Perth and Kinross
Health and Social Care Partnership

Annual Performance Report for 2019/20

Our Vision

"We will work together to support people living in Perth and Kinross to lead healthy and active lives and live as independently as possible, with choice and control over the decisions they make about their care and support."

FOREWORD & INTRODUCTION

I am pleased to introduce the fourth annual review of the performance of the Perth and Kinross Health and Social Care Partnership and my second annual review of services since I took up the role as Chief Officer in April 2019.

The challenges we have faced from COVID-19 have determined our priorities and activities since March 2020 and will continue to do so for the remainder of this financial year, at the very least. However, despite the challenges of maintaining and adapting essential health and social care services in the face of a global pandemic, this experience has taught us that we can adapt, regroup and mobilise to meet the needs of our population. In the worst of times, we have witnessed a number of positives that as a Health and Social Care Partnership we will seek to capitalise on moving forward; our partnership work with stakeholders; the swiftness of our decision-making and action; the versatility, commitment and compassion of our workforce; our use of digital technology; initiating new ways of working; and the ability and willingness of local communities to mobilise support for their citizens. Capitalising on these positives provides the opportunities for us to build a better Health and Social Care Partnership.

Even while still within this pandemic, it is important that we look back to celebrate our achievements and identify areas where greater focus is needed to improve the quality of our services and the outcomes that they deliver. There are many important lessons for us to take away from our review of 2019-20, alongside a great many achievements that highlight the hard work and professionalism of those working to make health and social care services better across Perth and Kinross.

While the size, scale and complexity of the Health and Social Care Partnership (HSCP) encompasses many different services, I hope that this report provides a useful snapshot of the overall performance of the HSCP in delivering against the priorities in our Strategic Plan. This report highlights our strategic ambition to improve and transform how health and social care is planned, delivered and experienced across Perth and Kinross and improve performance against the key indicators that identify those areas in which we excel and those in which we continue to strive for improvement.

Gordon Paterson, Chief Officer
Perth and Kinross Health and Social Care Partnership

SECTION 1

OUR HEALTH AND SOCIAL CARE PARTNERSHIP

Our Vision, Aims, Values and Principles

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 the decisions they make about their care and support.

Our aim is to improve the wellbeing and outcomes of local people, to intervene early and to work with the third and independent sectors and communities, to prevent longer-term issues arising.

Our values are important in guiding how we interact with service users and carers, with partners and stakeholders and with each other:

■ Person-focused ■ Integrity ■ Caring ■ Respectful ■Inclusive ■Empowering

As a Health and Social Care Partnership we have adopted the principles underpinning the Scottish Government's **National Health and Social Care Standards** http://www.newcarestandards.scot/ which were published in June 2017. These seek to provide better outcomes for everyone, to ensure that individuals are treated with respect and dignity and to ensure that the basic human rights we are all entitled to are upheld. We are committed to embedding the Care Standards in all that we do, and we seek to achieve this during the period covered by this plan.

Perth and Kinross Integration Joint Board and the Health and Social Care Partnership

Since its inception in April 2016, Perth and Kinross Health and Social Care Partnership (HSCP) has been developing more integrated health and social care services across the three Perth and Kinross localities, on behalf of the Integration Joint Boards (IJB).

Our focus has been on working together with partners to ensure that the services that we provide, or commission make a demonstrable and positive impact on the outcomes that Perth and Kinross citizens experience. In doing so, our activity and plans seek to contribute towards the achievement of the Scottish Government's **National Health and Wellbeing Outcomes,** which are described in more detail in the Performance section below.

Our Strategic Plan

A review of our Strategic Commissioning Plan was undertaken during 2019/20. Over a 5-week period in July and August 2019, we engaged with local communities in Perth and Kinross to identify their priorities for the Health and Social Care Partnership for the next 3 - 5 years. This engagement programme built on the initial consultation programme "Join the Conversation" completed prior to publishing our Strategic Plan 2016 –2019.

Strategic Plan 2020:2025
1,420 people completed an engagement survey (online and paper based). Respondent numbers were fairly equal across all three Perth & Kinross Localities. Although people completed individual surveys, we targeted 90 community organisations, mainly by attending a group session, to explain more about the survey and to encourage people to participate who would not normally complete an online survey.

Our Strategic Objectives

The responses we received to this consultation have informed the Strategic Objectives and Intentions outlined in our refreshed Strategic Commissioning Plan 2020:25, which was approved by the IJB in December 2019.

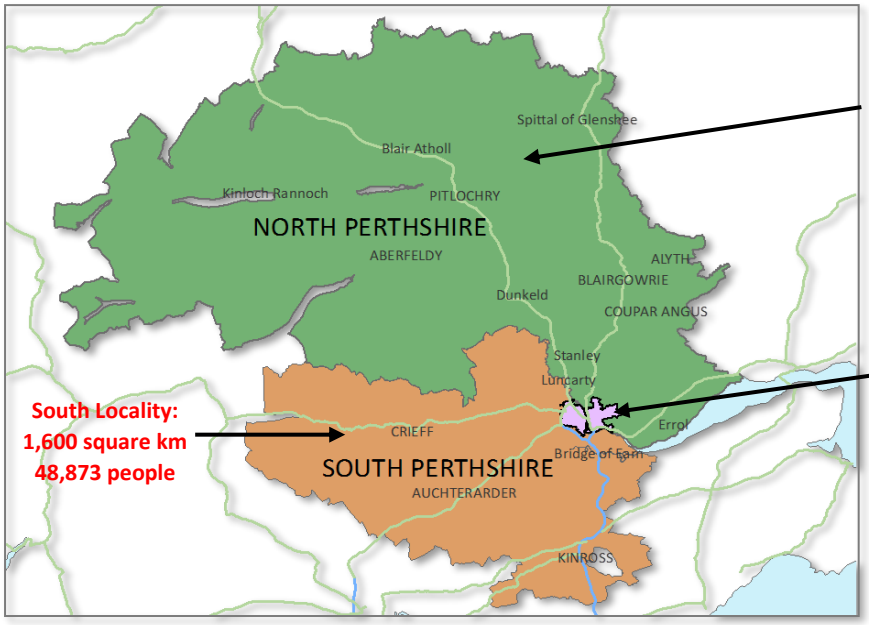
These ensure a direction of travel by the Perth and Kinross Health and Social Care Partnership that is consistent with National Health and Wellbeing Outcomes:

1. Working together with our communities
2. Prevention and early intervention
3. Person-centred health, care and support
4. Reducing health and social inequalities and promoting healthy living
5. Making best use of available facilities, people and other resources

The consultation exercise was only one component of our planned, ongoing programme of consultation and engagement as we deliver on our strategic priorities and redesign services, to ensure that we improve our performance and better meet the needs of the communities and citizens of Perth and Kinross.

Our Localities

Perth and Kinross HSCP has committed to the three localities which are detailed in the map below. These localities form the geographical basis on which we engage with our communities and how we deliver services.



Perth and Kinross is the 8th most densely populated local authority area in Scotland, however the area covers a large geography, and this leads to an above average percentage of the population being in some way "access deprived" (36.8% for Perth and Kinross compared to 20.2% for Scotland). These figures demonstrate the impact of remoteness and illustrate the challenges of providing and accessing health and social care services across Perth and Kinross.

Currently, as a percentage of our whole Perth and Kinross population, and comparing to other Scottish Local Authority areas, we have the 8th largest 65+ population, the 5th largest 75+ population and the 2nd largest 85+ population.

As our people get older they rely on health and social care services to support them to stay at home safely and for longer notwithstanding the fact that our elderly population within Perth and Kinross are generally healthy. We can see this when we look at the average age, for example, of people receiving Care at Home services in Perth and Kinross being 82.

However, an elderly population has a greater need for urgent care and support from specialist hospital services. With and elderly population we see higher usage of hospital services and an increased likelihood of readmission within 28 days. In response, we continue to invest in community-based services to reduce admissions and support people in their own homes.

It is well recognised that local people are well placed to identify local solutions and we are committed to working with them to continue to develop the services that they use in their areas. This approach is reflected in our strategic priorities which show our commitment to work with partners and local communities across our three localities, in a person centred and preventative manner.

Recognising the geographical challenges we encounter, as well as the benefits that can be gained from community engagement, we have:

- Continued to develop our Local Action Plans via Area Action Partnerships;
- Worked closely with our Community Engagement colleagues to better understand the needs of communities and how they can assist to provide support on a sustained basis;
- Developed services which are wrapped around GP practices and provide locality based, multidisciplinary team approaches.

SECTION 2

OUR PERFORMANCE

Introduction

The following section provides an overview of the achievements within Perth and Kinross Health and Social Care Partnership in pursuance of the objectives set out in the recently approved Strategic Commissioning Plan. These are aligned to the National Health and Wellbeing Outcomes, as follows:

National Health and Wellbeing Outcomes	
1	People are able to look after and improve their own health and well-being 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 experiences 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 well-being, including to reduce any negative impact of their caring role on their own health and well being
7	People using 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

This report covers the period April 2019 to March 2020. It provides a broad range of information and includes detail on partnership performance in relation to the National Indicators, as well as those that were identified by the Ministerial Strategic Group (MSG).

The table below provides an overview of performance taking into account the latest available data for the reporting period.

Indicator Origin		RAG	
National Indicators	Ministerial Strategic Group Indicators		
17	4	Green	Within 3%, or are meeting or exceeding the number we compare against
0	1	Amber	Between 3% and 6% away from meeting the number we compare against
2	0	Red	More than 6% away from meeting the number we compare against
0	1	Not yet available	

Our performance over the 2019/20 period has largely fallen within the national target value. Of the 19 National Indicators (summarised on page 10), 17 are within the target range and are designated Green. Of the six Ministerial Strategic Group Indicators four are designated Green, one is designated Amber with none designated Red (detailed on page 12).

National Indicators Overview

The National Indicators (detailed in the table below) were identified by the Scottish Government to provide a basis for benchmarking against all other Health and Social Care Partnerships across Scotland. Currently the national indicators comprise of:

- 9 Health and Care experience survey indicators collected every two years, that inform us as to what our people think of our services, and
- 10 activity indicators derived from operational data that are collected monthly and demonstrate our performance against the national indicators

To allow comparison to the Scotland value and to our own previous years' performance, all of these indicators are expressed as percentages and rates. Presenting the data for each indicator has been a challenge this year as COVID-19 has impacted on the ability of HSCPs to submit their data returns in time. This has not been universally possible and so we have therefore followed Public Health Scotland guidance to ensure the most up to date and comparable data has been provided.

