



Health and Social Care Integration

Locality Planning Conversations

September 2013 – April 2014

Locality Planning Conversations Report – Executive Summary

In August 2013 the Joint Improvement Team (JIT), along with a number of national improvement partners, was tasked with supporting partnerships to develop solutions for implementing locality planning in the context of health and social care integration. A working group was established comprising representatives of :

- Health and Social Care Alliance
- Improvement Service
- Joint Improvement Team
- NHS Education for Scotland
- Quality and Efficiency Support Team
- Scottish Care
- Scottish Government (Primary Care and Health and Social Care Integration)
- Scottish Social Services Council

Work was done to map existing workstreams and key issues which would impact on locality planning. The group then held appreciative enquiry style conversations with 22 local partnerships and key national organisations around locality planning. During these conversations a wealth of information was gathered and refined into 9 key themes which partnerships identified as requiring further exploration.

1. Interface between Health and Social Care Partnerships and Community Planning Partnerships
2. Partnership relationship/development/maturity
3. Development of local performance/outcomes framework from local planning and service delivery
4. Universality vs targeting – impact on equalities
5. Engaging/resourcing communities and public
6. Locality professional engagement
7. Practitioner/professional culture and skill development
8. Engagement of secondary care
9. Spread and sustainability of reliable good practice

In February 2014 a national workshop (All Integration is Local) was held in Perth for 150 participants from across Scotland, which aimed to test out early finding from partnership conversations, inform the development of national guidance and shape the development of improvement and support for integration.

This report explores the nine key themes in more detail and goes on to identify national guidance requests and improvement and mutual supports which partnerships felt would assist in their integration process.

Guidance

In general there was unanimous support for the view that guidance should be 'light' and not overly prescriptive, giving sufficient direction but allowing for appropriate local arrangements. There was also a clear consensus that any guidance must be

written in plain English and make sense to local people and all those involved in the partnerships.

Guidance was sought around each of the themes and included:

- Seeking clarity around the role and function of localities and recognising the importance of natural communities.
- Recognising that time is required for the development of new structures and that localities will have to deal with competing priorities.
- It should be addressed equally to all sectors and organisations involved in partnerships to give a consistent message across all sectors on the expectation for leadership, engagement and relationship building to sustain positive relationships.
- It should set out a single framework for performance reporting that balances core measures for national reporting with others devolved to localities. It should also be outcomes, not process, focussed.
- It should emphasise the need to address inequalities and recognise the importance of community development and coproduction processes.
- The importance of local staff engagement and culture and skill development was also highlighted as was the importance of fully engaging secondary care.

Improvement and mutual supports

Partnerships clearly recognise the value in supporting each other through the process of integration, offering mutual support and examples of practice to share.

Support requests highlighted the range of issues which partnerships are tackling and common requests were:

- Partnership development and engagement particularly with local CPP decision makers in understanding the relevance of integration to stakeholders who operate beyond health and social care. Further exploration is required to make sense of locality boundaries for professionals, community planning partners, and for financial and resource allocation.
- The need for whole system learning on sustainable engagement of all sectors.
- Support around how to use SMART technology/social media to link existing assets and connections
- Culture and skill development for all those involved – including Shadow Board members, locality practitioners and members of communities.
- Increased use of improvement tools and integrated team development processes to support staff skill development.
- Development of professional skills/teaching for all practitioners to reflect personalisation/outcomes principles. Values, language and unique skill sets common to individual agencies should be examined, understood and adapted.

Practice Examples

Throughout the report are excellent examples of practice to share which illustrate the variety and depth of partnerships' integration journey. They also underline the willingness and the benefit to be derived from sharing and encouraging spread of practice.

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1. INTRODUCTION

Localities are acknowledged as the ‘engine room’ of the reform agenda and where the greatest impact on outcomes can be achieved. Localities are acknowledged as the ‘engine room’ of the reform agenda and where the greatest impact on outcomes can be achieved. The [Public Bodies \(Joint Working\) \(Scotland\) Act 2014](#) requires Integration Authorities (or Health and Social Care Partnerships as referred to in this document) to identify at least two localities and to include representatives from these localities in the strategic planning group. The Act gives Scottish Ministers the power to prescribe who should be consulted on and involved in locality decision making.

‘All Hands on Deck’ was published in July 2013 as a ‘think piece’, commissioned by the Scottish Government, to explore how best to involve the full range of stakeholders in health and social care integration. The paper set out the many challenges and highlighted key issues to be addressed. It endorsed the ten key principles listed on the opposite page and further explored these in terms of:

- Right Lines on the Map
- Right Role
- Right Powers
- Right Accountability
- Right Support for Stakeholder Involvement
- Right Culture
- Right Preparation

The Joint Improvement Team (JIT), along with a number of national improvement partners, was tasked with supporting partnerships to develop solutions for implementing locality planning. In August 2013, JIT convened a Locality Planning Working Group involving:

- Health and Social Care Alliance
- Improvement Service
- Joint Improvement Team
- NHS Education for Scotland
- Quality and Efficiency Support Team
- Scottish Care
- Scottish Government
- Scottish Social Services Council

The group agreed that appreciative enquiry style conversations would be the most productive way to gather insights and examine the issues. A series of conversations were held with partnerships and key national organisations over a period of three months. This report outlines the process, key themes identified, examples of practice to share, requests for national guidance and areas for improvement and support.

Locality Principles

In the summer of 2012, two workshops shaped the development of ten draft principles by which localities will be developed:

1. They are co-produced with local communities, users of services and their unpaid carers.
2. They are an integral part of their Health and Social Care Partnership and will be held to account for the delivery of local priorities.
3. They are based on trust and parity of respect between all partners.
4. They are multidisciplinary and multi-sector.
5. They have common purpose through an agreed scope and local outcomes for the population.
6. There is a clear understanding of the measurable outcomes for both services and service users, that will be delivered by multi-disciplinary teams.
7. They have a level of devolved financial and operational responsibility within the Health and Social Care Partnership to make decisions on the use of resources and service delivery for their communities.
8. They make a central contribution to the development and delivery of the joint strategic commissioning plans.
9. They will have a focus on creating health and tackling inequalities through service planning, co-production, support for self-management and asset-based approaches.
10. They embody non-competitive direct engagement in the commissioning of support and services.

2. PROCESS

The group of national partners agreed 'All Hands on Deck' was a useful starting point and identified nine objectives for this next phase of enquiry.

1. As health and social care partners are forming, to explore how they are approaching locality planning and lessons learned to date
2. To explore and further develop the suggested principles for locality planning.
3. To help partnerships consider how these principles translate into practice to energise, inform and support local solutions.
4. To explore links with community planning and community planning capacity building.
5. To inform developing guidance and statutory instruments via the policy team.
6. To collate examples from practice to help people learn.
7. To scope requirement for improvement and support going forward.
8. To understand how locality planning is seen as supporting health inequalities.
9. To explore balance between professional engagement and community empowerment.

Three stages for the work were identified

Aug – Sept 2013	Map and link current improvement and support activity and opportunities against the principles of locality planning.
Oct 2013 - Jan 2014	Invite partnerships to participate in an appreciative enquiry dialogue.
Feb – Mar 2014	Facilitate focus groups to reflect on emerging themes and feed output into this report to be circulated to Scottish Government policy colleagues, national improvement organisations and partnerships and national organisations with whom we had conversations.

