Perth and Kinross Health and Social Care Partnership

Annual Performance Report 2017/18


Answer's
Avengers
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Introduction

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Chief Officer

Welcome to the second annual review of the performance of the Perth and Kinross Health and Social Care Partnership. This is the second annual performance report since the Perth and Kinross Health and Social Care Partnership came together in 2016. As we completed our second year, we have continued to focus our efforts on providing services that improve the lives of local people.

Our Strategic Commissioning Plan places a lot of emphasis on the need for services and support to intervene early to prevent later, longer term issues arising. It aims to enable people to manage their own care and support by taking control and being empowered to manage their situation. Where this is not possible, our aim is for services to target resources where they are needed most, reducing ill health and deterioration and ultimately reducing health inequalities.

To enable the Partnership to fulfil this vision, we have focused on these five objectives:

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

Our five key objectives detailed within our Strategic Commissioning Plan link directly to the nine National Health and Wellbeing Outcomes set out by the Scottish Government (please refer to Appendix 1 attached). These outcomes provide a useful roadmap for us as we demonstrate our progress against them.

In this report, we look back on the progress we have made, share some of our successes and reflect on some areas that have proved challenging. These themes run through each of the sections within this report, the contents of which are defined by legislation and measure:

- *Scottish Government's National Health and Wellbeing Outcomes (ref Appendix 1)*
- *Financial Planning and Best Value*
- *Performance in respect of localities*
- *Inspection of services*
- *Review of our Strategic Plan*

Section 1: Our vision for Health and Social Care 2016-2019

Our Vision

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

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

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

The strategic plan is currently being reviewed to ensure our vision and objectives are fit for the next stage of our integration journey. This report summarises our progress over the past year in meeting our key priorities and challenges and analyses performance around the 9 national outcomes for health and social care, as well our five objectives.

Review for the Year

The Integrated Joint Board (IJB) strategic ambitions sit alongside operational imperatives across a wide range of services. This creates a very challenging landscape to deliver major service redesign at the pace expected. However much progress has been made including:

Older People and Unscheduled Care

- *During the year, the fully implemented **Discharge Hub at Perth Royal Infirmary** has had a significant impact on ensuring timely and appropriate discharge from hospital, improving health and wellbeing outcomes by reducing significantly the length of stay in a hospital setting and the overall risk of a delay. Furthermore, a new social care 'HART' team (Home Assessment Recovery Team) has been established in further support of timely discharge and early intervention and prevention. Care Home Liaison services have also been enhanced ensuring timely and appropriate discharge to Care Home settings. A better locality focus on Care Home Liaison has also been established.*

- *A redesign of **Psychiatry of Old Age (POA)** services has been taken forward increasing the Older People's Mental Health community-based teams across Perth and Kinross allowing enhanced care in people's homes. The enhanced teams are an integral part of the Integrated Care Team in each locality. In addition a multidisciplinary POA Liaison Service has been established supporting wards at Perth Royal Infirmary and Murray Royal Hospital dementia care, diagnosis of delirium and managing cognitive impairment needs.*
- *During the year, a **full review of residential care** was undertaken. In Perth and Kinross there is a decline in demand for residential Care Home placements in line with the national trend. However demand for nursing Care Home placements continues to increase and further investment will be required moving forward.*
- *We have worked closely with clinicians at Perth Royal Infirmary and with staff across Community Hospitals to develop a **sustainable service model for the future** with pathways that ensure appropriate capacity and flow in and out of the inpatient environments.*
- *The implementation of a **new Care at Home contract** was completed following an extensive tendering process. The demand of care at home continues to increase however and the sector has struggled to keep pace with demand. A review of the sustainability of the current service model is required.*
- *Perth and Kinross HSCP are one of the pilot sites for the Care Inspectorate **'Care About Physical Activity' CAPA** improvement programme which seeks to build the skills, knowledge and confidence of our care staff to enable those they care for to increase their levels of physical activity and move more often. This involves 13 Care Homes, 4 day care services, 2 sheltered housing organisations and 5 Care at Home Providers.*
- ***Health pathways** have been developed and are being implemented within Community Nursing Teams across Perth and Kinross. This development is part of the National Health Service Trust (NHST) Transforming District Nursing Programme for Frailty Pathways and Deteriorating Patient Pathways.*

Mental Health and Wellbeing

- *As the IJB responsible for hosting **Inpatient Mental Health and Learning Disabilities**, we have completed an extensive review of these services with options identified and a three month public consultation on proposals for the future delivery of services. The preferred option will see the relocation of all 4 General Adult Psychiatry wards at the Carseview Centre in Dundee and all Learning Disability Inpatient Wards relocated to Murray Royal Hospital in Perth.*
- *Drug and Alcohol support in Perth and Kinross are currently being redesigned as part of the implementation of a **Recovery Oriented System of Care (ROSC)** which is a Scottish Government initiative to join up services and make them easily accessible.*
- *The **Suicide Prevention Programme** in Perth and Kinross continues to be promoted by the Health and Social Care Partnership.*

- *The most recent Scottish Public Health Observatory (ScotPHO) figures indicates that the suicide rate for Perth and Kinross matches that of Scotland overall (13 per 100,000 population). Through the funded post of Suicide Prevention Assistant Project Officer in 2017, it was possible to erect new signage at locations of concern along the riverside in Perth City; run a suicide prevention awareness campaign; and pull together guidance for employers to help them put policies in place for suicide/self-harm.*

A comprehensive suicide prevention programme continues to be run, including introductory level Scotland's Mental Health First Aid, Suicide Intervention and Prevention Programme, safeTALK; and more specialist level Applied Suicide Intervention Skills Training and Safety Plan Training.

- ***Collaboration with colleagues across Tayside** resulted in the Suicide? Help! App and website being updated, enabling people with thoughts of suicide to put their own Safety Plan in place.*
  - *Funding was provided to a range of projects, including counselling and support projects with CAIR, Mindspace, Perthshire Women's Aid, and the Rape and Sexual Abuse Centre.*
  - *A grant awarded to the Samaritans enable them to continue to recruit and train volunteers - they provide a listening service to over 7,000 callers a year, of whom more than 20% present suicidal ideation.*
- *Monies are also provided to the **Tayside Multi Agency Suicide Review Group**, who analyse cases of suicide to establish if there is learning for services to help prevent suicides in the future. The Bereaved by Suicide Project run jointly through the Early Intervention and Prevention Team and Police Scotland continues to provide vital support for people bereaved by suicide - since January 2017, this involved 15 people affected by 7 suicides.*

Carers

- *The **implementation of the Carer's Act 2016** has been a significant program of work, the IJB approved eligibility criteria during the year following consultation with key stakeholders. An extensive training programme has been developed and implemented and additional capacity has been created through the recruitment of carer support workers. Further significant investment will be required moving forward.*
- *We know many people who provide an unpaid caring role may be unaware of the support they could receive, so we want to **radically improve support for carers**, particularly access to flexible respite. We have focused on delivering a much more tailored approach to support and care for each individual and/or carers so that they are better supported to maintain or improve their quality of life.*

Primary Care

- *During 2017/18, we provided funding to support GP capacity to work with us on **quality, safe and cost-effective prescribing**.*

The program of engagement will step up further in 2018/19.

- *We have brought GP practices together in **locality-based clusters** to share information so as to improve the quality of care in the wider health and social care system and secondary care.*

Working in Communities

- *Integrated working in localities continues to develop. The **locality management teams** are established across the three localities and they are developing local multi-disciplinary teams. A number of different organisational development techniques have been used to support this including action learning sets to facilitate this work.*
- *The development of **Integrated Care Teams (ICTs)** across the three localities in Perth and Kinross has continually aimed at providing targeted health and social care to restore and improve the quality of life for individuals in our communities. A Person-Centred Framework has been developed for the purposes of identification of a named key worker.*
- *During 2017/18 the **significant restructure of social work** and social care field work teams was completed, ensuring a shift in resources to provide early and preventative interventions. Moving forward we will be working with communities to support the work that they can do to reduce isolation and loneliness. This shift in resources has also enhanced the work of the hospital discharge team and has supported the capacity and flow programme.*

- *With the **support of PKAVS as the Third Sector Interface** in Perth and Kinross, our partnership work with the Third Sector continues to develop and strengthen. The Third Sector Health & Social Care Strategic Forum now extends to 118 members across 43 organisations. The Forum serves as an important conduit for the engagement of the Third Sector around the partnership's business at a strategic level. It enables new connections to form, Third Sector influence on strategies and plans, and joint action.*
- *Third Sector leadership has supported the **development of new pathways** around pain management and the strengthening of our focus on physical activity. At a local level, a series of **Health & Wellbeing Groups** have been established across Perth and Kinross to bring together Third Sector groups, residents and staff to address local issues in partnership and progress ideas and innovations.*

Housing

- *We have **worked with housing partners** to make sure there's a good supply of affordable mainstream and supported housing, with services attached to support people to live as independently as possible. We completed an extensive research programme with various agencies regarding specialist housing. The focus of the project was to understand how current supported accommodation in Perth and Kinross is working for people living there, and what the future housing demand will be for people with housing care and support needs. Further details on the project are provided on Page 15.*

Staffing

- *Both NHS Tayside and Perth & Kinross Council are fully committed to the **National Healthy Working Lives** programme in order to support staff health and wellbeing. This programme supports workplaces in providing a positive working environment by creating a healthy workforce, a healthy workplace and a healthy organisation. NHS Tayside sites have achieved a range of Silver and Gold awards with Perth & Kinross Council having achieved Silver award level throughout the organisation.*

  Through the Healthy Working Lives Programme Perth & Kinross Council and NHS Tayside staff have also had access to a whole range of training including Mentally Healthy Workplace, Resilience and Wellbeing, Managers Competencies and Alcohol and Drugs in the workplace.

Corporate

- *The role of the **Executive Management Team** has been strengthened and this pivotal group now provides scrutiny review and support to all key transformation projects across the Partnership.*
- *Work has continued on the **Workforce Organisational and Development Plan** and on receipt of the national guidance we will develop a three year plan.*

Hosted Services

- *Across our other hosted services, the **Podiatry Service** has successfully implemented a move to single use instrumentation in a number of areas. Further it has undertaken a review of workforce to ensure equity of access to specialist podiatry care across each locality. Within our **Public Dental Service**, the provision of person-centred care has continued with close community working to promote oral health prevention and intervention across all ages. Within **Prisoner Healthcare**, the completion of significant redesign of workforce has improved the effectiveness of service delivery including medicines prescribing.*
- *We have implemented the **National Dental Inspection Programme** where all Primary 1 and 7 children attending local authority schools across Tayside are offered a screening for dental disease under standard inspection conditions. Oral Health Improvement Team provides the **Childsmile Programme** which has universal and targeted aspects focussed on children, particularly those with the highest disease burden and/or higher disease risk.*

Key Priorities Looking Forward to 2018/19

The Partnership has a number of key priorities focused on ensuring future sustainability of services:

- *We will take forward the development of our **Primary Care Improvement Plan** aimed at ensuring that the benefits set out in the new contract for GPs are realised.*
- *We plan to expand **Technology Enabled Care** in the year ahead and enable people to choose the way their care support are provided. This will complement our support to carers and reduce the need for Care at Home where this is appropriate.*

- *We will increase our **support to carers** through further enhanced community support, enabling people to remain at home for longer and avoiding unnecessary admissions and longer stays in hospital.*
- *For **Inpatient Mental Health** services the planning for and implementation of approved transformational changes will be taken forward. This will for example include a review of the current inpatient drug and alcohol service.*
- *We will finalise the review of **Inpatient model for Tay Ward, Stroke Services and our Community Hospitals**. This forms a significant part of the wider development of a Perth & Kinross Integrated Clinical Strategy. The timescales for this will be determined by the broader NHS Tayside review of Unscheduled Care for which an Option Appraisal is to be completed by July. This will include a review of Emergency Department and General Medical Wards at PRI which form part of the IJB's large hospital set-aside budget.*
- *There will be a further review of **Psychiatry of Old Age Inpatient Services** with an even greater focus on community-based provision through the Integrated Care Teams in each locality.*
- *Within **Prisoner Healthcare** we will work with the Scottish Prison Service to consider implications of a move to Smoke Free Prisons in October 2017. NHS Tayside Mental Health Inpatient Units became smoke free which aligned them with the other secondary care units.*

- *We continue to **promote health and wellbeing** of our wider community and supported this through a range of activities, partnership events to promote mental wellbeing, self-management and to improve access and tackle inequalities.*

What are our key challenges in delivering these key priorities?

