Minute

P & K HSCP Strategic Planning Group

Minute of the above meeting held on **17 May 2022 at 1pm via Microsoft Teams**
(Recorded for minute purposes only)

Attendees:

Jacquie Pepper	Chief Officer & Chief Social Work Officer (Chair)
Zoe Robertson	Interim Head of Adult Social Work and Social Care - Commissioning (Vice Chair)
Maureen Summers	Chair of Carers' Voice & Carers' Representative on IJB
Melvyn Gibson	Carers' Rep
Ian McCartney	Volunteer
Christopher Lamont	Locality Manager
Amanda Taylor	Locality Manager
Kenny Ogilvy	Interim Head of Adult Social Work and Social Care-Operations
Jillian Milne	Chief Executive, Mindspace/Third Sector Forum
Maureen Taggart	Alzheimer Scotland/Older People
Sandra Young	Tayside Services Manager, Supporting Mind Scotland
Danny Smith	GP
Colin Paton	Communication and Improvement
Angie McManus	AHP Lead
Lynn Blair	Local Integration Lead (Scottish Care)
Sandra Auld	Service User Rep & IJB
Raymond Jamieson	Young Carers' Rep (PKAVS)
Shona MacLean	Service Manager
Christopher Jolly	Service Manager Business Planning and Performance
Careen Mullen-McKay	Nurse Consultant, Urgent Care
Carolyn Wilson	Falls Service Manager
Karen Donaldson	Chief Operating Officer **(Item 4)**
Shara Lumsden	(Minutes)

Apologies:

Ingrid Hainey	Hillcrest Futures/ Substance Use Rep
David Stokoe	CPP
Karyn Sharp	Service Manager
Alison Fairlie	Service Manager
Elaine Ritchie	Housing and Communities
Bernie Campbell	Carer Rep & IJB Rep
Bill Wood	Sense Scotland/Learning Disability Rep
Angie Ferguson	Perth Autism Support/ Autism Rep
Evelyn Devine	Head of Health

Agenda Item No.		Action

1	**Welcome, Introductions & Apologies**	
	JP welcomed everyone to the meeting and introduced herself as the new Chief Officer for the Health & Social Care Partnership.	
2	**Previous minutes**	
	Previous minutes were not discussed.	
3	**Older People National Consultation**	
	Breakout Session Groups – 4 Groups using the questions for each theme.	
	Place and Wellbeing (Theme 1)	
Q1	Do you have examples of communities, voluntary / third sector and public sector organisations working together to improve older people's health and wellbeing? And to reduce any health inequalities which they experience? What could we do to improve your access to mental health services? **Feedback Session – Group 1** • The linkage between clinical and community-based services, the need to share skill sets but the need to understand the context in which both groups of staff are working within. • Increase in need for telephone befriending service (early proactive relationship building, hugely helpful in identifying increasing need at an early stage) and the day centre is close to its capacity with people from Coupar Angus needing to come to Perth to access the service/ but high demand for this service – predominantly frail, elderly, and complex individuals. • Wide array of services wrapped around older people, but they are not always aware of these services. • Food poverty for older people – awareness and how to access. Join up some of the different services. The same people are accessing services but there are some people that the services are not reaching. • Access to foodbanks, Food Train and understanding how people can access. A need for more community food fridges. Suggestion to write to elderly people with advice on how to access. Consider the audience that need the service. Use existing partnerships to get the message out to service users. • Older population view the advice from medical professionals as gospel, this could be another option for communication. • Signposting to other services. • Social isolation – transport issues can mean people are unable to access services that they would like to go to especially if they live in rural areas. Health and mobility can also cause issues for people to even leave their home to access services. Possible solution would be to deliver services in the home or escorts to	

take people to clinics or services
- Telehealth or telecare.

Feedback Session – Group 3

- Aberfeldy hospital example
    - Community engagement & buy-in as people attached to bricks and mortar.
    - Model of health and social care that would best suit needs.
    - Became non-operational but infrastructure is there and successful model around Dalweem care home
    - Example of joint working.
- Often communities reluctant to consider change.
- Blair Atholl – lack of understanding and lack of honesty about the challenges.
- Working together more effectively – communication and engagement to stop campaigns to prevent closure – we want to consult about new services. People feel they are losing rather than gaining.
- Communication and engagement should be the primary concern.
- Community improvement groups which decide on the model of care is an example from Angus we can learn from – joint engagement.
- We need to really think carefully as a HSCP/IJB about the structures to support local decision-making and Strategic planning at a local level about how health and social care needs are met – could be LAPs etc – but we need an agreed structure to have proper future focused discussions.
- Staff are critical to get onside about the changes that need to happen – otherwise they cause distrust in their patients – use clinicians.