2.1 Partnership Conversations

Through contact with Chief Executives of all Health Boards and Local Authorities, Third Sector Interfaces and Scottish Care development leads, all partnerships were invited to participate in an appreciate enquiry style conversation with members of the locality planning working group. Twenty one partnerships accepted the invitation:

Aberdeenshire	Edinburgh City	North Lanarkshire
Angus	Falkirk	Shetland
Argyll & Bute	Fife	Stirling & Clackmannanshire
Dumfries & Galloway	Glasgow City	South Ayrshire
Dundee City	Highland	South Lanarkshire
East Ayrshire	Orkney	West Lothian
East Lothian	Perth & Kinross	Western Isles

A template was designed to guide the conversations and gather and record information around the key areas for discussion.

- What is currently working well in localities
- Examples of practice to share
- Areas for future improvement support
- Advice for development of national guidance

The format and participation in partnership conversations varied greatly. Some involved a small number of key people meeting solely for the purpose of the conversation, others had wider participation as part of a regular shadow board meeting or other partnership meeting.

2.2 National Conversations

The working group recognised the important contribution of key national organisations in the emerging thinking and developing ideas around localities. Views and input were received through on-going engagement or specific conversations with the following:

ADSW (Social Work Scotland)	Community Hospitals Improvement Network
AHP Directors	Housing Co-ordinating Group
Area Clinical Forum Chairs group	RCN
British Geriatrics Society Scotland	Senscot
Carers Coalition	SCVO
CHEX/SCDC	SOLACE
CCPS	The Alliance
Chief Health Professions' Officer	Voluntary Action Scotland
Chief Social Work Officer	Voluntary Health Scotland

2.3 Key Themes

Partnership conversations varied greatly in style depending on where partnerships were on their journey towards integration, who participated and the format for the conversation. However there were many similarities in the prominent issues raised. Similar themes emerged from the national conversations albeit articulated from another perspective.

Improvement partners in the working group reflected on their own experiences to cross check emerging issues and themes where partnerships and national organisations sought further guidance, improvement support or mutual learning.

National Workshop

In February 2014 a national workshop (All Integration is Local) was held in Perth for 150 participants from across Scotland and from health, housing and social care across the statutory, third and independent sectors. The event aimed to:

- To explore the principles in 'All Hands on Deck' and co-create steps to turn these principles into practical realities;
- To test out early findings from partnership conversations around locality planning;
- To inform the development of national guidance; and
- To shape the development of improvement and support for integration.

Representatives of 25 partnerships, 20 national voluntary organisations, eight local third sector interface and six independent sector organisations attended. Representatives of the national improvement partners facilitated the sessions. A full report is detailed at Annex A.

The programme included an update on the legislation, feedback from local and national conversations and an opportunity to discuss and share experiences on key themes. At the end of the session, participants spent time within their partnership groupings to identify local actions that had been stimulated by the discussions.

3. OUTPUT FROM PROCESS

3.1 Principles

There was very strong support for the principles developed in 2012, set out in 'All Hands on Deck', and reinforced in Section 31 of the Act. It is recommended that these principles form the basis for any secondary legislation and statutory guidance and underpin the way that Integration Authorities implement locality planning.

3.2 Practice examples

A range of practice examples drawn from Locality Planning conversations, achievements in Reshaping Care and from the national workshop in February 2014, illustrate how the locality planning principles can be implemented as localities are developed.

3.3 Guidance - General Comments

The general view was that guidance should be 'light' and not overly prescriptive, giving sufficient direction but allowing for appropriate local arrangements.

There was a clear consensus that any guidance must be written in plain English and make sense to local people and all those involved in the partnerships.

There must be a 'read across' between the range of relevant legislation guidance, for example, Community Empowerment Bill and Children and Young People Act.

3.4 Joint Strategic Commissioning

The links and interaction between locality arrangements and Joint Strategic Commissioning within an Integration Authority will be key to delivering better outcomes. Localities are where planning is turned into practice and made real. The localities will need to shape the strategic plan, based on their knowledge and experience, for their community and put it into practice. The Act requires that representatives of localities are included within the strategic planning group and the guidance will need to ensure that their role and responsibilities with regards to planning are clear.

3.5 Specific guidance

The remainder of this report expands on the nine themes for which partners would welcome further guidance, improvement support or mutual learning:

10. Interface between Health and Social Care Partnerships and Community Planning Partnerships
11. Partnership relationship/development/maturity
12. Development of local performance/outcomes framework from local planning and service delivery
13. Universality vs targeting – impact on equalities
14. Engaging/resourcing communities and public
15. Locality professional engagement
16. Practitioner/professional culture and skill development
17. Engagement of secondary care
18. Spread and sustainability of reliable good practice

Sections 4-12 set out, for each of these themes, how people described the **issue**, the **guidance** which was being requested, the **improvement or mutual support** sought and **examples of practice** which emerged during the conversations.

4. Interface between Health and Social Care Partnerships (HSCPs) and Community Planning Partnerships (CPPs)

4.1 The Issue

HSCPs are intended to be statutory partners in CPPs and are likely to cover the same geographical area. 'All Hands on Deck' describes HSCPs as strong allies of CPPs – and vice versa. It will be important for partnerships to develop a functional relationship with their local CPP – a relationship that is mutually reinforcing and avoids duplication. Many partnerships are building on CPP experiences of planning and working at locality level but some have identified a need for far greater clarity on the relationship between CPPs and the locality planning aspect of health and social care integration.

Some partnerships have said that they will continue to develop CPPs and HSCPs hand in hand. However there are some concerns about the lack of connectedness between CPPs and proposed HSCPs and a general lack of interaction and engagement between relevant partners. Partnerships were seeking assurance against duplication of effort.

There was a general sense that localities may be where the strongest relationship should be developed between CPPs and HSCPs. Most people felt that locality boundaries should follow natural communities, but it was also stressed that boundaries need to make sense to the range of stakeholders. Housing providers raised some concern around how they would play in at the locality level.

4.2 Guidance sought

Guidance should articulate the function of localities and stress the importance of natural communities as defined by the people in the communities themselves but obviously aggregated into sensibly manageable localities. It should recognise that time is required for the development of new structures and that localities will have to deal with competing priorities.

Absolute clarity is required around the respective roles, relationships, delegated authority and reporting accountability for CPPs, HSCPs and localities.

There also needs to be a clear line of sight across guidance on Single Outcome Agreements, the Community Empowerment Bill, the revised role of CPPs and NHS Local Delivery Plans.

4.3 Improvement support

Support was asked for around engaging local CPP decision makers in understanding the relevance of integration to stakeholders who operate beyond health and social care.

There was recognition that localities need coherence at a variety of potentially conflicting levels. Further exploration is required to make sense of locality boundaries for professionals, community planning partners, and for financial and resource allocation.

Support was sought to help partnerships define for themselves and ensure shared understanding of the language they use locally.

Partnerships will also need to be aware of the [Local Government Boundary Commission's Fifth Electoral Review](#) which will have some focus on natural communities.

