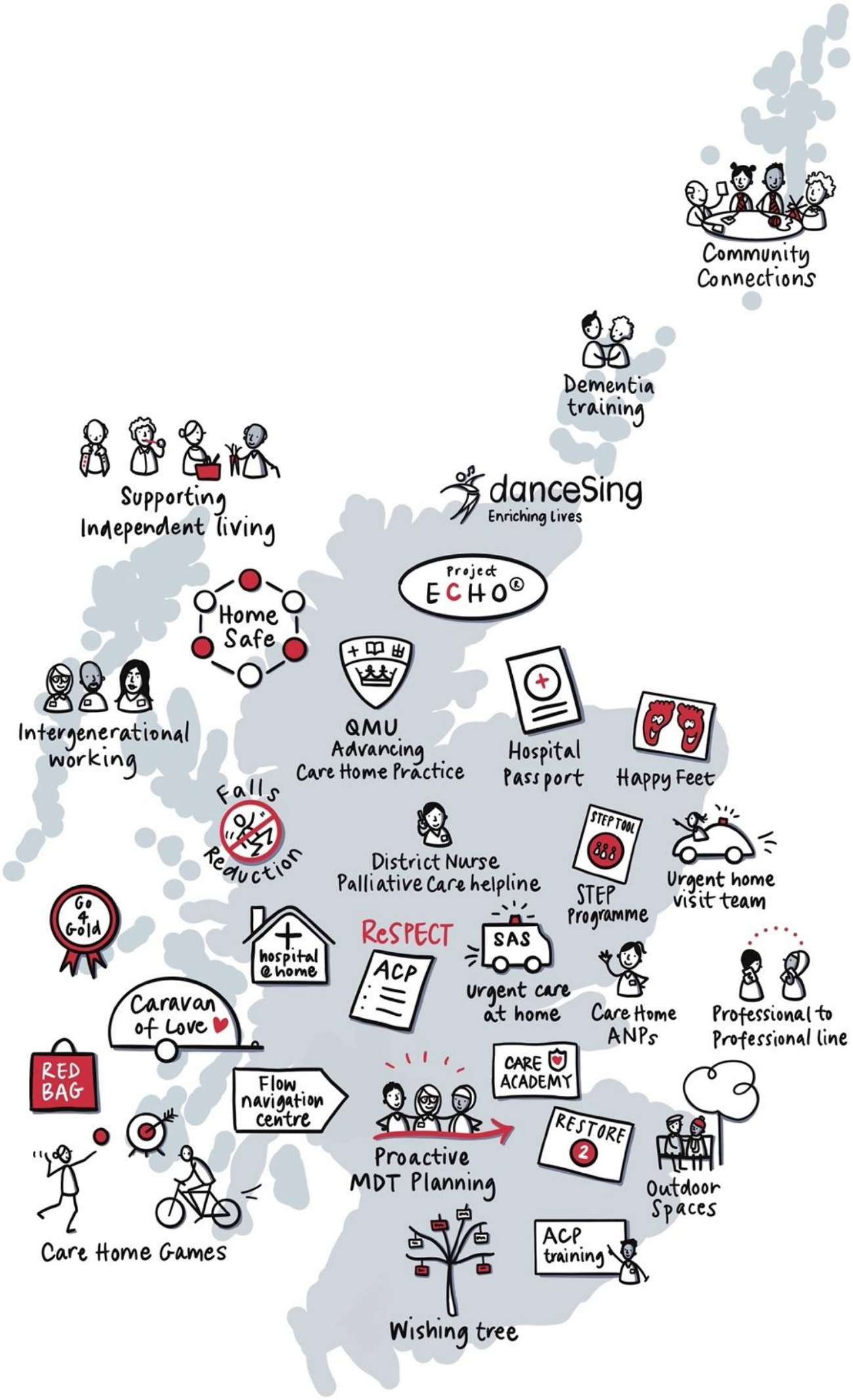
Scottish Government

Healthcare framework for adults living in care homes

My Health – My Care – My Home

Annual Progress Report
September 2023

Scottish Government
Riaghaltas na h-Alba


Community Connections
Dementia training
Supporting Independent living
danceSing
Enriching Lives
Project ECHO®
Home Safe
Intergenerational working
QMU Advancing Care Home Practice
Hospital Passport
Happy Feet
Falls Reduction
District Nurse Palliative Care helpline
STEP TOOL
STEP Programme
Urgent home visit team
Go 4 Gold
hospital @ home
ReSPECT
ACP
SAS
Urgent care at home
Care Home ANPs
Professional to Professional line
Caravan of Love
RED BAG
Flow navigation centre
CARE ACADEMY
RESTORE 2
Proactive MDT Planning
Outdoor Spaces
Care Home Games
ACP training
Wishing tree

Contents

Ministerial Note

This is the first annual progress report for My Health, My Care, My Home, which was published in June 2022.

Publication of this bold and ambitious document came at a pivotal time for the sector as it began to transition out of the pandemic. The focus on the person, their immediate network and multi-disciplinary team (MDT) is entirely right and a model of care that is as appropriate for those living in care homes as across communities.

We applaud the pillar approach in the framework from “anticipation/prevention” to “end of life care” and the recommendations that have and will continue to support the sector in improving experience and outcomes for those living and working in care homes. The framework cuts through several strategic and policy drivers in social care, health and beyond, such as the place-based approach; reducing inequalities; community wellbeing; and inclusive local economic development.

We also recognise that putting the person at the centre of their care and supporting staff to deliver a MDT led model not only benefits residents and staff, but also contributes to the recovery of a resilient health and care system, which was outlined in the recent First Minister’s policy perspective.

It is really encouraging that we have been able to fund the development of the Collaborative Care Home Support Teams and we recognise just how vital a role they play in locally supporting care homes and driving improvement.

We have been fortunate to see first-hand so much excellent practice and innovation that is happening across the care home sector and look forward to seeing that continue.

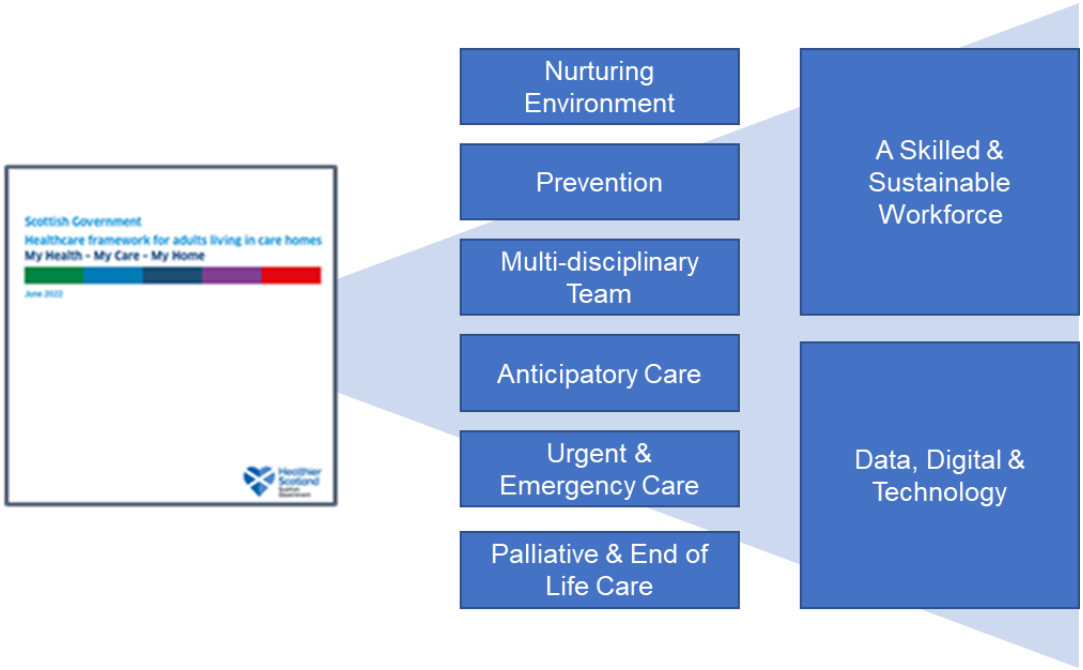
Maree Todd
Minister for Social Care, Mental Wellbeing and Sport

Michael Matheson
Cabinet Secretary for NHS Recovery, Health and Social Care

Introduction

In 2021-22, My Health, My Care, My Home (the framework) was co-produced by Scottish Government and stakeholders from across health and social care with the aim of improving outcomes for adults living in care homes across Scotland.

The document was centred around six core elements, and underpinned by two key enablers, which were felt to be crucial in helping the sector to implement its vision. It also makes several recommendations to reduce the inequalities facing people living in care homes.



A care home is where a person lives, and calls home, and so they should expect the same level of involvement, choice and support for their health and wellbeing as they would if they were living elsewhere in the community. Their requirements go beyond physical health, and include social, psychological, and spiritual care. Unfortunately, healthcare is often fragmented and access to wraparound support is often disjointed. This is evidenced by poorer outcomes across the system that negatively impact people living in care homes and undermine an integrated, rights-based, person-centred approach.

> "The Healthcare Framework is really clear. All the answers are in the framework, people just need to take the time to read and understand it."
> Sanctuary, Regional Manager

Although focused on care homes, the "reach" of the framework extends far beyond this setting. It can have a transformational influence on several areas across Scottish Government's Health and Social Care Directorate and, by consequence, the First Minister's policy prospective with the recovery and reform of our NHS and other vital public services, and help us to achieve the priorities it sets out to drive our decision-making.

NHS recovery/reform and delivering sustainable, person-centred public services that tackles inequalities and ensures people get the right care, at the right time, and in the right place.

The framework is also central to transformational change and social care improvement across the sector. Funding has been provided to Collaborative Care Home Support Teams (CCHST) to maintain, and build on, the whole system multi-disciplinary approach, and to drive improvement by supporting the implementation and embedding of the recommendations made in the framework and the Health and Social Care Standards.

It is encouraging to see, and hear, evidence that a move to a care home is seen as no more than a change of address. This enables the individual to live as active a life as they wish, while still being able to contribute to their community, and retain access to the same services they did when living in their own home.

While we are striving for national improvement, and early indications show improvements are, and can be made, we understand it will take a while to implement them nationally. We also acknowledge that variation in some places will still exist, but the framework has provided a shared vision for everyone in the sector to work towards a common goal.

We have been really heartened by the early adoption and the proactive use of the framework to deliver local change and improvement. As a team we have enjoyed, and continued, positive engagement with professionals, organisations and leaders from across the sector to shape and aid the delivery of the recommendations. By doing so we have seen how positively stakeholders have responded.

Many Health and Social Care Partnerships (HSCP) and Health Boards are undertaking self-assessments to identify priority areas, and introduce a number of improvement initiatives, to deliver better outcomes for people living in care homes. We will highlight a number of these initiatives throughout the document, as well as referencing others that started prior to June 2022 that have since progressed.

NHS Tayside have developed a Supporting Tayside Excellence Programme (STEP) in response to both their experiences of the pandemic and the framework to promote a whole system approach to improving outcomes for care homes. A key component of the programme is the STEP self-assessment tool, which is based on the core elements of the framework and uses the concentric wheels documented in the main document.

By completing the self-assessment every care home has the chance to reflect on their provision of care from a wide range of perspectives and consider the support it provides to its residents. The self-assessment is to be completed prior to an annual STEP visit, during which the team will work with the care home management to develop a plan for improvement and report emerging themes and trends to the various oversight groups that support the sector across Tayside. An initial trial took place across 6 care homes at the end of last year before a more expansive roll out earlier this year. It is expected that the programme, and self-assessment tool will be rolled out across NHS Tayside in 2024.

Implementation

As mentioned in the previous chapter, the framework can have a transformational influence on several areas of Government, including Primary Care, Population Health, Social Work, and Health and Social Care Workforce.

This is why we have been building strong, positive networks with policy teams across Government, to integrate the framework as a policy making tool, which delivers common policies and programmes, and ensures that the vision of the framework is threaded through a number of different strategies and action plans. To date this has included:

- Dementia Strategy
- Palliative and End of Life Care Strategy, and
- Value Based Healthcare Action Plan

We have also made connections with cross-portfolio programmes of work such as Getting It Right For Everyone (GIRFE), Anticipatory and Future Care Planning, Dementia and Primary Care Access. This will help ensure that care homes are not considered in isolation and are part of the overall policy making discussions.

