Perth & Kinross Health & Social Care Partnership

Care & Professional Governance Forum - Annual Assurance Framework

Services / Locality Reporting:	North Locality
Date of report:	15th June 2022
Report Author(s):	Angela Milne & Karyn Sharp

OVERALL PURPOSE OF THE SERVICES/LOCALITY

The North Perthshire Locality delivers Health & Social Care Services to two GP Cluster areas - Strathmore and Northwest Perthshire. There are four GP Practices within each Cluster which cover a wide geographical area.

Services delivered diverse and include:

- Community Hospital GP Units – Pitlochry (9 beds) and Blairgowrie (17 beds)
- Care and Treatment Services – Hub and in-reach model
- Community Nursing delivered from 7 GP Practice aligned sites across Strathmore and North West Perthshire
- Adult Social Work Teams including Social Workers, Carers Support Workers, Reviewing Officers, Occupational Therapists, Social Prescribers and Community Engagement Team.
- Physiotherapy - inpatient/outpatient/community
- Occupational Therapy - inpatient/community
- Adult Mental Health Services, including mental health ANP
- Mental Health and Wellbeing Team
- Older Peoples Community Mental Health Teams – see patients over 65 years of age. They also support our Community Hospital inpatients.
- Healthy Communities Collaborative
- LInC Service
- ANP Service
- Administration Services
- Learning Disability team are hosted by the North Locality

DEMOGRAPHIC INFORMATION

North Perthshire Locality

Unless otherwise indicated, the figures and data contained within this report were sourced from Public Health Scotland Locality Profile 2020/21 North Perthshire Locality.

Our locality consists of three distinct areas: Highland Perthshire, Strathmore for Health boundaries and the Carse of Gowrie for social work boundaries, although this is about to realign. Most of its settlements are located on or close to the main transport corridors (A9, A93 and A90) but access to services can be a challenge for residents in more rural areas. The wide geographical area can also present obstacles to

service delivery in a Community setting. North Perthshire comprises of the following major settlements of: Aberfeldy, Alyth, Blair Atholl, Blairgowrie, Coupar Angus, Dunkeld, Errol, Invergowrie and Pitlochry.

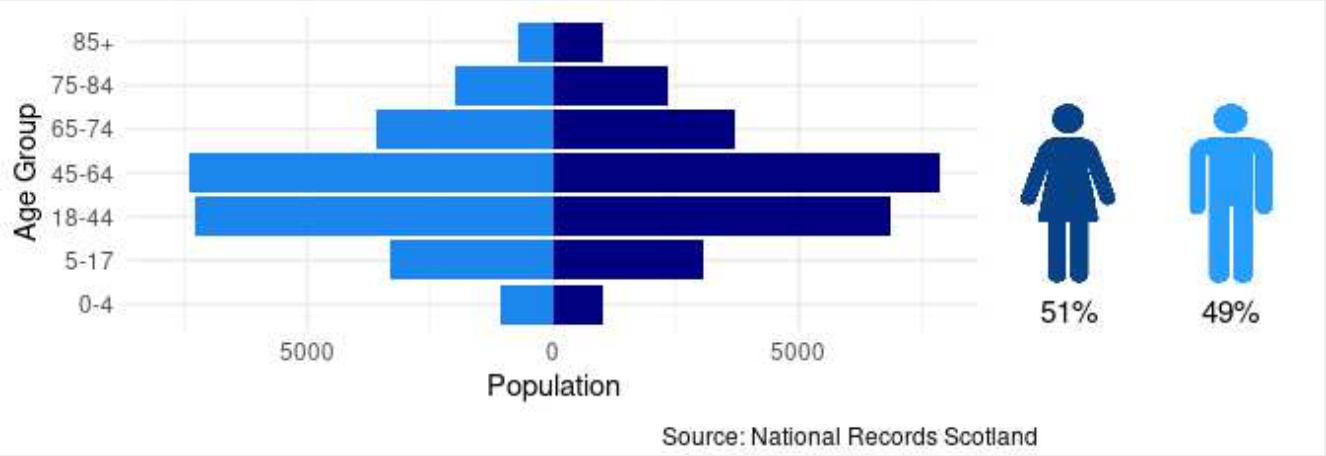
Population

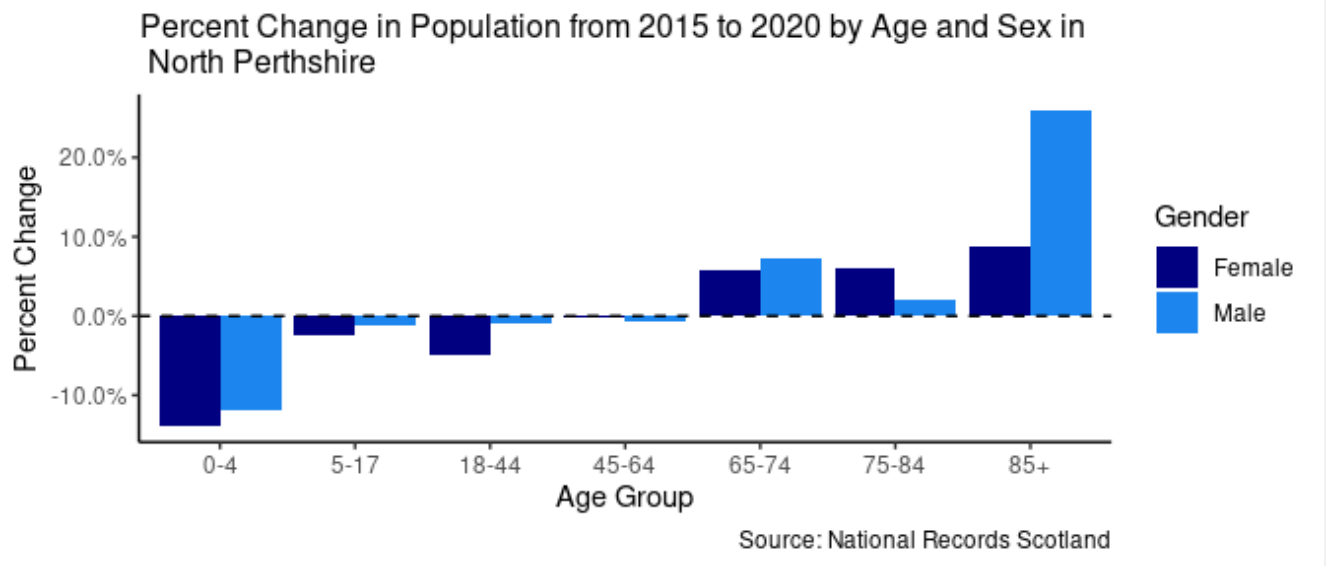
With an overall population of 51,165 residents, it has the highest number and proportion of individuals aged over 65 years, at 26% of the population and the lowest number and proportion of children. Its population can be summarised as below:

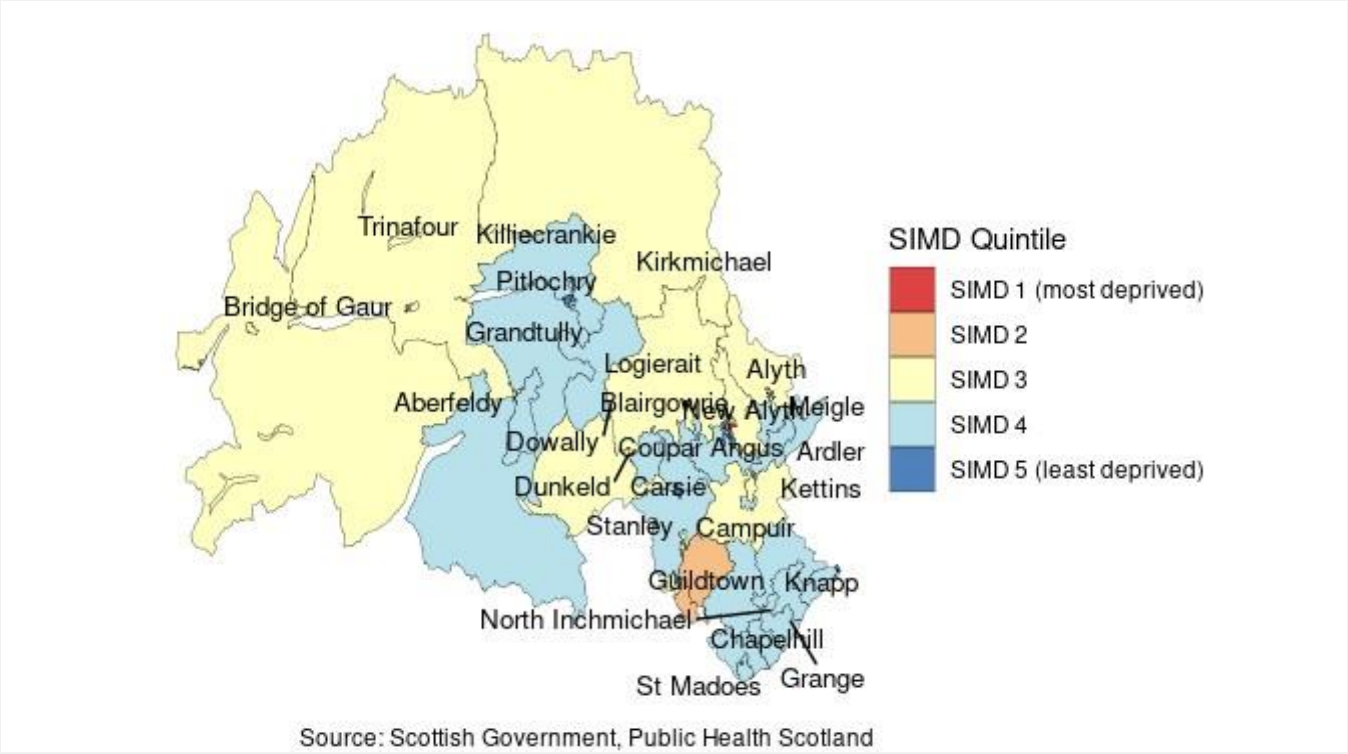
- A total population of **51,165** people, where **49%** were male, and **26%** were aged over 65.

Key Issues

- Highest number and proportion of those aged over 65(1% increase on last year) of all 3 localities.