What Works/Practice Examples

Vibrant Communities – East Ayrshire

Vibrant Communities works with, rather than for, communities. The aim is to change culture and unlock the knowledge, skills and experience of local people and employees. Focusing on empowering and building the capacity of local people and communities and developing strong social networks, the service provides a single point of contact through a community worker to help people to engage with Council and partner services. Specifically, in communities there is a focus upon identifying local assets, bringing together local groups, associations, communities of interest and organisations, prioritising action through local surveys and consultation and planning for change.

Work is already underway to support the development of locally-led action plans in every one of East Ayrshire's communities over the next three years. The approach is integrated across Community Planning and planning and service delivery in thematic areas, including health and social care.

The Dundee 'Weave' - Dundee



The Dundee 'Weave' – linking local communities with the themes of the Community Planning Partnership - has been particularly successful in the Community Safety Partnership which addresses the issues of crime, anti-social behaviour, reducing substance misuse and building the capacity of communities to tackle safety issues.

The integrated approach to community safety links the Dundee Partnership with eight Local Community Planning Partnerships and their eight Local Community Plans delivering more effective partnership working to tackle key community safety issues affecting local communities. The Local Action Fund has had a high impact in terms of reducing fear of crime, quality of life and reducing workload for the community planning partners.

Natural Neighbourhoods Project - Edinburgh

In preparation for the Fifth Electoral Review, Edinburgh City Council has undertaken a project looking at the idea of natural neighbourhoods. The project emphasised that there was not right or wrong answer: it aimed to look at how people choose to define where they live, rather than any official definition of a neighbourhood.

Information was captured through a short online survey and this will be used to create a new set of natural neighbourhood boundaries. This will help the Council's understanding of their customers, their measurement of outcomes and enable closer working with their partners.

A (Total) Placed Based Approach – East Edinburgh

A (Total) Placed Based approach in East Edinburgh, sponsored by the Edinburgh Community Planning Partnership, identified that at least £200m of public funding is used for the economically disadvantaged population of 50,000. Less than 1% of this was determined through locally recognised consultation or negotiation. The approach seeks to change this dynamic through involving communities, service users and professionals more closely in relevant decision making. The approach started with facilitated conversations between practitioners about recognising that well-delivered but silo'd approaches to complex problems are seldom effective ["Guilty Knowledge"]. The simultaneous community engagement exercise with vulnerable groups of the community underpinned behavioural change and orientation in staff towards a more assets-based philosophy of intervention.

The approach is now less systemic than cultural and behavioural, with an extended family of professionals and community members working in seven overlapping work streams: young people; single men; community capacity building; violence; clients in common?; organisational development. The approach has increasing buy-in and momentum from local community members and professionals alike. A number of case studies are being prepared to illustrate the effectiveness and economic impact of this 'improvised revolution'.

Neighbourhood Planning - Edinburgh

For the past five years Midlothian has been working with communities by placing an increasing emphasis on developing neighbourhood planning as a more localised approach to community planning. Central to the approach has been the commitment to work with communities, and being responsive to their expressed needs and their views as to how these might best be addressed.

Neighbourhoods have been defined by natural communities and using a capacity building and co-production ethos, these arrangements provide a sound basis for the development of a locality-focused approach to the delivery of health and social care services.

5. Partnership Relationship/Development/Maturity

5.1 The Issue

Partnerships recognise that they each have their own history built up over many years of cross-sector working and HSCPs will use that history to inform their development.

Partnerships who have experiences of integrated working across health and social care suggest that significant time is necessary to build the key ingredients required - of openness and trust, shared outcomes, regular communications and clarity over roles, governance and decision-making.

Some partnerships are using their experiences from Reshaping Care for Older People (RCOP) however there are concerns that this good practice in partnership working is not always migrating into integration discussions.

5.2 Guidance sought

Guidance should be addressed equally to all sectors and organisations involved in partnerships to give a consistent message across all sectors on the expectation for leadership, engagement and relationship building to sustain positive relationships.

Guidance should also address issues around sharing of information.

5.3 Improvement support

Some clarity was sought around where support goes and at what level should it be targeted. Some partnerships are buying in support from external consultants and organisations.

It was suggested that development support similar to the Joint Strategic Commissioning Development Programme would be appropriate for Integration Boards.

There is a need for whole system learning on sustainable engagement of all sectors.

What Works/Practice Examples

Stakeholder and Speed Networking Event – Clackmannanshire and Stirling

Clackmannanshire and Stirling held a one day Stakeholder and Speed Networking Event for all sectors and community planning partners. There were information tables to advertise services, short presentations from current Change Fund recipients, and two one-hour long speed networking sessions. Each attendee was challenged to make contact with someone from the event within one month. The Support Team also produced a comprehensive information document of all the Change Fund recipients and their services. This was issued to each attendee for future reference.

A total of 94 attendees from 29 different organisations attended the event; the organisations came from both Stirlingshire and Clackmannanshire. There has been further development of partnership working and relationship building, additional links and contacts made. Partners have been able to establish where there are gaps in the current provision.

The Highland Partnership - Highland

The Highland Partnership has had locality planning in place for almost two years, with nine co-terminus health and social care District Partnerships covering adult and children's services.

District Partnerships have clear roles and remits and initially time was spent developing an increased understanding of agencies and organisations and building relationships. Initially standard guidance, structured agendas and clear reporting arrangements were seen as helpful in establishing the Partnerships. Police Scotland and Scottish Fire and Rescue are now joining the Partnerships, to reflect the local community planning partnership, with a particular focus on community safety issues.

District Partnerships have created a strong base of shared understanding and trust and it is anticipated that this will prove invaluable as health and social care integration progresses.

Partners in Highland recognise that time and commitment is necessary in developing partnerships and whilst the process may be lengthy, it is essential and gives lasting benefits.

Health and Care Network

A Health and Care Network was established for GPs, local team managers and practitioners to come together to constructively challenge and improve practice, behaviours and pathways of care for older people, towards a shared outcome of shifting the balance of care. Action Learning Sets were created in 11 areas in Aberdeenshire and meetings scheduled on a six weekly cycle. Significant progress has been made with improved communication and positive relationships within and between health and social care staff.

Areas focused on included understanding factors contributing to multiple admissions and understanding local data regarding 'length of stay', which provided clarity of where to focus efforts that would reduce length of stay. Each Action Learning Set has taken a number of actions to improve care for older people.

6. Development of Local Performance/Outcomes Frameworks from Local Planning and Service Delivery

6.1 The Issue

There is a strong message that partnerships should be clear on purpose and work forward and back from shared and agreed outcomes. A shared outcomes framework developed through locality planning is seen as pivotal in creating the necessary culture for integration. Partnerships recognise the importance of developing performance and outcomes frameworks at the locality level but are not always clear how this can be done in a practical, meaningful way.

Progress will be measured against national health and wellbeing outcomes, measures and indicators, and the use of budgets. Partnerships identified challenges around data collection, capacity and skill development, data interpretation and aggregating qualitative data.

Some partnerships noted that good data analysis can be (and is) used to drive culture change and provide a firm basis for integration at the point of service delivery, however there is concern that outcomes can have different meanings to different partners and that impact on other areas of a complex system can be difficult to identify and track. Using information from several sources (local data from all sectors including housing and national data), whilst essential, can cause confusion as the systems do not talk to one another and can deliver very different interpretations.

