Perth and Kinross Health and Social Care Partnership

Annual Performance Report 2016/17 *Summary*

NHS Tayside

PKAVS Enhancing Lives, Connecting Communities

PERTH & KINROSS COUNCIL

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 2016-2019**. 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 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*

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.

How have we performed?

National Outcome 1

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

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.*

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.

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%		Local

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National Outcome 3

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

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)

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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.

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 people delayed in hospital for more than 14 days.	191	198		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 with a dementia diagnosis who have received peer support.	178	225		Local

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National Outcome 5

Health and social care services contribute to reducing health inequalities.

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

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.

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)

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National Outcome 7

People who use services are safe from harm.

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

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.

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

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How are we doing in meeting our strategic priorities?

A varied and responsive community-based health, care and support service that enable people to live as independently at home as possible with a better quality of life.

- *We supported 188 more people with a range of care at home support in April 2017, compared to the previous April (1,638 and 1,450).*
- *The number of hours care at home people received also increased between these two dates, from over 11,681 to 14,313.*
- *We placed more people aged 65+ in care homes than the previous year (652 compared to 583), although they were older when they moved in, 86 compared to 85 years.*
- *More people received technology enabled care to remain in their homes than the previous year (1,464 compared to 1,296).*
- *A higher proportion of people preferred to organise their own care, through Self-Directed Support through Options 1 and 2 than the previous year (14% compared to 11.7%).*
- *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.*
- *The % rate of people readmitted to hospital within 28 days of discharge remained similar to last year, at 115 per 1,000 admissions. This needs to improve and plans are in place for this.*
- *The number of people delayed in hospital for more than 14 days increased from 191 last year, to 198 in 2016/17, although people spent a shorter time in hospital, from 17.7 days in 2015/16 to 15 days in 2016/17.*
- *There were fewer people admitted to hospital in an emergency than across Scotland (11,121 per 100,000 compared to 12,037).*
- *92% said that they had a positive experience of care at their GP practice compared to the Scottish average of 87%.*
- *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 95% compared to 94% in 2015/16.*
- *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.*
- *90% 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.*

How are we doing in meeting our strategic priorities?

We need to reduce the number of days people aged 75+ spend in hospital when they are ready to be discharged per 1,000 population. We still need to:

- *reduce the number of people delayed in hospital for more than 14 days;*
- *reduce the rate of emergency admissions for adults;*
- *increase the percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life;*
- *increase the percentage of adults supported at home who agree they felt safe.*

We aim to have fewer admissions to residential care, and none from acute hospitals. We still need to:

- *Reduce admissions as during 2016/17 652 (+65) people were admitted to care homes, compared to 583 in 2015/16. However, people admitted were older than previous years (86 years, compared to 85 years) and stayed for less time, reflecting an increasing older and frail population going into residential care.*
- *During 2016/7 1,518 people were permanently placed in care homes, compared to 1,480 the previous year.*
- *These figures are reflected in our balance of care which was 36.2% in care homes and 63.8% care at home, compared to 35% and 65% respectively in 2015/16.*

We aim to reduce health inequity and increase health and wellbeing.

- *We have had some success in reducing health inequalities, as detailed in the section on National Outcome 5. Some highlights include:*
  - *more people with disabilities supported through the employability network;*
  - *fewer people presenting as homeless and fewer households living in overcrowded accommodation;*
  - *some positive feedback from people involved in our digital inclusion and employability projects;*
  - *we have also continued to support more people with mental illness through our wellbeing fair, as well as community initiatives, including dementia cafés, the Golf Memories project, Tullochnet and the Smart Recovery Family and Friends initiative.*

So, what are some of our most notable achievements?

- ✔ *Implemented a new **discharge hub** at Perth Royal Infirmary to support individuals and their carers/ families to safely and quickly be discharged from hospital.*
- ✔ ***Hospital Link Worker** introduced to provide early identification of carers in hospital and support them to access services and support for themselves or the person they care for.*
- ✔ *The **Enhanced Community Support** Model has been rolled out to 10 GP practices, and is being rolled out in South and Northwest Perthshire. This multidisciplinary approach supports people to remain in their own homes.*
- ✔ *Introduced a new, **more flexible care at home** contract with 10 providers to expand capacity and meet current and future needs.*
- ✔ *Introduced **Participatory Budgeting** for carers bringing in their expertise into the development of services called 'Carers Voice, Carers Choice'.*
- ✔ *Rolled out **Participatory Budgeting** which has seen 16 groups receive funding for projects which support local people.*
- ✔ *Implemented a successful **'Why should I care?' campaign** to encourage more people to become home carers.*
- ✔ *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.*
- ✔ *Started a review of **mental health services**.*
- ✔ ***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.*
- ✔ *The **Community Mental Health Team** began health assessment clinics in collaboration with Tayside Substance Misuse Services.*
- ✔ *Expanded the use of **Technology Enabled Care** to allow people to remain safely and independently at home. We have expanded our use of technology, particularly in rural areas and more people now have technology enabled care than last year.*
- ✔ ***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.*
- ✔ *We received extremely **positive results from external inspections** of our services with awards of very good to excellent over a range of residential and day care provision.*

Where have we still to improve?

- *Ensure people are prevented from unnecessary admissions to hospital and for those who are admitted, discharging them as quickly as possible remains a key priority.*
- *Develop our workforce to meet the key aspirations of the Partnership: prevention and early intervention, person-centred care, working with local communities to shift that balance of care remain key priorities.*
- *Increase the pace with the Third Sector to build capacity in our communities to support and enable people to remain in their home and develop the Emarket place to share information about services and support.*
- *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 alternative 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;*
    - *take 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 reviewing our 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 links 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.*
- *Take forward the review of Community Hospital, Intermediate Care and Medicine for the Elderly Services and consider the development of Community Hubs.*
- *Implement the Medicine Management Quality Prescribing Programme working with local GPs and Pharmacists.*
- *Continue to build on our engagement with GPs using the established GP Cluster approach.*

What are our key challenges?

- *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.*

Preparing for the future

We want to make sure the services and support we offer people are:

- *developed locally, in partnership with communities, the third and independent sectors;*
- *integrated from the point of view of individuals, families and communities and responsive to the particular needs of individuals and families in our different localities;*
- *commissioned to best anticipate people's needs and prevent them arising;*
- *provided in such a way to make the best use of available facilities, people and resources;*
- *provided in a way that ensures our quality and safety standards are maintained and are given the highest priority.*

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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