please contact the Early Intervention and Prevention Team / Out of Hours Service on 03453011120.	Service users aged 16 Up - all areas of Adult Care	**North:** 0 waiting lists – AIS will send you a report of the number of clients with mental health issues in each locality **Perth City:** Yes there are waiting lists within the team that vary from week to week. **South:**	Yes	**North:** 08.45-17.00 **Perth City:** 09.00 – 17:00 **South:**	**North:** The person will be seen if they consent. We would visit without consent if we believed they were at significant risk if harm **Perth City:** If a person refuses input or support and they have been assessed as having capacity we will record this information on their case record. In addition, we would attempt a face

Wider Mental Health and Wellbeing Support – Level 2	How is the service accessed?	What are the criteria for services?	Number of Service Users? Are there waiting lists?	Can service respond to a crisis?	Hours of Operation	What happens if a person refused or cannot be seen?
						to face visit to try to encourage the individual to engage. If the person has been assessed as not having capacity we would attempt to contact and liaise with their legal representative such as POA / Guardian. If in either case as described above it was felt that the adult was at imminent risk of harm, information would be shared with appropriate agencies. This includes police, health, social work colleagues, individuals and relevant others to agree safeguarding measures and appropriate supports. Every referral the team receives is screened by the team leader. They then assess the level of priority of the request. The Perth City North and South Teams operate a daily duty system, where there is a dedicated worker appointed to provide immediate support to individuals as and when required. **South:**
2.7 **Perth Six Circle Project -** supports adults aged 18+ with a variety of complex and challenging issues such as those with severe and enduring mental health needs, those recovering from the effects of substance misuse and those who have prison experience.	Self-referral Signposted by other agency or referrer.	An individual who has complex and challenging issues such as those previously noted	30 service users per yr There may be a waiting list from time to time	Out of hours Talking Therapy	Currently 8am-3.30pm	If we find we are not best placed to support an individual, then we would sign post them to a potential alternative
2.8 **Perthshire Women's Aid –** Offers support, information and	Self-referral Signposted by other agency or referrer.	Child, young person or woman who has experienced domestic abuse.	Yes – we have just reopened our counselling	Yes within office hours	9.30-4.30 with diversion to	Engagement is with service users consent, if someone

	Wider Mental Health and Wellbeing Support – Level 2	How is the service accessed?	What are the criteria for services?	Number of Service Users? Are there waiting lists?	Can service respond to a crisis?	Hours of Operation	What happens if a person refused or cannot be seen?
	refuge accommodation to women, children and young people who have or are experiencing domestic abuse.			waiting list and there is a waiting list for a key worker to be allocated in our women and children services, phone support is provided until this happens		Scottish Domestic Abuse helpline outwith office hours	is referred and we cannot engage we would let referrer know.
2.9	**PKAVS Mental Health and Wellbeing Hub -** Community-based and outcomes-focussed support for adults (16+ years) recovering from mental health difficulties. Our Hub services are based across two locations – The Walled Garden in Perth City and Wisecraft in Blairgowrie.	PKAVS Mental Health & Wellbeing Hub is accessed by self-referral or a referral from another professional /agency supporting the individual.	PKAVS Mental Health & Wellbeing Hub provides support and opportunities to adults (16+ years) facing mental health and wellbeing difficulties. Clients do not require a mental health diagnosis to submit a referral but will be experiencing symptoms of poor mental health such as low mood, anxiety and self-harm.	There are currently 120 individuals accessing our service across both Hub locations. Many engage in activities at both sites. We currently do not have a waiting list.	We respond to and support clients in crisis who already attend our service.	**The Walled Garden** -Open to clients from 9.30am to 3.30pm Mon-Fri **Wisecraft** – Open to clients from 9.30am to 3.30pm Mon-Thurs	Individuals attend and engage in the activities offered within our service on a voluntary basis.
2.10	**Rape and Sexual Abuse Centre, Perth & Kinross -** Offers free and confidential support and advocacy to women and young people who have experienced rape or sexual abuse at any time in their life.	Self-referral Signposted by other agency or referrer. Outreach service available.	Anyone who identifies as a woman and all young people age 12-18, who have experienced rape or sexual abuse. Families affected by sexual violence. Support for individual family members, friends, partners of survivors.	Support: Waiting lists are in operation. Currently 2 months for YP and 6 months for adults. Justice Advocacy: Currently no waiting list. Crisis: Up to 3 crisis appointments if required. No waiting list for crisis.	Up to 3 crisis appointments available. Support available in the immediate aftermath of sexual assault with referral to SARN (Sexual Assault Referral Network) if required. Drop-in weekly, Tuesdays from 12-2.	Monday – Friday, 9am – 5pm. Evening appointments available. SARN helpline operational during business hours and every evening 6pm – midnight, 365 days a year.	Survivors will be seen at the earliest possible point. All referrals responded to within 7 days. Crisis support available same day whenever possible or next available business day. Should anyone not be able to access for any reason, we would support access to another RC Centre or work with other local services in order to meet need. Telephone or online appointments available if face to face not possible.
2.11	**Social Prescribers** - Social Prescribing seeks to improve a person's health and wellbeing by helping them to access clubs, organisations and activities in their community.	Self-referral Signposted by other agency or referrer.	Age 16+ with lower level health needs.	84 active cases between City, North and South. No waiting list at present but will be put in place if needed	No	Monday – Friday 0845 - 1700	Inform the referrer that the referral cannot be taken; look at other options if appropriate.
2.12	**Suicide and Self-Harm Support Group –** Peer/Mutual Aid support group for family and friends of people who self-harm, attempted to take their own life or have died as a result of self-harm/suicide.	Self-referral	People affected by others self harm and/or suicide	No waiting lists. Numbers vary week to week as a mutual aid group	Group is run by people with lived experience of caring for someone who self harms, has tried to or has taken their own life.	Tuesday evenings 18.30-20.30	This is a drop in so no-one is not seen

Wider Mental Health and Wellbeing Support – Level 2	How is the service accessed?	What are the criteria for services?	Number of Service Users? Are there waiting lists?	Can service respond to a crisis?	Hours of Operation	What happens if a person refused or cannot be seen?
2.13 **Support in Mind - A** range of services across Perth and Kinross for those supporting someone with a mental illness.	Self-referral Signposted by other agency or referrer.	Supporter of someone with a mental illness.	121 people in 17/18 Tends not to operate with waiting list.	No	Monday to Friday 9-5 approx with flexibility as part-time staff covering service	Sign post to appropriate service Telephone or email support offered
2.14 **Tayside Council on Alcohol** - Provide a range of counselling modalities to people affected by own, or another's substance/gambling problematic use.	Self-referral Signposted by other agency or referrer.	Age 16+ affected by own, or another's substance or gambling problematic use.	Currently have 110 active clients. We currently have a waiting list and are working our way to reducing this following some additional ADP investment	We are not a crisis service but can offer advice or provide information if required	Monday to Friday 9am to 5 pm. Open late on a Wednesday until 7 pm,	Appointments are arranged for clients and attendance isn't compulsory by us.
2.15 **Victim Support -** Emotional support and practical help will be given for people struggling to cope with a crime, or who have been called as a witness in a court case.	Self-refer Referral from other agency even if crime not reported to Police	All victims and witnesses of crime including young people (aged 12-18) and all adults.	There are no waiting lists and users can usually be seen within a few days from referral.	If someone needs to be seen urgently we would try to do so within 24 hours.	9am - 4pm for office appointments, in some cases we can arrange home visits outwith this, users can also access our helpline/webchats online.	if they are a victim or witness of crime they will be contacted by phone/and or appointment arranged/and or letter sent to offer support
2.16 Wellbeing Support Team – Community based services, offering individual and group support to improve mental wellbeing, social inclusion and recovery.	Self-referral Signposted by other agency or referrer with the consent of the individual	Adults with mental health needs aged 16 years and over in rural Perth and Kinross. (North and South Locality boundaries) Generally low/moderate mental health needs, but can accept referrals for people with enduring mental illness if symptoms are well managed.	Only currently supporting 55 service users due to 4 vacancies in the team from 6.5 direct service delivery posts (over 60%). Recruitment is in progress. We have waiting lists across all areas of the team, with some people waiting up to 6 months for assessment and support. Current waiting list across the team of 42 people. When fully staffed we should be able to support approximately 140 people at any given point in time and respond to complete an assessment and arrange support within a 4 week period, once we have caught up with the backlog of referrals.	Yes – to those open and known to us in working hours only. Would support people to put together a Safe Plan for use in crisis when required, including out of hours crisis support options.	Generally Mon to Fri 9am to 5pm, with some flexibility for evening appointments if required for people in work.	Broad referral criteria so an inclusive approach to referral screening. Would screen out if needs/risks were greater than our resources or skill set. If cannot be seen, will try to arrange alternative support option, or reschedule for later date if an open involvement to team. People on the waiting list are given information on alternative options for support, including useful on-line resources.
2.17 OWLS [Description]						

Wider Mental Health and Wellbeing Support – Level 2	How is the service accessed?	What are the criteria for services?	Number of Service Users? Are there waiting lists?	Can service respond to a crisis?	Hours of Operation	What happens if a person refused or cannot be seen?
2.18 Barnardo's [Description]						
2.19 Floating Housing Support - [Description]						
2.20 CATH - [Description]						
2.21 College Student Support - [Description]						
2.22 Perth Creative Community Collaborative - [Description]						
2.23 Listening Service - Appointments made directly within G.P practices where possible.	GP team referral, self-referral, some community referrals.	Anyone over 16 who needs to talk about anything that troubles them. Grief, stress, sadness, family, addiction, health, anger, loss, relationships.	230 seen over the previous 6 months across 10 practices in P&K. Generally no waiting lists.	Yes	GP practice hours	N/a
2.24 Men's Shed [Description]						
2.25 Crieff Recovery Café - This weekly drop-in is for anyone with an interest in improving their wellbeing and needing support on their recovery journey from addiction or substance misuse.	Community cafe, drop-in. self-referral and worker referral - informal	Anybody with addiction issues, although door not closed to anyone who feels they would benefit from the group support.	6 no waiting list	No	Wednesday 10.30am to 12.30pm	N/a
2.26 Wellbeing Cafes - [Description]						
2.27 **MoveAhead –** MoveAhead is a locally based support service which enables people to access opportunities and services in the community. It aims to enhance the wellbeing of individuals through participation and engagement in their local community. The service provides support to people who wish to participate in a variety of community based activities, signposting on to other relevant services and organisations if appropriate to the individual's needs. MoveAhead has a community development remit, working in partnership with a host of local statutory, voluntary and community sector agencies and organisations to develop new opportunities.	The service accepts referrals from anyone and actively encourages people to self-refer.	People do not need to have a mental health diagnosis to access community groups and anyone living in Perth and Kinross can come along. Support service is for individuals age 16 years and above who experience severe and/or enduring mental health problems. The service accepts re-referrals from people experiencing severe and enduring and mild to moderate mental health problems. The service also supports People who do not have a have a mental health diagnosis and who require support on a short term basis to address a wellbeing need. People age 16(how have left school) and above can access the service who live in the Perth City Integrated Team boundaries. Community groups can be accessed by anyone living in Perth and Kinross.	This fluctuates and although there are no waiting lists at present this can change depending on service demand. From March 2019-26th June 19 MoveAhead have received 50 referrals.	No	Monday to Friday 08.30-16.30pm. However if a persons needs dictate staff will work evenings and weekends to meet this need. So very flexible depending on the needs of the individual,	If a person is refused or cannot be seen- If a referral is rejected this is based on the needs of that person. We will always endeavour to sign post to the appropriate service to meet that need providing direct and comprehensive information.

Community Based Specialist Mental Health Support – Level 3	How is the service accessed?	What are the criteria for services?	Number of Service Users? Are there waiting lists?	Can service respond to a crisis?	Hours of Operation	What happens if a person refused or cannot be seen?
3.1 **CAMHS -** NHS Tayside CAMHS service provides *speci*alist assessment and treatment for children and young people aged up to 18 who remain on a school roll who have or are suspected to have a **mental health condition.**	**Referral:** • GP • Hospital • School Staff • School Nurses • Paediatricians • Social Work • Universal Services • General Hospitals • 3rd Sector	**Refer for Specialist CAMH services if there are;** 1. Concerns Regarding Serious Mental Health. This is defined as mental, behavioural or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activity. I have removed lists of conditions – this will be a point of discuss for stake holder feedback) 2. Or regarding Looked after Children (L.A.C.) - **where there is concern about mental health that may lead to breakdown of placement**, please make the referral to Consultation re LAC. 3. Refer for the Neurodevelopmental Hub at the Centre for Child Health if there is concern regarding; • Attention Deficit Hyperactivity Disorder (ADHD) • Autistic Spectrum Disorder • Complex ADHD cases with co-morbidity	2	Yes within the hours of 9am-5pm Monday to Friday	9am-5pm	Assessment of risk would take place within a multi-disciplinary discussion and appropriate decisions would be made regarding the response. ie If refusing to attend with serious mental health concerns a visit would be offered at home.
3.2 **Clinical Psychology to General Adult Psychology CMHT** - provides support to people with mild to moderate symptoms of psychological distress (such as anxiety or depression.	Referrals to the Clinical Psychologists are managed internally	**ELIGIBLE** Individuals in age range 18-64 years (also 16 and 17 year olds who have left school) with diagnosed moderate to severe psychological disorders likely to respond to a period of psychological treatment and are open to the CMHT. **NOT ELIGIBLE** As above for primary care	The North and South CMHTs are currently working within the 18 week referral to treatment target. Due to staff vacancy over the past year the Perth City CMHT has had an extensive waiting list and whilst this has reduced is currently sitting at 11 months.	The CMHT has a duty worker	Monday – Friday 9am – 5pm	Cases are discussed with the psychologist prior to referral to ensure it is appropriate and to consult on psychological work which can be undertaken by (for example) the CMHN.
3.3 **Perth and Kinross Adult Community Mental Health Team -** The Perth and Kinross Adult Community Mental Health Service consists of multidisciplinary teams of Administration Staff, Clinical Psychologists, Community Mental Health Nurses, Community Support Workers, Clinical Pharmacist, Consultant Psychiatrists and other medical staff and Occupational Therapists. The Teams also benefit from access to a mental health specialist Dietician, Physiotherapist,	Community Mental Health Teams & Therapeutics Team – any Health or Social care staff member.	Community Mental Health Teams will receive referrals for people aged 16 – 64 years of age presenting with the following mental health problems: The individual is experiencing problems of a severity, complexity or duration that require a multi-disciplinary approach to assessment and management AND where the individual is experiencing one OR more of the following features: • A substantial impairment of function due to mental health problems. • Displaying obvious and severe symptoms.	Cumulatively the CMHTs will work with around 1,800 people at any given time. Currently there are no waiting lists for an individual to receive an initial mental health assessment. People will be offered an assessment appointment within 12 weeks as per our referral criteria however in reality many people will be offered an appointment within 6 weeks depending on referral	The CMHTS provide a crisis response to patients who are currently open to the Teams. Urgent assessment can be provided to individuals not open to the Team within 3 working days and the individual would be presenting with a marked levels of mental health risk.	9.00am – 5.00pm, Monday to Friday, excluding Public Holidays	The CMHTS work with individuals who are described as informal or formal patients. Patients who are currently working with the CMHTS within the parameters of a Community Treatment Order (CTO) will be followed up robustly. On most occasions a CTO will determine that the individual must engage with CMHT intervention or be recalled to hospital for ongoing

Community Based Specialist Mental Health Support – Level 3	How is the service accessed?	What are the criteria for services?	Number of Service Users? Are there waiting lists?	Can service respond to a crisis?	Hours of Operation	What happens if a person refused or cannot be seen?
and Speech and Language Therapist.		• A relapsing /remitting condition where early intervention could prevent relapse. • A significant risk to his/her owns safety or the safety of others. Risks include self-harm, neglect and abuse by others. • A previous history of severe and/or enduring mental illness requiring an assessment during pregnancy.	demand and Team capacity. Once accepted on to the CMHT caseload there are internal waits for Mental Health OT and for Clinical Psychology interventions.	The Teams provide a Duty Worker System where cases can be discussed. Our Duty Worker can be accessed within the Teams working hours on: 01738 413070		treatment. Informal patients, of which most of the CMHT caseload consists of, have the right to engage or not in CMHT intervention. Any patient open to the CMHT who requires crisis assessment later in the day can be seen by the Tayside Crisis Assessment Team in Dundee.
3.4 Perth & Kinross Intensive Home Treatment Team	Referrers: • Dundee CRHTT • GAP In Patient wards • Psychiatric Liaison Team • P&K CMHTs	Individual is at the point of requiring hospital admission, requires a response within 4 hours, requires intensive, at least daily, support.	No waiting list. Small caseload. Up to 25 but depends upon the intensity of the caseload needs.	Yes	7 days, 365 days per year 8am to 8pm	Patient has to agree to work with the team or referrer would have to consider different outcome/ disposal.
3.5 Older Peoples CMHT - [Description]						
3.6 Psychological Therapies Service - [Description]						
3.7 Primary Care Mental Health Nurses - [Description]						

In Patient – Level 4	How is the service accessed?	What are the criteria for services?	Number of Service Users? Are there waiting lists?	Can service respond to a crisis?	Hours of Operation	What happens if a person refused or cannot be seen?
4.1 Amulree Rehabilitation wards - Amulree Ward which amalgamated with the female service Rannoch ward in Oct last year	Through referral document or initial phone contact if the referral is from another area within inpatient services.	This is documented on referral form which can be requested from Dr Caesar or Dr Subbaryan's secretaries.	Currently 18 beds, with a waiting list	No in the main planned admissions	24 hour care	Advice is given regarding any other interventions which may be beneficial and if necessary signposted to an appropriate service
4.2 Forensic MHO and Social Work services – Rohallion	Those who are placed in Rohallion either as part of medium secure, low secure or are supported in the community by the forensic community mental health team will have access to the forensic social work and MHO service. For those who are subject to compulsory measures of care and treatment from within a forensic legal framework and are placed in a secure provision across Scotland will have access to a forensic MHO	The adult needs to be part of wider forensics health services in order to access forensic social work where necessary. Where a forensic based legal framework is considered as a means to safeguard the welfare of others and/or the adult, forensic MHO will be involved in that process and decision making	Forensic social work currently work directly with 22 adults either as inpatients or indeed in the community. There is no waiting list.	Yes	Forensic services primarily works across Monday to Friday, 9-5pm. However, the wider out of hours social work role s able to respond should a crisis occur out with normal office hours	If a person cannot be seen and it is considered that they are considered to be a risk or at risk as a consequence of a mental illness, the use of detention can be considered. If an adult is already subject to compulsory measures of care and treatment, this legal framework may be used to recall the adult into hospital for assessment if it is considered that recall is required. The MHO would have an integral role in this.
4.3 Mental Health Officer Input - Provide service to people who are subject to Mental Health Act and/or Adults with Incapacity Acts. Contribute to medical assessments, ensure people have info about legal right and access to representation, have involvement in decisions about the patients' care and treatment, and have involvement in tribunals/case conferences.	There are 2 key ways the service is accessed. If a medical clinician considers the use of formal detention is necessary, an MHO will be available to give consent or not to the need for detention. MHOs also complete welfare guardianship reports on behalf of the local authority and for those who seek private application via solicitor. A MHO will always be available Mon-Fr for advice on incapacity legislation.	The criteria for accessing the service is defined by the MHO role within different Incapacity legislative frameworks and the 2 key functions of the role. There is no criteria for any practitioner, service user, family/carer/other professional seeking advice from an MHO. This is open to everyone.	Numbers fluctuate and largely irrelevant due to the nature of the role, but at this time, have 259 SU's open to the team across different MHO functions. There is no waiting list.	Yes, the fundamental role in the dentition process often is a result of crisis. There is a statutory responsibility placed on all LA's to have a MHO available at all times to respond to crisis.	The MHO team predominately works Mon-Fri, 9-5. However, there is a MHO available 24/7 via OOHs social work to respond to a request to give consideration to a detention if required.	This is not an option for the MHO role. There is a statutory responsibility placed on all LAs to have sufficient MHOs available 24/7
4.4 POA – Inpatients [Description]						
4.5 GAP – Inpatients [Description]						
4.6 Learning Disabilities – Inpatients [Description]						

Crisis and Out of Hours	How is the service accessed?	What are the criteria for services?	Number of Service Users? Are there waiting lists?	Can service respond to a crisis?	Hours of Operation	What happens if a person refused or cannot be seen?
5.1 Crisis Response Service, Carseview Emergency mental health assessment within 4hrs of referral, for individuals requiring immediate/crisis type support. 24/7 crisis assessment for adults residing in Dundee / Perth & Kinross aged 16-64 who are not under CMHT care of General Adult Psychiatry Service Out of hours crisis assessment for adults aged 16-64 residing in Angus (new & existing GAP patients) Out of hours crisis assessment for adults aged 16-64 residing in Dundee / Perth & Kinross currently under CMHT care of General Adult Psychiatry Service (however if referred by Police Scotland then crisis assessment available 24/7) Out of hours crisis assessment for CAMHS, POA & LD patients	A&E CMHT Police Community Police Triage Primary Care NHS 24 Psychology OOHS GP ISMS	As per Standard Operating Procedure Referrals will be considered if a person suffers from a mental disorder and: • Is at risk of significant self-harm and /or • Is a significant risk to others due their mental health and • Admission to a mental health in-patient is being considered and • The patient is unable to adequately manage in the community, leading to a breakdown in their social circumstances.	They are a crisis response service	Yes	The out-of-hours assessments take place at Carseview Centre between 3pm and 9am weekdays and at weekends.	At point of referral a disengagement plan is agreed with the referring agent. This plan informs assessing clinician's what action should be taken in the event a person refuses/fails to attend scheduled crisis assessment appointment
5.2 Out of Hours Social Work - Access to social work service outwith normal office hours. Service provided by a coordinator and social worker, with potential access to other social work personnel.	Phone Access or Child Protection Team Numbers: 03453011120 or 01738 476268	Those requiring a social work service. It is however a crisis service and non-crisis contacts may be referred to main stream services on the next working day	No specific number, and no waiting list, although because has a skeletal staff contact cannot be guaranteed instantly. We provide MHOs on about 50 occasions each year at request of a medic.	Yes	Operates from 5.00pm – 8.45am Monday to Friday, and 24 hrs on Saturday, Sunday and public holidays. Office based until 23.00 hrs, and then on call overnight.	We would not routinely see clients, although this does happen on occasion. Can assist with referral to alternative agencies.
5.3 Samaritans - non-religious, confidential emotional support service and will listen to anyone about anything that is worrying them.	Self-referrals – telephone, face to face, text, email.	It is open to everyone.	They are often referred to as an out of hours service by other services – but they cannot respond in a crisis in terms of advice. They can signpost, but only to those that are given by Central Office of Samaritans.	The Director is to be contacted who will attempt to get other volunteers to attend a crisis, but this is not a guaranteed response, especially during the night.	Monday 7:30 p.m. – 9:30 p.m. Wednesday 7 p.m. – 9:30 p.m. Thursday 6 p.m. – 8:30 p.m. Friday 8 a.m. – 1:30 p.m. Sunday 8 a.m. – 2 p.m. 7 p.m. – 9:30 p.m.	No person is refused, but if the caller appears to be severely under the influence of alcohol and/or drugs or who is violent, they will not be allowed access to the branch, but will still be listened to. Visitors are reminded that volunteers may be on the phones, so there may be a wait, but they will be seen.
5.4 Street Pastors - [Description]						

PERTH AND KINROSS INTEGRATION JOINT BOARD

Minute of Meeting of the Perth and Kinross Integration Joint Board (IJB) held in the Council Chamber, Ground Floor, Council Building, 2 High Street, Perth on Friday 27 September 2019 at 10.30am.

Present:

Voting Members

Councillor C Stewart, Perth and Kinross Council (Vice-Chair)
Councillor E Drysdale, Perth and Kinross Council
Councillor X McDade, Perth and Kinross Council (up to and including Item 3.2)
Councillor C Purves, Perth and Kinross Council (up to Item 8.1)
Mr B Benson, Tayside NHS Board
Ms P Kilpatrick, Tayside NHS Board (up to Item 8.2)
Dr N Pratt, Tayside NHS Board
Ms J Alexander, Tayside NHS Board (substituting for Ms L Birse-Stewart) (up to Item 8.1).

Non-Voting Members

Mr G Paterson, Chief Officer / Director – Integrated Health & Social Care
Ms J Pepper, Chief Social Work Officer, Perth and Kinross Council (up to and including Item 8.2)
Ms J Smith, Chief Financial Officer (up to and including Item 8.2).

Stakeholder Members

Ms B Campbell, Carer Public Partner
Mr A Drummond, Staff Representative, NHS Tayside (until Item 9.1)
Ms S Gourlay, NHS Tayside
Mr S Hope, Staff Representative, Perth and Kinross Council (up to and including Item 4.2)
Ms S Watts, Third Sector Representative (substituting for Ms C Gallagher) (up to and including Item 4.2)
Ms S Auld, Service User Public Partner (substituting for Ms L Lennie) (up to and including Item 4.2).

In Attendance: K Reid, Chief Executive, Perth and Kinross Council; L Simpson, S Hendry, K Molley and S Watson (all Perth and Kinross Council); D Fraser, D Mitchell, H Dougall, D Fraser and V Aitken (all Perth and Kinross Health and Social Care Partnership); S Dickie, K Russell, P Stonebridge, and A Wood (all NHS Tayside); Dr D Strang (up to and including Item 3.1).

Apologies: Ms L Birse-Stewart, Tayside NHS Board
Ms L Lennie, Service User Public Partner
Ms C Gallagher, Third Sector Representative

1. WELCOME AND APOLOGIES

Councillor Stewart welcomed all those present to the meeting. Councillor Stewart referred to the fact that Robert Peat had recently resigned as Chair and as a member of the IJB and gave a special thanks to him for all his contribution as a member and Chair of the Integration Joint Board.

It was agreed that the Chair and Vice-Chair would discuss the future layout of IJB meetings.

Apologies and substitutions were noted as above. It was agreed that further clarification on rules for substituting for vacant positions on the Board would be highlighted in the next review of Standing Orders.

2. DECLARATIONS OF INTEREST

There were no Declarations of Interest made in terms of the Perth and Kinross Integration Joint Board Code of Conduct.

3. MENTAL HEALTH

3.1 UPDATE FROM THE INDEPENDENT INQUIRY INTO MENTAL HEALTH SERVICES IN TAYSIDE – UPDATE FROM MR DAVID STRANG

There was a Verbal Update by Dr D Strang, Chair of the Independent Inquiry on Mental Health Services in Tayside regarding the Interim Report published in May 2019 and the status of the Independent Inquiry on Mental Health Services.
Dr D Strang advised that debate was raised in parliament last summer over the lack of public confidence, clinical leadership and pressures on staff in relation to mental health services in Tayside which lead to the independent inquiry. The following five principles guided the remit of the independent inquiry:

(i) Inquiry to be truly independent – Dr Strang was interviewed for the position of Chair by the stakeholder participation group, convened by the Health and Social Care Alliance. This group was made up of patients, carers and staff.
(ii) Open and Transparent – Regular updates of the Inquiry provided on website.
(iii) Include and involve staff from NHS, partner organisations and third sector organisations. Participation group formed which conducted a survey, providing vital evidence for the inquiry.
(iv) Involve patients, families and carers who were met with regularly over the period of the inquiry.
(v) Include a public call for evidence in the inquiry - 1,300 respondents over a wide range of different groups.

An interim report had been published in May 2019 entitled Inquiry Update and Emergent Key Themes. It was noted that the identified themes would enable the Inquiry to focus on next steps, drawing firm conclusions and making specific recommendations in due course.

Areas of concern that were raised through the findings of the inquiry were highlighted as follows:

- Recognition that significant change is needed and can only be achieved through strong leadership and clarity of responsibility and direction. Implementation Plan to be drafted.
- Fundamental redesign required for the needs of Community/Patients.
- The importance of the level of trust and continuity of staff to provide high level quality services.
- Clear communication between Perth and Kinross Council and NHS Tayside on the quality of mental health services provided to patients.
- More focus on community services required.

In response to a question from Councillor Drysdale on whether it was being recommended that the current service redesign programme should be stopped, D Strang suggested that there should be a strategic redesign review.

In response to a question from Councillor McDade on the urgency that was highlighted at the time of the original decision in 2018 to commence with the service redesign programme, D Strang commented on the need for a wide review and major organisational change within this one area.

The Board noted the position and thanked D Strang for his attendance.

H DOUGALL LEFT THE MEETING DURING THE ABOVE ITEM.

DR D STRANG LEFT THE MEETING AT THIS POINT.

THERE FOLLOWED A RECESS AND THE MEETING RECONVENED AT 12.05PM.

3.2 ADULT MENTAL HEALTH AND LEARNING DISABILITY, SERVICE REDESIGN PROGRAMME PROGRESS REPORT AND RISK REVIEW PAPER

There was submitted a report by the Chief Officer/Director of Integrated Health and Social Care (G/19/159) updating on progress with the Mental Health and Learning Disability Service Redesign Programme.

In response to a question from K Reid regarding other Integration Joint Boards across Tayside and what they are doing in terms of strategic planning which could have an impact on Perth and Kinross, G Paterson advised that each of the Integration Joint Boards and Health and Social Care Partnerships across Tayside are committed to developing a local strategy which shows that sufficient provision is made to provide high quality mental health services to their local areas. Each area have considered the implications of the re-design programme and are working to ensure that local strategies are aligned with the strategic planning and commissioning activity of the Perth and Kinross IJB in relation to mental health services.

P Kilpatrick added that the Dundee Mental Health and Wellbeing Strategic Commissioning Plan is a positive piece of work which focuses on social prescribing and prevention, highlighting that a strategy is in place to cope with community mental health. G Paterson advised that a similar strategy is being developed in Perth and Kinross and would be brought to the next IJB meeting.

In response to a question from Councillor Drysdale regarding the role of the Mental Health Alliance in terms of the role of the IJB, G Paterson advised that it is important for these roles to be clarified. The Alliance is to act as an enabler across Tayside to develop service changes, redesign patient pathways and provide support to the partnership.

In relation to sections 3.1 and 3.4 of the report, A Drummond requested that it be noted that concerns were raised on behalf of staff at the time at the proposed arrangements for the relocation of staff and that it was the staff side area partnership that were not supportive of the proposals.

S HOPE AND S AULD LEFT THE MEETING AT THIS POINT.

Motion (Councillor X McDade and Councillor C Purves)

- Note the significant clinical and operational risks that the services are currently experiencing and the impact on patient safety and quality of care but consider that many of these remain regardless of the progression of the redesign;
- Further note significant delays to parts of the redesign programme that have resulted in measures that were previously suggested to be critical not being fully implemented 21 months after the programme was first agreed;
- Consider the fact that a recommendation has been made by The *Independent Inquiry into Mental Health Services in Tayside* in its interim report in advance of the final report to be significant;
- Agree that there is a clear case for a 'comprehensive review of the mental health strategy rather than simply undertaking a move of beds and sites' in order to ensure that permanent changes are not made prematurely;
- Therefore, does not endorse the continued implementation of the MHLDSRP at this time and instead agree that the redesign programme be paused until such a time as a review of the mental health strategy has been completed;
- Agree that this review should not be led by the Tayside Mental Health Alliance, any Tayside IJB, NHS Tayside or any Tayside council but should be led independently by an individual/organisation agreed by the IJB;
- Agree that this independent review should focus on existing and required community mental health infrastructure across Tayside before determining any requirements for and changes to beds and sites;
- Agree the pause does not prevent any necessary temporary actions to ensure inpatient requirements are met and environmental improvements, including anti-ligature measures, should continue to be undertaken meantime; and
- Instructs the Chief Officer to issue any necessary directions to NHS Tayside to give effect to this motion and asks him to report back to the IJB with progress on the establishment of an independent review at the earliest opportunity.

THERE FOLLOWED A RECESS AND THE MEETING RECONVENED AT 2.33PM.

Following advice from officers, Councillor McDade and Councillor Purves agreed to revise their Motion as follows:

Perth and Kinross IJB are asked to:

(i) Consider the content of this report and provide constructive comment.

(ii) Note the significant clinical and operational risks that the services are currently experiencing and the impact on patient safety and quality of care.
(iii) Agree our full commitment to a full review of end-to-end mental health services across Tayside and endorse our participation in such a review.
(iv) Agree the continued implementation of the approved MHLDSRP to secure current patient safety and quality of care insofar as the implementation of any changes does not prejudice the outcome of such a holistic transformation review of mental health services.
(v) Ask the chief officer to prepare a revised programme plan with key milestones and a timeline.
(vi) Commit the chief officer to provide regular reports on progress, risk and delivery of the MHLDSRP
(vii) Commit the Tayside Mental Health Alliance to provide regular update reports on their ongoing work to support the IJB in shaping their strategic outcomes for the service.

P Kilpatrick proposed an amendment to agree the recommendations as set out in Report G/19/159.

THERE FOLLOWED A RECESS AND THE MEETING RECONVENED AT 2.44PM.

Following advice from officers, P Kilpatrick withdrew the amendment.

Following suggestions by both P Kilpatrick and Councillor Drysdale, Councillor McDade and Councillor Purves agreed to further amend the revised motion.

Resolved:
(i) The contents of Report G/19/159 be noted.
(ii) The significant clinical and operational risks which services are currently experiencing and the impact on patient safety and the quality of care be noted.
(iii) The Perth and Kinross IJB's full commitment and participation in on-going and end to end transformation of mental health services in Tayside be agreed.
(iv) The continued implementation of the approved MHLDSRP to secure current patient safety and quality of care insofar as the implementation of any changes does not prejudice the outcome of such a holistic transformation review of mental health services be agreed.
(v) The Chief Officer to prepare a revised programme plan with key milestones and a timeline.
(vi) As a standing item for future IJB meetings, the Chief Officer be committed to provide an update on progress, risk and delivery of the MHLDSRP.
(vii) As a standing item for future IJB meetings, the Tayside Mental Health Alliance be requested to provide an update on their ongoing work to support the IJB in shaping their strategic outcomes for the service.

COUNCILLOR MCDADE LEFT THE MEETING AT THIS POINT.

4. FINANCE AND GOVERNANCE

IT WAS AGREED TO VARY THE ORDER OF BUSINESS AT THIS POINT

4.2 ANNUAL ACCOUNTS 2018/19

There was submitted a report by the Chief Financial Officer (G/19/161) presenting the IJB's Audited Annual Accounts for the period to 31 March 2019.

Resolved:

(i) It be noted that the Audit and Performance Committee have considered the Audited Annual Accounts, the Letter of Representation and KPMG's Annual Audit Report on 16 September 2019.

(ii) The contents of KPMG's Annual Audit Report to Members of the Perth and Kinross IJB and the Controller of Audit on the 2018/19 Audit be noted.

(iii) The Audited Annual Accounts for 2018/19 be approved.

(iv) The Letter of Representation be approved for signature by the Chief Financial Officer.

THERE FOLLOWED A RECESS AND THE MEETING RECONVENED AT 3.10PM

3.3 THE MENTAL HEALTH ALLIANCE

The Chief Officer provided a verbal update on the Mental Health Alliance which is formed of representation from the three Health and Social Care partnerships, NHS Staff and representation from third sector and advocacy organisations. The aim is to work collaboratively with partners of the alliance who are responsible for the planning, commissioning and delivery of mental health services across Tayside and by recognising current challenges to then develop a three year strategy on mental health, care and treatment. Health and Social Care standards will be core to the work of the Mental Health Alliance which will enhance innovation and flexibility. The Chief Officer advised the Board that the Memorandum of Understanding for the Mental Health Alliance would be brought to the next meeting of the IJB for approval.

B Benson and M Summers highlighted the importance of having representation from service users and carers on the Mental Health Alliance. On behalf of the third sector, S Watts raised concerns over the confusion of membership on the mental health alliance, if the member should be representing as an advocacy member or as an IJB member. She added that it is crucial for the third sector to have significant representation on the alliance for effective design of services.

G Paterson advised that work was underway to enhance the membership of the Alliance by making sure that partners voices can be easily heard and to look at how the alliance can support the work of the partnership. He added that discussions are being held with the Third Sector Forum regarding their role on the Alliance and emphasised how important their contribution is to the enhancing the quality of Mental Health Services. G Paterson stated that there is a commitment to ensure that the Mental Health Alliance has adequate representation.

The Board noted the position.

3.4 INPATIENT MENTAL HEALTH BUDGET 2019/20; 2021/22

K REID LEFT THE MEETING DURING THIS ITEM.

There was submitted a report by the Chief Financial Officer (G/19/160) recommending setting the 2019/20 budget for Inpatient Mental Health Services.

The Chief Financial Officer advised the Board of revised figures in relation to the number of savings in Appendix 2 of Report (G/19/160) as follows:

- Temporary merger GAP Rehabilitation Wards Murray Royal Hospital (MRH) Workforce redesign (No.4) – £300,000 to **£204,000**.
- General Adult Psychiatry Acute Admissions Moredun Ward (No.7) -£203,000 to **£107,000**.

Resolved:

(i) The 2019/20 Financial Plan for Inpatient Mental Health Services be approved and the budget be set thereon noting the gap of £1.713m which remains.
(ii) The Chief Officer to work with NHS Tayside to identify an action plan for reducing medical locum costs.
(iii) The Chief Officer to issue the necessary Direction to NHS Tayside to implement the actions within the 2019/20 Financial plan.
(iv) It be noted that the formal budget deficit for the IJB for 2019/20 is now £4.168m.

5. MINUTE OF MEETING OF THE PERTH AND KINROSS INTEGRATION JOINT BOARD OF 26 JUNE 2019

The minute of meeting of the Perth and Kinross Integration Joint Board of 26 June 2019 was submitted and approved as a correct record.

6. ACTION POINTS UPDATE

There was submitted and noted the action point update for the Perth and Kinross IJB as at 27 September 2019.

7. MATTERS ARISING

Strategic Commissioning Plan (item 8.1 refers)

The Chief Officer advised the Board that there is now a draft version of the Strategic Commissioning Plan complete. He advised that the aim is circulate the plan to IJB members for comment before the development session on 23 October 2019.

9. MEMBERSHIP UPDATE

There was a verbal report by the Clerk to the Board updating the Board on the membership of both voting and non-voting members of the Board.

Resolved:

(i) It be noted that Councillor Stewart had been appointed as Chair of the Integration Joint Board from 4 October 2019.

(ii) It be noted that Mr B Benson had been nominated as Vice-Chair of the Integration Joint Board which would be ratified by NHS Tayside Board on 31 October 2019.

(iii) It be noted that Dr N Pratt would be appointed as an NHS Tayside voting member on the Board.

(iv) It be noted that Ms J Alexander would replace Ms L Birse-Stewart as an NHS Tayside voting member from 1 October 2019.

(v) It be agreed that Ms S Gourlay replace Ms S Dickie as the nurse representative on the Integration Joint Board.