6.2 Guidance sought

Guidance should set out a single framework for performance reporting that balances core measures for national reporting with others devolved to localities. National data collection should be reviewed and simplified and performance indicators should be outcome, not process, focused.

Guidance should acknowledge the importance of co-production and recognise that use of other data (often proxy) assists in measuring outcomes at different (partnership, locality and individual) levels.

6.3 Improvement support

Some partnerships feel they need support in understanding and using data to assist in developing local outcomes and to evidence and attribute improvement.

Shared learning around approaches to developing outcome frameworks was frequently requested.

Partnerships also asked for support in measuring progress in relationship building, an essential element of integration, and how to use other 'soft' information.

What Works/Practice Examples

New Approaches - Midlothian

Midlothian's journey towards stronger integration of health and social care seeks to build on a number of important new approaches developed in recent years. These provide the building blocks for evaluating performance and quality as the delivery of health and social care seeks to become more responsive to the needs and assets of local communities.

Assessment and Care Management - A Focus on Outcomes: There has been a strong drive to ensure that a focus on positive outcomes for users and carers determines how services are designed and delivered. This programme of personalisation has delivered tangible success without requiring increased financial investment. This has been supported by staff training programmes including Action Learning Sets. Because these processes are integral to the Management Information System, comprehensive reports are generated on how effectively positive outcomes are being achieved, which in turn enables strategic planning and commissioning to be directly based upon aggregated outcomes information.

Measuring Performance on the Basis of Outcomes: Progress in achieving desired outcomes is measured in a variety of ways. Through the documentation underpinning the shift in emphasis in the assessment process towards establishing more meaningful objectives for individual service users, it is possible to provide aggregated data broken down by postcodes to measure local progress as a result of the delivery of care plans. Through aggregation, performance can be measured in terms of outcomes at both service level and, through the "golden thread", to the community plan and the single outcome agreement.

Talking Points – East Renfrewshire CHCP

Since 2008, an outcomes-focused approach to assessment and care management within adult services in East Renfrewshire CHCP has been developed using Talking Points – Personal Outcomes tools within health and community care. The 'Outcomes into Practice' was used to develop an approach within practice with support of JIT associates and academic institutions.

The approach was piloted and rolled-out and there is continued development and review with practitioner groups and teams. Outcomes focused assessment, support planning and review process in place at individual level enabling aggregate information to be produced to provide feedback loop and to inform planning and commissioning.

Joint Performance and Electronic Dashboard - Lanarkshire

The Lanarkshire partnerships' joint performance framework and electronic dashboard was developed initially to measure progress and impact in Reshaping Care across both the North and South Lanarkshire Partnerships. This dashboard system of key measures is now being rolled out to support the improvement of wider outcomes for health and social care integration across all adult groups.

The system tracks progress overtime against significant key performance indicators. Utilising software already used within NHS Lanarkshire, it has brought about a number of benefits in supporting the performance agenda including 1) an interactive tool which will allow data to be interrogated and analysed for different localities and for trends over time 2) ease of access and the ability to now undertake formal quarterly reporting to the Business Planning Group 3) the ability to extend access to the dashboard beyond the organisation where it is hosted.

7. Universality vs Targeting – Impact on Inequalities

7.1 The Issue

There is a legal responsibility for a locality to include everyone within that area, to assess the needs of their resident population and focus energy where they can improve outcomes.

Locality planning provides an opportunity to tackle health inequalities, however there is a danger of disproportionate benefit by articulate communities more able to organise and express their needs. This could exacerbate inequalities in access and outcomes.

‘Proportionate’ universality may be an appropriate response but is difficult to put into practice. Some partnerships are using experience of anti-poverty and regeneration initiatives to inform their approach to integration where they have areas of obvious inequality.

7.2 Guidance sought

Guidance is requested on how differential approaches, when appropriate, can support efforts to reduce inequalities. It should reflect an understanding of the health improvement opportunity, make clear the public health focus on tackling inequalities and need for radical change in traditional health approaches.

It should emphasise the need to develop different methods of measuring success particularly qualitative indicators and community feedback with an outcomes focus.

7.3 Improvement support

Support to understand what locality approaches can be used to tackle inequalities. Irrespective of whether children's services are included in the integration proposals, a clear focus on children and families will be essential to any locality approach that addresses inequalities.

Support to challenge approaches that are based on single disease pathways or a curative/passive-paternalistic ethos.

What Works/Practice Examples

Total Craigroyston – Edinburgh Partnership

‘Total Craigroyston’ has been established by the Edinburgh Partnership to improve outcomes for children and families in the neighbourhood around Craigroyston Community High School with a particular focus on those children currently looked after by the public authorities. Reducing the need for children to become looked after is the longer term aim.

One of the most important principles of ‘Total Craigroyston’ is to engage with the local community and people who work in the community in order to understand their experience of living and working in the area and to use that experience to shape the future development of services.

‘Total Craigroyston’, broadly informed by the ideas generated by ‘Total Place’ pilot projects developed in England, is about changing the relationship between service providers and people who ‘receive’ services.

This new relationship is one that is more dynamic and equal, where the experience and aspirations of local people and local staff are used to achieve real, long term change. It also means recognising that the community has strengths that can be built on, engaging more effectively with local people, building on their capacity to identify and resolve their own issues, offering support where it is needed at an earlier stage, creating better links between partners, improving communication and developing parity of esteem between organisations.

<http://www.totalcraigroyston.co.uk/wp-content/uploads/2012/11/Road-Map-2012-09-03.pdf>

Place Approach - Glasgow

Included in the development of Glasgow’s Single Outcome Agreement, is a strong element of geographic targeting and a strong focus on a ‘Place Approach’. This means that the community planning partners work in a more intensive joint way with the community to achieve positive outcomes. This includes three levels:

- Thematic programmes of activity (on youth employability, alcohol and vulnerable people) across the whole city;
- Focused thematic activity in neighbourhoods which exhibit particular issues, challenges or opportunities in relation to these three themes; and
- An intensive neighbourhood approach in a small number of areas, with community planning partners jointly working together across a range of issues, with associated infrastructure and support, such as community capacity building

Partners agreed to focus on nine neighbourhoods experiencing the most disadvantage and to work jointly together on a range of issues. Key characteristics of the approach area long term focus, joint working at a very local community level, a focus on community capacity building and working with community anchors, a focus on co-production between communities and organisations and intensive, asset based activity to build social capital and empower communities

It is intended that this change will be achieved not through the introduction of additional dedicated ‘ring-fenced’ funding for the priority neighbourhoods, but through changing the way in which the mainstream resources of community planning partners are deployed to ensure that the needs of these neighbourhoods can be prioritised.

8. Engaging/Resourcing Communities and General Public

8.1 The Issue

Many partnerships have a long history and experience of consulting and engaging with communities and the wider public, but there is still a need for an increased understanding of the approach and processes of community capacity building and/community development.

The role of the third sector is crucial but as with the statutory sector, there is often a significant resourcing gap. Evidence shows that the most effective services are those that are developed and designed in partnership with local communities. Local communities, people who use services and their carers are best placed to know what support they want and what benefit they derive from existing arrangements.