While the results of the 2019/20 'Health and Care Experience Survey' have not yet been published, we have re-produced the 2018/19 data. In response, we intend to provide updated performance data on these indicators via Quarterly Performance Reports, as soon as the data becomes available.

The following table provides an overview of current performance in relation to all national indicators with full performance data supplied in the Appendix to this report. Furthermore we have provided commentary on National Indicators 11-20 in the sections below and we have linked these indicators to our strategic objectives.

ID	Indicator	How we compared to Scotland	ID	Indicator	How we compared to Scotland
NI 01	% of adults able to look after their health very well or quite well	↑ 1.6%	NI 11	Premature Mortality rate per 100,000*	↓ 82
NI 02	% of adults supported at home who agree that they are supported to live as independently as possible	↑ 2.0%	NI 12	Rate of emergency admissions per 100,000 population for adults	↓ 1,089
NI 03	% of adults supported at home who agree that they had a say in how their help, care or support was provided	↑ 1.7%	NI 13	Rate of emergency bed day per 100,000 population for adults	↓ 10,687
NI 04	% of adults supported at home who agree that their health and care services seemed to be well co-ordinated	↑ 0.5%	NI 14	Readmissions to hospital within 28 days of discharge per 1,000 admissions	↑ 11
NI 05	Percentage of adults receiving any care or support who rate it as excellent or good	↑ 0.3%	NI 15	Proportion of last 6 months of life spent at home or in a community setting	↑ 1.13%
NI 06	% of people with positive experience of care at their GP practice.	↑ 5.4%	NI 16	Falls rate per 1,000 population aged 65+	↑ 0.014
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.	↑ 0.6%	NI 17	Proportion of care and care services rated good or better in Care Inspectorate inspections	↑ 4%
NI 08	% of carers who feel supported to continue in their caring role	↑ 3.9%	NI 18	Percentage 18+ with intensive social care needs receiving care at home**	↑ 1.35%
NI 09	% of adults supported at home who agreed they felt safe.	↑ 4.9%	NI 19	Number of days people aged 75+ spend in hospital when they are ready to be discharged per 1,000 population**	↓ 139
			NI 20	Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	↑ 1.76%

Performance Key We have used the following definitions to set the colour and arrows:	**We are within 3%, or are meeting or exceeding the number we compare against**	*Green*	**We are between 3% and 6% away from meeting the number we compare against**	**Amber**	**We are more than 6% away from meeting the number we compare against**	*Red*	***An arrow indicates the direction the numbers are going in***

Across eight of these indicators we performed close to or better than the Scottish value. In particular we have seen high levels of performance against the following 3 indicators:

- The rate of emergency admissions per 100,000 population for adults. (NI 12)
- The rate of emergency bed days per 100,000 population. (NI 13)
- The number of days people aged 75+ spend in hospital when they are ready to be discharged per 100,000 population. (NI 19)

Our performance in relation to national performance indicator NI12 demonstrates that we continue to perform well compared to Scotland as a whole and that the services, and early

interventions, which are delivered in Perth and Kinross continue to prevent deteriorations in patients, reducing emergency admissions.

In relation to NI13 we continue to see improved performance. This indicator is showing a steady year-on-year improvement and is always better than the Scotland average. The work of the HART team and other locality teams in supporting early hospital discharge contributes to this improved performance.

Considering NI19 we can see a considerable improvement in relation to delayed discharge performance across the comparator period (from 2016/17) and also when compared to Scotland. This significantly reflects the changes we have delivered through the Home Assessment and Reablement Team (HART) and our work with our private care providers in Perth and Kinross to create capacity. We have further planned improvements to the HART service in 2020/21.

Given the demographic and geographic challenges we face, our positive performance against these indicators in particular confirms that we are supporting people at home by intervening early and when discharged from hospital we are providing early rehabilitation and access to wider supportive services. These results reflect our commitment to early intervention, reablement and to supporting people in their own communities.

However, we did not achieve the same level of performance relative to the Scottish value in relation to:

- "Readmissions to hospital within 28 days of discharge" (NI14), and
- "% of health and care resources spent on hospital stays where the patient was admitted as an emergency" (NI20).

With regard to readmissions, this was an area identified for improved performance in the 2018/19 Annual Performance Report. A number of pieces or work have been undertaken during 2019/20 and the outcomes of these will be pulled together by a short life working group to identify specific improvement actions.

We can see that more work is needed to improve our performance in relation to NI20. Our performance reflects our large elderly population and their increased likelihood of an emergency admission to hospital. The introduction of our new Locality Integrated Care Service (Lincs) is expected to deliver a reduction in our emergency admissions and a reduction in the specialist care they need whilst in hospital.

Moving forward improving performance across all indicators will continue to be our focus, however the challenging demands placed on the partnership by the ever increasing need for urgent care, as our population lives longer, mean more effective interventions are required. This work is underway and the section below explains the significant developments we are advancing, such as the introduction and extension of our Locality Integrated Care Service.

Ministerial Strategic Group Indicators Overview

The MSG indicators have been provided by the Scottish Government to support local monitoring of progress towards integration. We regularly feedback our results to the Scottish Government.

MSG Indicator	MSG Description	Perth and Kinross 2017/18	Perth and Kinross 2018/19	Perth and Kinross 2019/20	Movement in our performance last year
1a	Emergency Admissions	14,880	14,772	15,380	608 (4.12%)
2a	Unscheduled Hospital Bed Days	102,767	100,157	102,237	2,080 (2.08%)
3a	A&E Attendances	32,273	33,264	34,018	754 (2.27%)
4	Delayed Discharge Bed Days*	16,785	14,203	12,414	1,789 (-12.60%)
5.1	Proportion of last 6 months of life spent at home or in a community setting	89.52%	89.56%	89.75%	0.20%
6.1	Percentage of population at home unsupported	92.13%	92.32%	Not yet available	Not yet available

Performance Key We have used the following definitions to set the colour and arrows:	**We are within 3%, or are meeting or exceeding the number we compare against**	*Green*	**We are between 3% and 6% away from meeting the number we compare against**	**Amber**	**We are more than 6% away from meeting the number we compare against**	*Red*	***An arrow indicates the direction the numbers are going in***

These indicators reflect good performance across all indicators, with the exception of emergency admissions. Our performance in relation to emergency admissions (Indicator 1a) has declined by 4% over the reporting period and is now amber.

The level of unscheduled hospital beds days (Indicator 2a) is remaining stable. This is in part linked to our delayed discharge performance.

A&E attendances (Indicator 3a) were also stable this year and we have further improvement actions identified which will support future improvement.

The proportion of last 6 months spent in a home or a community setting (Indicator 5.1) is a long term indicator that continues to steadily improve with more people achieving their wish of being at home when they receive end of life care.

Overall these indicators demonstrate a high level of performance, a measure of our commitment to improving outcomes through effective collaboration with the independent and third sector partners.

STRATEGIC OBJECTIVE 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.*

Contributes to National Health and Wellbeing Outcome 2 & 6

How well are we doing?

The Health and Social Care Partnership (HSCP) engages with our communities through a range of means. In larger scale service developments, we engage early to gather views that then shape future service delivery. Similarly, we regularly take the opportunity to engage on smaller scale developments and to support continuous service improvement.

Locality Action Partnerships

An integral part of locality working is undertaken through our Locality Action Partnerships. These groups bring together community representatives, elected members, service and locality representatives to discuss and agree the key actions for inclusion in Locality Action Plans. These action plans create a focus on the area's priorities and support our efforts to reducing inequalities.

Examples of Localities Engagement

Within each Locality there have been a number of service user and community-based engagement exercises and events throughout 2019/20.

Where	What	Outcome
Community Engagement		
North Locality	The Aberfeldy Model of Care A short life working group was established to address community concern regarding the 2015 Community Hospital closure Focused on addressing local concern regarding healthcare provision in the locality	An NHS Tayside Informing, Engaging and Consulting Plan was designed and followed Community stakeholders were engaged, with a focus on information sharing Met local need - Aberfeldy Care and Treatment Hub was opened in late 2019
South Locality	Engagement on Health Provision in Lower Earn Provided a platform for community stakeholders to express views on	Highlighted Local demand for an expanded service. Action has taken place to renovate the Bridge of Earn Nurses' Cottage

	Future of healthcare, including mental health Provided opportunity to deliver feedback to staff in respect to the level of care provided	The aim is that an upgraded building will provide accommodation for the District Nurse Team and facilities to deliver Care and Treatment Services for the locality
Perth City	Evaluation of the Primary Care Mental Health and Wellbeing Nursing Service Gathered views of service users, GPs and GP practice staff, in response to the expansion of the Primary Care Improvement Plan -	Feedback highlighted positive reception by both Practice Staff and Patients Revealed patients value quick access to a Mental Health professional. Demonstrated an appetite for service expansion. Demand for: - use not limited to be limited to 'crisis' times - check-up sessions This will be useful when service rolls out to other areas

- **Big January Get Together**
  - Local feedback suggested January was a time of stress and loneliness. To combat this a number of agencies and local community organisations put on a month of events, attracting 500 attendees. This acted as a platform for engagement with individuals whom we were then able to signpost to appropriate support services
- **South Perth Wellbeing Day**
  - We supported an information day with a focus on health and wellbeing for local residents, with 50 community stallholders involved and over 250 people in attendance. This celebrated and promoted the work being done by groups across the community and created opportunities to come together locally.
- **Jump into Wellbeing Festival**
  - This festival involved 30 local community groups, offering 76 activities and learning opportunities. This highlighted work being done across the community by key stakeholders and led to greater attendance at local civil society groups.

"We have had some more enquiries about the group and support, and the event raised awareness of the organisation and the youth group. It also allowed young people to self-refer to other services for support".

(South Perth Wellbeing Day)

"It has provided some ideas to try with the children to assist in developing their confidence and to build coping mechanisms."