(vi) Following discussion at the Third Sector Health and Social Care Strategic Forum, it be agreed that the Third Sector representative on the Integration Joint Board be Ms S Watts, with Ms C Gallagher as the substitute member. These appointments be until 31 December 2019 with a further election process to take place in early 2020.

(vii) It be agreed that Ms L Blair, Independent Sector Lead with Scottish Care for Perth and Kinross be appointed as an additional non-voting member of the Integration Joint Board initially for one year.

4.1 AUDIT AND PERFORMANCE COMMITTEE UPDATE

Verbal Update by Chair of Audit and Performance Committee

Councillor Purves, Chair of the Audit and Performance Committee, provided the board with an update from the recent meeting of the Audit and Performance Committee that had taken place on 16 September 2019.

Audit and Performance Committee of the Perth and Kinross Integration Joint Board - 16 September 2019

The Board noted the position.

8.1 2019/20 FINANCIAL POSITION

K REID RETURNED TO THE MEETING DURING THIS ITEM. COUNCILLOR PURVES, J ALEXANDER AND A DRUMMOND LEFT THE MEETING DURING CONSIDERATION OF THIS ITEM.

There was submitted a report by Chief Financial Officer (G/19/163) providing an update to the Perth and Kinross Integration Joint Board on the year end financial forecast based on actual expenditure for the 4 months to 31 July 2019.

In response to a question from B Benson regarding the significant deterioration of the forecast position from July 2019, J Smith advised that this had been due to a number of unanticipated pressures relating to older people services such as care home placements and the level of significant demand of inpatient beds in Tay Ward, PRI and psychiatry of old age.

In response to a question from S Gourlay regarding timescales of a workforce plan and how this is being developed across the partnership, G Paterson emphasised the issue of staffing and how crucial it is for the challenges to be addressed, especially in regards to the psychiatric workforce. The Scottish Government have requested a workforce plan be submitted by the 31 March 2020. G Paterson advised that work is underway to look at succession planning under the care sector and how staff can be used differently in general roles. There will be an update on progress of the plan to the IJB in early 2020.

Resolved:

(i) The 2019/20 forecast year end overspend of 4,860m for the IJB be noted.

(ii) It be noted that this compares to a gap anticipated based on the Financial Plan approved by the IJB, adjusted for IPMH Services, of £4,104m.

(iii) The updated position regarding IJB reserves as set out in the report be noted.

8.2 2019/20 FINANCIAL RECOVERY PLAN

There was submitted a report by the Chief Financial Officer (G/19/164) seeking approval from the Integration Joint Board to actions discussed with both NHS Tayside and Perth and Kinross Council to respond to the £4.1m gap in the IJB's 2019/20 Financial Plan as well as the further additional pressures that have emerged in the first 4 months of the 2019/20 Financial Year.

J Smith highlighted an error in sections 2 and 6 of the report. The final paragraph of section 2 should read that the financial recovery review plans have been discussed with both the NHS Tayside and Perth and Kinross Council Chief Executives. The second sentence of section 6 of the report should read that the actions set out have been discussed with the Executive Teams of both NHS Tayside and Perth and Kinross Council.

In response to a question from J Pepper, regarding the Alcohol and Drug Partnership and what consultation had taken place with the Children, Young People and Families Partnership as, J Smith advised there has been engagement with the Chair of the partnership, however specific discussion with the Council's Children's Services would need to be clarified. J Pepper stressed the importance of this as pressures and demands are rising on the child protection system, with substance misuse being a key factor.

Resolved:

(i) The actions identified in the report to address the forecast in-year deficit be agreed;

(ii) The Chief Officer to bring back further proposals to the next meeting as part of a report regarding the financial position update.

J SMITH, P KILPATRICK AND J PEPPER LEFT THE MEETING AT THIS POINT.

10. CHIEF OFFICER UPDATES

10.1 BRIDGE OF EARN GP PRACTICE

There was submitted a report by the Chief Officer/Director of Integrated Health and Social Care (G/19/165) providing IJB members with information on the background to the closure of Bridge of Earn GP practice and the actions that the Health and Social Care Partnership, NHS Tayside and Perth and Kinross Council have taken in response.

Resolved:

(i) The contents of report G/19/165 be noted.
(ii) The current situation regarding the closure of the Bridge of Earn GP Practice as outlined in the report be noted;
(iii) The proposed strategic approach set out in the report to encourage the re-introduction of Primary Medical Services for Bridge of Earn patients be agreed;
(iv) The Chief Officer to work with partners to implement the necessary operational arrangements to ensure the delivery of the relevant services in Bridge of Earn.

10.2 JOINT INSPECTION OF THE EFFECTIVENESS OF STRATEGIC PLANNING IN PERTH AND KINROSS HEALTH AND SOCIAL CARE PARTNERSHIP

There was submitted a report by Chief Officer/Director of Integrated Health and Social Care (G/19/166) providing IJB members with information on the Joint Inspection of the HSCP carried out by Healthcare Improvement Scotland and the Care Inspectorate and their final report which was published on the 23 September 2019; and (2) outlining the context, findings and recommendations and providing details of the action plan that the Partnership has begun work on in response.

Dr N Pratt and Councillor E Drysdale praised the partnership for their efforts and stated how encouraging it is to see the work of the partnership moving in a positive direction. In response to a question from Councillor Drysdale, regarding concerns over the collation and use of data (paragraph 3.4) and if funding had been made available for staff regarding the data collection process, K Reid advised that work on data analysis is currently underway across the Council. This would create better performance management information. K Reid added that the Council are currently waiting on correspondence from NHS Tayside on match funding.

Resolved:

(i) The report on the Joint Inspection (G/19/166) be noted.
(ii) The detailed findings in the full Joint Inspection Report be noted.
(iii) The Chief Officer to produce a comprehensive improvement plan to address the areas for improvement outlined within the Joint Inspection Report and report back to the Board on early progress at the IJB Meeting on 11 December 2019.

11. FOR INFORMATION

11.1 ANNUAL PERFORMANCE REPORT FOR 2018/19

There was submitted and noted the report (G/19/167) for information.

12. FUTURE IJB MEETING/DEVELOPMENT SESSION DATES 2019

Wednesday 6 November 2019 at 9.30am (Agreed Additional Meeting)
Wednesday 11 December 2019 at 2.00pm
Wednesday 23 October 2019 at 2.00pm (Development Session)

G/19/172

ACTION POINTS UPDATE

Perth & Kinross Integration Joint Board
06 November 2019

	Meeting	Minute Ref	Heading	Action Point	Responsibility	Timescale	Status
104 b	28 Sept 2018	6.2	Perth & Kinross Joint Strategy to Support Independent Living	Progress report to be submitted	D Fraser	11 Dec 2019	
111	01 May 2019	8.2	Chief Officer Strategic Update	Frank's Law report to be submitted at future IJB meeting to include Financial Impact.	G Paterson	11 Dec 2019	
115	01 May 2019	9.1	Tayside Primary Care Improvement Plan – Implementation Update Report	Progress report to be provided in 12 months.	H Dougall	24 June 2020	
116	01 May 2019		Additional Request received	Care Home Market Provision and Capacity – report to be submitted at future IJB meeting.	D Fraser	11 Dec 2019	Deferred from 27 Sept 2019
118	26 June 2019	9.1	P&K Alcohol & Drug Partnership	Update to be provided including framework and data in 6-9 months time.	C Mailer	29 April 2020	
119	27 Sept 2019	3.2	Adult MH&LD Service Redesign Progress Report and Risk Review Paper	Regular reports to be provided on progress, risk and delivery of MHLDSRP.	Chief Officer/A Wood	11 Dec 2019	
120	27 Sept 2019	3.2	Mental Health Alliance	To present MOU and provide regular updates on the ongoing work to support IJB in shaping the strategic outcomes for the service.	Chief Officer	11 Dec 2019	

ACTION POINTS UPDATE

Perth & Kinross Integration Joint Board
06 November 2019

	Meeting	Minute Ref	Heading	Action Point	Responsibility	Timescale	Status
121	27 Sept 2019	3.2	Adult MH&LD Service Redesign Progress Report and Risk Review Paper	Detailed timeline to be provided re redesign programme and improvement work undertaken in Mental Health Wards since 2015.	Keith Russell	11 Dec 2019	
122	27 Sept 2019	10.1	Bridge of Earn Practice	Assess impact and provide update report.	Chief Officer	23 Sept 2020	

PERTH & KINROSS INTEGRATION JOINT BOARD

06 NOVEMBER 2019

2019/20 FINANCIAL POSITION

Report by the Chief Financial Officer (Report No. G/19/173)

PURPOSE OF REPORT

This report is to update Perth & Kinross Integration Joint Board (IJB) on the year end financial forecast based on actual expenditure for the 6 months to 30th September 2019 and to identify risks which may impact on the financial forecast in future months.

1. RECOMMENDATION(S)

It is recommended that the IJB:-

(i) Notes the 2019/20 forecast year-end overspend of £4.4m for the IJB;

(ii) Notes that £1.1m of the £1.3m Financial Recovery Plan Actions approved by the IJB have been approved by Perth & Kinross Council, but are still under discussion with NHS Tayside. Application of these actions would reduce the forecast to £3.3m;

(iii) Notes the risks which may impact on the financial position in future months;

(iv) Notes the work underway to develop a 3 Year Financial Plan across all services. This includes longer term service change to address financial sustainability.

2. OVERVIEW

OVERALL

Based on actual expenditure to 30 September 2019, Perth & Kinross IJB is forecasting an overspend of £4.4m. This is largely driven by the £4.1m 2019/20 formal budget deficit. Whilst there are areas of unanticipated demand across core services, these are being significantly offset by over recovery of income, vacancies, slippage in investment plans, and an improved position on GP Prescribing. Full implementation of £1.1m 2019/20 Financial Recovery

Plan actions approved by PKC would reduce the overspend to £3.3m. Feedback is awaited from NHS Tayside and therefore the forecast has not been formally adjusted at this stage. PKHSCP continue to identify all possible further actions to reduce costs in year. However the 3 Year Financial Planning process now underway provides the mechanism to set out, consult and engage on longer term service changes that will be required to deliver future financial balance.

KEY ISSUES

A break down of the £4.4m year end forecast is provided in Table 1 below:-

TABLE 1 YEAR END FORECAST

	Forecast Over/(Under Spend)	
	£m	
2019/20 Budget Deficit	4.1	2019/20 Financial Plan Budget deficit approved by the IJB
Core Health & Social Care Services	0.5	Driven primarily by nursing costs across Inpatient Services, demand for Care Home Placements including interim care, increased complex care packages and a shortfall in savings against trajectory. Offset by increased social care income, slippage in investments, vacancies and other one off benefits.
Prescribing	(0.4)	Item and price growth lower than plan.
General Medical Services/Family Health Services	0.1	Cost of 2C practices across Tayside spread across all 3 HSCP's.
Inpatient Mental Health (PKIJB share)	0.2	Increased pay costs.
Other Hosted Services (PKIJB share)	(0.1)	Delays in recruitment
Total Forecast Overspend	**4.4**	

Movement from last report: the Finance Report to the IJB in September 2019 forecast an overspend of £4.8m.This updated position represents an improvement of £0.4m.

Financial Recovery Plan: the Financial Recovery Plan approved by the IJB at its September 2019 meeting, identified up to £1.3m of proposed recovery actions. PKC have confirmed approval to £1.1m of proposed actions. However NHS Tayside have yet to confirm the outcome of their review. Therefore the year end forecast has not yet been adjusted. If implemented, these could reduce the forecast overspend to £3.3m.

Financial Risk Sharing Arrangements-: based on 2018/19 risk sharing arrangements, Perth & Kinross Council's share of forecast overspend after implementation of £1.1m Financial Recovery Plan actions would be £2.1m and NHS Tayside £1.2m. Discussions on 2019/20 risk sharing arrangements are ongoing between Perth & Kinross Council and NHS Tayside.

Reserves: PKIJB carried forward £2.5m of earmarked reserves from 2018/19 to meet specific spending commitments in 2019/20. It carried forward no under marked reserves. For 2019/20 a further carry forward of earmarked reserves is anticipated in relation to the Primary Care Improvement Fund, Mental Health Action 15 and Alcohol and Drugs Funding. Updates will be provided in future months.

3 Year Financial Plan 2020-23: A robust 3 Year plan is being developed across all services. A first draft is due to be completed by early November for early discussion with NHS Tayside and Perth & Kinross Council Executive Management Teams.

3. SERVICE FINANCIAL PERFORMANCE

3.1 Core Health & Social Care Services

The key issues impacting on the forecast position for Core Health & Social Care Services are summarised in the Table 2 below.

TABLE 2 FORECAST CORE HEALTH & SOCIAL CARE SERVICES

	Forecast Over/(Under Spend)		
	£m	£m	£m
	Health	Social Care	Total
Nursing overspend across POA/MFE/Community Hospital Inpatient Beds	0.7		0.7
Care Home Placements/Internal Care Home Provision		0.9	0.9
Step Up/Interim beds		0.2	0.2
Savings plans behind trajectory	0.2	0.5	0.7
Learning Disability/Mental Health Complex Care Packages	0.4	0.2	0.6
Income from charging		(0.3)	(0.3)
Underspend on ring fenced investments	(0.5)	(0.5)	(1.0)
Other	(0.6)	(0.7)	(1.3)
Total Forecast Overspend	**0.2**	**0.3**	**0.5**

The £0.5m forecast overspend compares to £0.7m forecast in the last IJB report. Key variances are explained below:-

Nursing Staffing across Inpatient Services: overall a net overspend of £0.7m is forecast across core health bed based services.

Medicine for the Elderly (Tay and Stroke wards) are forecasting a £0.2m overspend. This is due to increased bed numbers above budget and supplementary staffing costs to cover vacancies.

Psychiatry of Old Age (POA) Wards are forecasting a £0.4m overspend. Costs from increased staffing and supplementary staffing are being incurred, due to vacancies and an increase in acuity and dependency levels.

This is being offset by an underspend (£0.2m) within POA Community Mental Health Teams, driven by vacancies.

The Financial Recovery Plan outlines plans to mitigate the increased requirement for nursing staff within POA wards. This is not yet built into the year end forecast.

Community Hospitals are forecasting a £0.3m overspend due to incremental drift, supplementary staffing costs driven by sickness, vacancies and over-establishment within the previous Aberfeldy Community Hospital. Overall the Inpatient Services forecast overspend is £0.1m less than previously reported.

Care Home Placements/ Internal care Home Provision: overall an overspend of £0.9m is forecast for care home provision. External Older People Residential and Nursing Care Homes are forecasting a £0.7m over spend, due to higher than anticipated demand. Internal care Homes are forecasting a £0.2m overspend due to higher than anticipated costs (staffing and supplies) and lower than anticipated income due to a change in the financial profile of residents. Overall the forecast is £0.1m more than previously reported.

Step Up/Interim Beds: An overspend of £0.2m is forecast from the use of step up beds in care homes, for which where there is no budget.

Care at Home - Overall the Care at Home forecast is projecting a breakeven position, this is £0.1m better than last forecast. The financial recovery plan anticipates a further improvement in the Care at Home position.

Delivery of approved savings: A shortfall on savings delivery of £0.6m is now forecast. This is a deterioration of £0.1m from last month. This shortfall is due to slippage in implementation within 4 areas:

- The transformation of Fairer/Better Futures for People with Learning Disabilities and Autism
- IT Efficiencies/Productivity
- Integration of Workforce
- Unmet savings in 2018/19 from OT Integration have carried forward and remain undelivered.

Learning Disability & Mental Health Complex Care Packages: Overall an overspend of £0.6m is forecast. This is due to new service users and current user's costs increasing and an increase in the cost of external transport**.** This is broadly in line with last month.

Income from charging: A £0.3m surplus is anticipated from an over-recovery of income**.** This is broadly in line with last month.

Slippage on ring fenced investments: Slippage in use of ringfenced investment is forecast at £0.9m The main areas of slippage relate to:

- the delay in implementation of Enhanced Community Support and the Respiratory Service (£0.3m).
- the less than budgeted expenditure in year for Free Personal Care for under 65's (£0.4m).

Slippage on investments has reduced by £0.3m from the last report. This movement is mainly due to a forecast expenditure increase in Free Personal Care for under 65's.

Other: In year opportunities, identified in the first quarter of 2019/20, are benefiting the financial position. These opportunities were identified as part of initial financial recovery management. In addition there is a level of unplanned vacancies across a number of services.

3.2 Prescribing

The 2019/20 Financial Plan assumed item growth of 1.7% and price growth of 3%. Actual item and price growth for the first quarter is lower than plan resulting in an underspend of £0.3m. This is an improvement of £0.4m from the last report to the IJB.

3.3 General Medical Services and Family Health Services

A forecast overspend of £0.1m is reported being Perth & Kinross IJB's share of 2C GP Practices across Tayside (including one –off Bridge of Earn dispersal costs).

3.4 Other Hosted Services

Overall an underspend of £0.1m is forecast for Perth & Kinross IJB's share of other Hosted Services across Tayside, including those hosted by Perth & Kinross IJB.

3.5 Inpatient Mental Health Services

The service is forecasting an overspend of £2.1m, a deterioration of £0.5m from the gap identified in the approved 2019/20 Financial Plan. Perth & Kinross IJB's share of this variance is £0.2m. The movement broadly arises from unanticipated superannuation costs and pay awards for Medical Staffing.

4. AREAS OF FURTHER FINANCIAL RISK

The degree of certainty around risks increases as the year progresses. However there are a number of key factors that remain uncertain:-

- Prescribing Price fluctuations: an increase in price growth by 0.5% would lead to an increase in costs of £0.2m
- Inpatient Mental Health Medical Locum Costs to respond to service: an additional 1 WTE Medical Locum would cost up to £0.3m.
- Learning Disability Complex Care Packages: Continued uncertainty around client numbers and package costs. The average cost of a Learning Disability complex care package in the year to date is £0.05m however the highest individual package is over £0.3m.
- Capacity Issues across PRI and protection of elective capacity, leading to opening further PKHSCP Medicine for Elderly beds at agency nursing rates.

5. SUMMARY

The forecast overspend of £4.4m is largely driven by the £4.1m 2019/20 formal budget deficit. Whilst there are areas of unanticipated demand across core services, these are being significantly offset by over recovery of income, vacancies, slippage in investment plans, and an improved position on GP Prescribing. Full implementation of the £1.1m 2019/20 Financial Recovery Plan actions approved by PKC would reduce the overspend to £3.3m. PKHSCP continue to identify all possible further actions to reduce costs in year. However the 3 Year Financial Planning process now underway provides the mechanism to set out, consult and engage on longer term service changes that will be required to deliver future financial balance.

PERTH AND KINROSS INTEGRATED JOINT BOARD

6 November 2019

CHIEF OFFICER STRATEGIC UPDATE

Report by Chief Officer/Director - Integrated Health & Social Care
(Report No. G/19/176)

PURPOSE OF REPORT

This report provides the Perth and Kinross Integration Joint Board with an update from the Chief Officer on progress with several key developments, more details on which will be provided in full reports at the next meeting of the IJB.

1. RECOMMENDATION

It is recommended that Members of the Integration Joint Board note the following updates and commit the Chief Officer to provide further reports, in due course, in relation to the matters covered.

2. STRATEGIC COMMISSIONING PLAN

The latest version of the draft Strategic Commissioning Plan was considered by members of the IJB at a development session on the 23rd October. This provided the opportunity for IJB Members to convey their views on how the draft plan might be further developed, with helpful comments regarding;

- the need to produce a shorter plan, with less contextual and background information, thus bringing the key strategic priorities to the fore.

- the importance of ensuring that the strategic priorities and shifts were at a high enough level, distinguishing these from operational delivery priorities.

- the potential to present a stronger public health focus throughout the key actions, reflecting the strategic ambition to support people to remain well, to tackle inequalities and to shift the balance of care towards preventative, community services and supports.

- the recognition that hosted services are Tayside-wide and that the data in relation to Perth and Kinross does not adequately represent the challenges and priorities of these services, to the extent that hosted services should perhaps be dealt with separately.

- the need to be clearer about what difference the plan and the actions falling from it will mean in terms of people's outcomes.

These factors will be taken into account as we develop the final draft Strategic Commissioning Plan, which we will present to the December meeting of the Integration Joint Board.

3. JOINT INSPECTION

An Action Plan is currently being developed in response to the recommendations in the joint inspection report. We are bringing together the key findings from the inspection, the annual governance review and the Ministerial Strategic Group Self-Evaluation, along with the relevant findings from the interim report of the Independent Inquiry into Mental Health services, into a Corporate Improvement Plan. This will consolidate and rationalise a number of improvement actions into a single framework and will assign responsibility, identify milestones and measure progress.

The Corporate Improvement Plan will be presented to the next meeting of the IJB.

4. MENTAL HEALTH ALLIANCE

Given the specific strategic responsibilities of the Perth and Kinross IJB for hosted inpatient mental health services and in light of comments received at the September IJB, we have further reviewed the Mental Health Alliance's Memorandum of Understanding. To ensure that this accurately represents the accountabilities of the different boards and to support and ensure effective governance Perth and Kinross HSCP will be proposing some amendments to how the MOU is currently framed. Given the MOU supports partnership working by the three HSCPs and the NHS any revisions will require to be agreed by all parties.

Despite this, we are committed to supporting and contributing to the work of the Mental Health Alliance as it considers improvements to end-to-end patient pathways and supports the development of a Tayside-wide Mental Health Strategy. To achieve this the Alliance has begun to progress work across a number of workstreams and priorities, including:

- Community Mental Health, Crisis Care and Home Treatment Design group
- Emotionally Unstable Personality Disorder Pathway Implementation Group
- Learning Disability design group
- Workforce Design Group

- Rehabilitation Design Group
- MHLD Redesign Programme

As requested at the IJB in September, the Chief Officer will bring regular updates on the work of the Mental Health Alliance to future IJB meetings.

Author(s)

Name	Designation	Contact Details
Gordon Paterson	Chief Officer/Director - Integrated Health & Social Care	g.paterson2@nhs.net

NOTE: No background papers, as defined by Section 50D of the Local Government (Scotland) Act 1973 (other than any containing confidential or exempt information), were relied on to any material extent in preparing this report.

Perth & Kinross Integration Joint Board

6 November 2019

Carers and Young Carers Strategy for 2019-2022

Report by Head of Adult Social Work and Social Care (Report No. G/19/174)

PURPOSE OF REPORT

This report presents the Carers and Young Carers Strategy 2019-2022 (Appendix 1), as required by the Carers (Scotland) Act 2016, for consideration and direction by the Integration Joint Board.

The strategy is also being presented to Lifelong Learning Committee of Perth and Kinross Council for their consideration.

1. RECOMMENDATIONS

It is recommended that the Integration Joint Board:

- Consider, direct and approve the Strategy to further improve outcomes for carers living and caring in Perth & Kinross;
- Commit the Chief Officer to provide annual reports providing updates on performance on on progress in delivering the Action Plan.

2. BACKGROUND

2.1 Introduction

Unpaid carers make a vital contribution to the lives of the people they support and the communities they live in. This contribution is often overlooked or taken for granted, particularly as unpaid carers often do not identify, or recognise themselves as being carers. Carers often take on an informal caring role to support someone, a family member, friend or neighbour, due to disability, illness, age frailty, mental health or substance misuse. Carers can be of any age, providing support in a wide range of ways from practical support like shopping and household chores, to helping with medication or personal care. Many carers report on the positive and rewarding aspects of

their role and how it brings a family closer together. However, in undertaking a caring role, carers assume responsibility for the care of someone else, through compassion and selflessness, often at a cost to their own health and wellbeing.

For adult carers the impact of caring may include needing to reduce hours at work or ending employment leading to a loss of income, at the same time as financial pressures increase. Carers may experience an increase in isolation, loss of sleep and the resulting effect on health, a sense of guilt and the change in the dynamic of the relationship with the person being cared for. For young carers, caring can affect their childhood, making friends, and having similar opportunities as their peers. Their attendance at school, attainment and social development can be impacted, which can lead to experiences of isolation and bullying.

Perth and Kinross Health and Social Care Partnership's commitment to unpaid carers is demonstrated through the work of the Carers Strategy Group, which is to addressing the requirements of the relevant legislation, working collaboratively with carers and ensuring that carers are supported consistently, enabling them to sustain their caring roles for as long as they are willing and able. To this end, we worked with unpaid carers as equal partners in developing the commitments and the action plan in this Carers and Young Carers Strategy.

The Carers (Scotland) Act 2016 ('the Act'), which came into force in April 2018, gave the Health and Social Care Partnership and Perth and Kinross Council new responsibilities for supporting Young and Adult Carers.

These include:

- Development and publishing Eligibility Criteria Frameworks for young and adult carers, so that carers are supported on a consistent and transparent basis;
- Development of a Short Breaks Services Statement to enable carers to find out what services and supports are available to give them a break from their caring role;
- Giving carers, by offer or on request, either a Young Carer Statement or Adult Carer Support Plan, as applicable.
- Ensuring that carers services and hospital discharge planning has involvement of carers.
- Development of a Carers Strategy, making clear future plans to support carers, following consultation with carers.

The responsibility to offer carers an Adult Carer Support Plan lies with Perth and Kinross Council when the 'cared-for' person lives within Perth and Kinross, even if the carer lives outside of this area. The opposite is true for young carers, with Perth and Kinross Council generally being responsible for young carers living in our area, even if the person they care for lives outside this area. Where a carer cares for different people living across local authority areas, local authorities are advised to work together to support the carer.

Since the implementation of this legislation, Perth and Kinross HSCP has been effective in fulfilling the requirements in the timeframe required by the Act. The Strategy attached is the latest of these required changes.

2.2 **Strategy Consultation**

Unpaid carers have been involved as equal partners throughout the development of this strategy, from developing the initial consultation survey, to the development of the commitments of the strategy underpinning the action plan.

The development of this strategy included a robust engagement and consultation process with young and adult carers, their families and the professionals who support them. Throughout the lifespan of this strategy, we have also had the involvement and input of:

- Unpaid carers of all ages, including Carer Voice representatives and Carer Public Partners.
- Carers and representatives from the HSCP who sit on the Carer Programme Board and the Carer Strategy Steering Group.
- Education and Children Services.
- Advice given by Legal and Equalities.
- Voluntary sector partners, including PKAVS, MECOPP, and Support in Mind.

The initial consultation took place for three weeks from 1 October 2018 and 324 responses were received through social media, emails, post, focus groups, consultation stalls and drop-in events. We received feedback from carers in different localities across Perth and Kinross. This was the most successful consultation of the views of carers undertaken in this area. Responses included the views of carers and their families from various backgrounds, cultures and community groups, such as gypsy/traveller carers, carers of people with drug and alcohol use issues, and ethnic minority carers.

We received a further 35 responses to a follow-up consultation survey at the Carers Conference in November 2018, which asked carers what they felt were important to them based on the key themes arising from the feedback to the first survey. The seven strategic outcomes of the strategy are our response to the consultation feedback, to which carers had told us what mattered most to them.

In December 2018, we held a workshop with carers and professionals from both the public and voluntary sectors who support carers to develop the six commitments, based on the EPiC (Equal Partners in Care) Principles.

The strategy has had continued input from carers and carer representatives from December 2018 to present, in reaching the final draft.

2.3 **Strategic Outcomes**

Our vision in Perth & Kinross is that carers are supported throughout their caring life. This includes firstly, carers recognising their caregiving role, so that they are aware of the information, advice and support available. Secondly, this involves ensuring that carers continue to be respected, and involved as equal partners in shaping and developing support that that would reduce the impact that caring has on different areas of their lives, including their health and wellbeing and life balance. This vision is incorporated within the strategic outcomes, against which we have set a number of actions which we commit to deliver over the next three years.

At the end of the three years, carers can expect:

1. Clear, reliable, accessible information about local and national support to made available across a range of locations within Perth & Kinross;

2. Promoted awareness in the community, schools and workplaces to improve early identification and support of carers;

3. To be listened to and have their opinions valued;

4. Opportunities to participate as active partners to the planning and shaping of carer services in their local areas, including services for the people who are cared for;

5. The development of wider carer networks including enriched peer support;

6. Improved provision of flexible and personalised support, to support their emotional/physical wellbeing and to have a life alongside caring.

7. In addition to the above, young carers will be supported to achieve their educational potential, to have similar opportunities as their peers, and to enjoy their childhood.

2.4 **Strategic Commitments**

To drive the achievement of the outcomes and to demonstrate our purpose for carers, we have developed six commitments, based on the Equal Partners in Care principles, as to how we will make changes to ensure that carers are involved in the development and planning of services and are supported as individuals caring for others, to be sustained in their caring role:

Commitment 1: Carers will be supported with clear information and consistent and flexible support to empower them to manage their caring role.

Commitment 2: Everyone will have the information, opportunities and support to be identified as a carer.

Commitment 3: Carers voices will be critical to influencing the planning, development and improvement of supports.

Commitment 4: Carers will be supported to actively participate in developing a course of supports within the local community to enable them to have a life out with their caring role.

Commitment 5: Carers will be valued, listened to and empowered to share their experiences.

Commitment 6: We will provide specialist and person centred support to avoid disadvantage to carers of all ages.

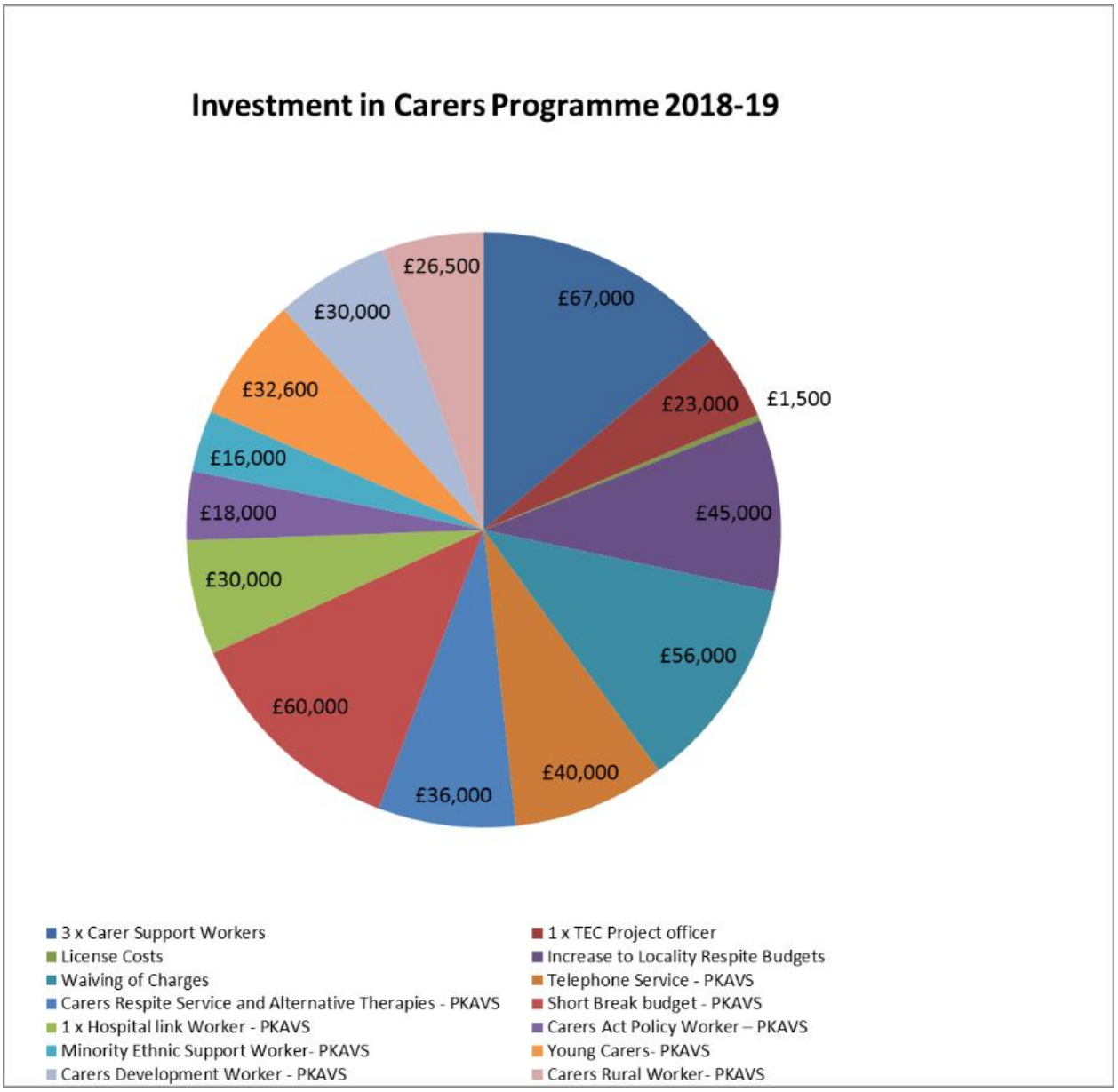
The strategy also includes an ambitious action plan which will ensure that carers are supported throughout their caring journey, enabling them to access the support they are entitled to, to reduce the impact of their caring role on their health and wellbeing, to empower them to have a life alongside caring, reducing carer breakdown and keeping families together.

2.5 **Investment in Carers**

Key to the success of the implementation of the Act was our investment in capacity, ensuring that the necessary support was in place to meet the needs of carers in the area. To this end we commissioned services from the third sector, which includes the establishment of a Carers Support Telephone Service. The telephone befriending service has been very well received by those who benefit from regular telephone calls. We also recruited three additional Carer Support Workers who work across the different localities, supporting carers who are over 65 or who care for someone who is over 65. We continue to invest in support through a respite voucher scheme to help carers to take breaks from their caring role. In addition, we continue to provide to social care, health and commissioned voluntary sector professionals of our new responsibilities under the Act, and raising awareness of carers' rights.

Our investment for carers of all ages for 2018-19 to ensure that they are able to find the support that best meet their needs is shown in Diagram 1:

Diagram 1



Monitoring

Throughout the lifetime of the strategy the achievement of its objectives and implementation of the Action Plan will be monitored by the Carers Strategy Group. Regular review of performance indicators will ensure that we are meeting our outcomes and will enable remedial action to be taken when appropriate. Annual reports of the progress of the implementation of the Strategy will be brought to the Integration Joint Board for information.

3. RECOMMENDATION

The Carer Strategy (2019-22) sets out how we plan to provide better support to carers of all ages, living in or providing care in Perth and Kinross. The strategy has been based on consultation with carers in the area which captured their views in respect of the support they currently receive and what

they would like to see to make a real difference in their lives. Key to this is to ensure that carers know what help and support is available and where to find information which will enable them to manage better, and have a life alongside caring.

The Carer Strategy is being presented to seek approval from the Integration Joint Board and this marks the latest stage in the implementation of the Carers (Scotland) Act 2016, by the Health and Social Care Partnership.

4. CONCLUSION

This report presents the draft Carers Strategy to the Integration Joint Board. The strategy represents the culmination of activity over the last twelve months; the strategy is shaped by unpaid carers who were central to its development. The strategy sets out the plans to ensure that unpaid carers, of all ages, living or caring in Perth and Kinross have the information and support, to enable them to sustain their caring role for as long as they are willing and able to do so and to have a life alongside caring.

Author(s)

Name	Designation	Contact Details
Karyn Sharp	Service Manager	carers@pkc.gov.uk

NOTE: No background papers, as defined by Section 50D of the Local Government (Scotland) Act 1973 (other than any containing confidential or exempt information), were relied on to any material extent in preparing this report.

ANNEX

IMPLICATIONS, ASSESSMENTS, CONSULTATION AND COMMUNICATION

Strategic Implications	**Yes / None**
HSCP Strategic Commissioning Plan	**Yes**
Transformation Programme	**No**
Resource Implications	
Financial	**Yes**
Workforce	**Yes**
Assessments	
Equality Impact Assessment	**Yes**
Risk	**No**
Other assessments (enter here from para 3.3)	**No**
Consultation	
External	**Yes**
Internal	**Yes**
Legal & Governance	
Legal	**Yes**
Clinical/Care/Professional Governance	**No**
Corporate Governance	**No**
Directions	**Yes**
Communication	
Communications Plan	**Yes**

1. STRATEGIC IMPLICATIONS

1.1 Strategic Commissioning Plan

This report and its proposals relate to the achievement of the following Perth and Kinross Strategic Commissioning Plan themes:

1. Prevention and early intervention.
2. Person centred health, care and support.
3. Work together with communities.
4. Inequality, inequity and healthy living.
5. Best use of facilities, people and resources.

2. RESOURCE IMPLICATIONS

2.1 Financial

Within the strategy, there is a focus on widening the provision of more holistic forms of support, supporting and encouraging peer support amongst carers and carer groups, to which there is expected to be none or very little financial implications. However, there may be financial implications where there are current gaps in provision, such as respite beds in care homes, to which we are exploring ways of addressing. We are also in the process of reviewing our range of current supports, ensuring that resources are used appropriately,

promoting early intervention and prevention. Further to this, we will develop financial planning so that this runs alongside the deliverables of the strategy throughout its lifetime. All related finances will be met through resources allocated by the annual budgeting processes, for 2019-20 of £811,488.

2.2 **Workforce**

Finance from the Carers budget has been allocated for a workforce model to support the plan for 2019-20.

3. ASSESSMENTS

3.1 **Equalities & Fairness Impact Assessment**

Under the Equality Act 2010, PKC and NHS Tayside is required to eliminate discrimination, advance equality of opportunity, and foster good relations between equality groups. Carrying out Equality Impact Assessments for plans and policies allows the HSCP to demonstrate that it is meeting these duties.

The Equalities & Fairness Impact Assessment undertaken in relation to this report can be viewed (Appendix 2). This report has been considered under the Corporate Equalities & Fairness Impact Assessment process (EFIA) and assessed as relevant and the following positive outcomes are expected following implementation:

Carers with protected characteristics will be supported to have equal access to information and support, and to minimise discrimination.

3.2 **Risk**

Not applicable. Legal obligations will be met by the introduction of this strategy as set out in the Carers (Scotland) Act 2016.

3.3 **Other Assessments**

Not applicable.

4. CONSULTATION – PATIENT/SERVICE USER FIRST PRIORITY

4.1 **External**

As described in 2.2 of this report. A sincere thank you to Ina and James for sharing their life stories within the content of the strategy.

4.2 **Internal**

As described in 2.2 of this report.

4.3 **Impact of Recommendation**

The implementation of the Carers (Scotland) Act 2016 is considered to have had a positive impact on service users, carers and the third sector. The implementation of the Act has been subject to ongoing engagement throughout, in accordance with the legislation and good practice, as described in Section 2.2.

5. LEGAL AND GOVERNANCE

5.1 This report presents the Carers Strategy 2019-2022 to further implement statutory duties under the Carers (Scotland) Act 2016, to support carers in their caring role and to have a life alongside caring.

5.2 The Carers Programme Board has delegated responsibility for the implementation of the Act, to ensure the adequacy and monitoring of the arrangements for Carers and the management of risks.

6. DIRECTIONS

Perth & Kinross Council and NHS Tayside are directed to make the necessary arrangements to implement the actions in the Carers Strategy 2019-2022.

