PERTH AND KINROSS INTEGRATION JOINT BOARD

Council Building
2 High Street
Perth
PH1 5PH

13/09/2023

A hybrid meeting of the **Perth and Kinross Integration Joint Board** will be held in **the Council Chamber** on **Wednesday, 20 September 2023** at **13:00**.

If you have any queries please contact Committee Services - Committee@pkc.gov.uk.

Jacquie Pepper
Chief Officer – Health and Social Care Partnership

Please note that the meeting will be streamed live via Microsoft Teams, a link to the Broadcast can be found via the Perth and Kinross Council website. A recording will also be made publicly available on the Integration Joint Board pages of the Perth and Kinross Council website as soon as possible following the meeting.

Voting Members
Councillor Michelle Frampton, Perth and Kinross Council
Councillor David Illingworth, Perth and Kinross Council
Councillor Sheila McCole, Perth and Kinross Council
Councillor Colin Stewart, Perth and Kinross Council (Vice-Chair)
Bob Benson, Tayside NHS Board (Chair)
Martin Black, Tayside NHS Board
Beth Hamilton, Tayside NHS Board
Jacqui Jensen, Tayside NHS Board

Non-Voting Members
Jacquie Pepper, Chief Officer- Health and Social Care Partnership/Chief Social Work Officer, Perth and Kinross Council
Donna Mitchell, Acting Chief Financial Officer, Perth and Kinross Integration Joint Board
Susie Flowers, NHS Tayside
Dr Sally Peterson, NHS Tayside
Dr Lee Robertson, NHS Tayside
Dr Emma Fletcher, NHS Tayside

Stakeholder Members
Sandra Auld, Service User Public Partner
Bernie Campbell, Carer Public Partner
Lyndsay Hunter, Staff Representative, NHS Tayside
Dave Henderson, Scottish Care
Stuart Hope, Staff Representative, Perth and Kinross Council
Ian McCartney, Service User Public Partner
Maureen Summers, Carer Public Partner
Sandy Watts, Third Sector Forum

Perth and Kinross Integration Joint Board

Wednesday, 20 September 2023

AGENDA

1	**WELCOME AND APOLOGIES/SUBSTITUTES**	
2	**DECLARATIONS OF INTEREST** Members are reminded of their obligation to declare any financial or non-financial interest which they may have in any item on this agenda in accordance with the Perth and Kinross Integration Joint Board Code of Conduct.	
3	**MINUTE OF MEETING OF THE PERTH AND KINROSS INTEGRATION JOINT BOARD OF 21 JUNE 2023 FOR APPROVAL** (copy herewith)	**5 - 10**
4	**ACTION POINTS UPDATE** (copy herewith G/23/120)	**11 - 12**
5	**MATTERS ARISING**	
6	**MEMBERSHIP UPDATE** Verbal update by Clerk to the Board	
7	**DELIVERING ON STRATEGIC OBJECTIVES**	
7.1	**CHIEF OFFICER STRATEGIC UPDATE** Verbal update by Chief Officer	
7.2	**TAYSIDE MENTAL HEALTH SERVICES: STRATEGIC UPDATE** Report by Chief Officer (copy herewith G/23/125)	**13 - 20**
7.3	**PROGRESS AGAINST OLDER PEOPLE'S STRATEGIC DELIVERY PLAN** Report by Chief Officer (copy herewith G/23/121)	**21 - 50**
7.4	**ANNUAL UPDATE ON SUBSTANCE USE SERVICES** Report by Chief Officer (copy herewith G/23/122)	**51 - 88**
7.5	**STRATEGIC PLANNING GROUP - UPDATE** Verbal update by Chief Officer	

8 AUDIT AND PERFORMANCE

8.1 AUDIT AND PERFORMANCE COMMITTEE UPDATE
Verbal report by Chair of Audit and Performance Committee

8.2 AUDIT AND PERFORMANCE COMMITTEE ANNUAL REPORT 2022-2023 **89 - 104**
Report by Chief Officer (copy herewith G/23/123)

9 GOVERNANCE

9.1 IJB DIRECTION POLICY
Verbal update by Chief Officer

10 FOR INFORMATION

10.1 ANNUAL PERFORMANCE REPORT 2022/23 **105 - 168**
Report by Chief Officer (copy herewith G/23/124)

10.2 INTEGRATION JOINT BOARD REPORTING FORWARD PLANNER - 2023/24 **169 - 172**
(copy herewith G/23/126)

10.3 FUTURE MEETING DATES 2023/24
(Council Chambers, 1.00pm - 5.00pm)
Friday 27 October 2023
Wednesday 29 November 2023
Wednesday 14 February 2024
Wednesday 27 March 2024

10.4 FUTURE IJB DEVELOPMENT SESSIONS 2023/24
(10.00am - 1.00pm)
Friday 27 October 2023
Friday 26 January 2024
Friday 15 March 2024

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PERTH AND KINROSS INTEGRATION JOINT BOARD

Minute of hybrid meeting of the Perth and Kinross Integration Joint Board (IJB) held in the Council Chambers, 2 High Street, Perth on Wednesday 21 June 2023 at 1.00pm.

Present:

Voting Members:
Mr B Benson, Tayside NHS Board (Chair)
Mr M Black, Tayside NHS Board
Ms B Hamilton, Tayside NHS Board
Ms J Jensen, Tayside NHS Board (from Item 5 onwards)
Councillor C Stewart, Perth and Kinross Council (Vice Chair)
Councillor D Illingworth, Perth and Kinross Council
Councillor S McCole, Perth and Kinross Council
Councillor M Frampton, Perth and Kinross Council

Non-Voting Members
Ms J Pepper, Chief Officer / Director – Integrated Health & Social Care, Chief Social Work Officer, Perth and Kinross Council
Ms D Mitchell, Acting Chief Financial Officer, Perth and Kinross Health and Social Care Partnership
Ms Susannah Flower, NHS Tayside
Dr S Peterson, NHS Tayside

Stakeholder Members
Ms S Auld, Service User Public Partner (from Item 6.4 onwards)
Ms B Campbell, Carer Public Partner
Ms L Hunter, Staff Representative, NHS Tayside
D Henderson (Scottish Care Sector)
Mr S Hope, Staff Representative, Perth and Kinross Council (from Item 5 onwards)
Mr I McCartney, Service User Public Partner
Ms M Summers, Carer Public Partner
Ms S Watts, Third Sector Forum

In Attendance:
A Taylor, K Molley, A Brown and M Pasternak (all Perth and Kinross Council); K Ogilvy, E Devine, Z Robertson, H Dougall, C Jolly, L Milligan, A McManus and P Jerrard (all Perth and Kinross Health and Social Care Partnership).

1. WELCOME AND APOLOGIES

B Benson, Chair, welcomed all those present to the meeting. There were no apologies for absence submitted.

2. DECLARATIONS OF INTEREST

There were no Declarations of Interest made in terms of the Perth and Kinross Integration Joint Board Code of Conduct.

3. MINUTES

3.1 MINUTE OF MEETING OF THE PERTH AND KINROSS INTEGRATION JOINT BOARD OF 29 MARCH 2023

The minute of the meeting of the Perth and Kinross Integration Joint Board of 29 March 2023 was submitted and approved as a correct record.

3.2 MINUTE OF SPECIAL MEETING OF THE PERTH AND KINROSS INTEGRATION JOINT BOARD OF 30 MAY 2023

The minute of the special meeting of the Perth and Kinross Integration Joint Board of 30 May 2023 was submitted and approved as a correct record.

4. ACTIONS POINT UPDATE

The action points update (G/23/81) was submitted and noted.

5. MATTERS ARISING

(i) Invergowrie Medical Practice

The Chief Officer advised that Tayside NHS Board met on 1 June 2023 where they considered a report produced by the Chief Officer of the Angus Integration Joint Board as Lead Partner for Primary Care Services and agreed to support the recommendations contained therein. She also advised that she has been liaising with Gail Smith, the Chief Officer of Angus IJB with regards to carrying out a lessons learned exercise specifically looking at providing some clarity over the role and remit of the Lead Partner for Primary Care Services, and what is and what is not delegated to the IJB's and their role in providing direction to NHS Tayside.

Councillor Stewart referred to logistical and HR issues in providing cover being diverted into discussions on clinical matters and requested whether in any lessons learned exercise carried out this could be included. The Chair and Chief Officer both confirmed that this would happen.

6. DELIVERING ON STRATEGIC OBJECTIVES

6.1 CHIEF OFFICER STRATEGIC UPDATE

The Chief Officer provided a verbal update covering three specific areas, (1) the improved performance in discharge without delay where she also provided

members with a slide-based presentation detailing the improvements; (2) Public Health Scotland's 2022-23 Benchmarking Report on progress with the implementation of Medication Assisted Treatment (MAT) Standards; and (3) the consultation and engagement taking place over the summer in relation to a review of the Strategic Commissioning Plan.

B Hamilton referred to the improvement in delayed discharge and queried whether there was confidence that lessons had been learned and whether these improvements can be sustained going forward as winter pressures arrive. In response, E Devine confirmed the discharge without delay programme monitors all activity and includes a large amount of work focussing on improvement, process work and pathway work which should provide a good foundation for maintaining the improvements already being seen.

Resolved:
The Board noted the position.

6.2 TAYSIDE MENTAL HEALTH SERVICES: MENTAL HEALTH AND LEARNING DISABILITY WHOLE SYSTEM CHANGE PROGRAMME

There was submitted a report by the Chief Officer (G/23/65) providing the Board with the completed Whole System Mental Health and Learning Disabilities Change Programme for approval.

Councillor Stewart raised concerns at the number of action points which were due to be completed by the end of June and queried what progress had been made with these. He also referred to the redesign of learning disability in terms of the physical environment at Strathmartine and queried how progress against these actions would be monitored as a Board or as part of all three IJB Boards. In response, J Pepper confirmed the programme team who were supporting this were currently preparing a very detailed and complex Gantt chart which will set out the whole schedule and timeline over several years. She also confirmed that progress would be reported to the Programme Board which has a wide range of stakeholders involved then on to the Executive Leadership Group and then directly on to the IJBs. She also confirmed that all three IJBs were keen to have mental health services and progress updates as standing items across all three IJBs.

Councillor McCole referred to Priority 7 of the Change Programme on engagement with patients, families, partners and communities specifically around the timeline and queried whether after 31 August 2024 where we move to business as usual that this will mean an ongoing process of engagement going forward. In response, J Pepper confirmed that once this workstream was completed then this would become the standard way of working which will mean a continuation of the engagement and the skills around engagement are continued going forward.

I McCartney referred to the issue around capital resources in terms of improving services and queried whether as part of the review that was currently underway whether it would be possible to look at the capital assets we currently have. In response, J Pepper confirmed that this was an important point and that

across Tayside there were a number of assets, and this was something that would be getting looked into.

Resolved:

(i) The Mental Health and Learning Disability Whole System Change Programme as detailed in Appendix 1 to Report G/23/65, be approved.
(ii) The emerging partnership with the V&A in Dundee, be noted.
(iii) The additional investment required to deliver the programme, be noted.

6.3 STRATEGIC PLANNING GROUP

The Strategic Planning Group Minutes – 25 April 2023 (G/23/82) were submitted for Board Members' information.

Resolved:

The contents of Report G/23/82, be noted.

THERE WAS A SHORT 10 MINUTE RECESS AND THE MEETING RECONVENED AT 2.24PM.

Members heard a slide-based presentation delivered by Hamish Dougall, Associate Medical Director which covered both Items 6.4 – Primary Care Strategic Delivery Plan and 6.5 – Primary Care Premises Strategy. Following the presentation, the Chair opened it up for questions covering both items 6.4 and 6.5.

Councillor McCole commented that there was a lot of information contained within the Presentation and suggested that this may be a good topic for a future development session. She also referred to Public Health Scotland and queried what part of the process, if any, involves them. In response, H Dougall confirmed that currently Public Health Scotland have not been directly involved in this process, but this was something he was very keen to do, and he had been trying to engage directly with public health colleagues in terms of how we can be more pro-active and was hopeful this was something that would be included in any future work.

B Hamilton referred to Primary Care Strategy across Tayside and queried whether H Dougall still felt as involved and as able to influence what was going on across the area rather than just Perth and Kinross. In response, H Dougall confirmed that he was working closely with colleagues in Angus and in primary care services.

Councillor Illingworth queried what the process was for a GP Practice to decide to close its list. In response, H Dougall confirmed that in terms of a temporary closure of a list this can't be done unilaterally, and they would have to ask for permission to do so.

J Jensen referred to the IT Strategy, specifically 'Near Me' and queried whether this had now been rolled out to all GP Practices and if so, sought some details on the uptake by GPs. In response, H Dougall confirmed that there was

some very specific data held on this but confirmed unfortunately it was not being well utilised in primary care in Tayside.

Councillor Frampton referred to Priority 5 within the Premises Strategy, specifically with regards to the Methven Branch Surgery and expressed her concern that there may be a reduction in the GP Sessions of availability at the Practice. She further stated that she receives many complaints from constituents where they are still unable to see a GP and gave her opinion that to reduce the available GP hours would have a more negative impact on those people in Methven and the surrounding area who are registered at the Practice.

6.4 PRIMARY CARE STRATEGIC DELIVERY PLAN

There was submitted a report by the Chief Officer (G/23/58) presenting the updated Primary Care Strategic Delivery Plan (SDP) for the period 2023-26 to the Board for approval.

Resolved:

(i) The updated Primary Care Strategic Delivery Plan as set out in Appendix 1 to Report G/23/58, be approved.

(ii) It be noted that consultation and engagement with key stakeholders inclusive of the Chief Officer of Angus Integration Joint Board as Lead Partner for Strategic Coordination of Primary Care Services had taken place prior to submission of the updated Strategic Delivery Plan.

(iii) The Chief Officer be instructed to bring back progress reports to the Board on an annual basis.

(iv) Directions as set out in Section 6 and Appendix 3 of Report G/23/58, be issued.

6.5 PRIMARY CARE PREMISES STRATEGY

There was submitted a report by the Chief Officer (G/23/59) presenting the Primary Care Premises Strategy for the period 2023-28 to the Board for approval.

Resolved:

(i) The Primary Care Premises Strategy as set out in Appendix 1 to Report G/23/59, be approved.

(ii) It be noted that consultation and engagement with key stakeholders inclusive of the Chief Officer of Angus Integration Joint Board as Lead Partner for Strategic Coordination of Primary Care Services had taken place prior to submission of the updated Strategic Delivery Plan.

(iii) The Chief Officer be instructed to bring back progress reports to the Board on an annual basis.

(iv) Directions as set out in Section 6 and Appendix 3 of Report G/23/59, be issued.

6.6 JOINT CARERS' STRATEGY 2023-2026

There was submitted a report by the Chief Officer (G/23/84) presenting the revised Joint Carers' Strategy 2023-26 for Young and Adult Carers.

B Benson referred to the Palliative Care offer detailed in the report and expressed his delight to see this. He also queried whether there is the same priority for complex care cases or whether there was a different funding model for these situations. In response, K Ogilvy confirmed that anyone caring for someone with complex needs such as a learning disability and/or autism, then there was a dedicated carer within the Multi-Disciplinary Scope Team to support these people. He also confirmed that there was dedicated ring-fenced resources for that client group.

Resolved:

(i) The revised Joint Carers' Strategy as detailed in Appendix 2 to Report G/23/84, be approved.

(ii) The Chief Officer be instructed to bring back an update in twelve months on the implementation of the strategy.

(iii) Directions as set out in Appendix 5 of Report G/23/84, be issued.

7. FOR INFORMATION

7.1 INTEGRATION JOINT BOARD REPORTING FORWARD PLANNER 2023/24

Resolved:

The contents of Report G/23/83, be noted.

8. FUTURE IJB MEETING DATES 2023/24

Wednesday 20 September 2023 at 1.00pm
Wednesday 29 November 2023 at 1.00pm
Wednesday 14 February 2024 at 1.00pm
Wednesday 27 March 2024 at 1.00pm

Future IJB Development Sessions 2023/24

Venue – Council Chambers (hybrid) unless otherwise stated.

Friday 11 August 2023 at 10.00am
Friday 27 October 2023 at 10.00am
Friday 26 January 2024 at 10.00am
Friday 15 March 2024 at 10.00am

ACTION POINTS UPDATE

Perth & Kinross Integration Joint Board
20 September 2023
(Report No. G/23/120)

Ref.	Meeting	Minute Ref	Heading	Action Point	Responsibility	Timescale	Status
142	20 Jun 2023	6.4	Primary Care Strategic Delivery Plan	IJB Development Session on Primary Care Strategies to be considered.	Chief Officer	29 Nov 2023	Ongoing

PERTH & KINROSS INTEGRATION JOINT BOARD

20 September 2023

TAYSIDE MENTAL HEALTH SERVICES: STRATEGIC UPDATE

Report by Chief Officer
(Report No. G/23/125)

PURPOSE OF REPORT

This report provides the IJB with an update from the Chief Officer as Lead Partner for the coordination and strategic planning of inpatient mental health and Learning Disability and in relation to the *Whole System Mental Health and Learning Disabilities Change Programme* approved in June 2023.

1. RECOMMENDATION(S)

It is recommended that the Integration Joint Board (IJB):

- Notes the updated position and the high-level progress update; and
- Notes the upcoming joint development session for Perth and Kinross Integration Joint Board Members along with members of NHS Tayside Board, Angus, and Dundee Integration Joint Boards.

2. SITUATION/BACKGROUND / MAIN ISSUES

2.1 The *Whole System Mental Health and Learning Disabilities Change Programme* was approved by the three Tayside Integration Joint Boards and NHS Tayside Board at the end of June 2023. This report provides an update to the IJB since the end of June 2023 on recent activity.

2.2 The Whole System Mental Health and Learning Disabilities Change Programme plan is set in the context of a revised governance structure and refines the priorities set out in the Living Life Well Strategy.

2.3 The Executive Leadership Group and the Programme Board have continued to meet over the summer period. This is providing leadership and challenge to deliver on the strategic direction for a whole system model of care and promoting an energized culture focused on transformation and whole-system

collaborative working. It is also providing formal engagement of a wide range of stakeholders including people with lived experience as members of the Board and within the workstreams.

2.4 The Executive Leadership group met on 17 July, 16 August and 13 September 2023 and has agreed to meet regularly to ensure sufficient pace is achieved in the early stages of the programme.

2.5 The Minister for Social Care, Wellbeing and Sport, Ms Maree Todd met with members of the Tayside Executive Partners on 24 July 2023. The meeting was positive, and the Minister acknowledged the pressure that has been placed on Tayside as a result of continued scrutiny, emphasising the system should be self-scrutinising and focused on continual improvement. She ended the meeting with an offer of support and this offer has since been taken up via meetings with the Scottish Government Mental Health Division and there are ongoing discussions about the extent to which they can advise and support the delivery of new models of care.

2.6 The Programme Board met on 19 July 2023 and received comprehensive updates and presentations on two of the key areas of redesign: Adult Inpatient Redesign and Specialist Community Mental Health Services Redesign. The interdependencies across these two workstreams were highlighted along with the redesign of Urgent and Crisis Care. A number of executive sponsors and workstream leads have gone on to engage in positive discussions with Scottish Government and national professional advisers to draw down support and expertise for our direction of travel. As a result, it is proposed that the first Design Thinking workshop, to be held in October and facilitated by experts through the V&A Museum in Dundee, will bring together three interdependent workstreams (Priority 1, 11 and 12: Adult Inpatient Redesign, Crisis and Urgent Care and Specialist Community Mental Health Services Redesign) and focus on developing a new model of care across the continuum of need using design methodology. It is recognised that there needs to be a clear, concrete, and compelling vision for a new model of care which will provide a consistent focus and move services forward. The outputs will visualise a whole system model of care for people who experience mental ill-health.

3. PROPOSALS

3.1 As reported to the IJB Audit and Performance Committee, work has advanced in developing a strategic risk profile for the Mental Health and Learning Disability Whole System Change Programme. As the Lead Partner, the Perth & Kinross Chief Officer will become the risk owner with risk actions being managed across members of the Executive Leadership Group. The strategic risk related to the delivery of the strategy will be replicated in the risk registers for all partners, including the Perth and Kinross IJB as this is a whole system programme of change requiring collective leadership, ownership and management of risk and mitigations. An initial workshop has identified the key risks across the Programme with controls, mitigating actions, improvement actions, risk scores and level of appetite drafted for consideration of the Programme Board at its next meeting on 26 September 2023.

3.2 The Mental Health and Learning Disability Whole System Change Programme Board will receive detailed progress reports across the whole programme at its next meeting on 26 September 2023. Highlight reports were considered by the Executive Leadership Group on 13 September 2023 noting the following:

Tayside Mental Health and Learning Disability Whole System Change Programme		
Priority	**Description**	**Update**
Priority 1 Adult Inpatient Redesign	Redesign	Phase 1 in progress and reported to Programme Board with recommendations. Presentation Planned to Joint Board Workshop 31 October 2023. Phase 2 commenced.
Priority 2 Strathmartine Physical Environment	Improvement	Analysis of current environment completed & programme of environmental improvements commenced. Re-evaluation involving views of residents/patients underway.
Priority 3 Addressing Significant Delayed discharges	Improvement	On track but may require revision of some later milestones.
Priority 9 Integrated Substance Use and Mental Health	Redesign	On track
Priority 10 Whole System Redesign of Learning Disabilities Services	Redesign	Requires revision of milestones
Priority 11 Crisis and Urgent Care	Redesign	Requires revision of milestones
Priority 12 Specialist Community Mental Health Services	Redesign	On track

3.3 The development of a financial recovery plan for Inpatient Mental Health Services and a strategic finance and resource framework has been slowed down due to staff absence, however focused activity is taking place in week beginning 28 August 2023 in recognition of the end of September deadline. The three IJB Chief Finance Officers and the Director of Finance for NHS Tayside will be represented at the Design Thinking workshop and have agreed to work collaboratively on a financial framework which will deliver on the new model of care across the continuum of need.

3.4 The Scottish Government published a new National Mental Health and Wellbeing Strategy and a mapping exercise across our programme is underway. The strong focus on prevention and person-centred, non-stigmatised services in the community in the new national strategy aligns well with the direction of travel across the Programme.

3.5 A workshop is planned for members of NHS Tayside Board and the three Integration Joint Boards on 31 October 2023 providing an opportunity to consider whole-system wide data and to hear progress in relation to key areas of redesign (Inpatient and Specialist Community). The workshop will also provide an opportunity for members to comment on the proposed method for

reporting progress on the programme to all Boards from October onwards ensuring that our public reporting on progress is concurrent and sufficient.

4. CONCLUSION

This report provides the Integration Joint Board with a brief update on the work associated with the Mental Health and Learning Disability Whole System Change Programme. A more detailed progress report will be presented to the Programme Board on 26 September 2023. A detailed programme for a joint workshop on 31 October is under development to which all members of the three Integration Joint Boards and NHS Tayside will be invited, and the agenda will include consideration of a shared approach to monitoring and reporting on progress to ensure concurrency and the level of detail required.

Author(s)

Name	Designation	Contact Details
Jacquie Pepper	Chief Officer, Perth and Kinross Health and Social Care Partnership and Lead Partner for coordinating strategic planning for inpatient mental health and learning disability services.	tay.pkijbbusinesssupport@nhs.scot

NOTE: No background papers, as defined by Section 50D of the Local Government (Scotland) Act 1973 (other than any containing confidential or exempt information), were relied on to any material extent in preparing this report.

ANNEX

1. IMPLICATIONS, ASSESSMENTS, CONSULTATION AND COMMUNICATION

Strategic Implications	**Yes / None**
HSCP Strategic Commissioning Plan	None
Transformation Programme	None
Resource Implications	
Financial	Yes
Workforce	Yes
Assessments	
Equality Impact Assessment	Yes
Risk	Yes
Other assessments (enter here from para 3.3)	None
Consultation	
External	Yes
Internal	Yes
Legal & Governance	
Legal	None
Clinical/Care/Professional Governance	None
Corporate Governance	None
Directions	None
Communication	
Communications Plan	Yes

1. Strategic Implications

1.1 Strategic Commissioning Plan

n/a

1.2 Transformation

n/a

2. Resource Implications

2.1 Financial

The Mental Health and Learning Disability Whole System Change Programme will require financial investment in order to the necessary additional capacity and support to deliver on the ambitious plans for service redesign and transformational change. An initial assessment of the additional resourcing requirements has been carried out and this will be addressed in the development of a whole-system financial framework.

2.2 Workforce

The Mental Health and Learning Disability Whole System Change Programme includes provision for staff engagement throughout the workstreams and there

are arrangements in place to ensure robust staff-side representation and to meet the NHS Staff Governance Standards.

3. Assessments

3.1 Equality Impact Assessment

Assessed as **relevant** for the purposes of EqIA at this stage. The EqIA for the commencement of the programme is reproduced at Appendix 2 and will be further supplemented by individual assessments for each of the workstreams.

The programme seeks to improve outcomes and experiences for anyone in Tayside who either has or is connected to someone with a mental health or learning disability need. It seeks to do so regardless of protected characteristics, so it is not anticipated that people with protected characteristics will be specifically affected in a different way to those without. Each work stream of the programme will conduct its own EQIA to ensure that, where necessary, steps/activity are included to ensure those with protected characteristics and those with circumstances that are known to affect people more (Health inequalities) receive equitable service.

3.2 Risk

The strategic risks associated with the delivery of the Mental Health and Learning Disability Whole System Change Programme will be identified and managed within the programme and reported to the Executive Leadership Group and Programme Board.

4. Consultation – Patient/Service User first priority

4.1 External

A wide range of stakeholders are involved within the programme and consulted in its development.

4.2 Internal

The Executive Leadership Group has been consulted in the preparation of this report.

4.3 Impact of Recommendation

N/A

5. Legal and Governance

5.1 N/A

6. Directions

N/A at this stage.

7. Communication

7.1 NHS Tayside Communications team are supporting a communications plan associated with the programme.

2. BACKGROUND PAPERS/REFERENCES

3. APPENDICES

None

PERTH & KINROSS INTEGRATION JOINT BOARD

20 SEPTEMBER 2023

PROGRESS AGAINST OLDER PEOPLE'S STRATEGIC DELIVERY PLAN

Report By Chief Officer
(Report No. G/23/121)

PURPOSE OF REPORT

The purpose of this report is to provide the IJB with an update on progress of the Older People's Strategic Delivery Plan for the period 2022-2025.

1. RECOMMENDATION(S)

It is recommended that the Integration Joint Board:

- Notes progress to date against the programme of work outlined and funded under the Older People's Strategic Delivery Plan 2022-2025;
- Requests a further progress update in twelve months' time; and
- Endorses the intention to evaluate the impact of the IJB investment in the Older People's Strategic Delivery Plan and for the outcomes to be fed into the budget setting processes for 2024-2027.

2. SITUATION/BACKGROUND/MAIN ISSUES

The three-year Older People's Strategic Delivery Plan for 2022-2025 was agreed by the IJB in March 2022, with a significant investment within year 1 to support the achievement of the objectives. This report provides the first update on progress against the plan .

Considerable progress has been made towards achieving the key strategic ambition of whole system integration. This is against a backdrop of continued Covid-19 recovery, a rising demographic and complexity of presenting conditions of people aged 75 or older and staff recruitment and retention challenges.

Wider context

The heatmap in Figure 1 illustrates how the Perth and Kinross population has changed in structure over the last 40 years. Since 1981, the proportion of the population aged ≥ 75 years old has more than doubled, the proportion aged ≥ 85 years old has trebled, and the proportion aged ≥ 90 years old has nearly quadrupled. Currently, 24% (nearly a quarter) of the local population is over 65 years of age[1].

	Age groups																		
Year	0-4	5-9	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80-84	85-89	90+
1981	6,632	7,466	9,592	10,288	8,602	7,321	8,342	7,259	6,668	6,849	7,128	7,403	6,618	7,047	6,139	4,383	2,527	1,116	479
	6,838	7,053	9,596	9,737	9,121	7,570	7,833	7,878	6,818	6,821	7,120	7,315	6,884	6,815	6,139	4,472	2,567	1,126	507
	7,020	6,849	9,359	9,507	9,343	7,797	7,716	8,277	7,015	6,866	7,005	7,264	7,253	6,439	6,141	4,554	2,644	1,191	510
	7,028	6,827	9,104	9,545	9,173	7,994	7,708	8,557	7,040	7,002	6,956	7,181	7,626	6,124	6,084	4,713	2,666	1,226	496
	7,090	6,919	8,803	9,424	9,101	8,249	7,799	8,737	7,228	7,013	6,997	7,207	7,483	6,228	6,087	4,778	2,756	1,274	497
1986	7,036	7,095	8,366	9,596	8,663	8,500	7,877	8,768	7,650	6,989	6,929	7,216	7,397	6,298	6,150	4,722	2,880	1,333	495
	7,003	7,297	7,927	9,548	8,283	8,808	8,023	8,264	8,244	7,131	6,955	7,179	7,358	6,580	6,005	4,812	2,994	1,380	519
	7,101	7,499	7,735	9,287	8,144	8,775	8,129	8,227	8,668	7,340	7,010	7,115	7,301	6,961	5,689	4,873	3,102	1,445	589
	7,079	7,536	7,749	9,029	8,003	8,652	8,166	8,205	9,025	7,441	7,148	7,141	7,266	7,323	5,438	4,821	3,251	1,491	646
	7,131	7,646	7,943	8,662	7,859	8,801	8,377	8,305	9,318	7,636	7,225	7,264	7,323	7,202	5,517	4,822	3,305	1,540	654
1991	7,304	7,619	8,109	8,282	7,914	8,685	8,524	8,452	9,402	8,121	7,179	7,177	7,385	7,177	5,616	4,864	3,292	1,619	649
	7,573	7,613	8,371	7,822	8,145	8,759	8,926	8,680	8,976	8,854	7,422	7,248	7,332	7,144	5,933	4,763	3,343	1,689	707
	7,690	7,766	8,484	7,592	8,111	8,859	9,137	8,824	8,922	9,294	7,709	7,279	7,266	7,054	6,236	4,512	3,353	1,729	753
	7,730	7,807	8,605	7,672	8,128	8,949	9,491	9,043	8,914	9,647	7,841	7,381	7,276	6,984	6,500	4,360	3,329	1,821	752
	7,787	7,816	8,610	7,730	7,826	8,840	9,797	9,226	8,966	9,926	8,033	7,427	7,297	7,071	6,335	4,482	3,379	1,888	784
1996	7,543	7,973	8,485	7,717	7,195	8,728	9,812	9,459	9,062	9,933	8,472	7,396	7,258	7,088	6,331	4,533	3,445	1,903	797
	7,460	8,076	8,558	7,961	6,702	8,624	9,765	9,714	9,266	9,459	9,141	7,623	7,322	7,046	6,368	4,777	3,347	1,936	835
	7,364	8,146	8,673	8,032	6,400	8,251	9,761	9,879	9,405	9,359	9,568	7,940	7,369	6,990	6,343	5,044	3,200	1,947	909
	7,255	8,220	8,614	8,177	6,237	7,943	9,632	10,114	9,616	9,366	9,887	8,047	7,544	6,999	6,322	5,301	3,028	1,964	934
	7,120	8,223	8,592	8,032	6,141	7,380	9,295	10,443	9,669	9,379	10,103	8,232	7,537	7,058	6,386	5,234	3,153	2,007	986
2001	7,178	7,941	8,653	7,929	6,050	6,849	9,007	10,470	9,932	9,457	10,161	8,686	7,543	7,039	6,444	5,252	3,295	2,040	1,024
	6,992	7,940	8,451	7,765	6,138	6,431	8,818	10,476	10,178	9,647	9,729	9,374	7,772	7,106	6,418	5,304	3,574	1,984	1,033
	6,907	7,935	8,402	7,689	6,210	6,211	8,539	10,517	10,427	9,743	9,686	9,869	8,065	7,229	6,458	5,327	3,767	1,939	1,040
	6,919	7,888	8,534	7,304	6,315	6,213	8,268	10,438	10,671	9,958	9,737	10,207	8,181	7,491	6,481	5,333	4,049	1,846	1,067
	6,904	7,892	8,710	7,098	6,671	6,360	7,946	10,070	11,105	10,013	9,745	10,438	8,426	7,571	6,623	5,435	3,970	1,987	1,096
2006	6,810	7,975	8,616	7,303	6,941	6,654	7,527	9,929	11,238	10,264	9,811	10,561	8,835	7,567	6,629	5,500	3,987	2,141	1,092
	6,909	7,794	8,748	7,554	7,232	7,068	7,220	9,720	11,298	10,532	10,011	10,117	9,537	7,788	6,705	5,541	4,032	2,303	1,031
	7,014	7,602	8,808	7,858	7,505	7,562	7,070	9,411	11,322	10,862	10,138	10,016	9,990	8,035	6,853	5,612	4,027	2,412	1,033
	7,143	7,491	8,655	8,215	7,552	7,890	7,066	9,054	11,178	11,122	10,301	9,941	10,308	8,073	7,058	5,639	4,106	2,557	1,021
	7,244	7,422	8,683	8,633	7,391	8,000	7,319	8,661	10,850	11,539	10,341	9,933	10,512	8,224	7,141	5,801	4,228	2,538	1,140
2011	7,377	7,226	8,667	8,744	7,487	8,103	7,581	8,289	10,659	11,724	10,574	9,982	10,597	8,584	7,184	5,864	4,369	2,589	1,250
	7,367	7,296	8,427	8,861	7,734	8,079	7,875	7,884	10,426	11,792	10,799	10,169	10,049	9,328	7,250	5,950	4,435	2,688	1,331
	7,239	7,400	8,112	8,767	7,804	8,046	8,086	7,664	9,982	11,689	11,031	10,210	10,006	9,660	7,498	6,038	4,456	2,682	1,400
	7,158	7,587	7,984	8,668	8,197	7,932	8,357	7,670	9,591	11,548	11,333	10,418	9,971	9,975	7,537	6,224	4,544	2,738	1,498
	7,272	7,665	7,913	8,577	8,409	7,766	8,596	7,830	9,149	11,192	11,796	10,504	10,005	10,266	7,659	6,317	4,660	2,825	1,529
2016	7,181	7,899	7,708	8,450	8,284	7,931	8,571	8,191	8,785	10,947	11,972	10,769	10,076	10,338	8,038	6,299	4,710	2,928	1,603
	7,064	7,976	7,832	8,223	8,029	8,101	8,503	8,478	8,372	10,753	12,059	10,954	10,241	9,901	8,691	6,453	4,752	3,012	1,706
	6,897	7,956	7,954	8,043	7,710	8,235	8,534	8,677	8,185	10,320	12,014	11,289	10,277	9,914	9,023	6,638	4,845	3,054	1,725
	6,799	7,841	8,152	7,941	7,432	8,473	8,400	8,986	8,214	9,999	11,797	11,540	10,542	9,875	9,300	6,697	5,048	3,112	1,802
	6,551	7,869	8,124	7,870	7,474	8,479	8,174	9,103	8,445	9,466	11,439	11,986	10,613	9,859	9,610	6,742	5,124	3,167	1,815
2021	6,439	7,818	8,419	7,815	7,565	8,396	8,511	9,219	8,824	9,260	11,283	12,324	10,939	9,984	9,721	7,088	5,103	3,218	1,884

Figure 1 Demographic heatmap illustrating population structural change for Perth and Kinross since 1981 (source: NRS mid-year population estimates).

Overall since the early 1980s, the proportion of the local population aged ≥ 75 years has grown at a rate over three times that for the population as a whole, reflecting a trend seen across Scotland[2]. The scale of this demographic change has clear implications for increasing demand for health and social care services for older people.

One measure of the extent to which the working age population supports those in retirement is the “old age dependency ratio”, the number of people aged ≥65 years per working age person. Using this measure, Perth and Kinross is in the top Scottish quartile for old age dependency, with a rate of increase that has outstripped Scotland as a whole, particularly since 2010[3]. The current old age dependency ratio for Perth & Kinross is 400; meaning there are around 400 people aged ≥ 65 years of age per 1,000 people of working age. As this proportion of the population continues to age, this ratio is likely to increase meaning that a smaller pool of working age people will be available to recruit into health and social care services to look after the older age groups in the population.

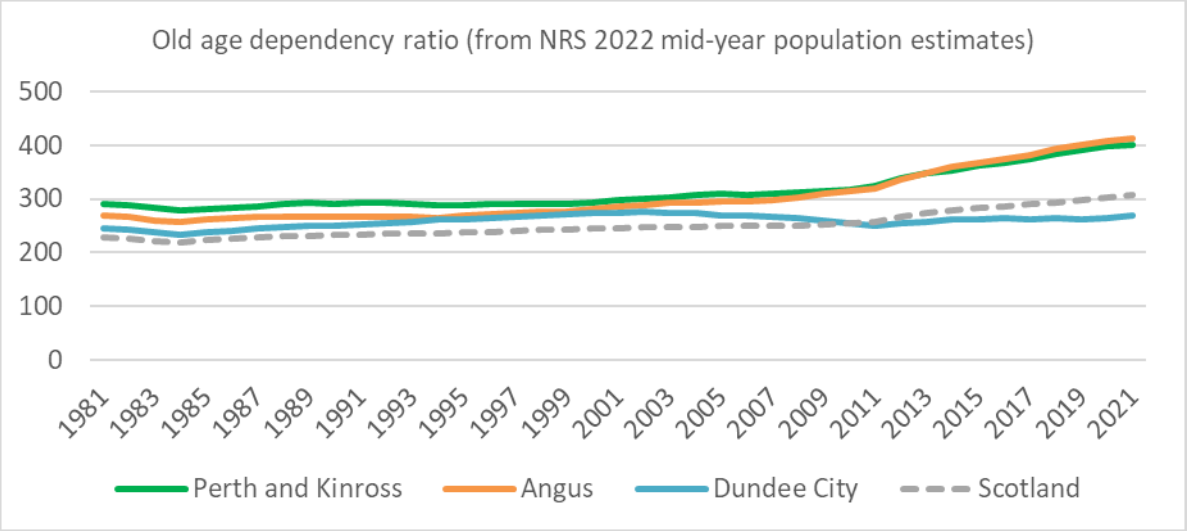

Figure 2: comparison of the old age dependency ratio for Perth & Kinross against other Tayside HSCPs and Scotland as a whole

Despite the effects of the Covid-19 pandemic, work to support older people to be able to remain mentally and physical active, and to continue to live independently for as long as possible means that the older people who require health and social care support tend to be frailer and have a more complex medical history. As people age, they are more likely to be living with more than one long term health condition[4] which in turn makes it more likely that they will need to seek help from our services.

Figure 3 (below) illustrates the prevalence of a number of long-term conditions within Perth City, North Perthshire and South Perthshire that accumulate within the population as comorbidities associated with age.

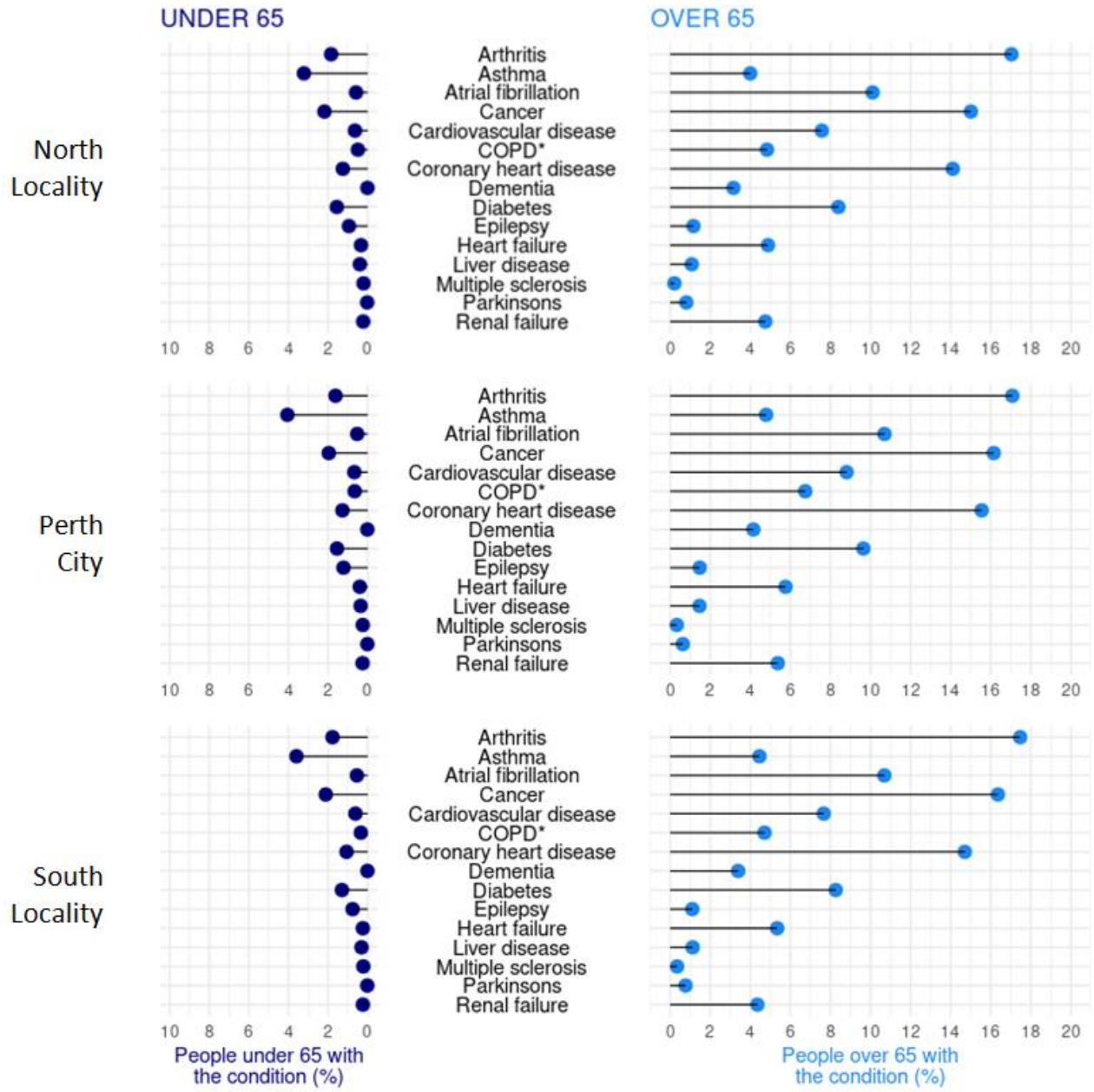

Figure 3: Estimated prevalence of long-term conditions in Perth City, North Perthshire, and South Perthshire (source: Public Health Scotland Locality Profiles 2020/21)

Overall, 21% of people in Perth & Kinross were living with a long-term condition, compared to 19% in Scotland as a whole in 2019/20 (the most recent data available from Public Health Scotland).

