Perth and Kinross Health and Social Care Strategic Commissioning Plan 2016 - 2019

Contents

Foreword

Welcome to our first integrated health and social care strategic commissioning plan. This plan has been approved by our newly formed Integrated Joint Board. The integration of adult health and social care is part of the Scottish Government's programme of reform of public services designed to improve the outcomes for people and the communities in which they live.

The plan describes our commitment in Perth and Kinross to change the way we support and deliver health and social care services to meet the many challenges facing individuals and our communities. It outlines the positive experiences that people have when services and support connect effectively putting each person and their situation at the heart of the decisions and choices that are made. Importantly, the plan also focuses on the important role our communities, the Third and Independent Sector have in supporting and enabling people to live healthy, independent lives at home or in a homely setting.

You will see we have also placed a lot of emphasis on the need for services and support to intervene early to prevent later, longer term issues arising, and enabling people to manage their own care and support by taking control and being empowered to manage their situation. Where this is not possible, we want services to be able to target resources where they are needed most, reducing ill health and deterioration and ultimately reducing health inequalities.

Councillor Dave Doogan	**Linda Dunion,**
Chair, Integration Joint Board	**Vice Chair, Integration Joint Board**

1. Introduction: our commitment and challenge

Health and Social Care is changing and from April 2016 health and social care services will be provided through the Perth and Kinross Health and Social Care Partnership. This document sets out how these services will work together to meet people's needs now and into the future. In Perth and Kinross, we recognise that people who are ill, vulnerable or have disabilities, often need support from a number of services to enable them **to live as independently as possible** and to prevent unnecessary stays in hospital or in residential care. We also recognise the distinctive needs of different areas of Perth and Kinross and the need to take account this in planning our services. We value the **diversity** of the communities of Perth and Kinross and will work with them to make sure we have an integrated health and social care system that **is inclusive and accessible.**

We will work together to make sure people are supported to lead as independent, healthy and active lives as possible in their own homes. Children and young people's services are not formally included in the Health and Social Care Partnership and we will continue to work collaboratively with the Children, Young People and Families Partnership to meet the needs of the whole community.

Our challenge is to be **open-minded and find innovative and creative** ways of doing this at a time of increased demand and expectations and reducing public finances.

Our vision

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

Our aim is to improve the wellbeing and outcomes of people living in Perth and Kinross, to **intervene early** and work with the Third and Independent sectors and communities, to **prevent longer term issues** arising.

Perth and Kinross

Perth and Kinross has a population of around 150,000 people living and working across its expansive 5,000 square kilometres. Over the coming decades the area is expected to experience significant demographic change, especially in relation to older people, the majority of whom are increasingly fit and active until much later in life and are an important and significant resource, with a great contribution to make in their local communities. We know that the need for support from health and social care services increases with age and the challenge for services and communities will be to ensure that people are supported to be able to lead healthy, fulfilling lives at home for as long as possible.

It is positive that people are living longer and the projected population of people aged 65-74 (+25%), 75-84 (+54%) and 85 plus (+151%) over the next fifteen years is summarised in table 1 below.

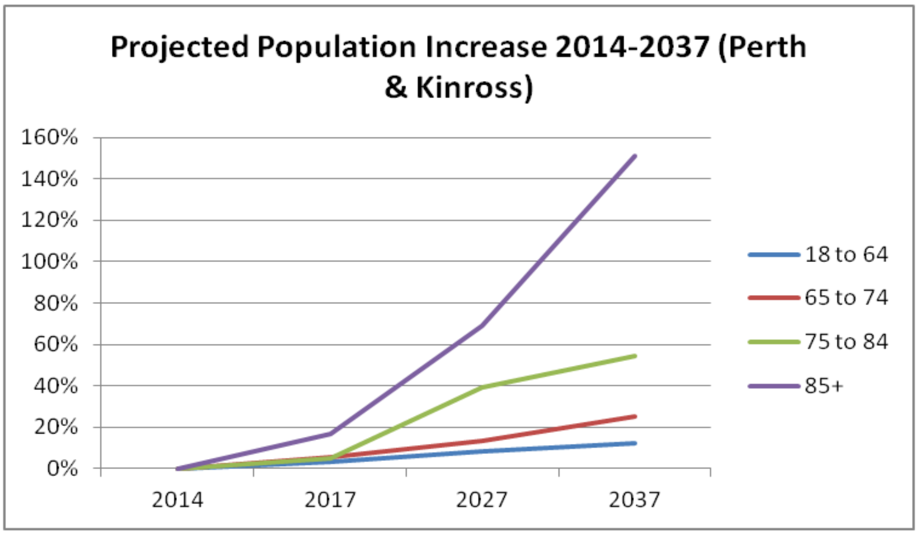

Table 1 Locality Profiles 2015/16

- Those aged 75+ are projected to almost double over the next 15 years, from 14,406 to 27,250
- Those aged 85+ are projected to more than double from 4,027, to 10,651 by 2037
- Based on current dementia prevalence rates for Scotland, people with a dementia diagnosis are expected to double over the next 21 years

Other identified needs

- Other vulnerable people, including those with learning or physical disabilities, may require the support of health and/or social care services to live as independently as possible and people with mental health needs or substance misuse problems need support on their journey to recovery
- There is a small number of people with learning disabilities with specialist care needs who require high levels of care and a growing number of young people with learning disabilities with particular needs
- People with multiple morbidities and who have complex needs will be targeted by our partnership services, particularly with early support and intervention
- The needs of the population who are affected by poverty and health inequalities will also need to be targeted by partnership services
- A small but growing minority ethnic population, including gypsy travellers, Asian and Eastern European people, experience barriers to access to services either because of a lack of awareness of services, cultural or language barriers
- A large proportion of people caring for children, adults with disabilities and older people are over 65 years, and many community organisations and activities depend on the voluntary contributions of this age group

- Around two-thirds of people who are dying would prefer to die at home, but in practice only about one-third actually do and there are wide variations in the quality of end of life and palliative care

The case for change

We believe that the growing numbers of people in Perth and Kinross who have complex care needs or are growing older will require better joined-up care, better anticipatory and preventative care and a greater emphasis on community-based care. We know that people want to have care and support delivered to them in or as near to their own homes and communities as possible and that community members are a rich resource of innovation, support and intelligence about what is needed, what works and what role they can play in their local areas.

We already know from the success of projects tested out in recent years with funding from the Change Fund[1], that through working in partnership with the third sector and with communities we can make a difference to people's quality of life. Community based and third sector initiatives have demonstrated improved outcomes for a whole range of vulnerable and older people in the community:

- ✓ Although unplanned admissions of people aged over 65 years had been rising, these have levelled since 2012. It is believed that investment in innovation through various funding streams may have had a part to play in this, supporting early intervention.
- ✓ Reablement (targeted short term support to help people regain skills for independence) has led to significant improvements for older people following a period in hospital or illness and has meant that many people do not require further care.
- ✓ A Homeless Voice Boxing project in Perth City aimed at very vulnerable and deprived people has demonstrated health and wellbeing improvements for the people who participate.
- ✓ Time banking projects which developed in some of the most isolated rural communities have demonstrated many positive impacts including members feeling more supported by their neighbours and more valued by their communities, increasing their community participation.
- ✓ A whole range of community projects and volunteering across Perth and Kinross make a valuable contribution to the health and wellbeing of many vulnerable people
- ✓ Third sector initiatives have developed opportunities for people to support themselves and others in many creative ways
- ✓ The vital contribution through unpaid caring is fully valued, and we recognise that organisations and citizens together produce solutions that best support caring and a life beyond caring

We are learning from these initiatives. We also know that the way we deliver services at the moment is not sustainable. Population changes, the need to integrate services and the significant financial challenges facing the partnership over the next five years, make a strong case for fundamental change in the way we deliver health and social care services and support opportunities for people to improve their health and wellbeing outcomes.

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[1] A £230 million Older People's Change Fund was made available to Health and Social Care Partnerships across Scotland from the 2011-12 financial year. A further £70 million was made available for the 2014-15 financial year. The funding supported partnerships to develop a strategy for reshaping care for older to improve the quality and outcomes of models of care.

Rising demand and pressures on services

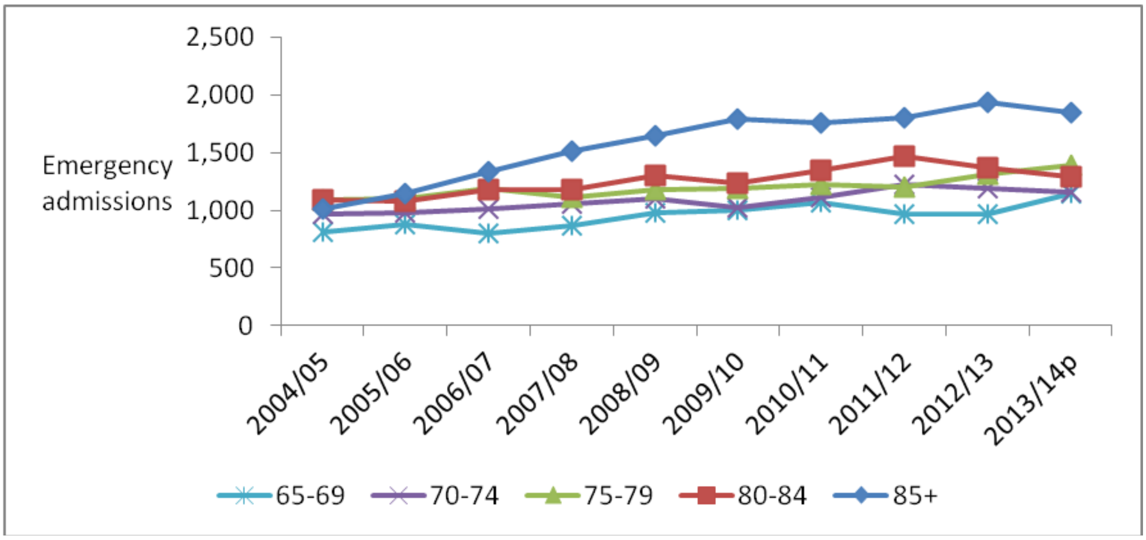
In Perth and Kinross, as with other areas, health and social care services are seeing an increase in demand for key services and it is clear that the demand for health and social care is likely to increase unless we do something differently.

Unplanned hospital admissions remain high, particularly for the older age group, as are the number of re-admissions, including people readmitted within 7 days of discharge. The pressures of people waiting to be discharged from hospital to appropriate community or residential settings remain; and the number of people entering residential care is increasing and projected to continue to increase if we do nothing. In addition, there is pressure on home care and community health services, with rising demand and waiting lists for services.

Some of our pressures are highlighted below:

- Crisis placements into care homes are increasing and many result later in permanent placements
- There is increased demand for home care services causing pressure on the current budget
- People receiving home care services are more frail, which is reflected in an increase in the average hours each new person receives, particularly in the last couple of years
- The number of people supported in care homes had been reducing since 2010 but recently increased, resulting in pressure on the care home budget for older people.
- The need for palliative care is rising and referrals to specialist palliative care services are increasing year on year.
- There are increasing demands on general practice as a result of population changes
- There are pressures on mental health services, with people requiring care and support
- Prevalence of Autism is likely to be higher than we are currently aware and increased rates of diagnosis for young people will impact on adult services
- There has been an increase in the number of people presenting as homeless, many of whom have a range of complex needs
- Between 2004 -2013 there was 38% increase in unplanned hospital admissions of people aged 65+ admitted as an emergency admission
- The increase in unplanned admissions for those aged 85+ is higher than other age groups and this age group is more likely to be delayed in hospital
- We are experiencing an increase in the numbers of people being readmitted to hospital within 28 days of discharge.
- Emergency admissions create pressures across the health and social care system with knock-on effects on delayed discharge, social work assessments and care at home.
- The number of emergency detentions for people with mental health needs remains high and we need to find ways to use short term detention instead

Table 2– Emergency Admissions for 65+ population by age group – Source ISD



Health inequalities

The health of individuals is determined by a complex mix of factors including income, housing and employment, life styles and access to health, care and other services. There are significant inequalities in health between individuals and different groups in society and deprivation is a major factor, with people in more affluent areas living longer and having significantly better health. Health and community care services are not the only solution to this issue but evidence suggests that primary and community care can reduce the impact of these inequalities. Many of the people suffering the greatest negative health effects relating to mental health, obesity and long term disease are those experiencing poverty and social disadvantage. Whilst Perth and Kinross has a relatively affluent population compared with the rest of Scotland, there are areas of deprivation and in our rural communities there is inequity in relation to access to services.

Income Deprivation, Employment Deprivation, Access Deprivation, and Child Poverty

We need to consider how issues of deprivation and poverty impact on the different areas of Perth and Kinross when planning our services. For example, Perth City had higher levels of income deprivation and employment deprivation than North and South Perthshire & Kinross in 2013. However, deprivation affects communities in different ways and just under half of those living in North and South Perthshire & Kinross are 'access deprived' i.e. they struggle to access services because they live in predominantly rural areas.

Levels of childhood poverty varied considerably between the localities. In 2012, 12.4% of the population in Perth City were in poverty, compared with 9.6% and 6.4% in North and South Perthshire & Kinross respectively. A number of people who are affected by poverty have multiple and complex needs, which need to be dealt with early and appropriately to avoid the need for a more costly response at a later stage.

We also know that:

- There is a proportionately greater use of acute hospital services by patients from deprived communities
- Substance misuse disproportionately affects the most vulnerable and socio-economically deprived in our community.
- People with mental health problems are at greater risk of poor physical health and of dying at a younger age.
- The rate of self-reported mental health conditions across Scotland, according to the 2011 Census, shows that mental health needs are more prevalent among those living in deprived areas.
- Minority ethnic populations can face greater difficulties when trying to access services, often as a result of lack of knowledge and differences in language and cultural expectations
- The Gypsy/Traveller population has some of the poorest health outcomes in Scotland
- There is clear evidence that those with chronic physical illnesses are more likely to suffer from mental health problems, particularly depression, and that those with co-occurring chronic physical health problems and mental health needs have poorer outcomes.
- There are stark health inequalities faced by people with learning disabilities (LD);
    - significantly shorter life expectancy,
    - increased risk of accompanying sensory and physical impairments
    - poorer physical and mental health than the general population. For example, the average number of health co-morbidities in the population of people with LD at age 20 is the same as for the general population at age 50. (The Keys to Life ten-year strategy)

Services need to be able to respond to the needs of those mentioned above, working with them and local communities to respond effectively, but importantly, to act early on to prevent later problems arising.

High costs, increasing demand and reduced budgets

All of this represents a significant challenge for the Health and Social Care Partnership and emphasises the need for a change in the way health and social services are planned, commissioned and delivered. Unless we embrace a radical, new and collaborative way of working, embedded in a new culture throughout public services, both budgets and provision of services will struggle to meet the needs of the population. By using our resources in a different way we aim to put an **emphasis on prevention and anticipatory care.** This will support a reduction in unplanned admissions to hospital or long-term care and reliance on traditional high cost care arrangements, while improving quality of life for individuals by maintaining independence for longer and potentially minimising the support they will need.

Many areas across the UK and internationally face the same challenges in relation to increasing demands for health and social care, alongside declining public expenditure. Research indicates that countries facing similar challenges: an ageing population; people living with complex needs; lack of co-operation between health and social care; fragmentation of health and social care systems and providing services to rural and remote areas[2], will often be

2 SPICe The Information Centre, "The Integration of Health and Social Care: International Comparisons", Scottish Government, 16 July 2012

the stimulus to integrated working arrangements. The ambition of integration is not new, therefore we can learn from examples across the UK and elsewhere to support our plans to improve the lives of people in Perth and Kinross.

Learning from others

Sweden

Sweden was one of the first countries to recognise the limitations of hospital delivered care and the importance of primary care and prevention care strategies, especially for older people. Hospital reforms in the 1990s focused on 2 main objectives: increased specialisation and concentration of services. Smaller hospitals provided more specialised care such as outpatient and community services whilst 24/7 emergency services were concentrated in larger hospitals.

Torbay

Closer to home, the success of Torbay's integrated health and social care teams is an example of the positive results of integration. The teams work closely with GPs to support older people at home. This is achieved through increased spending on a wider range of intermediate care services, thereby avoiding inappropriate hospital admissions.

- A close working relationship was developed with nurses, allied health professionals and social care staff through an integrated approach to put in place appropriate care packages and support, alongside the sharing of information to support positive outcomes for individuals.

Outcomes Achieved:

- ✓ Reduced use of hospital beds;
- ✓ Low rates of emergency hospital admission for people aged over 65 and minimal delayed transfer of care;
- ✓ A fall in the use of residential and nursing home care;
- ✓ Increase in home care services and direct payments.

So, what will a successful Perth and Kinross health and social care system look like in future?

The Swedish and Torbay examples demonstrate that, in spite of the challenges, it is possible to improve outcomes for people through changes in services and the way we work together. A greater focus on multi-disciplinary working, on primary and community care with the statutory, third and independent sectors will support the transformation of our health and social care system. In summary we want:

- ✓ Varied and responsive community-based health, care and support services that enable people to live as independently at home as possible with a better quality of life
- ✓ High numbers of people supported through reablement and recovery, with no further need for care
- ✓ Better use of inpatient hospital facilities
- ✓ Fewer unnecessary unplanned hospital admissions
- ✓ Fewer people delayed unnecessarily from hospital
- ✓ Fewer admissions to residential care, and none from acute hospitals
- ✓ Reduced health inequity and increased health and well being

The actions set out in the final section of the plan show how we aim to achieve these.

