RAG KEY	
	PROJECT ON TRACK
	PROJECT HAS MISSED SOME TARGETS BUT OVERALL IS NOT AT RISK
	PROJECT IS LIKELY TO DELIVER LATE / OVER BUDGET
	COMPLETE: PROJECT CLOSED

EARLY INTERVENTION: ACTIONS	RAG STATUS	NOTES
Work with Community Planning Partnership and Public Health to adopt and promote healthy lifestyle choices and improve physical wellbeing to delay impact of ageing.	In Progress	Ongoing: a representative from Public Health attends the OPSDG. We are working with PH colleagues to integrate Public Health themes into the Older People's plan. .
Continue to arrange annual Go4Gold Care Home Games Challenge event in Bells Sports Centre whilst also running a separate virtual event for residents unable to attend the live event.	Progressing well	Go4Gold completed successfully in July 2022, and has just been completed successfully in July / August 2023;
Live Active Wellbeing Service to develop an exercise pathway continuum from working one to one with care at home to offering gentle exercise groups, health walks, wellbeing classes, to community strength and balance groups and social outlets.	Progressing well	Work is ongoing with Live Active colleagues to improve on local exercise groups. Please see **Figure 7** (page 7 of the paper) for a breakdown of engagement with LAL exercise groups and sessions. Numbers displayed in green demonstrate significant advances in engagement; those displayed in red illustrate where the Live Active team have had to step away a little to focus on priority areas.
Continue to develop and widen the spread of the Care About Physical Activity (CAPA) model across all care services including hospital inpatient settings, care at home services, Home Assessment Recovery clients, Sheltered Housing, care homes, unpaid carers, and prison	Progressing well	Embedding of Paths for All approach to develop dementia friendly walking initiatives, across P&K. The indoor and outdoor spaces at Blairgowrie Community Hospital has been transformed into more dementia friendly environments. Work has commenced on the Murray Royal site to provide a dementia friendly outside space, with completion expected by the end of the year. Discussions are underway with Paths for All to take forward the same programme of improvements to outside spaces at Crieff and Pitlochry community hospitals; wards at Pitlochry have already been transformed to support increased activity in inpatients living with dementia.
In partnership with Paths for All continue to develop dementia friendly walking initiatives including strength and balance exercises to care homes, HART, care at home, sheltered housing and hospital inpatient services	Progressing well	

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Implement two Care at Home Wellbeing Teams as a test of change, to enable more flexible, person-centred approaches to care to improve working conditions for carers, and to incentivise better outcomes for individuals	Progressing well	Two Living Well teams are now operational (one in North Perthshire and one in South Perthshire) supported by a team coach, learning and development officer and admin support. Both teams are achieving personalised outcomes and are able to provide consistent and flexible care depending on individual need. Recruitment has been, and remains, a challenge given the unique skill mix required of potential team members. Currently, the team are supporting 13 people, and have received some excellent feedback about the service and level of care they provide. A programme of self-evaluation will be completed by the teams by mid-September 2023, and a review of the project will be completed by November 2023. **Service user feedback:** Service User XX (recovering from knee surgery) was struggling with her concentration and focus to do the exercises she was supposed to do every day between the weekly visits from the Wellbeing Coordinator. XX was given a set of activities to do during the week but she rarely completed these, blaming a lack of focus/concentration rather than a willingness to try. After talking to her carer, our Wellbeing Coordinator introduced a set of exercises adapted from a "Scottish Gymnastics" programme aiming at slowing the progression of dementia - a set of simple, but not easy, movements forcing a person to concentrate more fully while performing. After a few sessions with the lady and some guidance for the carer, the lady started enjoying the exercises and cooperated more willingly. The carer reports that the effectiveness of exercises has increased drastically and simple tasks like going for a shower or moving more often from one room to another are done with more ease and less pain. Moreover, the exercises started to be "more fun and less of a chore".

