# Getting it Right for Everyone (GIRFE) – The Team Around The Person

Draft Toolkit

10 September 2024

Scottish Government
Riaghaltas na h-Alba

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# 1. Introduction

Getting it right for everyone (GIRFE) is a multi-agency approach to health, social work, and social care support and services from young adulthood to end of life care.

GIRFE intends to shape the design and delivery of health and social care services, ensuring that people's needs are met. It is about providing a more personalised way to access help and support when it is needed. The ambition of GIRFE is to place the person at the centre of all the decision making that affects them, with a joined-up consistent approach regardless of the support needed at any stage of life.

GIRFE is currently being co-designed by the Scottish Government, Health and Social Care Partnerships, and the people of Scotland. This has included the co-design of a national toolkit, focused on developing a 'Team Around The Person', which can help support the move towards a person-centred approach to care and support in Scotland.

The GIRFE 'Team Around The Person' toolkit has not just been informed by, but has been collaboratively designed with, the people with the lived experience, lived expertise, and professional experience, who will be impacted by its implementation. This means that real people across Scotland have actively helped to identify the barriers that stop us Getting It Right For Everyone across health, social work, and social care and have worked with their local pathfinder teams to shape the solutions detailed within this toolkit.

The draft tools within this toolkit form a national toolkit which aims to support implementation of a more person-centred, consistent, individualised approach to health and social care support, which will help to embed inter-agency working across Scotland. This is fundamental to ensuring a GIRFE approach can be taken forward at a local level, as well as across the nation.

The 'Team Around The Person' toolkit provides a starting point for pathfinders, partners, and policymakers across Scotland, to begin testing and implementing tools which can support us all as we move towards adopting a GIRFE approach.

This draft toolkit, which will be updated iteratively as GIRFE draft tools are tested and implemented across Scotland, is also the starting point

for a wider conversation on how we all start Getting It Right For Everyone across Scotland. This should include discussion on any systemic barriers to the implementation of these tools.

Following further testing and implementation by pathfinders this Summer, the ambition is to publish an iterated version of the GIRFE toolkit for 'the Team Around The Person' in Autumn 2024, to enable further implementation across Scotland, and a national approach to be taken forward.

Further detail on next steps can be found at the end of this toolkit, including on where we see the next focus areas of GIRFE to be, and how this toolkit can act as a catalyst for a collective call to action for the Scottish Government, health and social care system, and beyond, so that we can all start Getting It Right For Everyone.

## Further Resources

Health and Social Care ALLIANCE video on GIRFE - An introduction to Getting It Right For Everyone (GIRFE) (youtube.com)

Health and Social Care ALLIANCE video on GIRFE (Part 2) - An introduction to Getting It Right for Everyone (GIRFE) part 2 (youtube.com)

Getting It Right For Everyone (Factsheet) - https://www.gov.scot/publications/getting-it-right-for-everyone-girfe/

## 2. GIRFE Principles

The GIRFE principles have been designed to reflect the standards and best practice required to successfully deliver meaningful change to health and social care services.

They can be embedded across health and social care services, as well as across other areas of the public sector and beyond, which impact a persons' life.

While the toolkit provides practitioners with the tools to implement the 'Team Around The Person' approach, the GIRFE principles help to ensure the ethos of GIRFE is present in all areas of policy development and professional practice.

The principles have been through multiple iterations, with significant input from GIRFE pathfinders, people with lived experience, Scottish Government policy officials, the office of the chief designer, and professional leads.

**The GIRFE principles form the foundations of a GIRFE approach.**

The development of the GIRFE principles has been and continues to be an ongoing iterative process. It has been vital to ensure that the principles themselves are person-centred, reflecting the ethos of GIRFE. Within the co-design of the principles, we have sought to:

- Understand people's experiences of accessing health and social care services in a range of different settings, across geographic and thematic areas.

- Embed their expertise and knowledge into each version of the principles.

This engagement includes individuals with lived experience and expertise in delivering services and has enabled rich collaboration across teams to consider the principles and how they should be expressed.

We are keen to ensure that these principles reflect the ethos of GIRFE and that we do not lose the voice of the person, while iterating these. We

ask for any further reflections from pathfinders over the Summer, to be sent to GIRFE@gov.scot.

## 2.1 GIRFE Principles - updated

- I have the information I need to make decisions about my life, in a format that works for me, and I am supported to understand what options are available to me, and trusted to know what is right for me. *

- The people who support me take the time to listen to and understand me as a person and communicate in a way that works for me. We consider my whole life when making decisions about my life. *

- I know that I can be clear about what matters to me, and I trust that my choices will be respected and taken into account by the people who support me.

- I am treated with kindness, dignity and respect at all times.

- The people I am involved with work together with me and each other to share relevant information, in a format that is accessible to me, and develop a clear understanding of how to support my wellbeing. *

*Within this principle, 'I' or 'Me' can be substituted for / include the addition of 'my guardian' or 'my power of attorney' where relevant.

## 3. GIRFE Draft Toolkit: The Team Around The Person

Throughout our conversations with people across Scotland, we have heard that the following is frustrating:

- having to tell your story multiple times
- information that is too complex
- multiple appointments with different people

Through GIRFE, we are committed to ensuring everyone in Scotland can access the care and support they need throughout their lives.

The GIRFE 'Team Around The Person' will support Health and Social Care professionals across Scotland to provide support holistically to individuals in the health and social care system.

This will help ensure that people do not have to tell their story repeatedly, that they are supported to understand information about their own health and care and are supported to navigate the system to get the support that matters to them as an individual.

## 4. GIRFE Draft Tool: My Plan

As part of co-designing the 'My Plan' prototype, insights were gathered through user research and other engagement sessions with people with lived experience and staff.

'My Plan' is a live document that is created, and updated, collaboratively between the person and their team and it is centred around the person's whole life and what matters to them.

'My Plan' can be completed by the individual, with support from a professional or trusted person (e.g. care coordinator).

The ambition of the Scottish Government is to ensure that anyone who has multiple professionals involved in their care, is supported by a plan.

'My Plan' will enable information sharing across services to avoid people retelling their stories multiple times while accessing support.

'My Plan' should include non-stigmatising language and avoid jargon and technical terms, enabling individuals to understand their plan and feel empowered when sharing their plan and making decisions in collaboration with the professionals who are supporting them.

'My Plan' is flexible and will be tailored to the individual's needs, including those related to significant life events such as bereavement and unemployment for example.

Below is the 'My Plan' Draft Tool. The tool details: what a plan is, how to update it, and includes sections for a person to fill in and complete.

An example of these tools are available below – however, you may wish to tailor these to the specific context in which you are working. This could include using a pre-existing template and ensuring alignment with this prototype and the principles of GIRFE.

# GIRFE Tool: My Plan

This document is for anyone who wants to record details about themselves. The plan can be tailored to the individual's requirements and sections added/removed depending on what is relevant.