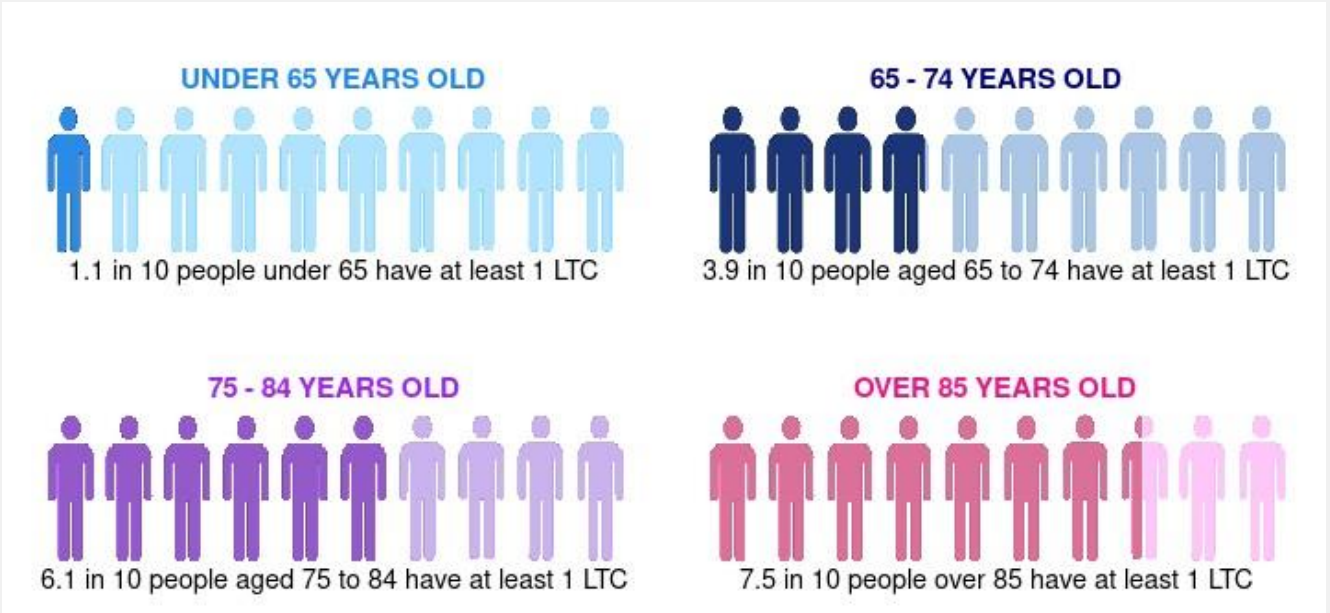


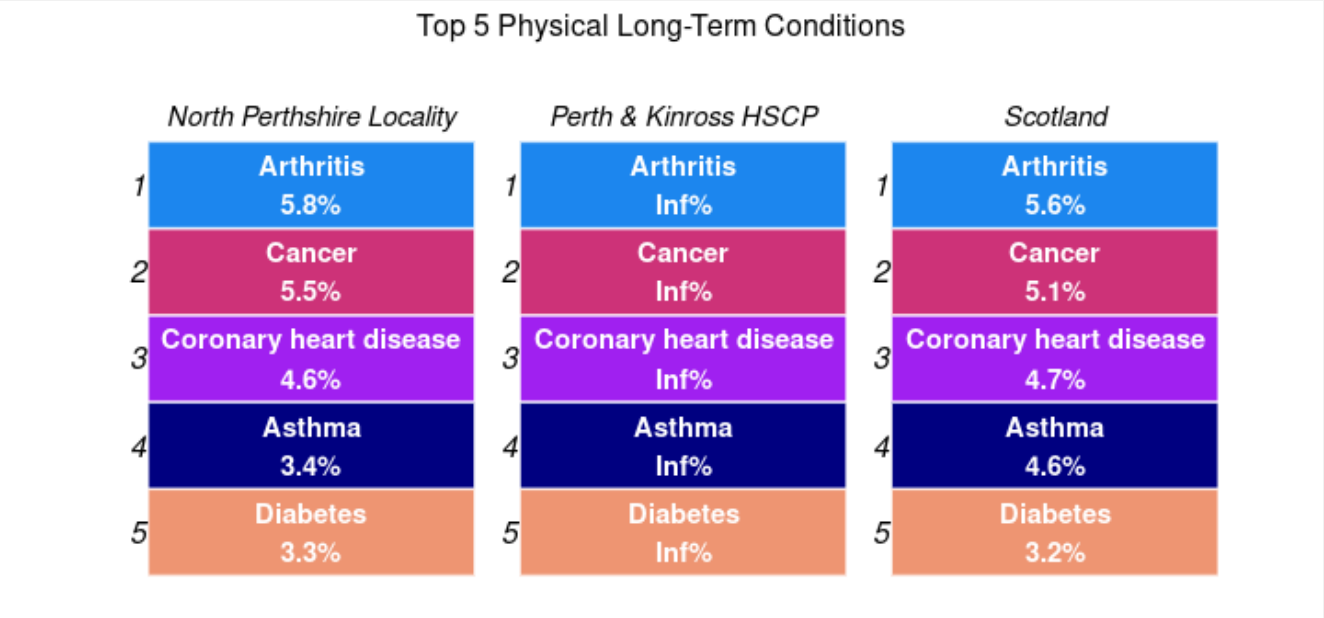
Source: Scottish Government, Public Health Scotland

- **14%** of people lived in the least deprived SIMD quintile, and **2.4%** lived in the most deprived quintile.

For the most recent time periods available[2], North Perthshire Locality had:

- An average life expectancy of **79.8** years for males and **82.8** years for females.
- A death rate for ages 15 to 44 has significantly decreased from **120** to **87** deaths per 100,000 to age-sex standardised population[3]. This is the lowest across the whole of Perth and Kinross (Perth City 148, South Locality 108)
- **21%** of the locality's population has at least one long-term physical health condition.





- A cancer registration rate has dropped from **603 to 563** registrations per 100,000 age-sex standardised population[3] – is this partly to do with people not presenting during the pandemic?
- **17.74%** of the population being prescribed medication for anxiety, depression, or psychosis. This is a 2.2% increase from the previous year. This equates to the average across Perth and Kinross.

CARE & PROFESSIONAL GOVERNANCE ARRANGEMENTS WITHIN SERVICES /LOCALITY

The Locality has an established Safety, Clinical Governance and Risk Meeting which meets every 6 to 8 weeks and reports into the P & K Care & Professional Governance Forum. This is chaired by the Locality Manager and attendees are staff members who have a leadership role and a responsibility for all aspects of clinical governance for their teams. The agenda focuses on: Exception Reporting, Continuous Improvement & Service Development, Workforce, Risk Management & Safety, Person Centeredness including staff wellbeing, staff and patient feedback, Clinical Effectiveness and Information Governance. It also provides a forum to celebrate success. This meeting was predominantly health lead initially, but has evolved to make it a fully integrated health and social care governance meeting.

The Teams have held a daily safety huddle during the course of the pandemic, which has enabled real time reporting, timely problem solving, facilitated early escalation of risk and issues that affect the delivery of care. This has also become a forum for peer support and has strengthened relationships and flexible working across teams as a bonus.

Teams also meet monthly as an integrated management group to address operational and strategic priorities. Protection processes and induction for newly qualified staff. Learning is also brought to the Quality Assurance meeting for example from adverse event reviews and complaints. A risk log is in place for Adult Social Work which is updated at this meeting.

The Adult Social Work and Social Care Forum is split into a Quality Assurance Meeting and a Business Meeting, which each meet 4-weekly. The meetings are attended by Heads of Service, Service Managers and Team Leaders across Adult Social Work and Social Care. The Quality Assurance meeting has an action plan to look at improvements across Adult Social Work and Social Care which includes data quality, Adult Protection processes and induction for newly qualified staff. Learning is also shared through this forum for example from adverse event reviews and complaints. A risk log is in place for Adult Social Work which is

updated at this meeting.

The Business Meeting is for any information that requires to be shared within Adult Social Work and Social Care extended management team. Exception reports from teams are brought to this meeting for any LSI's, IRD's or risk to service. A high level EMT performance report is shared with this meeting so that staff are aware of where the service is meeting targets and where improvements are required. Current issues and information around staff health and safety and wellbeing are shared at this meeting. Each team/ service has a standing agenda item where the Team Leader or Service Manager can provide any updates on any business in their area that requires to be shared with the wider team for example, Swift Replacement Programme, Adult Support and Protection and Contracts and Commissioning.

EXCEPTIONS REPORTED SINCE LAST ANNUAL REPORT

Staffing: Ongoing issues with recruitment and retention of Nursing and AHP staff leading to instability across the locality and prolonged concerted efforts to attract staff. This has also resulted in the temporarily non operational status of Pitlochry Community Hospital since Jan 22.

Bed capacity: Reduced bed capacity due to Pitlochry being non operational. This has had impact on the wider system as well as the community based locality teams.

Delayed discharges: System wide, prolonged and multi-factorial.

Staff redeployment: Pitlochry staff have been redeployed to other Locality services through a process of temporary Organisational Change. This is due to end on the 20th of June.

Shortage of medical cover for General Adult Psychiatry: This has been extremely difficult to sustain and resulted in the formation of a P & K contingency hub earlier in the year to enable some equity of service delivery across the localities, This cover continues to be a challenge.

Remobilisation: Services have continued reinstate face to face appointments when safe and appropriate to do so in relation to Covid guidance at the time. Other methods of service delivery have however been maintained to provide patient choice and flexibility.

Wellbeing: The Wellbeing profile is raised and has become a higher priority for all teams. The need for this has become clearer as we have emerged from the pandemic and we have sought ways to support staff in both their physical and mental health. The wellbeing service has assisted us with resources and support sessions which have been delivered to teams and individuals. Our referral rates to this service have never been higher; Our daily safety huddle is used to check in with staff and to share wellbeing information and opportunities. Wellbeing Champions have been identified within local services and training has taken place along with the beginnings of a Tayside wide Champions network to support this work.

Minor Injuries Service: The service has been introduced in line with the new national GP contract and as part of the Scottish Government's Redesign of Urgent Care programme which is changing the way people access urgent care across Scotland. The introduction of the centres means that the majority of minor injury services previously provided at the three Minor Injury Units in Perth and Kinross have now been incorporated into the CCATS. MIU staff in the North, have now transitioned in to these roles.

Adult Mental Health Services:
In response to Listen, Learn, Change, the Strang report and HIS recommendations, work is progressing to address the identified themes.

SIGNIFICANT RISKS TO THE PROVISION OF SAFE, EFFECTIVE AND PERSON CENTRED CARE

Details of any significant risks identified within the service, along with risk scoring and controls in place and planned.

DATIX Risk 1139

- **Risk Description** As a result of the heating system being unable to be accessed and controlled there are extremes of temperature across the Pitlochry hospital site. This is due to the company which manages the heating system has ceased trading.
- **Risk Scoring:** **Current**: Almost Certain (5), Moderate (3) **Planned**: Unlikely (2), Moderate (3) = **6** = **15**
- **Controls:** Estates are progressing with the landlord urgently

DATIX Risk 657

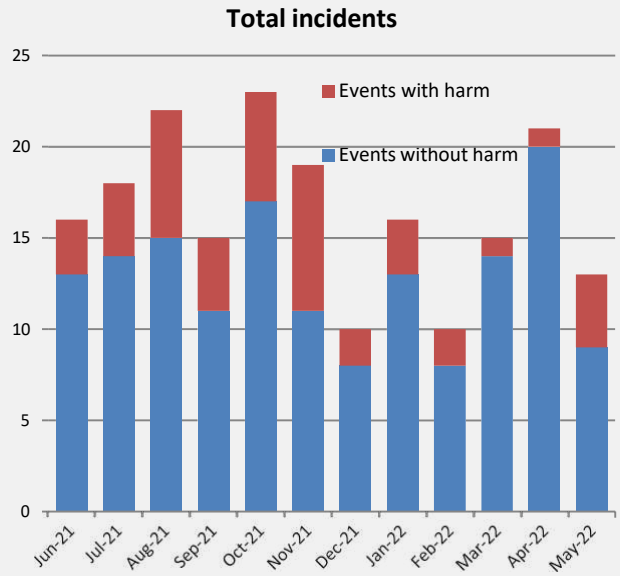
- **Risk Description** As a result of current recruitment and retention difficulties across all Community Hospital Inpatient wards, these are understaffed which is causing the registered nurse cover arrangements on each shift to be compromised leading to unsafe staffing levels. This also has safety implications regarding Fire Evacuation and minimum staffing levels required for this. It also has financial implications due to spend on agency cover. Further difficulties are being managed due to staff being required to self-isolate whilst COVID test results are being processed.
  There is a risk of disruption to service, sustainability of service and potential harm to patients.
- **Risk Scoring:** **Current**: Likely (4), Major (4) = **16** **Planned**: Possible (3), Moderate (3) = **9**
- **Controls:** Multi factorial including Bank and Agency, alternative shift patterns, strong communication and flexible working across all 4 sites, risk assessments and establishment of agreed safe staffing level numbers/ skill mix

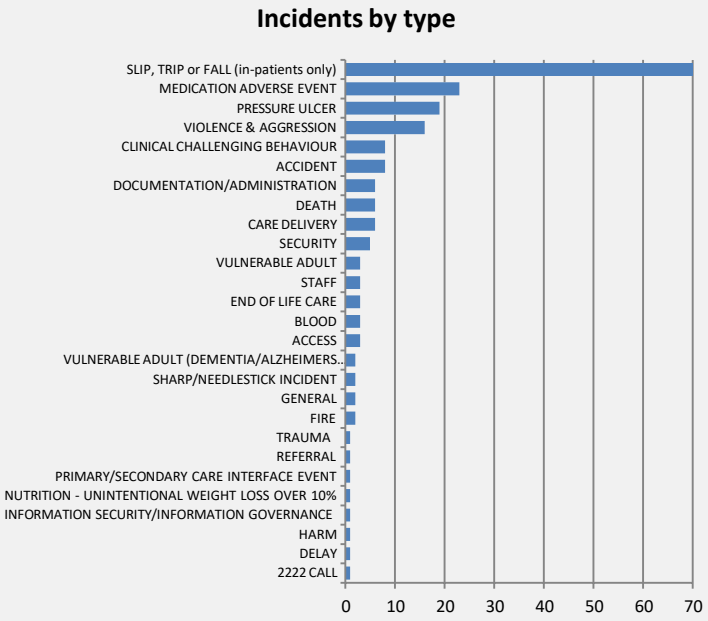
Staffing in Pitlochry Community Hospital has greatly improved and will reopen to patients on the 20th of July. This will be with reduced bed numbers initially until new staff induct and undertake any training required to meet the needs of the service. Potential future models are being explored though a multi disciplinary working group.