(Jump into Wellbeing Festival)

More information is available through our regular Locality Newsletters:

https://yourcommunitypk.org/2019/01/latest-health-and-wellbeing-newsletters/

Consultations

As well as consulting to inform our review of the Strategic Commissioning Plan, consultations were carried out to gain people's views on Carers, Mental Health and Wellbeing and our Keys to Life strategies. The following examples evidence our commitment to this strategic aim.

- Carers - The Carers (Scotland) Act, launched in April 2018. It applies to both Adult and Young Carers and aims to support carers health and wellbeing and make it more sustainable.
- Embracing the Carers (Scotland) Act, we consulted with our Stakeholders to produce the Adult Carers Eligibility Criteria and the Short Breaks Services Statement which assisted in the development of the Joint Carers Strategy that was approved at the December 2019 meeting of the IJB.
- During that consultation exercise we received feedback from carers in different localities across Perth and Kinross. With 359 people giving their views and feedback this was the most successful consultation with carers and stakeholders we have undertaken.
- Responses were received from carers and their families from a wide variety of backgrounds, cultures and community groups, such as gypsy/traveller carers, carers of people with drug and alcohol use issues, and ethnic minority carers.
- Emerging themes highlighted during the consultation enabled our staff to work closely with Carers to shape the commitments included in our new Carers Strategy.

Six commitments were identified:

Joint Carers Strategy 2019-2022		
Carers will be supported with clear information, consistent and flexible support to empower them to manage their caring role.	Everyone will have the information, opportunities and support to be identified as a carer.	Carers' voices will be critical to influencing the planning, development and improvement of supports.
Carers will be supported to actively participate in developing a course of supports within the local community to enable them to have a life out with their caring role	Carers will be valued, listened to and empowered to share their experiences.	We will provide specialist and person-centred support to avoid disadvantage to carers of all ages.

Mental Health

To inform the development of our local Community Mental Health Strategy in Perth and Kinross, we undertook a public consultation exercise last Autumn, in order to gather stakeholders' views and opinions. While 40% of respondents were satisfied with the services being provided a quarter highlighted the lack of equity of service provision and access in rural areas. There was however some positive acknowledgement that online and social media related support had been helpful, and that information was also available to help people find mental health services for their needs.

In response to concerns about the lack of services in rural communities, we have invested in "Mindspace" to provide counselling services throughout Perth and Kinross, with a particularly focus in rural areas. This service now extends to include Auchterarder, Crieff, Kinross and Blairgowrie with in excess of 140 sessions per week being provided to meet the support needs of people within their own local communities.

Learning Disabilities

Through our Keys to Life Strategy we are committed to ensuring that people with learning disabilities can achieve the highest attainable standard of living, health, and family life, and can live active and independent lives in the community.

In developing the refreshed Keys to Life Strategy, we carried out a consultation exercises (March and October 2019) with our stakeholders; private providers; third sector; voluntary; service users, family members / carers and with professionals. Service users were engaged in this process through their existing groups and networks, such as the 'Making Where We Live Better' group. Other groups were supported to participate by the Centre for Inclusive Living Perth & Kinross and Independent Advocacy Perth & Kinross.

Individuals were also encouraged to respond, often with the support of their family members of carers. Responses to our consultation, further feedback and an analysis of areas which require support, enabled us to identify 6 priority themes which will inform the content of our Keys to Life Strategy as it develops.

Themes included:

Keys to Life Strategy - 2020-2025		
Provide access to a greater range of quality 'short breaks'	Ensure that people with learning disabilities are central to and involved in their own life plans	Ensure a greater voice for people with learning disabilities in our society
Support people with learning disabilities to participate in their communities, which are welcoming and accessible	Address barriers to equality	All people with a learning disability have the right to live as independently as possible in their community and be supported

A Strategy for People with a Physical Disability

During 2019/20 work began to develop a new strategy and action plan 2020 - 2024 for people with a physical disability, including sight loss and hearing loss. The Strategy for People with a Physical Disability will draw on;

- the five ambitions set out in 'A Fairer Scotland for Disabled People'[1] which is the Scottish Government's delivery plan for the UN Convention on the Rights of persons with disabilities,
- the strategic priorities in the HSCP's Strategic Commissioning Plan
- recommendations from the National See Hear Framework, views and experience of with people who live with physical disabilities and/or sensory impairment
- knowledge, experience and contributions from members of the Physical Disability Strategy Group and See Hear Steering Group members.

To identify areas of strength and gaps we have mapped out statutory and commissioned services, as well as community resources. This also enabled us to share information on all existing services, in accessible formats. We have broadened the membership of the Strategy Group to include greater input from social work locality teams and third sector partners. The outline for the new Strategy was agreed at the IJB in February 2020, with the following priority themes.

[1] A Fairer Scotland for Disabled People: delivery plan - gov.scot

Physical Disabilities Strategy 2020-24		
Accepting and addressing Inequalities	Housing and Support	Specialist services and equipment
Independent living and Active Participation	Employment and Volunteering	Person centred care and support
Communication	Early Intervention and prevention	Accessibility

The impact of Covid19 on services and providers has delayed the planned strategy development work. Action is now being recommenced and we plan to carry out a survey and engage widely with stakeholders in Autumn 2020.

Further information is available through our regular Locality Newsletters.

https://yourcommunitypk.org/2019/01/latest-health-and-wellbeing-newsletters/

National and MSG Performance Indicators related to Objective/National Outcomes

NI 03 - % of adults supported at home who agree that they had a say in how their help, care or support was provided (Health And Care Experience survey – HACE)

NI 04 - % of adults supported at home who agree their health and care services seemed to be well co-ordinated (HACE)

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 (HACE)

NI O8 Carers - % of carers who feel supported to continue in their caring role (HACE)

STRATEGIC OBJECTIVE 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*

Contributes to National Health and Wellbeing Outcomes 1,2, 4, 5 and 7

How well are we doing?

Locality Integrated Care Team (LINCs)

We invested around £1.2 m for additional staffing to enhance our Locality Integrated Care Teams. LINCS is intended to provide a short period of enhanced care, coordinated by a lead professional. The lead professional has access to a range of community support and services, including Home Assessment Recovery Team who will provide additional support when required.

This is enabling us to monitor and manage patients to prevent further deterioration and complications, to prevent hospital admission by providing a range of early interventions and support. It also enables early supported discharges from hospital.

LINCS has now been rolled out across the three localities of Perth and Kinross.

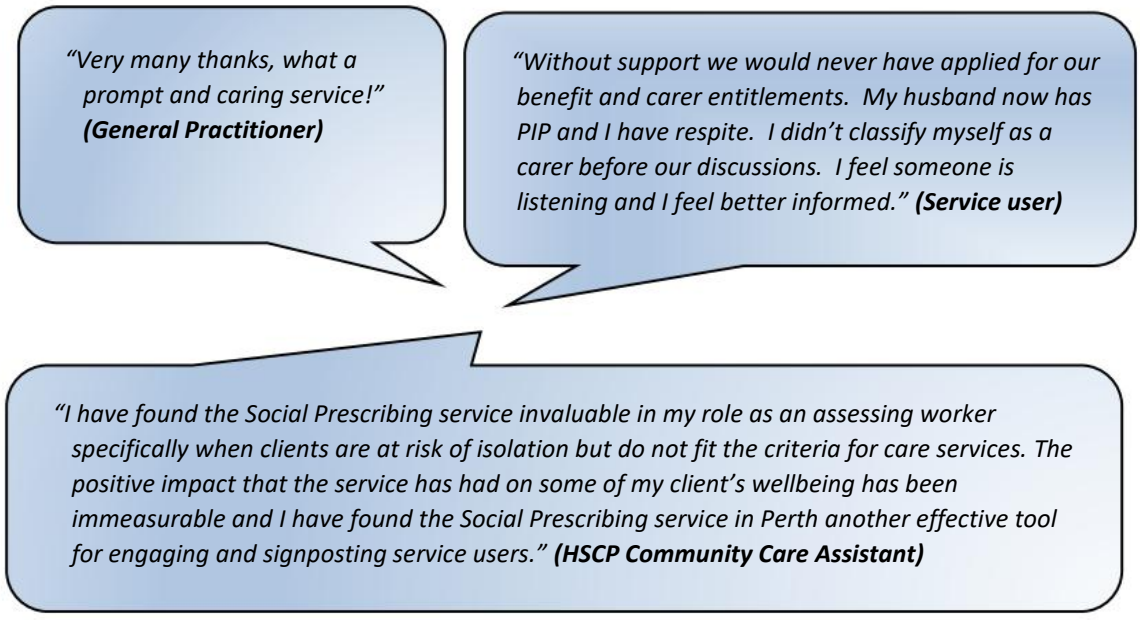
Primary Care

Primary Care is healthcare delivered in the community by health professionals that can be accessed directly usually through self-referral. These professionals include GP's, Nurses, Dentists, Pharmacists, Optometrists and Allied Health Professionals such as podiatrists and physiotherapists

During 2019/20 our Primary Care Improvement Plan for Perth and Kinross was in year 2 of a 3-year implementation period. This involves the establishment of multi-disciplinary teams connected to GP practices, in order that patients can see the right health professional at the right time in the right setting. Progress made to date includes:

- Six Primary Care Mental Health Nursing posts, 2 per locality, have been established to Support the provision of Mental Health services early. Additional mental health capacity has been brought in to support these posts with the introduction of a further 3 well-being support workers. This allows patients to see a mental health professional within their GP practice rather than waiting for a referral. It can be seen from early activity data that 71% of available appointments have been utilised and user feedback has been positive.
- Three Community Link Workers/Social Prescribers have also now been appointed to permanent positions, again bolstering support within GP practices and forming part of a wider group including Healthy Communities Project Officers and Move Ahead Project Officers. This is in keeping with the HSCP's overarching strategy of increased integration of health and social care, as Community Link Workers/Social Prescribers collaborate across local authority services to identify and respond to the specific needs of locality plans, school plans and research data. The HSCP is thus better placed to deliver a person centred service, with a greater level of coordinated activity delivering the best possible outcomes for our communities.

