Perth and Kinross Health and Social Care Partnership

Annual Performance Report 2016/17

NHS Tayside

PKAVS Enhancing Lives, Connecting Communities

Perth & Kinross Council

Contents

Introduction

Welcome to our first annual review of the performance of the Perth and Kinross Health and Social Care Partnership (HSCP). We've continued our commitment to change the way we support and deliver health and social care services in Perth and Kinross to meet the many challenges facing individuals and our communities.

This commitment and our specific plans and priorities are set out in our Strategic Commissioning Plan 2016-19. The plan places a lot of emphasis on the need for services and support **to intervene early to prevent later, longer term issues arising, and enabling people to manage their own care and support by taking control and being empowered to manage their situation**. Where this is not possible, our aim is for services to **target resources** where they are needed most, reducing ill health and deterioration and ultimately reducing health inequalities.

This document reviews our performance in the first year of our partnership and the extent to which we have been able to deliver our ambitious programme of change and reform.

Our work has focused around the five key themes of the Strategic Commissioning Plan:

1. ***Prevention and early intervention:*** *intervening early to prevent later issues and problems arising.*
2. ***Person-centred health, care and support:*** *putting people at the heart of what we do, listening, empowering and supporting.*
3. ***Working together with our communities:*** *recognising the wealth of knowledge, experience and talents that local people have within their communities.*
4. ***Reducing inequalities and unequal health outcomes and promoting healthy living:*** *focusing our efforts on those who most need care and support.*
5. ***Making best use of available facilities, people and other resources:*** *spending our time and money wisely, focusing on what will make the biggest impact to meet the above priorities.*

These themes run through each of the sections within this report, the contents of which are defined by legislation and measure:

- *Scottish Government's National Health and Wellbeing Outcomes.*
- *Financial planning and Best Value.*
- *Performance in respect of localities.*
- *Inspection of services.*
- *Review of our strategic plan.*

Robert Packham
IJB Chief Officer

Section 1: What will a successful Perth and Kinross health and social care system look like in future?

Our Vision

We will work together to support people living in Perth and Kinross to lead healthy and active lives and live as independently as possible with choice and control over the decisions they make about their care and support. Our aim is to improve the wellbeing and outcomes of people living in Perth and Kinross, to ***intervene early*** *and work with the third and independent sectors and communities, to* ***prevent longer term issues*** *arising.*

We will do this by:

- *developing integrated locality teams, so that all clinical, professional and non-clinical staff can work together in a co-ordinated way to improve access and the quality of services;*
- *ensuring that people, including carers and families, are at the centre of all decisions;*
- *combining staff and resources to deliver a wider range of care within communities and supporting people to be cared for at home;*
- *improving the health of communities through wider partnership working to:*
    - *identify the health and care needs;*
    - *focus on health promoting activity;*
    - *taking action to improve wellbeing, life circumstances and lifestyles and actively.*

What have we achieved?

In our Strategic Commissioning Plan we describe key aspirations and a vision for the future delivery of health and social care services:

- *what we see as our future health and social care system;*
- *key transformation projects and changes to meet these challenges;*
- *how staff will be supported to deliver integrated services;*
- *the whole system as we prepare for the future.*

This report summarises our progress over the past year in meeting the above priorities and challenges and analyses performance around the 9 national outcomes for health and social care, as well as some key themes.

Some **key areas of focus** have been:

- ***Reducing unplanned admissions to hospital*** *remains a key priority for the Partnership. This is complex as it requires a range of partners to work together, including GP's, independent care*

providers, third sector, health and social work staff, to deliver person-centred care. Although we have seen both a decrease in emergency admissions and a reduction in the length of time people are spending in hospital, it has been a challenging period, and we recognise the need for continued improvements across the system to support our ambitions.

- *Managing **delayed discharge** continues to be a key priority and we have a wide ranging improvement plan in place which aims to:*
    - *implement our new more flexible care at home contract with external providers;*
    - *work with providers to attract people into the care profession;*
    - *introduce a new procedure whereby the Council will take over the Welfare Guardianship if the family are not making reasonable steps to complete the process quickly;*
    - *we have doubled the size of the hospital discharge team to ensure we have sufficient social work capacity to manage the number of assessments;*
    - *we will implement a discharge lounge to support timely person centred discharge.*
- *We introduced a **discharge hub** to improve the patient pathway by placing the patient and their carers at the centre of their care and discharge from hospital by ensuring an integrated, co-ordinated response which is consistent, safe and timely.*
- *Our **Enhanced Community Support** initiative facilitates a multidisciplinary approach to support people to remain in their homes and is now in 10 GP practices in Perth City and Strathmore. The initiative is currently being rolled out across Perth and Kinross (North West and South Perthshire). The approach aims to keep hospital admissions as short as possible or to prevent them where appropriate. It provides prompt identification and timely support to adults and older people's healthcare needs, helping to avoid crisis management and unnecessary or prolonged hospital or care home admissions. The patient plays a key role in the process.*

Other developments have been:

- ✔ *Introduced a new, more flexible care at home contract with 10 providers to expand capacity and meet current and future needs.*
- ✔ *Implemented a successful 'Why should I care?' campaign to encourage more people to become home carers.*
- ✔ *We introduced Participatory Budgeting for carers bringing in their expertise into the development of services called "Carers Voice, Carers Choice".*
- ✔ *Agreed a new internal care at home model to meet the rising demand for care at home services.*
- ✔ *Made significant efficiencies and savings through our transformation programmes, including reviewing care packages and communities first and agreed the next stages of transforming residential and day care during 2017.*
- ✔ *Developed a transformation programme for 2017 and beyond which includes transforming District Nursing Services, improving older people clinical pathways from community to hospital and back into the community.*

Where have we still to improve?

We need to plan and deliver across the whole system of health and social care, and include the Third and Independent Sectors, as well as Housing and other key partners, if we are to enable people to have the health and care services they need in their local communities. They need to be empowered and supported to have greater control over their lives and manage their own health and care where appropriate. This means looking at the **whole system** and we set out to**:**

- *further develop locally-based integrated teams to drive and manage health and social care locally and develop locality-based planning and commissioning;*
- *continue to engage, and with the General Practitioners using the established GP Cluster approach, to identify improvement actions for 2017/18;*
- *work with primary care colleagues to integrate community health services that work with GP practices, community pharmacists, dental practitioners and optometrists;*
- *connect relevant third and independent sector staff into integrated care teams in localities;*
- *work with local communities, Primary and Secondary Care to identify how community hospitals can be developed to provide planned and enhanced care with better access to diagnostics;*
- *enable more effective planning with acute (hospital services) to support new ways of working;*
- *expand our use of technology, particularly in rural areas;*
- *provide access to the extended Primary Care Teams;*
- *better support for mental health and wellbeing.*

And thereby reduce unplanned hospital admissions and people delayed in hospital.

What are our key challenges in delivering these improvements?

- *Preparing for the population increase, along with the rising demand for services, whilst managing significant change in public services and finance.*
- *Predicted increase in the number of people living with dementia and long-term conditions.*
- *Shifting the balance of care by reducing the use of large hospital services and to invest more in community health and social care services.*
- *Redesigning and introducing new innovative models of care which enable people to be supported in and by their local communities for example through the Communities First transformation project.*
- *Progressing with our transformation projects to radically change services and achieve challenging savings targets.*
- *Recruitment and retention of health and social care staff particularly as there are well reported national shortages.*
- *Supporting staff with a culture of new ways of working, individual personalised care and support.*
- *Continuing our review of Care at Home provision to ensure it meets demands.*

Section 2: Our performance in relation to the 9 national health and social care outcomes

National Outcome 1

People are able to look after and improve their own health and wellbeing and live in good health for longer.

We are working together to make sure people are supported to lead as independent, healthy and active lives as possible.

In 2016/17, we redesigned social work and social care fieldwork teams and there is now a team dedicated to focus on early intervention and complex care to help improve people's ability to look after and improve their own wellbeing. The table below highlights progress towards achievement of our objectives. The indicator on reablement reflects the fact that there are more people with complex needs requiring support, so this is an area for continued monitoring. We have also increased the number of people using Technology Enabled Care which has enabled people to stay at home (Outcome 7 refers).

Indicator	2015/16 Perth and Kinross	2016/17 Perth and Kinross	RAG*	2016/17 Scotland *(unless otherwise noted)*
Percentage of adults able to look after their health very well or quite well. *(Source: HACE**)*	96%	n/a		94% (2015/16)
Rate of emergency admissions per 100,000 population for adults.	11,041	11,121 (prov)		12,037 (prov)
Percentage of people who have received a newly confirmed dementia diagnosis who are supported to understand the illness and manage their symptoms.	84%	86%		Local
Percentage of people requiring no further services following Reablement.	38%	34%		Local

**RAG: Red = performance is declining above tolerance level; Amber = performance is declining but within tolerance level; Green = performance is improving.*

***HACE survey is undertaken every two years therefore information is not available for 2016/17.*

How did we do?