We have also immersed ourselves across the breadth of the sector to develop a clear and robust understanding of the existing challenges across the social care landscape. This has helped us to gain an awareness of the work being done across localities to implement our vision.

Our increased engagement with those living and working in care homes has also enabled us to hear about what matters to them and gain a better understanding of the local challenges they are facing. We have always encouraged an open approach to enable families and those working in, and with, care homes to contact us, at formal arranged meetings, events or via email and social media.

We have been reflecting on our processes of engagement throughout the development of the framework, reviewing where engagement has gone well and identifying areas for improvement to ensure that we continue to engage with the right people in the most effective and inclusive ways. As part of this process, we worked with an independent academic who carried out a research study to explore people's experiences of being involved in the framework development process.

The findings of this research are summarised in the box below and a full research report will be published later in the year. We are actively using these research findings to inform how we continue to engage effectively across the sector as we implement and evaluate the framework.

Dr Jenna Breckenridge, ESRC Policy Fellow from the University of Dundee carried out a qualitative research study to explore how different types of evidence contributed to the design of the framework.

She interviewed 20 stakeholders involved in its development, including: social care representatives (n=5), care home owners/managers (n=4), health representatives (n=3), policymakers (n=5), and government professional advisors (n=3). Interviews lasted approximately one hour and took place between November 2022 and February 2023. Participants were asked to talk about their experiences of being involved in the framework design.

What participants liked about how we developed the framework:

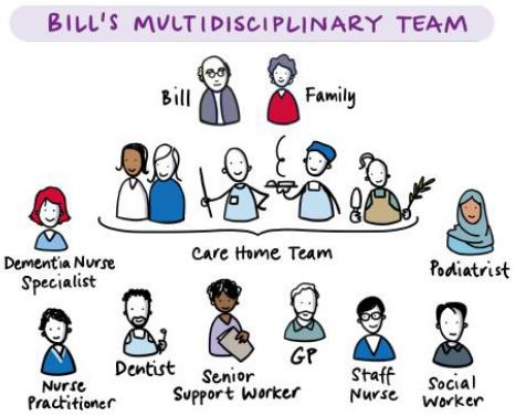
- Our openness to different perspectives and willingness to listen to people from across social care and healthcare
- Our focus on 'good' practice and recognition of the excellent work already happening in care homes across Scotland
- Our commitment to sharing good practice examples to facilitate cross-sector learning and to inspire and motivate others.

What participants wanted us to improve on:

- Keeping a strong focus on social care values, practice and evidence
- Including a broader diversity of voices, particularly from people living in care homes and from under-represented groups
- Making sure that people living and working in care homes continue to be involved collaboratively in implementing and evaluating the framework, without increasing engagement burden.

To support implementation, and to raise awareness of what the vision of the framework looks like in practice, we worked with Scottish Care, Alzheimer's Scotland, and a care home provider to produce two short animations detailing the life of 'Bill', a fictional character, who moves into a care home following a decline in health.

In the first animation we see how Bill is supported in his move to the care home, with the care home staff taking time to develop a personal care plan and how the wider MDT support Bill and his wife, Jean, to develop an anticipatory future care plan that reflects their preferences for care.



The second animation is set some time later when Bill's health has deteriorated. We see how his anticipatory future care plan is used to ensure that his care reflects his wishes and how the care home team provide compassionate palliative and end of life care.

We have also produced and distributed posters to all care homes in Scotland, to help raise awareness of the key pillars of the framework and to promote MDT working. These were sent to care homes for display and to encourage discussion with staff, residents and their families. These can be found on our website.

Over the winter of 2022/23 we held a series of webinars to raise awareness of the core elements of the framework and to shine a light on a number of local initiatives which are addressing local challenges and improving outcomes for people living in care homes. Our full programme of webinars, including speakers, can be found at Annex A.

Feedback from participants was positive, with those involved commenting that it had been really interesting to see how others were interpreting the framework and the practical improvements being made to meet the recommendations.

"It was good to see how it had all moved forward ….to see the innovative work in the care home environment …. how it is developing and what support they all have. The innovation in some areas was amazing."

"It reinforced the approach we are taking ….. made me proud of care homes in my area and care homes support team."

"The session on relatives' experience of visiting during COVID…..very emotional and thought provoking."

Most recently we have established an 'Implementation Advisory Group' to support implementation. The group will provide strategic direction on how to deliver local and national improvement as well as raising awareness of good practice taking place across the country. The group will also align the framework with SG policies, national outcomes and other workstreams across the health and social care system. A list of the organisations who make up the group's membership is provided at Annex B.

Lastly, we are working across DG Health and Social Care to develop a monitoring and evaluation programme, which will enable us to introduce a mixture of qualitative and quantitative methods to measure the impact the framework is having. We will touch on this in more detail in the Monitoring and Evaluation chapter.

Nurturing Environment

Developing a nurturing environment for all those living in the care home is important, but it is also vital that this is balanced for every individual living in the care home.

The direct and indirect impact of the COVID pandemic on people living in care homes has been immense and damaging. However, the lifting of visiting restrictions and the resumption of a multitude of meaningful activities has greatly benefitted people living in care homes.

During the past year we enjoyed engaging with care homes to explore how they are taking a proactive approach to care that also provides access to meaningful activities and social connections, to help improve physical activity and mobility and reduce ill-health and deterioration.

A Dementia Care Manager at HC-One Scotland described a situation to us where 'establishing the why' about an individual's behaviour was so important to how staff provide care and support and build a care plan that supports them to enjoy a better quality of life.

The gentleman had become very challenging to support and live within the care home. One to one care was being funded to support and prevent altercations with other residents and staff – who were becoming scared.

The team set out to establish the root cause of the gentleman's behaviour and developed a collaborative approach to better understand the issues and find a positive outcome for the individual. Management provided training and created a safe, encouraging environment for staff to engage and explore ideas.

This helped staff identify that the lack of occupation and engagement during the day was leading to the gentleman becoming bored. In response, staff built up a meaningful day for him, starting with him helping the maintenance operative bring in deliveries, followed by him establishing and attending to his own space within the communal garden. Every day the resident now has purpose and meaning to his day that has enhanced his wellbeing and quality of life.

Meaningful Activities

Meaningful activities have become embedded in staff routines across the country. Staff create a proactive approach to care that makes the resident feel included, as well as improving their physical activity and mobility, reducing ill-health and deterioration.

For example, Belsize Healthcare Scotland have commissioned a company to create an e-learning training programme that looks at meaningful activities. One of their care homes in Grampian, Laurels Lodge, have made this e-learning course mandatory for all staff, including carers and domestic staff, who are encouraged to get to know residents and involve them in jobs around the home.

We have also heard how moving into a care home brings with it many changes, not only for the person, but for their family too. It can bring disruption to their routine daily activities and connections, but it can also enhance them. This transition is enabled by the professional, dedicated and committed workforce across the care home.

While speaking with care homes we heard of numerous examples where individuals were helping out the gardener, handyman and kitchen staff. We also heard how care homes were creating and maintaining strong links within their local community.

Kincarrathie House in Perth undertake many activities, including lots of inter-generational work with nurseries, schools and universities in the local area. This has resulted in a positive influence on both the young people in the community and the residents in the care home.

Durnhythe Care Home in Portsoy use their digital devices to have “10 minutes of fun” sessions with music. Everyone gets involved however they want; this could be listening or dancing to the music. These sessions are now daily with care staff, domestic and kitchen staff all getting involved.

Parklands Care Home in Alloa have a close relationship with local school children who visit the care home to take part in a number of activities, such as drawing and reading. In June this year, the care home and local primary school had a joint sports day and took part in fun games like an egg and spoon race.

Abbotsford Care in Fife have created unique namaste boxes which help to create a sense of security and tranquillity for residents and staff. The use of various senses, such as touch, scent, and sound, in a calming and intentional manner has proven to be a powerful way to communicate care and affection without relying solely on verbal communication.

> “The impact on staff is bringing the staff closer to the resident and promoting person centred care, with the impact on residents is reducing agitation levels, promoting 1-2-1 time with staff and residents are able to build closer bonds with staff.”
> Abbotsford care staff member

Care homes across Perth and Kinross hold an annual Go4Gold event. Now in its eleventh year, the event has far exceeded expectations with significant physical and mental health benefits being realised as well as the creation of opportunities for socialising. We wrote a blog about last year’s event.

We also spoke to a number of staff who have a support worker or “activity co-ordinator” role. It is their job to support residents to create their own meaningful day. Whilst we are aware not every care home has a full-time activity co-ordinator, those that do really emphasised the positive impact the activities and connections they organise, no matter how big or small, have on an individual’s self-esteem and independence. You can read more about the experiences of those we spoke to at Annex C.

Care Inspectorate and Meaningful Connections Project

The Meaningful Connections Project being undertaken by the Care Inspectorate aims to uphold the rights of those who live in care homes, with a particular focus on promoting meaningful social connection and community involvement. There is a clear overlap between this and the framework, given their person-centred outcomes and seeing social connection as an essential and fundamental component of good healthcare and positive wellbeing.

In addition, the Care Inspectorate have created a Practice guide to show how technology and digital devices can be used to make a positive impact on health and wellbeing for people experiencing care. They also developed and published a poster during the pandemic on the Enriched Model of Psychological Needs which highlights the importance of engaging in activities that are important to the individual and of being an active member of the community.

Provision of danceSing Care for Care Homes

We are delighted to be working with danceSing Care and the University of Stirling to roll out danceSing to 60 care homes across Scotland.

This ‘tech-powered, human-led' creative healthcare platform focuses on improving personal and preventative care for inspirational and fulfilled living through the power of music, movement, and the community.

The participating care homes cover the length and breadth of the country and are representative of the whole sector. Training for staff will commence in September before the service is rolled out between October 2023 and September 2024. During this time, care homes will be able to take part in music and movement sessions, as well as listen to a “reminiscence radio station”. The programme will also be evaluated by the University of Stirling.

Cabinet Secretary's visit to Barleystone Court care home

When Mr Matheson, Cabinet Secretary for NHS Recovery, Health and Social Care, visited Barleystone in August 2023, we were able to have a discussion with their wellbeing co-ordinator and see first-hand a sample of the wide range of activities available to residents.

We were lucky enough to take part in an arts and crafts session where residents were painting butterflies while chatting to the care home staff. This is a frequent activity at the care home as it is very popular. We also got to see residents take part in a live, virtual exercise class.

The wellbeing co-ordinator told us of the positive impact the activities have on residents, and in particular, the live, virtual exercise is a favourite that lifts the mood of residents after they have taken part. The care home's close links to local schools and nurseries also has a positive impact on the residents.

The Multi-Disciplinary Team (MDT)

The benefits of a multi-disciplinary approach to care are clear. Having an effective, proactive MDT in place is the catalyst to providing better outcomes for people living in care homes and is the foundation of implementing the overall vision of the framework.

The framework has a strong focus on MDT working, which places the individual at the centre of the MDT, and we are delighted that there are many examples of this happening across the country, some of which are highlighted below.

In February 2022, NHS Lanarkshire began a Care Home MDT pilot. Initially staff working in the care homes and GP practices identified patients new to living in the care home who were deteriorating or had complex needs. The care home liaison nurse and pharmacist reviewed the patient in collaboration with care home staff, completing a comprehensive assessment, accessing GP records and clinical portal with support as required from a Care of the Elderly Consultant. They also reviewed the individual's assessments and care plans to produce a summary for the MDT to consider.

As of March 2023, this has resulted in 40% of residents reviewed having one or more medications that are linked to increased falls risk stopped. In June 2023 the pilot began to roll out to all new residents admitted to care homes in three localities. The MDT has continued to work collaboratively with the care home staff, assisting with care planning and introducing ReSPECT (Recommended Summary Plan for Emergency Care and Treatment). The team have now joined up with Social Work to attend the residents' 4-6 week review in the care home.