7. COMMUNICATION

7.1 A Communications Plan for the Carers Strategy 2019-2022 has been produced and will support the ongoing implementation of the Carers (Scotland) Act 2016.

8. BACKGROUND PAPERS/REFERENCES

Not applicable.

9. APPENDICES

Appendix 1 – Draft Carers Strategy 2019-22
Appendix 2 – Equality and Fairness Impact Assessment
Appendix 3 – Communications and Engagement Plan
Appendix 4 – Direction PKC
Appendix 5 – Direction NHST

APPENDIX 1

CARERS STRATEGY
2019-2022
For Young and Adult Carers

A Life Alongside Caring

Contents

CHAPTER 1: INTRODUCTION, OBJECTIVES AND LEGISLATIVE FRAMEWORK

1. Introduction

The Carer Strategy 2019 – 2022 demonstrates our continued commitments to **unpaid carers of all ages** and gives direction for developing support and services for carers over the next 3 years. While this strategy will continue to make progress from where we left off in our previous Adult Carer Strategy 2015 – 2018 and Young Carer Strategy 2015 – 2018, this is the first Carers Strategy presented by the Health and Social Care Partnership in conjunction with Education and Children's Services.

Our vision is to deliver better outcomes for carers living or caring in Perth & Kinross, using resources effectively to support them on a consistent basis to allow them to continue caring, if they wish, while reducing the impact on their health and wellbeing, life balance, and social and financial inclusion, where these are affected by their caring roles. One particular key focus is to improve the provision of personalised short breaks through the use of different funds and resources, encouraging carers to individualise and define what 'time out' from their caring roles means to them. Our vision for young carers is that they are supported to be children first and foremost, having similar opportunities as their peers.

This strategy is shaped by carers, their families, service users, and staff from the Health & Social Care Partnership (Perth & Kinross Council, NHS Tayside, and Third and Independent Sector organisations). Views of young and adult carers and their representatives have been sought via consultation into their needs, challenges, hopes and concerns to ensure that this strategy is relevant and useful. We also listened to what carers told us about gaps in service provision, ideas for improvements and what works well for them. In Chapter 4 of this strategy, we outline the feedback we received and set out both our commitments and the outcomes we will deliver in response to that feedback.

The strategy will be reviewed annually, in addition to ongoing monitoring, to ensure that it remains robust and meaningful, and will be in place until 2022.

2. Policy Statement

We believe that unpaid carers of all ages play a vital role in the lives of the people they care for and in the wider community. We are committed to supporting carers to ensure they can continue to provide that care for as long as they wish. Our aim is to ensure that carers are recognised and valued as equal partners in care to plan the personalised support they need in their caring role; and to support carers to live in good health and wellbeing, allowing for a life of their own alongside caring, to the best of our ability.

3. The Legislative Framework

The strategy is underpinned by the Carers (Scotland) Act 2016, and Social Care (Self-Directed Support) (Scotland) Act 2013.

3.1 Carers (Scotland) Act 2016

This legislation came into effect from 1 April 2018 and enhances the rights of carers in Scotland. The purpose of the Carers Act is to ensure that unpaid carers, who are able and willing to continue caring, are better and more consistently supported to have a life alongside caring. For young

carers, the intention is to ensure that they are children first and foremost, and that any caring role they have is secondary.

This legislation gives carers a right to be offered, or to request, an Adult Carer Support Plan or Young Carer Statement, which supports the carer to identify the advice and support that is needed to reduce the impact of caring on their health and wellbeing and other aspects of their lives. It also puts a duty on the Health and Social Care Partnership to set local eligibility criteria for supporting carers, to develop the adult carer support plan and young carer statement, to develop a Short Breaks Services Statement, to involve carers in carers services and in hospital discharge planning, and to maintain advice and information services.

We have worked, and will continue to work, collaboratively with carers, their families and groups who represent carers to implement the changes required under this new law locally across Perth & Kinross.

3.2 Social Care (Self-Directed Support) (Scotland) Act 2013

Under this legislation, we will provide information and advice about Self-Directed Support (SDS) options. We have a duty to offer people who are eligible for social care a range of choices over how they receive their social care and support. SDS allows people, their carers, and their families to make informed choices on what their support looks like and how it is delivered, making it possible to meet agreed personal outcomes.

SDS includes a range of options to ensure everyone can exercise choice and control. Carers have four options in relation to how their budget is controlled, which are:

- Choosing to receive a Direct Payment (also called a cash payment).
- Choosing to have the funding allocated to a service provider of their choice (this means that Perth & Kinross Council holds the budget but the carer is in charge of how that money is spent).
- Choosing to have Perth & Kinross Council to arrange a service for the carer.
- Choosing to have a mix of the above options for different types of support.

Carers can use SDS in different ways; for instance to support the carer to live in their own home. Outside of the home, it could support the carer to go to college/work or enjoy leisure pursuits. It could help the carer arrange for a personal assistant (PA) or be used to help to provide a short break or equipment for the carer.

4. Objectives and Strategic Framework

This Strategy reflects and supports the five commitments of the Strategic Commissioning Plan for the Health & Social Care Partnership (HSCP):

1. Working together with communities
2. Prevention and early intervention
3. Person-centred health, care and support
4. Reducing inequalities etc.
5. Making best use of resources

To meet these goals, we want to provide more opportunities for people to achieve their potential, at all life stages, using these themes which underpin the work of the Health and Social Care Partnership.

We will listen to and work with carers along with their families and friends in accordance with the Health and Social Care Standards (my support, my life) (https://www.gov.scot/Resource/0052/00520693.pdf), prioritising and respecting people and their choices when they seek support.

The strategy embraces the National Health and Wellbeing Outcomes, in particular Health and Wellbeing Outcome 6: People who provide unpaid care are supported to look after their own health and wellbeing, including reducing any negative impact of their caring role on their own health and wellbeing.

In addition, the strategy embeds the Equal Partners in Care (EPiC) core principles:

- Carers are identified
- Carers are supported and empowered to manage their caring role
- Carers are enabled to have a life outside of caring
- Carers are free from disadvantage and discrimination related to their caring role
- Carers are fully engaged in the planning of services
- Carers are recognised and valued as equal partners in care

The strategy also reflects the Perth and Kinross vision that children and young people will have the best start in life and will be supported to achieve their potential. This is in line with our commitment to Getting it Right for Every Child (GIRFEC) and the ethos of the Carers (Scotland) Act 2016, which places emphasis on young carers being children first, carers second, ensuring that they are supported to achieve the best possible outcomes in life. Getting it right for every child (GIRFEC) is the national approach in Scotland to improving outcomes for children and young people and supporting their wellbeing by offering the right help at the right time from the right people. GIRFEC promotes a preventative and early intervention approach which underpins this Strategy to support young carers.

5. Equalities

In accordance with the Public Sector Equality Duty (General Equality Duty), Perth & Kinross Health and Social Care Partnership, and Perth & Kinross Council Education and Children's Services) have a duty to eliminate unlawful discrimination, harassment and victimisation and to advance equality of opportunity between people who share a protected characteristic. Protected characteristics, under equalities legislation, include age, race, sex, disability, colour, ethnic origin, religion or belief sexual orientation or gender re-assignment. Under the Fairer Scotland Duty, we must actively consider how we can reduce inequalities of outcome caused by socioeconomic disadvantage, when making strategic decisions.

6. Monitoring, Reviewing and Reporting on the Strategy

Perth & Kinross Health & Social Care Partnership established a Carers Programme Board in September 2018 for which there is strategic sub groups to ensure that we continue to implement legislative requirements and that carers' experiences are improved. These groups include carer representatives and relevant stakeholders from NHS Tayside, Adult Services and Education and Children Services from Perth and Kinross Council, Perth & Kinross Association of Voluntary Service (PKAVS), and other Third and Independent Sector organisations. Throughout the lifetime of this strategy, the Carer Strategy Steering Group will monitor the achievement of the objectives and the activities put in place to realise the strategy's commitments in relation to both young and adult carers.

One of the main purposes of the Carers Programme Board is to ensure the effective delivery and governance of the work we do, and to monitor and report on its progress on an ongoing basis. Representation on these groups will be reviewed regularly to ensure members are committed to continuing this important work, with ownership of this joint strategy given to the groups and encouraged by its members.

We will work collaboratively with three Perth & Kinross Health & Social Care Partnership Programme Boards: Mental Health and Wellbeing, Older People and Unscheduled Care, and Primary Care, to ensure the significance and importance of carers across Perth & Kinross is recognised and given priority.

We will also report progress annually to the Integrated Joint Board and the Lifelong Learning Committee, which deals with adult services and children services respectively; on how well we are delivering on our strategic outcomes. Our Action Plan (Section 19) illustrates the actions we will undertake to deliver these outcomes, and how performance of each action will be measured.

7. Definition of Young and Adult Carers

The **Carers (Scotland) Act 2016** defines an unpaid carer as an *'individual who provides or intends to provide care for another individual (the 'cared for person')'*.

An unpaid carer can be a child or an adult who gives help and support to someone else who has a disability, illness, health condition, a mental health or substance misuse issue, and/or who is elderly or frail. The person being cared for may be a spouse, parent, child, sibling, a relative, neighbour or a friend of the carer.

Unpaid carers can be kinship carers or parent carers who provide care to an ill or disabled child to a greater extent than would be expected in a parenting role. Unpaid carers may have paid or voluntary work other than their caring role, be in education, retired, or be unemployed. They may be in receipt of welfare benefits, pensions or be earning wages unrelated to their caring role.

All carers provide a vital contribution to their families and to society. They provide often-unseen care and support to relatives within their household and the wider family. Additionally, they can often keep families together and reduce the need for organised and formal care services.

This strategy is for carers of all ages:

- **Young carers**, who are under 18 or are 18 and are still at school, who live within Perth & Kinross, even if the cared-for person lives outside of this area.

- **Adult carers**, who are 18 or over, who have left school and are caring for someone who lives within Perth & Kinross, even if the carer lives outside of this area.

8. Young Carers

8.1 The Impact of Caring on Young Carers

Being a carer can be a positive experience for a young person. The caring role can give a sense of responsibility and identity, and can build self-confidence and esteem. By making an important and positive contribution to family life, the young carer can feel more valued and included and can enable them to develop important life skills. However, when young people are required to take on too many caring responsibilities, or carry out caring roles that are not appropriate, there can be limiting or adverse effects on their health and overall well-being. This can impact every area of their lives including school, health, community and home:

- It is important to support young carers to consistently attend school.
- Young carers may require support to complete homework on time and may require additional support in class.
- Without the right support their young carer role can potentially limit the young person's ability to achieve their full potential.
- Young carers often feel different from peers with an increased likelihood of being bullied – PKC Anti-Bullying Strategy.
- The demands of consistently providing intensive physical care for the cared for person can impact on a young carer's physical and emotional wellbeing over time.
- Taking on responsibilities that would normally be carried out by an adult can lead to a young person experiencing mental health and wellbeing issues, such as depression and stress.

- Young carers may not be looking after themselves as their focus is on the cared for person.
- They may be worrying about the cared for person.
- Due to their caring responsibilities young carers often have very little free time to socialise so their friendships can be limited leading to increased isolation; this also creates barriers to joining after school clubs and/or other groups which normally help build relationships and improves the quality of our lives, increases resilience and reduces isolation.
- Some young carers may be reluctant to bring friends home due to their home environment and may also experience bullying within their community for being different.

- Financial constraints within the family home can limit the life opportunities of young carers. The effects of a cared for person's disability can add additional costs to the running of a home such extra heating, specialised equipment or maintaining a special diet hence limiting available funds.

Where there is a barrier to learning, under The Education (Additional Support for Learning) (Scotland) Act 2004 (as amended 2009) schools have a responsibility to identify needs and keep these under review following the PKC staged intervention framework. For most young carers their needs may be met at a universal level by the class teacher(s).

8.2 The Young Carer Statement (YCS)

Any young carer, or parent/guardian for young carers under 16, can request a Young Carer Statement (YCS). Perth and Kinross Council is the responsible authority for arranging a YCS for young carers under 18 years old, or 18 years old and still at school. All requests for a YCS are referred to PKAVS Young Carers Hub where a multiagency discussion will take place on a monthly basis to respond to the level of need. However urgent referrals will be considered immediately.

NHS Tayside is responsible for arranging a YCS for children under the age of five before they start school.

The YCS is a plan made with the child/young person to determine if the impact of their caring role is preventing them from achieving their life long potential. Our YCS was developed based on the National Practice model of *Getting it Right for Every Child*, using the SHANARRI wellbeing indicators (Safe, Healthy, Active, Nurtured, Achieving, Responsible, Respected, Included).

Getting It Right For Young Carers: A Framework for Support sets out our eligibility criteria for young carers, used to identify what supports will be available based on the impact of the caring role: low impact (Level 1), moderate impact (Level 2) or significant impact (Level 3). The YCS helps the young carer to identify personal outcomes which forms a detailed plan of support. The personal outcomes identified in the YCS should help to lessen the impact of their caring role to a level which better supports them to achieve their potential.

8.3 Working in Partnership

We recognise that meeting the needs of young carers cannot rest with one organisation alone and that it takes strong partnerships and effective joint working across a wide range of services, including the Third Sector, to support the varied needs of young carers and their families.

There will be occasions where there will be a need for partnership working across services for adults and children (Children, Young People and Family Services (CYP&FS) when assessing the needs of the young carer. The relevant professionals from across services will work together with the young carer and the person they give support to, to identify the necessary supports. This may involve drawing on appropriate resources from across services as necessary to meet the young carer and cared for person's needs to prevent breakdown and keep families together.

James'* Story

James is 13 years old and cares for his mum, a single parent who has fibromyalgia and ME. James carries out domestic tasks such as cooking, doing the laundry, tidying the house and making sure any medication is taken on time. James' mum is concerned about the emotional impact the caring role is having on James. She feels he is struggling to cope with her condition; as a family they now struggle to do many of the things they loved such as going on long walks, bike rides and exploring new places.

James' mum made a referral to PKAVS' Young Carers' service in April 2016. After visiting the family, it became clear that James was a young carer and that the role was having an impact on him. James was offered support from PKAVS and invited to attend weekly respite groups (with transport provided if required). He took priority for day trips and residential breaks away and was also offered regular one to one support sessions. In August 2018, James attended a week long residential break with PKAVS Young Carers service and enjoyed five days on an Ocean Youth Trust sail boat sailing along the West Coast of Scotland. James thoroughly enjoyed the week away and sent a thank you card to the staff who attended saying 'thank you for the best week of my life'. James' mum also said, "my son went on a sailing adventure with young carers and came back a different child. He was more confident and so proud to have learned all the new skills he had the opportunity to learn. I'm so grateful to PKAVS for all their support".

**name changed to protect young carer's identity*

9. Young Adult Carers

When young carers reach 18 years and are no longer in school they are entitled to an Adult Carer Support Plan (ACSP). The carer will be offered continued support via an ACSP. This will be completed by the Young Adult Carer Support Worker at PKAVS. It is vital that there is no gap in support for the young person.

Although the Carers Act does not give special definition for young adult carers (aged 16 to 25), we commission services from PKAVS for young adult carers as we recognise the importance of supporting carers through the transition phase from child to adult.

The impact of caring on a young adult carer can be a varying combination of the impacts on young carers and adult carers. In particular there may be:

- Limited opportunities to socialise, to make or sustain friendships.
- Difficulties in meeting education demands at school, college or university.
- Challenges in accessing work opportunities or maintaining jobs where employers lack awareness about carers.
- Feelings of guilt, anxiety, stress, worry and isolation.
- Concerns about moving away, leaving their family and the person who needs support.

According to the 2011 Census, young carers and young adult carers are twice as likely to report a mental health condition compared to those without caring responsibilities, and young adult carers are three times more likely to report a mental health condition compared to young carers.

While the information throughout this strategy for young and adult carers is also applicable to young adult carers, it is vital to ensure that this age group of carers is also supported in their own right throughout this important transitioning stage of life from child to adult.

10. Adult Carers

10.1 The Impact of Caring on Adult Carers

Adult carers may give physical support, help with practical tasks and provide emotional support such as reassurance and encouragement. Caring can be extremely demanding but also rewarding. Care may be provided throughout the day and night seven days a week, or may fluctuate depending on the needs of the person they look after. Each carer, and their caring situation, is unique. As such, carers experience varying degrees of positive and negative impacts.

Sometimes, a caring role can feel very challenging and can lead to:

- Social isolation due to not having time to develop or nurture relationships with friends or family members.
- Stress of coordinating care with wider family responsibilities.
- Having very limited or no opportunity to have 'time out' or a break to recharge.
- Difficulties in maintaining education or employment, leading to the loss of opportunities and income.
- Increased financial pressures due to caring role.
- Making long-term lifestyle changes.
- Health and wellbeing being impaired due to pressure and stress of the caring role.

10.2 The Adult Carer Support Plan

As a consequence of some of the challenges a caring role can present, the areas that are most often impacted in a carer's life include:

- Their health and wellbeing.
- Their relationship with the cared-for person.
- Their finances.
- Their ability to achieve their potential because they have been unable to continue education, training or employment.
- Their living environment.
- Their life balance beyond their caring role and future and emergency planning.

These are the main areas we discuss with carers in their Adult Carer Support Plans in order to identify how we could help each carer feel better supported to manage their caring role, as well as to have a life they enjoy alongside their caring role.

Adult Carer Support Plans can be completed by both Perth & Kinross Council and PKAVS Carers Centre. The eligibility criteria framework was developed in line with the requirements set out by the Carers (Scotland) Act 2016 and the best practice framework by the Coalition of Carers. The support available is dependent on the impact of caring on the adult carer.

The personal outcomes identified in the Adult Carer Support Plan should help to lessen the impact of their caring role to a level which supports their health and wellbeing, and helps them to enjoy a life alongside their caring role.

Ina's Story

Ina was referred by her GP to PKAVS Carers Hub in 2009. Looking after her husband in his 80's, and who is becoming frail with age, she doesn't see herself as a carer, simply as a 'wife'. In response to feedback received from carers, PKAVS established a telephone service from February 2018. Ina has been supported through this service since May 2018, and now looks forward to her weekly phone calls where she enjoys chatting about her daily life, as sometimes she feels socially isolated.

Through the ongoing conversations she has had with our telephone support worker, it was identified that she would benefit from Digital Skills Drop-In training sessions organised by Lead Scotland. Additionally, a successful Time4Me application was made to fund a second hand £250 iPad, which has enabled her to manage their budgets better, do online food shopping so that the shopping is delivered to them, as well as keep her mind active by doing daily crosswords. Ina often remarks that having an iPad is so much more beneficial to her than a holiday.

11. Carer Support in Perth & Kinross

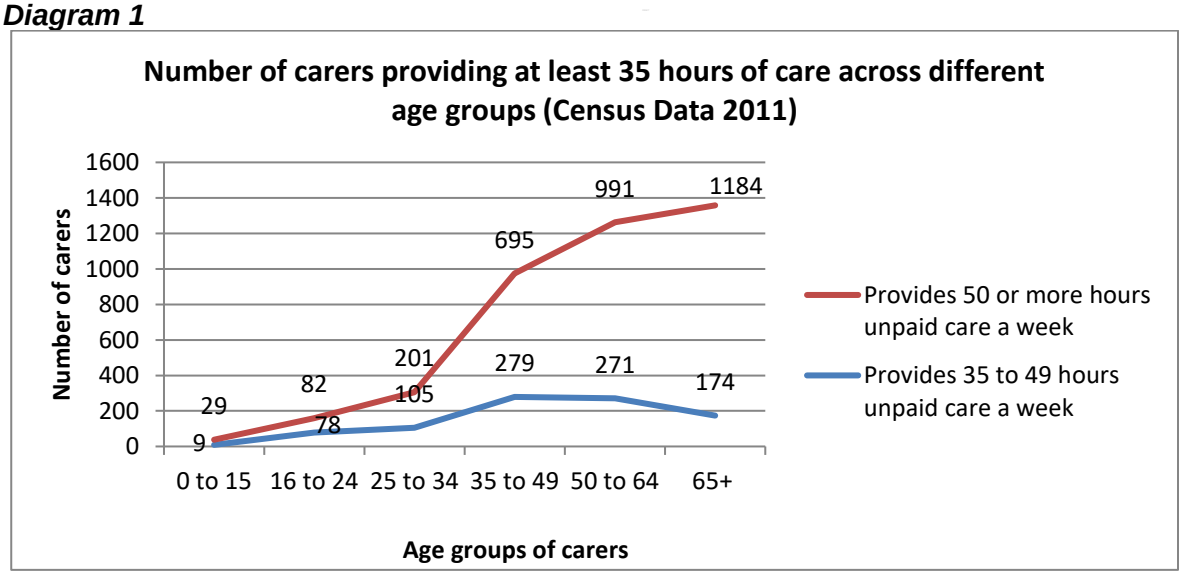
The most recent national census in 2011 asked people who provided unpaid care to give details regarding the amount of time they spent caring each week. In 2011, 13,308 (9%) of the 146,652 people who responded to the census in Perth & Kinross identified themselves as carers, of which:

- 3.5% of these carers provide over 20 hours of care per week.
- 59% of these carers are female.
- 2% of these carers are under 16 while 23% are aged 65 or over, meaning that 75% of these carers are of working age.
- 54.5% of these carers are employed (excluding full-time students).
- 16% of households have one or more carer resident.

Of the carers aged over 16, 5% of these carers reported that their health is 'bad' or 'very bad' and 79% reported that their health is 'good' or 'very good'. However, where the carers provide at least 20 hours of care per week, the proportion reporting that their health is 'bad' or 'very bad' increases to 9% and those reporting that their health is 'good' or 'very good' decreases to 70%. This suggests a negative impact to health related to an increased amount of care provided. The next national census will be in 2021, which will provide more up-to-date information.

Diagram 1 shows the number of carers providing 35 hours or more of care per week across different age groups. This shows that there is around 6 times the amount of older carers (aged 65 or over) who are caring for at least 50 hours or more per week in comparison to those aged 25-34.

Diagram 1



Based on information from the National Records of Scotland, the number of people providing unpaid care over the next 3 years can be projected (see *Table 1*) to show an estimated 1% growth in the overall numbers of carers.

Table 1

	2019	2020	2021	2022
0 to 15	270	272	272	273
16 to 24	571	566	562	551
25 to 34	922	923	927	931
35 to 49	2,906	2,902	2,892	2,878
50 to 64	5,675	5,714	5,748	5,768
65 and over	3,762	3,830	3,897	3,972
Total	**14,106**	**14,207**	**14,298**	**14,373**

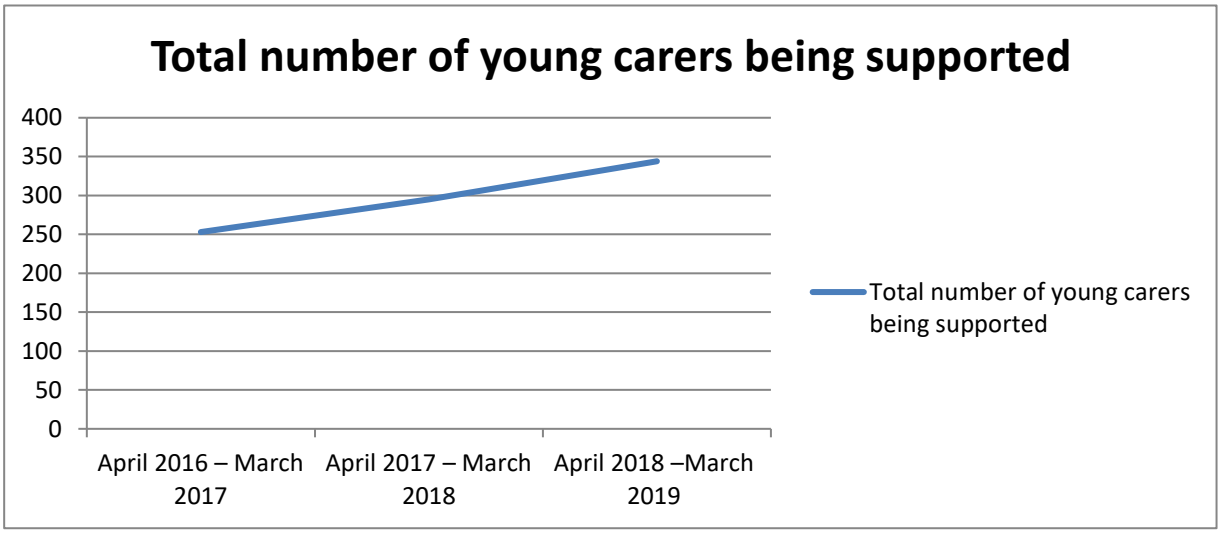
Overall, based on the National Records of Scotland data, it is expected that the proportion of the population who are providing unpaid care will remain largely the same. Yet, the number of people living in the area will increase, resulting in a rise in the number of unpaid carers of 2% by 2022. Whilst, the proportion of the Perth & Kinross population over 65 providing care is projected to increase by 6%, we believe that the figures for both population and growth are understated.

12. Identifying Young Carers

The 2011 Scotland Census indicates that:

- Children who live with a lone parent are 6.6% more likely to be a Young Carer and have significantly greater caring responsibilities (35 hrs or more a week) compared to a child who lives with two parents (2.5%)

- 133 (40%) young carers who are being supported by PKAVS Young Carer Hub live in lone parent families



Perth and Kinross Association of Voluntary Service (PKAVS) Young Carers Hub statistics tell us that:

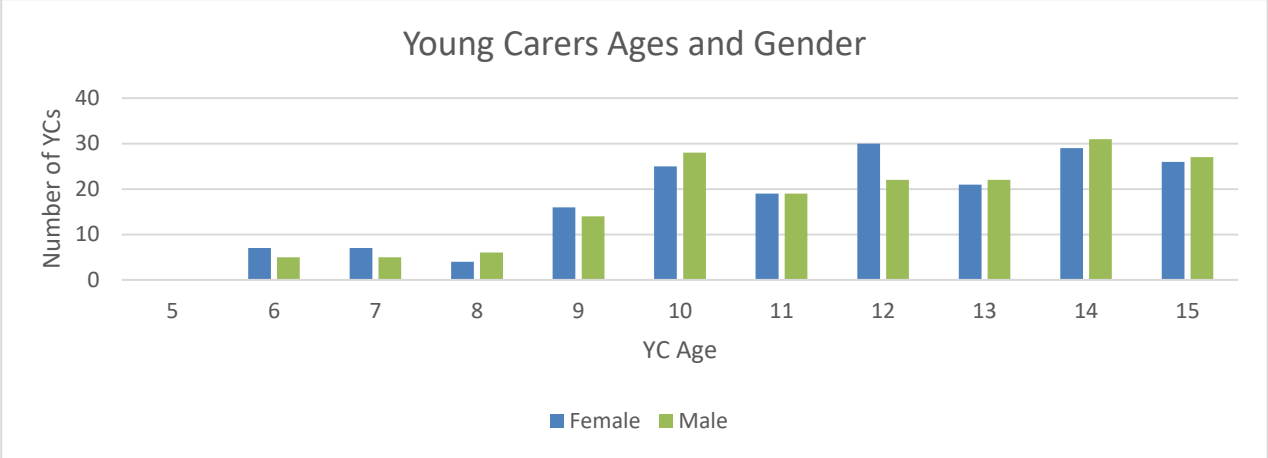
The increase in referrals suggests that the number of young carers being supported in Perth and Kinross have been well identified and will continue to increase year on year.

Hidden Carers

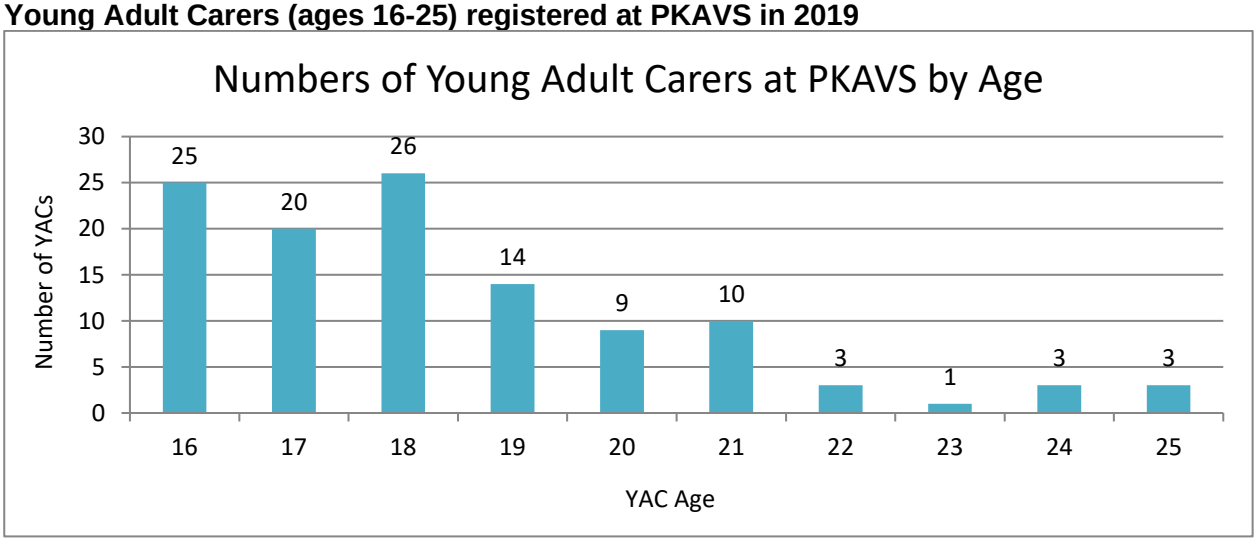
We recognise that there will be children and young people who do not want to identify as a Young Carer and others who do not see themselves as young carers but do have significant caring roles within their families which impact on their wellbeing. Services in Perth and Kinross are working with schools and other agencies to raise awareness of all young carers and to ensure the young

carers who do not wish to be formally identified are still aware of their right to be supported. We set out in our Action Plan at Section 19 the actions we will take to raise awareness of, and identify, young carers. Within the Young Carer Statements and through the course of this strategy, we aim to increase our understanding about the caring roles young carers we support provide in order to help us to make service changes required to better meet their identified needs.

Known Young Carers in Perth and Kinross 2019 (by gender /age)



Young Adult Carers (ages 16-25) registered at PKAVS in 2019



Of the 114 young adult carers registered at PKAVS within the dedicated 16-25 YAC service, 45 of these are young carers and 69 of these are adult carers.

13. Identifying Adult Carers

We estimate that approximately 2400 adult carers are registered across PKAVS, Perth & Kinross Health & Social Care Partnership and at the Perth & Kinross Carers Support Project at Support in Mind at the time of writing. This suggests that up to 80% of adult carers might be missing out on preventative support, information and advice that might assist them in reducing the impact of their caring role. Whilst this likely includes a proportion of carers who do not feel they need or want support, there is still disparity between the number of carers in the 2011 census and the number of carers registered for support in Perth & Kinross.

The census data on carers' reported health and wellbeing suggests that at least 5% of carers might have significant support needs related to managing their caring role, for which we could put support in place to reduce the impact. However, we estimate that the percentage of carers with

significant support needs could be higher than this as of April 2019, based on the numbers of adult carers who currently access services in Perth & Kinross with at least some eligible needs for which we have a duty to support.

We set out in our Action Plan at Section 19 the actions we will take to raise awareness and to provide information about support for carers in a wider range of places throughout Perth & Kinross, which remains one of our priorities. Ensuring that carers are able to easily access information and support from a range of agencies at an earlier stage can help them to prepare for their caring role and make plans, promoting better health and wellbeing for carers, their families and the people they look after. Additionally, we also set out our plans to understand more about the caring roles carers we support have in order to help us review current support and services. This is a process we have already begun, to explore different types of support to meet the different needs of carers.

14. Timescales for Completing Young Carer Statements and Adult Carer Support Plans

When we receive a referral from a carer or third party on behalf of the carer to receive information, advice and/or support, we will take into account the priority and urgency of each situation. When it is brought to our attention that urgent support is required, we will prioritise this. Demand for services is generally high and may be subject to external factors which are out of our control. However, we aim to provide carers with:

- Young Carer Statements within 12 weeks of their request.
- Adult Carer Support Plans within 10 weeks of their request.

These timelines will be kept under review to ensure that we are meeting demand appropriately.

15. Current Support Available in the Local Area

- Perth & Kinross HSCP's Short Breaks Services Statement (viewable at https://bit.ly/2UOPewX) contains a more extensive list of the short breaks services available for carers locally and nationally. The below provides a more condensed list of support currently available to carers from commissioned services and other bodies.

15.1 Local Resources for Young and Adult Carers

- PKAVS Carers Hub has three separate services to support carers from school age upwards. It provides a range of information, advice and support to carers. Types of support include respite and activity groups for young and young-adult carers, social (massage) therapies, carer cafes, training opportunities, short breaks, day services for people with long term conditions or disabilities, emotional support telephone services, 1-2-1 support from dedicated carer support workers, Self-Directed Support advice, and up-to-date information about different resources available in their local community. Information and support in completing emergency plans can also be provided, as well as support for unpaid carers whose role has changed due to bereavement or when the cared for person enters long-term residential care (the 'Bridge Project').

- Crossroads primarily aims to provide respite care for carers in the community, with home-based respite and domiciliary care service for adults with any of the following: mental health problems, dementia, physical disabilities, learning disabilities, or other serious health problems.

- MECOPP works with Gypsy/Traveller Carers of any age across Perth & Kinross who live in housing, on sites and in roadside camps. The support includes outreach work, community-lead research, film-making, limited case work and training.

- The Care and Wellbeing Co-operative members are micro enterprises finding new ways to provide care and wellbeing services in rural areas of East and Highland Perthshire.

- Support in Mind is a Mental Health Organisation providing information and support for people who have mental health problems or mental illness and for their families and carers. It runs a Carer Support Project in Perth & Kinross, providing individual support, as well as a range of information and advice.

- Alzheimer's Scotland is the local point of contact for people living with Dementia, family members, carers and communities. The Dementia advisor can provide information, support and advice, and signpost to local groups and services.

- Independent Advocacy Perth & Kinross provides information and advocacy support when needed by carers.

- Social Prescribers offer signposting and support for people to access and use community based activities, to help address influences which contribute to health problems, with the aim of improving health and wellbeing.

- There is also a range of universal services available such as leisure centres, libraries, support groups and emotional support.

15.2 Statutory Services Support for Young and Adult Carers

- Perth & Kinross Health and Social Care Partnership can provide a range of services which are available with a Young Carer Statement or Adult Carer Support Plan. These include arranging care for the cared-for person, day care services, short breaks/respite, telecare support, emergency carers card, rapid response.

- Perth & Kinross Council Welfare Rights Service offers advice and information on benefit entitlements when your circumstances change, when you are struggling financially or when you have been turned down for a benefit or are unhappy about a benefits decision. Carers may be entitled to Carers Allowance or Carers Allowance Supplement.

- Health Services will provide support at the point of diagnosis, along a health pathway, and with hospital discharge planning supported by a dedicated hospital link worker.

16. Progress Summary

16.1 Young Carers Strategy 2015-2018

Examples of progress made in supporting young carers during 2015 – 2018 from our previous Young Carers Strategy include:

- Increase in numbers of young carers identified and supported.
- Launching the Young Carers Identification Card to help schools better identify young carers.
- Appointing a dedicated Young Carers Support Worker who is tasked with raising awareness of young carers in schools.
- Launching an e-learning tool for professionals to learn about young carers and the support provided by PKAVS.

16.2 Adult Carer Strategy 2015-2018

The Adult Carer Strategy 2015 – 2018 made significant progress in supporting the lives of carers in Perth and Kinross. This is demonstrated by the following examples:

- Increase in numbers of adult carers identified and supported.
- Increased opportunities for carers to shape their own support and services.
- Increased flexible and personalised support options.
- Promoting equality of opportunity by working with different communities.
- Encouraging employers to join the Carer Positive Initiative, which recognises carers within the workplace.

One of the key themes arising from consultation feedback is the importance of short breaks in allowing carers to have time out and recuperate; reducing the impact caring has on their health and wellbeing. Since our previous strategy, we have increased the range of support and opportunities for carers in Perth & Kinross. There is now a range of short breaks and Respitality opportunities ('respite + hospitality' – these are short breaks for carers gifted by local businesses), social/massage therapies and carers cafes, providing flexible and personalised options of support for carers. These grants have provided carers with support in a range of forms to meet carers' desired outcomes, improving their life balance as well as health and wellbeing.

Additionally, there is now improved choice and control for carers to direct their own support through a personalised support package, otherwise called self-directed support (SDS).

17. Carer Consultation and Feedback

17.1 Timeline of how the strategy was developed

Embracing our vision that carers should be equal partners in care and be involved in shaping the services that are designed to support them, the development of this strategy was undertaken through engagement and consultation with young and adult carers, their families, and the professionals who support them.

Across Perth & Kinross 324 people were able to provide their views to the first consultation and 35 people provided views to the follow-up consultation. These gave us valuable opinions and insight into carers' experiences. We have based this new strategy on what carers have told us matters to them.

This was what the consultation process looked like:

September 2018: The consultation survey was created with carers

The consultation survey was developed through several meetings held with key stakeholders, including two separate focus groups with adult carers and young carers.

October 2018: The first consultation

We consulted with carers using the finalised survey. This was done through social media, letter, email, focus groups, consultation stalls and events. We received 324 responses.

November 2018: The follow-up consultation

After carrying out a detailed data analysis of the responses, we developed a one page follow-up consultation survey. This served a joint purpose: to provide feedback of the main themes from the first consultation and to ask for further feedback which will help us to target the areas that are most important to carers. We received 35 follow-up responses.

December 2018: Strategy Workshop

Carers, their representatives and professionals who support carers, worked together to develop the commitments for the strategy based on the EPiC (Equal Partners in Care) Principles.

December 2018: Short Breaks Services Statement

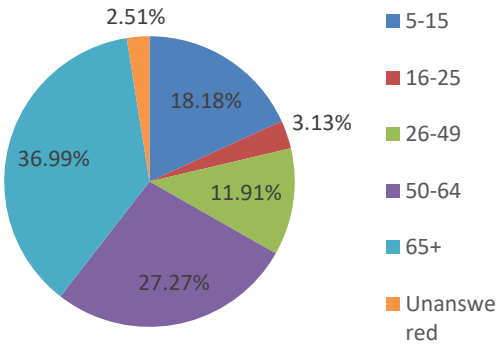
Our Short Breaks Services Statement was published following consultation with young and adult carers in June and July 2018.

