Appendix 1

Strategic Delivery Plan

Older People

Perth & Kinross Health & Social Care Partnership

2022-2025

TABLE OF CONTENTS

INTRODUCTION

The purpose of the Perth & Kinross Health and Social Care Partnership (HSCP) Strategic Delivery Plan for Older People is to set out the actions being taken to achieve the objectives relating to older people in the Perth & Kinross HSCP Strategic Commissioning Plan, and, connect them to the Perth & Kinross HSCP Financial Framework.

Generally, someone over 65 years might be considered an older person. However, it is not easy to apply a strict definition because people can biologically age at different rates so, for example, someone aged 75 years may be healthier than someone aged 65 years.

Instead of age, frailty has a bigger impact on a person's likelihood to require care and support. Therefore, it is important to support people to optimise their health and independence. Evidence shows that if older people are able to participate in social and leisure activities, this can make them more resilient as they age, reduce the risk of developing dementia, widen social circles to reduce the feeling of social isolation and help prevent falls. This can delay frailty, the stage at which someone becomes more at risk of illness and disability or become dependent on others for care.

That said, there are numerous conditions, such as dementia, the prevalence of which increases as people age along with an increased likelihood of requiring health and social care support. Therefore, whilst it is important to intervene early to try and delay frailty, it is also vital to have services that provide effective and efficient support for frail, older people when they require it.

For this Strategic Delivery Plan an older person is defined as someone who is over 65 years. However, due to increased life expectancy, the approximate age when the majority of people need the support of health and social care services is 75 years. Therefore, this age is used in the modelling and impact assessments below.

National Context

In March 2021, the Scottish Government issued a statement of intent relating to health and social care for older people. It emphasised the importance of valuing the contribution older people make to society and prioritised removing barriers, tackling inequality and allowing people to 'flourish and be themselves.'

The following priority areas have been identified: maximising capacity; ensuring staff wellbeing; ensuring system flow; and improving outcomes.

Local Context

This three-year plan for 2022-2025 is based on learning from delivering on the previous Strategic Delivery Plan 2019-22 approved by the Integrated Joint Board in March 2019. The Plan also builds on the improvements achieved since the establishment of the Health & Social Care Partnership in 2016.

Perth and Kinross HSCP's vision is to support older people to lead healthy and active lives and to live as independently as possible, with choice and control over their support. This Delivery Plan focuses on the following key areas