Many partnerships stated they are using existing long standing networks and relationships to engage with communities. They understood the importance of building from the ground up, from starting where communities and localities are and that the process is lengthy and time and resource consuming. There was a recognition that any engagement process requires to be dynamic and inclusive, and be sufficiently flexible to allow for change and development over time.

8.2 Guidance sought

Guidance should state that locality planning is about community development and that partnerships should take account of the National Standards of Community Engagement (<http://www.scotland.gov.uk/Resource/Doc/94257/0084550.pdf>) and Building Stronger Communities (<http://www.scdc.org.uk/what/building-stronger-communities>).

Guidance should recognise the need for funding maturity and identify which investment decisions will be taken at locality level. There was also a request to acknowledge the negative impact of short term funding.

Requests were also made for guidance to clarify how national voluntary organisations will be included in locality engagement.

8.3 Improvement support

Support was sought around to involve other services/agencies with a contribution to make e.g. transport, libraries etc and how to consider investment from a whole system perspective.

Support around how to use SMART technology / social media to link existing assets and connections and enable alternative mechanisms for participation other than meetings would be of value.

Partnerships would welcome exploration around how to balance involvement of communities of interest and geographic communities.

What Works/Practice Examples

Community-Led Health for All and Building Stronger Communities

Scottish Community Development Centre/ Community Health Exchange publications - Community Led Health for All and Building Stronger Communities are practical learning resources which focus on the necessary competency areas for developing and building strong communities which are:

1. Know and understand the community in which we work
2. Build and support groups and relationships
3. Build capacity to take action on priority health issues
4. Build equality and tackle inequalities
5. Develop and support collaborative working
6. Develop and support sustainable community influence

Community Led Health for All also highlights a number of practice examples under each competence.

<http://www.scdc.org.uk/>



Co-Production – NEF (Ned Economics Foundation Principles)

There is a recognition that future health and social care support and services will require to be developed in partnerships, using co-production models. There are varying degrees of understanding surrounding the concept and implementation of co-production, however the New Economics Foundation (NEF) identifies six principles which are seen as helpful in providing a framework. These are:

- Recognises people are assets
- Builds on and develops people's capabilities
- Is about developing mutual and reciprocal relationships between users and providers
- Results in peer support networks
- Demands that barriers are broken down between professionals and service users
- Is about facilitation - not necessarily doing for and to people

Queens Cross Housing - Glasgow

Queens Cross Housing Association (QCHA) is a community-based and controlled registered social landlord providing services to over 4500 tenanted households and over 2000 owner occupiers.

QCHA are involved in a number of activities which support engagement and empowerment of local communities. Following a comprehensive tenants survey tenants 'Getting to Know You' QCHA brought together public and housing sector partners, local residents and politicians to discuss the key findings. The survey drew attention to issues relating to poverty, low incomes, fuel poverty, lack of internet access, significant long term health conditions and social isolation.

Bringing together key stakeholders enabled the development of an action of plan to enhance the activities which QCHA were already undertaking to tackle these issues. This included:

- Exploring multiagency partnership working/funding
- Research the links with Older People's Housing Strategy particularly around preventative action and social isolation
- Explore partnership project to tackle health inequalities

Other engagement activities include Queens Cross in Bloom which aims to support local people reclaim derelict land to create growing spaces and promote health and wellbeing. The project operates in four neighbourhoods, providing relaxing and creative opportunities, promoting self-esteem, a sense of belonging and promoting social cohesion between local people from different cultures.

Aberdeenshire Signposting Project - Aberdeen

The Aberdeenshire Signposting Project works by linking people to local organisations, services, clubs and societies in their community that address issues in a person's life. There has been an average 22% improvement on people's Mental Well-Being score, significant reductions in GP visits and use of prescribed drugs. People have been referred to over 123 local groups, organisations and services.

Link Up – West Dunbartonshire

Link Up is a partnership led by West Dunbartonshire Community Health and Care Partnership (CHCP) and West Dunbartonshire Community and Volunteering Services (CVS). It is an integrated community support service which uses a single telephone point of contact to streamline referrals to, from and between key community and third sector agencies in West Dunbartonshire. It helps local residents quickly and effectively make contact and receive support and supports older people to maintain independence at home and in the community.

Key features are developed ? local third sector consortium arrangements, formalising all provider partners' commitments and responsibilities within the service and structured improved referral and engagement processes including common referral information and joint reporting system.

The partnership has enabled an increased level of annual cross referral between the third sector organisations involved - from around 10% pre-consortium to around 34% - meaning that the right interventions are being better delivered, more effectively.

Multi-Agency Community Engagement Team – Perth and Kinross

The Change Fund Community Engagement Team is active in three localities in Perth and Kinross and has developed new models of working with communities to engage them in identifying and developing community capacity/co-production opportunities using an asset based approach.

Three Community Engagement Workers have been employed through the Perth and Kinross Association of Voluntary Services and have developed a locality-based partnership model alongside staff from Perth and Kinross Council and NHS Tayside. These localities are Highland Perthshire, Strathmore and Strathearn with the following ? joint community engagement plans being developed:

- Working with communities as partners in the identification of need and the development of support.
- Supporting communities to engage, discuss and act upon the agenda of the Change Fund: Reshaping Care for Older People programme.
- Identifying the positives and challenges of living within the rural and remote/rural communities within Highland Perthshire, Strathearn and Strathmore.
- Winter Watch meetings in Pitlochry and Blair Atholl and the development of local emergency winter plans.
- Mapping of community assets using the ALISS database.
- Launch of the Community Start Up Grant.
- Piloting the BIG PLAN and a Community Circle in Pitlochry.

9. Locality Professional Engagement

9.1 The Issue

It is recognised that all local staff require to be engaged in localities from the outset. Partnerships described varying degrees of involvement of their primary and community care staff and are seeking positive, productive ways to enable engagement by all practitioners. Concern was raised that greater emphasis was being given to engaging with contracted professionals e.g. GPs and pharmacists, than engaging with nurses, social workers, AHPs and care staff from all sectors working in community services and in community hospitals.

The GP contract for 2014-15 supports the creation of links between HSCPs and practices by resourcing a liaison GP role in each practice. This is to ensure that at least one GP in each practice is able to input to local developments/decision making.

Some partnerships stated that it takes time to build up relationships and trust. Many things can contribute to positive engagement including a focus on outcomes, getting beyond what is wrong to what matters, and understanding each other's disciplines and contributions. An increased knowledge of third sector and community resources, along with building capacity through local needs assessments and mobilising volunteers, can increase involvement,

Using a common language and a focus on outcomes supports professional engagement. Multi-disciplinary working and development is crucial and there is a need to legitimise engagement in locality planning within professional roles and job plans. This may be supported by the Integration Fund.

9.2 Guidance sought

Guidance should enable the necessary time, space and finance for local professionals to engage with each other and with localities.

Guidance should also task national professional bodies and employing authorities to support this process by creating capacity and space for engagement and multi-disciplinary working. This should include staff in community hospitals as well as those based in community services and across all sectors.

9.3 Improvement support

Support to develop 'engagement' skills and to increase awareness and understanding for elected members and Non-Executive Health Board Directors/Shadow Board Members.

Capacity to spread valued multi-disciplinary team conversations to build relationships.

Support to increase knowledge of the full range of local resources and assets available and to build confidence in alternative models of care through evaluation and sharing practice examples.