Supply of care staff remains a significant challenge across the care sector from Care at Home through to medical staff in our hospitals. We will continue to work with partners in the independent and Third Sector to improve supply recruitment and retention of staff across the partnership in order to make sure that people can be supported to live independently in the community. This year will prove to be a significant challenge with the planning and implementation of the approved changes to both the inpatient and community services for Mental Health and Learning Disability and Low secure inpatient services.

In 2018/19 there will be:

- *locally-based integrated, multi-agency teams including GPs, pharmacies and the Third and Independent Sector to facilitate opportunities for more personalised, joined up care and support for people;*
- *continued delivery of outreach activities to promote health and wellbeing;*
- *work with our communities to design our services around prevention and early intervention. Services will be designed with our local communities who are well-suited to enable early, preventive support, encouraging people to live independent and active lives;*

- *a focus on reducing inequalities and unequal health outcomes and promoting healthy living: focusing our efforts on those who most need care and support.*

Performance Review

The Ministerial Strategic Group for Health and Community Care (MSG) agreed a suite of indicators that will be used by Integration Authorities to measure progress under integration. These agreed indicators are in Table 1 below and show our current 2017/18 values against previous year 2016/17 values.

We are making good progress in all these indicators and our work to ensure effective and appropriate flow into and from our hospital services has impacted positively on both levels of delayed discharge and unplanned admissions. The exception is A&E attendances which shows a slight 2.1% rise in attendances since last year. We will monitor this indicator to help us understand what different strategies we can introduce that may reduce this number.

Table 1: *MSG Indicators*

MSG Indicator	MSG Description	Perth and Kinross Total Previous Year 2016/17	Perth and Kinross Current Year 2017/18	Perth and Kinross YTD difference from 2016/17
1a	Emergency admissions	15,128	15,021	↓107
2a	Unscheduled hospital bed days	111,324	102,451	↓8,873
3a	A&E attendances	31,825	32,506	↑681
4.1	Delayed discharge bed days**	19,176	16,785	↓2,391
5.1	Proportion of last 6 months of life spent at home or in a community setting	88.27%	89.64%	↑1.37%
6.1	Percentage of population at home unsupported	97.97%	98.00%	↑0.03%

** All ages including complex cases

Section 2: Our performance in relation to the 9 National Health and Wellbeing Outcomes

Partnership Objective 1

Prevention and early intervention: intervening early to prevent later issues and problems arising.

National Health and Wellbeing Outcome 1

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

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

The following section provides detail on performance and achievements using indicators, progress on improvement areas and stakeholder feedback including case studies.

How did we do?

Table 2 below summarises some key indicators which support the National Health and Wellbeing Outcome 1.

Indicator	2015/16 Perth and Kinross	2016/17 Perth and Kinross	2017/18 Perth and Kinross	How we compared to our last Perth and Kinross result	How we compared to the Scottish Average	2017/18 Scotland Average
% of adults able to look after their health very well or quite well. *(Source HACE**)*	95%*	n/a	95%	no change	↑2%	93%
Rate of emergency admissions per 100,000 population for adults.	11,040	11,158	10,762	↓396	↓1,197	11,959
% of people requiring no further services following Reablement.	38%	34%	31%	↓3%	n/a	n/a
Within 12 Months of a Diagnosis of Dementia, all patients will have commenced Post Diagnosis Support***	94%	98%	100%	↑2%	n/a	n/a

How we compared to our previous year/period performance or National Average:

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

** 2015/16 recalculated by Scot Gov with new weighting. ** HACE survey is undertaken every two years therefore information is not available for 2016/17. *** Refined measure for Dementia Diagnosis for 16/17 and onward - Source NHS MIDAS system.*

People of Perth and Kinross are reporting that they are **able to look after their health very well**. Whilst this is unchanged over the last 2 years, it remains higher than the Scottish average and is encouraging for our focus on prevention and early intervention.

- ***Emergency Admissions***
  Our rate of emergency admissions has improved against our previous year's rate: a reduction of 3.5% is a good reduction in the number of people being admitted to hospital in an emergency. This rate is also better than the national average. Over the same period we have seen a 7.4% reduction in the number of hospital bed days taken up by these emergency admissions, which means people are spending less time in a hospital bed after an emergency admission. Although these indicators are showing good improvement we recognise with an aging population that work needs to continue to further reduce this rate. We will continue to focus on increasing the number of people who we can support to live safely at home for longer. The ongoing focus on early intervention and prevention and the hospital Front Door Model to ensure appropriate admissions into hospital are some of the strategies that will contribute to reducing further our rate of emergency admissions.
- ***Reablement Services***
  Although the number of people who require no further services following Reablement has dropped since last year, this is because we are supporting a very elderly population with increased frailty. This means it is less likely for us to reable these people to full independence.
- ***Post-Diagnostic Support***
  The number of people with post-diagnostic support has moved to 100%. This is a reflection of the hard work of our community teams to improve processes and ensure that people with dementia are supported to live safely in their communities.

What else have we achieved?

- ***Social Prescribing***
  Through our current model of social prescribing we have made progress in the establishment of an infrastructure for the prescribing of physical activity and weight management. There is strong evidence that this will improve the wellbeing of the population of Perth and Kinross and avoid some of the future costs of a physically unhealthy population.
- ***Long-Term Conditions and Self-Management***
  People experiencing long-term conditions are learning self-management techniques such as goal-setting, problem-solving, the benefits of healthy eating and physical activity, relaxation, managing symptoms, and medication compliance. The increasing demand from clinicians, particularly those delivering pain services, mental health and diabetes care pathways, for sources of support other than medical prescriptions is increasing and we aim to reduce the burden of polypharmacy and develop a number of options.
- ***Reducing Social Isolation***
  In response to a national awareness campaign highlighting the impact of social isolation, particularly in older adults with multiple morbidities, Perth and Kinross is responding with a particular focus on developing the social aspects of walking, cycling, swimming, gardening and walking football. As set out in the recommendations from the Fairness Commission we will seek to provide opportunities for all people at all ages and abilities to participate in physical activity with a priority of reducing inequalities. Through a series of local engagement events across Perth and Kinross, PKAVS produced a report looking at the contributors to loneliness and social isolation and community ideas and aspirations

to address key issues. The report will help inform locality action in the coming year.

- ***Living Independently***
  The population of Perth and Kinross is changing and those using services are older and living at home with complex needs. We have seen yearly increases in the numbers of people receiving Intensive Care at Home. Our reablement service has shown a reduction in the number of people who no longer require a service following reablement. However, this is a crucial service that continues to demonstrate good outcomes for service users with almost a third of people leaving the service and able to live independently in the community.

  The transformation of the Reablement Service to become the Home Assessment and Recovery Team (HART) will continue to support our aim to work with vulnerable people to support improved independence.

- ***Special Needs Housing Research Project***
  Working with our partners in housing, the Special Needs Housing Research Project sought to understand how current supported accommodation in Perth and Kinross is working for people living there, and what the future housing demand will be for people with housing, care and support needs to be able to live independently in the community and prevent them going to more institutional settings.

  - *The focus of the research was on older people, people with learning disabilities, Autism Spectrum Conditions, physical disabilities, Profound and Multiple Learning Disabilities (PMLD) and mental health needs. The project was influenced by feedback from over 500 people including staff, families, and individuals with special needs. This was undertaken mainly through focus groups, interviews and visits to supported living projects in Perth and Kinross.*
  - *The feedback found that current accommodation with support options in Perth and Kinross is highly valued by the people who live there. Overall, feedback was very positive in relation to the models of accommodation, the choices available to support independent living as well as recovery and rehabilitation; staff support was also one of the most positive aspects highlighted, and was seen to be just as important as the accommodation itself.*

The challenge for the future is to improve pathways from hospital to community, along with information about housing options for people with care and support needs.

Case Study
Supported Accommodation

One individual with a learning disability has been living in supported accommodation for 6 years. They said they feel supported through the care and help they receive, and it's more comfortable than where they were previously. They said the best thing is keeping busy - they said if they were not supported to have hobbies, they'd be sitting doing nothing. They felt living in this accommodation has made a very big difference because before they were alone and not doing a lot. They felt the people they share the home with are their friends, and it's important to have friends and company. They love where they live - *"It's the first time I'm getting a future and there's a lot in my future now"*.

Improvement Areas for 2018/19

- *The new General Medical Services (GMS) arrangements will allow for a robust focus on long-term condition management through early intervention and prevention and promotion of self management. A Primary Care improvement plan will be taken to the June IJB for approval.*
- *Social Prescribing is being taken forward as a priority area in the Health and Social Care Partnership (HSCP). A partnership group was established to develop a strategic approach, and we have invested in three new social prescribing posts - one per locality. The Partnership is gaining more detailed understanding of effective social prescribing models; next steps will be to agree a vision and approach that works for local infrastructures*
- *We are planning future housing for people with particular needs, including people with learning disabilities, physical disabilities, mental health needs and older people, developing new build and supported accommodation over the next five years. Work is underway to improve housing options in mainstream housing as well as prioritising the development of specialist accommodation for people with complex needs. A housing project for people with Autism Spectrum Condition is being developed and should be ready for occupation in 2019.*
- *In partnership with housing, we will commission a new floating housing support service to support people to maintain their housing, promote health and wellbeing and improve connections for people in their local communities*
- *Health interventions and physical activity for people who are at the highest risk of ill health to prevent illness including smoking, alcohol and drug use, oral health, sexual health and undernutrition.*
- *Varied local initiatives will take place to encourage physical activity and social interaction.*

The 'Luncarty Alive' Group

The Luncarty Alive Group aims to encourage an active and healthy life for people who have physical limitations or health conditions.

www.youtube.com/watch?v=fiV84Yumjmk

Partnership Objective 2

Person-centred health, care and support - putting people at the heart of what we do, listening, empowering and supporting.

National Health and Wellbeing Outcome 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.

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.

National Health and Wellbeing Outcome 3

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

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

The following section provides detail on performance and achievements using indicators, progress on improvement areas and stakeholder feedback including case studies.

How did we do?

Table 3 below summarises some key indicators which supports the National Health and Wellbeing Outcomes 2 and 3.

Indicator	2015/16 Perth and Kinross	2016/17 Perth and Kinross	2017/18 Perth and Kinross	How we compared to our last Perth and Kinross result	How we compared to the Scottish Average	2017/18 Scotland Average
Percentage of adults supported at home who agree that they are supported to live as independently as possible. *(Source: HACE**)*	81.00%*	n/a	83.00%	↑2.00%	↑2.00%	81.00%
Rate of emergency bed day per 100,000 population for adults.	124,651	118,566	109,842	↓8,724	↓5,676	115,518
Readmissions to hospital within 28 days of discharge per 1,000 admissions.	115	117.97	109.7	↓8.27	↑13	96.7
Proportion of last 6 months of life spent at home or in a community setting.	87.90%	88.27%	89.64%	↑1.37%	↑1.38%	88.26%
Percentage 65+ with intensive social care needs receiving care at home.	32.00%	37.00%	38.00%	↑1.00%	n/a	n/a
Number of people using SDS Options 1 and 2 as a percentage of all people accessing services via SDS.	11.70%	14.40%	18.6%	↑4.20%	n/a	n/a
Percentage of adults with intensive needs receiving care at home.	58.00%	60.00%	n/a	n/a	n/a	Not available until Dec 2018

How we compared to our previous year/period performance or National Average:

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

** 2015/16 recalculated by Scot Gov with new weighting. ** HACE survey is undertaken every two years therefore information is not available for 2016/17.*

There have been improvements in a number of areas which has seen an increase in the number of people remaining at home with increased support needs. This information supports our vision to have the health and care services they need in their local communities. We will continue to strive to provide the necessary support to enable people to live in their own home or community setting in the last six months of life with the previous table showing a slow upward trend for that indicator that is also above the national average.