Over the past year a care home in Perth and Kinross have been holding fortnightly virtual MDT meetings. These meetings involve the care home manager, the care home support workers, the GP, a specialist neurology nurse and, when required, a psychiatrist and social worker. Feedback from those involved has been very positive:

"The benefit of these meetings is that we can meet to discuss the residents, any concerns, and ideas for improvement of care. As the meetings are pre-arranged we are all able to attend and give the meeting our full attention. It gives an opportunity to speak to other professionals, to get their input, ideas and support to best help the resident in the care home. These MDT meetings help ensure we are providing a high quality of care and offering a person-centred approach so that residents can maintain a good quality of life."
Senior Home Manager, Balhousie Rumbling Bridge

"As the MDT's are regular it's easier to plan and discuss any non-urgent issues. This makes the best use of time and cuts down on contacts for the care home between the HD Specialists and the GP. The MDTs ensure I am up to date on where the patient is at in terms of their care, current medications, health issues and so I am then able to plan my support around this."
Specialist Nurse, NHS Tayside

"By sharing our knowledge of the patients and their medical conditions, we are able to plan care more effectively. We can then agree who would be the best person to take forward any actions, referrals or discussions with the patients and/or their families. Due to the MDT it is easier to have regular ACP discussions. This ensures the patient's wishes are respected and the ACP is agreed and shared across all relevant systems."
Huntington's Disease Specialist, NHS Tayside

Stirling and Clackmannanshire HSCP have developed a team of care home liaison nurses who work across all the care homes and GP practices within the area, assessing residents and providing advice and support for both the care home team and the GP practices.

Other areas of Scotland have recruited Advanced Nurse Practitioners (ANPs) to provide direct support to care homes. One example of this is Fife HSCP, who now have ANPs in each of their seven local clusters that work alongside the GP practice and the care home and are able to respond quickly to the urgent healthcare needs of people living there. This provision of proactive urgent care can reduce the number of GP visits required to care homes. Their data shows that there were 47% less Emergency Department unplanned attendances from care homes between October 2022 compared to October 2021, and 54% less inpatient admissions over the same period.

Dundee HSCP has introduced an Urgent Home Visiting Team that has direct contact with GP practices and will conduct all urgent care visits to care homes as well as being able to prescribe 'just in case' medication. The team supports care home staff to identify people approaching end of life and works closely with multi-disciplinary colleagues to support residents, their relatives, and care staff to prepare for and deal effectively with supporting symptom management and end of life care. To provide continuity, they also plan routine visits to follow up on some actions. Between March and April 2023, the team made 931 visits to care home residents. From September 2023 this model will cover all GP practices in Dundee.

General Practitioners are an important part of the MDT, and the framework highlighted the benefits of close relationships between individual GP practices and care homes. The framework highlighted that care home staff can encounter difficulties when working with several different GP practices, as they each have different ways for requesting advice, visits, and prescriptions.

We attended the Scottish Primary Care Leads group in May 2023 and were able to hear about other work that is taking place in this area. We discussed 'local enhanced services' (LES) in relation to care homes, which provide additional funding to supplement services already offered within the core GP contract. There is a desire in some areas to review their LES that relate to care homes in line with the aspirations of the 2018 GP contract and the ambitions of this framework.

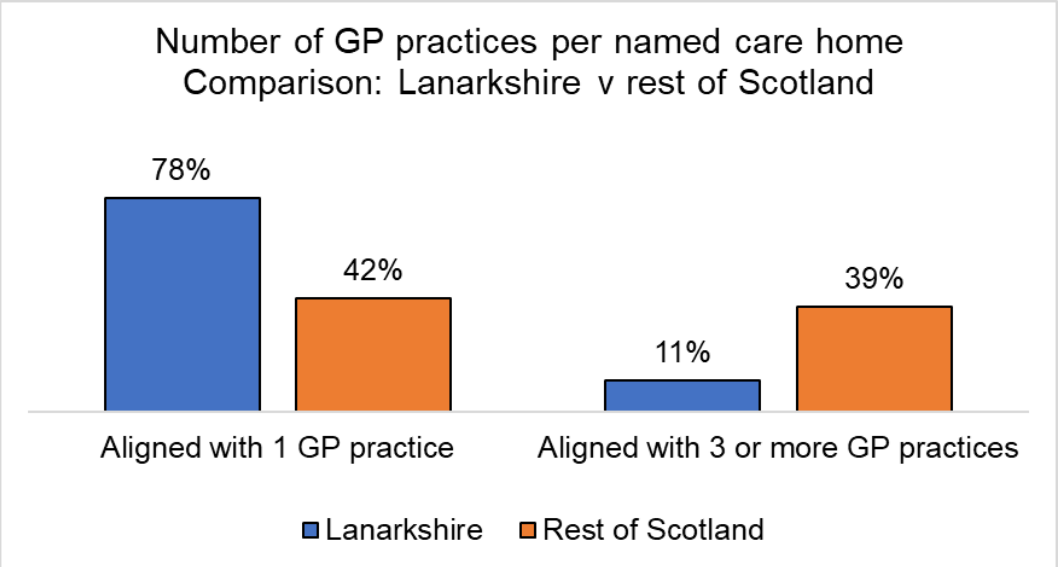
Data on alignment between care homes and named GP practices

Public Health Scotland data shows that, as of 1 April 2023, there were 905 GP practices in Scotland, and the Care Inspectorate Datastore indicates that, as at 31 March 2023, there were 1037 adult care homes registered in Scotland.

While the data shows 905 GP practices, not all of these will have patients registered that are living in care homes. Similarly, some of the 1,037 care homes will provide respite or step-down facilities, so patients only stay temporarily and then return to their usual home address and GP practice.

To gain an insight into the number of care homes currently aligned to named GP practices, we obtained data from National Services Scotland (NSS). This data identified that, as of March 2023, 64% of care homes in Scotland are aligned to either 1 or 2 GP practices. Annex D provides a breakdown of this data by Health Board. Moving forward we will continue to receive quarterly data from NSS relating to the number of GP practices that are linked to each care home.

Many HSCPs have reported success from aligning care homes with individual GP practices. This is true in Lanarkshire where a LES has helped to align most care homes with a specific GP practice. 78% of care homes in Lanarkshire are currently linked with a single GP practice, providing care for all the people living in the care home; and only 11% of Lanarkshire care homes are required to engage with 3 or more different GP practices. This compares with the national figures of 45% and 36% respectively. They report subsequent benefits in working relationships and improved outcomes for people living in care homes with a reduction in unnecessary admissions to hospital.



We recognise that it will not be possible, practical, or desirable to align every care home in Scotland with an individual GP practice, but we do see it as essential that close working relationships are developed between every care home and the GP practice(s) covering them.

Prevention

A preventative approach to healthcare has sometimes been seen as a clinical intervention but it is the everyday things we do to keep ourselves healthy and well, which help prevent the onset or delay of health conditions.

There are a number of groups which are in place to come together to consider how best help and support people living in care homes. The Allied Health Professional (AHP) care homes network have met on a regular basis to share challenges, solutions and good practice. They are in the process of developing a document "AHPs in care homes, supporting health and wellbeing" which will highlight a shared vision and ideas to support people to live well and help prevent the onset or decline of conditions associated with long term conditions and aging.

Initiated before the covid pandemic, Fullerton Care Home in Irvine took a new approach to mealtimes which enabled people to be more independent, increase confidence and better fluid and nutritional intake, all of which are vital for preventative healthcare. Something similar is being adopted in St Ronan's care home in the Borders. When we visited, they shared that they are moving back to giving people the option to enjoy their meal in the communal dining room. Residents are now able to contribute by setting the table, preparing aspects of meals, tidying up, putting water on the table and more.

Targeted meaningful activities for an individual, such as an intergenerational reading group, can help prevent cognitive or mental health decline. Other examples can be found at Age Scotland's website where they have a multitude of resources, which includes fun active games for strength and balance and free advice guides for increasing physical activity.

A large proportion of our focus in the past year has centred around falls reduction and associated harm.

Hawkhill House care home have created a "Happy Feet" programme which centres around a visual prompt for staff in the care home to check-in with residents who are deemed to be at a higher risk of falling.

A poster of feet is displayed on the resident's door to increase awareness of the risks and encourage collective responsibility. When we spoke with the care home manager we were advised of the success of this simple, yet very effective, programme which significantly reduced the number of falls in the care home and was having a cultural impact across all staff, with maintenance and kitchen staff also taking responsibility to engage and check-in on residents.

We were delighted to be invited to join the Scottish sub group of the Four Nations Falls Forum. The group provides the opportunity to discuss developing approaches and facilitates the sharing of good practice, new initiatives and concerns regarding falls. In the most recent meeting, the group agreed on removing the term "prevention" from falls work and replacing it with "falls reduction".

We are also participating in conversations which are taking place to look at the definition of a fall and fall with harm, which will enable better data collection and subsequent improvement opportunities.

More widely, we have had conversations with a range of stakeholders, including the Care Inspectorate, regarding how best to collect data around falls in a meaningful way. While these conversations are ongoing, we are hopeful this will be incorporated into their data collection moving forward. Having this data will help maintain an awareness of the multiple risks associated with falls and provide a focus towards the quality and outcomes of care. It will also reduce data requests, increase data sharing, and provide a stepping stone to standardised data as recommended in the Care Home data review.

At a local level we have also been invited to NHS Lothian's Falls Forum which builds on a lot of great work they did pre-pandemic which yielded significant reductions in falls. Lothian are currently consulting on a suite of documents which will enable improved awareness, assessment and response for people who are likely to fall.

Between May and June this year, we carried out a case study with care homes in Borders and Fife to raise their awareness on activities that contribute towards falls reduction and gathering examples that happen within care homes:

Supporting people to continue with their hobbies and activities can really contribute to falls reduction. A care home manager in the Borders shared with us some examples of this, including daily household activities, moving indoors and outdoors for socialisation, musical bingo, air hockey, and much more, which lead to improved strength and balance.

In addition, having a lovely garden encourages many more outdoor activities which lead to more stability and confidence. The residents help to cut the grass, water plants and plant items in the greenhouse.

In one care home in Fife, small trolleys are provided for residents to uplift their daily essentials from the worktop where there is a collection of teapots and baskets of snacks available.

When it was discovered that one resident, who struggled with socialising, had a talent for soup making, staff worked with her to develop recipes and prepare soup which everyone was able to enjoy together.

In another home, over 65s are encouraged to carry out as many daily living activities themselves as possible. They enjoy collecting the lunch trolley to share with others and being supported to make tea.

Anticipatory and Future Care Planning

Edinburgh's 7 steps to ACP programme, which originally launched prior to publication of the framework, demonstrates that where there is a shared understanding of an individual's health and care, better outcomes can be achieved. A study by Health Improvement Scotland demonstrates this.

Recent developments include digitising the 7 steps model through the Homecare Decisions platform and app and making the model easily accessible to all cross-sector health and social care professionals, people living in care homes and their families. Two e-learning modules are also now available on the City of Edinburgh Council learning hub and will soon be available to all care homes in Scotland on the TURAS learning platform.

To achieve scale, spread and sustainability, the Lothian Care Academy is providing strategic oversight, training and improvement support to embed the 7 steps model throughout Lothian. To date, 40 care homes in Edinburgh, and several in Midlothian, have engaged in training or improvement support using the 7 steps model.

Fife HSCP have implemented a small test of change using a new approach to anticipatory care planning across 16 care homes. A small group consisting of a GP, Practice Manager and Medical Consultant met to develop an information sharing process where the information on the ACP is shared with the linked GP practice to the care home and this information is transferred onto the Patient Electronic Key Information Summary (EKIS). This information will then be 'copied' onto the Patient Portal, in order that staff within Secondary Care have access to the ACP information. Evaluation of the test of change is currently taking place and its findings will inform the next stage of implementation in the area.

There is still a lot of national variance in how anticipatory care plans are documented and held but the Key Information Summary (KIS) remains the primary method for recording, sharing, and reviewing all care plans (including ACPs) for every patient registered with a GP practice in Scotland. Creating and updating the KIS is important, but does not always happen, particularly when healthcare professionals are stretched.

Forth Valley have been using the digital ReSPECT tool to develop ACPs for their care home residents. It provides health and care professionals responding to an emergency with a summary of recommendations to help them to make immediate decisions about that person's care and treatment. The ReSPECT document is held digitally within the 'clinical portal' and can be emailed or printed for care homes. Care homes reported quicker access to support out of hours care which reduced the need for calls to 999, and staff were more confident in advocating for residents to remain at home.

Making Anticipatory Care More Accessible

As we have been supporting anticipatory care planning initiatives, it became clear that the phrase is not well understood by people living in care homes, their families, and general members of the public.

Over the next year Scottish Government will undertake a new programme of work to make Anticipatory Care Planning more accessible to people who are becoming older or more frail or living with a long term health condition or disability that could mean their health may change at some stage. This will include renaming Anticipatory Care Planning to Future Care Planning, so that it is easier to understand.