It has also been challenging to recruit to Blairgowrie Community Hospital but have recently been successful recruiting to all our vacant posts and expect to be back up to full staffing levels by Autumn.

ADVERSE EVENTS

Adverse events recorded on DATIX during the last year categorised as being reported within the North locality:





There were 198 incidents reported in total over the 12 month period. Falls, Medication and Pressure area were the top three incident categories, respectively.

Falls data is reflective of the increasing numbers of frail, complex and cognitively impaired patients that we are seeing on our wards. They are also deconditioned due to the impact of Covid19 restrictions. Mitigating actions such as falls alarms, non slip socks, patient placement within the ward and increasing HCSW numbers on shift as necessary, are all in place. OPCHMT colleagues support the ward with patients who may be falling due to cognitive impairment. We are currently investigating whether there is a pattern in the time of day when falls occur so that we can consider staffing levels at that time of day.

Time period: 1st June 2021 – 31st May 2022

INFECTION PREVENTION & CONTROL

Hand Hygiene Opportunity:

Ward	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22
Blairgowrie CH	95%	100%	100%	100%	100%	100%	95%	95%	100%	100%	ND	95%
Pitlochry CH	ND	100%	100%	ND	ND	ND	100%	Non operational	Non operational	Non operational	Non operational	Non operational

Hand Hygiene Technique:

Ward	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22
Blairgowrie CH	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	ND	95%
Pitlochry CH	ND	100%	100%	ND	ND	ND	100%	Non operational	Non operational	Non operational	Non operational	Non operational

The data for Blairgowrie was submitted in March but missed the reporting date. Staff have been reminded that it must be input before the 5th to be included in reporting.

There are several omissions in data from Pitlochry, which is reflective of the pressures that staff were under last year. The residual team were heavily supported by Bank and Agency with the SCN working clinically. This should be resolved on reopening.

All staff have an Infection Control objective as part of their TURAS development plan.

Infection Prevention & Control unannounced audit visits are to be recommenced to all areas after being stood down during the last 12 months.

Covid19 – We have had several Covid positive / Covid contact inpatients as well as VRE and MRSA positives. Robust adherence to guidance, escalation and stringent infection control processes has prevented the spread of these within Blairgowrie community hospital.

NATIONAL KEY PERFORMANCE INDICATORS

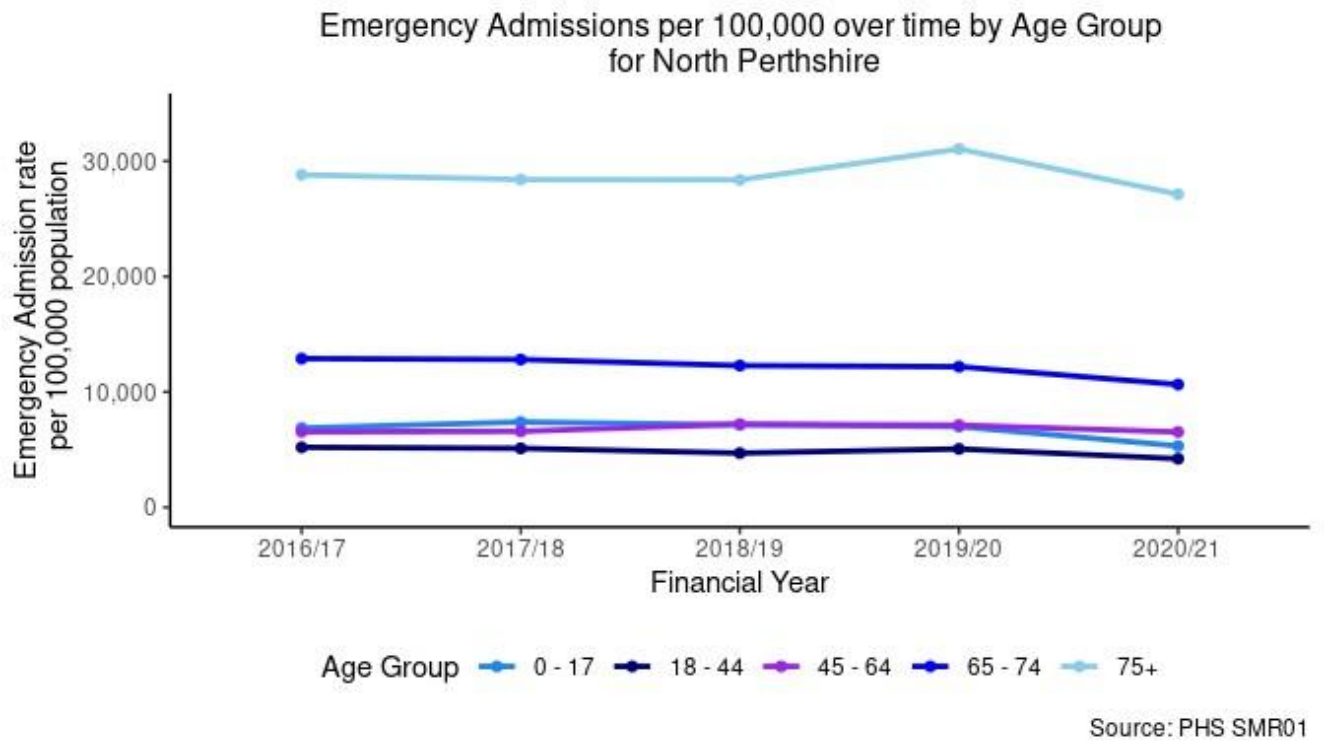
Indicators	Data Type	Time Period	North Perthshire Locality	Perth City Locality	South Perthshire Locality	Perth & Kinross HSCP	Scotland
Lifestyle & Risk Factors							
Drug-related hospital admissions per 100,000	rate	2017/18 - 2019/20	61	331	92	168	221
Alcohol-related hospital admissions per 100,000	rate	2019/20	330	606	305	415	673
Alcohol-specific mortality per 100,000	rate	2015 - 2019	9.7	24	12	15	20
Bowel screening uptake	%	2017 - 2019	68	63	69	67	62
Hospital and Community Care							
Emergency admissions per 100,000	rate	2020/21	8,699	10,123	8,505	NA	9,368
Unscheduled acute bed days per 100,000	rate	2020/21	56,503	61,655	56,963	NA	61,542
A&E attendances per 100,000	rate	2020/21	12,182	18,018	12,653	NA	20,422
Delayed discharge bed days per 100,000	rate	2020/21	2,809	6,165	3,574	NA	8,080
Falls emergency admissions per 100,000	rate	2020/21	817	866	815	NA	658
Emergency readmissions per 1,000	rate	2020/21	128	141	132	134	115
Last 6 months of life spent in community setting	%	2020/21	90	91	90	90	90
Potentially Preventable Admissions per 100,000	rate	2020/21	1,018	1,257	1,011	NA	1,180
Unscheduled Care (Mental Health related)							
Emergency admissions per 100,000	rate	2020/21	188	390	220	NA	253
Unscheduled bed days per 100,000	rate	2020/21	10,771	32,661	16,557	NA	18,404

