Community-Led Care Project Business Plan 2025/26 to 2029/30

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Preface

Rural and remote communities in North Perthshire do not have the same equality of access to care at home services that are provided in large urban areas. Demographic trends mean that this situation continues to worsen. Local communities in Rannoch and Tummel, and Dunkeld and Birnam have come together to co-create an innovative approach to address this issue. This will see the establishment of a community-led charitable trust, which will act as the infrastructure body, providing care services within these communities through the local community-based development trusts. Each local trust will oversee local care co-ordination and integrate it with other vital social support services, to deliver a comprehensive range of community led health and wellbeing services.

An initial investment commitment of £356k over two years from Perth and Kinross Council and grant funding bodies will enable this vital community infrastructure asset to be up and running in 2025-26. This organisation will be the conduit to deliver these services across the communities with a social enterprise model which builds on the community assets. As part of this mixed economy approach, through commissioning arrangements with Perth and Kinross HSCP, the organisation will be delivering care at home services by 2026-27. With the achievement of adequate scale, it will then operate as a financially self-sustaining business for 2027-28, with minimal additional grant support.

This investment will deliver long-term, multiple benefits and outcomes for individual health and wellbeing, community resilience, community wealth building, employability, skills and training, and help to strengthen the rural economy. It will deliver directly against five Perth and Kinross HSCP Strategic Commissioning Plan priorities and outcomes for older people and help towards building Age Friendly Communities in remote, rural areas. This approach will provide a workable, scalable model that Perth and Kinross Council can expand to other rural and remote communities in and across Perthshire. In the words of a local GP:

"This is a unique opportunity for Perth and Kinross Council, the Health and Social Care Partnership, and the Joint Integration Board to show their forward-thinking project can lead Scotland into a new era care model benefitting rural communities and hospital services alike." *Dr Deborah Shann, GP Kinloch Rannoch*

1. Introduction

Across Scotland there is a pressing need in rural areas to provide equal access to care at home and other social care services, in particular for older and vulnerable people. Demographic trends mean the situation will deteriorate further unless addressed. In response to this, the Rannoch Community Trust and Dunkeld, Birnam and District Community Development Trust have collaborated to co-create an innovative community-led approach to providing a range of social care services for their localities. This approach draws strongly on the Boleskine Model, and the current Sunflower Homecare service model delivered by Highland Hospice but is unique in being established by and for the local community. The work has been funded by the Perth and Kinross Community Led Development Fund and supported by consultants SKS Scotland.

This innovative approach will deliver on the ambitions set out in the draft Perth & Kinross Strategic Commissioning Plan 2023-2026 and is adding to the growing national knowledge base and movement in relation to a more ethical, collaborative approach to the commissioning of social care services. It builds on a whole system approach, bringing together the statutory, independent, voluntary and community sectors.

The establishment of this community-led service will deliver a range of important outcomes for the communities of Rannoch and Tummel, and Dunkeld and Birnam in terms of health and wellbeing, employment and training, and community resilience. It is also anticipated that once established, other Perthshire communities struggling with similar issues, will join forces with these two existing communities, to enhance the scale and reach of this vital work.

2. Policy landscape

The national programme to reform adult social care was launched in 2019 but paused in early 2020 due to the COVID-19 pandemic. Following the Independent Review of Adult Social Care in 2021, the focus was on the creation of a National Care Service, which was due to be in place in 2029. As of January 2025, plans to create this service have changed. While a National Care Service Bill will still go ahead it will not include plans for a National Care Service as it stands (Third Force News, 27/1/25).

Alongside this, the Self-directed Support National Improvement Plan 2023-27 has been developed to make sure that work taking place to improve SDS is more coherent and better co-ordinated, through a partnership approach, with delivery partners across statutory, third and independent sectors. The plan specifically highlights the needs of rural, island and remote communities and the role of the third sector and care providers as two of the cross-cutting 'Golden Threads' that are fundamental to the full delivery of SDS.

The model proposed by Rannoch Community Trust and Dunkeld, Birnam and District Community Development Trust aligns strongly with these national policy ambitions. It provides a real world model of how to deliver these ambitions in the context of rural, remote communities, providing services that directly meet the needs and priorities of the local communities. It will provide an opportunity to place a Wellbeing Economy approach at the heart of these communities, creating a stronger economic structure and enabling greater resilience.

3. Community engagement, demand and needs assessment

Extensive research and engagement using a range of quantitative and qualitative methods was undertaken to understand the need and demand for a community-led service, and the community capacities to manage and deliver this service. This included:

- Desk-based research
- Semi-structured interviews with 24 key stakeholders and informants
- Two community surveys
- Community drop-in sessions and focus groups

The key findings from this work have highlighted the following:

3.1 Need and demand for care at home and other social care support services

- The populations of Rannoch and Tummel, and Dunkeld and Birnam are ageing, leading to an increasing demand for care at home services.
- 98%-100% of community survey respondents said 'yes' or 'maybe' to having the option of receiving care at home.
- There is a well-recognised level of unmet need for care at home services within the communities.
- NHS resources are being used to deliver tasks that could be undertaken by a care at home service.
- Hospital discharge is delayed due to a lack of care providers, impacting negatively on the health and wellbeing of hospital patients and those waiting to be admitted.
- People at end of life are not able to return home due to a lack of care providers.

3.2 Current provision of services

- Inequality of access to care at home services for the community of Rannoch and Tummel, and Dunkeld and Birnam.
- Enabling people to stay in their own homes benefits their health and wellbeing and quality of life.
- Informal care by family, friends and neighbours is vital in supporting and enabling local people to stay in their own homes.
- Relying on informal care is unsustainable going forward.

- Insufficient resources from PKC/HSCP to upskill and support personal assistants.
- Challenges exist for some individuals in managing their personal assistants through SDS Option 1.
- Provision of care at home services reduces the burden and costs for Perth and Kinross Council associated with moving people into nursing or residential care.
- Provision of care at home services can reduce pressure on hospital beds and care homes and ensure more efficient use of NHS resources.

3.3 Community-based activities and social support

- The community has a strong social support network through a wide range of activities and groups.
- Befriending plays a key role in supporting the health and wellbeing of local people.
- Volunteer run hospital transport services are essential in enabling local people to access hospital treatment in Perth, Dundee and Edinburgh.
- Strong interest in paid and voluntary roles as part of a new community-led service

3.4 Community assets: infrastructure, services, people

- Lack of access to services – both communities in the SIMD 10% most deprived category. Rannoch and Aberfeldy is the most access deprived data zone in Scotland.
- Both community trusts are very capable and forward-thinking, and working hard to secure a sustainable future for their communities.
- Volunteers are very active and capable, although there is a tendency to rely on the usual suspects.
- People across the two communities are interested in paid and voluntary work as part of the new community-led service.
- A co-ordinated network of health/social care services and other infrastructure, e.g. transport and housing, is vital to enable and ensure that local people can continue to live well in their community.

This in-depth research has clearly identified both a need and demand for care at home and other social care support services, along with a strong community desire and capacities to deliver this. In addition, discussions with key stakeholders from health and social care professionals, Perth and Kinross Council and Health Improvement Scotland, also provided strong support for the establishment of a new community-led service.

4. Proposed organisational model

Drawing strongly on the principles of the Boleskine model and the operation of Sunflower Homecare, the Rannoch Community Trust, in collaboration with Dunkeld, Birnam and District Community Development Trust, has developed a model for a community-led approach to delivering care at home services for Rannoch and Tummel, Dunkeld and Birnam, and other rural, remote communities in North Perthshire. This is a 'hub and spoke' approach, with a new community-led organisation acting as the core infrastructure body, providing central services to community-based development trusts, which oversee local care co-ordination and integrate with other community assets and services.

This model is capable of fitting into an alliance contracting model or standing alone within the HSCP's existing care at home commissioning arrangements. It also has the potential to grow as more community localities join in, whilst maintaining a single point of contracting with the HSCP. In effect, the model is creating a community-led alliance partnership for the HSCP to work with.

As a social enterprise, the organisation will have the opportunity to drive a mixed economy of income streams to support its financial sustainability, whilst also being able to build on local community assets.

5. Governance and management

The new organisation will be community-led and not for profit. Establishing the new organisation as a company limited by guarantee with charitable status is the preferred mechanism to deliver this.

A new Board will be recruited and established, responsible for the governance and strategic direction of the charity. To ensure local accountability and representation, the Members of the new charity will be the local development trusts i.e. the localities within which the social care support services are being provided. These Members will be represented on a Management Group, which reports to and is accountable to the Board for operational oversight and the effective delivery of care at home and other social care services in line with the needs of the local communities. Over time, as the organisation expands its geographical coverage, it is envisaged that new communities will come on board, who will also become Members and have representation on the Management Group.

Each Member will have a partnership agreement with the new organisation. This will set out how each will work in partnership to deliver social care support services within each community, their respective roles and responsibilities, and the terms and conditions under which each partner will deliver these. This structure will ensure that localities retain control over their own areas as they have best knowledge of needs, are best placed to respond quickly to changes in needs and can access local charitable funds to support local delivery. The new non-profit organisation exists to support local community development trusts in their aspirations, not to determine those aspirations.

The staffing structure will consist of a core team responsible for the daily management and delivery of the organisation. This will be operational in Year 1 (2025-26). It is anticipated that Care Workers will be recruited in Year 2 (2026-27), once a contract has been secured with Perth and Kinross Health and Social Care Partnership.

6. Financial summary

An initial five-year financial cash flow forecast has been prepared, as below, to indicate the financial implications of establishing and running this new community-led organisation and attendant service delivery. In Years 1 to 2, the organisation will comprise Rannoch Community Trust and Dunkeld, Birnam and District Community Development Trust. In Year 3, it is forecast that a further community Trust will join the organisation.

There will be an initial start-up period of 1 year, during which the organisation will deliver social support services including Befriending and Hospital Transport. Following in Year 2, it will also deliver homecare services as the organisation works towards financial sustainability for Year 3 onwards. With the achievement of adequate scale, it will operate as a self-sustaining business based on HSCP commissioned care at home services, private care fee income and grant funding to support other community-led activities.

	April 25/26	April 26/27	April 27/28	April 28/29	April 29/30
Opening Balance	£0	£0	£0	£0	£0
Revenue income, incl Grants *	£239,004	£482,663	£872,720	£873,358	£874,189
Revenue costs	£239,004	£482,663	£872,720	£873,358	£874,189
Balance	£0	£0	£0	£0	£0
***Grant Income**	£239,004	£117,123	£32,302	£32,941	£33,772

7. Outcomes

By establishing and delivering this new, innovative community-led approach, the new organisation will deliver a wide range of significant outcomes from the individual to the community and organisational levels. These will be secured by delivering a comprehensive range of community led health and wellbeing initiatives, including care at home services alongside Befriending, Hospital Transport and others:

7.1 For individuals

- People are able to continue to live independently in their own homes, in their local community.
- People experience an improvement in their health, wellbeing and quality of life.
- There is less need for people to move away from their community into residential or nursing care.
- Hospital discharge is timelier and frees up beds for others.
- People have the choice to have end of life care in their own homes.
- Local people have new opportunities for employment and training within their local communities.
- People are making an active contribution to their community.

7.2 For local communities

- Increased resilience through providing a range of local jobs, circa 39 jobs by Year 3, and training opportunities, encouraging people to stay living and working locally.
- Increased social connection and social capital.
- Sense of agency and achievement through delivering on key priorities within their Community Action Plans.

7.3 For Perth and Kinross Health and Social Care Partnership

Delivers directly against 5 Strategic Commissioning Plan strategic priorities

- Make it easier for people to get the help and support they need.
- Work with communities to design the health and social care supports they need.
- Target resources to where people and communities need help most.
- Provide health and social care support close to home.
- Improved Integrated Working.

Delivers directly against Strategic Commissioning Plan outcomes for older people

- People who provide unpaid care are supported to maintain or improve their quality of life and look after their own health and wellbeing.
- Older people are supported to maintain or improve their quality of life and look after their own health and wellbeing.
- Older People are supported to live actively and independently at home or in a community setting.
- Resources are used effectively and efficiently.
- Timelier discharge from hospital.
- Health & Social Care workforce feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.

And in addition:

- The HSCP delivers on its statutory obligations and commitment to ensuring equality of access to care at home services.
- Preventative cost savings through enabling people to live longer in their own homes.
- Cost savings through a reduction in the number and length of stays in or residential/nursing home accommodation.
- Reduction in the burden of use of NHS resources for delivery of tasks that can be undertaken by a care at home service.
- Increase in the resources are available within the system to provide vital social care support services, through collaboration with local community trusts.

7.4 For Perth and Kinross Council

- Aligns with and supports delivery of the revised Community Planning Partnership.
- Supports delivery of the draft PKC Economic Action Plan 2024-28 through the establishment of a community-led care enterprise.
- Increased number of micro-enterprises and self-employed individuals.
- Local communities delivering on key priorities within Community Action Plans.
- Increased community resilience and Community Wealth Building.
- Supporting creation of Age Friendly Communities in rural, remote areas.

8. Next steps

To ensure that this vital work can be taken forward in a timely manner, early agreement from the Integrated Joint Board, the HSCP, and Perth and Kinross Council, should be gained in relation to: (i) agreement in principle to the model; (ii) securing pump-priming funding for 3-5 years, to enable the establishment and early stage development of the organisation; and (iii) ensuring that the new community-led service can be commissioned in future years to deliver care at home services in these communities. In addition, timely applications to identified funding sources need to be made to provide match funding.

This Business Plan is intended to be a working document, which provides Rannoch Community Trust and Dunkeld, Birnam and District Community Development Trust with a strong foundation and case upon which to build. It can be used to further engage with local communities, key stakeholders and funders to continue to build support and secure funding to ensure the realisation of this vital, exciting and ambitious project.

1. Introduction

Across Scotland there is a pressing need in remote, rural areas to provide equal access to care at home and other social care services for older and vulnerable people. Care service delivery models designed for populated areas and based on purely market forces do not work where there is, as currently, insufficient resource in the system. Across Perth and Kinross approximately 40% of the population lives in villages and smaller settlements, primarily in rural, remote locations. This means that at present people living in these localities do not have equal access to the options which should be available to all. Demographic trends mean the situation will deteriorate further unless addressed.

The Perth and Kinross HSCP is acutely aware of this inequality of access and is committed to working with local communities to find new ways of working to address it (Perth & Kinross HSCP, Draft Strategic Commissioning Plan 2023-2026).

In response to this, the Rannoch Community Trust (RCT) secured funding from Perth and Kinross Council's Community Led Local Development Fund (CLLD) for a Community-Led Care Project. Initially, this project aimed to gain an in-depth understanding of, and develop agreed solutions to, the challenges of providing care and support to people in and around Rannoch and Tummel. In December 2023 SKS Scotland were commissioned by RCT to undertake this project, working in close partnership with RCT and Perth and Kinross Health and Social Care Partnership (PKC HSCP).