From January 2019: Ongoing consultation and dialogue

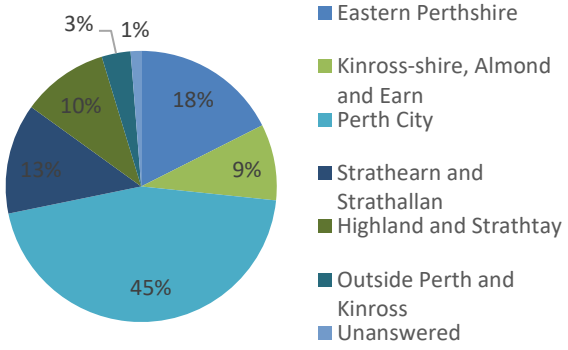
Through strategy and programme board meetings, we have continued to seek the views and experiences of carers, including Carers Voice, professionals and our third sector partners, to inform and shape this strategy and the Action Plan.

17.2 Summary of the results from the first consultation – 324 respondents

Age groups of carers who responded



Where these carers are from



Type of care provided

55% provide a range of practical, physical **and** emotional support to the cared-for person. **81%** of carers said they provide some form of **emotional support** on its own or alongside other types of support.

Length of time in caring role before support

65% waited over a year before receiving support outside of family and friends. **5%** said they never received any support at all from a service.

Reasons include: feeling like they were able to manage themselves initially, the support offered was not suitable, they were not aware that support was available or other reasons not given.

What could we improve?

The single most common comment related to difficulty in finding the information they need. This includes knowing the **range of support that is available** and where to look for this information from one, easily accessible place.

Before support, how were different areas of your life impacted?

45% said that caring had **'a lot'** of impact on different areas of their lives before receiving support. Around **35%** said that there was **'a little'** impact.

Areas that the caring role impacted on include: health and wellbeing, relationships, work/education/training, finances, living environment and life balance.

After support, how much did things improve?

55% said that after receiving support, things improved **'a little'**, **28%** said that things improved **'a lot'**.

Reasons include: support offered was unsuitable or inadequate, too early for the carer to tell, the support and services available are not able to meet their needs or resolve their particular problem, eg the cared-for person is reluctant to receive support from a third party, or other reasons not given.

Amongst the things that carers said they valued most are **1-2-1 support**, the **telephone service emotional support** and being supported to have **short breaks**.

17.3 Results from the follow-up consultation – 35 respondents

Availability, accessibility and clarity of information

The information people most want to find out about is the **range of support available** and the **short breaks** they could access.

They want to receive this information on **emails, letters or leaflets**.

They prefer to find information leaflets about carer support at **supermarkets, local convenience stores, GP surgeries/hospital, libraries and local chemists/pharmacies**.

What carers said matters most to them:

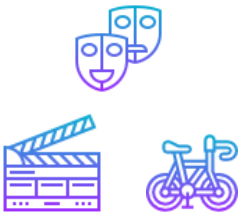
Listed in order of importance according to those who responded in the follow-up consultation, these are the key themes from the feedback of carers in the first consultation, and what carers told us matters most to them:

- I want better support for the person I care for and to be more involved in the discussions around their care.
- I want to be able to access clear information from one person or place.
- I want to be supported to have a life outside of caring.
- I want to be updated when there are changes that affect my support.
- I want professionals to listen to me more.
- I want the same worker to provide care for the person I look after as much as possible.
- I want to be able to contact someone for support in the evenings and at weekends.
- I want there to be a variety of support options in rural areas of Perth & Kinross.
- I want more specialist support for the person I care for.

We used these to develop our key strategic outcomes (set out in Section 18) to support carers of Perth & Kinross over the next three years, which will be delivered by means of the Action Plan (set out in Section 19).

18. Our Strategic Outcomes: What Carers Can Expect

Our response to the consultation feedback by carers, is that by 2022, <u>all unpaid carers</u> can expect:

			
Clear, reliable, accessible information about local and national support to made available across a range of locations within Perth & Kinross.	Promoted awareness in the community, schools and workplaces to improve early identification and support of carers.	To be listened to and have their opinions valued.	Opportunities to participate as active partners to the planning and shaping of carer services in their local areas, including services for the people who are cared for.
			
The development of wider carer networks including enriched peer support	Improved provision of flexible and personalised support, to support their emotional/physical wellbeing and to have a life alongside caring.	In addition, young carers will be supported to achieve their educational potential, to have similar opportunities as their peers, and to enjoy their childhood	

These are the areas we will give particular focus on for Young Carers:

We will support the growth of local support for young carers.

We will work with young carers over the life of this strategy to make the service changes required to better meet their identified needs.

We will support young carers and their families to improve their lives where the caring role is impacting their wellbeing.

We will work across services to meet the needs of both the young carer and the cared-for person.

We will ensure support is in place to help identify and support young carers as early as possible (Level 1). We have invested in a Young Carer Support Worker to work with our schools to raise awareness about the needs of young carers.

We will enhance resources to allow schools to work creatively to reduce the attainment gap. Expanding opportunities for young carers to achieve their full potential.

We will increase a variety of respite opportunities by making funds available for young carers to make choices about their own needs and interests.

19. Action Plan

Our commitments, which are based on the EPiC principles and developed with carers to support the delivery of our strategic outcomes (set out in the previous section and in our action plan), are:

1. Carers will be supported with clear information, consistent and flexible support to empower them to manage their caring role.

2. Everyone will have the information, opportunities and support to be identified as a carer.

3. Carers voices will be critical to influencing the planning, development and improvement of supports.

4. Carers will be supported to actively participate in developing a course of supports within the local community to enable them to have a life out with their caring role.

5. Carers will be valued, listened to and empowered to share their experiences.

6. We will provide specialist and person-centred support to avoid disadvantage to carers of all ages.

CARERS WILL BE SUPPORTED WITH CLEAR INFORMATION, CONSISTENT AND FLEXIBLE SUPPORT TO EMPOWER THEM TO MANAGE THEIR CARING ROLE				
What we will do	**How we will do this**	**Responsibilities and timescales**	**How we will measure how well we are doing**	**National Health & Wellbeing Outcomes delivered**
<u>OUTCOME 1</u> **Provide clear, reliable, accessible information about local and national support is available across a wide range of locations in Perth & Kinross.**	1. Review and update information about carer support and services for accuracy and relevance on paper and electronic formats. Electronic formats include PKAVS Carers Hub Website, YourCommunityPK, www.pkc.gov.uk.	*Communications Participation & Engagement Steering Group* **Target date:** May 2020 and periodically thereafter	• Number of carers registered with PKAVS and P&K HSCP. • Percentage of carers reporting they feel informed and able to access a range of information and advice. • Number of completed Adult Carer Support Plans/Young Carer Statements.	People who work in Health & Social Care Services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide. Health & Social Care Services contribute to reducing health inequalities. People who provide unpaid care are supported to look after their own health and wellbeing, including reducing any negative impact of their caring role on their own health and wellbeing. People are able to look after and improve their own health and wellbeing and live in good health for longer. Health & Social Care Services contribute to reducing health inequalities.
	2. Distribute and display information in a range of community and commercial premises, such as supermarkets, pharmacies, hospitals, GP surgeries, dental practices, local grocery shops, schools, libraries, PKAVS, council buildings etc.	*Communications Participation & Engagement Steering Group* **Target date:** Sept 2020 and ongoing	• Number of carers registered with PKAVS and P&K HSCP. • Percentage of carers reporting they feel informed and able to access a range of information and advice. • Number of requests for information and advice.	
	3. Provide information about anticipatory care planning/emergency planning to every carer to increase the number of carers having emergency plans in place.	*Process & Infrastructure Steering Group* **Target date**: Currently implemented and ongoing	• Number of Emergency Care Plans completed. • Number of Carer Cards issued by Community Alarms.	
	4. Work with partners to ensure there is relevant information for ethnic minority and gypsy/traveller carers.	*Communications Participation & Engagement Steering Group* **Target date:** May 2020	• Number of carers from ethnic minority backgrounds, gypsy/traveller community, learning disabilities, etc. engaging with our services.	

EVERYONE WILL HAVE THE INFORMATION, OPPORTUNITIES AND SUPPORT TO BE IDENTIFIED AS A CARER.				
What we will do	**How we will do this**	**Responsibilities and timescales**	**How we will measure how well we are doing**	**National Health & Wellbeing Outcomes delivered**
<u>OUTCOME 2</u> **Promote awareness about the Carers Act in the community and workplaces to improve early identification and support of carers.**	1. Develop information and guidance material to support training to health and social care and wider partners to better identify and support carers as well as to help carers to better self-identify and to seek support.	*Communications Participation & Engagement Steering Group* **Target date:** Aug 2020	• Number of carers registered with PKAVS and P&K HSCP. • Percentage of carers who feel supported to continue in caring role. • Number of professionals completing training.	People who work in Health & Social Care Services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide. People who provide unpaid care are supported to look after their own health and wellbeing, including reduce any negative impact of their caring role on their own health and wellbeing. Health & Social Care Services are centred on helping to maintain or improve the quality of life of people who use those services. Health & Social Care Services contribute to reducing health inequalities.
	2. Develop carer champions and networks to share knowledge about the support available to carers.	*Communications Participation & Engagement Steering Group* **Target date:** Mar 2020 and ongoing	• Number of carer champions/networks within Perth & Kinross.	
	3. Support employers in Perth & Kinross to recognise carers in the workplace and to gain Carer Positive accreditation.	*Communications Participation & Engagement Steering Group* **Target date:** Aug 2020 and ongoing	• Number of 'Carer Positive' awards to local businesses. • Number of carers who feel supported at work/college/university.	
	4. Work with GP practices to improve the early identifcation of carers at the point of diagnosis of the cared-for person.	*Communications Participation & Engagement Steering Group* **Target date:** April 2020	• Number of carers referred by GP.	

CARERS VOICES WILL BE CRITICAL TO INFLUENCING THE PLANNING, DEVELOPMENT AND IMPROVEMENT OF SUPPORTS.				
What we will do	**How we will do this**	**Responsibilities and timescales**	**How we will measure how well we are doing**	**National Health & Wellbeing Outcomes delivered**
<u>OUTCOME 3</u> **Ensure carers are listened to and have their opinions valued by professionals.**	1. Review hospital discharge planning in relation to involving carers and raise awareness across professionals and carers to increase early identification and involvement of carers.	*Carer Strategy Steering Group* **Target date:** Jul 2020	• Percentage of carers involved in discharge planning. • Number of carers referred through hospital discharge.	People who use health & social care services have positive experiences of those services, and have their dignity respected. People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable independently and at home or in a homely setting in their community. People who work in Health & Social Care Services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide. People who provide unpaid care are supported to look after their own health and wellbeing, including reduce any negative impact of their caring role on their own health and wellbeing.
	2. Work with Health, Social Work and Education professionals to involve carers in decisions about the support of the cared-for person, bridging the needs of cared-for person with the support needs of the carer as much as practicable.	*Communications Participation & Engagement Steering Group* **Target date:** Sept 2020	• Percentage of carers who feel that local services are well coordinated for them and the person they look after. • Percentage of carers who feel they have a say in services provided for the cared-for person.	
	3. Develop and take forward actions from carer feedback obtained from carer consultations, meetings, surveys. Review and revise processes, eligibility frameworks and short breaks services statement where necessary to improve carer experience.	*Carer Strategy Steering Group* **Target date:** Implemented and ongoing	• Percentage of carers who feel that local services are well coordinated for them and the person they look after. • Percentage of carers who have a positive experience of services designed to support them.	
	4. Review how to better support carers who are bereaved or where the cared-for person enters permanent residential care.	*Carer Strategy Steering Group* **Target date:** April 2020	• Number of bereaved carers supported. • Percentage of carers who have a positive experience of services designed to support them.	
	5. Ensure that there is a smooth transition of support for young adult carers.	*Process & Infrastructure Steering Group* **Target date:** Nov 2019 and ongoing	• Percentage of carers who have a positive experience of services designed to support them. • Percentage of carers who are satisfied with transition support.	

CARERS WILL BE SUPPORTED TO ACTIVELY PARTICIPATE IN DEVELOPING A COURSE OF SUPPORTS WITHIN THE LOCAL COMMUNITY TO ENABLE THEM TO HAVE A LIFE OUTWITH THEIR CARING ROLE.				
What we will do	**How we will do this**	**Responsibilities and timescales**	**How we will measure how well we are doing**	**National Health & Wellbeing Outcomes delivered**
<u>OUTCOME 4</u> **Provide opportunities for carers to participate as active partners to the planning and shaping of carer services in their local areas including services for the people who are cared for.**	1. Include carer representatives on relevant steering and working groups so that they can be active partners in the planning and shaping of carer services across Perth & Kinross.	*Carer Strategy Steering Group* **Target date:** Implemented and ongoing	• Number of carers who feel they have been involved in planning services. • Percentage of carers who feel that local services are well coordinated for them and the person they look after. • Percentage of carers who feel they have a say in services provided for the cared-for person.	People are able to look after and improve their own health and wellbeing and life in good health for longer. People who use health and social care services have positive experiences of those services, and have their dignity respected. Health & Social Care Services contribute to reducing health inequalities. Resources are used effectively and efficiently in the provision of Health & Social Care Services. People who work in Health & Social Care Services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.
	2. Provide opportunities for carers to recognise their own contribution in the life of those they care for, to receive updates on current developments, and to give feedback on future changes.	*Communications Participation & Engagement Steering Group* **Target date:** Implemented and ongoing	• Number of carers attending Carers Events (adult/young carers). • Number of carers who feel they have been involved in planning services. • Percentage of carers who feel they have a say in services provided for the cared-for person.	
	3. Work with carers and partners to shape services to ensure they remain meaningful and responsive to demand and explore more holistic forms of support for carers through a working group including carers' representatives and social enterprise providers.	*Communications Participation & Engagement Steering Group* **Target date:** Apr 2020 and ongoing	• Percentage of carers reporting improved outcomes. • Percentage of carers who feel they have a good balance between caring and other things in their lives. • Percentage of carers who are satisfied with opportunities to maintain or improve their health and wellbeing.	
	4. Develop carer satisfaction survey for carers to obtain information about the care they provide and their experiences of carers services used, to review effectiveness and efficiency of resources used.	*Carer Strategy Steering Group* **Target date:** Jan 2020	• Percentage of carers who have a positive experience of services designed to support them. • Percentage of carers who feel supported to be able to continue in caring role.	

CARERS WILL BE VALUED, LISTENED TO AND EMPOWERED TO SHARE THEIR EXPERIENCES.				
What we will do	**How we will do this**	**Responsibilities and timescales**	**How we will measure how well we are doing**	**National Health & Wellbeing Outcomes delivered**
<u>OUTCOME 5</u> **Develop wider carer networks to enrich peer support.**	1. Provide support in localities and within Care Groups to develop Carer Peer Support Groups to improve the provision of peer support amongst carers.	*Communications Participation & Engagement Steering Group* **Target date:** Jun 2020 and ongoing	• Number of carers who attend carer cafes and other groups. • Increase in number of groups in localities that are regularly attended. • Percentage of carers who feel supported to be able to continue in caring role.	People are able to look after and improve their own health and wellbeing and life in good health for longer. Resources are used effectively and efficiently in the provision of Health & Social Care Services.
	2. Support Carers Voice for adult carers and establish Young Carer Forum.	*Communications Participation & Engagement Steering Group* **Target date:** Implemented and ongoing	• Number of members at Carers Voice and Young Carers Forum • Number of carers who feel they have been involved in planning services. • Percentage of carers who feel supported to be able to continue in caring role.	

WE WILL PROVIDE SPECIALIST AND PERSON-CENTRED SUPPORT TO AVOID DISADVANTAGE TO CARERS OF ALL AGES.				
What we will done	**How we will do this**	**Responsibilities and timescales**	**How we will measure how well we are doing**	**National Health & Wellbeing Outcomes delivered**
<u>OUTCOME 6</u> **Improve provision of flexible and personalised support, to support emotional/ physical wellbeing of carers and to support them to have a life alongside caring.**	1. Provide a wide range of training opportunities for carers to develop confidence and skills.	*Communications Participation & Engagement Steering Group* **Target date:** Implemented and ongoing	• Number of carers who are accessing training opportunities. • Number of training opportunities made available.	Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services. People who provide unpaid care are supported to look after their own health and wellbeing, including reduce any negative impact of their caring role on their own health and wellbeing. Health and social care services contribute to reducing health inequalities.
	2. Provide opportunities for carers to be active partners in planning and shaping supports that promotes better emotional/physical wellbeing and life balance.	*Communications Participation & Engagement Steering Group* **Target date:** Apr 2020 and ongoing	• Percentage of carers who are satisfied with opportunities to maintain or improve their health and wellbeing. • Number of carers who feel they have a good balance between caring and other things in their lives. • Number of carers who feel the support they received had a positive impact on their 1) health & wellbeing 2) quality of life.	
	3. Work with partners to recognise how to provide cultural specific support to carers of different cultural backgrounds and communities.	*Communications Participation & Engagement Steering Group* **Target date:** Sept 2020	• Number of carers from ethnic minority backgrounds, gypsy/traveller community, learning disabilities, etc engaging with our services.	
	4. Review the range of outcome-focussed support across localities for accessibility, availability, relevance and suitability.	*Carer Strategy Steering Group* **Target date:** Aug 2020 and ongoing	• Number of carers accessing short breaks/respite. • Number of carers issued with leisure cards. • Number of carers accessing therapies. • Number of carers exercising choice and control under SDS. • Number of carers who report improved outcomes. • Uptake of Technology Enabled Care.	
	5. Explore further opportunities for social and financial inclusion.	*Carer Strategy Steering Group* **Target date:**	• Number of carers referred to Welfare Rights. • Number of 'Carer Positive' awards to local businesses. • Number of carers accessing short breaks/respite.	

WE WILL PROVIDE SPECIALIST AND PERSON-CENTRED SUPPORT TO AVOID DISADVANTAGE TO CARERS OF ALL AGES.			
What we will do	**How we will do this**	**Responsibilities and timescales**	**How we will measure how well we are doing**
<u>OUTCOME 7</u> **Young Carers will have the best start in life and will be supported to achieve their potential, irrespective of their caring responsibilities will be supported to achieve their potential**	1. Complete a Young Carer Statement when requests are made by the Young Carer / parent / guardian.	*Education & Children Services and PKAVS* **Target date:** Implemented and ongoing	• Number of completed Young Carer Statements. • Number of Young Carer Statements offered.
	2. Support young carers where their caring role is having an impact on their attainment, and work creatively with schools to reduce the attainment gap for young carers.		• Number of young carers who are supported through schools. • Number of young carers with improved outcomes at school.
	3. Increase a variety of respite opportunities by making funds available for young carers to make choices about their own needs and interests.		• Number of young carers accessing short breaks. • Number of young carers who feel they have a good balance between caring and other things in their lives.
	4. Work with schools to identify young carers to provide preventative support, as early as possible (Level 1). Increase opportunities to creatively engage with learning and identify what support is needed at home to improve attendance in school.		• Number of young carers who are identified at Level 1. • Percentage of young carers who feel supported in their caring role.
	5. Support young carers and their families to improve their lives where the caring role is impacting their wellbeing.		• Improved school attendance rates. • Number of young carers who feel supported in education. • Number of children being supported at Level 2-3.
	6. Work across services to meet the needs of both the Young Carer and the cared-for person.		• Number of young carers who feel they have a good balance between caring and other things in their lives.
	7. Support young carers pre-school age.	*NHS Tayside Health Visiting* **Target date:** Implemented and ongoing	• Number of pre-school young carers supported.
	8. Work with young carers over the life of this strategy to make the Service changes required to better meet their identified needs.	*Carer Strategy Steering Group* **Target date:** Implemented and ongoing	• Number of young carers accessing short breaks of their own choice. • Number of young carers who feel they have a good balance between caring and other things in their lives.

APPENDIX 2

Equality and Fairness Impact Assessment (EFIA) Form and Guidance

If the *'policy or practice'** you are developing or going to develop is assessed as relevant after undertaking the online screening process (the Integrated Appraisal Toolkit) - that is, it will have an impact on people - you should complete an Equality and Fairness Impact Assessment (EFIA).

This form (which includes accompanying guidance) should be completed.

*see definition below on Page 5

EFIA – Guidance

The purpose of the EFIA is to ensure that decision makers are fully informed, at a formative stage in the decision-making process.

Under the Equality Act 2010, the Council is required to eliminate discrimination, advance equality of opportunity, and foster good relations between equality groups. Under Part 1 of the Act 'The Fairer Scotland Duty', the Council is required to actively consider how it can reduce inequalities of outcome caused by socioeconomic disadvantage, when making strategic decisions.

The online Integrated Appraisal Toolkit (IAT) has been developed within the Council to assess all proposals against criteria for reducing poverty and socio-economic disadvantage, eliminating discrimination, advancing equality of opportunity, and fostering good relations between equality groups.

The IAT should first be used at the initial stages of proposal development to **screen** the proposal for any likely positive or negative effects in relation to equality, fairness and human rights. After completing the IAT, it should be evident if your proposal is likely (or not) to have significant implications for: reducing poverty and socio-economic advantage, eliminating discrimination, advancing equality of opportunity, and fostering good relations between equality groups. **If the screening process identifies that there are implications then this full Equality and Fairness Impact Assessment (EFIA) should be undertaken.**

When should I carry out an EFIA?

In order to fulfil our general duty it is critical that the all services conduct an EFIA in the following circumstances:

- **All** significant policies, strategies and projects* should have as a minimum an EFIA screening inbuilt as part of the risk assessment process.

- **All** budget options for the each financial year will require to be EFIA screened. (It is possible to group individual options if they relate to one particular service area).

- **All** Reports to Committee now require Equalities Impacts to be reported either as a screening or full EFIA. Significant service reforms **may** require a Full Report to be completed, or as a minimum, a justification in a Screening Report as to why the Full Report was unnecessary.

Equality and Fairness Impact Assessment Screening
A screening can be undertaken as part of a scoping exercise prior to a full report, or it can stand alone as final summary if no significant Equality and Fairness Impacts are identified or arise subsequently in the policy or plan implementation. This is done using the online Integrated Appraisal Toolkit.

Equality and Fairness Impact Assessment Full Report
A full report (using this form) should be conducted where a Screening indicates an area or areas that require more detailed consideration.

*see full definition Page 5

Stage 1: Screening

As noted above, a screening should ideally be carried out at the outset of a policy, service reform, or budget proposal* in order to embed consideration of equalities and fairness at the earliest part of the project plan or process.

In order to complete screening please follow the guidance provided within the online Integrated Appraisal Toolkit.

A Screening Report should be conducted prior to identifying if a Full Impact Assessment is required, and the findings of the report should inform the introduction to the assessment; and provide the context and background, to outline the purpose and direction of the Full Impact Assessment.

Stage 2: Full Impact Assessment

If there are any areas that arise as part of the screening process that require further investigation or highlight areas of concern with regard to likely impacts across any or all protected characteristics, then a Full Impact Assessment report be conducted.

*see full definition Page 5

EFIA Form

Complete this for all *relevant policies.*
***'Relevant'* means it will have an impact on people.**
***'Policy or Practice'* - see definition below.**

Definition of policy or practice for the purposes of EFIA:
For the purposes of an EFIA the term 'policy or practice' covers Service delivery and Employment. This can include a Policy, a Plan, a Strategy, a Project, a Service Review, a function, practice or service activity or a Budget option.

Section 1: Policy Details *(see definition of 'Policy'or Practice' above)*

Name of Policy or Practice:

Carers Strategy 2019-22

Service and Division/Team:

Perth and Kinross Health and Social Care Partnership

Owner/Person Responsible *(include your Name and Position):*

Karyn Sharp, Strategic Lead

Impact Assessment Team *(include your Names and Positions).* This team can consist of two people or more as appropriate:

Alison Gallacher, Business Improvement Officer, Christine Tse, Policy Officer and David McPhee, Equalities Team Leader.

Is the *'policy' or practice'* being impact assessed new or existing?
Please tick the appropriate box below to indicate.

X New ☐ Existing

What are the main aims of the policy or practice?

To provide improved support to Young and Adult Unpaid Carers living or caring in Perth & Kinross

Who are the main target groups/beneficiaries?

Unpaid Carers of all ages, and, indirectly, the people who they care for, which may include other family members.

What are the intended outcomes of the policy or practice?

That people who provide unpaid care are given support on a sustainable basis as long as they are able and willing to continue in that caring role. Support can be given to improve their health and wellbeing and other areas of their lives that are impacted, as well as to help them to be able to have a life alongside caring. Additionally, for Young Carers, they are supported to be a child first and foremost and have similar opportunities as their peers.

Section 2: Information Gathering

You should list here the sources of information used to assess the impact of the relevant policy or practice. This can include local sources such as reports, information and data, relevant partners' information, data and reports, other Council's relevant information, data and reports, national information, research outcomes, data profiles and any other evidence which has led to the development of this policy. You may wish to refer to Appendix 1 for reference when gathering information relating to Equality Monitoring Data.

Information/Evidence Gained and Used to Shape this Policy or Practice	**List Details, Source and Date** *(Continue on a separate sheet if necessary. Tick to indicate this has been done.* ☐)
Community consultation/involvement outcomes from earlier contacts - this usually includes formally arranged contact with individuals or community, voluntary sector and other relevant interest groups.	Public consultation was held in October 2018 via social media, letters to registered carers, emails, focus groups with carers of all ages, consultation stalls and events. 324 responses were received. A follow-up consultation was carried out at the Carers Conference, Perth, which was open to all across Perth and Kinross, whereby 35 responses were received. Carer representatives are able to provide ongoing feedback on the draft consultation through the Carer Programme Board, Carers Strategic Group, Carers Voice and related subgroups.
Employee involvement/consultation feedback *(eg survey, focus groups)*	Strategy consultation survey was developed through: • Several meetings held with key stakeholders on 12th, 13th, 19th, 20th, and 26th September 2018, and • 2 focus groups: one with adult carers and the other with young carers, both held on 20/9/2018. • Draft consultation has ongoing feedback from key stakeholders across the Partnership and carers.
Research and information list main sources.	Census 2011, General Registrar of Scotland and Relevant legislation where applicable.
Officer knowledge and experience.	Involvement from Strategic Lead for Health and Social Care Partnership; Christine Tse, Policy Officer; Alison Gallacher, Business Improvement Officer; and David McPhee, Equalities Team Leader. All contributors have a vast range of experience and broad knowledge in this area.
Equality monitoring data.	Cross referenced existing information in Appendix 1 and final draft will be shared with Equalities Strategic Forum.
Service user feedback (including customer contact, services and complaints).	Received through events outlined above.
Partner feedback.	Received through events outlined above.
Other - this may be information gathered in another Council area, nationally or in partner organisations which is considered to have relevance	

Section 3: Consultation/Involvement

Consultation with key stakeholders can be undertaken throughout the whole of the equality and fairness impact assessment process. This section can include details of outcomes from current, earlier or ongoing consultation/involvement activities. This activity **can also** help to **reach people not previously involved** with these processes, but who will be affected by this policy or practice when it is implemented.

The Consultation/Involvement process can also help **identify or agree changes** that need to be made to ensure the policy or practice will be inclusive when implemented.

The Equalities Team Leader (equalities@pkc.gov.uk) may be able to provide advice relating to potential contact with consultees from equality protected characteristic groups via existing mechanisms such as the Community Equalities Advisory Group (CEAG) or Equalities Strategic Forum.

A summary of the replies received from individuals and stakeholders consulted/involved. Include any previous feedback or complaints relating to equality and diversity issues and the policy or practice currently being assessed.

Equality Protected Characteristic	**Specific Characteristics**	**Date**	**Outcome of Consultation/Involvement** ***(continue on a separate sheet if necessary – tick to indicate this has been done*** ☐
Age	Older People (65+)	October 2018	Approx 37% of 324 carers gave feedback on their experience of carer services locally which helped us to develop the themes and commitments of the strategy.
	Younger People (16-64)	October 2018	Approx 42% of 324 carers gave feedback on their experience of carer services locally which helped us to develop the themes and commitments of the strategy.
	Children (0-16)	October 2018	Approx 18% of 324 carers gave feedback on their experience of carer services locally which helped us to develop the themes and commitments of the strategy.
	Looked After Children (Corporate Parenting)		
Disability	Physical Disability		N/A – not particularly relevant due to our strategy relating to supporting carers who look after people with disabilities.
	Sensory Impairment		N/A – not particularly relevant due to our strategy relating to supporting carers who look after people with disabilities.
	Mental Health		N/A – not particularly relevant due to our strategy relating to supporting carers who look after people with disabilities.
	Learning Disability		N/A – not particularly relevant due to our strategy relating to supporting carers who look after people with disabilities.

Gender Reassignment	Male transitioning to female		Consultation opportunities offered through press/social media.
	Female transitioning to male		Consultation opportunities offered through press/social media.
Marriage/Civil Partnership	Women		Consultation opportunities offered through press/social media.
	Men		Consultation opportunities offered through press/social media.
	Same Sex Couple (Male)		Consultation opportunities offered through press/social media.
	Same Sex Couple (Female)		Consultation opportunities offered through press/social media.
Pregnancy / Maternity/Paternity	Women		Carer Positive Employer
	Men (Paternity)		Carer Positive Employer
Race	A list of categories used in the census is here		MECOPP consulted with 6 carers from the Gypsy/Traveller community. Consultation opportunities offered through PKAVS Minorities Hub and through press/social media.
Religion / Belief	A list of categories used in the census is here		Consultation opportunities offered through press/social media.
Sex	Female		Consultation opportunities offered through press/social media.
	Male		Consultation opportunities offered through press/social media.
	Other Gender Identity		Consultation opportunities offered through press/social media.
Sexual Orientation	Lesbian		Consultation opportunities offered through press/social media.
	Gay		Consultation opportunities offered through press/social media.
	Bisexual		Consultation opportunities offered through press/social media.
Socio-economic (fairness)	Options detailed in Appendix 2		Consultation opportunities offered through press/social media.

Section 4: Detail the Positive and/or Negative Impacts or Tick to Indicate No Impact

Key Questions to Address

The Assessment should highlight areas of interest covering the following:

> Positive and Negative impacts across all protected characteristics.
> Scale of the Impact: An indication of the degree of potential impact, and whether this is judged to have a High, Medium or Low impact potential.
> Anticipated duration of the impact if relevant.
> Whether there is a specific differential impact to a particular protected characteristic or characteristics.
> Or if the impact is more wide ranging and general in its effect.
> Whether any impacts identified would/could be mitigated by an amendment to the policy, practice budget decision or service reform proposal.

This information will be indicated by activities at Section 2 and Section 3 above.

Equality Protected Characteristic	Specific Characteristics	Positive Impact (it could benefit the group concerned)	Negative Impact (it could disadvantage the group concerned)	No Impact
Age	Older People (65+)	The Carers Strategy seeks to improve the lives of all carers regardless of age.		
	Younger People (16-64)	The Carers Strategy seeks to improve the lives of all carers regardless of age.		
	Children (0-16)	The Carers Strategy seeks to improve the lives of all carers regardless of age.		
	Looked After Children (Corporate Parenting)	The Carers Strategy seeks to improve the lives of all carers regardless of age.		
Disability	Physical Disability	The strategy intends to raise awareness of carer support and services to enable all carers to be supported in their caring role and to meet their own outcomes. Carer Support Workers or Social Workers are able to travel to any carers who may not be able to travel outside of their own homes.		

Disability *(Contd)*	Sensory Impairment	The strategy intends to raise awareness of carer support and services to enable all carers to be supported in their caring role and to meet their own outcomes.	There may be an indirect impact on people with sensory impairment due to difficultly in receiving information (eg from posters advertising help and support). However, once they have contacted our service, we are able to make measures to support them in understanding information given to them. Links to existing strategies would be considered eg See Hear, British Sign Language, TEC Strategy.	
	Mental Health	The strategy intends to raise awareness of carer support and services to enable all carers to be supported in their caring role and to meet their own outcomes.	There may be an indirect impact on people with mental health problems and their carers due to perceived societal stigma in accessing services or support. Links to existing strategies would be considered eg Mental Health Strategy.	

Disability *(Contd)*	Learning Disability	The strategy intends to raise awareness of carer support and services to enable all carers to be supported in their caring role and to meet their own outcomes.	There may be an indirect impact on people with learning disability due to difficultly in receiving information (eg from posters advertising help and support). However, once they have contacted our service, we are able to make measures to support them in understanding information given to them. Links to existing strategies would be considered eg Keys to Life Strategy.	
Gender Reassignment	Male transitioning to female	This strategy is all-encompassing and does not differentiate carers or the cared-for by their gender. As carers are assessed only on the impact their caring role has on them using a published eligibility criteria, this ensures that there will be no discrimination against people on gender.		
	Female transitioning to male	This strategy is all-encompassing and does not differentiate carers or the cared-for by their gender. As carers are assessed only on the impact their caring role has on them using a published eligibility criteria, this ensures that there will be no discrimination against people on gender.		

Marriage/Civil Partnership	Women	The strategy seeks to improve the circumstances of each individual carer and enables them to meet their own individual outcomes.		
	Men			There is no evidence of a prevalence which indicated that there would be a specific impact on the strategy at this stage.
	Same Sex Couple (Male)			There is no evidence of a prevalence which indicated that there would be a specific impact on the strategy at this stage.
	Same Sex Couple (Female)			There is no evidence of a prevalence which indicated that there would be a specific impact on the strategy at this stage.
Pregnancy / Maternity/Paternity	Women			There is no evidence of a prevalence which indicated that there would be a specific impact on the strategy at this stage.
	Men (Paternity)			There is no evidence of a prevalence which indicated that there would be a specific impact on the strategy at this stage.

Race	A list of categories used in the census is here.	The strategy seeks to improve the circumstances of each individual carer and enables them to meet their own individual outcomes.	However, where there are language or culture barriers, this may indirectly mean that these people are negatively impacted due to lack of understanding (of published information etc). Additionally, for example, carers from the gypsy/traveler community can find it difficult to access services or support and prefer dedicated workers who can develop a relationship with their community and provide information/support to them. Would work with existing organisations eg PKAVS and MECOPP. An Ethnic Minority Support Worker is also funded as a frontline interface and support. Practice is non-discriminatory and policies would support this throughout any commissioned services.	

Religion / Belief	A list of categories used in the census is here.	The strategy seeks to improve the circumstances of each individual carer and enables them to meet their own individual outcomes.	However, where there are language or culture barriers, this may indirectly mean that these people are negatively impacted (due to difference in cultures which may prevent them from accessing support or certain types of support). Would work with existing organisations eg PKAVS and MECOPP. An Ethnic Minority Support Worker is also funded as a frontline interface and support. Practice is non-discriminatory and policies would support this throughout any commissioned services.	
Sex	Female	The strategy seeks to improve the circumstances of each individual carer and enables them to meet their own individual outcomes.	Some forms of support may appeal more to the other sex or there may not be a female equivalent, eg mens shed, certain leisure activities.	
	Male	The strategy seeks to improve the circumstances of each individual carer and enables them to meet their own individual outcomes.	Some forms of support may appeal more to the other sex, eg carer cafes, therapies, which may indirectly but negatively exclude male carers.	
	Other Gender Identity	The strategy seeks to improve the circumstances of each individual carer and enables them to meet their own individual outcomes.	Some forms of support may appeal more to the other sex, which may indirectly but negatively exclude these carers.	

Sexual Orientation	Lesbian	The strategy seeks to improve the circumstances of each individual carer and enables them to meet their own individual outcomes.	There may be feelings of societal stigma which may prevent some carers from accessing services. Otherwise, the strategy does not discriminate or promote one 'type' of carer over another.	
	Gay	The strategy seeks to improve the circumstances of each individual carer and enables them to meet their own individual outcomes.	There may be feelings of societal stigma which may prevent some carers from accessing services. Otherwise, the strategy does not discriminate or promote one 'type' of carer over another.	
	Bisexual	The strategy seeks to improve the circumstances of each individual carer and enables them to meet their own individual outcomes.	There may be feelings of societal stigma which may prevent some carers from accessing services. Otherwise, the strategy does not discriminate or promote one 'type' of carer over another.	
Socio-economic (fairness)	Options detailed in Appendix 2.	The strategy seeks to improve the circumstances of each individual carer and enables them to meet their own individual outcomes and would consider the needs of those affected particularly by socio-economic disadvantage eg rurality, low income, substance misuse.		

Section 5: Recommendations and Actions

As a result of this equality impact assessment, please **clearly describe practical actions** you plan to take to:

> *reduce or remove any identified **negative impact***
> *promote any **positive impact** or*
> ***gather** further information/evidence*

Equality Protected Characteristic	Specific Characteristics	Action	Who is responsible	Date for completion
Age	Older People (65+)	If an issue were to arise we would reduce or remove any identified negative impact.	Carers Programme Board and Strategy Group through the Risk Mitigation Plan.	
	Younger People (16-64)	If an issue were to arise we would reduce or remove any identified negative impact.	Carers Programme Board and Strategy Group through the Risk Mitigation Plan.	
	Children (0-16)	If an issue were to arise we would reduce or remove any identified negative impact.	Carers Programme Board and Strategy Group through the Risk Mitigation Plan.	
	Looked After Children (Corporate Parenting)	If an issue were to arise we would reduce or remove any identified negative impact.	Carers Programme Board and Strategy Group through the Risk Mitigation Plan.	
Disability	Physical Disability	If an issue were to arise we would reduce or remove any identified negative impact.	Carers Programme Board and Strategy Group through the Risk Mitigation Plan.	
	Sensory Impairment	If an issue were to arise we would reduce or remove any identified negative impact.	Carers Programme Board and Strategy Group through the Risk Mitigation Plan.	
	Mental Health	If an issue were to arise we would reduce or remove any identified negative impact.	Carers Programme Board and Strategy Group through the Risk Mitigation Plan.	
	Learning Disability	If an issue were to arise we would reduce or remove any identified negative impact.	Carers Programme Board and Strategy Group through the Risk Mitigation Plan	

Gender Reassignment	Male transitioning to female	If an issue were to arise we would reduce or remove any identified negative impact.	Carers Programme Board and Strategy Group through the Risk Mitigation Plan.	
	Female transitioning to male	If an issue were to arise we would reduce or remove any identified negative impact.	Carers Programme Board and Strategy Group through the Risk Mitigation Plan.	
Marriage/Civil Partnership	Women	If an issue were to arise we would reduce or remove any identified negative impact.	Carers Programme Board and Strategy Group through the Risk Mitigation Plan.	
	Men	If an issue were to arise we would reduce or remove any identified negative impact.	Carers Programme Board and Strategy Group through the Risk Mitigation Plan.	
	Same Sex Couple (Male)	If an issue were to arise we would reduce or remove any identified negative impact.	Carers Programme Board and Strategy Group through the Risk Mitigation Plan.	
	Same Sex Couple (Female)	If an issue were to arise we would reduce or remove any identified negative impact.	Carers Programme Board and Strategy Group through the Risk Mitigation Plan.	
Pregnancy / Maternity/Paternity	Women	If an issue were to arise we would reduce or remove any identified negative impact.	Carers Programme Board and Strategy Group through the Risk Mitigation Plan and Employer Responsibility.	
	Men (Paternity)	If an issue were to arise we would reduce or remove any identified negative impact.	Carers Programme Board and Strategy Group through the Risk Mitigation Plan and Employer Responsibility.	
Race	A list of categories used in the census is here.	Services have been commissioned through Minorities Community Hub and MECOPP to mitigate and support carers where there is a risk that carers may be indirectly disadvantaged due to race. An Ethnic Minority Support Worker is also funded as a frontline interface and support.	Carers Programme Board and Strategy Group through the Risk Mitigation Plan.	