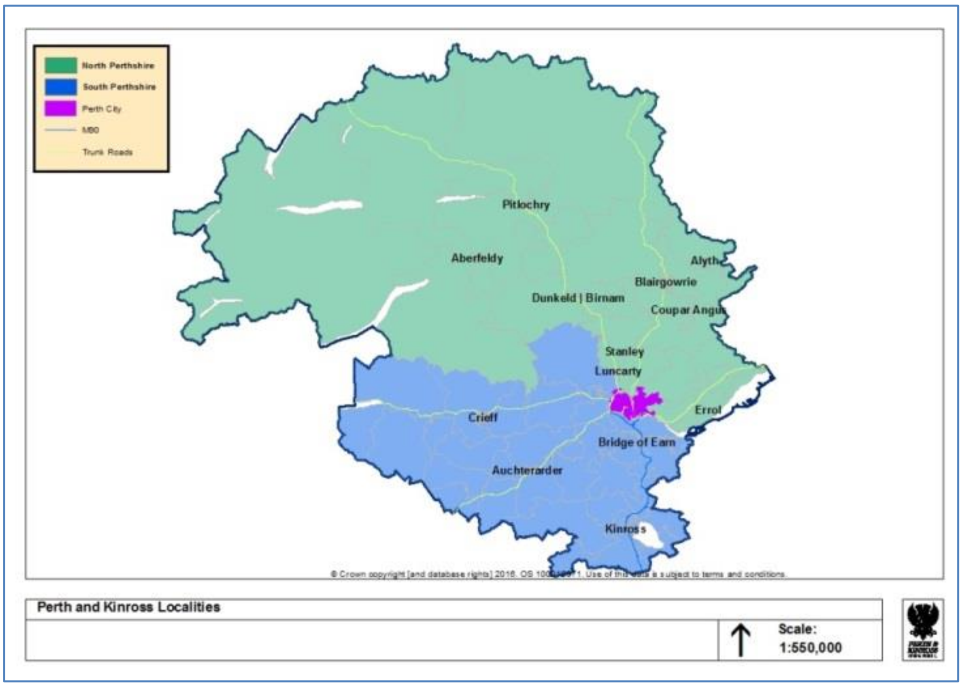
Working and delivering locally

A key part of our strategic plan is to plan and deliver local services. We have divided Perth and Kinross into 3 broad areas or localities as outlined in the map below:

- North Perthshire
- South Perthshire & Kinross
- Perth City.

Our partnership services will integrate work around GP practices, community pharmacy, dentistry, third sector providers, statutory health and social care services and communities to focus on early intervention and prevention.

Figure 1: Map of Perth and Kinross 3 localities (South Perthshire is South Perthshire & Kinross)[3]



Supporting Staff to Deliver Integrated Services

In order to deliver effective locally based integrated services we will need a **confident, competent professional workforce** who feel supported and valued. We need to ensure that across the health and social care sector the workforce is engaged and involved in all of our planning and development. We experience a high turnover and shortages of suitably skilled staff in key areas and recruitment and retention of high quality health and social care staff across the sector is a key challenge for the partnership.

Through our Organisational and Workforce Development Plan we aim to address these issues, promote a positive culture and encourage integrated working to deliver the best possible outcomes with communities. The plan will support staff in three key ways:

[3] "You are granted a non-exclusive, royalty free, revocable licence solely to view the Licensed Data for non-commercial purposes for the period during which Perth & Kinross Council makes it available. You are not permitted to copy, sub-license, distribute, sell or otherwise make available the Licensed Data to third parties in any form. Third party rights to enforce the terms of this licence shall be reserved to OS."

- Providing accessible information, and raising awareness, understanding and participation around integrated working
- Providing access across the Health & Social Care workforce to the development programmes of partner organisations in the statutory, third and independent sector.
- Creating specific development opportunities which support Health & Social Care Integration.

It is crucial to recognise the role played by the range of organisations beyond NHS and local authority and to understand that services are and will be delivered by a range of professionals, including third sector organisations, the independent sector and bodies such as GPs, pharmacists, dentists and others. We will need to work in partnership to make sure staff across all professional groups are focussed on providing high quality care that is person centred and delivered flexibly according to the needs of all vulnerable residents.

Preparing for the Future

We want to improve outcomes and ensure that people get the health and care services they need by providing support and services in local communities, empowering people to have greater control over their lives and managing their own health and care where appropriate. This means looking at the whole system:

- ✓ Locality based planning and commissioning
- ✓ Allocating resources to support prevention and early intervention.
- ✓ More effective planning with acute (hospital services) to support new ways of working
- ✓ Citizen and community empowerment and capacity building
- ✓ Workforce planning and development
- ✓ Partnership with the voluntary and independent sectors
- ✓ Developing locally based integrated teams to drive and manage health and social care locally
- ✓ Bringing GP practices together in locality based clusters
- ✓ Working with primary care colleagues to integrate community health services that work with GP practices, community pharmacists, dental practitioners and optometrists
- ✓ Expanding our use of technology, particularly in rural areas
- ✓ Using local community hospitals to provide planned care
- ✓ Tackling the rise in unplanned hospital admissions.
- ✓ Reducing delayed discharges from hospital
- ✓ Ensuring equitable access to services from all sections of the community

Transforming the way we do things

A number of planned transformation programmes are set out in the action plan (Appendix 1 of the strategy) to deliver change to the way we currently deliver services. The financial planning environment will be challenging and there is much to do to ensure that the partnership will achieve the ambitions for integrated health and social care in Perth and Kinross.

2. Vision and context

- Vision
- Principles
- National context
- National outcomes
- Our strategic plan
- Locality planning
- Meeting specialist needs
- Housing and homelessness

Our Vision

Our commitment to the Public Service Reform agenda is articulated in our Community Plan/Single Outcome Agreement 2013-2023. This sets out a vision of a confident and ambitious Perth and Kinross, to which everyone can contribute and in which all can share. Through our strategic objectives we aim to maximise the opportunities available to people to achieve their potential, at every life stage and there are cross cutting themes that will underpin the work of the Health and Social Care partnership. The Community Plan sets out five strategic objectives:

- Giving every child the best start in life
- Developing educated, responsible and informed citizens
- Promoting a prosperous, inclusive and sustainable economy
- Supporting people to lead independent, healthy and active lives
- Creating a safe and sustainable place for future generations

For the Health and Social Care Partnership this supports our vision:

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

We will do this by:

- ✓ Developing integrated locality teams, so that all clinical, professional and non-clinical staff can work together in a coordinated way to improve access and the quality of services.
- ✓ Ensuring that people are at the centre of all decisions, including carers and families
- ✓ Combining staff and resources to deliver a wider range of care within communities and supporting people to be cared for at home.
- ✓ Improving the health of communities through wider partnership working to:
    - identify the health and care needs,
    - focus on health promoting activity;
    - taking action to improve well-being, life circumstances and lifestyles and actively addressing health and care inequalities.

Our Principles and Key Actions

Our vision can only become a reality through actions which reflect the principles that underpin our approach. In the first 3 years we will make sure the services and support we offer people are:

- Developed locally, in partnership with communities, the third and independent sectors

- Integrated from the point of view of individuals, families and communities and responsive to the particular needs of individuals and families in our different localities
- Commission services that best anticipate people's needs and prevent them arising
- Make the best use of available facilities, people and resources
- Maintain quality and safety standards as the highest priority

National Context

The Scottish Government's 2020 Vision

Our vision is that by 2020 everyone is able to live longer healthier lives at home, or in a homely setting. We will have a healthcare system where we have integrated health and social care, a focus on prevention, anticipation and supported self-management. When hospital treatment is required, and cannot be provided in a community setting, day case treatment will be the norm. Whatever the setting, care will be provided to the highest standards of quality and safety, with the person at the centre of all decisions. There will be a focus on ensuring that people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission

The Public Bodies (Joint Working) (Scotland) Act 2014 provides the legislation for integrating health and social care services and requires local integration authorities to create a strategic plan for the areas it controls. The key purpose of integration is to:

- provide seamless integrated quality health and social care services, and
- ensure resources are used effectively to deliver services that meet the needs of increasing numbers of people with long term conditions and complex needs.

National Outcomes

A national outcomes framework (set out below) has been developed to assess progress towards achieving these. In Perth and Kinross we see health and social care integration as a vehicle to improve the wellbeing of local people. By involving people and their communities in decisions which affect them and through more joined up working and delivery of services earlier to prevent ill health, it is intended we will meet the 9 national outcomes set out below and in detail as appendix 2.

Our vision: People are supported to lead independent, healthy and active lives and live their lives as independently as possible in their own homes, or in a homely setting with choice and control over the decisions they make about their care and support

National Outcomes

- People are able to look after and improve their own health and wellbeing and live in good health for longer
- People including those with disabilities, long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community
- Health and social care services are centred on helping to maintain or improve the quality of life of service users
- Health and social care services contribute to reducing health inequalities
- People who provide unpaid care are supported to reduce the potential impact of their caring role on their own health and well-being
- People who work in health and social care are supported continuously to improve the information, support, care and treatment they provide and feel engaged with the work they do
- People who use health and social care services have positive experiences of those services and have their dignity respected
- Resources are used effectively in the provision of health and social care services, without waste
- People who use health and social care services are safe from harm

Scope of Perth & Kinross Social care Partnership

Perth & Kinross is one of three Health and Social Care Partnerships that have responsibility for services previously planned for and delivered by NHS Tayside, some of which operate on a Tayside wide basis. Whilst it has been relatively straightforward to transfer resources for some services to individual partnerships, in other cases it is much more complicated. Agreement has therefore been reached among the three partnerships and NHS Tayside as to how these services should be managed to ensure they operate as effectively and efficiently as possible. As a result, the services that Perth & Kinross Integration Joint Board is responsible for planning fall into three groups:

- Services that are managed through the Perth & Kinross Health and Social Care Partnership
- Services that are managed by Angus or Dundee Health & Social Care Partnerships on behalf of all three organisations – these are referred to as "hosted" services
- Services that are managed by NHS Tayside but used by one or more of the Health and Social Care Partnerships where it is not sensible to split the resources available among them without destabilising the services, these are referred to as 'set aside Hospital Services'.

The table below summarises the main services for which the Perth Integration Joint Board (IJB) has a strategic planning responsibility.

Partnership services

Commuity Care Services	Community Health Services	Hospital Services

•Social work services for adults with physical disability and older people
•Services and support for adults with learning disabilities.
•Mental health services
•Drug and alcohol services
•Adult protection and domestic abuse services
•Carers support services
•Health improvement services
•Housing support services (in Sheltered Housing)
•Aids and adaptations equipment and telecare
•Residential care homes / nursing care home placements
•Care at home
•Reablement services
•Respite and day care
	•District nursing services
	•Substance misuse services
	•Primary medical services
	•General dental services
	•Ophthalmic services
	•Community geriatric medicine
	•Primary medical services to patients out-of-hours
	•Community palliative care services
	•Community learning disability services
	•Community mental health services
	•Community continence services
	•Community kidney dialysis services
	•Public Health promotion
	•Allied health professionals
	•Community hospitals
		•Accident and Emergency services provided in a hospital
		•Inpatient hospital services relating to the following areas:
		  •General medicine;
		  •Geriatric medicine;
		  •Rehabilitation medicine;
		  •Respiratory medicine; and
		  •Psychiatry of learning disability.
		•Palliative care services provided in a hospital
		•Inpatient hospital services provided by GP's
		•Services provided in a hospital in relation to an addiction or dependence on any substance
		•Mental health services provided in a hospital, except secure forensic mental health services
		•Pharmaceutical services

Hosted services

The services to be managed by each Health & Social care Partnership (HSCP) on a pan Tayside basis are set out below.

Dundee	Angus	Perth and Kinross
•Psychology services •Sexual and Reproductive Health services •Homeopathy service •Specialist Palliative Care •The Centre for Brian Injury Rehabilitation (CBIRU) •Eating disorders •Dietetics •Medical Advisory Service •Tayside Health Arts Trust •Keep Well •Psychotherapy	•Locality Pharmacy •Primary Care Services (excludes the NHS Board administrative, contracting and professional advisory functions) •GP Out of Hours •Forensic Medicine •Continence service •Speech and Language Therapy	•Learning disability inpatient services •Substance misuse inpatient services •Public Dental Services/Community Dental Services •General Adult Psychiatry Inpatient Services •Prisoner Healthcare •Podiatry

The three NHS Tayside HSCPs are finalising a memorandum of understanding to set out clear principles for how hosted services will be managed effectively and consistently and which recognises that strategic planning responsibility for the services is retained by all three IJB's in respect of their own population.

Hospital Services

Any programme of change for general hospital services will be delivered in partnership with NHS Tayside as a key stakeholder with responsibility for specialist clinical services across the three partnership areas of Dundee, Angus and Perth and Kinross.

The **National Clinical Strategy for Scotland (2016)** [4] sets out the framework for developing health services across Scotland for the next 15 years, setting out the case for an increased diversion of resources to primary and community care. It sets out how NHS Scotland will change and this will inform our plans for the review of hospital activity in Perth and Kinross in the context of a shift in resources to primary and community care.

A review of hospital activity will be undertaken to establish a programme of transformation over the longer term. This is a complex task and will be delivered in partnership at the local, regional and national levels to ensure that a high quality service to all patients is maintained and sustainable

Future work on general acute hospital and hosted services in Perth and Kinross will include:

- A review of hospital activity to establish a programme of transformation over the longer term
- Review and evaluation of all services hosted by the Perth and Kinross Partnership including:
    - Delivery of an improvement plan for mental health services
    - A healthcare needs assessments across prison establishments
    - Review and redesign of prisoner healthcare.

[4] Published by the Scottish Government February 2016

Our Strategic Plan

The next section of our Strategic Plan sets out how we will achieve our vision and priorities over the next three years, targeting resources where they are needed most. It is based on:

- an analysis of the needs of our population
- relevant legislation and guidance on services to meet the needs of the populations and areas most in need
- feedback from individuals, communities and other key stakeholders
- current and potential services, available resources and the extent to which they are likely to meet our future population and community needs
- Research and evidence based practice
- Reviews of the strengths and limitations of our current services and the changes needed to meet the growing and varying needs of our population

Strategic Commissioning

Through strategic commissioning we will plan, develop and deliver services for people through engagement with individuals, communities, the statutory, third and independent sectors at locality level, investing to achieve positive outcomes for individuals and communities over the long term.

This means:

- Understanding the needs of the population and the long term demand for services
- Improving and modernising services to achieve better outcomes
- Achieving value for money
- Agreeing where we should invest, reinvest and disinvest, spending our money wisely to meet agreed priorities
- Facilitating and managing the market to ensure that providers understand our priorities and can deliver appropriate services

Principles based on promoting equality and inclusion will underpin the planning and monitoring for all health, social care and support services. In practice this means:

Principles underpinning our approach

- Planning and designing future services and supporting opportunities by working in partnership with the people who use services and with providers in the third and independent sectors. (co-production)
- Engaging with minority and marginalised communities and/or their representatives to make sure services are inclusive
- Commissioning services that are inclusive, personalised, promote choice and achieve positive outcomes and good quality care for those who use them
- Decommissioning services that no longer meet the needs and priorities of people and communities
- Promoting social value by placing social, environmental and economic outcomes at the heart of our commissioning

With increased demand for services and reductions in public expenditure, it is clear that the current pattern of service provision is not sustainable. In addition the evolution of Self Directed Support and a more personalised health and social care system will require a wider range of options that support people's independence. Through the commissioning process, we will review a range of services, reduce duplication and improve pathways across health, social care, the voluntary and independent sectors. This includes:

- identifying the needs of individuals and communities, across Perth and Kinross and at local level,
- engaging with communities to decide what will address those needs
- working to put the right services and support in place – at the right time.

The way we provide or purchase services will need to fundamentally change over the next 3-5 years:

- Over the next 3 years our plans to review existing health and social care provision will help us decide how to transform services to ensure that all, irrespective of their sector, enhance the quality of life for the individuals and their carers now and in the future.
- We will develop a market position statement to ensure that all stakeholders are aware of our plans and where services are commissioned externally, potential providers are able to plan and develop services that will meet the health and wellbeing needs of individuals and communities
- We will remodel, decommission some services and recommission others to meet our priorities

Locality Planning

We need to take account of the needs of different communities in Perth and Kinross and have identified three localities: North Perthshire, Perth City and South Perthshire &Kinross.

There are specific challenges facing Perth and Kinross with a population spread over a large rural area. The area is the 8th least densely populated local authority area in Scotland and a relatively high proportion of residents are classed as being in some way 'access-deprived'. This means that issues of financial cost, time and inconvenience of having to travel may affect access to basic health and social care services. 29.6% of Perth & Kinross's older population (65+ years) live in areas classed as being among the '15% most access-deprived' in Scotland, well above the national average of 15%. In North Perthshire, this figure rises to 45% for the whole population. This presents some particular challenges in the delivery of health and social care services and we need to plan to support equity in access to services.

Meeting specialist needs

We also need to understand the specialist needs of some individuals who require health, care and support. For hospital services this will be addressed through the wider review of hospital activity planned by the partnership and informed by the National Clinical Strategy for Scotland (2016).

More generally, NHS clinical care strategies will complement our plans and these are primarily focussed on the quality of care that people can expect to receive. Our overarching strategy around clinical care will be underpinned by strong clinical and professional governance, with adult support and protection a key priority across the partnership. We will take account of a range of national strategies focused on people with specialist needs such as the National Dementia Strategy, 'Keys to Life' for people with learning disabilities and others.

We already have key joint strategies in place for particular groups of people and the priorities and actions set out in these will form part of this strategic plan. A continued focus on people with specific needs will ensure that we are able to offer personalised care and support to ensure they are able to overcome specific barriers to independent living. Ultimately our focus on locality planning, equalities and personalised care and support will ensure that the specific needs of individuals are recognised and addressed.

For people with learning disabilities our priorities are informed by the Scottish Government's Keys to Life Strategy. Specifically this focuses on effective support through life's transitions at all stages and ages and improving these pathways: (1) from school to adulthood, (2) into parenthood, (3) from adulthood to older age (4) from older age or illness to dying and death.

For physically disabled people or those with a physical or sensory impairment our local Joint Strategy to Support Independent Living & Quality of Life for Adults with a Physical Disability and / or Sensory Impairment (2014–2017) sets out our priorities to make sure people are able to access accessible and appropriate housing, employment, appropriate health care and information to fully participate in all aspects of life.

For people with mental health needs our Joint Mental Health Strategy (2012-2015) is being evaluated and an action plan will follow. There has been a deliberate intent to embrace mental wellbeing in a holistic way rather than focus on mental ill health. We will deliver services which are person-centred, accessible, integrated and comprehensive by:

- Supporting initiatives and services which promote good mental health and wellbeing in our local communities.
- Enabling access to services for those with mental health needs and poor mental wellbeing and embracing a social prescribing and self-help approach
- Enhancing services to support people in distress and at risk of suicide

Recovery is central to our approach and defined by the Scottish Recovery Network as “being able to live a meaningful and satisfying life, as defined by each person, in the presence or absence of symptoms...” It encourages us to work within a wellness concept, not illness.

For people with Autism our 2015 Local Action Plan sets out how we will improve outcomes for people with autism and their families/carers. It is informed by the Scottish Autism Strategy 2011 giving high priority to the principles of prevention, early identification of problems assessment, diagnosis and support across the lifespan. The action plan recognises that people on the autism spectrum have a unique set of conditions which will not necessarily fall under the categories of learning disability and mental health although these conditions may also be present. Flexibility and a multi-agency approach is essential to meet the needs of people with this complex condition.