SERVICE/LOCALITY SPECIFIC KEY PERFORMANCE INDICATORS

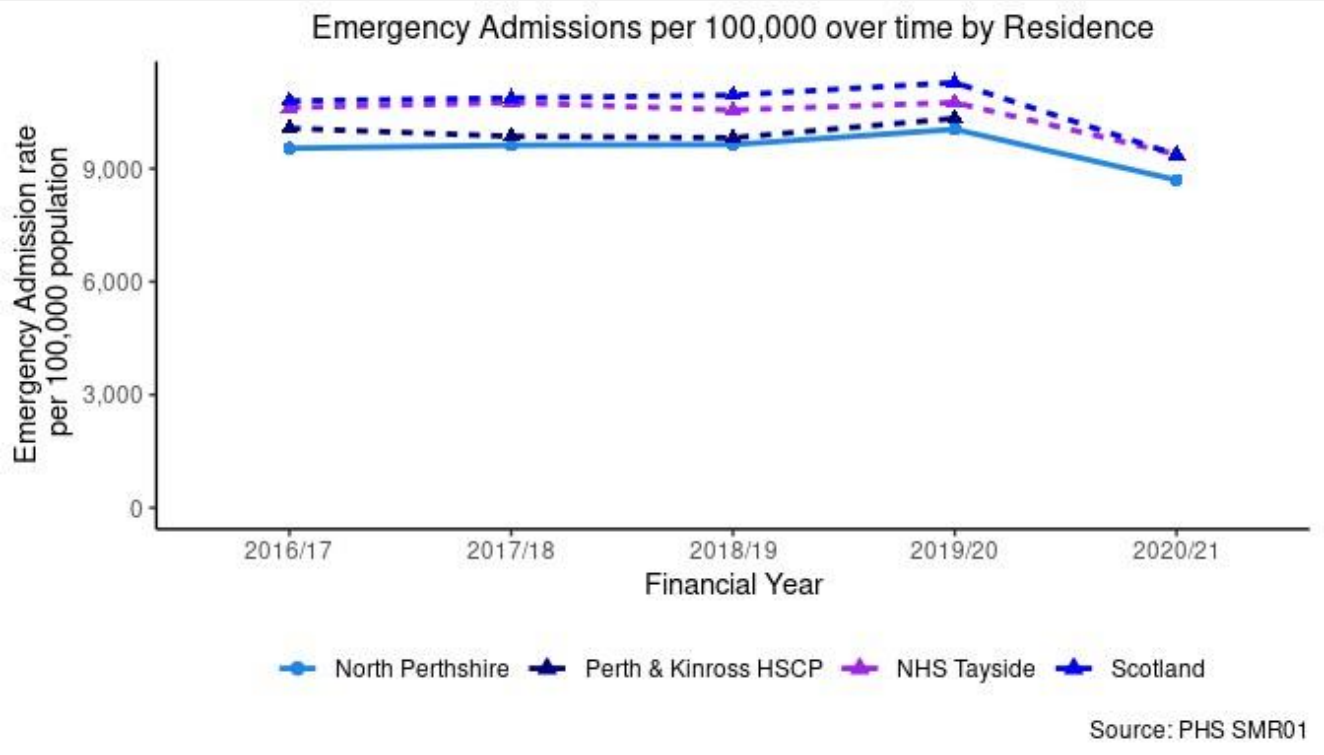
Hospital and Community Care

Emergency Admissions

Emergency admissions by age group

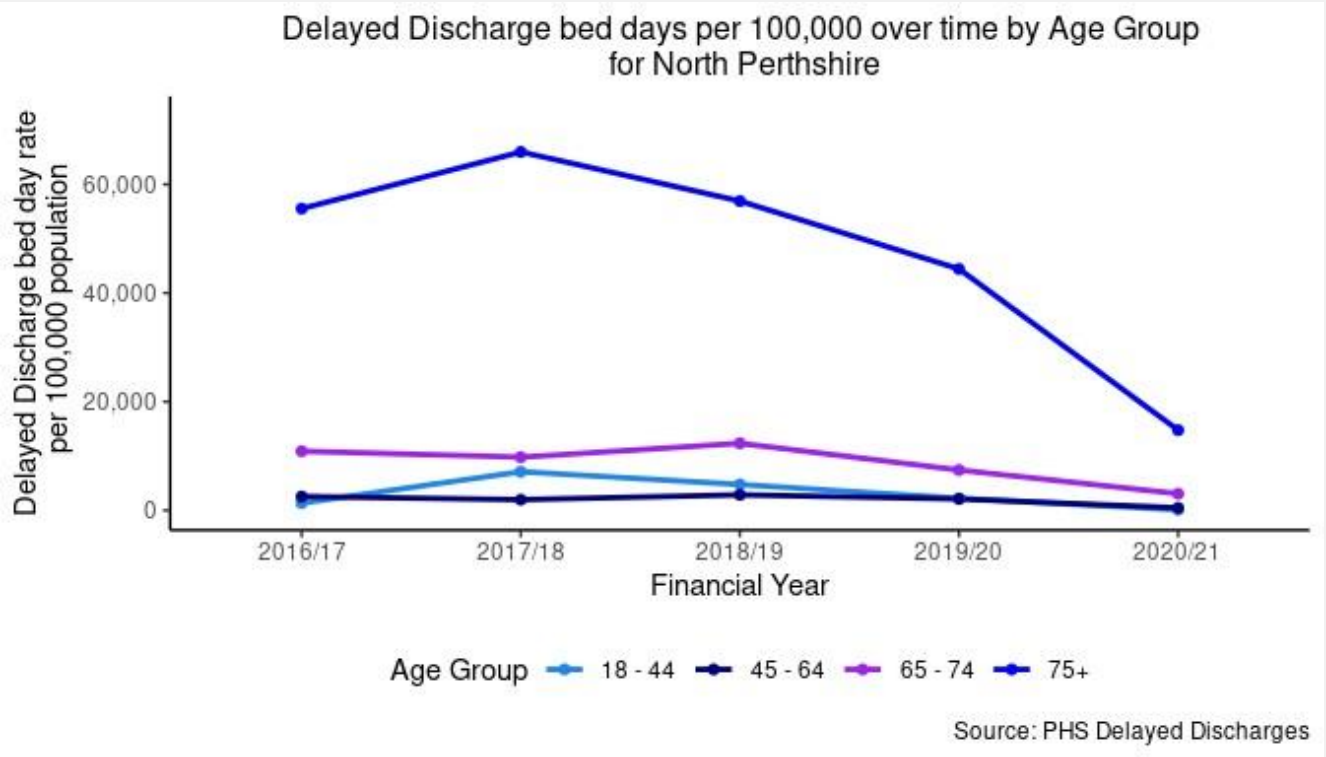


Emergency admissions by geographical area



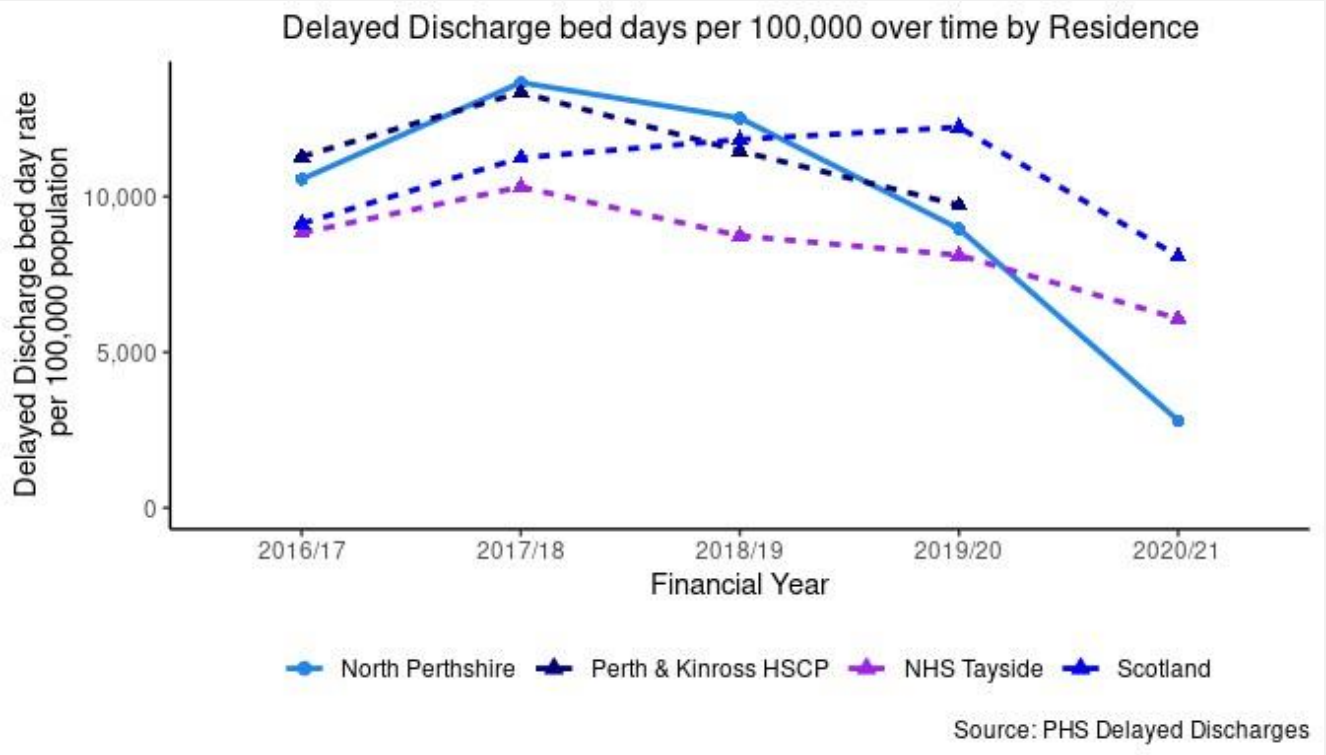
Delayed Discharge Bed Days

Delayed discharge bed days by age group



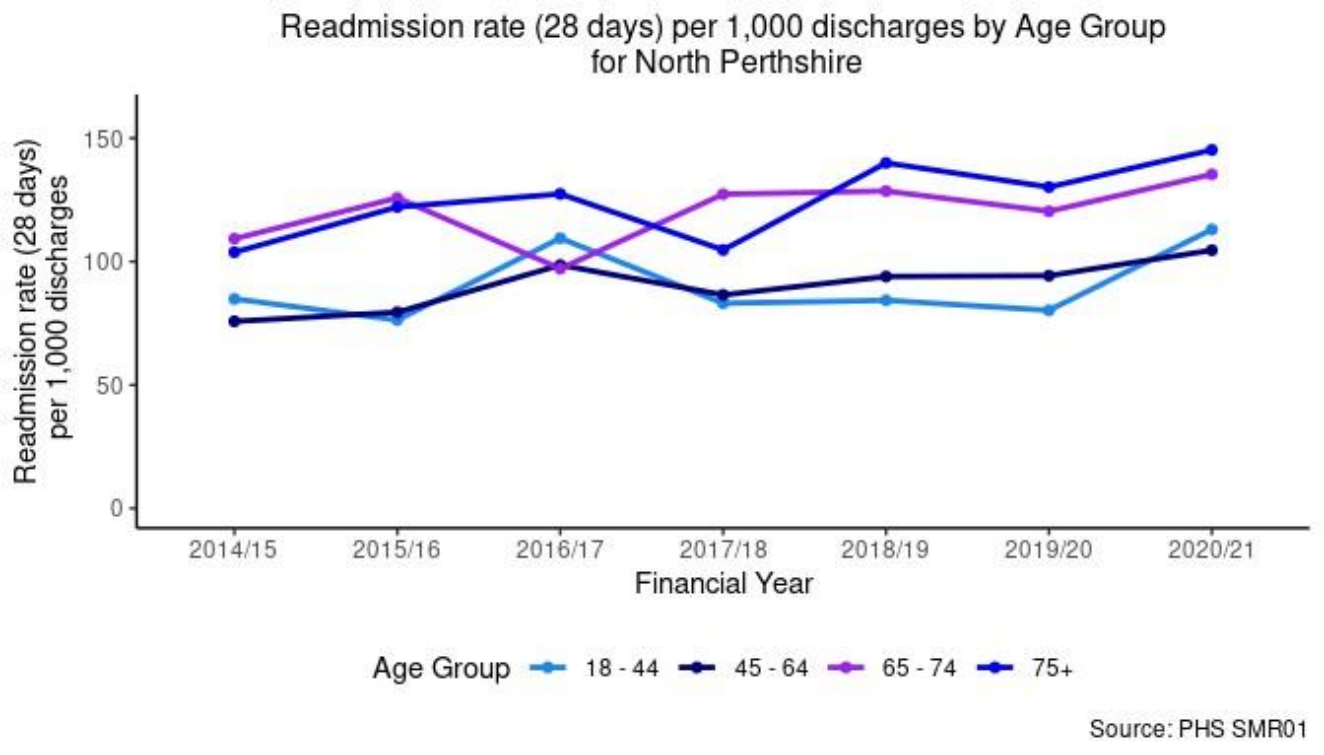
This figure has been dropping consistently but recent challenges may change this trend significantly

Delayed discharge bed days by geographical area



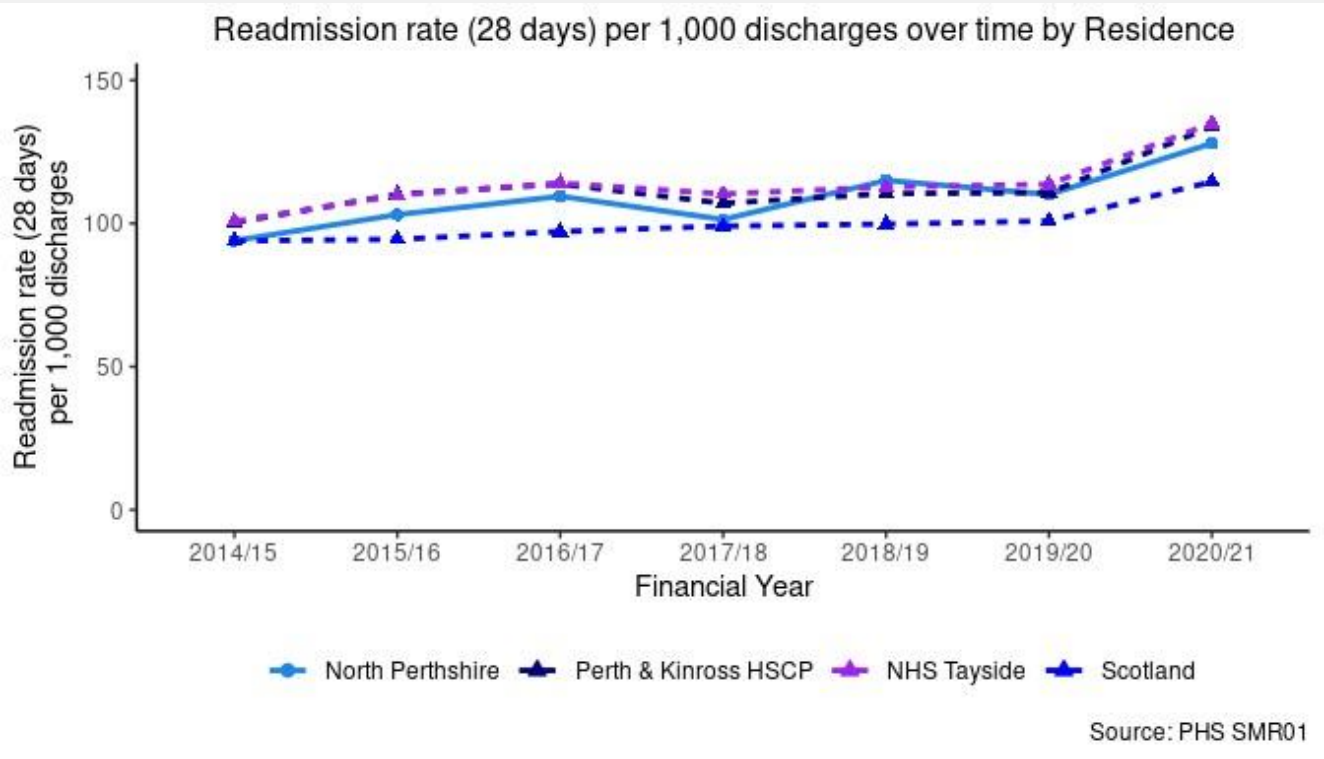
Emergency Readmissions (28 days)