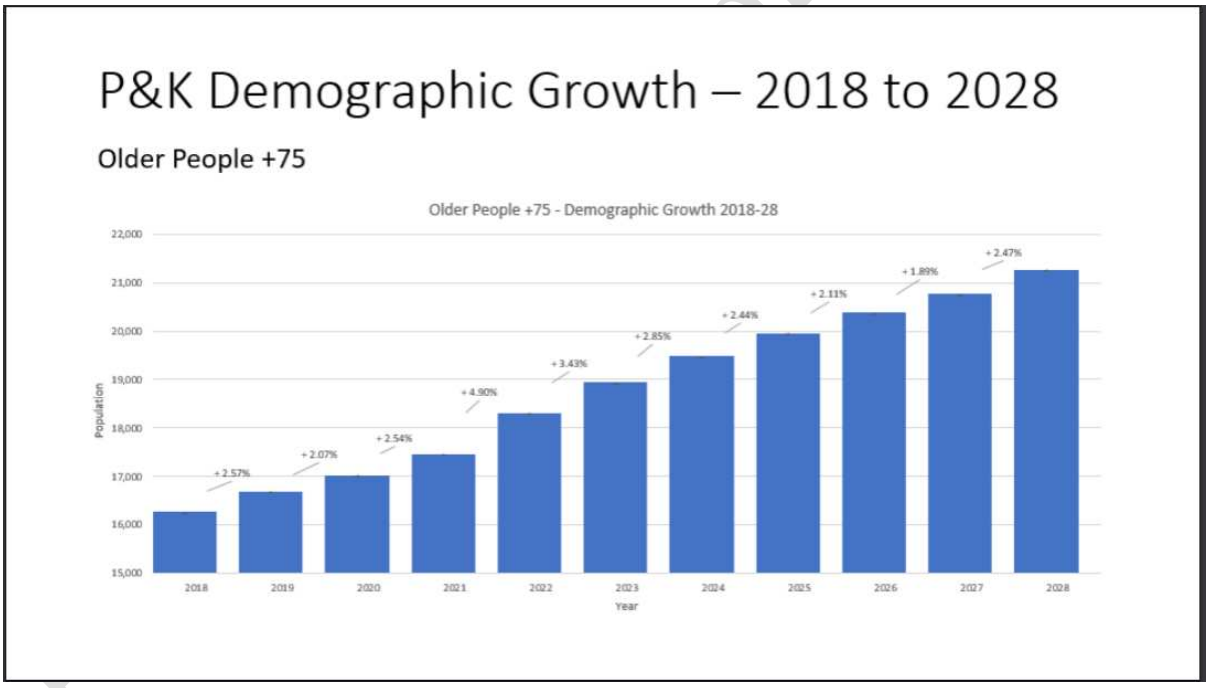
- Early intervention

- Interface Care
- Optimising Capacity & Flow
- Urgent Care Services

DEMOGRAPHICS

Perth and Kinross has a population of just over 151,000 (2018 NRS MYE). By 2028, it is expected to increase slightly to just under 153,000. We have an older population compared to the rest of Scotland. In 2018, 23% of our population was over 65 years compared with 19% in the rest of Scotland and 11% was over 75 years compared to 8% in the rest of Scotland.

The population of those over 75 years of age has increased by 9.6% since 2017 from approximately 15,900 to 17,500. This is projected to increase further and reach 19,500 by 2024 (the period covered by this Strategic Delivery Plan). This equates to an overall growth of 22.3% and represents an average growth rate of over 2.5% per annum. However, the year-on-year increases expected over 2022 to 2024 are higher with an expected 4.9% increase from 2021 to 2022.



There are an estimated 3,300 people who have dementia in Perth and Kinross. Numbers are expected to increase by around 120 year-on-year, equating to a 50% increase within the next 15 years.

The increasing older population is already affecting demand for services in Perth and Kinross:

- There has been a 5.9% increase in average, weekly Care at Home hours from September 2019 to December 2021;
- The number of people supported by Community Alarm has doubled from 2,000 to over 4,000 since 2018;

- Capacity and flow has been significantly affected by the growing number of frail older people living with multiple, complex and fluctuating conditions requiring longer lengths of stay in hospital or more complex support on discharge;
- An increase in the number of referrals for Locality Integrated Care Teams, including HART;
- An increasing number of people requiring rehabilitation input;
- An increase in the number of out of hour emergency admissions to hospital; and
- An increase in demand for support for people who have a form of dementia including access to Psychiatry of Old Age Mental Health Inpatient Beds (functional and organic).

Although Perth and Kinross is a relatively prosperous area compared to the rest of Scotland there are significant pockets of deprivation with one in five of the population in the two most deprived quintiles of the Scottish Index of Multiple Deprivation. Poverty is directly linked to increased prevalence of numerous conditions including depression, heart disease, stroke and diabetes. The likelihood of these conditions also increases with age.

STRATEGIC PRIORITIES

In order to meet increasing demand, provide high quality, effective support for older people and meet the objectives outlined in the Strategic Commissioning Plan (2020-25), Perth and Kinross HSCP will prioritise the following themes: Early Intervention, Interface Care, Optimising Capacity & Flow and Urgent Care. This will be achieved by:

- Intervening early by working with communities and partners across all sectors to develop a range of supports to encourage older people to be active and engaged and reduce social isolation to mitigate some of the effects of aging;
- Offering personalised, locally based support, including optimising the use of Technology Enabled Care (TEC), across Perth and Kinross to reduce reliance on institutional care;
- Providing a rapid, multi-disciplinary response for older people if their health deteriorates to prevent admission to hospital or a care home;
- If hospital admission is required, supporting people to return home as soon as possible once they are clinically fit; and
- Designing and implementing safe, sustainable, patient and outcomes focused systems of urgent care access, pathways and treatment for Perth & Kinross residents in the in-hour and out of hour period in collaboration with NHS Tayside.

PROGRESS TO DATE: STRATEGIC DELIVERY PLAN PHASE 1

1 EARLY INTERVENTION/ WORKING WITH COMMUNITIES

Older people have been encouraged to adopt healthier lifestyles by improving access to leisure, sport and community activities. This helps reduce isolation and loneliness and mitigates against the three major causes of death; cancer, heart disease and stroke. It also reduces the risk of isolation, depression, developing diabetes and excessive alcohol intake, all of which are significant risk factors for older people. Examples include

