Appendix 1

Perth and Kinross Health and Social Care Partnership

Supporting healthy and independent lives

IJB Strategic Plan 2024 -27

AMBITION

COMPASSION

INTEGRITY

Contents

Foreword

Jacquie Pepper

Chief Officer,
Perth and Kinross health and Social Care Partnership

I am pleased to introduce the third Strategic Plan for integrated health and social care services in Perth and Kinross. It covers the period 2024-27 and updates our aims and ambitions for people living in Perth and Kinross. We want to provide outstanding services and help people to live their best possible lives.

Our communities, individuals, and staff are at the heart of this plan and their voices are the golden thread throughout. We refreshed our strategic needs assessment and have adapted our approach, learning the lessons of the pandemic in order to re-energise and refocus on delivering the very best in health and social care.

We passionately believe that our greatest strength is our staff, and every day they show how committed, resilient, and skilled they are. We want our staff to work in an organisation with a clear vision, and to experience positive leadership and an optimistic culture. We are committed to maintaining strong, meaningful connections with our communities and to co-create new ways of working and transformative change to ensure people have the right care and support at the right time and in the right place.

Over 2023/24 we worked closely with the Health and Social Care Alliance to engage with staff, investing in their wellbeing and being thankful for the work they do. We built on the well-established What Matters To You? approach and focussed on our workforce retention, recruitment and alignment to the Perth & Kinross values of Ambition, Compassion and Integrity.

We gathered eight success stories to promote cross-sectoral partnerships and provide a blueprint for embedding compassion, active listening, intelligent kindness, and a ‘What Matters to You’ approach into practice.

This gives us the confidence to publish an ambitious strategic plan with the needs of people who rely on our services at its heart and a workforce keen to deliver at their very best.

Vision

We want every person in Perth and Kinross to live in the place they call home with the people and things they love, in good health and with the care and support they need, in communities that look out for one another and doing the things that matter most to them. Our vision builds on our work to support people to live good and fulfilling lives but is set in the context of today. It reflects what we have learned from the challenges that we have faced in recent years and what we know is important to people.

We want to be ambitious and to innovate but we are also planning this at a time of unprecedented increase in demand and complexity of need, when public sector finances are increasingly pressured and as we face significant recruitment challenges. We know if we continue to deliver the same services in the same way, we will face a significant financial gap over the next three years and that we run the risk of over promising and under delivering.

The Integration Joint Board is aiming over the next three years to invest in health and social care services that are focused on improving health and wellbeing outcomes. For this to be successful we know we will need to be transformative in our thinking, the way we organise ourselves and in our approach to providing and arranging care and support services.

We will achieve our plan by intervening early, by providing outstanding health and social care support, by supporting people to live their lives better on their own terms, by ensuring we improve wellbeing and by creating simple pathways to an integrated offer from Health and Social Care.

Whilst this Strategic Plan is focused on health and social care, we also want to consider the ways in which other parts of the Council and wider community partners can support people.

Perth and Kinross's Local Outcome Improvement Plan sets out what the Community Planning Partnership (CPP) will do over the next 12 months and beyond to make Perth and Kinross a place where everyone can live life well. Community planning in Perth and Kinross is about how we realise our ambition for our area to be the best place in Scotland for everyone to live life well, free from poverty and inequality. The Community Planning Partnership and Health and Social Care Partnership's work is intertwined, and it is essential we work closely together to maximise the impact of our collective response.

Wider partnerships include a range of highly innovative and high quality Third and Independent sector organisations, community groups and organisations, without them we simply couldn't achieve what this Strategic Plan aims for, we highly value their input and are clear in our intentions to continue to support them to support us in delivering high quality health and social care supports.

Our cross-organisational approach recognises the role that all our services play in helping people in Perth and Kinross to live well, good and fulfilling lives. Key to the implementation of the IJBs Strategic Plan is the sharing of ideas and learning, working in genuine partnership, being ambitious about our collective impact, and using resources and assets efficiently and effectively as we work towards a common goal. Only then will we realise our ambition to be recognised as a high performing Health and Social Care Partnership, that places people and improved outcomes at the foremost of their planning and service delivery.

What is a Strategic Plan and why do we have it?

Each Integration Authority must produce a strategic commissioning plan that sets out how they will plan and deliver services for their area over the medium term, using the integrated budgets under their control.

Stakeholders must be fully engaged in the preparation, publication, and review of the strategic commissioning plan, in order to establish a meaningful co-productive approach, to enable Integration Authorities to deliver the national outcomes for health and wellbeing, and achieve the core aims of integration:

- To improve the quality and consistency of services for patients, carers, service users and their families.
- To provide seamless, integrated, quality health and social care services in order to care for people in their homes, or a homely setting, where it is safe to do so.
- To ensure resources are used effectively and efficiently to deliver services that meet the needs of the increasing number of people with long term conditions and often complex needs, many of whom are older.

An Integration Authority is required to review its strategic commissioning plan at least every three years and may carry out additional reviews from time to time. In carrying out a review of the strategic commissioning plan, Integration Authorities must consider:

- The national health and wellbeing outcomes
- The indicators associated with the national outcomes
- The integration delivery principles
- The views of the Strategic Planning Group

Perth and Kinross HSCP have an existing Strategic Commissioning Plan 2020 -2025, developed during 2019, pre-pandemic, prior to the Feeley Review and before the announcement of proposals for a National Care Service.

As the landscape has changed markedly since 2019 and so much of what is now being delivered by the HSCP has been heavily influenced by the pandemic it was proposed that we revise the Strategic Commissioning Plan.