In summary, progress against the Older People's Strategic Delivery Plan has taken place against a backdrop of Covid-19 and a population cohort accessing our services which is increasingly older and frailer.

Performance in the wider context:

Despite extreme challenges associated with demographic change, the effects of the pandemic and workforce pressures, key indicator data supports notable performance improvements. This is particularly the case in recent months.

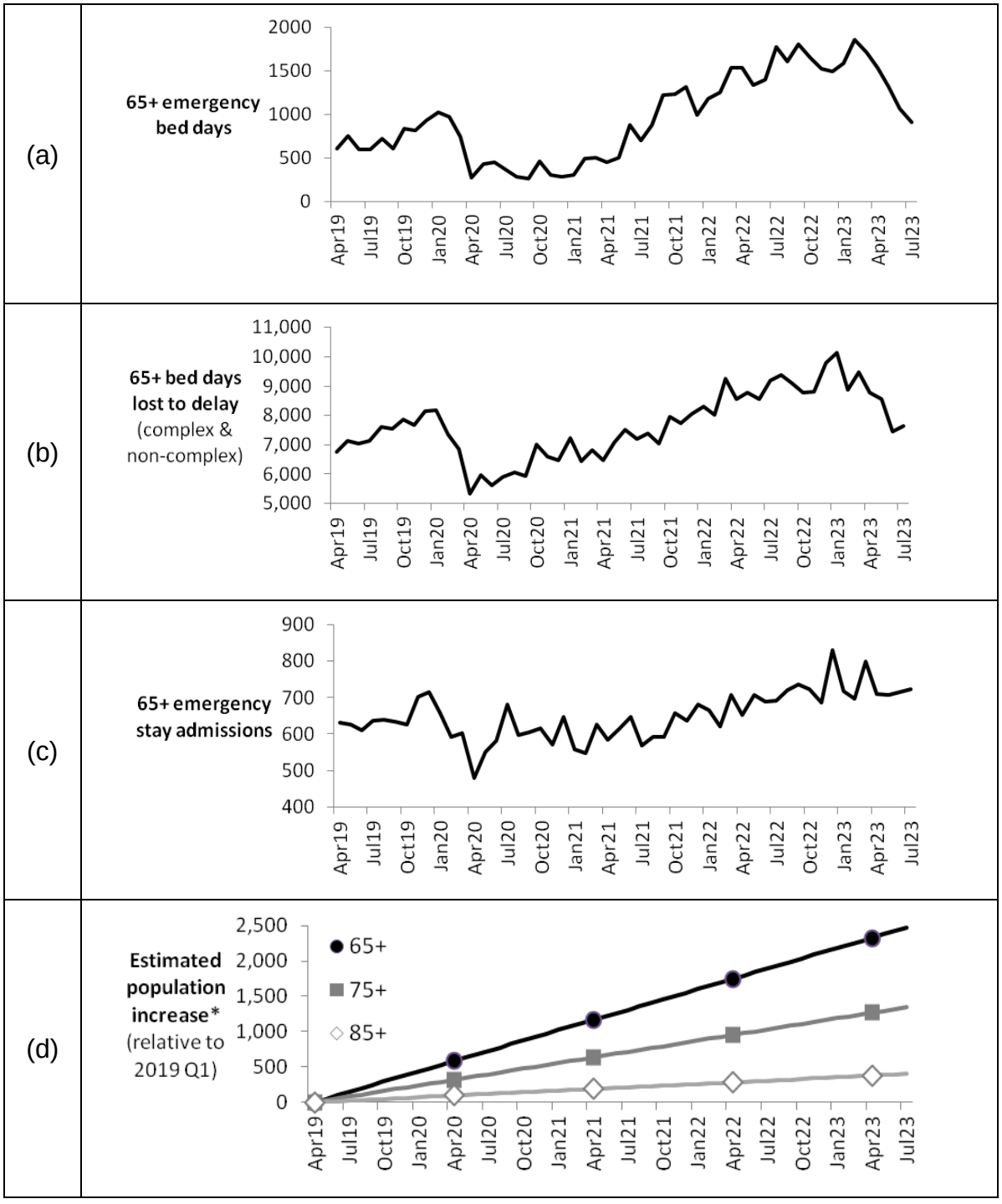

Figure 5 Key 65+ indicators for Perth and Kinross[5]: Demonstrating that as the population continues to age (d), demand for our services is also increasing, although emergency bed days and bed days lost to delay are starting to reduce from their respective peaks in January 2023.

The charts in Figure illustrate that, while there has been an increase in in ≥65-year-old emergency admissions, the associated bed days have seen a rapid reduction, supported also by improved delayed discharge performance. This illustrates the positive impact of the Strategic Delivery Plan to improve capacity and flow through secondary care and shift the balance of care back into the community.

Comparing our local performance to Scotland shows we are demonstrating strong performance despite our particular local challenges. (Figure 6 & 7, below).

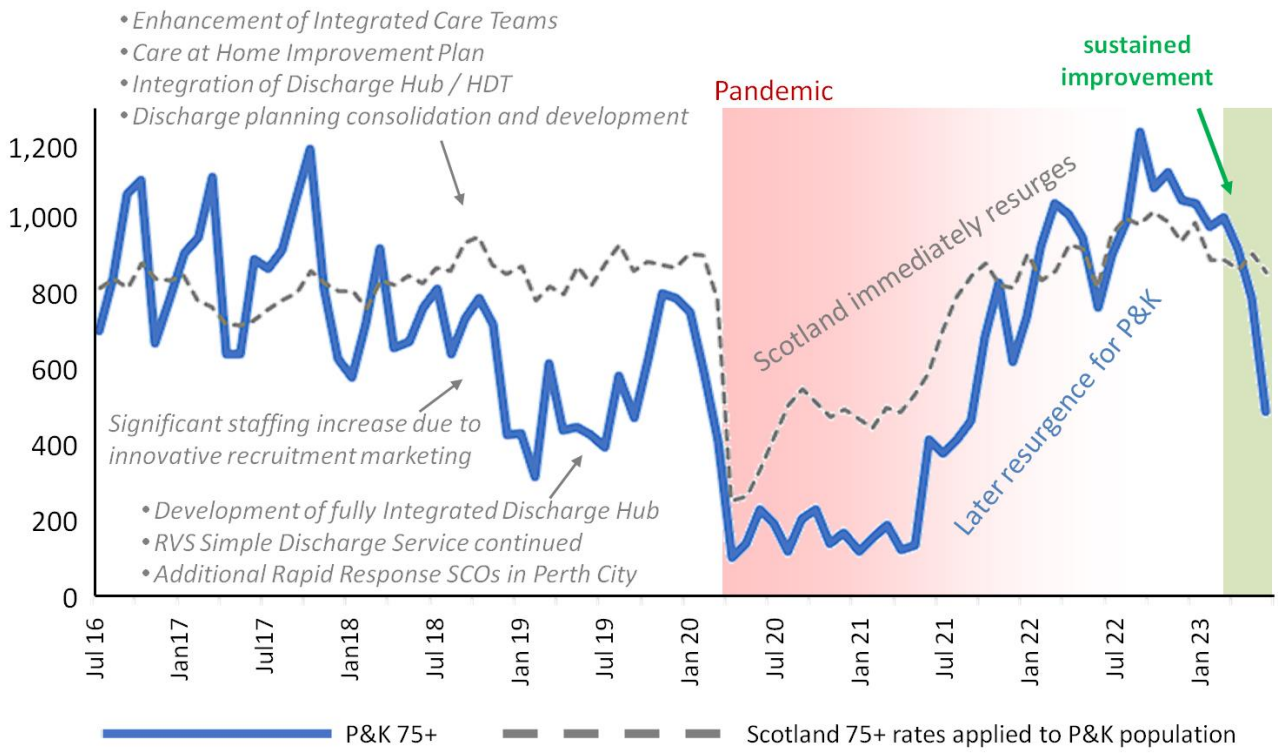

Figure 6: 75+ bed days lost to delayed discharges: Perth and Kinross and Scottish performance comparison: the number of bed days lost to delays in discharge have declined sharply in P&K from a peak in October 2022 compared to the national picture, where delays have been more sustained for longer and are reducing more slowly[67].

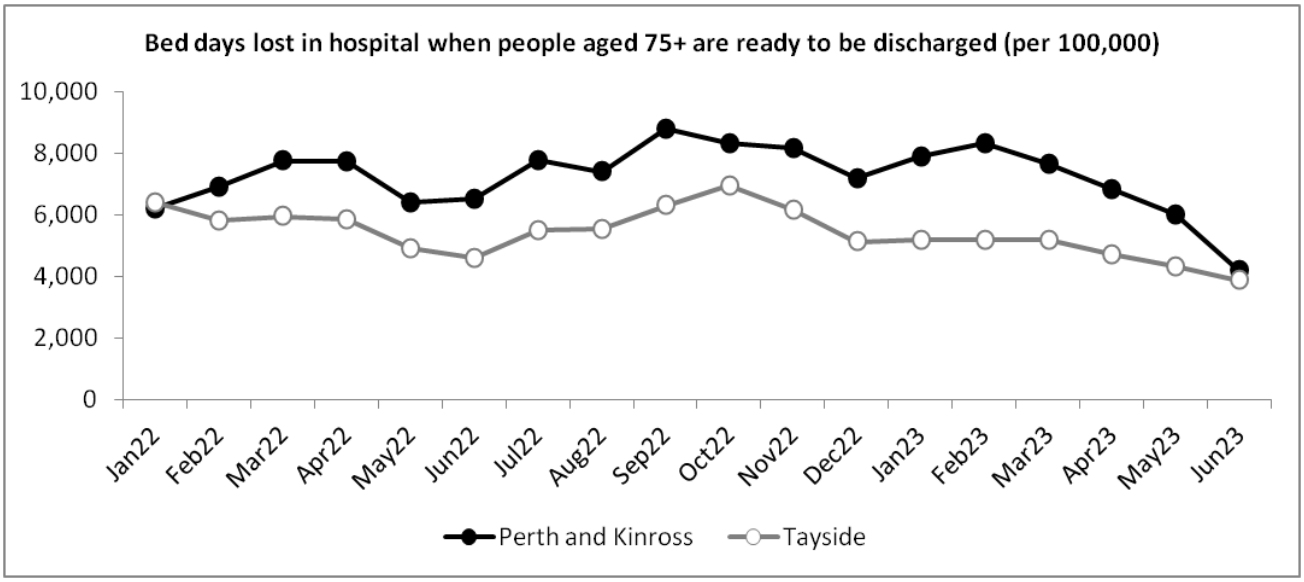

Figure 7: demonstrating the significant progress made in reducing the number of people delayed in hospital when they are clinically well.

3.1 PROGRESS TO DATE

Workstream 1: Early intervention

Over the past 12 months, we have continued to work with key stakeholders to further strengthen our alliances with community partners, third and independent sectors with a focus on prevention, early intervention, and targeted actions on the wider determinants of health delivering a range of programmes to support older people to remain as active as possible. The embedding of the Paths for All approach to develop dementia friendly walking initiatives has been particularly successful, with the indoor and outdoor spaces at Blairgowrie Community Hospital transformed into more dementia friendly environments. Work to expand this approach at Murray Royal Hospital has commenced, and discussions are underway to extend the approach to Crieff and Pitlochry Community Hospitals. Of particular note is the work undertaken in partnership with Live Active Leisure to encourage older people (whether living at home or in a care home) to take part in physical activities to help improve their mobility and strength, and to protect against falls. Figure 8 (below) illustrates the great strides made with this work, with significantly more older people taking part in the 2022/23 financial year than in the first phase of the programme.

Area of Work	**Annual Total (21/22)**	**Annual Total (22/23)**
Care Homes receiving regular group activity sessions	18	16
Attendances at Care Home Activities	3,639	4,290
Referrals received for Care at Home intervention	166	203

Area of Work	Annual Total (21/22)	Annual Total (22/23)
Care at Home visits made (1-2-1 home exercise programme)	896	1,313
Referrals received for Activity Referral Scheme (clinical populations)	353	483
Health Walk attendances	7,752	7,100
Attendances at Sheltered Housing group activity	1,909	2,848
Community Classes delivered	1,630	1,727
Attendances at Community Classes	9,755	16,281

Figure 8: Engagement with Live Active physical activity programmes

We have also had considerable success with the implementation of activity workers to support older people to remain mentally and physically active while they are in hospital. Despite some early recruitment challenges, the workers are now in post and supporting people in Tay Ward, Perth Royal Infirmary, St Margaret's Community Hospital and Psychiatry of Old Age wards in Murray Royal Hospital to undertake activities which are meaningful to, and enjoyable for, them while they are in hospital.

The Enhanced Care Home Support Team has received positive feedback from care homes about the work they have undertaken, a selection of which is provided below:

"*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 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 Camphill Community)

"*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.*" Jean Beggs, Manager

Workstream 2: Shifting the Balance of Care

Over the past 12 months, we have continued to take forward programmes of work to enable older people to access the health and social care supports they need at home, or as close to home as possible, with the intention of avoiding hospital admissions unless absolutely clinically necessary.

Notable successes have been the continued drive to further develop integrated ways of working through the development of integrated community staff bases, and the implementation of the "What Matters To You?" (WMTY) approach, to re-centre staff around a shared understanding and continuous improvement. Feedback on the WMTY sessions, delivered in partnership with The Alliance, has been excellent, with staff commenting on the way the sessions have helped them to remember why they wanted to work in the sector, and to gain a sense of pride in the service they provide.

> *"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"*
> Member of Staff attending one of the WMTY sessions

We have also been able to make significant progress in reducing waiting times for assessment by increasing capacity within social work teams using ring-fenced Scottish Government funding.

The Hospital at Home (H@H) service has also been tested and implemented, allowing us to provide acute hospital-level care in a person's own home. A full evaluation is planned to be completed once the service has been operational for six months to allow us to identify any teething problems or emergent risks and take steps to rectify them.

A selection of feedback from Care Opinion relating to our work in communities is shown in Figure 9, below:

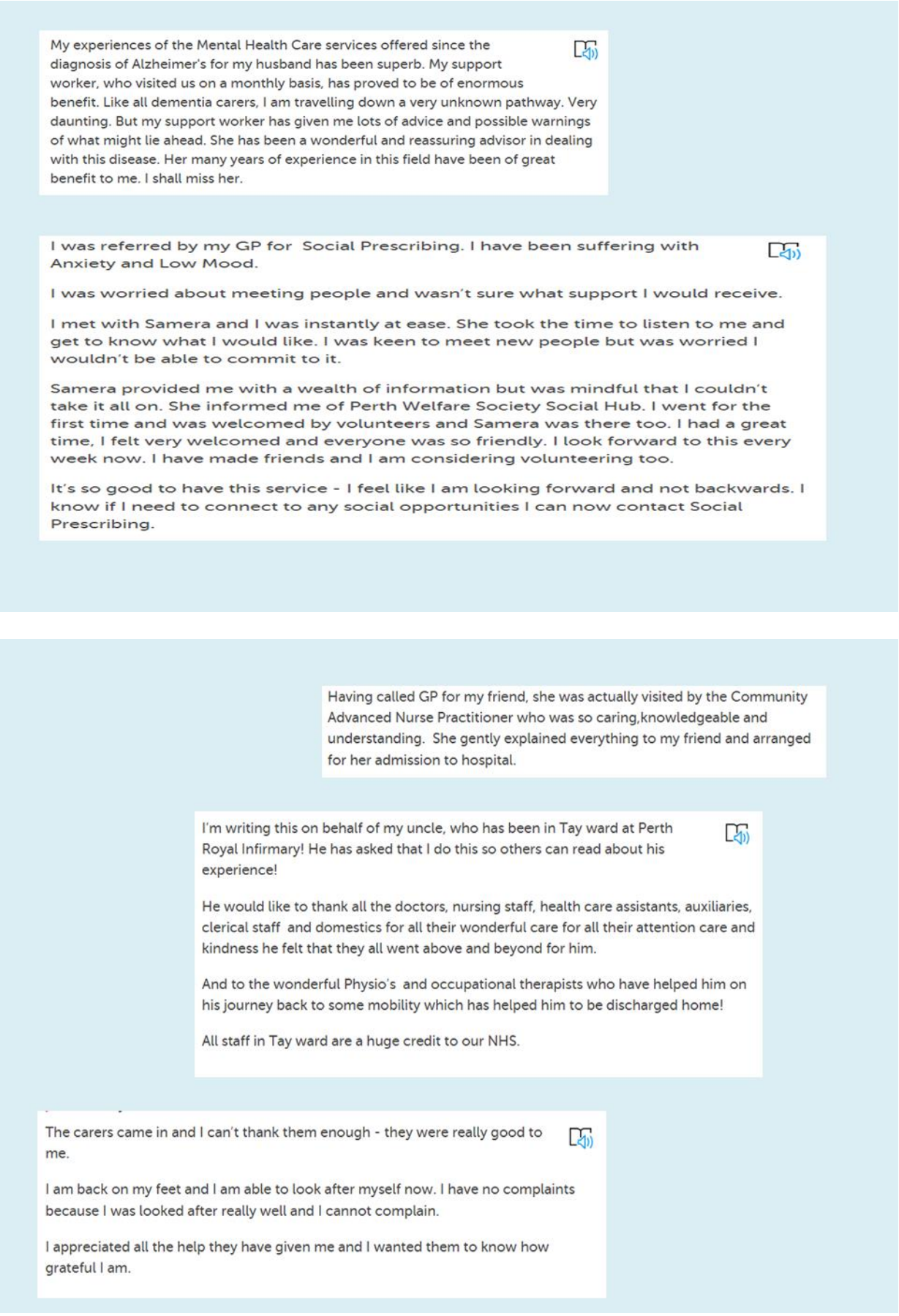

Figure 9: a selection of Care Opinion feedback on the services we provide to help people access care in their communities.

Workstream 3: Optimising Capacity and Flow

Over the past 12 months, we have continued to optimise capacity and flow through Perth Royal Infirmary (PRI) by working to reduce delays in discharges, make stronger connections between our frailty pathway and community services and enhancing the integration of the PRI discharge hub and hospital discharge team. This work is ongoing, but significant successes in reducing delays in the discharge process have been achieved by implementing a whole system approach to discharge planning.

3.2 FINANCIAL IMPLICATIONS

Funding totalling c£8m was earmarked to support the delivery of the strategic plan. Due to the timing of the investment and recruitment challenges there has been slippage throughout 2022/23. This has been reported as part of the regular financial reporting to the IJB and was considered as part of the 2023/24 Budget.

Perth & Kinross HSCP is currently undergoing financial planning for the next 3-year cycle 2024/25 to 2026/27.

3.3 PROPOSALS & FUTURE PROGRESS

It is proposed that is now appropriate to take stock and evaluate the impact of the Strategic Delivery Plan to inform decisions around future investment. At the same time the HSCP will take forward a programme of transformation associated with making the best use of our resources, ensuring our services are fit for the future and optimising outcomes for people. In relation to services for older people the following three priority areas have been identified.

- **Optimising independence and quality of life for people at home**
  This programme of work is focused on whole service transformation of care at home and address unmet care needs, recruitment and retention challenges, and support work to reduce length of hospital stays and promote prompt discharge.
- **Enhancing capacity in dementia services**
  This programme of work is focused on delivering whole service transformation to address unmet support needs in people newly diagnosed with dementia, their families, and carers.
- **Developing a person-centred approach to rehabilitation and reablement**
  This programme of work is focused on delivering whole system transformation to provide sustainable and effective rehabilitation and reablement services which are fully integrated with other PKHSCP locality-based services in a patient centred approach to service delivery.

4. DIRECTIONS

The Integration Joint Board requires a mechanism to action its strategic commissioning plans and this is provided for in Section 26 to 28 of the Public Bodies (Joint Working) (Scotland) Act 2014. This mechanism takes the form

of binding directions from the Integration Joint Board to one or both of Perth & Kinross Council and NHS Tayside.

Direction Required to Perth & Kinross Council, NHS Tayside, or Both	Direction to:
No Direction Required	X
Perth & Kinross Council	
NHS Tayside	
Perth & Kinross Council and NHS Tayside	

5. CONCLUSION

Considerable progress has been made towards achieving the key strategic ambition of whole system integration. This is against a backdrop of continued Covid-19 recovery, a rising demographic and complexity of presenting conditions of people aged 75 or older, alongside staff recruitment and retention challenges. Over the next six months, we will evaluate the whole system collaborative approach and the impact of the IJB's investment into older people's services. The outcomes will be fed into the IJB's budget-setting process for 2024-2027.

Author(s)

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NOTE: No background papers, as defined by Section 50D of the Local Government (Scotland) Act 1973 (other than any containing confidential or exempt information), were relied on to any material extent in preparing this report.

ANNEX

1. IMPLICATIONS, ASSESSMENTS, CONSULTATION AND COMMUNICATION

Strategic Implications	**Yes / None**
HSCP Strategic Commissioning Plan	**YES**
Transformation Programme	**YES**
Resource Implications	
Financial	**YES**
Workforce	**YES**
Assessments	
Equality Impact Assessment	**YES**
Risk	**YES**
Other assessments (enter here from para 3.3)	**NO**
Consultation	
External	**YES**
Internal	**YES**
Legal & Governance	
Legal	**NO**
Clinical/Care/Professional Governance	**YES**
Corporate Governance	**N/A**
Directions	
Communication	
Communications Plan	**YES**

1. Strategic Implications

1.1 Strategic Commissioning Plan

The Strategic Delivery Plan supports the delivery of the Perth & Kinross Strategic
Commissioning Plan in relation to all five deliverables below:

1 prevention and early intervention,
2 person centred health, care, and support
3 work together with communities
4 inequality, inequity, and healthy living
5 best use of facilities, people, and resources

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

- Intervening early by working with communities and partners across all sectors to develop a range of supports to encourage older people to be active and engaged and reduce social isolation to mitigate some of the effects of aging
- Offering personalised, locally based support, including optimising the use of Technology Enabled Care (TEC), across Perth and Kinross to reduce reliance on institutional care

- Providing a rapid, multi-disciplinary response for older people if their health deteriorates to prevent admission to hospital or a care home
- If hospital admission is required, supporting people to return home as soon as possible once they are clinically fit.
- Designing and implementing safe, sustainable, patient and outcomes focused systems of urgent care access, pathways, and treatment for Perth & Kinross residents in the in-hour and out of hour period in collaboration with NHS Tayside.

2. Resource Implications

2.1 Financial

The Older Peoples Strategic Delivery Plan provides a clearly defined Financial Framework which provides full information on the financial implications of the proposals.

2.2 Workforce

The workforce implications are significant and are set out in the 3-Year Workforce Plan 2022-2025.

3. Assessments

3.1 Equality Impact Assessment

Under the Equality Act 2010, PKC and NHS Tayside is required to eliminate discrimination, advance equality of opportunity, and foster good relations between equality groups. Carrying out Equality Impact Assessments for plans and policies allows the HSCP to demonstrate that it is meeting these duties.

This section should reflect that the proposals have been considered under the Corporate Equalities Impact Assessment process (EqIA) with the following outcome:

(i) Assessed as **relevant** previously and the following positive outcomes expected following implementation: to continue taking into account the statutory obligation to ensure due regard to the removal of inequity of outcomes as a result of socioeconomic disadvantage or characteristics protected under the Equality Act (2010). Each programme of work will complete an Equality and Fairness Impact Assessment to allow the early identification of risks in this regard, and enable the implementation of satisfactory mitigations.

3.2 Risk

The IJB's strategic risk register aims to identify risks that could impact on the achievement of PKIJB's objectives. The register includes strategic risks related to workforce, financial resources, and viability of external providers for which the development and implementation of the Older Peoples SDP is a key mitigatory measure and expected to be a positive influence on the risk

exposure for the risks identified above. The success of the SDP will have a significant influence on the IJB achieving its objectives.

3.3 Other assessments

Measures for Improvement

Regular updates will be provided for all the workstreams, in the form of highlight reports, to identified groups including the Older People's Strategic Delivery Group (improvement programmes) and the PKHSCP Transformation Board (transformation programmes).

We are reviewing the Older Peoples KPI report to ensure it reflects progress made against our agreed objectives.

Patient Experience

Regular patient and service user feedback is already collated through care opinion and feedback and complaints. Learning from any adverse events is in place and fed through local governance groups and the P&K Clinical Care and Professional Governance Group (PKC) and the Quality and Performance Review Forum (NHST). Examples of recently received patient feedback are:

SOCIAL PRESCRIBERS:
"It's so good to have this service. I feel like I'm moving forward and not backwards. I know if I need to connect to any social opportunities I can now contact Social Prescribing."

"She helped me a lot with my confidence and social skills from our face to face meetings".

"I think it's having somebody to talk to that helps a lot. I don't think I could have done it without them".

COMMUNITY AHPs:
"I have had physio in the past and just been given physio instructions before on a sheet of paper, but not to the same extent that I got from Gillian. This time having Gillian actually show me what to do which was mush better than having a piece of paper" (Community Physiotherapy)

"I can now share this with the carers as a solution to the problems I was having...she was lovely and knew her stuff" (Community OT)

PARTNERSHIP INPATIENT CARE
"He dealt with my father in challenging circumstances and he was very good, even being available when I called him later in the middle of the night. What an outstanding doctor." (PRI AMU)

"I must admit to pushing the boundaries with the physio staff and did cause a few anxious moments...but all respect to them and the job they do" (PRI Stroke Unit)

"When I arrived at PRI I could not talk or walk and struggled with movement and sensation on my right side. With the treatment I received, I have almost returned back to my old self". (PRI Stroke Unit)

"All staff in Tay ward are a huge credit to our NHS" (PRI Tay Ward)

"We cannot thank them enough, they are truly wonderful nurses, adn the environment was so lovely and calming for all patients and a pleasure to visit" (Blairgowrie Community Hospital End of Life Care)

(Extract from Care Opinion patient feedback data)

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 that really has to be seen and experienced to fully understand it. The supportive approach and time spent visiting the service by XX in particular, has been a significant step in fostering very positive relationships that are proactive rather than reactive, and have been much appreciated.”

"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 XX over the phone, who completed the form on my behalf. XX kept me up to date with her progress in organising everything and worked with hospital staff to arrange time of pick up”.

LAL- 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, they 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".

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.

Health and Safety

No major health and safety implications have been identified.

Healthcare Associated Inspection.

No impact on Healthcare Associated Infection has been identified.

Benefit Realisation

The OPSDP sets out the aim of benefitting the people of Perth & Kinross by ensuring access to the right care at the right time and in the right place for all. This will put the person at the centre of the decision-making process in relation to their treatment, support, and care. Health and social care services will work together, and with a range of external stakeholders, to make sure people can access the care and support that is best for them at the point of need.

Quality

The older peoples plan will use quality improvement approach to promote a culture of continuous quality improvement is key to all our programmes of improvement and transformation.

IT

There are ongoing challenges with access to common IT systems, particularly Microsoft Office suite, depending on whether staff has a PKC or NHST log in.

4. Consultation – Patient/Service User first priority

4.1 External

Consultation exercises with patients, service users, carers and key external stakeholders have been undertaken in conjunction with colleagues in the P&K strategic commissioning team to support a range of strategic developments including the OPSDP and the PKHSCP Joint Strategic Needs Assessment.

4.2 Internal

Internally, the 3-year strategic delivery plan and proposals for programme development (which have enabled the progress and future progress sections of this paper) have been shared and consulted on with the Integrated Management Team (IMT), Strategic Planning Group, Older People's Strategic Delivery Group (OPSDG), Clinical and Care Governance Forum, Executive Management Team (EMT) and Integrated Joint Board (IJB).

5. Legal and Governance

The OPSDP will be governed through the Older People's Strategic Delivery Group and Improvement workstreams identified in the OPSDP will be governed via the OPSDG; transformation workstreams will be governed via the PKHSCP Transformation Board.

6. Directions

There are no directions required for NHS Tayside and Perth & Kinross Council in relation to the contents of this paper.

7. Communication

7.1 The OPSDP and associated action plan will be closely monitored and supported through the OPSDG, and where appropriate the PKHSCP Transformation Board. This forum will be supported by key themes sub-groups and updates and communications will be provided to EMT and IJB accordingly.

2. BACKGROUND PAPERS/REFERENCES

N/A

3. APPENDICES

Appendix 1: Progress against actions from OPSDP 2022-2023

References

[1] Public Health Scotland *Locality Profiles 2020/2021* Public Health Scotland, 2021
[2] National Records of Scotland: *Population Projections, 2018* NRS, 2020
[3] National Records of Scotland: *Mid Year Population Estimates, 2020* NRS, 2021

[4] Public Health Scotland *Locality Profiles 2020/2021* Public Health Scotland, 2021
[5] Stay data sourced from TrakCare via QlikView. Note: live system data subject to standard management information caveats – may differ from subsequent PHS cleansed data.

[6] National Records of Scotland: *Mid Year Population Estimates, 2020* NRS, 2021
[7] Public Health Scotland *Delayed Discharges in NHS Scotland Monthly* Public Health Scotland, 2021

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	

EARLY INTERVENTION: ACTIONS	RAG STATUS	NOTES
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".

EARLY INTERVENTION: ACTIONS	RAG STATUS	NOTES
		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

EARLY INTERVENTION: ACTIONS	RAG STATUS	NOTES
		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

EARLY INTERVENTION: ACTIONS	RAG STATUS	NOTES
		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.

SHIFTING THE BALANCE OF CARE: PHASE 2 ACTIONS	RAG STATUS	NOTES
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.

SHIFTING THE BALANCE OF CARE: PHASE 2 ACTIONS	RAG STATUS	NOTES
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.

PERTH & KINROSS INTEGRATION JOINT BOARD

20 SEPTEMBER 2023

ANNUAL UPDATE ON SUBSTANCE USE SERVICES

Report by Chief Officer
(Report No. G/23/122)

PURPOSE OF REPORT

To provide an update to the IJB on substance use services including embedding and implementing the MAT (Medication Assisted Treatment) Standards and work to progress the outcomes of the current ADP Strategic Delivery Plan 2020-23.

1. RECOMMENDATION(S)

It is recommended the IJB:

1.1 Notes progress in embedding and implementing the MAT Standards.
1.2 Notes progress with ADP Strategic Delivery Plan 2020-23
1.3 Retrospectively approves the ADP Annual Reporting Survey 2023, attached as Appendix 1
1.4 Requests an update in 12 months' time.

2. SITUATION/BACKGROUND / MAIN ISSUES

2.1 ADP Governance

2.1.1 The Integration Joint Board (IJB) is the legal entity responsible for the strategic planning and commissioning of integrated community health and care services including drug and alcohol services. The Health and Social Care Partnership (HSCP) has responsibility for the operational delivery of these services and is the lead partner for the ADP and will report at least annually to the IJB on performance and progress.

2.1.2 Perth and Kinross Alcohol and Drug Partnership (ADP) provides strategic leadership across Perth and Kinross for all agencies working within the alcohol and drugs field and other agencies with a significant role to play such as housing and education. As the success of this work requires the collaboration and efforts of a wide range of partners across the public, independent and voluntary sectors the work of the Alcohol and Drug Partnership provides reports to the IJB, COG, Community Planning

Partnership, Children, Young People and Families Partnership, as well as to the Executive Leadership in NHS Tayside and Perth and Kinross Council.

2.1.3 The multi-agency partnership approach to reducing substance use mortality and harm is overseen by the Perth and Kinross Chief Officer's Group for Public Protection (COG), of which the Chief Officer is a member and the COG. In line with the terms of reference for the COG, the ADP Chair is in attendance and provides regular reports.

2.1.4 The ADP is part of the Community Planning Partnership. Through this, the ADP works with partner organisations to try and address wider issues which impact on substance use including reducing poverty and improving the mental and physical health of the population.

2.1.5 Perth and Kinross ADP takes a multi-agency and collaborative approach to the allocation of funding from a number of sources. The main sources are NHS Tayside, Perth and Kinross Council and ringfenced monies from the Scottish Government via NHS Tayside.

2.2 Drug-related deaths in 2022

2.2.1 National data was published in August 2023 for Drug-related deaths in Scotland in 2022. There were 1,051 recorded drug use deaths in 2022, which is 21% (279 deaths) fewer than in 2021. In Perth and Kinross, the number of drug use deaths was 21 in 2022, which is 5% (1 death) more than in 2021.

2.2.2 The age standardised five-year average drug use death rate between 2018 and 2022 for Scotland was 23.4 per 100,000 population. This is an increase of 0.5 per 100,000 from the previous five-year period. In Perth and Kinross, the rate between 2018 and 2022 was 18.4 per 100,000. This is an increase of 0.1 per 100,000 from the previous period.

2.2.3 The age standardised death rates are presented as they take account of the size of the population and its age structure, to promote more reliable comparisons over time and/ or between areas.

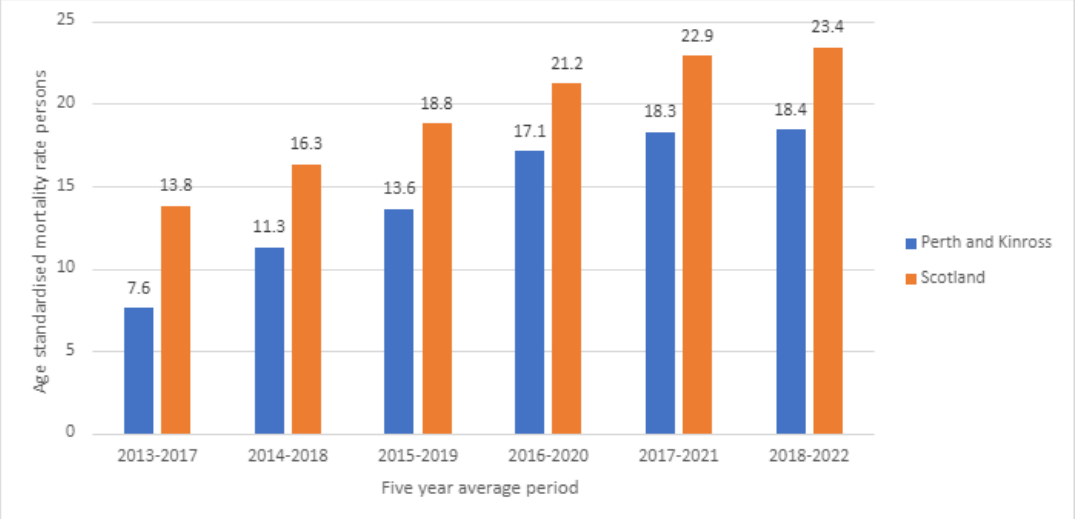


Figure 1. Age-standardised five-year drug use death rate for Perth and Kinross and Scotland

2.3 MAT Standards

2.3.1 In response to the increasing number of drug deaths across Scotland, the Scottish Government published the Medication-Assisted Treatment (MAT) Standards in 2021. The ten Standards aim to reduce drug-related harm, including premature death, through a programme of sustained funding, workforce development, system and culture change across services and wider communities. In 2022-23, the Scottish Government tasked all areas with implementing and embedding Standards 1-5.

2.3.2 In June 2023, PHS (Public Health Scotland) published a benchmarking report on the progress that ADPs are making. National benchmarking report – MAT standards. Using a RAGB rating system, Perth and Kinross has made good progress and achieved three provisional greens and two ambers by April 2023. Subsequent work has seen the provisional green criteria met for all of the first five Standards.

2.4 Alcohol-specific deaths

2.4.1 There were 1,276 alcohol-specific deaths in Scotland in 2022. This is an increase of 2% (31 deaths) since 2021 and is the highest number of deaths registered since 2008. In Perth and Kinross, there were 32 alcohol-specific deaths in 2022. This is an increase of 6% (2 deaths) since 2021.

2.4.2 The age standardised five-year average alcohol-specific use death rate between 2018 and 2022 for Scotland was 21.2 per 100,000 population. This is an increase of 0.4 per 100,000 from the previous five-year period. In Perth and Kinross, the rate between 2018 and 2022 was 17.0 per 100,000. This is an increase of 1.7 per 100,000 from the previous period.

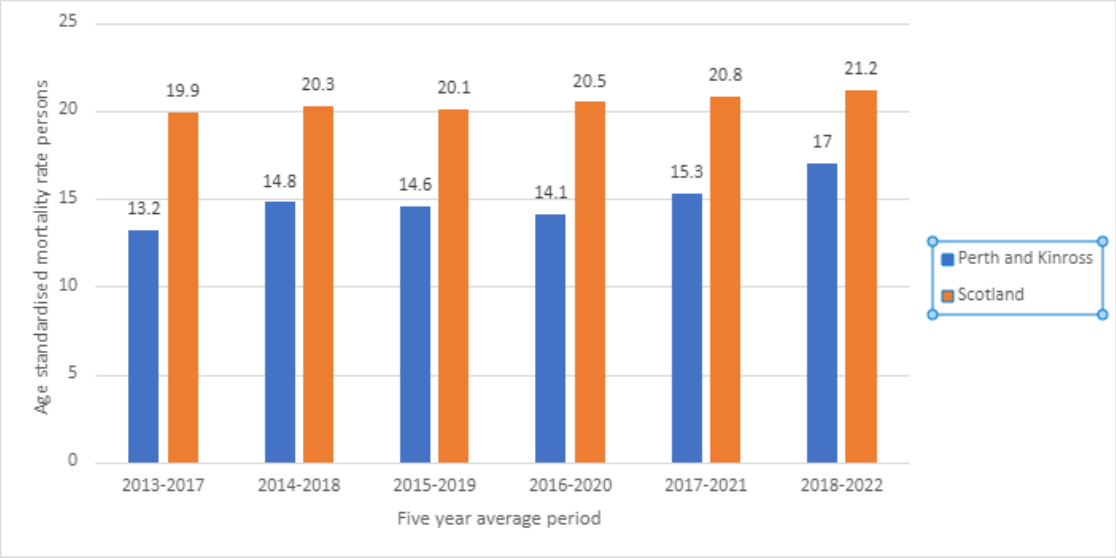


Figure 2. Age standardised five-year averages of alcohol-specific deaths in Perth and Kinross and Scotland.

2.4.3 Data from iDART (Integrated Drug and Alcohol Recovery Team) shows that the number of people seeking support with drug issues has fallen, from 313 in 2021-22 to 211 in 2022-23. The number of people seeking support with alcohol issues has also fallen from 395 referrals in 2021-22 to 368 referrals in 2022-23. However, there has been an increase in the number of people seeking support for both alcohol and drug use, with 37 people recorded in 2022-23 compared with fewer than 10 in 2021-22. Current caseloads for iDART remain high, with 670 people working with the service, and an increasing number of people presenting with complex needs in addition to poly drug use including physical health and mental health issues.

3. ADP STRATEGIC DELIVERY PLAN 2020-23

3.1 Outcomes

3.1.1 The Perth and Kinross ADP Strategic Delivery Plan 2020-23 was refreshed in 2023 in response to the volume of change and new challenges that have arisen since the plan's inception in early 2020. These include the publication of the Drug Death Task Force Final report "Changing Lives" and the Scottish Government's response to this, the publication of the National Mission on Drug Deaths Plan 2022-26 and the MAT Standards in 2021.

3.1.2 The Strategic Delivery Plan has six outcomes which together contribute to the overall aim of the plan to reduce the harms associated with alcohol and drugs and facilitate opportunities for recovery for people affected by substance use. The outcomes are:

Outcome 1: Fewer people suffer harm as a result of alcohol and drug use.
Outcome 2: Risk is reduced for people who take harmful drugs.
Outcome 3: People receive high quality treatment and recovery services.
Outcome 4: People at most risk have access to treatment and recovery.
Outcome 5: Quality of life is improved by addressing multiple disadvantages.
Outcome 6: Children and families affected by substance use will be safe, healthy, included and supported.

3.1.3 Significant progress has been made during 2022-23 in achieving the aims of the Plan. Relevant performance information and examples of work that has been undertaken to progress each outcome is highlighted below. Further information can also be found in Appendix 1: ADP Annual Reporting Survey 2023-23 – Perth and Kinross.