- Deployment of six Social Prescribers, linked to GP Practices, to help people access community-based groups and activities in their area;
- Development of pathways for Older People to engage in regular physical activity including buddy walking, health walking groups, easy exercise classes (Cardiac, Strength, and Balance, Chronic Pain) as well as an activity referral scheme for people living with long term conditions through supervised gym sessions;
- Offering a 12 week tailored exercise programme to people in their own home, with a written plan for the person to follow with encouragement from care staff and relatives. 37 referrals have been received to date with over 80 sessions taking place;
- All Home Assessment Recovery Team (HART) clients receive a Care about Walking booklet and record charts;
- Senior Home Assessment Recovery Carers have been trained to deliver strength and balance exercises;
- Day Centres/Day Opportunities run by Third Sector in Pitlochry, Bankfoot and Kinross;
- Lunch clubs supported across Perth and Kinross;
- A befriending service linked to the Timebank in Stanley;
- Working with Paths for All (PFA), to create opportunities for walking and strength and balance activities in 16 Care Homes;
- Investment in Live Active Leisure to provide exercise programmes in 11 care homes with 815 residents attending the sessions (virtual and now in person);
- Four hundred residents from 30 care homes participating in Go4Gold;
- A range of supports are available for unpaid carers to help them continue in their caring role including respite, a sitting service, replacement care, telephone helplines and alternative therapies; and
- Increased capacity for counselling to address excessive alcohol consumption.

2 SHIFTING THE BALANCE OF CARE

People overwhelmingly state they wish to remain in their own homes for as long as possible and receive support at home or in their local community rather than institutions such as hospitals or care homes.

Over the last three years there has been a focus on developing integrated models of care to provide health and social care support in local communities where people live. This includes providing alternatives to admission to hospital and care homes.

The key mechanism for delivering this has been the implementation of the Locality Integrated Care Service (LInCs) in each of the three localities in Perth and Kinross. These are multi-disciplinary teams of staff from professional groups across health and social care who provide rapid support to older people who are frail and deteriorating at home. The aim is to help the older person to improve their level of independence and prevent them having to be admitted to hospital or a care home. Over 700 people have been referred with 72% being supported to remain at home.

Other developments include:

- Commenced a redesign of the Care At Home model to improve access to support across Perth and Kinross, especially in rural areas.

- The continued roll out of Self Directed Support and ensuring all four options are available across Perth and Kinross.

- Increased uptake of Telecare and started implementation of a digital end to end service.

- Increased use of Home Health Monitoring such as using Flo to monitor people's blood pressure.

- Implemented the Advanced Nurse Practitioner role to assess and proactively manage frail adults with complex needs to help prevent further deterioration and to ensure that the right care is provided in the right place by the right person. The Advanced Nurse Practitioners have supported over 1,000 individuals working with General Practice, the Locality Integrated Care Teams, Care Homes and Inpatient Services

- Commenced a review of Psychiatry of Old Age Services to support older people with mental health issues to receive the right care, at the right time in the right place.

- Opened eight Community Care and Treatment Services across Perth & Kinross to provide care closer to the person's home.

- Implemented a Specialist Community Respiratory Team to improve the quality of life and outcomes for people living with COPD and asthma by preventing further deterioration and complications of their condition. Currently around 130 individuals have been supported through this service

- Invested in the development of a COPD App that can be downloaded on to a phone or laptop. It provides information and advice on services available locally as well as self management techniques. There are currently 55 active users with over 1,000 user interactions.

3 IMPROVING CAPACITY AND FLOW

When there is alternative to an admission to hospital, action has been taken to improve the experience of people to ensure they have access to the right treatment at the right time and to enable them to return home as soon as they are fit to do so.

Developments include:

- Developed an Integrated Discharge Hub in PRI to support effective discharge planning
- Improvements in Tay Ward, PRI focusing on environment, person centred care, ward admission criteria and discharge pathways and implementing a rehab area on the ward to ensure full MDT and carer engagement in the rehab journey.
- Commenced redesign of the Stroke Unit in PRI to deliver an effective rehabilitation model with additional allied health professional resource.
- Development of a frailty model in PRI and improving the pathway to community services to reduce occupied bed days.
- Investment in a Transitional Care Nurse for Psychiatry Old Age inpatient Services to support complex discharges
- Review of Hospital Discharge Team to improve efficiency by creating mini teams aligned to wards and introducing self allocation for workers
- A Third Sector Home From Hospital Service

IMPACT OF PHASE 1

Hospitals

The actions above, together with improvements implemented when the HSCP was first formed, have contributed to a significant reduction in occupied bed days in hospital since 2017. From analysing the Large Hospital Set Aside data for Occupied Bed Days based on the three specialty areas of General Medicine, Geriatric Medicine and Respiratory, there has been a year-on-year reduction in occupied bed days for the period 2017/8 to 2019/20 (2020/21 activity data is not yet available).