- ***Supported to Live Independently***
  We are above the national average for the number of adults who agree they are supported to live independently at home. In spite of the challenges in delivering care at home, we support increasing numbers of older people to live independently at home and have a good range of sheltered and supported housing options for vulnerable people with complex needs. We recommissioned Care at Home services delivered by the Independent and Third Sector and the full transition to new contracts was completed in August 2017. We will continue to work with care at home providers to create a more flexible, outcome-focussed care at home service for local people.
- ***Reduction in Emergency Bed Days***
  There has also been a 7.4% reduction in the number of hospital bed days taken up by emergency admissions. And although these have reduced we recognise that, with an aging population, work needs to be ongoing to both maintain and further reduce this rate. To that end we need to continue to focus on increasing the number of people who live at home with intensive support needs and we will continue to invest in this area. The investment in a frailty model and front door model should contribute towards this.
- ***Readmissions to Hospital***
  Although there has been a reduction in the emergency readmission rate for Perth and Kinross residents, the rate is still higher than the Scotland figure. Having a high proportion of elderly people in the Perth and Kinross population, along with the more complex needs of that elderly population will have contributed towards this. This national outcome remains a priority for the HSCP.
- ***Proportion of Last 6 Months of Life Spent at Home or in a Community Setting***
  Annual figures show improvements in this area, the 2017/18 (89.64%) figure sits above the national average. The strategic direction for Palliative and End of Life Care in Scotland is to ensure the patient, relatives and carers are kept at the centre of decision-making that will influence the dare requirements for each individual. Each person's individual wish regarding their choice of where they wish to die should be carefully considered and met to the best of our ability. In Perth and Kinross the Partnership focus on delivering end of life care where the patient's choices demonstrates a commitment to achieving this as much as is possible. Each year we have been improving the journey for people receiving palliative or end of life care by enabling more to die in their own home or a homely setting.
- ***Percentage 65+ with Intensive Social Care Needs Receiving Care at Home***
  The number of individuals requiring 10.5 hours per week is increasing slowly representing those who have complex care needs. Given the demographics we would expect this to rise over the next few years reflecting a shift in the balance of care.

- ***Self-Directed Support***
  The rise in the number of people using Self-Directed Support (SDS) continues to expand and enable people to choose the way their care and support are provided, promoting choice and control. The challenge for services is to work to increase options for people to exercise their choice and make sure they have control over their service that the legislation seeks to empower people to achieve.

What did people say about our services?

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

Underpinning the way we deliver health and social care, the national Health and Social Care Standards - My Support, My Life (published 9 June 2017), set out what people should expect when using health, social care or social work services in Scotland. They seek to provide better outcomes for everyone, to ensure that individuals are treated with respect and dignity, and that the basic human rights we are all entitled to are upheld. The Standards are underpinned by five principles: dignity and respect, compassion, be included, responsive care, and support and wellbeing.

- *I experience high-quality care and support that is right for me.*
- *I am fully involved in all decisions about my care and support.*
- *I have confidence in the people who support and care for me.*
- *I have confidence in the organisation providing my care and support.*
- *I experience a high-quality environment if the organisation provides the premises.*

The following section provides key findings from various surveys carried out across the Partnership.

How did we do?

Table 4 below highlights results from HACE surveys which lets us see what people think of the services they have received.

Indicator	2015/16 Perth and Kinross	2016/17 Perth and Kinross	2017/18 Perth and Kinross	How we compared to our last Perth and Kinross result	How we compared to the Scottish Average	2017/18 Scotland Average
Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided. *(Source: HACE**)*	82%*	n/a	78%	↓4%	↑2%	76%
Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated. *(Source: HACE**)*	76%	n/a	75%	↓1%	↑1%	74%
Proportion of care and care services rated good or better in Care Inspectorate inspections.	85%	83%	88%	↑5%	↑3%	85%

RAG: *RAG is against our previous year/period performance. Red = performance is declining above tolerance level; Amber = performance is declining but within tolerance level; Green = performance is improving.*

** 15/16 recalculated by Scot Gov with new weighting. ** HACE survey is undertaken every two years therefore information is not available for 2016/17.*

Based on peoples' perceptions of our services we perform better or slightly better than the Scottish average and people say that they have a say and that health and care services seem to be well co-ordinated. We have improved the quality of services which are regulated with 94% rated good or better in 2017/18; this now sits above the Scottish Average for 2016/17 of 88%.

Other surveys that the Partnership has undertaken during 2017/18 include:

- *The **Perth and Kinross Annual Social Work Survey** for 2017/18 was sent out to residents of Perth and Kinross in June this year; response rate was 26%. The table below provides details on key findings from the survey.*

Table 5: *The Perth and Kinross Annual Social Work Survey 2017/18.*

Perth and Kinross Social Care Survey Results	Perth and Kinross Social Work Client Survey Result 2016/17	Perth and Kinross Social Work Client Survey 2017/18	Perth and Kinross Social Work Client Survey Difference from previous year	HACE 2017/18 Scottish Average *(where applicable)*
I received a high-quality service.	89.7%	91.1%	↑1.4%	80.0%
I can rely on the services I receive.	86.8%	85.7%	↓1.1%	74.0%
I am supported to live as independently as possible.	89.9%	91.7%	↑1.8%	81.0%
The help, care or support I received helps me feel safer at home and in the community.	87.9%	82.4%	5.5%	83.0%
I have felt involved in making decisions about the help, care and support I receive.	83.0%	85.2%	2.2%	76.0%
The services I have received have helped me to feel part of my local community	64.9%	72.3%	7.4%	n/a
I get a good response from social work services when I contact them during the day	72.6%	88.5%	↑15.9%	n/a

RAG: *RAG is against our previous year/period performance. Red = performance is declining above tolerance level; Amber = performance is declining but within tolerance level; Green = performance is improving.*

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

At the time of writing this report (based on surveys received) key findings indicate that there have been improvements in a number of areas. We will also focus on improvement areas that have been highlighted in the overall survey.

- *A **Telecare and Community Alarm Survey** was carried out during 2017/18 to assess people's views on the services provide. Key findings included:*
  - *100% of respondents strongly agreed/ agreed that they were supported to live as independently as possible.*
  - *90.2% of respondents strongly agreed/ agreed that support received helped to make them feel safer.*
  - *91.9% of respondents strongly agreed/ agreed that they received help when they needed it.*
  - *95.5% of respondents rated the quality of equipment provided as very good/good.*
  - *84.4% of respondents felt that the service provided was very good/good value for money.*
  - *93.5% of respondents said that overall the service provided was very good/good.*
  - *Comments provided from service users - "They do a good job, I feel safe knowing they are there", "I feel very well looked after by alarm system and carers", "It is reassurance for the family".*

- ***Older Peoples Community Mental Health Team** carried out surveys during 2017/18 across various services including Memory Clinic, Post-Diagnostic Support and South Perthshire Assistant Practitioners/Health Care Support (AP/HSW) and Carers. Some of the comments and feedback included:*
  - *Patients fed back that the memory clinic is presented in a professional and understandable manner allowing any questions and queries to be answered. In general they felt they have been listened to and are satisfied with the amount and accuracy of information that is provided.*
  - *Patients felt well-supported by their Assistant Practitioners/Healthcare Support Workers (AP/HSW). They were described as being "very helpful and easy to talk to about any problems that they might have". They were seen as "great motivators", "lifting the mood" of patients in their care "It is an excellent service" and an "important and trusted point of contact".*
  - *Carers of people living in Care Homes fed back that the support they receive is excellent as they keep family members up-to-date with the treatment of their loved one. They report that the team is approachable and easy to talk to.*

There has been a general improvement in the way in which we capture feedback from across the service as noted above from the various elements of the Older Peoples Community Mental Health Teams. Feedback is predominantly very positive.

Holiday@Home

The Holiday@Home offered a week of activities and trips aimed at older people who may not have the financial or physical ability to go on a holiday.

www.youtube.com/watch?v=BfgRGg8amkc

Improvement Areas for 2018/19

- *Undertake a wider local survey that captures all people who receive a health and/or social work service.*
- *Through locality teams, local surveys will be undertaken with people who use our services to inform and design future delivery.*
- *Take forward improvement actions highlighted in recent local and national surveys.*

Partnership Objective 3

Working together with our communities: Recognising the wealth of knowledge, experience and talents that local people have within their communities. 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.

National Health and Wellbeing Outcome 4

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

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

National Health and Wellbeing Outcome 6

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

The partnership recognises the significant input from carers and families in supporting people to live at home and through our local Carer's Strategy we will focus on early intervention and prevention by developing alternative support, such as the Carer's Hub. We know many people who provide an unpaid caring role may be unaware of the support they could receive, so we want to radically improve support for carers, particularly access to flexible respite.

The following section provides detail on performance and achievements using indicators, progress on improvement areas and stakeholder feedback including case studies.

How did we do?

Table 6 below summarises some key indicators which support the National Health and Wellbeing Outcomes 4 and 6.

Indicator	2015/16 Perth and Kinross	2016/17 Perth and Kinross	2017/18 Perth and Kinross	How we compared to our last Perth and Kinross result	How we compared to the Scottish Average	2017/18 Scotland Average
Percentage of people with positive experience of care at their GP practice. *(Source: HACE**)*	91%*	n/a	88%	↓3%	↑5%	83%
Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life. *(Source: HACE**)*	84%*	n/a	81%	↓3%	↑1%	80%
Number of bed days lost to delayed discharge (excluding complex cases).	17,029	15,429	15,078	↓351	n/a	n/a
Number of days people aged 75+ spend in hospital when they are ready to be discharged per 1,000 population.	1,005	875.2	674.3	↓200.9	↓97.7	772
Number of people delayed in hospital for more than 14 days.	191	198	239	↑41	n/a	n/a
Percentage of carers who feel supported to continue in their caring role. *(Source: HACE)*	40%	n/a	41%	↑1%	↑4%	37%

How we compared to our previous year/period performance or National Average:

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

** 2015/16 recalculated by Scot Gov with new weighting.*
*** HACE survey is undertaken every two years therefore information is not available for 2016/17.*

Just over 80% of adults supported at home agreed that their services and support had an impact in improving and/or maintaining their quality of life, just around the Scottish average.

- ***Carers***
  For Carers, the national survey suggests that the majority of family carers do not feel supported in their caring role; the 2017/18 figure sits above the national average. We know many people who provide an unpaid caring role may be unaware of the support they could receive so we want to radically improve support for carers, particularly access to flexible respite.
- ***Hospital Discharge***
  Sustained work on hospital discharge and care at home is beginning to see some improvement in the number of bed days lost in hospital as a result of delays. However, at the same time there appears to be an increase in the number of people delayed in hospital. Reducing delays for people being discharged from hospital will remain a priority for the partnership and we will work in partnership with the third and Independent Sectors to achieve sustained reductions in this area.

What else have we achieved?

A key priority has been our work with communities to support the work that they are doing in relation to health and social care and whilst we think there is more work to do, a number of significant initiatives have supported this work. The second stage of the Communities First transformation project has supported communities including:

- ***Participatory budgeting*** *has been successful enabling joint working with the Local Action Partnerships and seen small grants go to innovative projects supported by local community groups. For example:*
  - *The Stanley exercise group is an independent community group to support local people to continue a healthy life through strength and balance and help prevent falls. The group continues to grow with 25-30 people attending weekly classes. For many people attending the exercise class, this is the only person-to-person contact they have from one week to the next. A Christmas and summer lunch was held with many praising how much this means to them to spend Christmas lunch surrounded by lots of friends in what is a lonely time of year for many.*
  - *The Huddle was created to offer the opportunity to bring people of all ages and abilities in our scattered community together on a regular basis. It is an affordable community café - offering a nutritious lunch and a space to meet friends and make new ones. The project aims to benefit the people living in and around the villages of Kinrossie, Saucher and Collace.*

- *Digital inclusion - this is a small group aged 50-83 learning how to use our modern day digital technology in everyday life. There is a peer support worker and volunteer that give their time and knowledge to help others better understand how Smartphones, iPads, tablets and computers can have a positive impact on their lives.*

- ***Market Facilitation** funding was available to support market facilitation with local groups. For example, Growbiz supports small enterprises to develop sustainable business models for care and support.*
- ***Social Prescribers** have been recruited to work in localities. We have also established a wide partnership group, co-led by the Third Sector, to develop pathways to better support pain management with Third Sector support and intervention.*
- ***Social isolation and loneliness** affects people of all ages. Having contact with others is important and participating in activities improves people's physical and mental wellbeing. Working alongside local communities we have developed a range of projects to reduce isolation and will continue to build on this.*
- *A series of local **Health & Wellbeing Groups** have been established across localities to support community dialogue and action around health and enable direct connections with Locality Steering/ Management groups.*
- *An annual survey was distributed to members of the **Third Sector Health & Social Care Strategic Forum** in Perth and Kinross in 2017. The Forum is facilitated by PKAVS as the Third Sector Interface and has 45 organisational members. Feedback highlighted that 95% of respondents felt more knowledgeable about policy and strategy and that the Forum strengthens connections with the Third Sector and Health and Social Care Partnership. 86% felt the Forum enables the Third Sector's views to be well reflected at Integration Joint Board and 82% at strategic planning level.*