Following the success of the initial work undertaken in Rannoch and Tummel, and in recognition of the similar needs and challenges faced in other nearby rural communities, additional CCLD funding was agreed with Perth and Kinross Council to extend the project to include Dunkeld, Birnam and District, and to scope out other potential communities of need in North Perthshire.

Through extensive community engagement, stakeholder consultation, and research, this business plan has been developed, which identifies the need and demand for care at home and other social support services in Rannoch and Tummel, and Dunkeld, Birnam and District, and sets out:

Business plan aims

- An innovative, unique and scalable community-led approach to ensuring equality of access to care at home and other social care services for rural, remote communities in North Perthshire
- A clear governance and management structure for a new community-led organisation
- An implementation plan for the establishment and development of the new organisation
- A five-year financial plan and funding strategy

2.Development of business plan

This business plan has been prepared by SKS Scotland in partnership with Rannoch Community Trust and Dunkeld, Birnam and District Community Development Trust, and their respective communities. Diagram 1 summarises the methodology and delivery pathway for the project and development of the business plan. Through this process SKS conducted a comprehensive and flexible range of engagement opportunities to ensure that the process was community-led and co-designed, with opportunities for a wide range of other key stakeholders and informants to influence and understand the emerging approach. Throughout its development, there has been ongoing discussion and collaboration with PKC HSCP and PKC CLLD team.

In co-designing the model and infrastructure for the new community-led service, SKS and the two community trusts drew strongly the knowledge and expertise of Highland Hospice, and their Sunflower Homecare service, which provides care at home services to rural, remote localities through partnership agreements with local community trusts.

The aim of this business plan is to provide a clear, robust and well evidenced case for the funding, establishment and development of a sustainable, community-led service providing care at home and other social care services to rural, remote communities in North Perthshire.

This ambitious project has the potential to produce a step change in the delivery of vital social care services to these communities, and in so doing ensure the future health, wellbeing and resilience of individuals and their communities.

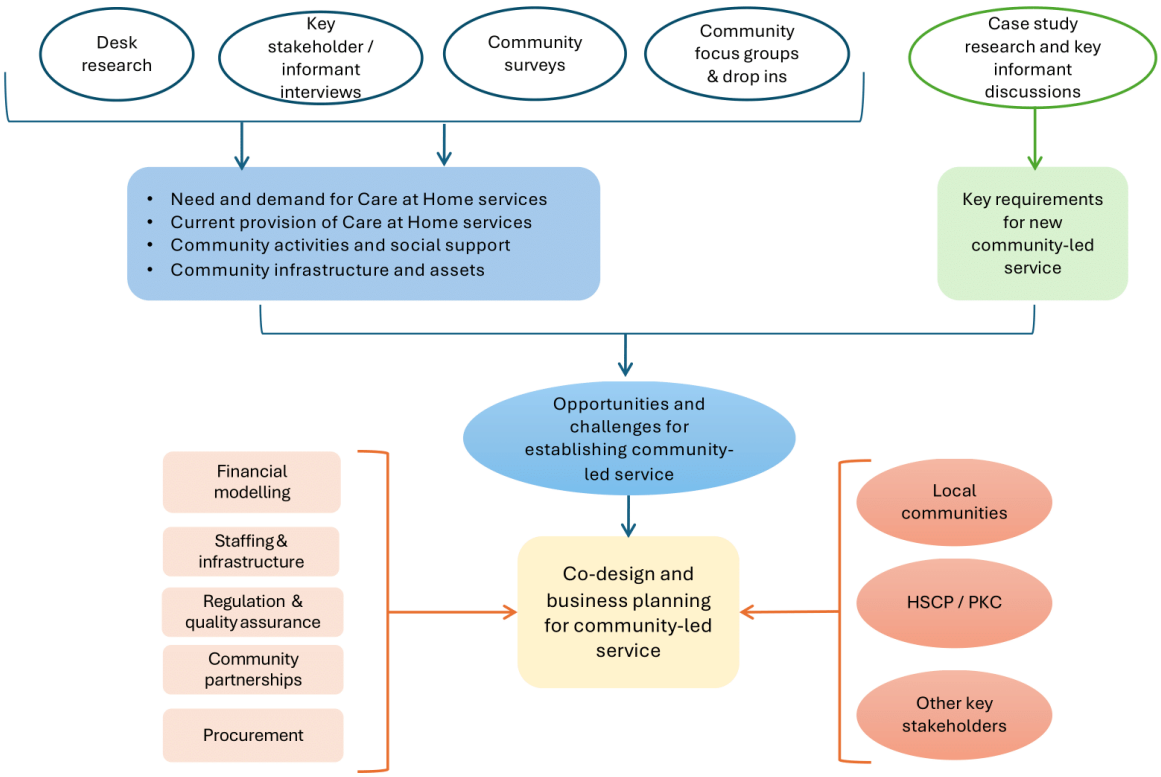


Diagram 1: Community Care Project Methodology and Delivery Pathway

In addition, a Communications Plan was developed and implemented, to raise awareness of the project within the local community, and to encourage and ensure active community participation throughout.

3. Strategic context and policy landscape

3.1 National policy landscape

Recent research indicates the critical state of social care provision across Scotland. The number of elderly people who died while waiting for social care in Scotland more than doubled over the past six years – the latest available data shows a death toll of 632 in 2022 (although this is based on information supplied by only half of local authorities, so is likely to be an underestimate). Scotland-wide, at the end of 2023, 5,056 people were awaiting initial assessment and 3,399 vulnerable individuals were waiting for their care to be provided. Figures for Perth and Kinross show that 246 adults are waiting for an assessment.
[source: The Times online, 10th January 2024]

Scottish Government

Health and Social Care Delivery Plan

The Health and Social Care Delivery Plan was published in December 2016, setting out actions for government and local health and care to better deliver patient care and support for people and better population health.

Reform of adult social care support and National Care Service

The Scottish Government focus is on "helping people to live independently, be active citizens who participate in and contribute to society and maintain their dignity and human rights. With COSLA and other partners we have announced a national programme of refer to better support people whether they live in a home, in a community setting, in a care home or in palliative care". This national programme to reform adult social care was launched in 2019, working with a range of people and stakeholders. The programme was paused in early 2020 to allow the social care sector to focus on responding to the COVID-19 pandemic. Following the Independent Review of Adult Social Care in 2021, the focus has been on the creation of a National Care Service for "the delivery of consistent and high standards in health and social care services." However, as at January 2025, plans for this new service have changed. While a National Care Service Bill will still go ahead it will not include plans for a National Care Service as it stands (Third Force News, 27/1/25). However, it is expected that the reform of adult social care will still focus on helping people to live independently and be active citizens who participate in and contribute to society and maintain their dignity and human rights.

Health and social care integration

The Public Bodies (Joint Working) (Scotland) Act 2014 sets the framework for integrating adult health and social care support. Integrated care leads to improvements in the quality and consistency of health and social care. There are 31 integration authorities in Scotland who are required to work with local communities and providers of care to ensure care is responsive to people's needs.

The Public Bodies (Joint Working) (National Health and Wellbeing Outcomes) (Scotland) Regulations 2014 require each integration authority to publish an annual performance report showing how they are improving the National Health and Wellbeing outcomes.

The Community Care and Health (Scotland) Act 2002 introduced free personal care for adults, regardless of income or whether they live at home or in residential care.

Adult Social Care - Self-directed Support

Self- directed support is the way social care is delivered in Scotland. For adults, children and families and carers, it runs through the plans for a National Care Service. The Self-directed Support National Improvement Plan 2023-2027 aims to support and enable people to achieve the outcomes that are important to them, to lead full and meaningful lives, and to participate in and contribute to the economy and society. This plan recognises the need for a whole-system approach to improving the delivery of SDS: delivery partners across

statutory, third and independent sectors all play an essential role in SDS improvement. Within the plan, the needs and the needs of rural, island and remote communities and the role of the third sector and care providers in SDS improvement are highlighted as two of the crossing-cutting 'Golden Threads' that are fundamental to the full delivery of SDS. The plan also identifies that there are large gaps in social care data in relation to unmet needs, and people's experiences and outcomes.

"Scotland has a wealth of social care data, but there still remains large gaps in our current knowledge, such as around unmet needs and people's experiences and outcomes, including the extent to which information about SDS options is made available, the extent to which eligible people receive the SDS option that they wanted, and whether that option met their outcomes."

Self-directed Support Statutory Guidance is used by HSCP/ Local authorities to interpret the Act.

Self-directed Support Standards, describe what "good Self-directed Support" looks like for local authorities.

Community Wealth Building

The Scottish Government has adopted this approach to economic development and to use it to support systematic challenges and structural inequalities within our communities, with the aim that communities can have a greater stake in, access and benefit from the wealth generated within their community. This creates local jobs, business growth, community owned assets and shorter supply chains, creating greater resilience and supporting net zero ambitions.

Developing Scotland's Economy: Increasing The Role of Inclusive and Democratic Business Models[1]

The role of social enterprise as a business model, within the development of the Scottish economy, creating a fairer society, building social impact and community resilience, is highlighted in this document.

Further enablers include:

- Health and social care standards (June 2017) setting out what people should expect when accessing care and support
- Digital health care strategy (April 2018) setting out how technology can support person-centred care
- Ministerial Strategic Group for Health and Community Care to direct transformational change in health and community care
- Investment of over £7.2 million in the Support in the Right Direction 2021 programme since October 2018 to deliver support across 31 local authority areas to help people and carers make informed decisions and plans for their care and support
- self-directed support implementation plan (June 2019) guiding local social care planning, delivery and actions for implementation.
- Support for independent living through the Independent Living Fund.

3.2 Perth & Kinross strategic landscape

Integration

As highlighted above in Section 3.1 all Health Boards and Local Authorities in Scotland have been required to establish integrated partnership arrangements. In Perth and Kinross, the local authority, including voluntary and independent service provider partners, and NHS Tayside, chose the body corporate model of integration which is the delegation of functions and resources by Health Boards and Local Authorities to an Integration Joint Board. The Chief Officer/Director, Integrated Health and Social Care for the Perth and Kinross Health and Social Care Partnership, and the Board oversee this delivery of integrated adult health and social care

[1] https://www.gov.scot/publications/developing-scotlands-economy-increasing-role-inclusive-democratic-business-models/pages/2/

services. An integrated budget has been established to support delivery of integrated health and social care functions.

Perth and Kinross Strategic Commissioning Plan

The 2020-25 Perth and Kinross Strategic Commissioning Plan was developed during 2019, pre-pandemic, prior to the Feeley Review and before the announcement of proposals for a National Care Service. As the landscape has changed markedly since 2019 and so much of what is now being delivered by the HSCP has been heavily influenced by the pandemic, the Strategic Commissioning Plan is now being revised and updated and result in a new three-year plan for 2023- 2026. The vision within this new draft plan is as follows:

"We want every person in Perth and Kinross to live in the place they call home with the people and things they love, in good health and with the care and support they need, in communities that look out for one another, doing the things that matter most to them."

This vision is underpinned by **seven strategic priorities**:

- Value our workforce, support them to keep well, learn and develop
- Make it easier for people to get the help and support they need
- Work with communities to design the health and social care supports they need
- Promote Self-management and Living Well
- Target resources to where people and communities need help most
- Provide health and social care support close to home
- Improved Integrated Working

Within this draft plan, the **outcomes for older people**, which is the key audience for this project, are as follows:

- People who provide unpaid care are supported to maintain or improve their quality of life and look after their own health and wellbeing.
- Older people are supported to maintain or improve their quality of life and look after their own health and wellbeing.
- Older People are supported to live actively and independently at home or in a community setting.
- Resources are used effectively and efficiently.
- People are safe from harm.
- Timelier discharge from hospital.
- Health & Social Care workforce feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.

In terms of the future delivery of care at home support, the draft plan identifies that:

"We will work with communities to develop bespoke care and support models of delivery, develop new models of rural service provision to develop a sustainable solution."

Alongside this, Perth & Kinross Integration Joint Board has an Older People Strategic Delivery Plan (March 2022) including App 1 P&K SCP Strategic Delivery Plan Older People 2022-2025. "The purpose of this report is to provide the IJB with an updated version of the Older People Strategic Delivery Plan for the period 2022-25. This updated version has taken into consideration the feedback from IJB members and also the guidance received from the Scottish Government for additional funding to Health and Social care Partnerships".

In addition, the Council has a Transformation and Change Strategy 2022/23-2027/28 which outlines: *"This strategy sets out the next chapter of transformation for us as a Council and the communities we serve. It begins the process of detailing how over the next five years, we will deliver an ambitious programme of transformation and change across the organisation. These changes will impact on our communities, our teams and how they deliver as we seek to respond to changing demands and resourcing levels."*

Networks and Communities

Age-Friendly Communities

An Age-friendly Community is somewhere where local people come together to make life better for the people who live there, particularly as they age. These places make it possible for people to continue to stay living in their homes, participate in the activities that they value, and contribute to their communities, for as long as possible. Being Age-friendly means designing services and facilities with older people, not for them. The Age-friendly Communities Framework was developed by the World Health Organisation (WHO). The WHO Age-friendly Communities Framework identifies eight essential features of an Age-friendly Community, illustrated in Figure 1, with older people clearly at the centre.

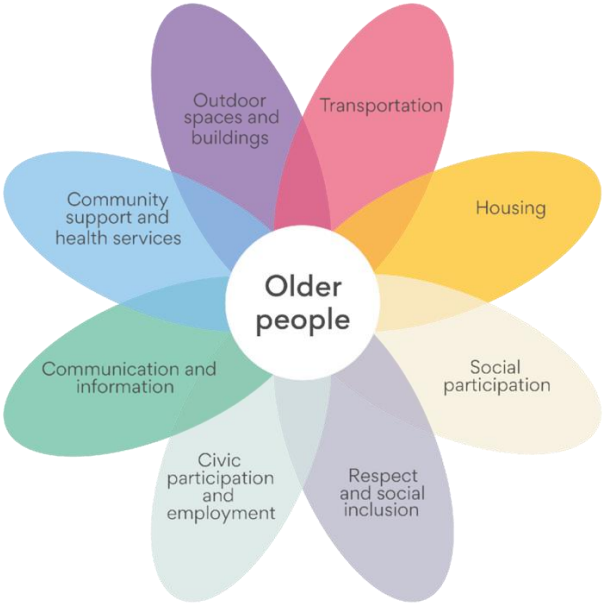


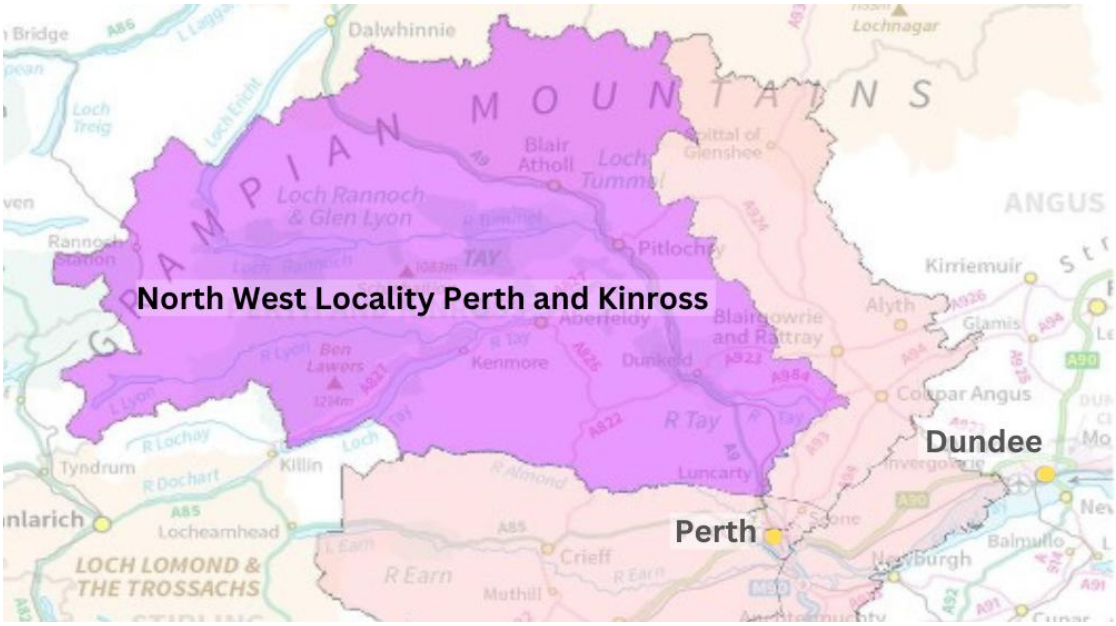
Figure 1: The elements of an Age Friendly Community (Source: Centre for Ageing)

Perth and Kinross Council has now joined this network. Network members pledge to develop and implement an Age Friendly Strategy for their locality.