3.2 Fewer people suffer harm as a result of alcohol and drug use

3.2.1 Prevention of the harms associated with substance use and early intervention to support people with substance use issues needs to be viewed in relation to other policy areas such as education and social inclusion. Crucial to achieving this is the development of education-based, person-centred approaches which aim to reach all children and young people. Recent work with young people in Crieff and Blairgowrie highlights this approach.

3.2.2 Young people from Crieff have been working with Perth and Kinross Council's Services for Young People and Hillcrest Futures to create an interactive and informal approach to drug education. The Drug and Alcohol Ambassadors Project has seen the creation of an eight-week peer education programme which gives young people, who are deemed to be engaging in risk-taking behaviour, the opportunity to learn about the risks they are taking and the consequences from their peers. Following the successful launch of the project in Crieff, plans are in development to run this in other areas of Perth and Kinross in 2023-24.

3.2.3 The ADP has co-funded, with the Perth and Kinross Council Safer Communities Team, a project run by the SCYD (Strathmore Centre for Youth Development) which focuses on the impact substance use is having on young people in the Blairgowrie and Rattray area. The project team worked with 124 pupils in four local schools running four-week programmes focusing on team building, alcohol and drug awareness and accessing support and services. The team also regularly attended Blairgowrie High School where they ran a pop-up stall to provide information and ran interactive workshops on smoking/ vaping, alcohol and drugs.

3.3 Risk is reduced for people who take harmful drugs

3.3.1 Timely access to services, readily available needles and syringes and accessible Naloxone when required, all contribute to a reduction in the harms that are caused by people using substances.

3.3.2 In response to MAT Standard 4, which focuses on the provision of harm reduction, working on a Tayside wide basis, harm reduction support has been expanded. This includes training and equipping staff with a carry-pack of equipment and supplies to increase the supply of IEP (Injecting Equipment Provision) at the point of receiving OST (Opiate Substitution Therapy). In addition, the IEP service also provides IEP when iDART (integrated Drug and Alcohol Recovery Team) conduct outreach visits and provides harm reduction support to new patients who attend clinics.

3.3.3 The last three years has seen a continued increase in the number of Take-Home Naloxone (THN) kits issued in Perth and Kinross. There were 658 THN kits issued in 2022-23 compared with 339 in 2020-21. Increases in kits supplied by iDART and by peers have significantly contributed to this. Plans are in place to support all local pharmacies to carry a supply of kits to increase the supply to more community members.

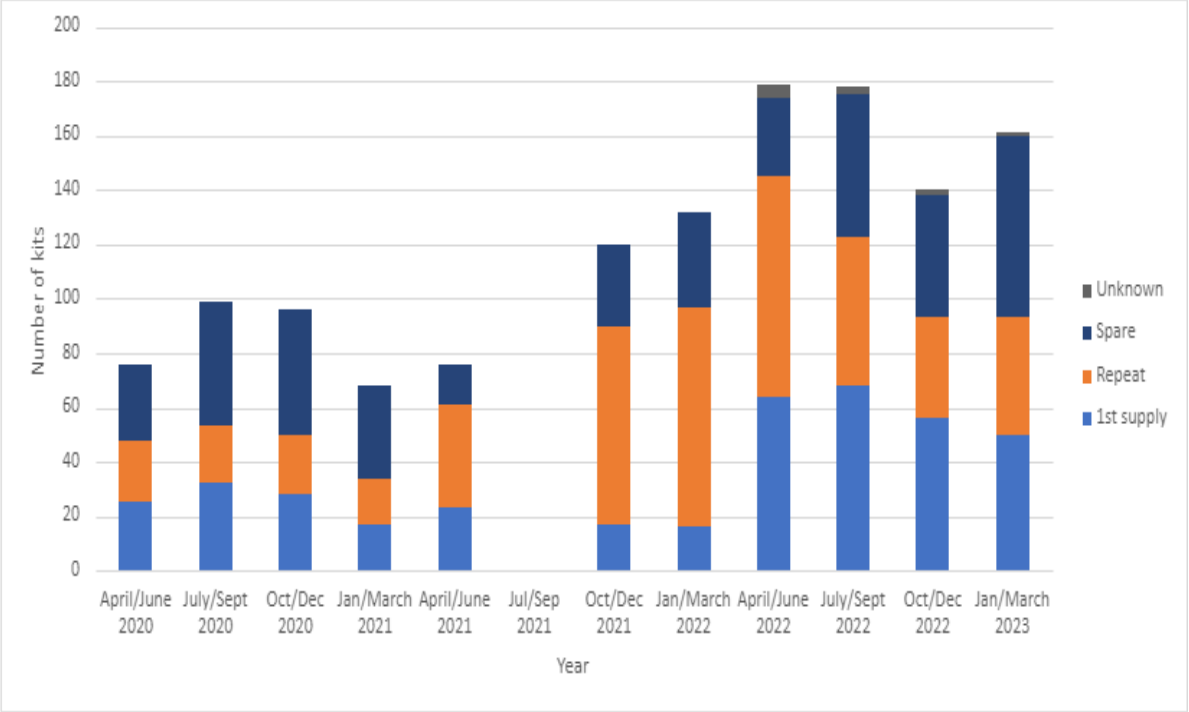


Figure 3. Number of Take-Home Naloxone (THN) Kits issued in Perth and Kinross

Note: Data for July –September 2021 is missing owing to a database handover issue

3.3.4 In 2022-23, the average number of needles and syringes distributed per person who used drugs problematically was 46.6. This is a large reduction from the previous year when the average number was 85.9. This reduction potentially reflects local shifts in the numbers of people using crack cocaine and benzodiazepines rather than opiates.

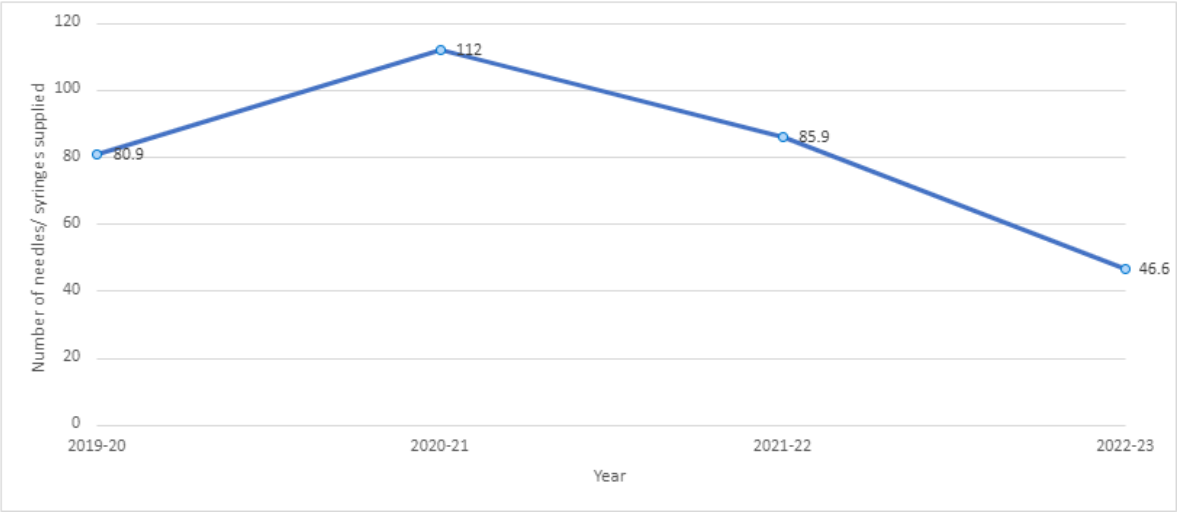


Figure 4. Number of needles/ syringes supplied per unique IEP (Injecting Equipment Provision) client in Perth and Kinross.

3.3.5 There has been a continued expansion of the available options for accessing IEP across services. Hillcrest Futures delivers an enhanced harm reduction and IEP service in Perth and Kinross. This includes assessment, overdose awareness, injecting equipment provision, blood borne virus testing, vaccination, and wound care. This is based with iDART in Drumhar Health Centre. In 2022-23 Hillcrest Futures expanded their provision to include Skinnergate and began outreach IEP drop-ins at Greyfriars, CATH day centre and OWLS (One-Stop Women's Learning Service).

3.4 People receive high quality treatment and recovery services.

3.4.1 A significant amount of work has been undertaken throughout 2022-23 to ensure that a range of services are available to people which are good quality, provide compassionate responses and are person and family centred.

3.4.2 Improving the coordination of all community-based substance use services has continued. IDART has a fully integrated, multi-disciplinary model which provides seamless support to help people manage and address substance use issues.

3.4.3 The continued development of iDART has been supported by the implementation of an integrated management structure and the creation of new posts to enable the team to expand its work. This has included the recruitment of a social worker with specialist mental health experience to provide support to clients with dual diagnosis of mental health and substance use issues and the recruitment of two workers to provide substance use support to people who have been given community sentences by the courts.

3.4.4 To meet the requirements of MAT Standards 1,2 and 5, which are concerned with access to treatment and choice, drug and alcohol procedures and pathways were reviewed and practical changes implemented where required. These included the introduction of same day prescribing, initially one day a week. In 2022-23, 13 people benefitted from this service. Information about treatment options provided to service users to enable informed decisions; linkages to other support services made and strengthened to support people at risk and a review of staff caseloads to ensure staff have the capacity to work with service users to support their continued engagement with services. As a result of these changes people can choose the treatment best suited to their needs and will be able to start their treatment earlier.

3.4.5 Following a declining trend in waiting times performance, the last six months of 2022-23 saw a steady improvement, resulting in 94% of people referred for help with problematic drug or alcohol use having to wait no longer than three weeks for specialist treatment that supports their recovery. This was the result of the implementation of same day prescribing, improvements in recording processes and an increase in staffing capacity of both clinical and administrative staff.

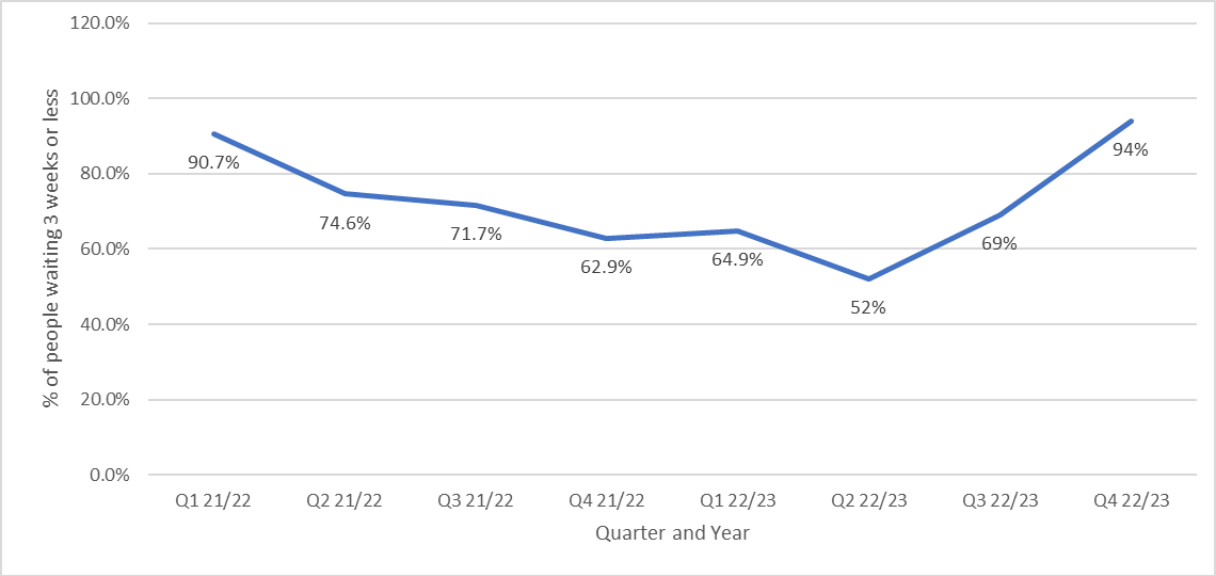


Figure 5: Waiting times for people accessing specialist substance use treatment in Perth and Kinross

3.4.6 As part of the criteria for MAT Standard 2, which concerns choice of treatment, methadone and long and short-acting buprenorphine formulations are required to be equally available in local formularies and dispensing locations. Buprenorphine, which causes significantly less sedation than methadone and its long-acting injectable formulation, Buvidal, allows dosage intervals of up to several weeks.

3.4.7 85 people in Perth and Kinross were prescribed Buvidal, the long-acting injectable formulation of buprenorphine, in the community in 2022-23. The use of Buvidal has continued to produce positive outcomes for people by reducing the number of non-fatal overdose incidents and allowing people to remain in treatment.

3.4.8 In order to ensure a range of treatment options are available, the Perth and Kinross residential rehabilitation pathway and screening group was established in 2021-22 to support people who wanted to access this treatment option. In 2022-23, 17 requests to access residential rehabilitation facilities were approved by the screening group, costing £255,409 in total.

3.4.9 Perth and Kinross ADP and other local ADPs are currently working with HIS (Health Improvement Scotland) to review and enhance the current pathways into and out of residential rehabilitation to ensure that this is an effective form of treatment for as many people as possible.

3.4.10 In response to the high number of referrals for support with alcohol issues, iDART expanded its treatment options by trialling a community alcohol detox service. The service supported 14 people in 2022/23 and because of this success, is now looking at ways to expand its work to increase patient numbers and to potentially offer a service to people who require support with benzodiazepine use.

3.4.11 TCA's (Tayside Council on Alcohol) local counselling and creative therapies service has also seen an increase in referrals for support with local issues. TCA received 272 referrals in 2022-23; an increase of 27 referrals compared to the same time last year. To cope with the high demand, TCA have utilised counselling students to create additional capacity. This has had a significant impact on waiting times, following first contact assessment, reducing the average time from first referral to being allocated to a counsellor from 6-8 weeks to 3-4 weeks.

3.4.12 The recovery community is a vital part of a person's recovery journey and 2022-23 saw the expansion of this. There are now eight recovery cafés operating throughout Perth and Kinross with cafes in Perth City, Aberfeldy, Dunkeld, Pitlochry, Blairgowrie, Crieff, Kinross, HMP Perth with a further cafe planned in Letham. There are also a variety of groups in operation which provide wider social interaction helping people to be at ease and work through difficult times. These include a walking group, fishing group, badminton group, art and craft group and a woman's wellbeing group.

3.4.13 Feedback suggests members feel more empowered. For example: *"This is the longest I have been abstinent over 6 months now and I am now able to participate at other activities." - "I've never been sober for years, been in and out of Detox nearly monthly this has opened my mind up toward my own recovery." - "This gets me out of my flat and has stopped my loneliness. I now have a friend!"*

3.4.14 The first RecoverMay took place across Perth and Kinross during May 2023. The purpose of RecoverMay is to highlight what recovery means to people with living and lived experience of recovery, their families and carers and people working in support services. During the month, an art exhibition, podcasts, social media promotions, and other events took place to highlight recovery from both substance use and mental health. As part of the art exhibition, a short film titled "Walk the Inch" was premiered, which had been created by residents of HMP Perth, showing the journey of an individual entering and leaving the prison.

3.5 People most at risk have access to treatment and recovery

3.5.1 The focus of MAT Standard 3 is for services to proactively identify those people who are most at risk of harm from substance use and ensure they are offered support. Perth and Kinross benefits from the operation of several groups who work to achieve these aims.

3.5.2 These include the substance use multiagency referral hub which reviews all referrals to substance use services to link people to the most appropriate service; the prisoner release multiagency group which meets to improve coordination of prisoner release information, the HMP Perth Persons of Concern review group which meets daily to consider residents in crisis and the NFOD (Near-Fatal Overdose) Group which meet to review all near-fatal overdose incidents and provide support to those individuals who have experienced this.

3.5.3 93 people were discussed by the NFOD group during 2022-23 and where required, were offered assistance via an assertive outreach service provided by Hillcrest Futures and Positive Steps, in partnership with iDART. This number is slightly less than in 2021-22 when there were 98 people discussed by the group and highlights the positive impact the formation of the group has had on the number of NFOD incidents since its inception.

3.5.4 Following the success of the Tayside NFOD model, the Perth and Kinross NFOD group are working with the newly appointed Tayside NFOD coordinator, to review the pathway and to consider how to co-ordinate the work of the other groups who work with individuals who are at risk.

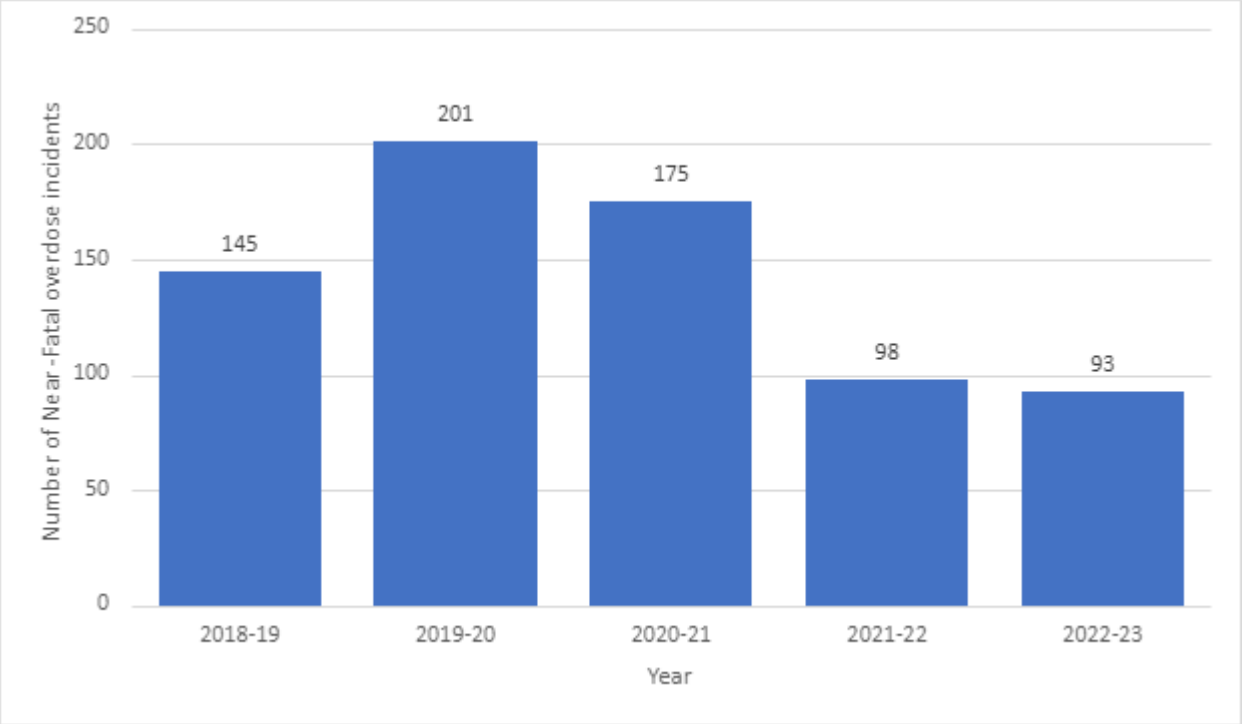


Figure 6. Number of Near-Fatal Overdose incidents reported to the Perth and Kinross NFOD Group by year.

3.6 Quality of life is improved by addressing multiple disadvantages

3.6.1 In addition to high quality treatment and recovery services, people with substance use issues require access to health and social care services to improve their quality of life. Much of the focus of MAT Standards 6-10 is concerned with achieving this.

3.6.2 Work is already underway to implement MAT Standards 6-10 to meet the April 2024 deadline. This has seen the Tayside Drug and Alcohol Psychology Service progressing with the recruitment of a psychology assistant whose key role will be to improve access to psychological interventions. The ADP has also been working with Perth and Kinross Council's new Trauma Coordinator to ensure that appropriate trauma awareness training is available to all staff working in key services.

3.6.3 MAT Standard 9 concerns the development of pathways for people with co-occurring substance use and mental health issues. Work is now underway at a Tayside level to carry out this work. Locally, the development a model for integrated mental health and substance use provision will help to support this work. Work to date has seen the creation of a service manager post with responsibility for both mental health and substance use services and the recruitment of a social work post within iDART to specifically work with people who are experiencing both substance use and mental health issues.

3.6.4 The ADP is continuing to work with the Community Justice Partnership to support services who are working with people with substance use issues and who are currently part of the justice system. The partnerships are collaborating on a range of projects and includes jointly funding an arrest referral test of change to explore how best to support people with substance use issues who are arrested and held in police custody. The service supported 92 people in 2022-23 with housing, mental health, substance use and finance needs.

3.6.5 The partnerships have also collaborated to develop and jointly fund a new model of voluntary throughcare to support people on short term sentences, which is being delivered by colleagues from CATH (Churches Action for the Homeless) and APEX. Face-to-face interaction both pre- and post-liberation has seen success with 39 people supported during the year. Plans are in development to expand to model to offer the service to remand and long-term prisoners.

3.6.6 In addition, initial work to implement the MAT Standards across the prison estate by April 2025 has been taking place, supported by the PHS MIST (MAT Standards Implementation and Support Team). The ADP is a member of the HMP Perth implementation group and early work has included the production of an induction booklet for families, a new process being tested to ensure all prisoners are registered with a GP on release and further expansion of the recovery hub.

3.7 Children and Families affected by substance use will be safe, healthy included and supported.

3.7.1 A key strategic aim of the ADP is to ensure that a whole family/ system approach is embedded across services. The ADP has funded several projects that are designed to implement a Whole Family Approach. These include providing funding for a project worker for the Families Empowering Communities project, which is a community-led intervention in Letham and Crieff which seeks to reduce disadvantage and inequality for families by encouraging co-designed solutions and foster better collaborative working between community members and services. Some of the positive outcomes the project has achieved to date include the provision of whole family support and one-to-one support, the development of a wellbeing group for primary aged children and a summer activity programme designed by parents.

3.7.2 The ADP is also a member of the Whole Family Wellbeing Fund Steering Group which aims to increase provision of early intervention and preventative holistic family support that addresses the needs of families, including those

with substance use issues, at the earliest time of need. Work is ongoing to identify gaps in current service provision and how these can be addressed.

4. CONCLUSION

4.1 2022-23 saw the ADP make significant progress in achieving the aims of its current Strategic Delivery Plan. A further reduction in the number of drug-related deaths in Perth and Kinross, a significant reduction in waiting times and the implementation of MAT Standards 1-5 all contributed to this progress. Further details are in the ADP Annual Reporting Survey 2022-23 in Appendix 1.

4.2 However, there is still much work to do as the numbers for both drug-related deaths and alcohol-related deaths remain high, as do the number of referrals to alcohol and drug services. Therefore, during 2023-24, several key actions will be progressed. These include the implementation of MAT Standards 6-10, the expansion of the successful community alcohol detox service and consideration of how to respond to the emerging trend of benzodiazepine and stimulant use, both locally and across Tayside.

4.3 A new three-year ADP Strategic Delivery Plan will also be developed which will allow partners to plan and respond flexibly to the short- and longer-term challenges and monitor the impact of their response.

Authors

Name	Designation	Contact Details
Kenny Ogilvy	ADP Chair	
Charlie Cranmer	ADP Coordinator	

Appendix 1: ADP Annual Reporting Survey 2022-23 – Perth and Kinross.

Appendix 1

Alcohol and Drug Partnership (ADP) Annual Reporting Survey: 2022/23

This survey is designed to collect information from all ADPs across Scotland on a range of aspects relating to the delivery of the National Mission **during the financial year 2022/23**. This will not reflect the totality of your work but will cover those areas where you do not already report progress nationally through other means.

The survey is primarily composed of single option and multiple-choice questions, but we want to emphasise that the options provided are for ease of completion and it is not expected that every ADP will have all of these in place. We have also included open text questions where you can share more detail.

We do not expect you to go out to services in order to respond to questions relating to activities undertaken by them in your area. Where questions refer to service level activities, we are interested in the extent to which you are aware of these at an ADP level.

We are aware of some element of duplication with regards to questions relating to MAT Standards and services for children and young people. To mitigate this, we've reviewed the relevant questions in this survey and determined the ones that absolutely need to be included in order to evidence progress against the national mission in the long-term. While some of the data we are now asking for may appear to have been supplied through other means, this was not in a form that allows for consistently tracking change over time.

The data collected will be used to better understand the challenges and opportunities at the local level and the findings will be used to help inform the following:

- The monitoring of the National Mission;
- The work of a number of national groups including the Whole Family Approach Group, the Public Health Surveillance Group and the Residential Rehabilitation Working Group, amongst others; and
- The priority areas of work for national organisations which support local delivery.

The data will be analysed and findings will be published at an aggregate level as Official Statistics on the Scottish Government website. All data will be shared with Public Health Scotland to inform drug and alcohol policy monitoring and evaluation, and excerpts and/or summary data may be used in published reports. It should also be noted that the data provided will be available on request under freedom of information regulations and so we would encourage you to publish your return.

The deadline for returns is Monday 19th June 2023. Your submission should be signed off by the ADP and the IJB, with confirmation of this required at the end of the questionnaire. We are aware that there is variation in the timings of IJB meetings so please let us know if this will be an issue.

If you require clarification on any areas of the survey or would like any more information, please do not hesitate to get in touch by email at substanceuseanalyticalteam@gov.scot.

Cross-cutting priority: Surveillance and Data Informed

Q1) Which Alcohol and Drug Partnership (ADP) do you represent?
[single option, drop-down menu]

Perth & Kinross ADP

Q2) Which groups or structures were in place **at an ADP level** to inform surveillance and monitoring of alcohol and drug harms or deaths? (select all that apply)
[multiple choice]

- ☐ Alcohol harms group
- ☐ Alcohol death audits (work being supported by AFS)
- ☒ Drug death review group
- ☒ Drug trend monitoring group/Early Warning System
- ☐ None
- ☐ Other (please specify):

Q3a) Do Chief Officers for Public Protection receive feedback from drug death reviews? (select only one)
[single option]

☐ Yes
☒ No
☐ Don't know

Q3b) If no, please provide details on why this is not the case.
[open text – maximum 255 characters]

At present, IDART review alcohol related deaths if the service user dies in service. There are occasions where service users who are open due to alcohol issues die as a result of drug use, and they are reviewed in the same process. IDART receive information from Public Health about deaths, and they are reported on DATIX, NHS Tayside's risk reporting system. A local adverse event review (LAER) is planned and take place. All services involved in the care of the service user are invited. The review looks for any learning or good practice that can be identified and shared. Learning is shared in IDART by memos to staff and discussion in team meetings. This approach can lead to a change in practice where improvement is identified. It is an opportunity for the family to receive feedback and support around the death of a loved one.

Q4a) As part of the structures in place for the monitoring and surveillance of alcohol and drugs harms or deaths, are there local processes to record lessons learnt and how these are implemented? (select only one)
[single option]

☒ Yes
☐ No
☐ Don't know

Q4b) If no, please provide details.
[open text – maximum 255 characters]

Cross-cutting priority: Resilient and Skilled Workforce

Q5a) What is the whole-time equivalent staffing resource routinely dedicated to your ADP Support Team as of 31st March 2023.
[open text, decimal]

Total current staff (whole-time equivalent including fixed-term and temporary staff, and those shared with other business areas)	3.7
Total vacancies (whole-time equivalent)	0

Q5b) What type of roles/support (e.g. analytical support, project management support, etc.) do you think your ADP support team might need locally? Please indicate on what basis this support would be of benefit in terms of whole-time equivalence.
[open text – maximum 255 characters]

The current staffing resource comprises 1 Lead Officer, 1 Development Officer, 0.5 MAT Standards Project Officer, 0.4 Business Improvement Officer, 0.3 Contracts and Commissioning Officer, 2 x 0.1 Finance Officers, 1x 0.1 Admin support and 0.17 Analyst.

The ADP support team would benefit from more dedicated support as presently, only 3 posts (2.5 WTE) are employed to provide this, with the others splitting their time between the ADP and other services. In particular, having a dedicated 1.0 WTE Recovery Communities Development Officer would support and enhance the development of recovery communities across Perth and Kinross.

Q6a) Do you have access to data on **alcohol and drug services** workforce statistics in your ADP area? (select only one)
[single option]
☐ Yes
☐ No (please specify who does):
☒ Don't know

6b) If yes, please provide the whole-time equivalent staffing resource **for alcohol and drug services** in your ADP area.
[open text, decimal]

Total current staff (whole-time equivalent)	
Total vacancies (whole-time equivalent)	

Q7) Which, if any, of the following activities are you aware of having been undertaken in your ADP area to improve and support workforce wellbeing (volunteers as well as salaried staff)? (select all that apply)
[multiple choice]
☒ Coaching, supervision or reflective practice groups with a focus on staff wellbeing
☒ Flexible working arrangements
☒ Management of caseload demands

☒ Provision of support and well-being resources to staff
☒ Psychological support and wellbeing services
☐ Staff recognitions schemes
☐ None
☐ Other (please specify):

Cross cutting priorities: Lived and Living Experience

Q8a) Do you have a formal mechanism at an ADP level for gathering feedback from people with lived/living experience using services you fund? (select all that apply)
[multiple choice]

☒ Feedback/complaints process
☒ Questionnaire/survey
☐ No
☐ Other (please specify):

Q8b) How do you, as an ADP, use feedback received from people with lived/living experience and family members to improve service provision? (select all that apply)
[multiple choice]

	Lived/living experience	Family members
Feedback used to inform service design	☒	☒
Feedback used to inform service improvement	☒	☒
Feedback used in assessment and appraisal processes for staff	☐	☐
Feedback is presented at the ADP board level	☒	☒
Feedback is integrated into strategy	☒	☒
Other (please specify)		

Q9a) How are **people with lived/living experience** involved within the ADP structure?
(select all that apply)
[multiple choice]

	Planning (e.g. prioritisation and funding decisions)	Implementation (e.g. commissioning process, service design)	Scrutiny (e.g. monitoring and evaluation of services)	Other (please specify)
Board representation at ADP	☐	☒	☒	
Focus group	☐	☐	☐	
Lived experience panel/forum	☐	☒	☒	
Questionnaire/ surveys	☐	☒	☒	
Other (please specify)				

Q9b) How are **family members** involved within the ADP structure? (select all that apply)
[matrix, multiple choice]

	Planning (e.g. prioritisation and funding decisions)	Implementation (e.g. commissioning process, service design)	Scrutiny (e.g. monitoring and evaluation of services)	Other stage (please specify)
Board representation at ADP	☒	☒	☒	
Focus group	☐	☒	☒	
Lived experience panel/forum	☐	☐	☐	
Questionnaire/ surveys	☐	☒	☒	
Other (please specify)				

Q9c) If any of the above are in development for either people with lived/living experience and/or family members, please provide details.
[open text – maximum 2000 characters]

PKADP is currently in the process of developing a Living Experience Group. This is an SDF (Scottish Drugs Forum) supported group. This is 'Engagement Group' which focuses on supporting people who are using services to take an active part in the ADP by giving feedback to a management group, which is made up of key members of the Adult Delivery Group. This supports the ADP's aims around the MAT Standards. The ADP Development Officer is the direct link to the Engagement Group and meets regularly with them to discuss ways of engaging and feeding back to the ADP.

Once the Engagement Group has been established, it is intended that this group will be represented at the ADP Strategy Group, thereby enabling the group to play an active role in strategic planning.

Q10) What monitoring mechanisms are in place to ensure that services you fund are encouraged/supported to involve people with lived/living experience and/or family members in the different stages of service delivery (i.e. planning, implementation and scrutiny)?
[open text – maximum 2000 characters]

All funding applications are submitted using our ADP funding application template. This asks the requester to consider how their project matches our priorities as outlined in our Strategic Delivery Plan. Cross cutting priority 1 in the plan is "Lived experience at the heart". This seeks to ensure that people with lived experience will play a key role in system and service development. Therefore, all funded projects are required to ensure people with lived experience are involved with the proposed project. Following the award of funding, ADP contracts and commissioning colleagues employ a logic model and service specification to establish outcomes. Performance is regularly monitored with monitoring employed to evidence that the outcomes are being met/achieved.

Q11) Which of the following support is available to people with lived/living experience and/or family members to reduce barriers to involvement? (select that apply)
[multiple choice]
☒ Advocacy
☒ Peer support
☒ Provision of technology/materials
☒ Training and development opportunities
☒ Travel expenses/compensation
☒ Wellbeing support
☐ None
☐ Other (please specify):

Q12a) Which of the following volunteering and employment opportunities for people with lived/living experience are offered by services in your area? (select all that apply)
[multiple choice]
☒ Community/recovery cafes
☒ Job skills support
☒ Naloxone distribution
☒ Peer support/mentoring
☐ Psychosocial counselling
☐ None
☐ Other (please specify):

Q12b) What are the main barriers to providing volunteering and employment opportunities to people with lived/living experience within your area?
[open text – maximum 2000 characters]

People with lived experience are employed by several partner organisations such as Hillcrest Futures and IDART. However, the geography of Perth and Kinross poses challenges in providing volunteering and employment opportunities, with travel throughout the often region often required.

Q13) Which organisations or groups are you working with to develop your approaches and support your work on meaningful inclusion? (select all that apply)
[multiple choice]
☒ MAT Implementation Support Team (MIST)
☒ Scottish Drugs Forum (SDF)
☒ Scottish Families Affected by Drugs and Alcohol (SFAD)
☐ Scottish Recovery Consortium (SRC)
☐ None
☐ Other (please specify):

Cross cutting priorities: Stigma Reduction

Q14) Do you consider stigma reduction for people who use substances and/or their families in any of your written strategies or policies (e.g. Service Improvement Plan)? (select only one)
[single option]
☒ Yes (please specify which): The current P&K ADP Strategic Delivery Plan 2020-23
☐ No
☐ Don't know

Q15) Please describe what work is underway to reduce stigma for people who use substance and/or their families in your ADP area.
[open text – maximum 2000 characters]

The current ADP Strategic Delivery plan has stigma as our 3rd Cross-cutting Priority. We aim to address stigma in our communities by working together and individually to reduce stigma across Perth and Kinross. This will result in people with lived experience of substance use experiencing less stigma, as will staff who work in substance use services.

We have identified 3 key actions to achieve these outcomes. Firstly, we will support local activity to challenge stigma. The ADP has previously supported Hillcrest Futures in the developed of its overdose campaign which was developed in partnership with people who have lived experience of substance use. The campaign has continued to raise awareness of the risk factors of drug-related overdose, provide safety advice and reduce community stigma around overdose. Posters for the campaign were distributed to hostels, GPs, pharmacies and local partner agencies.

The ADP has also supported the pan-Tayside Language Matters campaign which challenges the use of negative language towards people who use substances. This is part of wider work in response to the recommendations from the Dundee Drugs Commission.

Our second and third key actions focus on supporting the Scottish Government's work to tackle stigma. The Scottish Government recently published a new Stigma Strategy Action Plan. This will see the Government coproduce interventions to tackle social stigma and commission the third sector to establish and deliver a national programme of work. In addition, the Scottish Government will design an accreditation scheme for businesses and services which will include commitments to take defined and measurable actions to challenge and remove structural stigma. The Scottish Government will commission the third sector and living and lived experience community to deliver this.

Fewer people develop problem substance use

Q16) How is information on local treatment and support services made available to different audiences **at an ADP level** (not at a service level)? (select all that apply) [multiple choice]

	Non-native English speakers (English Second Language)	People with hearing impairments	People with learning disabilities and literacy difficulties	People with visual impairments	Other audience (please specify)
In person (e.g. at events, workshops, etc)	☒	☒	☒	☒	
Leaflets/posters	☐	☐	☐	☐	
Online (e.g. websites, social media, apps, etc.)	☒	☒	☒	☒	
Other (please specify)					

Q17) Which of the following education or prevention activities were funded or supported by the ADP? (select all that apply)
[multiple choice]

	0-4 (early years)	5-12 (primary)	13-15 (secondary S1-4)	16-24 (young people)	25+ (adults)	Parents	People in contact with the justice system	Other audience (please specify)
Counselling services	☒	☒	☒	☒	☒	☒	☒	
Information services	☐	☒	☒	☒	☒	☒	☒	
Physical health	☐	☐	☐	☒	☒	☒	☒	
Mental health	☒	☒	☒	☒	☒	☒	☒	
Naloxone	☐	☐	☐	☒	☒	☒	☒	
Overdose awareness and prevention	☐	☐	☐	☒	☒	☒	☒	
Parenting	☐	☐	☐	☒	☒	☒	☒	
Peer-led interventions	☐	☐	☒	☒	☒	☒	☒	
Personal and social skills	☐	☐	☒	☒	☒	☒	☒	
Planet Youth	☐	☐	☐	☐	☐	☐	☐	
Pre-natal/pregnancy	☐	☐	☒	☒	☒	☒	☒	
Reducing stigma	☐	☐	☒	☒	☒	☒	☒	
Seasonal campaigns	☐	☐	☐	☒	☒	☒	☒	
Sexual health	☐	☐	☒	☒	☒	☒	☒	
Teaching materials for schools	☐	☒	☒	☒	☐	☐	☐	
Wellbeing services	☐	☐	☐	☒	☒	☒	☒	
Youth activities (e.g. sports, art)	☐	☒	☒	☒	☐	☐	☐	
Youth worker materials/training	☐	☒	☒	☒	☐	☐	☐	
Other (please specify)								

Risk is reduced for people who use substances

Q18a) In which of the following settings is **naloxone** supplied in your ADP area? (select all that apply)
[multiple choice]
☐ Accident & Emergency departments
☒ Community pharmacies
☒ Drug services (NHS, third sector, council)
☐ Family support services
☐ General practices
☒ Homelessness services
☐ Justice services
☐ Mental health services
☒ Mobile/outreach services
☐ Peer-led initiatives
☒ Women support services
☐ None
☒ Other (please specify): HMP Perth and HMP Castle Huntly

Q18b) In which of the following settings is **Hepatitis C testing** delivered in your ADP area? (select all that apply)
[multiple choice]
☐ Accident & Emergency departments
☐ Community pharmacies
☒ Drug services (NHS, third sector, council)
☐ Family support services
☒ General practices
☐ Homelessness services
☐ Justice services
☐ Mental health services
☐ Mobile/outreach services
☐ Peer-led initiatives
☐ Women support services
☐ None
☐ Other (please specify):

Q18c) In which of the following settings is the **provision of injecting equipment** delivered in your ADP area? (select all that apply)
[multiple choice]
☒ Accident & Emergency departments
☒ Community pharmacies
☒ Drug services (NHS, third sector, council)
☐ Family support services
☐ General practices
☐ Homelessness services
☐ Justice services
☐ Mental health services
☐ Mobile/outreach services
☐ Peer-led initiatives
☐ Women support services
☐ None
☐ Other (please specify):

Q18d) In which of the following settings is **wound care** delivered in your ADP area? (select all that apply)
[multiple choice]
☒ Accident & Emergency departments
☐ Community pharmacies
☒ Drug services (NHS, third sector, council)
☐ Family support services
☒ General practices
☐ Homelessness services
☐ Justice services
☐ Mental health services
☐ Mobile/outreach services
☐ Peer-led initiatives
☐ Women support services
☐ None
☐ Other (please specify):

Q19a) Are there protocols in place to ensure **all** prisoners identified as at risk are offered with naloxone upon leaving prison? (select only one)
[single option]
☒ Yes
☐ No
☐ No prison in ADP area

Q19b) If no, please provide details.
[open text – maximum 255 characters]

People most at risk have access to treatment and recovery

Q20a) Are referral pathways in place in your ADP area to ensure people who experience a near-fatal overdose (NFO) are identified and offered support? (select only one)
[single option]
☒ Yes
☐ No
☐ Don't know

Q20b) If yes, have people who have experienced a near-fatal overdose been successfully referred using this pathway? (select only one)
[single option]
☒ Yes
☐ No
☐ Don't know

Q20c) If no, when do you intend to have this in place?
[open text – maximum 255 characters]

Q21) In what ways have you worked with justice partners? (select all that apply)
[multiple choice]
☒ Contributed towards justice strategic plans (e.g. diversion from justice)
☒ Coordinating activities
☒ Information sharing
☒ Joint funding of activities
☒ Justice partners presented on the ADP
☒ Prisons represented on the ADP (if applicable)
☒ Providing advice/guidance
☐ None
☐ Other (please specify):

Q22a) Do you have a prison in your ADP area? (select only one)
[single option]
☒ Yes
☐ No

Q22b) Which of the following activities did the ADP support or fund at the different stages of engagement with the justice system? (select all that apply)
[multiple choice]

	Pre-arrest	In police custody	Court	Prison (if applicable)	Upon release	Community justice
Advocacy	☐	☐	☐	☐	☒	☒
Alcohol interventions	☐	☒	☐	☒	☒	☒
Alcohol screening	☐	☐	☐	☐	☐	☐
Buvidal provision	☐	☐	☐	☒	☒	☒
Detoxification	☐	☐	☐	☐	☐	☒
Drugs screening	☐	☐	☐	☐	☐	☐
Psychological screening	☐	☐	☐	☐	☐	☐
Harm reduction	☒	☒	☐	☒	☒	☒
Health education	☐	☐	☐	☐	☐	☒
"Life skills" support or training (e.g. personal/social skills, employability)	☒	☒	☐	☒	☒	☒
Opioid Substitution Therapy (excluding Buvidal)	☐	☒	☐	☒	☒	☒
Peer-to-peer naloxone	☒	☒	☐	☒	☒	☒
Recovery cafe	☐	☐	☐	☒	☒	☒
Recovery community	☐	☐	☐	☒	☒	☒
Recovery wing	☐	☐	☐	☒	☐	☐
Referrals to alcohol treatment services	☒	☒	☐	☒	☒	☒
Referrals to drug treatment services	☒	☒	☐	☒	☒	☒
Staff training	☒	☒	☐	☒	☒	☒
Other (please specify)						

Q23a) How many recovery communities are you aware of in your ADP area?
[open text, integer]

7

Q23b) How many recovery communities are you actively engaging with or providing support to?
[open text, integer]

7

Q24a) Which of the following options are you using to engage with or provide support to recovery communities in your area? (select all that apply)
[multiple choice]

☒ Funding
☒ Networking with other services
☒ Training
☐ None
☐ Other (please specify):

Q24b) How are recovery communities involved **within the ADP**? (select all that apply)
[multiple choice]

☒ Advisory role
☒ Consultation
☒ Informal feedback
☒ Representation on the ADP board
☐ Recovery communities are not involved within the ADP
☐ Other (please specify):

People receive high quality treatment and recovery services

Q25) What treatment or screening options are in place to address **alcohol harms**? (select all that apply)
[multiple choice]
☒ Access to alcohol medication (Antabuse, Acamprase, etc.)
☒ Alcohol hospital liaison
☒ Alcohol related cognitive testing (e.g. for alcohol related brain damage)
☒ Arrangements for the delivery of alcohol brief interventions in all priority settings
☒ Arrangement of the delivery of alcohol brief interventions in non-priority settings
☒ Community alcohol detox
☒ In-patient alcohol detox
☒ Fibro scanning
☒ Psychosocial counselling
☐ None
☐ Other (please specify):

Q26) Which, if any, of the following barriers to residential rehabilitation exist in your ADP area? (select all that apply)
[multiple choice]
☐ Current models are not working
☐ Difficulty identifying all those who will benefit
☐ Further workforce training required
☒ Insufficient funds
☒ Lack of specialist providers
☐ Scope to further improve/refine your own pathways
☐ None
☐ Other (please specify):

Q27) Have you made any revisions in your pathway to residential rehabilitation in the last year? (select only one)
[single option]
☐ No revisions or updates made in 2022/23
☒ Revised or updated in 2022/23 and this has been published
☐ Revised or updated in 2022/23 but not currently published

Q28) Which, if any, of the following barriers to implementing MAT exist in your area? (select all that apply)
[multiple choice]
☐ Difficulty identifying all those who will benefit
☐ Further workforce training is needed
☒ Insufficient funds
☐ Scope to further improve/refine your own pathways
☐ None
☐ Other (please specify):

Q29a) Which of the following treatment and support services are in place specifically for children and young people **aged between 13 and 24** using **alcohol**? (select all that apply) [multiple choice]

	13-15 (secondary S1-4)	16-24 (young people)
Alcohol-related medication (e.g. acamprosate, disulfiram, naltrexone, nalmefene)	☐	☒
Diversionary activities	☒	☒
Employability support	☐	☒
Family support services	☒	☒
Information services	☒	☒
Justice services	☐	☒
Mental health services	☒	☒
Outreach/mobile	☒	☒
Recovery communities	☐	☒
School outreach	☒	☒
Support/discussion groups	☒	☒
Other (please specify)		

Q29b) Please describe what treatment and support is in place **specifically for children aged 0-4 (early years)** and **5-12 (primary)** affected by **alcohol**.
[open text – maximum 2000 characters]

Hopscotch – 1:1 therapeutic and didactic family support to children and young people and parents/ carers impacted by substance use. Uses a relationship-based, trauma-informed and Whole Family Approach

Space4U – 1:1 family sessions providing a range of intensive emotional/ practical support to children and young people and families impacted by substance use, mental health and domestic abuse. Supports families who are on the cusp of requiring social work support. Uses a relationship-based trauma-informed and Whole Family Approach.