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		Residents still look forward to the weekly activity sessions delivered by Wellbeing Coordinators as a highlight of their week, both from a physical and social point of view.
Recruit to a Volunteer and Community Circles Co-ordinator posts to increase the number of volunteers available and the range of activities that can be undertaken by volunteers	Progressing well	This post has been recruited and is working to improve take up of volunteering options across Perth & Kinross.
Invest in the Volunteer App which is a platform to make volunteering as easy as clicking a button	In progress	Investment in the "Volunteero" app was agreed, to support greater public involvement in community initiatives. The app has been "soft launched" with local volunteers, and work is underway to develop the app to better suit our business needs, including improvements to accessibility. The final version of the app is expected to be operational by 31st December 2023, with an evaluation expected within the same timeframe.
Review and develop third Sector contribution to Older People Services in response to demographic pressures and identified need	In progress	Implementation of a Community Brokerage test of change programme in remote and rural areas to support people to identify and access support in their local area. A new Alzheimer's Brain Health Hub / Day Centre has also been set up in partnership with Alzheimer's Scotland.
Continue to promote and support psychological wellbeing resources for care home staff; implement an Enhanced Care Home Team to support and mentor care homes in sustained improvements in high quality personalised care delivery	Progressing well	Implementation of an enhanced Care Home Support Team to support care homes to identify staff education and support needs and improve the quality of service they are able to deliver. This model is currently being reviewed across Tayside. **Service user feedback:** "The input provided to date from the Enhanced Care Home Team has been very welcomed at Corbenic Camphill Community. Their active approach, with time taken to really get to know the service has been both refreshing and reassuring. The level of interest shown has helped foster a genuine sense of working together to move toward solutions for some of the challenges faced in the service delivery. The visits to Corbenic have helped us communicate and demonstrate the quality and type of service we are striving to achieve in a place

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		that really has to be seen and experienced to fully understand it. The supportive approach and time spent visiting the service by Kerry in particular, has been a significant step in fostering very positive relationships that are proactive rather than reactive, and have been much appreciated." (Corbenic) "The enhanced care home visits were good for the home, they weren't about looking for faults they focused on helping the home well done to all involved." ** Manager LAL – "My mental health is still variable but I know that once I get to the session I will be like my old self again and it helps to release the anxiety and PTSD that I experience". Alzheimer Scotland - "The Link Worker gave us fantastic support in dealing with mums dementia helping us in making decisions and putting things in motion for us , also sending links to information etc , cannot praise her highly enough ! Thank you, X." "As a family we have learnt so much about dementia and how to support Mum and each other. We are very grateful for this service; it has made a massive difference to us. Thank you!" RVS-"Excellent service and it was started so quickly! The referral process was also very good as no forms to fill in. I spoke to Jayne over the phone, who completed the form on my behalf. Jayne kept me up to date with her progress in organising everything and worked with hospital staff to arrange time of pick up".
Promote Age Friendly communities	In progress	A proposal to achieve accreditation with the World Health Organisation's Global Network of Age Friendly Cities and Communities will be taken forward.
Activity Workers to support older people to be active while they are in hospital	Progressing well	Investment was identified to employ activity workers to support older people to remain physically and mentally active while in hospital. Activity workers are now in post and supporting patients

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		with meaningful activities. A formal evaluation is in progress and will be completed later this year.
Identify older people most at risk of fuel poverty and signpost to supports	Progressing well	In collaboration with wider groups of PKC and NHST colleagues, we developed an HSCP operational process for staff to identify older people at risk of fuel poverty on admission to hospital or health & social care caseloads and refer and signpost them to the PKC housing team.
Establish a Foodshare network to coordinate activity to address food poverty	Progressing well	There is a nationally-run FareShare Network which a number of community food redistribution projects are connected with. These include BaRI (Blairgowrie), CAP (Aberfeldy), Dunkeld Church, and Crieff Connexions. Additionally, there are a number of established foodbanks, including the Perth Foodbank, Broke not Broken (Kinross) Blue Door (Auchterarder) and Crieff Foodbank. HSCP staff signpost older people to these services where appropriate through our social prescribers and healthy community staff.

