Annual Performance Report 2021/22

Perth and Kinross Health and Social Care Partnership

Supporting healthy and independent lives

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Introduction

The Health and Social Care Partnership

The Perth and Kinross Integration Joint Board (IJB) was established in 2016 to improve the wellbeing of people who use health and social care services, in particular those whose needs are complex, requiring support from health and social care services at the same time.

Perth and Kinross Health and Social Care Partnership (HSCP) is responsible for the operational management and performance of integrated services in line with the IJB's strategic commissioning plan. Our workforce is made up of staff employed by Perth and Kinross Council, NHS Tayside, and we commission a wide range of third sector and independent organisations to meet the health and social care needs of Perth and Kinross. Our focus is on meeting needs and providing the right care and support in the right way and at the right time.

Vision, Aims and Values

Our vision as a Health and Social Care Partnership is to work together to support people living in Perth and Kinross to lead healthy and active lives and to live as independently as possible, with choice and control over their care and support.

Our aim is to improve the wellbeing and outcomes of people living in Perth and Kinross, to intervene early and to work with the third and independent sectors and communities, to prevent longer-term issues arising. Services and support will be developed locally, in partnership with communities, the third and independent sectors. As a partnership we will be 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. We will make the best use of available facilities, people and resources ensuring we maintain quality and safety standards as the highest priority.

Our values guide everything we do. They guide us to act with ambition, compassion and with integrity and always with the person at the centre.

Our Action Plan

The current IJB Strategic Commissioning Plan 2020-25 outlines five strategic objectives:

1. Working Together with Our Communities Strategic Aim: 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 and stronger connections in their community.

2. Prevention and Early Intervention Strategic Aim: We will aim to intervene early, to support people to remain healthy, active and connected in order to prevent later issues and problems arising.

3. Person-Centred Health, Care and Support Strategic Aim: By embedding the national Health and Care Standards we will put people at the heart of what we do.

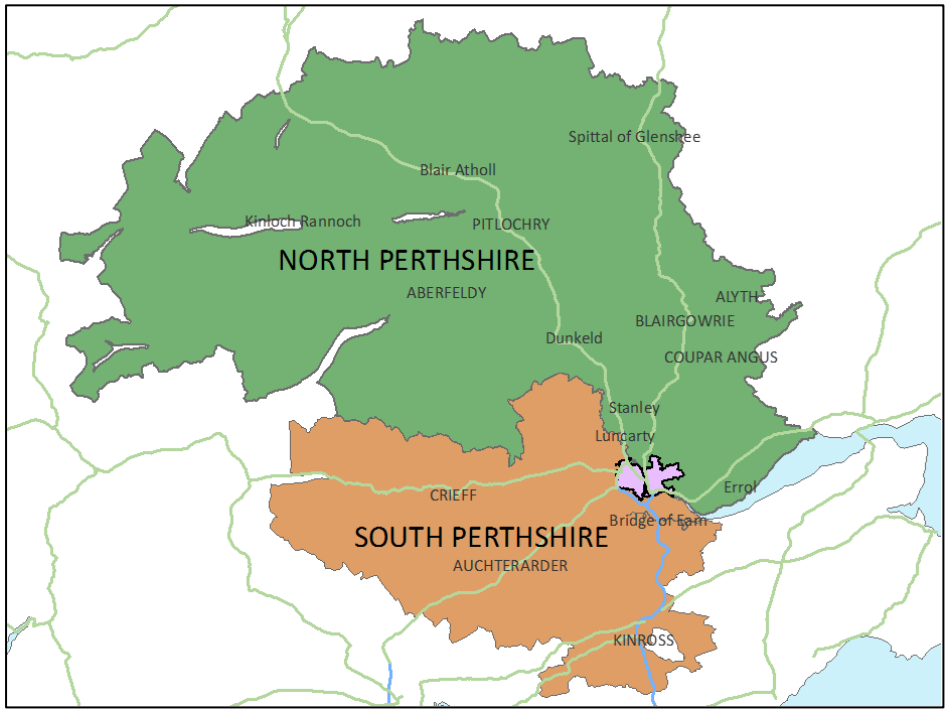
4. Reducing Inequalities and Unequal Health Outcomes and Promoting Healthy Living Strategic Aim: Our services and plans will seek to reduce health inequalities, to increase life expectancy, increase people's health and wellbeing and to reduce the personal and social impact of poverty and inequality.

5. Making Best Use of Available Facilities, People and Other Resources Strategic Aim: We will use our combined health and social care resources efficiently, economically and effectively to improve health and wellbeing outcomes for the people of Perth and Kinross.

Our Localities

In delivering effective and person-centred health and social care support, we recognise the benefits derived by people being connected to their local communities. These connections and relationships support people to retain independence and remain healthy, safe and well. We acknowledge that local people are best placed to identify local challenges and solutions and are committed to working with local people and enabling local partnerships to devise local solutions.

Perth and Kinross HSCP is organised into three localities, North Perthshire, South Perthshire and Kinross-shire, and Perth City.



Our Population

There are specific challenges facing Perth and Kinross given the spread of our population over a large rural area. While our area is the eighth most densely populated local authority area in Scotland, nearly 40% of our residents are classed as being in some way 'access deprived' due to rurality. This compares to 20.2% nationally. We are also facing particular challenges in recruiting to key social care and nursing roles to work in our rural communities.

The proportion of people in older age groups is growing substantially. An older population will require a greater level of

health and social care support than is currently being provided so our strategic commissioning plan must take account of projected levels of need and demand for community health and social care services. Our strategic focus will be on an ambitious programme of transformation with a focus on:

Older People, Physical Disabilities, Primary Care, Mental Health and Wellbeing, Substance Misuse, Autism, Carers, Technology-Enabled Care, Learning Disabilities, Complex Care.

Community Mental Health and Wellbeing

Our Year in Action

Service Delivery: Improving and Adapting Throughout the Year

Mental health and wellbeing remain significant priority areas as we continue to recover from the pandemic.

Our Community Mental Health and Wellbeing Strategy (2022-25) was created in consultation with stakeholders and third sector providers, people with lived experience, carers and professionals. It builds on collaborative work with NHS Tayside via the Mental Health and Wellbeing Strategy - Living Life Well, and was approved by the Integration Joint Board in December 2021.

The Neuk, established through Anchor House, is proving to be very effective and works well as a collaborative approach to help those in mental health crisis. The Neuk complements investments made to implement Distress Brief Interventions, and combining these services improves speed of access. In recognition of the excellent progress made, work is currently underway to examine how this model can be replicated in both Dundee and Angus.

A wide range of statutory and third sector service providers are enhancing the level of support via easily accessible and non-stigmatised routes. This includes expansion of the provision of Computerised Cognitive Behavioural Therapies (cCBT).

The awareness and prevention of suicide has increased. In collaboration with the University of Dundee almost 200 people attending webinars for the public and voluntary sector providers, including community groups and organisations. Attendees were from predominately non-specialist mental health backgrounds and feedback indicated that the training was well received. This has resulted in further collaboration on the national suicide action plan, Every Day Matters with the University.

Recognising the strong role that colleagues in primary care play in delivering effective mental health services, we have created a new role of 'Mental Health Link GP'. This post assists in creating greater opportunities for collaboration with GPs and a single point of contact. Strong relationships and seamless routing of patients, through initial contact to the most appropriate point of support are key success factors in ensuring those needing support can access services quickly and conveniently. This is reducing the number of referrals required between services and professionals, improving accessibility.

> *"Very useful and gave me tools that I can use in my job. I feel confident to address and challenge difficult situations. I thought it would be very long doing this online but feel it was pitched perfectly and it was engaging. Would definitely recommend to my colleagues."*
>
> Feedback from an attendee of our suicide awareness and prevention webinar

Inequalities Hubs, focusing on Mental Health and Wellbeing, are being planned at community level. This is in partnership with Perth and Kinross Council and third sector organisations, with the aim of creating a sustainable and accessible resource.

Increasing the available capacity of Community Adult Mental Health Services was the key focus of the Scottish Government's Action 15 funding. Using this funding we have expanded the mental health workforce in the community and created over 40 additional permanent posts. This was significantly beyond the target set by the Scottish Government of 28. We were commended by Scottish Government on our ability to work in partnership, and for our creativity.

Older People's Mental Health teams supported in-patient services as the effects of the pandemic continued into 2021/22. By working closely with other health and social care colleagues via the established Locality Integrated Care Model, they provided an enhanced, integrated and co-ordinated approach to support people with their physical health as well as those with dementia and cognitive impairment, in the home or in community settings. This has benefited carers with their caring responsibilities and this successful approach will be extended to 'post diagnostic support' in localities.

In partnership with Alzheimer Scotland we expanded access to advanced practice nursing support for those awaiting memory assessments.

> *"Made good progress with support of the team; doctors, nurses and staff"*
>
> Older People's Psychiatric Inpatient (Murray Royal Hospital)
>
> - Patient Feedback

Digital inclusion for people with dementia and their carers remains a priority and to support this, local staff became digital champions, creating greater opportunities for people to be engaged in consultation around service delivery, and tackling isolation and loneliness. With the easing of pandemic restrictions there was more face-to-face contact, however improved digital accessibility continues to ensure greater choice for people.

In in-patient areas we made further investment in Activity Support workers and nursing. This built on the successful intervention to give one-to-one support resulting in increased meaningful activities for people isolating due to COVID-19.

Our in-patient areas have faced significant challenges with delayed discharges, often relating to the very complex needs of patients. This is a similar position to that seen nationally as it can be difficult to source specialist community-based support. Work continues with agencies, nationally and locally, to utilise resources in the best way possible.

In the early in stages of the pandemic, we increased specialist nursing capacity to support patient transitions from in-patient settings to more homely settings.

This support is on-going and, despite significant challenges in sourcing necessary capacity, working with care homes via the care home liaison teams across Perth and Kinross, patients with complex care needs have been successfully supported into placements in more homely settings.

> *"Found [my transition nurse] very good, straight to the point. She took me to the bank and Asda. [The nurse] made my transition from ward to home a good experience"*
>
> *"Memorable visit [with the nurse]. Cheered me up. Was nice and the sun was out."*
>
> Transition Patient Testimonial:

A new Transitions Nurse provides direct support to people after hospital discharge into care settings. This is proving highly effective for the individuals and also for Care homes.

"I cannot begin to say how helpful and approachable I have found [the nurse] to be from our initial meeting she went above and beyond what I would have expected. After explaining we had visited Balhousie Care in Coupar Angus and told they could not take my cousin she said she had visited and said there was space.

She continued to look into and follow up on this which has ultimately led to him being placed there. At all times her manner was friendly and relaxing and was a pleasure to have someone like this dealing with special requirements."

CMHW POA Transition - Patient Family Testimonial

We are working with partners in Tayside to review the future needs of patients in in-patient settings to identify not only the need for Intensive Psychiatric Care Unit (IPCU) access for older people, but also the future plan for the delivery of Specialist Dementia In-patient facilities**.**

Improvement Journey

Community Mental Health and Wellbeing Teams are responding and changing the way in which services are being offered to provide people with the care and support that is best for them.

This illustration is an example of service improvements and the difference these make to people living with complex mental health needs within a hospital setting.

Case Study

MoveAhead. Angela's Story

I have experienced long term mental health issues. Although I initially thought that this started after the death of my lovely husband 16 years ago, I now know that my problems go way back as far as my childhood. I had it all, a loving husband, great job, wonderful social life, but that all changed after I lost him. From then on, my life slowly started taking a tumble, down this black hole. I felt like I was a nobody and wondered why I was still here, suffering low self-esteem, isolation, feeling second best. This slowly got worse and my life was a huge mess until in I moved to Bridge of Earn.

I was contacted by a HSCP social worker. This was a shock to my system – why a social worker, was I that bad? Well, he couldn't have been nicer and asked me how he could help, what did I need. there starts my journey with the fabulous MoveAhead.

A key part to my journey has been having access to fantastic facilities that are on offer via MoveAhead Mental Health Service. With the involvement from the team, I have been able to face my problems and learn to cope.

They got me out of the house, introduced me to key workers, a fantastic Psychologist, Occupational Therapist, Live Active Activities. Over the year I was able to achieve my small positive goals and bit by bit, with assistance I was able to break down the barriers and finally move on. When it came time to discharge me, I asked if I could give back and volunteer. The team arranged many positions that I was suitable for ranging from Exercise buddy, shopping buddy, power plates coordinator, to my now existing role as Community Conveyor at the Health Hub, situated in Murray Royal Hospital, which has been a huge success.

Now, not only do I volunteer for MoveAhead but I volunteer for SSAFA the Armed Forces Charity and am their Branch Secretary for Perth and Kinross and a Specialist Caseworker for Veterans that are in our Criminal Justice Service. There is no way I would have come this far if it hadn't been for MoveAhead, I owe so much to this service.

How our Commissioned Services are meeting needs

Perth Six Circle and Mindspace provide an example of how our Commissioned Services are helping support the delivery of community mental health and wellbeing services.

Perth Six Circle

Perth Six Circle seeks to support disadvantaged adults facing challenging circumstances such as substance use, mental health, imprisonment, unemployment and community service orders, to improve the quality of their lives. This is achieved through support that helps people who often face significant barriers: to gain skills and knowledge; access a full range of external support; pick up the skills and understanding to live healthier and more independent lives; and ultimately helping them to return to and thrive within their own local community.

This service continued to be provided, despite the added challenges of COVID-19. However, due to social distancing restrictions, support activities were delivered in small group clusters to ensure that national guidelines were adhered to, and that people's health and safety was protected. To ensure their usual level of service provision, as restrictions limited groups sizes, Perth Six Circle adapted, increasing the duration of activities to enable them to run full day activities and events, through which people continued to receive the help and support they needed.

Activities Included:
Bike Maintenance Workshops; Walking groups; Arts and crafts; Baking; Sports – Golf, Table tennis; Basketball, Cycling; Introduction to iPads; and Day trips to places of interest.

Current uptake of service:

29 people have used the service.
95% of people reported feeling they have increased confidence when connecting with others.
100% of people reported they have made more friends and feel less anxious and are more sociable.
65% of people reported feeling more relaxed in social situations.
95% of people reported feeling they have increased confidence when using IT skills.

Feedback and comments:

"The Project is like a family to me. You go out your way and bend over backwards for us. It has made a massive difference to my life."

"The Project has made a huge difference to my life. I look forward to coming and feel much more socially connected. The team's good and I know if there's trouble I can phone."

"When I came, I had no friends. Since coming here I have started to make friends. We also meet up most weeks and go to the swimming. It was the staff that started us doing this but four or five of us have started going together."

Mindspace Recovery College

Mindspace is community based and challenges the stigma associated with mental ill health, The Mindspace Recovery College provides a service that is flexible and bespoke to individual needs, making it accessible and inclusive and based on the principles of mental health recovery and self-management. Through the provision of a safe and creative environment, it aims to help people to:

- Improve their knowledge of mental health
- Build their confidence
- Realise their potential and
- Participate in community life

Current uptake of service:

1,538 participants attending all sessions/activities.
924 adult recovery college participants.
Out of hours - 614 participants.

Mindspace are aware that there is a need to work steadily to review and develop the Recovery College communication and social media presence.

There also appears to have been a move away in interest from our more traditional in house delivered courses and participants are relishing the opportunity to try new experiences and develop self-management tools in the supportive environment created by the Recovery College facilitators.

Service User Story:

Anonymous (Anon) had been a user of Mindspace for 12 months. They had been low, adapting to life with a health problem which had meant early retirement from work and they struggled with their mood.

Anon became a regular attender of mindfulness sessions on zoom. Anon then became involved in several other groups, a creative arts group and Sophrology course, which aims to bring internal and external harmony. They also took part in several of the understanding mental health sessions.
Whilst still having episodes of self-doubt and low mood these episodes have lessened.

In September 2021 Anon decided to undertake peer support training, to enable them to support others who had ongoing mental health issues. Anon is now supporting individuals with physical and mental health problems whilst on placement for their peer support training.

Anon has really grown in the last twenty-four months. They are an active member of the Recovery college and was a co-facilitator in the planning and proposed delivery of a forthcoming course.

Looking Forward

The Mental Health and Wellbeing Strategy for Perth and Kinross (2022-25), focuses on working collectively and collaboratively to deliver the best outcomes. The strategy sets out the actions required to achieve service improvements.

The strategy reflects the views of hundreds of local people and communities and focuses on improving access to services, concentrating on person-centred care. It targets early intervention and prevention as a priority as well as developing the workforce to deliver.

Several programmes of work will be progressed in collaboration with key stakeholders in Health, Education and Children's Services, the Alcohol and Drug Partnership and within local communities. This includes work to reduce stigma and discrimination towards mental health, substance use and suicide awareness. There will be a focus on improving the physical health needs of those with mental health problems, progressing this through a Health Hub Model, functioning from Murray Royal Hospital.

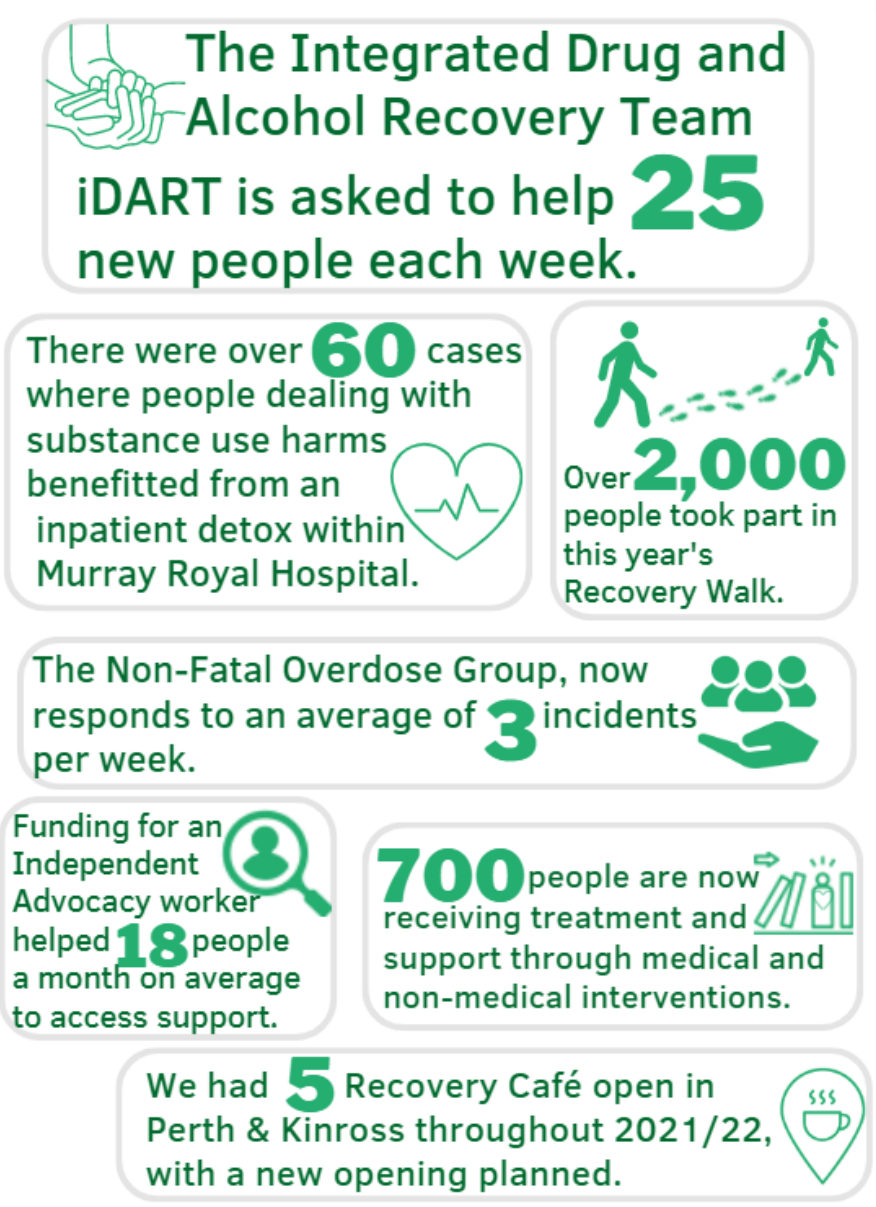
The Mental Health and Wellbeing of the people of Perth and Kinross remains a priority across all age groups and our local priorities include:

- Reducing suicide through education, training and awareness raising.
- Recruiting and developing Mental Health Advanced Practitioners to improve care and treatment, including a new Suicide Prevention Coordinator.
- Increasing the availability of Distress Brief Interventions.
- Continuing to develop the Crisis Hub and planning to expand its availability.
- Exploring the implementation of a Health and Wellbeing Hub in partnership with other organisations.
- Developing a resilient and sustainable future workforce.