Family Mentoring Service – Supports families to achieve their goals using a Whole Family Approach with goal-focused mentoring. Uses a WFA tool developed as part of an ADP multi-agency group. Supports families who are on the cusp of requiring social work support.

TCA Family Sessions – This is an offer of family group sessions, facilitated by 2 staff, of which one is a trained counsellor. The focus is on supporting communication developing a whole family recovery plan.

Kith 'n' Kin – The service offers support to kinship carers and the children in their care where parents are unable to care due to substance use issues. The service offers 1:1 and group support and school holiday activity programmes.

IDART – The service offers family group therapy, in addition to sign-posting and harm reduction information and intervention.

Hillcrest Futures Young People's Drug and Alcohol Service – The services uses a 4-tier intervention model aimed at providing interventions rom universal awareness to a structures 6-8 week programme using a variety of tools and resources to support a young person's substance use.

Change is a Must – This is a multi-agency partnership between Perth and Kinross Council and IDART. The team offers assessment and intensive family support for infants and their families affected by issues such as parental substance use, parental mental health issues and domestic violence.

Q30a) Which of the following treatment and support services are in place specifically for children and young people **aged between 13 and 24** using **drugs**? (select all that apply) [multiple choice]

	13-15 (secondary S1-4)	16-24 (young people)
Diversionary activities	☒	☒
Employability support	☐	☒
Family support services	☒	☒
Information services	☒	☒
Justice services	☐	☒
Mental health services	☒	☒
Opioid Substitution Therapy	☐	☒
Outreach/mobile	☒	☒
Recovery communities	☐	☒
School outreach	☒	☒
Support/discussion groups	☒	☒
Other (please specify)		

Q30b) Please describe what treatment and support is in place **specifically for children aged 0-4 (early years)** and **5-12 (primary)** affected by **drugs**.
[open text – maximum 2000 characters]

Hopscotch – 1:1 therapeutic and didactic family support to children and young people and parents/ carers impacted by substance use. Uses a relationship-based, trauma-informed and Whole Family Approach

Space4U – 1:1 family sessions providing a range of intensive emotional/ practical support to children and young people and families impacted by substance use, mental health and domestic abuse. Supports families who are on the cusp of requiring social work support. Uses a relationship-based trauma-informed and Whole Family Approach.

Family Mentoring Service – Supports families to achieve their goals using a Whole Family Approach with goal-focused mentoring. Uses a WFA tool developed as part of an ADP multi-agency group. Supports families who are on the cusp of requiring social work support.

TCA Family Sessions – This is an offer of family group sessions, facilitated by 2 staff, of which one is a trained counsellor. The focus is on supporting communication developing a whole family recovery plan.

Kith 'n' Kin – The service offers support to kinship carers and the children in their care where parents are unable to care due to substance use issues. The service offers 1:1 and group support and school holiday activity programmes.

IDART – The service offers family group therapy, in addition to sign-posting and harm reduction information and intervention.

Hillcrest Futures Young People's Drug and Alcohol Service – The services uses a 4-tier intervention model aimed at providing interventions rom universal awareness to a structures 6-8 week programme using a variety of tools and resources to support a young person's substance use.

Change is a Must – This is a multi-agency partnership between Perth and Kinross Council and IDART. The team offers assessment and intensive family support for infants and their families affected by issues such as parental substance use, parental mental health issues and domestic violence.

Quality of life is improved by addressing multiple disadvantages

Q31) Do you have specific treatment and support services in place for the following groups? (select all that apply)
[multiple choice]

	Yes	No
Non-native English speakers (English Second Language)	☐	☒
People from minority ethnic groups	☐	☒
People from religious groups	☐	☒
People who are experiencing homelessness	☐	☒
People who are LGBTQI+	☐	☒
People who are pregnant or peri-natal	☐	☒
People who engage in transactional sex	☐	☒
People with hearing impairments	☐	☒
People with learning disabilities and literacy difficulties	☐	☒
People with visual impairments	☐	☒
Veterans	☐	☒
Women	☒	☐
Other (please specify)		

Q32a) Are there formal joint working protocols in place to support people **with co-occurring substance use and mental health diagnoses** to receive mental health care? (select only one)
[single choice]
☐ Yes (please provide link here or attach file to email when submitting response):
☒ No

Q32b) If no, please provide details.
[open text – maximum 255 characters]

The ADP is a member of the HIS-led Integrated Mental Health and Substance Use Pathfinder Steering Group. The Pathfinder Project seeks to improve outcomes for people with a dual diagnosis of mental ill health and substance use by developing a new model and pathway of care, with a view to developing and delivering integrated and inclusive mental health and substance use services.

Following an initial discovery phase, local working groups have been established to review local service design. A Tayside working group has also been established to bring together the work of the local pathways to produce an overall Tayside pathway.

Q33) Are there arrangements (in any stage of development) within your ADP area for people who present at substance use services with mental health concerns **for which they do not have a diagnosis**?
[open text – maximum 2000 characters]

A key action in the Perth and Kinross Community Mental Health and Wellbeing Strategy 22-25 is to develop a model for integrated mental health and substance use provision. Local

work to date has seen the creation of a service manager post with responsibility for both mental health and substance use services. Additionally, the ADP has funded a social work post within its IDART service to specifically work with people who are experiencing both substance use and mental health issues.

The ADP is also funding a test of change which will see the establishment of a new Multiagency Mental Health triage meeting and out-of-hours crisis support service for people who experience mental health and substance use issues.

Q34) How are you, as an ADP, linked up with support service **not directly linked to substance use** (e.g. welfare advice, housing support, etc.)?
[open text – maximum 2000 characters]

The ADP works with a range of partners, many of which are not directly linked to substance use. This can be evidenced by considering 3 areas of ADP work

ADP Groups membership: In addition to key statutory and third sector substance use services, membership of the ADP Strategy Group and various ADP subgroups includes a range of other services. These include: Police Scotland, Scottish Prison Service (SPS), PKC Housing, Scottish Fire and Rescue Service (SFRS), Independent Advocacy Perth and Kinross (IAPK), Community Justice and Safety, Mental Health, Primary Care, Schools and Services for Young People.

Third Sector collaborative: The ADP is a member of the Perth and Kinross Third Sector Collaborative. This is a collaborative of third sector organisations with an interest in community justice, safety and substance use outcomes. Members of the collaborative include organisations working in housing, welfare rights, employability and mental health. Being a member of the collaborative has afforded the ADP the opportunity to make slinks with a range of organisations that are not currently part of the ADP.

Voluntary Throughcare test of change: The ADP and Community Justice are currently piloting a new voluntary throughcare model for short-term and remand prisoners from Perth and Kinross who are residing in HMP Perth. This has resulted in the ADP working with a range of service providers, including those from justice, housing, welfare rights and employability.

Q35) Which of the following activities are you aware of having been undertaken in local services to implement a trauma-informed approach? (select all that apply)
[multiple choice]
☒ Engaging with people with lived/living experience
☒ Engaging with third sector/community partners
☒ Recruiting staff
☒ Training existing workforce
☒ Working group
☐ None
☐ Other (please specify):

Children, families and communities affected by substance use are supported

Q36) Which of the following treatment and support services are in place for **children and young people** (under the age of 25) **affected by a parent's or carer's substance use**? (select all that apply)
[multiple choice]

	0-4 (early years)	5-12 (primary)	13-15 (secondary S1-4)	16-24 (young people)
Carer support	☒	☒	☒	☒
Diversionary activities	☐	☐	☒	☒
Employability support	☐	☐	☐	☒
Family support services	☒	☒	☒	☒
Information services	☒	☒	☒	☒
Mental health services	☒	☒	☒	☒
Outreach/mobile services	☐	☐	☒	☒
Recovery communities	☐	☐	☐	☒
School outreach	☒	☒	☒	☒
Support/discussion groups	☒	☒	☒	☒
Other (please specify)				

Q37a) Do you contribute toward the integrated children's service plan? (select only one)
[single option]

☒ Yes
☐ No
☐ Don't know

Q37b) If no, when do you plan to implement this?
[open text – maximum 255 characters]

Q38) Which of the following support services are in place **for adults** affected by **another person's substance use**? (select all that apply)
[multiple choice]
☒ Advocacy
☒ Commissioned services
☒ Counselling
☒ One to one support
☒ Mental health support
☒ Naloxone training
☒ Support groups
☒ Training
☐ None
☐ Other (please specify):

Q39a): Do you have an agreed set of activities and priorities with local partners to implement the Holistic Whole Family Approach Framework in your ADP area? (select only one)
[single option]
☒ Yes
☐ No
☐ Don't know

Q39b) Please provide details.
[open text – maximum 255 characters]

The current ADP Strategic Delivery Plan 20-23 outlines key priorities and actions that are broadly aligned with the Framework. Current ADP activity is therefore designed to deliver the aims of the Strategic Delivery Plan. Key activities include: ensuring people with lived experience are seen in the context of their families and friends; providing support to children affected by substance use and working with children and adult services to develop an improved interface that will provide support that is joined up and comprehensive and thus ensuring that services are family inclusive as part of their practice.

The ADP has funded several projects that are designed to implement a Whole Family Approach. These include providing funding for a resource worker for the Family Mentoring Project, which supports families to achieve their goals using a Whole Family Approach with goal-focused mentoring; proving funding for a project worker for the Families Empowering Communities project, which is a community-led intervention which seeks to reduce disadvantage and inequality for families by encouraging co-designed solutions and foster better collaborative working between community members and services; and providing funding for a mental health nurse for the Change is a Must project, which is a multi-agency partnership between PKC and IDART and offers assessment and intensive family support for infants and their families affected by parental substance use issues.

The ADP is also a member of the Whole Family Wellbeing Fund Steering Group which aims to increase provision of early intervention and preventative holistic family support that

addresses the needs of families, including those with substance use issues, at the earliest time of need.

Q40) Which of the following services supporting Family Inclusive Practice or a Whole Family Approach are in place? (select all that apply)
[multiple choice]

	Family member in treatment	Family member **not in treatment**
Advice	☒	☒
Advocacy	☒	☒
Mentoring	☒	☒
Peer support	☒	☒
Personal development	☒	☒
Social activities	☒	☒
Support for victims of gender based violence	☒	☒
Other (please specify)		

Confirmation of sign-off

Q41) Has your response been signed off at the following levels?
[multiple choice]
☒ ADP
☒ IJB
☐ Not signed off by IJB (please specify date of the next meeting):

Thank you for taking the time to complete this survey, your response is highly valued. The results will be published in the forthcoming ADP annual report, scheduled for publication in the autumn.

Please do not hesitate to get in touch via email at substanceuseanalyticalteam@gov.scot should you have any questions.

[End of survey]

PERTH & KINROSS INTEGRATION JOINT BOARD

20 SEPTEMBER 2023

AUDIT & PERFORMANCE COMMITTEE ANNUAL REPORT 2022-2023

Report by Chief Officer
(Report No. G/23/123)

PURPOSE OF REPORT

This report presents the Perth and Kinross Integrated Joint Board Audit and Performance Committee's Annual Report for 2022/2023 for the purposes of providing assurance to the Perth and Kinross Integrated Joint Board (IJB) that governance arrangements and internal controls are adequate for the IJB.

1. RECOMMENDATION(S)

It is recommended that the IJB:

- Notes the report and agrees to the level of assurance provided by the Chair of the Audit and Performance Committee as outlined in the Conclusion on of the Annual Report (Page 5 of Appendix 1); and
- Acknowledges the work of the Audit and Performance Committee Members.

2. BACKGROUND

The Perth and Kinross Integrated Joint Board Audit and Performance Committee (A&PC) was established in 2016 to ensure that the IJB met its responsibilities for governance under the Integrated Resources Advisory Group (IRAG) guidance.

The purpose of the A&PC is to provide independent assurance on the adequacy of the risk management framework, the internal control environment, and the integrity of the financial reporting and annual governance processes as well as scrutinising performance.

The Terms of Reference for the A&PC include a requirement to provide the IJB with an annual report summarising its conclusions from the work it has done during the year and providing an opinion on the adequacy and effectiveness of the systems of internal control.

3. SITUATION

The A&PC Annual Report 2022-2023 provides an overview of the Committee's activity during the financial year 2022-2023. The report at Appendix 1 provides information in relation to the programme of work and includes key points related to the following areas:

- Meetings; Membership and Attendance
- Governance and Assurance
- Internal and External Audit
- Performance
- Finance

A conclusion on the effectiveness of the business conducted by the A&PC is provided by the Chair.

4. CONCLUSION

The Audit and Performance Committee Annual Report 2022-2023 provides assurance to the IJB that it has taken appropriate steps to perform its delegated duties and fulfilled its agreed Terms of Reference .

Author(s)

Name	Designation	Contact Details
Beth Hamilton	Chair of the Audit and Performance Committee	tay.pkijbbusinesssupport@nhs.scot
Donna Mitchell	Interim Chief Finance Officer	tay.pkijbbusinesssupport@nhs.scot
Phil Jerrard	Governance and Risk Coordinator	tay.pkijbbusinesssupport@nhs.scot

NOTE: No background papers, as defined by Section 50D of the Local Government (Scotland) Act 1973 (other than any containing confidential or exempt information), were relied on to any material extent in preparing this report.

ANNEX

1. IMPLICATIONS, ASSESSMENTS, CONSULTATION AND COMMUNICATION

Strategic Implications	**Yes / None**
HSCP Strategic Commissioning Plan	**YES**
Transformation Programme	**NO**
Resource Implications	
Financial	**NO**
Workforce	**NO**
Assessments	
Equality Impact Assessment	**NO**
Risk	**NO**
Other assessments (enter here from para 3.3)	**NO**
Consultation	
External	**NO**
Internal	**YES**
Legal & Governance	
Legal	**YES**
Clinical/Care/Professional Governance	**NO**
Corporate Governance	**NO**
Directions	**NO**
Communication	
Communications Plan	**NO**

1. Strategic Implications

1.1 Strategic Commissioning Plan

The Strategic Delivery Plan supports the delivery of the Perth and Kinross Strategic Commissioning Plan in relation to all five deliverables below:

1 prevention and early intervention,
2 person centred health, care and support
3 work together with communities
4 inequality, inequity and healthy living
5 best use of facilities, people and resources

There are no direct strategic implications arising from the Audit and Performance Committee Annual Report 2022-2023 but it provides assurance that effective governance, risk management and internal controls are in place which will assist the achievement of all of the above strategic aims.

2. Resource Implications

2.1 Financial

N/a.

2.2 Workforce

N/a.

3. Assessments

3.1 Equality Impact Assessment

N/a.

3.2 Risk

N/a

3.3 Other assessments

N/a.

4. Consultation

4.1 External

N/a.

4.2 Internal

Internally, the Audit and Performance Committee Annual Report 2022-2023 has been shared and consulted upon with the Executive Management Team (EMT).

5. Legal and Governance

5.1 The Audit and Performance Committee Annual Report 2022-2023 supports the requirements of the Public Bodies (Joint Working) (Scotland) Act 2014 to establish an Audit and Performance Committee to provide assurance to the IJB.

6. Directions

N/a.

7. Communication

N/a.

2. BACKGROUND PAPERS/REFERENCES

(i) Internal Audit Strategy & Plan 2022/23
(ii) Internal audit Annual Report 2022/23
(iii) Audit Scotland Annual Audit Plan 2022/23
(iv) Audit and Performance Committee Workplan 2022/23

3. APPENDICES

Appendix 1 – Audit and Performance Committee Annual Report 2022-2023

ANNUAL REPORT OF THE PERTH AND KINROSS INTEGRATION BOARD

AUDIT AND PERFORMANCE COMMITTEE 2022-2023

FOREWORD

This report is the Annual Report of the Perth & Kinross Integration Joint Board's Audit and Performance Committee (the Committee) and provides an overview of the Committee's activity during the year 2022-2023.

This report sets out how the Audit and Performance Committee provides the independence, questioning and thoroughness across a wide range of internal control, governance, finance and performance related matters. The work of the Committee is a technical and challenging role but undoubtably is a crucial part in ensuring the success of the IJB's aims.

Therefore, it is important to formally recognise the commitment of the members of the Audit and Performance Committee, who are also members of the IJB, for their dedication and commitment to ensuring they deliver for the people of Perth and Kinross. Being a Committee Member brings additional workload, responsibilities as well as challenges with schedules. This is very much appreciated and acknowledged.

It is noteworthy and recognised that there are a range of skills, knowledge and experience that Audit and Performance Committee members bring to the Committee to fulfil its functions. This enhances the quality of scrutiny and discussion of reports at the meetings. No one committee member would be expected to be expert in all areas. The attendance of wider IJB members at some of the meetings provides further scrutiny and is very much welcomed and encouraged. Having a strong and committed Audit and Performance Committee is essential to ensure that the IJB can achieve its strategic aims and objectives efficiently.

Finally, it is also important to acknowledge the excellent work of Perth and Kinross Council's Committee Services into the production of papers that are submitted to the IJB and the running of the Committee generally.

Beth Hamilton

Chair of the Audit and Performance Committee

BACKGROUND

The Audit and Performance Committee was established in 2016 to ensure that the Integration Joint Board met its responsibilities for governance under the Integrated Resources Advisory Group (IRAG) guidance.

The Terms of Reference include a requirement for the Audit and Performance Committee to 'provide the IJB with an annual report summarising its conclusions from the work it has done during the year and providing an opinion on the adequacy and effectiveness of the systems of internal control.' The Scottish Government also issues guidance stating that the provision of an annual report is consistent with good practice for 'Audit and Assurance Committees'.

ROLE OF THE AUDIT AND PERFORMANCE COMMITTEE

The Audit and Performance Committee provides an independent and high-level resource to support good governance and strong financial management. It seeks to deliver independent assurance on the adequacy of the risk management framework and the associated internal control environment, the integrity of the financial and non-financial performance and oversees the financial reporting process.

The Committee's specific powers and duties are set out in the Terms of Reference as attached at Appendix 1. The Terms of Reference are reviewed on a regular basis.

MEETINGS AND MEMBERSHIP

The Terms of Reference for the Audit and Performance Committee state that the Committee meet at least three times each financial year. In 2022-2023 the Committee met on three occasions in September, November 2022 and March 2023.

The Committee received and considered reports on the following areas of delegated authority from the IJB:

- Governance and Assurance
- Audit
- Performance
- Finance

During the financial year 2022/23, the Audit and Performance Committee comprised of two Non-Executive Directors from NHS Tayside, two Elected Members from Perth and Kinross Council and two Public Partners. The Committee was Chaired by NHS Tayside Non-Executive Director Beth Hamilton.

Further information on membership and attendance at meetings is attached at Appendix 2.

The specific work undertaken by the Committee is set out below:

GOVERNANCE AND ASSURANCE

- The Audit and Performance Committee continued to review the adequacy and effectiveness of the systems and processes in place to manage the IJB's strategic risks via the consideration of a report on the strategic risk register at each meeting.
- Progress on the achievement of actions within the Partnership Improvement Plan were scrutinised by the Committee in September 2022 and March 2023. The Partnership Improvement Plan consolidates all improvement actions arising from internal and external audit recommendations, the annual review of governance and external inspections.
- The Committee received assurance reports in November 2022 and March 2023 in respect of the Clinical, Care and Professional Governance arrangements in place for delegated and hosted services commissioned by the IJB and managed by Perth and Kinross Health and Social Care Partnership.
- The Annual Governance Statement is usually considered and approved by the Audit and Performance Committee. However, due to local government elections taking place, this was not possible, so the draft Annual Governance Statement was approved by the IJB in June 2022 for inclusion in the Unaudited Annual Accounts.
- 18 actions were identified in the AGS in 2022-23 to strengthen governance arrangements. Of these, 8 have been fully completed with the rest remaining on the Partnership Improvement Plan. The Partnership Improvement Plan.
- Reliance is placed on the IJB's partners systems of internal control and as such, assurance was provided in September 2022 to the IJB via the Audit and Performance Committee that effective and adequate governance arrangements were in place with Perth and Kinross Council, NHS Tayside, Dundee and Angus IJBs.
- The Audit and Performance Committee discuss the annual work plan for the financial year at each of their meetings. This is attached at appendix 3 for reference.

AUDIT

INTERNAL AUDIT ASSURANCE

Internal Audit is a key source of assurance for Committee Members and the Executive Management Team on the effectiveness of the internal control environment. Key activities during 2022-23 include:

- The Audit and Performance Committee approved the risk based Internal Audit Plan for 2022-2023 at its meeting in September 2023. The plan took account of the IJB's objectives, risk and performance management arrangements.
- The following specific assignments were highlighted for review during 2022-2023:

Reference	Title	Indicative Scope
PKIJB 22-01	Leadership Capacity	To act as 'critical friend' for the Chief Officer in the review of leadership capacity.

PKIJB 22-02	Sustainability of commissioned service providers	To review the sustainability of commissioned service providers.
PKIJB 22-03	Premises and Property	To provide assurance over the risks arising from premises and property which support the delivery of services on behalf of the IJB.

- Progress reports on the delivery of the Audit Plan were received by the Committee at each of its meetings in 2022-23.
- One assignment has been deferred until later in 2023, due to resource availability to support this review. The remaining planned assignments have commenced and will be delivered to the Committee in October 2023.
- An Annual Assurance Statement on the overall adequacy and effectiveness of the framework of governance, risk management and control in place during 2022-2023 was provided by the Chief Internal Auditor to the Audit and Performance Committee in June 2023 as part of the Annual Report.
- In the Chief Internal Auditor's opinion, reasonable reliance can be placed on the IJB's risk management, governance arrangements and systems of internal control for 2022-2023, subject to management implementation of the agreed actions detailed in Internal Audit reports.

EXTERNAL AUDIT ASSURANCE

External Audit is an essential part of the process of providing assurance for public funds providing an independent opinion on the financial statements , aspects of governance and overall financial management. Audit Scotland were appointed as external auditors in 2023 for a five-year period.

Key activities during 2022-23 include:

- The Annual Audit Plan of Perth and Kinross IJB for 2022-2023 was presented to the Audit and Performance Committee by Audit Scotland in March 2023. Audit Scotland provided the Committee with a summary of the work plan for their 2022-2023 external audit.
- The audit of the IJB's financial statements for 2022-2023 is ongoing at the moment and is expected to be received by the Audit and Performance Committee in October 2023. Consequently, this reduces the assurance that can be taken at the current time until this is delivered.

PERFORMANCE

- The Audit and Performance Committee received progress reports on the key national indicator set designated by the Scottish Government at each of its meetings in 2022-2023.
- Strategic delivery plans for Care Groups have been approved by the IJB which are closely aligned to the Financial Plan and the Workforce Plan. During 2022-2023 the Committee received key performance indicator reports for the strategic delivery plans concerning

Community Mental Health & Wellbeing and Learning Disability & Autism. A key performance indicator report will come forward to each Audit and Performance Committee meeting for each of the care group strategic delivery plans.

- In September 2022, the Audit and Performance Committee received and approved the IJB's Annual Performance Report which demonstrated the progress towards the IJB's strategic objectives. The Public Bodies (Joint Working) (Scotland) Act 2014 requires the IJB to publish an Annual Performance Report setting out an assessment of performance in respect to those functions for which it has responsibility.

FINANCE

- The Audit and Performance Committee considered Financial Position reports in September and November 2022 and in March 2023. These reports provided the Committee with the opportunity to scrutinise and to be assured that effective and accurate budgeting and in-year forecasting is in operation.
- The IJB's Unaudited Annual Accounts for 2021-22 were approved by the IJB in June 2022 rather than the Audit and Performance Committee, as is usual practice. This was due to local elections having taken place and new Committee Members from Perth and Kinross Council not being officially appointed at that point in time. The IJB duly approved the draft Annual Accounts.
- The Committee approved the signing of the letter of representation by senior management attesting to the external auditor that the financial statements and internal controls are accurate and that all information has been disclosed in the annual accounts.

CONCLUSION BY THE CHAIR OF THE AUDIT AND PERFORMANCE COMMITTEE

Based on the reports received by the Audit and Performance Committee during the year and the work demonstrated above, I, and the Committee Members, are of the view that appropriate steps have been taken by the Audit and Performance Committee to perform its delegated duties and fulfil its remit detailed in the Terms of Reference and that there are no significant issues to raise to the Integration Joint Board arising from the work in 2022-2023.

Beth Hamilton
Chair of the Audit and Performance Committee

Appendices

1 Terms of Reference
2 Membership and Attendance 2022-23
3 Annual Work Plan 2022-23

AUDIT & PERFORMANCE COMMITTEE

TERMS OF REFERENCE

Introduction

1. The Audit & Performance Committee (the Committee) is identified as a Committee of the Integration Joint Board (IJB). The approved Terms of Reference and information on the composition and frequency of the Committee shall be considered as an integral part of the Standing Orders. The Committee shall be a standing Committee of the IJB.

Purpose

2. The Committee shall provide independent assurance on the adequacy of the risk management framework, the internal control environment, and the integrity of the financial reporting and annual governance processes. The Committee shall scrutinise performance and best value arrangements.

Authority

3. The Committee is a decision-making committee which will include the approval of the Annual Audit Plan. The Committee is authorised to request reports and to make recommendations to the IJB for further investigation on any matters that fall within its Terms of Reference. The Committee will scrutinise and approve the draft unaudited accounts and the final audited accounts prior to submission to the IJB for information.

Membership

4. The IJB shall appoint the Committee. Membership must consist of an equal number of voting members from Perth & Kinross Council (the Council) and NHS Tayside (the NHS). The Committee shall comprise two voting members from the Council, two voting members from the NHS and two non-voting members from the IJB. The Chair of the IJB cannot be a member of the Audit & Performance Committee.

5. Any member of the IJB can attend the Audit & Performance Committee.

6. Members of the IJB, or their proxies or substitute members, may substitute for members of the Committee who represent the same organisation or group.

Chair

7. The Chair of the Committee shall be a voting member nominated by the IJB.

8. In the absence of the Chair, the Committee shall elect a voting member as Chair for the purposes of that meeting.

Quorum

9. Three members of the Committee shall constitute a quorum. At least two members present at a meeting of the Committee shall be voting members.

Meetings

10. Meetings of the Committee shall be conducted in accordance with the Standing Orders of the IJB.

11. The Committee shall meet at least three times each financial year.

12. The Chief Officer, Head of Finance and Corporate Services, Chief Internal Auditor, Head of Health, Head of Adult Social Work and Social Care, Chief Social Work Officer, P&K HSCP Associate Medical Director and other professional advisors or their nominated representatives shall normally attend meetings. Other persons shall attend meetings at the invitation of the Committee.

13. The External Auditor shall attend at least one meeting per annum. At the end of each meeting of the Audit & Performance Committee there will be an opportunity on request for a private discussion with the external and Chief Internal Auditors without other senior officers present.

Reporting

14. The Committee shall provide the IJB with an annual report summarising its conclusions from the work it has done during the year and providing an opinion on the adequacy and effectiveness of the systems of internal control. The Committee shall review its own effectiveness yearly through self assessment against its duties and report the results to the IJB.

15. The Chair of the Committee, or, in his/her absence, a nominated member, shall provide updates on the work of the Committee at each meeting of the IJB.

Duties

16. The Committee shall review the overall internal control arrangements of the IJB and make recommendations to the IJB regarding signing of the Governance Statement.

17. It shall be responsible for the following duties:

17.1 Performance/Best value/Scrutiny

- To prepare and implement the strategy for Performance Review
- To ensure that the Chief Officer establishes and implements satisfactory arrangements for reviewing and appraising service performance against set objectives, levels and standards of service, to receive regular reports on these and to review progress against the outcomes in the Strategic Plan
- To monitor progress and review updates on various pieces of work across the Health & Social Care system on behalf of the IJB, particularly in relation to the Strategic Planning & Commissioning Board and its underpinning Strategy Groups To ensure that quarterly performance reporting to the Audit & Performance Committee takes place utilising a core data set linked to the 6 Ministerial Steering Group (MSG) Performance Indicators and the 20 National Indicators
- To act as a focus for best value and performance initiatives and provide assurance on Best Value
- To scrutinise self evaluation documentation and inspection reports prior to submission to external inspectors
- To review reports of external inspections of health and social care services
- To maintain oversight of the Partnership's performance in statutory functions such as complaints handling, freedom of information and participation requests

17.2 Governance

- To review and approve the annual Internal Audit Plan on behalf of the IJB, receive reports and oversee and review progress on actions taken on audit recommendations and report to the IJB on these as appropriate
- To receive monitoring reports on the activity of Internal Audit
- To consider External Audit Plans and reports (including annual audit certificate/ annual report), matters arising from these and management actions identified in response
- To monitor the effectiveness of the control environment, including arrangements for ensuring value for money, supporting standards and ethics and for managing the Partnership's exposure to the risks of fraud and corruption.

- To review assurances provided from NHS Tayside and Perth & Kinross Council as to the effectiveness of their governance arrangements and systems of internal controls including Clinical Care Governance
- To review on a regular basis the implementation of actions agreed by management to remedy weaknesses identified by Internal or External Audit
- To consider the effectiveness of the authority's risk management arrangements and the control environment, reviewing the risk profile of the organisation and assurances that action is being taken on risk-related issues, including partnerships and collaborations with other Organisations
- To ensure the existence of and compliance with an appropriate Risk Management Strategy
- To be satisfied that the Integration Joint Board's annual assurance statements, including the Annual Governance Statement, properly reflect the risk environment and any actions required to improve it and demonstrate how governance supports the achievement of the authority's objectives

17.3 Audit

- To scrutinise and approve the draft unaudited annual accounts and the final audited annual accounts prior to submission to the IJB for information. To review the financial statements, external auditor's opinion and reports to members, and monitor management action in response to the issues raised by the external audit
- To be responsible for setting its own work programme, which shall include the right to undertake reviews following input from the IJB Committees and the Chief Officer, Chief Financial Officer and Chief Auditor
- In relation to the Partnership's internal audit functions:
  a) oversee its independence, objectivity, performance and professionalism
  b) support the effectiveness of the internal audit process
  c) promote the effective use of internal audit within the assurance framework
  d) To support effective relationships between external audit and internal audit, inspection agencies and other relevant bodies and encourage the active promotion of the value of the audit process
  e) To provide oversight of other public reports, such as the annual report

17.4 Standards

- To promote the highest standards of conduct and professional behaviour by IJB members in line with The Ethical Standards and Public Life etc (Scotland) Act 2000
- To assist IJB members in observing the relevant Codes of Conduct
- To monitor and keep under review the Codes of Conduct maintained by the IJB

Perth & Kinross Integration Joint Board
Audit & Performance Committee

Record of Attendance 1 April 2022 - 31 March 2023

Members

Name	Designation	Organisation	27 Jun 22	26 Sep 22	28 Nov 22	13 Mar 23
Beth Hamilton	Non Executive Director	Non Executive Director		PRESENT	PRESENT	PRESENT
Martin Black	Non Executive Director	Non Executive Director				PRESENT
Bernie Campbell	Carer's Representative	Public Partner		PRESENT	PRESENT	APOLOGIES
Councillor David Illingworth	Elected Member	Perth & Kinross Council		PRESENT	PRESENT	PRESENT
Councillor Sheila McCole	Non Executive Director	Perth & Kinross Council		PRESENT	PRESENT	PRESENT
Donald McPherson	Non Executive Director	NHS Tayside		PRESENT		
Sandy Watts	Third Sector Forum	Public Partner		PRESENT	PRESENT	PRESENT

In Attendance

Name	Designation	Organisation	27 Jun 22	26 Sep 22	28 Nov 22	13 Mar 23
Jane Smith	Chief Financial Officer	P&K HSCP		PRESENT	PRESENT	
Bob Benson	IJB Chair			PRESENT		
Jacquie Pepper	Chief Officer	P&K HSCP			PRESENT	PRESENT
Hamish Dougall	Associate Medical Director	P&K HSCP			PRESENT	PRESENT
Phil Jerrard	Governance & Risk Coordinator	P&K HSCP		PRESENT	PRESENT	PRESENT
Marc Grant	Finance Team Leader	P&K HSCP		PRESENT	PRESENT	PRESENT
Scott Hendry	Team Leader (Committee Services)	Perth & Kinross Council		PRESENT	PRESENT	
Adam Taylor	Assistant Committee Officer	Perth & Kinross Council		PRESENT		PRESENT
Magda Pasternack	Corporate and Democratic Services	Perth & Kinross Council		PRESENT		PRESENT
Audrey Brown	Corporate and Democratic Services	Perth & Kinross Council		PRESENT		PRESENT
Donna Mitchell	Interim Chief Finance Officer	P&K HSCP				PRESENT
Jackie Clark	Chief Internal Auditor	Perth & Kinross Council		PRESENT	PRESENT	PRESENT
Michael Wilkie	External Auditor	KPMG		PRESENT		
Carol Batchelor	External Auditor	KPMG		PRESENT		
Moira Bruce	External Auditor	Audit Scotland				PRESENT
Chris Jolly	Service Manager	P&K HSCP		PRESENT	PRESENT	PRESENT
Kenny Ogilvy	Acting Head of Service ASWSC Operations	P&K HSCP			PRESENT	PRESENT
Zoe Robertson	Acting Head of Service ASWSC Commissioning	P&K HSCP		PRESENT	PRESENT	PRESENT
Lyndsay Hunter	IJB Member			PRESENT	PRESENT	PRESENT
Stuart Hope	IJB Member			PRESENT		
Karyn Sharp	North Locality Manager	P&K HSCP		PRESENT		
Mark Dickson	Clinical Governance Coordinator	P&K HSCP		PRESENT	PRESENT	
Dave Henderson	IJB Member					PRESENT
Amanda Taylor	Senior Service Manager	P&K HSCP		PRESENT		
Chris Lamont	Senior Service Manager	P&K HSCP				PRESENT

Meeting Cancelled

PERTH & KINROSS INTEGRATION JOINT BOARD
AUDIT AND PERFORMANCE COMMITTEE
WORK PLAN 2022/23

This work plan outlines the major items the Audit and Performance Committee has to consider as part of its schedule of work for the year. This should allow the Committee to fulfil its terms of reference. It will continue to be kept under review throughout the year.

Item	Standing Item	Non Standing Item	Responsibility	June 27th 2022	September 26th 2022	November 28th 2022	March 13th 2023
Governance and Assurance							
Strategic Risk Management Update	✓		Chief Officer	✓	✓	✓	✓
Partnership Improvement Plan / Audit Recommendations Update		✓	Chief Officer	✓	✓		✓
Internal Audit Annual Report and Assurance Statement		✓	Chief Internal Auditor	✓[1]			
Internal Audit Reports 2021/22:							
• Primary Care Improvement Plan PKIJB 21-02		✓	Chief Internal Auditor	✓		✓[2]	✓
Internal Audit Reports 2022/23:		✓	Chief Internal Auditor				
• Leadership Capacity PKIJB 22-01[3]		✓	Chief Internal Auditor				
• Sustainability of Commissioned Service Providers PKIJB 22-02		✓	Chief Internal Auditor				
• Premises and Property PKIJB 22-03[4]		✓	Chief Internal Auditor				
Internal Audit Strategy and Plan 2022/23		✓	Chief Internal Auditor		✓		
Internal Audit Plan Progress Report	✓		Chief Internal Auditor	✓	✓	✓	✓
External Audit Strategy		✓	External Auditor				✓
External Audit – Proposed Audit Fee 2022/23		✓	Interim CFO				✓
External Audit Annual Report 2021/22		✓	External Auditor		✓		
Appointment of External Auditor 2022/23 to 2026/27		✓	HOFCS		✓		
Performance							
Financial Position	✓		HOFCS/Interim CFO	✓	✓	✓	✓
Progress Report - Key National Indicator Set	✓		Chief Officer	✓	✓	✓	✓
Annual Performance Report		✓	Chief Officer		✓		

Meeting Cancelled

[1] Considered at IJB meeting 27/6/22
[2] 'Draft Final' report
[3] Target Committee June 2023
[4] Target Committee June 2023

Item	Standing Item	Non Standing Item	Responsibility	June 27th 2022	September 26th 2022	November 28th 2022	March 13th 2023
Annual Accounts							
Annual Governance Statement		✓	HOFCS	✓[5]			
Unaudited Annual Accounts 2021/22		✓	HOFCS	✓[6]			
Audited Annual Accounts 2021/22		✓	HOFCS		✓		
Letter of Representation to External Audit		✓	HOFCS		✓		
Assurances Received from Partners		✓	HOFCS		✓		
Clinical and Care Governance							
Clinical & Care Governance Risk Escalation Report	✓		Chief Officer		✓		
Clinical & Care Governance Assurance	✓		Chief Officer			✓	✓
For Information							
Audit & Performance Committee Record of Attendance	✓		For information	✓	✓	✓	✓
Audit & Performance Committee Work Plan	✓		For information	✓	✓	✓	✓

Meeting Cancelled

[5] Considered at IJB meeting 27/6/22
[6] Considered at IJB meeting 27/6/22

PERTH & KINROSS INTEGRATION JOINT BOARD

20 September 2023

ANNUAL PERFORMANCE REPORT 2022/23

Report by Chief Officer
(Report No. G/23/124)

PURPOSE OF REPORT

This report presents the Annual Performance Report (APR) for 2022/23 to the Integration Joint Board (IJB) for noting.

1. RECOMMENDATION(S)

1.1 The Integration Joint Board is asked to note the Annual Performance Report for 2022/23.

2. BACKGROUND

2.1 The Public Bodies (Joint Working) (Scotland) Act 2014 requires the Integration Joint Board to publish an Annual Performance Report (APR) setting out an assessment of performance in respect to those functions for which it has responsibility. There is a statutory deadline for public of such reports no later than 4 months following the end of the financial year.

3. OVERVIEW

3.1 The Annual Performance Report provides an overview of activities undertaken in the reporting year to deliver services, improve outcomes and demonstrates progress towards the achievement of our strategic aims as set out in the Strategic Commissioning Plan.