Our Drug and Alcohol Strategy 2015-2020 focuses on a preventative approach to reduce the adverse impact of alcohol and drug use and is similarly focussed on recovery. It prioritises a need to actively promote health, well-being and encourage recovery though preventative approaches to substance misuse and a healthy and responsible attitude to alcohol consumption.

We recognise the contribution that adult carers make to the health and wellbeing of the people they care for. Our Joint Strategy for Adult Carers (2015-2018) is an ambitious plan to improve the lives of carers in Perth and Kinross and, as a consequence, support more people to live independently in their communities.

For older people our vision is to promote the independence and wellbeing of older people at home or in a homely setting. We still have work to do to embed some successful models of care to support older people and this strategic plan will support our ambition to create integrated services that support older people to live successfully in the community, avoiding unnecessary prolonged periods in hospital. Our key priorities and actions are set out in the draft Older People’s Action Plan (2016) and will focus on delivering or enabling personalised care and support, independence and a good quality of life. For people with a diagnosis of dementia Scotland’s National Dementia Strategy (2010) will also inform our approach to provide support for people following diagnosis and improve the response to dementia in general hospital settings.

Good practice example

Reablement,
The reablement team helps people to regain skills to live safely and as independently as possible at home. Support can be given if people need help to live at home, or support to return home from hospital. People are supported for a short period to relearn the skills they need to feel confident about being at home without the need for further support.
Outcomes Achieved:
- ✓ 1/3 of people required no further ongoing social support and returned to their previous level of independence
- ✓ 40% regained their full independence

"If the reablement service was not in place, I would have been in hospital for a lot longer as I couldn't manage on my own"

For the Gypsy Traveller Population, the Community Planning Partnership has an agreed Gypsy/Traveller Strategy (2013-18) recognising the specific needs of this population and its key aims include:

- ensuring that services provided to meet the needs of the Gypsy/Traveller community in Perth and Kinross are provided in a non-discriminatory way and take account of cultural requirements;
- involving Gypsy/Traveller community members in planning any future service developments which may be relevant to them;
- improving access to local services for the Gypsy/Traveller community in Perth and Kinross;

We will continue to work with the Community Planning Partnership to address the health and social care needs of the Gypsy Traveller Community in order to improve health and wellbeing outcomes.

Housing and homelessness

Housing and housing support services are central to supporting people to live independently at home or in a homely setting and make a vital contribution to the 9 national health and wellbeing outcomes. The vision for housing set out in the Council's draft local housing strategy (2016-2021) is that "Perth and Kinross is a place where everyone will have access to good quality housing that they can afford that is in a safe and pleasant environment. People will have access to services that will enable them to live independently and participate in their communities". Our housing strategy will set out key outcomes and play a central role in meeting our key priorities for integration. Currently we provide or support:

- care and repair services, aids and adaptations and to make sure that people are supported to stay at home or able to move to suitable alternative accommodation
- specialist housing (sheltered, very sheltered, extra care) for older people
- housing with additional support in sheltered housing units to support people remain in the community
- specialist supported accommodation for homeless people and people with a range of support needs
- preventative 'floating' housing support services to a wider range of people, including older people, homeless people, people with disabilities, people with mental ill-health and those with substance misuse issues to enable them to live at home

Integration and the need to shift the balance of care to support more people in the community for longer recognises the central role that housing plays a central role in the strategic planning of services.

3. Needs and resources

- Needs of the population
- Key demographics
- How health and social care services are consumed
- Feedback from community engagement
- Good practice and innovative models
- Partnership resources

Needs of the population

We have used a wide range of information to inform the priorities of this plan, including:

- the joint strategic needs assessment (JSNA)/Locality Profiles
- feedback from community engagement
- the national and local strategies, including the Tayside NHS local delivery plan plan and local joint care group strategies

The JSNA provides us with good information about the local population, issues that can impact on the need for health and social care services as well as the use of current services. It is published as a separate document insert link and some of the key messages are set out below.

Perth and Kinross

Perth & Kinross has a diverse mix of urban and rural communities and has a population of 148,880 (2014) living across the area's 5,268 square kilometres. The geographical distribution of the population is important as it brings challenges for the delivery of services to rural and remote communities.

Some key demographics

- There are 31,735 people aged 65+, 21.5% of the population
- The number of individuals aged 75+ is projected to increase by the greatest proportion by 2037, at 58.9%. While the growth of a comparatively small population will invariably result in a large proportional increase, this is important due to the high health and social care costs associated with individuals aged 75+ and over.
- The number of people aged 65-74 is also expected to increase between 2012-2037 by one third (32.6%), which will likely add further pressures to service delivery.
- Those aged 85+ are projected to more than double from 4,027, to 10,651 by 2037
- Hence older people (aged 85+) are a specific target group for the purposes of our strategic plan.
- In the 2011 Census 18.1% (26,499 individuals) considered their day to day movement to be in some way limited by a condition that had lasted, or was expected to last at least 12 months.

In general health and well-being in Perth and Kinross is better than that of other places in Scotland, although there is some variation in need across the different localities. For example, there is evidence that health inequalities are more pronounced for older people in rural areas than for their contemporaries in urban settlements (Locality Profiles 2015).

Recognising the needs of different communities, the strategic plan provides information for 3 localities or areas and our planning will increasingly be delivered on this locality basis:

- **North Perthshire** locality consists of three distinct areas: Highland Perthshire, Strathmore and Carse of Gowrie

- With an overall population of 50,338 residents, it has the highest number and proportion of people aged 65+, and the lowest number and proportion of children.

- **Perth City locality** is the largest settlement in Perth & Kinross and includes the sub-localities of Perth City North and Perth City South.
  - It has the largest population of the 3 localities, 50,814 with the highest number of individuals of working age, and the lowest number people aged 65+.

- **South Perthshire & Kinross** consists of the distinct areas of Strathearn and Kinross.
  - With the smallest population of the 3 localities with 46,598 residents, the population also has the lowest number of working age individuals of all 3 localities.

Perth and Kinross Health and Social Care localities

Figure 3 [NB South Perthshire is South Perthshire & Kinross]

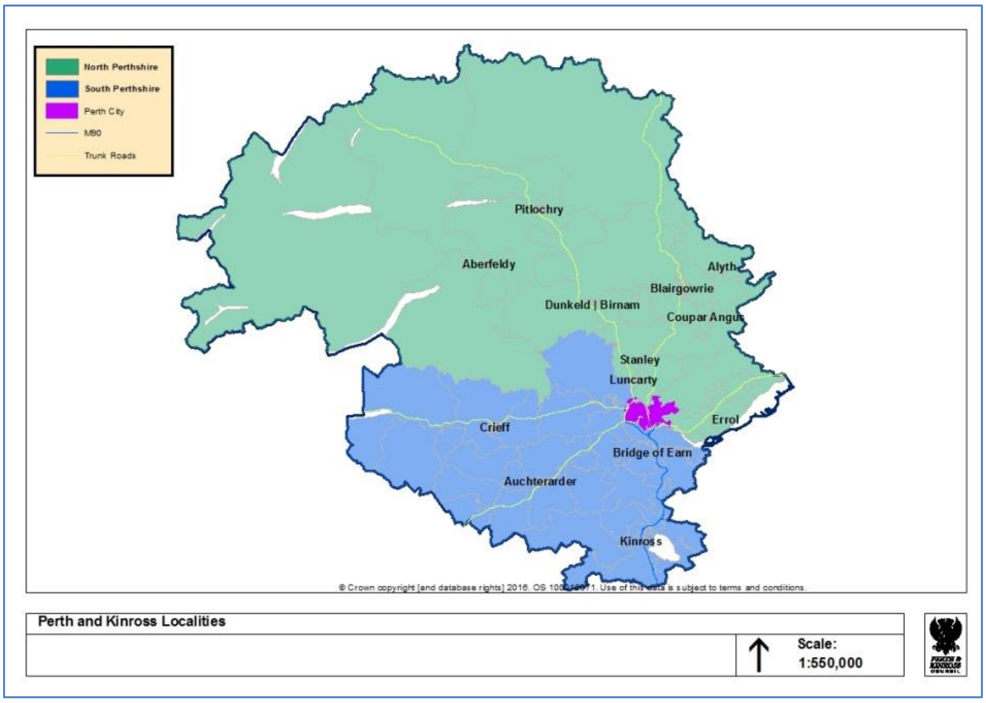


Table 3 Perth and Kinross adult population by age group

Age Group	Current Population (2014 MYE)	Projected Population 2017	Projected Population 2027	Projected Population 2037	% Change 2014 – 2037
18-64	88,205	91,347	95,661	98,948	12%
65-74	17,512	18,463	19,828	21,962	25%
75-79	6,226	6,470	8,363	9,260	49%
80+	8,778	9,753	13,813	17,990	105%
Total 18+ all ages	148,880	154,101	168,904	183,468	23%

Source: Mid-Year Estimates (MYE) NRS (National records of Scotland)2014-based population projections

The adult population (18+yrs) is relatively evenly spread across the 3 localities although more concentrated in a smaller geographical area in Perth City. There are some concentrations of the population in the main towns of North and South Perthshire & Kinross, but the population in these areas is spread over a larger rural area and in villages and smaller towns.

Table 4 Perth and Kinross Adult Population by Locality – Updated with 2014 population estimates (Source: NRS)

Age Band	North Perthshire	South Perthshire & Kinross	Perth City	Perth and Kinross
18-24	3,549	3,420	4,420	11,389
25-34	5,107	3,830	7,336	16,273
35-44	5,837	5,258	6,173	17,268
45-54	7,806	7,755	7,335	22,896
55-64	7,448	6,707	6,224	20,379
65-74	6,648	5,770	5,094	17,512
75-84	4,025	3,395	3,346	10,766
85+	1,441	1,345	1,452	4,238
Total	41,861	37,480	41,380	120,721

Ethnicity

According to the 2011 census, the population is predominantly white Scottish (82%). 98% of Perth and Kinross residents self-reported that they were of white ethnicity, above the Scottish average of 96%.

Of all three localities, Perth City has the most diverse ethnic population, with 3.% of residents self-reporting to be black or minority ethnic (BME), compared to just 2.0% of the population of Perth and Kinross overall. Perth City has the highest prevalence of people identifying as white Polish, at 3%. This is twice as high as in North Perthshire (1.4%) and over three times the rate in South Perthshire (0.8%).

Ethnicity	Perth & Kinross	Scotland
White- Scottish	82%	84%
White- Other British	11%	8%
White- Irish	1%	1%
White- Polish	2%	1%
White- “Other”	2%	2%
Asian, Asian-Scottish or Asian-British	1%	3%
“Other” Ethnic Groups	1%	1%

TABLE 5 ETHNIC POPULATIONS IN PERTH & KINROSS (SOURCE: NATIONAL CENSUS, 2011)

Gypsy Traveller Population

An often hidden population is the Gypsy/ Traveller population and Perth and Kinross has traditionally been an area that Gypsy/Traveller community members have lived in or travelled through. Exact figures are difficult to quantify, particularly if individuals live in mainstream housing or do not ‘identify’ themselves as Gypsy/Travellers for possible fear of discrimination. The Scottish Census figures for 2011 included “Gypsy/Traveller” for the first time and nationally 4,212 people were recorded as such, with the highest individual local authority population being 415 in Perth and Kinross.

Whilst numbers may be small, the Gypsy/Traveller Strategy 2013-18 identifies that this group has faced discrimination and have not always received services to standards expected. The community themselves, identified a need for better healthcare in a survey conducted between 2012 and 2013.

A similar picture emerges for people from BME communities where it is recognised have poorer health and well-being outcomes than the general population. For example, the South Asian population in the UK are at greater risk of developing type 2 diabetes and are one of the larger minority ethnic groups in Perth and Kinross[5].

Multiple Deprivation

The table below show Perth & Kinross's population according to the Scottish Index of Multiple Deprivation (SIMD) quintiles. Almost two thirds of the population are in Quintiles 4 and 5 (i.e. the two 'least deprived') but there is significant variation between the localities, with Perth City having the highest level of deprivation at over 14%.

	SIMD Quintiles				
	Most deprived			Least deprived	
Locality	**1**	**2**	**3**	**4**	**5**
Perth & Kinross	6%	13%	19%	41%	22%
North Perthshire	2.5%	5%	20%	62%	11%
South Perthshire & Kinross	0%	0%	27%	46%	27%
Perth City	14%	32%	11%	15.5%	27%

Table 6: Percentage of residents per SIMD quintile for Perth and Kinross and each locality (2012)

Housing and Homelessness

The impact of poor housing and homelessness on the health and wellbeing of the population is well documented as is the crucial role of housing in supporting people to remain independent at home.

Housing Tenure

The table below shows that the majority of people living in Perth and Kinross are owner occupiers with some variation across the three localities. A lower percentage of houses in Perth City are owner occupied while a higher percentage are owned by the local authority or housing associations than in North and South Perthshire & Kinross. Perth City also has a higher percentage of its houses owned by a social landlord than in North and South Perthshire & Kinross.

Housing Tenure	Perth & Kinross		North Perthshire		South Perthshire and Kinross		Perth City	
	Number	%	Number	%	Number	%	Number	%
Owner Occupied	42,694	66%	14,815	67%	13,941	72%	13,938	59 %

[5] Type 2 diabetes in the UK South Asian population :An update from the South Asian Health Foundation (2014)

Private Rented	9,474	15%	3,290	15%	2,434	13%	3,750	16 %
Local Authority	7,473	11.5%	2,228	10%	1,577	8 %	3,668	16%
Housing Association	3,647	6%	977	4%	805	4 %	1,865	8%
Other	1,489	2%	668	3%	550	3%	271	1%
Total	***64,777***		***21,978***		***19,307***		***23,492***	

Table 7 Housing tenure in Perth and Kinross and each locality (2011)

A recent house conditions survey (2015) that sampled 30% of local authority housing and 2.5% of independently provided housing highlighted a number of issues relevant to our joint strategic plan. In particular, there are significant numbers of households who are overcrowded, particularly in the Strathearn area and in Council and privately rented stock. Under occupancy is also an issue and high in the owner occupied and council sector, mainly among the older adult population.

16% of households surveyed (over 10,000 households) stated that at least one member of the household had a limiting long term illness, health problems or disability. The majority of those households were older people and a significant proportion felt that their homes would not be suitable to meet their needs in the longer term.

The issue of affordable housing is also important and the draft Housing Strategy (2016-21) highlights issues of affordability in the owner occupied sector linked to low incomes. There is a high demand for more affordable housing and this is particularly in rural areas where it is also difficult to recruit and retain health and social care staff and is an issue for the partnership.

<u>Homelessness</u>

Over the past couple of years there has been a reduction in homelessness, but in 2015 the figures have been increasing. Data for 2015 indicates:

- an increase in the number of couples with and without children presenting as homeless
- an increase in homelessness as a result of violent and / or abusive behaviour towards women
- an increase in the number of people presenting following discharge from hospital, prison and/or care

The Council's Housing Needs and Demand Assessment (2015) acknowledges a need for a wide range of housing which is suited to the needs of an ageing population, people with mobility problems and others who may have particular needs, including individuals who require suitable accommodation and support as part of any discharge or resettlement programmes. The Council and RSL (Housing Association) partners are committed to building new affordable housing units and will set targets in the 2016-21 Housing Strategy. Part of the strategy will also target housing developments that assist individuals with community care needs to live independently in the community.

People Living Alone

- There are 20,875 one-person households in Perth and Kinross of which approximately 45% are occupied by people aged 65+. Nearly 1 in 3 (33%) of people aged 65+ in Perth and Kinross live alone.

- A higher percentage (38%) of people aged 65+ lives alone in Perth city, compared with North Perthshire (31%) and South Perthshire & Kinross (31%).

	Perth & Kinross	North Perthshire	South Perthshire and Kinross	Perth City
Total one-person households	20,875	6,734	5,435	8,706
Total one-person (65+ yrs) households	9,404	3,268	2,749	3,387
Total households aged 65+	28,337	10,498	8,913	8,926
% 65+ households living alone	33%	31%	31%	38%

Table 8 One person households, Locality profiles 2015/16

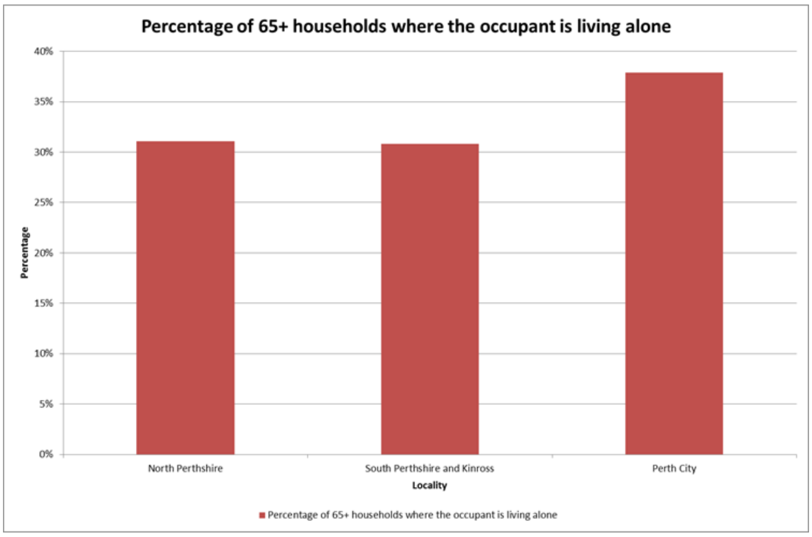


Table 9 1 person household (locality profiles 2015/16)

Target population

While the majority of the population use health care services, such as GPs, pharmacy and dental services, our focus in this section is on those people whose needs may be complex, who may be at risk of developing long term conditions or who sometimes require the intervention of social care and other support services.

Analysis, demographics:

As highlighted previously, our needs assessment tells us that the population is living healthier and longer lives. We compare favourably with the rest of Scotland in key areas relating to health and deprivation, but the analysis tells us that there are some key challenges across and within the three localities relating to deprivation, age, prevalence of long term conditions, substance misuse, mental health and learning disability. In addition a particular challenge for service planning is the nature of the dispersed and rural population of Perth and Kinross, where a relatively high proportion of residents are classed as being access deprived (31.3% compared with 15% nationally. This means that compared with an urban population they face particular challenges in being able to access services easily. Feedback from community engagement confirms that transport and access to services is a key issue in the rural communities of Perth and Kinross.