- ***Carers***

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

  Through the PKAVS Carers' Hub, we have generated a growth of at least 11% of total users to approximately 16,000 new users since the date of launch from 2016. We have seen a significant increase in the number of referrals received since last year (+62%) and in the number of support plans completed (+45.5%). Key actions during 2017/18 include:

  - *Established a new carers' telephone support service for two new workers from February 2018 following feedback from local carers which recognised a gap in services. This service has been really well received, with lots of positive feedback from carers. To date, there are already 128 carers we regularly engage with on the carer's own terms (whether this is weekly, fortnightly, or monthly). This has also helped to identify carers who need to be referred for re-engagement with a support worker, and to signpost to other services.*

- *In identifying and supporting more family carers, we have created new services for carers who look after people aged 65+ to meet an identified gap in services:*
  - *Created 3 new positions for adult carer support workers to work specifically with carers who care for someone over the age of 65 covering 3 different localities across Perth and Kinross.*
  - *226 carers have received Time4Me grants from October 2015, 51 of which are carers from the Time4Me 65+ fund in the last year.*
- *We have also increased funding, which, alongside funds from Shared Care Scotland, has allowed carers to continue to have short breaks, helping to reduce the impact that their caring roles have on their health and wellbeing.*
  - *94 respitality breaks have been matched from October 2016 to April 2018, from funding from SharedCare Scotland.*

Improvement Areas for 2018/19

- *Improve the quality of our care and support services.*
- *Recognition of the role of unpaid carers and flexible support to help them cope with the challenges they may face.*
- *More support to local communities to build on their skills, knowledge and experience, fostering self-reliance and resilience and more access to Participatory Budgeting where local people choose how resources are spent.*

All Ability Cycling

All Ability Cycling promotes a fun, active and healthy lifestyle for people with disabilities by offering access to adapted bikes.

www.youtube.com/watch?v=KCM3sHJaU-U

Niki's Story and New Carers Act

www.youtube.com/watch?v=nXkaclhovds

Partnership Objective 4

Reducing inequalities and unequal health outcomes and promoting healthy living, focusing our efforts on those who most need care and support.

National Health and Wellbeing Outcome 5

Health and social care services contribute to reducing health inequalities.

Tackling health inequalities is challenging because it involves access to education, employment opportunities, suitable housing which is warm, safe and affordable, equitable access to healthcare, and individual circumstances and behaviour. Reducing health inequalities will increase life expectancy, increase health and wellbeing of individuals, and reduce the personal, social and economic cost of reacting to the impact of poverty and inequality.

National Health and Wellbeing Outcome 7

People who use health and social care services are safe from harm.

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

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

We are committed to delivering the vision and outcomes of the Fairness Commission so that we make people aware of poverty and inequality and the impact these have on too many people in Perth and Kinross.

By working with our partners to understand the particular needs of individual localities we will aim to address the key themes emerging from the Fairness Commission. Agencies such as Perth and Kinross Association of Voluntary Services (PKAVS) and Live Active Leisure, as well as NHS Tayside partners, have identified the value of a health inequalities plan which can be used as a local resource and as a tool for setting actions for locality partnerships.

The following section provides detail on performance and achievements using indicators, progress on improvement areas and stakeholder feedback including case studies.

How Did We Do?

Table 7: Performance Indicators relating to National Health Wellbeing Outcome 5.

Indicator	2015/16 Perth and Kinross	2016/17 Perth and Kinross	2017/18 Perth and Kinross	How we compared to our last Perth and Kinross result	How we compared to the Scottish Average	2017/18 Scotland Average
Percentage of adults receiving any care or support who rate it as excellent or good. *(Source: HACE**)*	83%	n/a	81%	↓2%	↑1%	80%
Premature Mortality Rate per 100,000.	352	348	364	↑16	↓61	425
Number of households presented to the Council as homeless.	898	825	999	↑174	n/a	n/a
Number of overcrowded households in Council tenancies.	127	115	108	↓7	n/a	n/a
Percentage of households in fuel poverty.	38%	22.3%	32%	↑9.7%	n/a	n/a

How we compared to our previous year/period performance or National Average:

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

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

- ***Care and Support***
  Just over 80% of adults rate their care as excellent or good, just around the Scottish average. This is encouraging for the partnership but still leaves 19% of the population who do not feel as positive about their care. This should be an area for improvement in the next year. We also recognise that whilst we are reducing the number of bed days lost to delayed discharge across the population the number of people delayed for more than 2 weeks has risen. This may be due to complexities but further improvement work is necessary.

- ***Fuel Poverty***
  Households that are experiencing the consequences of poverty are found in both our rural and urban areas, which provides a significant challenge in terms of how to best meet everyone's needs. Within Perth and Kinross, 2% of the population live in households where there is no central heating and 7% of the population live in households which are overcrowded. One of the key challenges for those living in rural areas is fuel poverty. In the 2015 Local House Condition Survey 22.3% of all households in Perth and Kinross are in fuel poverty and spend more than 10% of their income on household fuel.

  There is a strong relationship between cold and damp homes and health-related issues such as respiratory problems. During 2017/18 various works have been carried out including 694 upgraded central heating systems have been installed, 526 houses have received new triple glazed windows and insulated exterior doors, 367 Council houses have had cavity wall insulation. We will continue to support people to improve the energy efficiency of their homes.

- ***Homelessness***
  As with other Councils we have seen a rise in the number of households presenting as homeless with a proportion of this increase attributable to young people (16-25). However through working with individuals to review their various housing options only 793 (79%) proceed to requiring settled accommodation. As well as working with individuals to look at their housing options we also work together with other services such as employability, mental health, money advice and family mediation.

- ***Overcrowding***
  We have exceeded our target for the number of families living in overcrowded Council tenancies to the lowest level recorded. This has been achieved by various approaches such as the buyback scheme, new affordable housing supply, the new allocations policy and the delivery of realistic housing information and advice to families to enable them to make informed decisions regarding their housing options.

- ***Premature Mortality Rate***
  The premature mortality rate is a measure of the prevention of early death in our <75 age population and is an indicator of the overall health of that population. When compared to other partnerships, our premature mortality rate is better than the national average and amongst the best in Scotland. Our Premature Mortality rate this year has risen by 16 deaths per 100,000 population to 364.1 per 100,000 population when compared to last year.

  This is a very small change that reflects the natural variation we can expect to see but reflects also the continuous low rate we have been recording over the last few years.

For Perth and Kinross, this value has dropped significantly since 2006 from 442.7 per 100,000 to its current low value.

What else have we achieved?

- ***Impact on Poverty Training***
  During 2017/18 NHS Tayside Workplace Programme team and Perth & Kinross Council Welfare Rights team delivered 'Impact of Poverty' training. This training is provided for NHS Tayside staff and Perth & Kinross Council staff who are in frontline, customer-facing roles. The training raises awareness of poverty, including in-work poverty, aims to reduce stigma associated with being in poverty, helps people to consider how to support poverty and inequalities sensitive practice and raises awareness of how to signpost people in poverty to sources of support. During 2017/18 three courses were delivered with 26 attendees from the NHS and Local Authority.

- ***Reducing Health Inequalities***
  A Health Inequalities Plan for Perth and Kinross was presented to the Housing & Health Committee of Perth & Kinross Council and Perth and Kinross Integration Joint Board in April 2017. Around the same time a Fairness Commission for Perth and Kinross was brought together in order to learn about what life was like for people living in Perth and Kinross. The Commission produced nine recommendations within their Fairer Futures publication, with the social determinants of health underpinning most of these.

  We have used the framework within the role of Health and Social Care Partnerships in reducing Health Inequalities to identify what we have achieved. Key actions included:

  - *Established a new Equalities Strategic Forum with partners from the statutory (including PKC and NHS) and Third Sectors focussing on strategic issues affecting equalities 'communities of interest' through representation by PKAVS Minority Communities Hub; Ethnic Minorities Law Centre; MECOPP Gypsy/Traveller Carers project; St Johnstone Community Trust; LGBT Youth Scotland; Pink Saltire; Stonewall Scotland and the Centre for Inclusive Living.*
  - *Continued to facilitate the community-led Golf Memories Group in Perth for older adults with dementia or age-related memory conditions which has had an average weekly attendance of 12 participants and 7 volunteers - group has received international media coverage.*
  - *Supported the Safe Place programme for people with disabilities (currently has 73 clients registered and 27 venues signed up) and associated series of meetings.*
  - *Commissioned a range of external Third Sector projects which continue to support the health and wellbeing of equality communities of interest.*
  - *Introduced 1st Language film clips on access to social care services on PKC website through work with the Bridging the Gap Project (available in Chinese, English, Polish and Urdu) which has continued to be supported by the Health and Social Care Partnership. Bridging the Gap won a Gold Award at our recent Securing the Future Awards in Perth Concert Hall.*

Case Study
Bridging the Gap

Bridging the Gap is a Health and Social Care project run by PKAVS Minority Communities Hub (MCH), in partnership with the Perth and Kinross Health and Social Care Partnership and MECOPP. The service is available to all members of minority ethnic communities who are aged over 50. It aims to tackle inequalities in health and social care provision and improve awareness and access to services. Through the project, MCH has been working to provide connections and relationships to build up a better understanding of services available to black and minority ethnic communities (including gypsy/ travellers) and support them to access those services more easily.

- ***Live Active Leisure***
  Live Active Leisure (LAL) has provided services to address the issue of physical inactivity in relation to health for over 15 years and works with partners to address local needs, particularly for vulnerable groups and those living with the greatest inequalities. They work with our partners to support inactive people to assess local needs, design and deliver services to become active in the way that is most appropriate to them, and in places that make it accessible and sustainable. This is delivered through core service provision and more specifically the LAL Wellbeing Team. 2 Wellbeing Co-ordinators have supported over 225 inactive individuals on a weekly basis who have been connected with health and social care support of some kind over the previous year.

- ***Tayside Plan for Children, Young People and Families***
  The Health and Social Care Partnership contributes to the Tayside Plan for Children, Young People and Families (2017-2020) helping to achieve a shared vision across Tayside. Areas of work include:
  - *The health of expectant mothers across Perth and Kinross is similar to the Scottish average but there are communities which experience much higher rates of smoking and using drugs throughout pregnancy. It is these differences in pregnancy and early years that our Health Visiting Pathway and Family Nurse Partnership Programme aim to reduce.*

- *To help reduce the number of children who are at risk of obesity, nurseries and schools are being encouraged to participate in The Daily Mile, a simple initiative which motivates children to run or walk for 15 minutes every day. Additionally, we have been piloting Food, Families and Fun programmes in targeted areas to help tackle childhood obesity.*
- *We are members of the Child Protection Committee (CPC) which continues to be dedicated to the protection of children and young people in Perth and Kinross. One of the ways the CPC safeguards and promotes the wellbeing of children is through its work promoting the development of staff from all partners. Learning and development sessions are offered across a wide range of subjects such as Child Sexual Exploitation and Working with Children and Families Affected by Parental Substance Use.*

- ***Employability***
  The Perth & Kinross Employability Network's objective is to seek to improve employability services for young people and adults with additional challenges and barriers to work (disabilities, illness or a history of offending). The Network provides a wide range of supports, opportunities, and volunteering or work experience placements to help people achieve their personal goals/outcomes. Some member organisations also offer a range of supports to local employers.
  - *The Perth & Kinross Council Employment Support Team continue to provide supported employment to individuals across all 5 stages of the employability pipeline. The team offer employability-related support to people facing additional challenges, to prepare for, find and maintain employment. New initiatives such as Working Roots and Retails Roots offer a portfolio of opportunities to support individuals with significant barriers to work to develop skills relating to the horticulture and retail sectors. This is positive collaborative working with local retailers supporting individuals to achieve their employability outcomes and matching the workforce requirements of local businesses.*

Dementia Café

The Dementia Café offers people with dementia and their caregivers a safe, bright and welcoming environment so they can spend quality time together.

www.youtube.com/watch?v=3DhzCaj5MWc

- *Perth & Kinross Council are committed to providing opportunities for young people aged between 16 and 24. Modern Apprenticeships (MA) incorporate a work-based qualification while gaining valuable work experience in their chosen career path. Learning Disability services in partnership with Human Resources have recently been awarded full funding to support 4 Modern Apprentices through an SVQ2 in Social Care whilst developing work skills through a rotational 18 month programme. This programme will include positive development of skills and experiences across Day Opportunities, Supporting Living, and Employment Support services.*
- *Perth & Kinross Autism Modern Apprentice (MA) Scheme had its first graduate this year, with her being chosen as a finalist for the MA of the Year by the Judging Panel who stated that:*

  "They were overwhelmed with your achievements and how you have overcome significant challenges to achieve your qualification. This is testament to your commitment and determination to succeed. You have clearly flourished within the role and your happy positive outlook and enthusiasm shone through. The judges were incredibly proud to hear your journey and the support your colleagues and supervisor has provided. Well done!"