- ✔ *96% of people within Perth and Kinross feel that they are able to look after their health well compared to 94% across Scotland.*
- ✔ *Our premature mortality rate is significantly less than the Scottish average.*
- ✔ *We had an increase in people who received a newly confirmed diagnosis of dementia who were supported to understand and manage their symptoms.*
- ! ***Reablement - fewer older people** required no further service after being supported by the Reablement service, which reflects the increasing number of frail and complex people needing support. In addition, slightly fewer people received Reablement in 2016/17 (882, compared to 893 in 2015/16). Work is ongoing to increase these numbers and move people on to care at homes, as appropriate.*

What else have we done?

Working alongside the Third Sector, we have supported initiatives which help people to look after their health and wellbeing, including:

- ***The Letham Wellbeing Mini Hub** developed to give local people easy access to a range of services, including childcare provision and adult learning therapies.*
- ***Wellbeing Fair** is a unique series of partnership events to promote mental wellbeing, self-management and sustainability, and to help tackle the stigma of mental illness.*
- ***Dementia Cafés** offer conversation, company, tea and cake and support people who might otherwise find it difficult to get out of the house.*
- ***Golf Memories** provides a forum for older people to meet and talk about their golfing days and also revive their golf skills. It boosts mental health and provides valuable social interaction and exercise.*
- *A new **'Friendship Network'** was launched in October 2016 to connect older people in their communities and help reduce social isolation. Other initiatives aiming to reduce social isolation include:*
  - *The Craigie Tea Dancers Group*
  - *Clicking Needles Knitting Group*
  - *The Boxing Project which helps young people with social issues to turn their lives around.*

Craigie Tea Dance not only brings me entertainment, it keeps me active and healthy. I also enjoy the social aspect of the group.

I didn't like leaving the house…. the hub (TullochNET) has given me somewhere to go and I have made new friends.

- ***Tullochnet*** *helps reduce social isolation through drop-ins at the Hub, Lunch Clubs, Craft Sessions as well as providing a much needed venue for outreach services.*
- *The launch of* ***Smart Recovery Family & Friends*** *supports people who are directly affected by a loved one's addiction.*
- ***Positive Choices*** *supports adults with multiple health issues with self-management techniques to help them to become more in control and empower and live their lives well.*
- ***Care Home Activity Network*** *supports care homes to provide individualised person-centred, meaningful activity opportunities to improve their residents' physical and mental health and wellbeing.*

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PERTH & KINROSS

AN INITIATIVE FROM PERTH AND KINROSS HEALTH AND SOCIAL CARE PARTNERSHIP:

Case Study

Activity Referral Programme - Live Active Leisure

Supports adults referred by GPs and healthcare practitioners and is aimed at people with a range of low to medium risk conditions - weight management underpins many referrals due to the impact on health conditions.

Outcomes

- *73% of customers had reduced blood pressure after completing 24 sessions.*
- *62% had reduced their weight.*

Improvement Areas

- *Continuing to support staff to focus on early intervention and prevention by anticipating people's needs and by taking a person-centred approach. This will be a key area of focus within our workforce and organisational development plans.*
- *Continuing to build capacity in local communities to enable people to take control and develop initiatives in their local areas, improving access to support and information, and expanding the Emarket place.*
- *Increase our focus on promoting self-management of long-term conditions, including improved pain management, through third sector partnerships.*

- *Working with wider partners to tackle inequality and exclusion, eg employability, transport and isolation.*
- *We are embarking on a Care About Physical Activity Improvement Programme involving 15 care homes and 15 care at home providers, day care, and housing with care services to increase levels of physical activity with older people.*

Go for Gold Challenge

National Outcome 2

People, including those with disabilities or long-term conditions, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.

We want people to have the health and care services they need within their local communities and to empower people to have greater control over their lives.

Self- directed support (SDS) has enabled people to choose the way their care and support are provided, promoting choice and control and the number of people choosing SDS has increased. We have also continued to invest and increase Technology Enabled Care to support more people at home and our figures show that people are remaining at home longer - the average age of a person entering a care home is now 86.6 and average length of stay is 1.5 years, compared to the previous year of 85 years and 1.7 years respectively.

Reducing unplanned admissions to hospital remains a key priority for the Partnership. This is complex as it requires a range of partners to work together, including GPs, Scottish Ambulance service, independent care providers, third sector, health and social work staff, to deliver person-centred care. Although we have seen both a decrease in emergency admissions and a reduction in the length of time people are spending in hospital, it has been a challenging period, and we recognise the need for continued improvements across the system to support our ambitions. We hope to see this realised through the redesign of community and hospital services such as redesign of care at home, Enhanced Community Support and Front Door model in

Perth Royal Infirmary. The Front Door model involves an enhanced multi-disciplinary team within the medical admission unit to provide a comprehensive geriatric assessment to those over 65 to identify the most appropriate pathway for the individual so as to reduce the time spent in hospital and timely discharge.

The table below summarises some key indicators which support this outcome.

Indicator	2015/16 Perth and Kinross	2016/17 Perth and Kinross	RAG*	2016/17 Scotland *(unless otherwise noted)*
Percentage of adults supported at home who agree that they are supported to live as independently as possible. *(Source: HACE**)*	79% (84.9% Perth and Kinross)	n/a		84% (2015/16)
Rate of emergency bed day per 100,000 population for adults.	124,438	117,545 (prov)		119,649 (prov)
Readmissions to hospital within 28 days of discharge per 1,000 admissions.	115	117 (prov)		95 (prov)
Proportion of last 6 months of life spent at home or in a community setting.	88%	88% (prov)		88% (prov)
Percentage of adults with intensive needs receiving care at home.	57%	Sep 2017		62% (2015/16)
Percentage 65+ with intensive care needs receiving care at home.	32%	37%		Local
Number of people using SDS Options 1 and 2 as a percentage of all people accessing services via SDS.	11.7%	14.4%		n/a

**RAG: Red = performance is declining above tolerance level; Amber = performance is declining but within tolerance level; Green = performance is improving.*

***HACE survey is undertaken every two years therefore information is not available for 2016/17.*

How did we do?

- ✔ *In our local survey 85% of people said they were supported to live as independently as possible however in the national survey only 79% agreed.*
- ✔ *We had a lower % of adults with intensive care needs receiving care at home than across Scotland (57% and 62% respectively). Through locally developed indicators we reported 32% for 2015/16 and 37% in 2016/17.*
- ✔ *88% of people spent their last 6 months of life at home or in a community setting, which was similar to Scotland.*
- ✔ *More people managed their own care through Self-Directed Support - 2016/17 - 14.4% compared to 11.7% in 2015/16.*
- ✔ *We supported 168 more people to remain at home with the help of Technology Enabled Care (1,464 in 2016/17, compared to 1,296 in 2015/16).*
- ✔ *The emergency admission rate to hospital was lower than across Scotland (11,121 per 100,000 compared to 12,037).*
- ✔ *188 more people received the wide range of care at home services in 2016/17 (1,638) than the year before (1,450).*
- ✔ *More people were able to remain at home due to support from the Small Repair or Major Adaptation Service. During 2016/17, 70% for major adaptions responded and 47% for small repairs - all indicated they were satisfied with the service received.*
- ✔ *We introduced a new and more flexible care at home contract with 10 care providers to enable more people to be supported and home and to support discharge from hospital.*

What else have we done?

- *The **Capacity and Flow** approach is currently being developed to ensure we have the right resources available when and where they are needed and includes hospital beds, clinics, community service and trained staff. People will then be provided with the care and support they require in the right place at the right time and by the right person. The programme continues to implement 6 essential actions for unscheduled care as follows:*
    - *clinically focussed and empowered hospital management;*
    - *hospital capacity and patient flow;*
    - *patient rather than bed management;*
    - *medical and surgical processes arranged to improve patient flow;*
    - *7 days services to reduce variation.*
    - *ensuring patients are optimally cared for in their own homes or homely setting.*
- *We have created a **Discharge Hub** to support individuals and their carers/families to safely and quickly be discharged from hospital supported by a wide range of staff including Occupational Therapists, Nurses, Social Workers and Social Care staff.*
- *Our **Care and Repair Service** is fast tracking level access showers for people aged 80+; adaptations for people diagnosed with dementia; and installing smoke for people given a grant.*
- *Our **Enhanced Community Support (ECS)** initiative facilitates a multidisciplinary approach to support people to remain in their homes and is now in 10 GP practices in Perth City and Strathmore and is to be rolled out across North West and South Perthshire. It helps reduce hospital admissions and provides prompt identification and timely support to people thereby avoiding crisis management and unnecessary or prolonged hospital or care home admissions. The patient plays a key role in the process.*

It's amazing to see such great communication between all carers and professionals - they work well together as a team.