- We have recruited physiotherapists to deliver a dedicated "First Contact Physiotherapy Service' (FCP). This enables patients to access services and treatment directly and more swiftly from the appropriate professional, rather than via traditional referral routes.
  - As at January 2020, 7 clinics are located in Perth City and 3 in the South Locality (Kinross)
  - On average 80 patients per month were seen between January - November 2019
  - Outcomes included: 73% of patients discharged, 15% were referred to Physio, 7% for follow up with FCP and 4% Onward referral
  - As of June, as part of an ongoing Covid response to support other services, FCP service was fast tracked and was accessible from all GP Practices across Perth & Kinross.
  - In July when 645 appointments were available across P&K; 642 of these were filled, demonstrating a 99.53% utilisation of this service.
  - Feedback from patients: 97% of people were either satisfied or very satisfied with the overall quality of physiotherapy assessment and advice received. Comments included "I do not have any negative comments, it is a brilliant service" and "The physio made me feel at ease and spoke in clear simple terms."



Care About Physical Activity (CAPA)

The mental and social health benefits of increased physical activity are widely recognised bringing increased independence, a sense of wellbeing, reduced falls risk, and improved quality of life.

Throughout 2019/20 we continued to support Care About Physical Activity (CAPA) which is a programme being run between Scottish Social Services Council (SSSC), the Care Inspectorate, and Care Homes, and is focused on improving the health and wellbeing of residents through physical activity by improving balance, fitness and strength for older people which will reduce falls that in turn will reduce some of our unplanned admissions for older people.

Other examples of initiatives which support improvements in physical and mental wellbeing include:

- A dementia friendly walking group in partnership with 'Paths for All' has been developed to support 10 care homes across Perth & Kinross;
- Strength and balance exercises have been introduced by the way of apparatus in 5 care homes in Perth and Kinross. This enhances the creation of dementia friendly sensory areas;
- A weekly Golf Memories Group for older adults with dementia and age-related memory conditions;
- Saints Community Trust delivers various initiatives such as Football Memories working with our client groups from mental wellbeing, autism and learning disabilities.

"I have Parkinson's and have to move every day, it is so important to me. I enjoy the posts and getting out and I do sit to stand exercises daily and am improving well. Some days are better than others, but exercise is great for me."

"Since the start of this initiative my health has improved with the walking and exercise that I have been doing, I have lost weight and I have been able to come off my diabetic medication which I am pleased about."

Mental Health

In enhancing community mental health support, we have delivered a Mental Health and Suicide Prevention training programme throughout 2019/20. This raises awareness and links to Mental Health Awareness Week in May, Suicide Prevention Week in September, and Mental Health Awareness Day in October. These campaigns supported our commitment to early intervention and preventative approaches by raising awareness of mental health and suicide and creating informed communities within Perth and Kinross.

National and MSG Performance Indicators related to Objective/National Outcomes

NI 01 - % of adults able to look after their health very well or quite well (HACE)

NI 02 - % of adults supported at home who agree that they are supported to live as independently as possible (HACE)

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 (HACE)

NI 09 - % of adults supported at home who agree they felt safe (HACE)

NI 11 – Premature mortality rate per 100,000

NI 12 – Rate of emergency admissions per 100,000 population for adults

NI 13 – Rate of emergency bed day per 100,000 population for adults

NI 16 – Falls rate per 1,000 population age 65

MSG 1a – Number of emergency admissions

MSG 2a – Number of unscheduled hospital days; acute specialties

MSG 3a – A&E attendances

STRATEGIC OBJECTIVE 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*

Contributes to National Health and Wellbeing outcomes 1,2,3,4,and 9

How well are we doing?

Single Handed Care

To improve the effectiveness of the services we provide and to take a more person-centred approach we are implementing "Single Handed Care". Training on this has now been rolled out to a wider staffing group, enabling people to be supported by one instead of two carers, through the use of appropriate equipment. This delivers tailored packages of care for the individual and improves efficiency in allocating our scarce resources to more people.

Occupational Therapists are integral to the implementation of Single Handed Care and our ambition to integrate our Occupational Therapy service will support the success of this approach. All moving and handling training and refresher courses now include the concept of Single Handed Care ensuring that all our service users can benefit from this service.

Mental Health Services

To deliver on their Mental Health Strategy 2017-2027 the Scottish Government has provided funding through Action 15 to enhance the mental health workforce and improve access to dedicated Mental Health Professionals in all A&E departments, GP practices, police custody suite and in our prisons.

In 2019, we used this funding to create a new post of co-ordinator for the Lighthouse project. This position was filled in January 2020 and enables the service to assist in supporting people in distress, out of hours and at weekends.

Action 15 funding was also used to create a Mental Health Practitioner (MHP) position within the Access Team to now provide person-centred care for individuals in crisis, at point of first contact. This was in addition to Social Prescribers who enhanced our provision for early intervention and prevention, creating a whole systems approach.

These posts provide support to individuals who come into contact with the service but do not necessarily meet the eligibility criteria for more formal social work services. Intervening early to provide appropriate support at this stage provides great benefit to the individual.

Investing in these roles has ensured that in our communities, we can intervene quicker and earlier in a person's deteriorating in mental health and wellbeing issues and support them to have better and more positive outcomes.

Home Assessment and Recovery Team (HART)

Over the last 12 months 45% of people in receipt of reablement via HART were able to re-establish independence within their own home. This represents an improvement on the previous year evidencing our commitment to support people to remain at home for as long as possible, including after discharge from hospital.

Key activities during 2019/20 included:

- Training and Development: Induction and training for new staff has helped retain staff and develop confident carers.
- Inspection by the Care Inspectorate: HART was awarded 'Very Good' gradings for both Quality of Care and Support and Staffing. People using the service reported that they were respected as individuals and treated with dignity and respect. They were positive about the encouragement they receive to have control over their own support and to be as independent as possible.
- Total Mobile: A Project group has taken forward a move to be more digitally enabled. This "Total Mobile" tool improves working practices and efficiency in ways which can also support carer consistency. This has supported a digital solution to real time monitoring of Care at Home provision, falls screening tools, incident reports realising time efficiencies and creating better quality record keeping.

To assess the quality of care delivered by the HART team we have introduced 7-day review, together feedback from service users. The review is based on the key principles within the Health and Social Care Standards. 107 respondents between January 2019 to Mar 2020 provided overall positive feedback on the service. Key highlights from the survey included:

- 100% agreed that they were treated with dignity and respect
- 100% agreed that Members of staff pay attention to details that are important to them
- 98% agreed that staff ask about how people wanted support delivered
- 99% agreed that they have confidence and trust in the staff

Care Homes

As people get older and require more support, Care Homes provide residents with the opportunity to continue to live in homely settings when they are no longer able to do that safely on their own. The HSCP is committed to ensuring that all care homes maximise the quality of care and the experience for their residents.

We continue to engage with Care Home providers on their approach to quality improvement. The Care Inspectorate and Scottish Care are trialling an approach to Care Homes developing their own improvement plans. Four homes in Scotland are involved in this pilot of which two are in Perth and Kinross. Our local Scottish Care Integration Lead is working with these care homes on an individual basis to assist with, care planning, improvement planning and peer support, working closely with the Care Inspectorate.

The staff involved have found this a very positive experience and it has given these teams the ownership of their improvement plan and a commitment to delivering on their plans.

Floating Housing Support and Hostel

Since October 2019, three Housing Support Providers have worked with people who are at risk of losing their tenancy to live independently. This short term, flexible, service works with people to achieve individual outcomes which maximise their independence. A mix of practical and emotional skills are developed which supports people to become self–sustaining and connected to their community. As we transition from the Covid 19 'lockdown' period a range of virtual and face-to-face support is being provided. In partnership with PKC Housing Service this service supports individuals into permanent accommodation. This approach aims to reduce reliance on temporary accommodation, which can have a detrimental effect on a person's health and well-being.

National and MSG Performance Indicators related to Objective/National Outcomes

NI 02 - % of adults supported at home who agree that they are supported to live as independently as possible (HACE)

NI 03 - % of adults supported at home who agree that they had a say in how their help, care or support was provided (HACE)

NI 06 - % of people with positive experience of care at their GP Practice (HACE)

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 (HACE)

NI 08 - % of carers who feel supported to continue in their caring role

STRATEGIC OBJECTIVE 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*

Contributes to National Health and Wellbeing Outcomes 5, 6 and 7

How well are we doing?

Equalities Outcomes

In June 2019, we reported to the IJB on how we are contributing to the Equalities Agenda within our partnership. Examples of the developing work in support of the reduction of health inequalities includes the following:

- In response to increased demand we have increased the number of available British Sign Language (BSL) interpreters. Additionally, BSL interpreters can now engage patients through new video call facilities, which improves access and limits the number of cancelled or missed appointments.
- The Perth and Kinross Gypsy Traveller Strategy was approved by Perth & Kinross Council Housing & Communities Committee in 2018. This is fully supported by the HSCP. An annual Gypsy/Traveller community wellbeing event was held in October 2019 and attracted 112 attendees.
- We continue to support the 'MoveAhead' service. MoveAhead is a locally based support service which enables people with mental health support needs to access opportunities and services in the community. It aims to help people regain confidence self-esteem and enhance individual skills and encourages people to realise their full potential.
- We are promoting Physical Health Check monitoring for individuals who are accessing Adult Mental Health services, Psychiatry of Old Age services and Learning Disability services.
- Recovery Cafes have been developed to provide additional support mechanisms to a range of individuals with varying complex needs from mental health and wellbeing, loneliness, substance use. These have been developed across Perth and Kinross including rural areas.

Carers

At the 'Carers Connect' event in 2019, we worked with carers to assess the availability of peer and community support groups across Perth and Kinross. This identified 46 local groups and organisations Our Carer Support Workers, Community Engagement Team and PKAVS are thus better able to support carers to access community services wherever they live.

We are promoting a digital training resource that has been produced by NHS Education for Scotland and Scottish Social Services Council, to raise awareness of carer issues amongst health and

social care professionals. This updates previous materials to reflect changes following the introduction of the Carers (Scotland) Act 2016. This new resource is now available for all health and care professionals including those in the Third Sector.

To combat inequalities we have commissioned Minority Ethnic Carers of People Project (MECOPP) and PKAVS Minorities Communities Hub to provide support to carers from the gypsy traveller community

Diabetes

We are progressing a range of actions in support of the Type 2 Diabetes (T2D) Prevention, Early Detection and Early Intervention Framework which is being delivered pan Tayside.