Perth and Kinross IJB Strategic Plan on a Page

Our Vision

We want every person in Perth and Kinross to live in the place they call home with the people and things they love, in good health and with the care and support they need, in communities that look out for one another, doing the things that matter most to them.

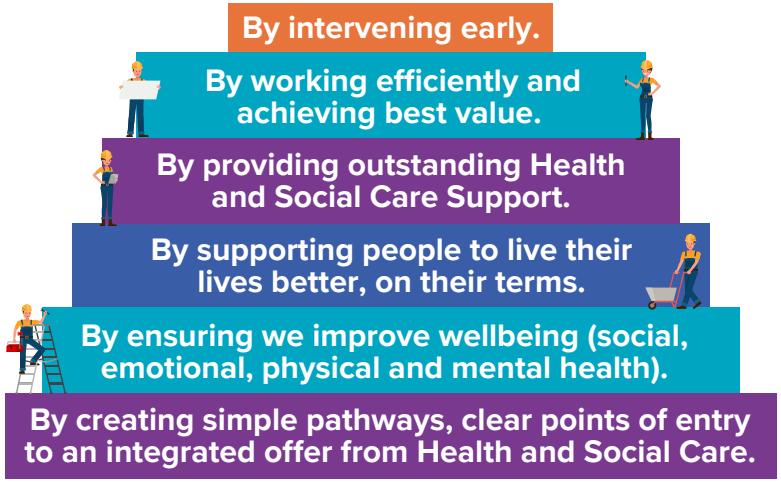
Outcomes

- **NHWO1** People are able to look after and improve their own health and wellbeing and live in good health.
- **NHWO2** 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.
- **NHWO3** People who use Health and Social Care services have positive experiences of those services and have their dignity respected.
- **NHWO4** Health and Social Care services are centred on helping to maintain or improve the quality of life of people who use those services.
- **NHWO5** Health and Social care services contribute to reducing health inequalities.
- **NHWO6** People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact on their caring roles on their own health and wellbeing.
- **NHWO7** People using health and social care services are safe from harm.
- **NHWO8** 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.
- **NHWO9** Resources are used effectively and efficiently in the provision of health and social care services.

Our Priorities

- **Target resources to where people and communities need help most.**
- **Make it easier for people to understand where and how to access services**
- **Provide health and social care supports close to home.**
- **Work with communities to design the health and social care supports they need.**
- **Improved Integrated Working**
- **Promote Self-management and Living Well**
- **Value our workforce, support them to keep well, learn and develop.**

How we'll do it



Our ambitions

- We want people to stay as well as possible for as long as possible.
- We want people to live as independently as possible for as long as is safely possible.
- We want people to be able to thrive and feel valued members of their community

How we'll know we've made a difference

- Carers feel supported to be able to continue in the caring role.
- More people will agree that they live in suitable accommodation at home and in their community.
- People will feel their Health and Social Care support was well communicated and accessible.
- People will feel they have had a say in how the Health and Social Care support was provided.
- People will feel their Health and Social Care Support is well coordinated
- Our communities will see their thoughts and ideas in our service delivery.
- People will feel that services supported them to look after their own health and wellbeing.
- People experience quicker access to to the right services at the right time
- There will be a reduction in unnecessary admissions and readmission's to hospital
- We will see a reduction in Long Term Hospital stays
- People will have greater access to employment and day opportunities
- Our staff feel that they are treated fairly and consistently with dignity and respect in an environment where diversity is valued;

Our Values and Behaviour Framework

Perth & Kinross Council have developed our organisational values of Ambition, Compassion, Integrity into a behavioural framework.

The Framework was developed through extensive consultation with our workforce to describe the way we do things; they are drivers of our behaviours as an organisation and as individuals, influencing the way we work with each other as well as the people and communities we serve.

We believe that they should shine through everything we do and will support us in the delivery of all of our services.

Ambition

Around here we:	Around here we don't:
think 'yes' and strive to do our best every day	create unnecessary rules and red tape
listen to creative ideas and build opportunities	micro-manage others
are curious and look to improve what we do	work in silos
have business heads and social hearts	dwell on the past and forget about the future
focus on positive outcomes for the people we serve	

Compassion

Around here we:	Around here we don't:
put people before process	exclude others
treat everyone with kindness, dignity and respect	point the finger when things go wrong
look after our own wellbeing and encourage others to do the same	tolerate negativity and gossip
speak up and respectfully challenge	act like 'jobs-worths' or bystanders
listen to understand other perspectives	

Integrity

Around here we	Around here we don't
are open and honest	ignore behaviour that conflicts with our values
are fair and consistent in our approach	speak negatively about our organisation
speak up when someone is being marginalised	use influence or status to undermine or favour colleagues
do what we say we will (and own it)	

What is the Integration Joint Board and Integration?

Local authorities and health boards are required by law to work together to plan and deliver adult community health and social care services. At its heart, integration is about ensuring those who use health and social care services get the right care and support whatever their needs, at the right time and in the right setting at any point in their care journey, with a focus on community-based and preventative care.

The IJB membership is broad, it includes councillors and NHS non-executive directors in all cases, plus other members (who do not have voting rights) including professional representatives and community and staff stakeholders. Each IJB receives funds from the health board and local authority (there is no separate direct funding from the Scottish Government).

The IJB is required to produce a single strategic plan to deliver the nine National Health and Wellbeing Outcomes. The IJB then commissions (or 'directs') the local authority and health board to deliver services in line with the strategic plan, and the IJB allocates the budget for delivery accordingly. The local authority and health board deliver these services within the budget and any other parameters directed by the IJB.