(ECS Patient)

We have felt that we have been listened to have felt relaxed. It makes you feel that you can cope and you are confident.

(ECS Carer)

- *We are supporting the development of the **Care Co-operative in Highland Perthshire**, including a referral pilot scheme in partnership with the GP surgery in Aberfeldy and a befriending scheme, to support isolated people in that area.*

(continued overleaf)

What else have we done?

(continued)

- ***Self -Directed Support (SDS)** Week was held nationally, in June 2017 and in Perth and Kinross a number of events was held to raise awareness of SDS and how it can help people to live independent and happy lives, and achieve their own agreed positive outcomes. SDS training has been delivered to South Asian, Chinese, Easter European and Gypsy/Traveller communities. An outreach link officer now attends social work assessment meetings to provide support with cultural aspects for minority ethnic individuals.*
- *We have delivered **localised specialist** Ultraviolet Light Therapy treatment in Crieff Community Hospital for the treatment of skin conditions. This has allowed specialist treatment to be provided much closer to home rather than people travelling to Ninewells Hospital. In 2017 we will be providing this clinic in Pitlochry.*

Improvement Areas

- *We will implement a new model for care at home which will support prevention, reablement and care package reviews.*
- *We will develop frailty and deteriorating health pathways to improve the health and wellbeing of people and to empower them to take responsibility of their own care.*
- *We will work with GP practices to optimise cost effective prescribing, tackle the issue of unplanned admissions, work with locality teams and roll out Enhanced Community Support.*
- *We will work in partnership with clinicians, social care and the third sector to review and redesign our clinical inpatient pathways for older people to improve the experience and journey of care.*
- *We will conclude the first phase of our review of Older People Mental Health Services which is focusing on intervening early and improving support for older people and their carers living with a mental illness.*
- *Although we reduced the number of bed days lost due to people remaining in hospital after they were ready to be discharged to 15,429 days, this is still too high, so we have to implement a number of changes to improve this figure for next year.*

Case Study

Enhanced Community Support

A person who received Enhanced Community Support explained about her collapse at home and the support she received. The District Nursing Team responded within 10 minutes with the GP visiting soon after. The District Nursing Team then arranged for intensive support for her at home for the first week between themselves and the Rapid Response team to get her back on her feet.

After the first week Occupational and Physiotherapists assessed the person's mobility with equipment installed in her home. Mrs X has been supported by the multi-disciplinary team to remain in her own home without the need for admission to hospital.

National Outcome 3

People who use health and social care services have a positive experience of those services and have their dignity respected.

We work in partnership with individual service users, carers, tenants and a range of other stakeholders to develop and improve services through individual and community engagement, service satisfaction surveys, user reference groups, service planning groups and tenant scrutiny groups.

The health and social care ***'Join the Conversation'***, which was led by the 3rd sector, health and social care staff, engaged over 4,000 people across Perth and Kinross to inform the priorities and actions in the health and social care Strategic Commissioning Plan. The extensive engagement programme revealed a lot about how individuals and communities experience health and social care services and their priorities for future delivery. Importantly, many of those involved in the events are continuing to influence and inform local planning and priorities through local network groups.

The following tables highlight the results from national and local surveys which lets us see what people think of the services they have received.

Indicator	2015/16 Perth and Kinross	2016/17 Perth and Kinross	RAG*	2016/17 Scotland *(unless otherwise noted)*
Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided. *(Source: HACE**)*	78%	n/a		79% (2015/16)
Proportion of care and care services rated good or better in Care Inspectorate inspections.	85%	Sep 2017		83% (2015/16)
Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated. *(Source: HACE**)*	73%	n/a		75% (2015/16)

**RAG: Red = performance is declining above tolerance level; Amber = performance is declining but within tolerance level; Green = performance is improving.*

***HACE survey is undertaken every two years therefore information is not available for 2016/17.*

How did we do?

- ✔ *The national Health and Care Experience Survey (HACE) found that 73% of adults supported at home agreed that their health and care services seemed to be well co-ordinated.*
- ✔ *National HACE survey results will not be available for 2016/17, however we carry out our own annual Social Care survey to gather feedback from people who are service users. The results are summarised below. In future, this annual survey will be expanded to include the feedback from Health service users in 2018.*

A small survey of patients receiving care from District Nurses was undertaken in October 2016 with a 100% response rate. 90% of patients and 80% of carers responded that they felt able to look after their own health and wellbeing or able to support the health and wellbeing of the person they care for. 90% of carers felt that they were supported to continue in their caring role and 90% of patients felt that the District Nursing service helps to maintain or improve their quality of life. However, only 50% of patients and carers agreed that they had a say in how the care and support was provided. The transformation of district nursing services will embed a person-centred approach to the care and support provided.

The partnership, and several community organisations working in health and wellbeing, contributed to a Perth and Kinross Fairness Commission in 2016/17. The final report is a challenge to all local partners to increase awareness and understanding of poverty and inequality and be inspired to act. In addition to themes such as Fair Work and Better Connections, the report brought out the need, around our older population to see the individual person, to recognise and support their needs, aspirations and circumstances, ensuring people are treated with dignity and respect. This includes the role of unpaid carers in caring for loved ones. The Community Planning Partnership will take forward key recommendations from 2017.

Perth and Kinross Social Care Survey Results for relevant indicators that match to the survey (HACE) indicators	Perth and Kinross Client Survey Result (Social Work)	HACE Result Perth and Kinross	HACE Scottish Average
I received a high-quality service.	✔ 87.5%	81.2%	81.8%
I can rely on the services I receive.	✔ 85.4%	73.1%	76.5%
The help, care or support I received helps me feel safer at home and in the community.	✔ 87.3%	80.0%	84.6%
I am supported to live as independently as possible.	✔ 84.9%	78.6%	84.2%
I have felt involved in making decisions about the help, care and support I receive.	✔ 85.2%	77.3%	79.4%
The help, care or support I received improved or maintained my quality of life.	✔ 90%	81.3%	84.6%

What else did people tell us?

As part of our continuing engagement with individuals and communities through *'Join the Conservation'* we are working to develop their ideas and aspirations to increase access to health and wellbeing activities. Excellent examples of this can be seen across Perth and Kinross, including:

✔ *"I cannot speak highly enough of this service. The wonderful staff and leadership at Lewis Place has kept him alive, well and they have equally supported me."*

(Lewis Place Day Centre)

✔ *"Initially after applying for SD (Self-Directed) payment the department were slow to respond to the particular care package being sought as it was somewhat out of the ordinary. However these teething problems have been resolved and all in place".*

✔ *"I would like to thank everyone concerned for putting me on my feet after a fall. Especially the lady who arranged the stair lift, it is perfect for my needs and so good to be able to go upstairs again. Thank you all."*

✔ *"The service was spot on. It has helped me with my daily living ability. The person who came took time to explain everything to me in detail. My only problem now is the long sweeping stairs I have to get up to my flat. I am awaiting another house."*

Improvement Areas

- *Undertake a wider local survey that captures all people who receive a health and/or a social work service in 2017/18.*
- *Embed person-centred approaches across all health and social care services through our Organisational Development and Workforce Plan.*
- *Through locality teams, local surveys will be undertaken with people who use our services to inform and design future delivery.*

National Outcome 4

Health and social care services are centred on helping to maintain or improve the quality of life of people who use services.

We will develop self-management programmes for people with long-term conditions in order to reduce unplanned admissions to hospital and improve peoples' experience and health outcomes - where there is evidence that people can benefit from this approach.

Indicator	2015/16 Perth and Kinross	2016/17 Perth and Kinross	RAG*	2016/17 Scotland *(unless otherwise noted)*
Percentage of people with positive experience of care at their GP practice. *(Source: HACE**)*	92%	n/a		87% (2015/16)
Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life. *(Source: HACE**)*	81%	n/a		84% (2015/16)
Number of bed days lost to delayed discharge (excluding complex cases).	17,029	15,429		Local
Number of days people aged 75+ spend in hospital when they are ready to be discharged per 1,000 population.	1,005	875 (prov)		842 (prov)
Number of people delayed in hospital for more than 14 days.	191	198		Local
Number of people with a dementia diagnosis who have received peer support.	178	225		Local

**RAG: Red = performance is declining above tolerance level; Amber = performance is declining but within tolerance level; Green = performance is improving.*

***HACE survey is undertaken every two years therefore information is not available for 2016/17.*

How did we do?