What Works/Practice Examples

GP Practice Annan – Dumfries and Galloway

In the Annandale and Eskdale locality there has been active engagement with the public and the workforce (across the sectors) to identify what keeps people well. Questions have been asked around what matters to people and what supports them to self-manage their condition, maintain and improve their quality of life and allow them work towards achieving the best outcomes they can.

Community Engagement Workers and Link Workers are working in close partnership with the GP Practice and Community Nurses to encourage Forward Looking Care Planning, whereby people identify what matters to them, their wishes and preferences should they require care... this also leads to people identifying aspirations and goals and things they want to do... and Community Link Worker can help people find activities and services or low level support in their local community.

Members of the community are also actively involved in identifying local assets and developing activities and support groups which meet their needs, (active co-production) ... and these local assets are being used to develop ALISS (a search engine to enable people to find activities and services in their area). ALISS is being tested as part of a patient portal in the Annan North GP Practice.

Workforce development across the sectors includes Talking Points which focuses on personal outcomes and some joint facilitated Coaching and Mentoring sessions with those involved in Forward Looking Care (GPs, Community Link Workers, Social Services and Community Nursing). The team are also currently looking at Value Based Reflective Practice.

Action Learning Sets – Perth and Kinross

Action Learning Sets in Perth and Kinross have empowered staff in integrated teams to develop and improve local services with a focus on personal outcomes and engagement.

Ten team leaders (from health and social care in north west Perthshire) were initially nominated and took part in the Highland Perthshire Action Learning programme which has since been rolled out to more localities and staff across the partnership.

The aims included:

- developing further understanding of each others' roles and responsibilities
- developing new ways of working more closely together within specific communities
- sharing experiences and problems and assisting colleagues in finding achievable solutions

Carers Support Service – Locality Workers - Angus

The Carers Support Service – Locality Workers – Angus has developed a preventative carers assessment and support service targeted at carers and cared for people over the age of 60 years.

They have improved support to carers by co-locating Carer Support Workers within local GP practices, who work in partnership with local GP practices, particularly with practice nurses, to ensure that carers registers are up to date and that all carers had been offered a carers health check.

Some of the benefits:

- Carer Support Workers are now part of a range of local groups e.g. multi-disciplinary groups and palliative care groups where the needs of the cared for and the carers role are identified as part of patient care planning.
- Better support for carers has contributed to a reduction in hospital admissions e.g. one cared for person was able to remain living at home as a bespoke care package was put in place for the carers.
- There is an increase in locality-based training programmes available to carers to assist them in undertaking their caring role, e.g. new to caring course, stress management.

Locality Team Model – North Lanarkshire

North Lanarkshire’s vision is that ‘older people are valued as an asset, have their voices heard and are supported to enjoy full and positive lives in their own homes or a homely setting. We will work together to provide information, support, care and treatment in ways that promote value and enable wellbeing, independent and recovery’. Locality modelling work based on a set of principles is being undertaken in relation to what optimal delivery of integrated care and support looks like.

Tapping into detailed knowledge of the individual profile of strengths and needs of each locality, the locality modelling work brings together local leadership from the statutory, independent and third sectors and all relevant disciplines including GPs, social workers, acute clinicians, long term conditions nurses, home support, community mental health services and AHPs.

A wide range of stakeholders are participating in focus groups and action learning sets as part of the preparation, planning and shaping of the locality model approach. The strategic intention is to fashion an integrated locality model within which preventative and anticipatory approaches through to more intensive supports and care are delivered through an outcomes-based approach.

In West Dunbartonshire the Pharmacy Support Team has been aligned with the Care at Home Reablement Team to offer support to older people and their families around medication management. The Team has identified that 79% of older people are better able to manage their medication, Care at Home staff routinely ask for advice re medication and Community pharmacists report increased knowledge of conditions affecting older people e.g. Dementia, continence issues.

10. Practitioner and Professional Culture and Skill Development

10.1 The Issue

There is a widespread recognition of the need for continuing cultural shifts and skill development for practitioners working in localities as integration is fully realised. A focus on shared outcomes was seen as essential in developing the practitioner role, along with shared development of operational procedures and systems and the creation of capacity for staff to enable change 'on the ground'. Strong leadership and buy in from middle and senior managers is critical in creating this positive culture and requires a new skill set for managers.

Locality planning will require genuine listening and being influenced by local communities and practitioners.

10.2 Guidance sought

Guidance should address the purpose and clarity of the practitioner role (health, social care and housing) in achieving personal outcomes.

Job descriptions and remits should recognise the changing landscape and the time commitment from practitioners to fully embrace integration.

Guidance is sought on how to minimise the impact of differences in terms and conditions of staff across all sectors.

10.3 Improvement support

Increased use of improvement tools and integrated team development processes to support staff skill development, including coaching, shadowing, leadership exchanges, action learning sets and Releasing Time to Care module. Capacity needs to be built to enable lessons gleaned from development to be applied back at the workplace.

Development of professional skills/teaching for all practitioners to reflect personalisation/outcomes principles. Values, language and unique skill sets common to individual agencies should be examined, understood and adapted.

Partnerships requested more sharing of good practice examples and enabling networking – particularly at locality level.

It was recognised that there is a need to address the 'readiness' for change for all agencies and make it real by encouraging difficult conversations.

Integrated working seen as the norm where working with vulnerable people and some partnerships wanted support to spread this across universal and preventative services.

The development of specialist networks and professional supports across agencies was also viewed as requiring further attention.

An appropriate 'blurring' of roles, enabling increased flexibility and generic working whilst ensuring appropriate professional development and supervision was seen as necessary for successful integration and supporting positive recruitment and retention of staff. This may require some reviewing of regulatory arrangements.

What Works/Practice Examples

Independent Sector Workforce Development – East Lothian

Cross sectorial representatives are being supported to collaborate to develop learning programmes to meet current and future skills needs. The project has developed initial programmes for workers at the point of care and manager roles, focusing on skills, knowledge and behaviours which will use a variety of media to deliver skills training.

Learn-pro is being developed alongside this as an accessible resource to all, allowing for accessible and flexible learning and giving the opportunity to engage informal carers, increasing confidence and skills. Working with local providers, an agreed core workforce development programme has developed that can act as a 'care passport' providing a consistent skills base at “foundation” and “leadership” levels, informed by behaviours from the Continuous Learning Framework.

Early successful outcomes from workforce development planning include collaboration and engagement. In addition, the scope of the project is now more inclusive, to include other stakeholders. Learn Pro pilot established that the e-learning approach has enabled greater accessibility for staff, who can do some of the elements in their own time, or during breaks at work.

Integrated Community Support Teams – East Kilbride and Strathaven

The Integrated Community Support Teams in East Kilbride and Strathaven - winner of the Continuity of Care Category, Patient Experience National Awards 2013 - provide inter-agency support for frail older adults requiring coordinated care in their homes.



This includes Social Care, Nursing, Physiotherapy and Occupational Therapy with palliative or rehabilitation/re enablement programmes as appropriate. The Community Nursing, Allied Health Professionals and support staff are now operationally managed together.