Table 1 below illustrates the movement over the 3 years:

Table 1

	Occupied Beds Days
2017/18	40,222
2018/19	38,696
2019/20	34,859
Reduction in Beds days over 3 years	5,363

This reduction of 5,363 bed days equates to approximately 15 beds in total and a cost of £1.5m. This has been achieved in a period that saw considerable growth in the over 75s population. From 2018 to 2020, there was a 4.6% increase in the over 75s population. If the above developments had not

been implemented there would have been a significant increase in the number of beds days occupied due to demographics.

Table 2 highlights the demographic growth and cost that has been avoided.

Table 2

Over 75 Population Increase	**4.6%**
Occupied Beds Days Avoided	1,850
Number of Beds	5
Demographic Growth Cost Avoided	£0.5m

Perth & Kinross has seen not only a reduction in occupied bed days leading to a reduction in cost of £1.5m but has also avoided the demographic growth cost of £0.5m over the same period.

Care Homes

Table 3 shows the number of older people from Perth and Kinross in permanent, care home placements at the end of 2018 and the number in September 2021. The figure shows that the number of placements has increased slightly. However, the number of over 75's in Perth and Kinross has increased during this time by 7.2%. When this demographic growth is taken into account, the expected number of older people in a care home by September 2021 would be 1,001. Therefore, there are 55 fewer older people living in a care home than would have been expected.

Table 3

Year	**Number of Older People Care Home Placements**
2018	941
2021	954

It is likely the actions above, especially those in sections 1 and 2, have contributed to this reduction in the number of older people living in a care home.

Achieving this significant shift in the balance of care away from hospital and care homes by supporting more older people to remain living at home has required substantial investment from the HSCP.

NEXT STEPS: STRATEGIC DELIVERY PLAN PHASES 2 & 3

Over the next 3 years we will continue to build on the significant progress already made in supporting people to adopt healthy lifestyles to mitigate some of the effects of aging, supporting people to remain in their own homes for as long as possible, offering a range of supports for older people in their communities and, where hospital admission is necessary, ensure people receive the right support at the right time and are able to return home as soon as they are ready.

This will include learning from the experience of responding to the Covid pandemic and taking account of any ongoing impact. There is evidence of increased demand. Capacity and flow has been significantly affected by the growing number of frail, older people living with multiple, complex and fluctuating conditions who are presenting to hospitals and GP Practices in a deconditioned state requiring enhanced clinical assessment, social care support and rehabilitation input. It is likely these complex presentations are, at least partly, caused by the pandemic and people having restricted access to health, social care and community services and supports during lockdown.

Other priority areas for action include improving access to Care at Home support, especially in rural areas and increasing the range of support for people with a form of dementia.

We will continue to develop early intervention/self management approaches, managing unscheduled care by avoiding admissions to hospital and care homes where appropriate, and integrating pathways of care across primary, secondary and community care. To support this, we will develop skills and practice across our workforce to ensure the adoption of a human rights approach to assessment, treatment, care and support with a clear focus on prevention, early intervention and tackling inequalities aimed at supporting Public Health Scotland's public health priorities.

The Older People Strategic Delivery Plan also aligns to the actions contained within the Carers' Strategy which aims to support those with a caring role to care in good health and wellbeing and to have a life alongside caring.

1 EARLY INTERVENTION KEY ACTIONS 2022-25

Over the next three years we will further strengthen our alliances with community partners and Third and Independent Sectors to improve lives and opportunities through a stronger focus on prevention, early intervention, and targeted actions on the wider determinants of health. We will increase opportunities and access for older people and carers to participate in leisure, sport, and community activity. Evidence shows that if older people are able to participate in social and leisure activities, this can make them more resilient as they age, reduce risks of dementia, widen social circles to reduce the feeling of social isolation, and help prevent falls. This can delay frailty, the stage at which someone becomes more at risk of illness and disability or become dependent on others for care.

PHASE 2

These actions have been considered and are included within the financial framework:

- Work with Community Planning Partnership and Public Health to adopt and promote healthy lifestyle choices and improve physical wellbeing to delay impact of aging

- Continue to arrange annual Go4Gold Care Home Games Challenge event in Bells Sports Centre whilst also running a separate virtual event for residents unable to attend the live event.

- Live Active Wellbeing Service to develop an exercise pathway continuum from working one to one with care at home to offering gentle exercise groups, health walks, wellbeing classes, to community strength and balance groups and social outlets.