4. Local context

4.1 Rannoch and Tummel

Rannoch and Tummel is a scenic and remote area of outstanding natural beauty in Perthshire, Scotland. It sits within the North West Locality area of Perth and Kinross Council (Map 1).



Map 1: North West Locality, Perth and Kinross Council

It is a remote, highland community, with a small population of approximately 750 people mainly living in two small villages, Kinloch Rannoch and Bridge of Gaur, and a number of even smaller villages spread across a large geographical area spanning Tummel Bridge in the east to Rannoch Station in the west, a distance of over 25 miles (Rannoch and Tummel Community Action Plan). For the purposes of this business plan, the area is defined by the boundary of the Rannoch and Tummel Community Council (Map 2).

Map 2: Rannoch & Tummel Community Council boundary

The rural location and terrain brings challenges to the local population. The Scottish Index of Multiple Deprivation (SIMD) identifies geographic access to services as the predominant issue for the area. This domain within the SIMD is the mean travel time (in minutes) to key services, by car or public transport.

The new draft Strategic Commissioning Plan for Perth and Kinross highlights that across Perth and Kinross, there are 37 data zones classed in the 10% most access deprived category in Scotland, with Rannoch and Aberfeldy judged to be the most access deprived data zone in the whole of Scotland (Perth & Kinross Health and Social Care Partnership, Draft Strategic Commissioning Plan, 2023-26).

Map 3: Extract from Scottish Indices of Multiple Deprivation Rannoch and Tummel area

Data provided by the Aberfeldy and Kinloch Rannoch Medical Practice identifies that the area has significant ageing population, with people aged 55 and over make up 51% of the Practice's current 624 patients (Table 1).

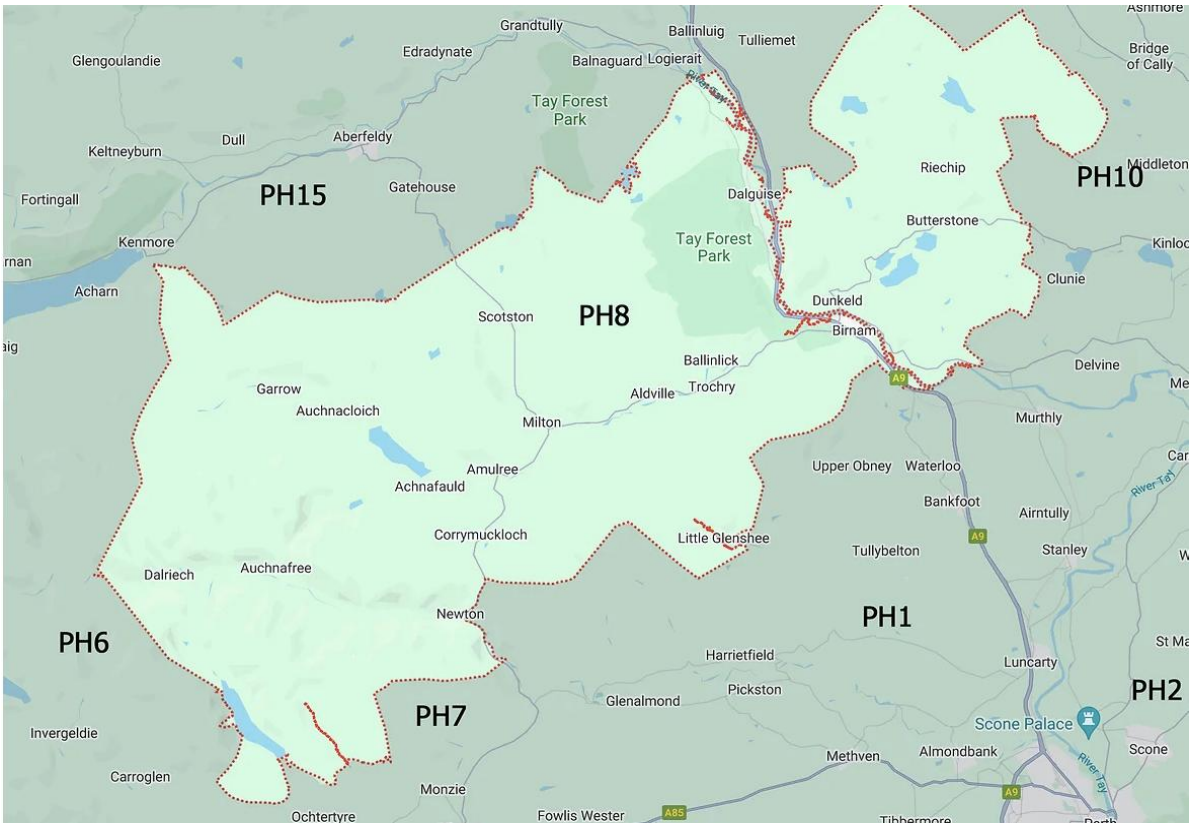
Age	0-4	5-14	15-24	25-34	35-44	45-54	55-64	65-74	75-84	85-99	Total
Female	3	21	26	34	28	36	69	51	39	8	315
Male	7	13	27	39	38	40	53	49	39	4	309
Total as %	2%	5%	8%	12%	11%	12%	20%	16%	13%	2%	100%

Table: Patient Age Sex Distribution for Kinloch Rannoch Medical Practice @ February 2024 (Source: Rannoch Medical Centre)

Formed in 2016, the Rannoch Community Trust (RCT) is working to deliver a sustainable future and positive outlook for the community focusing on community development, community support, recreational activities, environmental projects and advancement of the arts, heritage, culture or science. As an isolated, rural locality, with an ageing population and a lack of care service provisions in the village and surrounding area, the Trust's Community Development Plan (2016) identifies ***"Support, socialisation and mobility for older residents"*** as a key priority (see Sections 5.3 and 5.4 for more information).

4.2 Dunkeld and Birnam

Dunkeld, Birnam and District is a largely rural area that covers the PH8 postcode within Perth and Kinross (Map 4). It has a population of 2,416 with the majority (1,400) concentrated in Dunkeld & Birnam (PH8 Community Action Plan 2022-27). Outlying villages include Amulree, Butterstone, Dalguise, Inver and Trochry plus several other smaller settlements all connected as a community through the shops, businesses and services located in and around the main population concentration in Dunkeld & Birnam.



Map 4: Area of Perth and Kinross covered by Dunkeld, Birnam and District

The over 75 age range accounts for 11.1% of the population, compared with 6.4% for the whole Perth and Kinross Council area. The Scottish Index of Multiple Deprivation (SIMD) identifies geographic access to services is also the predominant issue for the Dunkeld and Birnam area (Map 5). Whilst not as remote as Rannoch and Tummel, Rannoch area, it is again within the 10% most access deprived category in Scotland.

Map 5: Extract from Scottish Indices of Multiple Deprivation Dunkeld and Birnam area

Data provided by the Craigvinean Medical Practice identifies that people aged 55 and over make up over 42% of the Practice's current 4,305 patients (Table 2).

Age	0-4	5-14	15-24	25-34	35-44	45-54	55-64	65-74	75-84	85-99	Total
Female	82	171	239	229	247	297	371	294	215	81	2,226
Male	92	197	189	226	237	273	329	282	195	59	2,079
Total as %	4%	8.5%	10%	10.5%	11%	13.5%	16.5%	13%	9.5%	3.5%	100%

Table 2: Patient Age Sex Distribution for Craigvinean Medical Practice @ August 2024 (Source: Craigvinean Medical Practice)

The Dunkeld, Birnam and District Community Development Trust was officially formed in November 2022 as a means of taking forward the initiatives highlighted in the Community Action Plan 2022-2027. The Trust is a charitable organisation which is owned and managed by the local community in Dunkeld, Birnam and District. Its work is centred around core themes, all stemming from the community action plan.

The Trust's Care Group emerged out of the PH8 Community Action Plan which clearly identified Care provision in PH8 as an area of concern. The community is very active in providing a wide range of activities and services to support the health and wellbeing of its residents (See Sections 5.3 and 5.4 for more information). The Care Group successfully applied for funding for a Project to demonstrate that a local Care Coordinator could more effectively tap into and promote the roles of Personal Assistant and Befriender.

4.3 Other localities

Through this research, it was identified that a number of other rural communities across North Perthshire are also struggling in relation to the provision of care at home, other social care services, and wider infrastructure services e.g. transport.

Discussions were had with the **Aberfeldy Development Trust** about their engagement in this project. Whilst the issue of social care is of concern to the Trust, at this early stage in the Trust's development, it is focusing on the provision of affordable housing as its main priority. Alongside this, during 2024, the Trust is undertaking a community consultation to inform the development of a Community Action Plan, which will identify other priority actions for the future. However, the Trust is keen to stay abreast of developments in the project and there may be opportunities to revisit their involvement in 2025/26.

PKC HSCP also highlighted a number of communities where they currently provide little or no care at home support, including **Blair Atholl, Fearnan and Glen Lyon**. Initial discussions with these communities, highlighted the following:

- **Blair Atholl** - very limited provision through the privately commissioned provider (Stuart Wright Ltd.) and a strong reliance on informal care from family, friends and neighbours. In addition, the community runs a volunteer hospital transport service, where clients pay fuel costs to their volunteer drivers.
- **Fearnan** – limited privately commissioned care. 20 minute trip from Aberfeldy, so it's problematic if multiple visits are needed each day. Some people have had to move away to residential/nursing care in Pitlochry. The Fearnan Village Association produces a leaflet 'Staying Connected', which has local people's contact details along with what they can help out with e.g. shopping etc. They would benefit from someone in a co-ordinating role to help maximise the support that people are willing to give.

Research into other areas is currently ongoing. The emerging community-based model for social care provision (Section 7) can enable other communities to become involved in the future, as Members of the newly formed organisation. In some areas where there is no community development trust, but the area is geographically adjacent to Rannoch and Tummel or Dunkeld and Birnam it may be possible over time to provide care at home services to this wider area.

5.Market Research and Analysis

A variety of methodologies were used to understand the potential market for a community-led service, and community capacities to manage and deliver this service.

- Desk-based research
- Semi-structured interviews with key stakeholders and informants
- Community surveys
- Community drop-in sessions and focus groups

This work is summarised below in Sections 5.1 to 5.4, with full details provided in Appendix 1. Further supplementary evidence and information is provided at Appendix 2 (Key stakeholders/informants and interview summaries), Appendix 3 (Rannoch and Tummel Community Survey, Drop-in event, Craft Group and Focus Group), and Appendix 4 (Dunkeld and Birnam Community Survey).

5.1 Need and demand for care at home services

This section summarises data on the need and demand for care at home services in the North Locality, particularly in Rannoch and Tummel, and Dunkeld, Birnam and District. The findings highlight the challenges these areas face in meeting the health and social care needs of people aged 60 and older.

Key findings

- The populations of both communities are ageing, leading to an increasing demand for care at home.
- 98-100% of survey respondents said 'yes' or 'maybe' to having the option of receiving care at home.
- The 65+ age group faces a number of health issues and conditions.
- There is a well recognised level of unmet need for care at home services within the communities.
- Informal care by family, friends and neighbours is vital in supporting and enabling local people to stay in their own homes.
- NHS resources are being used to deliver tasks that could be undertaken by a care at home service.
- Hospital discharge is delayed due to a lack of care providers, impacting negatively on the health and wellbeing of hospital patients and those waiting to be admitted.
- People at end of life are not able to return home due to a lack of care providers.
- The need to develop a solution for the provision of care at home services in rural communities in North Perthshire is well understood and welcomed.

Perth & Kinross North Locality

Joint Strategic Needs Assessment - Perth and Kinross North Locality Area

A number of current and future challenges in meeting the needs of these communities have been identified:

- **Ageing population**
- **Greater demand for older peoples' services**
- **Limited local health and support services for local people**
- **Workforce supply across the North Locality**
- **Accessing services due to poor transport links and/or long travel times to Perth or Dundee**
- **Pressures on housing supply (for workers and older people)**
- **High settlement dependency ratios**

Rannoch & Tummel

Increasing need and demand

The community and key stakeholders are very aware that the demand for care at home services will rise, with some residents expressing concerns about needing to leave the area due to a lack of reliable care options. The value and importance of enabling people to stay in their own homes was highlighted repeatedly.

Unmet need

The unmet need for care is significant, with issues such as patients waiting in hospitals for care packages and hidden unmet needs where people rely on informal care or are too proud to seek help.

"It's a nightmare for anyone with no family in the community when they come out of hospital." Local community member, Rannoch & Tummel

"People are fearful and too proud to ask for assessment support…they'd rather die than be assessed and have the risk of being removed." GP Aberfeldy & Rannoch Medical Practice

Inefficient use of NHS resources

Community nurses are often used inefficiently for simple tasks, and the lack of care services in the North Locality affects hospital discharges and end-of-life care.

"You have Community Nurses doing what carers could do." Aberfeldy & Kinloch Rannoch Medical Practice staff

Support for a new community-led service

There is strong support for a new community-led care at home service, though concerns remain about the effectiveness of past discussions with Perth and Kinross Council.

"Have a community-led care at home team would be so beneficial. Supporting people to stay at home is our goal, and is a critical aspect of prolonging life." North Locality Social Work Team, PKC HSCP

Dunkeld and Birnam

The picture is similar in Dunkeld and Birnam. Hospital discharges, particularly for palliative care, are frequently delayed, and some residents are reluctant to seek the care they need, which raises concerns for local health professionals.