Religion / Belief	A list of categories used in the census is here.	Services have been commissioned through Minorities Community Hub and MECOPP to mitigate and support carers where there is a risk that carers may be indirectly disadvantaged due to cultural and religious belief. An Ethnic Minority Support Worker is also funded as a frontline interface and support.	Carers Programme Board and Strategy Group through the Risk Mitigation Plan.	
Sex	Female	If an issue were to arise we would reduce or remove any identified negative impact.	Carers Programme Board and Strategy Group through the Risk Mitigation Plan.	
	Male	If an issue were to arise we would reduce or remove any identified negative impact.	Carers Programme Board and Strategy Group through the Risk Mitigation Plan.	
	Other Gender Identity	If an issue were to arise we would reduce or remove any identified negative impact.	Carers Programme Board and Strategy Group through the Risk Mitigation Plan.	
Sexual Orientation	Lesbian	If an issue were to arise we would reduce or remove any identified negative impact.	Carers Programme Board and Strategy Group through the Risk Mitigation Plan.	
	Gay	If an issue were to arise we would reduce or remove any identified negative impact.	Carers Programme Board and Strategy Group through the Risk Mitigation Plan.	
	Bisexual	If an issue were to arise we would reduce or remove any identified negative impact.	Carers Programme Board and Strategy Group through the Risk Mitigation Plan.	
Socio-economic (fairness)	As detailed in Appendix 2.	If an issue were to arise we would reduce or remove any identified negative impact.	Carers Programme Board and Strategy Group through the Risk Mitigation Plan.	

Section 6:Outcomes

When the evidence has been considered in relation to the proposed Policy, Practice, Project, Service Reform or Budget Option, it will be apparent what the likely impacts are. The type, scale, duration, and specificity of the likely impacts will inform the direction of the outcome of the EFIA.

There are four potential outcomes as follows:

1. No major change required The Policy, Practice, Project, Service Reform or Budget Option is robust and can continue without amendment.
2. Continue the Policy, Practice, Project, Service Reform or Budget Option. A justification is required for continuing despite the potential for adverse impact.
3. Adjust or Amend the Policy, Practice, Project, Service Reform or Budget Option. Remove barriers, make changes to better advance equality or remove or mitigate negative impact.
4. Stop, or Remove the Policy, Practice Project, Service Reform or Budget Option if adverse effects cannot be justified and cannot be mitigated.

1. No major change required The Policy, Practice, Project, Service Reform or Budget Option is robust and can continue without amendment.

The successful implementation of the strategy including communication and engagement with all groups of carers and support to groups of carers who may be indirectly disadvantaged, will improve the lives of carers across Perth & Kinross.

Section 7: Authorising the Assessment

The following signatures are required:

Service Manager

Signed	K Sharp	Name	Karyn Sharp	Date	09/05/2019

Quality Assured by PKC Equality and Fairness Impact Assessment Trained Officer (within service)

Signed	D McPhee	Name	David McPhee	Date	09/05/2019

Section 8: Publishing the Assessment

The completed and authorised EFIA should be added to your Service pages on the internet.

Date Action Completed	10/06/2019	Date for Review of EFIA	September 2019

Section 9: Committee Reporting

Ensure your Committee **report** to accompany this policy **includes information** about any **actions** taken to reduce or remove **negative impacts** identified, or include any **positive impacts** expected when the policy is implemented.

Section 10: Review and Monitor

Note of Action required (from Section 5)

If any equalities issues are identified through consultation at the Equalities Strategic Forum or as part of our ongoing work we would refer to existing mechanisms for specialist advice as required. The Strategic Lead is a member of the NHS Tayside Equality and Diversity Forum and the Perth and Kinross Equality and Strategic Forum.

Date completed:

August 2019

Note of Action required (from Section 5)

Date completed:

Note of Action required (from Section 5)

Date completed:

Note of Action required (from Section 5)

Date completed:

Add more sections as required

Appendix 1 – Equality Monitoring Data Guidance

The Equality Protected Characteristics in Our Area

There are nine protected characteristics in the Equality Act and these are disability, sex, race, sexual orientation, gender reassignment, age, marriage and civil partnership, pregnancy and maternity and religion and belief.

The Scottish Government Equality Evidence Finder is updated twice a year with data surrounding equality evidence from a wide range of policy areas. Some key local statistics should be noted:

Disability - 28% of the Perth & Kinross population consider themselves to have a long term physical or mental health condition, compared to 22% for Scotland overall. *(Scottish Household Survey 2016).*

Sex - 49% of the Perth & Kinross population identify as male, the same as Scotland overall. *(Scottish Household Survey 2016).*

Race - 98% of the Perth & Kinross adult population classify themselves as 'White', compared to 96% for Scotland as a whole *(Scottish Household Survey 2016).*

Sexual orientation - 99% of the Perth & Kinross adult population identify as Heterosexual, compared to 98% for Scotland overall*. (Scottish Household Survey 2016).*

Gender reassignment - The Registrar General for Scotland maintains a Gender Recognition Register in which the birth of a transgender person whose acquired gender has been legally recognised is registered showing any new name(s) and the acquired gender. This enables the transgender person to apply to the Registrar General for Scotland for a new birth certificate showing the new name(s) and the acquired gender. The Gender Recognition Register is not open to public scrutiny. Local information is not available. *(NRS Registration Division 2016).*

Age - Young people under 16 currently make up 16% of the population in Perth & Kinross, compared to the national average of 17%. People aged 65 and over account for 23% of the total population, higher than the national average of 19%. By 2039 this proportion is set to increase to 30%. *(ONS Population data).*

Marriage and civil partnership - 58% of the Perth & Kinross adult population are married or in a civil partnership, compared to 47% for Scotland as a whole. *(Scottish Household Survey 2016).*

Pregnancy and maternity - In 2016, the birth rate was 53.5 per 1000 women aged 15-44. In other words, broadly 5.4% of women of child bearing age were pregnant in 2016 in Perth and Kinross, compared to 5.2% for Scotland as a whole. *(NRS Vital events 2016).*

Religion and belief - 52% of the Perth & Kinross adult population consider themselves to have a religious belief, compared to 49% for Scotland as a whole. *(Scottish Household Survey 2016). National data sources have been used to provide this information but it should be noted that the Scottish Household Survey is only based on a sample of respondents so variations may not be statistically significant.*

Appendix 2– Socio-economic (Fairness)

Socio-Economic Disadvantage:

Low Income – (in comparison to most others) – can be measured in a range of ways eg relative poverty (after housing costs) looks at number of individuals living in households with incomes below 60% of UK median income. Statistics on absolute poverty (household living standards over time) and persistent poverty (where households live in poverty for 3 years out of 4) are also available. Poverty statistics can also be broken down by gender, disability, ethnicity, tenure and urban/rural.

Low/No Wealth – having access to wealth eg financial products, equity from housing and a pension, provides some protection from socio-economic disadvantage. Single adult households (including single parent households) have very high risks of low wealth; households with lower educational qualifications and in routine or manual occupations have significantly higher risks of low wealth.

Material deprivation – refers to households being unable to access basic goods and services and tends to focus on families with children.

Area deprivation - living in a deprived area can exacerbate negative outcomes for individuals and households already affected by issues of low income.

Socio-economic background – the structural disadvantage that can arise from parents' education, employment and income (ie social class) is more difficult to measure.

Inequalities of Outcome – any measurable differences for communities of interest or communities of place such as:

- Poorer skills and attainment.
- Lower quality, less secure and lower paid work.
- Greater chance of being a victim of crime.
- Lower healthy life expectancy.
- Less chance of a dignified and respectful life.

Communities of Place – refers to people who are bound together because of where they reside, work, visit or otherwise spend a continuous proportion of their time. Poverty is often hidden in smaller rural communities with issues such as cost of living and accessibility of transport, education and employment impacting more negatively.

Communities of Interest – refers to people who share an identity eg an equality protected characteristic. Consideration of the impact on those groups can help develop a deeper understanding of socio-economic impact, particularly by talking to people with lived experiences.

For further information refer to Fairer Scotland Duty -Interim Guidance for Public Bodies

Appendix 3– Human Rights Based Approach

A Human Rights approach should also be an embedded consideration in an EFIA.

In summary; we need to consider, where applicable, to what (if any) extent policies, practices, projects, Service Reforms, or Budget Options impact on three key strands of Human Rights:

Absolute Rights
> The right to life.
> The right to freedom from inhuman and degrading treatment.

Limited Rights
> The right to liberty.
> The right to a fair trial.

Qualified Rights
> The right to respect for private and family life, home and correspondence.
> The right to freedom of thought, conscience and religion.
> The right to freedom of assembly and association.
> The right to protection of property.

Any restriction of Qualified Rights must be:
> In accordance with the law: have a basis in domestic law, safeguards against arbitrary interference, foreseeable.
> In pursuit of a legitimate aim: including "the economic wellbeing of the country"; "the protection of health", "protection of the rights and freedoms of others".
> Necessary.
> Proportionate.
> Not discriminatory.

There is further guidance on integrating human rights into the equality impact assessment process available on the Scottish Human Rights Commission website following previous pilots with local authorities: http://eghria.scottishhumanrights.com/.

APPENDIX 3

Perth & Kinross Health and Social Care Partnership

Communications & Engagement Plan: Carers Strategy 2019-2022

Version V0.5 October 2019
Project Lead: Karyn Sharp,

Contents

Document version control:

Date Published:	8.October 2019
Version:	0.5
Owner/Author:	Alison Gallacher / Christine Tse
Contact details:	abgallacher@pkc.gov.uk 01738 476285

1. Introduction

1.1 Unpaid carers play a vital but under-valued role in our society; providing care and support to family members or friends. Without carers, many people with long term conditions, illness and disabilities would not be able to be supported to stay at home. Many carers fulfil a caring role without identifying as such and therefore are not being able to access the support that is available to them. Without information and support, carers risk their own health and wellbeing and so the provision of an Communications Plan is necessary to ensure that carers are aware of the resources that are available to them to enable them to sustain their caring role.

1.2 The Carers Programme Board was established in September 2018, by the Health and Social Care Partnership as part of the refresh of how services are delivered across Perth & Kinross. The role of the Board is to provide oversight and direction to ensure the achievement of the Board's Strategic Delivery Plan. Legislatively, the Carers (Scotland) Act 2016 (the Act) was implemented in April 2018 giving carers new rights to ensure that they were supported to sustain their caring role. The Act places a duty on the local authorities and health boards to provide information and advice for carers as to the Services that are available for them.

1.3 A further requirement of the Act is that the IJB publish a Carers Strategy to align with the Strategic Commissioning Plan indicating how it would ensure that carers were supported and to improve the level of support in the area. The Carers Strategy will be in place from 2019 to 2022 and this Communications Plan will apply during the lifetime of the Strategy.

1.4 A consultation process took place as part of the development of the Strategy which highlighted the importance of providing information in a range of formats at locations throughout the community. Carers wanted information in a range of locations and in a range of formats including digital. Communication is required within the Partnership to ensure shared understanding of the legislation and the outcomes of the Strategy and outwith the Partnership in our wider communities to ensure Carers receive the support that they need and are entitled to.

1.5 This Plan and the Carers Strategy link to the Strategic Commissioning Plan, the Mental Health and Wellbeing Strategy, the Keys to Life Strategy, Physical disability/Sensory Impairment Strategy, the Autism Strategy and the Alcohol & Drug Partnership Strategy.

2. Communication Aim

2.1 To raise Carers awareness and uptake of the range supports that are available to them.

2.2 To raise awareness of the Carers Strategy.

3. Communication Objectives

The communications objectives for this project are:

- Increase the number of carer referrals by 25% in the first year of the Plan, by 10% in the second year of the Plan and by 10% in the third year of the Plan, for both Young and Adult Carers;
- Increase the number of Adult Carer Support Plans by 10% in the first year of the Plan, by 10% of the Second year of the Plan and by 10% in the third year of the Plan;
- Increase the number of Young Carer Statements by 10% in the first year of the Plan, by 10% in the second year of the Plan and by 10% in the third year of the Plan;
- Increase the number of TEC equipment issues for carers by 10% in each of the 3 years of the Plan;
- Reduce the number of admissions to long-term or permanent residential care due to carer breakdown by 5% in year 1, by 10% in year 2 and 10% in year 3;
- Increase the number of businesses who are recognised as Carer Positive at level 1 (Engaged) by 10 through the life of the strategy.

4. Stakeholders

4.1 We will communicate and engage with the following internal and/or external audiences:

Carers
People who are Cared For
Carer Representatives
All staff working for the Health and Social Care Partnership (HSCP)
Integration Joint Board (IJB)
Perth & Kinross Council
NHS Tayside
Residents
Voluntary/Private and 3rd Sector Groups

Commissioned Services
Elected members
Chamber of Commerce
Local Businesses
Trade Unions
Scottish Government Carers Leads

5. Key Messages

5.1 The key messages for this project are:

i. Information and support for all carers is available from PKAVS;
ii. Carers should be supported to enable them to sustain their caring role, to have a life alongside caring;
iii. Young carers should be children first and foremost;
iv. Carers have a right to be offered or to request an Adult Carer Support Plan or Young Carer Statement;
v. Carers' opinions matter and we will take account of their wishes and ambitions to help plan and develop how we work;
vi. By supporting unpaid carers, people will be able to stay at home for longer and so families will be able to stay together;
vii. Carers should not be disadvantaged due to their caring role.

6. Tactics

6.1 A wide range of communication channels will be used to ensure we reach all of our stakeholders.

- Information Stalls/leaflets – based on Carer Coalition literature.
- Conference (Central Event)/ local events.
- Advertising – radio – electronic media.
- Briefings/meetings with Elected members/partnership/ IJB/Carer Representatives/local community groups supporting carers/Employers.
- Press Releases.
- Inside News Bulletins for staff.
- Conversations with Carers.
- Training sessions to support Carers.
- Outreach for Young Carers.
- Locality Newsletters.
- Social Media Messages inc. Your Community PK, PKAVS social media, and PKC FB & Twitter pages.
- Plasma Screens in PKC buildings/libraries/ PKAVS/Health Centres.
- Council website – for new resources/updates.
- PKAVS website – new resources.

- NHS Website – to confirm details.
- ***Eric*** Carer page for employees' link from Carer page for Adult Care staff.
- Partner Publications.
- Training Sessions with Staff.
- Consultation Hub – on pkc.gov.uk – you said /we did.
- Consultation questionnaires/ user surveys.

7. Design and Branding

- Leaflets relating to the resources for carers that are available, using the Partnership's colour palette; Partnership logo and where commissioned services are involved PKAVS logo. A range of materials have been printed based on literature from the Carers Coalition.
- To include "Translation/Other Formats" panel.
- For distribution through Community Engagement and commissioned services.
- Overall annual budget £5,000 for 2019/20.
- Posters for events through commissioned services – included in commissioned services budgets – need clarity on use of the Partnership logo.
- Digital platforms: Social Media/Plasma screens as above.
- Upright Banner – Supporting Unpaid Carers using Health & Social Care Partnership brand.
- Young Carers may want further branding.

8. Responsibilities

The diagram below illustrates who will be involved in the communication activities for this project:

Health & Social Care Partnership	
Project Sponsor	Diane Fraser Head of Adult Social Work and Social Care, Chair Carers Programme Board
Senior Responsible Owner	Karyn Sharp, Service Manager, Strategic Lead (Carers) & Sharon Cooper, Children's Services Service Manager
Project Advisor	Paul Henderson, Service Manager, Co-chair Carers Programme Board
Project Co-ordinator	Alison Gallacher, Business Improvement Officer
Corporate Communications Lead	Caroline Vaskevicius
Service Communication Lead	Mary Begbie
Press Lead (Corporate)	TBA
Design Lead (Corporate)	TBA
ACCOUNTABLE TO: Project Lead and Communications & Engagement Group	

9. Budget

This communications plan will be delivered in-house by existing employees. However, additional budget may be required for engagement and printing activities. Costs are detailed below:

- Radio advertisement on Carers Week £816 +VAT.
- City Centre stand costs for Carers Week £60 + VAT.
- Printing to supplement existing leaflets as and when stocks are exhausted.
- Consideration should be given to ensure that costs of communications and engagement undertaken by PKAVS commissioned services are properly branded and costed as part of the Service Level Agreement.
- Total Carer's Programme Budget for 2019/20 is £811,488 of which the budget for information and promotional materials is £5,000.

10. Milestones

Date	Key milestone
10 – 16 June 2019	Carer Week activities to promote and engage with carers
6 November 2019	Presentation of Strategy to Lifelong Learning Committee, PKC
6 November 2019	Presentation of Strategy to IJB
29 November 2019	Carers Conference Event

11. Risks

Risk Description	**Impact (Scale 1 to 5)**	**Probability (Scale 1 to 5)**	**Action Plan to mitigate risk**
There is a risk that the Strategy will not be completed in sufficient time for further consultation prior to presentation to Integration Joint Board and Lifelong Learning Committee.	4	5	A timeline has been prepared for use by officers responsible for submissions for the Strategy.

There is a risk that a clear and consistent message about the help that is available to support carers is not presented to Carers in the area.	3	3	This Plan: Partnership planning and working together with commissioned services, voluntary and community groups will ensure that a clear and consistent message is presented, raising awareness across the area and care groups, so that carers are aware of the help that is available and how to access it.

12. Review & Evaluation

12.1 This Communications and Engagement Plan will be reviewed and evaluated by the Health and Social Care Partnership Communications and Engagement Group periodically and the Carer's Strategy Group and the Carers Programme Board at each meeting.

13. Equality Assessment

13.1 An equality impact assessment needs to be carried out for functions, policies, procedures or strategies in relation to race, gender and disability and other relevant protected characteristics. This supports the Council's legal requirement to comply with the duty to assess and consult on relevant new and existing policies.

13.2 Please refer to the information that is available on the Council's Equality **Impact Assessment Toolkit** which is available on ***eric*** in the 'Equalities and Diversity Section' of the 'A-Z of Resources'.
The Carers' Strategy has been subject to an Equalities Impact Assessment which ensures that supports have been put in place to minimise the impact of a caring role on people with protected characteristics.

14. Strategic Environmental Assessment

14.1 Strategic Environmental Assessment (SEA) is a legal requirement under the Environmental Assessment (Scotland) Act 2005 that applies to all qualifying plans, programmes and strategies, including policies (PPS). Further information on strategic environmental assessment is available on ***eric***.

15. Communications and Engagement Stakeholder Activity Plan

Phase 1:Strategy Development									
No	**Activity**	**Objective No**	**Channel**	**Key Messages**	**Key Stakeholder(s)**	**Start**	**End**	**Lead Officers**	**Progress**
1.1	Promote and engage with Carer Strategy 2019-22 stakeholders	1, 4, 5, 6		v	• Carers	Sep 18	~~Sep 19~~ Nov 19	K Sharp L Baillie	
1.2	Initial consultation	1, 4, 5, 6	Form online and paper	v	• Carers	Oct 18	Oct 18	K Sharp	
1.3	Update at Carers' conference	1, 4, 5, 6	Information stall	v	• Carers • Professionals	Nov 18	Nov 18	K Sharp L Baillie	
1.4	Supplementary Questionnaire presented at Conference	1, 4, 5, 6	Paper	v	• Carers • Professionals	Nov 18	Nov 18	K Sharp S Cooper	
1.5	Engagement through workshop building Action Plan	1, 4, 5, 6	Meeting	v	• Carers • Carers Representatives • Professionals	Dec 18	Dec 18	K Sharp S Cooper	
1.6	Critical Friend review groups for draft Strategy	1, 4, 5, 6	Circulation of draft to range stakeholders	v, vi	• Carers • Carers Representatives • Professionals	Jan 19	Feb 19	K Sharp S Cooper	
1.7	Feedback implemented	1, 4, 5, 6		v, vi	• Carers • Carers Representatives • Professionals	Feb 19	Feb 19	K Sharp S Cooper	
1.8	Circulated to IJB	1, 4, 5, 6	Electronic & paper version	v, vi	IJB – Public Partners	Feb 19	Feb 19	K Sharp S Cooper	

1.9	Circulate to key stakeholders	1, 4, 5, 6	Electronic version	v, vi	Wider Partnership representatives				
1.10	Arrange glossy version with Corporate Communications	1, 4, 5, 6	Paper/ electronic online	All	All	Oct 19	~~Mar 19~~ ~~Aug 19~~ Nov 19	K Sharp S Cooper	
1.11	Summary, online and easy read versions to be made available	1, 4, 5, 6	Electronic online & Leaflet	All	All	Oct 19	~~Mar 19~~ ~~Sep 19~~ Nov 19	K Sharp S Cooper	
1.12	Press Release to accompany	1, 4, 5, 6	Electronic	All	All	Nov 19	~~Mar 19~~ ~~Sep 19~~ Nov 19	K Sharp S Cooper	

Strategy Outcome 1:									
Clear, reliable, accessible information about local and national support is available across a wide range of locations in Perth & Kinross									
No	**Activity**	**Objective No**	**Channel**	**Key Messages**	**Key Stakeholder(s)**	**Start**	**End**	**Lead Officers**	**Progress**
2.1	Range of formats and relevant language translations to be available- Polish, Mandarin, Easy Read	2, 7	Leaflets	i, ii, iii, iv, vi, vii	Carers	~~Apr 19~~ Oct 19	~~Apr 19~~ Dec 19	K Sharp S Cooper	
2.2	Review of existing literature available regarding rights under the Carers (Scotland) Act 2016 – Short Breaks Services Statement	2	Leaflets	i, ii, iii, iv, vi, vii	Carers	~~May 19~~ Oct-19	~~Sep 19~~ Dec-19	K Sharp R Jamieson	
2.3	Review of PKC website information and resources for accuracy	2, 7	Websites	i, ii, iii, iv, vi, vii	Carers, Cared for	Jun-19	Oct-19 & 6-month review	K Sharp	
2.4	Provision of information for carers on social media on ongoing basis	2, 7	Social Media Facebook Twitter Instagram	i, ii, iii, iv, vi, vii	Carers	Jun-19	Jun-19 Monthly item	K Sharp	
2.5	Review of Your Community PK resources to ensure current and relevant	2, 7	Websites	i, ii, iii, iv, vi, vii	Carers, Cared For, Professionals	Aug-19	Oct-19 6-month review	K Sharp	

2.6	Emergency Planning information for carers to be made available to support carers to be confirmed	2, 3, 7	Leaflets	i, ii, iii, iv, vi, vii	Carers, Cared For	Aug-19	Oct-19	K Sharp R Jamieson	
2.7	Distribution of printed material across area in noted health and community locations	2, 7	Leaflets	i, ii, iii, iv, vi, vii	Carers	Sep-19	Dec-19	R Jamieson	
2.8	Review of content of Carers Hub website information	2, 7	Websites	i, ii, iii, iv, vi, vii	Carers	Sep-19	Oct-19	R Jamieson	
2.9	Design of specific Plasma screens for use in public buildings on ongoing basis	2, 7	Plasma Screens	i, ii, iii, iv, vi, vii	Carers, Cared For	Sep-19	Dec-19 6-month review	K Sharp	
2.10	Creation of posters for highlighting available resources	2, 7	Posters	i, ii, iii, iv, vi, vii	Carers	Oct-19	Dec-19	R Jamieson	

Strategy Outcome 2:

Promoted awareness about the Carers Act in the community and workplaces to improve early identification and support of carers.

No	Activity	Objective No	Channel	Key Messages	Key Stakeholder(s)	Start	End	Lead Officers	Progress
3.1	Work with employers in Perth & Kinross to recognise carers in the workplace	1, 2, 5, 7	Meetings, Business Events, internal news bulletins	i, ii, vii	Chamber of Commerce/ Individual employers or groups	Jan 20	Ongoing	K Sharp	

3.2	Develop network of workers across various organisations to share information about the different types of support available to carers.	2, 3	Meetings, Events, internal news bulletins,	i, ii, vii	Employees of range of employers	Oct 19	Jun-20	A Moir	
3.3	Carer Champions to be developed across all in-house registered services.	2, 3	Meetings, drop-in sessions Events, internal news bulletins,	i, ii, vii	Carers, Cared for	Nov 19	May 2020	S Thompson	
3.3	Training to health, social care and wider partners to support carers and to help carers to self-identify more easily.	3	Meetings, Events, e-learning	All	Professionals, Commissioned Services, Charities	Oct 19	Apr-20	K Sharp L Baillie R Jamieson	
3.4	Work with GPs and Practice Managers for the early identification of carers.	3	Meetings, events, information cards, leaflets	All	GPs lead groups/ Practice Managers	Oct 19	Apr-20	R Jamieson L Baillie	

Strategy Outcome 3									
Carers will be listened to and have their opinions valued by professionals.									
No	**Activity**	**Objective No**	**Channel**	**Key Messages**	**Key Stakeholder(s)**	**Start**	**End**	**Lead Officers**	**Progress**
4.1	Provide training and processes for professionals to improve communication with carers with regard to changes in support to cared for.	2, 3	Meetings, training events, e-learning	All	Professionals	Aug-19	Dec-19	K Sharp S Cooper L Baillie R Jamieson	
4.2	Provide information and training to: Health, Social Work Education professionals with respect to the health needs of the individual and the support needs of the carer.	2, 3, 4	Leaflets, training events, e-learning	All	Professionals	Sep-19	Jun-20	K Sharp S Cooper M Neill L Baillie R Jamieson	
4.3	Develop hospital discharge planning awareness to include all carers.	2, 3, 4	Events, meetings	All	Professionals	Oct-19	Jun-20	K Sharp L Baillie R Jamieson	
4.4	Consultation and Engagement events with carers around: Eligibility frameworks Short breaks services statement, to ensure relevance and consistency Provide Easy Read.	1, 3, 4, 6	Meetings, Events	i, ii, iii, v, iv	Carers, Cared For	Oct-19	Jan-21	K Sharp S Cooper A Moir	
4.5	Review support for carers who are bereaved or where the cared-for person enters permanent residential care	2, 3	Meetings, events, leaflets, posters	I, ii, iii, vii	Carers, Commissioned Services	Nov-19	Apr-20	T Allan	

Strategy Outcome 4

Opportunities to participate as active partners to the planning and shaping of carer services in their local areas including services for the people who are cared for.

No	Activity	Objective No	Channel	Key Messages	Key Stakeholder(s)	Start	End	Lead Officers	Progress
5.1	Carer respresentatives on the Programme Board and relevant steering, working groups.	1, 4, 6	Meetings, emails, events	ii, iii, v, vii	Carers, Representative Groups, Commissioned Services	Apr-19	Ongoing	K Sharp S Cooper R Jamieson	
5.2	Support for carers will be developed including social enterprise providers.	1, 2, 4, 5, 6, 7	Meetings, emails, events	ii, v, vii	Carers, Representative Groups, Commissioned Services, Social Enterprises	Apr-19	Ongoing	K Sharp S Cooper R Jamieson T Allan	
5.3	Work with carers and partners to shape services to ensure they remain meaningful and responsive to demand.	All	Meetings, Social Media,	All	Carers, Representative Groups, Commissioned Services, Social Enterprises	Apr-19	Ongoing	K Sharp S Cooper R Jamieson T Allan	
5.4	Opportunities for carers to recognise their own contribution in the life of those they care for, to receive updates on current developments, and to give feedback on future changes, such as at the Carers Conference, during Carers Week and the Young Carers Consultation event.	1, 4, 6, 7	Annual conference event, Leaflets Information events surveys, questionnaires Carers Stories	All	Carers, Carer Representative Groups, Cared For, Commissioned Services, Social Enterprises	Jun-19	Ongoing	K Sharp S Cooper R Jamieson	
5.5	Develop carer experience survey for carers to obtain information about the care they provide and their experiences of carers services used, to review effectiveness and efficiency of resources used.	1, 4, 5, 6, 7	Meetings, social media,	v,vi	Carers, Carer Representative groups, Commissioned services	Jun-19	Oct-19	K Sharp S Cooper R Jamieson	

Strategy Outcome 5									
The development of wider carer networks to enrich peer support.									
No	**Activity**	**Objective No**	**Channel**	**Key Messages**	**Key Stakeholder(s)**	**Start**	**End**	**Lead Officers**	**Progress**
6.1	Develop & support Carer Peer Support Groups	1,4	Social media, press releases, information stalls/leaflets	i, ii, iii, v, vi	Carers Carer Rep Groups Charity Groups Statutory Services	Apr-19	Ongoing	A Moir K Sharp	
6.2	Support to Carers Voice for adult carers	1, 4	Social media, meetings, events, plasma screens, press releases, information stalls/leaflets	i, ii, v, vi	Carers Carer Rep Groups Charity Groups Statutory Services	Apr-19	Ongoing	R Jamieson K Sharp	
6.3	Establishment of Young Carer Forum	1, 4	Social media, Plasma screens, school information /leaflets	i, ii, iii, v	Carers Carer Rep Groups Charity Groups Statutory Services	Apr-19	Apr 20 & ongoing	R Jamieson M Neill S Cooper	

Strategy Outcome 6

Improved provision of flexible and personalised support, to support their emotional/physical wellbeing and to have a life alongside caring.

No	Activity	Objective No	Channel	Key Messages	Key Stakeholder(s)	Start	End	Lead Officers	Progress
7.1	Provide training opportunities for carers to develop confidence and skills.	1, 2, 3	Meetings, Training Sessions	i, ii, vi	Carers, Care For, Commissioned Services, Health & Social Care Professionals	Apr-19	Ongoing	K Sharp S Cooper R Jamieson	
7.2	Provide opportunities for carers to be active partners in planning and shaping supports that promotes better emotional/physical wellbeing and life balance.	1, 4, 5. 6, 7	Conversation Meetings, Training Sessions	i, ii, vi	Carers, Care For, Health & Social Care Professionals, Commissioned Services, Universal Services	Apr-19	Ongoing	K Sharp S Cooper R Jamieson L Baillie A Moir	
7.3	Review provision to support carers of different cultural backgrounds and communities.	1, 2, 3, 4	Conversation Information leaflets and events, Meetings	i, ii, v, vi	Carers, Cared for, Commissioned Services, Carer Representatives Charitable Organisations	Jan-20	Jun 20 & Ongoing	K Sharp S Cooper R Jamieson	
7.4	Improve the range of flexible support in different localities across Perth & Kinross.	1, 2	Meetings, Briefings	i, ii, v, vi	Carers, Cared for, Commissioned Services, Social Enterprises, Private Sector	Jan-20	Jun 20 & Ongoing	K Sharp S Cooper R Jamieson T Allan	

Strategy Outcome 7									
Young Carers will be supported to achieve their educational potential to have similar opportunities as to peers and to enjoy their childhood.									
No	**Activity**	**Objective No**	**Channel**	**Key Messages**	**Key Stakeholder(s)**	**Start**	**End**	**Lead Officers**	**Progress**
8.1	Complete a Young Carer Satement when requested by a Young Carer/Parent /guardian	1, 2	Conversations, meetings	All esp. iii, iv,	Young Carers, Cared For, Professionals, Commissioned Services	Apr-18	Ongoing Legal requirement	S Cooper M Neill	
8.2	Support young carers where their caring role is having an impact on their attainment.	1, 2, 3	Conversations, meetings	All esp. iii, iv,	Young Carers, Cared For, Professionals	Apr -19	Ongoing	S Cooper R Jamieson M Neill	
8.3	Support young carers to improve their emotional and physical wellbeing of young carers by accessing a variety of resources and respite opportunities.	1, 2, 3	Conversations, meetings, activities	All esp. iii, iv,	Young Carers, Cared For, Professionals	Apr-19	Ongoing	S Cooper R Jamieson M Neill	
8.4	Work with schools to identify young carers to provide preventative support, as early as possible (Level 1).	3	Conversations, meetings	All esp. iii, iv,	Young Carers, Cared For, Professionals	Apr-19	Ongoing	S Cooper R Jamieson M Neill	
8.5	Increase opportunities to creatively engage with learning and identify what support is needed at home to improve attendance in school.	1, 2,	Conversations, tutorials, meetings	All esp. iii, iv,	Young Carers, Cared For, Professionals	Apr-19	Ongoing	S Cooper R Jamieson M Neill	
8.6	Provide Mind of My Own training to Young Carers who would benefit from this.	1, 2	Conversations, meetings, training sessions	All esp. iii, iv,	Young Carers, Cared For, Professionals, Commissioned Services.	Apr-19	Ongoing	S Cooper R Jamieson M Neill	

APPENDIX 4

DIRECTION FROM PERTH & KINROSS INTEGRATION JOINT BOARD

1	Reference Number	**7/2019-20/191106**
2	Date of direction issued by Integration Joint Board	6 November 2019
3	Date from which direction takes effect	6 November 2019
4	Direction to:	Perth & Kinross Council
5	Does this direction supersede, amend or cancel a previous direction – if yes, include the reference number (s)	No
6	Functions covered by direction	In terms of the Perth and Kinross Integration Scheme, this Direction relates to the following adult social work functions: Carers (Scotland) Act 2016 - duty to prepare a carer strategy.
7	Full text of direction	Perth & Kinross Council is directed to implement and monitor the progress of the Carers' Strategy 2019 – 2022.
8	Budget allocated by Integration Joint Board to carry out direction	Within resources allocated through annual budgeting processes (for 2019-20) of £811,488.
9	Performance monitoring arrangements	Carers Programme Board
10	Date direction to be reviewed.	6 December 2020

APPENDIX 5

DIRECTION FROM PERTH & KINROSS INTEGRATION JOINT BOARD

1	Reference Number	**8/2019-20/191106**
2	Date of direction issued by Integration Joint Board	6 November 2019
3	Date from which direction takes effect	6 November 2019
4	Direction to:	NHS Tayside
5	Does this direction supersede, amend or cancel a previous direction – if yes, include the reference number (s)	No
6	Functions covered by direction	In terms of the Perth and Kinross Integration Scheme, this Direction relates to the following health board functions: Carers (Scotland) Act 2016 - duty to prepare a carer strategy.
7	Full text of direction	NHS Tayside is directed to implement and monitor the progress of the Carers' Strategy 2019 – 2022.
8	Budget allocated by Integration Joint Board to carry out direction	Within resources allocated through annual budgeting processes (for 2019-20) of £811,488.
9	Performance monitoring arrangements	Carers Programme Board

Perth & Kinross Integration Joint Board

6 November 2019

Winter Planning 2019/2020

Report by Chief Officer/Director – Integrated Health & Social Care
(Report No. G/19/175)

PURPOSE OF REPORT

The purpose of this report is to inform Perth & Kinross Integrated Joint Board of the Winter Planning arrangements for NHS Tayside and Partner Organisations for 2019/20. The Winter Plan describes the collaborative approach to planning for winter by NHS Tayside and the Health & Social Care Partners. The plan informs our local Unscheduled Care Action Plan, underpinned by the Six Essential Actions for Unscheduled Care and is aligned to Transforming Tayside and NHS Tayside Annual Operational Plan as well as the strategic improvement plans of the Health and Social Care Partnerships in Angus, Dundee and Perth & Kinross.

1. RECOMMENDATION(S)

The IJB is asked to:

- Endorse the Winter Plan, including the festive arrangements, which is submitted to the Scottish Government.
- Note the cost pressures associated with service delivery required to meet winter demand within the context of ongoing patient flow challenges.
- Note the whole system collaborative approach taken in preparation for anticipated winter challenges.

2. SITUATION/BACKGROUND / MAIN ISSUES

The 2019/20 Winter Plan has been prepared taking full account of the Scottish Government's winter planning correspondence; 'Preparing for Winter, 2019/20', Supplementary Checklist of Winter Preparedness, as well as acknowledging our corporate performance for Access Targets.

The aim of the Winter Plan 2019/20 is to assure NHS Tayside Board, the Scottish Government and the population of Tayside that plans and systems are in place to support early intervention, action at points of pressure, and to minimise the potential disruption to services, people who use services and their carers. The winter period is defined as 1 December 2019 to 31 March 2020. The NHS Tayside Board contingency and resilience planning also assists to strengthen our Winter Plan.

Importantly this is an integrated plan, to ensure Health & Social Care Partnerships and Acute Hospital Services are developing cohesive plans for winter with key partners. The Winter Plan, again focuses on maintaining "business as usual" through periods where we may have reduced services, such as public holidays; and in response to increased seasonal illness such as flu as well as adverse weather. The plan will address the key areas in line with the Scottish Government 'Preparing for Winter', (2019/20) through an approach of prevent, inform, respond and communicate;

- Resilience
- Unscheduled/ Elective care
- OOH
- Norovirus
- Seasonal Influenza/ Influenza-like illness
- Respiratory Pathway
- Integration of key partners/ Services
- Mental Health

A separate plan is in place for broader aspects of unscheduled care which is directed by an Unscheduled Care Programme Board and appointed Clinical Leads.

The National Unscheduled Care Programme, Six Essential Actions for Improving Unscheduled Care are:

- Clinically focused and empowered hospital management
- Hospital capacity and patient flow (emergency and elective) realignment
- Patient rather than bed management
- Medical and surgical processes arranged to improve patient flow through the unscheduled care pathway
- Seven day services appropriately targeted to reduce variation in weekend and out of hours working
- Ensuring patients are optimally cared for in their own homes or a homely setting.

The Winter Plan is based on the 2020 Vision for Health and Social Care, and describes a Health and Social Care system centred on:

- Integrated health and social care services;
- A focus on prevention, anticipation and supported self-management;
- Day case treatment as the norm where hospital treatment is required, and cannot be provided in a community setting;
- Care being provided to the highest standards of quality and safety, with the person at the centre of all decisions;

- Ensuring that people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission.

Specific to the Winter Plan are the following standards:

- 4 hours from arrival to admission, discharge or transfer for A&E treatment (95% with stretch 98%)
- Earlier in the Day Discharges - Hour of Discharge (inpatient wards)
- Weekend Discharge Rates - Day of Discharge weekday v's weekend discharges
- Reduction in Delayed Discharges
- Maintain performance against the 12 week treatment time guarantee (TTG)
- Maintain achievement of waiting times standards for patients with a newly diagnosed primary cancer:
    - 31-day target from decision to treat until first treatment, regardless of the route of referral.
    - 62-day target from urgent referral with suspicion of cancer, including referrals from national cancer screening programmes, until first treatment.

3. PROPOSALS

In accordance with Scottish Government's 'Preparing for Winter' (2019/20) correspondence, NHS Tayside and Integrated Joint Boards will receive an allocation of £368,938, of which Perth & Kinross H&SCP will be allocated £13,000, which will be specifically targeted to deliver a key focus on:

- Reducing Attendances
- Managing/Avoiding Admissions wherever possible
- Reducing Length of Stay
- Focus on Flow through Acute Care
- Workforce – appropriate levels of staffing are in place across the whole system to facilitate efficient and effective patient care, to ensure consistent discharge during weekends and holiday periods. Adequate festive staffing cover across acute, primary and social care settings

The Tayside Unscheduled Care Board provides the governance and oversight required for the allocation of winter planning funding for 2019/20. The plan for 2019/20 is to proactively invest in activities that aim to maintain "business as usual". This will include periods where we may have reduced services such as public holidays and in response to increased seasonal illness such as flu as well as adverse weather.