- ✔ *81% of those surveyed locally by social care services agreed that their services and support had an impact on improving or maintaining their quality of life.*
- ✔ *92% said that they had a positive experience of care at their GP practice compared to the Scottish average of 87%.*
- ✔ *There were fewer people admitted to hospital in an emergency than across Scotland (11,121 per 100,000 compared to 12,037).*
- ✔ *The number of people who have received a newly confirmed dementia diagnosis who have been provided with peer support has risen from 178 in the previous period to 225 currently.*
- ! *The number of people delayed in hospital for more than 14 days for 2016/17 was 198. We have therefore doubled the size of the hospital discharge team to ensure we have sufficient social work capacity to manage the number of assessments.*
- ✔ *People remained in hospital for shorter periods, with their average length of stay reducing from 17.7 days to a recent 15 days however this needs to be reduced further.*
- ✔ *The number of bed days lost due to people remaining in hospital after they were ready to be discharged reduced from 17,029 in 2015/16, to 15,429 days in 2016/17. However, this is still too high, so there are a significant changes being implemented to improve this figure for next year.*

*"A big focus for **sport**scotland is equalities and inclusion and yesterday certainly emphasised how sport/physical activity is being used to engage older people who may face barriers to participation. This is a tremendous even which everyone really enjoyed taking part in."*

*(Derek Keir, **sport**scotland)*

What else have we done?

- *At the **Generations Working Together Conference**, the Perth & Kinross Care Home Physical Activity Project won the outstanding achievement for "building successful partnership through intergenerational work". The Scheme provided 12 week activity programme incorporating strength and balance exercises, chair-based exercises and physical games to older frailer residents in nine Perth City care homes. The project had benefits for both residents and students alike where younger and older generations worked together to build relationships and increased physical activity in a fun way.*
- ***Drug and Alcohol SMART Recovery** is supported by the Partnership and other key partners. Recovery meetings are very well attended and we have evidence that peers are beginning to co-facilitate and facilitate meetings, supporting the ethos of SMART Recovery. This is a good example of services connecting with communities and is a key feature of the Recovery Oriented System of Care.*
- *20 residents from 40 different care homes and day care services attended the **Go4Gold Olympics** event which is supported by a range of partners including support form volunteers within schools, the Rotary Club and Modern Apprentices. The event aims to increase physical activity levels for all care home residents in a fun and meaningful way.*

Case Study

Duke of Edinburgh Awards for People with a Learning Disability

A Physiotherapy Support worker in the Perth and Kinross Adult Learning Disability team wanted to give young people with Learning Disabilities the opportunity to experience the Duke of Edinburgh award scheme and all the benefits it provided. Working with the local development officer she facilitated and supported the group through the various required stages with the result that five young people achieved Duke of Edinburgh awards which were presented to them by the Duke of Edinburgh at Holyrood Palace.

Awards apart, this provided new, exciting and rewarding opportunities to a group of historically isolated young people and enabled them to participate in an internationally recognised and esteemed award. Through all of the sections of the award, they learned and developed a range of skills and physical activity, as well as experienced innovative volunteering opportunities.

Improvement Areas

- *Managing delayed discharge continues to be a key priority and we have a wide ranging improvement plan including:*
  - *Recruitment to Health and Social Care along with Children's Services to attract people into the care profession.*
  - *Implementation of a discharge lounge to support timely person-centred discharge.*
  - *Enhancement of the multi-disciplinary team in the medical admission ward to identify quickly people's clinical and social care needs to prevent admission, where appropriate, and enable timelier discharge.*
- *Develop more personalised services for people living with complex mental health needs, including dementia, we will focus on delivering a much more tailored approach to support and care for each individual and their family and/or carer so that they are better supported to maintain or improve their quality of life. We will do this by:*
  - *ensuring that there is the relevant and appropriate professionals and skill mix in place across our Older People's Mental Health teams to deliver care that is truly person-centred;*
  - *enhancing specialist and transitional care to reduce admissions to hospital or long-term care, where appropriate, and ensure timely discharge from hospital;*
  - *enhancing liaison services to hospital and care home staff and provide training to hospital and care home staff to understand the needs of Older People living with mental health needs.*
- *Work with local communities, and a range of health and social care staff to identify how our community hospitals can be developed to provide planned and enhanced care.*

National Outcome 5

Health and social care services contribute to reducing health inequalities.

The Perth and Kinross Health Inequalities Plan 2017 focuses on addressing avoidable and unfair health inequalities which exist in our local area. The plan is to be implemented by Health & Social Care Locality Teams and our Community Planning partners.

We are committed to delivering the vision and outcomes of the Fairness Commission so that we make people aware of poverty and inequality and the impact these have on too many people in Perth and Kinross. By working with our partners to understand the particular needs of individual localities we will aim to address the key themes emerging from the Fairness Commission.

Agencies such as Perth and Kinross Association of Voluntary Services (PKAVS) and Live Active Leisure, as well as NHS Tayside partners, have identified the value of a health inequalities plan which can be used as a local resource and as a tool for setting actions for locality partnerships.

Indicator	2015/16 Perth and Kinross	2016/17 Perth and Kinross	RAG*	2016/17 Scotland *(unless otherwise noted)*
Percentage of adults receiving any care or support who rate it as excellent or good.	81%	Sep 2017		81% (2015/16)
Premature Mortality Rate per 100,000.	352	n/a		441 (2015/16)
Number of households presented to the Council as homeless.	898	825		n/a
Number of overcrowded households in Council tenancies.	127	115		n/a
Number of people involved in Employability Network.	1,815	1,817		n/a
Percentage of households in fuel poverty.	38%	22.3%		n/a
Number of people supported by the digital inclusion project.	50	134		Local

**RAG: Red = performance is declining above tolerance level; Amber = performance is declining but within tolerance level; Green = performance is improving.*

How did we do?

- ✔ *Premature mortality is an indicator of the health status of our population by measuring the number of deaths per thousand of people aged 75 or less. Perth and Kinross had a lower premature mortality rate than Scotland, at 352 per 100,000, compared to 441.*
- ✔ *The percentage of Houses in Fuel Poverty for the current period is reduced to 22.3% down from a previous high of 38%.*
- ✔ *No. people involved in Employability Network has remained roughly the same and was at 1,817 for 2016/17.*

The **Making Where we Live Better** *group came together in 2010 to promote inclusion.*

The Boxing Project *helps people to focus on their health and wellbeing.*

What else have we done?

- *The **Community Mental Health Team** began health assessment clinics in collaboration with Tayside Substance Misuse Services. This primarily targets substance misusers to assess the impact on their health and to offer support and preventative measures.*

  The team also offers health information, health assessments and provide healthy living advice to those most vulnerable in collaboration with Churches Action for the Homeless (CATH) and Housing Services
- *The number of people supported by the **digital inclusion** project has risen from 50 last year to 134 in the current period.*

"I've learnt a lot. I wasn't at all confident about using the internet. In our two sessions so far I have learnt about different apps and email. I now have the confidence to access my apps, have downloaded others and can now send emails. I feel a lot more secure when online. Kevin has the patience of a saint with people like me who haven't used a lot of technology previously."

- *A number of **cultural awareness** training for staff in frontline/customer facing roles was delivered to the Drug and Alcohol Team and third sector agencies Churches Action for The Homeless (CATH) and Rape and Sexual Abuse Centre (RASAC) in 2016.*

  Feedback has shown that key workers are more equipped with the knowledge, skills and confidence to work more effectively with minority ethnic clients.

  Other key initiatives which support equalities are described under Outcome 1.

Improvement Areas

- *Over the next year we will implement the recommendations of the Fairness Commission:*
  - *Ensure our resources are allocated according to need with a focus on prevention.*
  - *Promote awareness and knowledge of poverty and inequalities.*
  - *Review our strategies, policies and procedures.*
  - *Create knowledge and ways of support which are right for individuals and families.*

Case Study
Digital Inclusion

Ms M (69) lives in the Perth area and used the internet for a few things, such as email and online banking, but wanted to make a lot more use, especially to contact her family in Australia.

Ms M learnt about Skype and Facebook as the best tools to keep in touch with Australian family. She is now a lot calmer on the internet and more relaxed. She found the 1:1 sessions in her home the best way to learn and would fully support this being rolled out much more.

Case Study
Employment

Ms W (35) has a learning disability and works at a children's nursery. Although Ms W was quite capable of working with the children, her learning disability made it extremely hard for her to complete a Level 3 qualification (a required qualification for registration purposes). Following discussions with Ms W, her mother, the nursery and the SVQ assessor it was agreed to make some adjustments to her post which meant that Ms W could, with some support and guidance, work towards a Level 2 SVQ.

Staff provided some in-work support and built a good relationship with the employer and Ms W achieved her qualification and maintained her employment. This was much to the relief of the employer, the family and of course Ms W.