Practitioners have informed the development of joint processes which has proved effective in building confidence and improving communication. Proactive links have been made with other services e.g. Carers Development Officer, Specialist Health Services and the Acute Health Sector. Nursing and Home care has now been made available 24 hrs/ 7 days per week with other elements currently working weekdays.

Both qualitative and quantitative outcomes have been achieved including that nine out of every ten older people supported by the team, were able to remain in their own home. Also available are independent evaluations of patient and carer views, staff views of goal setting and outcomes, and GP and practice staff views on using ICST. This approach is now being extended across South Lanarkshire.

Falls – Scottish Ambulance Service - Aberdeen

Falls are the most common call received by the Scottish Ambulance Service in Aberdeen, with a mid-morning peak.

A project was set up to maximise the number of older people who can be supported to remain at home, following a fall.

Scottish Ambulance Service staff were trained to 'See and Treat' older people who had fallen and link them in to other community supports. In year one of the project 35% of people who fell were supported to continue to remain at home.

Embedding Personal Outcomes - Midlothian

Midlothian Council has been running Embedding Personal Outcomes workshops since the end of January 2013 for over 400 staff across the Local Authority, Health and the voluntary and independent sectors.

These workshops used the Sliding Doors approach developed by the Scottish Social Services Workforce (SSSC) and NHS Education for Scotland (NES). The main objective of the workshops has been to give staff time and space to consider the effect of their actions at 'turning points' in peoples' lives and to consider how they may step back and avoid 'fixing' and really listen to the outcomes that individuals want to achieve.

11. Engagement of Secondary Care

11.1 The Issue

There are differing views across partnerships about the level of engagement in the integration agenda by secondary care. Some partnerships raised concern about the lack of engagement and also the apparent lack of connection between secondary and primary care.

However other areas reported significant work in developing links and relationships between secondary and primary care to combat concerns about the potential 'disintegration' of these systems as a result of the current activity on health and social care integration.

11.2 Guidance sought

Guidance should require secondary care to be engaged in partnerships and localities and that staff should be given time and space to participate fully. It should position care pathways as an appropriate focus for linking secondary care with community hospitals and localities.

What Works/Practice Examples

Pathfinder Board – Perth and Kinross

Perth and Kinross Pathfinder Board recognises the need to engage secondary care and senior practitioners and enhance their capabilities to operate out in localities to focus on a health and care maintenance approach.

This approach includes a focus on prevention, early intervention and proactive outreach care and support that takes the services further into the community setting. The deployment for examples of secondary care practitioners such as Medicine for the Elderly Consultants to support GPs and locality teams with diagnosis and decision making can have a significant impact on the ability of locality resources to manage the care and avoid or avert crisis and manage avoidable unscheduled care admissions.

An example of this is work on Polypharmacy to reduce numbers of medications and develop proactive programmes of medication reviews. In addition the administration of medication by care staff providing domiciliary care to support clients with their medicines is being piloted.

Teviot Community-Based Allied Health Professional Provision - Borders

This project aimed to test a new model of community-based Allied Health Professional (AHP) provision in the Teviot Locality.

The service is designed to support: earlier discharge from acute settings for stroke and fractured neck of femur patients; earlier discharge from community in-patient beds and the avoidance of unnecessary admissions and re-admissions for patients who require physiotherapy and/or occupational therapy intervention.

Reductions in length of stay for people following hip fracture and an increase in discharge to home for people following stroke have been achieved.

Intermediate Care and Enablement Service – East Ayrshire

The Intermediate Care and Enablement Service (IC&ES) East Ayrshire has brought together health and social care resources previously managed separately in local authority and hospital sectors.

The integrated budget for the new service includes contributions from Health Board, Local Authority and national funding to support the transition of services to a community setting.

A single point of contact for referrals reduces admissions and readmissions to hospital, maximise older people's abilities and independence and at the same reduce reliance on services.

Hospital at Home - Fife

Hospital at Home - Fife treats appropriately identified patients at home or in a care home setting.

It is an alternative to hospital admission and will provide the same level of care expected had the older person been admitted to hospital. The team is led by a medical consultant and supported by GPs, healthcare support workers, allied health professionals, pharmacists and specialist nurses.

Referrals are accepted by GPs and through the Acute Medical Receiving Unit. The service also provides very early supported discharge and maintains or facilitates a return to independent living. The service started as a pilot in Dunfermline and West Fife in April 2012, rolling out in a phased approach across Fife since.

Hospital at Home is run as a 'virtual ward' whereby the team meet every morning to discuss and review each patient on the case load and agree any changes required to treatments or care plan.

Results have included:

- Early comprehensive geriatric assessment in home environment taking into account home circumstances and involving carers and families
- Speedy response – target of within one hour of referral from a GP
- Continuity of care tailored to the individual.
- Rapid access to equipment, investigations, treatment and therapies
- Seamless transfer between the different levels of the overall ICASS Team.
- Development of pathways and protocols and a guide for Care Homes.
- Positive feedback from patients and carers
- Shorter lengths of stay when an admission is required and prevents morbidity associated with a hospital stay

12. Spread and Sustainability of Reliable Good Practice

12.1 The Issue

Most partnerships can cite numerous examples of good practice/pilots/innovative projects. Many have noted frustration and difficulty in sustainably embedding and spreading new ways of working to make them 'business as usual' throughout their area. Integration will often require a widespread shift in practice and a more systematic approach to adopting or adapting practice that reliably delivers quality and safety.

Some partnerships identified that co-producing services with the community as equal partners can encourage spread of good practice.

Many providers noted difficulties in spreading services across partnerships as they often have different standard agreements and contracts

Matching the strategic approach to locality budgeting was also viewed as important for spread and sustainability.

12.2 Guidance sought

Guidance should highlight the need for practice to influence strategic planning. It should emphasise the importance of strategic needs assessment and asset mapping in each locality to identify opportunities to embed new ways of working.

Guidance should emphasise strengthening the involvement of the third and independent sector as their knowledge and experience as service provider, community connector and employer of local people is invaluable in understanding local assets.

12.3 Improvement support

Assistance to use joint strategic commissioning to make shared investment and procurement decisions about spreading practice from successful demonstrators/pilots.

Some partnerships identified the power of hearing and using people's individual stories as a positive way of changing practice and suggested creating a central resource of powerful stories, including those from elsewhere in the UK.

Many providers asked for help with aligning different agreements and contracts across partnerships.

Intermediate Care: Readiness to Scale – Joint Improvement Team

The Joint Improvement Team Report - Intermediate Care: Readiness to Scale demonstrated that Intermediate Care services such as Reablement, Community Rehabilitation Teams, Early Supported Discharge and Rapid Response / Crisis Care are now widespread, albeit tailored to the local context.

An Intermediate Care Community of Practice supports those working in or connected with intermediate care across Scotland with a resource for sharing learning across Scotland and spreading new and innovative practice new and innovative practice.

Care and Repair Scotland

Care and Repair services started in a small way and now operate in 37 offices throughout Scotland, working in partnership with health, housing, social care, police and fire and rescue services.

Care and Repair was established to respond to issues identified by older home owners who lived in poor housing but lacked the resources or skills need to address problems. The service offers independent advice and assistance to help homeowners repair, improve or adapt their homes so that they can live in comfort and safety in their own community and is available to owner-occupiers, private tenants and crofters who are aged over 60 or who have a disability.