Some key demographics

- There are 31,735 people aged 65+, 21.5% of the population
- The number of individuals aged 75+ is projected to increase by the greatest proportion by 2037, at 58.9%. While the growth of a comparatively small population will invariably result in a large proportional increase, this is important due to the high health and social care costs associated with individuals aged 75+ and over.
- The number of people aged 65-74 is also expected to increase between 2012-2037 by one third (32.6%), which will likely add further pressures to service delivery.
- Those aged 85+ are projected to more than double from 4,027, to 10,651 by 2037
- Hence older people (aged 85+) are a specific target group for the purposes of our strategic plan.

Substance misuse

In 2013, alcohol misuse was identified as the underlying cause of 11.2 deaths in every 100,000 in Perth & Kinross. This is well below the national average (21.4) but over the last 3 years there has been an increase of 3% in the number of deaths directly attributable to alcohol misuse.

- Residents of the most deprived areas of Perth & Kinross were five times more likely to die of an alcohol-related condition than those living in the least deprived areas.
- Around 2% (national average: 2.4%) of males and 0.5% (national average: 1%) of females in Perth & Kinross were estimated to be 'problem drug users' in 2012. Though these prevalence-levels fall below the levels nationally, in 2012/13, 961 new individuals across Tayside were reported to the Scottish Drug Misuse Database (SDMD), an increase of 17% on the number of new clients from the previous year.
- As with alcohol misuse, there is a clear deprivation factor with regard to drug-related A&E presentations in Perth & Kinross. Those registered to the most deprived are significantly more likely to present at A&E as a result of drug misuse.

Mental Health

- Around 1 in 4 adults experiences a mental health episode in a year, ranging from anxiety and depression to more acute symptoms.
- Third sector services indicate high numbers of referrals from people seeking counselling and other support relating to mental health
- Perth city is the locality with the highest referral rate to the Community Mental Health team compared to the other 2 localities.
- The percentage of Perth & Kinross residents prescribed drugs for anxiety/depression/psychosis in 2013 was 14.9%, below the national average of 17%
- However, in 2013/14 there were 1,373 (almost 1%) patients who had a serious mental illness such as schizophrenia, bipolar affective disorder or other psychoses.
- Almost 1% (n=1,385; three-year rolling average, 2011/12-2013/14) of Perth & Kinross population (based on 2013 estimates) were the subject of a psychiatric hospitalisation.
    - Perth City: 1.7%

- North Perthshire: 0.5%
- South Perthshire & Kinross: 0.6%

Learning Disability

The locality with the highest number of adults registered with a learning disability is North Perthshire, with 191 individuals.

Table 9 Adults with a learning disability

Locality	Number of adults registered with a learning disability
North Perthshire	191
South Perthshire and Kinross	124
Perth City	156
Total	471

However, there will be higher numbers of people known to health services and the 2011 Census shows that 683 individuals reported having a learning disability in Perth and Kinross. This is 0.5% of the population.

- Whilst the numbers known to the local authority may be small, a number of people with learning disabilities have very complex conditions that require high levels of care and support.

People with Long term Conditions

There is a strong connection between poverty and long term health problems. However, those who live longer may spend many years dealing with the complexities associated with long term conditions. We need to support people who are affected by, or who may go on to develop, long term conditions and the complex problems that accompany them. People with symptomatic conditions need effective clinical and support management but targeted and effective prevention is also necessary to prevent future need, and to address the increasing health gap.

Registers kept by GP practices, show slightly higher prevalence rates of specific long term conditions in Perth & Kinross than in Scotland as a whole. These include:

- Hypertension (15.0% vs 13.9%),
- Hypothyroidism (5.6% vs 3.8%), Coronary Heart Disease (4.6% vs 4.3%),
- Cancer (2.5% vs 2.2%) and dementia (1.1% vs 0.8%).

Future planning also needs to consider the expected rise in conditions such as diabetes. Currently 4% of the population have been diagnosed with diabetes – slightly below the Scottish average of 5% but a condition that is expected to rise as the population gets older.

There is a high risk of readmission to hospital for people with long term conditions. Analysis indicates that 8,000 adults have more than a 20% risk of readmission to hospital in the following year have one or more long term condition. Of these 5,282 (66%) have 2 or more conditions (multi-morbidity).

The table below shows the prevalence of people with two or more long term conditions by age and locality with North Perthshire showing a higher prevalence in the older population (60+).

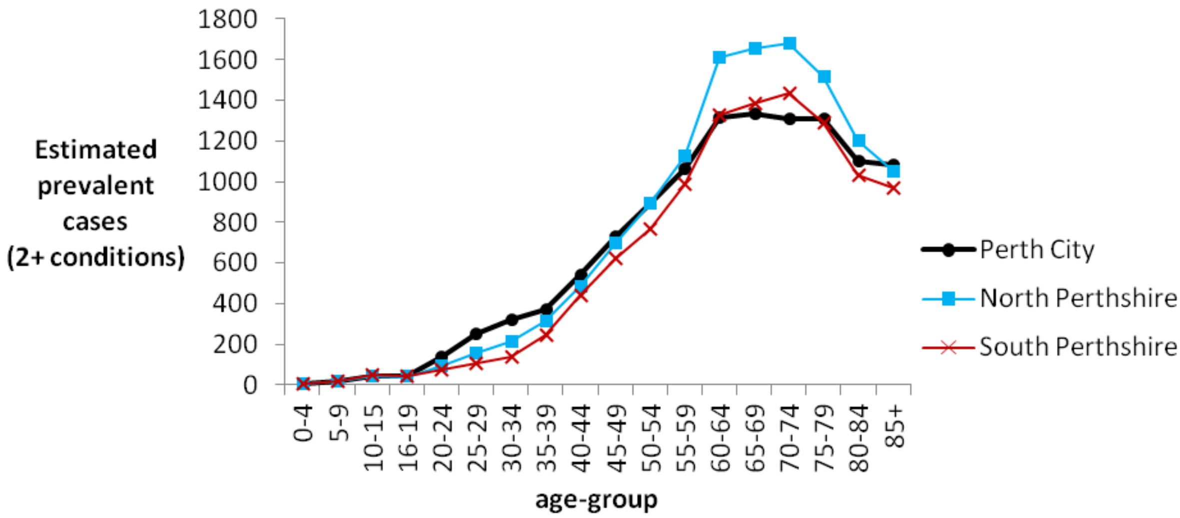


Figure 3. Estimated prevalent cases of two or more long term conditions for Perth and Kinross localities

Based on the 2011 census the % and numbers of people who considered their day to day movement to be in some way limited by a condition that had lasted, or was expected to last, at least 12 months was as follows.

- **North Perthshire:** 9,239 individuals (18.5% of the population)
- **South Perthshire & Kinross:** 7,829 individuals (17.1% of the population) This is a lower rate than the other two localities.
- **Perth City:** 9,431(18.5% of the population) The highest number of individuals out of the 3 localities,

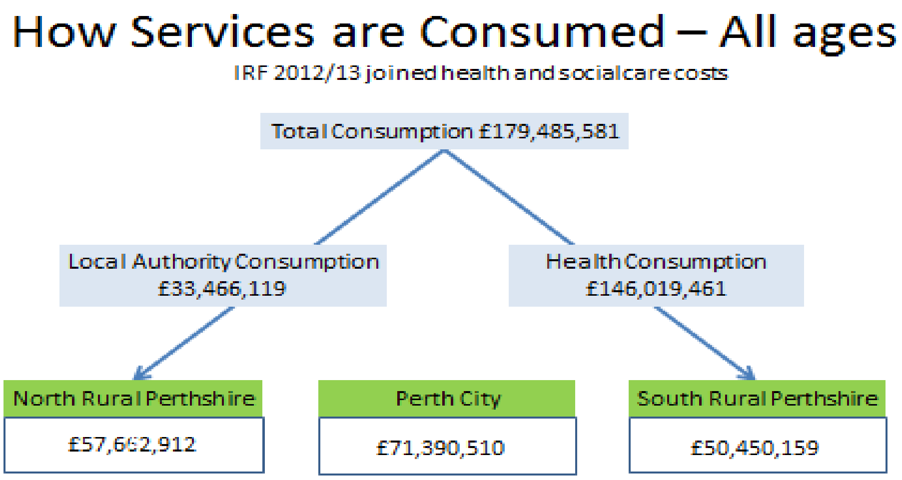
In addition Perth City has the highest number of individuals of the 3 localities on General Practice Dementia registers, 698. This represents 1.1% of the population and is higher than the national average of 0.8%.

Summary

Our population profile information by locality presents us with a picture of difference across the three areas of Perth & Kinross and highlights the need to ensure a local response to the needs of the local populations in some cases.

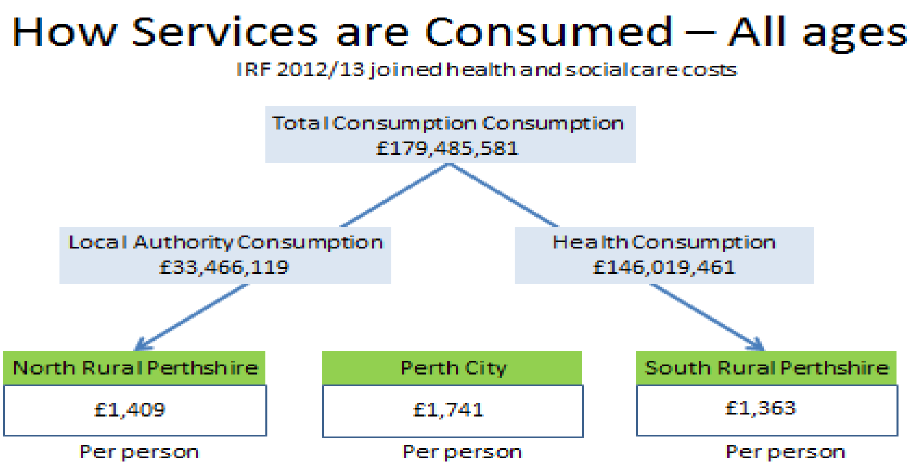
How health and social care resources are consumed

The section below looks at the way health and social care service are consumed by the public. The information is analysed using the Integrated Resource Framework (IRF) which enables us to examine expenditure across the majority of local health and social care services, totalling almost £180m worth of services. The data allows us to examine activity, equity, efficiency, variation and quality across the three localities of Perth and Kinross. The tables below give us an indication of how our current health and social care resources are spent.



***Note** – the figures above are not the same as the figures set out in the resources section above giving indicative budgets for the partnership. They are based on the use of some NHS and social care services.*

The chart above that overall expenditure on health and social care is greater in Perth City than in the less densely populated areas of North and South Perthshire. The table below also shows when broken down by expenditure per person, it is much higher in Perth City although there will be variation across age and client group.



Further analysis of the data will highlight some key issues that will need examination as we plan, review and develop services in the three localities. For example, our analysis has shown that a greater % of people over 65yrs resident in care homes is from an urban area, just over

1.% from rural localities and almost 3% in urban localities. Table 9 below shows that residents from Perth City are more likely to be referred into residential care than those who live in rural areas and the % of older people living at home is higher in North Perthshire and South Perthshire and Kinross.

Table 10 % age of people in care homes, at home (source ISD)

	Institutional Environments		% Living at Home	Hospital Environments	
Locality	%65+ in Hospital	%65+ in Care Homes		% 65+ receiving >10.5 hrs Care at Home	%65+ living at Home
North Perthshire	1.07%	1.35%	97.59%	1.04%	96.54%
Perth City	1.08%	2.66%	96.26%	1.05%	95.21%
South Perthshire	1.05%	1.08%	97.87%	1.02%	96.85%

Deprivation

Our analysis shows that although people living in the most deprived communities use greater health and social care resources than people in least deprived communities; this appears to be as a result of the greater numbers of this population in services. Further analysis shows that the per person spend of an individual classed as least deprived is almost always higher than the most deprived. This points to a need to look more closely at equity issues and how the most deprived populations access health and social care services.

Multi-morbidities

For people with 2 or more long term conditions (multi-morbidities), the 50-64 age group have been identified as the largest consumers of health services, and again when the data is analysed at a per person level, then the "least deprived individual" typically is a higher consumer of health services than the people from the most deprived communities.

Re-admission to hospital

Analysis of the rates of 7 and 28 day emergency readmissions to hospital identified that the **average** re-admissions **per 100 discharges** from hospital over a **7 year** period were significantly higher in Perth City than in Scotland as a whole and higher again compared with the two more rural areas:

- ✓ Scotland wide: 3.81 re-admissions within 7 days and 8.33 re-admissions within 28 days
- ✓ Perth City: 4.35 re-admissions within 7 days and 9.29 re-admissions within 28 days (urban locality)

- ✓ Perth City 2014/15 4.45 re-admissions within 7 days and 9.17 re-admissions within 28 days
- ✓ North and South Perthshire localities have below the yearly numbers and the national averages

Summary

We do not yet have a clear explanation for the differences in service use across the three localities. However, we do know that there are higher levels of income and employment deprivation in Perth City, more older people who live alone and higher numbers of the population with mental health needs and issues with substance misuse. We also know that access is likely to be easier in Perth City than in the more remote and rural areas. Whilst these issues do not offer an explanation of the higher spend person, the information suggests a need to better understand how access to services is organised by staff and service users in our three localities, and what we need to change, so that the people who are most vulnerable to illness, disability and exclusion have equitable access to preventive and health and social care services.

For example, we need to look at what we can do in Perth City to support more people live independently at home instead of entering residential care. Our analysis suggests a need to target preventative services in deprived populations to minimise the risk of developing long term conditions and to develop strategies to support people to manage their conditions avoiding unnecessary hospital stays.

- ✓ Further examination of data on how people use existing services will highlight different patterns of service provision and use which will be further explored as health and social, care integration becomes embedded across the area.
- ✓ We will then use this information to support to infomr future health and social care services.

Community Engagement

Many of the priorities and actions set out in the plan were influenced by local people and staff during these 'Join the Conversation' events in 2015. An extensive programme of community engagement, led by the 3rd sector, health and social care, had a number of objectives:

- To have a meaningful discussion with communities, service users, carers and their representatives.
- Increase the involvement of all community stakeholders in developing community profiling and planning
- Deliver effective engagement to help us meet the National Health and Wellbeing Outcomes.
- support the capacity of all involved to take forward effective engagement

The community engagement revealed a lot about how individuals and communities experience health and social care services as well as insights into the priorities of communities. Over 4,000 people 'joined the conversation' and feedback has been used to influence this strategic plan, priorities and actions. Feedback from our local community engagement is fairly consistent with key messages from national research about service users and community experience of the health and social care system.

Issues highlighted include:

- The need for clear information about who to contact and how to access services.
- Caring and understanding attitudes - being treated with respect and dignity.
- Care delivered as close to home as possible.
- Safe, effective services that provide the right care, support and information at the right time.
- Information and support to live well for people with a long term condition.
- Equitable access to services irrespective of area.
- How a joint approach between families, communities and services was the way forward

Additional themes from 'join the conversation' include:

- A sense that people struggle to make the system work for them and have the necessary information available to them to make this work. This was a strong theme throughout as well as frustration about the number of times people have to tell their story to professionals as they transfer between services
- Knowing how to access services: people don't know what is available or how to access services and staff sometimes also struggle to support people to navigate the system. There is a feeling that services aren't joined up, well-co-ordinated or personalised and some positive views that people and communities can do more to support themselves.
- Some delays in accessing care at home, lack of continuity of staff and lack of time can sometimes make it a negative experience
- Experience of GP services varied: there was some very good feedback about GP practices and very high public expectations about the role of GPs as a gateway for all health and wellbeing issues
- A feeling that services are designed to suit services.
- Transport to and from health and social care services and for hospital appointments in particular is highlighted as an issue particularly, but not exclusively from rural areas

These and other issues highlighted are shaping the changes we want to make to our health and social care system to make it more personalised and is designed to meet the needs of individuals and communities.

Partnership resources

Financial context

In an environment of increasing demographic pressures and a growing financial challenge, the ability to redesign services in ways that make the best use of precious resource will be critical. Aligned with this is the challenge of managing rising public expectation that health and social care services should be able to deliver the increased capacity required to fully meet changing needs.

Our resources

Functions are delegated to the Perth & Kinross Integration Joint Board from Perth & Kinross Council and NHS Tayside and the resources associated with these functions form the budget for the Integration Joint Board. It then becomes the responsibility of the Board to deploy these resources in support of the strategic plan. As such the Board can choose to spend the money differently.

There are 4 component parts to the resources delegated to the Integration Joint Board are summarised below:

Indicative 2016/17 Budget	£000
Community Care Services (P&K Council)	**57,450**
Core & Hosted Health Services (NHS Tayside)	**116,053**
Large Hospital Services (NHS Tayside)	**17, 672**
Total	**191,175**

An explanation of each of these component parts is included on page 16 of the strategic plan along with a list of the services in each category. During 2015/16 the IJB has been working closely with NHS Tayside and Perth & Kinross Council to reach agreement on which elements of budget will transfer to the partnership. For hosted and delegated acute services this has required the agreement of a mechanism equitably to share budgets currently held on a NHS Tayside wide basis, between the three Tayside Integration Joint Boards. Final agreement has not yet been reached and the budgets above are indicative at this stage.

Our financial challenge

As the resources available to the Integration Joint Board flow through Perth & Kinross Council and NHS Tayside, the financial constraints facing these organisations are equally relevant for the Board. There is no doubt, given the financial constraints of both Partners both now and in the medium term, that the Board will have a significant financial challenge to address. In this environment achieving financial balance will require a focus on service redesign within the overall resources available.

In 2016/17, we will continue to work in collaboration with NHS Tayside, Angus and Dundee Integration Joint Boards to develop sustainable plans to achieve financial balance across core and hosted services. The scale of this challenge will require us to use our resources wisely, to make sure we make the most of any funds available for investment, disinvesting carefully where it is agreed that change is required.

These resources include the new Social Care Fund referred to above as well as any time limited or specific sources of funding such as the Integrated Care Fund.

Financial planning and management

Perth & Kinross HSCP's financial plan will continue to be developed during 2016/17. Many of the issues that will be reflected in further detailed financial planning are described in Action Plan section of this document. These individual plans along with efficiency savings plans will form Perth & Kinross's overall financial plan.