National Outcome 6

People who provide unpaid care are supported to look after their own health and wellbeing, including reducing any negative impact of their caring role on their health and wellbeing.

The Partnership recognises the significant input from carers and families in supporting people to live at home and through our local Carers' Strategy we will focus on early intervention and prevention by developing alternative support, such as the Carers' Hub.

Indicator	2015/16 Perth and Kinross	2016/17 Perth and Kinross	RAG*	2016/17 Scotland *(unless otherwise noted)*
Percentage of carers who feel supported to continue in their caring role. *(Source: HACE**)*	41%	n/a		41% (2015/16)

**RAG: Red = performance is declining above tolerance level; Amber = performance is declining but within tolerance level; Green = performance is improving.*

***HACE survey is undertaken every two years therefore information is not available for 2016/17.*

How did we do?

- ✔ *Carer Positive is one of the Scottish Government's key policies to help Scotland's carers. Perth & Kinross Council and NHS Tayside were both awarded Level 1 (Engaged) status as a 'Carer Positive Employer' and will continue to work towards Levels 2 and 3 throughout the lifetime of this strategy. Third Sector organisation and local Carers Hub, Perth and Kinross Association of Voluntary Services (PKAVS) achieved Level 3 (Exemplary) status in 2016/17.*
- ✔ *We introduced Participatory Budgeting for carers bringing in their expertise into the development of services called 'Carers Voice, Carers Choice'.*
- ✔ *Carers voted on 23 projects to receive funding, 15 of which were awarded, including respite for families with children with additional needs, day trips and weekend respite for older carers.*
- ✔ *Our District Nursing service undertook a small survey asking carers about their experience of the service. 50% of carers felt they had a say in how the care was provided to their loved one. 90% felt that the District Nursing Service supported them to continue in their caring role and 95% felt that the support they received helped them to feel safe.*

"I am a carer for my husband who has deteriorated over the past 10 years. It has been increasingly difficult but I must say I have had super support from Lewis Place and one day [a week] at Gateway. Thank you for making it possible for him to remain at home during the last 10 years".

What else have we done?

- *We have **Carer Support Workers** in each locality and continue to work with PKAVS to provide support for carers of all ages. A new model of Care for Carers has been implemented in a multi-disciplinary carers' hub. The hub offers co-ordinated and localised supports for carers and provides a centre of excellence for information, support and engagement of carers.*
- ***Hospital Link Worker** provides early identification of carers in hospital and supports them to access services and support for themselves or the person they care for.*
- *Through PKAVS, a **Respite Development Officer** has been employed to deliver and develop respite opportunities for unpaid carers.*
- *The **Perth Carers Theatrics Group** has been set up to support carers with an interest in drama and theatre and to bring carers together. The group have staged several productions.*

Improvement Areas

- *Review our Carer's Strategy and prepare for the April 2018 implementation of the Carers (Scotland) Act 2016 to plan the partnerships response to the provisions within the act.*
- *Continue to take forward the actions outlined within our Joint Carer's Strategy which aims to:*
  - *work with people on their terms, including identifying people who may not recognise themselves as a carer;*
  - *help carers to be independent while also offering support as needed to all people in a caring role;*
  - *support carers in providing opportunities for shaping and improving services as needed;*
  - *support people to maintain their health, wellbeing and a life beyond their caring role.*
- *Further roll out Participatory Budgeting opportunities across localities.*

Participatory Budgeting Event for carers.

National Outcome 7

People who use services are safe from harm.

We want to ensure that people feel safe whatever environment they are in, whether at home, hospital or other care setting and we will ensure that our practices support this aim.

Indicator	2015/16 Perth and Kinross	2016/17 Perth and Kinross	RAG*	2016/17 Scotland *(unless otherwise noted)*
Percentage of adults supported at home who agree they felt safe. *(Source: HACE**)*	80%	n/a		84% (2015/16)
Falls rate per 1,000 population age 65+.	21	22 (prov)		21 (prov)
Percentage of adult protection cases screened within 24 hours of notification.	94%	96%		Local
Number of service users with Telecare equipment installed (excluding community alarms).	1,296	1,464		Local
Community alarm: Service Users (number).	3,565	3,853		Local

**RAG: Red = performance is declining above tolerance level; Amber = performance is declining but within tolerance level; Green = performance is improving.*

***HACE survey is undertaken every two years therefore information is not available for 2016/17.*

How did we do?

- ! *The baseline figure for the percentage of adults supported at home who agree they felt safe in 2015/16 was 80% which was lower than the Scottish average of 84.6%.*
- ! *The falls rate per 1,000 population for those over 65 in 2016/17 was 22 which is slightly higher that the Scottish average of 21.*
- ✔ *The percentage of people determined as safer as a result of our adult protection intervention has been consistently 100%.*
- ✔ *The percentage of adult protection cases screened within 24 hours of notification is 96% compared to 94% in 2015/16.*

What else have we done?

- *Linked to the national **Keep Safe Scheme - I Am Me - Keep Safe** the partnership developed a local Safe Place Scheme. This scheme aims to help people with a disability who may have difficulties accessing assistance or advice whilst in the city centre. Four sessions were held: Safety in the Community; Safety in the Home; Safety on Public Transport; and Safety in the Workplace.*
- ***Suicide Prevention - 'Don't Hide It. Talk About It' -** We held week-long events to raise awareness of suicide and encourage people to talk openly and learn about agencies that offer support. The Tayside Suicide Help website and smartphone app were also relaunched.*
- ***New pathway to avoid unnecessary hospital admissions -** A referral process has been developed with the Scottish Ambulance Service where the Ambulance Crew can make a direct referral to the Rapid Response Service where they consider it would be inappropriate to admit to hospital. If the patient has fallen they can be referred to the Partnership's Falls Service.*
- ***Home Safety Visits -** Partnership approach between Scottish Fire and Rescue, PKC's Safer Communities Wardens, PKAVS, NHS and Police Scotland has enabled an increase in the number of home safety visits undertaken. Home Safety Visits covers the following areas: Falls, Home Security, Energy Efficiency, Electric/Gas Safety, Fire Safety, Adult Protection, Care and Repair. From April 2016 to March 2017 there were 417 joint home visits completed with onward referrals made to Community Alarm, PKC Access Team, Drugs and Alcohol Team and the Falls Service.*
- *Technology Enabled Care provides valuable support to help people live safely at home (eg fall detectors). We are currently testing home-health monitoring with a number of patients from the Tayside Weight Management Service and if successful, will explore other areas where people can 'self-manage' their condition.*
- ***I-care is a kit of sensors** (motion sensors, door contacts, electrical usage) linked through to the community alarm receiving centre. As well as providing a pendant to summon assistance, it records activity within the house and presents this to assessing workers and relatives in an easy to understand graphical form via a website. This info can help to show how well someone is managing to live independently at home, eg if they are up frequently at night, prone to leaving the house at odd times etc.*
- ***Perth and Kinross Safe Health and Active Booklet -** We have developed in Partnership a user friendly 'one stop' resource providing invaluable information for older and vulnerable people.*

Case Study
Adult Protection

Mrs B (68) and her daughter (37), who has learning and cognitive challenges, lived together and concern was raised regarding the decreasing ability of Mrs B to maintain her caring role. There was increasing conflict within the household and suspected physical harm to Mrs B. Various interventions were tried which finally resulted in Mrs B and her daughter living in separate accommodation although they have been able to maintain regular contact. Mrs B moved into a sheltered housing complex with support and Miss B remained at home with a package to support independent living skills.

Improvement Areas

- *"It's everyone's job to make sure I am alright" - rolled out, joint training through Locality action plans.*
- *Continuing to develop the range of support and services that are available for people to enable them to remain at home, such as expanding Technology Enabled Care and Community Alarms.*

National Outcome 8

People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.

We need a confident, competent professional workforce who feel, supported, valued and equipped to deliver the Partnership's vision and challenging priorities and actions. It is also aimed at addressing some key issues, including the high turnover and shortages of suitably skilled staff in key areas and recruitment and retention of high-quality health and social care across the sector.

It is important that we listen to what our staff are telling us and as part of the Council's annual staff survey Adult Social Work and Care staff agreed that their roles were clearly defined (91%) and that there was a good fit between the job they did and skills/abilities (86%). The staff survey also highlighted that staff know how their job contributes to the Councils objectives (82%), their team is passionate about delivering excellent customer service (89%) and staff feel that the people they work with are committed to doing their best (87%).