Emergency readmissions by age group



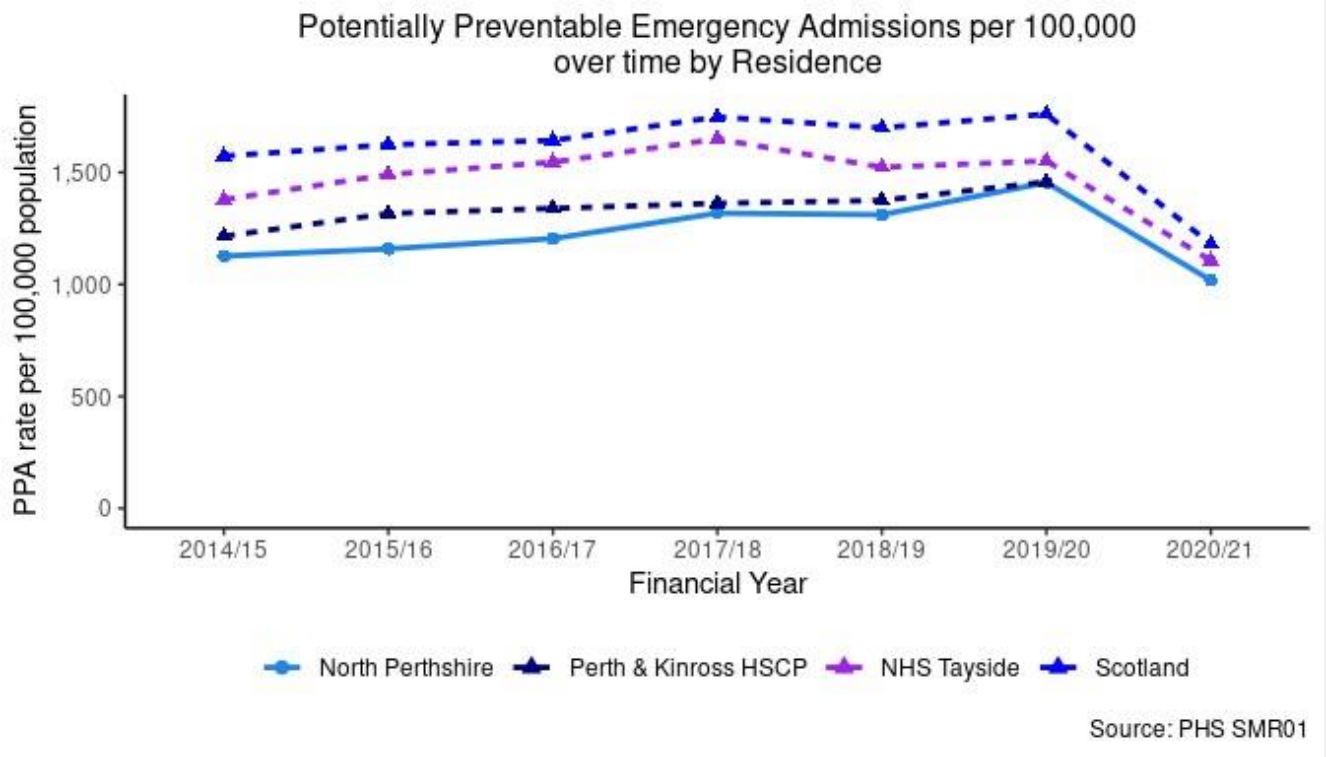
What can we do differently to prevent this significant number of people being re-admitted ?

Emergency readmissions by geographical area



This is a rising trend. The North Perthshire figure along with the rest of Tayside, is higher than Scotland overall. Initiatives such as the development of the ANP and Hospital at Home services will contribute to reducing this figure.

PPAs by geographical area



INSPECTIONS / GOVERNANCE ASSURANCE VISITS

There have been no external inspections during the past year with regards to services included within this report.

Care Assurance Tool: Care Assurance Tool walk arounds have continued despite the pandemic albeit less regularly than before. Feedback, both positive and negative, is shared across inpatient teams, discussed with lead nurse and any actions taken forward as required. Frequency of these will increase again as we continue to remobilise.

Teach tool: Teach tool is used by all teams who deliver a service within an inpatient setting. The main action from the teach tools has been to ensure the most up to date Infection Control posters are on display.

Current Adult Support and Protection Audit: All teams across the locality are preparing for, and participating in, the planned Adult Support and Protection Audit. The survey has been shared widely and participation encouraged. Resource folders have been prepared for easy accessibility of information for every team/base.

The North Locality Social Work Team has completed an internal Adult Support and Protection Audit.

General Adult Psychiatry: Scottish Government oversight visit to the North Locality Adult Community Mental Health team took place on the 6th June to establish progress in relation to specific actions laid out within the Listen, Learn, Change action plan. Work is in progress across Tayside mental health teams.

WHAT HAVE STAFF AND SERVICE USERS TOLD YOU ABOUT THE SERVICES YOU PROVIDE?

Staff feedback comes in the form of imatter as our formal process for gathering staff opinion about our Organisation. This is positive in terms of individual teams and their direct line managers, but comments have been noted on the level of visibility of the executive management team.

General feedback from the North Locality Teams:

- The Care Assurance Tool is used regularly across our inpatient areas.
- Staff receive feedback regularly through cards, letters or verbally.
- Complaints are investigated and responses prepared as per HSCP guidelines and timescales
- Frontline resolutions/Stage 1 complaints are completed and learning/development shared across the service
- Learning through complaints, LAERs, or compliments are shared and actions taken forward by specific teams as appropriate. A recent example is the development of an inpatient discharge planning and follow up proforma for families and carers, which was designed to improve communication after themes emerged from 3 separate complaints. Teams now have an opportunity to develop this further though the TQIP using a multi disciplinary approach with acute colleagues.
- Positive feedback tracker evidences regular positive feedback from service users, their families or carers.
- During huddles we share good practice and celebrate successes but also have the opportunity to highlight any potential issues and problem solve in real time.
- Community engagement work via our Community Engagement Worker**,** including the partnership strategic plan and development of locality ways of working.
- Health and Social Care Partnership Survey has been developed, piloted by the North Locality Social Work Team alongside other teams, and will now be rolled out to all service users and carers to capture service user feedback
- Feedback is gathered from service users during following Adult Protection Case Conferences, assessment visits and reviews
- Unpaid carers' representation and participation is actively encouraged in all aspects of the Carers Strategy and carers work social work is involved with

Feedback Mechanisms - Care opinion: Several teams have participated in a pilot to trial Care Opinion as a method of obtaining feedback. This has proved to be successful and will roll out to all other locality teams now. It is an easy method for patients to connect with the correct service via the website or QR code with Team Leads having the ability to provide an online response as per the examples below.

[redacted] NHS Tayside 05/05/2022

Dear Pitlochry Cyclist,

I wish to thank you very much for sharing your story with us regarding your recent care experience from the Care and Treatment Service team at Pitlochry Community Hospital.

I am so pleased to hear that you found the staff friendly and professional throughout and that you were very pleased with how well you were treated following your cycling accident.

We value this positive feedback and I have passed on your lovely comments and thanks to the team and have shared this with my Senior Managers.

Thank you once again for taking the time to share your story and best wishes for the future.

Kind regards

[redacted]

Senior Charge Nurse

Care and Treatment Service North Locality.

Just wonderful district nurses

[redacted] *a relative* 15/03/2022

I am the [redacted] and I just wanted to thank the district nurses who help me and come in and look after my mum with me. I genuinely do not know what we would do without them.

All the nurses that visit have been amazing, efficient and supportive especially to me. Mum has pressure sores which they attend to, they take her bloods as she is anaemic, and they keep an eye on this. They help with her mobility and organised for an occupational therapist to visit.

Just wonderful and cannot thank them enough.

[redacted] NHS Tayside 17/03/2022

Thank you for taking the time to share your feelings about the service and support that the district nurses offer to you and your mother. Its always very gratifying to the nurses to know that someone really appreciates the efforts they make to support patients and family.

The service user and patient experience survey- This has been recently launched as a tool that can be used by all HSCP services. It also comes in an easy read version. It gives more quantitative data than narrative. It will help to benchmark performance against national indicators.

Request for the option of longer shifts at Blairgowrie Community Hospital -Consistent staff feedback stated that they wanted to trial the longer shift patterns that were available in Pitlochry. Anecdotal evidence of staff applying for posts was that they had a strong preference for this option to support work-life balance and wellbeing. The cost of fuel, as most staff travel into Locality was also a factor. An SBAR was completed and engagement with Staffside and HR has taken place. Financial calculations have also proven that there is no detriment to the Organisation. Approval has now been given to trial with a PSDA cycle to monitor impact.

Care at Home service user feedback

"I cannot thank you enough for all the help and support that you have provided to my mother, without it she would have been in a care home."
"Your team are amazing, they are gently, kind, patient and caring – nothing is a bother. Please pass on my heartfelt thanks to everyone involved".
"My dad has been looked after at home by you all, second to none. Truth being he would have not had as much time at home with us if it were not for you. I am grateful to you all".
"The work ethic and culture that exists in HART has been critical, even with HART being at its most critical service levels all the staff have a "think yes" approach".

Carer's Story

"They (care provider) have been really good to me, they are always willing to help and they are great to dad and know how to respond to him when he asks tricky questions. I feel the care they give is extremely good. The break that I had has made a great difference to me and I am really looking forward to my next break for my daughter's wedding. Knowing that there was someone there looking after my dad that I could trust gave me some much-needed time with my daughter but also gave my daughter time with me which we miss out on so much. I know that I can just pick up the phone and I can get the support I need, it makes it so much easier for me to know you are there and that I can talk to you and I trust you".

Carer's Story

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

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

COMPLAINTS

Complaints closed during the following time periods:

	1st April 2019 – 31st Mar 2020	1st April 2020 – 31st Mar 2021	1st April 2021 – 31st Mar 2022
Number of complaints	3	2	6
Stage 1	2	0	1
Stage 2	1	2	5
% Stage 2 complaints responded to within timescale	100%	50%	100%
% complaints upheld or partially upheld	33%	50%	66%

The majority of complaints this year have been received though General Adult Psychiatry. This is reflective of the difficulties the service has struggled with in terms of medical cover and the need to set up the Contingency Hub. Improvement work is ongoing through the Listen, Learn, Change, action plan.

Social Work Complaints

Frontline Resolutions and Complaints are investigated, and responses are prepared as per Partnership guidelines and timescales.

	1st June 2021 – 31st May 2022
Number of complaints	9
Stage 1	8
Stage 2	1
% Stage 2 complaints responded to within timescale	0%
% complaints upheld or partially upheld	22%

The use of the newly introduced term resolved means that we are unable to label complaints as upheld or not upheld. 6 of these complaints are labelled resolved 2 were upheld and 1 remains open.

Complaints this year have included

· Poor communication in relation to information about Charging for Care Home,

· Poor communication with regard to cancelling a review at short notice

· Allegations of lack of support and from Social Workers

INFORMATION GOVERNANCE

This is a standing agenda item at Governance meetings.

Teams use a combination of paper records, EMIS and AIS to record interventions and related contacts. During induction, staff undertake e-learning modules on GDPR, Information Security and Freedom of Information. All teams comply with NHS Tayside Information Governance Policy and information is stored, shared and accessed in accordance with this. All staff undertake core mandatory training including safe information handling. NHS Tayside policy includes how key information governance requirements are managed to ensure compliance with relevant legislation including: Network and Information Systems Regulations (2018), General Data Protection Regulation (GDPR) and Data Protection Act 2018 (DPA) and the requirements of the Information Security Policy Framework (ISPF).

Regular documentation audits take place within all teams with a new audit tool adopted by Community Nursing

GDPR principles are implemented with the Learnpro module as mandatory training for all.
Information sharing challenges persist between Health and Social Care in that systems do not talk to one another.

Any Data Breach issues reported on DATIX are followed up by the Information Governance team to seek assurance that breaches of personal data have not taken place.

PROFESSIONAL REGULATION AND WORKFORCE DEVELOPMENT

All staff are registered with a professional body, including the Nursing and Midwifery Council (NMC), Health and Care Professions Council (HCPC) and are responsible for maintaining their own registration in order to practice. As employers we have responsibility to ensure staff remain fit to practice and maintain professional registration. (HCSW are not currently required to register).

Dashboard: This is being developed with support from Clinical Governance team to capture key indicators from the P&K minimum Core Standards of Care and Professional Governance.

INFORMATION GOVERNANCE	Data Source
% of records audited which fully comply with agreed clinical and professional standards	Documentation Audits
Number of events recorded involving a breach or non-compliance with Information Governance Policies	DATIX
% of staff completed the Learnpro module	LearnPro Dashboard
PATIENT, SERVICE USER, CARER & STAFF SAFETY	
% of staff who have completed required mandatory Learnpro training	Learnpro Dashboard
% of staff who have completed required V&A mandatory face to face training	Local information
% of staff who have completed required Manual Handling face to face training	Local information
% of staff who have completed required CPR mandatory face to face training	Local information
Number of LAER's per month	DATIX
PROFESSIONAL REGULATION & WORKFORCE DEVELOPMENT	
% completion with local area staff induction for new staff (within 3 months)	LearnPro / Local info
% of staff who have received clinical supervision (4 per year)	Dashboard
PATIENT, SERVICE USER, CARER & STAFF EXPERIENCE	
Number of complaints received (stage 1 & stage 2)	DATIX / local information
REGULATION, QUALITY & EFFECTIVENESS OF CARE	

Evidence of research alongside service improvement/developments		
Evidence of quality improvement work (PDSA etc)	Include improvement plans and any learning	

PROMOTION OF EQUALITY AND SOCIAL JUSTICE	
Evidence of appropriate use of translation and interpretation services	

Registration details are held within a locality database. These are reviewed monthly for Nursing Staff and every 2 years for AHPs

Education around Adult Support and Protection has been made available to include Professional Curiosity. This is open to all grades of staff to reinforce that this is everyone's business.