"A lot of people don't want others to know their business, especially the older generation" District Nurse, Dunked and Birnam

"We can't facilitate getting people home at end of life, which is their wish and it's really sad if we can't achieve this." District Nurse, Dunkeld and Birnam

5.2 Current provision of care at home services

This section summarises data on the current provision of care at home services in Rannoch and Tummel, and Dunkeld, Birnam and District, highlighting significant inequalities in access to these services. It indicates that Perth and Kinross Council has not met its statutory duty to provide all care options, leading to a reliance on the local community for formal and informal care solutions.

Key findings

- Inequality of access to care at home services for both communities.
- Enabling people to stay in their own homes benefits their health and wellbeing and quality of life.
- Informal care by family, friends and neighbours is vital.
- Relying on informal care is unsustainable going forward.
- Reliance on Rannoch Community Trust's Health and Wellbeing Co-ordinator to identify care at home needs, recruit and support personal assistants.
- Insufficient resources from PKC/HSCP to upskill and support personal assistants.
- Reliance on recruitment of local people to become personal assistants in their community.
- Challenges exist for some individuals in managing their personal assistants through SDS Option 1.
- Reduces the burden and costs for Perth and Kinross Council associated with moving people into nursing or residential care.
- Reduces pressure on hospital beds and care homes and ensure more efficient use of NHS resources.

Current provision of care at home services: Perth and Kinross North Locality

Self-Directed Support

As for all local authorities, Perth and Kinross Council has a statutory responsibility to provide care at home services to its communities. Self-Directed Support (SDS) is the process whereby an individual plans their care in conjunction with the local council. Councils have a legal duty to offer 4 options to people who have been assessed as needing a community care service. These options for SDS are as follows:

- Option 1: A direct payment, which is to a person or third party to purchase their own support.
- Option 2: The person directs the available support i.e. the person chooses how the budget is used, but the money is managed by someone else.
- Option 3: The local council arranges the support.
- Option 4: A mix of the above.

An individual may not be eligible for all of these 4 options.

The HSCP recognises the challenge in SDS provision in its rural communities, such as Rannoch and Tummel, and Dunkeld and Birnam:

"We have gaps in provision in our most rural areas. It is financially unsustainable for our commissioned providers to deliver a small number of packages within small, remote, and rural areas. This causes an issue for us – it means that we are unable to offer all Self-Directed Support Options in all areas of Perth and Kinross and has led to health inequalities." Strategic Commissioning Plan (Perth and Kinross HSCP, March 2024)

Table 3 shows the number of weekly hours of care provided to individuals across settlements in North West Perthshire under different SDS Options.

SDS Option	Weekly hours of care provision
Option 1	1007
Option 2	417
Rural Option 3	434

Table 3: Weekly hours of care under different SDS Options for North West Perthshire @March 2024 (Source: Perth & Kinross HSCP)

Table 4 shows the care at home hourly rate at March 2024. It should be noted that all provision within North West Perthshire is deemed to be Rural. However, unlike in the NHS Highland region, there is no rural and remote rate in Perth and Kinross.

Care at Home timing and location	Hourly care at home rate
Urban weekday	£24.17
Urban weekend	£25.45
Rural weekday	£26.34
Rural weekend	£27.70

Table 4: Care at home rates @July 2024 (Source: Perth & Kinross HSCP)

On average, care packages range from 14 hours a week to 20 hours per week. The HSCP's rural and very rural packages also include travel time as agreed with some providers, so overall an average of approximately 14-40 hours per week, depending on complexity of provision.

HART (Home Assessment Recovery Team)

This reablement service provided by Perth and Kinross HSCP provides personal care and support to people who, because of illness or disability, require intensive support to remain in their own homes or return home from hospital. However, the capacity of this service does not meet the current demand, and once the period of support from HART comes to an end, it can be challenging to find care support for those who still need it.

Support Choices

Support Choices provide free and independent information and advice about getting social care and community support in Perth and Kinross.

Value and importance of local care provision

Across interviews with all key stakeholders/informants, the value and importance of enabling people to stay in their own homes was identified in relation to several different elements:

- **Health and wellbeing:** Enabling people to stay living in their own homes benefits their health and quality of life
- **Significant cost saving to Perth and Kinross Council** by enabling people to stay at home, rather than being moved to residential or nursing care.
- **Hospital discharge:** Care at home services can help to speed up discharge from hospital.

Current provision of care at home services: Rannoch & Tummel

Inequality of access

Option 3 has not been available to individuals in Rannoch and Tummel for many years, so this community does not have the same options for access to services compared to those living in other parts of Perth and Kinross. Diagram 2 show the referral pathways that are currently available to individuals living in Rannoch and Tummel (this scenario is also applicable to individuals in Dunkeld and Birnam, and other rural, remote villages in North Perthshire).

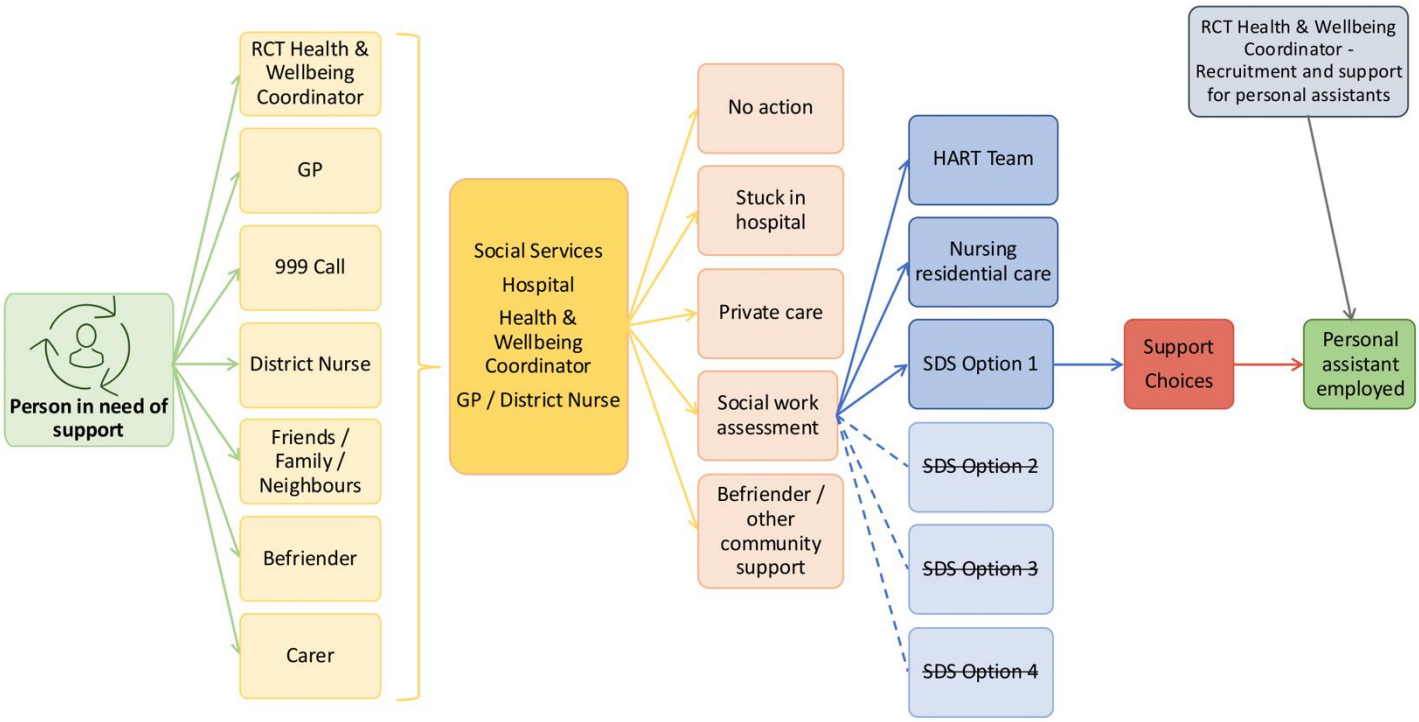


Diagram 2: Indicative schematic of referral pathways for members of Rannoch & Tummel community

Crucial role of Health & Wellbeing Co-ordinator

Rannoch Community Trust employs a Health and Wellbeing Co-ordinator, an 8 hours a week post. They play a pivotal role in ensuring that those in need of care are connected to the sources of help.

Personal Assistants

As local people are only able to access Option 1 of the Self Directed Support, the Health and Wellbeing Co-ordinator finds personal assistants for anyone who needs support. Identifying those in the community in need of this support is primarily done by word of mouth. Personal Assistants are self-employed, and therefore require a PVG (Protecting Vulnerable Groups) check and take out public liability insurance at a total cost of £144. These personal assistants do not receive formal training.

Table 5 shows the current hours and type of care (personal/non personal) for those receiving care under Option 1 in Rannoch and Tummel area. Personal care covers activities including help with washing, dressing, meals, and medication. Non personal care covers social support activities and can include respite care.

Client	Type and hours of care per week
Over 65 – receiving care since 2016	17.5 hours personal care
Over 65 – receiving care since 2022	8.5 hours personal care
Under 65 – receiving care since 2018	15.5 hours personal care and 8 hours non personal care
Learning Disability client – receiving care since 2017	2 hours personal care and 34 hours non personal care

Table 5: Type and hours of care per week for SDS Option 1 clients in Rannoch & Tummel (source: Perth and Kinross Council @October 2024)

Reliance on informal care

There is a great deal of reliance on informal care within the community and a recognition that this is not sustainable in the short or longer term.

"This neighbourly service [of informal care] is not sustainable. What happens when the neighbour falls ill? Then you have two people who are affected." North Locality Social Work Team, Perth & Kinross HSCP

Challenge for Option 1 recipients as employers

As Option 1 SDS support requires individuals to become employers, this can be a considerable challenge for those individuals and off-putting to others, although Support Choices is available to provide support.

Lack of transport infrastructure

The transport links to Pitlochry and Aberfeldy is very limited, so individuals become cut off from their friends and neighbours if they have to move.

Current provision of care at home services: Dunkeld and Birnam

The findings in relation to Dunkeld and Birnam serve to reinforce the issues in relation to need and demand identified for Rannoch and Tummel.

Inequality of access

As in the case of Rannoch and Tummel only Option 1 is available under SDS. Table 6 shows the current hours and type of care (personal/non personal) for those receiving care under Option 1 in Dunkeld and Birnam.

Client	Type and hours of care per week
Dunkeld	
Over 65 – receiving care since 2024	17.5 hours personal care
Over 65 – receiving care since 2023	15.5 hours personal care
Over 65 – receiving care since 2023	3.5 hours personal care and 11.5 hours respite funding
Carer respite – since 2023	2 hours personal care and 2 hours non personal care
Under 65 – receiving care since 2023	35 hours personal care
Over 65 – receiving care since 2024	10 hours personal care
Over 65 – receiving care since 2018	7 hours personal care
Over 65 – receiving care since 2024	14 hours personal care
Birnam	
Over 65 – receiving care since 2023	24.5 hours personal care
Over 65 – receiving care since 2024	15.75 hours personal care
Over 65 – receiving care since 2023	14 hours personal care and 8 hours non personal care
Over 65 – receiving care since 2023	12 hours personal care

Table 6: Type and hours of care per week for SDS Option 1 clients in Dunkeld & Birnam (source: Perth and Kinross Council @October 2024)

Project Co-ordinator – Care at Home and Befriending

The Dunkeld, Birnam and District Community Development Trust recruit and support Befrienders and Personal Assistants. This role involves mentoring and support for Personal Assistants, including the provision of funds for PVG checks where necessary, and providing their first year's insurance and signposting/funding of basic training.

Reliance on informal care

There is a great deal of informal care within the community, which is not sustainable going forward.

"Carer fatigue is the main problem. They can sustain it for a certain length and then they can't do it anymore…it takes over their life, and many are elderly too." Local GP Dunkeld & Birnam

Challenge for Option 1 recipients as employers

The challenges around recruiting and employing mirror those in Rannoch.

5.3 Community-based activities and social support

Community-led services playing a vital role in supporting the health and wellbeing of local people.

Key findings

- The community has a strong social support network through a wide range of activities and groups.
- Befriending plays a key role in supporting the health and wellbeing of local people.
- There is limited NHS hospital transport, the community's voluntary hospital transport service is essential.
- Volunteers are very active and capable, although there is a tendency to rely on the usual suspects.
- Strong interest in paid and voluntary roles as part of a new community-led service

Rannoch and Tummel

The following community-led services are provided:

- Befriending Service
- Hospital Transport Service
- Local groups and activities

"I have only discovered support and befriending schemes recently and they assist me get my prescriptions and will enable contact with others." Local community member, Rannoch & Tummel

"It is good to have a regular event in the week, to orientate you to time. If I didn't have this group to look forward to, I would become lonely, and probably make less and less effort." Local community member, Rannoch & Tummel

Dunkeld and Birnam

The following community-led services are provided:

- Befriending Service
- Social prescribing
- Outings and transport service
- Benches project
- Coordinator to promote and support Personal Assistants and Befrienders (See Section 5.2)
- Foodshare initiative
- Food Bank
- Hospital Transport Service
- Meeting Place
- Food Bank
- Men's Shed
- Knit and Natter
- Repair Café
- Men's breakfast
- Lunch Club

5.4 Community assets: infrastructure, services and people

The two communities have vibrant and committed community trusts and active pools of volunteers. However, lack of access to services is a significant issue.

Key findings

- Lack of access to services – both communities in the SIMD 10% most deprived category. Rannoch and Aberfeldy is the most access deprived data zone in Scotland.
- The Rannoch and Tummel DTR is a vital local service for accessing the medical practice and delivering prescriptions.
- Older residents do not always have access to the internet.
- Both community trusts are very capable and forward-thinking.
- Local people are interested in playing an active role in co-creating a new community-led service.
- Local people are interested in paid care-support roles and in voluntary work in support of a new community-led care at home service.
- A co-ordinated network of health/social care services and other infrastructure is vital to ensure that local people can continue to live well in their community.

6. Case studies: Community-led health and social care delivery models

As identified in discussion with the Care Inspectorate, there are a lack of registered care services working in a dispersed way/across rural and remote rural areas in Scotland. Therefore, to help inform the co-production and development of a community-led care service for Rannoch and Tummel, desk-based research and discussions explored existing approaches to community-led health and social care services, and an existing approach in the Highlands to provide care at home services in small, dispersed rural communities.

6.1 Innovation in health & social care

The Scottish Government commissioned report 'Community-led models: Innovation in health and social care' (Healthcare Improvement Scotland, ihub 2021) shares learning from innovative approaches to community-led health and social care provision, with a focus on Scotland:

"We refer to "community-led approaches" as those that leverage community assets (such as community groups) within health and social care provision, and those that work differently to empower people to improve community wellbeing."

The approaches, aims, and partnerships outlined in the report are diverse. However, there are common elements in relation to service design, enablers and barriers, which provide valuable insights that can help to inform the develop of the new care at home service, which are summarised in Table 6.