SHIFTING THE BALANCE OF CARE: PHASE 2 ACTIONS	RAG STATUS	NOTES
Building resilience into our Locality Integrated Care Teams to provide an enhanced 7-day service and increased overnight support and harmonise health and social care geographical boundaries to improve integrated working in localities.	In progress	We have built resilience into our Locality Integrated Care teams to provide enhanced services built around GP clusters, harmonise health and social care geographical boundaries and begin to develop integrated care hubs in North Perthshire (Blairgowrie community hospital) and South Perthshire (Crieff community hospital). We have worked hard to coordinate a service across P&K and to align care approaches in a standardised way to ensure the same standard of care across P&K. Further financial investment is required to develop this into a full 7-day service. Feedback from our integrated workshop allowed engagement with teams and gathered themes relating to integrated bases, co-location, shared information systems, key workers, person-centred care, and training and development. Actions identified at the workshop are being taken forward in the Community Focused Integrated Care action plan.

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Continuing to develop integrate ways of working in collaboration with staff across organisational boundaries to incorporate the What Matters To You? approach (in partnership with the Alliance) and align our work with the aims of the Perth & Kinross Offer.	Progressing well	Key themes gathered from staff engagement are: ○ Content of the sessions is excellent – interesting and emotive, and reminded people why they came into the job; ○ Partnership agencies are using WMTY type sessions with their staff in the workplace; ○ Promotes a positive workplace culture, learning, and the need to give praise to colleagues; ○ Being in the same room developed better understanding of what's available in hospital and in the community, resulting in increased joint working; ○ What Matters To the Patient should be incorporated into care plans; ○ Sessions confirmed the importance of continuous improvement and supporting staff in relation to the lived experiences of patients and carers with regard to the care they receive from us; ○ "What a profound effect Tommy Whitelaw's talk had on me. He was so charismatic that you couldn't help being swept up in his message of love and care. Colleagues and I still talk about the day, and the positive message it gave out. We have stuck the wee heart 'you matter' on the duty desk top as a reminder"
Reviewing and improving the co-ordination of health and social care supports out of hours	In progress	We have carried out an initial data review of our out of hours data and are aligning this work to our urgent care pathways and to the wider Tayside out of hours services.
Increasing capacity within Social Work Teams to reduce waiting times for assessment, support Adults with Incapacity/Adult Support and Protection work including large scale investigations and the wider statutory duties undertaken by Mental Health Officers and Social Workers	Progressing well	6 WTE additional posts were created in early 2022; the majority were recruited internally due to challenges in the recruitment process. A significant reduction in the number of people awaiting assessment has been achieved (from 483 in March 2022 to 197 in August 2023) due to an increase in social work capacity, a redesign of Adult Social Work to improve efficiency, data cleansing and staff no longer having to prioritise the Covid-19 response.

SHIFTING THE BALANCE OF CARE: PHASE 2 ACTIONS	RAG STATUS	NOTES
Implementing a Hospital at Home Service to offer acute level care in a person's own home or homely environment	In progress	We have tested and implemented a Hospital at Home service to provide acute level care in a person's own home within Perth City. We have been challenged around medical workforce and recruitment and now have an operating model and are actively supporting patients at home. From 5th August 2023, the team is now operational and actively accepting patients in the community and on discharge from hospital. A full evaluation will be completed in the next six months.
Implementing the recommendations from the review of Care at Home Services to address consistent high levels of unmet need in rural localities by: 1) Developing neighbourhood self-managing Care at Home Wellbeing Teams who take a sequenced approach to care starting with self care and technology, then considers aids and adaptations, thinking about support from family, friends and what is happening in the community, before looking at paid support 2) Promoting a more alliance-based commissioning model for external commissioned Care at Home Services	In progress	Significant work, redesign and review of current services has been completed in relation to Care at Home services so much so that following further examination of the operational model and ongoing recruitment challenges this has now developed into a transformation programme under the direction of the executive management team. We are reviewing the Living Well teams to determine how best to upscale the model across Perth & Kinross. As noted above, a programme of self-evaluation will be completed by the teams by mid-September 2023, and a review of the project will be completed by November 2023. New Care at Home contract due to commence 2024.
Increasing staffing capacity in the Community Alarm service to meet the growing demand and implement end to end digital telecare service.	Progressing well	These services are now in a position where they have adequate resources to deal with increased call volumes and call outs and are able to meet TSA standards for call handling. Services are now able to meet safe staffing levels, improving staff morale and welfare, and are in a position to support and adopt other essential functions such as CCTV management, Telehealth call monitoring and response and investigation and delivery of hosted calls.
Reviewing the 'ACE' clinic in Simpson Day Clinic PRI to provide rapid access to same day medical review and investigations.	In progress	This clinic is being reviewed in conjunction with our review of the Falls pathway.