The Plan means:

- You do not have to re-tell your story to people who support you with your health and social care.
- You can write down your goals for living well.
- To help health and social care professionals to build a better understanding of you, or the person you support, to be able to deliver the best support possible.

'My Plan' will have been given to you during a conversation about your living well goals with a person who can support you with your health or social care. For example, this could be when:

- You have gone to a health or social care appointment.
- When you have self-referred to a new service.
- When you have been diagnosed with an illness.

This document does not replace an assessment. You do not have to complete 'My Plan' if you do not want to.

**Updating your plan**

You own this plan. You can update, edit, archive, and delete information when you want to.

**Choosing who sees your plan**

If a person working in health and social care would like to see your plan, they will ask you. You can decide what they can and cannot see.

If you cannot decide because of a period of ill health or incapacity, the **[person supporting your health and social care]** will speak to **[add appropriate person]** to decide if the person requesting access can have it.

**What is in this document?**

The first section of the plan is called 'About me'. It asks questions about you, your wellness, your decisions and how you want to be treated, This section can be completed by you.

The second section provides tools to assess your health and wellbeing. If you choose, these can help give advice on staying healthy and well.

Further sections may be added to your plan by yourself, a parent or carer, or health and social care professionals.

# Dates and who can see my plan

**Date completed:**

**Completed by:**

**With the help of:**

**Important dates**

For noting changes and updates. For monitoring purposes by professionals and highlighting important dates.

**Who can see my plan:**

My decision on who can see each section.

| Date: | Name of person: | Section(s) they can see: |
|---|---|---|
| | | |

**The name I like to be called:**

**My full name:**

**My date of birth:**

**My pronouns:**

**Essential health information**
(Allergies, prescriptions, conditions)

**How I communicate and how to communicate with me**
Ways to communicate with me. Accessibility requirements (what I need to overcome communication barriers). How you can help me understand.

**People who are important to me**
This may be your partner, family, friends, neighbours, people who care for and support you (e.g. social care support and health professionals, third sector organisations / support groups), and people who can make decisions when you are not able to (next of kin, power of attorney).

**What is important to me**
How to respect me and enable my choice and autonomy, my routine and need for consistency, what motivates me, my goals, and my ambitions in life.

**My culture, faith, and religious beliefs**

**Things that may worry or upset me**

**What makes me feel better if I am anxious or upset**

**How I live well**

What is normal for me (e.g. current health / mental health conditions and how it affects me)

How to enhance my wellness – focusing on things that have positive impacts on my wellbeing.

**What I want help with to keep me living well**

**Signs I'm not living well**

**What happens if I'm unable to live well**
How my health impacts my independence and capacity.

**Notes from people who support me**

Include any details from people who support your care and important dates for you. You can include ay advance plans you have made, such as anyone you have appointed as your power of attorney.

# My goals

**What I want to achieve**

List the goals you want to achieve, how you will achieve them, and when you want to achieve them by, and how you plan to reflect and celebrate your achievements.

## 5. GIRFE Draft Tool: My Team

During the co-design of GIRFE, it was evident from people with lived experience that they often were receiving support from multiple professionals in Health and Social Care, along with support from third sector organisations, other public agencies, and also from their family members and their community.

Due to the number of individuals involved in providing care and support to people, it is often difficult for people to understand, or communicate, who is in their support network.

'My Team' was developed as a tool to record all the individuals and organisations providing care and support to a person. This document will make it easier for people to share who is in their support network and enable them, and the professionals involved in providing care and support, to identify where there are gaps or additional support needs.

'My Team' can be completed by the individual, with support from a professional or trusted person (e.g. care coordinator).

'My Team' can be used by professionals to support a conversation with individuals to assist them to consider and communicate who is in their support network.

'My Team' will enable professionals to view what other professionals, organisations and individuals are providing support to a person and allow them to work collaboratively, where appropriate, to ensure specific support needs are met.

The format of 'My Team' is flexible and should be adapted to the persons requirements. Two potential options that were generated from the GIRFE design process are below.

An example of these tools are available below – however, you may wish to tailor these to the specific context in which you are working. This could include using a pre-existing template and ensuring alignment with this prototype and the principles of GIRFE.

# GIRFE Tool: My Team

Date completed:

Completed by:

With the help of:

**How to use this:**

This is an example of how you can think about and share what is important in supporting your health and wellbeing. You can include anyone that matters to you – including family, friends, and professionals.

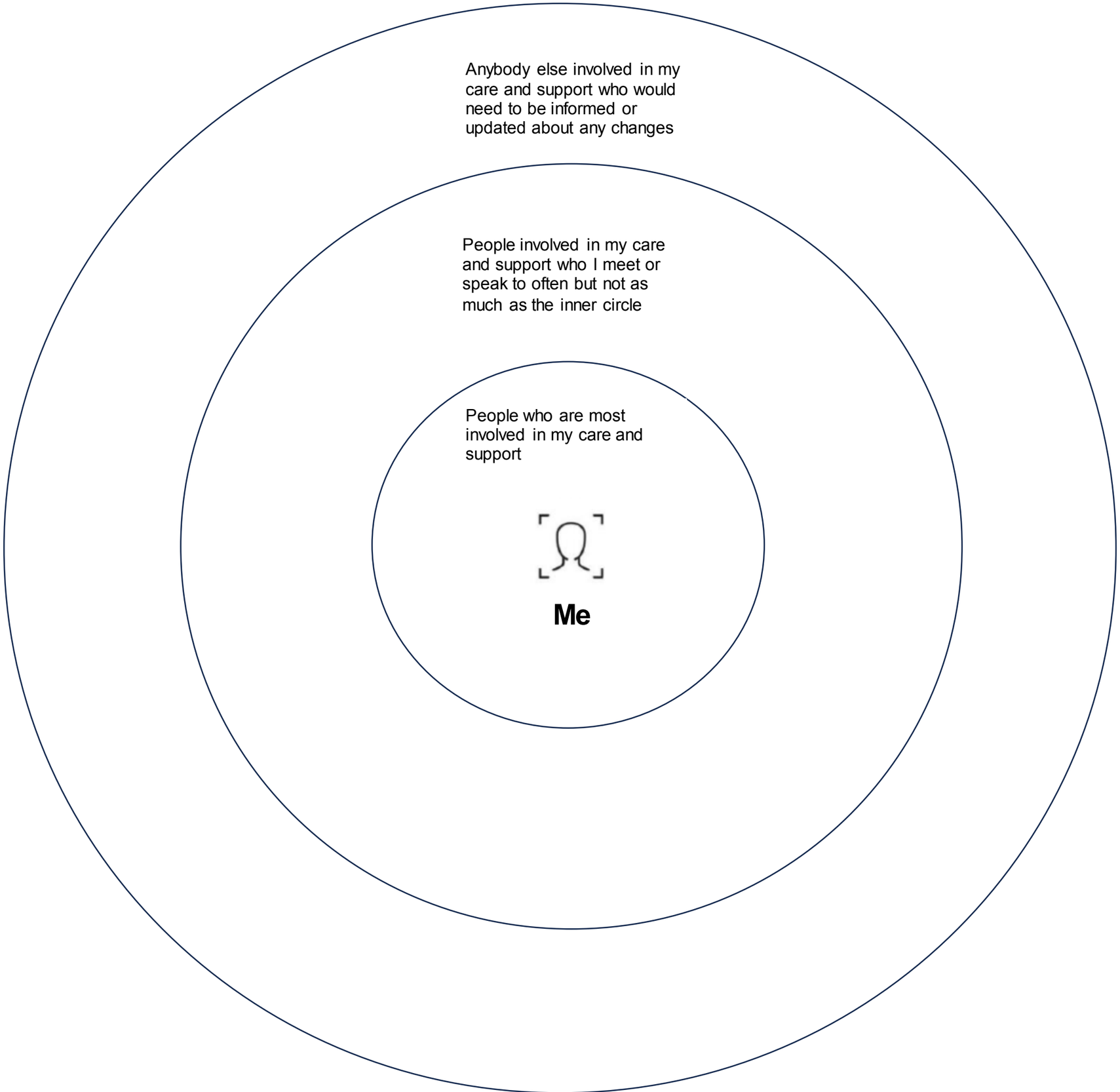
People can be removed or added at any time. You can include their details or contact information on here too.