Common design elements	Key features
Adaptation to the local context	Approaches tailored to local need and community assets; ongoing adaptation with stakeholders.
More involvement of community groups	Groups involved in supporting service delivery; collaborative working with third sector organisations.
Staff acting as community connectors	Fostering connections within local communities; help navigate and signpost people to local services.
Different conversations	Collaborative conversations for Councils and HSCPs with community groups and individuals to develop shared vision.

Enablers	Key features
Leadership	Strong senior leadership alongside valuing leadership from people and community partners. External leadership from e.g. NDTI and support from ihub.
Incremental change	Start with smaller changes and allow time to adjust to local needs.
Understanding local contexts	Planning with third sector organisations and opportunities for signposting. Identifying community assets.
Partnership with communities	Building capacity of community organisations; sharing responsibility with local partners; collaborating to share new approaches and design services.

Barriers	Key features
Upfront investment	Time to plan and adapt to local need; time to develop new partnerships and collaboration. Significant upfront investment may be required at the outset.
Cultural change	Working with clients in new ways requires buy-in from professionals experiencing diverse pressures; reporting measures expected to align with traditional services.

Table 7: Summary of design elements, enablers and barriers for community-led models of health and social care (source: Community-led models: Innovation in health and social care, Health Improvement Scotland, 2021)

Both the barriers of securing upfront investment and cultural change identified in this report are highly relevant and pertinent to the establishment of the new organisation.

"Significant investment may be required at the outset, even if the approach results in long-term cost savings."

Funds will be required to enable organisation set up and early-stage delivery, before it is fully established and able to generate sufficient funding streams to become financially sustainable. But the delivery of the service will secure long-term cost savings to Perth and Kinross Council/HSCP through a range of preventative measures.

6.2 Community-based care at home provision: The Boleskine Model and Sunflower Homecare

The Self-directed Support Implementation Study 2018. Report 3: Self-directed Support Case Studies provides an overview of the operation and key features of the approach developed for Boleskine, which is summarised below.

The Boleskine Model highlights how local communities in combination with statutory agencies can work together to develop services under Option 2 of SDS. It arose from a recognition that there was a growing local need, with an ageing community and lack of local service provision meant moving to homes outside the area for some people. However, there was recognition that there was potential capacity to boost the supply of care, as there were local residents who felt keen and able to provide support.

The case study report identified a number of key benefits of this approach, including:

- Local ownership through a community-based organisation, and a strong working relationship with a support organisation (HHC) and other local professional services.
- Strengthening of relationships with other local services – notably the local GPs and District Nurses.
- BCC and its services are seen as highly approachable, so that in the future there is less resistance to seeking and accepting support and so a reduced risk of unplanned hospital admissions related to a lack of support.
- The role of BCC is evolving, and it is extending its local services into a range of other activities for elderly people in the area.

"This approachable local service should be valued as part of an approach of investing in prevention."

The case study report also highlighted some key features which ensured the success of this partnership approach including:

- ***Community capacity and commitment:*** The need for a strong local group of potential trustees ready to take on responsibility for the approach and to drive its implementation. In all three areas to date, there has been a pre-existing community trust, which has provided a base of local commitment to build on.
- ***Infrastructure body:*** An organisation which is able to act as employer, trainer and source of technical HR support.
- ***Partnership working:*** A close, trusting relationship between the infrastructure body and the community group.
- ***Role of local people:*** It is paramount that local people are able and willing to provide support and keen to be trained to do this.
- ***Service Manager:*** They have a critical role and are central to the ethos and value of the approach and are important in building local trust and strong working relationships with others eg GPs, District Nurses.

- ***Local income:*** Whilst not vital, the existence of independent local income is important (e.g. community funds from hydro/wind schemes). A lack of alternative sources of income could be a limiting factor in other smaller communities.

Today, Boleskine Community Care works in partnership with a different NHS care service provider, Highland Hospice, to provide care at home services. Highland Hospice also works in partnership two other community organisations, Soirbheas and 3 Glens Community Care to provide Care at Home services in this way (Box).

Sunflower Home Care delivery model

The care at home service provided by Highland Hospice is funded through a contract with NHS Highland. The service is registered with the Care Inspectorate as 'Sunflower Home Care'. The Hospice employs a Care Manager and is responsible for the employment and support of all care at home staff and local care at home co-ordinators. Referrals from NHS Highland are passed to the local care at home co-ordinator, who then ensures that they are responded to by their local delivery team.

Establishing the community partnership

The Hospice carries out an initial Partnership Evaluation with the prospective community partner organisation, where the community organisation contacts the NHS care provider to confirm unmet need. This enables the Hospice to identify the number of carers that will be needed to deliver the service. The community partner also undertakes a preliminary check to determine that the area has the resources to provide a service, before a formal recruitment drive is started. There is clarity throughout from Highland Hospice that they can only provide a Sunflower Home Care service if there are sufficient people in the area willing to delivery homecare support.

Community support for service delivery

The community partners support and facilitate the delivery of the Sunflower care at home service in their local area, in line with a partnership agreement. The Hospice negotiates with community partners to identify which elements of the service the partners can help to fund, both through in kind and financial contributions. The nature of this support varies in accordance with each partner but can include:

(i) Promotion and awareness raising for staff recruitment and to increase the profile of the service within the local community; and

(ii) Financial support for items e.g. training, uniforms, rental of office space, incentives to retain staff such as childcare vouchers

A key part of the partnership model is the feeling of local ownership of the service. Although staff are employed by Highland Hospice, they are encouraged to consider themselves part of the community, offering local solutions to local problems. This is strengthened by the co-branding of uniforms and the support that comes from community partners to the team.

Challenges of service delivery

The main challenges experienced by Highland Hospice in establishing a service in these remote, rural communities centre on promotion of the service and the recruitment of homecare support workers.

[Source: An Evaluation of Befriending and Care at Home Community Partnerships, SKS Scotland CIC, 2023]

Box 1: Key elements of the Sunflower Home Care community partnership service

In terms of establishing the number of carers needed per community area, Highland Hospices advises:

- Minimum of one member of staff for a morning/afternoon and evening shift for 7 days a week all year round.
- If there is a higher need, 2 staff per shift may be required.

This equates to a minimum of approximately 50 to 70 hours per week, depending on need, plus bank staff to help cover for sickness and annual leave.

During 2023 SKS Scotland CIC undertook an evaluation of Highland Hospice's Befriending and Care at Home community partnerships (SKS Scotland, 2023). During this research, Boleskine Community Care described how they moved from a private Care at Home provider to Sunflower Care. This move was driven by:

- a desire to work with a care provider with a similar ethos and values to Boleskine Community Care;
- a desire to ensure that a local identity was retained for the carers, so that they felt part of the community, and local people recognised them as such; and
- the flexibility in care provision offered by the Sunflower Care team, to meet the bespoke needs of individual clients.

In addition, whilst all three community partners play an important role in facilitating and supporting service delivery, the role of Highland Hospice has been vital in enabling the establishment of service provision. Further details of the service set up and delivery requirements for Sunflower Home Care are at Appendix 5.

7. Proposed organisational model for community-led delivery of care at home services

7.1 Community-led model for care at home provision

Drawing on the principles of the Boleskine model and Sunflower Homecare, the Rannoch Community Trust, in collaboration with Dunkeld, Birnam and District Community Development Trust, has developed a model for a community-led approach to delivering care at home services for Rannoch and Tummel, Dunkeld and Birnam, and other rural, remote communities in North Perthshire (Diagram 3). A similar model is also delivered in South Ayrshire by the charity Ballantrae Rural Initiative Care in the Community Limited.

This is a 'hub and spoke' approach, with a new community-led organisation acting as the core infrastructure body, providing central services to community-based development trusts, which oversee local care co-ordination and integrate with other community assets and services (Diagram 3).

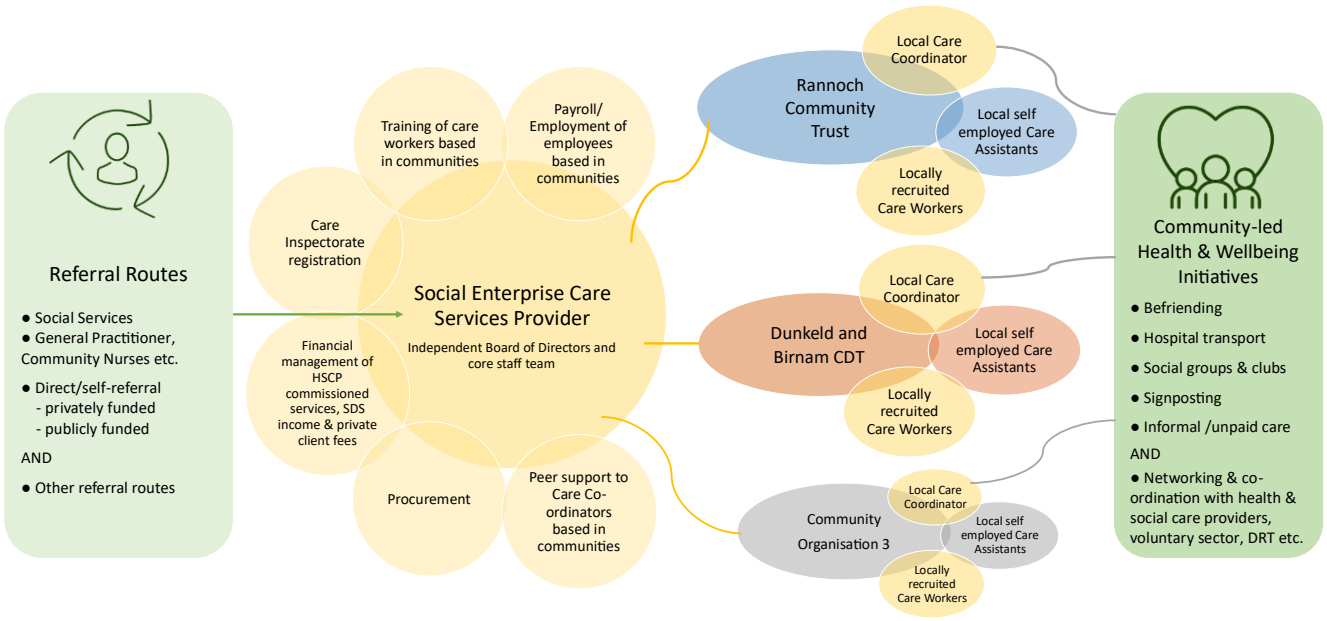


Diagram 3: Visual representation of new community-led delivery model

At this time the two inaugural communities engaged in the model are Rannoch and Tummel, and Dunkeld, Birnam and District. However, as the diagram depicts, other communities can become part of the delivery model over time.

This model is capable of fitting into an alliance contracting model or standing alone within the HSCP's existing care at home commissioning arrangements. It also has the potential to grow as more community localities join

in, whilst maintaining a single point of contracting with the HSCP. In effect, the model is creating a community-led alliance partnership for the HSCP to work with.

Discussion of this with Health Improvement Scotland has also highlighted the importance of community-based models influencing national policy and understanding of the need for a more collaborative and ethical approach to commissioning of social care services, which brings the values and principles of social care more centrally into the commissioning process. This model is now being shared at the national level for this purpose.

This model has been discussed with, and is endorsed by, PKC HSCP. It will be presented to the IJB on 20th December, for their additional endorsement. In addition, the model has been discussed with and is supported by:

- Rannoch Community Trust
- The community of Rannoch and Tummel
- Dunkeld and Birnam PH8 Care Group
- PKC CLLD Team
- Health Improvement Scotland
- Support Choices
- GrowBiz

The HSCP have indicated that if it can be shown that this model works, they will be keen to use it across Perth and Kinross for other communities where they are not currently delivering their statutory duty to provide Option 3 under SDS. For Perth and Kinross Council, this approach is also crucial in helping to deliver Community Action Plan priorities.

It is important to note that in the case of Sunflower Homecare, it has the back up and additional support of Highland Hospice behind it e.g. access to advice/support from other healthcare professionals - physiotherapy, occupational therapy, as well as organisational infrastructure support e.g. financial management, fundraising, marketing and communications, HR. As the Hospice's Community Services Manager described:

"It is very beneficial to have the knowledge and skills of so many behind us." (Community Services Manager, Highland Hospice)

In contrast, this new community-led organisation will stand alone, and will need to ensure that it is properly resourced in all areas to ensure that it can provide the quality and types of services required by its communities. The main features of this new model have been discussed in detail with all of the communities, individuals and key stakeholders, and are summarised in Table 8.

Components of community-led model	Description
Ownership and management	• The new service will be community owned, led and managed. • It will be a company limited by guarantee with charitable status and an asset lock. • Board of Directors responsible for governance and strategic direction. • Each community organisation will have a partnership agreement with the new organisation.
Capacity for growth	• The model will enable other communities to come on board over time, increasing the geographical scale of delivery.
Regulation	• The service will be accredited, regulated and quality assured by the Care Inspectorate. • The organisation will comply with Companies House and OSCR requirements.
Service provision	• The community-led organisation will deliver a care at home service in each community, in accordance with community need. • The organisation will support the co-ordination of community-led social care support services, which each community is currently, and will continue to, deliver.
Funding and finance	• The new organisation will require development/pump-priming funds to enable its set up and early implementation stages. • Once fully established, the service will be commissioned by the HSCP to deliver care at home services that are needed in Rannoch and Tummel, Dunkeld and Birnam, and other rural, remote communities in North Perthshire. The service needs to be of sufficient scale to secure sufficient SDS and other income (including private fees) to ensure a sustainable, mixed economy model. • Other sources of funding from charitable trusts, grants etc. will be secured by the local community trusts to support the delivery of local services e.g. befriending, hospital transport. These charitable funds will not and cannot be used to support the delivery of statutory care at home services. • As a not for profit organisation, any surpluses made by the organisation will be fed back into the community.
Employment	• The organisation will provide a range of local employment opportunities across a range of areas including social care, business management, administration, finance, communications. • Carers will be able to work locally and flexibly, ensuring that travel times are kept short, and that care work can be easily accommodated into people's lives.
Volunteering	• Volunteers will be a key part of service delivery in local communities and will be provided with ongoing training and support.
Training	• Training will be available locally for staff in each community, to meet specific needs, using a blend of online and in person approaches, delivered by local authority, other care providers and/or third sector bodies.

Table 8: Key features of community-led care model

7.2 Vision and outcomes

Vision

"A new, community-led, locality-based not for profit organisation is delivering high quality, person-centred care at home and other vital social care services in otherwise unserved remote, rural areas of Perth and Kinross in a way that is integrated with other community support systems and statutory structures. As a key pillar of an Age Friendly Community, this organisation is ensuring equality of access to care services, supporting independent living, the health and wellbeing of individuals, and the resilience of local communities. Through the delivery of the service, flexible employment opportunities are provided for local people, enabling them work and live locally.

There will be an initial start-up period of three years during which the business works towards financial sustainability. Thereafter, with the achievement of adequate scale, it will operate as a self-sustaining business based on HSCP commissioned care at home services and grant funding to support other community-led activities."