And to reduce any health inequalities which they experience?

- Issue is unmet need at the moment. Identify this and what can be done to address this and wider issue of poverty, education, and healthcare.
- Good examples of physical activity and LAL.
- Combat social isolation?
- Green pathways.

What could we do to improve your access to mental health services?

- Bad press – how do you turn that around.
- Sandwiches from 1970s – we all have the lived experience of this.

	• Commitment to rural services.	
	Preventative and Proactive Care (Theme 2)	
Q1	When thinking about health and social care services for older people in Scotland, what do you feel has worked well in the past? What is currently working well?	
Q9	How do you think services could be improved? When is a good time to have discussions about Anticipatory Care Planning with older people?	
Q10	Is there anything else you would like to add about preventative and proactive care for older people?	
	Feedback Session – Group 2 • Good examples of ongoing work through the Partnership to support older people. Strength and balance work. Care about walking. RVS service looking after people discharges from hospital. Care Home activity network is expanding its support around physical, mental wellbeing and a range of activities that are on offer. • What about people supported by Care at Home, which created a discussion about the people that are not able to access activities in the communities. • What age do we start with that work, should it be 50 plus? • Preparing and planning for dying – supporting work around the difficult conversations. • Should the Older People's Strategy focus on areas of high deprivation and health inequalities. Is it right to focus on areas across Perth & Kinross where there's significantly lower health outcomes for older people? • How might that work? Disinvestment in some areas of Perth & Kinross for investment in those areas where we want to see a bigger difference. Work with Community Planning Partners and whether that should be part of the Older Peoples Strategy. **Feedback Session – Group 4** • Discussions around about experience and approaches. • Conversations what is currently in place i.e., walking groups, keeping people well. How people can get their fitness back and feedback from carers. Learning from other areas around outside gyms – should this be an approach for Perth & Kinross and what that might look like. The right support at the right time. • Discussions around information and support groups in rural areas and communities. Understanding what's available and confusion around what can be accessed. • Access to respite beds. How carers are supported to access respite beds. The same beds in the same care homes.	

	• Crisis led decisions – debate around people not getting time to think proactively and when ACPs should be done. It was felt this should not be in hospital and should be started earlier in the communities. Thinking about ACPs and capacity. • Houses being set up for future proofing peoples' homes.	
	Integrated Care Planning (Theme 3)	
Q4 **Q12** **Q16**	What could be done to improve joint working between health and social care services? What is currently working well to support planned health care and treatment and what needs to be improved? When thinking about palliative and end of life care in Scotland, what is working well and what could be improved? **Feedback Session – Group 3** • Mental health problems – Alzheimer's – MP with constituents in England – have seen improvement – care quality commission – had a team of people trained as advocates and recognised by primary, mental health, and acute health trusts. • Culture issues – mistrust and loss of empathy of family – e.g., mother had fallen out of the bed. • Any system needs to be transparent and non-blame unless it is a criminal offence. • What will the complaints process be in new NCS – reduction of IJB powers. • Clarity and good discussion and open culture – open culture of learning – inside and out – pinching good ideas – investment in technology – celebrate what we do well. • Complaints: case reviews, Significant Event Analyses could be collated and contribute to the response – experiences, patient journeys – themed and detail. Creating a learning culture. • Consistency and joined up working. • Challenges around communication and IT. • Joint – multi-disciplinary training – COVID helped. • Use of care planning – understood by whole team – not sufficient. • Family carers are bought into what is happening. • When carers are old themselves and answer is not to split the family up – help couples stay at home. **Feedback Session – Group 1** • Joint accommodation and people sitting near each other is where conversations happen. Working collectively together in one building. • Colleagues taking responsibilities i.e., Carers Strategy. Unable to get representation from NHS. Need more health involvement. • Difficulty getting things moving. Understanding of the	