- Continue to develop and widen the spread of the Care About Physical Activity (CAPA) model across all care services including hospital inpatient settings, care at home services, Home Assessment Recovery clients, Sheltered Housing, care homes, unpaid carers and prison.

- In partnership with Paths for All continue to develop dementia friendly walking initiatives including strength and balance exercises to care homes, HART, care at home, sheltered housing and hospital inpatient services.

- Implement two Care at Home Wellbeing Teams as a test of change, to enable more flexible, person-centred approaches to care to improve working conditions for carers, and to incentivise better outcomes for individuals.

- Recruit to a Volunteer and Community Circles Co-ordinator posts to increase the number of volunteers available and the range of activities that can be undertaken by volunteers.

- Invest in the Volunteer App which is a platform to make volunteering as easy as clicking a button.

- Review and develop third Sector contribution to Older People Services in response to demographic pressures and identified need

- Continue to promote and support psychological wellbeing resources for care home staff

- Implement an Enhanced Care Home Team to support and mentor care homes in sustained improvements in high quality personalised care delivery.

- Promote Age Friendly communities

- Two Activity Workers to support older people to be active while they are in hospital

- Identify older people most at risk of fuel poverty and signpost to supports

- Establish a Foodshare network to coordinate activity to address food poverty

PHASE 3

Further actions under consideration, but not yet included within the Financial Framework are:

- In partnership with Alzheimer's Scotland, review existing post diagnostic support for people diagnosed with dementia to increase access and opportunities.

- Develop chronic pain education which is targeted at each level of the Chronic Pain model from public awareness, people living with chronic pain, staff education to specialist services

- Embed the non-pharmacology chronic pain management pathway into GP practices and across the services supporting people with chronic pain.

- Increase capacity in Falls Service to support the development and delivery of falls prevention initiatives, falls education, early identification, and effective assessment, treatment and rehabilitation for older people who are at risk of falling or who have fallen.

- Recruit to a MacMillan support Facilitator to provide practical, personal and emotional support to adults living with cancer and their families / carers to improve the cancer journey and support more people to die in their own homes if that is their wish.

2 SHIFTING THE BALANCE OF CARE KEY ACTIONS 2022-25

Interface Care

Emergency (including urgent or unscheduled) care remains a challenge for health and care systems and is in part related to increased demand. The impact of COVID-19 has further highlighted the necessity to manage individuals closer to home and minimise the need for admission to hospital or long term care. 'Interface Care' requires an integrated whole system approach across health and social care, in partnership with Third and Independent sectors to provide a range of community based short-term targeted specialist care and support services. These services will offer alternatives to hospital admission or care home admission and supports timely discharge to support people to live healthy, independent lives at home or in a homely setting.

PHASE 2

These actions have been considered and are included within the Financial framework:

- Building resilience into our Locality Integrated Care Teams to provide an enhanced 7 day service and increased overnight support and harmonise health and social care geographical boundaries to improve integrated working in localities.

- Reviewing and improving the co-ordination of health and social care supports out of hours

- Increasing capacity within Social Work Teams to reduce waiting times for assessment, support Adults with Incapacity/Adult Support and Protection work including large scale investigations and the wider statutory duties undertaken by Mental Health Officers and Social Workers.

- Implementing a Hospital at Home Service to offer acute level care in a person's own home or homely environment.

- Implementing the recommendations from the review of Care at Home Services to address consistent high levels of unmet need in rural localities by:

    - Developing neighbourhood self managing Care at Home Wellbeing Teams who take a sequenced approach to care starting with self care and technology, then considers aids and adaptations, thinking about support from family, friends and what is happening in the community, before looking at paid support
    - Promoting a more alliance based commissioning model for external commissioned Care at Home Services.

- Increasing staffing capacity in the Community Alarm service to meet the growing demand and implement end to end digital telecare service.

- Reviewing the 'ACE' clinic in Simpson Day Clinic PRI to provide rapid access to same day medical review and investigations

PHASE 3

Further actions under consideration, but not yet included within the Financial Framework are:

- Developing alternative solutions to support people living with dementia who have complex needs in more appropriate settings, in partnership with Alzheimer's Scotland and other key partners

- Reviewing and stabilising rehabilitation beds across Perth & Kinross and agree an optimum nursing and AHP model that can be safely staffed

- Implementing a sustainable model for Medicine for the Elderly/ Community Hospitals taking into account wider community models.