You can also choose if you would like to have a paper or digital version of this.

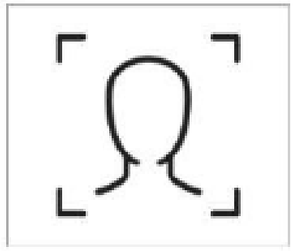
For the paper version, you can cut out the templates on page two and stick them on this diagram or just write he details on.

**What's next:**

Share this with anyone in your team or anyone that joins your team. It will allow them to see who is important to you and who should be involved in the discussions and your health and wellbeing.



# GIRFE Tool: My Team



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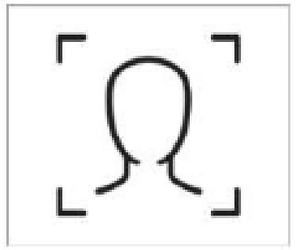
Their role:

Contact details:



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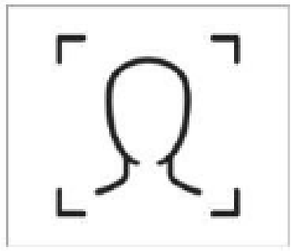
Contact details:



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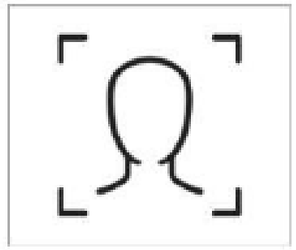

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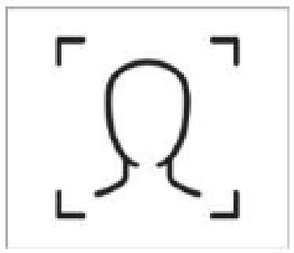

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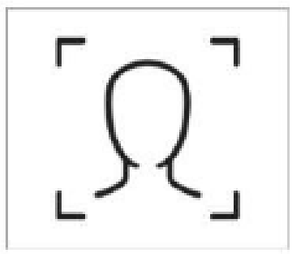
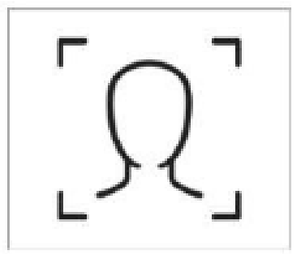


Their name:

Their role:

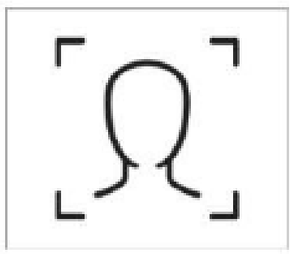
Contact details:



Their name:

Their role:

Contact details:



Their name:

Their role:

Contact details:

## 6. GIRFE Draft Tool: Co-ordinator

During the co design process, people with lived experience expressed that they often felt overwhelmed with the number of different people involved in their care and the number of different uncoordinated appointments that they were required to attend.

People found the Health and Social Care system very complex to navigate and it was often difficult to understand what services were available to them and how to access them.

Staff working within the system identified gaps in knowledge and training in relation to holding in depth trauma-informed discussions with people about their experiences and also their care needs.

The pathfinder and partner teams co-designed the 'co-ordinator' role description with people with lived experience. It aims to provide people who have ongoing care needs with a single point of contact from their multi-disciplinary team, who will provide a co-ordination role to ensure that their health and social care needs are understood and met.

The co-ordinator will take a trauma-informed approach to developing and maintaining a trusting relationship with the person receiving health and social care support and they will assist with creating/updating 'My Plan', navigating the system, co-ordinating appointments and ensuring that the persons is involved in planning and the decisions that affect them.

There are two parts of the 'co-ordinator' prototype. The first tool is for people receiving care. It is a role description which describes the role of the co-ordinator and how they will work the person and their family / guardians if appropriate.

The other part of the co-ordinator prototype is guidance for staff to assist with identifying an appropriate co-ordinator. It sets out guidelines around how the role works, when a co-ordinator is required and managing change related to the persons requirements or change of co-ordinator.

An example of these tools are available below – however, you may wish to tailor these to the specific context in which you are working. This could include using a pre-existing template and ensuring alignment with this prototype and the principles of GIRFE.

# GIRFE Tool: Co-ordinator – role description for service users

You will be offered support from a co-ordinator when:

- You have an ongoing need for care and support.
- You have told us you like support when co-ordinating your care.
- You have told us you would like support to understand who is in your team and to ensure your needs are heard and understood.

Your co-ordinator will be able to provide support for as long as you need them. They are a member of your multi-disciplinary team. They have access to your plan and understand what is important to you.

They will work with you and your family / guardians to:

- Make sure that you have a plan and that it is kept up to date.
- Make sure that your team follows your plan.

They will work with you and your team to:

- Provide you with the information you need about your care and support.
- Advocate for your needs and what is most important to you.

You can contact your co-ordinator by phone**: [Insert phone number]** or email: **[Insert email address]**

If your co-ordinator is unavailable, you can get in touch with **[Insert contact name] [ Insert contact number].**

If you have a question for somebody else in your team and feel comfortable reaching out to them, having a co-ordinator should not get in the way of you doing this.

# GIRFE Tool: Co-ordinator – role description for staff

**What is it?**
A co-ordinator is a trusted point of contact who will support people with the co-ordination of their plan and appointments. They will be able to answer any questions a person might have when working with a team.

They will work with a multi-disciplinary team to co-ordinate and meet someone's health and social care support needs.

This may describe how many multi-disciplinary teams already work. This role description is about ensuring that a co-ordinator is appointed for all cases where they are needed.

There must be respect and understanding of the co-ordinator role across multi-disciplinary teams in order for them to work effectively.