Further to the above we aim to re-design and implement a Primary Care Mental Health Service that will focus on people that require care, support and treatment with mild to moderate mental health issues. This integrated service will utilise the experience and expertise of clinicians, social care, third sector organisations and peer support staff to provide access to services without the need to first see a GP. This streamlined approach will make it as easy as possible to receive the right care and treatment at the right time with the right professional.

substance Use

Our Year in Action



Service Delivery: Improving and Adapting Throughout the Year

Through the Perth and Kinross Alcohol and Drug Partnership (ADP) we are continuing to develop and implement a Recovery Oriented System of Care (ROSC). This approach enables people and their families, affected by substance use, to have access to the support they need on their recovery journey.

Scottish Government funding, to reduce drug deaths and harms, was utilised to support the ROSC with the integration of substance use services. This has allowed for the expansion of access to residential rehabilitation; implementation of a Whole Family Approach Framework; and has supported the involvement of people with lived and living experience in service developments.

The implementation of the Medication-Assisted Treatment (MAT) Standards has also been supported by additional funding. In turn this helps to strengthen the ROSC by ensuring partner organisations work together to offer choice and achieve consistent delivery of safe and accessible treatments.

Integration of substance use services

The integration of all community-based substance use services continued throughout the year following the creation of the Integrated Drug and Alcohol Recovery Team (iDART) in

2020. The aim of iDART is to improve the effectiveness and efficiency of support for people who have substance use issues, and their families.

Additional funding was used to support the formation and development of the new service. Additional posts were created, including in occupational therapy, social work (with specialist mental health experience) and substance use recovery workers.

Further expansion to include nursing and psychology support will broaden the multi-disciplinary approach. Increasing capacity within the service provides the opportunity to reduce waiting times and caseloads of iDART workers and implement a new model of delivery; helping the various professions to operate at the higher end of their remit.

The new service has developed a model of integrated working which utilises recovery workers to support people throughout their recovery journey. People receive intensive support from initial contact with iDART through appropriate medical and non-medical treatments. These include group psychology sessions and community integration where they are supported to access a range of community recovery supports such as recovery cafés and walking groups.

Expansion of Residential Rehabilitation

In a revised process for accessing residential rehabilitation, people can either self-refer or be referred by a professional. Suitability is then assessed by the screening group which includes clinical and non-clinical colleagues from the statutory and third sectors.

Residential rehabilitation facilities across Scotland are accessible to all, irrespective of locality of residence and a number of Perth and Kinross residents have had their applications for entry to residential rehabilitation facilities accepted. Support on their return from rehabilitation is essential to help reduce the risk of relapse. Following a review of the process, everyone leaving residential rehabilitation now has a recovery worker to provide ongoing support.

Implementation of the Whole Family Approach Framework

A whole family/system approach was implemented, and work continues to ensure this is embedded across services. A specialist substance use carers' support worker, who is part of iDART, offers a range of supports, including harm reduction awareness, therapeutic support and financial advice and support, to carers and families, empowering them to have greater control over their lives.

We undertook a project to test a different approach for engaging with families where children live in the family home and where there are issues with drugs and/or alcohol; and where services are needed from more than one agency. Assessment is done at home and families are offered support through a joint plan, encompassing all elements of what the family needs. This is shared across all participating services.

An assessment of the impact of the project will take place during 2022/23, however several positive outcomes were already achieved: the development of a new assessment tool; better engagement with services for families; improved confidence and a sense of empowerment for families; and improved working relationships between services.

The Involvement of People with Lived and Living Experience in Service Developments

Following the success of 'Recovery Walk Scotland 2021', hosted in Perth, we developed a three-year plan to grow a grassroots recovery community, which will support the organic growth of a range of peer support groups and activities, including walking groups, fishing groups, and recovery cafés.

With the easing of COVID-19 restrictions, the network of community-based recovery cafés recommenced face-to-face meetings. These meeting are led by those in recovery themselves, or with an interest in recovery, providing a supportive and constructive environment for people to discuss their mental health and wellbeing during recovery from substance use or mental health issues. A new café is also being planned for Perth City, which will ensure people in the local area have access to the peer led recovery sessions.

Funding continued for specialist advocacy support for people with substance use issues. Independent Advocacy Perth and Kinross (IAPK) provided this support to help people navigate systems and overcome barriers to accessing services and to effectively engage with them.

IAPK received 41 referrals to work with people with substance use issues in the reporting year with support being provided to an average of 34 people per month. Engagement resulted in a variety of positive outcomes, including improved relationships with professionals, increased confidence in challenging situations, and improved engagement with services. COVID-19 restrictions did however make this more challenging.

MAT Standards

The Medication Assisted Treatment (MAT) Standards focus on the health and wider social needs of individuals who experience problems with their drug use. The purpose of the Standards is to improve access and retention in MAT, enable people to make an informed choice about care, include family members or nominated person(s) wherever appropriate and to strengthen accountability and leadership so that the necessary governance and resource is in place to implement them effectively.

The Perth and Kinross ADP works in partnership with the Scottish Government's MAT Standards Implementation Team (MIST), and a range of local partners to implement the Standards both in the community and within Prison Healthcare.

A significant amount of work has been done to implement the Standards. Standard 3 states "all people at high risk of drug-related harm are proactively identified and offered support to commence or continue MAT".

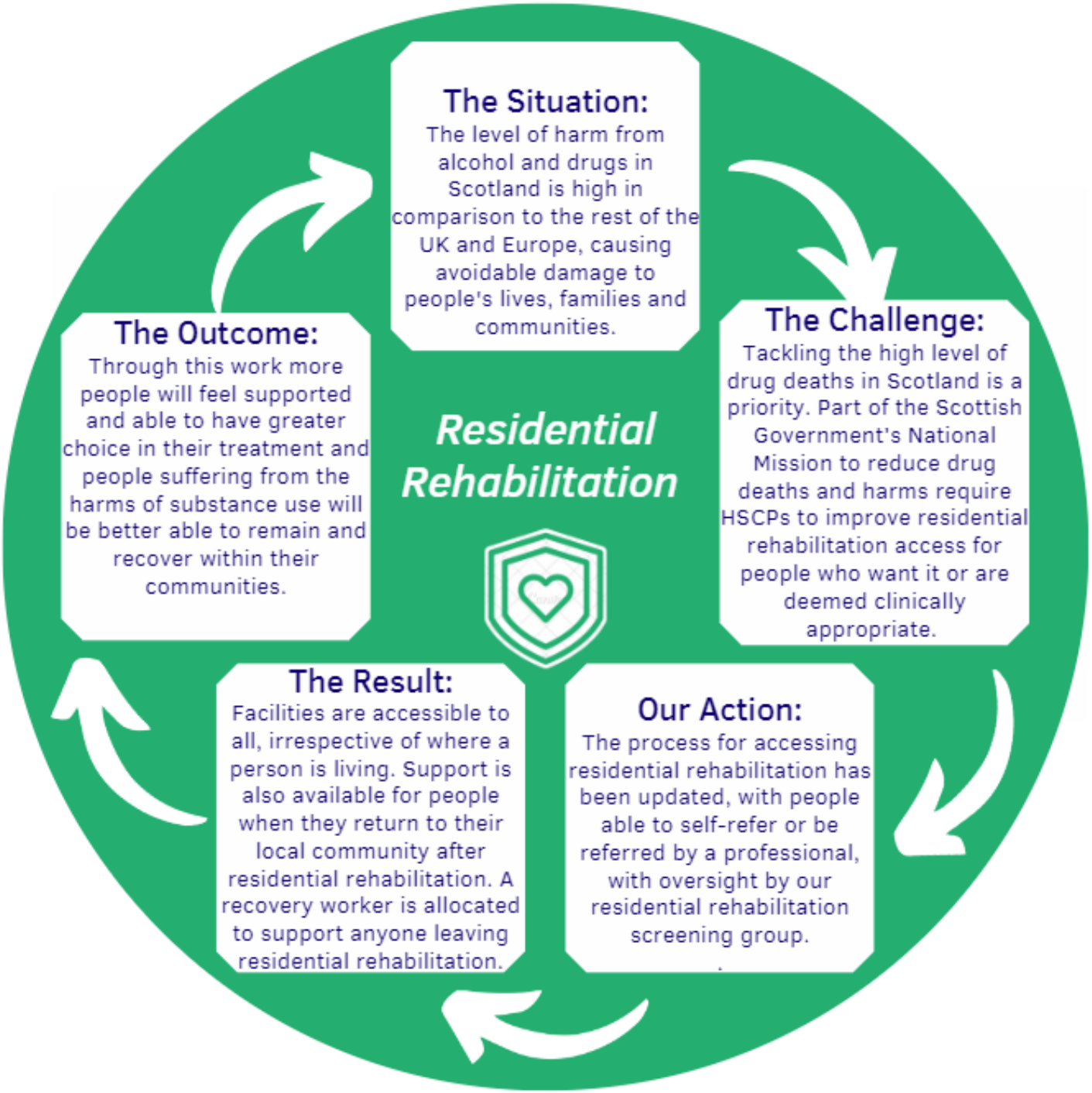
To implement this Standard, the Perth and Kinross non-fatal overdose group was established. The Group has representatives from substance use services across the statutory and third sectors. It receives information regarding all non-fatal overdose incidents attended from the Scottish Ambulance Service, NHS Tayside Public Health, Police Scotland and Adult Support and Protection Vulnerable Person Reports. Appropriate actions are then taken to ensure people are offered the help and support they need. There were 98 non-fatal overdose incidents reported in 2021/22 across Perth and Kinross, a reduction of 77 when compared to 2020/21.

However, there remains a notable gender disparity, with the male to female ratio at 84% to 16%.

Improvement Journey

Throughout the year there has been considerable work undertaken to improve services for those suffering from the harms of substance use.

This illustration highlights how the establishment of Residential Rehabilitation will work to empower people to have greater choice in the treatment they receive.



Case Study

Perth and Kinross Recovery Walk

In September 2021, Perth City hosted the Recovery Walk Scotland. The event, organised by Scottish Recovery Consortium, provides an excellent opportunity for members of the community to gather for a day which centres on stories of recovery from a wide range of harms, ranging from substance use to mental health.

The day seeks to celebrate those who have come through mental health or substance issues, and to support those who are still going through hard times. Events on the day included: The Roses in the River Memorial, The Recovery Walk Scotland procession through the city centre, and a Recovery Festival and Village in North Inch Park, Perth, with over 2,000 people taking part.

The event, the largest recovery event in Scotland, was very well received by those who attended:

Attendee Testimony:

"It was just a great experience being in the same place with others who have been on that journey."

“Seeing folk in their gardens clapping their hands made my day.”

Organiser Testimony:

“Some members have been deeply affected by suicide in their own family so it’s an important event for them to aid recovery.”

“Everyone was given a rose free of charge and poetry was read out by some survivors of addiction. At the end there were 2,500 roses floating in the river while a piper played. It was so beautiful and personal.”

How our Commissioned Services are meeting needs

CATH Outreach Day Centres provides an example of how our Commissioned Services are working to support our communities.

CATH Outreach Day Centres

The CATH Day Centre Outreach Team seeks to work within communities to reduce the numbers of people who are rough sleeping or at risk of losing their tenancy or are facing crisis. Its goal is to prevent and end homelessness, through rapid intervention.

Taking a person-centred approach, regardless of the circumstances a service user may find themselves in, this community-based service provides support, respect and dignity to those in need, without the need, nor delay, of a formal referral.
The team is based within the Day Centre, enabling them to offer a drop-in service for people in Perth City. In addition, surgeries have been provided in Alyth, Blairgowrie, Crieff, Kinross, Pitlochry, and both the Skinnergate and the Foodbank in Perth.

Outreach offers support to people who may not otherwise engage with services due to a high level of need. Its preventative approach supports people to avoid becoming homeless through the provision of support, advice and referrals. By taking a person-centred approach, CATH focuses on building individual capacities, skills, resilience, and connections to community. Using this approach helps to discover what people want, the support they need and how they can get it, ultimately assisting people to lead an independent and inclusive life.

Current uptake of service:

Current uptake of service:
Initial engagement – 192.
CATH are part of the triage partnership additional 123 interventions.
142 referrals made to external agencies over 2021/22.
Since January 2021, CATH have made 16 referrals regarding people's mental health.
Since January 2021, CATH have supported over 100 people offering alcohol/drug brief interventions.
Since April 2021, 84% of service users were supported with financial issues.

Feedback and comments:

"They have been great trying to sort things out and giving support and advice. Helping so much when you don't understand the paperwork."

"Got help with my bus pass – sorted out."
"Staff knew how to help and had resources at hand for any further assistance."

Looking Forward

The continued development of our ROSC and the implementation of MAT Standards remain key priorities for all substance use services and partners over the next 12 months. In addition, four other areas of work will be developed as follows:

Continued Integration of Substance Use Services

As iDART expands it will be able to continue to grow the breadth of treatment options available, focussing on recovery. These include help for people to stabilise chaotic lifestyles so they can engage with therapeutic interventions, increased access to individual and group psychological therapies and support with integration into local communities including accessing employment and further education. This investment will also support the ongoing development of multi-agency assessment clinic and triage.

Mental Health and Substance Use Integration

Recommendation 14 of the Trust and Respect report stated that NHS Tayside should "consider developing a model of integrated substance use and mental health services". The Scottish Government also requested that Healthcare Improvement Scotland, work with NHS Tayside to develop an Integrated Mental Health and Substance Use Pathfinder project which will improve outcomes for people with a dual diagnosis of mental ill health and substance use. The project will prototype a new model and pathway of care, with a view to spreading good practice, innovation and learning about "what works" in developing and delivering integrated and inclusive Mental Health and Substance Use services. HSCP colleagues are members of the Project Delivery Group which is developing the new model and care pathway. During the next 12 months, the programme team will work with people who have lived experience of mental health and substance use and with relevant services to identify what might improve care and support.

Alcohol

An increasing number of alcohol related referrals were received throughout the pandemic. Funding is in place to enable iDART to develop a community alcohol detox unit to complement existing services and additional investment has been made in Tayside Council on Alcohol (TCA) to increase counselling spaces. In collaboration with ADPs across Tayside, Perth and Kinross ADP has increased support for improved Alcohol Brief Intervention coordination. Alcohol Brief Interventions (ABIs) are short, evidence-based, structured conversations about alcohol consumption which are conducted in a non-confrontational way to motivate and support people to think about and/or plan a change in their drinking behaviour. This work is being taken forward across Tayside to increase capacity for the delivery of ABIs.

Developing a Justice Pathway

We are working with partners across Perth and Kinross including, Perth and Kinross ADP and Perth and Kinross Community Justice Partnership to develop a pathway for people who have lived or living experience of justice and have

substance use issues. Current projects to develop the pathway include a two-year test of change which will see the establishment of a Custody Arrest Referral Service (CARS) for Perth and Kinross. This will provide services in Perth and Kinross with the opportunity to identify people in crisis; engage or re-engage individuals with person-centred support targeted at addressing unmet need (such as support linked with problematic substance misuse, mental health and/or homelessness) with the intention of minimising escalating offending behaviour and further crises.

The Prisoner Release Delivery Group was established with the aim of ensuring there are clear pathways between prison and community support services, including support with substance use issues. The multi-agency group, which includes SPS (Scottish Prison Service), Health and Social Care, Housing and Safer Communities Teams, Skills Development Scotland (SDS) and Criminal Justice Social Work is seeking to build on and enhance the successful model that was developed to manage the early release of prisoners in 2020, in response to the pandemic.

Primary Care and Hosted Services

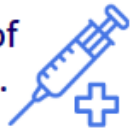
Our Year in Action

254
home visits made by Advanced Nurse Practitioners during test of change.
*Oct 2021 and Feb 2022

Community Care and Treatment Service
Delivers over **6000** appointments a month.

68% of First Contact Physiotherapy patients discharged after their first appointment.

123,777 given first dose of Covid-19 vaccine.
*as of Mar 2022



82% of Perth and Kinross residents have received a Covid-19 vaccine dose.
*as at Mar 2022

93% of Residents in receipt of Occupational Therapy rated it either good; very good or excellent

Service Delivery: Improving and Adapting Throughout the Year

As we transitioned to the next phase of the pandemic response, Primary Care, including hosted services of Public Dental Services, Podiatry and Prison Healthcare, maintained the focus on the safe delivery of care to those most in need. We also delivered on an ambitious programme of service transformation and improvement by the further expansion of services through the Primary Care Improvement Plan (PCIP). This Plan sets out ambitions to transform primary care in line with the Scottish Government's vision, and in collaboration with GP partners.

Community Care and Treatment Services (CCATS) are now established at seven hubs throughout Perth and Kinross:

Aberfeldy – Dalweem Care Home;

Auchterarder –St Margaret's Community Hospital;

Blairgowrie – Blairgowrie Community Hospital;

Bridge of Earn – Bridge of Earn Hub on Station Road;

Crieff – Crieff Community Hospital;

Perth – Beechgrove House on Hillend Road;

Pitlochry – based at Pitlochry Community Hospital.

CCATS also provides in-reach services at the following locations on a variety of days and times:

Alyth; Coupar Angus; Dunkeld; Stanley; Comrie; Errol; Abernethy; and Kinross

Having been rolled out through the pandemic, CCATS offers a broad range of services from routine blood tests to monitoring of chronic conditions, aural care and irrigation to the treatment of minor injuries.