- Facilitating cross boundary working between NHS Tayside's Neurological Services and P&K HSCP Locality Integrated Care Teams for neurological patients

- Improving the community Falls Pathway by making better connections with Locality Integrated Care Services (LInCS) and Care Homes

- Identifying and delivering palliative care training to the health and social care workforce in partnership with Specialist Palliative Care Services

Urgent Care

The redesign of urgent care is a national programme which represents a significant change in the provision of safe and effective urgent care in the in-hour and out-of-hour period. The redesign ensures individuals are seen in the most appropriate care environment. This will be done by managing people more effectively, closer to their home and by optimising existing pre-hospital care.

The national vision is for a "collaboration across the whole health and social care system to design and implement a safe, sustainable, patient and outcomes focused system of urgent care access, pathways and treatments that delivers better health, care and life outcomes for individuals, staff, families and the wider community".

The strategic aim is: "Right Care, in the Right Place, at the Right Time"

To support this vision and aim, Perth & Kinross Health & Social Care Partnership in collaboration with NHS Tayside will implement the following phases:

PHASE 2

These actions have been considered and are included within the Financial framework:

- Develop a co-located and integrated urgent care service with a single point of contact, 7 days a week in the in-hour period. The integrated urgent care service will include the following developments:
    - Build an operational management structure to support on the development and delivery of urgent care services in Perth & Kinross
    - Develop a GP resilience Team to provide a more proactive approach to supporting GP practices in Perth & Kinross.

PHASE 3

Further actions under consideration, but not yet included within the Financial Framework are:

- Build on the existing Advanced Nurse Practitioner model to enhance integration and co-ordination between primary and secondary care.
- Develop an Urgent Home Visiting Service with a single point of contact for General Practitioners to refer all patients that require an urgent review.
- Enhance the Specialist Community Respiratory Team to provide urgent response for deteriorating patients

3 IMPROVING CAPACITY & FLOW KEY ACTIONS 2022-25

Optimising Capacity & Flow considers a whole system solution to improving the journey from being an acute inpatient to going home or to a homely setting. Perth & Kinross Health & Social Care Partnership will adopt and embed a 'Home First' approach focusing on recovery which ensures assessment for longer-term care and support needs is undertaken in the most appropriate setting and at the right time for the person. The aim is to define best practice, centred around preventing delay and ensuring individuals stay in hospital only as long as is clinically and functionally necessary.

Perth & Kinross Health & Social Care Partnership will support this is the following phases:

PHASE 2

These actions have been considered and are included within the Financial framework:

- Implementing the recommendations from the Discharge without Delay self assessment
    - Introducing flexible Interim / Short term Assessment Rehabilitation Beds (STAR) in care homes for people requiring intensive rehabilitation / reablement in a homely environment prior to returning home from hospital
    - Improving the patient journey from admission to hospital to discharge to community by ensuring a whole system approach to discharge planning, embracing a 'Home First' approach.
- Implementing the reviewed Frailty Pathway making connections with Locality Integrated Care Services

- Reviewing the Discharge Hub and Hospital Discharge Team, enhance integration and improve effectiveness and efficiency

PHASE 3

Further actions under consideration, but not yet included within the Financial Framework are:

Planning and implementing Older peoples mental health transformation proposal, supporting a gap analysis to establish the extent of the challenge and taking in to account the following factors in relation to quality and sustainability for Older Peoples Mental Health Services for Perth & Kinross,

- Increasing mental health needs driven by population ageing and growth combined with the relationships between age and dementia prevalence
- Issues such a social isolation and carer workload further exacerbated by Covid
- A substantial shift from predominately bed-based models toward provision in community settings leading to increased inpatient complexity.
- Supply and capacity models are not linked systematically to demographics
- In-patient over utilisation, exacerbated by process and capacity issues in accessing appropriate community solutions for people with complex needs.

5. STRATEGIC ENABLERS

The Older People Strategic Delivery Plan will be driven by the key components set out above, however they will need to be supported by a series of strategic enablers which are essential supports that will help us to achieve our strategic directions over the next three years.

5.1 **Workforce Plan**

A Perth and Kinross H&SC Workforce plan is being developed which will include the workforce requirements for the OPSDP.

5.2 **Capital Planning**

The capital plan implications are included in the finance section.

5.3 **Consultation and Engagement**

A consultation and engagement programme will be required to promote the contents of the Strategic Delivery Plan for staff and the wider public involvement.

5.4 **Performance Framework**

The Performance Framework is included under section 7.