The partnership expects to operate in a difficult financial environment over the coming three years. This reinforces the need to maintain good quality financial management and to ensure we use all available resources as effectively and efficiently as possible. To do that we will need to:-

- understand our current available financial resources, likely future financial resources and ongoing resources utilisation as best we can. To deliver this we will need sound reflective financial planning and monitoring processes in place;
- work with Perth & Kinross Council and NHS Tayside to maintain and develop a good finance support structure that adopts the best practices from both Perth & Kinross Council and NHS Tayside finance functions and ensures all financial reporting requirement are met;
- develop good, informed decision making processes and forums that include representation from across the Partnership;
- develop financial planning and monitoring processes that reflects the role of localities, the use of resources within localities and large hospital resources;
- develop financial planning and monitoring processes that reflect Scottish Government reporting requirements regarding funding such as Integrated Care Funding and Delayed Discharge funding; and make decisions that reflect the challenging financial environment in which we are operating.

Transformation

The partnership will continue to work closely with NHS Tayside, Perth & Kinross Council and other Tayside HSCPs to ensure the effective and efficient use of resources across Perth & Kinross and NHS Tayside. We will work in conjunction with NHS Tayside to derive savings from efficiency work streams initiated within NHS Tayside. There are 6 of these as follows:-

- Workforce & Care Assurance
- Optimising Demand Management
- Optimising Our Care Environments
- Cost Effective Procurement
- Property, Sales and Brokerage Plan
- Clinical Strategy

We want to clarify with NHS Tayside the scope, timescales and delivery of each of these six areas.

We will work in conjunction with Dundee HSCP and Angus HSCP to develop financial plans for services hosted by Perth & Kinross Integrated Joint Board (IJB) on behalf of other Tayside partnerships and work with them to facilitate the successful financial planning of services managed elsewhere on behalf of Perth & Kinross HSCP. The partnership will also work in partnership with the Council to derive savings from transformation programmes agreed and set out later in the action plan.

Summary of key findings

We have identified a number of key issues through our community engagement work, analysis of the population of Perth and Kinross and understanding of the challenges facing the partnership to inform our strategic priorities. We know that:

- The population is ageing and although most people are living healthy and active lives, the need for health and social care services increases with age
- There is a growing older population in North Perthshire, a remote rural area where services are difficult to access
- There are significant pockets of income and employment deprivation in North Perthshire and Perth City
- Substance misuse disproportionately affects the most vulnerable and socio-economically deprived in our community.
- People with mental health problems are at greater risk of poor physical health and of dying at a younger age.
- There are stark health inequalities faced by people with learning disabilities and the Gypsy/Traveller community
- There are patterns of service use in relation to unplanned admissions, use of care homes and other issues that require further investigation and there is some indication that the people who are most deprived are not accessing support at an early stage
- There appears to be inequality in access and use of services with the most deprived individuals using fewer health and social care services with much higher patterns of consumption in urban areas when compared with rural areas.
- There is a proportionately greater use of acute hospital services by patients from deprived communities
- The partnership is facing significant budget pressures at a time when there is growing need for services

These issues and other issues highlighted throughout the plan have shaped the strategic priorities and actions set out below.

We know that there are many good examples of joint working across Perth and Kinross and the development of integrated health and social care services based in localities will help address the challenges set out above. Health and social care staff across the statutory, third and independent sectors will need to work collaboratively with individuals, families and communities to ensure we deliver high quality personalised health and social care services.

Our plan sets out our priorities and actions building on some of the good work already being developed across the partnership the lessons learned from the Integrated Care Fund (ICF) projects and from models established through the Change Fund.

4. Strategic Priorities

Based around 5 priority areas

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

Strategic priorities, future plan

The issues we have identified, demonstrate the need for a radical approach is needed to transform our health and social care system to prevent the avoidable use of health and social care and respond flexibly and appropriately to people who are vulnerable and need care and support. It is vital that our limited budgets are targeted at agreed priorities, transforming services to shift the balance of care to prevention and early intervention. We already have many strong, effective, person-centred services and support so need to build on these to continue to shift the balance of care towards locally, community based services, adapting to the specific needs of communities in the different areas of Perth and Kinross.

Based on our vision for health and social care, our knowledge and understanding of population, themes identified from community and stakeholder engagement and lessons learned from local initiatives and elsewhere we have identified 5 priority areas :

1. Prevention and early intervention
2. Person centred health, care and support
3. Work together with communities
4. Inequality, inequity and healthy living
5. Making the best use of available facilities, people and resources

Key theme 1 - Prevention and early intervention

A focus on prevention and early intervention will help us make the changes needed across health and social care to:

- improve outcomes for people
- provide services which reduce health inequalities
- promote people's independence
- deliver more personal health and care services closer to home
- reduce unplanned hospital admissions and delays in discharge
- Anticipate what people need and intervening early to prevent future, costly and unnecessary interventions.

Prevention is at the heart of public service reform, with integrated preventative approaches including anticipatory care, promoting physical activity and introducing technology and rehabilitation interventions to prevent or delay functional decline and disability.

With this approach, we aim to have a positive impact on the health and wellbeing of peoples' lives by preventing deterioration in health, dependency on health and social care services and delay in recovery and loss of independence.

We want to shift our resources to prevent harm rather than continually responding to acute needs and problems that could have been avoided. Successful prevention and early intervention measures will result in a reduction in unnecessary hospital admissions, more people with mental health or drug alcohol problems in recovery and more people supported to live independently at home.

Intervening early and anticipating what will be needed (preventative services and anticipatory care)

We will look at prevention on three levels:

- **Primary prevention/promoting wellbeing** –aimed at people who have little or no health or social care needs; or symptoms of illness. The focus is on maintaining independence and good health, and promoting wellbeing through information, advice and community engagement.

- **Secondary prevention/early intervention** - we need to identify people at risk, stop or slow down deterioration, and actively seek to improve their situation. This includes working more effectively with primary care to identify those at greatest risk of ill health.

- **Tertiary prevention** –aimed at minimising disability or deterioration from established health conditions or complex social care needs. The focus here is on maximising people's independence, and on preventing inappropriate use of more intensive services for people whose needs could be met by lower cost interventions.

Primary Prevention

We recognise that community and other local services can have a significant role in prevention and we want to ensure that people with health and social care needs benefit from access to universal services. There are many universal local services and activities which have a direct positive impact on wellbeing, particularly cultural, educational, recreational, and sports and community groups. These activities are open to everyone and we need to encourage and support people to look after their own health and wellbeing, living in good health for longer with reduced health inequalities. Working in partnership with agencies across the council and the NHS and through the local Health Equity Strategy 2016 we will take a whole population approach to health improvement as well as targeting vulnerable people to prevent problems arising as well as addressing them if they do.

Good practice – targeted support

Activity Referral programme – Live Active Leisure

Supports adults referred by GP's and health care practitioners. Aimed at people with a range of low to medium risk conditions – weight management underpins many referrals due to the impact on health conditions.

Outcomes

- 73% of customers have seen a reduction in the blood pressure after completing the 24 sessions.
- 62% have seen a reduction in their weight.

Resources in the community, such as primary health care, housing, information, support and advice, will also have central role in supporting our vision to support more people to live at home independently.

Consistent feedback from communities was that we needed to **improve information** about access to services as many people said they didn't know how to access information about health and social care, or what local activities were available to them. We recognise these concerns and want to improve access to information and help communities and people to support themselves through improved access to universal services and community resources in the locality.

- ✓ We will develop a virtual health and social care market place to improve information about services and how to access them for self directed support. In addition people with low to moderate needs will access information about universal services or lunch clubs, befriending and other supports without having to engage with statutory services

People felt there were significant benefits of local community groups in maintaining people's health, wellbeing and independence and there are some very good examples of where this is already happening. For example, five Time Banks were established across Perth and Kinross. They coordinate informal volunteering and a flexible framework for community members to offer each other some form of help or service, in direct response to expressed needs. Amongst many positive impacts, members reported feeling more supported by their neighbours, feeling more valued by their communities, feeling more comfortable asking for help, increasing their community participation and making new friends. There are many more examples of third sector initiatives in local communities and our Communities First Initiative 9one of our transformation projects) will support our work with communities to provide more choice and control for people.

Housing's Contribution

Housing is key to supporting people to live as independently as possible in their homes and has a major impact on people's health and wellbeing. Feedback from communities in North Perth and in Perth City in particular suggests that affordable housing is an important area of concern for people and is an issue across Perth and Kinross. A shortage of affordable housing impacts on people's ability to live independently and on people who work in the health care and support sector who struggle to afford to live locally.

The draft Local Housing Strategy 2016-2021 highlights how the local authority's housing contribution through the design and delivery of housing and housing related services can support the vision for health and social care.

It sets out clearly the priorities for housing including:

1. **Supply of housing**

   Creating more affordable homes and managing existing stock to create homes in the size, type and location people want to live with access to suitable services and facilities which encourage community integration.

2. **Neighbourhood services and homelessness**

   Promoting safe and secure communities for residents of Perth & Kinross with access to good quality, affordable accommodation with the necessary support in place to sustain them in their homes and prevent them from becoming homeless.

3. **Specialist provision and independent living**

   Support people to live independently at home for as long as possible with help from community – local support networks

4. **House condition, fuel poverty and climate change**

   Supporting residents of Perth and Kinross to live in warm, dry, energy efficient and low carbon homes which they can afford to heat.

Appropriate housing solutions can support people to live independently at home or in a homely setting in the community avoiding the need for more costly health and social care resources. We will continue to work with housing colleagues to make sure that there is a good supply of affordable mainstream and supported housing with services attached.

✓ Continue to work with our partners in housing to support people to live as independently as possible in housing that is suitable for their needs:

  - Deliver care and repair services to ensure access to adaptations for people in private sector accommodation
  - Review the use of aids and adaptations in social housing
  - Increase technology enabled care to compliment support for carers and to reduce the need for care at home, where this is appropriate
  - Support people and carers to use technology to support their independence
  - Increase the provision of affordable housing, particularly in areas where shortages have been identified
  - Identify and plan for new housing developments for people with specialised support needs

Secondary prevention/early intervention and tertiary prevention

There is a clear trend that indicates a higher level of need for health and social care services across all client groups and for older people with long term conditions in particular. We are seeing high levels of unplanned hospital admissions, delayed hospital discharge and greater use of residential care. We know that lengthy stays in hospital produce poor outcomes for people and this highlights the need for us to improve co-ordination and integration of care. There are some good examples of practice that will support improvements in this area in the future

Example of good practice

Rapid Response, Perth and Kinross
The Rapid Response Team was set up to provide an alternative to admission to a hospital or care home for people during a time of crisis. The service provides coordinated support from a range of professionals from health and social care, including GPs, District Nurses, Social Workers, Social Care Officers, Occupational Therapists and Physiotherapists. It is available throughout Perth and Kinross and is accessed through a telephone Single Point of Contact, with the aim to support people to remain in their own home. **Outcomes Achieved:** ✓ 84% of people receiving the service remained in their own homes ✓ 88% of GP practices have referred to Rapid Response ✓ The service is valued by 84% of GPs as an alternative to admitting people to hospital or a care home (2012/2013 data) *"I just wanted to say thank you, I appreciated so much, everything you did for my Mum. Your care enabled me to keep her at home and to be with her at the end and for that I will always be grateful."* Feedback from a family member

Primary care : GP practices

90% of all health care begins and ends in primary care. This is predominantly with a GP, traditionally the first point of contact a person has with the health service, who also acts as a gatekeeper to a range of other services. Primary care, and in particular care delivered by general practice, is viewed by communities as the gateway to health and social care services and over the next few years, GP practices will be faced with new challenges in terms of demand as a result of the changing population, increasing health and wellbeing needs and public expectations. Feedback about GPs was very positive and people have very high expectations about the role of GPs within their communities. Whilst this is positive, this can create pressure for general practice and we need to ensure that people are signposted to alternative services elsewhere if this is appropriate.

The partnership has already established GP cluster groups linked to the localities and these will be integral to the development and delivery of health and social integration. The aim of the clusters is to:

- share information between practices
- explore different and improved ways of working together
- support practices to enable consistent and sustainable changes and improvements in the delivery of healthcare

Local integrated teams based in local areas are central to supporting people as close as possible to or within their own home environment The locality model will include key components of the Enhanced Community Support (ECS) model; step up/prevention of admission, community rehabilitation with community based education, prevention work, reablement and hospital discharge. This locality model of care is currently being designed and is being tested in parts of Perth and Kinross.

Example of Good Practice

Enhanced Community Support, (ECS), Blairgowrie and Perth City [6]
Enhanced Community Support (ECS) aims to ensure healthcare professionals are in a position to provide prompt identification and appropriate, timely responses to adult and older people's health care needs, helping to avoid crisis management and unnecessary or prolonged hospital or care home admissions. The Enhanced Community Support model will support more people in their own homes and people will receive care coordination at a practice level by the primary care team. Delivery of the right amount of care, delivered by the right service, at the right point in the continuum of care, especially at the interfaces of illness, recovery and independence is essential to facilitate appropriate multidisciplinary healthcare planning. This in turn will allow us to enable people to maintain their health, independence and wellbeing for as long as possible. *Early indications suggest the model is delivering good outcomes for patients and some development work will be required to deliver the model as a fully integrated care service.*

More generally, locally based integrated working will support third sector organisations and individuals, as well as health and social care providers, work together to support individuals where they are all involved in the delivery of care and support. Staff will be support to develop new ways of working and build on good practice that already exists. Independent sector providers of residential care, care at home, GPs, pharmacies and the voluntary sector currently do play and will continue to play a key role in the delivery of health and social care, and we will ensure that they are fully involved. The role of the acute sector in developing locally based services is also critical.

During community engagement events it was apparent that for some people the transition from hospital to home was not seamless. Feedback suggested that this appeared to be a result of unclear communication between professionals and sometimes a delay in care packages being set up which people reported was distressing for individuals and their families/friends.

"It can be a complicated process being discharged from hospital with care package in place. Ensuring goals are wisely set and getting medications sorted with doctors. The patient needs support with this if no family/friends present."

We will:

- ✓ develop the role of GP clusters to become more integral to the development and delivery of health and social integration in order to:
  - share information between partners,
  - explore different and improved ways of working together and to support practices to enable consistent and sustainable changes and improvements in the delivery of healthcare.
- ✓ Roll out a locally based integrated approach within localities and designed around GP clusters, working in partnership with GPs, pharmacies and the voluntary sector to facilitate opportunities for personalised, joined up, planned care and support.

[6] Perth and Kinross CHP, Enhanced Community Support Project, Project Initiation Document, 2014.

Example

Complex Case Integrated Group (CCIG), Perth and Kinross

The Complex Case Integration Group (CCIG): a multi-agency group focussed on adults aged 16 and over with complex needs* which tested out a model of integrated working. ***The group no longer meets as a separate group and the principles which underpinned this approach are now embedded successfully as an integrated way of working***

People referred to CCIG were often not supported through another formal system and the group built on the successful and innovative integrated work of the Homeless Integration Team (HIT) and Equally Well model of practice. The core agencies involved included locality social work teams, the Access Team (Adult Care Services), Housing Service, Community Mental Health Team, Drug and Alcohol Services, Criminal Justice Services and Tayside Police. Other relevant agencies who are involved are invited to attend a CCIG meeting.

Outcomes Achieved:
- ✓ Improved health and wellbeing
- ✓ Reducing the number of re-referrals of adults with significant mental health problems
- ✓ Sustaining tenancy safely
- ✓ Reduction in reoffending
- ✓ Reducing and stabilising substance misuse
- ✓ Stabilising financial wellbeing

.*A person with complex needs is someone with health and social care needs which impact on their physical, social and emotional wellbeing. This often limits their ability to participate in society and can result in homelessness and social exclusion.

Secondary prevention in health, such as detecting the early stages of disease and intervening early has been shown to be cost effective and can reduce the gap in life expectancy and health outcomes.

- ✓ The partnership will work with GP practices and community and the third sector to engage with people who are hard to reach and less likely to be in touch with mainstream health services.

Where illness or disease is already developed (tertiary prevention), there is evidence to suggest that self-management programmes can be successful in reducing unplanned hospital admissions and improve the experience and health outcomes of some patients with long term conditions (Kings Fund). We know that there are high levels of need for support for people with long term conditions.

- ✓ We will support the development of self-management programmes for people with long term conditions where there is evidence that people can benefit from this approach.

<u>Pharmacy services</u>

Community pharmacies are significantly unrecognised as a community resource and offer great potential to support more people to live as independently as possible at home. We know that pharmacists have already demonstrated significant savings for the health care system through involvement in the community with medication reviews.

Through our Pharmacy Strategy we aim to ensure that all patients, regardless of their age and setting of care, receive high quality pharmaceutical care from clinical pharmacist independent prescribers. The aim to ensure that every patient gets the best possible outcomes from their medicines, and avoiding waste and harm.

We will

- ✓ Support pharmacy service to be integrated within the locality teams and able to develop their role to support people with complex needs in a range of settings within communities
- ✓ Support the priorities set out in the draft Pharmacy Strategy (2016)

Technology-enabled care

The vast majority of users of telecare services in Perth and Kinross are aged 75+ years, however, in comparison with Scotland and most other local authorities, a relatively low proportion of the 75+ population use technology enabled care. We know that this has the potential to transform people's lives, support independence and improve the health of vulnerable people with a range of needs. Feedback from the community suggests there is an appetite to explore how this can be used to support independence and manage a range of long term conditions. Work is already underway to increase opportunities for people to make use of technology which can support our use of technology enabled care to provide care closer to a person's home, in their own homes or local communities.

Our overall priorities

We will:

- ✓ Develop a virtual health and social care market place to:
  - o improve information about services and how to access them for self-directed support.
  - o offer access to information about universal services or lunch clubs, befriending and other supports without having to engage with statutory services
- ✓ Work with partners to design housing support for people most at risk of losing their independence
- ✓ Continue to work with housing partners to ensure that people are supported to live as independently as possible in housing that is suitable for their needs:
  - o develop care and repair services to ensure access to adaptations for people in private sector accommodation
  - o Review the use of aids and adaptations in social housing
  - o Plan new social housing developments to ensure that people are able to live at home as independently as possible

- ✓ Increase use of technology enabled care to compliment support for carers and to reduce the need for care at home, where this is appropriate
- ✓ Work to engage with people who are 'hard to reach' and less likely to be in touch with mainstream health services.
- ✓ Roll out locally based integrated approach within localities and designed around GP clusters, working in partnership with GPs, pharmacies and the voluntary sector to facilitate opportunities for personalised, joined up, planned care and support.