The first IMatters Questionnaire was distributed to the Partnership's 1,407 health staff which includes hosted and delegated service and had a response rate of 69%. The response rate compared with a similar questionnaire distributed by NHS Tayside in 2015/16. The majority of the workforce felt that their roles and responsibilities were clearly defined (87%) with 81% agreeing that their work gave them a sense of achievement. 79% of the workforce understood how their roles contribute to the goals and objectives of the organisation. The survey also highlighted that 83% of the workforce felt treated with dignity and respect.

Indicator	2015/16 Perth and Kinross	2016/17 Perth and Kinross	RAG*	2016/17 Scotland *(unless otherwise noted)*
Percentage of staff who say they are treated fairly at work.	82%	85%		Local
Percentage of staff who say their daily role provides them with opportunity to use their strengths.	79%	80%		Local
Percentage of health staff who say they are treated fairly and consistently.	79%	80%		Local
Percentage of health staff who say their work gave them a sense of achievement.	71%	81%		Local

**RAG: Red = performance is declining above tolerance level; Amber = performance is declining but within tolerance level; Green = performance is improving.*

Our partnership includes colleagues from the third and independent sector. A survey was distributed to members of the Third Sector Health & Social Care Strategic Forum in Perth and Kinross. 100% of respondents felt more connected with other organisations, compared to 92% last year, while 87% were better able to influence and contribute to public policy, compared to 75% last year. Evaluation of the depth of engagement of third sector showed that, primarily the third sector is consulted and increasingly involved and collaborating, however only 27% of respondents felt that the third sector is empowered to lead new developments.

The workforce of the Perth and Kinross Health and Social Care Partnership comprises of 2,215 people. The workforce is employed by their respective organisations as show below:

The partnership has developed a workforce plan where the aims are to:

- *be seen as an employer of choice, with strong career pathways and exciting opportunities to attract high quality and suitably qualified employees;*
- *ensure any potential workforce gaps are identified and steps are put in place to address these.*

There are a number of challenges that we require to be addressed which includes:

- *to retain and attract qualified staff particularly within rural areas and also being mindful of the age profile of the current workforce;*
- *providing a workforce that is flexible to meet the needs of the population with greater cover out with normal working hours;*
- *ensuring a shift towards community-led services.*

This will be an area of focus over the next year and beyond.

What else have we done?

- ***Your Career - Your Future*** *- we held a half-day workshop to support staff analyse their careers and think about the process of changing and moving with the times as we move through transformational change.*
- *We have moved some teams to support the shift in balance of care into community settings and expanded Third sector involvement/provision of health and social care services.*
- *We have continued to support staff to focus on early intervention and prevention.*
- *Staff have been supported to develop skills and initiatives around dementia to meet future needs and demands.*
- *A range of development sessions are held in localities to support integrated working across teams and services.*
- *The health and social care Communication and Engagement Sub Group is supporting the transformation of health and social care services and staff in the delivery of standards for community engagement and participation.*
- *Monthly workforce development sessions with health, social care, housing and community capacity staff have been delivered to develop integrated working.*
- *'Imagine the future' sessions held with independent sector care home in April 2017.*

Improvement Areas

- *Undertake a wider survey that captures all staff groups within the Partnership.*
- *Finalise the workforce organisational and development plan and implement key actions which will also be informed by input from service users, patients and carers.*
- *Bring GP Practices together in locality-based clusters to share information so as to improve the quality of care in the wider health and social care system and secondary care.*

Section 3: Working in localities: how we have delivered locally-based integrated services

There are specific challenges facing Perth and Kinross with a population spread over a large rural area. The area is the 8th least densely populated local authority area in Scotland and a relatively high proportion of residents are classed as being in some way *'access deprived'*. This means that issues of financial cost, time and inconvenience of having to travel may affect access to basic health and social care services and this is a particular issue in North Perthshire where 45% of the population are access denied.

We need to plan and deliver across the whole system of health and social care, and include the Third and Independent sectors, as well as housing and other key partners, if we are to enable people to have the health and care services they need in their local communities. They need to be empowered and supported to have greater control over their lives and manage their own health and care where appropriate. This means looking at the **whole system and we set out to:**

- *develop locally-based integrated teams to drive and manage health and social care locally and develop locality-based planning and commissioning;*
- *bring GP practices together in locality-based clusters;*
- *work with primary care colleagues to integrate community health services that work with GP practices, community pharmacists, dental practitioners and optometrists;*
- *use local community hospitals to provide planned care;*
- *enable more effective planning with acute (hospital services) to support new ways of working;*
- *expand our use of technology, particularly in rural areas.*

And thereby reduce unplanned hospital admissions and people delayed in hospital.

Key to the success of all this is also:

- *citizen and community empowerment and capacity building;*
- *partnership with the voluntary and independent sectors;*
- *workforce planning and development;*
- *allocating resources to support prevention and early intervention.*

How did we do?

During 2016 health managers and adult social work managers were allocated to 3 localities: Perth City, North and South localities. In addition, social care team leaders and teams were reorganised into prevention and early intervention teams to support this key aim, and into complex care teams to deal with longer term cases. This has been a significant change from staff who had previously been working in specialist teams, such as drug and alcohol or mental health, who now work across disciplines to support either early intervention or people with longer term, more complex needs - all with a locality focus.

Health Teams are currently based and working from the different localities and are working toward to the development of Integrated Care Teams.

- *In relation to GPs, the GP practices are developing their workplans, some of which include key primary and enhanced care services which will mean that key partnership staff are linked to practices to target individuals and enable quicker, co-ordinated access to services.*
- *Working with local communities, Primary and Secondary Care to identify how community hospitals can be developed to provide planned and enhanced care with better access to diagnostics.*
- *Our work with the acute sector continues, but more progress is needed to enable more effective planning and delivery of new ways of working to shift the balance of care.*
- *We are expanding our use of technology, particularly in rural areas and more people now have technology enabled care than last year. We are about to pilot an initiative with Margaret Blackwood Care to support people at home.*
- *We have made progress with our locality management teams and each of the three areas are preparing a locality action plan based on the priorities of the strategic plan and their particular local issues.*
- *The Care Home Liaison Group which has representation from Housing & Community Care, NHS and independent care home providers, continues to be the catalyst for all consultation with the local care home sector. The group also oversees the care home forums which meets three times per year and holds presentations/talks relating to good practice in care homes.*
- *The Care Home Activity Network (CHAN) Sub Group is represented on the Go4Gold steering group which is involved in the planning of the annual events. Go4Gold 2017 is supported by the partnership, Live Active Leisure and the local branch of Scottish Care. Volunteers on the day come from a wide range of inter-generational sources, eg secondary school pupils, Rotary Club, Perth & Kinross Council Modern Apprentices.*
- *Our community Occupational Therapists in health and social care are now co-located in the North and South localities with Perth City to follow in the very near future. Integrated working is progressing with joint screening and prioritisation of referrals and implementation of a seamless journey for people receiving Occupational Therapy.*
- *In the South Perthshire and Kinross locality, we are working swiftly towards integrated working with health, local authority and Third Sector agencies, and looking to forge effective working with other independent agencies. The South Integrated Care Team ensures that the support and care offered to the person is seamless and responsive and that the care delivered takes account of individual needs. The approach is anticipatory and preventative whilst making the best use of available resources, community services as well as inpatient beds to ensure fewer unnecessary hospital admissions, fewer delays in hospital and an overall increase in the local population's health and wellbeing.*

- *NHS Tayside launched a campaign over the Festive Period called Let's Talk Medicine to encourage people on repeat prescriptions to look again at the medicines they take and speak to their pharmacist or GP if they have any questions or concerns and only order the medicines they need.*
- *Across Tayside there are five services trialling the use of home health monitoring through 'Florence'. One particular project for the Perth and Kinross Partnership is the use of this device for weight management for bariatric patients. The technology allows patients to record their weight and receive motivational messages in between appointments. The pilot is also using video conferencing to allow house-bound individuals to participate in clinics*

TullochNET *is a community health and wellbeing project.*

Section 4: Finance: an evaluation of the balance of care and the extent to which integration services demonstrate best value

Financial information is part of our performance management governance with regular reporting throughout 2016/17 to the Integration Joint Board (IJB). This section summarises the main elements of our financial performance for 2016/17.