5.5 **Housing Contribution**

Perth & Kinross Council's Housing Contribution Statement (HCS), developed in partnership with Housing and Health and Social Care strategic planners and operational practitioners, acknowledges people's right to live at home or within a homely setting; that suitable, quality housing contributes to reducing health inequalities; and recognises Housing's key role within health and social care integration.

Through the HCS, we will continue to work jointly to ensure the Strategic Delivery Plan for Older People 2022-2025 is achieved. Housing has an

important influence on health inequalities through affordability, housing quality, fuel poverty, and the role of housing in community life. The Statement clearly articulates the links between Housing, Health and Social Care and highlights the shared outcomes and service priorities identified in both the Strategic Plan and the Local Housing Strategy (LHS).

To meet our joint aims and outcomes in relation to prevention and the ability to provide person-centred support we must make best use of available resources. There are many effective housing solutions that can prevent costly health and social care responses. The assessment of housing need and demand highlights many challenges that need to be collectively addressed by the Health and Social Care Partnership and Housing Partners to support people to live at home or in a homely setting for as long as possible

6. FINANCIAL FRAMEWORK

REVENUE

We have developed below a Financial Framework for the Older Peoples Services to support the development of an affordable Strategic Delivery Plan. This sets out the current recurring budget for services within scope of Older Peoples Strategic Planning , the future proposed investment, efficiency savings deliverable and funding available to support investment.

Overall, a recurring budget of £72.8m currently underpins services across Perth & Kinross.

Current Recurring Budget 2021/22

Service	Funded From	Recurring Budget £000
Allied Health Professionals	Health Core Budget / PCIF	4,415
Inpatient - Medicine for the Elderly	Health Core Budget	4,378
Inpatient - Community Hospitals	Health Core Budget	4,808
Psychiatry of Old Age Services	Health Core Budget	6,493
Community Services	Health Core Budget / PCIF	7,665
Community Services	Social Care Core Budget	21,529
Care Home Placements	Social Care Core Budget	23,471
	Total Current Recurring Budget	**72,759**

The investment required to meet demand, ensure effective capacity and flow over the next 3 years, and deliver on wider strategy objectives is set out below, along with efficiency savings planned from transformation and the significant recurring Scottish Government funding that is being made available for 2022/23 that ensures the affordability of our Year 1 Plans.

Recurring - Social Care	Year 1 2022/23	Year 2 2023/24	Year 3 2024/25	Total 3 Years
	£'000	£'000	£'000	£'000
Care at Home Current Demand Pressure	1,100	-	-	1,100
Care at Home Wellbeing Teams	661	507	507	1,675
Care at Home Alliance Based Commissioning	1,296	-	-	1,296
Care at Home Capacity and Resilience	556			556
Community Alarm Investment in Capacity	532	-	-	532
Enhanced LInCS	427	-	-	427
Social Work Capacity Investment	657	-	-	657
Live Active Leisure Wellbeing Service	60	-	-	60
Phase 3 of OP Health & Social Care Strategic Delivery Plan	852	-	-	852
Sub-Total Social Care Investment	**6,141**	**507**	**507**	**7,155**
Funding / Disinvestment				
Scottish Government Funding	5.641	-	-	5.641
Strategic Disinvestment - Phase 2	500	-	-	500
Sub-Total Social Care Funding / Disinvestment	**6,141**	**-**	**-**	6,141
Total Social Care Recurring Shortfall / (Surplus)	0	507	507	1,014
Recurring - Health	Year 1 2022/23	Year 2 2023/24	Year 3 2024/25	Total 3 Years
	£'000	£'000	£'000	£'000
AHP Current Staffing Demand Pressure	196	-	-	196
Hospital at Home	525	175	-	700
Enhanced LInCS	773	-	-	773

Recurring - Social Care	Year 1 2022/23	Year 2 2023/24	Year 3 2024/25	Total 3 Years
	£'000	£'000	£'000	£'000
Urgent Care	307	-	-	307
Frailty Interim Care	-	-	228	228
Enhanced Care Home Support	211	-	-	211
Shifting the Balance of Care	-	-	1,000	1,000
Sub-Total Health Investment	**2,012**	**175**	**1,228**	**3,415**
Funding / Disinvestment				
Scottish Government Funding	2,012	-	-	2.012
NHST Proposed LHSA	-	-	1,000	1,000
Sub-Total Health Funding / Disinvestment	**2,012**	**-**	**1,000**	**3,012**
Total Health Recurring Shortfall / (Surplus)	0	175	228	403
Total Health & Social Care Recurring Shortfall / (Surplus)	**0**	**682**	**735**	**1,417**

The scale of investment required reflects that the Perth and Kinross over 75 population has grown significantly over the last two years and is expected to increase by a further 11% in the next 3 years. If no further investment is made, or no further action is taken, this could lead to an increase of nearly 4,000 additional occupied bed days, equating to an additional 11 hospital beds. The cost of this would be in excess of £1.1m. The financial framework assumes that in Year 3, following successful measurement of the success of our plans in shifting the balance of care, NHS Tayside will transfer £1m of recurring resources as part of their commitment to supporting the aims of integration.