It is proposed that the funding be allocated in three phases in line with the winter planning approach:

Phase 1 - Prevent

- Additional funding across all three Health and Social Care Partnerships to prevent admissions/attendance managing care closer to home, supporting discharges.
- Out of Hours additional funding

Phase 2 - Assurance - Initiatives to ensure winter flow

- Extended Ambulatory Service, late access to senior decision making support
- Seven day rehabilitation model of care
- Near patient testing for Flu to prevent unnecessary admissions for Influenza like illnesses
- Cardiology initiatives
- Pharmacy
- ED additional junior medical cover
- Respiratory

Phase 3 - Provision of Surge Beds

- Acute Medicine for the Elderly (AME) beds in Ninewells to boost and target capacity
- Increased (surge) bed numbers across both acute hospital sites and same day discharge, social support

The investment and approval of surge beds prior to winter is aimed at preventing the opening of beds at a later stage at a potentially higher cost. It must be noted that the request for surge bed funding is for additional beds only. The funding will not be used to cover the additional beds that are currently in operation, and required as core capacity.

The bids submitted for funding approval are detailed in Appendix 1.

Our Winter Plan takes a whole system Health & Social Care response to support the best use of locally available resources as demand rises and/or capacity is limited in order to sustain safe, effective and person-centred care.

4. CONCLUSION

The Perth & Kinross H&SCP IJB is requested to note the Tayside Winter Plan for 2019/20 and support the local Partnership's Winter Planning arrangements and proposals outlined under section 4.5, page 24 of the Tayside Winter Planning paper.

The Tayside Winter Plan takes a whole system Health & Social Care response to support the best use of locally available resources as demand rises and/or capacity is limited in order to sustain safe, effective and person-centred care.

Author(s)

Name	Designation	Contact Details
Audrey Ryman	Program Manager – Older People	Audrey.ryman@nhs.net

NOTE: No background papers, as defined by Section 50D of the Local Government (Scotland) Act 1973 (other than any containing confidential or exempt information), were relied on to any material extent in preparing this report.

Attachments:

Appendix 1

. *Winter Preparedness Funding Allocation*

Appendix 2

Tayside Winter Planning Paper 2019/20

Appendix 3

Perth & Kinross H&SCP Draft Local Winter Action Plan

Appendix 1 Winter Preparedness Funding Allocation

WINTER PLANNING 2019/20

PROPOSED PLAN TO DELIVER SG PRIORITIES

	Description	£
Funding		
Funding Scottish Government		**£368,938**
Funding NHS Tayside	To match last year's allocation of £1m within the Financial Plan	**£631,062**
	TOTAL FUNDING AVAILABLE	**£1,000,000**
Proposed Commitment against Priority		
Phase 1	**Prevent** • Additional funding across all three Health and Social Care Partnerships to prevent admissions/attendance managing care closer to home, supporting discharges • Out of Hours additional funding	**£273,435**
Phase 2	**Assurance - Initiatives to ensure winter flow** • Extended Ambulatory Service, late access to senior decision maker support • Seven day rehabilitation model of care • Near patient testing for Flu prevent unnecessary admissions for Influenza like Illnesses • Cardiology initiatives • Pharmacy • ED additional junior medical cover • Respiratory	**£242,285**
Phase 3	**Provision of Surge Beds** • Acute Medicine for the Elderly (AME) beds in Ninewells to boost and target capacity. • Increased (surge)bed numbers across both acute main sites and same day discharge, social support	**£529,726**
Total Cost		**£1,045,446**
SURPLUS /(DEFICT)	*** it is anticipated that funding deficit will be managed through slippage on expenditure**	**(£45,446)**

PROPOSED RECOMMENDATION BY BOARD

Phase	Bid No	Lead	Directorate	Description	Requirement	Bid Duration	Duration	FY19-20	FY 20-21
Phase 1	1	Jillian Richmond George Bowie	Angus HCSP	Enhanced ERT Discharge Pilot	Social Grade Staff £169,305 staff costs plus £30,000 annual leave, sickness cover and training costs [7 days discharge]	12 months 1/10/19 - 30/9/20	6 months of which 2months USC and 4 months Winter Planning 1/10/19 - 31/03/20	£66,435	
Phase 2	2	Gillian Crighton Diane McCulloch	Dundee HCSP	Ward 5 / 6 generic support workers to provide a rehabilitation based model of daily care	Band 4 - 2 wte (6 months duration) £30,705 + (additional weekend working uplift)	6 months 1/11/19 - 30/04/19	6 months, of which 2 months USC and 4 months Winter Planning 1/11/19 - 30/04/20	£20,470	£5,118
Phase 2	3	Susan Bean	Medicine Division	Respiratory - increase in admissions	RN Nursing - support weekend working	21/12 /19 - 4/1/20		£1,000	
Phase 2	3	Susan Bean	Medicine Division	Respiratory - increase in admissions	Medical - support weekend working & public holidays	21/12 /19 - 4/1/20		£4,000	
Phase 2	4	Ally Moonie Dougie Lowdon	Medicine Division	Late Evening Senior Decision Maker Support	Medical -	4 months 1/12/19 - 31/3/20		£16,000	
Phase 2	5	Ally Moonie Dougie Lowdon	Medicine Division	Extended Ambulatory Service	Medical - ST Locum	4 months 1/12/19 - 31/3/20		£10,000	
Phase 2	6	Ally Moonie Dougie Lowdon	Medicine Division	FY Clerking doctor evening support	Medical - FY11/FY2 Locum	4 months 1/12/19 - 31/3/20		£18,000	
Phase 1	7	Lisa Prudon Jill Galloway Vicky iron	Angus HCSP	GP Out of Hours Service	GP workforce [5 costings see bid]	4 months 1/11/19 - 31/3/20		£87,000	
Phase 1	8	Chris Lamont Audrey Ryman Evelyn Devine	Perth HCSP	Supported Discharge for Perth City Patients	1 Band 6 Co-ordinator; 3 Band 3 HCSW ; 6 Social Care Officers; Supplies and Travel	???		£60,000	
Phase 2	9	Norma Patrick Audrey Ryman	Perth HCSP	Physiotherapy Weekend Working	Sat & Sun working	5 months 1/11/19 - 31/3/20		£15,000	
Phase 2	10	Norma Patrick Audrey Ryman Evelyn Devine	Perth HCSP	Occupational Therapy Weekend Working	Sat & Sun working	5 months 1/11/19 - 31/3/20		£0	
Phase 2	21	Ron Cook/Julie Greenlees/Sean Mc	Medicine Division	ED Nwells PR1	Pay	4 months 1/12/19 - 31/3/20		£40,000	
Phase 1	22			Dundee Home Care/Enablement				£60,000	
Phase 2	23			Near Patient Testing				£60,000	
Phase 2	24			Cardiology	Pay	4 months 1/12/19 - 31/3/20		£14,631	

Phase 2	25			Cardiology	Inhealth Staffing 8 sessions @ £730*3 staff plus vat			£21,024	
Phase 2	26			Cardiology	Pay			£2,160	
Phase 2	27	Arlene Shaw Carol Nairn Peter Buckner	Pharmacy	Pharmacy	Pay			£20,000	
Phase 3	11	Caitlin Charlton Audrey Ryman Evelyn Devine	Perth HCSP	Tay Ward - 4 Beds	Nursing Staff	4 months 1/12/19 - 31/3/20		£55,877	
Phase 3	12	Sean McCartney Julie Greenlees	Medicine Division	PRI Ward 1 - 3 beds	Nursing Staff - RN Agency & HCSW inhouse	4 months 1/12/19 - 31/3/20		£54,154	
Phase 3	12	Sean McCartney Julie Greenlees	Medicine Division	PRI Ward 1 - 3 beds	Non Pay	4 months 1/12/19 - 31/3/20			
Phase 3	13	Sean McCartney Julie Greenlees	Medicine Division	PRI Ward 6 - 4 beds	Nursing Staff - RN Agency & HCSW inhouse	4 months 1/12/19 - 31/3/20		£77,854	
Phase 3	13	Sean McCartney Julie Greenlees	Medicine Division	PRI Ward 6 - 4 beds	Non Pay	4 months 1/12/19 - 31/3/20			
Phase 3	14		Medicine Division	PRI - beds	Physio 0.25wte, OT 0.25wte	4 months 1/12/19 - 31/3/20		£7,000	
Phase 3	15	Audrey Warden Lynn McAteer	Surgical Division	Nws Ward 11 - 4 beds	Nursing Staff - RN Agency & HCSW inhouse	4 months 1/12/19 - 31/3/20		£79,814	
Phase 3	15	Audrey Warden Lynn McAteer	Surgical Division	Nws Ward 11 - 4 beds	Non Pay	4 months 1/12/19 - 31/3/20			
Phase 3	15	Sean McCartney Julie Greenlees	Medicine Division	Nws AME - 6 beds	Nursing Staff - RN Agency & HCSW inhouse	4 months 1/12/19 - 31/3/20		£101,283	
Phase 3	15			Nws AME - 6 beds	Non Pay	4 months 1/12/19 - 31/3/20		£4,000	
Phase 3	16	Meg Park Susan Bean	Medicine Division	Nws Ward 3 - 6 beds	Nursing Staff - RN Agency & HCSW inhouse	4 months 1/12/19 - 31/3/20		£66,120	
Phase 3	16	Meg Park Susan Bean	Medicine Division	Nws Ward 3 - 6 beds	Non Pay	4 months 1/12/19 - 31/3/20		£6,000	
Phase 3	17			NWs Beds Physio/OT	Physio 0.5wte, OT 0.5wte			£14,489	
Phase 3	18	Audrey Warden Lynn McAteer		Nws Ward 18 - 4 Beds	Nursing Staff - RN Agency & HCSW inhouse			£63,135	
	TOTAL							**£1,045,446**	**£5,118**

	BIDS CONSIDERED BUT NOT SUPPORTED					£0		**£322,843**	

Winter Plan

NHS Tayside and Partner Organisations

NHS Tayside Unscheduled Care Board

2019/20

Contents

Executive Leads for Winter

Lorna Wiggin, Director of Acute Services, NHS Tayside
Vicky Irons, Chief Officer, Angus, Health & Social Care Partnership
David Lynch, Chief Officer, Dundee, Health & Social Care Partnership
Gordon Paterson, Chief Officer, Perth & Kinross, Health & Social Care Partnership

Executive Summary

NHS Tayside, the Health and Social Care Partnerships of Angus, Dundee and Perth & Kinross, Scottish Ambulance Service and other key stakeholders have taken a collaborative approach towards preparedness and planning for winter 2019/20 through the Tayside Unscheduled Care Board.

The NHS Tayside Unscheduled Care Programme Board formed in 2016 has responsibility for supporting and facilitating the implementation of the National Unscheduled Care – Six Essential Actions Improvement Programme across NHS Tayside and the three Health and Social Care Partnerships, with the aim to improve patient safety, flow and sustainable performance in unscheduled care.

All three Health and Social Care Partnership plans sit within the overarching Tayside and Partners Winter Plan demonstrating the increased level of partnership thinking and integrated working. It is underpinned by the Unscheduled Care Six Essential Actions taking full account of the Scottish Government's winter planning correspondence, 'Preparing for Winter' 2019/20 and Supplementary Checklist of Winter Preparedness.

This year collaborative working has continued for winter preparedness with learning from previous winter challenges. Investments in initiatives have been aligned to maintain key services over public holidays and periods of increased illness as well as to try and prevent illness and admissions. NHS Tayside continues to undergo transformation and much of this work is integrated into our winter plan.

The winter plan has been developed based upon the key areas highlighted in the 'Preparing for Winter' Guidance (2019/20) to ensure early prevention and response to minimise potential disruption to services and ensure that we continue to provide safe and effective care of our population and timely access to services. In particular, continuous improvement work with our Partner organisations to reduce attendances, managing and avoiding admissions, with Emergency Departments and acute service areas to focus on the flow through acute care, cancer, mental health and outpatient services, to deliver against national standards and maintain progress over this winter. Our plan is strengthened by resilience planning and business continuity arrangements to provide to NHS Tayside Board, Scottish Government and our population for winter period December 2019 – March 2020.

In response to the needs of our frail, elderly population and patients with chronic conditions affected by winter, a whole system Health and Social Care approach to develop an integrated plan was essential. The Tayside and Fife Health and Social Care Partnerships, the Scottish Ambulance Service (SAS) as well as staff side/partnership representation have been involved in the development of the plan to ensure timely access to the right care in the right setting. Third sector involvement is through the Health and Social Care Partnerships.

The focus on improved resilience over the festive period taking account of learning from previous winters and actions form the Local Review of Winter 2018/19 Scottish Government's Report (May, 2019), will ensure arrangements are in place to mitigate disruption to critical services. The plan will be underpinned by full business as usual continuity arrangements and daily management of safety, capacity and flow through the NHS Tayside Safety and Flow Triggers and Escalation Framework with senior clinical and management leadership and multiprofessional input to the safety and flow huddle infrastructure seven days per week.

This Winter Plan will be supported by a suite of measures across the system. This will include the use of the 'SafeCare' System which provides information in relation to staffing capacity within each ward as well as System Watch providing predictive data to inform

decision support for the Safety and Flow Triggers and Escalation Framework. This will be further supported by weekly look back to encourage system learning and continuous improvement.

The NHS Tayside Medical Model is embedded, with the “Assess to Admit” model, at its core the principal tenet of realistic medicine that patients wish to be cared for in their own homes. Several strands across the whole Heath and Social Care community mean that enhanced social care, community nurses, therapists and doctors see that hospital admission is not inevitable.

Professional to other professional communication can share decision making and discharge home from an assessment area to complete investigation and treatment continues as the norm. This has helped to maintain our discharge rate from Acute Medicine Unit (AMU) and Acute Medicine for the Elderly (AME) at >65%.

1. Introduction

1.1 Aim

The Winter Plan aim is to demonstrate clear engagement and alignment between Health and Social Care Partnerships for winter planning across Tayside. Setting key Partnership actions and planning processes to effectively manage the potential challenges associated with the winter period for 2019/20 and delivering against the national and local targets and standards for Health and Social Care.

This is to ensure that Tayside is prepared as far as possible for the coming winter period in order to minimise any potential disruption to services or diminished experience for patients and carers.

1.2 Rationale and Planning Assumptions

This Winter Plan has been informed by external and internal sources, involving planning, discussions and feedback, learning from previous experience, assessing winter risk and agreeing shared approaches going forward for winter 2019/20. These sources include;

- Six Essential Actions, Unscheduled Care Programme
- Tayside Winter Planning Group
- NHS Tayside local Review of Winter 2019/20 Workshop (March 2019)
- Scottish Government Health & Social Care: Local Review of Winter 2018/19 Report (May 2019)
- Scottish Government Preparing for Winter correspondence & Winter Preparedness: Self Assessment Guidance 2019/20
- Partners', sectors' and services' winter plans and surge plans

Review and local feedback has informed that the winter period December to March creates a number of challenges for all partners delivering health and social care services. The main challenges are reflected by the key headings of the 'Supplementary Checklist of Winter Preparedness' (2019/20) detailed below in the approach taken to deliver the winter plan aims:

1.3 Approach

The scope of the plan is whole system with a focus on the following key areas in line with the Scottish Government 'Preparing for Winter', (2019/20) guidance:

- Resilience
- Unscheduled/ Elective care
- Out-of-Hours
- Norovirus
- Seasonal Influenza/ Influenza like illness
- Respiratory Pathway
- Integration of Key partners/ Services
- Mental Health. This has been added as a priority by our board.

The plan will be delivered, with each of the key areas underpinned by the following approach of prevent, inform, respond and communicate with corresponding key actions as follows:

Prevent:
Illness and Admissions within our population and staff:

- Infection Prevention and Control - Prevent illness in the first place
  - Flu Campaign, Respiratory Pathway
- Community based care : Enhanced Care Support (ECS)
- Rehabilitation at home or community rather than hospital
- Shared decision making: Professional to Professional advice
- Assess to Admit - Ninewells and Perth Royal Infirmary, >65% discharge rate

Inform:
Whole System Escalation Framework:

- System Pressures, Triggers & Escalation
- Safety and Flow Huddles
- Data Intelligence - using and applying information and intelligence to planning
  - Use of common themes in all learning
  - Predictive Data:
  - Out-of-Hours, NHS 24, General Practice
  - 'System watch" all can access
  - Health Protection Scotland (HPS)

Respond:
Whole System Escalation Framework & Business Continuity Planning (Health Social Care & Partner Organisations)

- Actions/Response to local triggers
- Departmental/sector winter action cards
- Pressure period hospital site huddle framework
- Communication plan – local knowledge & use of escalation & response processes
- Winter Plan two weekly planning meetings become operationally focussed from October

Business as Usual is the primary aim:
Strategies include:

- Increased capacity over and post public holiday
- Use data intelligence of pressures (Orthopaedics & Medicine for the Elderly)
- Whole system communication: optimise huddles and responses
- Urgent & planned care - Festive planning
- Respiratory Pathway – acute and community
- GP/Primary Care Services/Out-of-Hours capacity planning
- Health & Social Care Capacity
- Scottish Ambulance Service additional vehicle capacity
- Learning from Local Review of Winter

Plan for more Business as Usual Capacity
Unscheduled Care Board/Winter funding to prevent admission/ promote flow:

- Increase AMU capacity: >65% discharges
- More beds within footprint for medicine: two sites
- Increase Respiratory Unit capacity in Ninewells
- Increase business as usual to seven days/ longer days
- Ambulatory seven days
- More senior decision makers over public holidays/Festive Holidays
- Adequate Festive Staffing cover across acute, primary and social care setting including: Pharmacists, AHPs, Social Care Staff, Porters

Communicate:

- Communicate Identified pressures and the action needed to maintain Business as Usual
- Communicate Whole System Approach

- Final Winter Plan submission to Scottish Government by 31 October 2019
- Tayside wide Winter Communication Campaign (internal/external)
- Festive 'Ready Reckoner' including all key services and contacts communicated across Health Social Care & Partner Organisations

1.4 Finance

The Tayside Unscheduled Care Board provides the governance and oversight required around the allocation of winter planning funding for 2019/20.

The aim for 2019/20 is to proactively invest in work that will aim to maintain "business as usual". This will include periods where we may have reduced services such as public holidays and to respond to increased seasonal illness such as flu and adverse weather.

Preparing for Winter funding as well as the Unscheduled Care Programme 6EA funding, will be allocated across the eight target areas detailed throughout the Tayside Winter Plan 2019/20. In accordance with national 'Preparing for Winter' (2019/20) recommendations funding will be specifically targeted to deliver a key focus on the following areas:

- Reducing Attendances
- Managing/Avoiding Admissions wherever possible
- Reducing Length of Stay
- Focus on Flow through Acute Care
- Workforce – appropriate levels of staffing are in place across the whole system to facilitate efficient and effective patient care, to ensure consistent discharge during weekends and holiday periods. Adequate festive staffing cover across acute, primary and social care settings

The funding has been allocated in three phases in line with the winter planning approach:

Phase 1 Prevent

- Additional funding across all three Health and Social Care Partnerships to prevent admissions/attendance managing care closer to home, supporting discharges
- Out of Hours additional funding

Phase 2 Assurance - Initiatives to ensure winter flow

- Extended Ambulatory Service, late access to senior decision maker support
- Seven day rehabilitation model of care
- Near patient testing for Flu prevent unnecessary admissions for Influenza like Illnesses
- Cardiology initiatives
- Pharmacy
- ED additional junior medical cover
- Respiratory

Phase 3 Provision of Surge Beds

- Acute Medicine for the Elderly (AME) beds in Ninewells to boost and target capacity.
- Increased (surge)bed numbers across both acute main sites and same day discharge, social support

Appendix 1 provides detail of the indicative funding allocation to services.

As part of the governance and reporting arrangements of the Unscheduled Care Programme Board as these funding allocations are to pump prime services and enable tests of change to be implemented over the winter period it is expected that a progress report is completed and submitted to the Unscheduled Care Board. This report will include details around each initiative, funding allocated, spend to date with any variance, aligned outcome measures, progress update and exit strategy.

1.5 Approval of Plan

The process and timeline for preparation, review and approval of this plan allows for the following groups to discuss it as demonstrated in the table below:

Table 1.

Date	Format	Committee / Board
19 September	First Draft	Winter Planning Group/Executive Leads for Winter
23 September	First Draft	Executive Leadership Team Meeting
23 September	First Draft	Chief Executive Officers of Angus, Dundee Perth & Kinross Localities
23 September	First Draft	Scottish Government
25 September	First Draft	Unscheduled Care Programme Board
24 October	Final Approval	Unscheduled Care Programme Board
29 October	Final Approval	Dundee Integrated Joint Board
30 October	Final Approval	Angus Integrated Joint Board
31 October	Final Approval	NHS Tayside Board
31 October	Submission	Scottish Government
November (date to be confirmed)	Final Approval	Perth & Kinross Integrated Joint Board

1.6 Governance Arrangements

- The Unscheduled Care Board is chaired by the Associate Medical Director for Medicine and Head of Service, Health and Community Care for Dundee Health & Social Care Partnership and will use measures to assess the impact of the plan. Please see Reporting Structure Diagram (Appendix 2)
- An Unscheduled Care Programme Team is in place led by a programme manager, and with an improvement advisor and data analyst for each major site. These posts form part of the support teams for unscheduled care, continuous improvement and the implementation and evaluation of the winter plan.
- Resilience and Business Continuity arrangements and management plans are in place and have been tested prior to winter.
- NHS Tayside's Board Assurance Framework has a corporate whole system risk related to capacity and flow. A scoring system has been developed for the key

measures to enable an overall risk score to be presented. This is presented and discussed at each Board meeting.

- Weekly Senior Operational Leadership meeting chaired by Medical Director with senior clinical and managerial input
- Clinically-led and managerially-enabled operational structure for acute services
- Whole system Safety and Flow Huddle process including an additional huddle with key partners during pressure periods throughout winter i.e. Public Holidays
- A Tayside-wide severe weather plan is in place including triggers for multi-agency coordination.
- Communications teams will inform the public and staff on planning for winter, where to go for services and public health messages

2. Key Drivers and Changes from Previous Winters

Key drivers for winter planning include ensuring optimal patient flow through the hospital journey in particular to delivering against the 4 hour emergency access target as well as ensuring a robust whole system approach to planning for winter as part of the overall approach to the safe and effective delivery of unscheduled care.

This Winter Plan has been developed with a commitment to the Unscheduled Care Programme, 6 Essential Actions using a collaborative approach across Health and Social Care Partnerships to whole system planning across the local system and services. Progress of the 6 Essential Actions local improvement work is continuous, focussed on key actions to improve unscheduled care in all settings.

In addition, this Winter Plan has been developed aligned to Transforming Tayside and associated Improvement Programmes with shared priorities, focus and areas for improvement, working across partnership groups.

Unscheduled Care 6EA Programme key priorities for 2019/20 are illustrated in Appendix 3 with the key drivers to inform the winter planning illustrated in Appendix 4.

2.1 Striving To Deliver High Quality, Safe, Person-Centred Care

Tayside continuously strives to meet local and national standards and performance targets which focus on delivering high quality, safe, person-centred care. To do this we must deliver national standards and targets on an ongoing basis regardless of the pressures periods across the system. Tayside is fully committed to sustaining delivery of the 95% Emergency Access Target and National Waiting Times Plan and as such, will establish trajectories to work towards in relation to this as set out in the Chief Executive, NHS Scotland and Director General Health and Social Care's letter of 4th September 2019.

Specific to this winter plan are the following standards:

- 4 hours from arrival to admission, discharge or transfer for A&E treatment (95% with stretch 98%)
- Earlier in the Day Discharges - Hour of Discharge (inpatient wards)
- Weekend Discharge Rates - Day of Discharge weekday v's weekend discharges
- Reduction in delayed discharges
- Early initiation of flu vaccination programme to capture critical mass of staff with a target of >60% of staff vaccinated
- Site surge plans to optimise care
- Use of information and intelligence from Primary Care, OOH Services and NHS 24 to predict secondary care demand
- Standardised approach to departmental action plans
- Using whole system triggers and escalation with clear and timely communication
- Maintain performance against the 12 week treatment time guarantee (TTG)
- Maintain achievement of waiting times standards for patients with a newly diagnosed primary cancer
    - 31-day target from decision to treat until first treatment, regardless of the route of referral.
    - 62-day target from urgent referral with suspicion of cancer, including referrals from national cancer screening programmes, until first treatment.

The NHS Tayside Health and Business Intelligence produce and provide data all year round in relation to the above standards and targets. Appendix 1 illustrates some of the key data to support capacity and flow. Measure 1 in particular illustrates ED performance with the last 6 to 12 months showing a downward trend in the NHS Tayside Emergency Medicine performance against the 4 hour standard across both the Ninewells and Perth Royal Infirmary departments. The senior nursing and medical teams have had extensive discussions about the decline in performance to delineate cause and identify potential areas for quality improvement work to return performance to previous levels. The top breach category continues to be 'wait for first assessment', as such a workforce review has been carried out, with recruitment plans in place to address the staffing shortfall

This winter plan, inclusive of the actions relating to prevention and management of seasonal illness, reflects the collective actions NHS Tayside and its partner organisations will take to achieve our intention to provide a consistent high quality of service for all of our patients throughout winter and beyond.

2.2 Lessons Learned from Winter 2018/19

The following section outlines the key lessons learned from the review of the 2018/19 winter period. Key themes around areas that worked well and areas for improvement were collated and fed back into the Scottish Government's Health & Social Care: Local Review of Winter 2018/19 (May 2019) Report. This report is available separately.

Key themes, learning and actions from local reviews across Tayside have informed the development and approach of the Tayside Winter Plan 2019/20.

Main themes highlighted regarding areas of good practice include:

- Business Continuity Team was set up locally at senior management level working in collaboration with partner organisations across Health and Social Care
- Preparedness and pre-planning in relation to winter plan and associated Business Continuity Plans
- Whole system collaborative approach – Step Up Step down, communication
- Dedicated communication channels across the system to improve preparedness and planning
- Safety and Flow Huddles involving Partnership as well as Local Partnership Huddles
- Winter Planning meeting structure monthly, weekly & cross site huddles effective in promoting cross site and service working
- Built on relationships, promoting Business as Usual, trusting in good systems
- Emergency Department waiting times had been one of the strongest performing areas in Scotland
- Supported clinical risk assessment and management decisions at the front door
- Acute Medicine for the Elderly (AME)
- Increased senior clinical decision makers, including senior nurses over the public holiday period, to support a reduction in weekend discharge rates
- Specialist Mental Health Nurse input to the care of deliberate self-harm patients requiring psychiatric assessment at Perth Royal Infirmary showing very significant benefits
- Additional GPs on duty to deal with the increased winter demand had a positive impact not only for OOH Service itself but impacted positively on the system as a whole
- Earlier Flu Vaccination Campaign

- Point of Care Testing - Increased awareness, knowledge , education amongst staff and patients to prevent admissions
- Infection Prevention and Control - positive feedback in particular around the prevention of illness within our population and staff as well as the winter preparedness and planning - less reactive, planning in advance, promoting the 'prevent' message.
- Winter period was busy for OOH, the nature of the flu season last winter meant that there was a lot of lower level illnesses that OOH were able to deal with successfully in the community
- Winter preparedness for adverse weather communications campaign including the use of Smarty the Penguin to promote winter wellness

Common themes across all local reviews identified for improvement include:

- Despite increased seven day working, acute sites remained full on Sunday there is a need to increase weekend discharges and maximise ambulatory care over seven days
- Recruitment challenges, in particular problems recruiting to vacant therapy posts over winter reduced the ability to assess and discharge
- Reduction in homecare impacted adversely on inpatient bed capacity

The Tayside Winter Plan will aim to improve areas highlighted from the local review as well as the key priorities indicated within the 'Preparing for Winter' (2019/20) correspondence, as follows:

- Promoting all year round planning with a business as usual
- Maintaining a whole system, multi-professional, multi-agency approach to planning as well as informing and responding to system pressures
- Continuing with the development and investment of the infrastructure to support escalation and early resolution at weekends
- A focus on home care planning/Enhanced Community Support services with the aim of reducing attendances and admissions by managing care closer to home
- Continual access to senior decision makers who can support rapid assessments to avoid unnecessary admission and ensure effective discharge
- Focus on flow through acute with flexible staffing plans to enable the rapid deployment of surge capacity as soon as it is required
- Effective forecasting for unscheduled and elective winter demand and plan capacity accordingly
- Focus on reducing delayed discharges, continuing to support care in the right setting and an improved patient experience
- Staffing across multi-professions to facilitate efficient and effective patient care seven days a week, specifically during weekends and holiday periods
- Focus on frailty across all applicable services
- Plans in place to continue to increase staff flu vaccination across local health and social care systems

3. Winter Plan 2019/20

The Tayside Winter Plan 2019/20 is set out under the following key headings in line with the Scottish Government 'Preparing for Winter', (2019/20) guidance:

- Resilience
- Unscheduled/ Elective care
- Out of Hours (OOH)
- Norovirus
- Seasonal Influenza/ Influenza-like illness
- Respiratory Pathway
- Integration of Key partners/ Services
- Mental Health. This has been added as a priority by our board

3.1 Resilience Preparedness

NHS Tayside and its partner organisations have robust business continuity management arrangements and plans in place. Tayside wide groups involving all partner organisations such as the Local Resilience Partnership (LRP) meet regularly with a Winter Pressure Plan in place describing the structure and key areas to be addressed in the Tayside response to extreme winter pressure. The purpose of the Tayside Winter Plan is to:

- Provide information about the potential effects and local impact of the winter pressure
- Identify early and longer term actions for LRP
- Identify strategic objectives for LRP during winter pressures
- Describe the multi agency structure for co-ordination and delivery of outcomes

The LRP links directly with the Tayside Significant Infection Group around the co-ordination, command, control and communication required in the event of a significant winter pressure alert being triggered.

3.1.2 Adverse Weather

Previously themes highlighted from the local review of winter in relation to the effects of adverse weather were staff transport and accommodation. These issues were addressed by a short life working group which included Support Services and Resilience Planning in advance of winter last year. Areas addressed will remain the same for this coming winter:

- Organisational procedure for 4x4 vehicles review undertaken and policy in place
- The list of volunteers to be collated for 2019/20 highlighting any challenges/risks to procedure around obtaining volunteer
- List of available 4x4 vehicles, locations, access arrangements/keys etc
- List of lease owners who have 4x4 vehicles
- Accommodation arrangements to be clarified for 'essential' staff in the event of adverse weather
- Catering arrangements to be clarified for 'essential' staff in the event of adverse weather
- A 'Vital Signs' communication to be sent out seeking volunteer standby drivers
- Training and guidance for NHS Tayside volunteer drivers

- Structure to monitor requests for essential transportation of critical staff, criteria to establish 'essential' staff, dedicated email to collate requests across NHST including IJB's
- Contact arrangements to be co-ordinated for NHS Tayside wide volunteers
- Duty Executive awareness of status – linked into daily huddle meetings/Whole System Safety and Flow Framework
- Early and continued engagement with Local Resilience Partnership
- Engagement with Arnold Clark - this would be dependent on number of volunteer drivers
- Links to existing plans, NHS Tayside Contingency Arrangements, Adverse Weather Policy
- Link to HR policies
- Ownership - operational rather than service specific

3.1.3 Scottish Ambulance Service (SAS) Resilience Planning

The Scottish Ambulance Service maintains a comprehensive contingency planning framework to manage the consequences of when the level of demand exceeds the ability of the Service to meet it. The Generic Capacity Management Contingency Plan and Resource Escalatory Action Plan (REAP)[1] Guidance Document are used for this purpose. The Capacity Management Contingency Plan may need to be implemented in circumstances when there is: increased demand, reduced capacity or reduced wider NHS services over festive periods.

SAS manages capacity and contingency through the REAP, which establishes levels of 'stress' within service delivery, whether from increased demand or reduced resource, and identifies measures to be implemented to mitigate the impact of such stress. Measures are service-wide and include activity from the Operational Divisions, Ambulance Control Centres (ACCs), National Risk and Resilience Department (NRRD), and Airwing.

The REAP provides the actions to cope with increased demand at any point, with SAS making decisions regarding what is relevant for the circumstances. For example cancelling all non-essential meetings to allow the managers to provide support and concentrate on the management of resources / shift coverage etc.

The REAP is followed with a few additional directives for adverse weather:-

- Ensuring there are shovels on each vehicle
- Additional supplies of consumables, grit/salt for the stations etc
- Map out where staff reside so that they can be directed to their nearest station rather than their base station if they can't make it there
- List and map all 4x4 vehicles so that they can be allocated to transport essential staff and patients e.g. renal/ oncology patients
- Liaise with the Health Board around activity and ensure any resources freed up from cancellations are used as additional staff on vehicles that require to go out in the severe weather to give us resilience

Our finance plan has recognised the pivotal role played by SAS and we have committed to funding extra ambulance crew and SAS will provide the vehicle for the winter period. This is in addition to separate SAS national funding.

[1] Scottish Ambulance Service. 2016.Version 6., Generic Contingency Plan, Capacity Management Incorporating the Resource Escalatory Action Plan – REAP

3.1.4 System Wide Escalation Framework

The Whole System Safety and Flow Triggers and Escalation Framework has been produced to assist in the management of health and social care capacity across Tayside and Fife when the whole system, or one constituent part of the system is unable to manage the demand being placed upon it.

The aim of this Framework is to provide a consistent approach to provision of care in times of pressure by:

- Enabling local systems to maintain quality and safe care
- Providing a consistent set of escalation levels, triggers and protocols for local services to align with their existing business as usual and escalation processes
- Setting clear expectations around roles and responsibilities for all those involved in escalation in response to surge pressures at local level, within local authorities, and partner agencies
- Seeking to work within consistent terminology across partner organisations for person centred care

The whole system framework is currently under review in advance of winter 2018/19. The reviewed framework will be tested with partners to bring about a consistency to local approaches, improve management of system-wide escalation, encourage wider co-operation, and make local and regional oversight more efficient and effective. The framework will bring together the variance in operational escalation systems and protocols across the partner organisations across Tayside to manage local and regional monitoring of operational pressures.

A recurring them from our learning was that our whole system framework last winter missed opportunities for clear and simple communication of decisions. This has been addressed with simplification and clarity of huddles to allow staff at all levels to deliver consistent and relevant decision making.

3.1.5 Pressure Period Hospital Site Huddle Framework

The Safety & Flow Huddle process is fundamental in identifying triggers and supporting the subsequent escalation processes required in response to system pressures.

The current arrangement of daily, weekend and public holiday Safety & Flow Huddles as outlined in Appendix 6 provides a Safety & Flow Huddle framework across seven days at both Ninewells Hospital and Perth Royal Infirmary.

There are currently four huddles across NHS Tayside sites with input from the Integrated Joint Boards and Community Services. The huddle process steps up to address demand when required during pressure periods in winter. The Huddle process has been revised to reflect feedback from last winter's review of process, areas that have been considered included:

Communications

- Clear and co-ordinated expectations of Information that each service can provide, trigger points that require action to maintain "business as usual" and what response is needed to achieve this for example aiming to meet the call for rapid deployment of surge capacity
- Clear expectation of role and responsibilities as part of the safety and flow huddle process

- De-escalation as soon as the pressure is managed to prevent loss of engagement of staff
- Huddle Reports format and content review
- Data Dashboard to inform huddle

The revised Safety and Flow Huddles process will involve the Clinical Care Group Manager huddle taking place at 12:00 hrs. The huddle format will stay the same. Consideration is being given to changing the timing of the morning huddle to 08:30am and combining the Perth and Ninewells site huddles into one. There will be Senior Nurses based each day on a rota system in both flow hubs, 2 nurses in Ninewells and 1 nurse in Perth. They will be supported by a Leadership Team each day comprising of a Clinical Lead, Clinical Care Group Manager and a Lead Nurse.

Flow Hub: An area within the main hospital site has been refurbished with modern video conferencing equipment to facilitate cross site communication. This will improve real time flow management with co-location the flow team with the hospital at night and hospital at weekend team. By indentifying an area for teams to meet this will promote collaborative working.

3.1.6 Winter Planning Activity/Departmental/Sector Winter Action Cards

NHS Tayside has seen significant change in its management structure over in 2018/19. Triumvirates have been established and a clinically led and managerially delivered ethos embedded.

A template for local services to develop their own Winter Action Plan was developed to bring consistency of approach to winter preparedness. The Action Card used previous winter is being reviewed for 2019/20 to ensure suitability for use across all Health and Social Care Services. This follows the approach laid out at the start of this plan:

- Prevent illness and admission
- Inform of pressures and escalation
- Response required to maintain Business as Usual
- Communicate - When to de-escalate and recover

The Action Card Template is attached in Appendix 6.

The card is a single sided document that allows all services from a whole clinical care group to a small team of specialist nurses to organise their response to winter pressure. The aim is that it can be held by the team to co-ordinate planning for public holidays as well as combining to describe a whole system approach.

3.1.7. Safety and Flow - Using and Applying Information and Intelligence to Planning

The use of information and data is critical for effective forecasting of unscheduled and elective winter demand and capacity planning.
Feedback highlighted that our systems were not optimised, around being prepared and responding to demand on time.

Data intelligence from the following services should be considered to inform planning:

- OOH

- NHS 24
- General Practice
- Health Protection Scotland (HPS)

Public Heath will co-ordinate and report HPS data weekly to support better use of data for predictive decision making. This will be fed into the Triumvirate structure and cascaded out to sites and partners via site wide huddles.

The Infection and Prevention Control Team (IPCT) also share data from HPS regarding the current epidemiological picture on influenza and Norovirus surveillance data across Scotland. It is planned that this information will be routinely monitored over the winter period to help us detect early warning of imminent surges in activity.

System Watch will also be used locally to support forecasting of demand and capacity. The enhanced version of System Watch has been available from September 2018 with development of local processes linked to the daily Safety and Flow Huddles, to make full use of this predictive data.

Summary of Key Actions for Resilience

Adverse Weather

- Transport - procedure review for 4x4 vehicles
- Staff accommodation & catering arrangements
- Links to across resilience and contingency planning and adverse weather policies arrangements across Health and social care Partnerships

SAS

- REAP - for capacity management and contingency planning
- Additional directives regarding adverse weather planning
- Additional funding for extra ambulance crew for extra vehicles

System Wide Escalation Framework

- Whole System Safety and Flow Triggers and Escalation Framework with partner organisations

Pressure Period Hospital Site Huddle Framework

- Revised Safety and Flow Huddle Process
- Clear and concise communications as part of Safety and Flow Huddle Process
- Flow Hub

Sector Action Cards

- Use of Winter Actions Cards to support resilience planning across services

Safety and Flow Using and Forecasting and Applying Information Intelligence to Planning

- Effective forecasting and data intelligence for unscheduled and elective winter demand, planning accordingly through the use of predictive data systems

4. Unscheduled and Elective Care Preparedness

This is recognised as a key area for NHS Tayside. There has been considerable change to the bed model within Ninewells Hospital and the Transforming Tayside programmes will continue to have major changes on the configuration of services.