3.2 The APR was considered and approved by the Audit and Performance Committee on 31 July 2023 in compliance with the IJB's statutory duty. Following presentation to the IJB, the APR will be published on the Health and Social Care Partnership's webpage, circulated to NHS Tayside, Perth and Kinross Council and the Community Planning Partnership for their information.

4. CONCLUSION

4.1 The Annual Performance Report provides a summary of Health and Social Care performance in 2022/23. It sets out our performance against the national core indicator set, and local indicators, and provides an overview of the steps taken to deliver services in line with our strategic aims. The Annual Performance Report has been prepared with contributions from teams across all service areas within the Health and Social Care Partnership and has included a stronger emphasis on the voices and experiences of people who have used our services. The period 2022/23 presented challenges as a result of the ongoing impact of the pandemic and a particularly demanding winter period. The report acknowledges the significant and extremely valued role of unpaid carers, the outstanding contribution of each our health and social care teams over the period, and their collective efforts to achieve the best possible outcomes for the people of Perth and Kinross.

Author(s)

Name	Designation	Contact Details
Zoe Robertson	Interim Head of Adult Social Work Social Care/Commissioning	tay.pkijbbusinesssupport@nhs.scot
Chris Jolly	Service Manager (Business Planning and Performance)	

ANNEX

1. IMPLICATIONS, ASSESSMENTS, CONSULTATION AND COMMUNICATION

Strategic Implications	
HSCP Strategic Commissioning Plan	YES
Transformation Programme	None
Resource Implications Financial	
Financial	None
Workforce	None
Assessments	
Equality Impact Assessment	None
Risk	None
Other assessments (enter here from para 3.3)	None
Consultation	
External	YES
Internal	YES
Legal & Governance	
Legal	YES
Clinical/Care/Professional Governance	None
Corporate Governance	YES
Directions	None
Communication	
Communications Plan	None

1. Strategic Implications

1.1 Strategic Commissioning Plan

This routine performance report supports the delivery of the Perth and Kinross Strategic Commissioning Plan in relation to all five deliverables below:

1 prevention and early intervention,
2 person centred health, care and support,
3 work together with communities,
4 inequality, inequity and healthy living, and
5 best use of facilities, people and resources.

1.2 Transformation Programme

This report has no direct Transformation Programme implications.

2. Resource Implications

2.1 Financial

This report has no direct financial implications.

2.2 Workforce

This report has no direct workforce related implications.

3. Assessments

3.1 Equality Impact Assessment

This report sets out progress in respect to performance against the nationally agreed integration indicators. In doing so it provides assurance of progress in relation to our Strategic Commissioning Plan which includes the reduction of the impact of inequalities.

3.2 Risk

This report has no direct risk implications.

3.3 Other assessments

This report provides an assessment of performance against national integration indicators.

4. Consultation

4.1 External

This report was approved by the Audit and Performance Committee on 31st July 2023.

4.2 Internal

This report has been created in consultation and collaboration with Services and Care Groups and has been reviewed by the Executive Management Team.

4.3 Impact of Recommendation

N/A

5. Legal and Governance

This report supports the delivery of the IJB's public reporting responsibilities and meets the statutory requirement to produce an Annual Performance Report within four months of the end of the financial year to which the report relates.

6. Directions

N/A

7. Communication

N/A

2. BACKGROUND PAPERS/REFERENCES

The documents that have been relied on in preparing the report, other than those committee reports already referenced within the main body of the report are as follows:

Public Health Scotland Core Suite Integration Indicators 2023 (July Update)
Perth and Kinross Performance Update 06.23

All documents will be kept available for inspection by the public for four years from the date of the meeting at which the report is presented.

3. APPENDICES

Appendix 1 - Perth and Kinross Health and Social Care Partnership, Annual Performance Report 2022/23.

Perth and Kinross Health and Social Care Partnership

Supporting healthy and independent lives

ANNUAL PERFORMANCE REPORT 2022/23

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.

Contents

Section 1. Introduction

The Perth and Kinross Health and Social Care Partnership (HSCP) provides and commissions local health and social care services in line with the Perth and Kinross Integration Joint Board's (IJB) Strategic Commissioning Plan (2020-25).

Our main focus is to provide the appropriate care and support in the right way and at the right time to meet the health and care needs of our local communities. Our vision is to work together to support people to lead healthy and active lives and to live as independently as possible, with choice and control over their care and support.

None of what has been achieved over the last year would have been possible without our outstanding and dedicated workforce and the exceptional role of unpaid carers. Health and social care is all about people caring for others and over the next year we will focus heavily on our core values and support our staff and people who rely on our services through What Matters to You?

The COVID-19 pandemic presented very serious challenges and the longer-term impact is still being experienced in health and social care. Nevertheless, significant progress has been made in improving outcomes for people in 2022/23. As we look to revise the Strategic Commissioning Plan (2020-25) in the current year and develop the new plan for 2023-2026, we will build on what's been achieved, and learn from the challenges we have faced, and adapt to meet the changing needs of our population.

The Strategic Commissioning Plan (2020-25) will be revised and updated in the current year and result in a new three-year plan for 2023-2026 as we recognise that a lot has changed as a result of COVID and its long-term impact on health and social care.

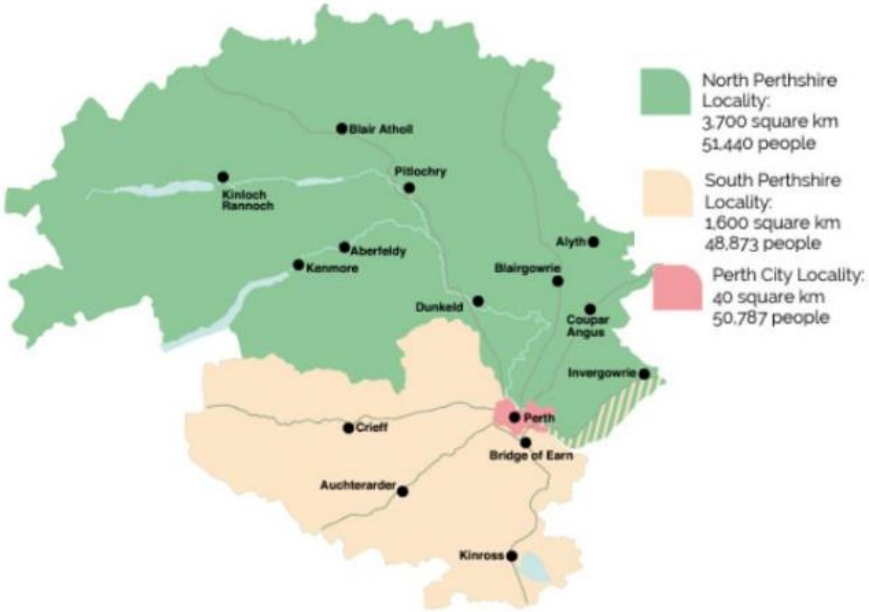
We aim to provide preventative support for people to remain healthy, active and connected. We also provide or commission social care services and embed the National Health and Care Standards to keep people at the heart of what we do and enhance quality of experience and outcomes. We seek to reduce health inequalities, increase life expectancy, enhance health and wellbeing and reduce the personal and social impact of poverty and inequality. The IJB's commissioning plan sets out five key priorities:

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

We measure our progress and impact via an assessment of how well we are doing in relation to the ten National Health and Wellbeing Outcomes.

1. People are able to look after and improve their own health and wellbeing and live in good health for longer.
2. People, including those with disabilities or 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.
3. People who use health and social care services have positive experiences of those services, and have their dignity respected.
4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.
5. Health and social care services contribute to reducing health inequalities.
6. 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 wellbeing.
7. People who use health and social care services are safe from harm.
8. 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.
9. Resources are used effectively and efficiently in the provision of health and social care services.

Section 2: Our Performance



To help understand our performance data, it's helpful to consider our population demographic, spread across our three localities, North Perthshire, South Perthshire and Kinross-shire, and Perth City.

The population of Perth and Kinross is older compared to Scotland with 24.1% over 65 compared to 19.6% for Scotland. Our 85+ population is projected to increase by 111% over the next 20 years. This presents a huge challenge because people's health and social care needs tend to rise as they age. We deliver a broad range of health and social care services (Appendix 1.1) and this section reflects our strategic performance in relation to those.

In Perth and Kinross, 154,000 people live across a large, mainly rural area, as defined by RESAS (Scottish Government Rural and Environment Science and Analytical Services). Just under 62,000 people (40%) live in remote, rural areas and do not have the same levels of access to services. We also experience challenges in providing services and we have a lower proportion of working age people within the population and lower economies of scale for providers of care.

National Indicator Performance

The Scottish Government requires us to measure our performance using a core set of National Indicators (NIs).

Table 1 below provides a summary of our performance for 2022/23 against these indicators. This reflects a period when services continued to recover from the impact of the pandemic and when capacity, supply and demand for services remained significantly different to provision pre-pandemic. The long-term impact this has had on our population is still being understood, with people presenting with much greater acuity, complexity and with higher levels of frailty which is leading to changes in the type of demand experienced.

To better reflect progress in delivering improved outcomes locally we intend to establish local targets for each of our performance indicators. These will be developed through the refresh of our Strategic Commissioning Plan and will provide opportunities for more meaningful comparisons.

Table 1. Core Suite Integration Indicators

Indicator	21/22 P&K	22/23 P&K (or latest)	Latest Data Available	How we compared to 21/22 %	How Scotland compared to 21/22 %	How we compared to Scotland 22/23 %	How Peer compared to 21/22 %	How we compared to Peer 22/23 %
Premature Mortality Rate per 100,000	357.3	N/A	Dec-21	N/A	N/A	N/A	N/A	N/A
Rate of emergency admissions per 100,000 population for adults (18+ all specialities)	11,312.6	12,221.1	Dec-22	8.0	-4.1	8.7	-3.9	12.8
Rate of emergency bed day per 100,000 population for adults (18+)	106,861.8	114,470.6	Dec-22	7.1	0.2	1.2	2.5	3.9
*Readmissions to hospital within 28 days of discharge per 1,000 discharges (18+)	128.8	135.8	Dec-22	5.4	-5.0	N/A	-3.2	N/A
Proportion of last 6 months of life spent at home or in a community setting	90.6%	89.0%	Dec-22	-1.6	-0.5	-0.3	-0.7	-0.7
Falls rate per 1,000 population (65+)	22.6	25.5	Dec-22	12.7	-1.8	12.8	-1.8	21.5
Proportion of Care Services rated good or better in Care Inspectorate inspections	76.5%	73.4%	Mar-23	-3.2	-0.6	-1.8	-2.0	-3.2
Percentage of 18+ with intensive social care needs receiving Care at Home	55.5%	57.6%	Dec-22	2.3	-1.0	-5.9	-0.5	-6.6
Number of days people aged 75+ spend in hospital when they are ready to be discharged per 1,000 population	593.8	939.2	Mar-23	58.2	22.9	2.1	39.2	12.7
Percentage of health and care resource spent on hospital stays where the patient was admitted as an emergency	N/A	N/A	Mar-20	N/A	N/A	N/A	N/A	N/A
*A&E attendances per 100,000 population	14,673.9	16,276.3	Mar-23	10.9	1.0	-32.6	4.9	-2.6

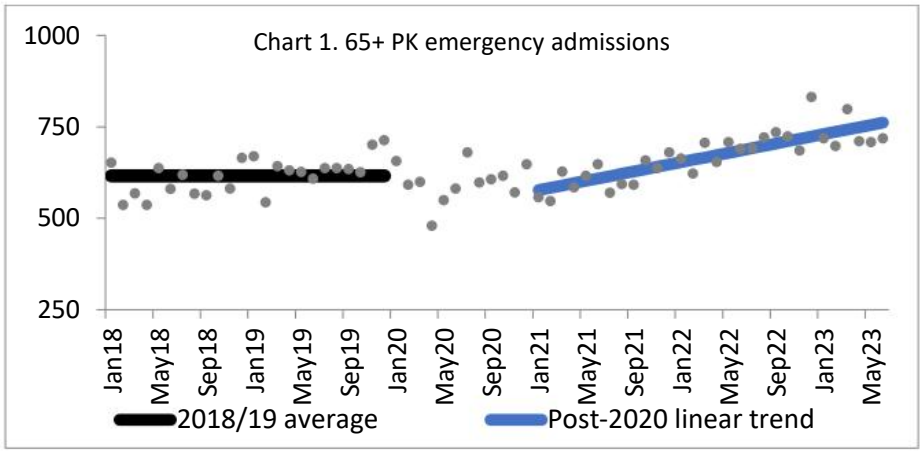
*Source: Public Health Scotland Core Suite Integration Indicators. July 2023 update. *A&E Source PHS Ministerial Strategic Group Indicator Update.*
Note: The figures presented are rounded to one decimal place, while calculations are done using the data as published by PHS.
**Comparisons for this indicator should not be undertaken against Scotland or the peer group, due to differences in Tayside recording practices.*
N/A = no data available

Within 3%, or are meeting or exceeding our target	Between 3% and 6% away from meeting our target	More than 6% away from meeting our target

See Appendix 2.1 for additional information.

Commentary

When considering strategic performance, it is helpful to look at trends over time, (Appendix 2.1 provides comparisons over 5 years). Looking back to 2020 we can see that demand for emergency care has increased and this has continued in this reporting year with emergency admission up 8.0%.



This indicator is linked closely to the rate of accident and emergency attendances which increased by 10.9%. Accident and emergency attendance across our peer group is 4.9% lower, however we perform 32.6% better than Scotland in this respect.

We increased investment in new frailty models/pathways to help address the flow of patients into hospital and more information on this is detailed within the Older People's chapter. As more people enter hospital the number of beds days tends also to increase and in this respect the rate of emergency bed days increased by 7.1%. The challenge is to limit this by continuing to increase available support in community settings, reducing the need for admission, and creating opportunities for swifter discharge.

Throughout 2022/23, 96% of people were discharged without delay. The overall rate of delayed discharges (increased by 58.2%) was impacted however by higher numbers of people with more complex needs. A significant reason for delays relates to difficulties with the supply of social care services, specifically care at home. These challenges were directly attributable to a lack of available workforce.

When people are discharged from hospital it is important they are able to access community-based services which meet their needs so that the requirement for readmission is reduced. There is more detail in the Primary Care, Urgent Care and Older People's chapters on this. The rate of readmission within 28 days increased by 5.4%. This figure covers all ages and masks good performance in respect to people aged +75, where the rate of readmissions beyond 8 days from discharge reduced by 11.8%. This is important as it suggests that when older people are discharged, they are being supported in the community sustainably.

The proportion of the last six months of life spent at home or in a community setting declined by 1.6%. This measures the effectiveness of end-of-life care delivery in a community setting. A case study in the Older People's chapter gives some insight into how we provide a person-centred approach to end-of-life care.

The rate of falls resulting in an admission to hospital increased by 12.7%. This remains a key area for improvement but is indicative of an increasingly frail and elderly population with an increased risk of falling. It is important to note that absolute figures are relatively small. More detail on falls prevention is contained in the Older People's chapter.

The Scottish Health and Care Experience survey (HACE), which seeks to measure how well people experience health and social care services is produced every two years and was not updated in 2022/23, the most recent results are set out in Appendix 2.1; with a summary in Table 2.

We recognise the importance of understanding how people experience our services and how they improve health and wellbeing outcomes. We regularly survey service users at or near the point of use via our Service User and Experience Reporting (SUPER) Survey; please see Table 2 below:

Table 2. HACE/SUPER Survey results (%)

Indicator	HACE 21/22 P&K %	HACE How we compared to 2019/20 %	HACE How we compared to Scotland 2021/22 %	HACE How we compared to Peer 2021/22 %	SUPER 2022/23 P&K %	*SUPER How we compared to HACE 2021/22 %
% of adults able to look after their health very well or quite well	93.6%	-0.6	2.8	1.5	72%	-21.7
% of adults supported at home who agree that they are supported to live as independently as possible	79.9%	-2.4	1.0	3.6	68%	-11.9
% of adults supported at home who agree that they had a say in how their help, care or support was provided	73.8%	-3.4	3.2	4.3	94%	20.2
% of adults supported at home who agree that their health and care services seemed to be well co-ordinated	65.1%	-7.9	-1.3	0.4	86%	21.0
% of adults receiving any care or support who rate it as excellent or good	79.1%	-3.7	3.8	4.9	96%	16.9
*% of people with positive experience of care at their GP practice.	74.1%	-12.3	7.6	6.8	98%	23.9
% of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life.	75.8%	-4.4	-2.3	-0.8	65%	-10.8
% of carers who feel supported to continue in their caring role	33.2%	-3.5	3.5	2.9	50%	16.8
% of adults supported at home who agreed they felt safe.	79.0%	-4.9	-0.7	1.4	97%	18.0

**Note: HACE - National Health and Care Experience survey undertaken biennially with respondents selected randomly from GP practice lists. SUPER Survey - Local service user/carer respondents with responses gathered at or near the point of delivery. Since its introduction in 2021, there have been 318 responses via the survey, with results reported as a rolling twelve-month average.*
Note: The figures presented are rounded to one decimal place, while calculations are done using the data as published by PHS.

To further broaden our understanding of people's experience of Health and Social Care we have commissioned Care Opinion which gathers and presents real stories of experiences. Some of these are reflected in the following chapters and many more can be read on the Care Opinion website, where our staff are listening and will respond to people's experiences. The word cloud on the right provides an overview of the words used by people to describe their experiences.

The HSCP began using Care Opinion in May 2022 with almost two thirds of teams now active on the system. We plan to have all of our HSCP services on this platform and to extend this to our commissioned services. The profile, impact and connections made via our Care Opinion experience is growing every day. In Scotland we have one of the highest rates of feedback and are being heralded as an exemplar with other areas keen to learn from our approach.

Performance against Strategic Commissioning Plan Aims

We have five strategic aims set out in our Strategic Commissioning Plan 2020-25 and to deliver these aims we are implementing Strategic Delivery Plans for our Care Groups, each of which have their own outcomes focussed performance management frameworks.

In 2022/23 we strengthened our performance reporting by providing the IJB Audit and Performance Committee with reports on progress against the approved Strategic Delivery Plans (SDPs) for Community Mental Health and Wellbeing and Learning Disability and Autism. As we move forward, further Care Group reports will be provided at each meeting of the Audit and Performance Committee starting with Older People in September 2023.

The following demonstrates the alignment of approved SDP outcomes with our five Strategic Aims and notes the number of KPIs (Key Performance Indicators) supporting those outcomes which are RAG rated Red, Amber or Green.

The implementation of our Strategic Delivery Plans is at an early stage with progress having been reported to the IJB for Community Mental Health and Wellbeing in Dec 2022 and Learning Disabilities & Autism in February 2023. Further annual updates are scheduled to be provided during the implementation of these plans and more detail is provided throughout the care group chapters of this report; In particular, Chapter 4 Learning Disability and Autism, Chapter 5 Community Mental Health and Wellbeing, and Chapter 10 Older People's Services.

Table 3 - Working together with our communities. Strategic aim - We want people to have the health and care services they need in their local communities and to empower people to have greater control over their lives and stronger connections in their community.

Outcomes from SDPs linked to this aim	Green	Amber	Red
OP- SO1. People who provide unpaid care are supported to maintain or improve their quality of life and look after their own health and wellbeing	2	0	0
OP-SO2. Older people are supported to maintain or improve their quality of life and look after their own health and wellbeing	2	0	1
LD&A-SO4 Ensure people can live well in their communities and have access to accommodation which is suitable for their needs and where they are supported to live as independently as possible.	1	0	1
LD&A-SO5. Ensure people are able to participate in their communities.	1	0	0
CMH-SO4.1. Through collaboration and co-production, we will deliver more effective services and enhance the mental health and wellbeing across our communities	1	0	1
CMH-SO4.2. Lived experience will be at the heart of service design, and the voices and views of people and their carers	0	0	1

will influence decisions about how care and support is received.			

Table 4 - Prevention and early intervention. Strategic aim - We want to intervene early to support people to remain healthy, active and connected in order to prevent issues and problems arising.

Outcomes from SDPs linked to this aim	Green	Amber	Red
LD&A-SO3. Service users have access to support by appropriately trained workforce.	1	0	0
LD&A-SO6. Individuals will have greater opportunities to be involved and participate in decisions that affect their lives.	1	0	0
CMH-SO1.1. People receive the right support at the right time	0	1	2
CMH-SO1.2. Reduced stigma and inequalities in relation to people with mental health and substance misuse issues	0	0	1
LD&A-SO 7. Improve access to quality and meaningful employment opportunities.	2	0	0
CMH-SO2.1. Improve access to a range of mental health and wellbeing supports and services by fully embedding the principle of Person-Centred Care and support.	1	0	1
CMH-SO2.2. People can make informed choices about their health and social care support.	1	0	1

Table 5 - Person-centred health, care and support, Strategic aim - By embedding the national Health and Care Standards we will put people at the heart of what we do.

Outcomes from SDPs linked to this aim	Green	Amber	Red
OP-SO3. Older People are supported to live actively and independently at home or in a community setting.	2	0	2
OP-SO4. Resources are used effectively and efficiently.	1	0	1
OP-SO5. People are safe from harm.	2	0	1
LDA-SO1. To support people to remain at home or in a homely setting.	2	1	1
CMH-SO3.2. Support pathways will be clear and robust, with a system of joined-up communication that ensures that service users, their families and carers receive the best possible support.	3	0	1

Table 6 - Reducing inequalities and unequal health outcomes and promoting healthy living, Strategic aim - Our services and plans will seek to reduce health inequalities, increase life expectancy, increase people's health and wellbeing and reduce the personal and social impact of poverty and inequality.

Table 7 - Making best use of available facilities, people and other resources, strategic aim - We will use our combined health and social care resources efficiently, economically and effectively to improve health and wellbeing outcomes.

Outcomes from SDPs linked to this aim	Green	Amber	Red
OP-SO6. Timelier discharge from hospital.	0	0	2
OP-SO7. Health and Social Care workforce feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.	1	0	0

Within 3%, or are meeting or exceeding our target	Between 3% and 6% away from meeting our target	More than 6% away from meeting our target

Section 3: A Journey through Health and Social Care Service Delivery in 2022/23

Chapter 1. Primary Care

Our vision is of general practice and primary care at the heart of the healthcare system, with people who need care, informed and empowered to access the right care, at the right time. A multi-disciplinary approach is key to delivering the right care at the right time. We strive to ensure this support remains at or near home. Our strategic priorities are:

1. We will endeavour to ensure that our patients' experience of primary care is enhanced, where they feel more informed and empowered and the right care is delivered in the right place, at the right time.
2. We will endeavour to deliver sustainable services by ensuring the wellbeing of our staff and that our primary care workforce is expanded, more integrated, aligned and better co-ordinated with community and secondary care.
3. We will work towards developing a primary care Infrastructure which provides modern, fit-for purpose premises and digital technology to support service delivery.
4. We will aim to deliver primary care services which better contribute to improving population health and addressing health inequalities.

These priorities are laid out in the Primary Care strategic delivery plan, approved by the Integration Joint Board in June 2023, and underpinned by a performance management framework that reflects progress against the achievement of outcomes.

To enable people to feel more empowered to inform the delivery of services, we have engaged with Care Opinion. Service users can provide details of their experience and staff acknowledge and engage to improve services.

Our **Community Care and Treatment Service** (CCATS) is at the centre of our approach to delivering effective, community based primary care services close to people's homes. Developed during COVID-19, CCATS is firmly established, providing a range of treatments, from routine blood tests to monitoring of chronic conditions, aural care and irrigation, to the treatment of wounds and minor injuries. In 2022/23 CCATS increased capacity to provide more ear care appointments. This has improved sustainability, helping to clear the waiting list. Delivery of electrocardiogram tests, which check heart rhythm and electrical activity, are also being trialled in Perth City. If successful, this treatment will be extended across rural areas reducing inequality of access to services.

Testimonial: CCAT Service

"I attended the Blairgowrie Community Hospital. This has been for pre chemotherapy blood work. I was welcomed into the department by a healthcare support worker who was incredibly kind, friendly, and professional. I was nervous having my bloods done due to my poor venous access, but she put me at ease straight away. She came across as very knowledgeable and experienced. The new department looks clean, bright, and welcoming. It was easy to find. The rooms are well equipped with equipment that is in a good state. The staff voiced how excited they are with their new surroundings and I could feel a nice sense of motivation, achievement, and excitement about their new service.

The staff were seen to be hand washing, cleaning equipment after use and using PPE. I felt very safe. One area I feel could be explored if appropriate is the delivery of PICC line care. I had a PICC line inserted due to my poor venous access however, I could not have my weekly line care at Blairgowrie, or my bloods done from this line. Therefore, I had to travel to Ninewells in Dundee weekly. Thank you again to the fantastic care at CCATs!"

Our **First Contact Physiotherapy** (FCP) service provides access to physiotherapy assessment and advice for muscle and joint problems. It is delivered in a primary care setting with appointments booked through GP practices. It was fully recruited to in 2022/23, with 352 appointments per week available across all GP practices, an increase of 128 per week compared to 2021/22. Current capacity is still insufficient and an evaluation to understand service demand and target improvements, such as optimising the process for referral, gave positive initial feedback.

Testimonial – FCP Service Users

"Physio was lovely, made sure to see how well I can move. Gave me reassurance. Gave me sheets of exercises to work on at home and assured I could contact again if required." - "Very prompt referral. Clear guidance on what to do next."

We will continue to gather feedback from those referring people to the service and staff delivering the service, to build a robust understanding of what is working and potential areas for improvement.

To ensure people receive the right level of care and support, in the right place and in a timely manner we continued our expansion of **Advanced Nurse Practitioners** (ANPs). All GP practices receive support from ANPs for Urgent Care, Medicine for the Elderly or the Locality Integrated Care Service. Most GP practices (15 of 23) are supported directly with dedicated ANP support specifically for Urgent Care home visiting. This aims to relieve pressure on GP capacity while ensuring people receive "urgent" home visits. This provides the correct level of expertise and treatment to ensure people can remain independent and living safely in a community setting.

The Vaccination Service continued to be part of maintaining population health. It went through a transformation to develop and provide vaccinations previously provided by GP practices. Our **Social Prescribers** continue to signpost people to wider services and open access to community-based activities.

Case Study: Social Prescribers

Mr L was referred to our Social Prescribers, struggling with anxiety and depression. He has also struggled with alcohol use but is managing to reduce this slowly. Having issues with neighbours Mr L was hoping for a move, however he was assessed as low on the housing register. Mr L also wanted to meet others and hoped to improve his mental health. Our Social Prescribing service referred Mr L to our commissioned service, Independent Advocacy, who supported him with a successful housing application, helping him to move to a new property. They also introduced him to the Peer Support group, Bag O' Chips, a walking group in Perth, which he now attends weekly, enjoying the exercise and opportunity to socialise.

A connection to the local Recovery Café helped him meet new people and empowered him to help set up and run a fishing group for people struggling with addiction or mental health. Information about the PKC Volunteer Fund was also given, with the hope of helping to buy equipment for the fishing group. Mr L reported that his life changed so much for the better and he now has things to look forward to. Mr L stated: "*your support has changed my life and without it I would probably still be sitting at home drinking a bottle a night".*

Our Primary Care Improvement Plan (PCIP) outlines how we will redesign and expand our integrated, multi-disciplinary workforce to ensure we have the capacity and expertise to improve population health and address health inequalities. In line with this vision, building capacity remains a priority for Primary Care. Each GP practice, on average, now has more than three additional professionals supporting patient care since the plan was approved in 2018/19. This multi-disciplinary workforce is supporting patients to access a wider range of expertise to see the right person, at the right time, for their care. This integrated and co-ordinated approach enables GPs to focus on patients with more complex needs.

Developing digital and physical infrastructure to help meet the needs of services to deliver the care and support required across communities continues to be a key long-term strategic priority.

Through our Premises Strategy (approved by the IJB in June 2023), we aim to develop an infrastructure which provides modern, fit-for-purpose premises and digital technology to support service delivery. This will build on progress in 2022/23 where we assisted practices to secure improvement grants. Projects included:

- Improvement scheme for the development of premises.
- Funding for additional disability access.
- Resources for the conversion to digital records platform.
- Improved health and safety.

To improve our approach to supporting Primary Care as a whole system of connected services and to grow our services, we restructured how we work. This improved governance, communication, increased focus on sustainability and improvement work with GP cluster leads. Our primary care team are better able to work together collaboratively on issues affecting service delivery.

In 2022/23, we continued to support GPs to increase efficiency by making patient records electronic. Funding was secured for Medlink, an online tool to streamline workload. This helps prioritise face-to-face contacts for people with complex needs, or those unable or unwilling to use the resource. The video on Medlink below opens in the browser.

Improvement Journey: Advance Nurse Practitioners (ANPs) Providing Urgent Care

The Situation	Increasing demand for urgent “on-the-day" visits in the community.
The Challenge	To develop a model to respond with the right person at the right time through an improvement approach.
Our Action	Learning from improvement over the last year, our ANPs are taking opportunities to further test a Single Point of Contact model on a Perth and Kinross wide basis.
The Result	ANP clinical knowledge has combined with established networks of services to successfully enable access to the right person or team. This includes maintaining patients at home, who without access to appropriate interventions were at risk of unplanned hospital admission.
The Outcome	These tests of change have led to an enhanced understanding of a single point of contact model in the context of urgent care. Improvements and opportunities include: the ability to maintain case oversight and track patient outcomes; unlocking capacity through a more agile and efficient deployment of urgent care response from the wider system; and the identification of urgent care training and development needs.

Looking Forward

We will continue to support Primary Care in line with our key priorities set out in our Strategic Delivery Plan and Premises’ Strategy.

We will continue our ongoing work with The Primary Care Communication, Participation and Engagement Plan on key identified areas.

Chapter 2. Dental

The Public Dental Service (PDS) is managed by the Perth and Kinross HSCP and delivered Tayside wide focussing on the following priorities:

- Continued provision of dental services and preventive care for core PDS patients across Tayside. (Core PDS patients are those who cannot access care in general dental).
- Maintain current service levels for sedation referral service for children and adults.
- Maintain current service levels for paediatric and special care adult referral service.
- Improved general anaesthetic (GA) access for special care adults through reinstatement of GA lists to pre-COVID levels.
- Improved equity of GA access for paediatric exodontia across Tayside through improved demographic access to GA lists given a recent reduction in waiting times in Ninewells.
- Continue rolling programme of dental examinations and comprehensive dental care for Care Home residents.
- Respond to patient feedback particularly through Care Opinion as a means of continued service improvement.

The PDS service provides care for people in high priority and vulnerable groups that cannot access dental care elsewhere. It provides a referral service for treatment which requires general anaesthetic or sedation, and for patients requiring specialist input. This covers a wide range of dental care for paediatric and adult patient groups. The service delivers national oral health programmes such as Childsmile, Caring for Smiles, Mouth Matters, Smile4Life and Open Wide.

The PDS delivers the National Dental Inspection Programme every year and assesses the dental health of P1 and P7 children. This data supports access to dental care for vulnerable and high-risk children. Teaching for undergraduate dental and dental therapy students is provided through the **Outreach Teaching Programme**, and there is a daily emergency service for unregistered patients. Dental care is provided at fixed clinic locations, in prisons, care homes and hospitals and in domiciliary settings. The service operates a mobile dental van for socially excluded groups and special care patients who cannot leave their care home setting and there is provision for bariatric services and wheelchair access at fixed clinics in Perth, Dundee and Arbroath. Patients can be treated in their wheelchairs.

The PDS continued to reinstate delivery equivalent to pre-pandemic levels. This included clinical care for core PDS patients and a return to full clinical capacity. In terms of the **Oral Health Improvement Team** (OHIT), fluoride varnish has been reinstated in the most deprived 20% of the population along with toothbrushing in schools and nurseries. The **National Dental Inspection Programme** (NDIP) which is a mandatory remit was re-introduced with P1 and P2 examined in 2021/22 and the full NDIP programme of P1 and P7 basic and detailed examination for 2022/23. The latest data showed an increase in the decay levels of those children examined.

Challenges with waiting lists for Perth Prison and adult special care general anaesthetic are being addressed. Routine recall appointments have not yet been reinstated post-pandemic and there are challenges with providing the level of care in nursing homes due to a staff recruitment freeze. This has resulted in an increased clinical commitment in terms of care homes with a reduced number of dentists. Workforce planning will be a major focus moving forward.

Case Study: Delivering Dental Care Story

The Public Dental Service has had an excellent response to the roll out of Care Opinion. This comment is from the June 2023 newsletter.

“Public Dental Service (Tayside) which launched Care Opinion in December 2022 have had an incredible 30 stories shared about them, well done!”

Testimonial: Fear of Dentists

Below is a story published about an adult patient's journey from referral to the Public Dental Service, through to treatment under general anaesthetic and post-surgery care.

"Recently I had to get major dental work done but the problem was I am absolutely terrified of dentists from my time in the army. When I first went to Kingscross to see the dentist there from the minute I walked in I was shaking really bad (I also suffer from PTSD). The nurse called me through and she seen straight away how I was and she was great, she spoke to me and told me nothing would be done without my ok and asked how she could help to make me feel better. I was taken in to see the dentist and I told her why I was so scared of dentists and she too was also great, she explained what work I would need done and I'd get an appointment to go to Stracathro.

I got my appointment and it was great from the start, they organised transport there and back, I went and registered at the ward and explained again what was getting done by my dentist and not someone new which I was worried about. I got taken in for my work and afterwards not only did the dentist come and check on me but the nurses and anaesthetist came to see me as well. I got my follow up appointment and I seen the nurse and my dentist again and once again they were great."

Improvement Journey: Dental Services

The Situation	Remobilisation of dental services saw children with pain and abscess waiting 20 weeks for treatment that required general anaesthetic. This length of wait had risen steadily since the onset of the pandemic.
The Challenge	We wanted to reduce the waiting list for paediatric general anaesthetic and open a Children's Theatre Suite in Ninewells.
Our Action	We worked collaboratively with colleagues across NHS Tayside, including other surgical specialities.
The Result	We have been able to open up additional theatre capacity to address this situation.
The Outcome	Children are not waiting as long for treatment.
Data	To date, waiting times for this group of patients have reduced from 20 to five weeks.

National Dental Outreach Centre review

Broxden Dental Centre was recently reviewed in respect to the training provided to dental students. Of the 15 categories assessed 14 were "Met" and 1 was "Partly Met" with none marked as "not met".

Looking Forward

We will continue to provide Public Dental Services in line with our set priorities. In particular we will:

- Continue work to reduce waiting times for treatments that required general anaesthetic in children.
- Focus on delivering dental examinations for all residents of care homes in Tayside**.**
- Reduce our waiting list for special care treatments which require general anaesthetics for adults.

Chapter 3. Podiatry

The Podiatry Service is managed by the Perth and Kinross HSCP and delivered Tayside wide. Podiatrists are experts in all aspects of foot and lower limb conditions, relieving pain, maintaining tissue viability, treating wounds/infections and keeping people mobile and active; thereby reducing the demand on other services. Early podiatry interventions play a key role in the prevention of problems and proactively support people to maintain their independence and standard of living for as long as possible. This is achieved through triage, screening, assessment, diagnosis, treatment and foot health education.

Demand remains high due to an ageing population and an increase in people presenting with long term conditions causing complex lower limb problems. The stepping down of routine care during the pandemic provided an opportunity to focus on delivering a service which best ensures a sustainable approach to continuous improvement. This was achieved through the robust application of eligibility criteria and the assessment of medical status and foot issues, to determine appropriate access and intervention. This enabled the service to remobilise effectively and use resources more efficiently, with improvements already visible in waiting times. In April 2022, the service had 1,025 new routine referrals waiting over 18 weeks for an initial appointment, however by March 2023 this had reduced by 43% to 586. We have an active caseload of approximately 12,000 people, generating over 38,500 appointments and other patient contacts.

To support foot health education the podiatry service provides a self-management programme 'Footstep'; Care Home education webinars; and information sessions for health and social care staff, such as 'CPR for Feet', all of which support early intervention, prevention and appropriate referral. We continue to support voluntary personal footcare providers across Tayside, for example the community initiative Footwise' in Perth City. We look to identify further opportunities to work with community partners to expand community capacity to deliver personal footcare in line with Scottish Government guidelines.

Case Study: Prioritising Care

To ensure those at greatest risk are assessed and treated at a timely stage, all new podiatry referrals are triaged in accordance with service eligibility criteria. Appointments are allocated accordingly with priority given to urgent and soon referrals, automatically booked into clinics, as follows:

- Urgent - infection/ulceration - appointment with 5 working days.
- Soon - high risk diabetes foot risk score, severe peripheral arterial disease - appointment within 12 weeks.
- Referrals triage as routine if they do not indicate any condition which puts the person at immediate risk but meets the clinical criteria for assessment. These referrals are placed on a waiting list with a target date of 18 weeks; however, this is rarely met.

Recruitment to podiatry is a national issue, however we successfully recruited newly qualified podiatrists to Tayside in August 2022. We were also able to increase our student placement capacity with the aim of attracting future recruits to Tayside.

Testimonial: A Care Opinion Story

"I had both my big toenails removed at Drumhar. Both podiatrists were amazing and kept me calm and my mind occupied during the removals. Went over wound care, dressings and general post care very well and made sure I understood what they were saying both pre and post removals. Wasn't the nicest procedure I've had done, but the podiatrists made it so much more comfortable for me."

Testimonial: A Care Opinion Story

"I visited the first podiatrist who referred me for partial removals. I had to go to Carnoustie for this procedure and I was very nervous. Both staff members talked me through the process and one of my nails was quite badly damaged so they explained various options to me. They were so kind and honest. I am only 17 so having my nail removed was a massive decision. They did not tell me what to do, but once my mum and I decided the lady said that she thought I'd made the right decision. My aftercare advice was explained really well too. Thank you."

Improvement Journey: Remobilisation of Tayside Podiatry Service

The Situation	Historical long waiting times linked with changing demographics, an increase in long-term conditions and an increased number of referrals with foot ulceration, compounded by the impact of the pandemic and national recruitment difficulties.
The Challenge	To remobilise elements of podiatry stepped down during the pandemic. We were not meeting the assessed needs of our caseload and we needed to ensure those with greatest need were prioritised and care delivered in line with escalation models.
Our Action	We employed robust application of podiatry eligibility criteria and ensured cleansing of data. Assessment hubs were set up to reassess patient needs and patients who had not been seen were invited to attend.
The Result	We ensured those with the highest risk remained in the service i.e., they had an identified clinical need and were provided with the appropriate care and treatment.
The Outcome	This is ensuring a contemporary podiatry service which has the ability to meet the clinical need of an evolving population with increasingly complex needs, supporting people to maintain their independence through timely intervention with the appropriately skilled member of the team.

Looking Forward

We are aiming to establish a podiatry led **Tayside Community Peripheral Arterial Disease Assessment Service**. This will facilitate the early diagnosis and intervention of peripheral arterial disease and improve the interchange of care between primary and secondary care.

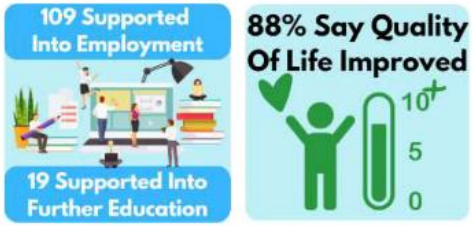
It is anticipated that this will reduce the need for both GP and unnecessary secondary care appointments. This new service will be underpinned by the forthcoming revised vascular pathways for Tayside. Evidence shows early detection and intervention reduces the risk of cardiovascular events and lower limb amputations. We will continue to collaborate with NHS Tayside vascular services to become an integrated partner in the multi-disciplinary team. This will enable us to support improvement in care pathways, reduce waiting times for vascular service, reduce hospital bed days and improve patient experience.

To ensure patients are more engaged and empowered to have an impact on their own care, we are planning to expand our utilisation of patient-initiated returns. This will remove unnecessary automatic recalls for people to be reviewed and instead ensure people are given the advice they need to know when to request a follow up. This will allow timelier and needs based access to care, in line with the principles of Realistic Medicine, rather than the default approach of patients being asked to attend follow up appointments when not required.

Chapter 4. Learning Disability and Autism

Our aim is to support people with a learning disability and/or autism to live as independently and healthily as possible, while enhancing their overall quality of life and to try and ensure they have the same opportunities in life as everyone else. A key focus is to reduce reliance on acute health services and institutional care, promoting more inclusive and person-centred support. Through our Autism and Learning Disability Strategic Delivery Plan (SDP) and our Complex Care Transformation Programme, we are implementing the national strategies for autism and learning disabilities. These strategies aim to provide comprehensive support and improve outcomes for individuals with complex needs. The outcomes we want to achieve are set out below and progress on our SDP was reported to the Integration Joint Board in February with performance against the strategy reported to the Audit and Performance Committee in March:

1. Support people to remain at home or in a homely setting.
2. Ensure services are more cost effective and financially sustainable.
3. Ensure service users have access to support by an appropriately trained workforce.
4. Ensure people can live well in their communities and have access to accommodation suitable for their needs, where they are supported to live as independently as possible.
5. Ensure people are able to participate in their communities.
6. Ensure individuals have greater opportunities to be involved in decisions that affect their lives.
7. Improve access to quality and meaningful employment opportunities.



Peer Support and Early Prevention – Many of our statutory and commissioned services help empower people to remain as independent as possible, providing expertise, guidance and support to remain safe, independent and active in their community, relieving the need for direct intervention by Health and Social Care services. This is the first stage of the journey through health and social care and is best delivered through peer support and early intervention within communities.