- ✓ Review the pathways between hospital and the community to make sure patient care is provided at the right time and in the right place and reduce delays in discharge from hospital
- ✓ Review existing services and pilot an enhanced role for community pharmacy, dentistry and optometry services to ensure closer integration with locality teams
- ✓ Promote condition-based self-management programmes for people with long term conditions where there is evidence that people can benefit from this approach.
- ✓ Continue to improve falls prevention initiatives, falls education, and establish effective falls pathways in all three localities which encompass falls assessment, treatment and rehabilitation.
- ✓ Implement findings from the evaluation of the Integrated Care Fund projects to inform our future service delivery models and commissioning plans.
- ✓ Support pharmacy service to be integrated within the locality teams and support the priorities set out in the Pharmacy Strategy

Key theme 2 – Person centred health, care and support

Involving people in decisions about their care is a key priority for the partnership and the Scottish Government. We need to see and treat people as partners in their own health, care and support, able to manage their conditions, putting them at the centre of the process. There is a strong body of evidence that involving people in health and social care planning leads to improved outcomes and there remain gaps in practice in taking on board the needs and wishes of individuals receiving care. Involving people in decisions about care will minimise misunderstanding and risks and support people to manage their care.

We have made much progress, but feedback from local communities through 'Join the Conversation' suggests that there is still work to do. The most common themes identified from community engagement events across the three localities of Perth and Kinross raised concerns about quality and consistency of care across the health and social care system; issues about access to services, proximity, timing and availability of appointments.

People told us about their concerns that information sharing between services, patients and community groups could be done better in order to prevent crisis and better support people. The need to ensure that information is accessible for people with literacy issues or whose first language is not English was highlighted.

What the needs assessment says?

Our needs assessment highlighted access issues in the rural areas of Perth and Kinross and significant issues of "access deprivation" in areas of rural North and South Perthshire and Kinross. Access to services was a consistent theme during the community engagement with people highlighting transport to appointments and travel time as issues that hindered their ability to get timely appointments close to home.

What are our priorities?

- ✓ Implement the joint OD and workforce development strategy to:

- make sure that we have a sustainable well skilled workforce ready to meet future needs and challenges
- empower people to make the most of their lives through participation in decisions about their health care and support
- embed a person-centred approach to the provision of health care and support services across statutory, voluntary and private sector
- support people to maximise personal assets and support self-management for long term conditions.

✓ Describe the requirements for a person-centred approach when we commission services so that all newly commissioned services are focussed on person centred outcomes

✓ Increase the number of opportunities for people to be able to exercise choice through self-directed support and commission and control their own care.

✓ Transform community nursing services and move towards models of care and outcome focussed assessments

✓ Transform care at home services to be person centred and outcomes focussed

✓ Review care pathways between hospital and the community for people at the end of life in order to ensure that they are supported to be at home or in a homely setting with support appropriate to their level of need, including voluntary and charitable agencies

✓ Introduce technology as a way of minimising travel time to and from hospital appointments

✓ Raise awareness of support available to people whose first language is not English

✓ At the end of a person's life, ensure that they have access to good quality palliative care and that they have the best quality of death possible in their preferred location where possible.

✓ Review Minor Injury & Illness units to ensure provision of clinical care is an appropriate alternative to hospital care

Key theme 3 – Work together with communities

We are committed to working in partnership with people in our communities ('co-production') to build on the skills, knowledge, experience and resources of individuals and communities. In response to the challenges facing the partnership we need to encourage an approach which is targeted and works within communities.

Through this we want to develop a shared understanding with communities which sets out what they can expect in terms of high quality health and care services, alongside their shared responsibility for their own health and the health of the local community. Our community engagement suggests that some people believe that we encourage dependency and could do more to plan for a health and social care system that encourages personal responsibility for health and wellbeing.

Good practice

Time Banking Perth and Kinross
The Time Bank project aims to support older people by: ✓ providing services on an informal basis, ✓ reducing isolation by extending friendship networks,

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- ✓ involving people in their communities and keeping them as active and supported as possible.

It was introduced to Perth and Kinross in 2011, funded by the Change Fund. Time Banks are a means of exchange used to organise people around a purpose or area or interest and their time is the commodity of exchange. Members agree to exchange one hour of their time to gain 1 hour of time credits that can be exchanged for services from other Time Bank members. Membership can include individuals, businesses, and public services. 5 time banks have been established across Perth and Kinross and an evaluation found the following:
</td></tr>
<tr><td>Outcomes predicted:</td><td>Additional unexpected outcomes evidence through the ‘social return on investment’</td></tr>
<tr><td>

- ✓ An increase in community wellbeing
- ✓ Simple solutions to support the over 65s living at home independently
- ✓ Increased capacity within communities
- ✓ Additional volunteering opportunities
</td><td>

- ✓ Increase in social networks – new friendships and reconnecting old friendships
- ✓ Giving members a purpose in life and their communities.
</td></tr>
</table>

We need to look at what is already in our local communities, build on existing relationships and invite and be open to new relationships, where individuals, families, communities and service providers have a reciprocal and equal relationship. This is an approach where services *‘do with, not to’* the people who use them and who also act as their own catalysts for change[7].

Through our Communities First Review we will work alongside communities to provide more choice and control for people, making sure the most vulnerable individuals receive responsive quality care delivered locally, and in a personalised way. We will build upon the principle that community resilience and empowerment are key to further developing and supporting people to live as independently as they can. With a relatively small investment through the Integrated Care Fund (ICF) we have been able to support a number of initiatives that developed opportunities for individuals and local communities, supporting self-reliance and developing sustained and meaningful engagement across communities. Through our evaluation, we will learn from these projects and work to create opportunities for service models that deliver alternative support provision, including social enterprise at local level.

Community engagement and a range of locally based interventions such as befriending, timebanking have demonstrated good outcomes relating to prevention across the country and in Perth and Kinross. Older people and others, such as people with mental health problems, are particularly vulnerable to social isolation and loneliness as a result of loss of friends, family, mobility or illness. There are a range of interventions developed within communities that can have a positive impact on the quality of people’s lives and their health and wellbeing and we will continue to explore initiatives that can support this.

[77] “Co-Production of Health and Wellbeing in Scotland”, Joint Improvement Team (JIT), p.14,

Good Practice Example

Participatory budgets

In February 2016, for the first time unpaid carers decided how money was to be spent to support them in their caring role. This is Participatory Budgeting (PB) in action, where unpaid carers decided how resources would be allocated to other carers like themselves.

£20K was up for consideration and only unpaid carers could vote. Projects could bid for up to £2,000 and gave a three minute presentation to carers on their initiative who then voted on their preferred option.

Around 100 people attended and 58 carers voted on the day. 15 of the 23 projects who applied were awarded funding, targeting some of our most vulnerable carers. Projects funded included respite for carers of children with additional support needs, older and young adult carers, support for Gypsy/Traveller and carers from the minority ethnic communities and additional therapy services.

'Carers Voice, Carers Choice!' was an outstanding first start to PB in Perth and Kinross but most importantly, it gave unpaid carers a voice in shaping services in a way that has never occurred before.

Some comments from participants on the day:

"A great example of taking PB into a new area and seeing it succeed brilliantly", Alan Budge, PB Partners UK

"Good to get the decision today – there are no layers between us and the decision" Participant Carers Voice, Carers Choice! 4 February 2016

Our priorities are to:

- ✓ Develop a *Communities First Initiative* to work alongside our communities to provide more choice and control for people and build upon the principle that community resilience and empowerment are key to further developing and supporting people to live as independently as they can

- ✓ Make sure community development and capacity building is recognised and will work with partners across the council and in the voluntary sector to support initiatives in this area
- ✓ Build on the lessons learnt from community initiatives tested through the Change and Integrated Care funds.
- ✓ Work across Perth and Kinross to reshape the market place through an approach which supports local enterprise and provides greater choice for people who need care and support
- ✓ Explore opportunities for Participatory Budgeting , and increase opportunities for people involving local communities and special interest groups to take more control over the way our resources are spent.

Key theme 4 – Reduce inequalities and unequal health outcomes and promote healthy living

Tackling health inequalities is challenging: they are influenced by a wide range of factors, including access to education, employment and good housing, equitable access to healthcare and individual circumstances and behaviour. Reducing health inequalities will:

- help increase life expectancy
- increase the health of disadvantaged groups and
- help reduce the direct statutory costs and wider societal costs.

The Letham Mini Well Being Hub

People in Letham are working to re-design an old housing office in their community into a Mini Well Being Hub. When the Hub opens it will provide greater access to free IT, information and advice on health and wellbeing and access to the Perth and Kinross Credit Union. It will offer a venue for Health Visitors, Mother and baby groups, meeting place for kinship carers, outreach appointments and counselling services. It will also offer more volunteering opportunities for people in Letham to gain skills and confidence in their own community. This has already started by members of the Community Steering Group who will take forward this project.

Health inequalities are highly localised and vary widely within individual areas and deprivation is a major factor with people in more affluent areas living longer and having significantly better health. Conversely, many of the people suffering the greatest negative health effects relating to mental health, obesity and long term disease are those experiencing poverty and social disadvantage. We need to encourage and support individuals and communities to look after and improve their health and wellbeing, resulting in more people living in good health for longer.

The biggest killers are heart disease, stroke and cancers and we have already demonstrated that there are significant issues in Perth and Kinross. Some of the contributing factors to these diseases are beyond the influence of the individual or of health services but we can encourage healthier lifestyles and prevent disease through early detection and screening. After smoking, obesity is the biggest underlying cause of ill health. It can lead to high blood pressure, heart disease, stroke, diabetes, cancer and early death. It also increases immobility and makes any other disability more severe than it would otherwise be.

Some risk factors for these, such as smoking, are strongly linked to deprivation. We recognise that there are a large number of vulnerable or marginalised groups within the Perth and Kinross area. Some of this is down to geographical location, e.g. living within an area of deprivation where communities experience higher levels of households living on benefit and poorer health status than Perth and Kinross overall. Interventions targeted at these communities are being tested through projects such as Equally Well, Keep Well and Evidence2 Success.

Our COSLA award winning SAINTS (Saints Academy Inclusion Through Sport) Project is for adults with learning disabilities and people with mental illness and provides inclusive support at a fraction of the cost of traditional day services.

Saints Academy inclusion Through Sport

Many adults with disabilities and poor mental health find the prospect of accessing mainstream sporting venues or teams daunting.

The idea of a 'sports academy' was based on a premise that sport and activity gives individuals a sense of wellbeing whether they have a diagnostic label such as mental illness or learning disability or not.

The project gained plaudits for its innovative approach: The Scottish Football Association has described the project's work within the field of mental health football as 'trailblazing', Her Majesty's Inspector of Further Education called the SAINTS project a 'sector leading and innovative practice'. Participants have taken part in the Special Olympics, local and national tournaments and undertaken their own coaching certificates. A number of different sports have been undertaken including football, cricket, golf, tennis, cycling and volleyball and participants travel to attend activities

<u>What the does the needs assessment say?</u>

Deprivation Type	Scotland	Perth & Kinross	North Perthshire	South Perthshire	Perth City
Income Deprived (2013)	13.2%	8.7%	7.8%	6.6%	11.4%

Employment Deprived (2013)[8]	12.2%	8.3%	7.3%	6.1%	11.0%
Access Deprived (2013)[9]	15.0%	31.3%	45.2%	45.2%	4.7%
Child Poverty (2012)	15.3%	9.4%	9.6%	6.4%	12.4%

Table 10 Percentage of population income, employment, and access deprived in Scotland, Perth and Kinross, and each locality (2013)[10]

Our analysis shows that although people living in the most deprived communities use greater health and social care resources than people in least deprived communities; this appears to be as a result of the greater numbers of this population in services compared with other populations. Further analysis shows that the per person spend of an individual classed as least deprived is almost always higher than the most deprived. This points to a need to look more closely at equity issues and how the most deprived populations access health and social care services.

What are our priorities?

We will:

- ✓ Continue to develop health interventions for people who are at the highest risk of ill health, to prevent illness and reduce health inequalities including:
  - Smoking
  - Alcohol and drug use
  - Oral health
  - Obesity
  - Undernutrition
  - Sexual health
- ✓ Target health improvement services on those who are most at risk of health inequalities and difficult to engage and will primarily work with the most deprived individuals who fall across the whole of Perth and Kinross. This will be achieved through community and partnership engagement, early intervention including health promotion and direct clinical interventions.
- ✓ Create health and wellbeing hubs across the localities, exploring opportunities for community hospitals as local community hubs
- ✓ Roll out the use of community pharmacy technicians and develop care pathways to enable engagement between patients, community pharmacists, locality pharmacist and general practitioner
- ✓ Reduce health inequalities for people who have a learning disability through the development of a SMART Action Plan
  - Increase take up of Health Screening & Health promotion activities for people with learning disabilities.
  - Prepare information for other agencies to inform them of the specific needs of people with learning disabilities e.g. health inequalities agenda/ accessible information agenda

[8] Of working age population (16-64)
[9] Population living in 15% most "access deprived" areas
[10] Ibid

- ✓ Embed recovery models of care, including developing mutual aid groups within each of the 3 the localities where change is initiated and driven by the individual and is supported by family and community
- ✓ Promote the value of Power of Attorney particularly at the time of dementia diagnosis through post diagnostic support
- ✓ Promote the uptake of adult support and protection training across our workforces
- ✓ We will continue to work with the Community Planning Partnership to address the health and social care needs of the Gypsy Traveller Community
- ✓ Make sure that the delivery of services is fair and inclusive for all individuals and communities

Key theme 5 – making the best use of available facilities, people and resources

As we prepare for integration both the council and the NHS are facing financial challenges at a time when demands for services are increasing due to a rising population, some of whom have complex health and social care needs. We need to look at our joint health and social care resources, how we use these to improve the health and well- being outcomes of the local populations and what we need to change in order to focus our funding on delivering health care and support for local people.

There will always be a need for hospitals and care homes, particularly as people get older, and we need to ensure that specialist services are used appropriately to meet people's needs. As we begin to develop our locality planning model there will be a need to focus on realigning resources to provide more community based delivery. This will develop over the life of the strategic plan at a time when public finances are reducing and requires a radical look at how we deliver services. The need for any service redesign should not require additional or new funding but to be "redesigned" from existing budgets and services.

Facilities

We will look at the best use of the health and social care estate and what service models are best delivered from where. We currently have a number of hospitals in Perth and Kinross, community hospital facilities, day centres and a large number of residential and nursing homes. A key theme emerging from our community engagement highlighted transport, long journeys for appointments for hospital services and transport more generally as an issue in the more rural communities. The availability and choice of services in North and South Perthshire is very different from Perth city. In some of the rural communities there is inequality in access to health, social care and other services.

Our priorities - we will:

- ✓ During 2016/17 review facilities across the health social care and independent sectors; develop and implement plans for the best use of local facilities to deliver integrated models of care in local communities.
- ✓ Review use of hospital beds for people with mental health problems and learning disabilities

- ✓ Redesign Community Hospitals to ensure better use of local community hospital beds. This will support our work to reduce the number of people being admitted as an unplanned admission to the acute sector.
- ✓ Increase the use of technology enabled care to compliment support for carers and to reduce the need for care at home where this is appropriate

People

Our workforce is essential to successful integration along with people who use services and independent and third sector providers. Quality and professional standards need to be at the core of everything we do to ensure safe care and support for people. Staff need to be supported to provide quality services, appropriately skilled, qualified and have the personal attributes to be in a role that has dignity and respect at its core. Our staff and care providers will operate within the relevant professional frameworks and with regulatory bodies such as the Care Inspectorate and Health Improvement Scotland.

We want care and support provision to adhere to essential standards of care and will work collaboratively to ensure best practice and continuous improvement. Staff employed across the statutory, voluntary and private sectors will be supported to take person-centred approaches to working with people who use services and improving the care they provide.

Our priorities – we will:

- ✓ Develop an integrated workforce development plan to engage, support and develop staff across all sectors
- ✓ Ensure that vulnerable people remain safe and are protected from harm from others, themselves and the community through the monitoring and implementation of clinical and care governance standards and adult protection measures
- ✓ Through commissioning and contract management ensure that services across the statutory, voluntary and private sectors, are designed and delivered to be safe, effective and sustainable; building high quality services which improve health and wellbeing across Perth and Kinross .
- ✓ Work with partners to make sure care is evidence-based, incorporates best practice and fosters innovation, achieving seamless and sustainable pathways of care.
- ✓ Continue to develop and deliver the Scottish Patient Safety Programmes, to reduce mortality, harm and avoidable injury in a variety of care settings including Acute Adult Care, Maternity, Neonatal, Paediatrics, Mental Health and Primary Care settings
- ✓ Complete the integration of Occupational Therapy Services.

Resources

As part of our priority to shift the balance of care so that we provide care closer to home, we want to maximise resources within communities, including the whole range of universal and voluntary services. A number of transformation programmes initiated by the Council and NHS partners have begun the process of challenge and review supporting our vision to support more people to live independently at home for longer. This will form part of our response to the financial challenges set out earlier enabling us to maximise our joint resources to deliver high quality, efficient health and social care services.

Example
Aberfeldy
A new model of care is being developed at Aberfeldy which aims to integrate care and support for older people who need care in a community hospital or care home. The vision is one of a community hub, integrating the community hospital and community services, primary care social work and a range of associated local health and social care services. The aim is to create a hub of services around the GP practice in the town by moving the community hospital to combine with a local authority care home. The local community hospital and the care home were not fully utilised and the new model will improve continuity of care alongside better use of facilities within the community. Local people have been engaged in the process through "Your Community, your voice, your future".

Transformation programmes

A number of planned reviews will help the partnership transform community care and health services. Some of these are referred to elsewhere and a summary of transformation plans is set out below

Summary of transformation programmes

We will:

- ✓ Review community care day services to increase locally based service opportunities for people to access appropriate support and develop more community based models across localities.
- ✓ Review Older People's Residential Care Services and outline how we will meet the demands of an increasing older population, manage the current and future financial constraints, and shift the balance of care.
- ✓ Achieve savings from procurement activities through more collaborative procurements, closer management of suppliers, reducing demand, and avoiding unnecessary expenditure. (Procurement review)
- ✓ In partnership with housing, review the homeless service – to provide options for direct access to settled accommodation for homeless people and families
- ✓ Review Community Care Packages for Adults to develop models of practice which enhance the individual's, their families and community's assets to create more resilience and which is financially sustainable.
- ✓ Develop and roll out an enhanced dementia service to provide support, both directly to people in their own homes and in their communities.
- ✓ Move towards community hospitals becoming local community hubs for health, social care and third and independent sector with a range of services and facilities to support health and wellbeing in local communities.
- ✓ Transformation of District Nursing
- ✓ Workforce review of Allied Health Professionals
- ✓ A review of hospital activity to establish a programme of transformation over the longer term
- ✓ Review of inpatient beds – capacity and demand
- ✓ Review of pathways, including stroke pathway and prescribing pain pathway
- ✓ Review and evaluation of all services hosted by the Perth and Kinross Partnership including:
    - Delivery of an improvement plan for mental health services
    - A healthcare needs assessments across prison establishments
    - Review and redesign of prisoner healthcare

- ✓ We will work in conjunction with NHS Tayside to derive savings from efficiency work streams initiated within NHS Tayside.