Outcomes

The delivery of this vision will secure outcomes in the arenas of:

- Health and wellbeing
- Employment, skills and training
- Community resilience
- Volunteering
- Resource utilisation and capacity
- Community Wealth Building

Specific outcomes will be secured at the individual, community and strategic level, including:

(i) For individuals

- People are able to continue to live independently in their own homes, in their local community.
- People experience an improvement in their health, wellbeing and quality of life.
- There is less need for people to move away from their community into residential or nursing care.
- Hospital discharge is timelier and frees up beds for others.
- People have the choice to have end of life care in their own homes.
- Local people have new opportunities for employment and training within their local communities.
- People are making an active contribution to their community.

(ii) For local communities

- Increased resilience through providing a range of local jobs and training opportunities, encouraging people to stay living and working locally.
- Increased social connection and social capital.
- Sense of agency and achievement through delivering on key priorities within their Community Action Plans.

(iii) For Perth and Kinross Council Health and Social Care Partnership

Delivers directly against 5 Strategic Commissioning Plan strategic priorities

- Make it easier for people to get the help and support they need.
- Work with communities to design the health and social care supports they need.
- Target resources to where people and communities need help most.
- Provide health and social care support close to home.
- Improved Integrated Working.

Delivers directly against Strategic Commissioning Plan outcomes for older people

- People who provide unpaid care are supported to maintain or improve their quality of life and look after their own health and wellbeing.
- Older people are supported to maintain or improve their quality of life and look after their own health and wellbeing.
- Older People are supported to live actively and independently at home or in a community setting.
- Resources are used effectively and efficiently.
- Timelier discharge from hospital.
- Health & Social Care workforce feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.

And in addition:

- The HSCP delivers on its statutory obligations and commitment to ensuring equality of access to care at home services.
- Preventative cost savings through enabling people to live longer in their own homes.
- Cost savings through a reduction in the number and length of stays in or residential/nursing home accommodation.
- Reduction in the burden of use of NHS resources for delivery of tasks that can be undertaken by a care at home service.
- Increase in the resources are available within the system to provide vital social care support services, through collaboration with local community trusts.

(iv) For Perth and Kinross Council

- Aligns with and supports delivery of the revised Community Planning Partnership.
- Supports delivery of the draft PKC Economic Action Plan 2024-28 through the establishment of a community-led care enterprise.
- Increased number of micro-enterprises and self-employed individuals.
- Local communities delivering on key priorities within Community Action Plans.
- Increased community resilience and Community Wealth Building.
- Supporting creation of Age Friendly Communities in rural, remote areas.

7.3 Legal and governance structures

At its core, both Rannoch Community Trust and Dunkeld, Birnam and District Community Trust want the new organisation to be a community led, not for profit organisation. Establishing the new organisation as a company limited by guarantee with an asset lock and registered charity and social enterprise principles is an appropriate structure to delivery this.

A new Board will be appointed, with the necessary skills and experience to meet the objectives of the charity. This Board will be responsible for the governance and strategic direction of the charity. Each community organisation will have a partnership agreement with the new organisation. This will set out how each will work in partnership to deliver social care support services within each community, their respective roles and responsibilities, and the terms and conditions under which each partner will deliver these. An organogram for the new organisation is provided in Diagram 4.

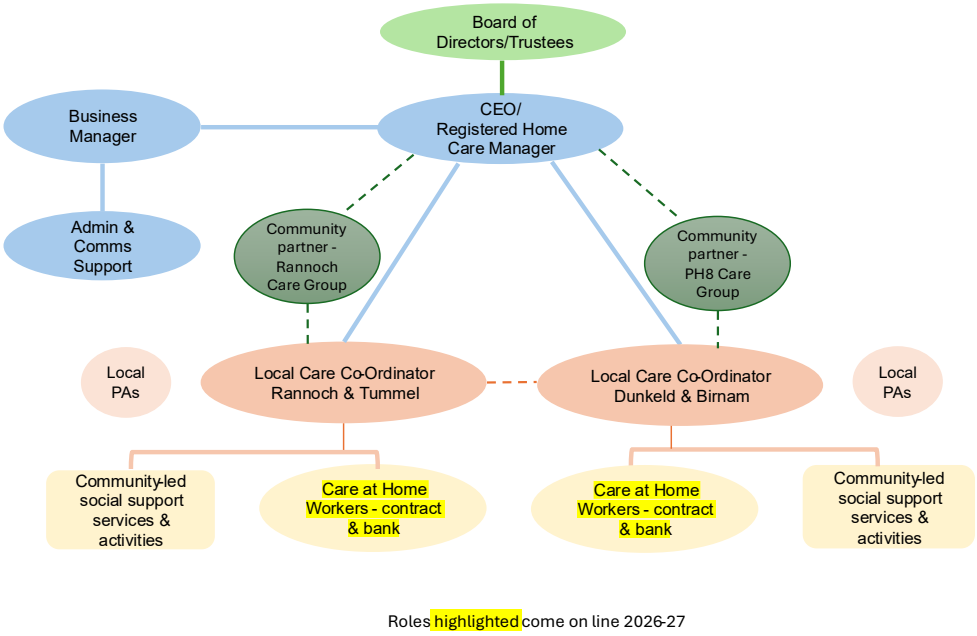


Diagram 4: Organogram for new community-led organisation

7.4 Staff and volunteers

Staff

It is assumed that initially, the organisation will be partnering with two community trusts (Rannoch Community Trust and Dunkeld, Birnam and District Community Development Trust) to deliver care at home and other social care services across these two communities. This will require the staff posts outlined in Table 9. Key roles and responsibilities for the CEO/Registered Home Care Manager and Local Community Care Co-ordinator roles are outlined at Appendix 6.

This staffing structure and key roles draws strongly on the Sunflower Homecare model (Section 6.1). Within this model, Highland Hospice acts as the umbrella organisation for the Sunflower Homecare service. The Sunflower Homecare Manager reports to the Highland Hospice Head of Clinical Services, and the Hospice provides the providing support and resources in a number of areas including: Care Inspectorate Registered person; commissioning/contracting with NHS, financial management, training, communications and marketing, and fundraising. However, in this case, all these functions will need to be delivered by the new community-led organisation, alongside the provision of care at home services and the recruitment and management of staff.

Table 10 provides a summary of the staffing structure, key responsibilities and recruitment timeline. The staff recruitment will be phased to match the developmental stage of the new organisation. **All staff will be employed by the organisation.** Full details of salaries, hourly rates and on costs are provided in the Financial Summary at Section 10. Local care delivery staff will be employed in year 2 (206-27) – staffing levels will ensure that the necessary cover is available to deliver the required care at home services.

The 'Safer Recruitment Through Better Recruitment' guidance document (Care Inspectorate, Scottish Social Services Council, 2023) will be used to inform the recruitment process for the Care Service Delivery Manager, Local Care Co-ordinators and Care Delivery Staff. This resource provides good practice guidance for employers, especially those in social care, early learning and childcare and social work to meet existing legislative and regulatory requirements in relation to the safer recruitment and selection of people to work

with people experiencing care and support services in Scotland. The guidance supports employers to safely recruit suitable staff for a range of roles involved in providing care and support.

Other paid roles and volunteers

As described in Section 5, volunteers and paid workers already play a key role in providing a range of community/social support services, including hospital transport and befriending. It is vital that these services continue. The new organisation will manage and co-ordinate these services, and provide training and support to befrienders, hospital transport volunteers as appropriate and required.

Staff post	Job purpose	Management & reporting lines	Salary & hours	Recruitment timeline
Chief Executive Officer/Registered Home Care Manager	• Provide strategic direction and leadership. • Overall responsibility for operational and financial management and delivery against organisational aims and objectives. • Registered Manager for the management and delivery of the Home Care service. • To develop, co-ordinate and manage a Home Care service across rural, remote communities in North Perthshire. • Secures and maintains Care Inspectorate registration. • Leads on commissioning with HSCP. • Responsible for the management and supervision of the locally-based Community Care Co-ordinators.	• Accountable to, reports to, and is advised and supported by the Board. • Managed by the Chair of the Board. • Manages Business Manager and Local Care Co-ordinators. • Manages partnerships with local community members.	Full time Salary £45k	Recruitment in Q4 of 2024-25
Business Manager	• Responsible for set up and management of organisational infrastructure, financial systems, operational delivery, administration and communications. • Leads on fundraising and supports CEO in commissioning and contracting with HSCP.	• Accountable to, reports to the CEO/Registered Home Care Manager • Manages Admin/Comms Support Officer. • Manages contracted out financial services: book-keeping, payroll and accounts.	Part time 0.6 FTE Salary £35k pro rata	Recruitment Q1of 2025-26
Administration and communications officer	• To provide administrative support, initially to the Business Manager & Local Care Co-ordinators. • To provide support with external and internal communications.	• Reports to and is managed by the Business Manager.	Part time 0.5 FTE Salary £22k pro rata	Recruitment Q1/2 of 2025-26
2 Local Community Care Co-ordinators	• Support and supervise a small group of care workers within a defined geographical area on a day to day basis	• Managed by, and reporting to the CEO/ Registered Home Care Manager.	Full-time Dunkeld & Birnam; 26	Recruitment Q1/2 2025-26

(Years 1 & 2)– one for Rannoch and Tummel, and one for Dunkeld & Birnam. (A third Co-ordinator for another community is planned at Yr 3)	to deliver a high standard of support to individuals and their families/carers. • To deliver care as and when required. • To manage and co-ordinate other local community-led health and wellbeing initiatives and volunteers as appropriate in their locality e.g. befriending, hospital transport.	• Manage local Care Delivery staff in their relevant community area.	hrs/week Rannoch & Tummel £15.63 hr rate plus on costs (see Section 10 for further information) Not managing care delivery until Yr 2.	
Local Care Delivery staff for Rannoch & Tummel, and Dunkeld & Birnam	• From April 2026, delivering care at home services to clients within a defined geographical area on a day to day basis.	• Reporting to the relevant Local Community Care Co-ordinator.	£12.54 hr rate plus on costs (see Section 10 for further information) Flexible delivery hours. Start in Yr 2.	Recruitment in Q4 of 2025-26

Table 9: Outline of staffing structure, key responsibilities and recruitment timeline

7.5 Service provision

The target audiences for service provision will initially focus on individuals living in the communities of Rannoch and Tummel, and Dunkeld, Birnam and District, including those who are:

- elderly, frail and vulnerable
- living alone
- have no access to transport for medical appointments
- live with poor mental health and/or physical wellbeing
- providing ongoing informal care and support to family/friends/neighbours
- require help or advice in accessing information/services to support their wellbeing

The key services managed and delivered by the new community-led organisation for these audiences will include:

Care at home provision
Providing varying levels of care at home, all tailored to the individuals' needs. This will include a variety of tasks from getting someone up and dressed or reminding them to take their medications, to prepping meals and providing much-needed company.

The Perth and Kinross HSCP Service Specification for Care at Home (2024) provides a list of support activities – tasks identified as those that may contribute to meeting an individual's agreed outcomes (although specification document notes that this list should not be seen as exhaustive, nor will all tasks/support be needed in all cases). *"In summary the service will support people to have a good quality of life in their own homes, by providing personal care, social and emotional support. This includes: Engagement with preventative services and social opportunities delivered by the third sector; and skilled end of life care where appropriate."* (page 6)

The tasks are described under five main headers:

- Personal care
- Escorting and Social activities – referral to social prescribers
- Respite Service
- Crisis Service
- Tasks excluded: Nursing care which is the responsibility of the Health Service; Domestic cleaning.

Befriending
This service can support people of all ages who are socially isolated or feeling lonely. Befrienders can visit a person in their own home and/or support them to connect with their local community. Befrienders can also provide respite care for those who care for a partner or family member, enabling the carer to have some time for themselves, safe in the knowledge that those they care for are in safe hands. (See Section 5.3 for further details). Befriending is also very important in identifying possible shift in level of needs of a client.

Hospital transport
The drivers are local people, who use their own cars to take people to hospital appointments. They receive petrol money for these journeys. This is a vital community service, as the distances to hospitals in the region are significant and the resources of the Scottish Ambulance Hospital Transport service cannot cover these rural, remoter communities. (See Section 5.3 for further details).

Signposting
Ensuring that local people are aware of and can access activities and resources provided by their local community, local council, voluntary sector and other organisations/interest groups, which can be of benefit in supporting their own wellbeing and/or that of their family, friends and neighbours.

Networking and co-ordination
Providing a focal point within each community to ensure that the activities and services provided by different organisations and professionals are joined-up and reach those in need.

Additional community-led social support services

New services will be developed to support needs that have been identified through the research for this project e.g. volunteer handyman service linked to Men's groups, lunch clubs (Rannoch), crafting groups. All such services are important in supporting general wellbeing and provide early intervention and prevention.

Note regarding information technology in future care service provision

The value and need for information technology to access a range of health and social care services is well recognised. Such approaches include:

Hospital at Home - a short-term, targeted intervention that provides a level of acute hospital care in an individual's own home that is equivalent to that provided within a hospital. Healthcare Improvement Scotland has established a programme to support the implementation of Hospital at Home, including work with a mixture of NHS boards and health and social care partnerships.

Near Me - Near Me is a video consulting service that enables people to attend appointments from home or wherever is convenient. The service is widely used across NHS Scotland, Social Security Scotland, Local Authorities and other organisations for appointments across a wide range of public services. All that is needed is a device for making video calls like a smartphone and an internet connection. Near Me is a secure form of video consulting approved for use by the Scottish Government and NHS Scotland.

In addition, information technology is increasing being deployed to help monitor individual health and wellbeing in the home, enabling people to stay living independently at homes, including the potential to prevent hospital admissions and enable hospital discharge. (in terms of supporting people to live independently e.g. Fit Homes – Albyn Housing Society).

The HSCP is committed to improving access and the use of digital technology, particularly for those living in remote and rural locations, including combatting digital poverty where it exists. Specifically, the North Perthshire Locality Social Work team are keen to look at some information technology-based applications within the project area (pers comm. 21/8/24). Whilst the initial priorities for the new organisation will focus on getting a fully operational service up and running, with support from the HSCP, future consideration will be given to how information technology can help to enhance the wellbeing of the communities that it serves.

7.6 Partnership Working

Partnership working and collaboration will lie at the heart of the new organisation. They are essential to ensure that the organisation is delivering the services required in each community, and that it is fully integrated with other community support systems and statutory structures. Table 11 provides a summary of key partners and their envisaged relationships with the new organisation. It is anticipated that this list will grow and shift over time, as more communities become part of the organisation, and its geographical coverage spreads.