NHS Tayside will maximise theatre efficiency by focussing on treating urgent and cancer patients to ensure that our most urgent elective cases are treated promptly over the festive period. This will eliminate the short notice cancellation of non-urgent elective cases during the winter/ festive pressure period. Simultaneously we will focus on maximising our day case activity through our dedicated day case facilities ward at Perth, Ninewells and optimise Stracathro to maintain a consistent level of elective activity during the winter pressure period.

Key activities regarding unscheduled and elective care preparedness across main hospital sites include:

- Theatre scheduling to determine the management of the unscheduled care/cancer and clinically urgent scheduled care as a priority
- Planned/Elective Care shut down over public holiday periods. Emergency and cancer care remain a priority
- Cancellation of non urgent scheduled care surgery to create unscheduled care capacity
- Surge Plans across main sites including respiratory
- 7 day and extended Ambulatory Care cover from 8am to 8pm, from 1st December 2019 to 31st March 2020 with Medical cover at weekends for surge beds
- Acute Frailty Unit to contribute to increased flow and reduced bed occupancy
- In preparation Medicine have now embedded a Red, Amber, Green (RAG) status on available beds on the medical floor from September to drive flow and optimise care
- Driving forward aspects of the Transforming Tayside programme: Orthogeriatric Pathway
- Continue with Prof to Prof discussion between Paediatrics and Medicine (AMU) regarding in-school 16-18 year olds being admitted to Paediatrics to create additional capacity
- Late evening senior decision maker support – AMU
- Rehabilitation model of daily care within wards – 7 days to support discharge process
- Implementation of Day Case Cardiology Lounge, extended cardiac device implantation service and Cath Lab Sessions
- Review of non urgent outpatient clinics to support potential staff redeployment for urgent care over days where there is often a high DNA rate i.e. Christmas Eve and Hogmanay where urgent and urgent suspect cancer patients are more likely to attend

4.1 Emergency Department (ED) - Winter Preparedness

Tayside ED attendances have been static over the last five years. Data does however indicate that the dependency scoring and age of patients presenting to the ED are increasing. With this comes the requirement to deliver a greater and more intensive level of care in the ED which impacts on patient flow within the department. This is evidenced by an increase in the number of 4 hour breaches and a shift in the average ED length of stay from 2-3 hours to 3-4 hours.

In response to this analysis the ED team will provide extra junior doctor shifts to decrease the time to first assessment and this has been put in place as a priority funding allocation as part of the winter plan.

Due to the demand led nature of Emergency Medicine, the service is subject to peaks in attendances resulting from seasonal illness such as influenza and injuries resulting from adverse weather. Festive public holidays and the resultant reduction in Primary Care services also impacts on ED attendances with the need for staff to redirect non-emergency patients to alternative services such as local pharmacies, NHS 24 and OOH. Surges in departmental activity can also occur due to timings of emergency ambulance arrivals, resulting from ambulance control dispatch procedures, which impact significantly on ED patient flow – evidenced by a recent ED review exercise.

To ensure the continued delivery of timely, high quality emergency care across Tayside adequate medical and nursing staffing of both Emergency Departments is essential.

Improvement work will continue using the ED breach analysis data to inform areas for consideration. This currently involves a focus on the 'Front Door' pathway, patient flow from ED and Acute Medical Admissions Unit (AMU), including diagnostics (chest x-rays) carried out on route from ED to AMU.

4.2 System Wide Planning

The aim is to have the appropriate levels of staffing in place across the whole system to facilitate efficient and effective patient care, to ensure consistent discharge during weekends and the holiday periods. As such system-wide planning is in place to ensure the appropriate levels of cover needed to effectively manage predicted activity across the wider system and discharge over the festive holiday periods. Examples of this include:

- Clinical Pharmacist cover as well as pharmacy distribution and dispensing centre to be available for extended opening hours to respond to service demand for medicine supply (e.g. discharge prescriptions and in-patient treatments)
- Infection, Prevention and Control Teams (IPCT) rotas organised to ensure appropriate levels of cover in particular to days following the festive break/public holiday periods
- Nursing rosters are managed in accordance with NHS Tayside Roster policy, Health roster are provided six weeks in advance. Patient demand and acuity is managed in accordance with Safecare to support reallocation of staff
- To manage staffing gaps in ward areas, proposed focused update for staff being moved or deployed through the clinical educators/Practice Education Facilitator with familiarisation to new areas, documentation and ways of working before winter and if possible aligning individual staff to identified wards where they will have confidence to be redeployed during the winter months
- Medical floor nurse co-ordinator post to support timely discharge and flow
- Within surgery there is a twice weekly senior charge nurse (SCN) staffing huddle to review next 72 hour period and identify concerns which may be mitigated through an internal plan
- Additional sessions for medical staff (including junior doctors)
- Seven day working over winter period across NHS Tayside and partner organisations i.e. AHPs, pharmacy and SAS. This is pan-Tayside and covers home care providers as well as high dependency areas. This has been planned and funded through winter plan money to increase the likelihood of sessions been filled
- Procurement of supplies e.g. PPE/facial protection

4.3 Angus Health and Social Care Partnership

Key areas highlighted as part of the system wide winter planning in the Angus Health and Social Care Partnership include:

- Development of the Angus Care Model continues incorporating a full review and utilisation of community hospitals including a review and redesign of the Psychiatry of Old Age (POA) discharge pathway
- Discharge checklist reviewed. Test of change in North localities and Care Homes underway
- Range of interventions which were applied last winter can be applied this year depending on severity of demand (e.g. free short term respite provision in certain circumstances, additional incentives to providers for prompt engagement, increase in ERT provision)
- A Day of Care Audit in POA was undertaken to capture meaningful information about availability and alternatives to admission, as well as considering barriers and challenges to timely discharge
- Improved focus on Anticipatory Care Planning (ACPs) and staff education. Work focused on raising awareness amongst public and staff, use of technology and accessing/sharing information, and ensuring carer support aligned with ACPs
- Enhanced Community Support (ECS) continues to work effectively. A sharing and learning event has taken place to review ECS across Angus and provide an opportunity to share good practice and inform future developments
- Additional care management investment to be provided to support Discharge Co-ordinator Team role
- Senior Nurse for Palliative and End of Life Care (PEOLC) in Angus appointed. The post holder will work alongside staff in community hospitals and care homes to improve care and have developed a PEOLC improvement plan. The plan for PEOLC includes all areas where people are cared for and supported
- Enablement and Response Team established in December 2017 continues to improve community capacity by developing an innovative approach to support care at home, provide preventative enablement and respond to short term care needs. This has been reviewed and additional capacity is required
- Personal Care Services are 7 days and we are attempting to strengthen co-ordination /matching processes
- Help to Live at Home is in its concluding stages. Resource Allocation Meetings are held jointly with private and third party providers to improve the matching process and to enable increase in capacity
- We have appointed a Mental Health Officer (MHO) team manager which has reduced the length of guardianship delays and improved the guardianship process to enable identification and status of all cases. Awareness training sessions have been provided to staff
- Continuing to promote the National Power of Attorney Campaign across Angus.
- Providers are supportive of 7 day discharges however, discharge planning from Acute Hospital requires review
- Successful pilot for AHP, 7 day service in Arbroath Infirmary, to provide cover Saturday, Sunday and public holidays from November 2018 to March 2019. Scoping out a solution to sustain this on a permanent basis
- Examination of 24 hour discharge model in Dundee for applicability in rural setting.
- Test of change with Dundee HSCP to provide Care Management support to ensure timely discharge of Angus patients in Ninewells
- The Discharge Team is involved in a Test of Change to develop a Tayside Integrated Discharge Hub
- Proactive review of all non complex patient delays by Health & Social Care Partnership senior staff
- A pilot has commenced with the introduction of three intermediate care beds in the North East locality. Evaluation underway
- All Health & Social Care Partnership staff have access and will be encouraged to accept the annual flu vaccination

- Managers to be requested to share rationale for effective winter holiday planning with all staff and highlight that the Monday following the festive weekend breaks should not be routinely used as a day off thereby creating a 5 day weekend
- AHSCP website to be updated to include: information on travel appointments during severe weather and prospective cancellation of clinics, MIIU opening times and arrangements for community pharmacies, dentists etc
- Introduction of CM2000 to approximately 12 personal care providers across Angus.
- Funding received from the Scottish Government Technology Enabled Care Programme to undertake a project entitled 'Check TEC Out' which enables people to test a range of telecare equipment for up to 4 weeks, before purchasing themselves. Initial test of change successful and additional improvement funding received to test expansion of range 'on offer'
- ASCHP participating in the iHub Living and Dying Well with Frailty Collaborative. Working with 21 other HSCPs we aim to improve earlier identification, anticipatory care planning and shared decision-making, and support a multidisciplinary approach so that people living with frailty get the support they need, at the right time and at the right place
- The new Integrated Overnight Service in Angus (IONA), where MIIU staff and the out of hours GPs to provide a multi-disciplinary approach to overnight care, offers a more flexible service by seeing patients at home

The Angus Hospital Admission & Discharge Management Group Improvement Plan is detailed in the Integrated Joint Board (IJB) Report. The NHS Tayside Winter Plan 2019/20 was submitted to the IJB meeting on 30 October 2019.

4.4 Dundee Health and Social Care Partnership

Key areas highlighted as part of the system wide winter planning in the Dundee Health and Social Care Partnership include:

- Further development and embedding of the Dundee Enhanced Community Support (DECSA) service including the acute element of the model
- Further development of the Acute Frailty model with enhanced support from Integrated Discharge Hub and strengthen links with ECS/DECSA
- Additional AHP and Discharge Coordinator resource funded through Unscheduled Care Board to extend the Acute Frailty model to Emergency Department and Acute Surgical Receiving Unit
- Continue to develop seven day discharge service across the whole system
- Expansion of Home First model over the winter period to ensure timely discharge
- Linking of Integrated Discharge Hub safety huddle to the wider cross site huddles to enhance whole system communication and escalation
- Expansion of 'Step Down Housing' model to incorporate substance misuse/homelessness pathway
- Further development of intermediate care model to enable completion of assessment in a more homely environment with provision of rehabilitation
- Provision of step down beds for younger adults to complete assessment in a community setting following brain injury rehabilitation
- Remodeling and realignment of resource allocation processes to enable Integrated Discharge Hub to ensure focus remains on patient flow
- Continued investment in Resource Matching Unit to ensure efficient allocation of social care resource
- Additional Mental Health Officer located in Integrated Discharge Hub which has reduced guardianship delays

- Continued promotion of Power of Attorney campaign to reduce number of guardianship requests made
- Ongoing development of Anticipatory Care Planning
- Ongoing development of a range of specialist accommodation with support through the strategic commissioning process to support adults with mental health problems and learning disabilities to leave hospital when they are ready
- Extension of COPD Team to improve support to people following discharge
- Development and expansion of the care home team
- Planned End of Life Care (PEOLC) improvement work in care homes
- Development of a Rehab Pathway which focuses the provision of social care more closely on rehabilitation
- Focus on the development of an ANP workforce which will enhance the community model
- All health and social care partnership staff will be encouraged to accept the flu vaccination

4.5 Perth & Kinross Health and Social Care Partnership

The focus of the winter plan and improvement actions for Perth & Kinross Health & Social Partnership is to ensure that people get the right care, at the right time, in the right place, avoiding unnecessary admissions to hospital and ensuring that, once admitted, people are discharged as soon as they are ready, contributing to better health outcomes and making best use of resources.

The key developments are;

- Review and update Business Continuity Plans, Festive Directory and Winter Action Cards
- Work in partnership with all sectors to ensure winter resilience planning for vulnerable adults in localities.
- Continue to promote National Power of Attorney Campaign across Perth & Kinross
- Additional Surge Beds in Tay ward
- Implement a Health & Social Care Perth City Supported Discharge service to increase capacity and support to actively 'pull' patients from PRI acute sector wards
- Develop and recruit to enhanced intermediate community care and specialist respiratory services to support more people at home.
- Work with Dunkeld GP Practice to commence implementing MDT improvements to identify people living with moderate to severe frailty
- Develop with British Red Cross home support option
- Expand the Royal Voluntary Service complimentary discharge service embedding 'Home from Hospital' in discharge process.
- Extended AHP Weekend Working for OT and PT staff within acute services to facilitate assessment and discharge
- Ensure process in place to continue to authorise care home placements rapidly over Festive Period
- Improvement plan to increase flow through Tay Ward back to Perth city
- Continue proactive review of all delayed patients on a daily basis by case holder and discharge teams across the HSCP including community hospital bed base, supported by Local MDT meetings.
- Undertake a Day of Care Audit in POA wards Murray Royal Hospital to identify improvements
- All health and social care staff will be encouraged to accept the flu vaccination
- Continue to develop and deliver frailty team linked to emerging Acute Frailty Unit to support the potential surge in emergency admissions

- Integrate the Discharge Hub and Hospital Discharge Team and put in place a rota for weekend / public holiday cover
- Ongoing developments with HART team following successful recruitment
- Collaborate with Third Sector for additional volunteer drivers as and when required
- Agree process for senior manager to participate in weekend cross site huddles during winter period
- Explore Friday huddle sessions for Partnership Services to support capacity and flow at weekends
- Review of Care Home liaison staff to support complex discharges to Care Homes from hospital settings
- Realignment of AHP staff to the Unscheduled Care flow across Perth Royal Infirmary linked to development of AME (Ward 1).
- ANP rapid assessment for Perth city for the deteriorating patient with workforce plan to extend to other localities.
- Development of community crisis admission pathway to community hospitals through ANP's and GP's
- Falls intelligence group set up to look at prevention indicators.

4.6 Fife Health and Social Care Partnership

North East Fife is a key area for NHS Tayside. Their Acute and Community plan for winter preparedness will be submitted as the NHS Fife Winter plan however we recognise the need to work with our partners in Fife and will continue to develop links to ensure continuity of services.

Current improvement work as part of the Unscheduled Care and Transforming Tayside Programmes include collaborations across Tayside and Fife Health and Social Care Partnerships to reduce delayed discharges. The work involving discharge teams across all localities is aimed at supporting an effective, timely, person centred discharge process with the development of a fully integrated acute hospital discharge service, working 7 days per week and functioning via the same agreed planned date discharge pathway across the localities.

Summary of Key Actions for Unscheduled and Elective Care Preparedness

Acute Sector

- Flexible Staffing plans to enable rapid deployment of surge capacity as required: Staff rosters aligned with demand and patient acuity including all professions; Medical, Nursing, AHP, Pharmacy
- 7 Day working across multiprofessions and partner services i.e. SAS, Pharmacy and AHP
- Acute Frailty Pathway
- 7 Day and extended hours in Ambulatory Care
- Acute bed & Respiratory Surge Plan
- Theatre Scheduling
- Planned /Elective Care shutdown over holiday period
- Orthogeriatric Pathway
- Review of non urgent Outpatient Clinics to support staffing resource

Health and Social Care Partnerships

- Enhance Community Support Services
- Anticipatory Care Planning/ Planned End Of Life Care in Care Homes
- 7 day discharge services and increased AHP provision
- Discharge Hubs supporting discharge planning
- Development of acute frailty models

5. Out of Hours Preparedness

5.1 Out of Hours Services

Planning for Out of Hours services includes the following actions:

- Increased capacity with number of GP shifts over the festive period
- NEWS (National Early Warning Score) pathways are in place to ensure rapid identification of deteriorating patient
- An Advanced Paramedic Practitioner will be based in the Kings Cross Primary Care Emergency Centre, Dundee to consult patients
- GP triage – it is intended that additional GP triage shifts will cover the busy public holiday periods with a view to increasing the time, appointing patients the following morning rather than within a four hour period, or dealing with problems over the telephone where appropriate.
- Community pharmacies can deal with minor illnesses with direct referral to out-of-hours where required
- Access to mental health out-of-hours crisis team to triage patients
- NHS24 prediction data is not available until late October but where this and out-of-hours service data differ, capacity will be planned around the greater of the two.
- Resource availability over festive public holiday period confirmed for all Primary Care Emergency Centres at Arbroath Infirmary, Kings Cross Health and Community Care Centre and Perth Royal Infirmary including GP shifts, drivers, nursing staff etc
- Annual leave applications from 17th December 2019 to 6th January 2020 will be considered on an individual basis but are unlikely to be compatible with maintaining full staff availability. Duty manager in place over the festive period

- The management team monitor activity weekly and decide on any extra capacity required.
- 10 cars will be available for use over the two festive holiday weekends to assist with the expected level of demand of home visits at peak times. (Three more than base level)
- Increase GP triage to two GPs on 25/26 December 2019 and 1/2 January 2020
- All Practices are contacted pre festive period requesting that they keep patient special notes up to date
- Demand Management - resources will be targeted around priorities across Tayside by the team leaders and dispatchers. Patients will be offered transportation to other Primary Care Emergency Centres if no alternatives can be identified
- Out-of-hours service staff will email a briefing in December to all staff outlining the arrangements for the festive period and winter period (January to March) which will include extra staffing and escalation plans and communication arrangements with NHS24 and other agencies both internal and external
- Tayside out-of-hours and NHS24 communicate regularly. Agreement around escalation process and local contingency arrangements for local centres. Agreement reached around the sharing of information between NHS 24 and out-of-hours.
- Contact arrangements are in place for a clear process for reporting vehicle faults and breakdowns over the public holiday period and emergency out-of-hours contact list is available to the management team in case of severe weather.
- An enhanced payment for GPs is offered across the festive period to support shift coverage
- A process has been developed to ensure effective and efficient use of the Scottish Ambulance Service paramedic service.

Summary of Key Actions for Out of Hours Preparedness

Out of Hours Service

- Resource availability over the winter season including arrangements for dealing with influenza.
- Resource availability over the Festive period
- Increased availability of cars for home visiting
- Additional Triage/ Professional Advice to support whole system working.
- Increased capacity re GP cover of festive period
- Demand management - resources targeted around priorities across Tayside
- Access to Mental Health OOH Crisis Team to triage patients
- OOH Escalation Process in place - agreed with key stakeholders

6. Infection Prevention and Control

6.1 Norovirus

NHS Tayside's Infection Prevention and Control Team (IPCT) ensures that staff have access to and are adhering to the national guidelines on *Preparing for and Managing Norovirus in Care Settings* along with the HPS National Infection Prevention and Control Manual (Chapter 2 Transmission Based Precautions). IPCT provides all guidance on the Infection Prevention Staffnet site. For those staff groups who are unable to access Staffnet

(Independent providers / social care teams), this information is available on the Health Protection Scotland (HPS) website.

6.2 Norovirus Training and Communications

There is an established communications process between the IPCT and the Health Protection Team to optimise resources and response to the rapidly changing norovirus situation. In addition there is established communication with Health & Social Care Partnership Leads and via Governance Forums to ensure the partnerships are aware of norovirus publicity materials and are prepared to distribute information internally and locally as appropriate, to support the 'Stay at Home Campaign' message.

To further support the communications and training requirements in preparation for Norovirus the following is in place:

- IPCT provides regular updates to the NHS Tayside Communication Team regarding ward closures, and advice for staff in relation to infection prevention and control precautions, communicated over winter period.
- Winter preparedness and raising awareness through education sessions for staff commenced by IPCT September 2019.
- A collaborative event with colleagues from NHS Tayside Health Protection Team in relation to a local Significant Hospital Infection Incident Tabletop Exercise was successfully held on Friday 06 September 2019 with approximately 72 key stakeholders. The event focused on a hospital response to an infectious incident taking into account systems and communication required to be able to rapidly respond
- Dedicated Transmission Based Precaution education sessions provided as per IPC Annual Training Programme
- Norovirus leaflets and posters provided to NHST by HPS shared across the Health and Social Care Partnerships
- Infection Prevention and Control: NHS Tayside prioritisation flow chart to aid decision making at 'front door'
- Information on Norovirus is sent out to all local care homes by Public Health. The Health Protection Team also supports the management of all outbreaks of diarrhoea and vomiting within care homes, and Public Health routinely informs the IPCT, Communication Team and Resilience Teams regarding the closure of homes.

6.3 Norovirus Planning and Control

IPCT plans are in place to support the execution of the Norovirus Preparedness Plan before the season starts. Norovirus Control Measures are accessible to all staff across Health and Social Care Partnerships on NHS Tayside's Staffnet intranet site, or on HPS website

Communications regarding bed pressures and norovirus ward closures will be managed through an agreed distribution list which will detail bay or ward closures due to a known or suspected infection is in place.

IPCT will ensure that the partnerships and NHS Tayside are kept up to date regarding the national norovirus situation by communicating HPS national prevalence data on a weekly basis. Debriefs will be provided following individual outbreaks or end of season outbreaks to ensure any system modifications required to reduce the risk of future outbreaks. The HPS Hot Debrief tool is currently used with clinical teams for this purpose. Lessons learnt are shared as required across clinical teams and at Safety, Clinical Governance and Risk Meetings and SCN Forums.

To ensure arrangements are in place to provide adequate cover across the whole of the festive holiday period there will be an on-call microbiologist available 7 days per week.

6.4 PPE Procurement (Flu and Norovirus)

Clinical areas must ensure adequate resources are in place to manage potential outbreaks of seasonal influenza like illness/norovirus that might coincide with, severe weather and festive holiday periods. Key actions for this winter include:

Key actions for this winter include:

- FFP3 Staff testing and fit tested, maintenance of staff fitting programme.
- Early procurement stock management of PPE
- Assurance of governance for respiratory powered hoods (3 in Ninewells, 2 in PRI)

6.5 Seasonal Flu

6.5.1 Flu Vaccination Programme

All Health Care staff have access and will be encouraged to accept the annual flu vaccination. Plans to significantly increase staff flu vaccinations across health and social care systems are in place and include:

- This year's target is >60%
- Flu vaccinations clinics will begin late September with Occupational Health sessions taking place in Ninewells and PRI several weeks earlier this year
- As in previous years, having Flu vaccination clinics within the Ninewells concourse area have been particularly successful in boosting staff uptake of the vaccination mainly due to the convenience of the location. Flu clinics will be held there this year again for a three month period
- Peer vaccination will also take place in clinical areas to boost the staff uptake of the Flu vaccination.
- Staff also able to attend participating community pharmacies to be vaccinated
- Vaccination Programme Manager has attended Head of Nursing Forum to plan requirements for the peer vaccination programme.
- Medical leads will also be asked to consider peer vaccination programme to boost uptake numbers.
- Plan to use in-hospital vaccination to "catch up" vulnerable patient who have missed community vaccination

6.5.2 Flu Communication Campaign

The NHS Tayside Communications Team has a communications plan in place specific to seasonal flu vaccination. The team promotes our flu vaccination campaign to all NHS Tayside staff and volunteers, as well as members of the public in at-risk groups.

A Communications Pack is produced for each area with posters giving details of local staff clinic sessions on NHS Tayside sites, participating community pharmacies offering the jab, 'myth busters' and key messages about protecting yourself and your family, your patients and the service. Information about public vaccination clinics in GP surgeries across Tayside are advertised in the local media, NHS Tayside website and on social media.

Regular updates about staff clinic sessions are shared through weekly e-bulletin LowDown, standalone e-bulletins targeted at staff on individual sites and on the homepage of our staff intranet and dedicated intranet flu page. Myth-busting digital assets, photographs and

quotes from staff getting vaccinated and 'talking head' videos using members of staff are also shared widely with staff and the public.

6.5.3 Near Patient Testing for Flu

Near Patient Testing was successfully carried out in winter 2018/19 contributing to reducing admissions and avoidance of ward closures due to Flu, maximising flow and reducing risk of harm to patients. The 'Preparing for Winter' funding 2019/20 will be used to support Near Patient Testing for Flu again, in addition to a planned and budgeted way to maximise bed utilisation across the main hospital sites.

A short term working group has assessed the evidence of benefit of this approach and identified that there is likely to be a reduction in bed closures and also a considerable reduction in the time to patients receiving appropriate anti viral medication which will reduce the duration of their illness.

6.5.4 Care Home Flu Management and High Risk Groups

Public Heath will monitor vaccination rates for High Risk, over 65s, Long Term Health Conditions and Pregnant Woman. The care home vaccination lead sits on Unscheduled Care Programme Board and will provide rapid updates regarding current status and impact of Flu within care homes.

Information on flu vaccination for residents is sent out to all local care homes by Public Health. The Health Protection Team, within Public Health also supports all local homes with their management of respiratory outbreaks. Information regarding home closures due to outbreaks is routinely shared with the Communications Team, IPCT and the Resilience Team.

Summary of Key Actions for Infection Prevention and Control

- Staff access to and adherence to national guidance on Preparing for and Managing Norovirus in Care Settings
- IPCT plans in place now to support the execution of Norovirus Preparedness Plan in advance of season
- IPCT guidance on Staff website and HPS Website
- Awareness event/sessions for winter preparedness
- Prioritisation Flow chart to aid decision making at the 'front door'
- Procurement and adequate resource availability
- Plans to increase staff Flu Vaccination Uptake: Programme - commenced one month earlier (September) for staff, convenient Flu clinic locations, peer vaccination programme to increase uptake
- Communication Campaign specific to seasonal illness including Flu
- Near Patient Testing for Flu

7. Respiratory Pathway

Winter planning in respect of the Respiratory Pathway will aim to ensure there is an effective, co-ordinated respiratory service provided. Clinicians across the relevant Primary and Secondary Care Services will have the required information and knowledge regarding their local pathways for patients with different levels of severity of exacerbation in their area.

There is effective discharge planning in place for people with chronic respiratory disease including COPD delivered seven days by the respiratory clinicians, with additional help from respiratory liaison team.

Plans are also in place to enhance home support respiratory services in particular for COPD patients post discharge.

People with an exacerbation of chronic respiratory disease/COPD have access to oxygen therapy and supportive ventilation where clinically indicated in Emergency Departments, Acute Admitting Units and hospital sites as well as GP and OOH services.

Anticipatory Care Planning is completed for people with significant COPD, and palliative care plans are in place across the Respiratory Pathway for those with end stage disease.

7.1 Respiratory Pathway Communications

As part of the wider Winter Planning Communications Strategy across the Health and Social Care Partnerships information and messages in relation to keeping warm throughout the winter months and potential adverse weather are well displayed at key points of contact, and are covered as part of any clinical review.

In addition, as part of the Communications Plan to support the work of the Respiratory Pathway and Service, 'Business Card' style information cards around Flu and Respiratory illness as part of the prevention approach will distributed across all localities, GP, Primary Care and OOH services

Summary of Key Actions for Respiratory Pathway

- Enhanced Home support to respiratory services in particular to COPD patients post discharge
- Effective Discharge planning for patient with COPD, 7 days by Respiratory Clinicians
- Access to Oxygen Therapy hospital sites, GP and OOH services
- ACP for patients with Significant COPD and Palliative Care plans for those with end stage disease are in place across respiratory pathway
- Extra Respiratory Nurses and Physicians over public holiday periods
- Respiratory surge beds
- Communication plans to support the work of the Respiratory Pathway and service
  - Information Cards - Prevention approach

8. Mental Health

Access to Mental Health Services is a national and local priority. NHS Tayside recognises that the majority of mental health acute presentations are as unscheduled care as such we have added this as one of our key priorities and recognise that this must continue beyond winter. There will be a requirement to build enquiry into the Safe Affordable Workforce (SAW) process about how the proposed clinical and staff models meet the mental health and well being needs of people in acute care.

To support winter planning arrangements in Mental Health, in particular to meeting demand and facilitating flow through Emergency Departments, Psychiatry Liaison Team provides support seven days per week.

Mental Health services are reviewed their trigger, escalation and business continuity plans and have developed Winter Action Cards in line with other areas using this approach for winter planning. Site Safety and Flow Huddles across Mental Health Services are also in place to support the triggers and escalation process, sharing safety, demand and capacity information. A proposal for an in-patient Capacity and Flow Coordinator will be implemented which will incorporate monitoring capacity of Tayside wide intensive home treatment teams to ensure provision of early supported discharge All of these processes aimed at ensuring robust business continuity management arrangements are in place to maintain business as usual throughout the winter period.

Summary of Key Actions for Mental Health

- Implement proposal for In Patient Capacity and Flow Co-ordinator 5 days per week
- To meet demand through ED enhance Psychiatry Liaison Team Capacity
- Escalation, Business Continuity arrangements and Winter Action Cards implemented across Mental Health Services to support winter and resilience planning

9. Communication Strategy

The NHS Tayside Communications Team has communication plans in place specific to the winter period including adverse weather and seasonal illness including Influenza, influenza like illness and Norovirus. The NHS Tayside communication team actively promotes related publicity materials and national campaign assets and shares widely through social media channels. This is targeted at staff, patients and the public alike.

As in previous years, the Communications Team support the organisation's preparations for winter through the local and national winter campaigns, tailoring the national key messages for the local situation and a local audience and releasing media releases and social media messages throughout the winter period. Social media is the best channel for instant updates to information and will be used extensively, along with media releases, website updates, radio updates and sharing of messages with local partners for onward distribution.

The Communications Team updates the NHS Tayside website with weather and travel information as necessary and promotes Ready Scotland on the front page of its website.

The Communications Team will continue with regular press releases reminding people where to go seek appropriate support out of hours and over the holiday period. They will have a public communications strategy to raise awareness of access arrangements over the festive period, which includes an advertising campaign in local media with GP, pharmacy and MIIU opening hours. This is supported by regular social media and website posts to share information and signpost to available services.

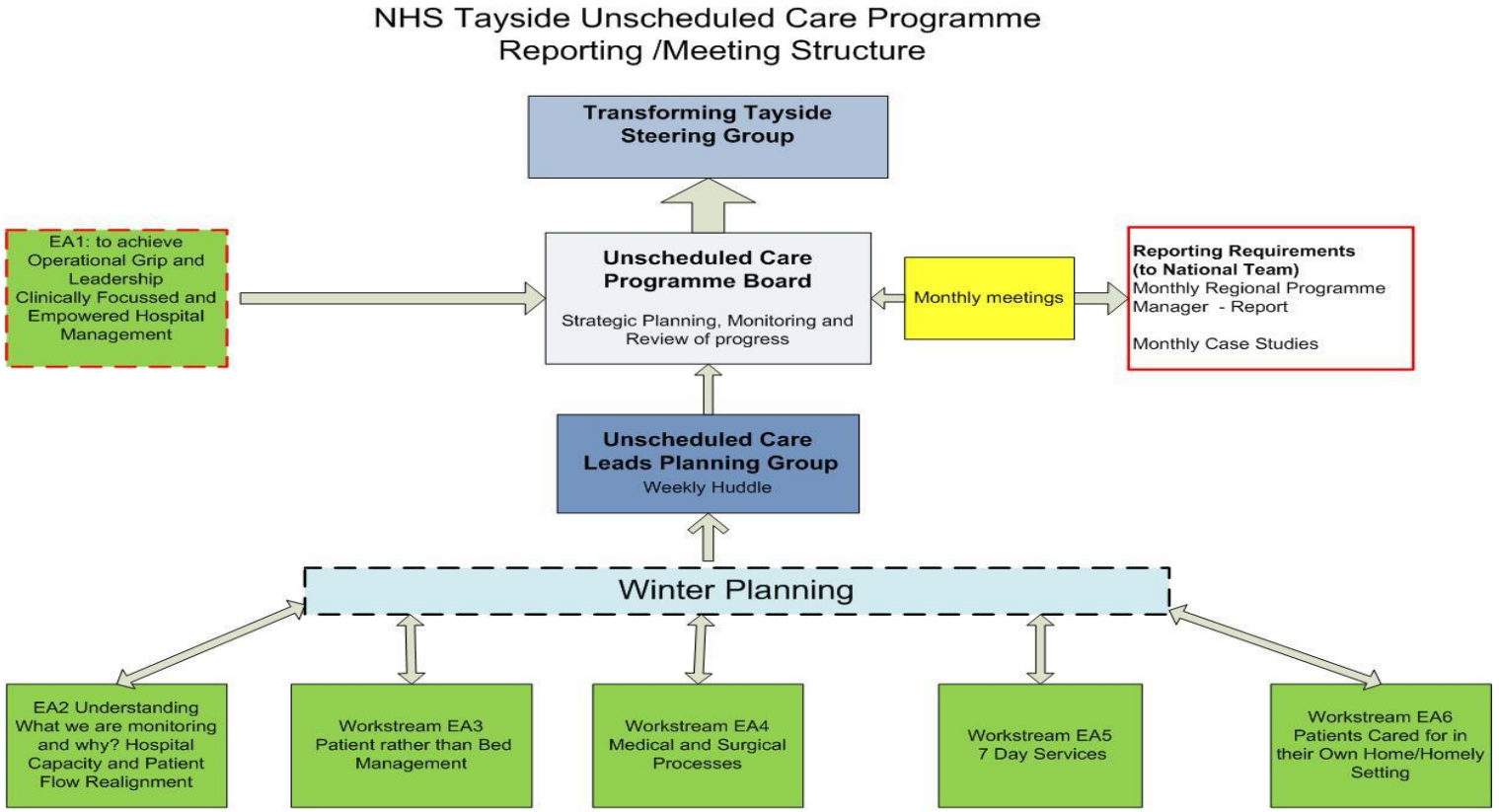
Appendix 1 Winter Preparedness Funding Summary

WINTER PLANNING 2019/20

PROPOSED PLAN TO DELIVER SG PRIORITIES

	Description	£
Funding		
Funding Scottish Government		**£368,938**
Funding NHS Tayside	To match last year's allocation of £737,734	**£368,796**
Proposed Commitment against Priority		
Phase 1	**Prevent** • Additional funding across all three Health and Social Care Partnerships to prevent admissions/attendance managing care closer to home, supporting discharges • Out of Hours additional funding	**£273,435**
Phase 2	**Assurance - Initiatives to ensure winter flow** • Extended Ambulatory Service, late access to senior decision maker support • Seven day rehabilitation model of care • Near patient testing for Flu prevent unnecessary admissions for Influenza like Illnesses • Cardiology initiatives • Pharmacy • ED additional junior medical cover • Respiratory	**£242,285**
Phase 3	**Provision of Surge Beds** • Acute Medicine for the Elderly (AME) beds in Ninewells to boost and target capacity. • Increased (surge)bed numbers across both acute main sites and same day discharge, social support	**£852,507**
Total Cost		**£1,368,227**
SURPLUS /(DEFICT)		**(£630,493)**

Appendix 2 Reporting Structure



Unscheduled Care Leads Planning Group: to include Clinical/Service Leads, Programme Board Chairs, Programme Manager & Improvement Support – agree priority actions from Programme Plan, activity planning, issues and risks. Programme Board Agenda Planning

Workstream Groups: to include site/locality teams involved as well as identified workstream leads. Testing and Implementation of agreed activities/interventions. Reports to Unscheduled Care Board via clinical area representative

Appendix 3 Unscheduled Care 6EA 2019/20 Priorities

NHS Tayside Key Priorities for Delivering Unscheduled Care 6EA 2019/20

Transforming Tayside

National Emergency Access Target
Sustained delivery of the 95% target, and work to deliver the 98% standard.

Key National Milestones 2019/20

Systematic removal of breach reasons to maximise patient flow through the ED and acute assessment areas to eliminate crowding and exit block.

Avoiding attendance and admission wherever clinically appropriate.

Eradicate boarding and minimise all delays where admission is required.

Reduce variation in out of hours, weekends and across 7 days.

Support patients to be cared for at home whenever appropriate.

NHS Tayside Operational Plan

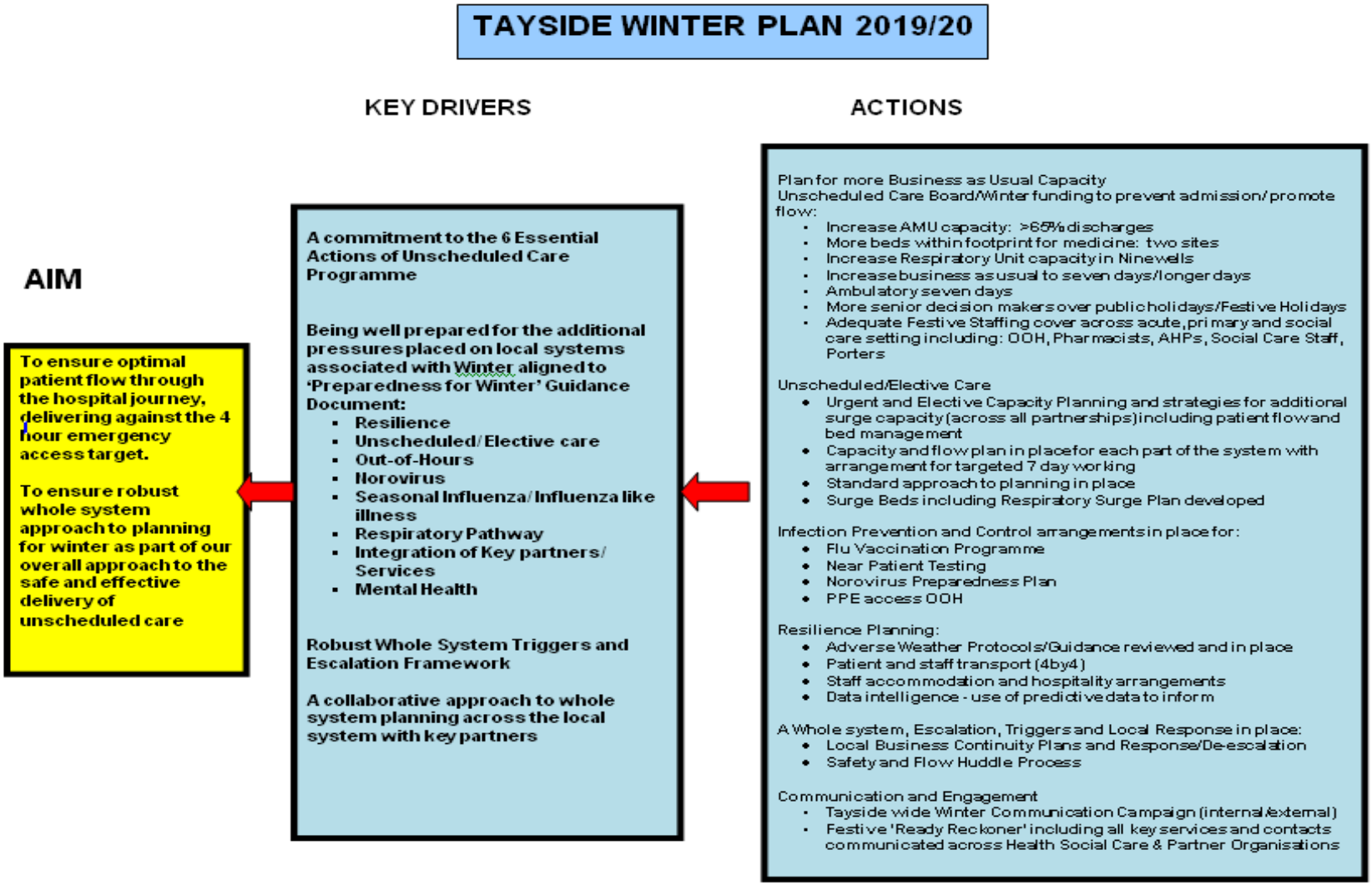
The plan is aligned to Transforming Tayside 2019-2022, our corporate plan to make sure we deliver safe, accessible, effective, high-quality, person-centred care for everyone in Tayside.