Throughout the development and implementation phases, feedback from people using the service has informed changes in delivery. CCATS has been a successful and transformative new service and people overall are very pleased with how services have been received. The delivery of CCATS also frees up time in General Practice to enable GPs to support of more complex cases. The small number of GP practices still to gain full access to CCATS will be addressed by a further expansion of service in the year ahead.

> *"What made this journey and its many highs and lows bearable was the incredible care of the staff at the Blairgowrie Community Hospital. What a team! I have felt listened to, cared about, and valued by all of the members of the team, and I have always had a warm reception and a high standard of care."*
>
> CCATS- Patient Testimonial

To enable the service to cater for greater demand and enable further patients to access CCATS, additional investment in buildings will be necessary to create more clinical space. This, and further buildings and infrastructure requirements, are captured in our draft premises strategy and by detailing our strategic needs, we are more able to engage and co-ordinate with partner organisations. This integration and co-ordination will secure access for people to services for the long term.

Advanced Nurse Practitioner Service (Urgent Care)

Continuing our approach to ensuring patients see the right professional in the right place at the right time we have now completed a test of change in collaboration with GP practices, where Advanced Nurse Practitioners (ANPs) undertook "urgent" home visits to treat patients across the Perth City Locality. Feedback from our GP partners and people in receipt of the service suggests this has been a huge success.

> *"Excellent service, have seen nurses previously who have not provided such a thorough check-up. Explained everything to me and I felt involved. Referred me on for other tests at PRI and appointment is already confirmed. Nurse was friendly and approachable"*
>
> ANP- Patient Testimonial

Similar to CCATS, it has enabled GPs to dedicate greater time to more complex caseloads. More work is now needed to implement lessons learned from the initial test. This includes improving efficiencies, streamlining ways of working and integration with wider services. A further expansion of the ANP service will see it rolled out across all localities.

First Contact Physiotherapy Service

Our First Contact Physiotherapy (FCP) service supports people presenting with musculoskeletal problems, including: soft tissue injuries; sprains and strains; back and neck pain; and joint problems to access physiotherapy expertise directly, with a first point of contact for assessment. This service now covers all 23 GP practices delivered via seven Hub sites and ensures timely access for diagnosis, early management and onward referral, if necessary. This benefits the person, primary care services and the wider musculoskeletal (MSK) outpatient services.

"Just continue with this wonderful service"
"Continue an excellent service"
"Service is needed and well used"
"Continue to have reasonable waiting times"
"Just continue with the way the service is currently running"
"Continue providing advice for appropriate patients"
"Rapid access seems to be working well. Exercises and phone advice good for the majority"
"Continue supporting requests for help and advice"
FCP - Stakeholder Feedback

The First Contact Physiotherapy Service provides people face-to-face or telephone appointments with a specialist physiotherapist, to assess their condition and provide advice. If appropriate, a further in-person assessment can be arranged, or alternatively, a referral for further treatment or specialist investigation arranged. This more direct route to physiotherapy expertise ensures people receive the right care in the right place, faster. GP time is similarly freed up, enabling them to focus on cases where their extensive expertise and generalist knowledge is most useful.

80% of people answered positively when asked, "How was the physiotherapist at helping you take control?

Patients have benefited with waiting times having reduced, as have the number of unnecessary and duplicate appointments.

Social Prescribing

Social Prescribers are generalist non-medical practitioners aligned to GP practices/clusters. They work directly to signpost people to wider services and support and use community-based activities to help address factors that contribute to health problems. The aim is to improve health and wellbeing, through the provision of a different response. Social Prescribing has been very successful and following redeployment during the pandemic all six of the initial Social Prescribers returned to the service in April 2021. A further three have been appointed to help promote people's health and mental wellbeing, through signposting and supporting individuals to make connections in their local and surrounding areas.

Primary Care Pharmacy Service

The Pharmacy Team maintained their support to General Practice and community hospitals, working with GP colleagues across 23 practices and collaborating with multi-disciplinary colleagues from primary and secondary care, including community and hospital pharmacy services. The Pharmacy Team ensures that people receive their medication in a safe and timely way.

With national shortages of suitably skilled and experienced staff, recruitment and retention remain a challenge and a priority. We have continued with campaigns to recruit to junior posts which we can then develop. This ongoing development of our workforce, our systems of working, and our optimisation of the workforce skill mix is designed to enhance service delivery, improve job satisfaction and maintain staff retention.

Work is ongoing with statutory partners to resolve accommodation issues through the Premises Strategy. Growing demands and workforce represent a challenge and a risk to the sustainable delivery of services.

Vaccination Service

The Vaccination Transformation Programme (VTP) delivered a phased service change for immunisations, based on locally agreed plans to meet nationally determined outcomes. Vaccinations traditionally given in GP practices are now delivered by a centrally organised and managed service. These include seasonal flu, shingles, pneumococcal as well as the very successful roll out of the COVID-19 vaccine.

Our Hosted Services

Prison Healthcare

Prison Healthcare is an extension of Primary Care and provided to the prison population in Her Majesty's Prisons, Perth and Castle Huntly. The pandemic presented particular challenges for the delivery of safe services in this secure environment however considerable progress was made to improve service provision.

> *"Help was excellent and advice given was clear and understandable; I was made to feel like a patient rather than just being a prisoner"*
>
> *"My experience with OT was really good, my health has got easier to manage and [this] has helped me lots"*
>
> OT - Patient Feedback

The prison population has complex health and support needs. Accordingly, a multi-disciplinary and multi-agency approach to the delivery of care is embedded, mirrored by the approach we have taken more broadly. For example, professionals from a broad range of disciplines review the needs of individual patients on a daily basis during 'person of concern' meetings. These meetings provide an opportunity to discuss anyone presenting a concern, including patients with mental health concerns, and complex physical health needs. They also provide an opportunity to discuss the management of offenders at risk of substance use. Nearly 700 of these reviews

were undertaken across the 2021/22 period, enabling appropriate interventions to take place by the most appropriate person at the earliest opportunity.

Improvements in service access was also made possible through the introduction of telephones for appointment booking and remote consultations. This has increased opportunities for patients to attend appointments resulting in a reduction in the number that do not attend.

To increase the provision of clinical Prison Healthcare, we have developed onsite access to clinical psychology and after some difficulties in securing GP cover across both prison sites, it is now anticipated that this will be in place in early 2022/23. These vital clinical posts are also supported by an onsite Clinical Pharmacist to ensure the safe and timely administration of medicines.

To increase access to a variety of clinical services within Prison Healthcare, we have developed onsite access to clinical psychology, and we are looking to increase capacity of our Occupational Therapists (OTs). The OTs are primarily working with people with mental health issues but there is a clear need for them to support people with substance use and physical health needs. OTs support through a range of measures, from helping with liberation planning and rehabilitation (across cognitive, physical and mental health) to environment assessment and specialist equipment provision. Throughout 2021/22, 80 referrals were received by our OTs, with 612 appointments offered.

The Prison Healthcare team have been working with the Scottish Prison Service to develop a model of care for the female Community Custody Unit (The Bella Centre) due to open in August 2022. This will provide a different approach to care for women in custody, supporting them to access community services as well as services being delivered by prison healthcare.

Podiatry

Podiatry works in close partnership with Community Nursing Teams and CCATS and have recently delivered the CCATS Healthcare Assistants with training to conduct diabetic foot screenings to support Primary Care delivery of diabetic reviews.

Throughout the pandemic in both 2020/21 and 2021/22, the podiatry service experienced staff vacancies; services being stepped down; and staff being redeployed to other areas.

Across 2021/22, 12 Online Foot Health Education Webinars were held for staff across Perth and Kinross, with 37 attendees from across 15 locations.

This had an impact on what the podiatry service was able to provide, resulting in a very focussed prioritisation of demand to ensure that those people with the most complex needs are provided with the most appropriate level of care.

Despite this, podiatry continues to support third sector partners that provide personal foot care to communities across Tayside - all of which had to withdraw during the height of lockdown restrictions. Most of these have now resumed this

service and Podiatry will continue to seek new partners to further support the building of community capability for safe care, capacity and enablement.

Specialised third sector partners providing personal foot care, resumed their services to communities albeit it in a limited capacity, to support the building of community capability for safe care and improve on the impact on individual's health and wellbeing. We will continue to seek new partners to grow this community-based service further.

Tayside Podiatry issued 4,045 new patient appointments and 421,731 return patient appointments in the 2021/22 period. As lockdown restrictions lifted, podiatry introduced assessment hubs to review the needs of its caseload and provide the most appropriate level of care: from self-management advice; short intensive episodes of care; to long-term intervention to promote health and minimise unplanned hospital admission. Podiatry is working in close partnership with Community Nursing Teams and CCATS and has recently delivered the CCATS Healthcare Assistants with training to conduct diabetic foot screenings to support Primary Care delivery of diabetic reviews. Work has also begun to conduct a test of change with CCATS wound hubs in Kinross and Blairgowrie to enhance collaboration between the two services and improve patient pathways.

Dental

Public Dental Services largely reopened in full after a reduced range of services through the pandemic.

A significant number of people had not been able to access routine dental treatment for a sustained period. To address this backlog an additional non-recurring investment of £367,000 has been made to grow the workforce with additional staff recruited through this Winter Preparedness Funding, now mostly in place.

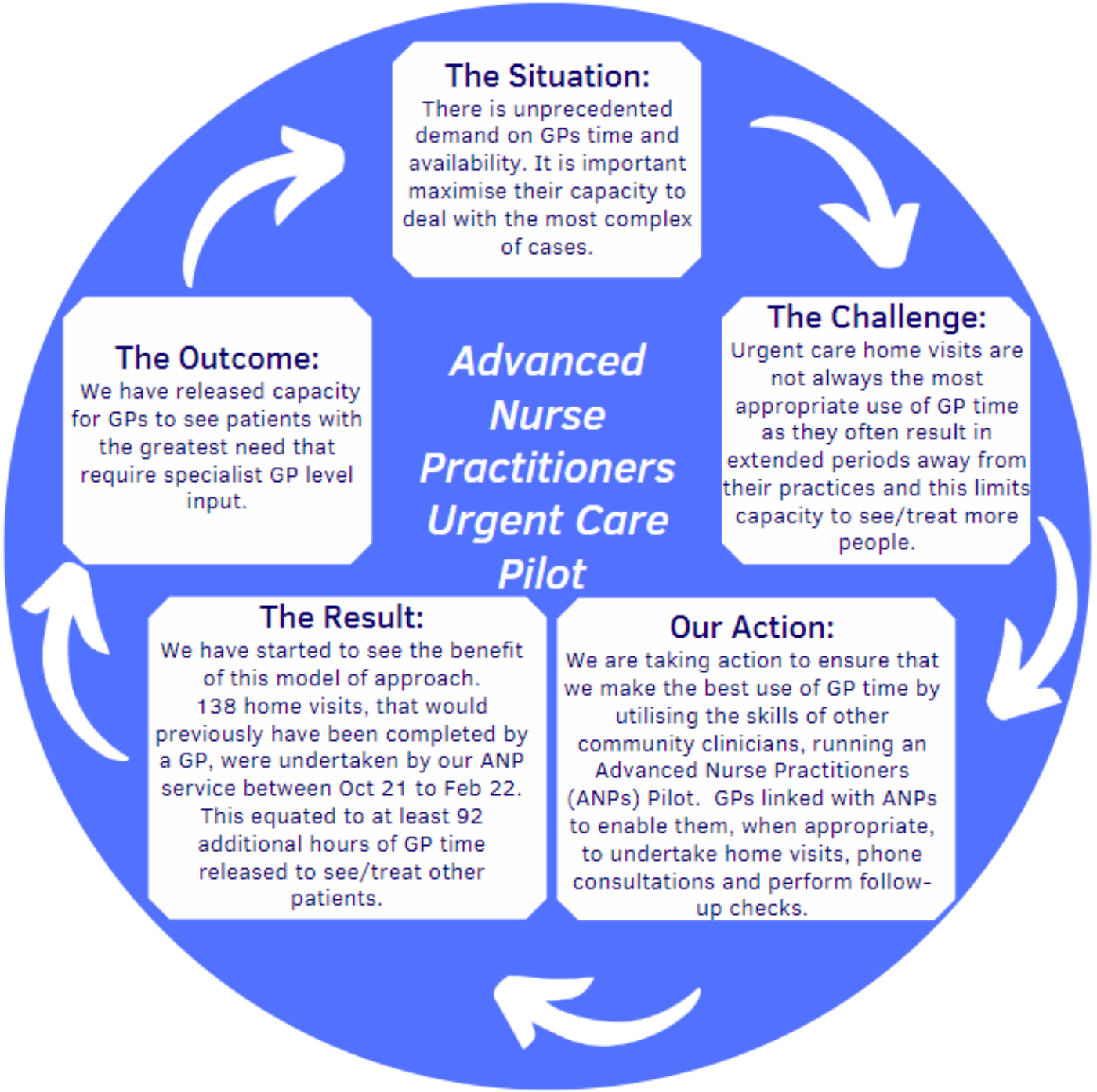
A backlog remains particularly for treatment under general anaesthetic, as sedation referrals were suspended for a period during COVID-19. We have now resumed and there is now a manageable waiting list. Moving forward, all residents in care homes will be offered examination and treatment as required as we reinstate the care home inspection programme. Re-establishing outreach services into care homes will also be addressed as this was not possible during the pandemic. Those in the greatest need are prioritised for care first and this includes the 1,000 patients each year who require sedation before treatment.

Changes in practice which are necessary following COVID-19 require additional investment in infrastructure and this is being addressed via partners and is covered in our premises strategy. Additional pressures also exist in respect to accessing the necessary theatre time for more complex cases.

Improvement Journey

Primary Care services have undertaken considerable improvement and transformation work throughout 2021/22.

This example shows how an Urgent Care Advanced Nurse Practitioner's (ANP) Pilot has helped to progress our efforts to ensure people receive the right care, at the right time and in the right place.



Case Study

CCATS Patient Story

"The CCATS wound team have endeavoured to find the most suitable treatment and called in GPs and dermatology to help treat infections and gain learning about wounds that are more difficult to manage."

"They have worked (with me) with empathy and a goal of helping me. It hasn't been easy as my wounds have to be cleaned and they have striven to be effective and reduce pain as much as possible (even though it's more a case of get it done and not prolong). Their empathy and including me in all treatment decisions have helped me get through. At times with pandemic lock downs and isolation I have been low but the chat and manner has lifted my spirits."

"Other factors have been their willingness to ensure appointments fit in to times when my wife is able to take me. In pre-Complex regional pain syndrome days I could walk in less than 10mins. I tried it recently and it was approaching an hour.

So, I'm saying a big thank you to the team who work brilliantly plus the healthcare assistants who help getting the dressings when I am there."

Looking Forward

GP colleagues remain at the heart of Primary Care service delivery. Increased sustainable communication routes have built stronger links with locality-based teams, leading to improvements in the quality of care provided. This success will be built on to support further improvements. This includes the reintroduction of support to GP practices to increase capacity for more in-depth medicines reviews which was not possible throughout the pandemic.

The achievements of colleagues in Primary Care, and with connected services, have been possible through staff dedication across a broad range of professions. By linking multi-disciplinary teams, people are better able to have a positive experience at all stages of the patient journey and can achieve the best outcomes. We will continue to invest in Primary Care services as the Primary Care Improvement Plan is further implemented and our Strategic Delivery Plan is developed.

GPs are now better supported by multi-disciplinary locality-based teams which is helping to secure GP sustainability. Further work will establish a Primary Care Resilience Team, which will have specialist skills and knowledge across a range of disciplines. The Resilience Team will support Primary Care in the widest sense and provide targeted support to GP practices.

While progress has been made, recruiting to this ambitious new model remains challenging but we intend to continue with this work developing innovative ways to attract people with the right skills and experience. Meanwhile, further recruitment to the primary care pharmacy service, including additional input to community services and our HSCP resilience team, is planned for 2022/23.

Some planned service development requires support from partners, such as the availability of suitable and sustainable premises. This issue relates to a number of primary care-based services and support from statutory partners will be necessary to overcome this.

Further difficulties exist in respect to the supply of suitably trained and experience workforce. Within Prison Healthcare and more broadly there is a need for greater access to physiotherapy or occupational therapy for example. Given national shortages of people with these skills it has not been possible to fill vacancies within the year. New and innovative approaches to cater for this demand are now being explored however, please see “Workforce” chapter.

Carers

Our Year in Action

Service Delivery: Improving and Adapting Throughout the Year

Demand for carer services grows each year. Since the approval of our Joint Carers Strategy 2019-22 we have seen referrals for carer support increase by 40%.

Improvements to the rights of carers has resulted in an overall increase in demand for services. These rights include: the right to access information and advice about their caring role, and to be involved in the development of services for carers and the people for whom they care. The demand includes greater access to person-centred support; this enables carers to continue caring and enjoy a life alongside their caring responsibilities.

Pandemic restrictions limited support for much of the year, both in terms of what services could be provided, and also due to fears expressed by carers about the risk of infection.

Where services could not be delivered or were delivered at a reduced level, alternative support mechanisms were provided where possible. For example, at the start of the pandemic, the telephone befriending service was resourced to reach more carers. Although re-tasked staff providing this service have returned to their posts, the service continues to give support to carers and helps mitigate isolation and loneliness.

Carer services are commissioned from PKAVS Carer Hub. This support ensures necessary early interventions are available to support carers to maintain their health and wellbeing in ways that relieve the burden of having or taking on a caring role. To ensure that carers are involved in the discharge process whenever the cared for person is admitted to hospital, a dedicated Hospital Link Worker is in place through PKAVS to assist in navigating what can be an anxious time.

In conjunction with the Carers' Hub, the 'Making Carers Visible and Valued' information booklet was distributed to nearly 2,000 adults with carer responsibilities, in support of Carers' Week 2021.

On Carer's Rights Day in November 2021 for our 'Carers Connect' event we used a blended approach, supported by the PKAVS Carers Hub and Carers Voice, with online and in-person presentations at three venues across Perth and Kinross to enable more carers to meet one another and access information that would help them to sustain their caring role.

Commissioned Services supported 122 carers with 68 receiving ongoing support. This has been a significant success, giving carers increased resilience, reasonable life balance and feeling more able to cope:

- The Carers' Hub team is dedicated to providing community-based support for carers.
- Sitting services is provided by Crossroads and other care providers to give carers a break.
- Support in Mind Scotland supports carers for people whose mental health problems or mental illness impacts their life.

Involving carers in the development of our services is recognised as key to the successful delivery of our Strategy. In this respect we have ensured that carers are represented, as equal decision-making partners on the Carers' Strategy Group and across each of our wider Strategy Groups. We have also continued to support the development of 'Carers Voice' – a carers' participation and representative membership group, which had approximately 90 members at the end of 2021/22. More work is needed in this area to ensure that all service developments are underpinned by carers as representatives of the people they care for, and whose perspective is vital to successful service design and implementation.