	partnership and the bureaucracy in Perth & Kinross. • Multi-agency referral pathway where recovery journeys are discussed to get to same day referral which is because agencies are working well for the care and treatment needs of the individual. If an individual meets a certain criterion for alcohol misuse the person is automatically moved to TCA, so the issue is not being resolved. It's moving from one waiting list to another. • Try to encourage people to identify the barriers to get the necessary support. • Carers are now being involved more in the IJB. • Confidentiality was an issue about passing information about a client for the carers. • Some people are involved and aware of what's going on before it gets to the IJB. • The Echo Project has made a huge difference to the Care Homes and care staff to look after clients with palliative care. • Dedicated resource for palliative care. • Improving cancer journey who will work with people who have been diagnosed with cancer. This will include signposting to Welfare Rights, Housing etc. • Non-standard hours support.	
	Integrated Unscheduled Care (Theme 4)	
Q1	What is currently working well to support older people who require urgent or emergency care and what could be improved? If you have no experience of Hospital at Home, do you think this is a service you would use if needed and benefit from? Is there anything else you would like to add about integrated planned care for older people? **Feedback Session – Group 4** • Hospital at Home and the Integrated Unscheduled Care elements. Hospital at Home is a good model, there was discussions around transitions of care and sharing of information of all relevant parties. • How carers are supported and wrap around the families as well as the person at home and what that might mean given that the person might be slightly more unwell given that they had just been in hospital. • Discussions around what other Pathways are available. • Other step-down community hospital models and how we would develop the workforce given the shortages which have currently been seen especially in rural areas. Also, how Third Sector and other partners could come in and wrap around those pathways.	

	• Discussions about compassionate care delivery and how could it be made a reality. How can it be connected locally rather than long journeys to PRI and Ninewells and what that means for family and carers. • Discussions around medication, processes, and pathways. • Telecare solutions, do they really need to travel to Ninewells to see a consultant unless it is a hand on. How could it be done better. • Conversations around Care Homes having a separate policy and approach. Feelings that this should not be separate and should be considered as part of the home. • Integration of teams, data and wrap around families. **Feedback Session – Group 2** • Discussions integrated and urgent care. • Development of Hospital at Home service and the need for it to be smoothly accessible. • Discussions around how both recipients and staff find it difficult to articulate. Needs to be better explained to the person and the staff. • Cultural challenge in terms of those that are receiving the care regarding the new integrated models are excellent integrated care services. It needs to be sold better to people. • Discussions around technology and being able to give choice especially to people in rural areas. Examples of the difference choices makes to older people. It would require investment for technology to truly support people in rural and remote areas. • Discussions around workforce challenges and the need for integrated to have staff that can move between health and social care easily. Tests are being done just now and there is a need to build on the work that is being done. • Discussions around routes of access to integrated care and how many routes there are. • Discussions around single point of referral and contact. How much of a difference this would make to people? Referral routes need to be simplified. • Discussions around 24-7, GPs weekend, step-down and how it interrupts the flow of integrated care. • Care and sheltered housing, this could be a focus moving forward. Services have been affected over the pandemic have been affected and we need to consider how to wrap this around the sheltered housing people in a different way.	
4	**Perth and Kinross Integration Scheme**	
	Karen Donaldson took on lead role to refresh and revise the Integration Scheme project between NHS Tayside and Perth & Kinross Council in relation to integrated health and social care.	

	KD will send out a copy of the presentation to the group. Integration Schemes are happening across Scotland. The 3 schemes for Angus, Dundee and Perth & Kinross will all be reviewed at the same time. The functions that are delegated to the three Tayside Integration Joint Boards are the same in the draft revised schemes as in the original schemes. The IJBs continue to be responsible for strategic planning in relation to all community-based health and social care services for adults, services related to unplanned admissions to hospital and a limited number of arrangements in relation to child health. The membership of the Integration Joint Boards is the same. SA raised the matter of membership of public partners on the IJB and the discussion that has taken place in relation to voting rights. SA indicated that there was open discussion at the IJB meeting on 30 March 2022. KD acknowledged that this would be require resolution through a change to current legislation and could not be addressed through the revision of the Integration Scheme. Public partners strongly asserted that this could be grasped as changes to structures are being forged nationally i.e., NCS. The Integration Scheme is out for consultation and is live until 27 May 2022. Feedback is encouraged from a wide range of stakeholders. The project team will be meeting to consider all the feedback that has been received. Many of the points being shared through the consultation process are not matters for the Integration Scheme. The information will be referred onto other groups. The timescale for the revised Integration Scheme will go to Perth & Kinross Council and NHS Tayside Board for approval by the respective governance bodies. It will then be submitted to the Scottish Government is 30 June 2022.	
	Older Peoples Strategy	
	ZR will collate all the information that has been received and feed this into the HSCPs National Older People Consultation response, this will be sent out to the group.	**ZR**