Skill mix – There is a recognised national shortage of registrants with staffing gaps being reflected in local workforce planning. While we are more than willing to recruit and develop NGPs, we have also recognised that there are many tasks that can be undertaken by skilled Band 4 HCSW. Band 4 roles are well established in AHPs teams but are new to Nursing in Perth & Kinross.
Work is progressing to establish competencies and agree the generic elements of the roles to support our Registrants to focus on complexity within our wards and community settings.

Social Work Registrations
All social workers in the North Locality Social Work Team are registered with the SSSC and registrations are checked monthly to ensure fees are up to date and registrations are still current. There is a mix of experienced and less experienced social workers within the team including Adult Protection Council Officers.

PROMOTION OF EQUALITY AND SOCIAL JUSTICE

Mental Health and Learning Disability Physical Health Screening

In line with the recent Scottish Government directive, The Annual Health Check for People with Learning Disabilities (Scotland) Directions 2022 now standardises a duty of care on Health Boards to provide Annual Health Checks to all people in Scotland aged 16 and over who have learning disabilities, using the Scottish Health Check for Adults with Learning Disabilities. This is a targeted invitation for a yearly check-up of the person with a learning disability's health. This must be undertaken by a registered nurse or a registered medical practitioner. Checks are to be offered to individuals aged 16 and over who are known by the Boards to have a learning disability, those who identify themselves as having a learning disability (whether or not that learning disability has been formally diagnosed and regardless of whether it is mild, moderate, severeor profound). Health Boards must also take all reasonable steps to identify persons within their catchment areas who are under the age of 16 and who have a learning disability, in order that an annual health check can be offered to them as soon as they attain the age of 16.
Through workforce redesign in 2021 and a change in delivery model, the LDISS service has provided both an in reach and outreach service ensuring equity of access to health care screening. Physical screening canat times be difficult for an individual with learning disabilities, particularly invasive treatments such as taking bloods. The service continues to expand and offers physical observations, side effect monitoring, blood monitoring and electrocardiogram. Further data will be available towards the end of 2022.

SCOPE- As the Learning Disability is hosted in the North Locality, the team has been involved in the set up of SCOPE. The Complex Care Transformation Programme aims to improve support for people with complex needs. An integrated multi-disciplinary team has been developed which will support people with autism and/or learning disability to address their care needs and offer choice.
Supporting young people and adults with complex needs
Community based approach
Offering young people and adults choice in their care packages
Person centred planning
Enriching people's lives

Community resilience - HIIC (Health Issues in the Community) is a training course that enables participants to develop their understanding of the range of factors that affect their health and the health of their communities and to explore how these factors can be addressed using community development approaches. Our Healthy Communities Project Worker has recently completed this training.
The core underpinning theme of HIIC is community development. Although this term can be used to describe many different types of activity the particular perspective that is taken here places value on supporting individuals to work collectively; on extending participatory democracy; and on social justice and equity.
The course draws on a social model of health which views health and illness as having as much to do with economic and social factors as with individual behaviour. It seeks to promote the value of equity in terms of equal access to health, and to counter discrimination. The course supports people to participate in decision-making processes and to take a more active role in the planning and delivery of services.

The food scheme Blairgowrie & Rattray Trust BaRi (Blairgowrie and Rattray Initiative) - Older Peoples sub group, part of the local Stronger Communities Group, are looking at the availability of healthy nutritious meals in the Blairgowrie area, BaRi already make meals with food share products and freeze them. They are delivered to older people in the area. Soup and sandwich lunches are planned along with meal taster sessions.

Drop in Hearing aid clinics – these have been reinstated within our community hospitals with the support of audiology and a group of local volunteers who are co-ordinated by RVS. These were difficult to reopen due to Covid guidance there return been welcomed by local residents who can now access the help they need locally again.

Social Work

Emerging from the pandemic, despite staffing levels often being in status Hot Amber or Red, the North Locality Social Work Team has continued to deliver a consistently high-quality service ensuring that our most vulnerable service users are protected and supported. We have continually recruited to any vacant posts and have sought and identified creative solutions both internally and externally to bridge gaps in staffing.

The challenges we have seen for the individuals we work with as we come out of the pandemic are multi-faceted but commonly, they centre around social isolation, loneliness, lack of confidence, reduced mobility, and stress on unpaid carers. Assessing workers are conscious of the emerging issues and team case discussions often focus on finding creative solutions to support individuals facing these challenges.

Staff have adapted to hybrid working arrangements and we have developed new ways of working to ensure new and existing staff are supported in their roles. We have introduced weekly "How to Do" sessions for all staff to allow for mentoring, the sharing of good practice and the opportunity for all staff to ask questions about the work they do. Staff have reported that these sessions have been most beneficial and supportive and they have provided an office type learning environment virtually when we have been unable to share learning and knowledge within a traditional office setting.

We are mindful of the challenges staff have faced throughout Covid 19 and we are continuously supporting staff wellbeing.

Social Work Interventions

1. An older person who had advanced dementia was at significant risk in the community due to them wandering and walking into the path of moving vehicles. The individual was unable to recognise risk or prevent harm from occurring to them. The social worker tried to support the person remain living at home for as long as possible with an increased support package and Technology Enabled Care, but the continued risks associated with the wandering and impulsivity resulted in the community arrangements being unsustainable and dangerous. The person was admitted to a care home on a crisis admission basis to ensure their immediate safety and assessments in relation to the person's long-term care concluded that the individual now required permanent care in a residential care home. Their family was appreciative of the support given throughout the social work intervention, from the point of crisis through to the decision regarding permanent care. They thanked the social worker for all the support provided at each point in the journey, for keeping them updated and included, and for ensuring their relative was safe and supported long-term.

2. A person with longstanding substance misuse issues who had continuously sought solace in the Emergency Services and Community Alarm Team and who was being financially harmed by their associates resulting in them having inadequate supplies of food and electricity was supported by the social worker to take back control of their life. The social worker worked with the individual alongside all partner agencies including the Police, Fire Service, Ambulance Service, Community Alarm Team and the care provider to promote the individual's wishes, to encourage a healthier and safer lifestyle, and to ensure the person had access to appropriate supports. As a result, there has been a dramatic reduction in the calls the individual has made seeking assistance from inappropriate services and there have been no further admissions to hospital. The person has regained control of their finances and safeguards have been put into place to ensure that basic needs such as food and electricity are always met.

3. We have continued to work closely with the Scottish Fire and Rescue Service and the Watch Commander has quoted the following: "If I can say it's been great creating lots of links and enhancing our partnership working from joint visits to referral training. Knowing I have direct links in the North Locality makes delivery very fluid and helps to meet the local needs of those most vulnerable in the community".

Care at Home

It is important to acknowledge the strengths that exist within our local Care at Home provision; this is a challenging and demanding area of social care delivery. Both our internal and external deliverers of Care at Home, work tirelessly to ensure the needs of those they care, and support are met. However, within Perth and Kinross and since we externalised our Care at Home provision, we have continued to see a level of unmet need which is reflected in the North Locality due to the rurality of the area and challenges this brings.

The Care at Home resiliency project has sought to explore why this unmet need continues and to review both our internal and external provision in order to improve our ability to meet this need but also to ensure we look at the overall model of delivery, to ensure we are delivering outcome-based support and care, to ensure we are optimising the range of partners involved in this delivery model and to ensure that the workforce feel engaged, valued and rewarded for the work they do. The work is aimed at empowering people to have greater control over their lives, have stronger connections in their community and have access to the support they need within their local community.

The Care at Home Resiliency project has been working to address the key challenges that have persistently presented within the current Care at Home model and are related to Rurality, Recruitment and Flexibility. These are not new to Care at Home, but Covid has further impacted on these existing challenges, and we have seen an increase in referrals within our Reablement and long-term Care at Home provision. This has been due to a variety of factors including a decrease in care home admissions and increased dependency of people due to decreased activity and reduced community supports during lockdown.

The pandemic has undeniably impacted on the projects ability to compare and contract methods of working

and improvements implemented by the Resilience Project. There does continue to be a level of unmet need within Care at Home but given the increased demand because of the Pandemic the team feels secure in asserting that the level of need would have been far greater without the improvements to processes, referral pathways and further investment. The ability to support people to remain at home rather than be admitted to a care home is a key achievement.

A series of co-production groups have been held, with a wide range of stakeholders interested and engaged in the project, and included organisations already providing services within rural locations, including but not limited to, community groups, private providers, care homes, Live Active, GP representation, Care and Wellbeing, PKAVS, NHS Healthy Communities, social work and Alzheimer's Scotland.

The rurality of Perth and Kinross and, as identified, particularly the North is extremely challenging with regards recruitment and retention, this is where, in the majority, we experience unmet need. We are clear that if we want to ensure we work in a proactive and person manner that enables more people live in their own homes for longer, that investing in more of the same will be ineffective in achieving this. Through our community engagement activity, trialling of different models and learning gained from other areas we understand that Community based approaches work well. The model we believe would work best within Perth and Kinross is that of the Wellbeing Team approach, small, self-managing teams, that operate in local neighbourhoods, they are values-led at every step, focussed on co-production, supporting people to make decisions about their life and support, committed to the wellbeing both of the people they support and the members of the team. Not only do Wellbeing Teams work well for the individuals receiving care and support but we know that where Self-Managed Teams exist in other areas they report a more flexible approach, improved quality of work life and increased job satisfaction, this is vital to our ability to recruit and retain high quality staff. We are currently in the process of recruiting for the North Locality to form a Living Well Care approach.

To further support recruitment and retention, the HSCP used part of financial allocation from the Scottish Government to improve pay and conditions for our External Care at Home providers and ensure a more equitable pay rate across Care at Home provision as a whole, in addition this funding has been aligned to the new Care at Home model (Wellbeing Teams), both of these financial investments will improve capacity and meet current and future demographic pressures.

Occupational Therapy Interventions in the North

We as a service have instigated a telephone assessment option. It was introduced before the pandemic to reduce waiting times on our waiting list for non-complex requirements such as provision of basic equipment and adaptations.

Previously people had to be placed on a waiting list however by introducing an option for telephone assessment we have been able to cut waiting times and greatly reduce the size of the waiting list for more complex interventions.

We set up a rota system with Occupational Therapy Assistants and devised an assessment to use over the telephone either with the service user or their carers/friends/family. This system allows for equipment or adaptations to be requested as soon as the assessment is completed. This reduces the risk of falls and supports independence for individuals. Sometimes early intervention with the simplest of solutions by providing basic equipment or for example a grab rail over steps or a second banister on stairs can support safety and independence effectively.

New systems have been developed because of the pandemic using a variety of assessments including use of photographs, video and Attend Anywhere. These services continue to be offered where appropriate to the benefit of all those who require an OT service and waiting times are kept to a minimum as a result.

Social Prescribing- Despite there not being the same opportunities for people to access community resources during the pandemic, social prescribers in both Strathmore and Highland have been there for individuals in the community, often encountering people when they were at their most lonely and isolated. Support from the social prescribers included weekly telephone calls, delivery of food parcels and medicines,

referral to online activities and groups and the exploration of technology and supporting individuals to use it.

Coming out of the pandemic, the social prescribers are working closely with GP's, colleagues within the Partnership, the voluntary sector and third sector to ensure that they are reaching out to all individuals who may benefit from community activities, groups and supports and are working in conjunction with community groups to develop services required in the North.

On a monthly basis, the social prescriber and the carers support worker, attend the Madoch Centre in St Madoes, where they support an informal carer drop-in service. There they meet with unpaid carers and the cared for person, chat to them about any issues they may have, take referrals and signpost individuals to other services which may be of benefit. Also in attendance are the Carer Therapists who are on hand to provide carers with relaxing treatments. Often, we have found these interventions support carers to have a life alongside caring.

A new initiative the social prescribers are involved in is the Nature/Green Prescribing at The Atholl Centre in Pitlochry which incorporates strategic priorities of the Health and Social Care Partnership including Early Intervention and Prevention; Working with Communities and Making the Best Use of Available Facilities, People and Resources. This gardening project is accessible to all, and any produce grown is shared with the community food larder. It is hoped this year that there will be further green spaces utilised by the project at Dalweem Care Home in Aberfeldy and Pitlochry Community Hospital.