Work will also be undertaken with Health Improvement Scotland (HIS) and NHS Education Scotland (NES) to update training, tools and resources for all staff, including those working in care homes, as well as updating and improving information for all people through NHS Inform.

Lastly, a programme of work will also explore how sharing and recording of information relating to Future Care Planning can be improved, including through the digital ReSPECT form which is currently used in NHS Forth Valley, NHS Tayside and NHS Western Isles, and NHS Lanarkshire are also close to using. Lessons learned from these areas will support a wider roll out across Scotland.

Reflecting on Personal Experiences of Anticipatory Care Planning

In November we held a webinar focusing on the MDT and Anticipatory Care Planning. At this webinar Wendy McLaren shared her first-hand experience of how valuable it can be:

Wendy's father developed vascular dementia and when he was no longer able to live in his own home, he moved to Almond View Care home in Glasgow. Wendy's mother asked the care home to contact her if any decisions were required to be made regarding his care. On one occasion, Wendy's father deteriorated unexpectedly in the middle of the night.

Wendy's mother was called at 2 am to discuss the options for his care and treatment. A quick decision was made to take him to hospital. This caused the family a lot of additional stress as her father was not happy in hospital. Once Wendy's father returned to the comfortable and familiar environment of the care home, the care team and local GP spent time with the family to update his Anticipatory Care Plan.

This reflected their desire to focus on symptom control and quality of life rather than invasive hospital level care. He spent the remaining months of his life in Almond View Care Home, where he received excellent palliative and end of life care. This whole experience prompted both Wendy and her mother to discuss and make their own Anticipatory Care Plans.

Palliative and End of Life Care

The Scottish Government is developing a new Palliative and End of Life Care (PEOLC) Strategy for all people in all settings, including care homes. The overarching aims of the strategy, which chime with the framework, are that:

- Everyone in Scotland receives well-coordinated, timely and high-quality palliative care, care around death and bereavement support based on their needs and preferences including support for families and carers.

- Scotland is a place where people and communities can come together to support each other, take action, and talk openly about planning ahead, serious illness, dying, death, and bereavement.

The PEOLC Strategy includes a priority to build, train and sustain the workforce. A new Workforce Education, Training and Resources Working Group has been set up to scope and review professional and multi-agency education and training programmes and resources, in order to identity areas for priority action. This will look across specialist and general clinical and social care in all settings.

At our PEOLC webinar in December 2022 we spoke to care home managers at Beechwood and Rashielee care homes to understand the impact effective palliative and end of life care has on both staff and residents:

Both care home managers highlighted the importance of giving the right care, in the right place, at the right time and reminded us that palliative care is not only about caring for the individual under their care, but also for the friends and family around them to ensure that there is a warm, comfortable environment to allow the resident to die with dignity.

Gathering information, as early as possible (before admission if possible), was particularly highlighted as a vital component in enabling staff to build the knowledge and confidence to speak about PEOLC with residents and their loved ones. This also helps with building relationships, which was also highlighted.

Being able to have open and honest conversations throughout the journey to end of life is so important. Rashielee care home have 3 staff trained in Namaste care which strengthens communication with residents when they are no longer able to communicate verbally. Instead they use sensory to communicate with them. This includes using music, pictures, touch (for example, massaging hands) which gives families comfort that their relative is being well cared for.

One of the recommendations within the framework is that care home providers and specialist palliative care teams should work together to explore shared learning and peer support opportunities, through initiatives such as Project ECHO. This has recently been a key part of the learning networks created in Highland and East Ayrshire. More information on this can be found in our Skilled and Sustainable Workforce chapter.

The framework also highlights the importance of the Scottish Palliative Care Guidelines as a source of practical evidence based on best practice guidance for people delivering palliative and end of life care. The guidelines have been embedded as part of Healthcare Improvement Scotland's (HIS) SIGN Guidelines so that this resource can be continually reviewed, improved and updated.

The new strategy will also prioritise and address timely, all-hours access to care and advice, and medicines and equipment, which are necessary to ensure that staff in care homes can respond promptly to any changes in a person's condition and in line with a person's preferences recorded through Future Care Planning.

Marie Curie have also established a Care Home programme which aims to work in collaboration and partnership with key stakeholders to influence and support sustainable system-wide delivery of consistently high-quality end of life care in care homes across Scotland. We are members of the Care Home Programme Reference Group which is supporting this work.

One of the key strands of work is the development of a PEOLC Network for the Collaborative Care Home Support Teams across Scotland. The network will seek to enhance the capacity and impact of external PEOLC expertise going into care homes and to maximise the potential of these on-the ground professional relationships, with the ultimate aim of empowering care home staff in the delivery of PEOLC.

Additionally, Scottish Ambulance Service (SAS) and MacMillan have embarked on a project to improve the PEOLC provided by SAS staff and thus improve patient / carer experiences by reducing the number of people being taken to hospital. To do this they are creating alternative pathways to admission to hospital by developing professional to professional communication pathways that avoid unnecessary hospital admissions, and they are also developing an education programme for staff. As of June 2023, test sites in Forth Valley, Ayrshire and Arran, and Grampian were reporting conveyance rates of 67%, 54% and 63% respectively with the most likely causes of these being: strokes, unconsciousness, falls and breathing problems.

Urgent and Emergency Care

Accessing responsive and appropriate care in an urgent or emergency situation is important for people living in care homes.

As noted in our MDT chapter, many areas in Scotland have recruited Advanced Practitioners to respond to the urgent care needs those in care homes. This includes Advanced Nurse Practitioners (ANPs) who have a primary remit to deliver care and build relationships with those who are living in care homes to provide direct, clinical support.

Scottish Ambulance Service is undertaking focused improvement work in several areas of Scotland. Following a 999 call to a care home, the paramedic staff are providing an urgent response and assessment within the home, then where appropriate are liaising with other members of the MDT to help avoid unnecessary admissions to hospital. In another pilot SAS is working with the charity Macmillan to respond to the urgent needs of people who are nearing the end of life in care homes.

Other areas have introduced dedicated professional to professional lines to support urgent care. At our webinar on urgent and emergency care we heard from colleagues in Fife HSCP about the professional to professional phoneline they are trialling which provides care homes with direct access to urgent care services. As of August 2023, 54 care homes (out of 75) were using this line and Fife HSCP are working with the others to get them on board too. Their latest data showed that only around 3% of calls resulted in a hospital admission, and there was an overall sense that care has been improving as the team grow in confidence around the processes.

NHS 24 are supportive of pathways like this as they have data to show that most calls to them from care homes are passed onto the out of hours services anyway. There is however caution from some of the health board out of hours services, who are worried about capacity to answer calls directly from care homes. We have been holding discussions with NHS 24 and Out of Hours services to explore this further.

Through the Urgent and Unscheduled Care Programme, Scottish Government have established local Flow Navigation Centres in every NHS Board which are designed to deliver 24/7 access to a senior clinical decision maker. This can play a role in providing the right care, at the right place, at the right time as Flow Navigation Centres can act as a point of contact for care homes when there is an urgent healthcare issue.

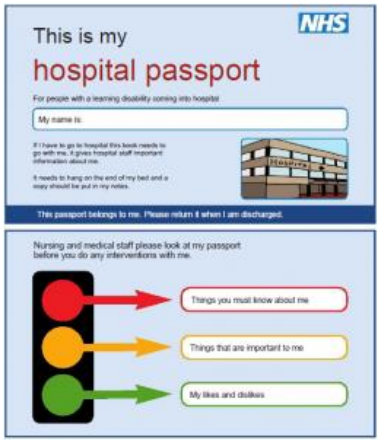
Ayrshire and Arran have introduced such a pathway, whereby care home staff can contact a senior clinician working within their Flow Navigation Centre during the out of hours period as an alternative to calling NHS 24. They now handle over 500 calls per month from care homes. Since introducing this pathway staff spend less time on the phone trying to access help, and there are fewer calls to Scottish Ambulance Service and fewer transfers to hospital. Their data show that only 10% of calls to the Flow Navigation Centre require the person living in the care home to attend hospital for further intervention. Good working relationships have been established between

care home staff, call handlers, and clinicians in the service, which has been helpful to build confidence and trust for decision making.

A new Flow Navigation Centre Speciality Delivery Group (SDG) has been established by the Centre for Sustainable Delivery (CfSD) which will focus on enhancing the pathway including to improve professional to professional access, such as care homes, which will support reduced admissions to hospital. The SDG will aim to reduce unwarranted variation by standardising service provision and pathways on a best-of-class and once-for-Scotland basis wherever possible.

Improving transitions of care

Over the past year we have also explored the various programmes of work taking place across the sector to improve communication and sharing of information between professionals.



Laurels Lodge care home in Grampian told us about their use of the Hospital Passport which they have been using to great effect to ensure salient information arrives at the hospital with their residents. Feedback from staff highlighted use of the passport has reduced the number of calls from hospitals seeking more information about patients.

'Red bags' are a great concept that have been used to varying degrees of success across the country over the years.

When they are used well there is improved communication and the transition of care in and out of hospital is smoother. However, feedback from care home managers was that it's often not an effective system and so the general uptake by care homes and hospitals has been slow.

More recently, NHS Ayrshire and Arran have been piloting a cabin style suitcase which includes the patient's anticipatory care plan, KIS, medical notes and other relevant information. As of June 2023, 41 of the 63 care homes in the area are now using the red bags, transfer document and yellow alert card. Providers and Acute colleagues continue to support the rolling out of the initiative, along with a transfer document that provides pertinent resident/patient information for staff during discharge or admission. The intention is to continue spreading this document along with Alert Cards and a checklist of itemised personal belongings that will stay with the resident throughout their admission to hospital and return with the resident to their care home.

NHS Lanarkshire have instead been trialling a patient transfer document with five care homes to improve the individual's journey with better communication and prevent discharge failures. This has proven to be a challenge to implement across all acute sites in the region, but the team are focusing on, and making progress in, elderly care wards and community.

The Care Home Liaison Team (CHLT) in Highland developed the Home Safe poster following a number of engagement events to understand hospital discharge experiences of care home residents, staff and providers. The poster has been put on display in ward areas across the region and has brought about greater levels of consistency for all staff when arranging and facilitating discharge.

The CHLT also started proactively following up every hospital discharge within 24 hours, which allowed them to gain an overview of themes and trends and offer targeted support to discharging areas. This has improved discharge experiences and increased partnership working between care homes and hospitals.

Furthermore, each area now has a ‘decision making team’ who collaborate with the Discharge Team / Wards to ensure safe and effective discharge. The team meet daily and have oversight of care home discharges in their areas. This has supported flow locally as care homes and local decision making teams have stronger relationships, and it has also reduced the burden on care homes receiving multiple calls from discharging areas.

A Skilled and Sustainable Workforce

A skilled and sustainable workforce is fundamental to the success of this framework, and over the course of the last year we have put our efforts into increasing the sector's access to a wide range of tools and resources that meet their education and training needs.

We have also funded education and peer support programmes and worked with stakeholders across the sector to explore how learning and development qualifications can be stored and updated.

Advancing Care Home Practice (PgCert)

The framework highlights that care home managers are responsible for the overall management, development and quality assurance of care and support provided in a care home service, including the supervision of staff and the management of resources.

In response to this, we provided funding for five experienced practitioners working in the care home sector across Scotland (Greater Glasgow and Clyde, Highland, Edinburgh, South Ayrshire and Aberdeenshire) to undertake the Person-Centred Practice (Advancing Care Home Practice) (PgCert) course run by Queen Margaret University (QMU) during the 2022/23 academic year.

The course is a work-based programme supported by blended teaching, learning and assessment approaches, offering flexibility for different learning styles and preferences. The PgCert consists of three core modules that are delivered through virtual online learning. These align well with the aims of the framework and enable learners to make positive changes in their own care homes:

Theory and Practice of Person-centred Health and Wellbeing

Learners develop expertise in understanding and responding to the needs of the person, families and communities in a way that is consistent with the theoretical underpinnings and the values of person-centredness throughout the lifespan.

Leading Person-centred Practice for Health and Wellbeing

A focus on leadership and collaborative ways of working, evidence generation and implementation of health and wellbeing approaches for healthful cultures.

Advancing Care Home Practice

Learners consider the strategic context of care home practice and relevant ethical, professional and legal frameworks within which they practice. They will critically evaluate their role in developing systems and processes that embed safe and effective holistic practices, focussing their practice on promoting health and well-being for people with a range of physical and cognitive impairments through person-centred approaches.