Partner organisation	Roles and relationships
Rannoch Community Trust	Key partner. Represented on Management Group. Secures additional funding to support local community-based social support services and activities.
Dunkeld, Birnam & District Community Development Trust	Key partner. Represented on Management Group. Secures additional funding to support local community-based social support services and activities.
Kinloch Rannoch Community Hub	Provides work and meeting space for staff and Board. Internet access for local people to access PKC and other health and social care support services/information.
Perth and Kinross HSCP	Contractual – commissioned to deliver care at home services. Support for staff training and development. Social Work and other teams to ensure referrals and appropriate care and other social support in place for individual clients and their family/friends/neighbours as required.
Perth and Kinross Council	Ongoing relationship – the new organisation will help support the delivery of Community Action Plan priorities and provide local employment and training opportunities.
GrowBiz	Ongoing relationship and support – advice, knowledge-sharing and networking re self-employment/micro-enterprises in the care sector.
Aberfeldy & Kinloch Rannoch Medical Practice; Craigvinean Surgery, Dunkeld	Ongoing relationship to ensure appropriate care and other social support in place for individual clients and their family/friends/neighbours as required. Referrals from Social Prescriber to community-based activities as appropriate.
Support Choices	Ongoing relationship – currently discussions ongoing in relation to a pilot Shared Management Service for SDS Option 1 recipients.
Community groups/activities	Ongoing relationship to promote local social/special interest groups to everyone in the local community.
TSI	Promotion and awareness raising of the organisation and its services. Networking and information exchange.
Health Improvement Scotland	Information and knowledge exchange to increase awareness and understanding of the opportunities and challenges of community-led approaches to delivering social care services.

Table 10: Key partner and collaborator organisations

7.7 Training and development needs

At the outset it is important that for all roles within the organisation, there is a clear understanding of training and development needs for staff and volunteers. Training providers can then be identified, and individual plans can be drawn up and reviewed over time, to ensure that the training needs are being met.

It is likely that some training can be delivered in-house by existing staff or by one of the community trusts. In addition, external providers could include:

- Perth and Kinross Council/HSCP
- Privately commissioned care providers e.g. Stuart Wright Care Ltd.
- Highland Hospice
- TSI (Perth and Kinross)
- Perth College
- NHS Education for Scotland (free health and social care training resources available at https://learn.nes.nhs.scot/)

At September 2024, The HSCP Learning and Development Group is in the early stages of scoping learning and development across Perth and Kinross, to identify current provision and how this offer can be strengthened in the future. The outcomes of this work will be important and helpful in identifying training and development opportunities for the new team.

7.8 Care Inspectorate Registration

Care services in Scotland must, by law, register with the Care Inspectorate, which regulates care services using the regulate care services using the Health and Social Care Standards and the Public Services Reform (Scotland) Act 2010. Therefore, in order for the new organisation to deliver the care at home element of its services, registration with the Care Inspectorate needs to be completed.

The new organisation will be delivering a 'Support Service' as defined by Schedule 12 'Care Services – Definitions', under the Public Services Reform (Scotland) Act 2010. Early stage advice from the Care Inspectorate has identified that the service will need one registered Care Manager for the whole care at home service, rather than needing separate ones for each community where the service is delivered. Within this operating model, the roles and responsibilities between the central hub and the local care delivery teams need to be very clearly thought through and defined.

As a new organisation, which has never applied to register a care service before, pre-application advice is available from the Care Inspectorate. Following this, a fee is payable before the registration process can begin. Care Inspectorate registration fees vary depending on the size of the care delivery service, but it is anticipated that the fee for registering this Support – Care at Home service will be £2,050 (fee for a 'Medium' service is a service that employs more than three but no more than 15 whole-time equivalent persons to provide and manage the service). Once the service is registered and operating, an annual continuation fee of £1,476 will be payable.

The Care Inspectorate provides detailed guidance on the requirements of the registration process.
It should be noted that at the initial point of application, if no Manager has yet been appointed, it is acceptable for this section of the application to be submitted in due course. However, **registration will not be granted until such time as an appropriate manager is in post.** (p12-13 of guidance note). As at August 2024, the Care Inspectorate has a back log of cases, and has advised commencing with the application process as soon as practicable, with the registration process taking up to 12 months.

7.9 Communications and Marketing

Strong, consistent and tailored communications and marketing of the new organisation and its services will be crucial to its success. There will be a number of phases to this work, related to the stage of set up, development and delivery of the organisation. The key elements of this work are summarised below, with Appendix 7 providing an outline plan for this process, which will be used to guide the development of this work in the pre-launch, launch, post-launch and ongoing phases of the new organisation.

Summary:

Branding

- A consistent brand identity will help build trust and emphasise the community focus of the service. The brand should reflect the organisation's values and be easily understood by clients.
- Key components include a simple, adaptable brand name (with domain name availability), a scalable logo reflecting local identity, and comprehensive brand guidelines covering colours, fonts, tone, and logo usage. Additionally, marketing materials like website templates, flyers, social media profiles, and newsletters will useful.
- Branding in each locality will ensure that the logo for the new organisation always appears alongside that of the relevant local community development trust.

Communications

- Launching the community-led care service will benefit from a well-structured marketing and communications strategy to build awareness, engage stakeholders, and drive participation.
- The schedule in Appendix 8 outlines the recommended communications plan for the service's development, launch, and continued operation. It also includes key messages and recommended communication channels.

7.10 Monitoring and Evaluation

The organisation will use a range of quantitative and qualitative methodologies to ensure effective ongoing monitoring and evaluation of service delivery. This is essential to meet the requirements of the Care Inspectorate and HSCP Social Work Department, and to provide a more rounded assessment of the extent to which the organisation is delivering for clients (and their partners/families as appropriate), key partners and funders. Table 12 provides an outline framework for the monitoring and evaluation methodologies, which will be built on and developed in detail in Year 1 (2025-26) of operation.

Service delivery area	Monitoring & evaluation methodologies
Care at home services	• Monitoring and assessment in line with Care Inspectorate requirements • Formal assessments through PKC Social Work Department to ensure that individual SDS outcomes are being supported and met. • Interviews and surveys (online and paper) with those receiving care, their family/friends, and care providers. • Regular meetings with GPs, District Nurses, PKC Social Work.
Befriending	• Record of: number of befrienders retained and recruited; number of requests for befrienders; number of weekly visits by befrienders. • Interviews and surveys (online and paper) with befrienders and their clients re impact of service provision, any issues, and opportunities for changes/improvements.
Hospital transport	• Record of: number of requests for hospital transport; number of registered volunteers. • Interviews and surveys (online and paper) with volunteers and clients re impact of service provision, any issues, and opportunities for any changes/improvements.
Signposting, networking and co-ordination	• Local Care Co-ordinators to arrange regular focus groups for volunteers, community members, health and social care professionals and other key stakeholders to ensure that service is: linking well with other social care services and activities; that signposting between services is effective; avoiding duplication of effort; ensuring that individuals in need of support are not 'falling through the net'.

Table 11: Outline framework for monitoring and evaluation methodologies

To supplement the data collected through survey, focus groups and meetings, short semi-structured interviews will be carried out with a range of participants in order to provide case studies of their lived experience of social care support. Clients will also be encouraged to use Care Opinion the UK's independent non-profit feedback platform for health and social care.

8. SWOT Analysis

An early-stage analysis of the strengths, weaknesses, opportunities and threats to the establishment and delivery of this new community-led services is as follows:

Strengths	Weaknesses
• Aligned with Perth & Kinross HSCP draft Strategic Commissioning Plan, which seeks to work with communities to deliver services differently and more flexibly. • Delivers significant preventative cost savings to PKC/HSCP/NHS. • Provides a solution to the limitations of the currently commissioned service providers, who do not deliver care at home in Rannoch and Tummel, Dunkeld and Birnam, and other rural, remote communities. • PKC wants to support enterprise and economic development in its local communities, and community-led local action planning. • The needs of the community are at the core of all services delivered. It can be flexible and agile in responding to the needs of its service users. • Support from a wide range of key stakeholders for this community-led approach. • Rannoch and Tummel and Dunkeld and Birnam are very active, engaged communities, with a high level of social capital. • Supported by a mixed economy model – local council, HSCP, charitable trusts and other avenues available to community trusts. • Enables better integration and knowledge exchange between health and social care professionals, statutory and community services/activities. • Removes the onus on those in need of care to employ a personal assistant under Option 1 of SDS. • Provides local people with the opportunity to stay at home to the end of their life/have end of life care at home. • Enables more timely discharge from hospital, supporting the health and wellbeing of the patient, and freeing up beds for others. • Vital part of the infrastructure of an Age Friendly Community, supporting the delivery of Perth and Kinross as an Age Friendly Communities network member. • Local people are prepared to fundraise and support a service delivered locally in their community.	• Significant investment is required to provide the pump-priming funding to enable organisational set up. • Securing initial investment from external funders who may view this as delivering a statutory service, which they will not fund. • Having a sufficient pool of people living locally who can be recruited and retained as care at home workers. • Inability to recruit and retain staff and volunteers to support service delivery. • This community-led model is untried and untested in Perth and Kinross.

Opportunities	Threats
• To address a clear gap in the provision of care at home services in rural, remote communities in North Perthshire. • To ensure the continued delivery and development of vital social services including hospital transport and befriending. • For the community to establish and run a service that meets their needs. • To provide a care at home and wider social care support service that is fully integrated into the wider network of health and social care support across North Perthshire.	• Inability to secure pump-priming funding. • Unable to secure a contract for care at home delivery through HSCP commissioning service. • Funding at the level required to deliver care at home in remote, rural areas is not forthcoming. • Unsustainable reliance on grant funding, if sufficient resources are unattainable through contracting with HSCP. • Volunteer burn out and reliance on 'the usual suspects' leading to insufficient volunteer capacity to delivery social care support services. • Inability of public sector to effect a cultural shift in working with local communities to deliver, monitor and evaluate social care services. • Wider infrastructure required to support the health and wellbeing of local people and the recruitment and retention of staff is not in place (e.g. local transport links, affordable housing).

9. Risks and Mitigation

The set up and implementation of the new organisation will have several inherent risks to its success. The key elements are listed below with a RAG score (Red/Amber/Green to signify high to low risk) and suggestions for mitigating the risk (Table 13).

Risk	Impact	RAG	Mitigation Action
Perth and Kinross Council does not commit to financial support for initial set up and implementation	Establishment of the new organisation is not feasible.		• Develop strong business case. • Ensure strategic buy in from IJB • Develop dialogue with PKC • Continue dialogue with HSCP CEO.
Delays in commitment of funding by Perth and Kinross Council	Lack of co-ordination with other potential funding streams. Loss of community engagement, delays to Care Inspectorate registration and delayed start to establishment of new organisation.		• Dialogue with PKC • Maintain dialogue and pressure on PKC HSCP for meeting with IJB. • Provide financial details for establishment and running of new organisation to HSCP/IJB in October, to fit with budget planning process.
PKC HSCP does not commit to commissioning care delivery by the new organisation	Establishment of the new organisation is not feasible.		• Develop strong business case. • Ensure strategic buy in from IJB. • Continue dialogue with HSCP CEO and Commissioning Team. • Support from Health Improvement Scotland re commissioning pathways and clarity of process by which HSCP commissioning will work for community-led providers.
Match funding is not secured for initial set up and implementation	Establishment of the new organisation is not feasible.		• Develop strong business case. • Build relationships in advance with potential funders.
A new organisation working in a new way to delivery key social care services and activities	Potential for failure to deliver.		• Appointment of skilled and experienced Board Members and Executive Team. • Management Group provides advice and guidance to ensure community needs are being met. • Strong relationships and networks with key partners.
Individual community trusts are unable to secure additional funding to support community-based activities and services	Shortfall in match funding for organisational delivery. Negative impact on individuals' health and wellbeing.		• Local community trusts continue to have good relationships with funders. • Support for local community trusts to provide strong business case to funders. • Review capacity and resource needs of participating communities.

Recruitment of sufficient trained care workers	Unable to meet demand for care.		• Proactive marketing and recruitment in partnership with local communities. • Well-resourced training programmes that meet workers needs.
Higher than expected uptake of services	Unmet need, hard to control growth.		• Flexible contracts and bank staff to respond to need. • Close co-ordination with self-employed Personal Assistants.
Lower than expected uptake in services in local communities	Reduced income.		• Control fixed costs • Increase awareness raising and engagement.
Community organisations operate outwith regulatory requirements	Organisation exposed to high risk of operational failure.		• Appointment of experienced Registered Home Care Manager. • Clear partnership agreements between community trusts and the new organisation at the outset. • Strong relationship between Management Group and Board to ensure that partnership arrangements are working well and being adhered to. • Investment in staff training.

Table 12: Summary of key risks and mitigations

10. Financial Summary

10.1 Detailed Financial Summary years 1 to 5

Income and Expenditure Years 1-5

A summary of the anticipated income and expenditure for the set up and delivery of the new community-led care organisation is provided below, with the assumptions that have been made at this developmental stage (Table 13). This clearly identifies the need for initial grant investment to enable the establishment of the new organisation.

	April 25/26	April 26/27	April 27/28	April 28/29	April 29/30
Year	**1**	**2**	**3**	**4**	**5**
No. Comm Orgs	0	2	3	3	3
No. hrs care delivery per week	0	263	633	633	633
No. people per week, based on 15 hours care/week	0	18	42	42	42
"Care Co Ord and					
H&SCP fees - Option 1	£0	£365,540	£490,977	£490,977	£490,977
Private fees & H&SCP fees - Options 2-4	£0	£0	£349,440	£349,440	£349,440
Grants	£239,004	£171,123	£32,302	£32,941	£33,772
Total Income	£239,004	£482,663	£872,720	£873,358	£874,189
Costs					
Care Org Infrastructure salaries	£100,100	£100,100	£100,100	£100,100	£100,100
Care Co ord & Carer salaries	£59,259	£299,385	£642,220	£642,220	£642,220
Finance, bookkeeping, payroll etc outsourced	£7,200	£7,200	£7,200	£7,200	£7,200
Recruitment costs	£300	£300	£300	£300	£300
Mobile phones*	£2,160	£2,160	£2,592	£2,592	£2,592
Laptops*	£3,000	£0	£600	£600	£600
Office space	£6,000	£6,000	£6,000	£6,000	£6,000
IT Support & software*	£1,800	£1,800	£1,800	£1,800	£1,800
Office supplies*	£600	£600	£600	£600	£600
Uniforms*	£600	£2,178	£4,520	£4,520	£4,520
Branding*	£1,200	£0	£0	£0	£0
Website set up *	£3,600	£0	£0	£0	£0
Marketing & promo materials*	£720	£720	£720	£720	£720
PPE	£45	£2,188	£5,269	£5,269	£5,269
Care Inspectorate fees	£2,050	£1,476	£1,476	£1,476	£1,476
Training (staff and volunteers)	£3,187	£7,990	£14,846	£14,846	£14,846
Staff mileage	£4,212	£13,443	£27,141	£27,141	£27,141
Board & Management Group mileage/exp	£1,890	£1,890	£1,890	£1,890	£1,890
Public & Prof liability insurance	£6,000	£6,000	£6,000	£6,000	£6,000
DBS/PVG checks	£300	£1,089	£2,260	£2,260	£2,260
Fixtures and fittings	£500	£500	£500	£500	£500
Accountants fee*	£1,800	£1,800	£1,800	£1,800	£1,800
Bank charges	£100	£100	£100	£100	£100
Legal fees*	£2,400	£1,200	£1,200	£1,200	£1,200
Consultancy*	£14,400	£0	£0	£0	£0
Hospital Transport petrol	£1,200	£1,560	£2,028	£2,636	£3,427
Contingency	£11,115	£22,626	£40,855	£40,886	£40,925
Total Costs	£239,004	£482,663	£872,720	£873,358	£874,189
Surplus/Loss	**£0**	**£0**	**£0**	**£0**	**£0**