- 300 places have been procured for NHS Tayside for the Oviva type 2 education and support programme. Additionally, the Tayside Adult Weight Management Service is also now part of the overall education and support programme. This programme will go live in April 2020
- 580 places for the Slimming World programme have been procured for weight management purposes for people with type 2 diabetes. This is awaiting sign off from NHS information governance.
- The Tayside Adult Weight Management Services are exploring other digital options such as YouTube for sharing resources, presentations and exercise sessions for all to access

National and MSG Performance Indicators related to Objective/National Outcomes

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 (HACE)

NI 08 - % of carers who feel supported to continue in their caring role

STRATEGIC OBJECTIVE 5

MAKING THE BEST USE OF PEOPLE, FACILITIES AND 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.*

Contributes to National Health and Wellbeing Outcomes 2,3 4 and 9

How well are we doing?

Review of Inpatient Rehabilitation

We are reviewing the provision of inpatient rehabilitation beds, assessing need and demand, to ensure equity of access to across Perth & Kinross. This review is also looking at the new community models being introduced to support and maintain people at home for longer (Locality Intermediate Care and Respiratory Services).

Our review has highlighted that given the changes in population need, not all the beds are in the right place to meet the needs of the current and projected population of frail, older people.

This review is also focusing on developing and enhancing community services to support more people at home or in homely environments. These evolving services will support our objective to shift the balance of care, by providing earlier intervention and preventative approaches to care, which allow effective management of more acute care needs in the persons own home and reduce reliance on the use of hospital beds.

Specialist Community Respiratory (Telecare)

We are responding to a recognised gap in the provision of specialist community services for adults living with long term respiratory conditions (mostly housebound COPD, chronic asthma, bronchiectasis or Interstitial Lung Disease). There are around 3,200 people registered with Perth and Kinross GP Practices with a diagnosis of COPD, along with around 1,400 respiratory emergency admissions to hospital in 2019. Many people struggle with chronic respiratory conditions and this will have a major impact on their lives. It is also common for people with respiratory conditions to have additional long-term conditions.

In response we are developing a new service that will align with the Locality Intermediate Care service. The service will provide an earlier response and assessment and self-management support for people living with COPD and asthma. To support self-management approaches, SMART technology is being identified to provide patient specific education and information links to community services.

Primary Care

As part of the Primary Care Improvement Plan a range of new services have been developed. The following examples illustrate how we are making best use of resources and giving better access to patients, so that they can be treated by the right professional in the right location at the right time.

- Advanced Nurse Practitioners (ANP) have been recruited to work alongside our General Practitioners and our Locality Integrated Care Service to provide specialist support to frail adults with complex needs and prevent unnecessary admissions and readmissions to hospital, or premature entry into residential care.
- The First Contact Physiotherapy Service provides access for patients through their GP, to specialist physiotherapists. This provides a swift response and diverts people from specialist services, making best use of resources by reducing the need for ongoing support.

Staffing

Making the Best Use of People, Facilities and Resources

We understand that we need a confident, competent and professional workforce who feel, supported, valued and equipped to deliver the Partnership's vision and priorities. We also need to plan to address some key issues, including the high turnover and shortages of suitably skilled staff in key areas and recruitment and retention challenges.

We recognise that our staff are our greatest asset and that it is important to have their feedback., We engage in different ways with staff, including through the annual iMatter survey the results from which are as follows:

iMatters Survey Questions	Health and Social Care Staff			
	2017/18	2018/19	2019/20	Difference compared to previous year
I am clear what is expected of me at work	86.5%	88.5%	**86.0%**	↓ **2.5%**
My team has a good team spirit	75.5%	79.0%	**84.0%**	↑ **5.0%**
I am treated with dignity and respect as an individual	82.0%	82.0%	**84.0%**	↑ **2.0%**
I know how my job contributes to the organisation's objectives	79.5%	80.5%	**81.0%**	↑ **0.5%**
I feel appreciated for the work I do	68.0%	70.5%	**75.0%**	↑ **4.5%**

**A joint Health and Social Care iMatters Staff Survey was carried out in 2019. The 2017/18 and 2018/19 surveys were carried out separately but have be combined to allow comparison.*

We are pleased to see an overall improvement in most key indicators. However, there is slight decline in how staff feel about what is expected of them at work. To address this we have been collaborating with our workforce to develop the action plan that will be implemented in 2020/21.

Workforce Planning

From last year's survey, we said we would continue to improve services and develop new ways of working, and that it was essential we have our staff in the right places.

In response, we embarked on a series of digital workshops to build our understanding of the key digital and technical infrastructures that could support our workforce in their daily activities and in their engagement with our service users. This has resulted in a Digital Strategy Group whose role now is to develop these key action plans for delivery during the coming years.

Supporting Staff – Healthy Working Lives

Last year we said we would undertake a programme of work to improve attendance and support the workforce. Planned actions to improve health and wellbeing and reduce sickness absence have included:

- HR Teams continuing to work closely with service management teams to identify areas that require additional support and proactively advise and support managers, particularly in teams where absence rates are high;
- the Council reviewing current attendance policies in collaboration with trade unions;
- close working with HR colleagues to deliver training on supporting attendance;
- ongoing health improvement activities and support through Healthy Working.

The result of this is that:

- We held accountability meetings with managers to support them to manage and improve attendance.
- We have seen an improvement in absence and a reduction long term absence over the year.
- We have had an iMatters and pulse survey undertaken where staff indicated that they felt well supported and we are working on the outcome of that to identify more actions

The work of the Learning and Development team is grounded in the values of participation and collaboration in order to support services including Team and Locality Support, Partnership Opportunities and Qualification Support.

During 2019/20, we have seen a wide range of learning and development sessions, quality improvement programmes and, accreditations taking place across the Partnership.

Some of the highlights include:

- Community Mental Health Nursing learning and development session to share information on developments across mental health services and consider future service delivery.
- South Locality staff had the opportunity to explore the organisational vision and values, the team values and to develop a South Locality mission/purpose statement using the 9 National Health and Wellbeing Outcomes, the Health and Social Care Standards and the Perth & Kinross HSCP Strategic Vision.
- Clinical and Professional Team Manager (Perth City) Lindsey Griffin, successfully achieved the Queens Nursing Institute (Scotland) Award in August 2019. Lindsey was the only nurse from Perth and Kinross as well as the only Mental Health Nurse from across Tayside to achieve the award. The award is internationally recognised and requires sponsorship from an Executive Nurse Director. In

order to achieve the award, Lindsey undertook an ongoing piece of development around Monitoring Physical Health within Mental Health service users.

- Staff from SouthLocality were involved in the SSSC Integrated Working Research as one of 3 sites in Scotland. The research was to gain deeper understanding of the workforce's experience of integrating health and social care, consider the conditions required for effective integrated working and identify what skills, competencies, qualities, values, behaviours and qualifications the workforce have or need in an integrated working environment.
- Perth City has successfully secured a place for a team of their health and social care staff commencing in October 2019 on Tayside's Quality Improvement Programme (TQuiP). Evidence of joint working, joint learning and development and the enhancement of quality improvement skills across integrated care.
- Pitlochry GP Unit have undertaken Values Management approach to service development and team working supported by the Improvement Academy. Expected outcome is to develop a team-based ethos of continuous improvement. It gives the team the tools and skills to do this in a structured and coordinated way while managing costs and focusing on the information that is important to them to reduce waste, harm and variation.

UPDATE ON SUMMARY OF PRIORITY IMPROVEMENTS FOR 2019/20

1.	**We require to be clearer about our performance, our achievements and the impact of our activity.** During 2019/20 we created and approved our performance framework. This framework provides structure around our performance reporting to ensure that our achievements and the impact of our activities are appropriately communicated. Examples of improvements that have been made in this regard are the publication of our first quarterly performance report in February 2020 as well as the creation of regular Clinical and Care Governance locality reports.
2.	**We will develop a performance framework that reports more effectively and routinely across a number of agreed measures.** Update: See above**.**
3.	**We will perform a "deep dive" audit to explore the root cause of the increase in Accident & Emergency (A&E) attendance.** Update: A model has now been developed that will deliver two independent outcomes during 2020: 1. Overall reduction in self-presenters to A&E where care can be delivered more appropriately 2. Effective management and scheduling of the flow of self-presenters to A&E and local Board services We will work with colleagues across Health and Social Care to better understand patient presentations.
4.	**We will ensure that all future reporting includes a benchmark comparative with Scottish averages and will also include upper quartile performance markers.** Update: The core data used within the performance framework is the National Indicators agreed with the Scottish Government. These indicators are expressed in percentages or rates per 100,000 for comparative purposes. Work has not been progressed in respect to further comparisons, for example quartile performance. In future we will provide additional performance measures based on HSCPs which are comparable as well as Scotland as a whole.
5.	**We will work closer with our communities to better understand public perception that services provided are not making people feel part of the local community.** Update: Engagement with our communities is supported by our Community Engagement Workers to determine people's priorities and perceptions of services being delivered, informing service improvements. A review of the Strategic Commissioning Plan was undertaken during 2019/20. Over a 5-week period in July/August 2019 the Health & Social Care Partnership engaged with local Perth & Kinross Communities to better determine what Strategic Priorities the Partnership should focus on over the next 3 - 5 years.

6.	**We will also perform a "deep dive" audit to explore the root cause of an increase in readmissions to a care establishment.** Update: A number of pieces or work has been undertaken during 2019/20 to understand readmissions. These will now be pulled together by a short life working group aimed at identifying any specific improvement actions which can be taken.
7.	**We will ensure a greater focus on physical disabilities and develop a performance framework to monitor the quality and effectiveness of service provision in that area.** Update: During 2019/20 work was undertaken to develop a new strategy and action plan 2020 - 2024 for people with a physical disability, including those with sight loss and hearing loss. The outline for the new Strategy was agreed at the IJB in February 2020. This will focus our resources from statutory and commissioned services and the community to ensure a person centred whole system approach is taken.
8.	**As part of our workforce plan, we will ensure robust auditing of our sickness/absence occurrence to better understand the root causes of such and enable mitigating actions to be put in place.** Update: During 2019/20 Social Work and Social Care saw an improvement in overall absence including long term. During this reporting period we held supportive meetings along with managers and Human Resource services to better understand sickness absence causes and what can be done to improve absence. Similarly within Health Services sickness absence is managed robustly through the Promoting Attendance At Work Policy (PAWS). The Health team receive monthly Absence Rate Information (AIR) reports which identify areas of concern. On a monthly basis these are worked through with individual managers, overseen by the Head of Health and Lead HR manager, in relation to standard setting and promoting attendance at work. The iMatters workforce engagement tool was also used for the first time across health and social care where, overall, staff indicated that they felt well supported. Further elements of the survey results are now being used to develop and further enhance the wellbeing of our staff.