Each IJB has responsibility to appoint a chief officer to lead implementation of the strategic plan and an officer responsible for its financial administration (Section 95, Chief Finance Officer). The chief officer has a direct line of accountability to the chief executives at the health board and the local authority. Chief officers lead the development of integrated services and actions at a local level, so that approaches are tailored to local communities and circumstances.

A requirement of the Act is that the IJB also produces an annual performance report outlining progress towards delivery of the nine National Health and Wellbeing Outcomes within its local area.

Integration is all about improving people's lives, and the wellbeing of our system of health and social care as a whole benefits from better joined-up care, better anticipatory and preventative care and a greater emphasis on community-based care.

The Public Bodies (Joint Working) (Scotland) Act 2014 Act required local authorities and health boards to jointly prepare an integration scheme. Each integration scheme sets out the key arrangements for how services are planned, delivered and monitored within their local area.

HEALTH AND SOCIAL CARE
SCOTLAND

Strategic Planning Group

As required by The Act, Perth and Kinross IJB has an established Strategic Planning Group (SPG) to support the strategic planning process. The SPG monitors the delivery of the strategic priorities. It also assesses new policies and strategies and provides a strategic perspective on these to the IJB.

What do we do and what does it cover?

Across Tayside there are three Health and Social Care Partnerships, aligned to the three local authority areas and reporting to their respective IJBs. Each Integrated Joint Board is responsible for the strategic planning and delivery of a range of services that are delegated to them by their Council and by NHS Tayside because they are specific to that geographical area, or that are hosted by one IJB on behalf of all three, because they provide services across Tayside. The services assigned to Perth and Kinross HSCP are:

Delegated Partnership Services

Community Care

- Social work services (adults and older people)
- Social work services (adults with physical disabilities, learning disabilities and autism)
- Social work services (Mental health)
- Drug and alcohol services and lead for Alcohol and Drug Partnership
- Adult Support and protection and lead for Suicide Prevention
- Carers support services
- Care Home internal and commissioned services
- Supported Living
- Employment Support
- Aspects of housing support
- Day services/opportunities/ respite care
- Community Engagement integrated health and care
- Occupational therapy and aids and adaptations/Joint Equipment and Loan Store (JELS)
- Reablement
- Care at Home
- TEC/telecare service - community alarm and rapid response

Health

- District Nursing
- Addiction services
- Allied health professional services
- Primary medical services (where no GP contact is in place)
- Primary medical services to patients out of hours (Angus Lead Partner)
- Ophthalmic services
- Pharmaceutical services
- Community geriatric medical services
- Community Palliative care services
- Community learning disability health services
- Community Mental health services
- Community continence services
- Community kidney dialysis services
- Local community services to promote public health

Hospital

- Tay Ward (PRI)
- Stroke Ward (PRI)
- Community Hopitals
  - Blairgowrie
  - Pitlochry
  - Crieff
  - St Margarets
- Psychiatry of Old Age
  - Gary Ward (MRH)
  - Leven Ward (MRH)
  - Tummel Ward (MRH)

Strategic Planning - Large Hospital Services

- Accident and Emergency
- Wards associated with unplanned admissions

Pan Tayside

Strategic and Operational:

- Public Dental Services/Community Dental Services
- Prison Healthcare
- Podiatry

Strategic planning coordination only (Chief Officer)

- Inpatient mental health services
- Inpatient learning disability services
- Inpatient drug and alcohol services

About Perth and Kinross

The following section gives an overview of our Joint Strategic Needs Assessment (JSNA), its purpose is to provide a clear understanding of the health and social care needs of our local population. It brings together qualitative and quantitative data on the health and care needs of the adult population of Perth & Kinross and creates a picture of service needs now and, in the future, whilst supporting strategic planning decision-making within the Partnership.

Perth and Kinross is a particularly beautiful local authority area, made so by its rural nature. This rurality however provides a challenge for us, with a large proportion of our people living in small settlements, our ageing demographic and reducing workforce, these three issues alone cause us a significant level of difficulty in delivering services.

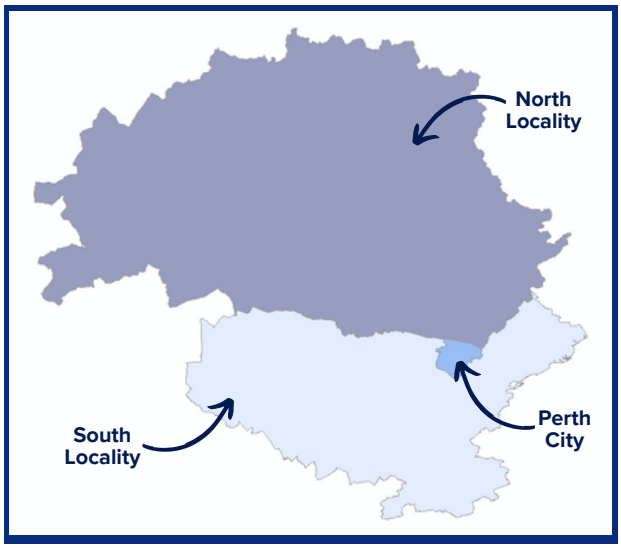
Population

153, 810 approx.