- *127 people from a range of mental health services registered with the Live Active Leisure Compass membership.*

Improvement Areas for 2018/19

- *Work with Scottish Prison Service and Public Health to support progress towards smoke free prisons.*
- *Initiatives to reduce the number of people who are overweight or obese, targeting resources at those most at risk.*
- *Mental Health and Wellbeing continues to be a priority. A continued focus on recovery and work to develop a recovery-focused model on substance misuse as well as mental health.*
- *We commenced development of the British Sign Language (BSL) Local Authority Action Plan which is due for publication in October 2018.*
- *A commissioning plan for mental health and wellbeing and for people with learning disabilities is being developed and will set out our priorities for the coming years.*
- *Development of welfare advice services in GP practices in Perth and Kinross, based on the co-location service model in Dundee City. This fits with the Scottish Government's commitment to establish additional community link worker roles in Primary Care, one of six priorities for Health and Social Care Partnerships in relation to Primary Care Improvement Plans.*

How did we do?

Table 8 below summarises some key indicators which support the National Health and Wellbeing Outcome 7 - Keeping People Safe from Harm.

Indicator	2015/16 Perth and Kinross	2016/17 Perth and Kinross	2017/18 Perth and Kinross	How we compared to our last Perth and Kinross result	How we compared to the Scottish Average	2017/18 Scotland
Percentage of adults supported at home who agree they felt safe. *(Source: HACE**)*	80.00%*	n/a	85.00%	↑5.00%	↑2.00%	83.00%
Falls rate per 1,000 population age 65+.	20.92%	21.67%	21.75%	↑0.08%	↑0.07%	21.68%
Percentage of adult protection cases screened within 24 hours of notification.	94.00%	96.00%	93.00%	↓3.00%	n/a	n/a
Number of service users with Telecare equipment installed (excluding community alarms).*	n/a	n/a	1,416	n/a	n/a	n/a
Community Alarm: service users (number).	n/a	2,864	3,681	↑817	n/a	n/a
Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency.	28.30%	27.18%	26.01%	↓1.17%	↑3.01%	23.00%

How we compared to our previous year/period performance or National Average:

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

** 2015/16 recalculated by Scot Gov with new weighting.*
*** HACE survey is undertaken every two years therefore information is not available for 2016/17.*

85% of adults supported at home agreed that they felt safe; this sits just above the National Average. We want to ensure that people feel safe whatever environment they are in, whether at home, hospital or other care setting and we will ensure that our practices support this aim. We have worked closely with partners within the Adult Protection Committee and continue to develop strategies and interventions that will reduce harm.

- ***Falls***
  The falls rate for over 65s has increased slightly as outlined in the table above. This is in spite of the preventative work we have undertaken to improve the level of physical activity through a number of initiatives including the CAPA project and the work undertaken through Active Communities. There is some evidence that the older population is living at home with more complex needs for longer and this highlights the need to ensure our services proactively focus on safety.

- ***Adult Protection Cases***
  Supporting vulnerable people in Perth and Kinross to live independent lives and make choices is one of our key priorities. Any adult who is deemed to be at risk of harm and is unable to protect themselves will come under the remit of adult support and protection (ASP). All ASP activity in Perth and Kinross is overseen by the Adult Protection Committee (APC), key themes identified are taken forward as part of the Public Protection Agenda.

  In 2017/18, 93% of all adult protection referrals were screened within 24 hours. This is lower than the 95% target but is monitored on a monthly basis. The last 2 quarters of the year showed 99.6% (third) and 97.55% (fourth) respectively so we are now achieving stated target.
  The performance associated with Adult Protection is reported to the Adult Protection Committee. It is expected that a report summarising the activity and improvement plan will be presented to the IJB.

- ***Telecare and Community Alarm***
  The Telecare and Community Alarm Survey carried out during 2017/18 to assess people's views on the services provided found that:
  - *100% of respondents strongly agreed/ agreed that they were supported to live as independently as possible;*
  - *90.2% of respondents strongly agreed/ agreed that support received helped to make them feel safer.*

  The telecare service replaced their old monitoring system 2 years ago and this has allowed us to more accurately report on the users. The 2017/18 value above is our new baseline from which we will be able to monitor the growing use of Technology Enabled Care distinct from traditionally simpler Community Alarm system user. The total community using a mix of Community Alarm and Telecare or both is up 28% on the previous year and sits at 3,681 at the end of the financial year.

- ***Resource Spent on Hospital Stays***
  We have been making progress in reducing the number of people admitted in an emergency. This is down to increased provision in relation to Step-Up care, the Rapid Response service, older people mental health support to Care Homes and Enhanced Community Support. These enhanced community supports are making a difference in terms of supporting people to remain within the community and avoid hospital admission.

What else have we achieved?

- ***Technology Enabled Care (TEC)***
  We continued to develop the range of support and services that are available for people to enable them to remain at home, such as:
  - *using the i-care assessment tool to provide better assessment of capability to live independently and reduce/delay admissions to care. 23 assessments have been carried out this year; results are being collated and early indications show a number of instances where the individual can remain at home longer safely with appropriate support;*
  - *encouraging more services to interact with patients/service users via video conferencing. Promoting the use of 'Attend Anywhere' to services such as OTs, respiratory nurses, PKAVS and Live Active;*
  - *increasing the use to telecare through engagement sessions and training delivered at the 'SMART Flat' and out in localities. Over 500 people have attended engagement sessions - staff members, partner organisations, carers, and service users. 175 staff have been trained on awareness of and assessing for telecare;*
  - *researching and introducing new technologies such as digital telecare which removes the need for a fixed landline, and new GPS solutions to keep service users safe when out and about;*
  - *piloting 'Brain in Hand' - a smartphone App that supports users with Autism, results of an initial pilot with 10 users are being collated.*
  - *exploring the use of Home Health Monitoring solutions to give service users more control over managing their conditions, using 'florence' to support weight management clinics, and pursuing funding to test solutions for COPD patients.*
- ***Care About Physical Activity (CAPA)***
  Perth and Kinross HSCP are one of the pilot sites for the Care Inspectorate 'Care About Physical Activity' CAPA improvement programme which

Case Study

One resident in a Care Home was overweight and on medication for diabetes. With moving more and doing a daily walk around the building with a fellow resident, they lost weight and also had their diabetes medication stopped. This has increased their confidence and encouraged them to be more sociable.

Go4Gold Challenge

The Go4Gold Challenge promotes physical activity in a fun and inclusive way for members of Care Homes and day centres.

www.youtube.com/watch?v=uHI7po0snmw

seeks to build the skills, knowledge and confidence of our care staff to enable those they care for to increase their levels of physical activity and move more often. This involves 13 Care Homes, 4 day care services, 2 sheltered housing organisations and 5 Care at Home Providers. Evidence of improvements and progress includes:

- *Environmental alterations are being made in garden grounds to promote activity, creating new paths and providing objects of interest. Altering dining experience has reduced passivity through self-serving ideas and promoted social connections and general wellbeing.*
- *Increased exercise classes delivered in the care settings with 41 care staff trained in strength and balance and chair-based exercises. Perth College UHI students provide a programme of exercise and activity sessions to residents within 7 care settings. Live Active Leisure supporting specific strength and balance exercise groups.*
- *One care setting is working alongside Paths for All and local services to create a Care Home walking pack with charts for recording steps, information booklets, challenges and mapping out routes both within and outwith the setting with a view to sharing locally and nationally.*
- *Individual powerful resident/client stories including residents returning to live at home from a Care Home, homebound residents now walking into town, increased independence in daily living activities. One of many examples below.*

Improvement Areas for 2018/19

- *An increase in the use of Technology Enabled Care to complement support for carers and to reduce the need for care at home where this is appropriate. Key areas of focus include:*
  - *Pilot digital telecare with 100 service users as part of Scottish Governments analogue to digital wave 1 work. We will be one of the first local authorities in Scotland to offer this to our service users and the outcomes will help determine the national direction of travel.*
  - *Continue with work to see our Telecare service accredited by the TSA (Telecare Services Association). This voluntary code of practice gives reassurance to staff and service users that we operate a safe and robust service that meet an industry recognised quality standard.*
  - *Continue to provide telecare solutions tailored to individual need in line with our ambition to enable people to live at home safely and independently for longer.*

Partnership Objective 5

Making the best use of people, facilities and resources.

National Health and Wellbeing Outcome 8

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

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

National Health and Wellbeing Outcome 9

Resources are used effectively and efficiently in the provision of health and social care services.

The theme of this outcome runs through the Annual Performance Report. More detail regarding resources being used effectively and efficiently are provided in Section 3: Working in Localities and Section 4: Finance and Best Value.

The following section provides detail on performance and achievements using indicators, progress on improvement areas and stakeholder feedback including case studies.

How did we do?

Table 9 below summarises some key indicators which support the National Outcome 8.

Indicator	2015/16 Perth and Kinross	2016/17 Perth and Kinross	2017/18 Perth and Kinross	RAG	2017/18 Scotland
Percentage of staff who say they are treated fairly at work.	82.0%	85.0%	83.4%	↓1.6%	n/a
Percentage of staff who say their daily role provides them with opportunity to use their strengths.	79.0%	80.0%	81.8%	↑1.8%	n/a
Percentage of health staff who say they are treated fairly and consistently.	79.0%	80.0%	Due July 18	n/a	n/a
Percentage of health staff who say their work gave them a sense of achievement.	71.0%	81.0%	Due July 18	n/a	n/a

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

Perth & Kinross Council carried out their **annual staff survey for Adult Social Care** in October 2017. Key findings highlighted that 83.4% of staff agreed that they were treated fairly at work, 81.8% of staff agreed that their daily role provides them with opportunity to use their strengths. 87% also agreed that their team were passionate about delivering excellent customer service and the people they work with are committed to doing their best. Improvement areas have been identified by senior management based on the results and actions are being taken forward.

The **second IMatter survey** was circulated to staff in June 2018, a report on key findings will be distributed to relevant teams to take forward improvement actions. It is intended that there will be a joint single survey undertaken for all staff during 2018/19.

What else have we achieved?

- ***Delayed Discharge***
  Managing delayed discharged continued to be a key priority. Activities for this year included:
  - *Various recruitment fairs have been held across Perth and Kinross to actively recruit to Health and Social Care services. A recruitment programme was held for Care at Home including a high-profile marketing campaign that successfully recruited additional staff to Care at Home.*
  - *Work has been carried out on enhancing the multidisciplinary team in the medical admission ward. The 'Assess to Admit' modelling in Perth Royal Infirmary has progressed well, as is the enhancement of the Medicine for the Elderly Frailty team (Mufti) which will help to reduce the number of admissions at the hospital front door and promote rapid discharge pathway activity either to a home, community hospital, intermediate care or a homecare setting.*
  - *The Social Care Hospital Discharge team has been increased by 100% capacity over the year and the PRI Liaison services have been enhanced with an increase in psychiatry of old age nurses and Care Home Liaison nursing. Social Care has also radically improved funding procedures for Care Home placements - eradicating delays due to awaiting funding. These improvements are supporting speedier discharge to a Care Home setting or repatriation to such.*
- ***Enhanced Community Support***
  Enhanced Community Support (to prevent hospital admission and crisis situations arising) is available across all localities including all General Practice surgeries. As a result staff receive referrals earlier and this helps towards positive outcomes for the clients, ie remaining within their own homes.
- ***Third Sector Level Agreements***
  A review of Third Sector Service Level Agreements 2017 found that Third Sector services are meeting key objectives of the Perth and Kinross Health and Social Care Strategic Commissioning Plan 2016-2019. They represent good value for money overall and lever in additional charitable funding. The review also demonstrates that the commissioned services are instrumental at stepping in at an early stage and intervening prior to a person reaching crisis stage. They are often successful in preventing people from requiring statutory services.