SECTION 3

HOSTED SERVICES

Delegated and Hosted services

Across Tayside there are three Health and Social Care Partnerships, aligned to the three local authority areas and reporting to their respective IJBs. Each Integrated Joint Board is responsible for the strategic planning and delivery of a range of services that are ***delegated*** to them by their Council and by NHS Tayside. Additionally there are a range of services which are hosted by each of the 3 Integration Joint Boards and are delivered on a pan-Tayside basis.
More information on the range of services delivered by Perth and Kinross Integration Joint Board is available here.

Perth and Kinross Hosted Services

- **Inpatient Mental Health and Learning Disability Services**
  (Note that the operational responsibility for inpatient Mental Health Services transferred to the new Interim Director for Mental Health Services in NHS Tayside in June).

  During the reporting period the Inpatient Mental Health and Learning Disability service has undergone a sustained period of improvement in a broad range of areas.

  The NHS Tayside Mental Health Nursing Standards for person centred care was referenced by the Mental Welfare Commission as an area of good practice and subsequently won a National award in November 2019.

  This achievement is complimented by our continued work towards rights based and person centred care to improve outcomes, support recovery and sustain wellbeing. Keeping the patient at the centre of all that we do, all inpatient wards have been focused on improving structured activity and therapeutic engagement. This has been developed with patients, and their carers, considering the whole process with the emphasis on linking activity.

  Continuing this theme we are working towards person centred visiting which seeks to provide flexible visiting for those family members and friends that matter the most in the lives of our patients.

  Through our "Listen, Learn Change" action plan which follows the "Trust and Respect" report, we have implemented measures which create systematic opportunities for learning lessons following challenging or difficult events as well as our related interventions. In particular we strive to deliver the Least Restrictive Care options whilst also reflecting on the reasons why an episode occurred, what could have been done differently and also examine the intervention itself to ensure the least restrictive care has been provided.

  To continue the success of this approach and to ensure transparency we report our restraint data on a monthly basis to the Scottish Patient Safety Programme for Mental Health. To maximise opportunities to learn and improve, we also report this data

internally within each ward and it is then also reviewed by our Least Restrictive Practice Steering Group.

In relation to patient self-harm, following an initiative developed in Ward 1, Carseview Centre, we have developed the use of self-soothing techniques and the use of alternatives to self-harm boxes. This approach has been successfully developed and implemented in collaboration with patients with lived experience and through gathering patient feedback.

It is recognised that to sustain the progress made over this period and to continue to develop our services we must invest in the development of our staff. In this regard we have a set aim of ensuring that 95% of inpatient staff will receive trauma-informed training commensurate with their role by the end of 2020. Achievement against this aim is being supported by our Senior Nurse for Practice Development and our Lead Nurse who have undertaken Scottish Trauma Leaders training. More broadly we have created and implemented a weekly programme of education and learning for staff. This has proved to be very successful and is well received with over 1000 attendees having taken part so far.

- **Public Dental Services/Community Dental Services**

  We continued to focus on providing high-quality and accessible care for patients who have special care needs or who have difficulty accessing mainstream clinical services. Referrals to the Public Dental Service (PDS) for dentally anxious patients continue to increase and we have organised additional sedation training to meet this demand. PDS has supported three independent practitioners through the enhanced practitioner training enabling them to care for residents in designated care homes.

- **Prison Healthcare**

  Prison Healthcare operational activity this year focused on ongoing service improvement following an inspection from Her Majesty's Inspectorate of Prisons and continuing with the Patient Safety Collaborative. The service has worked hard to improve the provision of high-quality healthcare services within both HMP Perth and HMP Castle Huntly for both planned and unscheduled care. In addition to this the service has had to respond to increase in prisoner numbers in HMP Perth. Despite these challenges the service has made some significant progress in relation to the provision of healthcare which has been commended by HMIPS in a follow-up inspection. The service was also successful in getting a poster accepted at the International Quality Forum held in Glasgow in March 2019: the poster and work going on within Prison Healthcare was highlighted in the closing remarks of the conference as an area of excellent work.

- **Podiatry**

  The Podiatry service continues to develop its workforce to provide person-centred approaches to wellbeing, prevention, care and support. We have increased the use of technology enabled care with partner organisations and providers of personal care to deliver foot health care education sessions remotely and provide individual 'Near Me'

consultations. We engage with our staff on service improvement through our podiatry service improvement group ensuring engagement and consultation of staff at all levels.

The service has continued to build on community capability for personal footcare through expanding work with local volunteer groups across Tayside and now has 3 groups in Perth and Kinross, 1 in Angus 1 in Dundee ready to start once restrictions allow.

SECTION 4

SCRUTINY AND INSPECTION OF SERVICES

The HSCP Care and Professional Governance Forum (CPGF) has responsibility for ensuring appropriate scrutiny, assurance and advice within the HSCP, and is co-chaired by the Chief Social Work Officer and Associate Medical Director.

The CPGF receives assurance reports 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 shared learning as well as ensuring effective Clinical and Care Governance processes across the locality.

Overall, registered care services (internal and external) in Perth and Kinross are providing high quality care to local people. In 2019/20, 86% of our care and care services for adults were rated good or better in Care Inspectorate Inspections and this is higher than the Scotland figure of 82%.

ID	Indicator	Latest Data available*	2016/17 Perth and Kinross	2017/18 Perth and Kinross	2018/19 Perth and Kinross	Latest Perth and Kinross	What is our trend over last three years	Latest Scotland	How we compared to Scotland
NI 17	Proportion of care and care services rated good or better in Care Inspectorate inspections	2019/20	83%	88%	87%	86%	↑ 3%	82%	↑ 4%

Highlights from 2019/20

Care Inspectorate

Perth and Kinross HSCP has 10 registered services, 6 of which were inspected in 2019/20: Parkdale Care Home and Day Service, New Rannoch Day Centre and Dalweem Care Home were inspected under the new inspection frameworks; Dalweem were inspected at end of February 2020 (due to Covid19 the final report has still to be published). Home Assessment and Recovery Team (HART) and Adults with Learning Disabilities Supported Living were inspected under the older inspection frameworks.

Care Homes and Day Services

Of the 4 services inspected under the new frameworks, 12 quality themes were assessed in the following key areas: How well do we support people's wellbeing? How good is our leadership? How good is our staff team? and How well is our care and support planned?

Out of the 12 quality themes assessed; 1 received Excellent (Level 6), 7 Very Good (Level 5) and 4 Adequate (Level 3). As part of the new inspection framework, the Care Inspectorate evaluate the following areas under 'How well do we support people's wellbeing?', grading is detailed in the table below:

Theme	Assessment
People experience compassion, dignity and respect	3 services received Excellent and 1 Good
People get the most out of life	2 services received Excellent, 1 Very Good and 1 Good
People's health benefits from their care and support	1 Service received Excellent, 2 Very Good and 1 Adequate

This demonstrates that services continue to perform well and offer high quality care. The care Inspectorate made no requirements or recommendations during their inspections. Feedback gathered during the inspection process was overall positive, comments included:

Home Assessment and Recovery Team (HART) and Adults with Learning Disabilities Supported Living

The Home Assessment and Recovery Team were inspected during January 2020 and Adults with Learning Disabilities (Supported Living Team) in September 2019, inspections were based on the older inspection frameworks.

Grading awarded at the time of inspection	Home Assessment Recovery Team (HART)	Adults with LD Supported Living
Care and Support	Very Good (Level 5)	Very Good (Level 5)
Environment	Not Assessed	Not Assessed
Staffing	Very Good (Level 5)	Not Assessed
Management and Leadership	Not Assessed	Very Good (Level 5)

Of the quality themes assessed both services received Very Good for the Quality of Care and Support, with HART receiving Very Good for Staffing and Adults with Learning Disabilities Very Good for Management and Leadership.

No requirements or recommendations were made at the time of inspections. Feedback from people using the services and their relatives' or carers was overall positive, comments included:

"My needs are being met and I am being encouraged to be as independent as I can and if my needs change, I have support from staff who have all been excellent with me in my short time with the service." (HART)

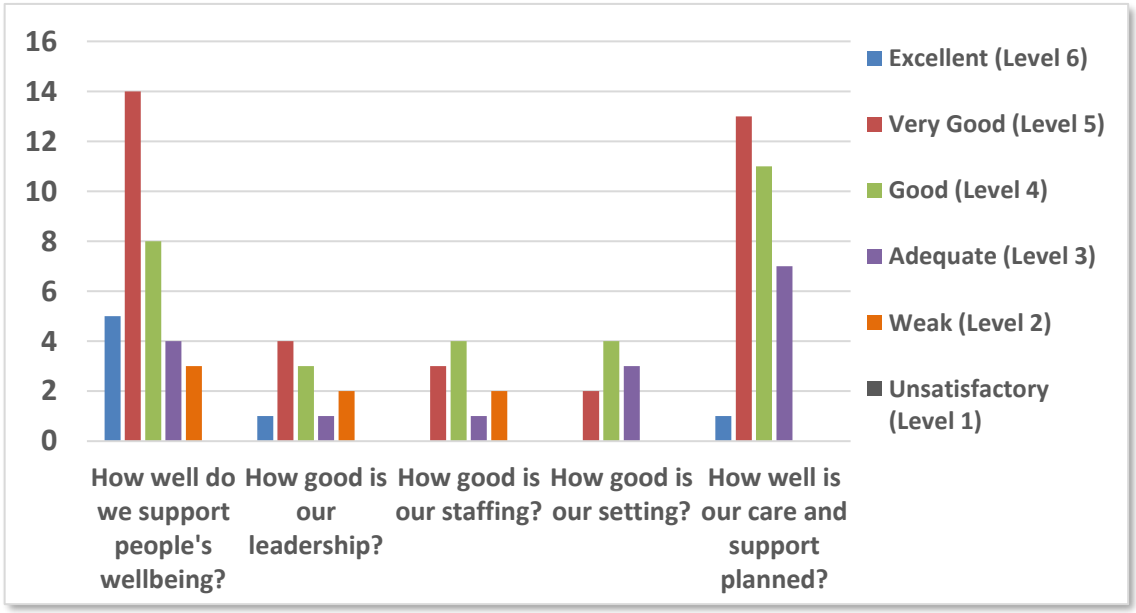
"I do lots activities", "Really happy with the Service", "Staff are all very professional" and "Very Good Communication" (Supported Living Team)

Commissioned Services

The following section provides details on grading awarded by the Care Inspectorate for inspections carried out during 2019/20. It includes services for Care Homes for Older People (inspected under the new frameworks), Care at Home for Older People and Supported Living Services for people with Learning Disabilities and Mental Health.