The learners evaluated the course, and the feedback they provided has been very positive, which has enabled us to provide funding for a further five candidates to take part in the course this academic year (2023/24).

The course gave them an appreciation that valuing and respecting staff, and looking after their health and well-being, is essential in ensuring the residents' care needs are met. It also reinforced the concept that providing person-centred care for residents involves the community as a whole. It has helped them better understand the barriers to improving standards, enabling them to introduce changes into their work practices effectively.

"Learning about person-centred care, it was a revolution to me that it involved the community, this has opened my eyes as a nurse. I thought of it as being the resident and their needs but it actually involves their community as a whole. This has made me re-evaluate the way I deliver care."

"This programme highlights the importance of care home nurses in their own right. As a result of being part of it, I now champion better recognition for care home nursing."

"The exploring of different theories around personhood have been fascinating and enlightening and have helped me to truly understand what matters to a person …….and how this understanding is helping me to become a better person-centred practitioner."

Project ECHO

We have also been working in collaboration with the Scottish ECHO Centre to establish four new Project ECHO learning hubs across Scotland. To date we have already launched two hubs in Highland (3rd May) and East Ayrshire (19th July) and will soon complete work in Dumfries and Galloway and Aberdeen City.

The hub areas work closely with the ECHO Centre to define the structure and content for their hub. However the key principles of the framework are underpinned throughout the sessions. This will allow the hubs to reach as many of the workforce as possible to optimise skills and knowledge in a way that alleviates pressure on services, remobilises health and social care and creates resilience.

The Highland programme has so far consisted of five sessions, facilitated by the lead nurse for care homes in NHS Highland. Topics covered complex care in the current landscape, delirium, safe care and staff resilience.

The East Ayrshire programme is still ongoing, with the first session on Palliative Care led by the lead consultant at Ayrshire Hospice. Other sessions include end of life care, comprehensive care within an MDT, and empowering residents to make choices around advance care planning.

The Scottish ECHO Centre are launching their new website in September. In the meantime you can hear updates via Twitter @HHProjectECHO.

Learning and Development Resources

We have also continued our engagement with the sector to better understand some of the issues facing the care home workforce. We are extremely grateful to colleagues in Scottish Care and Scottish Social Services Council (SSSC) for inviting us to join their Workforce Matters Regulatory Forum. This helps us better understand some of the issues facing the care home workforce, as well as keeping updated on some of the learning and development opportunities being developed.

Through our engagement with stakeholders we have learned about the value in having one resource that brings together all learning completed by social care staff. Currently, there are numerous learning and development resources made available by a number of providers and institutions, all in a variety of different platforms.

It is highly beneficial for learning to be validated and transferred to a staff member's new role. SSSC highlighted to us their MyLearning App as being an integral part of this process, with its functionality to log learning activities and its portability between roles.

National Induction Framework

Effective onboarding and support are critical requirements in order to support high-quality care, deliver good outcomes for people experiencing care, and provide a solid foundation for new employees that help develop the necessary skills and experience to build a career in care.

Recognising this, and in partnership with SSSC and NES, a National Induction Framework was developed. This framework provides a consistent foundation from which new entrants can start their career with confidence, by working alongside the employers existing internal onboarding journey. This makes it easier for organisations to deliver a consistent onboarding experience that covers all the minimum standards expected of a new entrant, supporting knowledge building and skills development of new care workers.

Digital and Technology

We have been working closely with colleagues in the Digital Health and Care division and Technology Enabled Care (TEC) to align the framework with the priorities within the Digital Approaches in Care Homes Action Plan.

Through this ongoing collaboration, we were invited to join the Digital Social Care Portfolio Board, where we have been able to raise awareness of the framework and the local improvement work that has been taking place. It has also enabled us to form a relationship with Digital Health and Care Innovation Centre (DHI) which has helped align the framework to their Scotland's Healthy Ageing Innovation Cluster.

We were also able to hear about great initiatives such as PainChek, which is an app that uses artificial intelligence (AI) technology and smart automation to assess pain in people who are unable to verbalise pain.

In March, colleagues from the Care Inspectorate presented their findings from the first participating care home: 831 pain assessments were completed using the app in the first six months; after 12 weeks falls within the home had reduced by 75% and episodes of stress and distress had reduced by 42%. Phase one had 6 participating care homes and is now coming to an end. The project team are now looking at the impact and key learnings from this stage.

Digital platforms can also play a key role in staff learning and development. Kirsty Bateson from the Scottish ECHO Centre also spoke at our webinar about Project ECHO which provides an 'all teach, all learn' environment, bringing together people working across the care home sector with subject experts, to reflect on complex cases and to gain insight and support from the specialists and their peers. More information on how Project ECHO is supporting staff across the country is included in the Skilled and Sustainable Workforce chapter.

Strathcarron Hospice in Denny has an active education programme with care homes in the Stirling and Falkirk area using the Project ECHO approach. Care Home staff come together virtually as a community of practice and identify topics relevant to them relating to palliative care. The specialist palliative care team at the Hospice facilitate a discussion around these areas of interest, with expert speakers contributing their knowledge. To date they have worked with 162 staff from 25 local care homes.

Digital and technology also plays an important role in sharing secure information. The Care Home Programme Team at NHS Lothian have been working on a 'Secure Email Project' to create a solution which enables the secure transfer of information using care home email addresses. To date, over 70% of care homes are involved and are reporting improvements in communications between care homes and NHS Lothian Services when dealing with personal and secure information. If you would like to find out more as this project progresses, you can contact carehomes@nhslothian.scot.nhs.uk.

Monitoring and Evaluation

To enable us to measure the impact of My Health, My Care, My Home, we have introduced a mixture of qualitative and quantitative methods and developed a set of outcomes (see below) that align with the core elements of the document and link with the wider outcomes across DG health and Social Care. They will also be measured through a set of metrics that are currently being devised and considered as part of the Scottish Governments care home data review:

1. People living in care homes have access to a nurturing and stimulating environment with the opportunity to do things that are meaningful and important to the individual.

2. People living in a care home are supported by an MDT that will play a lead role in delivering care that meets their health, social, psychological and spiritual care needs.

3. People living in care homes have timely and equitable access to care and support and have regularly reviewed and updated personal plans that support a preventative approach to their care by taking cognisance of their physical and mental wellbeing.

4. Care homes have regular and meaningful conversations with residents to discuss all aspects of their care and ensure outcomes are reviewed frequently and shared with everyone involved in delivering care.

5. People living in care homes receive timely support and intervention from members of their MDT and should be given equitable access to medication and equipment to best meet and support their needs.

6. People living in care homes are given timely access to specialist palliative care services, medication and equipment to best meet and support their needs and are provided with a person-centred and holistic approach to their health and care when length of remaining life is reducing.

7. Health and social care professionals are supported and empowered to work collaboratively and are provided with time, tools and resources to undertake the necessary training to ensure residents receive the care and treatment they need.

8. Digital access to an individual's health records, and clinical outcomes should be timely and accessible to all parts of the system and people living in care homes are able to attend appointments and connect to the outside world via video and digital technology.

Annex A – Webinar programme

Webinar Title	Date	Presenters (and Topic)
MDT and Anticipatory Care	22 Nov 2022	Claire Osprey and Caroline Martin (NHS Lanarkshire) - MDT model
		Andrew MacKay (Edinburgh HSCP) - 7 steps to ACP
		Wendy McLaren - personal experiences of Anticipatory Care Planning
A Skilled and Sustainable Workforce	30 Nov 2022	Helen Honoré (Care Inspectorate) - Staffing Method Prototype for Social Care
		Ali Upton (SSSC) - A skilled and sustainable workforce
		Mhairi Hastings (Scottish Government) - Transforming Roles
		Jane Douglas (Scottish Care) – A sustainable workforce: Social Care Nursing
Palliative and End of Life Care	8 Dec 2022	Sandra Campbell and Paul Watson (Scottish Ambulance Service) - SAS and MacMillan End of Life Care project
		Margaret Swankie (NHS Tayside) and Maggie Brand – (Harestane care home) - Urgent Home Visiting Team
		Karen Gillespie (Beechwood Care home)
		Kirsty Cartin (Rashielee Care Home)
Nurturing Environment and Prevention	24 Jan 2023	Alyson Vale (Abbotsford Care)
		Dr Maura Edwards (Caring For Smiles)
		Nicola McCallum and Karin Skeet (Kincarrathie House care home)
Urgent and Emergency Care	21 Feb 2023	Lynnette Marshall (Fife HSCP) – Professional to Professional line
		Dr Jane Douglas (Scottish care) - Effects of the INTERCARE nurse led model in reducing care home transfers
		Alison Leitch (Care Home Relatives Scotland) – Experiences of accessing urgent and emergency care
Digital and Technology	21 March 2023	Rikke Iversholt - Scottish Government Digital Health and Care
		Kirsty Bateson (Scottish Echo Centre) - Project Echo
		Nicky Cronin and Nicola McCardle (Care Inspectorate) – PainChek

Annex B – Implementation Advisory Group Membership

- Abbotsford Care
- Barchester Healthcare
- Care Home Relatives Scotland
- Care Inspectorate
- Convention Of Scottish Local Authorities (COSLA)
- Digital Health and Care Innovation (DHI)
- Dumfries and Galloway HSCP
- Fife HSCP
- Glasgow City HSCP
- HC-One Scotland
- Healthcare Improvement Scotland (HIS)
- Marie Curie
- NHS 24
- NHS Ayrshire and Arran
- NHS Borders
- NHS Education for Scotland (NES)
- NHS Forth Valley
- NHS Highland
- NHS Lothian
- Pacific Care
- Renaissance Care
- Scottish Ambulance Service
- Scottish Care
- Scottish Social Services Council (SSSC)
- Social Work Scotland

Annex C – The value of meaningful activities and connections

Regional Manager at Sanctuary

"Our staff are Support Workers with a focus on activities rather than 'activity co-ordinators'."

When speaking to the Regional Manager, he told us that this name change has helped to change mentality and staff recognise the impact they have on everyone's care. The manager described how by taking this approach, not only are there better outcomes for individuals and staff, but it also contributed hugely to the required Health and Social Care Standards for Scotland.

There is a focus on getting residents out into the community where possible, instead of bringing the community into the care homes. An example of this is with hairdressers: in two care homes they have removed in-house hairdressers and take residents to the local barbers/ hairdressers instead.

They have activities that take place in the care homes but try to have the majority away from the care home. Staff are encouraged to take residents out for the day and go to performances and events that are on in the community which relate to individual hobbies and interests. They are keen to move away from chair exercises and keep residents active through other activities. Group activities and one-to-one activities have equal importance and staff constantly review the activities planner and check in with residents. They are keen to only have activities where they can evidence the impact it has had on residents and that there has been a meaningful outcome.

Activities team at Kincarrathie House, Perth

"It would be easy to make every day the same, but it would be detrimental to the wellbeing of our residents."

By varying the activities available to residents, staff at Kincarrathie House hope to reach out to more of their residents and meet their needs.

On arriving at Kincarrathie, a resident is met by an activity member to discuss what may be important and meaningful to them and what their interests may be.

The activities team continually endeavour to create good working relationships with residents' families so that they can get to know residents and tailor activities to meet personal needs and interests. This person-centred approach maximises the benefit to the resident, reassures their family, and motivates staff.

Once a year, they undertake a formal review of activities, involving all residents, and the results inform forward planning. There is a quarterly meeting with residents to review their preferences and lots of informal discussions where relatives are also invited to express their views.

Some activities are very popular with a larger number of residents (e.g. musical events, visiting the gardens, evening tea-time social events), but they also have special interest small groups which are very successful (knitting, French lessons, creative writing, drawing and painting, classical music). One-to-one activities are also arranged when possible. At the end of the session, teas, coffees, biscuits and fruit are served to residents, and staff generally chat to them as they socialise.