Performance

Through the development of a performance framework and regular reporting the partnership will be able to understand how well it is meeting its aims and objectives. A suite of indicators and measures have being developed to enable regular reporting of the Partnership's performance within the strategic framework provided by the Health and Social Wellbeing Outcomes (attached as Appendices A and B). As well as regular monitoring, the framework will allow the partnership to publish an annual performance report with an assessment of performance in relation to the national health and wellbeing outcomes

In conclusion

We have set out an ambitious plan to integrate our health and social care system to improve the health and wellbeing of people living and working in Perth and Kinross. The challenge for the partnership is to build on existing good work and deliver transformational change in the context of a challenging financial climate. We have a lot of work to do and at the end of the 3 years' strategy will see a health and social care landscape transformed to keep more people living independently at home for longer leading healthier lives. We will know we are successful when we can demonstrate our evidence of change through performance on the national outcomes.

Action Plan

7/3/2016

Whole area – Perth and Kinross

The actions set out below will apply across Perth and Kinross and in some areas will be adapted to meet the needs of each of the three localities. This will require a joint approach by all partners and across the relevant areas. The locality management and planning structure is currently in development and some priorities have already been identified for each locality. Throughout the process the locality planning teams will further develop specific plans relevant to the local area and community.

Further work is required to identify and realign resources to ensure we are able to develop and embed integrated working across all sectors focussed on the priorities set out in the strategic plan. Some areas highlighted are funded from existing resources. For any new areas the relevant teams will further develop detailed action plans with timescales and resources identified.

National outcome and key theme	Key action	Timescale 2016 -17	2017-18	2018-19
National outcome 1 Theme Prevention and early intervention	✓ Develop a virtual health and social care market place through our Well Connected site to: ○ Improve information about services and how to access them for self-directed support. ○ offer access to information about universal services or lunch clubs, befriending and other supports without having to engage with statutory services	✓		
	✓ Continue to work with our partners in housing to support people to live as independently as possible in housing that is suitable for their needs: 1. deliver care and repair services to ensure access to adaptations for people in private sector accommodation 2. review the use of aids and adaptations in social housing 3. Increase use of technology enable care to compliment support for carers and to reduce the need for care at home where this is appropriate 4. Support service users and carers to enable them to use	✓	✓	✓

National outcome and key theme	Key action	Timescale 2016 -17	2017-18	2018-19
	technology to support their independence 5. Plan new social housing developments to make sure people are able to live at home as independently as possible 6. Identify and plan new housing developments for people with specialised support needs			
	✓ develop the role of GP clusters to become an integrated part of health and social in order to: ○ share information between partners, ○ explore different and improved ways of working together and to support practices to enable consistent and sustainable changes and improvements in the delivery of healthcare.	✓	✓	✓
	✓ Roll out a locally based integration teams designed around GP clusters, working in partnership with GPs, pharmacies and the voluntary sector to facilitate opportunities for personalised, joined up, planned care and support for people.	✓	✓	✓
	✓ Review existing services and pilot an enhanced role for community pharmacy, dentistry and optometry services to ensure closer integration with locality teams	✓	✓	✓
	✓ Build on work with GP practices, community and the third sector to engage with people who are hard to reach and less likely to be in touch with mainstream health services.	✓	✓	✓
	✓ Review the pathways between hospital and the community to ensure that patient care is provided at the right time and in the right place	✓	✓	
	✓ Continue to develop and implement falls prevention initiatives including public awareness, staff education, and establishing effective multi-agency falls referral pathways to falls assessment services, treatment and rehabilitation in all three localities.	✓	✓	✓
	✓ Establish an integrated approach to support people with/or before and after a dementia diagnosis in partnership with General Practice and the third sector	✓	✓	

National outcome and key theme	Key action	Timescale 2016 -17	2017-18	2018-19
	✓ Reduce the wait for diagnosis of dementia and ensure early intervention and treatment by implementing the diagnostic pathway across all sectors	✓	✓	
	✓ Continue to develop community based mental health services for older people living with a long and enduring mental health illness minimising crisis and preventing hospital admission	✓		
	✓ Develop community nursing teams to assess, plan implement and evaluate care for deteriorating patients to support early intervention.	✓	✓	✓
	✓ Support pharmacy service to be integrated within the locality teams and able to develop their role to support people with complex needs in a range of settings within communities ✓ Support the priorities set out in the Pharmacy Strategy ✓ Roll out the use of community pharmacy technicians and develop care pathways to enable engagement between patients, community pharmacists, locality pharmacist and general practitioner	✓	✓	✓
	✓ Support the development of self-management programmes for people with long term conditions where there is evidence that people can benefit from this approach.	✓	✓	✓
	✓ Implement findings from the evaluation of the Integrated Care Fund projects to inform our future service delivery models and commissioning plans.	✓	✓	✓
Outcome 2 and 3 Person centred health and social care	✓ Implement the joint organisational and workforce development strategy to: ○ Make sure that we have a sustainable well skilled flexible workforce across all sectors ○ encourage and support a person-centred approach which will maximise people's potential and support self-management for long term conditions. ○ empower people to make the most of their lives through participation in decisions about their health care and support ○ Embed a person-centred approach to the provision of health care	✓	✓	✓

National outcome and key theme	Key action	Timescale 2016 -17	2017-18	2018-19
	and support services across statutory, voluntary and private sector			
	✓ Require newly commissioned services to be person centred and outcomes focussed	✓	✓	✓
	✓ Increase the number of opportunities for people to be able to exercise choice through self-directed support and commission and control their own care.	✓	✓	✓
	✓ Implement the findings of the community nursing services review and move towards models of care based on outcome focussed assessments and care plans	✓	✓	✓
	✓ Review care pathways between hospital and the community for people at the end of their lives to ensure that they are supported to be at home or in a homely setting with support appropriate to their level of need			✓
	✓ Implement the recommendations in the Technology Enabled Care Strategy technology in local services in order to minimising people's travel time to and from hospital appointments	✓	✓	✓
	✓ Review Minor Injury & Illness units to ensure provision of clinical care is an appropriate alternative to hospital care and implement findings	✓	✓	✓
	✓ Raise awareness of support available to people whose first language is not English	✓	✓	✓
Outcome 4,6Work with communities	✓ Work with communities and provide more choice and control for individuals through: ○ Developing a community engagement strategy in each locality ○ Embedding community development to support individuals, groups and communities to work together to plan and deliver services. ○ Increasing opportunities for Participatory Budgeting so that local communities and special interest groups can take more control over	✓	✓	✓

National outcome and key theme	Key action	Timescale 2016 -17	2017-18	2018-19
	the way resources are spent			
	✓ Work with the Community Planning Partnership to embed community development to support individuals, groups and communities to work with us as partners in planning and delivering services	✓	✓	✓
	✓ Develop a *Communities First Initiative* to work alongside our communities to co-produce and provide more choice and control for individuals in their localities. ○ Work across Perth and Kinross to reshape the market place to support local enterprise and provides greater choice for people who need care and support	✓	✓	✓
	✓ Develop dementia awareness within communities to ensure "Dementia Friendly Communities"	✓	✓	✓
Outcome 5 Reduce inequalities	✓ Develop initiatives to reduce the number of people who are overweight or obese, targeting resources at those most at risk	✓	✓	✓
	✓ Develop health interventions for people who are at the highest risk of ill health, to prevent illness including: ○ Smoking ○ Alcohol and drug use ○ Oral health ○ Sexual health ○ Undernutrition	✓	✓	✓
	✓ Reduce health inequalities for people who have a learning disability through the development of a SMART Action Plan ○ Increase take up of Health Screening & Health promotion activities for people with learning disabilities. ○ Prepare information for other agencies to inform them of the specific needs of people with learning disabilities e.g. health inequalities	✓		

National outcome and key theme	Key action	Timescale 2016 -17	2017-18	2018-19
	agenda/ accessible information agenda etc.)			
	✓ Continue to work with the Community Planning Partnership to address the health and social care needs of the Gypsy Traveller Community	✓	✓	
	✓ Embed recovery models of care in mental health and substance misuse, including the development of mutual aid groups within each of the 3 the localities	✓	✓	
	✓ Promote the value of Power of Attorney particularly when people are diagnosed with dementia	✓	✓	✓
	✓ Promote the uptake of adult support and protection training across the workforce in the statutory, independent and third sectors	✓	✓	✓
	✓ Undertake healthcare needs assessment across the prison establishments and review and redesign prisoner healthcare.	✓	✓	✓
	✓ Monitor the delivery of services to ensure they are fair and inclusive for all individuals and communities	✓	✓	✓
Outcome 9 **Best use of facilities, people and resources**	✓ During 2016/17 review facilities across the health social care and independent sectors; following review develop and implement plans for the best use of local facilities to deliver integrated models of care in local communities.	✓	✓	✓
	✓ Review use of hospital beds for people with mental health needs and learning disabilities in hosted services and implement findings	✓	✓	
	✓ Increase the capacity of existing substance misuse inpatient facilities by improving throughput, keeping waiting times within the 3 week Scottish Government HEAT A11 standard. (JM)	✓		
	✓ Increase the use of technology enabled care to compliment support for carers and to reduce the need for care at home where this is appropriate	✓	✓	✓
Outcomes 4,8,7	✓ Develop and finalise the integrated workforce and organisational development plan to engage, support and develop staff across all sectors	✓		

National outcome and key theme	Key action	Timescale 2016 -17	2017-18	2018-19
	✓ Ensure that vulnerable people remain safe and are protected from harm from others, themselves and the community through the monitoring and implementation of clinical and care governance standards and adult protection measures	✓	✓	✓
	✓ Remodel, decommission some services and recommission others to meet the strategic plan priorities ✓ Develop a market position statement to ensure that all stakeholders are aware of our plans and where services are commissioned, potential providers are able to plan and develop services that will meet the health and wellbeing needs of individuals and communities	✓ `	✓	✓
	✓ Utilise the statutory, third and independent sectors to deliver on National Personal Foot care Guidelines.	✓		
	✓ Promote recruitment and retention of registered nursing staff by testing rotational models of care across in- patient and community settings	✓		
	✓ Continue to develop and deliver the Scottish Patient Safety Programmes, to reduce mortality, harm and avoidable injury in a variety of care settings including Acute Adult Care, Maternity, Neonatal, Paediatrics, Mental Health and Primary Care settings	✓	✓	✓
	✓ Complete the integration of Occupational Therapy Services.			
	Transformation			
	We have a number of planned reviews that will help the partnership transform community care and health services and will:			
	✓ Work with partners in the Council to achieve savings from procurement activities through more collaborative procurements, closer management of suppliers, reducing demand, and avoiding unnecessary expenditure	✓	✓	✓
	✓ Review community care day services to increase locally based opportunities for people to access support	✓	✓	✓
	✓ Review Older People's Residential Care Services and implement changes	✓	✓	

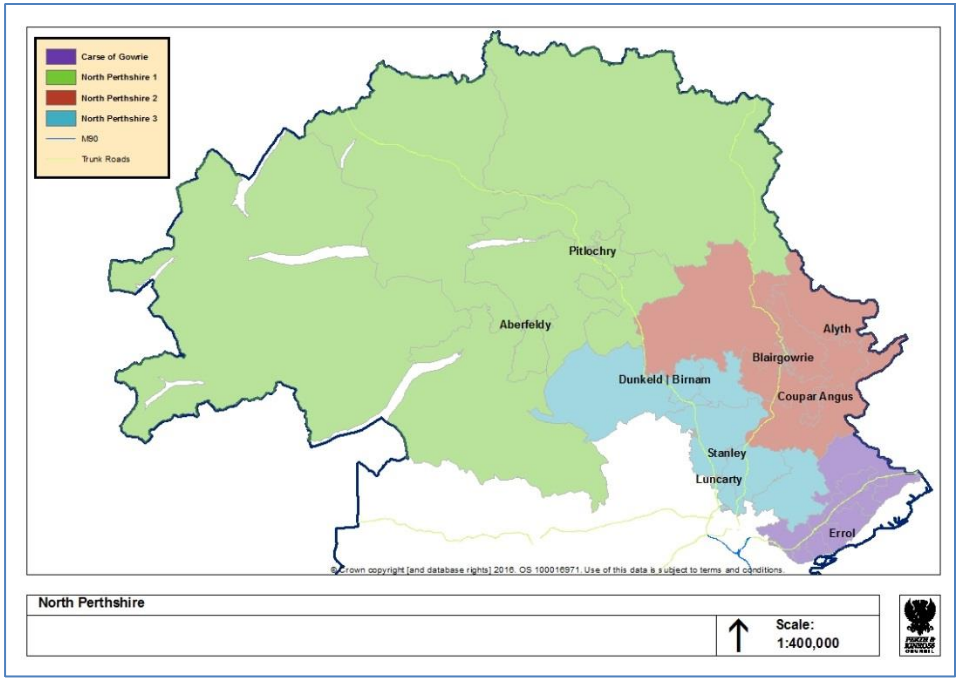
National outcome and key theme	Key action	Timescale 2016 -17	2017-18	2018-19
	to meet the demands of an increasing older population.			
	✓ Review and implement changes to care at home to help people to remain at home for longer, and shift the balance from traditional services to community focussed services	✓	✓	✓
	✓ In partnership with housing, review the homeless temporary accommodation service and implement findings to provide options for direct access to settled accommodation for homeless people (Home First)	✓		
	✓ Work with communities to develop the health and social care market, encouraging and empowering people to make informed choices to improve their health and wellbeing outcomes. (Communities First Review)	✓	✓	✓
	✓ Review community care packages to enhance the individual's, their families, and community's assets to create more resilience and which is financially sustainable	✓	✓	✓
	✓ Develop sustainable community detoxification models for substance misusing individuals that allow treatment to be delivered in a safe and cost effective manner, and that link with a wide range of longer term recovery orientated treatment options.	✓	✓	✓
	✓ Implement enhanced dementia and mental health services to provide support to people in their own homes and in their communities.	✓	✓	✓
	✓ Review JELS management of equipment accessed by community nursing teams to ensure robust and efficient processes are in place	✓		
	✓ Review Minor injury & illness units and implement finding to ensure provision of clinical care is an appropriate alternative to hospital care	✓	✓	✓
	✓ Explore opportunities for community hospitals as local community hubs for health, social care and third and independent sector with a range of services and facilities to support health and wellbeing in local communities	✓	✓	✓
	✓ Review hospital activity to establish a programme of transformation over the longer term	✓	✓	✓

National outcome and key theme	Key action	Timescale 2016 -17	2017-18	2018-19
	✓ Review and evaluate all services hosted by the Perth and Kinross Partnership in order to establish future service arrangements including: ○ Delivery of an improvement plan for mental health services ○ A healthcare needs assessments across prison establishments ○ Review and redesign of prisoner healthcare	✓	✓	✓
	✓ Use the Integrated Resource framework data to inform future provision and commissioing of services to meet the strategic plan priorties.	✓	✓	✓
	✓ Workforce review of Allied Health Professionals	✓	✓	✓
	✓ A review of hospital activity to establish a programme of transformation over the longer term ✓	✓	✓	✓
	✓ Review of inpatient beds – capacity and demand ✓	✓	✓	✓
	✓ Review of pathways, including stroke pathway and prescribing pain pathway	✓	✓	✓
	✓ We will work in conjunction with NHS Tayside to derive savings from efficiency work streams initiated within NHS Tayside.	✓	✓	✓

Locality actions 2016/17 -2018/19

We are still developing locality planning arrangements and the action plans for the three localities. The priorities identified for the three localities below were developed through consultation and engagement process. Further work is required.

Locality – North Perthshire



The North Perthshire locality consists of three distinct areas: Highland Perthshire, Strathmore and Carse of Gowrie. Most of its settlements are located on or close to the main transport corridors (A9, A93 and A90) but access to services remains a strong issue for residents. North Perthshire comprises of the following major settlements of: Aberfeldy, Alyth Blair Atholl, Blairgowrie, Coupar Angus, Dunkeld, Errol, Invergowrie, Pitlochry.

Population

With an overall population of 50,338 residents, it has the highest number and proportion of individuals aged over 65 years, and the lowest number and proportion of children. Its population can be summarised as below:

- 25,685 (51%) females and 24,653 (49%) males.
- 7,919 (16%) under the age of 16. This is the lowest number and proportion of all 3 localities.
- 30,603 (61%) working age (16 to 64).
- 11,818 (23.5%) 65 +years.