Care Home Providers

A total of 96 quality themes were inspected across Care Home Providers and the majority of gradings were good and above with very small numbers awarded adequate/weak evaluation, no services received unsatisfactory. Grading is detailed in the chart below:

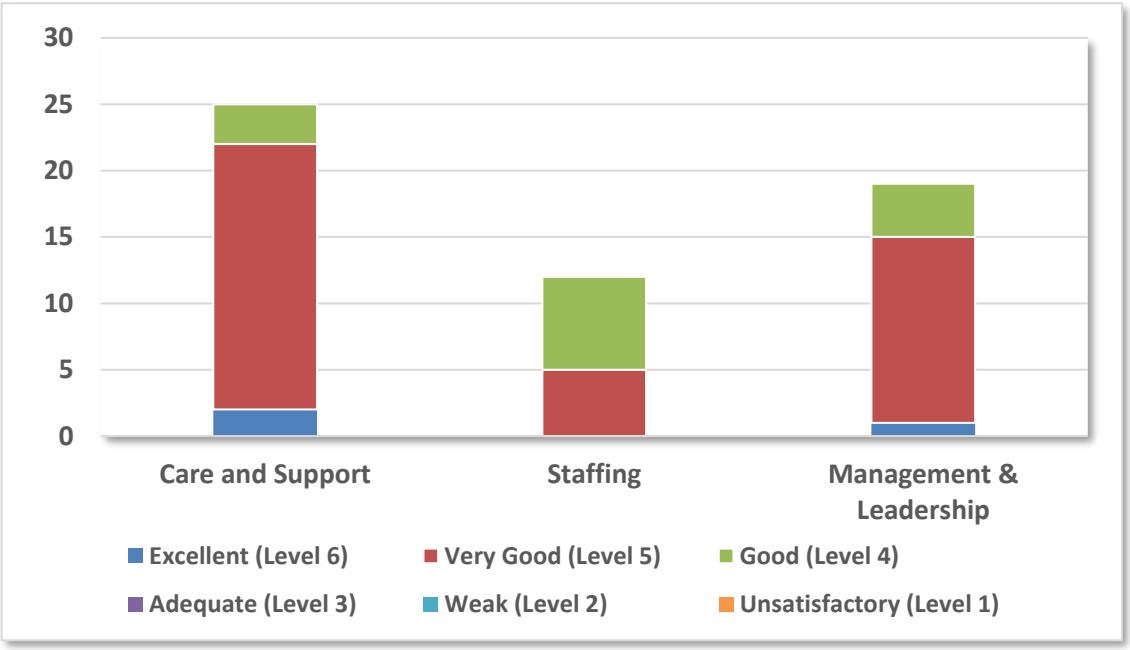


Taking a closer look at 'How well do we support people's wellbeing?' 14.7% of services received Excellent, 64.7% Very Good/Good and 20.6% at Adequate/Weak, no services received unsatisfactory grading.

Care at Home Providers and Supported Living Services

A total of 56 quality themes were inspected across Care at Home Providers and Supported Living services for Mental Health and Learning Disabilities (inspected under the older frameworks).

Grading detailed in the chart below highlights the majority of gradings were good and above, no services were awarded weak/adequate or unsatisfactory evaluation.



Feedback is gathered during the inspection process for Care Homes, Care at Home Providers and Supported Living services, comments included:

"My family can come and visit whenever they want".

"They are good at passing on information, the communication is excellent." (Care Homes)

'People have different needs, and this was reflected in how they received their support. Happy with the service and carers.' (Care at Home)

'Scottish Autism has made a remarkable difference to my relative's life. All carers that attend to my relative are all caring and competent in their job. This service is a god send'. (Scottish Autism)

Health Improvement Scotland

HMIPS Inspection

The Prison Healthcare service was inspected in October 2018. Following this, the service developed an improvement plan which identified 62 actions to support the issues identified as well as to continue to progress with the ongoing work around wider service improvement. All but one of these actions are now complete; the remaining action relates to reducing the time taken for medicines administration, and the service continues to identify ways of achieving this.

A return visit to HMP Perth took place in November 2018, where a further 9 actions were identified. All but one of these actions is now complete; the remaining action is regarding securing a Clinical Psychologist, and this is being progressed.

A further meeting was subsequently held in March 2020 at HMP Perth. The inspectors were assured that there was significant improvement made since the initial full inspection in May 2018 and the subsequent follow-up visit in November 2018, and they commended the commitment to improvements demonstrated.

Mental Welfare Commission

During 2019/20, Amulree Ward, Moredun Ward, Garry Ward and Tummel Ward at Murray Royal Hospital in Perth and the Learning Disability Assessment Unit, Carseview Centre, Dundee were visited by the Mental Welfare Commission.

TAYSIDE HOSTED SERVICES

Amulree and Moredun Wards, Murray Royal Hospital, Perth (Inpatient Mental Health)

Very positive feedback was received from the inspectors in relation to staff engagement with and support to patients. Patients were involved in meaningful activities and patients themselves spoke very positively about the support from and commitment of staff.

A total of 8 recommendations were made in relation to improved care planning, prescribing monitoring, patient involvement in planning activities, documentation of MDT meetings and in relation to improving the environment to support independent living. During the year, an improved approach to care planning has been introduced with care plan audits undertaken routinely to review for person centeredness and involvement of patients and carers. Weekly prescribing audit and monitoring is now in place. Activity champions have been appointed to plan structured patient activity. In relation to the environment and independent living, the whole estate is being reviewed to optimise the therapeutic environment.

Learning Disability Assessment Unit, Carseview Centre, Dundee (Inpatient Learning Disabilities)

Very positive feedback was received from inspectors in relation to patients who spoke very highly of the care and support from staff. The range of different professionals involved in the provision of care was positively noted including the Independent Sector.

A total of 3 recommendations were made. These were in relation to ensuring staffing for the ward is adequate, audit and review of care plans and the review of the environment to enhance space and condition.

In relation to staffing levels, recruitment remains a significant issue with supplementary staffing required on a daily basis. In relation to the environment, the whole estate is being reviewed to optimise the therapeutic environment.

Quality improvement work is ongoing in relation to Care Plan Review.

PERTH AND KINROSS HEALTH AND SOCIAL CARE PARTNERSHIP SERVICES

Garry and Tummel Wards, Murray Royal Hospital, Perth (Psychiatry of Old Age)

Very positive feedback was received from inspectors in relation to all family members who spoke highly of the staff and care their relatives received and that staff were always available and were supportive during difficult periods. Care plans were considered to be detailed, person centred and reviewed regularly.

A total of 3 recommendations were made in relation to consistency of audit of care plans, review of re-admissions to consider adequacy of discharge planning and community follow up care and record keeping in relation to prescribing.

Improvements have now been implemented in relation to person centred care planning and record keeping. Robust discharge planning is in place across both Garry and Tummel Wards. Both areas now have a designated Social worker to support discharge planning. Early referral to the Older Peoples Community Mental Health Team ensures there is support for individuals and their carers/relatives.

SECTION 5

FINANCIAL PERFORMANCE & BEST VALUE

Financial Performance 2019/20

The 2019/20 Financial Plan set out that based on the budget offers from Perth & Kinross Council and NHS Tayside, financial balance was not anticipated with an overall gap of £4.168m forecast due to legacy funding issues and scale of demand and pay/price pressures.

Across Core Health and Social Care services, the Financial Plan set out anticipated recurring savings of £2.6m. The level of savings required reflects the underlying level of unavoidable cost and demand pressures facing social care services in particular.

Financial performance for the year compared to Financial Plan is summarised in the table below:

		Financial Plan 2019/20	FRP Mid-Year 2019/20	2019/20 Year End Out-turn	Movement from Plan
	Finance Plan/Forecast	Over / (under) £m	Over / (under) £m	Over / (under) £m	Over / (under) £m
Core	PKHSCP	0.475	0.246	0.550	0.075
Other Hosted	ALL HSCP	0	(0.097)	(0.364)	(0.364)
Prescribing	NHST	0.752	0.322	(0.442)	(1.194)
GMS	NHST	0	0.123	(0.020)	(0.020)
IPMH	PKHSCP	0.574	0.672	0.623	0.049
Health		1.801	1.266	0.0347	(1.453)
Social Care	PKHSCP	2.367	2.053	1.451	(0.916)
Total		**4.168**	**3.319**	**1.798**	**(2.370)**

The out-turn in 2019/20 was an overspend of £1.798m. This compared to the financial plan deficit of £4.168m and a subsequent Financial Recovery Plan Target of £3.319m agreed with both Partner Bodies and the IJB during 2019/20. The significant improvement in out-turn against plan has largely been driven by GP Prescribing which has benefited from higher than anticipated national rebates and profit sharing claw backs. The key areas of overspend are:

- The Core Health Services year end overspend is driven by the underlying financial deficit of £0.475m arising from funding issues in relation to complex care pressures. Overspends in

inpatient beds during 2019/20 due to numbers and complexity of patients has been largely been managed through recovery plan actions and high levels of vacancies in some services.

- PKIJB's £0.623m share of an overall £1.8m overspend in Tayside Inpatient Mental Health Services was largely predicted as part of the Financial Plan and is driven by medical locum costs required to cover significant vacancies.
- Social Care year end overspend is largely driven by the underlying financial deficit of £2.367m arising from funding issues in relation to complex care packages and loss of charging income. Financial recovery plan actions and lower than anticipated spend on Care at Home have offset this at the year end.