Activity co-ordinator at Parklands Care Home, Buckie

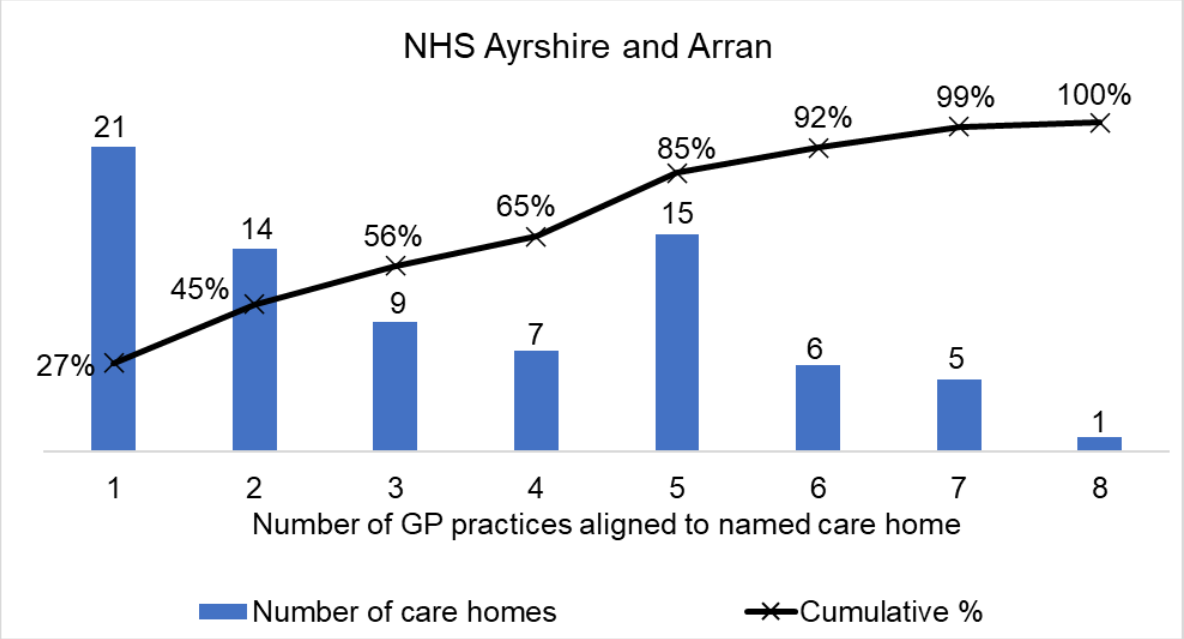
"When a resident moves into their care home, the only thing that should change is their address."

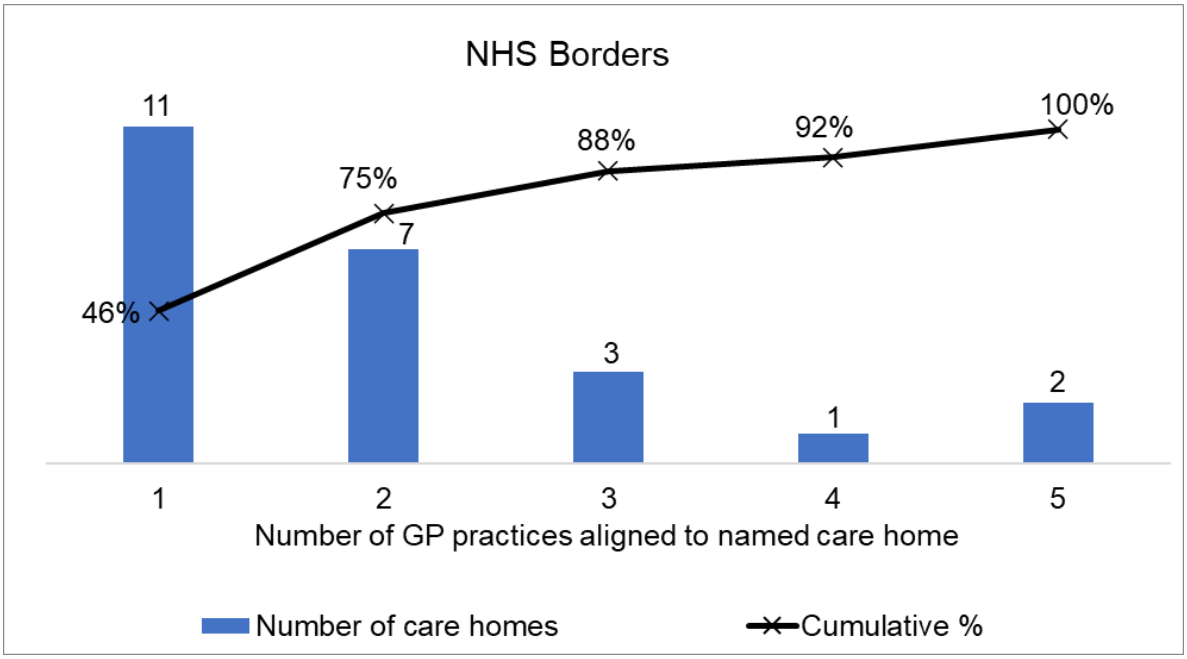
The activity co-ordinator works closely with residents, staff and families to make sure that each resident has a goal for the year, and they work together to help them achieve it. They also take this person-centred approach when creating their weekly activity planner, which takes into account the likes and dislikes of each resident. There is an effort made to not only have activities take place in the home, but also in the local community. Residents are encouraged to engage in activities, such as clubs, that they attended before moving into the care home.

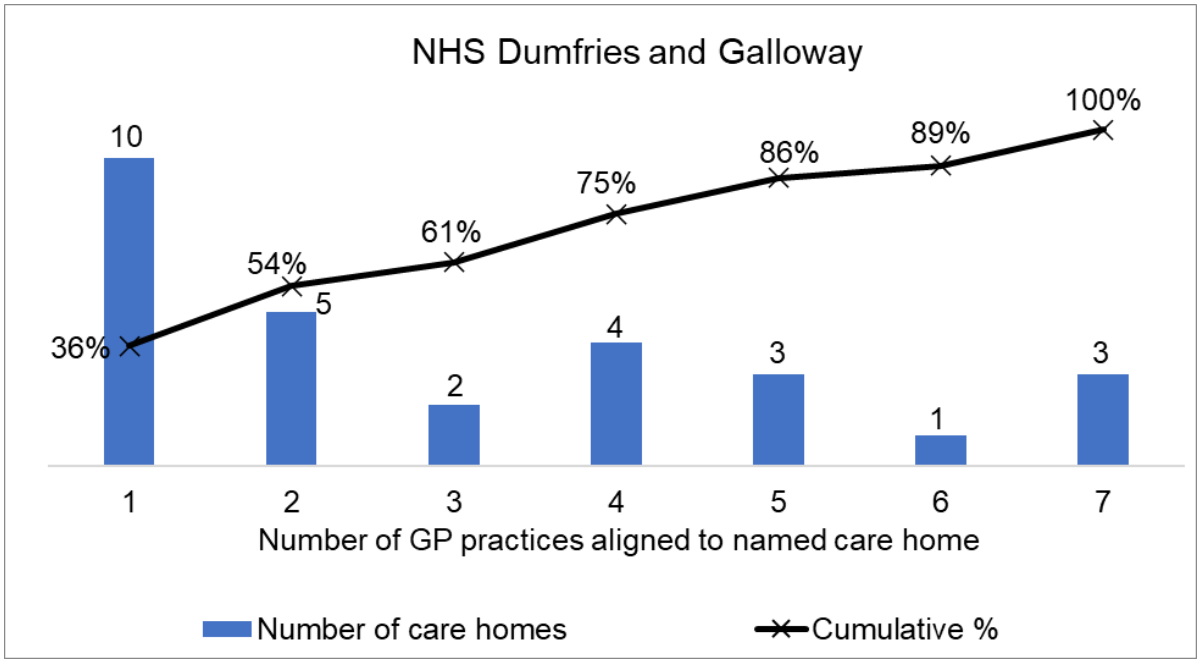
They told us about a lady who had baked a cake for her son's birthday every year and how this should not change now that she is in a care home. With the help of care home staff, she was able to continue this tradition and bake a cake for her son's 60th birthday.

The activity co-ordinator also has a close relationship with staff in the same role in other care homes and they use this network to engage with each other and share their experiences.

Annex D – NSS Data showing links between care homes and GP practices by Health Board






NHS Dumfries and Galloway
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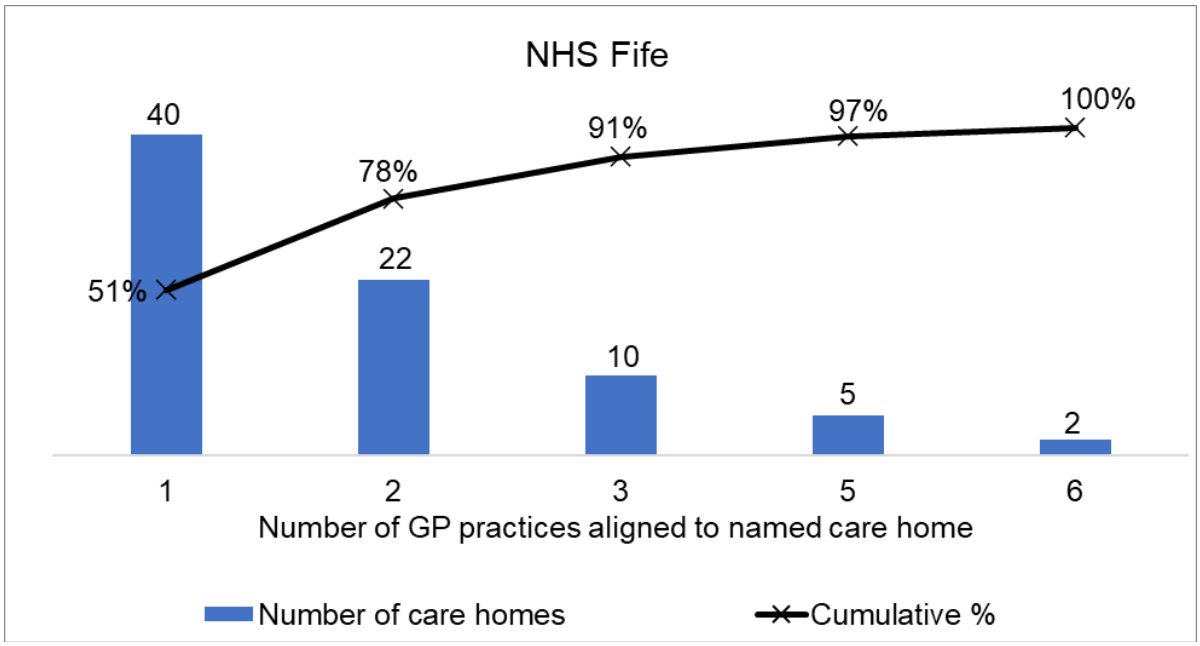
Number of GP practices aligned to named care home
Number of care homes
Cumulative %