Financial Outturn 2016/17

For the year ended 31 March 2017, an over spend of £225k is being reported:

	Budget £000	Actual £000	Variance over/ (-)under spend £000
Older Peoples Service/Physical Disabilities	62,102	60,422	(1,679)
Learning Disabilities	17,359	16,760	(599)
Mental Health and Addictions	5,898	5,874	(24)
Planning/Management/Other Services	7,729	7,424	(306)
Prescribing	26,187	28,190	2,003
General Medical Services	22,157	22,017	(140)
Family Health Services	13,448	13,431	(17)
Hosted Services	19,764	20,751	987
Large Hospital Set aside	17,672	17,672	-
Total Expenditure	**192,316**	**192,541**	**225**
Breakdown of Variance:			
Health	**142,924**	**145,698**	**2,774**
Social Care	**49,392**	**46,843**	**(2,549)**

A number of areas experienced significant budget variances in 2016/17:

Older Peoples Service/Physical Disabilities

- *Within Older Peoples Services, a significant under spend on Care Home Placements due to higher than anticipated income and client turnover was the main driver of the year end position. Within Community Care an under spend resulted from vacancies held whilst the service transitioned to a locality model. Further, an in-year benefit resulted from the re-assignment of staff within Aberfeldy Community Hospital which is currently non-operational and from the accelerated delivery of planned savings.*
- *Across a number of our hospital in-patient services (Medicine for the Elderly, St Margaret's and Crieff Community Hospitals and Psychiatry of Old Age) financial pressures arose due to continued recruitment and retention difficulties across the nursing and medical workforce.*

Learning Disabilities

- *The underspend in year resulted from vacancies and the accelerated delivery of savings.*

GP Prescribing

- *Prescribing costs were a further significant pressure in 2016/17 driven most significantly by growth in items prescribed and the challenge to deliver a significant savings target.*

Hosted Services

- *Pressures within a number of NHS Tayside-wide hosted Services impacted on the financial position of the Integrated Joint Board. Within Forensic Services and Inpatient Mental Health Services recruitment difficulties have resulted in high locum costs. Within Prisoner Healthcare planned expenditure reductions on prescribed medicines have not yet been realised due to delays in recruitment. These pressures have been offset by underspends within a number of other services.*

Large Hospital Set-aside

- *The budget shown in the table opposite includes £17.672m in respect of 'set aside' resources relating to acute hospital and other resources. These are provided by NHS Tayside which retains responsibility for managing the costs of providing the services. The IJB however has responsibility for the consumption of, and level of demand placed on, these resources. For financial reporting purposes the expenditure has been matched to the budget to show a break even position.*

Savings

- *Efficiency savings of £4.236m were delivered across health and social care budgets, with £1.120m being accelerated savings from social care. However, the significant target set against GP Prescribing and Inpatient Mental Health was only met in part leading to the considerable year end overspend on health budgets.*

Overall, health budgets reported an overspend of £2.774m. In line with the Integration Scheme, NHS Tayside devolved further budget to the IJB to deliver overall break-even at the year-end.

Overall, social care budgets reported an underspend of £2.549m. From this, £1.386m will be carried forward in the IJB reserves, with £598k of the balance being carried forward in Perth & Kinross Council's reserve in an earmarked reserve for use by the IJB. The remaining £565k was unanticipated additional underspend which will be retained by Perth & Kinross Council whilst further discussions take place around social care priorities.

In agreeing a budget for 2017/18 the service demands have been considered and, where possible, additional investment targeted at the areas with service pressures.

Integrated Care Fund

The recurring funding received from the Scottish Government for the Integrated Care Fund (ICF) for 2016/17 was £2.630m.

The ICF is used to deliver change in the way services are delivered with the overall aim of shifting the balance of care from a hospital based setting to the community.

Financial Outlook

The IJB, like many others, faces significant financial challenges and will be required to operate within very tight financial constraints for the foreseeable future due to the difficult national economic outlook and increasing demand for services.

A Financial Plan for 2017/18 is currently in development with the objective that the IJB operates within resources available. A budget settlement with Perth & Kinross Council has been agreed. Discussions are continuing with NHS Tayside in relation to Prescribing and Inpatient Mental Health (which Perth & Kinross IJB hosts on behalf of all three IJBs).

Both settlements present significant challenges in terms of accommodating demographic and inflationary type pressures and for health budgets the added requirement of delivering savings targets that have been carried forward from previous years.

The overall Financial Plan will require to address a savings requirement of £10.4m, of which £8m of plans have been identified.

This financial plan highlights the importance of Perth & Kinross IJB being able to deliver all the plans currently in place and, in discussion with NHS Tayside, the need to identify further savings/income measures. For Prescribing, a wider discussion will be required around sustainability.

Shifting the balance of care, a core strategic objective of the IJB, will be key to delivering a sustainable future financial position. Only through fundamental redesign of services will a number of the current workforce challenges be addressed and efficiencies delivered. Our workforce challenges include nursing staff across our hospital services, care at home and medical staffing for Mental Health Services and Psychiatry of Old Age.

The Partnership is leading an ambitious Pan-Tayside review of Inpatient Mental Health Services which is due to identify a preferred option in 2017/18 and this redesign along with a parallel review of clinical models represents a fundamental opportunity to bring services into recurring financial balance.

The significant gap between spend and current budget available to meet the cost of GP Prescribing represents the most significant financial risk to the IJB. The agreement of a GP Engagement Plan to put our GP's at the heart of the work to deliver a sustainable GP Prescribing position will be a priority focus for the Partnership in 2017/18 and beyond.

Best Value

NHS Tayside and Perth & Kinross Council delegate functions and budgets to the IJB. The IJB decides how to use these resources to achieve the objectives of the strategic plan. The IJB then directs NHS Tayside and Perth & Kinross Council to deliver services in line with this plan. The governance framework is the rules and practices by which the IJB ensures that decision making is accountable, transparent and carried out with integrity. The IJB has legal responsibilities and obligations to its stakeholders and residents of Perth and Kinross. The IJB ensures proper administration of its financial affairs by having a Chief Finance Officer, in line with Section 95 of the Local Government (Scotland) Act 1973. To strengthen governance arrangements and oversee the IJB's significant change programme, the Health & Social Care Partnership's Transformation Board was established during 2016/17. It is chaired by Robert Packham, IJB Chief Officer, with senior representation from all of the services within the Partnership and wider within our Parent Bodies. Evidence of transformational change taking place at strategic and operational levels includes:

- *Care at Home Review*
- *Review of Day Care*
- *Review of Residential Care*
- *Discharge Hub*
- *Mental Health Option Appraisal*
- *GP Engagement Plan*

Financial Reporting on Localities

The 2016/17 financial information is not split into localities at this level of financial reporting. This will be developed during 2017/18.

Section 5: Scrutiny and inspection of services: what did external agencies find during inspections?

Our services are subject to a range of inspections carried out by external organisations. These inspections check that our service delivery meets national standards, provides value for money and satisfies those who use our services.

How did we do?

- ***Dalweem Care Home*** *- awarded* ***Very Good*** *(Level 5) for the Quality of Care & Support and Management & Leadership. During inspection the Inspectorate found very good levels of satisfaction with the quality of the overall service.*
- ***Lewis Place Resource Centre*** *- awarded* ***Very Good*** *(Level 5) for the Quality of Care & Support and Staffing. During inspection the Inspectorate found that people using the service and their carers spoke very highly of the support they received. The staff team demonstrated a high level of commitment to providing a quality service in the ways people preferred.*
- ***Kinnoull Day Opportunities*** *- awarded* ***Excellent*** *for the Quality of Care & Support and Staffing. During the inspection the Inspectorate spoke with service users while visiting four community groups. All service users they spoke with were very happy with the service they received.*
- ***Housing Support Care Inspection*** *- awarded* ***Excellent*** *(Level 6) for Quality of Care & Support and for Management & Leadership and Very Good (Level 5) for the Quality of Staffing. The Inspectorate concluded that the housing support provides an excellent service in meeting the housing needs of older people, people with a disability and other complex needs.*
- ***Care at Home*** *- awarded* ***Good*** *(Level 4) for Quality of Care and Support, Staffing and Management & Leadership. During the inspection service users had the opportunity to comment on their experience of using the service. They found a high level of satisfaction with the support provided, service users told us they had good communication with the service and carers were appropriately skilled, respectful and flexible.*
- ***Prisoner Healthcare*** *- following inspection by the Mental Welfare Commission, prisoners spoke positively about the care and treatment provided by the mental health team in the health centre. Nurses were described as supportive and requests to see a mental health nurse were dealt with promptly.*
- ***Amulree and Rannoch Wards, Murray Royal Hospital*** *- following inspections by the Mental Welfare Commission, feedback from patients about support received was positive. Patients who had been in several hospitals said that they were getting the* ***best support*** *and that staff were attentive and the patients felt they were listened to.*
- ***Moredun Ward, Murray Royal Hospital*** *- has been highlighted twice as demonstrating* ***a high standard*** *in outcome-focussed discharge planning and having individualised, person-centred care plans.*

Improvement Areas

- *Following recent inspections of our Care at Home Service, although there were no requirements or recommendations, we have put in place an improvement plan which includes:*
  - *further develop the communication and engagement strategy to involve people in decisions around service delivery;*
  - *providing ongoing training and awareness in relation to the safe administration of medication and treatment and monitoring of skin conditions.*
- *We want to improve our services for those suffering from mental illness and we will improve the discharge planning process for patients who experience a delay on discharge from an adult inpatient beds in Murray Royal Hospital and ensure that independent advocacy support is available to support prisoner.*

Section 6: The Strategic Plan: review and actions taken in the year

The Integrated Joint Board agreed priority areas for 2016/17, primarily around the transformation of services. Progress against each of these is outlined below.