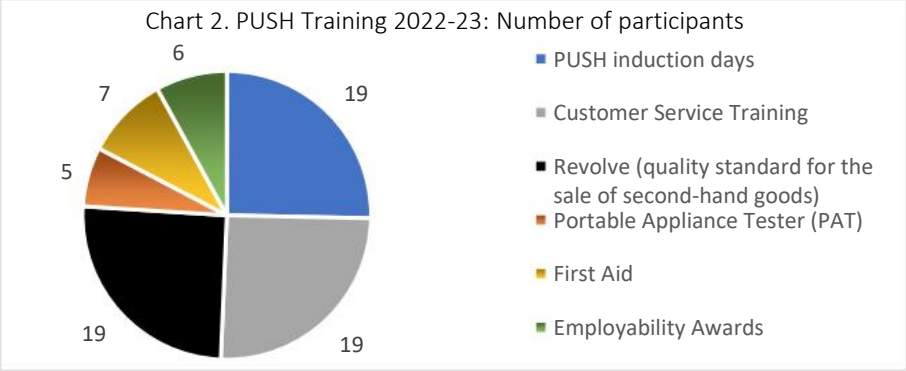
When we ask people what is important for them, they tell us they want to live in their own home in their local community. The following examples demonstrate the services and supports available, with case studies showing their impact over the past year.

The Friends Unlimited Network (FUN) has increased the number of people engaged through the network by 34%, with more people having the opportunity to meet with others and develop social connections.

Testimonial - FUN Activity

One FUN user said he likes coming to see everyone and going out for meals. He said he has lots of friends at FUN, some he already had before attending and some he has made when coming along, everyone has been really nice to him at the activities. Another said that she doesn't usually do anything at night if she doesn't have a FUN activity booked. She likes being able to come along to activities and see everyone during the week as well, as it gets her out of the house. Enjoys the days going away places and the cooking/baking nights.

The Number 3 One Stop Shop in Perth provides a Late Diagnosis Group and other support sessions to help people build independent living skills. Over the last year registrations increased by 78 with over 150 adults accessing a service monthly. This work contributed to 13 people being supported to move into their own tenancies which meet their needs. PUSH have been successful in delivering and expanding work-based training and peer support. It expanded placements and aims to increase them further to 20 from 15 for next year.



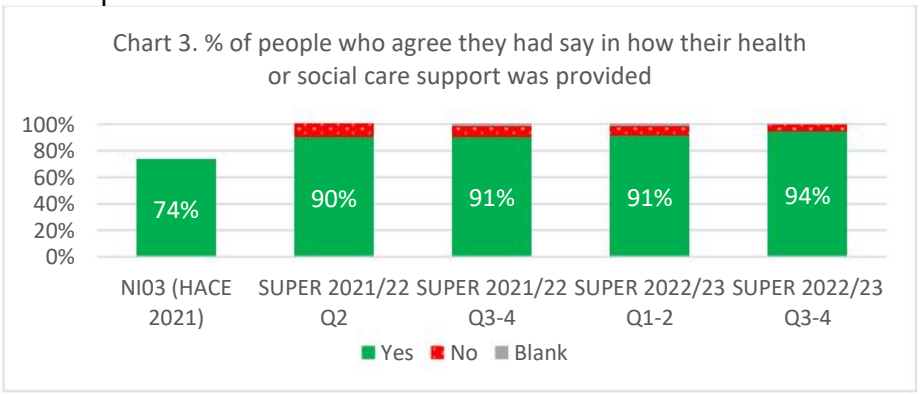
Case Study - PUSH

In 2021, a man in his early 20's was employed by PUSH on the kick-start scheme which supports young people into employment. He attended training in customer service, gained an industry relevant qualification and showed real dedication to his work - *"He is a very courteous and helpful young man"* (*staff testimony*). At the end of his kick start contract he was awarded a 12-hour contract with PUSH, which enabled him to go to college full time to study horticulture while having a steady income. In 2022 he successfully completed his first year and is now in year two working with PUSH. He has been supported to become a first aider and a Portable Appliance Tester and he has secured his own tenancy.

The **Perth and Kinross Employability Network** has been successful in facilitating job placements and opportunities to help people get into work. A new approach, which prioritises support for those furthest from the job market, had a positive effect, with 109 people moving through at least one of the employability pipeline stages.

As we prioritise active and early intervention to keep people empowered to live at home or in a homely setting, we acknowledge that people need to be able to participate in their communities and feel involved in making decisions that affect their lives. We recognise that people, especially those from minority backgrounds, may struggle to access our services. Promoting A More Inclusive Society (PAMIS) supported over 40 families from all backgrounds to help them in caring for their relatives, especially during stressful times of transition. They helped families gain the skills and understanding to provide care, circulating educational resources and holding engagement sessions aimed at helping people lead healthy, valued, and inclusive lives.

We are working to involve people in decision-making processes through a **Local Involvement Network.** This provides peer support for empowerment and independence. While nationally there has been a 4.8% reduction in people agreeing they had a say in support between 2019/20 and 2021/22 (latest), this decline has been lesser across Perth and Kinross, at 3.4%. Local data collected via our SUPER survey also demonstrates sustained high performance when people feedback on their experience.



N Range = 72-241

Community-Based Support and Intervention – as a health and social care journey progresses, additional community-based services become more involved to provide a greater level of support. This acts to ensure people remain healthy and safe, while ensuring they can maintain their independence to the greatest possible extent.

We are one of three Partnerships working with Health Improvement Scotland to co-design **Day Support** services through the "Joining Together for a Good Life" project. Collaboration is at the heart of this, and moving away from engagement to being truly present with people is hugely valued. The team had conversations with people who receive day support, their families, support workers and local partners. They listened to the stories and experiences of 26 people to help understand what needs to be improved. We are now working to understand the core themes and areas of improvement identified in these sessions before re-engaging with partners for the next phase of co-production.

Case Study: Day Opportunities Engagement "Jam"

In March 2023 people from across Perth and Kinross gathered to explore ways to create better day opportunities for people with learning disabilities. Some who took part use these services along with people who work in Health and Social Care, the Third Sector and Higher Education. In teams they tested how they could work together to design services that matter to the people who use them. The Jam was a collaborative co-design process. This approach emphasises relationships, empathy and a deep understanding of the needs and perspectives of everyone involved to identify areas for improvement. The teams developed a series of service ideas focusing on what matters to the individuals.

This video gives more details of the event. (Opens in browser).

Testimonials: Day Opportunities Jam

"It's good to know that more is going to be done to help disabled people." - "It's been really creative today." - "If everybody comes together and collaborates, we can actually find the answers." - "Everyone really does feel the same." - "Everyone else actually notices the gaps." - "We can really achieve because it's not all about resource. It might be at some point but the ideas and the inspiration come from the people who are already involved." - "Just getting the ideas down and presenting them hopefully widens people's views on disabilities."

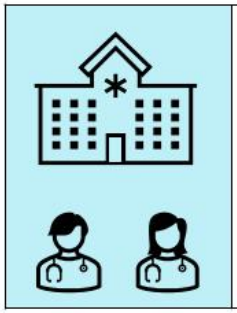
S – Supporting young people and adults with complex needs
C – Community based approach/assessment
O – Offering young people and adults' choice in their care packages
P – Person-centred planning
E – Enriching people's lives

The **SCOPE Team**, described within this Iriss report, launched in April 2022. This truly multi-disciplinary team provides specialist to 309 people from the age of 14 with autism and/or a learning disability and who have complex needs. We produced a robust **Learning Framework** to ensure staff can appropriately support learning disability, autism and sensory processing and adopted: CALM, First Aid, Moving and Handling, Infection control, Physical Intervention, MIDAS, Talking Mats, Autism, Positive Behavioural Support, and Makaton.

The Complex Care Transformation Programme is significantly transforming services for people with Learning Disabilities and Autism since its approval in 2021/22. We improved decision making in the Complex Care Panel by broadening membership to include Occupational Therapists. This is helping ensure people's needs are met in the most sustainable way with one of the key benefits, alongside improvements in care, being to reduce unnecessary expenditure. To date a total saving of £964k has been realised with the average cost per package reducing by over 24% since last year. This represents improved efficiency in service delivery, with the saving invested back into service delivery so that we can meet the increasing volume and complexity of needs throughout our communities.

Table 8. LD package numbers and costs

Financial Year	Number of recurring LD packages approved by Panel	Average package cost per annum
2020/21	13	£134,000
2021/22	16	£122,000
2022/23	32	£92,000



Residential and In-Patient Support – at the latter stage of a journey in health and social care, a person may become more reliant on help and support. Our services are equipped to provide a greater level of care to help keep people safe from harm, while still taking steps to ensure they remain in their own community, and as independent as possible making their own decisions to live as they choose.

Our approach to providing sustainable accommodation for people with complex needs, termed **Core and Cluster**, enables people to live in their community supported by local services. Working with Perth and Kinross Housing Services has extended people's independence by ensuring they have their own tenancies. Developments progressed substantially in 2022/23 with 8 people now living in purpose-built

housing in Rattray with our further development at Dunkeld Road, Perth, due for completion in 2023/24. These developments are helping reduce the number of people experiencing long term stays in hospital and are a demonstration of our commitment to realising the ambitions of the Scottish Government's Coming Home report reducing long stays in hospital and providing care closer to home for people with learning disabilities and complex needs.

Testimonial: Care Opinion Story

A person living in their own home required some help from the supported living team, but found their condition was making it increasingly challenging for them to shower. To ensure they remained safe and comfortable at home, an Occupational Therapist assisted in finding a solution.

"[The Perth City Community Rehabilitation Team] arranged an Occupational Therapy visit which was so helpful. She came and showered me and we talked through what was happening when the carers came. I realised that the problem wasn't with the carers it was with me. I was hurrying and getting into a panic. The OT showed me how to slow down, how to just take time to recover after each thing that I did. She suggested music as well as a way to calm me down. I can now share this with the carers as a solution to the problems I was having."

Improvement Journey: Learning Disability Intensive Support Service

The Situation	In 2022, due to reduced capacity among psychiatrists and variation in provision by GPs, it was no longer possible to provide health monitoring/screening for individuals with a learning disability.
The Challenge	As a consequence, people were at risk of experiencing greater health inequalities.
Our Action	The Learning Disability Intensive Support Service and the Quality Improvement and Practice Development Team introduced a test of change.
The Result	Specialist nurse led clinics were established for people requiring frequent monitoring of medication and conditions treatments. This was delivered both as outpatient and on an 'outreach' basis through a local physical health assessment "All about My Health".
The Outcome	This has helped identify unmet health needs and referring and signposting people to further services. Feedback has been very positive, recognising the specialist skills of learning disability nurses.
Data	90% of patients on the caseload are 100% compliant with health monitoring recommendations. 58 patients have been identified as requiring additional follow up checks. 134 out of 141 local health checks offered were completed.

Improvement Journey: Supporting Transition Pathways - Outreach Workers

The Situation	We try to ensure people receive the service they need in their own home and community.
The Challenge	There is an ongoing risk that when supporting complex cases, we will not be able to provide access to the service needed within Perth and Kinross. In these instances, a person will have to be placed out of area (OAP) taking them away from their home and community. This challenge is replicated throughout Tayside and elsewhere in Scotland.
Our Action	Additional Outreach Workers have been embedded in the SCOPE team and are supporting transitions. Currently we have three Transition Workers, with the recruitment of three more planned for 2023/24.
The Result	These workers are supporting people to transition through their care. This can be specialist support from school into adult life for example.
The Outcome	Outreach Workers are helping reduce the likelihood of people requiring services we are unable to provide locally. In 2022/23 there were no new OAPs. Further evidence will be *sourced as part of SCOPE Benefits Realisation work*.

Looking forward

SCOPE and Learning Disabilities Health Service redesign is ongoing. The range of expertise available has improved with the alignment of Learning Disability and Autism management structures.

Our Overnight Responder Service is preparing to launch in 2023/24 following engagement and consultation with the people who will be most affected by changes to service delivery. It is expected that this project, through innovative use of Technology Enabled Care, will deliver a streamlined and efficient service, able to support people to live independently and safely in their own communities.

Chapter 5. Community Mental Health and Wellbeing

Our vision is to put the person at the centre of decisions about their support, treatment, and care, with mental health services working together to support people to get the right help at the right time. It is a vision of a mentally healthy Perth and Kinross, with all people fully enjoying their rights, taking control of their own lives, and having their voices heard, completely free from stigma and discrimination. Our Community Mental Health and Wellbeing (CMHWB) Strategy 2022–2025 was approved by the Integration Joint Board in December 2021 and outlines how we plan to achieve this vision. Progress was reported to the Integration Joint Board in December 2022 with performance reported to the Audit and Performance Committee in March. Our themes are:

1. Good mental health for all – early intervention and prevention.
2. Access to mental health services and support.
3. Co-ordinated working and person-centred support.
4. Participation and engagement.
5. Review of workforce requirements.

A key element of early intervention and prevention is the empowerment of peer support. Shared experience, empathy and non-judgmental support within a community can help people receive the support they need to prevent their wellbeing deteriorating or a crisis developing. Through supporting and promoting local networks we help ensure peer support acts as the first stage of a journey through health and social care.

We launched our new **Health Hub** in May 2022**,** staffed by volunteers at Murray Royal Hospital. The Hub provides information regarding mental and physical health conditions and signposts to community organisations and support services to increase accessibility. We recognise there is a great deal of support for people that can be made available via organisations beyond our internal services. We commissioned a broad range of services and one such service, Mindspace works with people impacted with mental ill health through a group learning approach, to understanding and managing mental health, counselling support and peer support.

Testimonials: Mindspace

"The group to me has been amazing. You can tell as much or as little as you like with no pressure. You realise you are not alone. Taking part has made my confidence grow. Everyone here is like second family. I have learned another way to express my feelings. It has been a privilege." - "Thank you for an amazing time at paddle boarding, thank you so much all of you, I have really been struggling recently and it's helped me a lot".

The support it provides helps people live a meaningful life with or without the symptoms of poor mental health by offering recovery focussed training and skills-based courses. The Scottish Huntington's Association reaches people in the home or via telephone to provide advice and assistance of self-management. They also provide training and knowledge sharing sessions to help people and their carers'. These sessions have been very well received.

Testimonials: Scottish Huntington's Association

"I could have sat in this training all day; it was so interesting and factual. Very useful information." - "I enjoyed the informal training and interaction with other staff and hearing other opinions." - "Really good training, lots of information about HD I didn't know."

We work with **MoveAhead**, a locally based mental health and wellbeing service, working to enhance mental and physical wellbeing through community activities. It provides interventions, supporting people to address their mental wellbeing, and signposts to other services. In 2022/23, there were 219 referrals to MoveAhead, up from 195 in 2021/22. MoveAhead continues to deliver a high standard of service.

MoveAhead Feedback Performance:

82% of service users who responded to the survey said they were very satisfied, while 14% said they were satisfied with the service overall.
When asked if the service improved their mental health and wellbeing, 73% of people said they were very satisfied, and 23% said they were satisfied.
When asked if they were satisfied that they were fully involved in their care, 95% of people said they were very satisfied, and 5% said they were satisfied.

Testimonials:

"My communication is excellent with my support worker that we talk about everything and reassures me if I am not myself key worker takes the time to listen and I am so thankful. Thank you to my key worker."

"The support worker was lovely. We met a few times, but established the service was not really for me at this time."

"Now I am ready for employment on a voluntary basis to start with I think my key workers involvement could be helpful."

"I sometimes had suicidal thoughts and felt that I wouldn't be here or that I was just existing."

"Even though things ok still difficult knowing that the possibility is there to speak to someone again as a certain comfort knowing that someone could listen when days are difficult."

Suicide awareness and prevention is a complex topic and we have invested in dedicated support to improve co-ordination, promote safe practice, and maximise capacity and effectiveness. This service supports crisis and those bereaved by suicide and this connects directly to the commissioning of Cruse Bereavement Care. Cruse experienced a continuous increase in people experiencing grief after a bereavement over the previous two years and this has continued in 2022/23.

Perth & Kinross Level of provision	2020/21	2021/22	2022/23
Helpline - number of people supported	116	156	167
Early support Number of sessions	28	33	31
Early support Number of people	16	22	17
Counselling Number of sessions	187	159	218
Counselling Number of people	33	30	34

Despite this increase in demand, Cruse continues to provide an excellent service which is well received.

Testimonials:

"I found it extremely helpful to talk to someone who listened carefully and gave reassurance. She was very good and it felt like a weight off my shoulders to talk to someone instead of always being strong for everyone else."

"My bereavement was through suicide. Having been bereaved previously I feel strongly that this is different and is far more complex. Therefore, I think the limit on early support is inappropriate."

As a health and social care journey progresses, community-based support services may be required to play a role in providing accessible, inclusive, and holistic support.

To better leverage local resources and improve service accessibility we enhanced our integration between Community Mental Health and Primary Care services. Primary Care Mental Health and Wellbeing Nurses now see people with low to moderate mental health issues and support and treat them without the need for GP appointments. We are seeking to expand our workforce; however, challenges persist due to labour market issues and uncertainty around funding. To help mitigate these, we are collaborating on a pan-Tayside basis as we seek to redesign our Community Mental Health teams.

We improved our **Mental Health Crisis Response** via our Partnership work with the Neuk. This peer-led therapeutic space provides a place where people feel emotionally safe and supported, to receive person-centred help for their immediate mental health needs in a crisis. This service acts as a hub for services with similar aims and objectives, such as the Lighthouse, Andy's Man Club, and the Women's Wellbeing Club. The service is delivered closely with other services, particularly Community Mental Health teams, Police Scotland and local Primary Care services.

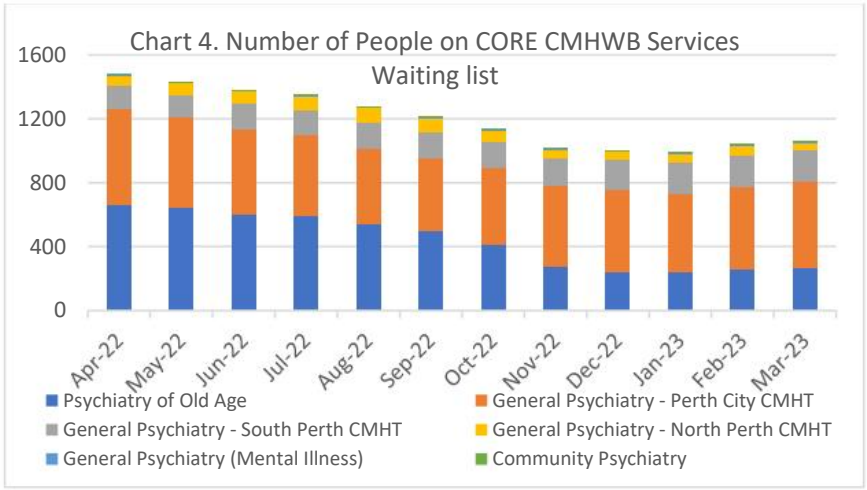
Testimonials: The Neuk

"The counselling helped me with coping strategies for my anxiety and helping me through the day-to-day issues as I'm going through the court with my ex-partner regarding our children. And helped me on a day-to-day basis when I was struggling." - "If I'd known about this place years ago, I'd come here" - "This is the right place to come. I feel safe like I could open up and talk about anything." - "They listened to me and saved my life; they stopped me from suicide. They also gave me counselling and they worked a lot to protect me."

Ensuring people receive the right care at the right time remains essential to ensuring people's mental health and wellbeing. Recognising this we implemented **Distress Brief Interventions**, providing timely compassionate supportive, problem-solving contact for individuals in distress. Through this approach, front line staff have the opportunity to signpost and refer people to additional services.

Complex cases and people suffering from a crisis in relation to their mental health or wellbeing can require more robust or in-patient support. We provide support and treatment in a structured, intensive, and specialised manner helping people with mental health and wellbeing issues. We provide crisis stabilisation support, intensive treatment and a safe environment for medication management. This, in collaboration with our outpatient services can help play a vital role in addressing acute and complex mental health needs and support individuals on their path to recovery.

Demand for CMHWB services continues to be high with waiting lists larger and longer than we would like. There has been a 27% decline in people waiting, although the average waiting time remains above target at 36 weeks. However, while the number of people waiting over 52 weeks has remained steady at 317, the number of people waiting between 26 to 52 weeks has reduced by 52%, to 495.



**Core MH services - Community Psychiatry, General Psychiatry (Mental Illness), Psychiatry of Old Age and CMH Locality Teams. Source – TRAKCARE.*

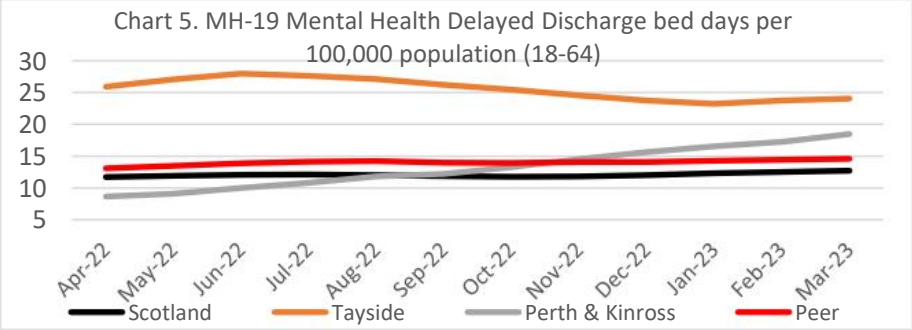
To improve access to services and reduce waiting we increased the availability of digital technology, particularly in rural areas. This was very effective, particularly for Consultant Psychiatrist appointments and enabled us to be more flexible in our support. We invested in **Advanced Nurse Practitioners** (ANPs) to work in our **Community Mental Health Teams** (CMHTs), helping achieve a reduction in the number of people waiting for ADHD assessments. However, workforce challenges remain a major issue with a lack of available experienced and skilled staff across a number of professions impacting progress.

We recognise that people with significant mental health issues have a higher morbidity and mortality rate relating to their physical health. To address this, we renewed our approach to **Enhanced Physical Health Monitoring**. This approach aims to deliver weekly physical health monitoring clinics, to help identify early symptoms of physical ill health, proactively preventing further deterioration.

We increased the capacity of our Mental Health Officer (MHO) Team. Aligned to our CMHTs, the Learning Disability Service and the Hospital Discharge Team, MHOs play a vital role including responding to Vulnerable Person Reports (VPRs) and supporting Adult Support and Protection concerns. Through our MHOs we helped families making challenging decisions around welfare guardianship. Guardianship issues can be a significant contributor to delayed discharges. We have connected our MHOs with the Hospital Discharge Team to identify where this may be an issue. Our approach was praised by the Scottish Government when representatives met locally.

A key element of this work relates to Social Circumstances Reports (SCRs), which provide a valuable tool for understanding events leading to someone needing to be protected from harm though compulsory measures and they contribute to our discharge planning approach. Nationally we compare favourably with 76% of SCR complete within the target time compared to 43% for Scotland. Out local data suggests that we are performing even higher with over 90% complete within time.

In keeping with this increased demand for community-based service, delayed discharges from inpatient areas also increased by 114% in 2022/23, although the rate remains low at 18 per 1,000 population. While this is a disappointing position at year end, it is reflective of the trend seen nationally. Considerable work has been undertaken to address this and early signs indicate that this position is now improving.



Combined with the measures set out above we have re-designed the leadership structure across our mental health and wellbeing services to offer greater leadership and enhance communication. We are collaborating across Tayside on discharge planning and are looking ahead to the re-design of our CMHT model. This will improve how people access services and reduce pressure at key points through better management of people's journey through care.

Older People's Mental Health

The rising age profile increases the potential prevalence of dementia and in Perth and Kinross this is 30% greater than for Scotland. To address this, we deliver services across inpatient and community settings, alongside other statutory and third sector partners. **Older Peoples Community Mental Health Team** supports those over the age of 6 (or under 65 if cognitive impairment is established) living in the community; either at home or within a care setting. We provide assessment, intervention and support to those with a mental disorder, as well as supporting those involved in the person's care.

Testimonial: Dementia Services

"The care and support given here is excellent." (patient) - "Thank you very much for your ongoing support and treatment!" (family member)

In partnership with Alzheimer Scotland (AS) we ensure people receive post diagnostic support, with 225 people supported during 2022/23. AS Link Workers helped support 165 people living with dementia.

Testimonials:

"The Link Worker gave us fantastic support in dealing with mum's dementia helping us in making decisions and putting things in motion for us, also sending links to information. cannot praise highly enough! Thank you." - "Link Worker was a great source of information and getting us heading in the right direction. Link Worker provided lots of useful info on the next steps for care for my granny and linked us in with lots of different services."

Looking forward

We will continue to deliver our Community Mental Health and Wellbeing Strategy 2022/25.

To help address some of the challenges we face, as mentioned above we are working on a pan-Tayside approach to redesigning our Community Mental Health Teams. In particular we are exploring the use of GP Specialists instead of Consultants, the utilisation of Associate Practitioners instead of registered Mental Health Nurses and we are exploring the wider role that Allied Health Professionals can play along with prescribing Pharmacists. We are re-designing services, to make current vacancies more attractive.

Additional service development is planned with the introduction of a Primary Care Mental Health Service. This compliments the introduction of Mental Health Nurses in GP practices and enables people with mild to moderate mental health issues to access support and treatment easier and sooner. We are also seeking to transform our Psychiatry of Old Age service, with significant pieces of development work progressing within the service; including the development of a Psychiatry of Old Age specific Physical Health Clinic which will ensure that those living in the community with severe and enduring mental health disorder have timely access to physical assessment and review; as well as providing regular monitoring of medicine. The main focus of this is mitigating the challenges posed by our ageing population to ensure people receive the best possible care and treatment in the most appropriate setting.

Chapter 6. Substance Use

Drug and Alcohol Services work to reduce the harm associated with drugs and alcohol, facilitating opportunities for recovery. The key priority is promoting recovery and harm reduction, with an overall aim of ensuring a consistent response to non-fatal overdose incidents and drug deaths. We are committed to the implementation of the Scottish Government led MAT Standards. The Alcohol and Drug Partnership (ADP), an organisation which includes members from health, social work, police and the voluntary sector, provides strategic co-ordination of substance use services and has the following strategic objectives:

1. Engaging with people with lived experience, to help us shape our policies and our services.
2. Taking a whole system/whole family approach to service planning and delivery.
3. Working to the recommendations made by the Drug Death Task Force, Scottish Health Action on Alcohol Problems (SHAAP), the national alcohol and drug strategies, and annual Tayside Drug Death Report, and the guidance provided by the Partnership Delivery Framework.
4. Working with the Health and Social Care Partnership and the Chief Officer's Group to promote a "level playing field" between statutory and third sector services.
5. Ensuring that our approach is consistent with Partners working under the sphere of "Public Protection".
6. Working to the recommendations of the Independent Inquiry into Mental Health service in Tayside; "Trust and Respect".

The main focus last year was the implementation of the national Medication Assisted Treatment (MAT) Standards. These put people at the centre of decisions about their care and how it is delivered, adopting a rights-based approach aligning with the national Health and Social Care Standards. Implementation of the ten MAT Standards aims to reduce drug related harm, including premature death, through a programme of sustained funding, workforce development, system and culture change across services and wider communities.

1. Help on the day you ask.
2. Choice of treatment.
3. Reaching out to people at high-risk of drug-related harm.
4. Harm reduction for everyone.
5. Staying in treatment.
6. Improving mental health and understanding.
7. Involving GPs and primary care.
8. Meeting everyday needs.
9. Recognising and treating mental health.
10. Respecting traumatic life experiences.

In 2022/23, the Scottish Government tasked all areas with implementing and embedding Standards 1-5. We reviewed our procedures and pathways and made practical changes. These include: the introduction of same day prescribing, initially one day a week; information about treatment options provided to service users to enable informed decisions; linkages to other support services made and strengthened to support people at risk; all staff trained in harm reduction and equipped with carry packs containing supplies to support harm reduction delivery; and a review of staff caseloads to ensure staff have the capacity to work with service users to support their continued engagement with services. These changes enable people to now choose the treatment best suited to their needs and start on the day they asked.

Interviews with service users, family carers or nominated individuals and commissioned services and partners identified three key themes. These are the provision or availability of information, support provided to service users and choice of support provided. This resulted in an improvement plan which will see the **Integrated Drug and Alcohol Recovery Team** (iDART) undertake improvement actions such as the use of texts as appointment reminders; improving access to bus passes and fares and ensuring all staff are aware of the work of our advocacy provider **Independent Advocacy**, Perth and Kinross (IAPK). This supports people to have their voice heard so they are involved in decisions which affect their lives, to express their needs and make their own informed decisions. IAPK supported an average of 84 people a month.

Our **Near-Fatal Overdose** pathway and multi-agency referral group is enabling services to identify and offer support long-term to those at highest risk of harm. The needs of 122 people were discussed by the Near-Fatal Overdose group and where required, people were offered assistance via the assertive outreach service.

The recovery community is vital and we empowered this to grow. There is now a robust level of activity in Perth City helping people contextualise their struggles and highlight a path to recovery.

Testimonials: Perth Based Peer Recovery Group

"This is the longest I have been abstinent over 6 months now and I am now able to participate at other activities." - "I've never been sober for years, been in and out of Detox nearly monthly this has opened my mind up toward my own recovery." - "This gets me out of my flat and has stopped my loneliness. I now have a friend!" - "Being inside prison for years this is great for building my confidence being outside."

There are nine **Recovery Cafés** based in Perth City, Aberfeldy, Dunkeld, Pitlochry, Blairgowrie, Crieff and Kinross, HMP Perth and online, with further additions planned. Other recovery activities have proven to be a great success. The Woman's Wellbeing Club operates from the **Neuk**, facilitated by staff but is peer led, providing a safe space to share experiences and give support. Providing facts of substance use, helps people be more aware of their reactions and, going forward, helps minimise the chance of a crisis. Groups provide wider social interaction helping people to be at ease and work through difficult times. Feedback suggests members feel more empowered.

Commissioned services play a vital role reducing harms of substance use. **Hillcrest Futures** delivers an enhanced harm reduction and **Injecting Equipment Provision** service in Tayside. This includes assessment, overdose awareness, injecting equipment provision, blood borne virus testing, vaccination and wound care. Locally, this is based in Drumhar Health Centre and is also provided to Greyfriars, Skinnergate, CATH Day Centre and Tayview House. Hillcrest Futures engaged in a range of activities including co-facilitating community recovery groups; playing an active role by providing assertive outreach support to the **Near-Fatal Overdose Pathway**; providing training to community members and professions in the use of Naloxone; which reverses overdose, and promoting alternatives to injecting. Hillcrest Futures distributed 446 Naloxone kits and provided crisis intervention, emotional and welfare support, food parcels, housing advice and support to access services.

Case study: Service User Story

A service user had a near fatal overdose. He uses heroin occasionally, and street Valium and he inhales lighter fluid. He begs on the street and was at risk of violence and intimidation, along with safety risks due to his tenancy. A multi-agency adult protection meeting resulted in his naloxone training being refreshed and he received an adequate supply of kits. Re-Solv, the organisation for Solvent Abuse provided harm reduction advice and acted as another point of contact to help reduce and eventually stop his use of solvents.

Hillcrest provided him with a warm jacket and other clothing, plus toiletries (purchased via the Foundation Award) to maintain his dignity and personal hygiene. He now has stable accommodation and can continue to use services if he needs to, including the harm reduction drop-in sessions. His use of solvents has reduced dramatically, and he is taking more care of himself physically. He now has a greater understanding of the risks he was putting himself in and seems better able to manage his safety.

Tayside Council on Alcohol (TCA) has over 300 active service users and, through counselling and creative therapies, it provides one to one therapeutic support, advice and information to any adult in Perth and Kinross, directly or indirectly affected by problematic alcohol use. The service works in partnership with other providers, like iDART and other third sector providers. TCA works to achieve three outcomes:

- Developing services to meet the needs of people in Perth and Kinross and ensuring staff are equipped to deliver these.
- Consolidating and developing partnerships.
- Planning for the future and building on capacity and learning to achieve sustainable change.

TCA is involved in multi-agency substance use triage meetings. They support the duty model to answer calls and take referrals and work in partnership with other providers, like Barnardo's and Criminal Justice Services, providing a specialist resource and information service to other professionals, enabling them to help people with alcohol problems achieve positive outcomes.

Testimonials: TCA Service Users

"Encouraged me to see a future without alcohol." - "Gave me confidence to pick myself up each time there was a challenge or I felt I'd failed." - "A positive impact, I've been alcohol free for months and I'm thinking differently now." - "Alcohol free for 3 months, service has been very good, better health physically and emotionally."

""I have vastly reduced my alcohol intake down to being tee total. I'm coping better with stress/anxiety." - "It has helped me to reflect on the issues which trigger my medication misuse and I feel so much more in control. I feel more alive, alert and happy in myself."

Churches Action For The Homeless (CATH) help residents of HMP Perth, on a short-term prison sentence, to have a positive transition back into the community. This supports people with housing, physical and emotional wellbeing, employment and volunteering opportunities and life skills, and aims to achieve the following:

- Offering substance use brief interventions and support to engage with recovery communities.
- Supporting people prior to liberation by identifying their needs post-liberation.
- Supporting people to integrate into their communities.
- Helping people to develop coping strategies to reduce reoffending and supporting them into meaningful employment.

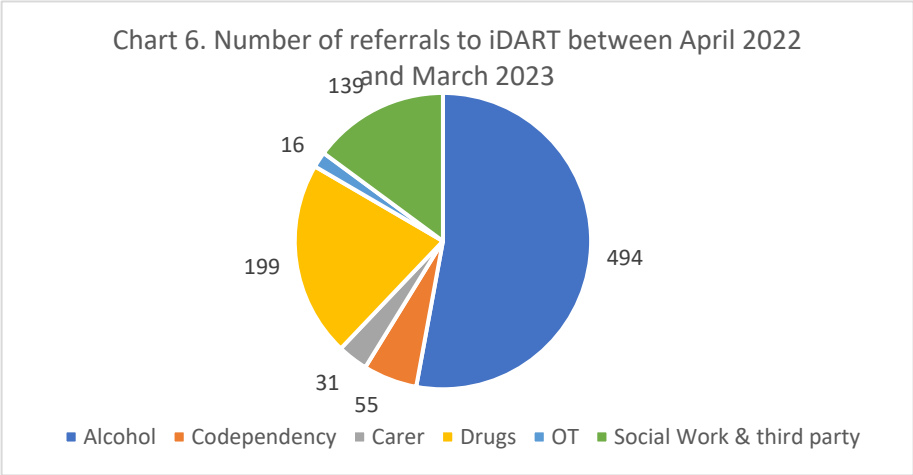
Face-to-face interaction both pre- and post-liberation has seen success with 39 people supported during the year. There are plans to expand to offer the service to remand and long-term prisoners.

Case study:

Mr X asked for help with housing in Perth. He was due to be released from custody at the end of November and wanted to stay in Perth, as he would have support from his family. The CATH worker discussed the case with the council to be advised that Mr X had to apply as homeless once he was released. The worker telephoned housing to ask about temporary accommodation and Mr X was offered a place in Greyfriars.

The worker organised a food parcel and for him to receive an advanced payment on Universal Credit to tide him over until his payments started. The worker has continued to provide support by helping him apply for Universal Credit, supporting him to visit his bank to ensure he had information for the arranged Job Centre appointment, and completed forms to register with a GP and dentist.

Integration of all community-based substance use services continued through the expansion of iDART. Adopting a fully integrated, multi-disciplinary approach, iDART facilitates options to help people manage substance use issues. In the reporting year, the service received 935 referrals.



Overall, the average iDART caseload increased, up from 480 in 2021/22 to 627 in 2022/23. Notably, much of this increase is due to people remaining in treatment for longer.

Using **Recovery Workers,** we help people receive intensive support from initial contact with iDART through appropriate medical and non-medical treatments. This includes group psychology and community integration where they are supported to access community recovery supports. iDART introduced **Same Day Prescribing** with specialist elements of our comprehensive programmes of care, treatment and recovery delivered to support those experiencing problematic drug and/or alcohol use. In 2022/23, 13 people received this treatment at Drumhar Health Centre. This is also helping to improve substance use waiting times, and while these increased slightly in 2022/23 overall as a result of staffing challenges, the last three months saw significant on-target improvements.

We invested in an upgrade of our facilities, complemented with an expanded workforce, looking to improve efficiency and better support people to navigate services.

Case Study: Mindspace

A person with ongoing issues around drug use and suffering from social isolation, anxiety, depression, and housing concerns, was connected to Mindspace and Independent Advocacy through iDART. They were referred to our Social Prescribers to help them become less socially isolated and empower them to engage more with the community and find new interests. Through signposting they were better supported with holistic support, which ultimately helped them move to a new property in a more suitable area. The Safer Communities team helped them gain a free ring doorbell, providing peace of mind and minimising anxiety. They were registered with the Bike Station and got a free second-hand bike, which has opened up new travel and leisure opportunities, as they joined group cycles, gaining social contact and exercise. They are now attending Andy's Men's Club, helping them meet others in the area and learning new skills, and were linked in with the Venture Trust, with plans in place to join a Wilderness Adventure.

Testimonial: Service User

"I was working with [the support worker] for about 6 months or so. They helped me a lot with my confidence and social skills from our face-to-face meetings and also the activities provided. They were a very nice, caring, understanding and hard-working person. I'd give them a ten out of ten all round."

In response to the high number of referrals for support with alcohol issues, we established our community alcohol detox service, which supported 14 people. We continued to expand our workforce, especially administration teams, improving knowledge and enabling better joined up working to provide effective and efficient services.

Improvement Journey: MAT Standard – Same Day Prescribing

The Situation	MAT Standard 1 requires all people accessing substance use services to have the option to start MAT from the day of presentation.
The Challenge	To meet this standard a test of change was needed.
Our Action	We introduced a drop-in clinic every Tuesday at Drumhar Health Centre which offered same-day assessments and prescribing where appropriate. Attendees were offered information and advice on other local services and support.
The Result	13 people were offered same day assessment and prescribing. There has been an improvement in the standard of referrals demonstrating that both people and professionals know how to access the service and what it offers.
The Outcome	Services have received positive comments from professionals, service users and families. There are now plans expand this service to five days a week.

We recognise the value in understanding the opinion of people, and their families, who use our services. We implemented Care Opinion and this will assist us with our learning approach to improvement.

Looking Forward

While 2022/23 saw a reduction in the number of suspected drug-related deaths, reducing to 12 from 19 the previous year, there is still progress to be made.

MAT Standards 1-5 will continue to be developed and embedded. Key developments will include the expansion of same day prescribing and the completion of our test of change to move to offering this five days a week. This will help ensure people can receive support at a time that works for them, greatly improving accessibility.

MAT Standards 6-10 will be implemented and embedded and will enhance the choice of treatment options and services. We plan to deliver same day prescribing five days a week for people suffering with opiate dependency and this will also greatly improve accessibility.

We plan to expand our workforce. improving access to psychology interventions.

A new recovery café is planned for Letham. This will operate for an initial eight-week period once a week. We are introducing RecoverMay, highlighting recovery work and journeys, through interviews, podcasts, art exhibitions, events and social media posts.

We will build on the success of our Near-Fatal Overdose Pathway by working with colleagues across Tayside to review and further enhance our pathway.

We will continue to develop our residential rehabilitation pathway with referrers, service users and providers to ensure this provides the best possible experience before, during and after residential rehabilitation.

We will continue work with colleagues across Tayside to respond to the challenges posed by the increased use of non-opiate based substances, such as cocaine, benzodiazepines and alcohol.

Chapter 7. Justice Healthcare - Prisons

Justice Healthcare is managed by Perth and Kinross HSCP and across HMP Perth, HMP Castle Huntly and the HMP Bella Unit (Dundee).

The National Strategy for Community Justice provides a clear roadmap for improvement work and highlights key aims for service delivery:

1. Optimise the use of diversion and intervention at the earliest opportunity.
2. Ensure that robust and high-quality community interventions and public protection arrangements are consistently available across Scotland.
3. Ensure that services are accessible and available to address the needs of individuals accused or convicted of an offence.
4. Strengthen the leadership, engagement, and partnership working of local and national community justice partners.

Justice Healthcare provides primary and some secondary health care services with the aim of ensuring equitable provision of healthcare to that delivered in the community, irrespective of a person's circumstances or residency within prison. In 2022/23 the number of residents increased, and demand for healthcare services was high.

Services are delivered to around 650 residents in HMP Perth at any one time, with an annual turnover of approximately 3,500. Prisoners are primarily from Tayside and Fife, while HMP Castle Huntly is a national establishment for those coming to the end of their sentence. For HMP Castle Huntly there are approximately 250 residents, receiving some community access, including work placements and home leave. The newly opened HMP Bella Unit is for women from Tayside and Fife, living in independent housing units, learning life skills, before accessing the community, building independence, self-reliance and resilience.

We are responsible for primary care, pharmacy management and distribution of medication (in possession medication), supervised medication administration, clinical pharmacy, optician, dentistry, podiatry, mental health, substance use, sexual health and blood borne virus, enhanced care, first responder to acutely unwell or injured and review of patients following a person removal and relocation to a new area. Everyone admitted to HMP Perth undergoes an assessment by a nurse on admission and by a doctor within two weeks. Residents transferred to HMP Castle Huntly or HMP Bella undergo a transfer admission assessment by a nurse within 72 hours of arrival.