Children up to the age of 14 account for 15% of the total population

The majority of the population is aged between 15 and 64 at 61%

Older people from the age of 65 account for 24% of the total population



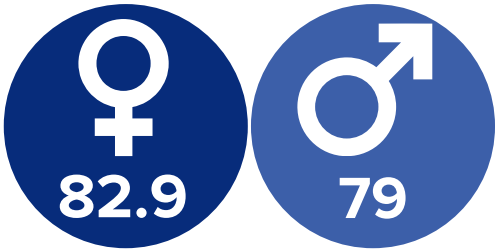
In Perth and Kinross we have a larger portion of people over the age of 65 compared to the national average of **20%**

North Locality	Perth City	South Locality
51, 847	50, 267	51, 696

65+ (%) in each locality

North - 26%
City - 22%
South - 24%

Average Life Expectancy



Women **Men**

We face greater challenges in comparison to other local authorities due to our ageing population.

Projected Decline/Growth

8.1%

By 2028

0-14 age group could have the largest decrease

Population with the largest increase **75+** **30.8%**

Dementia

11.1%

7.7%

In Perth and Kinross, the leading cause of death for females in 2021 was Dementia and Alzheimer's disease and was the second leading cause for males.

Projections estimate an extra hundred cases year on year.

Long Term Conditions (LTC)

Under 65 Years Old

1.1 in 10 people aged under 65 have at least 1 LTC

65 - 74 Years Old

4.1 in 10 people aged 65 tom 74 have at least 1 LTC

75 - 84 Years Old

6.2 in 10 people aged 75 tom 84 have at least 1 LTC

Over 75 Years Old

7.9 in 10 people aged over 85 have at least 1 LTC

The data for those aged under 65 indicate that a small proportion of the population might benefit from early intervention support to mitigate their chances of developing additional LTCs as they age

The main Long Term Conditions are:

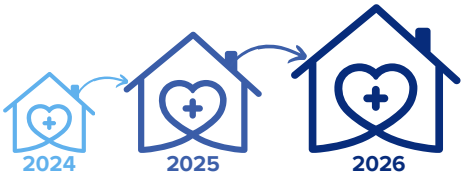
Cancer	Arthritis	Coronary Heart Disease	Asthma	Diabetes

this pattern is consistent across all localities.

In Perth and Kinross, we have 37 data zones classed in the 10% most access deprived category in Scotland, including Rannoch and Aberfeldy, which is judged to be the most access deprived data zone in the whole of Scotland.

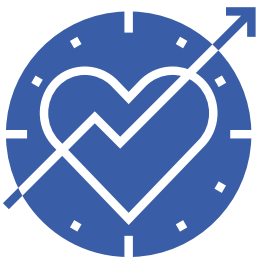
These 37 data zones represent, 31,993 people, 21% of our population.

Projections indicate a requirement for an increase in Care Home placements year on year.



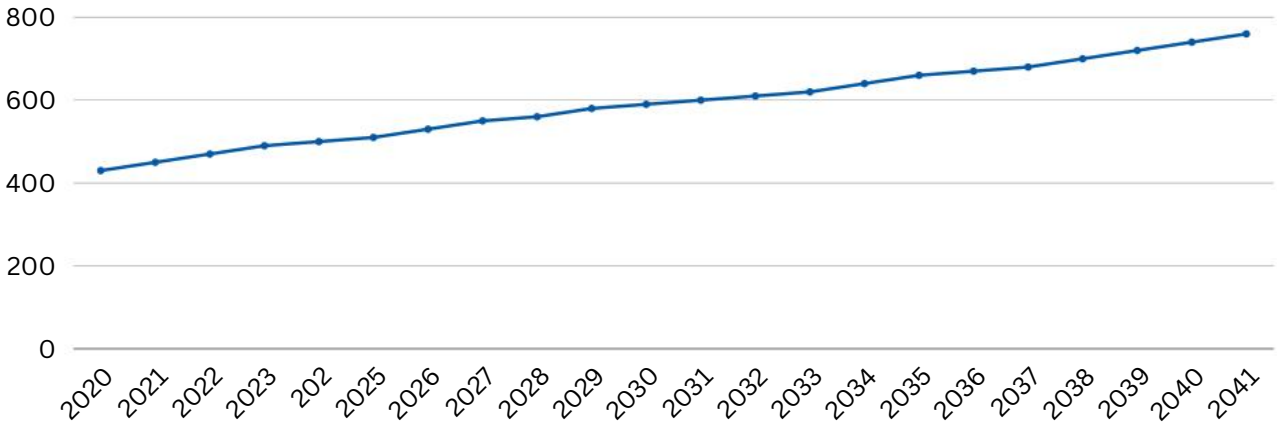
The life expectancy of people with learning disabilities is increasing, however it remains shorter by some 20 years.

People with autism experience poorer mental and physical health and may be more likely to have a shorter lifespan than their peers without autism



Care Homes

New placement projections (excludes crisis and physical disability)



Projections indicate a requirement for approximately 15 more placements year on year, with an approximate increase of 90% by the year 2041.

This is an issue the HSCP needs to address in order to provide sustainable, equitable access to services at the point of need and as close to people's home and communities as possible.

Hospital Admissions

Perth city locality has the highest number of unscheduled bed days. (Per 100,000)

North	South	City
68,502	69,787	76,354

The majority of the unscheduled beds are for the over 65 age group but Perth City has the lowest over 65 demographic in comparison to the North and South locality

Mental Health

Psychiatric patient hospitalisations per 100,000

North	South	City
212.5	213.9	404.7

Unscheduled bed days per 100,000

North	South	City
12,867	15,384	32,365

In terms of psychiatric patient hospitalisations all localities have seen a steady decline in admissions. However, a significant disparity between Perth City locality and the North and South localities.