Our social prescriber is further involved in the Home Care Resilience – Fit for the Future project, the purpose of which is to strengthen communities by involving community groups to support them to lead and develop response and resilience locally.

Having recently made links with The Community Listening Service (a service which provides 50-minute appointments with fully trained listeners to individuals either by telephone or within GP practices), we hope to be able to work alongside them, embedding the Social Prescribing service in the GP practices. It is hoped that this joined up working will help to strengthen the referral process and promote early intervention/prevention.

Some examples of working with individuals in the community by the Social Prescriber:

1. *A is the main carer for their mother. A was feeling quite overwhelmed and isolated in their caring role. They were new to the area and didn't know anyone. They were referred to the social prescriber to look at activities in the community that would give them some respite but also allow them to meet others. After speaking with A and finding out what they liked to do, we came up with joining the Garden Project and the Health Walk in Pitlochry on a Tuesday. After a few weeks of joining in with both activities, it became very apparent that this was benefitting them greatly. They were feeling less overwhelmed, their confidence had improved, and they didn't feel as lonely or isolated as they previously had. Their physical and mental health had significantly improved as a result of him getting some exercise and being outside in the fresh air. A was feeling so much better that they made the decision to do the Walk Leader Training Course and is now leading walks in Birnam and Pitlochry.*

2. *B moved to a rural village in the Strathmore area with their spouse approximately 5 years ago. Shortly after B was diagnosed with an illness affecting their memory, cognitive function and vision. Since moving, they have found it very difficult to get out and meet people due to them coming to terms with the health diagnosis and then being faced with the covid-19 pandemic. During this time B's sight deteriorated resulting in a loss of confidence and the spouse becoming the main carer. The social prescriber spoke to the couple to find out what mattered to them, what they enjoyed doing and what support they needed. They identified that B would really like to get out into the fresh air again and meet and chat to others.*

   During the conversation, B spoke about loving dogs and the social prescriber tapped into the Dementia Dog service. B is now delighted to be paired with a trained dementia dog and handler who, along with the social prescriber, will be supporting B to build her confidence and meet new people by joining a weekly walking group. This will also give the spouse invaluable respite time.

B has also been linked into a local macular support group where they are able to chat to others with similar challenges and share information and support.

Further, B is also currently receiving weekly telephone calls from a volunteer befriender and is on the waiting list for face-to-face visits which will also provide them with friendly company and some respite for the spouse. Both individuals have commented on how nice it is for B to be able to gain some independence back and have these things to look forward to. This intervention has been person-centred and holistic in nature, considering not only the needs of the cared for person but also the needs of the carer.

Supporting carers to have a life alongside caring- Our carers support worker supports all unpaid carers over the age of 16. Unpaid Carers have been significantly impacted by the pandemic and the lockdown restrictions meant a lot of the support they relied upon, lessened, or changed, for example groups and activities in the community and not being able to see family and friends. Being able to access services such as respite has also been challenging due to care homes being unable to accept admissions at times or due to them being closed. Many carers also chose to keep themselves and their loved ones safe by self-isolating and limiting the amount of people coming into their home. These were genuine, worrying times for carers and their families.

The Carers Support Worker along with the wider social work team focuses on building a relationship with carers, listening and empathising with them and their situation, treating them with respect, kindness and compassion and valuing them for who they are and what they do.

Our Carers Support Worker has been part of the working group supporting the development of the new Carers Act training which is now being implemented across the North Social Work sub teams. The training focusses on eligibility criteria, referral processes, legal duties and responsibilities, Adult Carer Support Plans and waiving of charges. All assessing workers in the North Locality Social Work Teams have undertaken the new training and have reported feeling more confident in their working knowledge of applying the Carers Act to practice. Team development discussions around supporting carers whilst adhering to the principles of the legislation are ongoing – during these sessions, good practice is shared particularly around creative support and positive outcomes for carers.

On 19th February 2022 the Dementia Friendly Aberfeldy Collaborative and partners organised the first carer afternoon tea in Aberfeldy. This was an afternoon where carers from Aberfeldy and the surrounding areas could attend and was open to all. It is anticipated that going forward, this event will be run each month to allow carers to come together and meet other people who are caring, offering much needed peer support in a friendly and relaxed atmosphere. There were colleagues from Dementia Friendly Aberfeldy, Social Prescribing, Health and Wellbeing collaboratives and Carer Support Worker to offer information, advice and support to carers and cared for people on the day. This initiative has created the opportunity to develop peer support and for individuals to develop natural friendships with others in their local area.

In September 2021 saw the launch of the new Carers Rights booklet which was launched in various locations throughout the North locality including Pitlochry, Carse of Gowrie, Coupar Angus and Alyth. This was a great opportunity to make some good connections with the community but also raised awareness around carers' rights to assessment and support.

Our Carers Support Worker is looking to create an online Carer Peer Support group prompted from conversations with carers who expressed their wish to connect with other carers in their home areas. The plan is to create face to face and virtual opportunities for carers in different locality areas in the North to enable them to meet with other carers, share their stories, feel supported and listened to which it is hoped will in turn create a natural support network for carers. It is planned that guest speakers could be invited to these sessions where appropriate e.g Welfare Rights, Self Directed Support, PKAVS.

Community Engagement- An example of an intervention by the Community Engagement Team in the Strathmore area which ultimately brought community groups together to help each other was demonstrated when our Community Engagement Officer met with a representative from Blairgowrie and District Senior

Outings (BADSO Freedom Coach) to invite them to join the Stronger Communities network. There had been low interest in using the coach, so the Community Engagement worker clarified exactly what the service was offering, created a poster and advertised the service on the Community Engagement news sway. She further invited the representative to speak at the Stronger Communities meeting and as a result, interest in the service was renewed and further the profile of the Freedom Coach was raised in the communities it serves. Blairgowrie and Rattray Development Trust also offered to help promote finding a driver for the coach through their volunteer network.

Safer Communities Wardens in Blairgowrie and Aberfeldy - The Safer Communities Wardens are a small team of uniformed council officers who carry out a wide range of activities across the Local Authority.

Most of the Team are based at the Fire Station in Perth but 2 wardens are dedicated to Aberfeldy and Blairgowrie respectively.

The wardens act as the eyes and ears of the community carrying out foot patrols and engaging with people of all ages. They have a particular focus on vulnerable people and carry out Home Safety Visits with Fire fighters and Keeping in Touch Visits to people who have been victims of crime, anti-social behaviour, mental ill-health or domestic abuse. These visits are reassuring and help other services to gather information and build trust. They also report fly-tipping and other environmental problems and report and remove graffiti whenever they can. Because they are a small team, Safer Communities Wardens are expected to work closely with other services such as Fire, Police, Housing, Waste Services, schools and the like to find sustainable solutions to problems being experienced by communities.

The Safer Communities Wardens help guide people through the complexity of public services and the 3rd sector and play a key role in sharing information to ensure people and communities are and feel safe.

WHAT IS THE SERVICE / LOCALITY DOING TO FURTHER IMPROVE?

SMARTSHEET – Smartsheet has been adopted as our reporting system for all things Health and Safety. All teams have registered and have completed baseline assessments to include:

- Display screen equipment
- Skin health
- Face fit testing
- Prevention and management of violence and aggression
- Manual Handling
- Risk Assessments for Covid 19, rooms and individuals

Health and Safety Passports have been issued to all staff to support this activity

GAP: The North Perthshire CMHT has developed a new role of liaison charge nurse who is based within the CMHT itself. The role of this nurse is to be involved in the planning of follow up care with patients who are currently being managed by inpatient or crisis services. They are involved in attending discharge planning meetings and communicating with ward-based and crisis team staff in regards to the needs of patients in their care. The nurse will also follow up the patient for a period of 6-8 weeks after discharge from inpatient / crisis services to provide further assessment and support while they transition to community care.This is in line with recommendation 21 from NHS Tayside's Listen Learn Change Action Plan. The hope for this new role is to improve communication and establish better links with inpatient and crisis services and to promote a smoother transition of patient care from inpatient and crisis services to community services. This should also improve the patient experience of mental health services

ANP Service - The ANP service is continuing to develop as staff progress through training to manage the shift in how we deliver urgent care. Going forward this service will report through the new ANP and Urgent Care structure.

Mental health ANP - This is a very new and evolving role which has been designed to support the Scottish Government (2017) Transforming nursing, midwifery and health professions roles: advanced nursing practice. The remit of this role is to manage the complete care of a patient, not solely any specific condition. Four pillars of practice define the core role and function of the ANP: Clinical Practice; Leadership; Facilitation of Learning; Evidence, Research and Development. Governance structures for Mental Health ANPs are being progressed and our ANP staff are working closely with Mental Health colleagues locally across Tayside and at a wider national level.

Inpatient activity worker role - Increased complexity and frailty of inpatients and delays in community care provision within the community hospitals have seen an increase in the length of stay (LOS) for our patients. It is clearly documented that increased LOS in hospital for frail, elderly patients causes deconditioning. To reduce this risk, a Therapeutic Activity Worker can enrich the inpatient environment with meaningful activity. The activity workers role will be to develop, implement and evaluate an activities programme of social, recreational and therapeutic activities, in both group and individual sessions, in order to promote and support the physical, social and mental well being of patients. Enriching inpatient environments with meaningful activity and the use of activity workers in psychiatry of old age and stroke care within the UK is well established. The benefits of this role will include promotion of health and wellbeing, with increased choice and control, social participation and involvement, occupation and dignity. Increased patient activity and reinforcement of therapy goals with focussed person centred care that will address the range of factors that can promote rehabilitation and recovery

LInC Service - LInCS service continuing to develop within the locality with training plans evolving for all levels of staff involved with the service, ensuring that staff of the same Band are trained to the same level and have the confidence to recognise when it is safe to maintain patients at home or not.

LInCs has enhanced the urgent care pathway and given patients the opportunity to remain at home rather than default to hospital when circumstances change.

We have a dedicated LInCs worker from social work who attends the daily meetings and works alongside the multidisciplinary team to improve outcomes for referred individuals and prevent deterioration in their health which could ultimately lead to them being admitted to hospital or a care home. Due to workforce pressures, our dedicated LInCs worker recently stepped in and worked as a second worker alongside a community nursing colleague. This offer of assistance was greatly appreciated and ensured that nursing staff were able to assist those most in need.

In order to prevent delayed discharges, the team also assist people to leave hospital on interim placements, Ongoing rehabilitation can continue to ensure that the person is as independent as possible when the time comes for them to leave the care facility and return to their own home within the community.

Clinical co-ordinator- We have recently recruited a clinical co-ordinator who has clinical experience as an OT, to support referrals to LInCs and the wider integrated locality teams. They are responsible for the clinical triage of all referrals to LINCS, ensuring an appropriate care pathway is established for each individual and to improve patient experience and outcomes whilst reducing the need for unnecessary emergency admission or readmission to hospital or to enable timely supported discharge. This role is very much evolving but is demonstrating its worth in terms of improved co-ordination and communication.

CCAT Service-
This service has continued to develop throughout the pandemic to meet the ask of the GP contract. As well as delivering

- Wound care and leg ulcer management
- Management of minor injuries
- Phlebotomy
- Aural care
- Suture removal

the service is now offering

- Chronic disease monitoring and related data collection.
- Anti-coagulation
- Phototherapy (at our Piltochry hub only)

Treatment rooms in Blairgowrie Community Hospital have recently undergone refurbishment providing spaces that are bright, modern and fit for purpose as well as future proofing against further expansion of the service.

First Contact Physiotherapy - Although these staff are managed centrally, they work within the localities to deliver timely access within the locality to MSK Physiotherapy assessment, advice and onward referral as required. This is a busy, in-demand service and current data supports that further appointment availability is required. Funding is being sought through PCIF to recruit more staff to enable the service to meet demand.

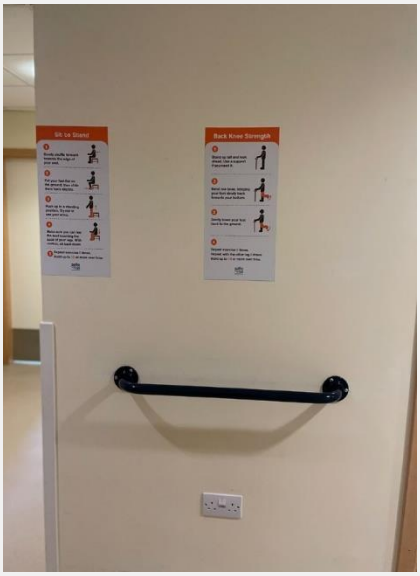
Adult Support and Protection - The North has representation at the ASP subgroup raising the profile and understanding of staff. We are building connections with our NHS ASP advisors to enhance the identification and referral of adult concerns within our services. Training has been organised to support Professional Curiosity. We have also taken forward actions following the Thematic Review. Smoking status of patients along with the presence of therapeutic oxygen and use of air mattresses should be routinely incorporated into discharge planning processes.