Learning from the practice and experiences of the initial services, many partnerships have used the Change Fund to invest in care and repair and aligned the services with other preventative approaches.

Key outcomes clients report are:

- They feel more confident about living independently
- That their homes are warmer at same or reduced cost
- That using their facilities in the home was easier
- They feel less anxious about safety and security since the work was carried out
- They feel that they are less likely to have a fall at home since the work was carried out
- They are more likely to go out or receive visitors

<http://www.careandrepairsotland.co.uk/about-us/>

All Integration is Local

Feedback from Event held on 13 February 2014

Summary Overview

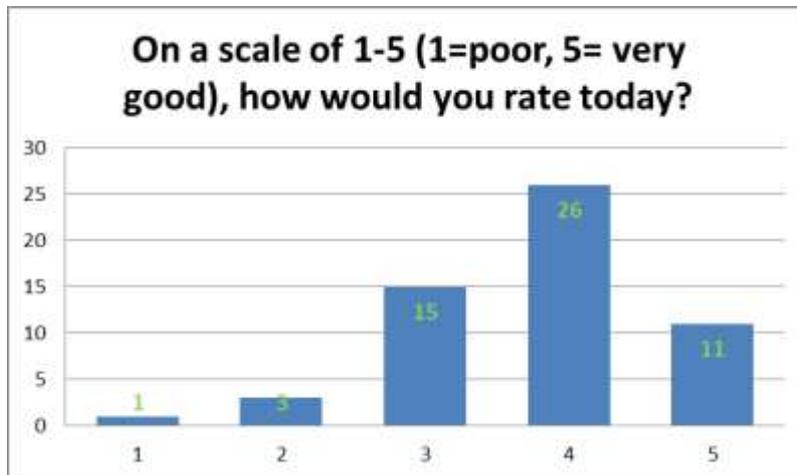
150 people attended the event from a range of backgrounds:

Health and social care service/planning/strategy managers, integration project managers/locality managers, and improvement organisations	86
Third sector	28
Independent sector	13
Director level Health and Social Care (CHP directors, medical/clinical directors, chief operating officer / Nursing/AHP directors)	8
Primary care (of which 4 GPs)	7
Housing	4
Public health/health improvement	4

58 people completed questionnaires, a response rate of nearly 40%.

How would you rate the event?

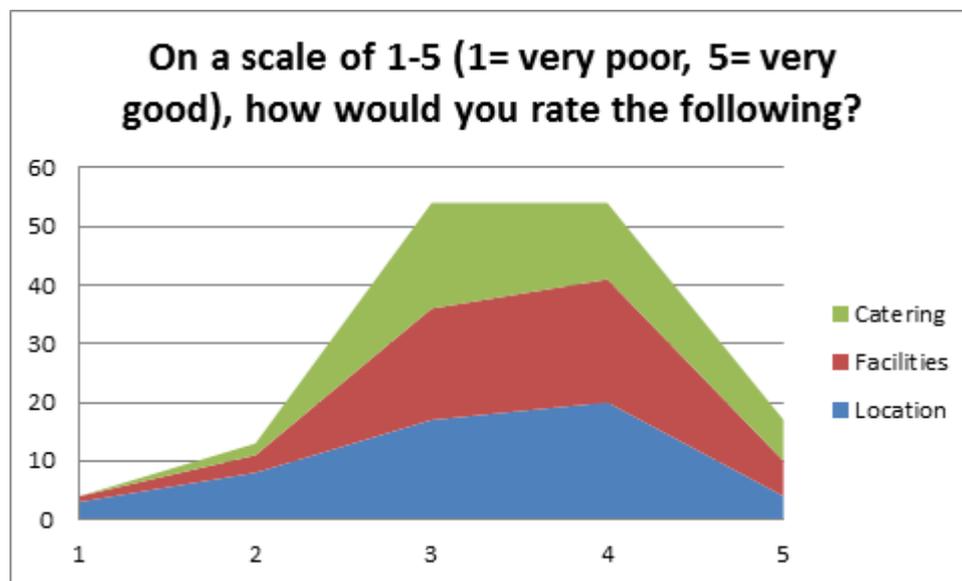
66% of those who responded rated the event four or five out of five



Nineteen respondents made the following comments:

- Nine comments complimented the table discussion, topic areas selected and opportunity to network 'well-structured event with good and discussions particularly liked the opportunity to choose topics to discuss'.... 'good format for the session - short presentations followed by plenty of time for discussion'.... 'good facilitated discussion'....'always good to meet colleagues from across the country to discuss common issues'.
- were general comments that it had been a good opportunity and a helpful event 'very helpful and positive - keep up the - keep talking to us and the wider communities'.....'very good to see true issues re locality as engage working through in practice'
- Two contributors – one from the third and one from the independent sector – felt that their sectors were poorly informed and represented/accepted 'found it very informative as a member of the third sector I have left with a bigger chip on my shoulder and feel that integration is a long way off'....'again felt the independent sector were an add on. Their contribution was barely mentioned and within workgroups/tables and other independent sector had to shout/argue their case to be as important a player as the 3rd sector - disheartening - When coming in own time to contribute'.
- Two people felt that the session was too short 'not enough time for learning and sharing - long way to come'.
- One person though it would be good to have more discussions like these at local/Board level.
- One person felt that it was 'difficult to find a direction of travel'.
- Asked what they found **most helpful** about the event, the overwhelming majority of the 58 responses cited the workshops, listening to practice from elsewhere, the opportunity for discussion and networking with/learning from others 'Examples are very inspiring and motivating' 'the range of involvement and the contributions' 'exploring this multi sided challenge', although several also appreciated the clarity of the introductory presentations – in particular learning more about the policy position on locality working.
- When asked what was **least helpful**, only 40 of 58 respondents answered and five responded 'nothing' or 'all useful'.
- Eight respondents said there was insufficient time and three of these specifically complained that it was too far to travel for a half day.
- Seven people mentioned the crowded and noisy room for the breakout tables.

- People found the national presentations least useful for a variety of reasons; lack of clarity; omission of independent sector role; limited guidance; assumptions that starting point is national outcomes rather than local experience.
- People mentioned the facilitated sessions - two felt one of workshop sessions had not worked well/were dominated by two particular voices; one felt stuck in the same group twice; one would have preferred the chance to participate in more than one session.
- The final local action planning session was singled out by five participants as the least useful because of lack of engagement of national organisations; circular conversations going nowhere; dominance by larger partner; repetition of what is already challenging locally.
- Forty one people took the opportunity to record one or more **specific actions that they were going back** to their locality to take forward.
- On the **venue**, there was an exact 50:50 split between those who rated location, facilities and catering four or five out of five and those who rated them as three or below. There were certainly problems with having had to move the hotel away from central Perth because of numbers and the location and layout of the room in particular for workshop sessions was less than ideal.



Twelve people took the time to make final comments.

- Nine of these were people recording thanks – ‘very useful and informative day’ ... ‘demand for places shows demand for such events’... ‘really useful session that kept the pace going’.... ‘thanks for the opportunity to attend could we have copies of presentation and any write up of the event’... ‘excellent event thank you’.
- Three were comments on areas for improvement - "not good for public transport a missed opportunity"... “should have been day session”... “noisy environment, too many people in the room”