NHS Fife
40
22
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5
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51%
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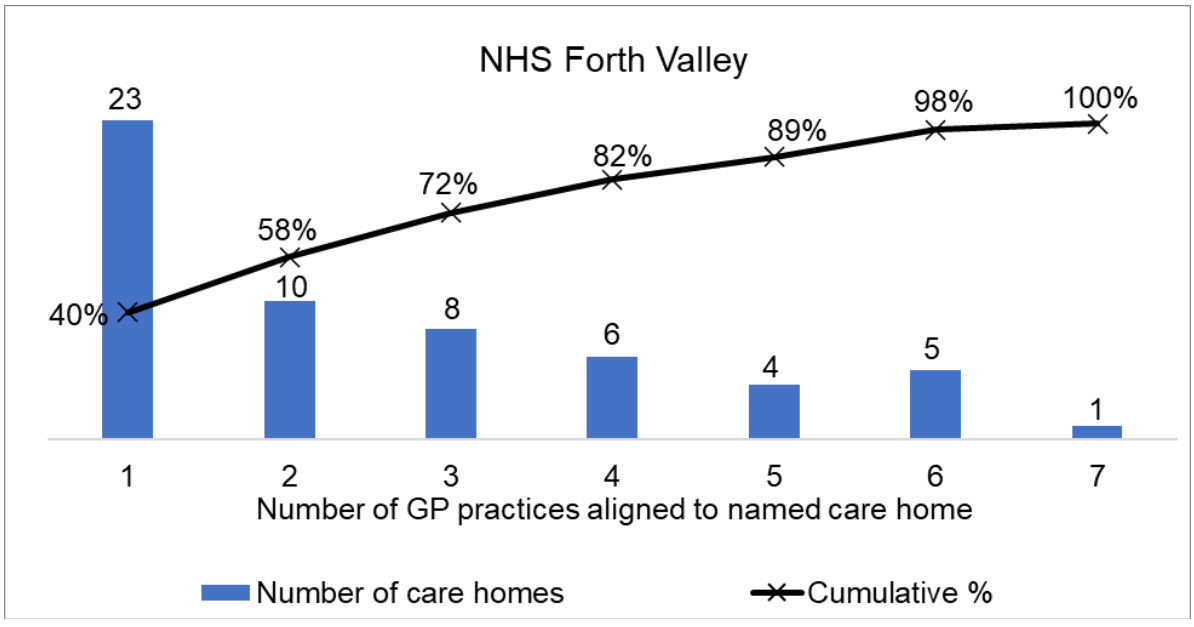
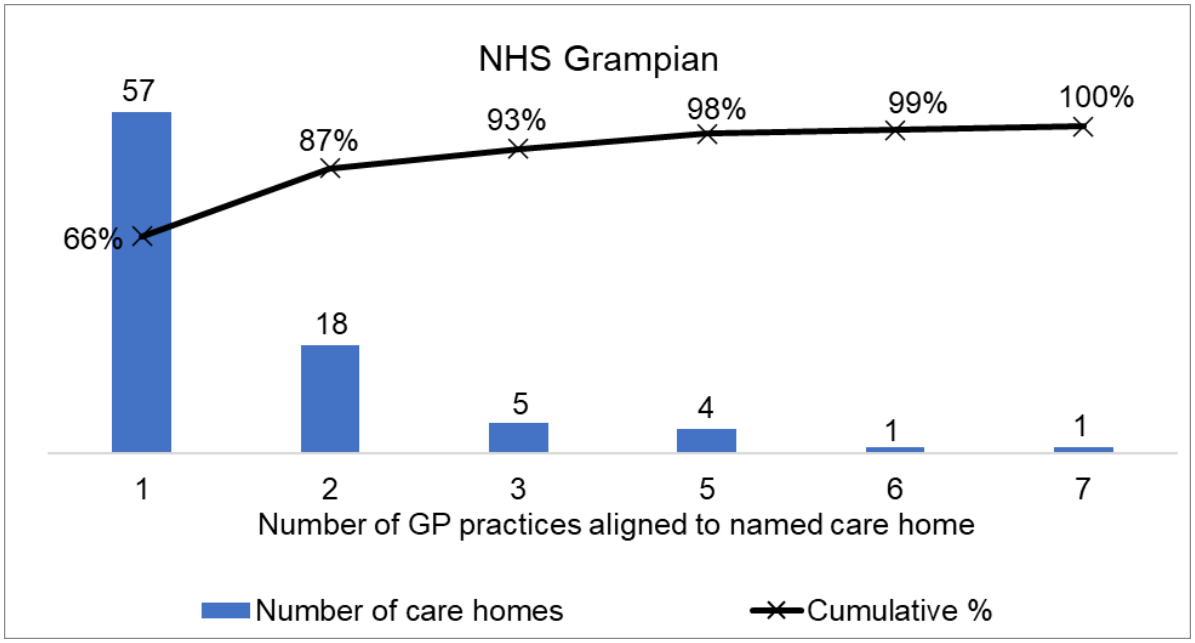
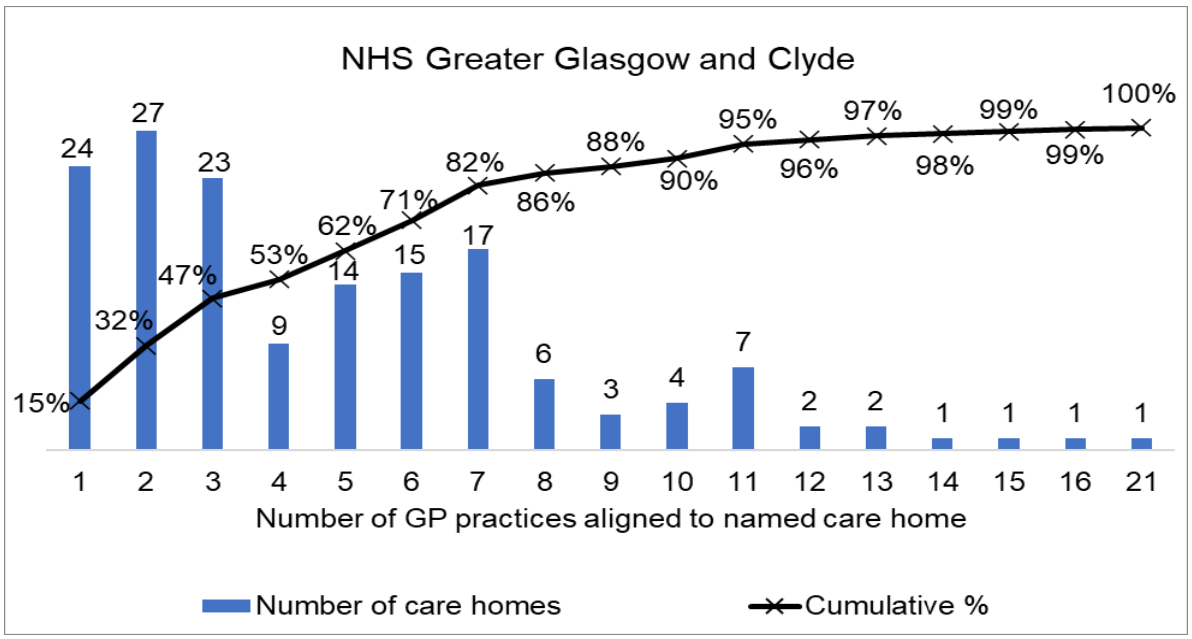
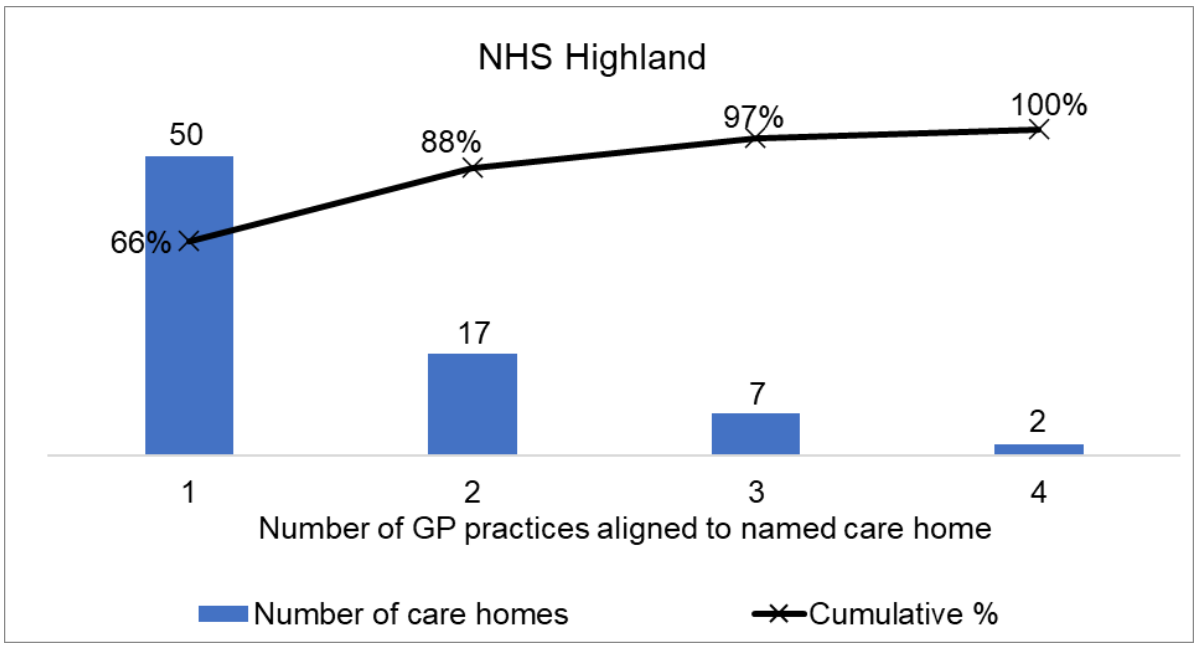
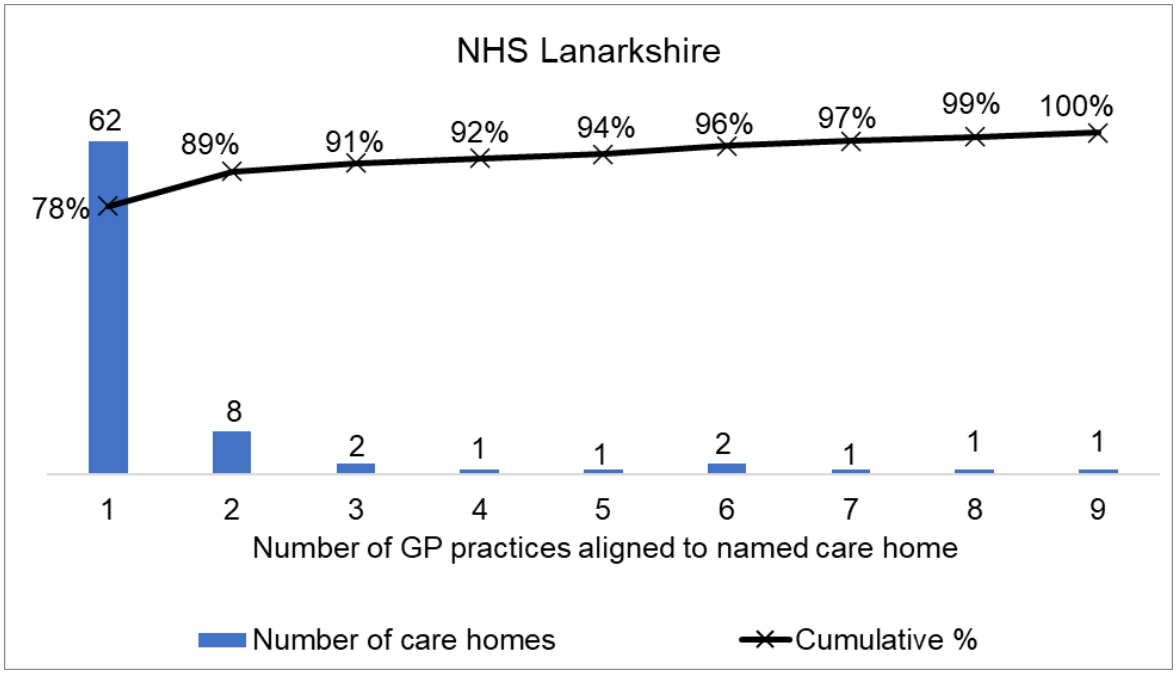
Number of GP practices aligned to named care home
Number of care homes
Cumulative %

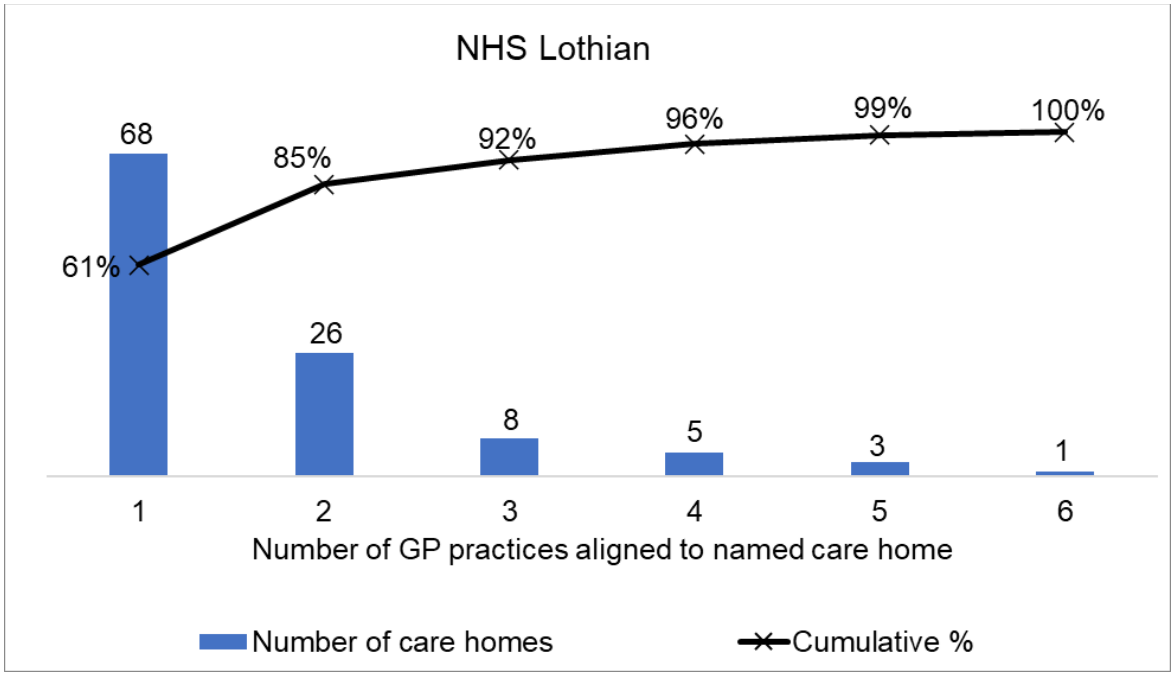

NHS Forth Valley
23
10
8
6
4
5
1
40%
58%
72%
82%
89%
98%
100%
1
2
3
4
5
6
7
Number of GP practices aligned to named care home
Number of care homes
Cumulative %