13308 carers according to the 2011 census

9% of populace at that time

In Perth and Kinross council, the split in registered carers is generally a third in each locality.

3,174

The number of P&K residents, of all ages, that were assessed as requiring Homecare services in 2021/22. This equates to a total of

1,754,030 homecare hours

This is the equivalent of 11.9 hours per person, per week

The majority of this service is delivered to people aged 65 years old and over.

P & K HSCP Strategy and Transformation Portfolio

A range of enabling strategies and Delivery Plans provide the infrastructure for our service improvements, performance reporting, and enhanced service delivery.
Our supporting strategies provide targeted activity in specialist areas, and are interlinked to ensure a consistent, collaborative approach that reduces the risk of duplication or potential gaps.

Each of our Strategies and Delivery Plans are outcome focussed and use a series of Performance indicators which measure performance against each outcome.

User Group Outcomes:

Carers Strategic Outcomes

C1 Carers have easy access to clear, reliable information about the local and national support which is available across a wide range of locations in Perth & Kinross.

C2 Carers are listened to and have their opinions valued by professionals.

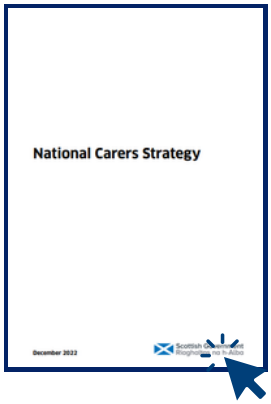
C3 Carers are supported to have a life alongside caring, with their emotional/physical wellbeing supported by flexible and personalised support.

C4 Carers have the opportunity to participate as active partners in the planning and shaping of carer services in their local areas, including services for the people who are cared for.

C5 There is an enriched carer network providing peer support.

C6 Carers are identified early and are aware of the information within the Carers Act (i.e. aware of the criteria and the support present in the community and workplace).

Related National Strategy



Learning Disability and Autism Strategic Outcomes

LDA1 To Support People to remain at home or in a homely setting.

LDA2 People have access to support by an appropriately trained workforce.

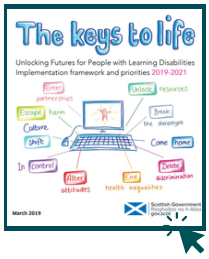
LDA3 People live well in their communities, have access to accommodation which is suitable to their needs and where they are supported to live independently.

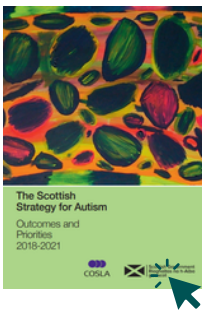
LDA4 People are able to participate in their communities.

LDA5 Improved access to quality and meaningful employment opportunities.

LDA6 Individuals have greater opportunities to be involved and participate in decisions that affect their lives.

Related National Strategies





Mental Health and Wellbeing Outcomes

MH1 People receive the right support at the right time" & "Reduced stigma and inequalities in relation to people with mental health and substance use issues.

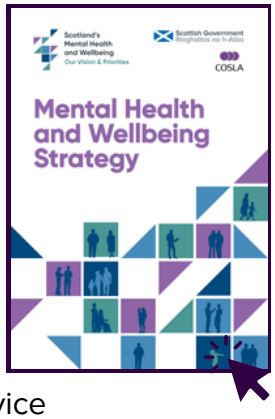
MH2 Improved access to a range of mental health & wellbeing supports and services by fully embedding the principle of Person- Centred Care and support & People can make informed choices about their health and social care support.

MH3 Support pathways will be clear and robust, with a system of joined-up communication that:

- Supports staff working across community and statutory mental health & wellbeing services.
- Provides support pathways which are clear and robust, with a system of joined-up communication and ensures service users, their families and carers receive the best possible support.

MH4 Through collaboration and co-production, we will deliver more effective services and enhance the mental health and wellbeing across our communities" & "Health & Social Care workforce feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.

Related National Strategy



Older People Strategic Outcomes

OP1 People who provide unpaid care are supported to maintain or improve their quality of life and look after their own health and wellbeing.

OP2 Older people are supported to maintain or improve their quality of life and look after their own health and wellbeing.

OP3 Older People are supported to live actively and independently at home or in a community setting.

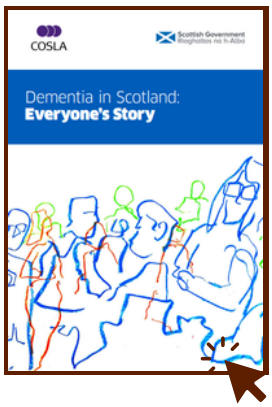
OP4 Resources are used effectively and efficiently.

OP5 People are safe from harm.

OP6 Timelier discharge from hospital.

OP7 Health & Social Care workforce feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.

Related National Strategy



Primary Care Strategic Outcomes

PC1 We will ensure that our patient's 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.

PC2 We will deliver sustainable services by ensuring that our primary care workforce is expanded, more integrated and better co-ordinated with community and secondary care.

PC3 We will develop a primary care Infrastructure which provides modern, fit-for-purpose premises and digital technology to support service delivery.

PC4 We will deliver primary care services which better contribute to improving population health and addressing health inequalities.

Substance Use Outcomes

SU1 Risk is reduced for people who take harmful drugs.

SU2 Fewer people develop problem substance use.