Further statutory obligations came into effect in relation to providing support to those caring for people with a terminal illness. A new service providing palliative carer support was created, and following feedback from carer representatives, was expanded to provide greater emotional support to carers of people admitted and discharged from hospital. The New Rannoch Carer Support Team provides the service and feedback was overwhelmingly positive.

The Joint Carers' Strategy 2019-22, highlighted the need for Health and Social Care professionals to have training to ensure obligations to carers are widely understood. Carers need to be identified early and enabled to find support to meet their needs. Training for staff was developed and presented to

58 professionals throughout localities and the hospital discharge teams. Feedback was positive as it gave learners an insight into being an unpaid carer, the potential impact on carers and the support carers are entitled to expect.

One key outcome identified from the Strategy was the need for greater peer support and so working with Richmond House we have established a monthly carers' café in Crieff. This was aligned with community wellbeing walks, resulting in more carers using the service throughout the year. This will be expanded to include weekend cafés, to enable carers who work to meet up for peer support and friendship.

> *"Thank you for the help and support, without her care and professionalism…I don't know how I would have coped"*
>
> Carer Support Team: Service user Feedback
> (Murray Royal Hospital)

Given the success of the Crieff model, work started with Dementia Friendly Aberfeldy to introduce the concept in Northwest Perthshire. Following some initial success, work continues to establish a regular meeting time and place in Aberfeldy so that carers can meet to share experiences, provide peer support and increase awareness of wider support services and community groups.

Across our localities we are working to establish and develop more opportunities for carer peer support including carer drop in at the Maddoch Centre in St. Maddoes and our Day Centre in Kinross. Peer support groups have also been developed during the year by PKAVS including walking groups, the Bridge Project which supports bereaved carers, and the creation of a Carers' Choir with Horsecross in Perth City.

Where caring has a significant impact on carers there may be a need to consider replacement care in order to allow them to have a break. Throughout the year, providing this support was a challenge as the effects of the pandemic and other pressures meant that recruitment to caring roles was affected. Similarly, with pressure on the availability of care home beds from other Health and Social Care services it was difficult to provide respite care home placements. Given the difficulties outlined we undertook a test of change in collaboration with Parkdale Residential Care Home to create capacity for planned placements. This allowed carers to plan breaks, take holidays and gain respite from their caring roles. Despite these pressures on services, the work of the locality teams, including our dedicated Carer Support Workers, mitigated the impact of a caring role. This has contributed to a reduction in care home admissions as a consequence of carer breakdown from 24.0% to 16.3% of permanent care home admissions during the year.

The Joint Carers' Strategy recognises the financial impact of caring. Working with partners, Carer Positive and PKAVS, we have engaged with employers to improve recognition of working carers and the support that employers can provide to enable them to continue working whilst caring.

The life impact of a caring role cannot be understated and so carers were signposted throughout the year to Citizens' Advice Scotland, resulting in 479 people with caring responsibilities, getting support with a range of issues including benefits and housing. A financial gain for carers of £343,000 was achieved. The uptake of advice continues to be monitored as the cost-of-living crisis impacts our population and our communities, especially for those looking after a family member or friend.

We reviewed our information resources and in September launched our new information booklet developed with Carers Voice. This was promoted throughout Perth and Kinross via Culture PK's mobile library service. We also considered minority ethnic carers, and with our Social Prescribers developed a relationship with Perthshire Welfare Society who support carers from a range of ethnic minority groups, including South Asia and Eastern Europe, to develop posters in a range of languages to ensure that carers from many backgrounds would be able to find out about the support available to them.

Improvement Journey

This illustration outlines the planning and delivery of Carers Connect, which works to improve the range of services and support networks carers have access to.

In achieving this, unpaid carers are better able to remain in their caring role and continue to deliver the vital support to those for whom they provide care.

Case Study

PKAVS: Jackie's Story

Jackie cared for her mum who had Alzheimer's and vascular dementia and her dad who had a serious heart condition. During this time Jackie was diagnosed with arthritis. The impact of caring meant that she found it difficult to maintain this support whilst caring for her own family, working and studying. She realised that, whilst she found caring for her parents rewarding and would not change being a carer for her mum and dad, as she knew how to support them in a way that they appreciated, it was becoming increasingly difficult to cope. Realising the impact on her own health and wellbeing led her to visiting PKAVS Carers' Hub.

This is her experience of the support from PKAVS in her own words:

"In 2017 I went into the Gateway Centre to ask for help and that moment changed my life. After chatting with Catriona, I went home lighter knowing I wasn't on my own. When my plan arrived, I cried again because I had been heard and finally accepted that I was an unpaid carer for my parents and in due course my son. From then onwards PKAVS have supported me and my family practically and emotionally through diagnosis, accessing services, professional interactions, bereavement and the pandemic! PKAVS have offered a consistent professional input to my family with realistic goals and compassionate support. Jo and Lorna have also provided consistent caring support through Telephone Befriending which continues to help me now. I am so very grateful for PKAVS and all they have done for me."

Crossroads Sitting Service: Family Testimony

"Having the Crossroads Sitting Service has made a huge difference to us.
Because of the type of dementia my partner has it means he wants to be on the go all the time and is very active. Because I'm not in the best of health, I cannot keep up with him and I get tired. When Crossroads come in, he looks forward to them coming and enjoys his time with them. It means they can take him out and I can go and rest if I feel tired and I don't need to worry about him. I know that he is safe and getting well looked after and is in good hands.

The difference it has made to me means I look forward to having some time to myself to do the things I enjoy whether that's just pottering about the house, having a rest/catch up on some sleep, meeting my sister-in-law for a coffee and a chat or just getting some time to do what I want to do. He's happy, so I'm happy and it means I can keep looking after him and we are together in our home".

How our Commissioned Services are meeting needs

Support in Mind and PKAVS Carers Hub provide an example of how our Commissioned Services are supporting Carers in their caring roles.

Support in Mind:

Support in Mind provides unique support to people with severe and enduring mental ill health. Support in Mind takes a human centred approach, believing people affected by poor mental health and illness deserve the highest quality of support in the community and that every person has the right to be valued and to share in the opportunities, challenges and joys of everyday life. In doing so, the people they work with have greater opportunities, can build confidence and social skills, and become more integrated to their communities.

Across Perth and Kinross, their Carers' Support Workers work remotely to provide targeted support to people who care for or support people experiencing mental ill health. Services for carers include:

- Individual support
- Emotional Support
- Telephone and email support
- A range of information, advice and access to local peer support groups
- Professional guest speakers on mental health topics
- Signposting to other relevant services

These services are provided completely free and confidentially.

The last year has seen a significant increase in the level of support provided by Support in Mind (SiM). They have increased their service footprint from Carers and Hearing Voices to now include Resilience early intervention. These services run in tandem with their Carers project which in the last year has continued to run at an enhanced level in response to increased demand from the pandemic. This approach has been beneficial to both carers and people they support with mental health needs.

Support in Mind have also worked with PKAVS to allocate funds from the Winter Recovery Fund, with £45,000 allocated from government funds to carers. 4 of the SiM carers benefitted and were collectively allocated £1400 and 5 new carers were identified during the process who would benefit from the more complex in-depth support their carers project offer
SiM continues to be involved in the local Mental Health and Wellbeing Strategy group, Carer Strategy Group and the Autism strategy group and the strategic planning group - with contributions made to planning, participation in workshops and group meetings.

Current uptake of service:

Over the period 2021 - 22 SiM Perth and Kinross Carer Support Service provided information, advice and support directly to 122 Carers
This was up 23 on last year, with 68 Carers (up 1 on last year) receiving ongoing support from Carer Support Workers.
In total there were 245 carers receiving information and advice from the service

Feedback and comments:

"You keep me sane."

"It was amazing to have the relevant information and be able to challenge the professionals, Thank you"

PKAVS:

PKAVS supports thousands of unpaid carers in Perth and Kinross, seeking to help people who take on caring responsibilities to be individuals first and carers second. This support is divided into distinct areas: Young Carers, Young Adult Carers, Adult Carers, Development, and Respite. The carers hub offers emotional and practical support to unpaid carers of all ages living in Perth and Kinross. This support is offered through carers accessing the universal services we offer plus signposting carers to our voluntary and statutory sector partners for any additional support they may need.

Current uptake of service:

46 referrals received across all services in the 11 months from 1st March 2021 to 28th February 2022.
254 adult carer support plans completed within that same timeframe.
4,024 contacts made with unpaid carers in the same time period through the Telephone Befriending Service offering access to both emotional and practical support.
210 applications received for the Winter Recovery Fund totalling nearly £60k in February
311 short break grant awards funded through Time4Me
645 packs of 12 complementary therapy vouchers issued to unpaid carers
Total Carers - 1,906, a 33% increase on last year

Feedback and comments:

"The informal and open forum, small group, really honest and straightforward answers to queries, no "hard sell" stuff, excellent input."

"I enjoyed the informal and relaxed manner in which [PKAVS] delivered the information. I left feeling more confident that I was doing things ok."

Of note, PKAVS also supports a Mental Health and Wellbeing hub and Minority Communities' Hub.

PKAVS Mental Health and Wellbeing Hub provides support and opportunities to people recovering from mental health and wellbeing difficulties, working in partnership to make sure the people they help are well-supported in their community. Based across two service locations, Walled Garden in Perth City and Wisecraft in Blairgowrie, PKAVS Mental Health and Wellbeing Hub has a strong focus on activities which promote recovery.

PKAVS Minority Communities Hub is the lead organisation supporting the expanding migrant population in Perth and Kinross, helping hundreds of people to access local services and play an active role in their community. The aims of the service are captured in the Hub's vision statement: "We believe that people of all backgrounds and their communities should have opportunities to flourish and to contribute to a fairer, more equal Perth and Kinross."

Looking Forward

We are consulting carers to help inform how we develop services to meet their needs as our current Joint Carers' Strategy 2019-22 draws to a close.

The views of carers will inform how better, more equitable support is provided. The over 75 population continues to increase significantly, and this will lead to more older people undertaking a caring role for family members or friends, who can no longer live independently. We will create a refreshed strategy with clear aims describing how we intend to improve the support that is provided for all carers at a time when they need it.

Meaningful and effective carer representation and engagement is crucial to our understanding of the lives of unpaid carers, the challenges they face and how we provide a better integrated health and social care service to meet their needs. Carers need to be considered as equal, expert and valued, and we have further work to do to ensure that they are supported to realise this ambition. Our carer representation is reliant on a number of focussed and dedicated volunteers, and we will support them to mentor and train others to be confident and comfortable in working with us to improve the services we provide.

Steps already taken to improve services following feedback include the expansion of the Telephone Befriending Service. We have invested to extended this to cover out of hours periods to further meet the needs of carers when other supports are unavailable. We are also developing the volunteer-based befriending service to ensure that carers can have a break from caring when they need it.

learning Disability and Autism

Our Year in Action

Service Delivery: Improving and Adapting Throughout the Year

People with learning disabilities have a significant, lifelong condition that started before they reached adulthood, and which has affected their development. As such, having a learning disability affects the way a person learns new things and it is different for everyone. No two people are the same. Learning disability is reduced intellectual ability and difficulty with everyday activities. People may take longer to learn and may need support to develop new skills.

A person with a learning disability might have some difficulty with:

- understanding information
- learning some skills
- looking after themselves or living alone

People with a learning disability may also have sensory needs regarding how they interpret the world around them, postural and physical issues, mental health needs or behavioural needs which may challenge. Some of these needs may be complex.

Autism is a developmental disorder of variable severity and is characterised by having difficulty in social interactions and communications.

Learning Disability and Autism Services provide support to vulnerable young people and adults, often with complex conditions and support needs. This is a complex area of service delivery and covers a range of services to support people with multiple needs.

We have now published our Learning Disability and Autism Strategic Delivery Plan setting out our ambitions to improve outcomes for people who use our services.

In line with the recent Scottish Government directive, The Annual Health Check for People with Learning Disabilities (Scotland) Directions 2022 now standardises a duty of care to provide Annual Health Checks to all people in Scotland aged 16 and over who have learning disabilities, using the Scottish Health Check for Adults with Learning Disabilities. This is a targeted invitation for a yearly health check for people aged over 16 with a learning disability. This must be undertaken by a registered nurse or a registered medical practitioner.

Through workforce redesign in 2021 and a change in delivery model, the Learning Disability Intensive Support Service (LDISS) has provided both an inreach and outreach service ensuring equity of access to health care screening. Physical screening can at times be difficult for an individual with learning disabilities, particularly invasive treatments such as taking blood. The service continues to expand and offers physical observations and monitoring of side effects, blood checks and monitoring of heart function. Further data will be available towards the end of 2022.

Test of change AIM: By introducing weekly specialised nurse led clinics, the LDIS seeks to have 80% of learning disability intensive support service patients receive full physical and mental health monitoring as per recommended guidelines.

It is recognised that service improvements are needed to ensure that the right services can be delivered to those most in need. To tackle this a large scale, multi-year transformation programme was approved in February 2020, covering a broad range of service areas, including the following:

Transitions

With colleagues across Health Services and Education and Children's Services we reviewed our transitions processes for young people moving into adulthood, and developed guidance for young people, parents/carers and professionals in relation to how transitions work for them. The guidance will now be trialled in early 2022/23.

We commenced the development of online information on services, resources and community opportunities for young people and their parents/carers. This will further support their transition from school into adult life. We are taking a collaborative approach to this ensuring people with lived experience can contribute to improvements and are supported in the best way possible.

We have created our new specialist multi-disciplinary team, SCOPE to support people who have Autism and/or a Learning Disability and complex needs aged 14 years and over.

SCOPE

S – Supporting young people and adults with complex needs
C – Community based approach/assessment
O – Offering young people and adults' choice in their care packages
P – Person-centred planning
E – Enriching people's lives

The development of a Transitions Flat has been progressed and is planned to be operational in December 2022. This exciting and innovative development will provide accommodation for two young people at a time. They will receive intensive support to maximise their independence before moving to tenancies of their own.

Independent Living

Following previous consultation with clients and their carers, it was established that people want to live in their own homes and within their own local communities. To deliver this ambition we worked with Housing colleagues to develop the desired accommodation which will support people to live as independently as possible.

This approach, referred to as "Core and Cluster", will allow people with complex needs to safely live more independently in purpose-built homes. These developments will enable people to have their own tenancies and access care as required from services based nearby. As well as creating a more natural environment for people this model provides better value as carers are able to support more than one person. Work on this development was halted during the pandemic however building resumed during 2021/22 and it is anticipated that this long term and ambitious development will see the first accommodation become available in late 2022.

Behavioural Support

We need the right environment(s) to help people cope better with their condition in a way that limits behavioural challenges. Through the Tayside Mental Health and Wellbeing Strategy, the Positive Behavioural Support (PBS) approach is being reviewed. PBS is already provided in Perth and Kinross in a limited fashion and we are expanding this to support more people. Pandemic restrictions frustrated progress on this however working collaboratively across a broad stakeholder base including people with lived experience, we are developing a framework which supports practice. Additionally, we will provide additional training to our staff and through the SCOPE team (see above) we have increased specialist psychology support.

Technology Enabled Care

The migration to a fully digital Community Alarms Service continues as planned and will see all 4,000 service users migrate to a digital service, improving connectivity and overall levels of service. 25% of service users now have digital alarms. Collaborate work is underway with local authorities and partnerships across Scotland to identify a shared national Alarm Receiving Centre platform.

"Excellent service from all the team"
"I am happy at the centre"
Day Centre Service - User Feedback

This is co-ordinated by the Local Government Digital Office and could offer the opportunity for data sharing and support, not possible with the current network. This joined up approach will strengthen bargaining power on behalf of service users to ensure a service that meets the needs of individuals at a competitive cost. By enhancing the use of Technology Enabled Care (TEC) through an Overnight Responder Service, we can more effectively support people who have previously received overnight support, usually on a one-to-one basis.

Day Services

Learning Disabilities and Older People registered day services were largely provided on an outreach or virtual basis through the pandemic. This maintained contact with service users and carers to the extent possible. Services re-opened with easing of restrictions in 2021/22 to the same or better levels of service than pre-pandemic. The virtual service continued and this gave greater choice to people in how they receive services. This is well received.

"He (My son) seems to really enjoy the contact with others via such sessions, I think it's really helping his mental wellbeing as well as giving me some time to get some work done"
Virtual Day Opportunities: Service User Family Feedback

Third Sector Sustainability and Collaboration

Partners in the third sector continued to provide a broad range of essential support services in a flexible and adaptable way, including services using digital solutions.

This approach meant services were delivered digitally and allowed for effective remobilisation. This also supported clients to access day activities from home and from school adding valued support to those in transition. We envisage a blended approach to future service delivery, inclusive of much needed and beneficial building-based services and enhanced digital approaches.

Small organisations have flourished and gained significant levels of volunteer support across communities. The value of these local and community-led organisations is well recognised and where possible will be replicated. Providing a swift response to the needs of service users is key and we are promoting organisations who intervene early as this can delay the need for statutory services or avoid the need arising altogether. An example of this approach has been seen through the commissioning of a new provider "Support Choices". This provider supports people to make the right choice for them through Self Directed Support options before there is any need for statutory services to be involved.

Improvement Journey

This example shows how our focus on Positive Behavioural Support is helping to ensure that people remain in their own community, as safe and as independent as possible.

Case Study

Brain in Hand

Brain in Hand is a digital self-management support system for people who need help remembering things, making decisions, planning, or managing anxiety. It's not condition-specific, but is often used by people who are autistic or managing anxiety-related mental health challenges. We are currently trialling this technology-enabled care.

Dylan's story: Dylan was referred to Brain in Hand by his supporter to help him cope with his anxiety. After researching the system, watching testimonials from other users and exploring a demo version, he decided that he would like to try it:
"When I saw what Brain in Hand does and the diary and the reminders, everything just seemed to come together. I just thought 'that really is for me'."

Dylan found the setting up quite easy and straightforward and whilst he was a bit nervous before his first session, his Specialist made him feel at ease.
"There's never been anything that's been tricky, because you go into depth explaining things and you've been very approachable, by letting me know that if I need anything, I can just email."

Dylan feels that Brain in Hand has given him an awareness of how he's feeling and day-to-day experiences:
"I just feel like it's helped me a lot that way, so that I know I've got it there if I need it. Usually, if I press the orange button, it also gives me a reminder to maybe give my mum a message to say that I'm not feeling very good but I'm not at the stage where I need to speak to someone from the Response Service at that point, instead just maybe letting mum know I'm not feeling good."

Both Dylan and his supporter said that they would recommend Brain in Hand to other users:
"When you're not having a good time, just to have something where you know you can press a button and there's going to support and help there for you, I think it's just amazing."

Outreach Workers

The Perth City Locality have been working alongside an individual and their father since 2016 to ensure they have the best quality of life possible. The individual has a diagnosis of learning disability with associated distressed behaviours. There had been a robust care package in place through Self Directed Support. However, as a result of numerous issues, the provider could no longer provide their package of care. As a result, the individual has not been in receipt of their assessed level of care since late 2021, placing significant extra responsibility on a family taking on the role of unpaid carer.