The prison population has complex health and support needs, requiring a. multi-disciplinary and multi-agency approach to delivering care. This is evident daily during 'person of concern' meetings, where professionals from a broad range of disciplines review the needs of individual patients. More than 1,650 cases have been discussed since April 2022. Nearly 90% are related to substance use, 8.5% to mental health and 1.5% to physical health.

Near Me Tayside is successfully used for outpatient appointments, with the implementation of telephone appointments also provided. This has improved accessibility and the dignity of patients as they are not required to attend hospital appointments handcuffed to officers unless absolutely necessary.

We continued to deliver onsite access to clinical psychology and we are increasing the capacity of our Occupational Therapists (OTs). OTs provide support through a range of measures, from liberation planning and rehabilitation (across cognitive, physical and mental health) to environment assessment and specialist equipment provision. While OTs primarily work with people with mental health issues, we have ensured there is capacity to also support people with substance use and physical health needs, supporting people with a range of occupational performance impairments across primary care, substance use and mental health areas. 82 new patients were assessed by our OTs, with 91 referrals received and 772 appointments offered.

To increase clinical prison healthcare, we developed onsite access to clinical psychology. An onsite Clinical Pharmacist provides specialist

advice regarding medicines as well as carrying out clinical and medication reviews. Joint working with clinical practitioners has been adopted to improve medicines administration with pharmacy colleagues offering controlled drug training to all staff.

Given the impact of COVID-19, infection prevention and control remain a priority. Prison healthcare continued to offer testing to all new admissions/transfers, with the associated isolation put in place for those who were symptomatic or positive for COVID-19. Symptomatic residents were tested and appropriate measures taken.

To improve efficiency of dental care and increase the number of appointments it is necessary to invest in buildings infrastructure, particularly in relation to ventilation. It was hoped this work would be completed in HMP Perth within the reporting year but this was not possible. We will continue to work with the Scottish Prison Service (SPS) to establish a timescale for completion of the work.

Following a review, we improved our complaints handling process. In 2022/23 the service received 429 complaints, up 25.4% from the previous year.

All complex complaints are triaged as Stage 1 in the first instance if they require some investigation and are escalated to Stage 2 if a person is not content with the response to Stage 1 or not responded to in the allotted time. Stage 1 complaints accounted for 83.5%, with only 71 either starting or escalating to stage 2. It should be noted that all Stage 1 complaints receive a written response.

The outcomes have shown that 14.0% of complaints were fully upheld, 19.8% partially upheld and 58.8% of complaint were not upheld. The main complaint category is clinical treatment, with 64.7% of all complaints. 32.0% of those refer to disagreement with the treatment plan. General Practice (GP) waiting times is likely to have been the focus with 20.2% of complaints relating to a date for an appointment. Action has been taken to address this. GP waiting times averaged at 14 weeks at the start of 2022/23. With regular locum sessions supporting prison healthcare these waiting times were reduced to three weeks by the end of the year. This positive trend is expected to drive a reduction in complaints for GP waiting times.

Looking forward

As part of our efforts to address waiting times, we are:

- Expanding the workforce across Justice Healthcare.
- Securing regular locum GPs to help mitigate the risk posed by limited GP cover for HMP Perth.
- Exploring ‘open days’ to boost interest and applicant numbers in our staff recruitment.

An Advanced Nurse Practitioner (ANP) model is under development. Similar to community-based services ANPs can effectively assess and treat patients without GP intervention, enabling GPs to dedicate greater time to more complex caseloads, and making it easier for residents to secure the care and treatment they need in a timely manner.

We aim to improve linkages with community Near Fatal Overdose Groups. This will better support patients at risk both entering and leaving custody, with particular benefit for those who are not currently involved with our substance use services. The service is exploring the establishment of joint trauma informed leadership training with SPS in HMP Perth. This will help develop a fully trauma informed prison, improving access to necessary support for those in residency.

We also aim to improve our use of GP locums for prescriptions to improve resident access to community pharmacies, with our initial focus on those in the HMP Bella Unit.

Chapter 8. Adult Support and Protection

People have the right to live as independently as possible in a safe environment, free from harm, to have their wishes and feelings considered and to have the minimal amount of intervention into their lives. For people unable to safeguard their own interests and who are at risk of harm due to disability, mental disorder, illness or physical or mental infirmity, we (and other partner organisations) have a duty to investigate and, where necessary, act to reduce the harm or risk of harm. Perth and Kinross HSCP manages the Council's statutory responsibilities for adult support and protection and works closely with partners through the Adult Protection Committee on the following identified improvements.

- Increased engagement with adults, families, and carers. Engaging better with violence against women groups, young adults and supporting better transitions between children's and adults' services, transition between home and care home and transition into and out of hospital.
- Better connections with other public protection agendas.
- Improving practice and service improvement by better use of data.

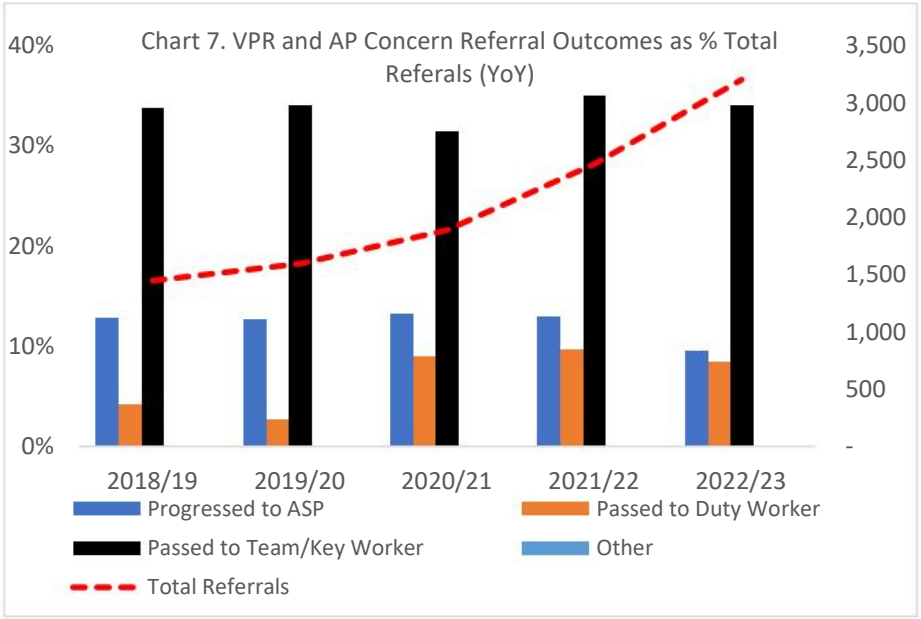
We supported people by remobilising from the pandemic in a challenging economic environment, where vulnerable people are at risk of greater levels of harm. We adapted working practices, using virtual means where appropriate to engage with people, investigate and gather information, to determine if people required support and intervention to keep them safe and protected. This enabled more people to access the help and support they needed to keep them safe.

While workforce challenges persisted, we maintained sufficient suitably trained social workers to ensure the right level of adult protection support and we expanded training opportunities for additional staff.

Demands on the service continued to rise both in respect of Vulnerable Person Reports and Adult Protection (AP) Concerns, up 30% in 2022/23. It is thought this is linked to the challenges of COVID-19 and the worsening of the financial environment. Greater awareness is also contributing to this increase in workload as we work with partners to raise awareness and increase accessibility through referrals from the Police and other services. Our dedicated ASP Coordinator is supporting this work, highlighting the need to report harm at the earliest opportunity via key stakeholders:

- The care at home forum.
- Perth City Locality management team.
- PKAVS.
- Third sector providers.
- Community sectors.
- Supporting public campaigns raising awareness of adults at risk of harm

The number of vulnerable person and adult protection concerns that necessitated formal inquiry or investigation decreased by 4% from 2021/22, accounting for 10% of total referral outcomes (see below, left axis). This trend occurred at the same time as the number of referrals (see below, right axis) increased by 30%, to 3,081. This increase in total referrals coincides with recent activity to promote and improve public and partner services' awareness of adult support and protection services, suggesting we have been successful in encouraging people to come forward with concerns.



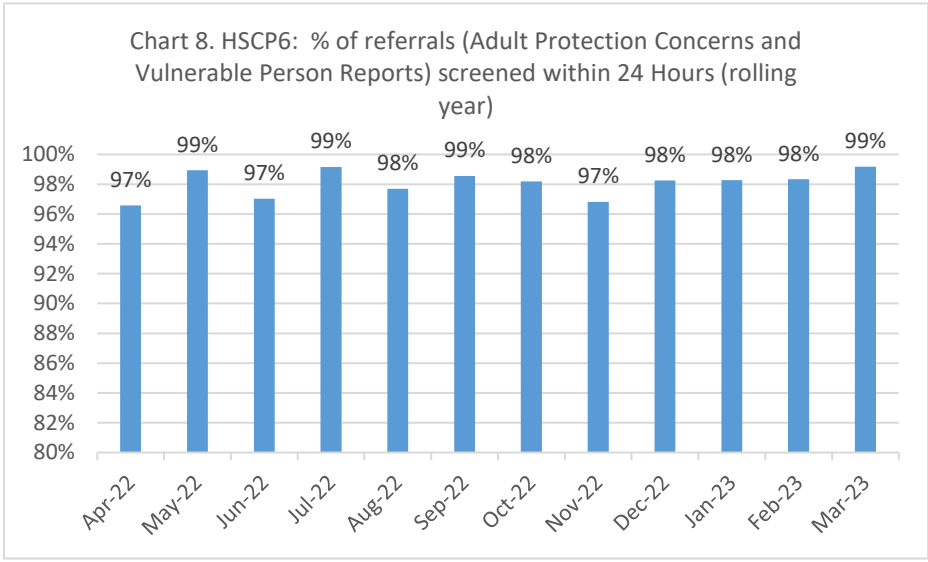
Across all referrals, mental ill-health continued to be the most prominent feature, rising from 404 in 2021/22 to 591 in 2022/23, accounting for 19% of the total. Frailty/illness remains the second largest reason for referral, accounting for 10% overall. This suggests that higher numbers of people requiring support and protection have experienced deteriorating mental ill-health and worsening health and wellbeing. While there are likely to be a variety of reasons for this increase, it is widely accepted that COVID-19 restrictions have had a lasting adverse effect on physical and mental wellbeing. Recognising this, we have invested in additional experienced mental health nurses to act as a 'first point of contact' via the Access Team to provide a more person-centred, timely and proportionate multi-agency response.

For the last reporting year, all localities reported a downward trend in the number of people subject to formal powers under the Mental Health Act, despite a notable increase in mental health related ASP referrals. This suggests our community-based services are working to prevent crisis from emerging and help people remain independent within their communities. Commissioned services are working to connect with and support vulnerable people on a range of issues, from mental health and learning disabilities to old age and frailty. Likewise, our Social Prescribers are making a vital difference identifying need and signposting and referring people to services to ensure they receive pre-emptive and preventative support at the right time and place.

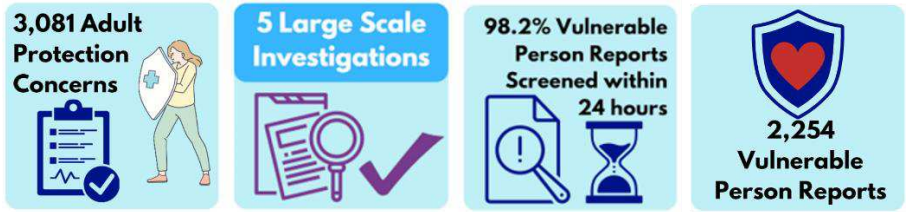
Case Study: Independent Advocacy - Safeguarding people's rights when they have more limited capacity.

Following a concern we supported a vulnerable person with significant communication difficulties to explain their situation though independent advocacy, a commissioned service. It became apparent though advanced communication techniques; talking mats, making use of buzzers and photographs that the person's family had prevented him from wearing his glasses, and stopped him from wearing a face covering, and denied him the opportunity to receive the coronavirus vaccine. Through this process other concerns were raised about the cleanliness of living conditions and wider vulnerabilities like being left at home alone inappropriately which could lead to further harm. Gathering the views of this person enabled their case to be heard and consequently their welfare was protected through the application of a welfare guardianship.

Performance in relation to screening of referrals within 24 hours remained strong at 98.2%, up 1.7% from the previous year. This strong performance was maintained across localities, highlighting our commitment to delivering an equal level of care and support irrespective of a person's location, background or circumstance.



Initial Referral Discussions (IRDs) were introduced into adult protection practices in December 2020 to provide a multi-agency way to identify adults at risk of harm and coordinate how any risk could be managed. Originally a three-day timeframe was set as a target, with 69% held within this target in 2022/23. However, a qualitative audit of IRDs found that legitimate reasons exist as to why an IRD may not be held within three days. That audit also found that no adult was left at risk of harm because of the IRD being delayed. A further qualitative IRD audit is planned for 2023 and if findings are replicated, a proposal to extend this timeframe will be considered to make our approach more consistent with other adult protection committee areas and similar to the pathway taken by colleagues in child protection.



We worked to improve participation and engagement available to people at risk, and to their families. Our services use Care Opinion to gather feedback on all aspects of ASP. Quarterly analysis of feedback is shared on this page of the care opinion site.

Case study: Independent Advocacy Supporting Participation

A person contacted IAPK and expressed they were nervous and anxious and had difficulty trusting people. Advocacy phoned him and identified he was living in poor conditions including no access to heat over winter, and other potential adult support and protection issues. Advocacy referred him to the access team and although he was 'hard to reach', both geographically and socially, advocacy provided a relevant and relatable person he felt he could depend on. Working with the advocate closely helped him access Support Choices and enabled him to participate directly in decision making about his life.

The main forms of harm experienced by vulnerable adults are neglect (34%), physical harm (26%), financial (23%), and psychological and emotional (17%). The key risk factors for people who need protection from harm are old age, dementia, and frailty. Older people (65+), particularly those over 80, account for a significant portion (55%) of adult support and protection investigations, indicating higher dependency and vulnerability. The most common location for harm is at home, accounting for 42%. This is an increase of 30% since last year. The number of investigations of care homes (private and local authority) has similarly increased, by 67% from last year.

The **Care Home Oversight Group** continues to drive improvements by delivering daily reports and providing an opportunity to increase levels of assurance in relation to the care and protection of care home residents. All care homes receive regular visits, and residents undergo care reviews which enhance measures to protect people from abuse and harm. The **Enhanced Care Home Team** supports residents, providing a multi-agency response to supporting adults with increasing complex needs, including supporting those with acute levels of dementia, learning disability, mental health and acquired brain injury. The ASP Coordinator and the Service Manager with Portfolio lead for the Perth and Kinross Carers' Strategy, sit as part of a wider Adult Social Work Leadership team. This relationship brings a good level of connection between the ASP and Carers' agenda. The Adult Protection Committee has third sector carer representation as part of the membership and the Adult Protection Committee subgroup also has third sector representation.

Looking Forward

We have developed an improvement plan for Adult Protection services, framed around the six high level improvement areas and activities as set out in the National ASP Improvement Plan 2019-22. It builds on what has been achieved to date and using our commitment to quality assurance, self-evaluation, audit, alongside a continued commitment to improvement and learning, we will use this plan as a means to improve outcomes for people.

To better connect our approach to ASP and to improve safeguarding of adults we established a thematic learning review group to examine the themes emerging from our Large-Scale Investigations, Initial Case Reviews, Significant Case Reviews, Serious Adverse Events Reviews. This learning will inform strategy, policy and service delivery moving forward.

Our new communication plan provides further details on how we plan to progress the ASP communication agenda, with a focus on making information more accessible and helping people to be involved in policy setting and decision making that impacts their lives. As part of this, all public facing ASP literature is being converted into easy read. This process has already started in partnership with colleagues from community safety as a test of change. Advice has been translated into easy read by the NHS Tayside speech and language team and shared publicly online and across social media channels. Initial feedback suggests more people are better able to understand how this might impact them.

We are planning to improve how we use data to inform our decision making and are developing our strategic delivery plan, key performance indicators and risk register. This will ensure we take meaningful steps to drive future improvements. As part of this, we are working with colleagues to ensure the new case management system is effective in supporting ASP processes efficiently. In addition, we are introducing dedicated case conference Chairs to help ensure consistency in the quality of decisions to improve the experiences of people in need of protection. This work has led to the development of an ASP Learning Pathway, which aims to improve the support we provide to practitioners and managers to improve practice.

Chapter 9. Unpaid Carers

We made good progress on our Joint Carers' Strategy 2019-22 despite the challenges of the pandemic which saw many face-to-face options for carer support removed or diminished. The following outcomes were achieved.

- More carers were identified and supported.
- Information about carer rights and support for carers was made more readily available and accessible.
- Carer representatives as key decision makers are more firmly embedded within our strategy and working groups.
- A more streamlined process for accessing and receiving support for carers was established.
- Extra investment into support for carers was made, through commissioning and an exploration of how we can all improve support for carers.

The Carers' (Scotland) Act 2016 (the Carers' Act) was implemented in April 2018 with the intention to provide better outcomes for unpaid carers. It placed duties on Local Authorities and Health Boards to jointly prepare and publish local carers' strategies following consultation with carers and local carer representative groups. Where a strategy is published, a review must take place within three years and a revised strategy produced. In 2022, we consulted with unpaid carers, their representatives and the professionals who work to support them. This was done through mailshots and open events in Carers' Week 2022. Their responses together with the National Carers' Strategy and findings from a recent inspection by the Care Inspectorate, were used to inform our revised Joint Carers' Strategy 2023-26.

Our aim is to ensure carers are recognised as equal partners in planning personalised support for themselves, and those they care for, and to support carers to live in good health allowing for a life of their own alongside caring. The new strategy continues to build on the ambition of the previous strategy, under the same strategic outcomes:

1. Carers can expect clear, reliable, accessible information about local and national support.
2. Carers can expect promoted awareness about unpaid carers in the community and workplaces to improve early identification and support of carers.
3. Carers can expect that they are listened to and have their opinions valued by professionals.
4. Carers can expect opportunities to participate as active partners to the planning and shaping of carer services in their local areas including services for the people who are cared for.
5. Carers can expect more opportunities for peer support.
6. Carers can expect improved provision of flexible and personalised support, to support emotional/ physical wellbeing of carers and to enable them to have a life alongside caring.
7. Young carers will have the best start in life and will be supported to achieve their potential, irrespective of their caring responsibilities*.

**Outcome owned by Education and Children's Services*

We can support unpaid carers to continue in their caring role and ensure they have a life outside of caring by providing access to services and support networks available through online awareness campaigns and in-person events. We promote and encourage peer support networks and organisations, such as Carers' Voice and our commissioned services to connect with carers. This ensures clear, reliable, and accessible information about services and helped contribute to a rise of 353 carers registered with PKAVS last year, one of our commissioned services and facilitator of the Carers' Hub.

Information about anticipatory care planning and emergency planning contributed to over 800 Emergency Care Plans being forwarded to

carers. There were 1,213 new carer referrals in 2022/23, an increase of 171 on 2021/22, and leading to the provision of 443 Adult Carer Support Plans (ACSP) and 318 Adult Carer Support Reviews. These plans help carers plan out what support might be needed to ensure they can continue supporting those they care for. Making an ASCP in particular helps to determine what support services a carer may need. By involving more carers in this discussion at the earliest possible stage, we can help support them continue in their caring role for as long as they want and prevent situations becoming unsustainable. Despite the impact of COVID-19 and challenging financial environment, this appears to be working. The percentage of people admitted to permanent care due to carer breakdown reduced to 17.3%, down from 20.2% in 2021/22. This positive trend demonstrates the impact of having support available for carers and highlights the success of this approach in keeping families together longer, staying at home.

We enhanced training materials on carers' rights to improve the confidence of people when seeking support. Providing training ensures unpaid carers are better able to cope with challenges and helps make life easier and more enjoyable for them and for those they care for. The training opportunities we provided in the last year includes:

First Aid, Self-advocacy, Self-directed Support, Dementia Awareness, Digital Skills, All Strong gym (wellbeing), Mental Health First Aid, ADHD, Six Legal Must Do's and Hart Start.

Over 200 carers accessed training and feedback was overwhelmingly positive:

Testimonials: Dementia Awareness Training

"Just to say what a great course it was last night and so glad you ensured I could take part. It is always good to meet other people in similar positions so we can support each other. Thank you again."

Testimonials: First Aid Training

"Just wanted to say thank you for giving me the opportunity to do the first aid course yesterday. It was beneficial and happy to say I am now qualified first aider. Guys teaching us were terrific. I'll keep checking for further courses you offer as it was nice doing something different and it's raised my self-confidence. Thanks again."

Working with third sector partners, we promoted and developed peer to peer support networks and there are now 15 groups. We worked with partners to set up carer cafés in Crieff, Aberfeldy and Blairgowrie as well as supporting PKAVS.

Change Mental Health are commissioned to help people affected by serious mental illness, including family members and carers. Since January 2023, in partnership with All Strong, they have supported carers to participate in programmes for fitness and wellbeing, helping them remain active and diminishing feelings of isolation. Referrals into the service remain high, and in the past year 225 carers received information and advice, with 154 carers receiving information from their monthly newsletter and 63 received ongoing 1-2-1 support. Whilst we have not increased the number of employers with Carer Positive accreditation, Crossroads, a commissioned services, has committed to applying and we presented to the Chamber of Commerce and other commissioned services to reduce the financial exclusion of carers and improve the recruitment of carers by local employers.

The Carers' Hub continues to provide social and complementary therapies and grants enabling carers to have breaks and more opportunities for peer support. They provide a telephone befriending service which provides out of hours support. 376 carers are registered for this service, making an average of 126 calls each week. This gives carers more flexible and personalised support which helps their wellbeing and gives an opportunity to do other things outside caring.

In 2022/23 we supported 1,683 respite bed nights in care homes and 10,978 hours of home respite. Under self-directed support option 1, carers were provided with a combined total of £43,700 to ensure they got the breaks they needed as flexible respite. Our partner Crossroads provided 84,304 hours of sitting service in the three years since the strategy launched.

We increased our capacity to support people (and their families) requiring palliative care, providing support when treatment is needed in hospital. In 2022/23 we ran a workshop to focus on adult palliative and end of life care, and carers with lived experience were invited to attend to ensure any service developments were reflective of their needs.

Case Study: Carers' Café

Karen and her husband, who she cares for, recently moved to Perth and Kinross to be nearer family. Karen had never been recognised as a carer and didn't have support before they moved. Karen finds caring exhausting and found lockdown difficult. Karen was told about the Crieff Carers' Café which is supported by a local Carer Support Worker and a Carers' Hub Support Worker. With the Carer Support Worker, Karen got a personal Adult Carer Support Plan so she gets weekly breaks to go to a painting class knowing her husband is looked after. Her husband occasionally stays in a local care home so she can get longer breaks and she was able to attend a funeral. She gets support from PKAVS Carers' Hub and finds caring for her husband with this support easier.

Case Study: Carer Support Services Commissioned Service, PKAVS

PKAVS Carers' Hub offers emotional and practical support to unpaid carers of all ages. It had 833 new referrals, compared to 735 for the previous year. It has over 2,526 unpaid carers of all ages registered compared to 1,973 in March 2022 (21.8% increase). The pandemic restricted availability to supports and this with the cost of living led to more complex needs. This presents challenges in how we best allocate resources for the best outcome. A carers' consultation in December 2022 highlighted the following feedback. Of the 207 responses, 199 either 'Strongly Agreed' or 'Agreed' that their emotional health and wellbeing had been affected over the past 12 months. When asked how it had been affected the largest numbers said they worry 'about the person I care for'; 'What happens if I become ill?' and 'I am worried I will become exhausted and not be able to cope'.

Unpaid Carer Testimonials:

''Thank you so much for the payment towards my unexpected Vet's bill. I was so worried about how to pay this as I have no savings and no extra money and am barely making ends meet but now I can sleep easier knowing that this has now been paid."

"Thank you for the information regarding the Self-Directed Support Options and for explaining these to my sister and me. It was extremely helpful. We are now aware of the other options open to us and have your contact details should we require any further advice."

"I'd just like to say that I feel fortunate to be supported by PKAVS. I've always felt listened to, and when I've had my assessments have felt supported and taken care of and been given plenty of opportunity to be heard and advised appropriately."

When asked 'What support for your caring role would help you most at this time?' the three largest responses were complementary therapy vouchers, short break grant awards and emotional support.

Day services, which runs five days a week from the Carers' Hub, continues to be very popular. Almost 4,000 spaces were taken during this reporting period against an initial target of 3,700. The Carers' Hub continues to be the first point of contact for information and advice for unpaid carers, with nearly 24,000 requests for information and advice, up from 17,000 in 2021/22. To address this need PKAVS delivered:

- 766 packs of complementary therapy vouchers to carers, up from 645 in the previous year.
- 453 short break grants awarded, 350 Time4Me/12 Carers' Trust awards and 91 through the Holiday Voucher Scheme, up from 324 the previous year.
- Over 500 telephone befriending team calls every month offering carers access to emotional and practical support.
- 204 carers signposted to additional support services.
- 61 cost of living crisis grant awards made.

Looking Forward

Our new strategy will continue to build on the ambition and previous work to ensure all carers have the information and support they need as well as to support them to enjoy a life alongside caring. We plan to improve awareness of the support available to carers and will increase their involvement.

As part of the national Carer Positive Initiative, we will support carers to find or maintain employment. We will roll out an improved carers' befriending service and enhance bereavement support for carers and support for people caring for someone who is at end of life. We plan to provide services for people caring for someone who has had a stroke or dementia.

We will continue to work with the third sector to improve the range of respite options for carers, including carers who are parents. We will look at what services are delivered to carers and how we might commission these in the future. We will ensure we get the best value for public money and guarantee the most capable and effective organisations seeking and able to deliver carers' services are given an opportunity to do so.

Chapter 10. Older People's Service

The population of Perth and Kinross is older compared to Scotland, with 24% of people over 65 compared to 20% nationally. It is estimated that 22% of the older adult population has at least one long-term condition affecting physical health, with the prevalence of long-term conditions known to increase with age. These factors contribute to the higher comparative level of demand for older people's health and social care services. To meet this demand in an efficient and effective manner our Strategic Delivery Plan for Older People, approved by the Integration Joint Board in March 2022, seeks to deliver the following outcomes:

1. People who provide unpaid care are supported to maintain or improve their quality of life and look after their own health and wellbeing.
2. Older people are supported to maintain or improve their quality of life and look after their own health and wellbeing.
3. Older people are supported to live actively and independently at home or in a community setting.
4. Resources are used effectively and efficiently.
5. People are safe from harm.
6. Timelier discharge from hospital.
7. The health and social care workforce feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.

In 2022/23 we focused improvement activity in three areas:

1. Early intervention and prevention, working with communities.
2. Shifting the balance of care.
3. Improving capacity and flow.

Transformation programmes focusing on care at home, dementia and psychiatry of old age services and the transformation of our inpatient rehabilitation models will support this work as we move forward.

1.	**Early Intervention and Prevention, Working with Communities -** Central to this approach is the understanding that older people can be supported to adopt healthier lifestyles by improving access to leisure, sport and community activities. This helps reduce isolation and loneliness and helps mitigate against the three major causes of death; cancer, heart disease and stroke. It reduces the risk of depression, developing diabetes and preventing excessive alcohol intake, all significant risk factors.

We work with partners throughout Tayside and in our communities to promote and support healthy lifestyle choices to improve physical and mental wellbeing to delay the impact of ageing. Community activities include:

- Live Active Leisure exercise pathway.
- Care About Physical Activity model.
- Paths For All dementia friendly walking initiatives.
- Annual Go4Gold Care Home Games challenge.

These help keep people active and engaged, improving physical condition, helping to establish and maintain participation in group activities, boosting wellbeing and improving community. To support people to keep active, minimise the risk of falls and improve physical resilience, we worked with third sector partners to develop a programme to engage with people using services, their families and carers, and this is now embedded in hospital sites, care homes and communities.

Case Study: Go4Gold

The Go4Gold Care Home challenge was held as a virtual event in 2022. It encouraged participation from all care homes in activities and competitions designed to increase physical activity levels in a fun and meaningful way. Participation was high, with 30 care homes and over 390 residents participating and competing. This was a big success with positive feedback gathered via surveys:

"We thoroughly enjoyed doing the sculpture though it was a lot of work. Residents enjoyed being involved in all aspects even using a drill! All our team got involved." - "It was fun to create it, especially the elephants painting and decorating them was fun." - "One of our gentlemen is blind and the choice of games was so good that with clear instructions he could take part no problem. The joy on this face was lovely to see."

In partnership with Paths For All, we transformed Blairgowrie Community Hospital outdoor space, creating a space to walk, exercise and do strength and balance exercises. Training and resources were provided to staff to emphasise the importance of physical activity and support them to teach people how to incorporate this in daily routines. Over the long term this will help older people lead active and healthy lives for longer. Similarly, we are part of a newly established Tayside Falls Steering Group, which will help ensure a more consistent approach.

Case Study: Care in the Community, North Locality

An elderly gentleman in interim care started to show signs of decline. He had made it clear he wanted to stay out of hospital and remain in a homely setting no matter what happened. Both the patient and care home struggled to cope with rapid deterioration. His key worker referred him to our single point of contact Clinical Coordinator. He was accepted into the care of the North Locality Integrated Care Service (LInCS). Our integrated multi-agency and multi-disciplinary team assessed his needs, updated care plans, provided additional equipment and services and provided everything they could to wrap care around him. This created a truly patient-centred response. With daily multi-disciplinary team discussions and input from other professionals, he was stabilised in the care setting. Unfortunately, his deterioration continued. Determined not to admit him to hospital in accordance with his wishes, they advocated to admit him to a local nursing home, worked hard to negotiate Scottish Ambulance Service protocols and sought advice from palliative specialist nurses to ensure his comfort and dignity.

The impact for the patient was, that against a backdrop of complex external service protocols, the integrated multi-disciplinary team was able to successfully advocate for his wishes to be respected. This allowed the gentleman to have a peaceful and dignified death in an environment of his own choosing. We often think success is about saving lives, but ensuring compassionate, dignified death in line with a patient's wishes is as important as any other element of care. This case showed exemplary integrated care, working as intended, that was professional, compassionate and patient-centred.

2.	**Shifting the balance of care -** People state they wish to remain at home for as long as possible and receive support at home or in their community. This requires an integrated approach, with third and independent sectors and provides community-based, short-term and targeted specialist care and support. This is a robust and appropriate alternative to care home or hospital and if hospital is required, it supports timely discharge to ensure people live healthy, independent lives at home or in a homely setting.

We continued to develop our approach of **Integrated Working**. Staff participated in learning sessions on how we incorporate the aims of the Perth and Kinross Offer, which sets out how we work together with local communities, and engage with colleagues to help focus efforts and resources toward making a positive difference to people's lives.

All Self-Directed Support options are embedded in major care pathways in Perth and Kinross. Rurality and recruitment issues are challenging and we work hard to develop and/or fund services. In the past year we funded a test of change, offering Community Brokerage. This supports adults identify the right social care support and assists them to put it in place. They prepare people for assessments, support agreed plans, help with understanding budgets and accessing local support and activities in the community. Funding has been secured to expand this project.

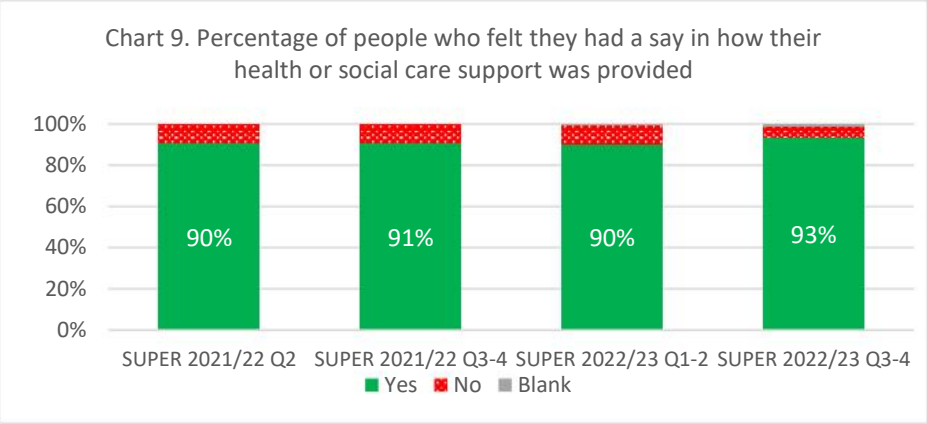
'What Matters to You' locality staff events were peer led by an unpaid carer representative from the Alliance, and gave an opportunity to come together, learn, build relationships, and strengthen resilience.

Testimonial: **From a member of staff**

"I feel inspired to do better. Reminds us of a carer's role and identity and show we can support."

We set up an **Enhanced Care Home Support Team** to work directly with care homes. The team encourages proactive working and focuses on quality and clinical evidence to support change, with the team's flexible approach ensuring they can provide education and support for care homes according to their individual needs. The care homes are directly involved in identifying the support they require, fostering a culture of learning and transparency that is helping Care homes improve outcomes for residents. This helped implement sustained improvements with a person-centred approach. The team have also intensively supported those care homes who have experienced issues in the quality of their delivery, preventing issues with quality of care and support from developing further. This has been successful, with adult support and protection Large Scale Investigations reducing since the team's introduction.

Our co-production ethos to delivering education demonstrated our commitment to the national My Health, My Care, My Home Strategy. The vast majority of SUPER survey respondents felt they had a say in how their support was provided.



SUPER Survey Feedback (N Range = 90-190)

The effective use of technology is vital to help protect people from harm and empower them to live as independently as possible. We invested in the community alarm and telecare service, with 1,244 new people receiving devices across 2022.23. Our use of digital technology for consultation, particularly in rural areas, is increasing. We started working with the 'Volunteero' app-based system which allows volunteering opportunities to be shared easily and provides better monitoring and reporting. Early signs are positive and other methods for volunteer recruitment remain.

In partnership with Alzheimer Scotland we expanded access to post diagnostic support services. Across 2022/23 447 people were supported in the early stages of their illness to understand their illness, manage their symptoms and plan for their future, up from 252 in the previous year.

Testimonial: From a service user

"Alzheimer Scotland support worker definitely helped us in various ways and a lot of good advice. They got in contact about dad's hearing and especially eye vision. He is now back reading with the help of a light magnifier, different glasses that help him watch TV and the colours are better. Dad always feels at ease talking to the support worker and told him not to get too stressed out when he couldn't remember things just try and relax. They also helped us to try and play some games on the iPad as it would help stimulate the brain. He now plays patience and puzzles. They also remind me that I needed time to myself as well as it is a full-time job, caring. I didn't know you could get so much help if it hadn't been for support worker. I could not fault them."

Our response #1: Occupational Therapy

Thank you so much for your lovely feedback about your experience of the service provided by Occupational Therapy. It is always encouraging for the staff members in the team to receive feedback like this and the team work very hard to do their best to make everyone's experience a positive one. As a team we do our best to work with people for a length of time that is best for them, however I do understand that sometimes it may feel like it would have been helpful to have the service for a bit longer. We have sourced information about the local Perth and Kinross MS group if you don't already have this information and hope that you will feel able to contact them to find out more about what they might be able to offer you and your son.

Our response #2: Carer Support

I'm sorry that you have not been able to get information about carer services. PKAVS Carers' Hub are the first point of contact for all carers in the area and together we try to get information about the support unpaid carers are entitled to, to every carer who needs it. We appreciate how difficult it can be for unpaid carers looking after someone, the concerns they have about the person they care for, and how important it is that carers look after themselves. I have been in touch to arrange getting leaflets about the support available to the OT Service at Murray Royal in the next few days - so that yourself and other carers using the service can get the support they need as carers.

Testimonial: Physiotherapy, Care Opinion Story

"Back at physio again with the lovely [staff member]. I have multiple sclerosis and it is now progressive so referred back. I've been to-and-fro over last probably 17 years. Always feel very comfortable and looked after so well. It's always never a stress to have an appointment because of the friendliness of the physiotherapist. I often get tired and there is understanding that I might not always manage all the exercises so never feel pressured but completely comfortable to trust all advice given."

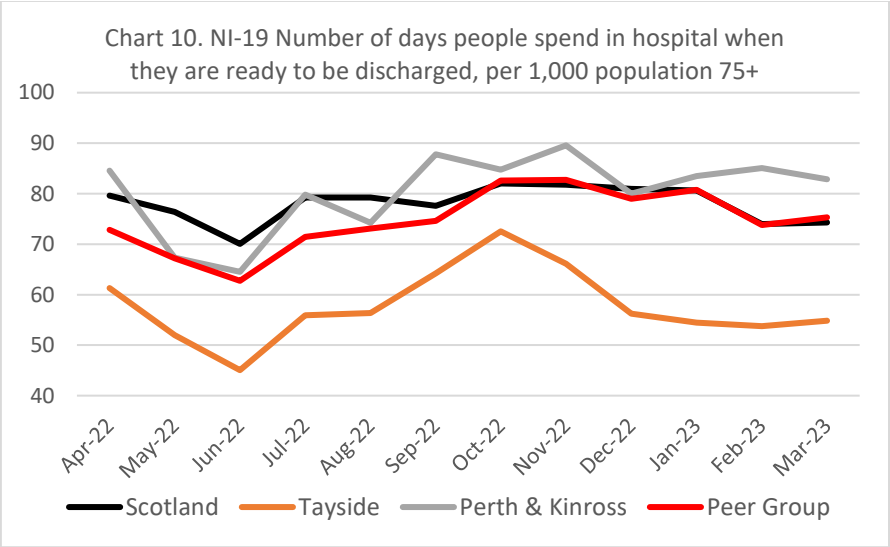
We recognise the value of feedback from the people using our services and are aware that having different methods of gathering this helps present evidence or otherwise of the achievement of objectives and improvement in outcomes. Beyond Care Opinion we continue to use our internal Service User and Patient Experience Reporting Survey**.** This is used across older people's services, enabling people who use our services to give feedback. The following quotes are examples of what people have said.

Testimonial: Service User and Patient Experience Reporting Survey

"I love coming to New Rannoch. You always have a good laugh" – 75+ year old male accessing day opportunities." - "Excellent care and support being provided. Also, advice on how best to utilise the equipment provided" – Adult receiving HART reablement support.

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

We have experienced pressures caused in part by the pandemic, increased complexity of conditions, combined with population makeup and frailty, alongside recruitment and retention challenges. These pressures coincide with increased numbers of people seeking emergency care with accident and emergency attendances up 10.9% and emergency admission up 8.0%. To provide the best care for older, frailer people when they require admission, we progressed our **Frailty at the Front Door** approach. We opened our **Acute Frailty Unit** and expanded its team who provide an assessment and adopt a rehabilitation or reablement approach. This is being further developed to support early discharge. When completed, reablement support at home will be provided immediately to prevent delayed discharge, helping people to return and live as independently as possible in their own homes.



The rate of delayed discharges increased 58.2% from the previous year. However, the vast majority of people (96%), were discharged on time and improvements are being delivered in early 2023/24 to drive further enhancements with significant gains already having been made, particularly in relation to the **Early Discharge Programme,** which began January 2023.

A further element of our response is our **Integrated Discharge Hub**, which manages complex discharges. It maintains vital links between inpatient and community health and social care services, playing a critical role in supporting capacity and flow. In 2022/23 we changed our workforce model and recruited Integrated Discharge Coordinators to cover all inpatient areas and attend Medical Discharge Team meetings. They provide consistent input to patient journey planning, increasing the speed of referring to services such as **HART** (Home Assessment and Reablement Team), ensuring patients are in the right place at the right time and the next step in the patient's journey is planned without delay. Assessments at home are a focus of our person-centred **Home First** approach. Enabling assessments for those with long-term care needs

outwith a hospital setting, we ensure they can return to and remain in a community setting, when possible.

Testimonial: From a service user's family

"You took his case on and within a few days you were meeting with him and contacting me, understanding his situation and him as a person and starting the job of finding him a care home that would suit his needs and trying to keep him close to where he used to live. I will be forever grateful to you. You are a fantastic person and extremely good at your job, I felt very at ease about the whole situation and you explained everything so I understood it. Thank you, thank you, thank you."

This intervention helps minimise harms that can occur due to a lack of timely discharge. However, we can see that the percentage of people re-abled to the point where they need no further support has reduced when compared to pre-pandemic levels. People who require longer inpatient stays for rehabilitation or assessment for long term care needs are transferred to community hospitals, when possible. This provides greater opportunities for community-based services, including social work, to support people to transition out of hospital.

A major contributor to discharge delays was difficulty securing timely and sustainable Care at Home which is complex with many variables. We continued to develop new models of Care at Home provision which see people supported more by communities. The **Living Well Teams Model** is evidenced as successful however it has not yet been possible to embed it locally, recruitment being a significant barrier. We are considering other options to promote sustainable and timely access.

Improvement Journey – Older People's Services, Early Supported Discharge

The Challenge	Delays were happening due to packages of care not being available and the lack of resources needed to complete the assessments required.
Our Action	Commissioned service, **Avenue Care** provided resources from 16 January, for non-complex cases.
The Result	Referrals to HART reduced with assessments completed from home rather than hospital. With a more accurate assessment of what is required for care in their homely setting, people are no longer waiting. Paperwork and processes are significantly streamlined helping people return home and to communities faster.
The Outcome	Over a 16-week period, over 80 people were discharged from hospital, and there were no delayed discharges in our Frailty Ward.