**Who should be offered a co-ordinator?**

Support from a co-ordinator should be offered to people who have an ongoing need for care and support.

They are most likely to be needed when there is more than one team involved in providing their care and support. This should be assessed based on the individual and discussing what would support them best.

**Who does it?**
A co-ordinator should be an existing member of a team providing care and support to a person.

They can work in any role in the team and are most likely to be based in the team a person interacts with most. For example, as a cancer patient is likely to be in touch most with an oncology team, you would expect the co-ordinator to be a member of this team. Or if a person has dementia and requires care at home, the co-ordinator may be a social worker.

However, if somebody else in the team has a strong relationship with a person, it is worth considering whether that would be a more helpful person to perform this role.

**How it works**
A co-ordinator is an integrated member of the team who supports everyone to work together to address the needs of an individual in a way that works best for them. This could include:

- Arranging appointments based on their work / caring schedules.
- Providing updates and alternative options if appointments need to change.
- Getting in touch with follow up information as/when needed.

They should have access to systems that allow for sharing of information between teams. This includes a person's plan, which is they key tool for understanding their history, needs and preferences.

**When to offer it?**
Teams should offer support when they see that things might become challenging or complicated.

For people who are new to receiving support from multiple teams, this should be offered at a time when at least two teams are coming together and there is a clear need for co-ordination to happen.

For people who currently receive support from multiple teams, this should be offered as part of ongoing conversations about whether any additional support is needed.

A person can be offered a co-ordinator and decide not to take up the offer if they or a member of their family/team feel able to manage this.

**What to do when a co-ordinator is no longer needed?**
How long a co-ordinator should provide support for depends on individual need. There should be regular check-ins to understand whether the support is still needed.

**Managing change**
If a co-ordinator moves on or there is a change in staffing, they should always be replaced and an update should be provided to the person they support as soon as possible.

## 7. GIRFE Draft Tool: Virtual Meetings

Throughout the co-design journey, it became clear that to facilitate a 'Team Around The Person', we need to be able to bring everyone in a team together in one place.

Pathfinder and partner teams reflected that a meeting space to enable these interactions would need to be accessible and easy to use and there would be clear support for the person before, during and after the meetings took place.

By having clear guidance around the use of virtual meetings, teams should be able to come together around a person more effectively. This also helps ensure a person's chosen support person and team are able to attend, while minimising the need for in-person appointments.

Virtual Meetings can also help practitioners to communicate with each other, and with the individual, around their plan.

Two tools have therefore been co-designed in order to implement effective Virtual Meetings. These are:

- a guide containing best practice tips for virtual meetings
- a storyboard detailing the example stages and steps of support required before, during and after a virtual meeting

An example of these tools are available below – however, you may wish to tailor these to the specific context in which you are working. This could include using a pre-existing template and ensuring alignment with this prototype and the principles of GIRFE.

# GIRFE Tool: Best practice for virtual meetings

**Preparation, preparation, preparation**
Don't underestimate how important this is (or how much though needs to go into it) to ensure a meeting is successful and makes the most of everyone's time.

Pre-meetings are a valuable way to have people involved in shaping the agenda and feeling involved in what matters to them. As is having a skilled meeting chair or facilitator who can keep the conversation on track.

**Purpose**
Focus on the 'why' behind the meeting and ensuring everyone is on the same page about it. Set expectations for all involved to ensure that the time spent together is productive.

Make sure the meeting invitation is clear and sets out what everybody should expect at the meeting.

**Offer technology support**
Do not make assumptions about skills or capability. Ensure technical support is offered to everyone when arranging a new virtual meeting. Prepare a draft of clearly written, step-by-step instructions for attending and joining a virtual meeting that you can re-use. Include details on requirements for a successful meeting, such as strong WIFI connection.

**Considering accessibility**
Ensure you understand a person's needs around a virtual meeting and what would be most helpful to them. Make any accommodations that are needed and make the team aware of what they might need to do too.

**Mutual respect**
You are entitled to respect from everybody on a virtual meeting. This respect works both ways.

# GIRFE Tool: Storyboard for Virtual Meetings

## Before meeting

Sally contacts her co-ordinator and tells them she wants to have a meeting about her plan. This is because there are multiple people involved and a meeting feels the simplest way of bringing the right professionals together.

The co-ordinator agrees this is a good idea and offers to give Sally support during the call. Sally agrees this is a good idea.

The co-ordinator asks Sally if she would like a meeting in person, online, or in a hybrid way. Sally would prefer it online. Her co-ordinator asks if she needs any tech support to have the meeting digitally. Sally has good wi-fi and a laptop, so feels comfortable.

Sally and her co-ordinator schefule in a virtiual pre-meeting to chat about what to expect from the meeting with the professionals. They co-design and agree the agenda and outcomes together. They also check Sally's sound and visuals are working ahead of the call.

The co-ordinator shares the agenda with Sally's team of professionals. The professionals are asked what they'd like to cover in the meeting too – and the co-ordinator checks Sally is comfortable with this. She is, and the final agenda is agreed by everyone.

## During meeting

The meeting has a chair: someone who is responsible for making sure everyone is heard, has support, and the meeting follows the agenda. The chair is the first to join the call.

Sally and her co-ordinator join the call next, just to make sure the tech is working.

The chair starts the meeting and asks everyone to agree to ground rules. Then they do some housekeeping, set out the agenda and explain how the call will be recorded. Everyone agrees to this.

During the meeting, Sally's co-ordinator checks in with her, asks if things make sense, or if she would like anything clarified. Sally asks for an explanation of a technical term. The chair helps explain the jargon and make sure everyone is on the same page.

Before the meeting ends, Sally, her co-ordinator and team of professionals agree next steps. There is transparency about what's next and the chair is responsible for making sure all actions are followed up. Sally feels reassured, listened to, and has clarity about her plan going forwards.

## After meeting

Sally's co-ordinator arranges a follow-up call and asks Sally for her feedback. They ask: how did you find it? Were the right people in the room? Was it accessible?

Sally gives her feedback. She also has the opportunity to ask any questions that she might have forgotten during the meeting. The co-ordinator agrees to follow up with these questions.

The co-ordinator gets back to Sally and provides answers to her questions. They also share an anonymous feedback form, so Sally can tell more about her experience in an anonymous way.

The co-ordinator ensures that there is a note summarising the meeting and follow up actions are recorded in a space that all team members an access.

## 8. GIRFE Draft Tool: Community Hub Principles

The positive impact of community and social connection has been a constant theme throughout the GIRFE co-design process.

Insights from engagement by pathfinders with people with lived experience have found that:

- social connection and the impact of loneliness is a factor on the health of older people and how they access services.
- services should be available in local areas, or support to travel to other areas if required.
- efforts should be made to use non-stigmatising language and avoid jargon and technical terms.

Building on these insights, the GIRFE pathfinders and partners have co-designed a set of principles which offer a vision for the 'community hub', representing its ambitions and how it should work. These principles can help support people within a community to build an inclusive, purposeful, and supportive community hub.