Our commitment to Unscheduled Care in 2019/20 is to:

- focus on frailty irrespective of age
- promote earlier time-of-day of discharge
- increase weekend discharges
- increase hospital front door discharges
- reduce length of stay
- deliver more timely diagnostics
- focus on admission and referral avoidance
- focus on review of unscheduled surgical pathways
- focus or redesign of orthopaedic trauma pathways

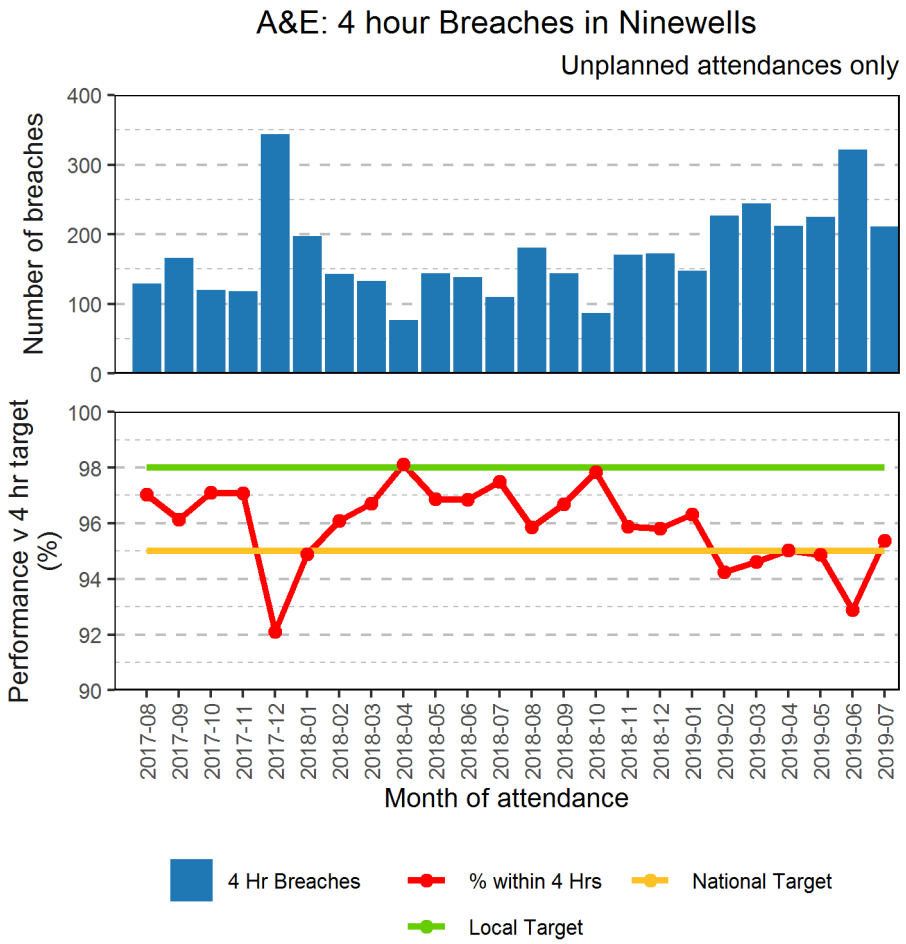
NHS Tayside
Dundee Health & Social Care Partnership
Perth and Kinross Health and Social Care Partnership
ANGUS

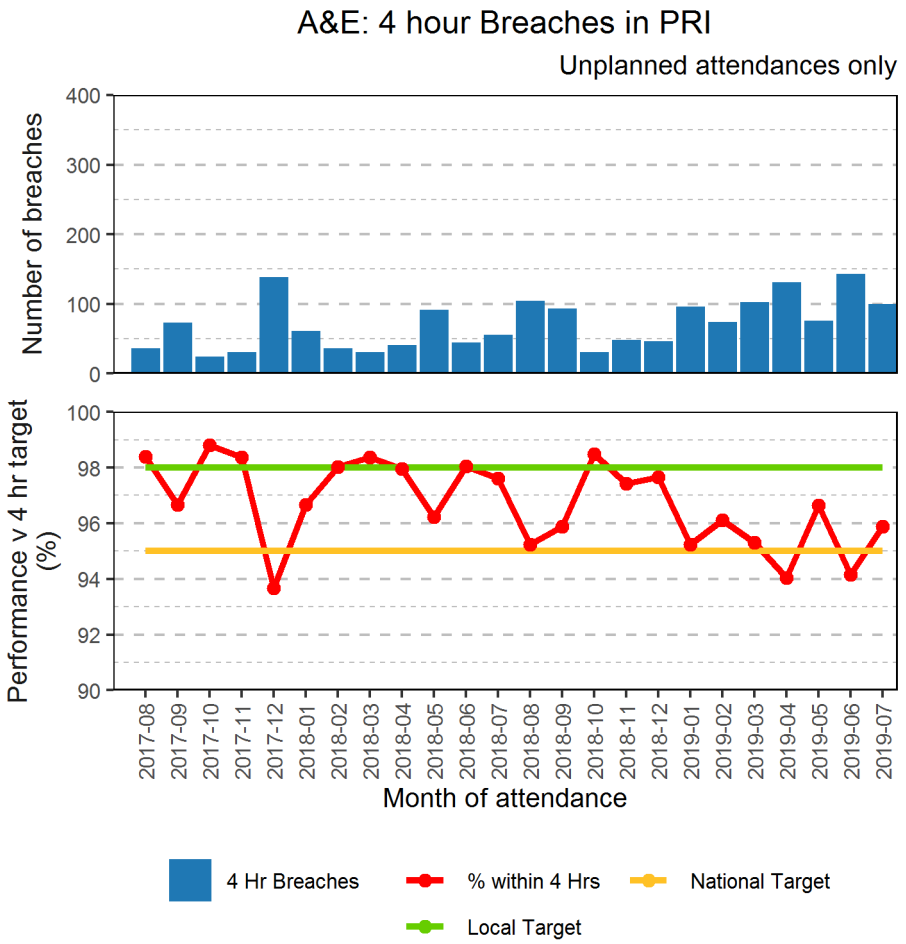
Appendix 4 Winter Plan Driver Diagram



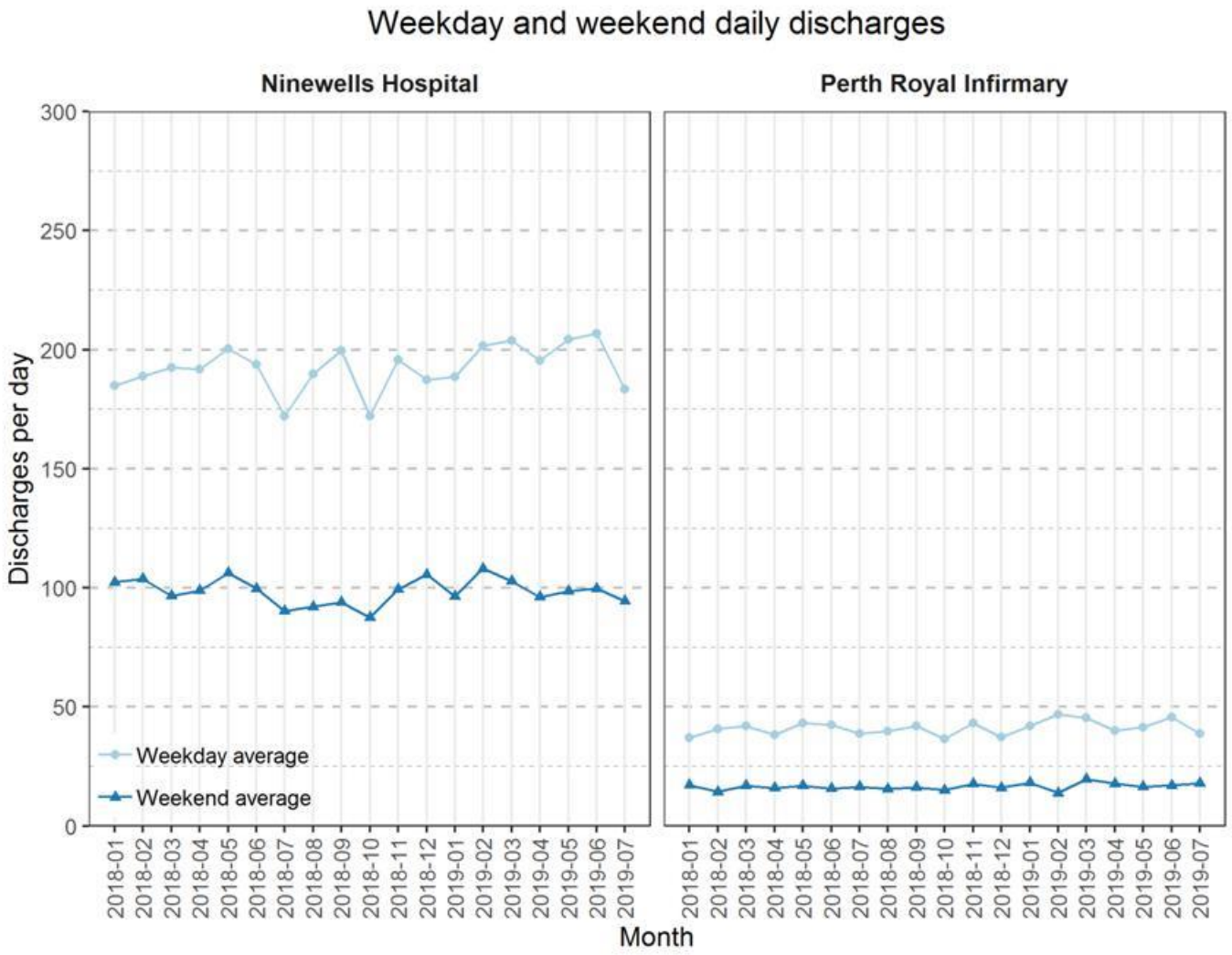
Appendix 5 Measures

Measure 1 – ED Performance



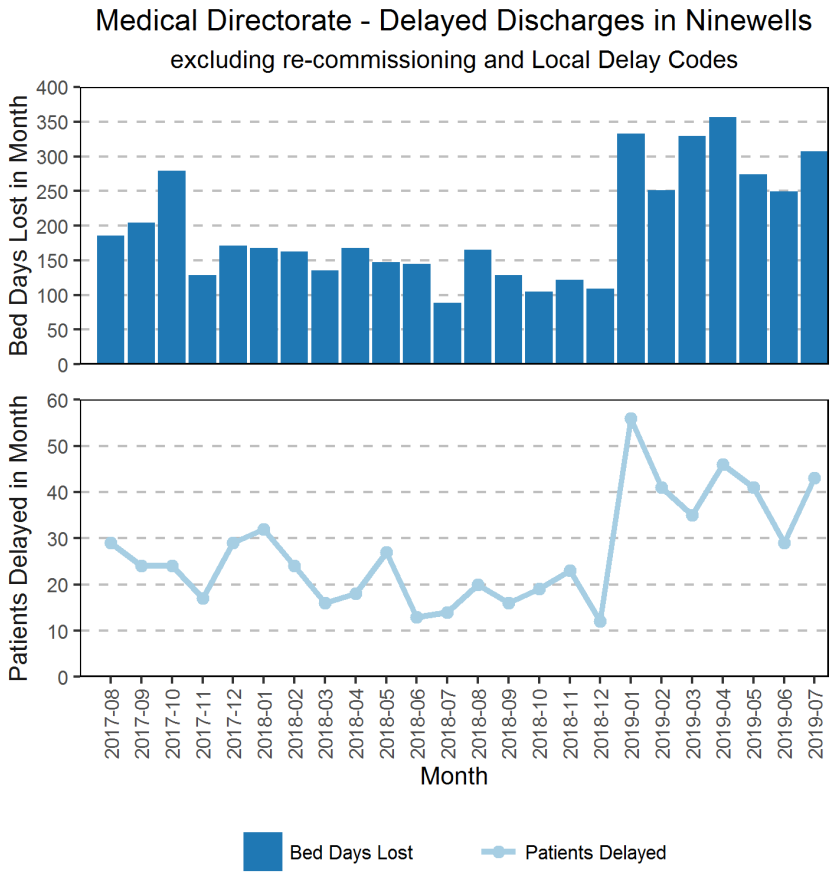


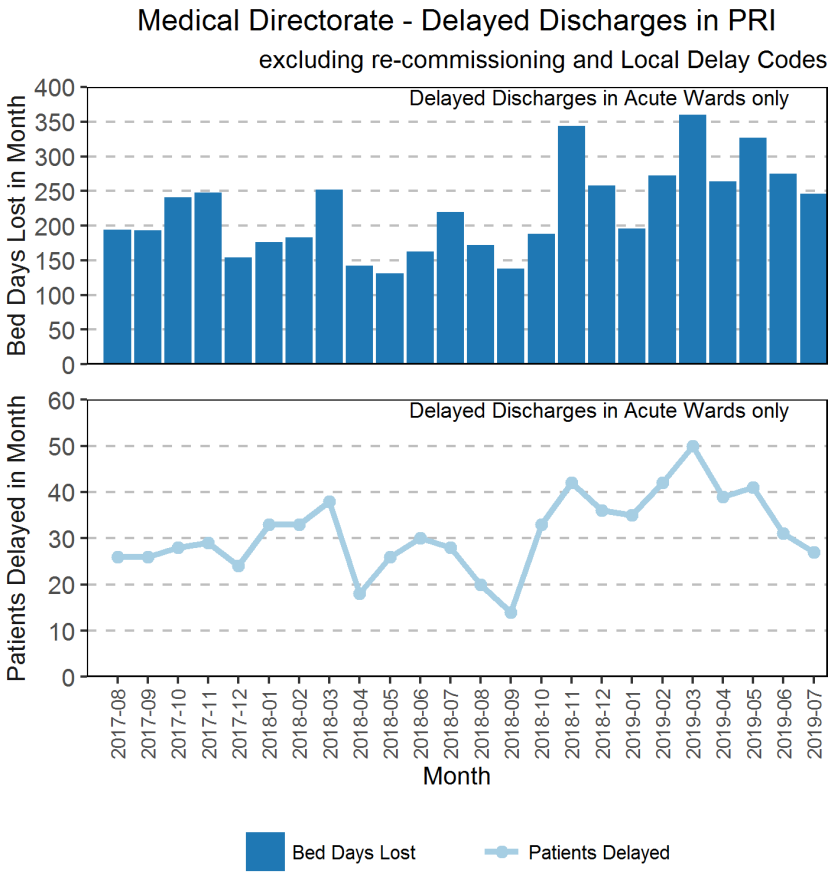
Measure 2 - Weekday v's Weekend Discharges

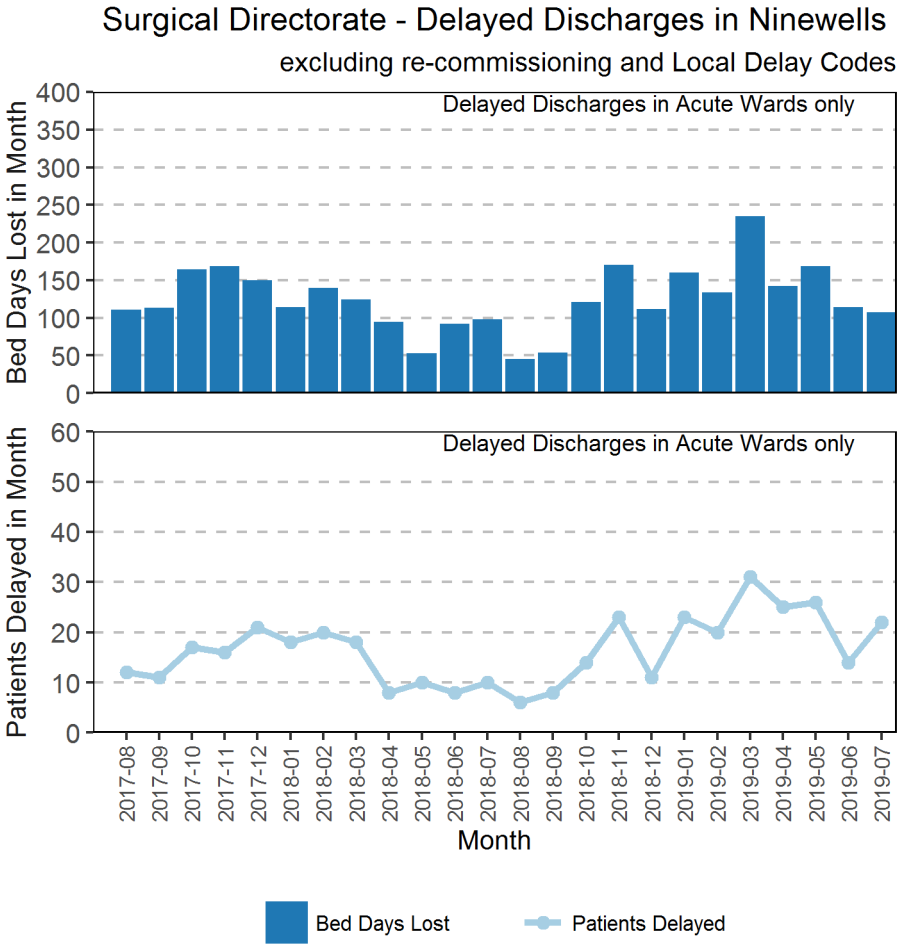


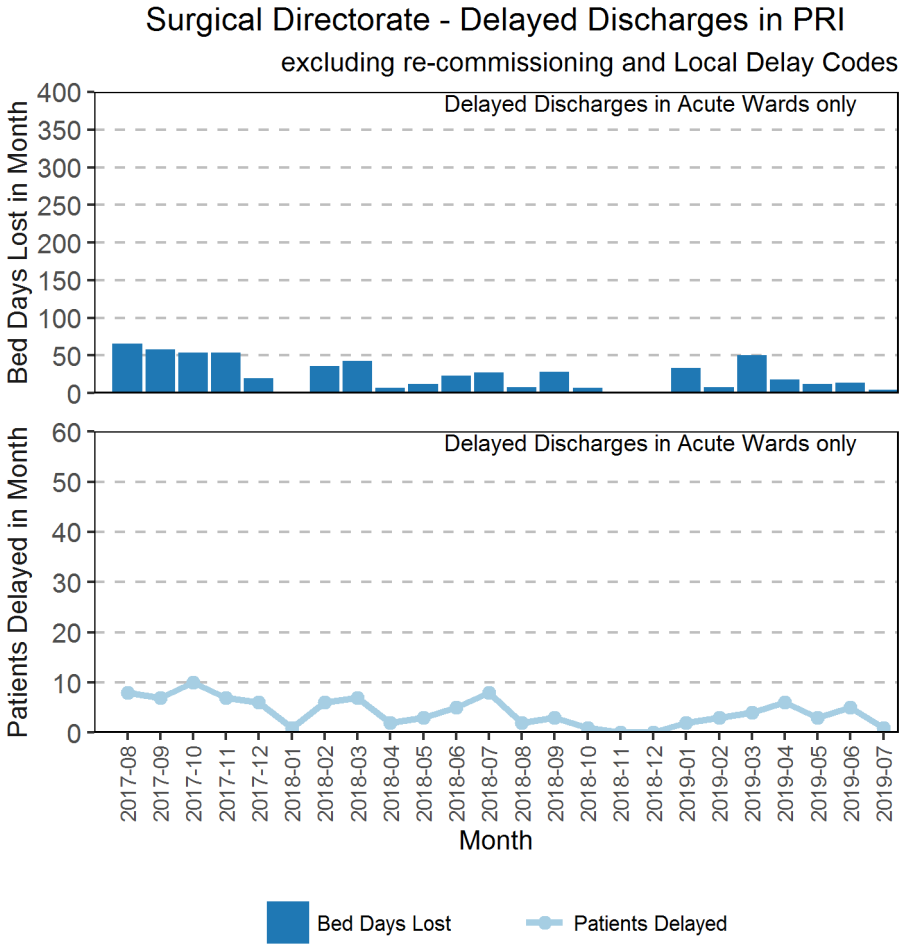
Measure 3

Patients in Inappropriate Locations - Delayed Discharges: No. of patients and bed days lost. Medicine Directorate and Surgical Directorate






Surgical Directorate - Delayed Discharges in Ninewells
excluding re-commissioning and Local Delay Codes
Delayed Discharges in Acute Wards only
Bed Days Lost in Month
Patients Delayed in Month
Month
Bed Days Lost
Patients Delayed

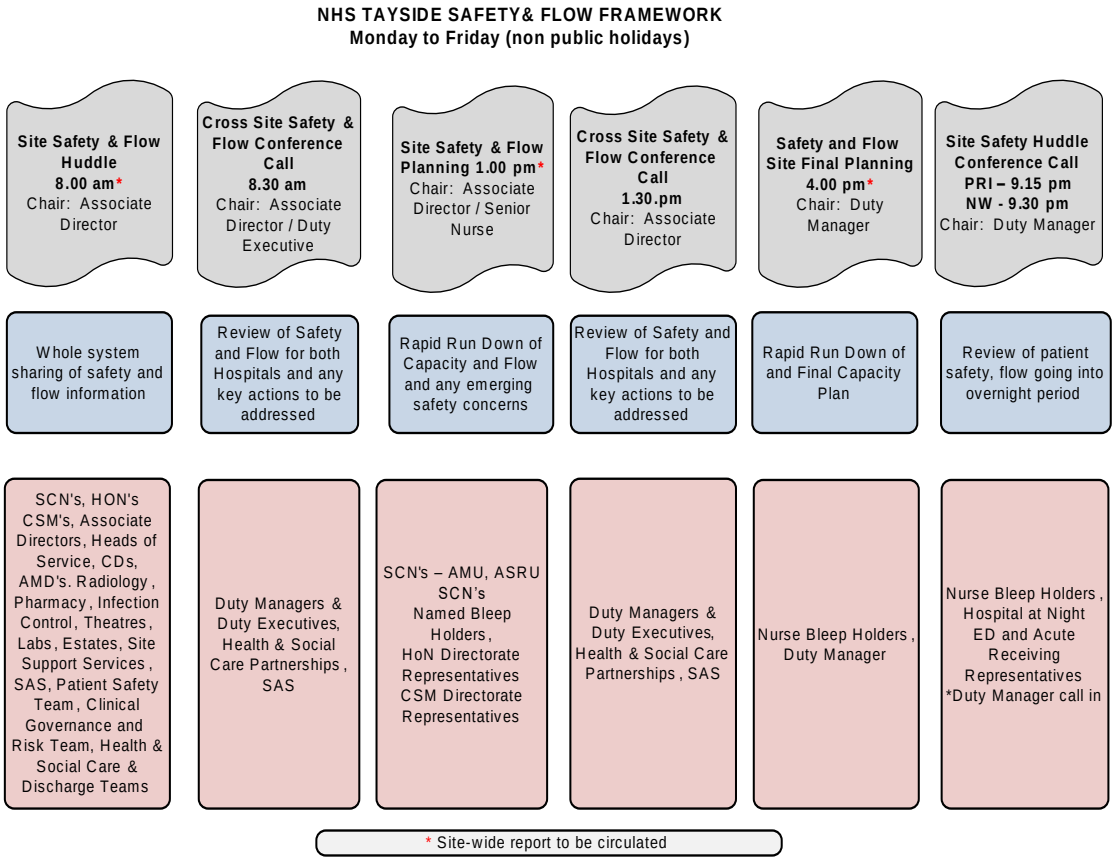

Surgical Directorate - Delayed Discharges in PRI
excluding re-commissioning and Local Delay Codes
Delayed Discharges in Acute Wards only
Bed Days Lost in Month
Patients Delayed in Month
Month
Bed Days Lost
Patients Delayed

Appendix 6 Safety and Flow Huddle

SAFETY AND FLOW HUDDLES NINEWELLS AND PRI

Safety & Flow Framework for Business as Usual, Weekend and Public Holiday Working

Figure 1: Monday to Friday Huddle Arrangements

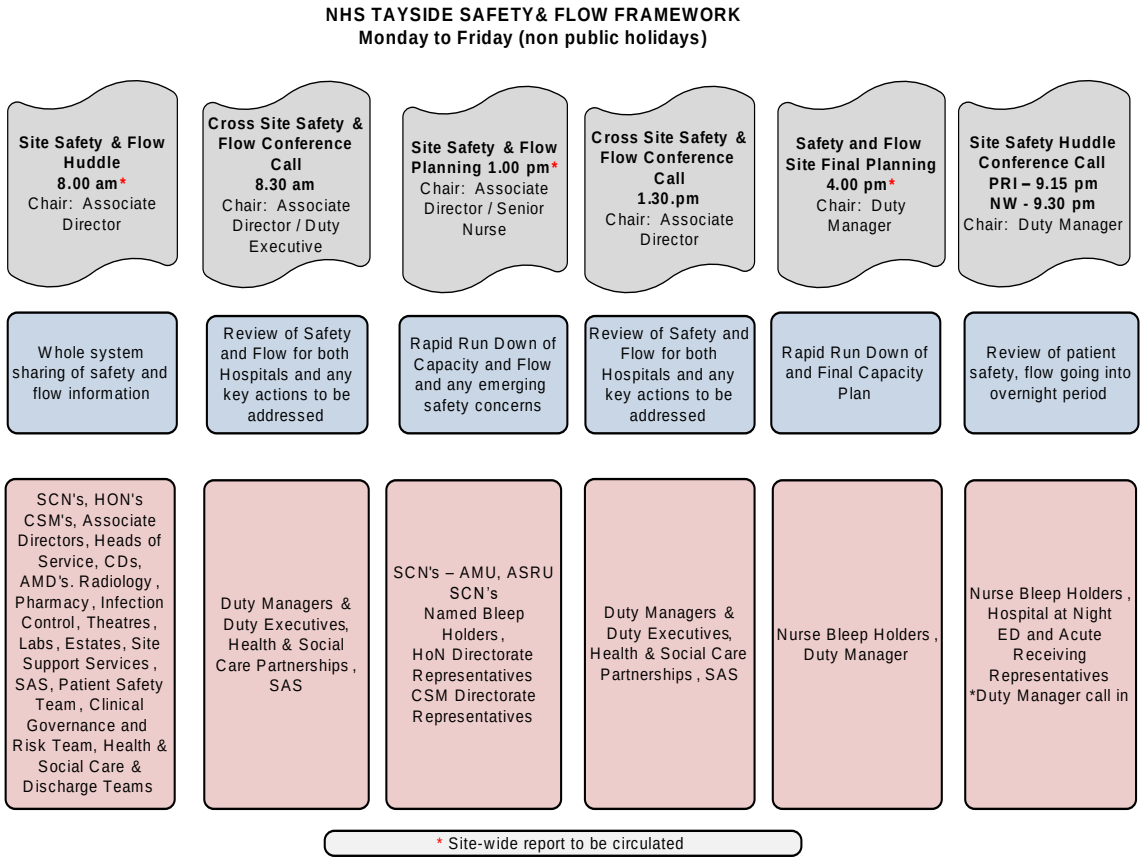


Appendix 6 Safety and Flow Huddle

SAFETY AND FLOW HUDDLES NINEWELLS AND PRI

Safety & Flow Framework for Business as Usual, Weekend and Public Holiday Working

Figure 1: Monday to Friday Huddle Arrangements



Appendix 7 Winter Action Card Template

WINTER ACTION CARD

DEPARTMENT:
LOCATION: (e.g. Ninewells, PRI)

YEAR ROUND PLANNING – BUSINESS AS USUAL (Summary of Activity)
Example: *Workforce Planning and development, Staff duty rotas* *Support Services – equipment, stores and transport* *Information Technology* *Risk of patient becoming delayed on their pathway is minimised*
WINTER PREPAREDNESS – PLANNING AHEAD
Develop activity plans for winter: Festive shutdown, elective and urgent care *Ensure timely and continuous access to local infrastructure services including:* *Workforce Capacity Plans, Staff duty rotas* *Sufficient levels and numbers of senior decision makers from all sectors are duty rostered at all times* *Support Services - equipment, stores and Transport(SAS), Information Technology* *Data Intelligence to inform planning, monitoring and action for winter capacity, activity, pressures and performance* *Instigate discharge planning at weekends & before pressure periods/public holidays* *Communication internal/external*
ALERT/TRIGGERS
Consider triggers: seasonal illness, adverse weather, effects on staffing, service pressures: *Pressures on timely and continuous access to local infrastructure services including:* *Workforce capacity – staff duty rotas* *Support Services - equipment, stores and transport, Information Technology* *Use of predictive data from partner agencies to inform alerts/triggers and actions to be taken* *Communication of Demand Capacity pressures via Hospital site huddle Framework* *Communication internal/external*
ESCALATION – Action & Response
What do we need to know? *Staffing levels* *Local Priorities* *Roles/responsibilities* *Demand capacity data from hospital site huddles/partner agencies* *Communications internal/external* *Consider:* *7 day working* *Duty rota cover* *Flexible ways of working*
DE-ESCALATION - Stepdown
How will we know we can step down? *Workforce capacity levels* *Demand Capacity levels etc*

PERTH & KINROSS HEALTH AND SOCIAL CARE PARTNERSHIP

UNSCHEDULED CARE – PREPARING FOR WINTER 2019/20

	Section	*Action / Improvement Area*	*Expected Outcome*	*Progress 08/10/19*	*Involved and Engaged*	*Timescale*
1.	Governance & Monitoring	Engage with Health, Social Care and Independent and Third Sector to develop/implement and evaluate Partnership's Winter Planning Arrangements	A co-ordinated approach to Winter Planning will be achieved to ensure that the Perth & Kinross Health & Social Care Partnership meet the requirements based on the Winter Planning Guidance 2019/20	Initial meeting held with Health & Social Care Managers. AR to prepare draft action plan and share to others for comments / additions – Complete. Agreed progress to be provided via email. Meeting to be arranged as and when required. P&KHSCP actions and progress to be fed into NHS Tayside Plan which is submitted to Scottish Government 31 October 2019.	Locality Managers Service Managers Commissioning Officer Clinical & Professional Team Managers Team Managers Independent Sector Rep 3rd Sector Plan to be shared with Key stakeholders eg: IJB EMT IMT GPs through GP Group Acute Sector	15/09/19

2	Business Continuity Plan	Review Business Continuity Plans across Partnership to manage and mitigate key disruptive risks including impact of severe weather. Undertake Joint Emergency Rest Centres table top exercise for Care Homes. Complete Winter Action Card (Attached) which prepares plan for additional workforce capacity, workforce rotas and annual leave for : • inpatient areas (CH/MFE) • sub locality Community teams(Attached) • Service specific eg HART, AHPs • Residential Care Homes  Winter Action Card template.doc	Ensures that clear robust plans are in place to ensure the continuous operational delivery of critical services when faced with a range of disruptive challenges eg staff shortages, severe weather conditions etc.	BCPs updated for North Locality. Consideration and discussion for one BCP per locality. *Crieff and Perth City submitted one BCP for local area in 2018/19.* Michelle Ruddock circulated Winter Action Cards to Locality Managers12 September 2019 with responses requested 18 October 2019	Locality Managers Clinical & Professional Team Service Managers Team Leaders Service Managers	November 2019 November 2019
		Identify available vehicles for use during winter (health and social care) Ensure awareness of NHST process for identifying and allocating vehicles during periods	To support transport for any period of adverse weather to ensure staff can continue to provide care and support to those most vulnerable and isolated. In addition to	One 4x4 for community nursing service for North.	Locality Managers CPTMs Service Managers Team Leaders	November 2019

		of adverse weather. (Single Point of Contact details NHS Tayside required).	support discharge from hospital, when require during periods of additional demand, adverse weather.	*Keith Colville PKC contact for road clearance and additional transport arrangements.*		
		Identify key contacts across all sectors with arrangements in place to access local road clearance and additional transport during adverse weather. Consider utilising 3rd sector for volunteer drivers to support discharge, if vehicles available for use.	Once database updated share with relevant key stakeholders.			
		Agree process for senior managers from Partnership to attend / call into cross site huddles at weekends. Identify and collect information required on a Friday for capacity and flow for Partnership beds.	Senior managers are visible at weekends to facilitate decision making.	*Process drafted. With ED for further discussion at huddle.* *Suggestion that a Friday huddle be introduced to obtain info. Caitlin to forward copy of information being collated for PRI.*	Locality Managers Locality Managers Caitlin Charlton	October 2019
		Encourage and promote Health & Social Care staff to access flu vaccination. Encourage vulnerable, frail, elderly residents of Perth & Kinross to access flu vaccination via sub locality community teams Liaise with 3rd sector if support required for people to attend vaccination clinics.	Reduction in staff sickness due to flu. Reduction in respiratory admissions to hospital	In place through operational meetings. Flu vacs commenced in North for patients.	Locality Managers CPTM Team Leaders	Ongoing

3	Escalation Plans	Review Escalation process for P&K patients in Tayside hospitals. Prepare and share escalation process and contact details for key senior managers for festive period		 P&K Info escalation patient information.d Michelle to send out for update.  STAFF EMERGENCY CONTACT NUMBERS	Locality Manager CPTM Inpatients Service Manager Business Support Manager	November 2019 December 2019
4	Effective admission & discharge Discharges at weekend and bank holidays Delayed discharges	Ensure continued delivery of discharge hub / Hospital Discharge Team service in PRI during Public Holidays and Weekends.	Ensure effective admission and discharge processes in place over the Festive and Winter period.	*Update required*	Locality Manager CPTM Service Manager MFTE Consultant CPTM Inpatients	December 2019
		Extend AHP OT & Physio Therapy Weekend working *Winter Planning Funding approved for extended AHP OT & Physio weekend working £15k (Dec to March)*	Supports assessment and discharge to improve hospital flow and improve patient care and experience over a 7 day period.	*Update required*	CPTM Inpatients AHP	December 2019
		Review and promote 2019/20 festive directory of services and alternatives to admissions to cover Primary/community/3rd and independent sector identifying any additional capacity requirements.	NHS Tayside, Health & Social Care Partnership and other sectors are aware of services available and contact details over Festive period.	*Circulate 2018/19 Festive Bernadette Tindel co-ordinating for North* Michelle Ruddock circulated Festive Directory to Managers 12 September 2019 with responses requested 18 October 2019	Locality Managers CPTMs Service Managers Team Leaders Independent Sector Representative Third Sector Interface	December 2019

		Locality Management Teams to identify vulnerable and / or at risk people in local areas to put support in place to reduce risk of admission.	Supports early discharge, and identifies frailty concerns in locality to reduce admission where appropriate..	In place in North through ongoing discussions through ICT/MDT meetings	Locality Managers CPTMs Service Manager Team Leaders	Ongoing
		Ensure process in place to continue to authorise care home placements rapidly over Festive Period and share.	Ensuring continued patient flow and bed capacity	Update required	OPUSC Strategic Lead	December 2019
5	Strategies for additional surge capacity	Increase capacity in MFE Tay Ward from ? to ? *Winter Planning Monies approved for increase of 4 beds in Tay Ward for period 1 December – 31 March*	Support capacity and flow in Acute Services	*Confirm increase in beds*	Locality Manager CPTM - Inpatients	November 2019
6	Whole system activity Plans	Continue to develop and deliver frailty team to support the potential surge in emergency admissions early January.	To support capacity and flow in PRI, older people are screened for frailty on admission to ward 4 to ensure the most appropriate patient pathway are established or avoid further admission into the unscheduled care system by facilitating rapid discharge where clinically fit to do so.	Update required.	Locality Manager CPTM – Inpatients Quality & Effectiveness Improvement Lead	Ongoing
		Test Perth City discharge model. Work in Partnership with British		*Paul H meeting BRC on Wednesday 18/09/19- update required date required on recruitment – B Kinnear*	Strategic Lead OPS/USC	October 2019

		Red X to support discharges. *Winter planning monies confirmed £60k*	Reduce the number of hospital delayed discharges for PRI.	*Update requested from Zoe Commissioning re start date, scope and outcomes*	Locality Manager Perth City Programme Manager	In place by December 2019
		In Partnership with RVS target simple same day discharge from PRI. *LUCAP monies confirmed of £32k*		*Project Charter drafted. MoU approved between PKHSCP & LWiC IHub.*	Zoe	In place by Sept 2019
		Work with Dunkeld GP Practice to commence implementing MDT improvements to identify people living with moderate to severe frailty	Increase in number of people identified with moderate to severe frailty who has MDT ACP	*Business Case approved. HR process commenced. Care Pathways being developed.*	Amanda Taylor	Oct 2020
		Develop and recruit to enhanced intermediate community care and specialist respiratory services to support more people at home	Reduction in emergency admissions and bed days. Reduction in delayed discharges	*POA Day of Care Tool being developed using other examples*	Locality / Service Managers	March 2020
		Complete day of care audit in Murray Royal Hospital POA beds to identify improvements in patient flow	Reduction in length of stay in hospital.	*Lindsey / Chris need to catch up with you on this.*	Caitlin Charlton	January 2020
		Review of Perth City care home liaison staff to support complex discharges to care homes from hospital settings		*Update required*	Lindsey Griffin / Chris Lamont	
		Realignment of AHP staff to the USC flow across PRI linked to development of AME			Caitlin Charlton ?	? ?

		Development of community crisis admissions pathway to community hospital through ANPs and GPs *ANP rapid assessment response for Perth City for the deteriorating patient as part of Perth City ECS model* *Falls intelligence group established to look at prevention indicators*	Reduction in falls?	*Update required*	Lindsey Bailie / Amanda Taylor Chris Lamont / Brian Kinnear Carolyn Wilson/ David McLaren	Ongoing
7	Communication Plans	Put in place effective communications to promote winter planning and service access and availability for Winter Period (in hours and out of hours). Continue to promote National Power of Attorney Campaign across Perth & Kinross	Robust communications with public, patients and staff on access arrangements over the festive period. Improved knowledge of service provision to enable continued capacity and flow across health and social care services.	Complete. Through NHS Tayside. Locality Managers to share Festive Directory. P&KHSCP information included on National website https://mypowerofattorney.org.uk/in-your-area/perth-and-kinross/ National Campaign Day - 19 November 2019.	Communication Department	End November 2019
8	Performance and Evaluation	Develop evaluation process for Winter Plan to measure effectiveness	Ability to report on outcomes and lessons learnt over Winter and Festive period to Scottish Government and IJB in March 2019		Local Winter Planning Group with support from performance lead.	October 2019