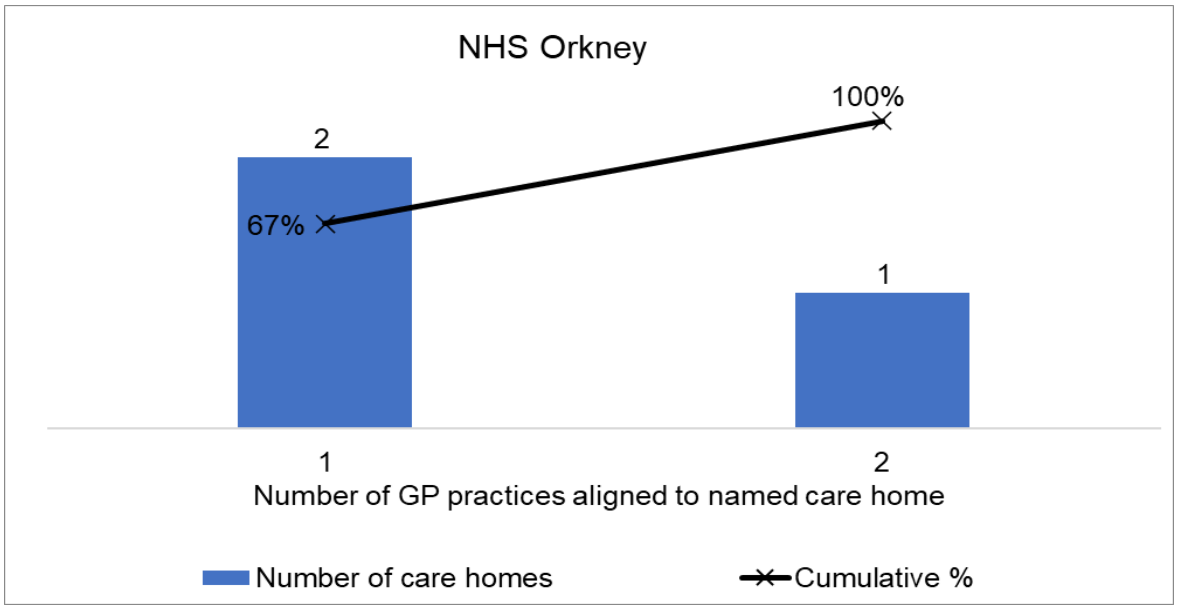

NHS Grampian
57
18
5
4
1
1
66%
87%
93%
98%
99%
100%
1
2
3
5
6
7
Number of GP practices aligned to named care home
Number of care homes
Cumulative %

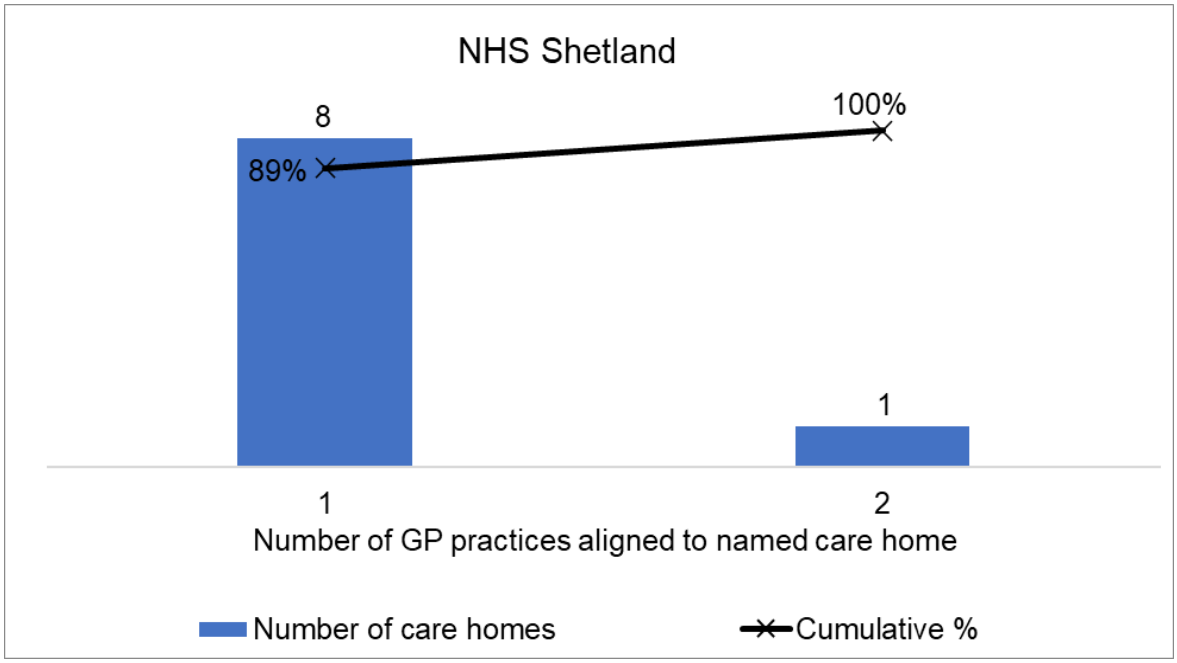

NHS Greater Glasgow and Clyde
24
27
23
9
14
15
17
6
3
4
7
2
2
1
1
1
1
15%
32%
47%
53%
62%
71%
82%
86%
88%
90%
95%
96%
97%
98%
99%
99%
100%
1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
21
Number of GP practices aligned to named care home
Number of care homes
Cumulative %

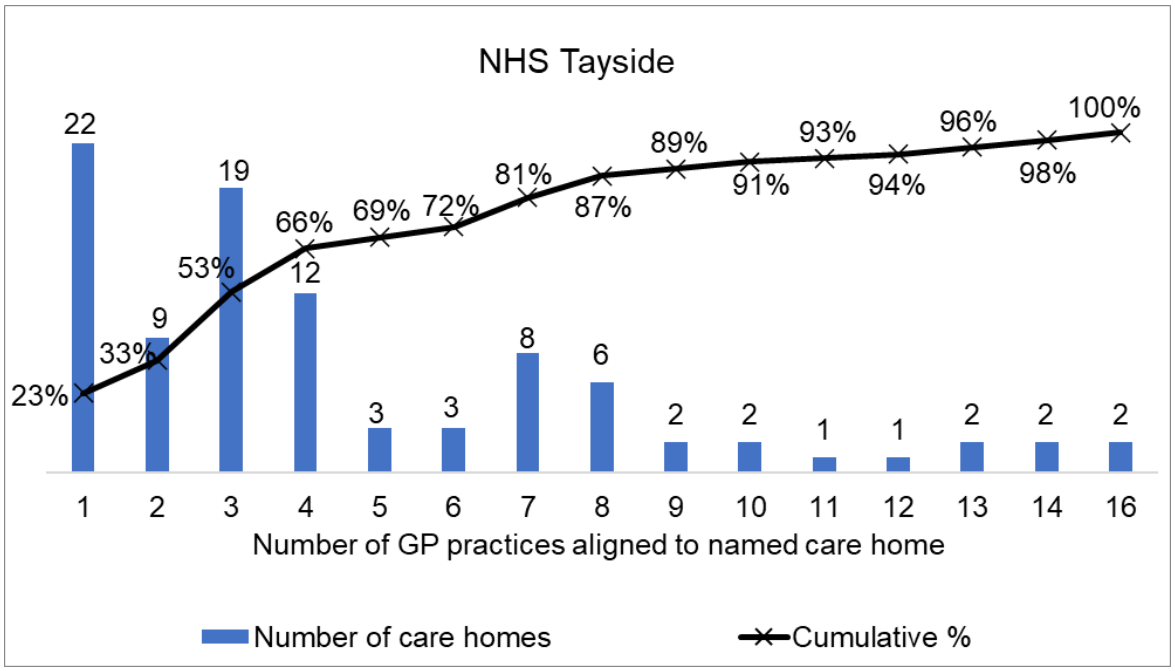

NHS Highland
50
17
7
2
66%
88%
97%
100%
1
2
3
4
Number of GP practices aligned to named care home
Number of care homes
Cumulative %

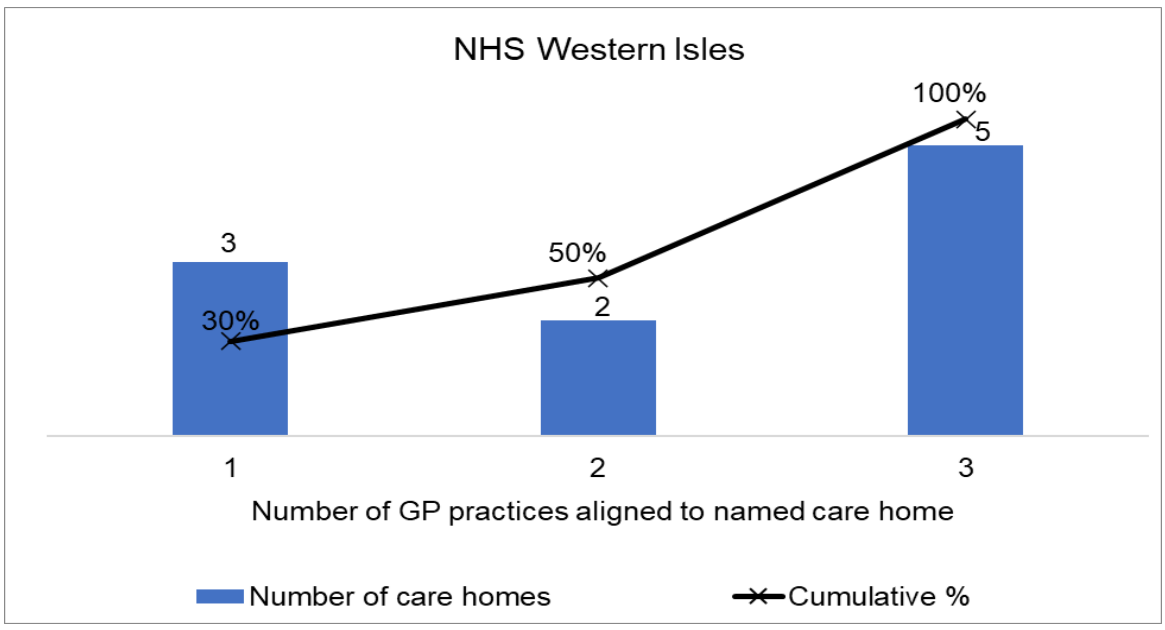

NHS Lanarkshire
62
8
2
1
1
2
1
1
1
78%
89%
91%
92%
94%
96%
97%
99%
100%
1
2
3
4
5
6
7
8
9
Number of GP practices aligned to named care home
Number of care homes
Cumulative %


NHS Lothian
68
26
8
5
3
1
61%
85%
92%
96%
99%
100%
1
2
3
4
5
6
Number of GP practices aligned to named care home
Number of care homes
Cumulative %


NHS Orkney
2
1
67%
100%
1
2
Number of GP practices aligned to named care home
Number of care homes
Cumulative %


NHS Shetland
8
89%
100%
1
1
2
Number of GP practices aligned to named care home
Number of care homes
Cumulative %


NHS Tayside
22
23%
9
33%
19
53%
12
66%
3
69%
3
72%
8
81%
6
87%
2
89%
2
91%
1
93%
1
94%
2
96%
2
98%
2
100%
1 2 3 4 5 6 7 8 9 10 11 12 13 14 16
Number of GP practices aligned to named care home
Number of care homes
Cumulative %


NHS Western Isles
3
30%
50%
2
100%
5
1
2
3
Number of GP practices aligned to named care home
Number of care homes
Cumulative %

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