As detailed on other sections of this report above, the substantial planned additional investment in 2022/23 builds upon our Phase 1 investment (funded from a significant savings programme) and will support the further expansion of community services, enabling the move from institutional care to supporting older people in the community.

In support of the strategic direction, referred to under “Interface Care Key Actions” above, the PKHSCP will offer alternatives to hospital admission or care home admission and supports timely discharge to support people to live healthy, independent lives at home or in a homely setting. The financial framework therefore includes £0.500m of strategic disinvestment from Care Home placements in order to support the overall investment detailed above.

There remains a shortfall across Health and Social Care of £0.682m in Years 2 and £0.735m in Year 3 (an assumed £1m transfer of shifting the balance funding from NHS Tayside). The need for net investment in Older Peoples services in future years is a key discussion with NHS Tayside and Perth &

Kinross Council. The extent of demographic demand in Perth & Kinross means additional investment is likely.

CAPITAL

Capital Investment will be required to deliver on strategic objectives. Perth & Kinross Health & Social Care Partnership currently provides analogue community alarm devices to around 4,000 clients with a further 1,400 in Telecare. BT Openreach have announced that the analogue telephone network will be terminated by 2025 and replaced with digital networks.

The Health & Social Care Partnership has been working in conjunction with the Local Authority Digital Office Programme, who are employed by the Scottish Government to support Local Authorities through the migration from an analogue to digital network and infrastructure, to transition to a fully digital community alarm and telecare service. The final stage in this transition to the digital network requires the use of fully compatible digital units to replace all existing analogue equipment.

A Strategic Business Case has been developed and anticipates that the cost of transferring all clients from analogue to digital, as well as dealing with increased demand, will be £6 million over six years. In February 2022, Perth & Kinross Council approved this funding as part of the Capital Budget.

7. PERFORMANCE FRAMEWORK

To provide the necessary assurance that our actions are making the impact so desired we have developed a strategic, outcomes focussed, performance management framework. This framework considers the key outcomes we seek to deliver through the implementation of this strategic delivery plan and links them directly to Key Performance Indicators which are themselves linked to the overall National Health and Wellbeing Outcomes.

The table below demonstrates how we will measure our progress towards the outcomes we seek to deliver. It is our intention that these performance measures will be used , along with supporting narrative and wider contextual information, to provide the necessary assurance that appropriate progress is being made. Where this isn't the case, or isn't possible, we will set-out what further actions we seek to take.

		NATIONAL HEALTH and WELLBEING OUTCOMES								
STRATEGIC OUTCOMES	KPI	1	2	3	4	5	6	7	8	9
People who provide unpaid care are supported to maintain or improve their quality of life and look after their own health and wellbeing.	% increase in unpaid carers that feel the service has supported them to look after their own health. % increase in carers who feel supported to continue in their caring role. % of carers who feel supported to continue in their caring role.	✓			✓	✓	✓			
Older people are supported to maintain or improve their quality of life and look after their own health and wellbeing	% increase in service users who feel that the service has supported them to look after their own health. % increase in service users who feel the service helped them live as independently as possible and maintain their quality of life. % increase in service users who felt safe and supported.	✓	✓		✓					
Older People are supported to live actively and independently at home or in a community setting	Rate of emergency occupied bed days Crisis Admissions to Care Homes 65+ % increase in service users who feel the service helped them live as independently as possible and maintain their quality of life. Falls rate per 1,000 population (65+) Proportion of last 6 months of life spent at home or in a community setting (18+)	✓	✓	✓	✓					
Resources are used effectively and efficiently	Percentage of health and care resource spent on hospital stays where the patient was admitted as an emergency									✓
People are safe from harm	% increase in service users who feel the health or social care support received ensure they felt safe and supported Falls rate per 1,000 population (65+)							✓		
Timelier discharge from hospital	Reduction in the length of delay for older people in emergency occupied bed days			✓	✓					✓
Health & Social Care workforce feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide	% of staff attending and completing training courses. % increase in staff who provide positive feedback regarding engaging with the work they do.								✓	