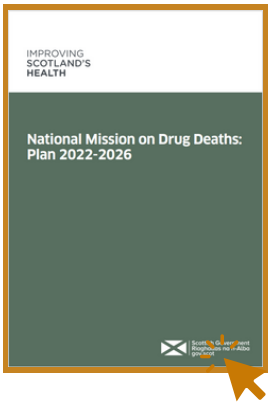
SU3 People at most risk have access to treatment and recovery.

SU4 People receive high quality treatment and recovery services.

SU5 Quality of life is improved by addressing multiple disadvantages.

SU6 Children, families and communities affected by substance use are supported.

Related National Strategies



Transformation - Shifting the Balance of Care

The Strategic Plan is supported by our linked transformational projects, whose objective is to transform services ensuring they meet current and future demands. This will involve service redesign, collaboration with other services and third parties, investment in some areas with disinvestment in others, and innovation in recruitment and retention.

Characteristics of Effective Integrated Care

- **People are supported to self-manage**
- **People set their own goals and priorities**
- **GPs support those with most complex needs**
- **People are safe and have equality of opportunity**
- **Focus on early intervention and prevention**
- **Integrated MDTs aligned to GP Practices**
- **Professionals know roles and responsibilities**
- **Focus on care and support at home**
- **Targeted care and support to meet changing needs**
- **People can easily access help and support**

1 Enhancing Capacity in Dementia Services

- Ageing population
- Dementia prevalence
- Shifting the balance of care to community

2 Optimising Independence and Quality of Life for Older People at Home

- Ageing population
- Unmet need in care at home
- Shifting the balance of care to community

3 Person Centered Approach to Rehabilitation and Reablement

- Ageing population
- Shifting the balance of care to community
- Geography/inequality

4 Primary Care Mental Health

- Mental health prevalence
- Suicide rates
- Drug/alcohol deaths
- Shifting the balance of care to early intervention and prevention in the community

5 Prescribing

- Ageing population
- Polypharmacy
- Mental health prevalence
- Financial pressures

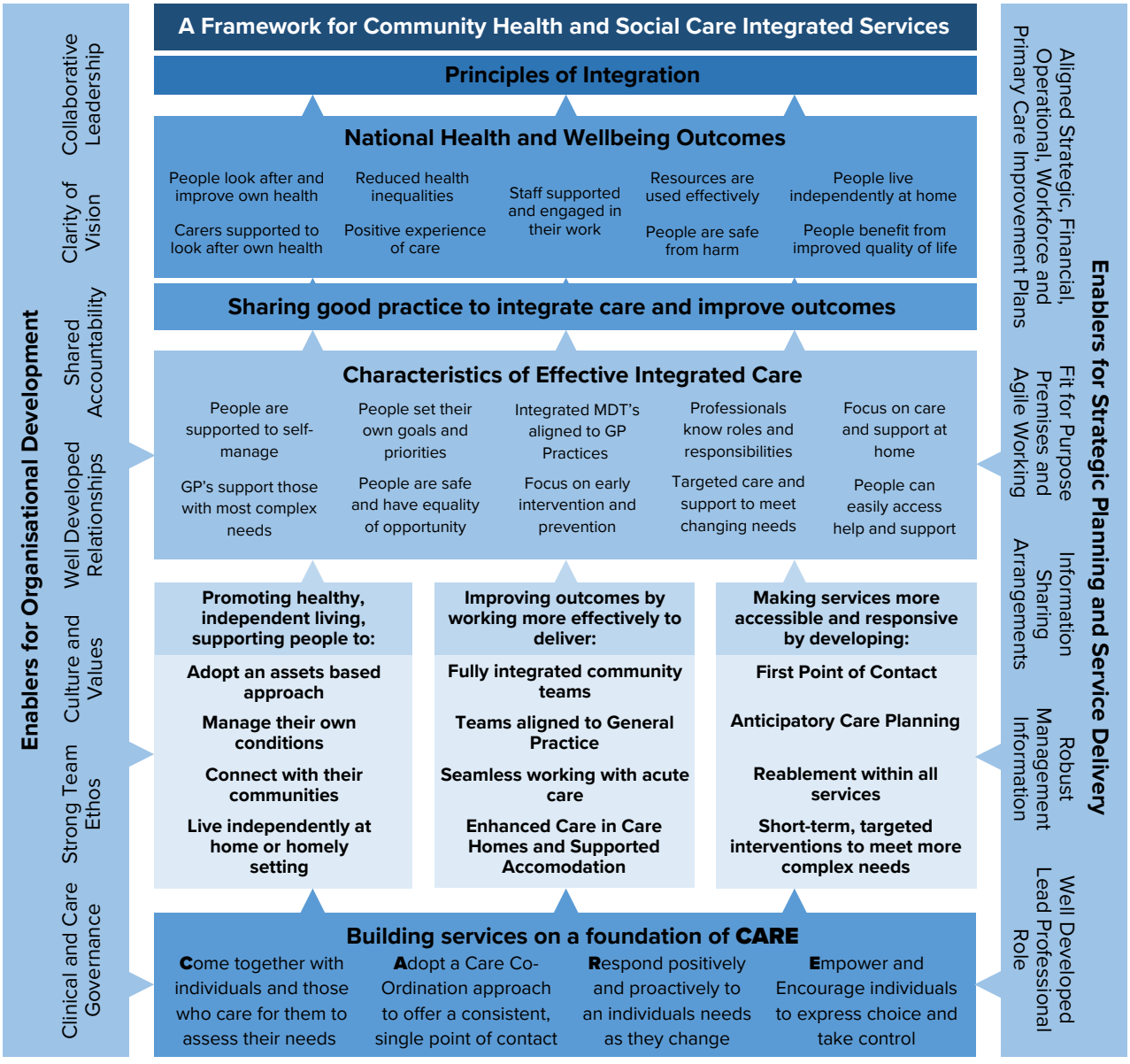
Embedding Characteristics of Effective, Sustainable Integrated Care

We will use the National Framework for Community and Social Care Integrated Services to inform the development of our transformation plans, drawing on what is known to work in other areas and applying learning from this locally.