Key issues

- Highest number and proportion of those aged over 65 of all 3 localities.
- North Perthshire has 45% of its population living in the 15% most access deprived[11] datazones in Scotland.
- 9.6%. of families with dependent children aged under 20 receive Child Tax Credits or income support/jobseekers allowance is This is seen as a proxy for children living in poverty. The figure for the whole of Perth & Kinross is 9.4%.
- Higher numbers of people with learning disabilities compared with South Perthshire and Perth City

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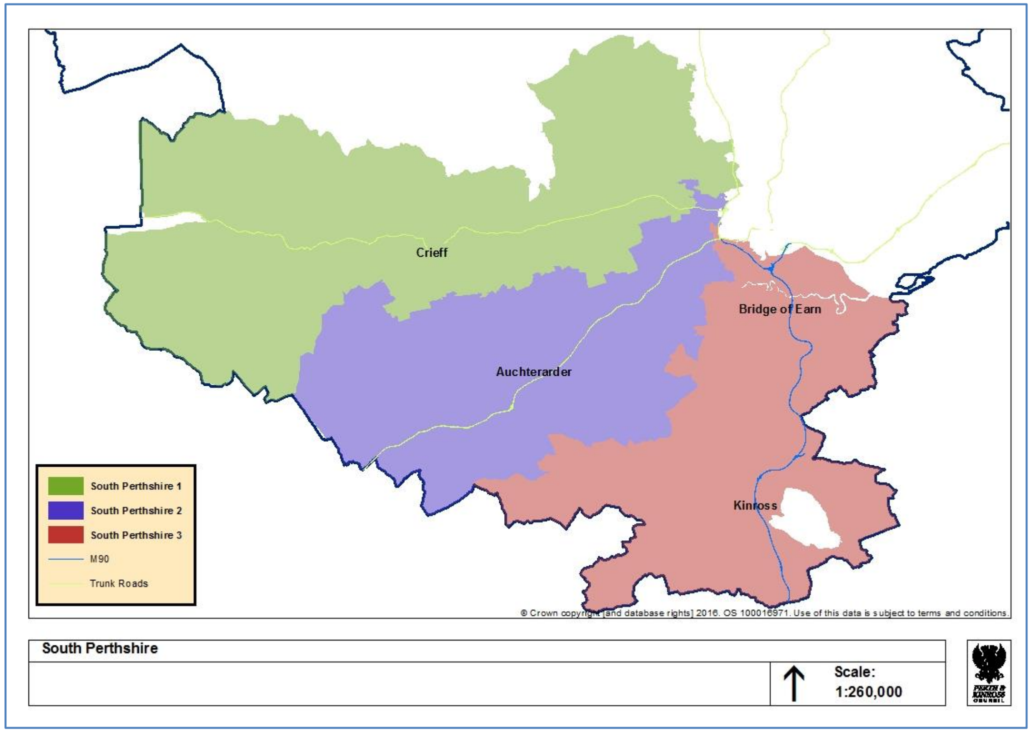
Meets national outcome	**Key strategic priority**	**Key actions – *identified by Integrated Leadership Group and Strategic Planning Group planning sessions***	**Timescale**	**Resources**
People are able to look after and improve their own health and wellbeing and live in good health for longer	Prevention and Early intervention	• Embed social prescribing model to support change in culture and increase referrals to mainstream services in the community		
		• Identify a range of community champions and deliver support to enable them to help people self-manage and find the support they needs		

[11] The Geographic Access domain was introduced in SIMD 2004 to capture the issues of financial cost, time and inconvenience of having to travel to access basic services from different locations in Scotland. It consists of two sub-domains. The first relates to journey times via private transport to the nearest GP, retail centre, petrol station, school (primary and secondary), and post office. The second sub-domain regards public transport (bus, train, metro, and ferry) journey times to the nearest GP, retail centre, and post office only.

Meets national outcome	**Key strategic priority**	**Key actions – *identified by Integrated Leadership Group and Strategic Planning Group planning sessions***	**Timescale**	**Resources**
		• Develop Dementia Ambassadors in ordinary places within communities such as post office, bus, supermarket		
		• Develop and embed role of 'link workers/ super conductors in GP surgeries. Roll out across all GP practices		
		• Identify a range of community champions and other key people and support / train them to help people and self-manage and find support they need		
		• Promote prevention and a self-reliant culture through education in schools and other community spaces		
		• Through development of technology enable care strategy, develop app for accessing info / services		
		• Ensure information is provided in accessible formats		
		• Develop specific strategies for health promotion, made relevant to local communities		
People, including those with disabilities, long term conditions or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community	Person centred health care and support Working with communities	• Create co-ordinated care pathways and link to the development of integrated and enhanced care teams		
		• Ensure co-location of teams where this possible		
		• Look to develop a health and well-being 'hub' in Pitlochry		
		• Examine capacity of drop in services to improve access for people living in rural areas		
People who use health and social care services have positive	Person centred health care	• Explore options to reduce the number of different people providing care		

Meets national outcome	Key strategic priority	Key actions – *identified by Integrated Leadership Group and Strategic Planning Group planning sessions*	Timescale	Resources
experiences of those services and have their dignity respected	and support			
		• Build in regular evaluation/feedback for all services		
		• Review issues of access and transport including scope for services to be delivered locally		
		• Review issues of quality, governance and workforce development		
	Working with communities	• Identify sub localities issues for health and social care in terms of community engagement		
	Prevention and early intervention Person centred health care and support	• Assess the best use of facilities and consider models that deliver care in our local communities.		
		• Redesign inpatient services to ensure better use of local resources.		
		• Improve use of technology enabled care to compliment support for carers and to reduce the need for care at home where this is appropriate		

Locality – South Perthshire and Kinross



The South Perthshire and Kinross locality consists of the distinct areas of Strathearn and Kinross. Its main settlements are mostly found on or close by the main transport corridors (M90, A9 and A85).

Population

- 23,636 (51%) females and 22,636 (49%) males.
- 8,269 (18%) under the age of 16 - the highest proportion of under 16s in all the 3 localities, though the number of under 16s is greater in Perth City.
- 28,103 (60.3%) working age (16 to 64) - the lowest number and proportion of all 3 localities.
- 10,226 (21.9%) 65 years old and above, this is slightly above the proportion for Perth & Kinross as a whole (21.5%).
- For both income and employment deprivation, South Perthshire and Kinross has the lowest percentages of all 3 localities.

Key issues

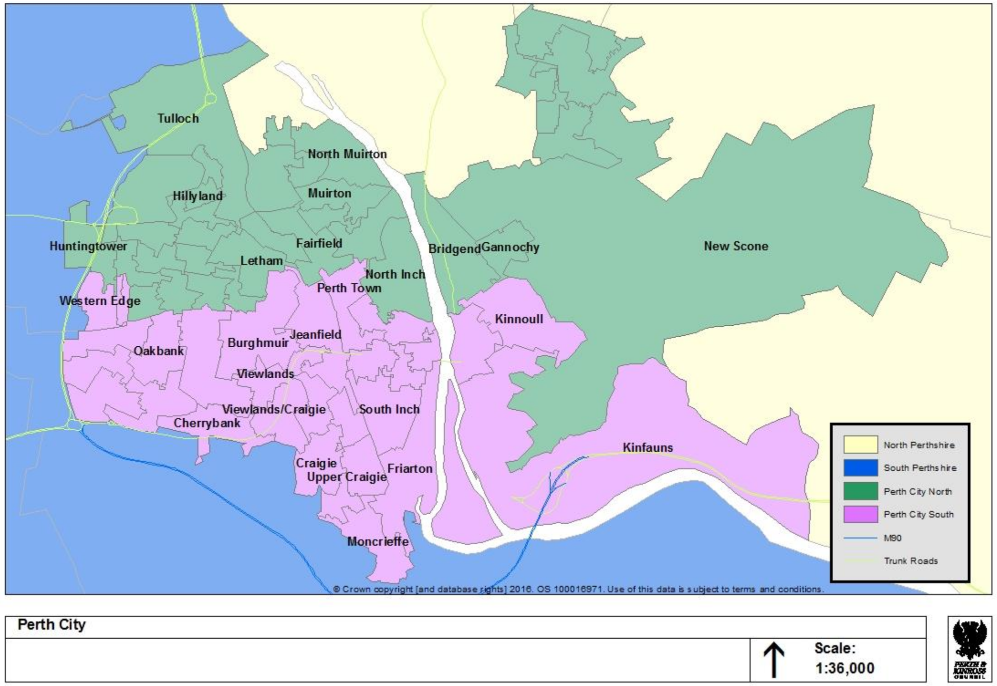
- Similar levels of access deprivation to North Perthshire – level of rurality a key factor
- Lower level of deprivation compared with the rest of Perth and Kinross

Meets national outcome	Key theme	Key action – *identified by Integrated Leadership Group and Strategic Planning Group planning sessions*	Timescale	Resources
People are able to look after and improve their own health and wellbeing and live in good health for longer	Prevention and early intervention	• Increase access to Technology enabled care (TEC) though: ○ The utilisation and promotion of wellbeing self-help apps ○ Promoting the use of TEC in all aspects of health and social care including video conferencing with patients, GP's and hospital staff		
		• Embed social prescribing model to support change in culture and increase referrals to mainstream services in the community		
People, including those with disabilities, long term conditions or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community	Person centred health care and support	• Develop integrated care teams to provide a seamless care approach		
		• Develop 24hr support at home using independent providers in a different way		
		• Increase/promote the use of technology enable care including Skype, video conferencing with patients and GPs and hospital staff		
		• Explore Nurse led Discharge and Admission to hospital		

Meets national outcome	Key theme	Key action – *identified by Integrated Leadership Group and Strategic Planning Group planning sessions*	Timescale	Resources
		• Encourage Community resilience e.g. upskill volunteers to support people at home and signpost to other services		
Health and Social Care Services are Centred on Helping to Maintain or improve the quality of life of service users	Making best use of facilities, people and resources	• Develop and Single Shared Referral process and one person centred plan		
		• Explore the develop of a community wellbeing centre including mobile options		
		• Develop a joint organisational development plan		
Health and Social care services contribute to reducing health inequalities	Making best use of facilities, people and resources Working with communities	• Develop one-stop health and social care wellbeing centre		
		• Improve awareness of the use of pharmacy services and broaden range of services / referrals that can be made by community pharmacy		
		• Increase engagement with community independent providers		
		• Map local services and pathways to reduce duplication		
People who work in Health and Social Care Services are supported to continuously improve the information, support, care and treatment they	Making best use of facilities, people and resources	• Explore opportunities for joint training and learning opportunities		

Meets national outcome	Key theme	Key action – ***identified by Integrated Leadership Group and Strategic Planning Group planning sessions***	Timescale	Resources
provide and feel engaged with the work they do	Working with communities			
		• Share good practice and examples of what is working across all localities		

Locality – Perth City



Perth City comprises of the following residential areas of: Bridgend, Fairfield, Gannochy, Hillyland, Hillyland & Tulloch, Huntingtower, Kinnoull, Letham, Muirton, North Inch, North Muirton, Perth Town, Scone, Tulloch, Burghmuir, Cherrybank, Craigie, Friarton, Kinfauns, Moncrieffe,Oakbank Perth Town, South Inch, Upper Craigie, Viewlands, Viewlands/Craigie, Western Edge.

Population

Perth City locality is the largest settlement in Perth & Kinross and includes the sub-localities Perth City North and Perth City South.

It has the largest population of the 3 localities, 50,814 with the highest number of individuals of working age, and the lowest number 65 and older. Its population can be summarised as below:

- 8,460 (17%) under the age of 16. This is the highest number of under 16s of all 3 localities, though the proportion is greater in South Perthshire.
- 32,661 (64%) working age (16 to 64). This is the highest number and proportion of all 3 localities.
- 9,693 (19%) 65 years old and above. This is the lowest number and proportion of all 3 localities.
- The highest proportion of its population in the most deprived SIMD quintiles 1and 2, at 46%. Perth City also has the highest percentage of its population in the least deprived quintile, with 27%.
- For both income and employment deprivation Perth City has the highest proportions of all 3 localities.
- The percentage of dependent children under the age of 20 in families that receive Child Tax Credits or income support/jobseekers allowance is 12%. This is seen as a proxy for children living in poverty. This is the highest for the 3 localities and the figure for the whole of Perth & Kinross

Key Issues

- High levels of income and employment deprivation
- High numbers of older people (over 65) living alone

Meets national outcome	Key theme	Key action – ***identified by Integrated Leadership Group and Strategic Planning Group planning sessions***	Timescales	Resources
People, including those with disabilities, long term conditions or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community	Prevention and early intervention Working with communities Reducing health inequalities	• Enhanced Community Support teams to be rolled out across Perth city		
		• Develop Integrated Care teams linked to zones using existing premises in the City e.g. Letham Centre		
		• Invest in Community in sub localities. For example men’s sheds		

Meets national outcome	Key theme	Key action – *identified by Integrated Leadership Group and Strategic Planning Group planning sessions*	Timescales	Resources
		• Develop community engagement and learn from good practice elsewhere e.g. Aberfeldy consultation as a model		
		• Develop role of Community pharmacy in relation to prevention and early intervention		
		• Develop support structure for GPs to divert people to other resources in the community		
People, including those with disabilities, long term conditions or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community	Prevention and early intervention Working with communities Reducing health inequalities	• Explore options to improve GP coverage in the Letham area		
		• Develop Discharge to Home Model to Assess from Acute care		
		• Continue with the redesign of District Nurse role and remit		
		• Redesign Care At Home service to increase capacity within rapid response and crisis services		
		• Undertake process mapping to reduce duplication and streamline services and systems of referral within and between agencies		
		• Make sure service users also have a voice in the development of localities and to inform what is required in their community.		
People, including those with disabilities, long term conditions or who are frail, are able to live, as far as reasonably practicable, independently	Person centred health care and support	• Promote the use of apps and link with SMART city to support self- management		

Meets national outcome	**Key theme**	**Key action – *identified by Integrated Leadership Group and Strategic Planning Group planning sessions***	**Timescales**	**Resources**
and at home or in a homely setting in their community				
People who work in health and care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide	Prevention and early intervention Person centred health care and support	• Develop an organisational/workforce development plan within the locality plan, encompassing a joint structure across all sectors in the locality to promote shared ownership e.g. NHS, PKC, independent/third/voluntary sectors;		
		• Develop a shared training plan across all agencies within the locality;		
		• Develop and enhance peer support models within agencies and across agencies;		
		• Promote the relevance of the strategy with operational frontline staff within workforce development plans to encourage and motivate staff to take ownership of the work they do		

Appendix A: DRAFT NATIONAL INDICATORS FOR INTEGRATION OF HEALTH AND SOCIAL CARE

This annex sets out the core suite of indicators currently being developed to support integration. These indicators have been developed where possible from national data sources so that the collection is consistent across areas. Further work will be taken forward with stakeholders before the final set of indicators is confirmed.

(a) Outcome indicators based on survey feedback:

1. Percentage of adults able to look after their health very well or quite well.
2. Percentage of adults supported at home who agree that they are supported to live as independently as possible.
3. Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided.
4. Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated.
5. Percentage of adults receiving any care or support who rate it as excellent or good
6. Percentage of people with positive experience of care at their GP practice.
7. Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life.
8. Percentage of carers who feel supported to continue in their caring role.
9. Percentage of adults supported at home who agree they felt safe.
10. Percentage of staff who say they would recommend their workplace as a good place to work.

(b) Outcome indicators based on administrative data:

11. Premature mortality rate.
12. Rate of emergency admissions for adults.*
13. Rate of emergency bed days for adults.*
14. Readmissions to hospital within 28 days of discharge.*
15. Proportion of last 6 months of life spent at home or in community setting.
16. Falls rate per 1,000 population in over 65s.*
17. Proportion of care services graded ‘good’ (4) or better in Care Inspectorate Inspections.
18. Percentage of adults with intensive needs receiving care at home.
19. Number of days people spend in hospital when they are ready to be discharged.
20. Percentage of total health and care spend on hospital stays where the patient was admitted in an emergency.
21. Percentage of people admitted from home to hospital during the year, who are discharged to a care home.*
22. Percentage of people who are discharged from hospital within 72 hours of being ready.
23. Expenditure on end of life care.

Appendix B National outcomes and key indicators

National Health and Wellbeing Outcome 1	What people can expect
People are able to look after and improve their own health and wellbeing and live in good health for longer.	▪I am supported to look after my own health and wellbeing ▪I am able to live a healthy life for as long as possible ▪I am able to access information

SG Core indicators

1. Percentage of adults able to look after their health very well or

National Health and Wellbeing Outcome 2	What people can expect
People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently at home or in a homely setting in their community.	▪I am able to live as independently as possible for as long as I wish ▪Community based services are available to me ▪I can engage and participate in my community

SG Core indicators

2. Percentage of adults supported at home who agree that they are supported to live as independently as possible
12. Emergency admission rate
14. Percentage of adults with intensive care needs receiving care at home
15. End of Life Care
21. Percentage of people admitted to hospital from home

National Health and Wellbeing Outcome 3	What people can expect
People who use health and social care services have positive experiences of those services, and have their dignity respected.	▪I have my privacy respected ▪I have positive experiences of services ▪I feel that my views are listened to ▪I feel that I am treated as a person by the people doing the work – we develop a relationship that helps us to work well together ▪Services and support are reliable and respond to what I say

SG Core indicators

3. Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated
4. Percentage of adults receiving any care or support who rate it as excellent or good

National Health and Wellbeing Outcome 4	What people can expect
Health and social care services are centered on helping to maintain or improve the quality of life of people who use those services.	▪I'm supported to do the things that matter most to me ▪Services and support help me to reduce the symptoms that I am concerned about ▪I feel that the services I am using are continuously improving ▪The services I use improve my quality of life

SG Core indicators

6. Percentage of adults supported at home who agree that their services and support had an impact in improving or
Maintaining their quality of life
12. Emergency admission rate
19. Delayed discharge bed days

National Health and Wellbeing Outcome 5	What people can expect
Health and social care services contribute to reducing health inequalities. SG Core indicators 11. Premature mortality rate 12. Emergency admission rate	▪My local community gets the support and information it needs to be a safe and healthy place to be ▪Support and services are available to me ▪My individual circumstances are taken into account

National Health and Wellbeing Outcome 6	What people can expect
People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being.	▪I feel I get the support I need to keep on with my caring role for as long as I want to do that ▪I am happy with the quality of my life and the life of the person I care for ▪I can look after my own health and wellbeing

SG Core indicators

7. Percentage of carers who feel supported to continue in their caring role
14. Percentage of adults with intensive

National Health and Wellbeing Outcome 7	What people can expect
People using health and social care services are safe from harm.	▪I feel safe and am protected from abuse and harm ▪Support and services I use protect me from harm ▪My choices are respected in making decisions about keeping me safe from harm

SG Core indicators

8. Percentage of adults supported at home who agree they felt safe
10. Suicide rate
12. Readmission to hospital within 28 days
18. Falls

National Health and Wellbeing Outcome 8	What people can expect
People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.	▪I feel that the outcomes that matter to me are taken account of in my work ▪I feel that I get the support and resources I need to do my job well ▪I feel my views are taken into account in decisions

SG Core indicators

10. Percentage of staff who say they would recommend their workplace as a good place to work

National Health and Wellbeing Outcome 9	What people can expect
Resources are used effectively and efficiently in the provision of health and social care services.	▪I feel resources are used appropriately ▪Services and support are available to me when I need them ▪The right care for me is delivered at the right time

SG Core indicators

12. Readmission to hospital within 28 days
19. Delayed discharge bed days
20. Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency
23. Expenditure on End of Life Care

NHS Tayside

PERTH & KINROSS COUNCIL

PKAVS
Enhancing Lives, Connecting Communities