Table 13: Income and Expenditure profile Years 1 to 5

The financial model is based on two community trusts (Rannoch Community Trust and Dunkeld, Birnam and District Community Development Trust) as the inaugural Members of the new charity, with a third organisation joining on the same model. The income and expenditure have been based on the following assumptions for the purposes of this business plan (Table 15):

Income	
H&SCP fees - Option 1	There is no income assumed for Year 1, the start up year. Care at home fees are set at the current rate paid @ July 2024 (Source P&K HSCP). It is assumed that the current level of care delivery under Option 1 for Rannoch & Tummel and Dunkeld and Birnam is provided as is, for Year 2 to 5; and is nil for the third organisation in Year 2, and then replicating Rannoch & Tummel for Years 3-5.
Private fees & H&SCP fees - Options 2-4	There is no income assumed for Year 1, the start up year. Care at home fees are set at £24/hour which takes into account private fees which are set at benchmark comparable rates e.g. Age UK and the rate for fees paid by P&K HSCP. These fees maybe higher than currently being paid to PA's, however, individuals will no longer require to be an employer and to deal with the attendant logistical and financial management. It is assumed that the level of care delivery is split between individuals paying privately for care, and those being provided with care packages from P&K HSCP under Options 2-4. The current level of informal care provided for Rannoch & Tummel has been identified and the income is based on this data for Years 3 to 5 for this area. For Dunkeld & Birnam and the additional organisation for Years 2 to 5, we have assumed that this would be half.
Grants	Level of grant funding required for the organisation to break even each year. See Funding Strategy for further details.
Costs	
Care Org Infrastructure salaries	Salary costs for CEO/Registered Home Care Manager, Business Manager and Admin and Comms support role, with 28% on costs for NI, pension, annual leave and sickness cover.
Care Co ord & Carer salaries	Salary costs Care Co Ordinator and Care at Home workers, with 28% on costs for NI, pension, annual leave and sickness cover. The hourly rate: paid to the employee cost to the organisation Care Co Ordinator £15.63 £20.01 Care at Home worker £12.60 £16.13 This reflects the additional costs to employing staff which in addition to the above, includes uniform, protective clothing, PVG checks (as required), travel time to and from clients etc., along with the training, support and mentoring provided to employees. Local Co-ordinators will also have laptops and mobile phones provided. For Rannoch & Tummel, Befriender roles are self-employed and an hourly rate is paid. For Dunkeld and Birnam, the Befriender role is currently voluntary, and only expenses are paid.
Finance, bookkeeping, payroll etc outsourced	Outsourced to provide financial support
Recruitment costs	Cost to advertise in media publications

Mobile phones*	£30/month contract/phone / per person. Provided to CEO/Registered Home Care Manager, Business Manager, Admin and Comms support role and Care Co-ordinators
Laptops*	£500 each for a "good" laptop with future capacity. E.g. Dell Inspiron 15 Laptop. Provided to CEO/Registered Home Care Manager, Business Manager, Admin and Comms support role and Care Co-ordinators
Office space	Benchmarked at £500/month
IT Support & software*	Based on paying annually for Microsoft 365 and annul support
Office supplies*	Budget for a printer and stationery
Uniforms*	Polo shirt £12 (two each), Fleece £25 (one each), Waterproof £50 (one each) https://customuniforms.co.uk/
Branding*	Branding for new organisation - e.g Monogram Creative £240 per day vs Bold £400 per day.
Website set up *	Development of a responsive website eg planning / design / build / training) - e.g. Monogram Creative £2-3k, Bold £6k
Marketing & promo materials*	Design and print of marketing collateral e.g. leaflets and posters
PPE	Year 1 - Hand gel and masks as required; Year 2 onwards - Assume 1 pair gloves, 1 apron, 1 face mask, 5ml hand gel) per visit
Care Inspectorate fees	For service with 3-15 FTE £2,050 (https://www.careinspectorate.com/images/documents/2354/Fees%20Table%20-%20Update%2017.11.16.pdf)
Training (staff and volunteers)	Based on 2% of staffing costs. Potentially could be delivered In house, through PKC and Stuart Wright have offered, SVQ price list: https://arcscotland.org.uk/training/svqs-price-list/. Level 2 is £1,410
Staff mileage	Based on 45p/mile . CEO/Registered Home Care Manager, Business Manager and Admin and Comms support role each covering 40 miles per week. Care Co Ordinators, 60 miles per week. Care at Home workers, 30 miles per week.
Board & Management Group mileage/exp	Based on 45p/mile. 5 Board members meeting 6 times/year and travelling 70 miles each time. Similarly for the Management Group.
Public & Prof liability insurance	Benchmarked with other care organisations
DBS/PVG checks	Based on £60 per person. Basic and Enhanced DBS checks both £25/person. PVG £59. (https://www.mygov.scot/disclosure-types)
Fixtures and fittings	Benchmarked with other social businesses
Accountants fee*	Benchmarked with other social businesses
Bank charges	Benchmarked with other social businesses
Legal fees*	Benchmarked with other social businesses, for start up and incorporation documents
Consultancy*	Based on 3 days/month @£400/day
Hospital Transport petrol	£1200 for R&T currently, increased by 1/3 each year
Contingency	5% of costs

Inflation is not included in this information

* VAT is included at 20%

Further benchmarking of this information was carried out using the report A Minimum Price for Homecare in Scotland, April 2024 to March 2025.

Cash Flow Years 1-5

	April 25/26	April 26/27	April 27/28	April 28/29	April 29/30
Opening Balance	£0	£0	£0	£0	£0
Revenue income, incl Grants *	£239,004	£482,663	£872,720	£873,358	£874,189
Revenue costs	£239,004	£482,663	£872,720	£873,358	£874,189
Balance	£0	£0	£0	£0	£0
***Grant Income**	£239,004	£117,123	£32,302	£32,941	£33,772

Table 14: Cash Flow Years 1 to 5

This cash flow assumes that:

- There is no start up funds as an Opening Balance in Year 1
- Year 1 will involve the setting up of the organisation, and does not generate any fee income for Care at Home services
- Staff and infrastructure set up costs are secured for the start of Yr 1
- Income from P&K HSCP commissioned contract starts in Yr 2

Funding Strategy (See Section 10.2 for further details)

	Year 1	Year 2	Year 3	Year 4	Year 5
Grant Funding Required	**£239,004**	**£117,123**	**£32,302**	**£32,941**	**£33,772**
Potential Source					
NHS Tayside Charitable Foundation	£83,333	£83,333	£83,333		
Perth & Kinross Council	£125,000	£125,000			
The Gannochy Trust	£20,000				
SSEN Community Benefits Fund	£20,000	£20,000	£20,000		
PKC CLLD Fund	£25,000	£15,000			
Surplus funding	-£48,329			£18,941	£19,772
Sub Total	**£225,004**	**£243,333**	**£103,333**	**£18,941**	**£19,772**
On going					
D&B CDT	£9,000	£9,000	£9,000	£9,000	£9,000
R&T CDT	£5,000	£5,000	£5,000	£5,000	£5,000
Sub Total	**£14,000**	**£14,000**	**£14,000**	**£14,000**	**£14,000**
Total Funding Available Potentially	**£239,004**	**£257,333**	**£117,333**	**£32,941**	**£33,772**

Table 15: Funding Strategy Years 1 to 5

Marginal Analysis

- Year 1 Start Up costs, circa £239k, will require to be met by grant funding. They are based on known costs where available and benchmark costs otherwise. A 5% Contingency budget is included.
- Year 2 is based on a continuation of the current levels of care funded by P&K HSCP through SDS Option 1. It will require to be subsidised by circa £117k grant funding. This assumes that the care transfers to the new organisation. However, individuals may choose not to do this and the target figure may not be achieved. Noting that this would significantly also reduce the costs of care being provided therefore reducing the financial impact.
- Years 3 to 5 reflect a financially sustainable organisation, with a small grant funding of circa £32k per annum. This is based on additional care being provided, and the data used reflects current informal care within Rannoch & Tummel currently. The total weekly hours of care delivered is circa 600, based on 15 hours per person, this would be circa 40 individuals across the three areas. In the areas of Rannoch & Tummel and Dunkeld & Birnam there is currently 263 hours of care delivery provided each week through SDS Option 1.
- The cost per hour of care delivery, excluding overhead costs, is circa £22. The average income per hour is circa £25.
- The element of overhead costs is circa £125k per annum and circa 710 hours per week of care delivery would ensure the model broke even.
- This financial model does not support loan funding with the low margin of surplus that could be generated to service any debt repayment.

10.2 Funding Strategy

10.2.1 Pump-priming/development funding

Perth and Kinross Council

Pump-priming/development funding is required in order for the new organisation to become established. The main source of funding for this is being sought through Perth and Kinross Council which, unlike the HSCP, is able to support infrastructure set up costs. At November 2024 a paper is being prepared by the Head of Integrated Health and Social Care Adults 65+ for the Perth and Kinross Council Senior Management Team to make this request. A presentation of the proposals is planned for the IJB on 20th December 2024.

In addition, the PKC CLLD team have identified that further funding is available during 2024/25 to support the continuation of the pre-establishment and early establishment phase for the new organisation.

Other potential funding sources to support infrastructure set up costs and/or the delivery of community-based social care services such as befriending and hospital transport have been identified and outlined below.

NHS Tayside Charitable Foundation

As the official charity of NHS Tayside, the foundation *"… supports NHS Tayside to empower the communities it serves: patients, families, donors, carers and staff. Together, we help make people's lives better and longer. We are dedicated to supporting NHS Tayside patients and staff and improving health and wellbeing for the people of Tayside."* Rannoch Community Trust has been in contact with the Fund Development Manager. The Foundation is happy for the Trust to apply for funding and has highlighted that they require a level of match funding. The next deadline for applications is 6th March 2025.

Gannochy Trust

Trust provides grants for charities in Perth and Kinross, and across Scotland. The Trust's current Grant Strategy 2022-27, funds charities delivering a variety of aims. The establishment of the new organisation fits very well with the aim of 'Improving the quality of life', which requires that projects deliver at least one of:

- Positive change in people's lives and communities
- Increased inclusion, enablement, independence, mental health and wellbeing
- Increased access to employment, volunteering, learning, culture, sport, and leisure opportunities.
- Increased equality of opportunity and active citizenship.

Applications under this aim can be made for core funding (operational costs including salaries, overheads, and day to day running costs) and project funding (delivery of projects and activities). Charities that are applying to the Trust for the first time or have not received funding within the past ten years, can only apply for one year of project funding for one of 3 grants: up to £10k, up to £30k, or over £30k per year. The intervention rate is 50%, so match funding will be required. The next deadline for applications is 2nd May 2025.

SSE Renewables – Hydro Fund

This fund is currently open for applications with a focus on projects which:

- Protect the natural environment of the local area
- Enhance access to safe, affordable and sustainable community transport opportunities.
- Improve access to affordable, quality and safe housing including developing community housing initiatives.
- Encourage the establishment and sustainable economic growth of small businesses, including social enterprises.
- Develop and improve community assets and infrastructure such as halls, hubs and paths.
- Promote the physical and mental well-being of communities through community arts, culture, sports and recreation.

In addition, the fund is also interested in projects that support education, skills development, and employment opportunities. Rannoch Community Trust is considering an application to support the salary and on costs for the Local Care Co-ordinator for their community during 2025.

10.2.2 HSCP 'Approved Provider' and Commissioned Service Delivery

It is the intention that the care at home service element of the new organisation can deliver all 4 SDS Options. From discussions with the HSCP, this will be a two-step process:

- Step 1: The new organisation applies to the HSCP to become an 'Approved Provider'. This would then enable the organisation to provide care at home services under SDS Options 1 and 2. This registration as an Approved Provider can be undertaken in Year 1 (2025-26) alongside the Care Inspectorate registration process.
- Step 2: The new organisation is commissioned by the HSCP to deliver care at home services under SDS Option 3. The HSCP has just completed its most recent tender process for care at home services. This process will not open up again in three years time but there is flexibility for the new organisation to be added in at some point before then. Insight from Health Improvement Scotland has highlighted that in a case where the market is not meeting demand in an area, a commissioning body should be allowed to give a direct award contract on the basis that there is no provision.

10.2.3 Community Trust funding

Rannoch Community Trust currently receives funding from Perth and Kinross Council for the delivery of befriending and hospital transport services. It is assumed that the Trust will continue to be successful in securing this funding for these vital services. Dunkeld, Birnam and District Community Development Trust is confident in its ability to secure local funding through community fundraising events and local charitable trusts. There is also the potential for both community trusts to apply to other local charitable trusts in the future.

10.2.4 Other income sources

It is also intended that the care at home service will be accessible to private clients requiring support, although the organisation will need to ensure that there is capacity to service this in addition to HSCP commissioned work.

11. Next steps and implementation timeline

Table 16 identifies a series of high-level milestones and delivery dates in relation to the set up and early stage delivery by the new community-led organisation, between March 2025 and March 2026. It should be noted that this is a working timetable at this time. The plan will be developed in more detail with the two community trusts in the coming months, to provide detail and clarity on roles and responsibilities. Once the new Board and CEO/Registered Home Care Manager are in place, a full operational plan will be developed.

Timeline	Milestone/key actions
By end March 2025	• Outcome of request to PKC for financial support confirmed.
By end April 2025	• Outcome of funding application to NHS Tayside Charitable Foundation (8th April). • Additional funding applications made, depending on outcomes from PKC and NHSTCF. • Update of 5 year financial plan to reflect outcomes from funding requests/applications. • Recruitment of Board Members and CEO/Registered Home Care Manager underway. • New organisation legally constituted and registered with Companies House & OSCR.
By end May 2025	• New Board Members appointed • New CEO/Registered Home Care Manager appointed (assumption that will need 3 month notice period).
By end June 2025	• Inaugural Board Meeting
By end July 2025	• Initial branding, marketing and communications complete and website set up.
By end September 2025	• CEO/Registered Home Care Manager in post. • Recruitment of Business Manager.
October 2025 to March 2026	• Organisational infrastructure and systems established. • Recruitment of Local Care Co-ordinators. • Recruitment of Admin/Comms Support Officer. • Care Inspectorate registration underway

Table 16: Next steps implementation Plan – Key Milestones

12. Appendices

Appendix 1 Market Research and Analysis

Appendix 2 Key stakeholder/informants list and discussion summaries

Appendix 3 Rannoch & Tummel Community Survey, Drop-In Event, Craft Group & Focus Group

Appendix 4 Dunkeld & Birnam Community Survey

Appendix 5 Sunflower Homecare Partnership Service Set up and Delivery

Appendix 6 Job Descriptions – Outline roles and responsibilities

Appendix 7 Communications and Marketing Plan