Due to the complex needs of this young person a Multi-Disciplinary Team approach was taken to inform the assessment and ensure a person-centred approach.

The family's needs were also fully respected and upheld especially in relation to their unpaid carer role. A Carer's Support Plan provided additional support for their emotional and social wellbeing, and assisted with benefit claims, transport and blue badge application.

The social worker requested input from the SCOPE Team which has Outreach Workers with knowledge and experience of the needs of those with a learning disability and autism with complex needs. They provide support to Social Workers by direct contribution to specialist risk assessments, care planning and positive solution focused interventions. They work alongside the Home Assessment and Reablement Team to give practical support during periods of crisis and as a result have reduce the need for admission to hospital or institutional care.

Supporting Independent Living:

An urgent referral was made to the Independent Living Panel for a person with care and support needs who needed a new ground floor property, due to the flat they rented privately being sold. Having had previous negative experiences of living in institutional settings, there were safety concerns which meant that it was important to work closely with the family to ensure a suitable home could be found and allowing enough time for a managed transition.

The multi-agency panel worked with the family, Social Work, Housing and Common Housing Register Partners to identify a property within a location the individual would be happy with, and enable them to be supported within the community. A new build property became available, and a viewing was arranged to see if they would want to live there. With support from family, Social Work, the Self-Directed Support Team, Personal Assistants and the Housing Association, the individual successfully moved into their new home in the Spring of 2021.

The action of the person's family and joint working and communication resulted in a home for life. This gave peace of mind and continuity of living in their community in an environment supporting independence. It provided a secure and cost-effective solution.
The home has a number of design features and minor alterations were made to each room including technology enabled care support to ensure they can live safely while also having the independence to make it the home they want.

In this case the move ensured the person could continue living independently in the community rather than leading to a crisis. It has highlighted how through effective communication and an integrated approach, people with a range of needs can be supported to remain in the community and remove the need for costly or inappropriate placements. This experience has also provided the Panel with valuable learning around what resources and supports need to be in place for a person to have a positive experience, both in transitioning to and living in a new home of their choice.

How our Commissioned Services are meeting needs

The Centre for Inclusive Living (CILPK) provides an example of how our Commissioned Services support people with complex conditions and support needs.

Centre for Inclusive Living (CILPK)

CILPK seeks to promote Independent Living in a wide range of ways including, Equality Issues/Advocacy, Self Directed Support, Community access, the Keep Safe Scheme and by Awareness Raising through awareness raising and training.This activity is centred on the understanding that people with a disability live a life of their own choosing, as fully participating, independent members of the wider community.

Current uptake of service:

CILPK received 8 iPads and MiFi units from Connecting Scotland and purchased 2 Kindles and MiFi units.
2 members of staff completed Digital Campion training.
All meetings have moved online resulting in all members gaining digital skills and devices.
All service users who received iPads also received 6 weeks of training with ongoing support.
Managed to support members to access online meetings and activities which has meant they have been able to stay in touch with people and also feel part of their communities by doing online sessions.

Looking Forward

The Scottish Government announced £20m funding for IJBs in February 2021 for a Community Living Change Fund. The fund is intended for a re-design of services for people with complex needs, including intellectual disabilities and autism, or for those who have enduring mental health problems. The plan in Perth and Kinross is to invest in services to support more individuals with complex needs in the community and disinvest in institutional care. For example, via Core and Cluster developments and additional SCOPE Team capacity.

Throughout 2022/23 there will be a test of change with Family Group Decision Making Co-ordinators. It is anticipated that by employing the same model of practice used successfully in Children's Services, the same positive impact will be achieved in Adult Services.

As Core and Cluster developments become operational, people with complex needs will be better able to transition out of long stay institutional settings. This will help improve their quality of life and reduce the risk of admission to hospital. These facilities will open opportunities for people placed outwith Perth and Kinross to return.

This approach through Core and Cluster developments is set to expand in the coming years. Plans for another Core and Cluster site have been submitted in collaboration with Perth and Kinross Council colleagues. This forms a significant element to future service delivery plans.

An overnight responder service is being developed to provide support using Technology Enabled Care and mobile responders. This is rather than relying on one-to-one carer support. Those for whom this service is appropriate, will benefit from more flexible and less intrusive support.

In the Keys to Life Strategy it was identified that being able to access public transport is important in order to support independence. Investment is planned for 2022/23 for more in day opportunities, SCOPE and Social Prescribers, to help build ability to develop independent travel skills. This will support outcomes, independence, provide opportunities through access to social and leisure activities, and improve health and wellbeing.

older People's Services

Our Year in Action

200 people at home with respiratory needs supported by the Specialist Community Respiratory Service.

LOCALITY INTEGRATED CARE TEAMS deliver a multi-disciplinary approach with **9** different Professions contributing to integrated care.

16 care homes promoted physical activity through "Care About Walking" booklets and record charts.

Supported Alzheimer's Scotland to provide **114** Dementia Advisor Enquiries, providing information, advice and help.

Supported community exercise provision through **5** Live Active Leisure Wellbeing Coordinators.

We have installed around **25%** of service users using digital alarm units onto the new digital network.

Service Delivery: Improving and Adapting Throughout the Year

Older People's Services provides a broad spectrum of support where people often have a range of needs with varying severity.

These services are provided in a seamless loop from inpatient to community health to social care all of which aim to ensure that people have the best possible outcomes. These services seek to intervene early to prevent deterioration in conditions and help people to live as independently as possible for longer.

Older People's Services have continued to be developed to meet rising demands and during 2021/22 we undertook significant research and consultation while producing our Older People's Strategic Delivery Plan which was approved by the IJB on 30 March 2022.

Hospital and Community Care

As we deliver our services and develop new approaches, we have ensured that person-centred care and early intervention and prevention are at the heart of our service delivery.

Our **Locality Integrated Care Service** (LInCS) has become our approach to working across community health and social care. It provides alternatives to hospital admission and early discharge and is delivered by professionals from a broad

range of Nursing, Allied Health Professionals (AHP), Pharmacy, Older People's Mental Health, Social Care and Third Sector services.

As the service continues to embed, we recognise that further enhancements to this service will be required. To ensure a robust 24/7 approach we are developing the model to provide overnight integrated health and care services to support discharge of patients with complex needs. Additionally, as we scope the potential for introducing a "Hospital at Home" model of care we have improved how people navigate our services by introducing a single point of contact. This simplifies access to services and ensures effective triage and most appropriate timeous input.

The **Specialist Community Respiratory Service** has further strengthened community services. This developing service continues to enhance effectiveness and responsiveness by linking through the LInCS model to other services and professionals. The service started in early 2021 and has supported almost 200 people with acute respiratory conditions. The majority of referrals came from a hospital setting. Each month saw an active caseload of over 100 people with around 160 patient interventions, checks and multi-disciplinary team reviews. Almost half of these interventions were undertaken face-to-face with patients.

This increased opportunities for patient education by delivering self-management skills, to those with chronic respiratory conditions, in their own homes. This is key to a person-centred approach to early intervention and preventing deterioration which then avoids hospital admission.

As our population ages, more interactions with specialist consultants and advanced practice professionals are likely to be required. This used to be provided by our Medicine for the Elderly consultants, alongside a multi-disciplinary team, via traditional centralised outpatient clinics from within Perth Royal Infirmary. To improve the person-centred approach, and increase efficiency, a community-based model was implemented providing comprehensive assessment at home by an Advanced Nurse Practitioner or Consultant. This continues to be rolled out and developed across communities and community hospitals. Our Advanced Nurse Practitioners are working alongside consultants and other senior clinicians, supporting ward rounds, responding to deteriorating patients and following up on patients at home post discharge from hospital.

Strong connections with the LInCS model mean referrals can go directly to other services to provide wrap around support and care as required. This model is aimed at reducing the need for people to travel, reduce the footfall into hospital and reduce the number of emergency admissions, thereby maintaining people's independence for longer.

Urgent Care is defined by the need to provide services for illnesses and injuries which require immediate attention and treatment but are not a threat to life and limb. The Scottish Government's Redesign of Urgent Care continues to progress across Tayside, assisting patients to access the most appropriate local service. The focus is for patients to access 'the right care in the right place at the right time'. Locally this work builds on our work to develop the Locality Integrated Care Service, community based Advanced Nurse Practitioners and our Minor Injury Units, which has now been

successfully integrated with the care and treatment service. Work with GPs to test the role of Advanced Nurse Practitioners in responding to urgent house calls was successful. In the next phase the model will be expanded to improve efficiency, by integrating through the LInCS model, to ensure people see the most appropriate professional as the first point of contact.

The **Integrated Discharge Hub** across Perth and Kinross continues to manage increasingly complex discharges. The increasing prevalence of complexity is associated with an aging population with a broad spectrum of need further impacted by the pandemic. The implementation of the Hub however ensures equity of service provision across all inpatient areas in Perth and Kinross and seeks to maintain capacity and flow across the whole system with strong links between inpatient services and community health and social care being a critical factor in success.

Working with NHS Tayside colleagues, we have implemented a new **Stroke Rehabilitation Model** within Perth Royal Infirmary (PRI). This model provides rehabilitative care facilitating the process of recovery. This high quality, person-centred care helps people regain maximum self-sufficiency.

Allied Health Professional services play a key role to support people to rehabilitate and recover. Work to improve the service offer follows the national Recovery and Rehabilitation Framework. This details the specific contributions Allied Health Professional services make in: Primary Care, Secondary Care, Community Care, Care Homes and dementia support; as well as the digital and workforce infrastructure to support this.

Rehabilitation journeys can differ, particularly given the effects of the pandemic on people's health, and in order to ensure effective support is provided a review of Allied Health Professional services commenced. This large piece of work considers: the views of professional bodies; existing guidance and standards of COVID-19 rehabilitation; and the Scottish Government's Framework for Supporting People through Recovery and Rehabilitation during and after the COVID-19 pandemic. This work recognises that services and traditional rehabilitation approaches need to adapt delivery methodology, timeframes and intensity. This extends to preparedness for further physical impacts which may present as people recover. The recently launched Once for Scotland approach will layout the principles behind this and the AHP Directorate intend to deliver a Tayside Rehabilitation Review later in 2022.

Providing a sustainable **Care at Home** service to meet the needs of a growing elderly population was a significant challenge, particularly in rural areas. Demand for care at home continued to increase, often with the need for greater levels of care to support people to live at home or in a homely setting for longer. When this isn't possible, patients may be required to stay in hospital for longer than necessary, adding to delayed discharge pressure and reducing outcomes.

It is recognised that traditional methods of delivering care at home do not provide access for people and communities in a sustainable way. This is largely due to recruitment being difficult along with a frequent inability to create the necessary capacity in the sector. This can often lead to internal services like the Home Assessment and Reablement Team (HART) being diverted from their core role to deliver care at home.

This then has a negative impact on the effectiveness of reablement. Other factors such as the complex effects of the pandemic and increasing population age also affect reablement and the combined effect of these has led to drop of 10% in the number of people re-abled to the extent they need no further support. To counteract this drop, the Home Assessment Reablement Team have worked closely with Paths for All and Live Active to encourage increased activity where safe and appropriate to do so. All staff have had additional training to deliver basic exercise activities and developed packs to encourage increased walking and activity within and outwith the home.

Many of the difficulties in delivering care at home are experienced nationally and will take time to rectify. Work continued through the year locally to increase stability and sustainability. Pay rates for staff were increased and this helped to attract new entrants and is stabilising the existing workforce, reducing the incentive for staff to move between employers.

It is clear that commissioned third sector providers deliver good quality services (see Scrutiny and Inspection Section) to increase sustainability and improve overall effectiveness of services however a blended model, with a broader range of supports, needs to be developed.

To progress this, we are continuing to review our current service provision and are implementing a whole new method developed in collaboration with broad stakeholders including commissioned providers and local communities. The focus is on the impact of the support and care provided to people being person-centred and involving them by targeting goals, priorities and achievements sought within their lives. This is very much an outcome-focused approach.

The changes developed over the year have sought to give providers greater ownership of the hours-of-service provision they are commissioned to deliver. Increasing freedom in this respect allows providers more opportunity to respond to the changing needs or desires of the people receiving the service.

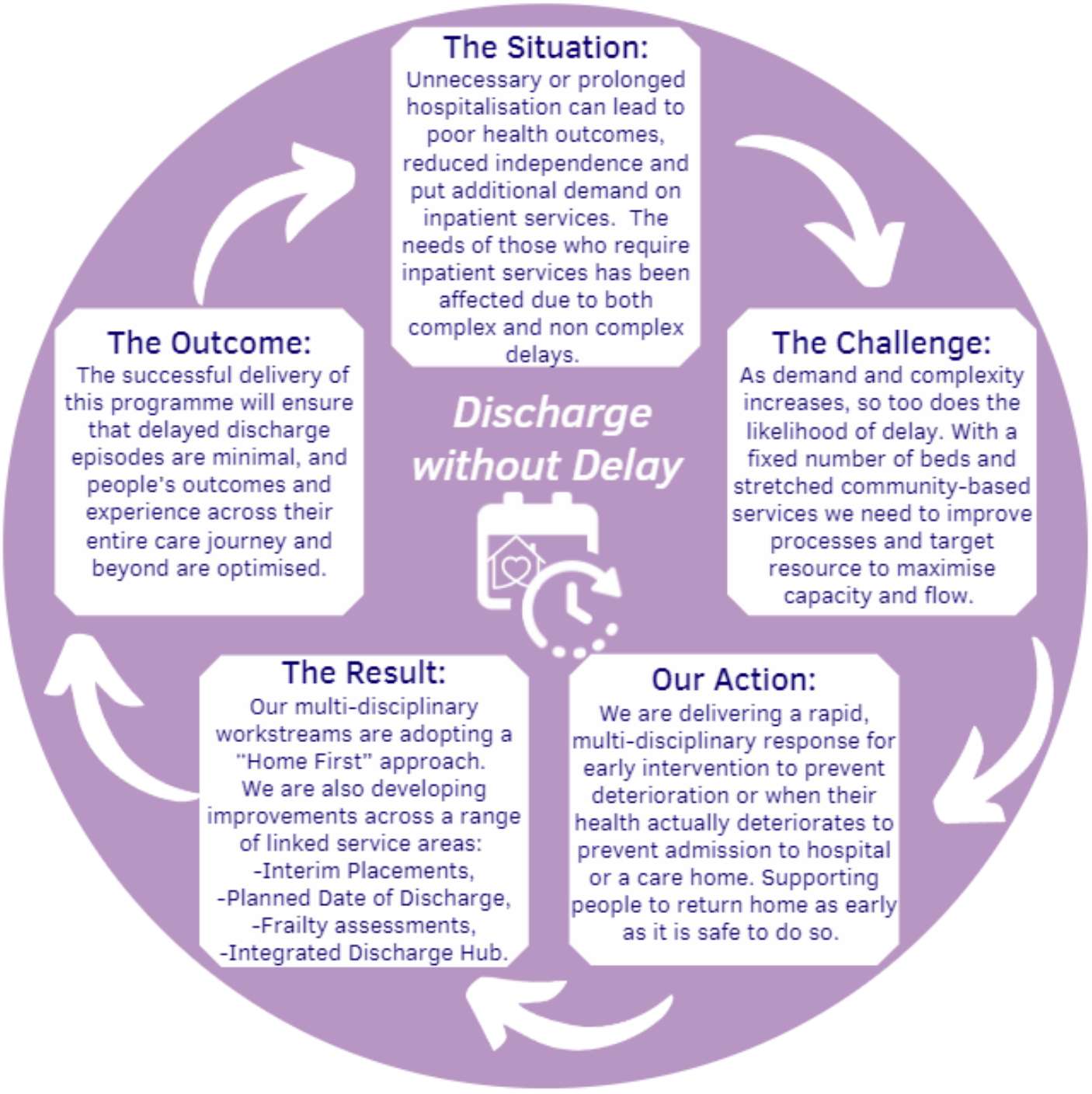
This is an exciting development and creates opportunities for support to be given to providers to promote skills within their workforce to enable them to work in a more community-led way. With providers more able to engage with local community groups, people can integrate through those groups to gain the support they need. This increases the quality of the services provided, improves people's quality of life and alleviates some of the service pressures which have been and continue to be experienced.

Care Homes in Perth and Kinross have continued to provide a high standard of care to residents despite the challenges of the pandemic. The Enhanced Care Home Support Team has been established throughout the last year to provide a further layer of support to care home colleagues. In collaboration with Care Homes, we have built on the substantial skills and experience already evident in these settings to create a community-based service with a multi-disciplinary approach. We have also invested in new and innovative Clinical Educator posts to support care homes and the wider professional interface, within our respective nursing and Allied Health Professions workforce. This multi-disciplinary approach is bolstering existing skills and support and has been well received.

Improvement Journey

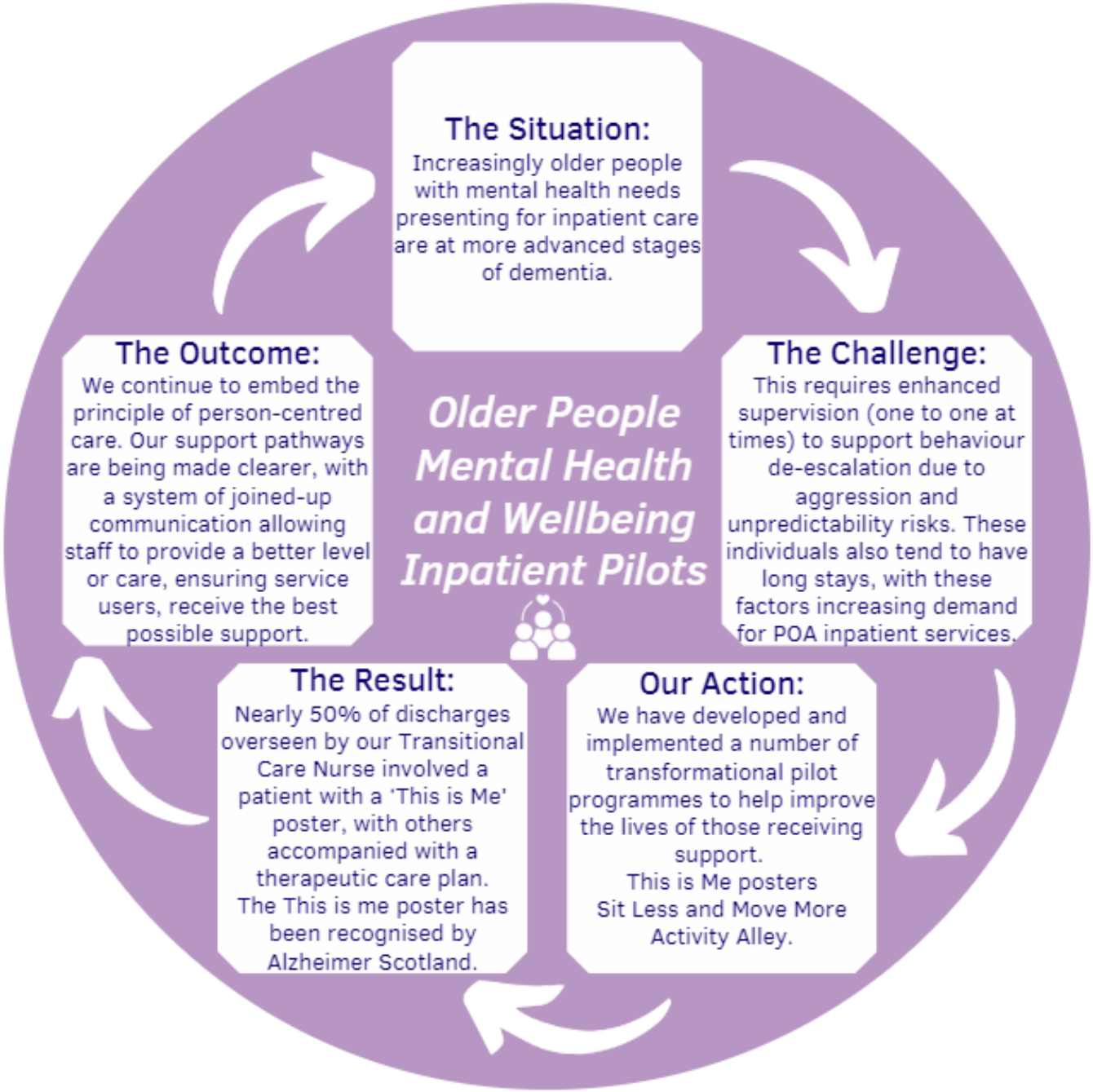
This illustration shows improvement in relation to discharge without delay, which seeks to improve capacity and flow and achieve timelier discharge from hospital. This will help get people out of hospital and back to their homes and communities, quickly, safely and at the point which works best for them.