Public Engagement Feedback – You Said, We Did

We held three public engagement events in November 2022, covering Coupar Angus and Dunkeld, and an online event. Community members from the North Locality attended, with the aim of providing feedback around service provision, challenges, priorities, and community involvement for health and social care services. Using the feedback, we developed an overview titled 'You Said, We Did' which outlined the key themes and noted our actions, which are being taken forward through our Strategic Delivery Plans. The themes identified largely related to the following:

- Increase volunteering opportunities.
- Improve use of accessible data and ensure communication is appropriate to audience.
- Improve communication around access to community support.
- Address shortages in access to GP and other medical/clinical care
- Improve transport links.
- Make more and better use of Technology to reduce isolation.
- Local appropriate housing required.
- Increase opportunities for intergenerational working.
- Ensure services targeted at those most in need.
- Innovative job roles needed to attracted people to the area.
- Increase early intervention activities.

Case Study – Circles of Support - Leigh's Story

Leigh spent all of the COVID-19 lockdown in her home, only being visited by care at home staff, and while she has a good neighbour, she doesn't like to bother them. A group that Leigh had previously attended and enjoyed on a weekly basis had started up again but Leigh was not feeling the same benefits from it that she had before. Having not been out on her own in so long Leigh felt unsure about going out in her wheelchair alone and while she wanted to try something new, she felt unable to take this forward by herself. Wanting to help, a friend made a few calls which resulted in the Circles Support Volunteer Coordinator getting in touch.

Leigh was keen to give a befriending support role a try and after a couple of home visits was supported to go out for a coffee on several occasions and then to join a local craft group. Looking at what was available close to Leigh meant that she did not need to rely on a wheelchair taxi and could get there under her own steam without expense.

"I was really surprised at how much I enjoyed it. I'm now comfortable in attending by myself as I know people and I've practiced the route, know where the dropped kerbs are and feel safe as I've become used to being out of the house again. It was so good to have someone walk with me to start with. I'd not been out for so long and I'd lost my confidence…it's not so much about how well I can do the craft activity but about feeling welcome."

Case Study: Older People's Services

A person was referred for support to reduce social isolation and increase physical activity to try and maintain mobility and reduce weight. The person is now receiving support to go for a weekly walk which is ensuring they undertake physical activity to maintain mobility and try to reduce weight. They started attending the RVS Social Club every fortnight, enjoying meeting others and getting involved in activities. They also attended the Festive Friends event, noting it was the first time they had been out like that in years, and were delighted when their son was able to show them the photographs.

They said: "I haven't been out to anything like that in years and I thoroughly enjoyed it. I would never have known about it if it wasn't for you so thank you. I hope to go again next year. The walking is really good and it encourages me to go out and get some exercises even on the days when the weather isn't so nice. Then I feel like I've done something with my day."

Looking Forward

In April 2023, the **Hospital Discharge Team (HDT)** conducted a scoping exercise into a **Seven-Day Service** to determine the benefit of expanding. Continuous discharge planning and patient discharges at weekends are obvious benefits with early communication with patients and families. As this was exploratory, the single recommendation is for the HDT to complete a six-to-eight-week trial of a seven-day service, to allow for data collection on patient flow and discharges achieved.

Training has been developed for the **Rockwood Frailty Tool** and we are about to start delivery of sessions to enhance the use and understanding of its value. This tool will help standardise frailty screening and quantify it, and through its adoption, we will be better able to evidence frailty and take a more proactive and preventative approach.

To enable co-location of health and social care services and the benefits that whole system integration provides, we are progressing the development of integrated bases in our localities to support the work of integrated, multi-disciplinary teams, make better and more sustainable use of resources and reduce duplication. We have initiated a combined scoping exercise and renovation plan at Blairgowrie Community Hospital. This aims to deliver an Integrated Hub for services in Blairgowrie Community Hospital, as well as enable us to consider the use of clinical space for visiting services. This will improve local access to services, such as vaccination and Health Visitors, taking a 'cradle to grave approach' for the delivery of care closer to home. This approach is also being considered for other Community Hospitals.

The Scottish Government has requested all health boards provide a self-assessment on our approach to caring for people who have suffered a Stroke. This is based on the **Progressive Stroke Pathway** and we will collaborate across Tayside to progress this with the lessons learned used to influence the development of a local improvement plan. It is anticipated that transition to new models of care will be implemented over the next two to three years. Work has already started on developing multi-disciplinary planning and person-centred objectives, and following discussions with the Tayside Stroke Managed Clinical Network, it is hoped that we will be able to lead this work for Tayside.

Chapter 11. Urgent Care

Urgent Care is defined by the need to provide services for illnesses and injuries which require immediate attention and treatment but are not a threat to life and limb.

The Scottish Government's Redesign of Urgent Care is a national programme which represents significant change in the provision of safe and effective urgent care. The national vision is for collaboration across the whole health and social care landscape to design and implement a safe, sustainable, patient and outcomes-focused system.

In Perth and Kinross, our urgent care redesign will ensure individuals are seen in the most appropriate care environment, seeking to progress towards the strategic aim of people receiving the 'Right Care, in the Right Place, at the Right Time'. This will be realised by managing people more effectively, closer to home and by optimising existing pre-hospital care, providing better health, care and life outcomes for individuals, staff, families and the wider community.

We have already undertaken significant steps in Perth and Kinross to implement this national vision. This work builds on the progress made in developing locality integrated care approach, access to appropriate minor injury treatments through our **Community Care and Treatment services**, and our community based **Advanced Nurse Practitioners** (ANPs) who support the wider community team through clinical leadership and expertise in addition to urgent care triage and care delivery.

Urgent care is being further developed and embedded to enable a timely, targeted response for older people who do not require emergency care but cannot wait until a scheduled appointment. This work is supported by a recently established urgent care programme team, with collaborative direction and feedback from local GP representation on our programme steering group.

A series of Single Point of Contact tests-of-change led by ANPs are exploring how best the urgent care multi-disciplinary integrated team can respond quickly to clinically triage, identify and action the most appropriate response. In the next phase we will expand the model to improve efficiency and integration with the wider community team, to ensure people see the most appropriate professional as the first point of contact (see case study - Urgent Care).

The multi-disciplinary **Hospital at Home** approach provides rapid assessment and short-term treatment service with the aim of providing a level of acute hospital care in an individual's own home that is equivalent to that provided in a hospital. Consequently, this helps to reduce pressure on acute inpatient services. Through recruitment, we are strengthening our comprehensive team with the inclusion of medical oversight necessary for safe clinical decision-making within community-based settings.

Since initiating two years ago, the **Specialist Community Respiratory Service** has seen a year-on-year doubling in caseload. The service now carries out around 160 patient contacts per month, preventing exacerbations and managing respiratory conditions such as Chronic Obstructive Pulmonary Disorder and other common reasons for hospital admission. Workforce requirements will need to be reviewed to meet increasing demand for this essential care as the caseload continues to rise.

Our focus will now shift to sustaining and developing urgent care to enhance patient experience and outcomes by improving their journey through care.

Improvement Journey: Urgent Care

The Situation	There is an increasing demand for urgent “on-the-day" visits in the community.
The Challenge	To develop a model to respond with the right person at the right time through an improvement approach.
Our Action	Learning from improvement over the last year, our ANPs are taking opportunities to further test a Single Point of Contact model on a Perth and Kinross wide basis and we are designing an ANP response.
The Result	In these tests-of-change, ANP clinical knowledge has combined with established connections and operational understanding of the network of services to successfully enable access to the right person or team. This includes maintaining patients at home, who without access to appropriate interventions were at risk of unplanned hospital admission.
The Outcome	These tests-of-change have led to an enhanced understanding of a single point of contact model in the context of urgent care. Improvements and opportunities include: the ability to maintain case oversight and track patient outcomes; unlocking capacity through a more agile and efficient deployment of urgent care response from the wider integrated system; and the identification of urgent care training and development needs.

Improvement Journey: Locality Integrated Care Service

The Situation	Access to multi-professional, multi-disciplinary care teams in Perth City was inequitable and complicated to arrange, leading to delays and duplications in the pathway to patient-centred care.
The Challenge	Better support for multi-disciplinary team working in Perth City.
Our Action	We worked with our Locality Integrated Care Service to recruit a Clinical Co-ordinator to support multi-disciplinary team working in Perth City. The post holder is now embedded in the wider team for the locality, improving access, communication and effectiveness.
The Result	Access to the multi-disciplinary team has improved, as has communication across and between professional groups, and care has become more co-ordinated and effective. This in turn has led to better outcomes for our patients.
The Outcome	A more effective, person-centred service in Perth City, with more sustainable and equitable access to the expertise of the multi-disciplinary team.

Looking Forward

To continue to advance whole system integration across Older People’s Services, and in line with national and local standards for the provision of health and social care to older people. In doing so, we will continue to implement the Scottish Government's Urgent Care redesign and these programmes of work will be further developed and implemented across 2023/24.

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Section 4: Workforce

Our workforce is at the heart of delivering high quality services for the people of Perth and Kinross. Over 4,500 skilled and compassionate people work in various roles and settings, including the independent and third sectors. During 2022/23 we faced significant difficulties in recruiting, especially social carers, nurses, allied health professions (AHP) and medical staff. This challenge will intensify due to demographics and increases in demand for mental health, learning disability and substance use services. Our workforce is getting older, vacancies are increasing and the overall working age population in Perth and Kinross is shrinking. This is compounded by rurality.

To address this a three-year Perth and Kinross HSCP Workforce Plan was developed in 2022. This sets out the ways in which we will respond to the significant challenges we face as well as the national action needed to support recruitment and retention. We have sought to build on the rapid innovation in working practices during the pandemic. The plan recognises the significant work underway, set out in the chapters above, to redesign services with an unstinting focus on early intervention, integration and locality working. This will improve outcomes for the people we serve but will also improve the experience of staff delivering services across our communities. The plan is being implemented under the oversight of the Workforce Plan Steering Group.

Recruitment

Social care was identified as being a particularly challenging area for recruitment with consistently high numbers of vacancies. A specific plan for social care has been implemented. Actions which have been taken include:

- Enhancing the use of social media – using Facebook, Twitter etc to circulate vacancies together with blogs and videos of positive stories of people currently working in social care.
- Advertising on billboards, buses, bus stops, bin lorries.
- Stalls at community events.
- Social care stall at the Job Centre.
- Information sessions at local schools and colleges.

This has contributed to over 80 people applying for HSCP social care posts, which is considerably more than we would normally attract. The Nursing Directorate and Allied Health Professions Directorate of NHS Tayside have been actively supporting International Recruitment and have successfully appointed employees from outwith the UK to posts locally. NHS Tayside Human Resources have supported all aspects of this approach and our professional education teams have created a range of resources to support new employees.

NHS Tayside is in the process of establishing an Agenda for Change generic template job description library. NHS Tayside holds over 5,000 job descriptions in the job evaluation TURAS system and this includes health posts within health and social care. The creation of the library is to streamline and consolidate many existing job descriptions into a suite of generic template job descriptions to assist with recruitment. There has been a call for nominations from professional group representatives to support this work by participating in a short life working group and this will include Nursing and Allied Health Professional representation.

Developing roles

Psychiatry of Old Age in-patients have commenced the employment of Associate Practitioners. These staff have skills and experience in specific areas of clinical practice. Although they are not registered practitioners, they have a high level of skill through their experience and training.

The NHS Tayside Nursing Directorate and AHP Directorate have been actively supporting the creation of advanced practitioner opportunities across all services and are developing competency frameworks. This provides opportunities to support development of new roles and attract applicants to these highly attractive emerging posts. There is also scope to develop in-house academy models, offering the opportunity to develop our workforce from within. This approach is being taken forward currently with five people in the HSCP undergoing training for the professional social work qualification.

The Nursing Directorate and AHP Directorate have been actively supporting our healthcare support workers using the opportunities that the NES Development and Education Framework for Healthcare Support Workers brings, such as developing new assistant practitioner roles.

The Scottish Government, COSLA and partners have a shared ambition for a trauma informed workforce and services across Scotland and have invested in the development of the National Trauma Training Programme led by NHS Education for Scotland. Having recruited a Trauma Approach Coordinator in February 2023, we are working collaboratively to co-produce, develop and implement a local strategy and action plan that embeds the principles of Trauma Informed Practice across all staff and services in Perth and Kinross. This person-centred approach aims to reframe the understanding of complex behaviours as potential responses to trauma, prioritising the building of trusting, mutual relationships above all else.

Data

A pan-Tayside data group has been established to co-ordinate and collate workforce information to meet the requirements of the workforce planning groups and local workforce strategies. This will ensure data, analysis and benchmarks are available to support workforce planning by both Perth and Kinross Council and NHS Tayside.

Monthly vacancy update data sheets are completed by all services in the HSCP and used to generate a monthly report that enables us to monitor nurse vacancy factors. This is enabling us to highlight hotspots and monitor the trend.

Agency and bank nursing usage is monitored and shared weekly with locality and service managers. This data is cross referenced against vacancies to highlight hotspots in our services and provide mitigation in those areas that require high usage of bank and agency coverage.

Most clinical nursing areas have tested workforce tools as a lead-in to this going live. Allied Health Professions have also been involved in supporting workforce template activity, based on the Common Staffing Method, and have been supported in running test activity by Healthcare Improvement Scotland. Part of this approach involves a data collection "snapshot" task which assists in producing a data informed report about that service and its workforce status, which can be utilised to support assessment of service provision.

Section 5: Scrutiny and Inspection

In the reporting year the Mental Welfare Commission (MWC) visited two of our Psychiatry of Old Age Wards at Murray Royal Hospital (Garry and Tummel Wards), and HMP Castle Huntly was inspected by HM Inspectorate of Prisons for Scotland.

Garry and Tummel Wards are both 12 bedded wards and provide assessment, care and treatment for people with dementia. The MWC last visited these wards in July 2019, and made recommendations regarding the auditing of care plans, authority to treat certificates, discharge planning arrangements and on the need to improve the décor in Garry Ward.

The MWC found that on both wards, nursing staff interacted in a kind and supportive way. The patients were not able to engage in a discussion about their care and treatment due to the extent of their cognitive impairment, but relatives were overwhelmingly positive about the care, treatment and support on the wards.

Staff were described as outstanding, exceptionally kind and that the care and attitude of staff was above and beyond what could be expected.

Feedback from relatives highlighted that staff kept in contact with them and they felt listened to. Some of the relatives said they had been invited to meetings, others had not, and all the relatives spoken to had been given copies of care plans. The relatives described the ward environment, including the bedrooms as adequate. Comments about food provided in the units were positive, with a range of choices. The laundry service was an issue for one relative who said that clothes were regularly ruined and/or lost.

The MWC made six recommendations from their visit; managers should:

- Ensure that staff completing care plans undertake care plan training and refer to NHS Tayside's person-centred care planning standards.
- Ensure that nursing staff include summative evaluations of care plans in patient notes that clearly indicate the effectiveness of the interventions being carried out and any required.
- Ensure that patient/relative involvement in care planning is encouraged and recorded.
- Ensure that multi-disciplinary team meetings are fully recorded.
- Ensure that where a patient lacks capacity in relation to medical treatment, S47 certificates are completed to safeguard and promote welfare, and treatment plans cover all relevant medical treatment the individual is receiving. Treatment should be described in full and abbreviations should not be used.
- Explore solutions to ensure patients are able to look out of the ward windows, without their privacy being compromised.

HMP Castle Huntly is Scotland's only open prison, accommodating low-supervision adult male offenders from areas across Scotland.

With regard to health and wellbeing, inspectors assessed 17 quality indicators during their inspection. Of these, two were rated as good, nine satisfactory and five were rated as generally acceptable.

The overall rating for health and wellbeing was satisfactory**.** There were eight examples of good practice highlighted and seven recommendations for improvement.

The good practice highlighted was:

- The Occupational Therapy Team conduct familiarisation visits and liberation planning.
- Caseworkers, the nursing teams and occupational therapy work focussed on supporting individuals to reintegrate into the community by establishing links with community services and engagement in groups or meaningful activity.
- Prompts on Vision system alerted staff that reviews were due for patients with long-term health conditions.
- NHS Tayside/HSCP developed a liberation referral form to advise the community drug and alcohol service of the patent's requirements to ensure continuity of care on liberation.

- Liaison with a patient's preferred community pharmacy takes place, where required, to ensure a seamless supply of medication on liberation.
- Healthcare staff complete a daily exception report as well as a night report. This was shared with senior nurses and Scottish Prison Service (SPS) and included details of any concerns regarding prisoners and also documents of any staffing issues. This mode of communication provided continuity of care for prisoners in the out of hours period.
- Healthcare staff politely challenge staff and prisoners entering the Health Centre without wearing masks.
- Complaints forms were available for patients and a feedback box for staff to make anonymous suggestions. Any suggestions were discussed at staff meetings.

The recommendations were to:

- Continue efforts to bring all staff core competency levels into compliance as soon as possible.
- Ensure that all patients have a regular review of risks of self-harm and suicide that is recorded within the patient care record.
- Review the psychology provision to ensure national waiting times are not exceeded.
- Ensure that patients with long-term health conditions have individualised, person-centred care plans. The care plans must evidence that patients have had an explanation regarding their condition and have had involvement in the planning of their care needs.
- Reinstate the health promotion support available regarding oral health and hygiene.
- Ensure that anticipatory care plans are in place for patients with palliative and end-of-life care needs.
- Have a recognised robust agreed protocol in place for accessing healthcare support in the absence of trained staff.
- Reintroduce clinical supervision as a priority within the Healthcare Team to support staff with the sustained pressures from staffing issues.

The recommendations made by both the Mental Welfare Commission and HM Inspectorate of Prisons form part of our Clinical Care Governance Improvement Plan and progress against these necessary improvements will be routinely monitored and reported through our Perth and Kinross Clinical Care Governance Forum.

Care Inspectorate Inspections

From April 2022 to March 2023, there were 30 inspections of Care Homes and Care at Home Services. The table shows the results of the Inspections and the overall gradings awarded.

Table 9. Care Inspectorate Quality Indicator Framework

Questions	Unsatisfactory	Weak	Adequate	Good	Very Good	Excellent	Not Reviewed
How well is care and support planned?	1	0	4	2	1	0	22
How good is our setting?	0	1	2	6	0	0	21
How good is our staff team?	1	0	4	3	2	0	20
How good is our leadership?	1	0	9	6	9	0	5
How well do we support people's wellbeing?	1	0	9	9	9	0	2

Not Reviewed = Not all quality indicators are graded at every inspection

Arrangements for Clinical and Care Governance assurance and reporting

The HSCP Care and Professional Governance Forum (CPGF) has responsibility for ensuring appropriate scrutiny, assurance and advice within the HSCP, and during 2022-2023 was co-chaired by the Head of Adult Social Work and Social Care and Associate Medical Director. The CPGF receives assurance reporting from all localities and services within the partnership, and all have provided an annual report providing details and assurances regarding the provision of safe, effective and person-centred services, and any ongoing improvement.

Each locality has in place a Clinical, Care and Professional Governance Group, all of which are now firmly established. These groups have representation across both Health and Social Care, and provide an opportunity for a focus on improvement, shared learning as well as

ensuring effective clinical and care governance processes across the locality.

Adult Support and Protection

The Care Inspectorate, Her Majesty's Inspectorate of Constabulary, and Healthcare Improvement Scotland carried out an inspection of our multi-agency adult support and protection services during June and July 2022. This is part of the Scottish Government's improvement programme for adult support and protection.

The inspection findings are positive and shows that there are strong multi-agency arrangements in Perth and Kinross, keeping adults who are at risk of harm safe and protected.

Summary of findings

Important strengths

- We have strong self-evaluation and quality assurance processes.
- We are providing opportunities for collaboration and information sharing between partners (screening and triage arrangements and Initial Referral Discussions (IRDs) were particularly highlighted).
- IRDs had improved the quality of inquiries and outcomes for people.
- The Council had put in place an electronic case management system to enhance current methods of recording social care information.
- We have very effective leadership and oversight of adult support and protection arrangements. We are promoting community engagement to take forward our vision and improvement plan.
- The Care Home Oversight Group has supported large scale investigations and provided guidance and support to staff in care homes at the height of the pandemic.

Key areas for improvement

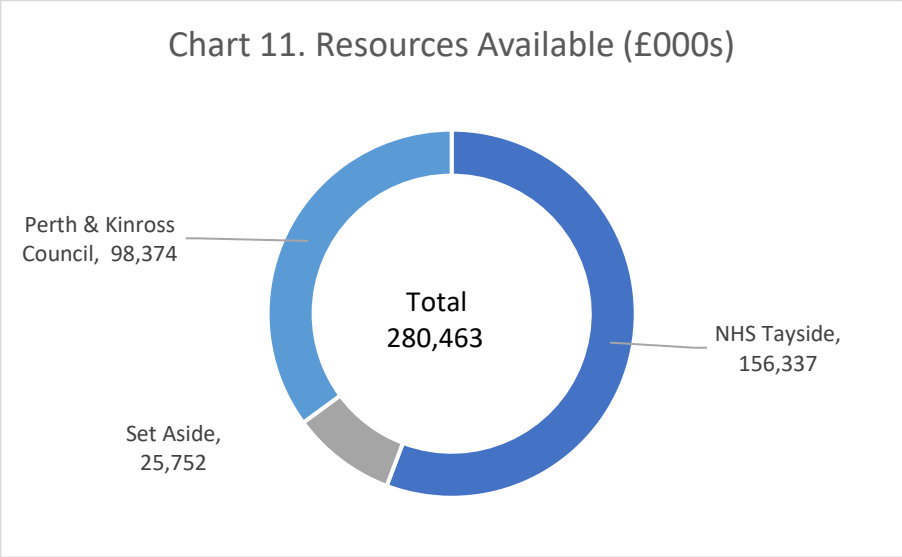
- We need to improve independent support through advocacy and the direct involvement of adults in need of protection in key processes including case conferences.
- We need to be more consistent in considering the need for medical examinations.
- We need to improve our recording of assessments of risk, and actions to support people at risk of financial harm.

Section 6: Finance

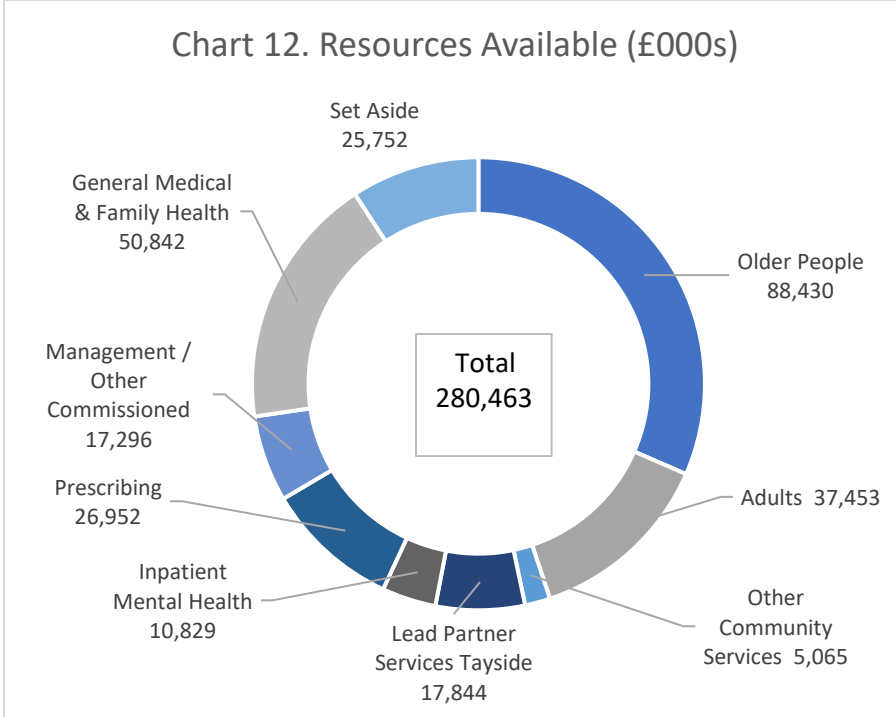
Financial Resources Available to the IJB 2022/23

The IJB is responsible for the planning and oversight of a broad range of health and adult social care services for the people of Perth and Kinross. These services are provided by Perth and Kinross Council and NHS Tayside via Perth and Kinross Health and Social Care Partnership. This is funded through budgets delegated from Perth and Kinross Council and NHS Tayside. The financial resources available to the IJB in 2022/23 totalled £280.463m.

The following charts provide a breakdown of where these resources came from, and how it was allocated.



Included within the Resources Available to the IJB is a 'Large Hospital Services' (Set Aside) budget totalling £25.752m. This budget is in respect of those functions carried out within a large hospital setting and operationally managed by NHS Tayside but for which planning is the responsibility of the IJB.



Financial Performance

In setting the 2022/23 budget, the IJB had planned to use reserves to deliver a break-even position. However, the actual financial performance against budget was a £4.0m underspend and reserves were not required. The main movement from plan related to:

- The significant investment by Scottish Government into health and social care. This included funding for care at home capacity, adult care social work capacity, multi-disciplinary teams working and additional health care support staff. At the time of the investment, operational and management capacity continued to be heavily impacted by COVID-19 activity, also the effect of recruitment challenges facing health and social care meant a higher underspend against staffing than planned.

The IJB Strategic Delivery Plans, supported by this investment, are now being implemented and recruitment is underway.

- In addition to the core budget, the IJB used earmarked reserves. This provided additional capacity and ensured resilience across services, whilst the Strategic Delivery Plan actions were being implemented.
- Expenditure of £5.2m was incurred in 2022/23 as a direct result of COVID-19 and this cost was met in full by Scottish Government funding.
- The number of people choosing Older People Care Home Placements continued to be below planned levels, leading to an underspend on this budget. This reduction has been considered as part of the 2023/24 Budget to support the Older People Strategic Delivery Plan objectives.

Financial Plan - In March 2023, the IJB approved a budget for 2023/24 and provisional budgets for 2024/25 and 2025/26. The budget requires the use of reserves to balance in year 1 and identified recurring shortfalls in years 2 and 3. The IJB is faced with significant and increasing financial challenges due to inflation, a growing ageing population, increasing demand and complexities, and funding uncertainty. In setting this budget the IJB remained committed to supporting the Strategic Commissioning Plan by prioritising and ensuring best use of available resources. The IJB understands there are key risks and uncertainties that require to be monitored and managed closely throughout 2023/24 and will need to consider additional funding solutions and reductions in overall expenditure to ensure the budget can be balanced in future years.

Best Value - Best Value is about creating an effective organisational context from which public bodies can deliver key outcomes. The following building blocks ensure we are organised to deliver good outcomes, by ensuring delivery in a manner which is: economic, efficient, sustainable, and supportive of continuous improvement.

Vision and Values - The scale of increased demand and increasing complex needs means that we cannot provide services in the way we have before - we don't have enough money to do so. A significant programme of change has been set out in strategies for Older People, Learning Disabilities and Autism, and Community Mental Health Services linked to our three-year Financial Plan. These strategies have been developed in partnership with the people of Perth and Kinross who use our services and are fully aligned with the aims and ambitions set out in the IJB's overarching Strategic Commissioning Plan.

Effective Partnerships - IJB Meetings are public meetings and membership includes wide stakeholder representation including carers, service users and the third sector. In addition, membership of the IJB's Strategic Planning Group ensures wide stakeholder involvement. This is further supported by other forums to ensure a strong contribution to joint strategic planning and commissioning including across our three localities. We maintain close links with the Community Planning Partnership and Local Action Partnerships.

Governance and Accountability
The IJB undertakes an annual review of its governance arrangements and is able to demonstrate structures, policies and leadership behaviours which demonstrate good standards of governance and accountability.

IJB Complaints - There have been no complaints received in respect of the IJB in the reporting year.

Use of Resources - The IJB is supported by a robust Financial Planning process which forms the basis for budget agreement each year with NHS Tayside and Perth and Kinross Council. Performance against the Financial Plan is reported to the IJB on a regular basis during the year. The use of our resources is directly linked to our strategic priorities. Finance update reports have been presented to the Audit and Performance Committee throughout 2022/23, reporting on the projected financial position and the impact of the pandemic. Our 3-year financial planning process is directly linked to the development of our strategic plans, ensuring resources are continuously prioritised to best meet the needs to the people of Perth and Kinross.

Performance Management - We continue to build our performance framework with effective and regular reporting at IJB, Care Programme and Locality level ensuring we understand and can measure progress against our objectives.

Section 7: Key Contact

For further information on any area of this report please contact: Chris Jolly, Service Manager, Business Planning and Performance at BIT@pkc.gov.uk

Section 8: Appendix

Appendix 1.1 Table 10. Perth and Kinross HSCP Service Breakdown

Perth City Locality	Community Nursing, Community Mental Health Teams (Adult and Older People's), Community Allied Health Profession Teams Integrated Drug & Alcohol Recovery Team, Advanced Nurse Practitioners, Community Hospitals (x4), Community Care & Treatment Teams, Community Learning Disability Services, Adult Social Work Teams Respiratory Team Care Home Liaison (Mental Health) Access Team Mental Health Officer Team Wellbeing Team Hospital Discharge Team Discharge Hub	Delegated
North Locality		Delegated
South Locality		Delegated
Perth Royal Infirmary	Stroke Ward Medicine for the Elderly Ward Discharge Liaison Team Allied Health Profession Team (Inpatients) Allied Health Professions (Outpatient Teams)	Delegated
Murray Royal Hospital	3 Older People's Mental Health Inpatient Wards	Delegated
Commissioned Services	Care at Home, 42 Care Homes, Supported Accommodation	Delegated
Registered Services	Dalweem & Parkdale Care Homes, Day Care, HART	Delegated
Equipment & TEC	Joint Equipment Loan Store, Community Alarm	Delegated
Mental Health Officer Team	Mental Health Officers across P&K	Delegated
Prison Healthcare	Across 2 sites – HMP Perth and HMP Castle Huntly Pharmacy Team Primary Care Medical & Nursing Team Integrated Mental Health & Substance Misuse Team Occupational Therapy Team Physiotherapy Clinical Psychology In-reach Podiatry In-reach Dental In-reach Blood Borne Virus	Lead Partner
Public Dental Service	Tayside wide Services	Lead Partner
Podiatry	Tayside wide Services	Lead Partner

Appendix 2.1 Table 11. National Core Suite Integration Indicator Tables

HACE Survey Indicators	17/18 P&K %	19/20 P&K %	21/22 P&K %	Five year trend %	How we compare to 19/20 %	17/18 Scotland %	19/20 Scotland %	21/22 Scotland %	Scotland's trend over last five years %	How we compare to Scotland (latest) %	17/18 Peer %	21/22 Peer %	Peer trend over last five years %	How we compare to Peer (latest) %
% of adults able to look after their health very well or quite well	94.6	94.3	93.7	-1.0	-0.6	92.9	92.9	90.9	-2.0	2.8	93.7	92.1	-1.5	1.5
% of adults supported at home who agree that they are supported to live as independently as possible	83.0	82.3	79.9	-3.1	-2.4	81.1	80.8	78.8	-2.3	1.0	81.1	76.3	-4.8	3.6
% of adults supported at home who agree that they had a say in how their help, care or support was provided	77.7	77.2	73.8	-3.9	-3.4	75.6	75.4	70.6	-5.0	3.2	75.4	69.5	-5.9	4.3
% of adults supported at home who agree that their health and care services seemed to be well co-ordinated	74.5	73.0	65.1	-9.5	-7.9	74.3	73.5	66.4	-7.9	-1.3	73.7	64.6	-9.1	0.4
% of adults receiving any care or support who rate it as excellent or good	81.3	82.9	79.1	-2.1	-3.7	80.2	80.2	75.3	-4.8	3.8	80.3	74.2	-6.1	4.9
% of people with positive experience of care at their GP practice.	88.4	86.4	74.1	-14.3	-12.3	82.7	78.7	66.5	-16.1	7.6	82.7	67.3	-15.4	6.8
% of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life.	80.6	80.2	75.8	-4.8	-4.4	80.0	80.0	78.1	-1.9	-2.3	79.6	76.6	-2.9	-0.8
% of carers who feel supported to continue in their caring role	40.9	36.7	33.2	-7.7	-3.5	36.6	34.3	29.7	-6.9	3.5	36.7	30.3	-6.4	2.9
% of adults supported at home who agreed they felt safe.	85.0	83.9	79.0	-5.9	-4.9	83.3	82.8	79.7	-3.6	-0.7	83.4	77.7	-5.7	1.4

Core Integration Indicators	18/19 P&K	19/20 P&K	20/21 P&K	21/22 P&K	22/23 P&K (Latest)	Latest Data Available	Trend over last 5 years %	How we compare to 21/22	21/22 Scotland	22/23 Scotland	Scotland trend over last five years %	How we compare to Scotland 22/23 %	Peer trend over last five years %	How we compare to Peer 22/23 %
Premature Mortality Rate per 100,000	350.2	332.8	364.9	357.3	N/A	Dec-21	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Rate of emergency admissions per 100,000 population for adults (18+ all specialities)	10,952.5	11,485.7	10,584.0	11,312.6	12,221.1	Dec-22	11.6	8.0	11,631.6	11,155.1	-9.2	8.7	-7.5	12.8
Rate of emergency bed day per 100,000 population for adults (18+)	104,227.7	107,689.8	91,213.8	106,861.8	114,470.6	Dec-22	9.8	7.1	112,939.1	113,134.2	-6.6	1.2	-1.2	3.9
Readmissions to hospital within 28 days of discharge per 1,000 discharges (18+)	115.1	115.8	141.0	128.8	135.8	Dec-22	17.9	5.4	106.7	101.7	-1.7	N/A	1.3	N/A
Proportion of last 6 months of life spent at home or in a community setting	89.6	89.6	90.2	90.6	89.0	Dec-22	-0.6	-1.6	89.8	89.3	1.3	-0.3	1.2	-0.7
Falls rate per 1,000 population (65+)	22.1	22.5	23.8	22.6	25.5	Dec-22	15.2	12.7	22.6	22.2	-1.3	12.8	2.5	21.5
Proportion of Care Services rated good or better in Care Inspectorate inspections	87.0	86.4	89.0	76.5	73.4	Mar-23	-13.7	-3.2	75.8	75.2	-7.0	-1.8	-8.3	-3.2
Percentage of 18+ with intensive social care needs receiving Care at Home	60.8	59.3	59.5	55.5	57.6	Dec-22	-3.1	2.3	64.6	63.5	1.5	-5.9	2.9	-6.6
Number of days people aged 75+ spend in hospital when they are ready to be discharged per 1,000 population	547.7	502.4	197.1	593.8	939.2	Mar-23	71.5	58.2	747.9	919.3	15.9	2.1	19.7	12.7
Percentage of health and care resource spent on hospital stays where the patient was admitted as an emergency	26.1	25.4	N/A	N/A	N/A	Mar-20	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Source: Public Health Scotland Core Suite Integration Indicators. July 2022 update.
N/A = no data available.
Note: The figures presented are rounded to one decimal place, while calculations are done using the data as published by PHS.

Appendix 3.1 HSCP Peer Group Makeup

The Peer Group figure is used to establish an averaged value against indicators which is more useful for benchmarking performance against than the figure for Scotland overall. It contains a set of similar HSCPs, as displayed below:

- Aberdeenshire Health and Social Care Partnership
- Angus Health and Social Care Partnership
- Argyll and Bute Health and Social Care Partnership
- Clackmannanshire and Stirling Health and Social Care Partnership*
- Dumfries and Galloway Health and Social Care Partnership
- East Ayrshire Health and Social Care Partnership
- East Lothian Health and Social Care Partnership
- Highland Health and Social Care Partnership
- Moray Health and Social Care Partnership
- Scottish Borders Health and Social Care Partnership

If you, a family member or someone you care for has recently used one of our services and you would like to share your experience, please use these QR Codes to access Care Opinion (top) or our local Service User and Patient Experience Survey (bottom).

Alternatively, you can visit
www.careopinion.org.uk/services/s37000023
or www.kwiksurveys.com/s/KUi4ANhf

PERTH & KINROSS INTEGRATION JOINT BOARD
WORK PLAN 2023/24
(Report No. G/23/126)

This work plan outlines the major items the Integration Joint Board has to consider as part of its schedule of work for the year. This plan will continue to be kept under review throughout the year.

Item	Standing Item	Non Standing Item	Responsibility	Feb 15th 2023	Mar 29th 2023	May 30th 2023[1]	Jun 21st 2023	Sep 20th 2023	Oct 27th 2023	Nov 29th 2023	Feb 24th 2024[2]	Mar 27th 2024[3]	Comments
Minute of Meeting	✓		Chief Officer	✓	✓		✓	✓	✓	✓	✓	✓	
Action Points Update	✓		Chief Officer	✓	✓		✓	✓	✓	✓	✓	✓	
Matters Arising	✓		All	✓	✓		✓	✓	✓	✓	✓	✓	
Membership Update		✓	Clerk to the Board	✓				✓					
Review of Standing Orders		✓	Clerk to the Board	✓						✓			
Delivering on Strategic Objectives													
Strategic Update	✓		Chief Officer	✓	✓		✓	✓		✓	✓		
Mental Health Services Improvement Plan		✓	Chief Officer		✓								For approval
Mental Health Services Update	✓		Chief Officer	✓	✓		✓	✓		✓	✓		
Older People's Strategic Delivery Plan		✓	Head of Health					✓					
Learning Disabilities & Autism Strategic Delivery Plan		✓	Head of Adult Social Work Operations	✓							✓		
Primary Care Strategic Delivery Plan		✓	Associate Medical Director				✓						For approval
Primary Care Premises Strategy		✓	Associate Medical Director				✓						For approval
Revised Carers Strategy		✓	Chief Officer				✓						For approval
Redesign of Substance Use Services		✓	Head of Adult Social Work Operations	✓				✓					
Strategic Planning Group Update	✓		Head of Adult Social Work Commissioning	✓	✓		✓	✓		✓	✓	✓	
Community Adult Mental Health Services in P&K		✓	Senior Service Manager							✓			
Workforce Plan		✓	Head of Adult Social Work Operations		✓					✓			
Strategic Commissioning Plan Refresh		✓	Head of Adult Social Work Commissioning							✓			For approval
Participation & Engagement Strategy		✓	Chief Officer								✓		For approval
Chief Social Work Officer Annual Report		✓	Chief Social Work Officer	✓							✓		For noting
Adult Support & Protection Biennial Report 2021/22		✓	Interagency Adult Protection Coordinator	✓									For noting & endorsement
Delivery of GMS at Invergowrie Medical Practice		✓	Chief Officer			✓							
Winter Plan		✓	Chief Officer						✓				For approval
Finance / Audit and Performance													
Budget Update		✓	Interim Chief Finance Officer		✓							✓	For approval
Audit and Performance Committee Update		✓	Chair of A&PC	✓	✓	✓		✓			✓	✓	
Audit and Performance Committee Annual Report		✓	Chair of A&PC					✓					
Governance													
Strategic Risk Appetite		✓	Chief Officer							✓			For approval
Direction Policy		✓	Chief Officer					✓					
IJB Reserve Policy		✓	Interim Chief Finance Officer								✓		For approval
Financial Regulations		✓	Interim Chief Finance Officer								✓		For approval

[1] Special Meeting
[2] Subject to change
[3] Subject to change

Item	Standing Item	Non Standing Item	Responsibility	Feb 15th 2023	Mar 29th 2023	May 30th 2023[1]	Jun 21st 2023	Sep 20th 2023	Oct 27th 2023	Nov 29th 2023	Feb 24th 2024[2]	Mar 27th 2024[3]	Comments
For Information													
Future Meeting Dates	✓		For information	✓	✓		✓	✓		✓	✓	✓	
Future Development Sessions	✓		For information	✓	✓		✓	✓		✓	✓	✓	
Forward Planner	✓		For information	✓	✓		✓						
Work Plan	✓		For information					✓		✓	✓	✓	
Annual Performance Report		✓	For information					✓					
Audited Annual Accounts		✓	For information							✓			

PERTH & KINROSS INTEGRATION JOINT BOARD
DEVELOPMENT SESSION WORK PLAN 2023-24

This development sessions work plan outlines the major items the Integration Joint Board has to consider as part of its schedule of work for the year. This plan will continue to be kept under review throughout the year.

IJB Development Sessions Item	Responsibility	27 Oct 2023	26 Jan 2024	15 Mar 2024	Comments
Mental Health & Wellbeing Update					Whole System Development Session for NHS Board and 3 IJB – date to be confirmed
Social Prescribing	Consultant Public Health Pharmacy/Associate MD	✓			
P&K HSCP Quality Safety & Efficiency in Prescribing QSEP	Associate Medical Director	✓			Deferred from December 2021
Digital Innovation/Technology	Interim Head of ASWSC (Operational)	✓			Date to be confirmed
Care Home Activity & Partnership Working	Interim Head of ASWSC (Commissioning)	✓			Date to be confirmed
Equality & Diversity	Sarah Rodger/David McPhee/Scott Hendry	✓			Deferred from May 2023 session – date to be confirmed
Risk Appetite		✓			Date to be confirmed
Review of Standing Orders	Standards Officer	✓			
Participation & Engagement Strategy	Chief Officer		✓		Deferred from May 2023 session Paper to IJB in Feb
Finance	Chief Finance Officer		✓	✓	
IJB Members Induction					Date to be confirmed
Primary Care Strategies	Evelyn Devine		✓		Date to be confirmed