1 **Rolling out locally-based integration teams designed around GP practices**, and **enhanced care** support, working in partnership with GPs, pharmacies and the voluntary sector to facilitate opportunities for personalised, joined-up, planned care and support for people.

2 Work around the **locality teams** is still being progressed (see section 3).

3 Embedding the role of **GP clusters** to become an integrated part of health and social care in order to share information between partners and explore different and improved ways of working together and to support practices to enable consistent and sustainable changes and improvements in the delivery of healthcare.

4 The **Enhanced Community Support** Model has been rolled out to 10 GP practices, and is being rolled out in South and Northwest Perthshire.

5 Review existing services and pilot an enhanced role for **community pharmacy, dentistry and optometry services** to ensure **closer integration with locality teams**.

6 We are working on engaging community **pharmacy technicians** and GPs in localities to support people in their local communities.

7 **Working with communities to develop the health and social care market,** encouraging and empowering them to make choices to improve their health and wellbeing. The Communities First transformation project is due for completion by March 2019 and although work is still needed to further develop social enterprises, community-based alternatives of which a key element of the eMarket place, we rolled out Participatory Budgeting which has seen 16 groups receive funding for projects which support local people. We are on target to achieve the savings identified through the delivery of this project.

8 **Review Allied Profession Services -** The workforce consists of occupational therapists, podiatrists and physiotherapists. The Occupational Therapists workforce has now been integrated and is co-located where possible. The workforce review will aim to ensure that the appropriate skills are in place, ensure professional leadership and that resources are directed to meet the objectives set out within the Strategic Commissioning plan.

9 **Transforming District Nursing -** Under the National Scottish Government Nursing Directorate direction we are delivering a refreshed District Nursing role and review of skills required for future service delivery. Clinical pathways have been developed with a focus on deterioration, frailty and end of life care to provide early identification and assessment

of frail older people to ensure that the right support and care is put in place. Locally, a Single Point of Contact for Perth City is being tested, which is in response to patient and carer requests for easier access to district nursing services. The Single Point also allows the district nurses to prioritise referrals so that they can respond timely to urgent referrals. A Single Point of Contact is currently being developed for North Perthshire. Leg Ulcer Clinics and Catheter Clinics are being developed in local areas to increase the number of patient appointments being offered, reduce travel time and duplication of effort and increase patient experience.

10 **Review pathways between hospital and the community** to ensure that individual care is provided at the right time and in the right place and reduce delayed discharges. Clinical Strategy Group to be established in 2017 to engage in this.

11 Explore opportunities for **community hospitals as local community hubs** for health, social care and third and independent sector with a range of services and facilities to support health and wellbeing in local communities.

12 **Review inpatient beds** across all health services to ensure a shift toward locality care as close to person's home as possible.

13 Review and implement changes to **care at home** to help people to remain at home for longer, and shift the balance from traditional services to community focussed services. A new in-house model for care at home was approved at the IJB in June 2017.

14 Review **community care day services**, part of our transformation programme, aims to increase locally based opportunities for people to access support - this project will begin formal consultation with staff and service users in June 2017. This project is progressing well and consultation is underway with staff and service users, the outcome of which will be reported to the IJB in the autumn 2017.

15 Develop and finalise the **integrated workforce and organisational development plan** to engage, support and develop staff across all care sectors. A draft plan has been developed and once finalised an implementation plan will be prepared.

16 Review **Older People's Residential Care Services,** part of our transformation programme, aims to implement changes to meet the demands of an increasing older population - this project began formal consultation with staff and service users in June 2017. Progress will be approved at the Housing & Communities Committee in September 2017 and thereafter the IJB in the autumn 2017.

17 Continue to work with **housing partners** to support people to live independently - achievements include the development and expansion of care and repair service to enable people to remain at home with a new combined, flexible and responsive service introduced in January 2017. Some initial initiatives already developed include level access showers for those aged 80+ and portable ramps. Specialist housing is planned for people with complex needs and for older people and are included in the housing investment plan for development this year.

18 Implement the recommendations in the **Technology Enabled Care Strategy**. A number of initiatives from the strategy have been introduced and plans are in place to expand this further. The number of people with technology enabled care has increased (Outcome 7 refers).

19 **Review community care packages,** part of our transformation programme, aims to review care packages and to enhance options available to individuals and their families by increasing resilience and maximising alternative supports - this project is on target to review people's care packages and to meet the savings identified.

20 Review and evaluate all **services hosted** by the Perth and Kinross Partnership in order to establish future service arrangements. The first such review is of Mental Health Services; an options review report on the mental health transformation programme is being presented to NHS Tayside Committees and three local Integration Joint Boards. Consultation with key stakeholders will help to inform the new service model.

21 Develop interventions **for people who are at the highest risk of ill health,** to prevent illness including smoking, alcohol and drug use, oral health, sexual health, undernutrition and initiatives to reduce the number of people who are overweight or obese, targeting resources at those most at risk. The Perth and Kinross Health Inequalities Strategy is being implemented with key actions for locality teams to progress in local areas. Some successes are outlined under Outcome 5. This work will be progressed through the Locality Action Plan and will be reflected in the priorities of the Community Planning Action Partnerships.

22 Develop a rolling **3 year savings plan** for health, supported by NHS Tayside transformation workstreams, ensuring all opportunities for joint transformation are delivered.

The Letham Community Hub

Your Community, Your Budget, Your Choice

Overall Assessment by Robert Packham, IJB Chief Officer

This report reflects the achievements of Perth and Kinross Health and Social Care Partnership in its first year. In legislating for Integration, the Scottish Government set bold ambitions to transform delivery of health and care. Perth and Kinross has risen to that challenge; local redesign has started. 4,000 people contributed to a Strategic Plan that sets out our ambitions to provide the best possible health and care services to our citizens; connecting ideas for local improvement with evidence of the best ways of delivering health and care services for the future.

Health and care services are always developing. In our first year we already see evidence of improvement. More people being supported at home and fewer people are relying on care in hospital. More people are living healthy independent lives into older age. When something goes wrong, people need to know that the right care is on hand when they need it, delivered by the right person in the right place. For this to happen, professional practice has to change. We will always need to provide treatment and care services; however, our teams will increasingly work with people to improve their health. By involving families, carers, communities and voluntary organisation and joining them up with more health and care services, we begin to see the benefits of Health and Social Care integration in practice. Looking forward, there is much to be done. We will continue to listen to the people who experience our services and for whom our decisions are important. Some changes will be down to improvement while other changes will require fundamental redesign. This change will require further consultation and wide engagement in the realities of the challenges ahead.

To achieve our ambitions we require input from the wide range of partners; health and social care professions; the third and private sectors, as well as the feedback and contributions received from our customers and local communities. Collectively this input has proven invaluable in the achievement of the successes we have had so far. We need to continue to maximise the opportunities of this collaborative working if we are to fully realise our ambitions and to transform the way services are delivered. There are many challenges ahead and we recognise that our dedicated, skilled staff are committed to providing high-quality and responsive care. We will continue to be innovative, resilient and, importantly, focused on positive outcomes for the people of Perth and Kinross.

Robert Packham, IJB Chief Officer

Next Steps

We recognise that to achieve our ambitious vision and objectives we need to:

- *develop integrated locality teams, so that all clinical, professional and non-clinical staff can work together in a co-ordinated way to improve access and the quality of services;*
- *ensure that people, including carers and families, are at the centre of all decisions;*
- *combine staff and resources to deliver a wider range of care within communities and supporting people to be cared for at home;*
- *fully engage and empower communities to create alternatives supports in the local communities;*
- *improve the health of communities through wider partnership working to:*
    - *identify the health and care needs;*
    - *focus on health promoting activity;*
    - *taking action to improve wellbeing, life circumstances and lifestyles and actively;*
- *move the money by shifting the balance of spend from hospital settings to the community by examining areas of investment and disinvestment by examining where resources and assets to enhance efficient joined up working;*
- *take forward the Mental Health redesign;*
- *take forward the Capacity and Flow model to ensure people receive the right care at the right time by the right person;*
- *take forward our extensive Transformation Programme which includes reviews of a number of projects under workstreams which link into the five priorities of the Strategic Plan;*
- *implement our workforce and organisation development plan to ensure our staff are provided with the skills and support required to meet our ambitions.*

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