Improvement Areas for 2018/19

- *Complete 3 year workforce plan in line with the refreshed Strategic Commissioning Plan.*
- *Managing delayed discharge will continue to be a priority and we will need an increased focus on recruitment and retention of care staff across the whole of the health and social care system with partners in the third and Independent Sectors.*
- *Mapping and managing corporate assets such as buildings will be a priority.*

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

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

We continued to plan and deliver across the whole system of health and social care, and include the Third and Independent sectors, as well as housing and other key partners, if we are to enable people to have the health and care services they need in their local communities. We are doing this through regular locality meetings at both management and community level. This had led to a number of integrated care teams developing across the Localities. The pace has been determined by local need and engagement however progress is being made.

The work with public health will be critical to developing a greater understanding of the issues that present in Perth and Kinross to enable us to tackle health and social care inequalities effectively.

As we stated last year the success of working in communities will see:

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

We have developed stronger links with the Local Action Partnerships (LAP) and working together on priority areas such as reducing social isolation. HSCP joined together with Local Action Partnerships to deliver a round in Participatory Budgeting in each locality. 221k was distributed to 151 projects with over 7,000 local people voting.

We are seeing a number of initiatives developing such as the collaborative work in Strathmore between social work fieldwork teams, Strathmore Centre for Youth Development (SCYD), day opportunities and stronger communities to support neighbourhood planning. Initiatives include local social events to bring people together; the development of a Neighbourhood Networking scheme; support for individuals who have no family or friends to call on to allow people to live independently in their own homes for as long as possible and the development of a garden project and café in the evenings and weekends to include people who would otherwise be socially isolated.

We also have plans to work with Housing and Mobile Library colleagues with the purpose of signposting in the more rural areas.

Highlights of 2017/18

The following section provides details on areas of work that have been taken forward across the three localities:

Perth City Locality

- *Scoping for the implementation of an **Integrated Care Team in Perth City** has been carried out and a number of meetings have taken place with relevant stakeholders around developing the Integrated Care Teams in Perth City. This will result in core professionals including District Nurses, Social Workers, OTs, GPs and Mental Health Nurses working in a co-ordinated manner to support people to live as healthily, happily and independently as possible in their own homes.*
- *Implementation of the **Perth City Steering Group**. This group consists of representatives from Health, Local Authority, Third Sector and the local community and influences service development to try and ensure they meet local requirements.*
- *Working with **local faith groups** to combat social isolation through day care, befriending and assistance with podiatry.*

South Locality

- *South Locality **Integrated Care Team** maintains a Locality Action Plan which identifies activities to support the achievement of the Strategic Plan objectives and ensuring that the partnership's priorities are met. The Action Plan is updated after each monthly meeting to ensure progress, and tasks are devolved across appropriate constituent partners, reflecting a holistic person-centred approach, and focussing on community engagement. Updates also enable the plans to develop reflecting changes in legislation and local strategies, and embedding best practice.*
    - *The Integrated Care Team in the South Locality meets on a weekly basis in different bases across the locality to enable front line practitioners and clinicians to attend where appropriate. The team includes Social Workers, District Nurses, Occupational Therapists, Mental Health Nurses, GPs and Third Sector representatives. The discussions focus on providing co-ordinated and effective assistance to people with complex support requirements including*

Perth Health and Wellbeing Café

The café meets monthly at the Salvation Army building in the centre of Perth and provides a place for adults and their cares to meet and chat in an informal setting. As well as providing emotional support to each other, statutory workers also attend and offer advice and information on a wide range of statutory, Independent Sector and community-based services and supports.

The café is community led and is financially self sufficient. It was set up in response to a survey of local people. One of the main findings was concerns about the lack of places for people to meet up in the city centre. The number of people attending the café continues to grow with new people coming every month as word spreads and the variety of people increases including older people, carers, people with a physical disability and people with mental health issues.

There is evidence the café is helping improve the quality of people's lives and access appropriate supports.

people who require support to return home from hospital.

- *The work of the ICT has contributed to a reduction in the number of people delayed in hospital in the south locality in recent months.*

- *In the past year, actions included the **implementation of Social Prescribing** to enable people needing support to be able to use community resources, the local promotion of working as a Personal Assistant and the use of participatory budgeting to enable local support groups to access funding.*
- *The **Local Network Group** is attended by most members of the Integrated Care Team along with community groups, local voluntary agencies, businesses and local Councillors. The group discusses local issues and how to address them. One of the key issues in the South Locality is the lack of availability of Care at Home. The Local Network Group is currently working on plans to support the Kinross Day Centre to provide an outreach lunch service to the rural areas around Kinross, such as the Crook of Devon. They are also supporting private Care at Home providers with recruiting and training staff.*

Complex Support Requirements

There are also numerous case studies of people with complex support requirements who are being maintained at home with support from the Team. The Team recently supported Mrs M who was delayed in a community hospital. She had been given a palliative diagnosis and it was her wish to return home. The team worked together to source a package of care, OT equipment and a hospital bed to enable her to return home to pass away in her own home.

North Locality

- *Scoping for the implementation of an **Integrated Care Team** in the North Locality has been carried out and there have been a number of meetings with relevant stakeholders around developing Integrated Care Teams in the North. This will result in core professionals including District Nurses, Social Workers, OTs, GPs and Mental Health Nurses working in a co-ordinated manner to support people to live as healthily, happily and independently as possible in their own homes, preventing admission to hospital where appropriate.*

- *Recent implementation of the weekly Integrated Care Team meeting ensures an operational approach to proactively managing our locality patients in a delayed discharge position and managing community frailty, vulnerability and risk, thereby supporting people to lead independent, healthy and active lives. This group has now been delegated to leads in the locality and an operational report is escalated to service managers following the meeting ensuring escalation of issues requiring senior management support are responded to appropriately. This has improved joint working and the monthly management meeting has been set up to support team leaders from all disciplines across health and social care to ensure leadership and action around the locality action plan and operational further developments.*

- ***Locality Staff Nurse Rotational Posts*** *- the philosophy of this development is about* ***putting patients at the centre of the nursing care pathway*** *within a rural integrated locality. Rotational posts will improve nurses knowledge and skills, provide development opportunities and the ability to recruit and retain nurses whilst developing a more versatile and flexible workforce across a locality. The nurses are employed on rotational contracts through Pitlochry Community Hospital and Pitlochry Community Nursing Teams. This project is being led locally by Head of Nursing, team leaders and senior charge nurses and led by the lead nurse.*

What else have we achieved?

- ***Social Prescribing Posts***
  Three new Social Prescribing posts are under recruitment and will be aligned to localities to work with identified GP practices and frontline statutory workers. Social Prescribers will support individuals to explore their goals relating to health and wellbeing and access appropriate community-based supports.
- ***Local Health and Wellbeing Groups***
  A series of Local Health and Wellbeing Groups have been established across localities to support community dialogue and action around health and enable direct connections with Locality Steering/ Management groups. For example in Perth City the Health and Wellbeing group identified the need for a city centre information and support hub. Representatives from the group presented their ideas to the Locality Steering Group and following a positive response, work is now ongoing bringing together key community organisations and other partners to develop a business plan. At present in Perth City, two community representatives sit on the Locality Steering Group.

Carers Options

Recent negotiations have successfully taken place with our Option 2 provider to add overnight care to their care options; this has enabled two service users to remain at home with extra support to allow their carers to have a break. The carers have reported the impact of knowing their loved one is being cared for in their own home as opposed to feeling guilty about having them move to a Care Home setting.

The local Care Home has also been supportive in agreeing to step in if for any reason these plans fall through, this has left carers feeling confident that contingency plans are in place. These arrangements have been made in conjunction with community nursing staff and the community psychiatric team who have provided extra support and reassurance and contributed to the success of these arrangements.

Building capacity and options in our Third Sector providers and confidence within the wider multi-disciplinary team gives people more choice and opens up positive conversations regarding how they would like their support. One carer said that she was *"dreading the thought of placing her mother in a Care Home to enable her to have a break"* and had not thought that there would be any other option for her.

- ***Locality Management Teams***
  The locality management teams are established across the three localities and they are developing local multi-disciplinary teams. A number of different organisational development techniques have been used to support this including action learning sets to facilitate this work.
- ***Healthy Communities Collaborative staff*** *are now disaggregated into our 3 localities focussing on early intervention and self-support.*

The Health & Wellbeing Café

www.youtube.com/watch?v=zuxV9Vh0ouw

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

Finance and Best Value

Financial Plan 2017/18

Strong financial planning is required to ensure that our limited resources are targeted to maximise the contribution to our objectives. Like many other public sector bodies, we face significant financial challenges and will be required to operate within extremely tight financial constraints for the foreseeable future due to the difficult national economic outlook and increasing demand for services.

The 2017/18 Financial Plan set out that based on the budget offer from Perth & Kinross Council and NHS Tayside, break-even was achievable on all services except GP Prescribing and Inpatient Mental Health (which is hosted by the Partnership on behalf of all three Tayside IJBs). We have been working with NHS Tayside to develop 3 Year Recovery Plans for both areas however financial balance was not anticipated in 2017/18 with an overall gap of £2.4m forecast.

Across all services, the Financial Plan set out anticipated recurring savings of £2.8m. The level of savings required reflects the underlying level of unavoidable cost and demand pressures facing health and social care services.

Financial Performance 2017/18

Budget monitoring of IJB delegated functions is undertaken by finance teams within the Perth & Kinross Council and NHS Tayside, reflecting the IJB's role as a strategic planning body which does not directly deliver services, employ staff or hold cash resources. However, it is important that the IJB has oversight of the in-year budget position as this highlights any issues that need to be accounted for when planning the future delivery of health and social care services.

In 2017/18 we achieved a balanced budget position despite there being key pressures on the system. During the year, we worked closely with NHS Tayside to identify transformation and cost reduction plans to address the shortfalls in GP Prescribing and Inpatient Mental Health, however as anticipated both areas incurred significant overspends. This was funded by NHS Tayside through their achievement of an overall break even position. The cost of NHS delivered services therefore matched the income available.

Within Social Care Services a significant under spend of £2.6m was achieved. £1.3m of this was through acceleration of 2018/19 planned savings. Perth & Kinross Council carried forward this under spend in a reserve earmarked for social care and therefore a break even position is also reported on social care services.

Our financial performance for the year is summarised in the table detailed on the following page.

	Budget £000	Actual £000	Variance Over/ (-)Underspend £000
Older Peoples Service/Physical Disabilities including AHPs	65,371	63,777	(1,594)
Learning Disabilities	18,237	17,378	(859)
Mental Health and Addictions	4,943	4,958	15
Planning/Management/Other Services	7,780	7,047	(733)
Prescribing	26,763	28,467	1,704
General Medical Services	23,392	23,204	(188)
Family Health Services	16,481	16,474	(7)
Hosted Services	20,666	20,970	303
Large Hospital Set-Aside	11,793	11,793	-
Total	**195,426**	**194,068**	**(1,358)**
Breakdown of Variance:			
Health	145,865	147,144	1,279
Social Care	49,561	46,924	(2,637)

Overall, recurring savings of £2.8m were delivered against the £2.8m plan.

The current challenging financial climate reinforces the importance of managing expenditure within the financial resources available and this will require close partnership working between the IJB as service commissioner and NHS Tayside and Perth & Kinross Council as providers of services.

Financial Outlook

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

A Financial Plan for 2018/19 is currently in development with the objective that the IJB operates within resources available. A budget settlement with Perth & Kinross Council and NHS Tayside has been agreed. Discussions are continuing with NHS Tayside in relation to Prescribing

and Inpatient Mental Health (which Perth & Kinross IJB hosts on behalf of all three IJBs). However significant transformation and cost improvement plans are being developed for both areas which should support future financial sustainability.

However both settlements present significant challenges in terms of accommodating demographic and inflationary type pressures across core services. In particular pay, price and demand pressures across social care services are estimated at £4.6m for 2018/19 with similar levels forecast for the next two years. Whilst a significant transformation and efficiency programme has been identified for 2018/19 the scope of opportunity for further major transformation across services will not be sufficient to address the level of social care pressures moving forward. Early discussions are taking place with NHS Tayside and Perth & Kinross Council around the 2019/20 Budget Settlement however both parent bodies are facing a very difficult financial outlook.