The Framework allows us to measure performance by assessing the extent to which the characteristics within the Framework are evident in local services. Based on this we will identify priorities for improvement and or transformation as well as measure and report the impact of these through our Annual Performance Report.

Delivering Components of Effective, Sustainable Integrated Care

A review of effective models of integrated care has confirmed that there are a number of key components that are consistently in place where services are improving outcomes for people and the performance of the health and social care system as a whole.



How will we know we are making a difference?

IJBs have a duty to measure the progress they are making against the 9 National Health and Wellbeing Outcomes. The Scottish Government has created a list of indicators to help IJBs to do this. Several of the indicators will measure progress towards more than one of the National Health and Wellbeing Outcomes. All of the outcomes and indicators are considered as important as each other, and so the suite needs to be considered as a package and not a set of individual unrelated indicators. Perth and Kinross IJB report publicly on its performance against these outcomes in quarterly and annual performance reports.

Performance

How we measure our performance is important, it helps us to improve our services. We will gather performance information from and in a variety of ways using National and Local Indicators, Priorities, Audit, Self-assessment, Frameworks and Engagement activity.

Performance must be assessed in the context of the arrangements set out in a Partnerships' strategic plan and financial statement, and describe how expenditure allocated in the financial statement have achieved, or contributed to achieving, the health and wellbeing outcomes. It should also cover how significant decisions made by the Partnership over the course of the reporting year have contributed to progress towards the outcomes.

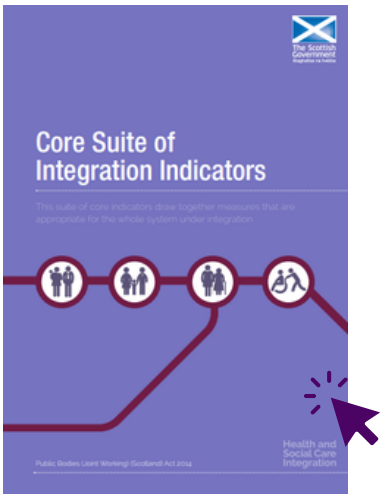
The purpose of any performance reporting is to provide an overview of our performance in planning and carrying out integrated functions and is produced for the benefit of Partnerships and our communities.

National Health and Wellbeing Outcomes for Health and Social Care

NHWO1	People are able to look after and improve their own health and wellbeing and live in good health.
NHWO2	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.
NHWO3	People who use Health and Social Care services have positive experiences of those services and have their dignity respected.
NHWO4	Health and Social Care services are centred on helping to maintain or improve the quality of life of people who use those services.
NHWO5	Health and Social care services contribute to reducing health inequalities.
NHWO6	People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact on their caring roles on their own health and wellbeing.
NHWO7	People using health and social care services are safe from harm.
NHWO8	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.
NHWO9	Resources are used effectively and efficiently in the provision of health and social care services.

As well as monitoring these national outcomes and associated indicators the IJB must also measure its progress towards meeting the ambition and priorities with this three-year plan. The detailed plan for measuring and reporting this information will be published in an IJB Performance Framework which will:

- Systemically monitor and review the implementation of the Strategic Plan.
- Evaluate the impact of individual delivery plans and strategies, ensuring their alignment to the Strategic Plan's priorities, ambitions and vision.
- Monitor the impact and effectiveness of our communication and engagement activity, ensuring this is achieved in a meaningful and accessible way.



Public Health Priorities for Scotland

Public Health's vision of a Scotland where everybody thrives, can only be achieved by a whole system approach which involves applying systems thinking, methods and practice to better understand public health challenges and identify collective actions. Adopting a whole system approach to Scotland's Public Health Priorities is a long-term endeavour and requires partnerships between a broad range of stakeholders to deliver better lives for the people of Scotland.

Health and Social Care Partnerships (HSCPs) have a duty to contribute to reducing heath inequalities as one of the National Health and Wellbeing outcomes and the people working in them have a vital role in providing leadership and governance around reducing inequalities.

Perth and Kinross Health and Social Care Partnership are committed to ensuring they play their part in the successful delivery of this outcome, as a meaningful and active partner within the public health system.

Finding out what matters

The Scottish Approach to Service Design engages people in the delivery of services as integral to reforming Public Sector services. It ensures a focus on people with living and lived experience being at the heart of designing services that meet their needs and rights.

The development of this Strategic Plan naturally aligns with this approach and has continued to be shaped by listening to what people have told us is important to them and what matters the most. It reflects the context of the present and recent past, the impact of Brexit; the collaboration required to deliver joined up services to strengthen our social care and NHS services; the support needed to recover from the long-term mental, physical and financial impacts of the COVID-19 pandemic; and the need to plan for the introduction of the National Care Service.

Methodology

To maximise public involvement and participation a mixed approach to engagement was adopted. By using both quantitative and qualitative methods it provided us with a more comprehensive and holistic understanding of the issues, needs and experiences of individuals and communities. A participation programme was agreed which offered participants a range of opportunities to participate including locality drop-in events, targeted focus groups and a survey.