At the year-end both Perth & Kinross Council and NHS Tayside increased the devolved budget to the IJB by £1.451m and £0.347m respectively, in order to support delivery of breakeven for 2019/20 in line with the Integration Scheme.

Of £2.6m approved savings within Core Health and Social Care, £2.5m were delivered (96%). During 2019/20, funding was received from Scottish Government for a number of initiatives. These included Mental Health Action 15 monies, Alcohol & Drug Partnership Funding and funding to implement the Primary Care Improvement Plan. The under spend of £1.159m against improvement funds in 2019/20 has been transferred to an earmarked IJB reserve to meet future year commitments.

Additional costs incurred in relation to Covid 19 in 2019/20 were met in full by the Scottish Government and had no impact on financial out-turn.

Covid-19, Financial Outlook and Plans for the Future

At the end of March 2020, the IJB approved 3 Year Financial Recovery aimed at delivering financial balance over the period with early investment in early intervention and prevention expected to deliver longer term benefits. However, whilst Perth & Kinross Council were able to meet the budget requisition in full, a gap remains in respect of Health services of £1.2m (excluding Inpatient mental Health Services).

The Covid 19 Pandemic impacted on service delivery from early March 2020. It is now recognised that it will be an ongoing challenge to varying levels for the foreseeable future with levels of social distancing and lockdown measures likely to be in place for 12 months or more. For health and social care services across Perth & Kinross the ongoing constraints of PPE use, isolation and shielding of both staff and service users has a significant impact on the ability to deliver services in the same way. The challenge is how PKHSCP rebuilds health and social care services whilst maintaining service capacity to respond to a potential further surge in Covid-19 activity.

The Covid-19 Pandemic response by PKHSCP has resulted in a dramatic and unprecedented level of change in how day to day services are delivered with new access channels, new ways of working implemented including significant use of digital and telephone services, as well as significant efforts to free up hospital bed capacity. Going forward into the recovery phase we are identifying how these changes were delivered and which changes should now be embedded in service models and practice moving forward, seizing the good practice and innovation that has emerged.

Predicting the immediate and future financial implications of the pandemic is extremely challenging. At this stage it is assumed that there will be sufficient Scottish Government to fund the

additional net costs. PKHSCP is working closely with the Scottish Government to provide necessary assurance for funding to be allocated for all of the additional activities and costs set out in the PKHSCP Mobilisation Plan. However, our estimates at this stage are subject to significant change. The further development of the PKHSCP Remobilisation Plan will set out a range of further service changes as the focus shifts from response to recovery and then to renewal in line with the Scottish Governments Re-Mobilise, Recover, Redesign Framework. A fundamental review of Strategic Objectives and the 3 Year Financial Recovery Plan will be required.

Workforce planning and development will be of upmost importance and ensuring the necessary capacity and expertise to support service leaders as they seek to embrace change creatively will be critical. In parallel, the historic gaps in leadership capacity must be addressed to ensure all opportunities can be seized with the momentum required.

Best Value

Best Value is about creating an effective organisational context from which public bodies can deliver key outcomes. The following four themes are considered to be the building blocks on which to deliver good outcomes by ensuring that they are delivered in a manner which is economic, efficient, sustainable and supportive of continuous improvement. The key arrangements in place within the IJB which support each theme are also set out.

Vision and Values

The IJB has agreed a Strategic Plan which sets out its key aims and ambitions and which guides the transformation of devolved Health and Social Care services lead by the Chief Officer and the wider Perth and Kinross HSCP Team. A refreshed Strategic Plan has been developed in close consultation with a wide range of stakeholders and this informs priorities moving forward.

Effective Partnerships

A communication and engagement group has been established to ensure that the most effective routes are identified to engage with stakeholders and partners in development of plans for service redesign. Partnership working with the Third Sector continues to develop and deepen. A key priority emerging as part of Covid 19 Remobilisation is the further development engagement with the Third Sector and with wider Communities.

Governance and Accountability

The governance framework is the rules and practices by which the IJB ensures that decision-making is accountable, transparent and carried out with integrity. The IJB undertakes an annual review of its governance arrangements based on CIPFA Good Governance Principles. The IJB is able to demonstrate structures, policies and leadership behaviours which demonstrate good standards of governance and accountability. In particular the robust financial planning arrangements and the

publication of this Annual Performance Report give a clear demonstration of our best value approach. A Partnership Improvement Plan has been developed which consolidates the improvements planned to strengthen the effectiveness of our delivery arrangements. This consolidates actions identified as part of our own self-assessment and from external review. Our ability to progress a number of the developments has been impacted by Covid 19. In parallel, responsive changes have been required to support PKHSCP's response to Covid 19.

Use of Resources

The IJB is now supported by a robust 3-Year Financial Planning process which forms the basis for budget agreement each year with NHS Tayside and Perth & Kinross Council. Performance against the Financial Plan is reported to the IJB on a regular basis throughout the year. All significant service reviews considered by the IJB are supported by an effective option appraisal. A budget review group has been established to ensure that investment and disinvestment plans are in line with Strategic Plan objectives. Whilst the impact of Covid 19 on future financial sustainability is currently unknown it is clear that robust prioritisation of resources will be key. PKHSCPs robust financial planning mechanisms will support this well moving forward.

Performance Management

Developing a consistent approach to performance review across all areas of the IJB has been a key objective in 2019/20 and a new framework for reporting was agreed by the Audit & Performance Committee in December 2019 that has been used as the basis for reporting in this Annual Performance Report.

Next Steps

The IJBs 3 Year Financial Recovery Plan reflects the economic outlook beyond 2020/21, adopting a strategic and sustainable approach linked to the delivery of priorities as detailed in our Strategic Plan. These priorities will provide a strong focus for future budget decisions. As we move into the remobilisation phase, we hope to embrace many of the positive changes over a difficult pandemic response period and accelerate delivery of strategic plan objectives to support future financial sustainability.

APPENDIX

NATIONAL INDICATOR TABLES

Performance Key – we have used the following definitions to set the colour and arrows:	**We are within 3%, or are meeting or exceeding the number we compare against**		**We are between 3% and 6% away from meeting the number we compare against**		**We are more than 6% away from meeting the number we compare against**	**An arrow indicates the direction the numbers are going in**

ID	Indicator	Latest Data available	2015/16 Perth and Kinross	2017/18 Perth and Kinross	Latest Perth and Kinross	What is our trend over last three years		Latest Scotland	How we compared to Scotland	
NI 01	% of adults able to look after their health very well or quite well	2017/18	95.4%	94.6%	94.6%	↓	0.7%	93.0%	↑	1.6%
NI 02	% of adults supported at home who agree that they are supported to live as independently as possible	2017/18	81.4%	83.0%	83.0%	↑	1.5%	81.0%	↑	2.0%
NI 03	% of adults supported at home who agree that they had a say in how their help, care or support was provided	2017/18	81.8%	77.7%	77.7%	↓	4.1%	76.0%	↑	1.7%
NI 04	% of adults supported at home who agree that their health and care services seemed to be well co-ordinated	2017/18	75.5%	74.5%	74.5%	↓	1.0%	74.0%	↑	0.5%
NI 05	Percentage of adults receiving any care or support who rate it as excellent or good	2017/18	83.4%	81.3%	81.3%	↓	2.1%	81.0%	↑	0.3%
NI 06	% of people with positive experience of care at their GP practice.	2017/18	91.3%	88.4%	88.4%	↓	2.9%	83.0%	↑	5.4%
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.	2017/18	83.6%	80.6%	80.6%	↓	3.0%	80.0%	↑	0.6%
NI 08	% of carers who feel supported to continue in their caring role	2017/18	40.3%	40.9%	40.9%	↑	0.6%	37.0%	↑	3.9%
NI 09	% of adults supported at home who agreed they felt safe.	2017/18	79.7%	84.9%	84.9%	↑	5.2%	80.0%	↑	4.9%

Note: The above indicators are from the Health and Care Experience Survey (HACE) which is undertaken every two years. Due to Covid-19, results for 2019/20 are not available.

ID	Indicator	Latest Data available	2016/17 Perth and Kinross	2017/18 Perth and Kinross	2018/19 Perth and Kinross	Latest Perth and Kinross	What is our trend over last three years		Latest Scotland	How we compared to Scotland	
NI 11	Premature Mortality rate per 100,000	2018 Calendar Year	348	364	350	350	↑	2	432	↓	82
NI 12	Rate of emergency admissions per 100,000 population for adults	2019 Calendar Year	11,159	10,777	10,947	11,513	↑	354	12,602	↓	1,089
NI 13	Rate of emergency bed day per 100,000 population for adults	2019 Calendar Year	118,411	109,670	107,609	106,791	↓	11,620	117,478	↓	10,687
NI 14	Readmissions to hospital within 28 days of discharge per 1,000 admissions	2019 Calendar Year	118	112	115	115	↓	3	104	↑	11
NI 15	Proportion of last 6 months of life spent at home or in a community setting	2019 Calendar Year	88.24%	89.52%	89.56%	89.76%	↑	1.52%	88.63%	↑	1.13%
NI 16	Falls rate per 1,000 population aged 65+	2019 Calendar Year	21.70	21.44	22.13	22.70	↑	1.00	22.69	↑	0.014
NI 17	Proportion of care and care services rated good or better in Care Inspectorate inspections	2019/20	83%	88%	87%	86%	↑	2.9%	82%	↑	4%
NI 18	Percentage 18+ with intensive social care needs receiving care at home	2018 Calendar Year	56.93%	58.08%	60.73%	60.73%	↑	3.80%	62.08%	↑	1.35%
NI 19	Number of days people aged 75+ spend in hospital when they are ready to be discharged per 1,000 population	2019 Calendar Year	866	658	548	644	↓	222	783	↓	139
NI 20	Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	2019 Calendar Year	25.68%	26.51%	25.61%	24.93%	↓	0.75%	23.18%	↑	1.76%

Note: Due to data completeness issues in the rest of Scotland for 2019/20, it has been advised by Public Health Scotland that the Scotland baseline should be based on 2019 calendar year for most national indicators. Updated data for NI11 and NI18 is expected later this year.