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Redesigning urgent care to develop a co-located and integrated service with a single point of contact, seven days a week in the in-hour period.	In progress	We have designed an urgent care approach with a new management structure and single point of triage for urgent visits for people who are deteriorating at home. The team, led by the Advanced Nurse Practitioners, triage, and assess and support people onto the relevant pathway. Further work is underway to roll this process out across P&K in the in hours period. We are currently reviewing how we make this a seven day approach.
Build an operational management structure to support the development and delivery of urgent care services in Perth & Kinross	Complete	This is now in place and working well.
Develop a GP resilience team to provide a more proactive approach to supporting GP practices in Perth & Kinross.	Removed	This has been re-allocated to the Primary Care Service delivery plan.

OPTIMISING CAPACITY AND FLOW: PHASE 2 ACTIONS	RAG STATUS	NOTES
Implementing the recommendations from the Discharge without Delay self-assessment ○ Introducing flexible Interim / Short term Assessment Rehabilitation Beds (STAR) in care homes for people requiring intensive rehabilitation / reablement in a homely environment prior to returning home from hospital; ○ Improving the patient journey from admission to hospital to discharge to community by ensuring a whole system approach to discharge planning, embracing a 'Home First' approach.	Progressing well	○ We have implemented the planned date of discharge process across all sites in P&K including PRI, Community Hospitals and POA inpatient areas. We are now connecting this to length of stay to further improve efficiencies and capacity and flow; ○ Introducing Interim/STAR beds in care homes for people a homely environment prior to returning home from hospital; As an HSCP we have agreed move away from this, as the evidence showed this approach was not supporting good outcomes for the people of Perth and Kinross and people want to be cared for in their own homes. The learning from this has supported one of our transformation programmes "Developing a person centred approach to rehabilitation and reablement" and will support Phase 3 of our strategic plan; ○ Improving the patient journey from admission to hospital to discharge to community by ensuring a whole system approach to discharge planning, embracing a 'Home First' approach. We have developed a discharge pathway with 4

OPTIMISING CAPACITY AND FLOW: PHASE 2 ACTIONS	RAG STATUS	NOTES
		agreed pathways adopting the ethos of home first, of early discharge and opening of interim beds in care homes as above. Introduction of the Early Discharge Project as a test of change in January 2023 with a member of the early discharge team embedded in the frailty MDT to respond quickly to referrals for reablement provision and to enable further assessment at home.
Implementing the reviewed Frailty Pathway making connections with Locality Integrated Care Services.	Progressing well	We have implemented the reviewed Frailty Pathway making connections with Locality Integrated Care Services. Acute Services have opened a 14 bed acute frailty unit on the PRI site as part of the development of an integrated frailty model which supports the early identification of the most appropriate treatment pathway for frail elderly people, avoiding hospital admission where possible. We have developed a frailty discharge team to support patients onto the right pathway. Evaluation is underway and nearly complete.
Reviewing the Discharge Hub and Hospital Discharge Team, enhance integration and improve effectiveness and efficiency.	In progress	○ We are reviewing the Hospital Discharge Team, enhancing integration and have improved effectiveness and efficiency by adopting a generic discharge coordinator role which is currently being evaluated. We will seek to adopt this role and support identified social workers to the most complex cases ensuring the right skill set at the right time; ○ Staff from the P&K integrated discharge team have participated in the Tayside Quality Improvement Programme (TQUIP) to improve discharge planning documentation and improve communications for the multi-disciplinary team and produced a poster presentation which will go forward to our Celebrating Event planned for May 2023.