The graphic on the next page highlights the work being done to ensure older people coping with mental health and wellbeing conditions are provided with the best level of care, while being supported in inpatient settings.



Strategic Objective	National Health and Wellbeing Outcomes								
	1	2	3	4	5	6	7	8	9
Prevention and Early Intervention	✓	✓	✓	✓	✓	✓	✓	✓	✓
Reducing inequalities and unequal health outcomes and promoting healthy living	✓	✓	✓	✓	✓		✓	✓	✓
Person Centred health, care and support	✓	✓	✓	✓	✓	✓	✓	✓	✓
Working together with our communities	✓	✓	✓	✓	✓	✓	✓		✓
Making best use of available facilities, people and other resources	✓	✓	✓	✓	✓	✓	✓	✓	✓

National Health and Wellbeing Outcomes	
1	People are able to look after and improve their own health and wellbeing and live in good health for longer.
2	People, including those with disabilities or long-term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.
3	People who use health and social care services have positive experience of those services, and have their dignity respected.
4	Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.
5	Health and social care services contribute to reducing health inequalities.
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.
7	People who use Health and Social Care services are safe from harm.
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.
9	Resources are used effectively and efficiently in the provision of health and social care services.


The Situation:
Increasingly older people with mental health needs presenting for inpatient care are at more advanced stages of dementia.
The Challenge:
This requires enhanced supervision (one to one at times) to support behaviour de-escalation due to aggression and unpredictability risks. These individuals also tend to have long stays, with these factors increasing demand for POA inpatient services.
Our Action:
We have developed and implemented a number of transformational pilot programmes to help improve the lives of those receiving support.
This is Me posters
Sit Less and Move More Activity Alley.
The Result:
Nearly 50% of discharges overseen by our Transitional Care Nurse involved a patient with a 'This is Me' poster, with others accompanied with a therapeutic care plan.
The This is me poster has been recognised by Alzheimer Scotland.
The Outcome:
We continue to embed the principle of person-centred care. Our support pathways are being made clearer, with a system of joined-up communication allowing staff to provide a better level or care, ensuring service users, receive the best possible support.
Older People Mental Health and Wellbeing Inpatient Pilots

Case Study

Go 4 Gold

This year's event met the social distancing requirements needed, while still delivering one of the highlights of the care home calendar year. The annual Perth and Kinross Go4Gold Care Home Games took place across the final weeks of August. This inter-care home event supports residents to increase their levels of physical and social activity in a fun and meaningful way, through a series of competitive challenges, tasks and activities.

The multi-agency group developed a virtual care home Go4Gold event, with events, equipment and instructions on how to participate distributed to care home to enable residents to safely take part. All equipment met strict infection control criteria, allowing the residents to take part in a number of fun physical and challenge activity including:
Cup Ping Pong, Skittles, Football Goal Scoring, Putting and Picking up objects of nature.

Residents also competed in a costume competition, as well as a poster challenge with the theme of Walking with Nature' to reflect the ongoing partnership with Paths for All. A live award ceremony was also relayed to the care homes, enabling residents, staff, family and friends to watch video footage of the games and events in which they had competed, with certificates and medals presented to the winners.

HSCP officers delivered an Olympic studio style commentary throughout the award ceremony, and special speakers included the Deputy First Minister, John Swinney and Hollywood actor, Brian Cox, and Jacquie Pepper, Chief Social Worker and now Chief Officer of the HSCP, provided some inspirational comments.

Over 330 residents from across 30 care homes participated with many other residents enjoying watching the proceedings.

Feedback and comments:

"We all enjoyed the competitions and supporting each other through the games. As some of us are wheelchair users or have mobility difficulties it was great being part of the event as we may not have been able to attend Bells Sport Centre."

"Made me feel good about myself"

"It could be done at our own pace and more of us could join in"

What Care Home Staff said:

"The residents could all get involved and the staff with it being held in the home. Great atmosphere created by excitement of events"

"All clients had a fantastic time, everyone felt so successful and content."

"One of our gentlemen is blind the choice of games was so good that with clear instructions he could take part no problem. The joy on his face was lovely to see."

How our Commissioned Services are meeting needs

Kinross Day Centre provides an example of how our Commissioned Service support older people throughout our communities.

Kinross Day Centre

Kinross Day Centre seeks to provide a range of different services geared towards the retired community of Kinross-Shire, particularly those who maybe be experiencing social isolation or loneliness.

Taking a flexible and human centred approach, the day centre encourages and supports elderly people to live independently in their own homes for as long as possible, as well as promoting behaviours and actions to help make people feel a valued part of their community. Accessible transport options are provided to the centre and people are encouraged to attend sessions and take part in the activities on the days that work best for them. These activities include:
Bingo, exercise classes, art & singing groups, relaxation, quizzes, day trips, concerts, board games and many more.

For those less able or willing to take part in the activities, they are encouraged them to attend, socialise and talk in a welcoming homely environment.

COVID-19 had a significant impact on service delivery, with the group forced to suspend face to face meetings in order to protect people from the dangers of community transmission of the virus.

From January 2021, the centre began reinstating in person services, albeit in limited numbers to promote social distancing. Initially this involved 4 people daily, although this has gradually increased to between 28 to 35 daily by the end of the 2021/22 period.

At present 99 people are getting support from the centre by attending the centre or through the delivery of a hot meal at lunch time, and there were approximately 13,500 meals, either in house or delivered, provided from 1st April to the end of March and ongoing.

Adapting to the new needs of the COVID-19 period, Kinross Day Centre has also collected and delivered 400 medications for individuals during this reporting period.

Feedback and comments:

"I couldn't have coped with my Mum if the Centre wasn't here."

"Never would we have survived without the centre bringing my lunch."

Looking Forward

Improvements in Older People's services continue to be developed in collaboration with a broad stakeholder base with a clear focus on integration. The overall goal with all developments is to improve outcomes by ensuring that people see the right professional in the right setting at the right time, reducing the need for unplanned admissions and supporting people to receive care in their own home wherever possible.

In addition to service developments described above we will continue our review of inpatient beds to support community hospital-based rehabilitation and pathways. This will ensure that the provision of inpatient beds complements the significant increases in support introduced for patients in their own home and within communities.

In Care at Home, we are proposing the introduction of a new "alliance" model of delivery which allows much greater opportunities for providers to support one another when gaps in provision emerge. This will take some time to be established but preparatory work undertaken within 2021/22 will allow this to be taken forward and will increase stability, flexibility and sustainability. This model increases the short-term responsiveness of providers overall when demand increases or capacity within one area reduces.

- During 2021/22 it was necessary to reduce the provision of services in Pitlochry Community Hospital, when the GP Ward became temporarily non-operational due to significant workforce challenges. To ensure future sustainability across the North Locality we are working in collaboration with GPs, wider professional groups, and key stakeholders. This development work is linked strongly to wider integrated service delivery developments referred to above.

- We will commence testing a dedicated Hospital at Home Model. This test will identify and provide a safe and effective alternative to hospital admission and improve opportunities for earlier discharge pathway for acutely frail elderly patients.

Workforce

Our workforce is at the heart of delivering integrated services to the people of Perth and Kinross. Over 4,500 skilled and compassionate people work in different roles and settings reaching every community.

During 2021/22 we have faced significant difficulties in recruiting. We know from our review of data that this challenge is likely to intensify. As demand for our services grows, our workforce is getting older, vacancies are increasing and the overall working age population in Perth and Kinross is shrinking. This is compounded by rurality, the impact of the pandemic and a fatigued workforce.

However, as well as posing challenges, the pandemic also brought a pace and scale of change never experienced before as staff across health and social care embraced new technologies, service innovations and ways of working. During 2021/22, working in partnership with our staff, with our partners in GP practice and the third and independent sector

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we have developed the Perth and Kinross Health and Social Care Partnership three-year Workforce Plan 2022-2025. This sets out the ways in which we will respond to the significant challenges we face as well as the national action necessary to support recruitment and retention. We have sought to build on the rapid innovation over the last two years and set out the actions that will give the best chance of meeting our future aspirations. At the heart of the plan is our commitment to provide staff with a working environment that provides strong, compassionate leadership, promotes wellbeing and supports them to grow and develop skills and knowledge.

The plan recognises the significant work already underway, set out in the sections above, to redesign services with an unstinting focus on early intervention, integration and locality working. This will improve outcomes for the people we serve but will also improve the experience of staff delivering services across our communities.

Our Performance

Introduction

Throughout 2021/22, we sought to maximise positive outcomes for the people we support through our Health and Social Care Services, particularly those in the greatest need.

The following section sets out performance against nationally and locally agreed key performance measures which are used to gauge how well we have performed over time. To provide context we have made a number of comparisons to assist with making informed assessments of performance.

The performance measures used are split into two main sections as follows:

- Health and Care Experience measures: These cover national indicators 1 to 9 and relate to the experience of people in Perth and Kinross when using our services. These are referred to as HACE indicators.
- Core Indicators Set: These cover national indicators 11 to 20 and relate to service activities.

Health and Care Experience

Every two years, on a national basis, people are asked to complete the Health and Care Experience Survey with responses being sought from GP practice lists. Within the survey people are questioned on their experience of their GP practice and wider health and social care services.

Across Scotland throughout November 2021, over 130,000 people responded to the 2021/22 survey. Of these 3,519 people from across Perth and Kinross responded and table 3 sets out the results in detail.

Table 1

ID	Indicator	Perth and Kinross 2019/20	Perth and Kinross 2021/22	Scotland Overall 2021/22	How we compared to 2019/20	How we compared to Scotland 2021/22
NI 01	% of adults able to look after their health very well or quite well	94.3%	93.7%	90.9%	-0.6%	2.8%
NI 02	% of adults supported at home who agree that they are supported to live as independently as possible	82.3%	79.9%	78.8%	-2.4%	1.0%
NI 03	% of adults supported at home who agree that they had a say in how their help, care or support was provided	77.2%	73.8%	70.6%	-3.4%	3.2%
NI 04	% of adults supported at home who agree that their health and care services seemed to be well co-ordinated	73.0%	65.1%	66.4%	-7.9%	-1.3%
NI 05	% of adults receiving any care or support who rate it as excellent or good	82.9%	79.1%	75.3%	-3.7%	3.8%
NI 06	% of people with positive experience of care at their GP practice.	86.4%	74.1%	66.5%	-12.3%	7.6%
NI 07	% of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life.	80.2%	75.8%	78.1%	-4.4%	-2.3%
NI 08	% of carers who feel supported to continue in their caring role	36.7%	33.2%	29.7%	-3.5%	3.5%
NI 09	% of adults supported at home who agreed they felt safe.	83.9%	79.0%	79.7%	-4.9%	-0.7%

Source: Public Health Scotland Core Suite Integration Indicators. July 2022 update

Within 3%, or are meeting or exceeding our target	Between 3% and 6% away from meeting our target	More than 6% away from meeting our target

Across the nine HACE indicators, performance in 2021/22 has reduced when compared to 2019/20, when the survey was last undertaken.

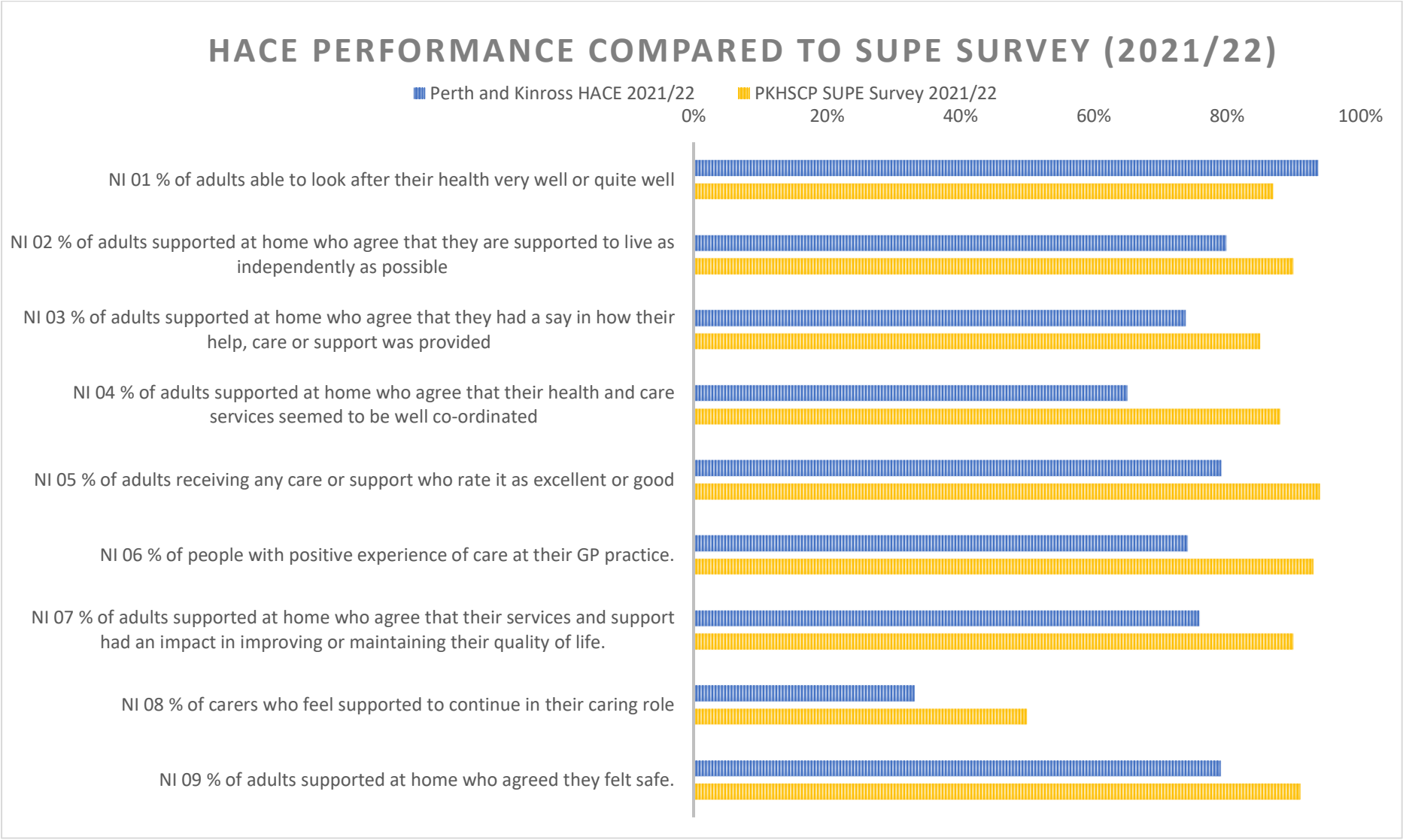
The reasons for this decline are complex in nature and not fully understood but the effects of the pandemic which reduced people's access to services is expected to be a significant influencing factor.

We can see that performance against these indicators has also declined across Scotland overall in the same period. Indeed, across Scotland the decline has been greater across all indicators than has been the case in Perth and Kinross. Performance against these indicators has also declined across our peer group of similar IJB areas. The effect of this is that although performance in Perth and Kinross has declined, we are still performing better than Scotland overall and better than our peer group.

In addition to the HACE survey we have developed our own local Service User and Patient Experience (SUPE) survey. This provides for more regular localised feedback from people (or their carers) that we know have used our services. The SUPE survey was undertaken between October 2021 and March 2022, and we gathered feedback from around 150 people at or very closely following the time they received the service provided. Table 2 provides the results of our SUPE survey and compares the results to those of the 2020/21 HACE survey.

Looking at the nine indicators measured we can see that performance is better across eight of the indicators when compared to the HACE results. Although this is from a smaller group of responses, the results demonstrate that we are making progress in improving outcomes for people.

Table 2


HACE PERFORMANCE COMPARED TO SUPE SURVEY (2021/22)
Perth and Kinross HACE 2021/22
PKHSCP SUPE Survey 2021/22
0%
20%
40%
60%
80%
100%
NI 01 % of adults able to look after their health very well or quite well
NI 02 % of adults supported at home who agree that they are supported to live as independently as possible
NI 03 % of adults supported at home who agree that they had a say in how their help, care or support was provided
NI 04 % of adults supported at home who agree that their health and care services seemed to be well co-ordinated
NI 05 % of adults receiving any care or support who rate it as excellent or good
NI 06 % of people with positive experience of care at their GP practice.
NI 07 % of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life.
NI 08 % of carers who feel supported to continue in their caring role
NI 09 % of adults supported at home who agreed they felt safe.

Core Indicator Set

These indicators provide insight into the activities of health and social care services and help us understand the effect of our work in improving outcomes for people by shifting the balance of care away from hospital-based services to those in the community. Where people are enabled to look after their own health and wellbeing for longer, they are less likely to need the intervention and support provided by our services. When people do need support, we seek to intervene early, prevent further deterioration and in doing so prevent the need for admission to hospital. Where this cannot be avoided our services are designed to help people be discharged from hospital as early as possible.