As well as a set of Community Hub Principles, pathfinders have prototyped a Community Hub toolkit and bank of case studies. Further work will be needed to consider where the toolkit and case studies would be held, however the following tools provides a starting point for these conversations and could be implemented on a smaller scale.

An example of these tools are available below – however, you may wish to tailor these to the specific context in which you are working. Existing services, third sector, and other organisations could also be considered as 'Community Hubs' if they follow the principles as set out.

# GIRFE Tool: Getting It Right For Everyone (GIRFE) Community Hub principles

**Community-led**
Local people are involved in decision making about how services are fun and how buildings are managed.

The community supports the delivery of the community hub through volunteering.

Ideally managed by a community-led organisation, but alternatively they can be owned or managed or supported by a public agency such as a housing association or local authority with substantial input from the community.

**Available and well-used**
A community hub could have a virtual and/or physical presence in a community.

Community hubs utilise local buildings and land to provide a base for these activities.

Maximises services on offer and open as much as possible.

**Engaging**
Key to the development of services/activities within the local community.

A place to engage with public services to ensure the communities voice is heard.

Linked to key service providers and local representatives in the community – e.g. community council, local councillors, location and areas manager, medical centre.

**Multi-purpose**
Providing and hosting a range of activities and services that are used by lots of different people.

The range of services reflect local need and may be delivered by local people, other organisations or public agencies – for example: parent and toddler groups, health and wellbeing activities, employment support, childcare, library services, advice and information.

**Financially sustainable and resilient**
Community hubs need an income to be sustainable.

A range of income sources are needed to cover the costs of running the building and maintenance.

Makes use of good ideas and resources within the community and can adapt to changing circumstances.

Receive and act upon feedback from the community on what is and what is not working.

# GIRFE Tool: Community Hub toolkit and case studies

**Available and well used**

Assets could be acquired through Community Asset Transfer (for example: an old school, sporting ground or town hall).

Community asset transfer summary guide: Asset transfer: summary guide - gov.scot (www.gov.scot)

**Community Led**

Conversations happen within a community and through existing planning and community development processes.

Locality planning should respond to the needs of the community. It must involve: people with lived experience, third sector organisations and local multi-disciplinary teams.

Need to develop a Service Level Agreement (SLA) with community led support and links into community hubs.

**Case Studies**

**Ochiltree Community Hub: Multipurpose Community Facility**

**Bailliefields Community Hub, Falkirk**

**Duncan Place Community Hub, Leith**

**Virtual Community Hub, West Dunbartonshire**

**Community Hub, Cumbernauld and Carbrain**

**Elephant and Castle Virtual Community Hub**

**Together Levenmouth, Fife**

**Virtual Village Hall, Royal Voluntary Service.**

**Financially sustainable and resilient**

A range of income sources are needed to cover the costs of running the building, maintenance, such as: grants, donations, hiring out space, delivering contracts.

**Engaging**

Staffed with a person / people who leads on community hub activity and providing information on services to people who access the hub.

**Multi-purpose**

See case studies

## GIRFE Draft Tool: Peer Support Training

The ‘Peer Support Training’ tool has been co-designed with an ambition to provide a framework to help consistently train and support people with lived experience, who want to support others who are or have experienced similar circumstances.

Pathfinder and partner teams worked together and agreed ‘Peer Support Training’ could make the following differences to a person’s life:

- the possible peer support mentor understands the role and shadows before they sign-up for training.
- peer support mentors are able to maintain their own wellbeing.
- peer support mentors feel confident in their knowledge.
- peer support mentors feel supported to carry out their role by a supervisor, peer, network.
- have adequate knowledge to signpost to services and activities.

Further consideration is needed to consider where the peer support training would be hosted, and to develop the content, however the following tool provides a starting point for these conversations and could be implemented on a smaller scale, while also informing a national approach.

This draft tool is available below and in PDF form to allow pathfinder and partner teams to further develop, test, and implement in areas where this training package would be most useful and to begin implementation, where possible, on a local scale.

An example of these tools are available below – however, you may wish to tailor these to the specific context in which you are working.

# GIRFE Tool: Peer Support Training Package

**Pre training information**

**Pre training shadowing**

**Training modules**

National and local case studies shared throughout the training. Followed by the questions: What would you do next? How would you react to this?

**End of training support**

Information and training modules

- Introduction to the organisation hosting the training
- What is peer support? What are the different levels of peer support? What are their principles, values and behaviours?
- Why become a peer supporter?
- What does peer support training involve?

- How to look after your personal wellbeing when being a peer supporter?
- How to follow confidential and legal guidance when peer supporting someone.
- How to share your lived experience in a trauma informed way.
- Shadowing an experienced peer support worker ◎

- Reminder of the principles, behaviours and values expected by peer supporters
- Understand more about the subject area where support will be provided
- Trauma training
- How to build knowledge of local services / activities
- Other information, general health and safety training for the buildings a person is working in, mental health first aid training, child protection guidance (if working in a recovery community)

- Knowledge of necessary professional, legal, ethical frameworks
- Understanding of confidentiality and data protection requirements and how to respond in a confidential way
- Other information: suicide awareness, drug awareness, naloxone training.

- Wellbeing resources / looking after myself
- Local / national mental health / wellbeing resources

- Developing skills e.g. active listening / communication, supporting wellbeing skills e.g. cooking, hygiene, health care
- Ability to share lived experience.
- How to deal with issues and challenges that arise

- Introduction to supervisor ◎
- Introduction to mentor or buddy ◎
- Introduction to peer support network ◎
- Opportunity to connect with my own peers and share learning. ◎
- Follow-up with continuous professional development

End of pre training information – decision to commit to

End of shadowing – decision to commit to training

End of training – quiz to test knowledge

End of training – role play scenario

Opportunity for progression into employed peer supporter or other paid employment

**Key:**

- Connection to a named person ◎
- Decision Point
- Assessment

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## 9. GIRFE Draft Tool: Community Connection

As part of co-designing the Community Connection draft tools, insights were gathered through research and engagement sessions with staff and people with lived experience and staff. Through this engagement it was clear that in all the GIRFE thematic areas, people felt isolated and lonely in their health and social care journeys. Many people found the system to be too 'reactive', with a lack of proactive and preventative care throughout. Often, people would access services for the social connection value and the impact of loneliness was repeatedly seen as a possible determinant of health, especially among older people.

A community connector's responsibility is to listen to, understand what matters to a person, and to link that person up with community resources, to empower them to make decisions about their own health and wellbeing.

For an individual accessing a community connector their experience will feel listened to, understood, and empowered to make decisions about their health and wellbeing. The community connector will make a difference for individuals by encouraging people to take preventative measures to support their health and wellbeing. The community connector will empower people to participate in their local community, articulate their desired outcomes and enable them to achieve those outcomes within their own communities. The community connector facilitates individuals finding purpose through community and connection with others.

There are two tools: one for professionals, to understand what values they would need to develop 'community connection' as part of their role. The second tool is for people with lived experience and what values they would expect to see in relation to community connection.