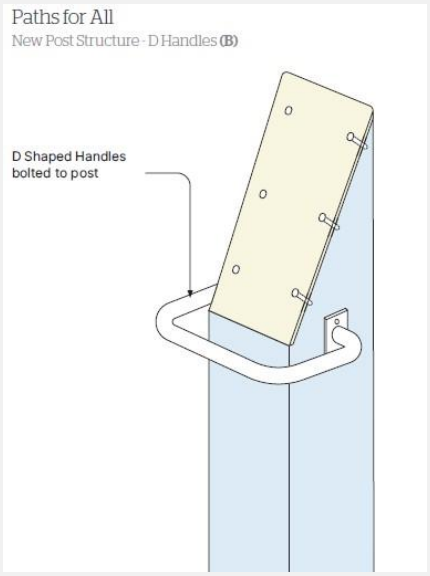
There have been 2 Large Scale Investigations completed in the North Locality over the past year.

Themes from the LSI's centred around concerns about delivery of care, staffing levels, management, compromised skin integrity, medication management, nutritional needs and falls. Protection plans were implemented and identified actions fully achieved.

In the past year, the North Locality Social Work Team has undertaken 45 Adult Support and Protection Inquiries and 14 Adult Support and Protection Investigations. To meet the demands of this statutory Adult Support and Protection work, the North Locality has to carefully balance the skill mix of the social workers in the team to ensure there are sufficient adequately skilled and trained Adult Protection Council Officers in the team staffing structure.

The Paths for All work, Blairgowrie Community Hospital- This has provided indoor exercise stations for our inpatients. This will encourage a rehab ethos and ongoing exercise opportunities outside of normal physiotherapy working hours. With our patients being more active more often, their length of stay in hospital should be reduced. This is now progressing to include an outdoor exercise path with exercise stations and safe walking opportunities similar to the pictures below.





Update on actions from extract 2021 -

Datix – 141323 Improvement plan actions have been completed with work ongoing to improve Discharge Planning across the Localities as noted above.

Any outstanding Datix relating to sudden death have been closed through confirmation of misadventure or LAER to explore any learning within teams. No themes have emerged locally but Mental Health services improvement work is progressing in line with the recommendations of the Strang report.

Record Retention Policy- All timescales were reviewed and records cleansed accordingly. The schedule is now embedded in practice.

"Mr A" SCR - Closer communication has been established with the District Nurses within residential care homes along side developing relationships with the enhanced care home team. Any advice in regard to individual patients given by any clinician is documented and followed up accordingly. The profile of adult support and protection has been raised through the support of the ASP team and learning around Professional Curiosity.

Pitlochry – Pitlochry Community Hospital remains on the Risk Register as part of the wider Community Hospital risk. As we expect to be fully staffed come October, this can be reviewed again soon.

CCGF MINUTE EXTRACT (PREVIOUS YEAR)

2nd July 2021 CPGF meeting extract:

[redacted] noted that the Locality Care and Governance Risk meeting occurs every eight weeks and these are reported to this forum. Due to COVID it was agreed to bring these forward to monthly meetings and is chaired by the Locality Manager and attended by staff members who have leadership roles and responsibilities within their teams. The meeting has evolved to a fully integrated health and social care governance meeting. Daily safety huddles allows early escalation of risks.

As part of a partnership approach learning has been around COVID which was completed in the early stages of the pandemic. All lateral flow tests have been offered to all staff for two weekly testing to capture positive cases. COVID learning (appendix1-1a) is available from [redacted] and [redacted]

Due to national shortages receiving equipment has been an ongoing challenge.

COVID vaccinations have been supported by Community Nursing teams for the housebound and we are preparing our nursing teams for step up again.

We have received the Bronze award and the Gold award through Healthy Working Lives for staff in Social Work there are regular health and wellbeing newsletters.

The team have benefitted greatly where staff have been redeployed during the pandemic including social work staff who were deployed to other positions at key times.

Service development continues to develop with CCATS service evolving last year despite the challenges of the pandemic. Implementation of LINCS and ANP services are continuing and these now sit under North locality management with Community LD teams also reporting through the North locality.

Due to the current recruitment within PCH this remains the highest risk on the risk register and current contingency plans are being developed across the HSCP. The Risk Assessment form for Social Work is completed and escalated when required.

There are currently three LAERs. A missed medication review at PCH and learning and reflections have been taken including supervision on drug rounds with changes being made to ensure lunchtimes are less busy and distractions minimised. Learning has been identified and an improvement plan agreed in regards to discharges from acute care to home where improvement could be made and an improvement plan is at Appendix 2 and there is one outstanding DATIX regarding a sudden death which will be completed on receipt of information from the Procurator Fiscal.

Large Scale Inquiries have been completed by Social Work for Corbenic, Balhousie Coupar Angus and Balhousie Stormont Lodge which have all been closed and social work are currently monitoring with improvement plans being put in place.

At Luncarty House there has been a Significant Event Analysis carried out with both Health and Social Work meeting with staff from the Care Home. This event followed a patient transfer from Ninewells with the Care Home Liaison Team carrying out an assessment. Communication and escalation processes have been improved however no action was required by the Care Home.

An unannounced visit was carried out at Glenhelenbank where concerns from the Lead Nurse led to input from the ANP and Community Nursing Service and a review of the patients was completed through visits and processes. The Enhanced Care Home Oversight Group supported care home staff.

Following queries from last year's falls data a deep dive was carried out and an SBAR has been completed. [redacted], Falls Service manager continues to support with reviews from DATIX. Assurance can be given that all mitigating actions or escalations are in place. (See SBAR at Appendix 3).

A good level of Infection Prevention and Control regarding PPE and IPC standards are monitored as part of the care assurance by the CPTMs.

Comparisons have been made to the unannounced Arbroath Infirmary visit and key themes have been noted. (Appendix 4). We are ensuring we are inspection ready by using the Care Assurance Tool.

In the past year there have been three ASP audits carried out. There are two outstanding ASP reports which are to be tabled at the next ASP committee and awaiting feedback when this will be shared

wider. One other area is in regards to the varied way ASP audits are being recorded by Social Work.

Due to the pandemic opportunities for feedback this has been limited primarily with losing face to face contact with relatives and visitors where paper questionnaires have not been appropriate. Alternative ways through Patient Opinion have been sourced but we have now been able to reinstate inpatient questionnaires through “you said” “we did” boards. The normal complaints procedure remained the same.

There has been one minor complaint and it has been fed into our governance group where any learning will be taken back to local teams.

The complaint from PCH around care delivery at the onset of the pandemic resulted in support through a PAG.

Record Retention Policy was recently reviewed which resulted in changes to meet the GDPR requirements. An action plan is being implemented at the moment.

Key indicators from the P&K minimum Core Standards have been captured on the dashboard and this is being developed with help from Clinical Governance.

Key themes were identified through the “Mr A” SCR. Closer communication has been identified with the District Nurses within residential care homes. Currently formalising and standardising processes in order to embed into day to day practices.

The Primary Care Mental Health and Wellbeing Team Evaluation is shown at Appendix 5. Appointments are managed through Vision with consultations taking place through NearMe or by telephone.

The Mental Health and Learning Disability Supervision Protocol is at Appendix 6 and has been formally adopted across the teams. This has not been fully embedded into practice.

The Mental Health and Learning Disability Standards for Care Planning is at Appendix 7. Work is currently progressing to adopt all aspects of these standards. All Social Work Staff are registered with SSSC and regular checks are carried out with the registration body.

We have endorsed better feedback in terms of Equality and Justice and other wider work is ongoing across the locality. Stronger Communities Team have been working in conjunction with Social Prescribers and currently working on loneliness at a time of crisis.

In Appendix 8 further improvement has been covered with the North Management Action Plan and the North Community engagement plan at Appendix 9. The ANP service is continuing to develop and is covered at Appendix 10. The next steps within the CCATS service is to start to support ear syringing work. The MIU Paramedic Test of Change report has been completed and is at Appendix 11.

Due to workforce challenges and recruitment the 12-hour shifts at PCH have been running since the pandemic. There has not been the opportunity to evaluate this. This will be shared with the group when completed.

Things are beginning to get back to normal therefore preparing for normal services to resume and can give assurance things are in place.

[redacted] gave an update regarding Social Work noting there are gaps for mobile working however everything is in place and will be reviewed. A DSE assessment will be undertaken to ensure people continue to be healthy while working at home with Community working and office space requiring the same DSE assessments. The AAA portal requires and oversees to continue to meet mandatory requirements for new staff.

The Carer Support Worker attracted a wide variation of different professionals who were interested in

the Carers Act and how that translated into the role as Social Prescriber. There was a healthy response for the post to be filled.

The ASP within Balhousie Stormont Lodge discretion was made in relation to improvement timelines and tended to be in relation to training requirements. A deep dive on handovers from Social Work to OOHs have now started.

[redacted] noted in reference to item 3.1 report referred to ANPs having no access to electronic prescribing systems and asked if this is referring to the HEMPA North of Scotland progamme? [redacted] noted it was her understanding the ANPs are unable to prescribe remotely within individual practices but will get an update for the next meeting. It may be in relation to being able to prescribe across P&K and currently Pharmacy are trying to resolve. [redacted] asked if it may be reworded as this is confusing.

[redacted] in relation to item 3.1 verbal presentation regarding Falls and supported work by [redacted]. It would be useful to have your mitigating actions as currently no confidence actions are going forward.

[redacted] comment on page 12 of the report referring to the SSSC code of practice and regulatory requirements but there is no reference to the NMC code of practice and given teams comprise of registrants it would be good to include their regulatory body here.

[redacted] noted in the report there is a risk identified around COVID. In line with visiting and moving around the level one protection level from 7 June. Strategically visiting in hospitals have been aligned to level two protection due to the increase in community incidents happening.

HD asked [redacted] if this was a typo however [redacted] acknowledged that due to the timescale of the report writing it was still at level one. However assurance can be given that level two guidance is in place.

[redacted] noted around the reference to appendixes and that these are unable to be accessed due to the PDF of documents. These can be obtained from [redacted] and [redacted].

[redacted] noted that ear syringing and blood pressure recording is being undertaken through CCATS but not seeing anything to support this. Can you give some assurance as to when this is likely to happen. AT noted this was sitting with [redacted] Primary Care who are currently working on the model. [redacted] noted that prior to [redacted] leaving an action plan was produced highlighting any actions to be addressed around oral care, MIU provision and other elements. A new Primary Care Manager has been appointed and would hope this will be picked up with CPTMs across the partnership. There is a CCATS meeting next week.

[redacted] noted the action being referred to is that somebody else will action at some point. [redacted] noted there is to be a centralised model to be designed and this is sitting with [redacted] Operationally we have stepped back from this piece of work and awaiting direction from the Primary Care Manager. The team is keen to progress and ready but we need to understand what the model will look like and this needs to be actioned as quickly as possible.

[redacted] noted that it is important to obtain clear pathways with equity across Tayside. A paper has been taken to Primary Care Board to explore how that will happen and secure professional nursing support to lead that work across Tayside. Next steps have been circulated to Chief Officers across the three partnerships to ensure a Tayside wide model is equitable across the CCATS services.

[redacted] noted one of the highest risks on the risk register is the PCH recruitment and it is good to see that this is now being recruited too [redacted] wondered if some consistency could be made to the risk register when scoring. [redacted] noted allowing another two weeks for any issues which may arise and then will remove from the risk register.

Perth & Kinross Health & Social Care Partnership

Care & Professional Governance Forum
Annual Assurance Framework Reporting Schedule (2021-2022, Cycle 3)

REPORTING TIMETABLE
October 2021 – South Locality
November 2022 – Inpatient Psychiatry of Old Age
December 2021 – Early Intervention & MHO Team
January 2021 – Public Dental Service
February 2022 – Perth City Locality
March 2022 – Prison Healthcare
April 2022 – MFTE & Intermediate Care
May 2022 – Equipment & TEC
June 2022 – North Locality
July 2022 – Commissioned Services
August 2022 – Registered Services
September 2022 – Podiatry

Reports should be received 2 weeks before each meeting to be included with the meeting papers.