Table 3 set out our performance against the Core Indicator Set and makes comparisons to previous performance as well as to Scotland overall and our peer group of similar IJB areas. Due to issues surrounding the availability of data at a national level a number of indicators are provided for the calendar year to December 2021 (or for a previous period) rather than the financial year. This is a similar approach to that taken previously**.**

Table 3

ID	Indicator	Reporting Period Year up to	2020/21 Perth and Kinross	2021/22 Perth and Kinross	2021/22 Scotland Overall	How we compared to 2020/21	How Scotland compared to 2020/21	How we compared to Scotland 2021/22
NI-11	Premature Mortality Rate per 100,000	Dec 2021	364.9	362.1	470.6	-0.8%	2.9%	-30.0%
NI 12	Rate of emergency admissions per 100,000 population for adults (18+ all specialities)	Dec 2021	10,583.1	11,117.0	11,635.5	5.0%	6.2%	-4.7%
NI 13	Rate of emergency bed day per 100,000 population for adults (18+)	Dec 2021	94,404.1	107,153.3	109,429.3	13.5%	8.2%	-2.1%
NI 14	Readmissions to hospital within 28 days of discharge per 1,000 discharges (18+)	Dec 2021	141.0	129.5	109.6	-8.1%	-8.8%	15.4%
NI 15	Proportion of last 6 months of life spent at home or in a community setting	Dec 2021	90.2%	90.9%	90.1%	0.7%	-0.2%	0.8%
NI 16	Falls rate per 1,000 population (65+)	Dec 2021	23.8	23.5	23.0	-0.9%	6.2%	2.1%
NI-17	Proportion of Care Services rated good or better in Care Inspectorate inspections	Mar 2022	89.0%	76.5%	75.8%	-12.4%	-6.7%	0.7%
NI-18	Percentage of 18+ with intensive social care needs receiving Care at Home	Dec 2021	59.5%	62.6%	64.9%	3.0%	1.9%	-2.4%

ID	Indicator	Reporting Period Year up to	2020/21 Perth and Kinross	2021/22 Perth and Kinross	2021/22 Scotland Overall	How we compared to 2020/21	How Scotland compared to 2020/21	How we compared to Scotland 2021/22
NI 19	Number of days people aged 75+ spend in hospital when they are ready to be discharged per 1,000 population	Mar 2022	197.1	609.4	761.4	209.3%	57.2%	-24.9%
*NI-20	Percentage of health and care resource spent on hospital stays where the patient was admitted as an emergency	Mar 2020	N/A	25.7%	24.2%	-0.5%	0.1%	1.5%
**MSG 3	A&E attendances per 100,000 population	Mar 2022	14,075.8	16,738.6	24,379.4	18.9%	19.6%	-45.6%

Source: Public Health Scotland Core Suite Integration Indicators. July 2022 update
**NI-20 latest data provided by PHS is for 2019/20 period. Column 2021/22 = 2019/20 period. Colum 2020/21 - 2018/19 period.*
*** Data not provided with PHS's Core Suite Integration Indicators update (12 Jul 2022). Data has not been validated and may be subject to change as more information becomes available.*

Within 3%, or are meeting or exceeding our target	Between 3% and 6% away from meeting our target	More than 6% away from meeting our target

When interpreting these measures, it is important to note that comparing performance to the previous year is particularly challenging due to the impact of the pandemic. Over this time service activity varied dramatically and this has had an impact on performance as measured from one year to the next.

Our performance against the core indicator set for the reporting period is mixed. We have reduced the rate of readmissions within 28 days of discharge by 8.1% (National Indicator 14) which indicates that we have been better able to support people at home or in the community following their discharge. However delayed discharges (National Indicator 19) have increased substantially as have; the rate of emergency bed days (National Indicator 13) and attendances at accident and emergency (MSG 3) albeit not to the same extent.

This pattern of performance indicates the number of people requiring hospital-based services has increased year on year and that we have not been able to support people to be discharged from hospital as quickly as previously achieved across the 2020/21 period. We can see that a similar pattern of decline in performance has been seen across Scotland and within our peer group over the same period.

When we compare our performance directly to Scotland and our peer group however, we can see that we have outperformed both across almost all indicators. This suggests that although it has not been possible to maintain the high levels of performance seen in 2020/21, we have supported our population to a greater extent than has been achieved across Scotland, or within our peer group**.**

National Health and Wellbeing Outcomes

The table below demonstrates the connection between our Strategic Objectives and the National Health and Wellbeing Outcomes. Our work in the last year, as set out in this report, demonstrates progress made in pursuing these objectives and in doing so, to support people to lead healthy and active lives, and to live as independently as possible for longer.

Strategic Objective	National Health and Wellbeing Outcomes								
	1	2	3	4	5	6	7	8	9
Prevention and Early Intervention	✓	✓	✓	✓	✓	✓	✓	✓	✓
Reducing inequalities and unequal health outcomes and promoting healthy living	✓	✓	✓	✓	✓		✓	✓	✓
Person Centred health, care and support	✓	✓	✓	✓	✓	✓	✓	✓	✓
Working together with our communities	✓	✓	✓	✓	✓	✓	✓		✓
Making best use of available facilities, people and other resources	✓	✓	✓	✓	✓	✓	✓	✓	✓

National Health and Wellbeing Outcomes	
1	People are able to look after and improve their own health and wellbeing and live in good health for longer.
2	People, including those with disabilities or long-term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.
3	People who use health and social care services have positive experience of those services, and have their dignity respected.
4	Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.
5	Health and social care services contribute to reducing health inequalities.
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.
7	People who use Health and Social Care services are safe from harm.
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.
9	Resources are used effectively and efficiently in the provision of health and social care services.

Reference: Perth and Kinross Integration Joint Board Strategic Commissioning Plan- 2020-2025

Scrutiny and Inspection

Service Delivery: Improving and Adapting Throughout the Year

During the period April 2021 to March 2022, the only external inspections that have taken place have been to our commissioned Care Homes. None of our 10 registered services had an external inspection during the year.

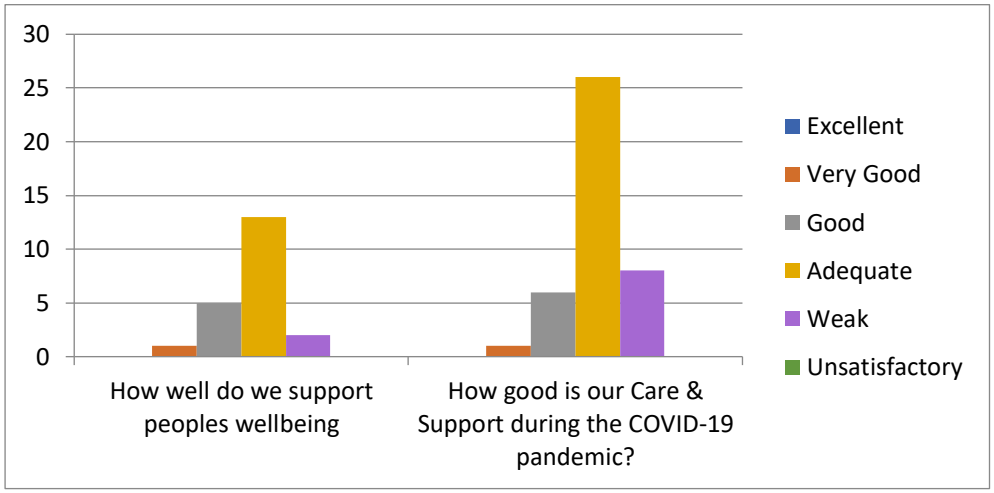
Her Majesty's Inspectorate of Prisons for Scotland conducted a liaison visit to HMP Castle Huntly on the 11th February 2021. This liaison visit and reports provide assurance to Ministers and the wider public that scrutiny of the treatment and conditions in which prisoners are held has been continued during the pandemic.

The report from this visit was published in July 2021, and a number of areas of good practice were highlighted, including continued access during the pandemic to mental health and occupational therapy and substance use support. There were no recommendations made with regards to the healthcare provision in the prison.

During the 2021-22 year, there were a total of 51 inspections across 14 different providers carried out by the Care Inspectorate to our commissioned care homes. Some care homes received more than one inspection throughout the year. It should be noted that over the reporting period the Care Inspectorate carried out inspections as a result of a risk assessment focusing on those care services where there were concerns about infection, prevention control, safety and quality.

Of the 51 total inspections, there were 40 total requirements identified. Work continues to address these, and the Perth and Kinross Care Home Oversight Group continues to work closely with our care homes to support improvement activity. Only three requirements were still outstanding at the end of the 2021-22 year.

The graph below shows the results of the Inspections (including COVID-19 specific inspections) and the overall grades.



The HSCP Care and Professional Governance Forum (CPGF) has responsibility for ensuring appropriate scrutiny, assurance and advice within the HSCP, and during 2021-2022 was co-

chaired by the Chief Social Work Officer and Associate Medical Director.

The CPGF receives assurance reporting from all localities and services within the partnership, and all have provided an annual report providing details and assurances regarding the provision of safe, effective and person-centred services, and any ongoing improvement.

Each locality has in place a Clinical, Care and Professional Governance Group, all of which are now firmly established. These groups have representation across both Health and Social Care, and provide an opportunity for a focus on improvement, shared learning as well as ensuring effective clinical and care governance processes across the locality.

Case Study

The Royal College of Psychiatrists: Quality Network for Prison Mental Health Services (QNPMHS) peer review to HMP Perth - 9th June 2022

In June 2022, the Mental Health Team at HMP Perth hosted their 4th cycle developmental peer review over the course of the day. The Quality Network for Prison Mental Health Services engage services in an annual process of self and peer-review against the standards for prison mental health services.

The verbal feedback was very positive for the Multi-Disciplinary Mental Health Team which reflects the commitment to providing the best care possible to their patients.

Areas of good practice were highlighted as being:

·The Mental Health Team are fully supportive of each other and appear a really dedicated and committed team.
·There is evidence of very good working relationships across the wider Prison Healthcare Team.
·There is a high value given to Scottish Prison Service (SPS) colleagues regarding their input and also the support the team provide to them, as well as being accessible and helpful with complex cases.
·The team are approachable and have supportive management.
·The team were found to be very pro-active in their approach to care delivery.
·There was a good self referral process, and patients know how to access service with ease.
·A psychology needs assessment is being progressed.
·There is support to the team from clinical psychology (Group and 1-1).
·A trauma informed care approach was very evident in care interactions and through discussion with team.
·Development of a triage tool to improve waiting time for early assessment and continuous improvement approach.
·Excellent development plans and initiatives to progress the service including psychology, Occupational Therapy and nursing.
·The service demonstrated an ability to deliver high quality care despite significant resource and workload challenges.

Areas for improvement

·Possibility of a recruitment drive to help address the challenge to recruit to nursing roles.
·Patients would like a healthcare /SPS combined leaflet to understand their journey (remand, convicted).
·Work towards a reduction in waiting times between appointments (identified due to current resource and clinical demand on staff).
·More multidisciplinary team staff meetings.
·Encouraging staff to take breaks and support wellbeing.
·The Mental Health Team could deliver training to wider group and SPS colleagues.

Feedback from virtual meeting session with review team

Patients felt listened to and respected from their care giver

Patients knew how to access care and could rely on staff to respond if their situation was deteriorating between appointments

Patients had established trust in mental health staff they couldn't do in the community

Looking Forward

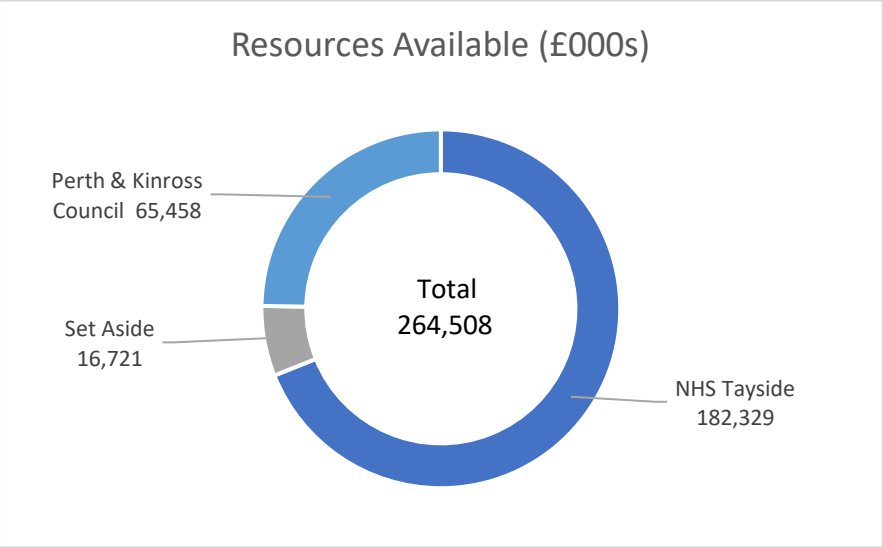
External inspection activity was adjusted during the height of COVID-19, with many inspections paused and others focussed on pandemic response. Now that external inspection activity has resumed, all HSCP services continue to work towards being inspection ready, and to maintain their focus on high quality care.

finance

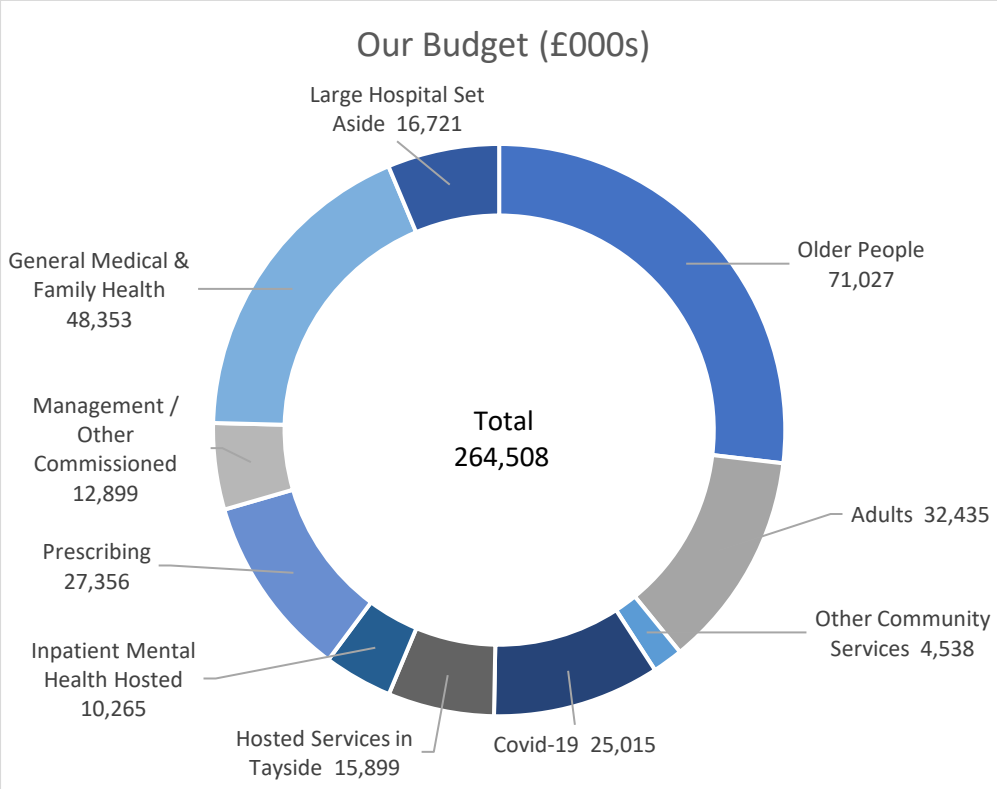
Financial Resources Available to the IJB 2021/22

The IJB is responsible for the planning and oversight of a broad range of health and adult social care services for the people of Perth and Kinross. These services are provided by Perth and Kinross Council and NHS Tayside via Perth and Kinross Health and Social Care Partnership. This is funded through budgets delegated from Perth and Kinross Council and NHS Tayside. The resources available to the IJB in 2021/22 totalled £264.508m.

The following charts provide a breakdown of where these resources came from, and how it was split over the range of services we deliver.



Included within the Resources Available to the IJB is a 'Large Hospital Services' (Set Aside) budget totalling £16.721m. This budget is in respect of those functions carried out within a large hospital setting and operationally managed by NHS Tayside but for which planning is the responsibility of the IJB.



In setting the budget for 2021/22, the IJB had planned to use reserves to deliver a break-even position. However, the actual financial performance against budget was a £1.6m underspend and reserves were not required.

One of the main contributions to the IJB underspend came from additional Scottish Government funding for the Living Wage. The IJB had allowed for Living Wage costs and set the budget prior to the funding being announced. Therefore, the unanticipated funding benefited the financial position.

The other main variance contributing to the underspend was within Prescribing. The level of nationally negotiated rebate accrued in the year was far higher than anticipated and was therefore a benefit to the overall position.

Expenditure of £9.6m was incurred in 2021/22 as a direct result of the pandemic and this cost was met in full by Scottish Government funding. A further £15m was allocated by the Scottish Government to IJBs towards the end of the financial year, and this is being held in reserve for use in 2022/23 for further pandemic related expenditure.

Financial Plan

In March 2022, the IJB approved the 2022/23 budget and indicative budgets for years 2023/24 and 2024/25. In setting the three-year budget, we developed financial frameworks underpinning our strategic delivery plans and this included taking account of additional Scottish Government funding. In addition to strategic delivery planning, the financial plan has quantified and included pay and price pressures, essential investment requirements, and savings opportunities across all areas of the budget, including those not within scope of current strategic delivery plans.

Best Value

Best Value is about creating an effective organisational context from which public bodies can deliver key outcomes. The following building blocks ensure we are organised to deliver good outcomes, by ensuring that they are delivered in a manner which is: economic, efficient, sustainable, and supportive of continuous improvement.

Vision and Values

The scale of increased demand and increasing complex needs means that we cannot provide services in the way we have before - we don’t have enough money to do so. A significant programme of change has been set out in strategies approved during 2021/22 for Older People, Learning Disabilities and Autism, and Community Mental Health Services fully linked to our three-year Financial Plan. These strategies have been developed in partnership with the people of Perth and Kinross who use our services and are fully aligned with the aims and ambitions set out in the IJB’s overarching Strategic Commissioning Plan.

Effective Partnerships

IJB Meetings are public meetings and membership includes wide stakeholder representation including carers, service users and the Third Sector. In addition, membership of the IJB's Strategic Planning Group ensures wide stakeholder involvement. This is further supported by other forums to ensure a strong contribution to joint strategic planning and commissioning including across our three localities. We maintain close links with the Community Planning Partnership and Local Action Partnerships.

Governance and Accountability

The IJB undertakes an annual review of its governance arrangements and is able to demonstrate structures, policies and leadership behaviours which demonstrate good standards of governance and accountability.

Use of Resources

The IJB is supported by a robust Financial Planning process which forms the basis for budget agreement each year with NHS Tayside and Perth and Kinross Council. Performance against the Financial Plan is reported to the IJB on a regular basis throughout the year. The use of our resources is directly linked to our strategic priorities.