An example of these tools are available below – however, you may wish to tailor these to the specific context in which you are working. This could include looking to see if existing roles (such as community link workers or other relevant roles) in your area could promote and embed 'community connection'.

# GIRFE Tool: Community Connection

My responsibility is to listen, to understand what matters to you, and to link you up to community resources to empower you to make decisions abut your health and wellbeing.

**How to use this checklist**
We would like to ensure that people in Scotland have someone who can support them to be connected in their community.

To help make this happen, what skills and values would you like to build on?

## Empowering communities

- ☐ I am someone who is visible and proactive in the community.
- ☐ I have a focus on what matters to people.
- ☐ I have an understanding of challenges people face.
- ☐ I have local knowledge of community, voluntary and statutory services.
- ☐ I provide people with accessible and usable information so they can make their own choices.

## Kindness, dignity and support

- ☐ I have an empathetic approach.
- ☐ I will work to support people in a non-judgemental and supportive way.
- ☐ I understand how life events, like bereavement, can impact someone's life.

## Supporting your choice to access the right services and support at the right time

- ☐ I collaborate with other services and promote their role to people.
- ☐ I am responsive and proactive.
- ☐ I have established working relationships with NHS, social work, housing and DWP / Social security services.
- ☐ I fill in the gap between helping people be independent and enabling them to have choice and opportunity within their community.
- ☐ I have the support of statutory services and connect people to the right support they need.
- ☐ I understand Adult and Child protection.

# GIRFE Tool: Community Connection

## Community Connection

My responsibility is to listen, understand what matters to you, and to link you up to community resources to empower you to make decisions about your health and wellbeing.

We would like to ensure that throughout Scotland you have someone who can support you to be connected in your community. This means someone who:

### Empowers communities

- you know where to find them
- they focus on what matters to people
- they know what is on in your community
- they have an understanding of the challenges people face
- They can support you to decide what you want to do
- they are trained to connect you to the right support for your needs

### Champions kindness, dignity and support

- they are friendly
- they don't judge
- they listen to what you have to say
- they understand how life events, like bereavement, can impact your life

## Supports your choice to access the right services and support at the right time

- they know who else in the community can support you
- they are responsive and proactive
- they always encourage you to keep your independence
- they have the support of statutory services and connect people to the right support they need
- they have relationships with NHS, social work, housing and DWP / Social Security services
- they understand adult and child protection

## 10. GIRFE Draft Tools: Accessible and Useable Information

As part of co-designing the 'Accessible and Useable Information' draft tools, insights were gathered through research and engagement sessions with staff and people with lived experience and staff. It was apparent through this engagement that information about services and support must be accessible so that people can get the support they need when they need it. Information should be available in local areas, or people should be supported to travel to areas where the information is available if required. When creating information about services, efforts should be made to use non-stigmatising language and avoid jargon and technical terms.

'Accessible and Useable Information' is centred on ensuring people know there is a place where they can access accurate and updated information on local services. People can find the right information, at the right time, to support their health and wellbeing in their local area.

When accessing this useable information, it is important that people aren't overwhelmed by information that isn't relevant or provided information that is inaccurate or outdated. The information should reduce stigma by being trauma informed and meet the needs of the person accessing the information.

The 'Accessible and Useable Information' tool is a set of content standards outlining what is needed to create and maintain findable, accessible, and usable information online. This could be used by anybody looking to share information.

These tools are available below and in PDF form to allow pathfinder and partner teams to begin implementation in areas where this approach would be most useful, and to feedback to each other and the Scottish Government on impact.

The GIRFE pathfinders have also recommended the use of Compass by ARC Scotland. The Compass website aims to provide guidance tailor-made for young people and for parents/carers, to support young people with additional support needs or experience of care, as they transition to young adult life.

# GIRFE Tool: content standards

These are content standards for creating and maintaining findable, accessible, and usable information online.

**Good content is findable.**

Findable means that people know where to access information, without relying on the help of someone else. It should be visible on search engines and easy to find on the website.

**Good content is accessible.**

Accessible means the content can be found and used by anyone. This includes people who have:

- Disabilities or use assistive technology.
- Are non-native English speakers.
- Have difficulty reading.
- Have barriers to digital access.

There are tools we can use to review websites and make sure they meet these needs.

**Good content is usable.**

Usable means the content helps someone complete a task, like finding information about a service. It gives them what they need without making them work hard for it.

**Good content is readable.**

Readable means short sentences, no jargon, and only providing the essential information someone needs to know. Good content is written in plain English and can be understood by anyone.

**Good content is accurate.**

Accurate means up to date and reliable. Good content is reviewed on a regular basis to make sure it is accurate.

## 11. GIRFE Draft Tool: Moving On (A Conversation)

As part of co-designing the 'Moving On' draft tool, insights were gathered through user research and engagement sessions with people with lived experience and staff. This included engagement with young people in transition from children's to adult's services, and those who had already been through the transition.

These insights captured the need for service availability in local areas, with travel support available if necessary. Schools and prisons were recognised as places where short term support would be provided, but that this support would disappear when a person was not in that place. Many people found that information and access points into our services were unclear and/or inaccessible. People reported that the system was complex, information was not proactively made available and often not kept up to date online.

A person's access to information about a service was seen to be dependent on whether they had a carer or another person co-ordinating or advocating for them. Information was not seen to be easy to access. Many people found that coordination and administration of support often fell on an individual or became the role of a care giver such as a parent or family member.

The 'Moving On (A Conversation)' Tool will providing quality and appropriate information at the right time for children, young people, their family members, and carers. Using the tool will provide young people with their own plan to transition using the relevant local and national information. They will have a person who will support them before, during and until they have moved on and built a relationship with their adult key worker.

The 'Moving On (A Conversation)' tool will be underpinned by national legislation and accessible, accurate, and relevant information provided to the young person, supporting them throughout their transition.

The draft tool is provided below in the form as a storyboard outlining a positive experience of a young person transitioning from child to adult services. The storyboard covers 4 experiences: the young person's, their family member/carer, a co-ordinator supporting them through the transition and an advocacy worker supporting them to leave school.

# GIRFE Tool: Moving On - A Conversation

## A young person's experience

I started having conversations with my co-ordinator from the age of 12 using my plan. We have used it when things change, such as when I moved from primary to secondary school.

I'm going to leave secondary school soon. My co-ordinator makes sure my wishes lead any decision making.

At one of our chats, my co-ordinator shares information with me. They ask me how I would like to view the information if I have a smart phone or if I would like a leaflet. It includes national and local information.

My co-ordinator supports me to sign up to the national information and search the website. I want to find out information about my needs and interests.

My co-ordinator and I plan another chat to discuss leaving school. My care co-ordinator checks the information makes sense to me.

We have a series of chats to plan leaving school. These chats continue until after the move has happened. Our chats are in bite sized chunks. I feel I have time to think about what I want and need.

## Family member / carer of a young person leaving school

At parents evening, my young person's teacher points out an information stand. It has resources about leaving school. I learn about national and local information.