Best Value

Best Value is about creating an effective organisational context from which Public Bodies can deliver key outcomes. The following five 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 Leadership***
  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 Health and Social Care Partnership (PKHSCP) Team. The Strategic Plan has been developed in close consultation with a wide range of stakeholders. PKHSCP are currently developing Strategic Delivery Plans for its 4 Key Care Programmes and each will be supported by a performance framework against which progress will be monitored.

- ***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 with the support of PKAVS as the Third Sector Interface in Perth and Kinross and a flourishing Third Sector Health & Social Care Strategic Forum. The Forum has 43 organisational members. Members meet regularly to engage with the Partnership's business, strengthen connections and progress joint action.

- ***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 intensive 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 development of a Strategic Plan in consultation with stakeholders, the robust financial planning arrangements and the publication of this Annual Performance Report give a clear demonstration of our best value approach.

- ***Use of Resources***
  The IJB is 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 transformation and efficiency proposals are in line with strategic plan objectives. The Clinical Care Governance Board has oversight of all transformation proposals to ensure that quality of care and service delivery is not compromised.

- ***Performance Management***
  The IJB's Performance Management Strategy focuses firmly on embedding a performance management culture throughout its activities. Regular reports on performance have been provided to the IJB. In addition the establishment of an Audit & Performance Committee ensures an effective level of performance review and scrutiny.

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

How did we do?

Care Inspectorate

During 2017/18, 8 Perth & Kinross Council services received an inspection by the Care Inspectorate at Beechgrove House, Dalweem Care Home, Parkdale Care Home, Care at Home, Strathmore Day Opportunities, Adults with Learning Disabilities Housing Support, Older People Housing Support and Homeless Housing Support.

Key findings from the Care Inspectorate across the services included:

- ***Parkdale Care Home***
  Quality of Care and Support awarded Excellent (Level 6) and Staffing Very Good (Level 5). Relatives were confident that their loved ones were well looked after and were receiving an excellent level of care. The inspectorate acknowledged that Parkdale has a very calm, friendly and welcoming atmosphere.
- ***Dalweem Care Home***
  Quality of Care and Support and Staffing both awarded Very Good (Level 5). All of the residents the Inspectorate spoke with were happy with the care and support received and said that staff treated them with respect and kindness.
- ***Beechgrove House***
  Quality of Care and Support and Management and Leadership both were awarded Excellent (Level 6). The Inspectorate received very positive feedback from residents and families during the course of the inspection.
- ***Care at Home***
  Quality of Care and Support and Management and Leadership both awarded Very Good Level 5 and Staffing received Good (Level 4). People were pleased, or very pleased, with the support that they had received from the new service. People were listened to, treated warmly with dignity and respect, and staff genuinely cared about the outcomes for people they supported.
- ***Adults with Learning Disabilities Housing Support***
  Quality of Care and Support and Staffing both awarded Very Good (Level 5). People who use the service were happy with the support they received and said they got on well with the staff who supported them.
- ***Strathmore Day Opportunities***
  Quality of Care and Support and Management and Leadership both awarded Very Good (Level 5). People felt less isolated and enjoyed what the service offered, relatives also described how they felt their relatives had increased in confidence as they had more opportunities to meet more people.
- ***Older People Housing Support***
  Quality of Care and Support and Management and Leadership both were awarded Very Good (Level 5). Support offered to tenants by the service was consistently very responsive, timely and caring. The staff team had a warm and friendly approach and had clearly built up very positive relationships with tenants in all of the sheltered housing complexes.

- ***Homeless Housing Support***
  Quality of Care and Support and Staffing both awarded Excellent (Level 6). People using the service were very positive about the support they had received and, in particular, praised the staff team for their efforts and commitment.

What people told the Care Inspectorate during their inspection visits:

- *"If I need to, the staff can help me go to appointments like the dentist."*
- *"It has given me my life back. I had lost the art of conversation."*
- *"The standard of care that my relative receives is very high and we are made to feel very welcome when we visit."*
- *"If you could give them above 10/10 I would."*

All services are committed to continuous improvement and have developed action plans in response to inspections including suggested areas for improvement by the Care Inspectorate and feedback from service users and relatives.

Commissioning Services

The following section provides details on grading awarded by the Care Inspectorate for inspections carried out during 2017/1/8 and includes services for Older People Care Home, Mental Health and Learning Disability Supported Living services.

Care at Home for Older People

During their inspection visits the Care Inspectorate carried out inspections across quality themes for Care and Support, Staffing and Management and Leadership. Out of the 11 services inspected **26 quality themes** were assessed in total. The following grading was awarded:

- ***2 quality themes*** *inspected received Excellent for the quality of Care and Support and for Management and Leadership.*
- ***17 quality themes*** *inspected received Very Good/ Good grading: 8 Care and Support, 6 Staffing and 3 for Management and Leadership. These grades awarded by the Care Inspectorate represent increasingly better levels of performance.*
- ***4 quality themes*** *inspected were awarded Adequate grading: 1 Care and Support, 2 for Staffing and 1 for Management and Leadership. Grading represents performance that the Inspectorate finds acceptable but which could be improved.*
- ***3 quality themes*** *inspected received grading of Weak for quality of Care and Support and Management and Leadership (2) which indicates concern about the performance of the service and that there are things which the service must improve.*

	Grading Awarded by the Care Inspectorate at Latest Inspection					
Quality Themes	**Excellent (Level 6)**	**Very Good (Level 5)**	**Good (Level 4)**	**Adequate (Level 3)**	**Weak (Level 2)**	**Unsatisfactory (Level 1)**
Care and Support	1	5	3	1	1	0
Staffing	0	5	1	2	0	0
Management and Leadership	1	2	1	1	2	0
Total	**2**	**12**	**5**	**4**	**3**	**0**

Feedback from service users/carers during the inspections included:

- *"Service users spoke highly of the carers and the care they received."*
- *"As a relatively new user of the service I am extremely impressed with it. I couldn't manage the care of my husband without their support."*
- *"I feel confident with the carers who support me; they keep me independent in my own home."*

Supported Living Services - Learning Disabilities and Mental Health

During their inspection visits the Care Inspectorate carried out inspections across Quality of Care and Support, Staffing and Management and Leadership. Out of the 10 services inspected **21 quality themes** were assessed in total. The following grading was awarded:

- ***7 quality themes*** *inspected were awarded Excellent grading: 5 for the quality of Care and Support and 2 for Management and Leadership.*
- ***14 quality themes*** *inspected received Very Good grading: 5 for quality of Care and Support, 4 for Management and Leadership, and 5 for quality of Staffing.*
- ***No services*** *received an Adequate or Weak grading for the quality of Care and Support, Staffing and Management and Leadership.*

Feedback from service users/carers during the inspections included:

- *"Staff make suggestions about what I should do but they don't force me to do anything I don't want to do."*
- *"Excellent service, is the best thing to have happened to X, he is very happy."*
- *"Big difference in X. When talking about how well their relative was getting on as a result of support from this service."*

	Grading Awarded by the Care Inspectorate at Latest Inspection					
Quality Themes	**Excellent (Level 6)**	**Very Good (Level 5)**	**Good (Level 4)**	**Adequate (Level 3)**	**Weak (Level 2)**	**Unsatisfactory (Level 1)**
Care and Support	5	5	0	0	0	0
Staffing	0	4	0	0	0	0
Management and Leadership	2	5	0	0	0	0
Total	**7**	**14**	**0**	**0**	**0**	**0**

- ***Mental Welfare Commission - Psychiatry of Old Age***

  The Mental Welfare Commission visited the Psychiatry of Old Age wards at Murray Royal Hospital on 7 June 2017. The visit was focused on care planning, but also to look generally at the provision of care and treatment in the three wards. The commission observed the care and treatment being provided in the three wards during the visit, and patients appeared to be well looked after. Patients spoke positively about staff, and felt staff were attentive and approachable. Relatives they met in all three wards also spoke highly about the care and treatment being provided, the attitudes of staff, and that they felt staff keep them very well informed.

  The commission made four recommendations, which are now being addressed by the service. These were in relation to enhancing activity provision, exploring ways for patients and/or relatives to participate in the MDT meetings, replacement of furniture, and the new electronic records system.

- ***Perth and Kinross Community Hospitals***

  The Mental Welfare Commission also visited the four Perth and Kinross Community Hospitals during August and September 2017 as part of a national programme of community hospital visits. This visit was for the commission to meet with health staff, carers, and inpatients with a diagnosis of dementia or who were being assessed for dementia. The commission noted good interactions between staff and patients, with the physical healthcare needs of patients being met, and good multidisciplinary working.

  The commission made several recommendations, which are now being addressed by the service. These were in relation to attendance at the multidisciplinary team meetings by GPs, more diverse set of activities for the patients to participate in, and environmental improvements.

- ***New Health and Social Care Standards***

  From 1 April 2018 the new Health and Social Care Standards will be taken into account by the Care Inspectorate, Healthcare Improvement Scotland and other scrutiny bodies in relation to inspections, and registration, of health and care services.

  The Perth and Kinross Health and Social Care Partnership have been working with IRISS as part of a larger project exploring the new standards and looking at how the new standards can be embedded into practice across services. The partnership meetings which are also attended by a range of multidisciplinary agencies which includes the Care Inspectorate provides opportunities to share learning around the new standards.

Overall Assessment

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

Health and care services are always developing and in our second year we continue to see evidence of improvement.

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

To achieve our ambitions we require input from the wide range of partners; health and social care professions; the third and private sectors, as well as the feedback and contributions received from our customers and local communities. We acknowledge the strong support from members of the Third Sector Health & Social Care Strategic Forum who are driving collaborative action and strengthening partnership working with the Third Sector. Similarly, Health and Wellbeing Groups in localities and many other service user and carer groups are integral in helping us ensure a partnership approach. Collectively this input has proven invaluable in the achievement of the successes we have had so far.

We need to continue to maximise the opportunities of this collaborative working if we are to fully realise our ambitions and to transform the way services are delivered. There are many challenges ahead and we recognise that our dedicated, skilled staff are committed to providing high-quality and responsive care. We will continue to be innovative, resilient and, importantly, focused on positive outcomes for the people of Perth and Kinross.

Review of our Strategic Plan

Our Strategic Commissioning Plan runs from 2016-2019 and work is now underway to refresh our priorities and plan from 2019 onwards. Much of this report has focussed on the key priorities set out in our strategic plan in order to deliver against our 5 key objectives and the 9 National Outcomes for Health and Social Care Integration. Whilst we have achieved a great deal, challenges remain and we have begun a process to ensure that the needs of a range of client groups are given a higher priority.

The financial challenge has already been outlined and we need to focus on the areas for improvement we have identified to ensure we are able to deliver integrated health, care and support services to people in need. Our plans for people with learning disabilities, mental health, older people and carers will clearly focus on commissioning priorities and we best work in partnership with the Independent Sector and Third Sector.

We will achieve further integrated strategic planning through organising our work around the following key priority areas:

- *Unscheduled Care and Older People*
- *Wellbeing and Mental Health*
- *Carers*
- *Primary Care*
- *Working in Communities*

This work will be supported by services such as Finance, Human Resources and clinical and professional leads. The involvement of those who use our services as well as engaging wider community members remains a priority and we are putting in steps to ensure participation. Our engagement and participation strategy outlines how we intend to do this, Public Partners along with the involvement of wider representatives will be central to this.

Robert Packham, Chief Officer

Appendix 1: National Health and Wellbeing Outcomes

National Health and Wellbeing Outcome 1	People are able to look after and improve their own health and wellbeing and live in good health for longer.
National Health and Wellbeing Outcome 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.
National Health and Wellbeing Outcome 3	People who use health and social care services have a positive experience of those services and have their dignity respected.
National Health and Wellbeing Outcome 4	Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.
National Health and Wellbeing Outcome 5	Health and social care services contribute to reducing health inequalities.
National Health and Wellbeing Outcome 6	People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their health and wellbeing.
National Health and Wellbeing Outcome 7	People who use health and social care services are safe from harm.
National Health and Wellbeing Outcome 8	People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.
National Health and Wellbeing Outcome 9	Resources are used effectively and efficiently in the provision of health and social care services.