Finance update reports have been presented to the Audit and Performance Committee throughout 2021/22, reporting on the projected financial position and the impact of the Pandemic. Our 3 Year Financial planning process is directly linked to the development of our strategic plans, ensuring resources are continuously prioritised to best meet the needs to the people of Perth & Kinross.

Performance Management

We continue to build on the implementation of our performance framework with effective and regular reporting at IJB, Care Programme and Locality level ensuring that we understand and can measure progress against our objectives.

Key Contact

For further information on any area of this report please contact: Chris Jolly, Service Manager, Business Planning and Performance at Christopher.Jolly@nhs.scot

Appendix

Appendix 1.1 National Indicator Tables

ID	Indicator	2017/18 Perth and Kinross	2018/19 Perth and Kinross	2019/20 Perth and Kinross	2020/21 Perth and Kinross	2021/22 Perth and Kinross	What is our trend over last five years?	How we compare to 2020/21	How we compare to Scotland 2021/22	2019/20 Scotland	2021/22 Scotland	Scotland's trend over last five year
NI 01	% of adults able to look after their health very well or quite well	94.6%	N/A	94.3%	N/A	93.7%	-1.0% ▼	-0.6%	2.8%	92.9%	-1.0%	-2.0% ▼
NI 02	% of adults supported at home who agree that they are supported to live as independently as possible	83.0%	N/A	82.3%	N/A	79.9%	-3.1% ▼	-2.4%	1.0%	80.8%	-3.1%	-2.3% ▼
NI 03	% of adults supported at home who agree that they had a say in how their help, care or support was provided	77.7%	N/A	77.2%	N/A	73.8%	-3.9% ▼	-3.4%	3.2%	75.4%	-3.9%	-5.0% ▼
NI 04	% of adults supported at home who agree that their health and care services seemed to be well co-ordinated	74.5%	N/A	73.0%	N/A	65.1%	-9.5% ▼	-7.9%	-1.3%	73.5%	-9.5%	-7.9% ▼

ID	Indicator	2017/18 Perth and Kinross	2018/19 Perth and Kinross	2019/20 Perth and Kinross	2020/21 Perth and Kinross	2021/22 Perth and Kinross	What is our trend over last five years?	How we compare to 2020/21	How we compare to Scotland 2021/22	2019/20 Scotland	2021/22 Scotland	Scotland's trend over last five year
NI 05	% of adults receiving any care or support who rate it as excellent or good	**81.3%**	**N/A**	**82.9%**	**N/A**	**79.1%**	**-2.1%** ▼	**-3.7%**	**3.8%**	**80.2%**	**-2.1%**	**-4.8%** ▼
NI 06	% of people with positive experience of care at their GP practice.	**88.4%**	**N/A**	**86.4%**	**N/A**	**74.1%**	**-14.3%** ▼	**-12.3%**	**7.6%**	**78.7%**	**-14.3%**	**-16.1%** ▼
NI 07	% of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life.	**80.6%**	**N/A**	**80.2%**	**N/A**	**75.8%**	**-4.8%** ▼	**-4.4%**	**-2.3%**	**80.0%**	**-4.8%**	**-1.8%** ▼
NI 08	% of carers who feel supported to continue in their caring role	**40.9%**	**N/A**	**36.7%**	**N/A**	**33.2%**	**-7.7%** ▼	**-3.5%**	**3.5%**	**34.3%**	**-7.7%**	**-6.9%** ▼
NI 09	% of adults supported at home who agreed they felt safe.	**84.9%**	**N/A**	**83.9%**	**N/A**	**79.0%**	**-5.9%** ▼	**-4.9%**	**-0.7%**	**82.8%**	**-5.9%**	**-3.6%** ▼

Source: Public Health Scotland Core Suite Integration Indicators. July 2022 update

ID	Indicator	2017/18 Perth and Kinross	2018/19 Perth and Kinross	2019/20 Perth and Kinross	2020/21 Perth and Kinross	2021/22 Perth and Kinross	Reporting Period Year up to	What is our trend over last five years?	How we compare to 2020/21	How we compare to Scotland 2021/22	2020/21 Scotland	2021/22 Scotland	Scotland's trend over last five year
NI-11	Premature Mortality Rate per 100,000	364.1	350.2	332.8	364.9	362.1	Dec 2021	-2.0 ▼	-0.8%	-30.0%	457.4	470.6	45.4 ▲
NI 12	Rate of emergency admissions per 100,000 population for adults (18+ all specialities)	10,775.8	10,953.3	11,483.3	10,583.1	11,117.0	Dec 2021	341.2 ▲	5.0%	-4.7%	10,952.2	11,635.5	-575.1 ▼
NI 13	Rate of emergency bed day per 100,000 population for adults (18+)	108,626.3	107,736.6	110,762.4	94,404.1	107,153.3	Dec 2021	-1,473.1 ▼	13.5%	-2.1%	101,114.8	109,429.3	-13,141.7 ▼
NI 14	Readmissions to hospital within 28 days of discharge per 1,000 discharges (18+)	112.2	115.1	115.7	141.0	129.5	Dec 2021	17.3 ▲	-8.1%	15.4%	120.1	109.6	6.8 ▲
NI 15	Proportion of last 6 months of life spent at home or in a community setting	89.5%	89.6%	89.6%	90.2%	90.9%	Dec 2021	1.4% ▲	0.7%	0.8%	90.3%	90.1%	2.1% ▲

ID	Indicator	2017/18 Perth and Kinross	2018/19 Perth and Kinross	2019/20 Perth and Kinross	2020/21 Perth and Kinross	2021/22 Perth and Kinross	Reporting Period Year up to	What is our trend over last five years?	How we compare to 2020/21	How we compare to Scotland 2021/22	2020/21 Scotland	2021/22 Scotland	Scotland's trend over last five year
NI 16	Falls rate per 1,000 population (65+)	21.4	22.1	22.5	23.8	23.5	Dec 2021	2.1 ▲	-0.9%	2.1%	21.7	23.0	0.8 ▲
NI-17	Proportion of Care Services rated good or better in Care Inspectorate inspections	88.1%	87.0%	86.4%	89.0%	76.5%	Mar 2022	-11.6% ▼	-12.4%	0.7%	82.5%	75.8%	-9.6% ▼
NI-18	Percentage of 18+ with intensive social care needs receiving Care at Home	58.0%	60.8%	59.3%	59.5%	62.6%	Dec 2021	4.6% ▲	3.0%	-2.4%	63.0%	64.9%	4.2% ▲
NI 19	Number of days people aged 75+ spend in hospital when they are ready to be discharged per 1,000 population	658.1	547.7	502.4	197.1	609.4	Mar 2022	-48.7 ▼	209.3%	-24.9%	484.3	761.4	-0.8 ▼

ID	Indicator	2017/18 Perth and Kinross	2018/19 Perth and Kinross	2019/20 Perth and Kinross	2020/21 Perth and Kinross	2021/22 Perth and Kinross	Reporting Period Year up to	What is our trend over last five years?	How we compare to 2020/21	How we compare to Scotland 2021/22	2020/21 Scotland	2021/22 Scotland	Scotland's trend over last five year
*NI-20	Percentage of health and care resource spent on hospital stays where the patient was admitted as an emergency	26.4%	26.2%	25.7%	N/A	N/A	Mar 2020	-0.7% ▼	-0.5%	1.5%	N/A	N/A	0.9% ▲
**MSG 3	A&E attendances per 100,000 population	20,326.6	21,119.4	22,134.7	14,075.8	16,738.6	Mar 2022	-3,588.0 ▼	23.7%	-46.4%	20,377.7	24,379.4	-1,944.7 ▼

Source: Public Health Scotland Core Suite Integration Indicators. July 2022 update.
**NI-20 latest data provided by PHS is for 2019/20 period. Column 2021/22 = 2019/20 period. Colum 2020/21 = 2018/19 period.*
*** Data not provided with PHS's Core Suite Integration Indicators update (12 Jul 2022). Data is subject to further validation and may be subject to change as more information becomes available.*

Within 3%, or are meeting or exceeding our target	Between 3% and 6% away from meeting our target	More than 6% away from meeting our target

KEY. Performance Trend Over Last Five Years

Trend Increased. Performance was Positive.	Trend Increased. Performance was Negative	Trend Decreased. Performance was Positive.	Trend Decreased. Performance was Negative
▲	▲	▼	▼

Appendix 2.1. Ni 01-09: Year On Year Comparison

ID	Indicator	2021/22 Perth and Kinross	2021/22 Scotland Overall	2021/22 Peer Group	How we compared to 2019/20	How Scotland compared to 2019/20	How Peer group compared to 2019/20
NI 01	% of adults able to look after their health very well or quite well	93.7%	90.9%	92.1%	-0.6%	-2.0%	-1.5%
NI 02	% of adults supported at home who agree that they are supported to live as independently as possible	79.9%	78.8%	76.3%	-2.4%	-2.0%	-4.8%
NI 03	% of adults supported at home who agree that they had a say in how their help, care or support was provided	73.8%	70.6%	69.5%	-3.4%	-4.8%	-6.8%
NI 04	% of adults supported at home who agree that their health and care services seemed to be well co-ordinated	65.1%	66.4%	64.6%	-7.9%	-7.1%	-8.9%
NI 05	% of adults receiving any care or support who rate it as excellent or good	79.1%	75.3%	74.2%	-3.7%	-4.8%	-6.2%
NI 06	% of people with positive experience of care at their GP practice.	74.1%	66.5%	67.3%	-12.3%	-12.2%	-11.3%
NI 07	% of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life.	75.8%	78.1%	76.6%	-4.4%	-1.9%	-3.5%
NI 08	% of carers who feel supported to continue in their caring role	33.2%	29.7%	30.3%	-3.5%	-4.6%	-3.3%
NI 09	% of adults supported at home who agreed they felt safe.	79.0%	79.7%	77.7%	-4.9%	-3.1%	-3.8%

Source: Public Health Scotland Core Suite Integration Indicators. July 2022 update.

Appendix 2.2. NI 11-20 and Msg 03: Year On Year Comparison

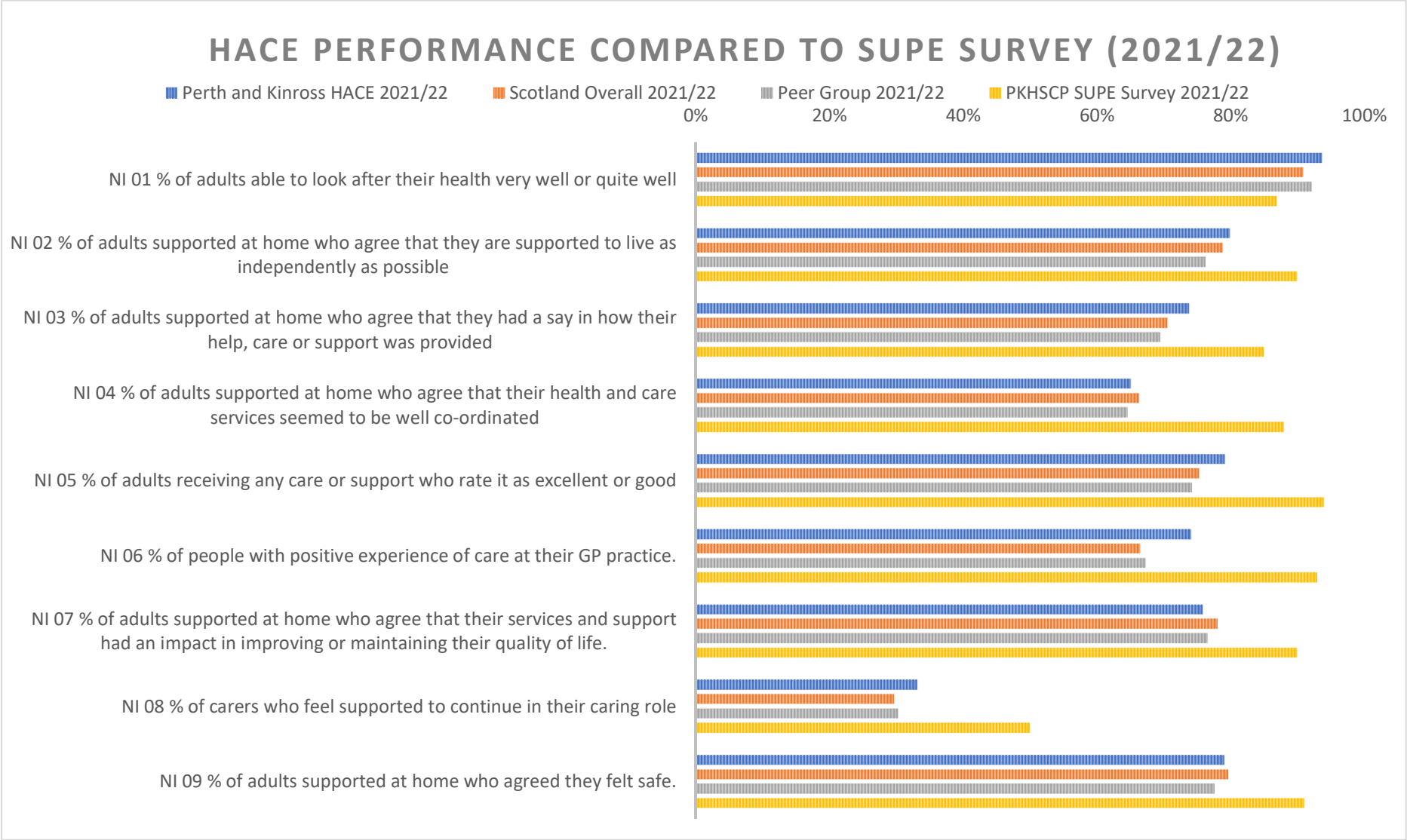
ID	Indicator	Reporting Period Year up to	2021/22 Perth and Kinross	2021/22 Scotland Overall	2021/22 Peer Group	How we compared to 2020/21	How Scotland compared to 2020/21	How Peer group compared to 2020/21
NI-11	Premature Mortality Rate per 100,000	Dec 2021	362.1	470.6	419.5	-0.8%	2.9%	6.4%
NI 12	Rate of emergency admissions per 100,000 population for adults (18+ all specialities)	Dec 2021	11,117.0	11,635.5	10,841.1	5.0%	6.2%	6.4%
NI 13	Rate of emergency bed day per 100,000 population for adults (18+)	Dec 2021	107,153.3	109,429.3	103,104.9	13.5%	8.2%	10.6%
NI 14	Readmissions to hospital within 28 days of discharge per 1,000 discharges (18+)	Dec 2021	129.5	109.6	108.4	-8.1%	-8.8%	-9.5%
NI 15	Proportion of last 6 months of life spent at home or in a community setting	Dec 2021	90.9%	90.1%	90.8%	0.7%	-0.2%	-0.4%
NI 16	Falls rate per 1,000 population (65+)	Dec 2021	23.5	23.0	19.7	-0.9%	6.2%	5.7%
NI-17	Proportion of Care Services rated good or better in Care Inspectorate inspections	Mar 2022	76.5%	75.8%	79.0%	-12.4%	-6.7%	-6.7%
NI-18	Percentage of 18+ with intensive social care needs receiving Care at Home	Dec 2021	62.6%	64.9%	64.4%	3.0%	1.9%	0.9%
NI 19	Number of days people aged 75+ spend in hospital when they are ready to be discharged per 1,000 population	Mar 2022	609.4	761.4	633.5	209.3%	57.2%	56.3%
*NI-20	Percentage of health and care resource spent on hospital stays where the patient was admitted as an emergency	Mar 2020	25.7%	24.2%	23.4%	-0.5%	0.1%	-0.1%
**MSG 3	A&E attendances per 100,000 population	Mar 2022	16,738.6	24,379.4	N/A	18.9%	19.6%	N/A

**NI-20 latest data provided by PHS is for 2019/20 period. Column 2021/22 = 2019/20 period. Colum 2020/21 = 2018/19 period.*
*** Data not provided with PHS's Core Suite Integration Indicators update (12 Jul 2022). Data is subject to further validation and may be subject to change as more information becomes available.*

Appendix 3.1. HACE Survey Comparison To SUPE

ID	Indicator	Perth and Kinross 2021/22	Scotland Overall 2021/22	Peer Group 2021/22	PKHSCP SUPE Survey 2021/22
NI 01	% of adults able to look after their health very well or quite well	**93.7%**	**90.9%**	**92.1%**	**87%**
NI 02	% of adults supported at home who agree that they are supported to live as independently as possible	**79.9%**	**78.8%**	**76.3%**	**90%**
NI 03	% of adults supported at home who agree that they had a say in how their help, care or support was provided	**73.8%**	**70.6%**	**69.5%**	**85%**
NI 04	% of adults supported at home who agree that their health and care services seemed to be well co-ordinated	**65.1%**	**66.4%**	**64.6%**	**88%**
NI 05	% of adults receiving any care or support who rate it as excellent or good	**79.1%**	**75.3%**	**74.2%**	**94%**
NI 06	% of people with positive experience of care at their GP practice.	**74.1%**	**66.5%**	**67.3%**	**93%**
NI 07	% of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life.	**75.8%**	**78.1%**	**76.6%**	**90%**
NI 08	% of carers who feel supported to continue in their caring role	**33.2%**	**29.7%**	**30.3%**	**50%**
NI 09	% of adults supported at home who agreed they felt safe.	**79.0%**	**79.7%**	**77.7%**	**91%**

Appendix 3.2. HACE and SUPE Full Comparison



Health and Social Care Surveys

The Scottish Health and Care Experience (HACE) Survey is a national postal survey sent to a random sample of people registered with a GP in Scotland. Circulated every two years, the questions asked relate to people's experience of health and social care services during the previous twelve months. More details are available via the Scottish Government's website. We have reported the 2021/22 results for Perth and Kinross, Scotland overall and the Peer group of similar HSCPs (see Appendix 6).

To capture regular localised feedback from people using our services we have developed our own local Service User and Patient Experience (SUPE) survey. This provides for more regular localised feedback from people (or their carers) that we know have used our services. The SUPE survey was undertaken between October 2021 and March 2022, with feedback received from approximately 150 people.

Appendix 4.1 MAT Standards

Appendix 5.1 This Is Me Poster

The posters are jointly created by inpatient staff, the transitional care nurse and with input from patients, families and carers. The poster then moves with the patient to their long-term care placement.

Appendix 6.1 HSCP Peer Group Makeup

Aberdeenshire Health and Social Care Partnership

Angus Health and Social Care Partnership

Argyll and Bute Health and Social Care Partnership

Dumfries and Galloway Health and Social Care Partnership

East Ayrshire Health and Social Care Partnership

East Lothian Health and Social Care Partnership

Highland Health and Social Care Partnership

Moray Health and Social Care Partnership

Scottish Borders Health and Social Care Partnership

Clackmannanshire and Stirling Health and Social Care Partnership*

** 2021/22 HACE results for Clackmannanshire and Stirling are only comparable to 2019/20 and not to results in earlier years.*