I hear about the national resource again when I take my young person for a planning review with their co-ordinator.

My young person logs in to the national resource and the care coordinator suggests I log in too.

I sign up to the national resource on my phone. I learn what support is available for me, as well as my young person.

Later that week, I'm chatting with another parent of a young person leaving school. They share resources that I didn't know about and I tell them about the national resource.

## Co-ordinator supporting a young person to leave school

I have annual training on how to have good conversations. At the training I'm given a toolbox of resources and given guidance on how and when to introduce them to children and young people.

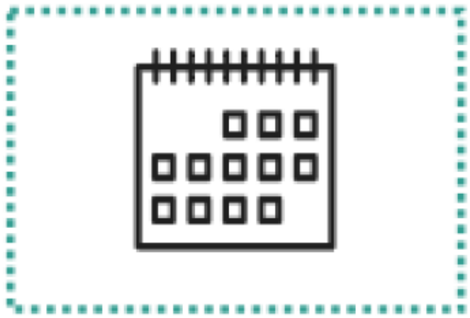
I have the skillset needed to support young people leaving school and I know I'll be able to support them until after they have settled into life after this move.

When I chat to the children and young people support, I know where to find information about leaving school. The toolbox supports me.

I support the young person until after they have left school and build a relationship with them.

## Advocacy worker supporting a young person to leave school

It's time for a young person I support to think about leaving school. We meet to chat about their views and wishes. During the chat, I make sure the young person understands their rights.



The young person asks me to come to chats with their care co-ordinator person.

Before the meeting, I hear an update from my organisation about national and local information. I'm confident I know more about what is available for children and young people in our area.

After the chat, I make sure the young person's views and wishes lead the decision-making.

I know I'll be able to support them until after they have settled into life after this move. I'll support the young person until they have built a relationship with their advocate in adult services.

# GIRFE Tool: Moving On – Leaflet template

## Prototype - Moving on leaflet

### Key resources

For young people moving on:

Compass

[Insert local resources] - e.g. Link to Community Hub webpage

GIRFE

GLOW

Do you know what clubs and supports are available as you grow up?

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Leaflet(A5)_print A4.pdf

**Would you like to extend your personal network?**

**[Tailored to age group]**

[Insert local community groups]

[Insert local services]

**Why is it important to chat about moving on to; primary school, secondary school, college, university, work?**

[Tailored to age group]

It's important to think about who you could call upon if you become unwell or are worried about something.

It can help to speak to your friends and peers about **your worries.**

**Would you like to speak to a care coordinator / named person about moving on?**

**Get in touch at...**
**[Insert contact details]**

We will arrange a chat for you to speak about what matters to you and how we can help connect with your peers.

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Leaflet(3 piece)_printA4.pdf

getting it right for everyone

## 12. GIRFE Draft Tool: Support Bag

As part of co-designing the 'Support Bag' prototype, insights were gathered through user research and other engagement sessions with people with lived experience and staff. Services available in and out of prison should be non-stigmatising and support those with feelings of low self-worth. People in prisons are more likely to engage with peer led support over other services and digital exclusion frequently occurred when a person was unable to access information or make appointments due to digital skills or costs associated with email and mobile phones. Feeling safe, supported, and having a routine is important for people upon release.

The 'Support Bag' Draft Tool is a bag of essentials to help people stay well and stay connected to their local community. The 'Support Bag' will provide dignity and respect to people moving back into the community at the moment they are liberated from prison. The bag will enable them to carry their belongings and additional essentials that help empower them to access local support and services.

The 'Support Bag' will make a difference by ensuring individuals are not leaving prison with their belongings in a bin bag and nowhere to go. The 'Support Bag will include a core bag of information and items. Each 'Support Bag' will utilise a pick and mix approach to ensure the information and items included in the bag are specific to that person's needs and preferences. Information in the bag should signpost a person to what is available to support them, so they feel empowered and are supported to access what can be a complicated system to navigate. It helps people to feel safer and better integrated back into their community.

The 'Support Bag' will be underpinned by national training for staff who deliver and have conversations around the bag. The quality of Support Bag content, conversations and delivery will be monitored consistently and ensure the information in the 'Support Bag' is accurate and relevant.

The draft tool below contains three PDF documents including a script to support a member of staff to have a conversation with a person in prison about what they might need in a 'Support Bag'. A checklist for a member of staff to make up the 'Support Bag' for the person who is due to leave prison and a timeline showing the steps from ordering to receiving a 'Support Bag'.

While the 'Support Bag' tool has been developed for people in prisons, the concept could be amended and expanded for other groups where a transition is taking place.

An example of these tools are available below – however, you may wish to tailor and amend these to the specific context in which you are working.

# GIRFE Tool: Leaving Prison – Support Bag – Script

Date _____ Name of person _____ Date of liberation _____

I am X, I am your peer support worker / support co-ordinator. You can get in touch with me in the run up to and when you have been released.

As it is 4 weeks until your liberation date, we need to plan for this, so you have as smooth a transition as possible. When you leave, you will be given a bag. The aim of this is to give you the essential for when you leave prison.

**All bags include:**

- A map of the local area with key places marked (for example: high street with shops and cafes, bus and/or train station, pharmacy, GP practice, supermarket, post office, job centre, place to charge phone, local services and support groups (A Local Information System for Scotland).
- Telephone number of local GP (who has open list and is able to take new patients).
- Information about the local pharmacy and how to get your prescriptions.
- A bus pass.
- Name of the person who will meet you at the gate and take you to your accommodation.
- Any prescriptions you have had while in prison so that you can collect these once released.
- A food voucher.

Are there any places that we have not mentioned that you would like to have marked on the map?

_____
_____
_____

Is there anything else you would like to know about what is on this list?

_____
_____
_____
_____
_____

You can also have some items you choose to add to the bag. Tell me which of these sound good for you. If you would like more time to think, I can give you the checklist and you can return it to me next week.

- ☐ Toothbrush
- ☐ Shower gel
- ☐ Shaving kit
- ☐ Socks
- ☐ Underwear
- ☐ New phone with charger
- ☐ New SIM Card
- ☐ Period products

Is there anything missing from this list that you think you would need? Tell us what else you need:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

☐ If you just want the bag, please tick this box.

Please can you tell us why these items would not be useful to you.