Appendix 2: Summary of the contextual indicators used within this report and previous APR

The following local indicators are used to give context to the 20 National Performance indicators that are the core indicators for the Annual Performance Report.

ID	Indicator	2015/16 Perth and Kinross	2016/17 Perth and Kinross	2017/18 Perth and Kinross	Perth and Kinross difference from previous year	2017/18 Scotland average *(unless otherwise noted)*	Perth and Kinross difference from 2017/18 Scottish Average	Notes
ISD National	Number of bed days lost to delayed discharge (excluding complex cases).	17,029	15,429	15,078	**↓351**	n/a	n/a	
ISD National	Number of people delayed in hospital for more than 14 days.	191	198	239	**↑41**	n/a	n/a	
Local ASW	Percentage of people requiring no further services following Reablement.	38.0%	34.0%	31.0%	**↓3%**	n/a	n/a	
LOCAL ASW	Percentage of adults 65+ with intensive needs receiving care at home.	32.0%	37.0%	38.0%	**↑1%**	n/a	n/a	

ID	Indicator	2015/16 Perth and Kinross	2016/17 Perth and Kinross	2017/18 Perth and Kinross	Perth and Kinross difference from previous year	2017/18 Scotland average *(unless otherwise noted)*	Perth and Kinross difference from 2017/18 Scottish Average	Notes
Local ASW	Number of people using SDS Options 1 and 2 as a percentage of all people accessing services via SDS.	11.7%	14.4%	18.6%	**↑4.2%**	n/a	n/a	
Local ASW	Percentage of adult protection cases screened within 24 hours of notification.	94.0%	96.0%	93.0%	**↓3%**	n/a	n/a	
Local ASW	Number of people with Telecare equipment installed (excluding community alarms).	n/a	n/a	1,416	n/a	n/a	n/a	
Local ASW	Number of people with a Community Alarm service.	n/a	2,864	3,681	**↑817**	n/a	n/a	
Local Housing	Number of households presented to the Council as homeless.	898	825	999	**↑174**	n/a	n/a	

ID	Indicator	2015/16 Perth and Kinross	2016/17 Perth and Kinross	2017/18 Perth and Kinross	Perth and Kinross difference from previous year	2017/18 Scotland average *(unless otherwise noted)*	Perth and Kinross difference from 2017/18 Scottish Average	Notes
Local Housing	Number of overcrowded households in Council tenancies.	127	115	108	↓7	n/a	n/a	
Local Housing	Percentage households in fuel poverty.	38.0%	22.3%	32.0%	↑9.7%	n/a	n/a	
Local NHS	Within 12 Months of a diagnosis of Dementia, all patients will have commenced Post Diagnosis Support***	94.0%	98.0%	100%	↑ 2%	n/a	n/a	

Appendix 3: Summary of local survey results used within this report and previous APR

ID	Indicator	2016/17 Perth and Kinross	2017/18 Perth and Kinross	Perth and Kinross difference from previous year	2017/18 Scotland average *(unless otherwise noted)*	Perth and Kinross difference from 2017/18 Scottish Average	HACE 2017/18 Scottish Average *(where applicable)*
NI 01a Local Client Survey	I received a high-quality service.	89.7%	91.1%	**↑1.4%**	Not yet available	n/a	80.0%
NI 02a Local Client Survey	I can rely on the services I receive.	86.6%	85.7%	**↓1.1%**	Not available yet	n/a	74.0%
NI 03a Local Client Survey	I am supported to live as independently as possible.	89.9%	91.7%	**↑1.8%**	Not yet available	n/a	81.0%
NI 04a Local Client Survey	The help, care or support I received helps me feel safer at home and in the community.	87.9%	82.4%	**↓5.5%**	Not yet available	n/a	83.0%
NI 05a Local Client Survey	I have felt involved in making decisions about the help, care and support I receive.	83.0%	85.2%	**↑2.2%**	Not available yet	n/a	76.0%

ID	Indicator	2016/17 Perth and Kinross	2017/18 Perth and Kinross	Perth and Kinross difference from previous year	2017/18 Scotland average *(unless otherwise noted)*	Perth and Kinross difference from 2017/18 Scottish Average	HACE 2017/18 Scottish Average *(where applicable)*
NI 06a Local Client Survey	The services I have received have helped me to feel part of my local community.	64.9%	72.3%	**↑7.4%**	Not available yet	n/a	n/a
NI 07a Local Client Survey	I get a good response from social work services when I contact them during the day.	72.6%	88.5%	**↑15.9%**	Not available yet	n/a	n/a

The following Indicators are extracted from our Annual Staff Survey. Current status of updated results being validated this week.

ID	Indicator	2015/16 Perth and Kinross	2016/17 Perth and Kinross	2017/18 Perth and Kinross	Perth and Kinross difference from previous year	2017/18 Scotland average *(unless otherwise noted)*	Perth and Kinross difference from 2017/18 Scottish Average	Notes
NI 10a Local Staff Survey	Percentage of social work staff who say they are treated fairly at work.	82.0%	85.0%	83.4%	**1.6%**	n/a	n/a	
NI 10b Local Staff Survey	Percentage of social work staff who say their daily role provides them with opportunity to use their strengths.	79.0%	80.0%	81.8%	**1.8%**	n/a	n/a	
NI 10c Local Staff Survey	Percentage of health staff who say they are treated fairly and consistently.	79.0%	80.0%	Due July 2018	n/a	n/a	n/a	waiting confirmation
NI 10d Local Staff Survey	Percentage of health staff who say their work gave them a sense of achievement.	71.0%	81.0%	Due July 2018	n/a	n/a	n/a	waiting confirmation

Appendix 4: National Indicator dataset used within this report

The indicators below are the national indicator dataset that is the core dataset for the APR.

ID	Indicator	2015/16 Perth and Kinross	2016/17 Perth and Kinross	2017/18 Perth and Kinross	Perth and Kinross difference from previous year	2017/18 Scotland average *(unless otherwise noted)*	Perth and Kinross difference from 2017/18 Scottish Average	Notes
NI 01	Percentage of adults able to look after their health very well or quite well. *(Source: HACE)*	95.0%	n/a	95.0%	**no change**	93.0%	**↑2.0%**	2015/16 recalculated by Scot Gov with new weighting
NI 02	Percentage of adults supported at home who agree that they are supported to live as independently as possible. *(Source: HACE)*	81.0%	n/a	83.0%	**↑2.0%**	81.0%	**↑2.0%**	2015/16 recalculated by Scot Gov with new weighting
NI 03	Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided. *(Source: HACE)*	82.0%	n/a	78.0%	**↓4.0%**	76.0%	**↑2.0%**	2015/16 recalculated by Scot Gov with new weighting

ID	Indicator	2015/16 Perth and Kinross	2016/17 Perth and Kinross	2017/18 Perth and Kinross	Perth and Kinross difference from previous year	2017/18 Scotland average *(unless otherwise noted)*	Perth and Kinross difference from 2017/18 Scottish Average	Notes
NI 04	Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated. *(Source: HACE)*	76.0%	n/a	75%	↓1%	74%	↑ 1%	2015/16 recalculated by Scot Gov with new weighting
NI 05	Percentage of adults receiving any care or support who rate it as excellent or ? *(Source: HACE)*	83%	n/a	81%	↓2%	80%	↑ 1%	2015/16 recalculated by Scot Gov with new weighting
NI 06	Percentage of people with positive experience of care at their GP practice. *(Source: HACE)*	91%	n/a	88%	↓3%	83%	↑ 5%	2015/16 recalculated by Scot Gov with new weighting

ID	Indicator	2015/16 Perth and Kinross	2016/17 Perth and Kinross	2017/18 Perth and Kinross	Perth and Kinross difference from previous year	2017/18 Scotland average *(unless otherwise noted)*	Perth and Kinross difference from 2017/18 Scottish Average	Notes
NI 07	Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life. *(Source: HACE)*	84%	n/a	81%	**↓3%**	80%	**↑ 1%**	2015/16 recalculated by Scot Gov with new weighting
NI 08	Percentage of carers who feel supported to continue in their caring role. *(Source: HACE)*	40%	n/a	41%	**↑ 1%**	37%	**↑ 4%**	2015/16 recalculated by Scot Gov with new weighting
NI 09	Percentage of adults supported at home who agree they felt safe. *(Source: HACE)*	80%	n/a	85%	**↑ 5%**	83%	**↑ 2%**	2015/16 recalculated by Scot Gov with new weighting
NI 11	Premature Mortality Rate per 100,000.	352	348	364	**↑ 16**	425	**↓61**	

ID	Indicator	2015/16 Perth and Kinross	2016/17 Perth and Kinross	2017/18 Perth and Kinross	Perth and Kinross difference from previous year	2017/18 Scotland average *(unless otherwise noted)*	Perth and Kinross difference from 2017/18 Scottish Average	Notes
NI 12	Rate of emergency admissions per 100,000 population for adults.	11,040	11,158	10,762	**↓396**	11,959	**↓1,197**	
NI 13	Rate of emergency bed day per 100,000 population for adults.	124,651	118,566	109,842	**↓8,724**	115,518	**↓5,676**	
NI 14	Readmissions to Hospital within 28 days of discharge per 1,000 admissions.	115	117.97	109.7	**↓8.27**	96.7	**↑ 13**	
NI 15	Proportion of last 6 months of life spent at home or in a community setting.	87.90%	88.27%	89.64%	**↑ 1.37%**	88.26	**↑ 1.38%**	
NI 16	Falls rate per 1,000 population age 65+.	20.92%	21.67%	21.75	**↑0.08%**	21.68%	**↑ 0.07%**	
NI 17	Proportion of care services graded Good (4) or better in Care Inspectorate inspections.	85%	83%	88%	**↑ 5%**	85%	**↑ 3%**	Scottish Average for 2017/18 available in September 2018

ID	Indicator	2015/16 Perth and Kinross	2016/17 Perth and Kinross	2017/18 Perth and Kinross	Perth and Kinross difference from previous year	2017/18 Scotland average *(unless otherwise noted)*	Perth and Kinross difference from 2017/18 Scottish Average	Notes
NI 18	Percentage of adults with intensive needs receiving care at home	58%	60%	n/a	n/a	n/a	n/a	Due December 2018
NI 19	Number of days people aged 75+ spend in hospital when they are ready to be discharged per 1,000 population	1,005	875.2	674.3	**↓200.9**	772	**↓97.7**	
NI 20	Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	28.30%	27.18%	26.01%	**↓ 1.17%**	23%	**↑3.01%**	

Notes for Indicators 1-9 above:

A review of the weighting methodology was undertaken by the Scottish Government in advance of the 2017/18 survey, leading to some changes in the weights applied. Details of the review, the full methodology applied to the 2017/18 results and the impacts of the change are available at ***www.gov.scot/Resource/0053/00533823.pdf*** *Results at all levels of reporting are weighted.*

Glossary of Terms

A&E	*Accident & Emergency*
AHP	*Allied Health Professional*
AP/HSW	*Assistant Practitioners/Health Care Support*
CAPA	*Care About Physical Activity*
CIPFA	*Chartered Institute of Public Finance & Accountancy*
FHS	*Family Health Service*
GP	*General Practitioner*
HART	*Home Assessment Recovery Team*
ICT	*Integrated Care Team*
IJB	*Integration Joint Board*
LAL	*Live Active Leisure*
LAP	*Local Action Partnerships*
LGBT	*Lesbian Gay Bisexual Transgender*
MA	*Modern Apprentice/Apprenticeship*
MDT	*Multidisciplinary Team*
MECOPP	*Minority Ethnic Carers of People Project*
MftE	*Medicine for the Elderly*
MSG	*Ministerial Strategic Group for Health & Community Care*
NHS	*National Health Service*
NHST	*National Health Service Trust*
OT	*Occupation Therapy/Therapist*
P&K	*Perth & Kinross*
PKAVS	*Perth & Kinross Association of Voluntary Service Ltd*
PKHSCP	*Perth and Kinross Health and Social Care Partnership*
PMLD	*Profound and Multiple Learning Disabilities*
POA	*Psychiatry of Old Age*
PRI	*Perth Royal Infirmary*
ROSC	*Recovery Orientated System of Care*
ScotPHO	*Scottish Public Health Observatory*
SCYD	*Strathmore Centre for Youth Development*
TEC	*Technology Enabled Care*
TMASRG	*Tayside Multi-Agency Suicide Review Group*

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