_____
_____
_____

# GIRFE Tool: Leaving Prison – Support Bag – Checklist

**Date** _____ **Name of person** _____ **Date of liberation** _____

| Requested | Added to bag | |
|---|---|---|
| ☐ | ☐ | Bag |
| ☐ | ☐ | A map of the local area with key places marked |
| ☐ | ☐ | Telephone number of local GP |
| ☐ | ☐ | Information about the local pharmacy and how to get your prescriptions |
| ☐ | ☐ | A bus pass |
| ☐ | ☐ | Name of the person who will meet you at the gate and take you to your accommodation |
| ☐ | ☐ | Any prescriptions you have had while in prison so that you can collect these |
| ☐ | ☐ | A food voucher |
| ☐ | ☐ | Places listed added to the map: |
| ☐ | ☐ | Toothbrush |
| ☐ | ☐ | Shower gel |
| ☐ | ☐ | Underwear |
| ☐ | ☐ | New phone with charger |

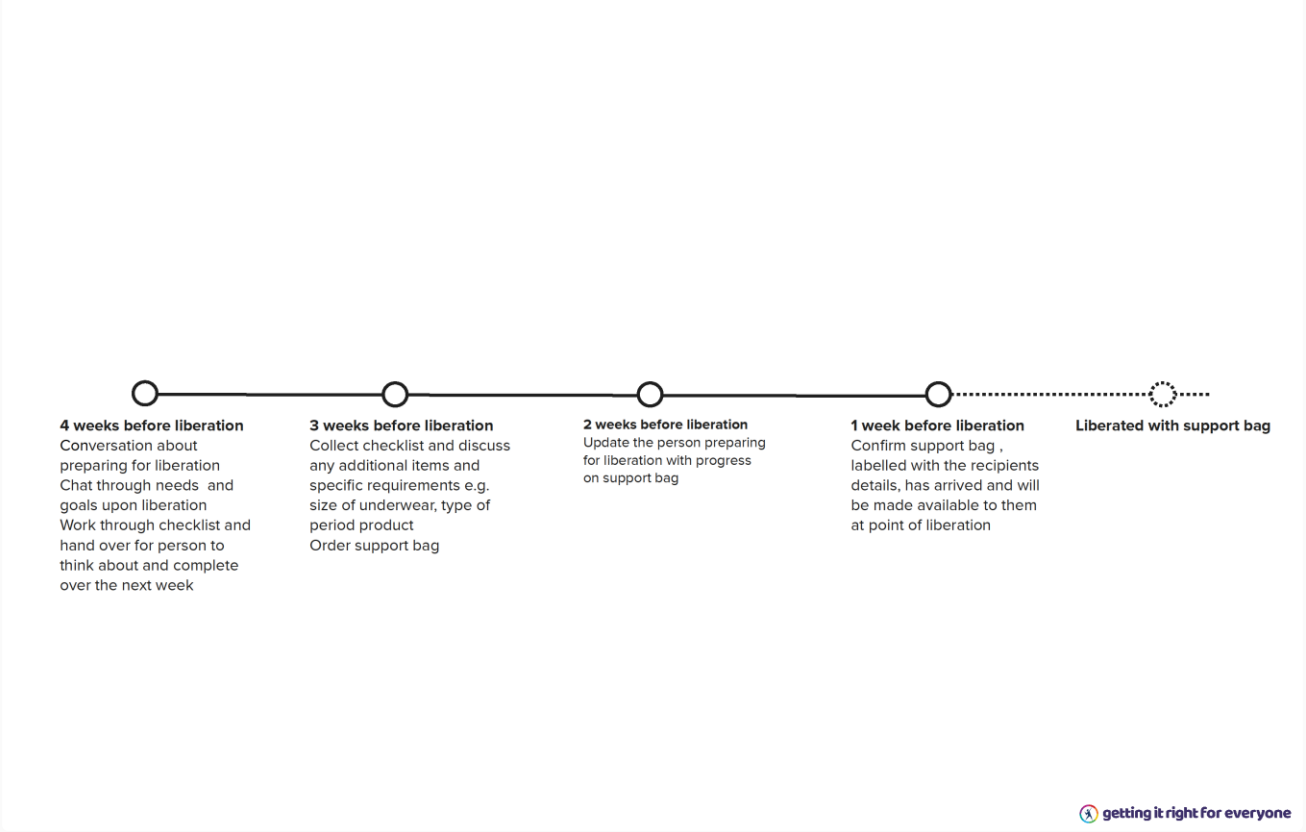
**Date** _____ **Name of person** _____ **Date of liberation** _____

| Requested | Added to bag | |
|---|---|---|
| ☐ | ☐ | New SIM card |
| ☐ | ☐ | Period products |
| ☐ | ☐ | Shaving Kit |
| ☐ | ☐ | Socks |

Other request:

| | | |
|---|---|---|
| ☐ | ☐ | _____ |
| ☐ | ☐ | _____ |
| ☐ | ☐ | _____ |
| ☐ | ☐ | _____ |

# GIRFE Tool: Support Bag - Timeline



# 13. Next Steps

While the draft toolkit for the 'Team Around The Person' is only the start of the GIRFE journey, it provides us all with the tools to be able to showcase the potential impact of a GIRFE approach across our public services, while also ensuring action can start to take place in the here and now, that will positively impact the people of Scotland. This draft toolkit provides a starting point for the implementation of a 'Team Around The Person' which will help us to embed the GIRFE approach across health and social care in Scotland.

The 'Team Around The Person' will help to provide a more personalised way to access help and support when it is needed – supporting practitioners to place the person at the centre of all decision making that affects them to achieve the best outcomes, with a joined-up, coherent and consistent multi-agency approach regardless of the support needed at any stage of life.

Furthermore, the insights which have been developed throughout the co-design process have further strengthened the case for a GIRFE approach to be taken across health and social care, and beyond. Discussions are now underway within the Scottish Government around the potential impact of a GIRFE approach being taken within Health and Social Care, the Scottish Government, and into wider public services.

The publication of the 'Team Around The Person' toolkit will help us to build this momentum further, to ignite further discussions and action around how a GIRFE approach can benefit the people of Scotland, and to build the evidence base of how a GIRFE approach can improve our public services and people's lives. The implementation of the GIRFE draft tools by pathfinders and partners will ensure positive action and change that can happen **now** – while those wider discussions continue around how we can continue to take the learnings from GIRFE, share best practice between professionals, and to implement a GIRFE approach into the wider Scottish context.

We would like to thank our GIRFE pathfinders and partners for the immense amount of work they have put into ensuring that this toolkit is co-designed with the people of Scotland. We would also like to thank the people with lived experience who have contributed their thoughts, ideas, and helped to co-design this toolkit.

As pathfinders and partners begin to test the tools within this toolkit across different contexts, the SG GIRFE policy team will socialise the tools further with policy areas across SG, to create a collaborative call to action within the SG and the system to further develop and implement these tools across Scotland. This will include exploring any barriers to the implementation of these tools. The intention will be to publish an updated version of the toolkit in Autumn 2024, once any amends have been made to the tools and any further detail added.

As well as ensuring pathfinders and partners are able to develop, implement, and share best practice around the 'Team Around The Person' toolkit, the SG policy team will work with the GIRFE pathfinders and partners to consider how the GIRFE approach, via embedding the GIRFE principles, can be rolled-out across the system.

The priority areas of focus for this next stage will be digital development and information sharing, as well as leadership and culture development.

We look forward to continuing to work with you as we take the 'Team Around The Person' and the GIRFE approach, across SG, the health and social care system, and beyond.

Thank you,

The GIRFE Team