A bespoke animated video "Planning a Better Future Together - Have your say" was prepared and distributed to over a thousand different stakeholder groups or individuals and promoted this activity through social media channels with a reach of **85,000 followers.**

200

people attended our locality drop in events were arranged throughout each locality.

Targeted Focus Groups - these sessions were organised to support the involvement of groups with protected status and people who are excluded from participating due to disadvantage relating to social or economic factors. We received over **163 responses** from 12 sessions.

Survey - 366 responses during 6 weeks

75% were filled out by women

highest response from **46–65 age,** constituting **46.45%** of the entire survey population

50 individuals from our workforce had an opportunity to privately convey their wishes for the future of the Health and Social Care Partnership at a separate event.

Consultation sessions were held with our Strategic Planning Group and Integrated Joint Board and focussed on our identified priorities. The membership of both bodies is diverse and inclusive of Third Sector partners, Public Partners and Carers, the Independent sector and a range of HSCP staff and local councillors.

Aims of Consultation

Involve people in shaping the future of health and social care services and develop a better understanding of what matters to people. Inform people of the challenges facing the HSCP and seek their views on:

- What did they feel, think and want?
- What needs to be changed or improved?
- How could things be done differently?

A 'World Café' approach was adopted, this promoted conversation and enabled participants to express their views more freely, and encouraging an exchange of ideas and solutions to challenging issues. Conversations were facilitated by Health and Social Care staff, with sessions being open to all community members, this included our workforce, and that of the Third and Independent sectors.
Participants were asked for their views on four themes:

- What matters to you?
- Social Care
- Primary Care
- Unscheduled Care

What Matters To You?

We asked participants a series of questions in relation to each theme.

'What do you think and want?'

"I want a staff team that know me well and do the things I want to do."	"Quicker access to services. Better rural services - GP's/Dentist."	"I want to feel confident that these discussions we are having here will actually result in some change."	"A better understanding from professionals around cultural and religious differences."

'What matters to you?'

"Family – we want to be able to ensure that our family is healthy, physically and mentally and will take any support that can help them stay well."	"Being able to access health and social care in one place, close to home, which would allow us to get to know the people helping us better, and we can feel more comfortable."	"What matters to me is to get access to recovery. Education in early age about addiction is important to me. I would like to be treated like a human being no matter my circumstances."

'How could things be done differently?'

"We need a more integrated approach to health and social care, with well trained, trauma informed, and non judgmental staff."	"Improved communication."	"GP receptionist and other call handlers having a better understanding and awareness that I struggle over the phone and its better for me to see someone because of my disabilities."
	"Less red tape. Less tick boxing."	

'What needs to be changed or improved?'

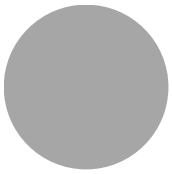
"Your website needs to be improved so that people get HSCP support updates and relevant documents in one place."	"There needs to other options rather than digital only. Repeat prescriptions are ordered online but some of them aren't online and other options aren't given."	"There should maybe be more resources out there for those of us with a language barrier, for a lot of us this puts us off even seeking help knowing that we might not be understood."

We specifically asked people via our survey to rate how important specific aspects of health and social care were to them, the underlying details this is in order of importance:

89%	**"I can access all health and social care support in one place, close to home."**
87%	**"Clearer and accessible information about the range of support and services available and who to contact for help."**
83%	**"More opportunities to support health and wellbeing in my local community."**
77%	**"Provide opportunities for local communities to influence how health and social care budgets should be spent."**
76%	**"People should get out of hospital more quickly to be supported at home."**
73%	**"Support more people to stay at home through better use of technology."**
73%	**"More consistent and regular opportunities that support carers' health and wellbeing."**
67%	**"Quicker access to health and social care support through use of telecare/internet."**
55%	**"Support for more volunteering/peer support as safe alternatives to services."**

People want to access support in their own communities where possible, have access to multi-disciplines in the one building and want to be involved in the planning and design of how services are delivered.

We asked people how they felt about the support or service that they accessed in the last 12 months, and then further if they were dissatisfied, what were the reasons?

Not Answered	Very Dissatisfied	Dissatisfied	Neither Satisfied or Dissatisfied	Satisfied	Very Satisfied
					
66 Participants (18%)	15 Participants (4%)	35 Participants (10%)	72 Participants (20%)	118 Participants (32%)	60 Participants (16%)

Of the 14% who were dissatisfied, it was commented that areas of challenge were distance and access to services, waiting times and delays in support, a lack of joined up working between services, quality of care and support and having to repeat the same story multiple times.

Strategic Priorities

We have identified 7 priorities for the following 3 years.

Target resources to where people and communities need help most

Make it easier for people to get the help and support they need

Provide health and social care supports close to home

Work with communities to design the health and social care supports they need

Improved Integrated Working

Promote Self-management and Living Well

Value our workforce, support them to keep well, learn and develop

Each priority identified resonates with what both our communities and staff told us during our consultation process, the intention of this plan is to be clear that we are listening to the people who live and work in Perth and Kinross and who come in to contact with Health and Social Care services.

We or somebody we love will all need, at some point in our lives, Health and Social Care support. Health and Social care services are essential to us all, they enable us to live well and to live in our own homes and communities for longer.

These priorities are applicable to us all, no matter what type of service we are accessing, each has linked Strategies, Delivery Plans or Transformation Programmes that describe specific actions and timeframes that will enable them to improve their services over the next 3 years, you can click on the links at the end of each section for more detail.

Each of the seven priorities are codependent on one another, in order for the whole system to function effectively we will be focussed on not only ensuring each independent priority is progressed, but that they all move forwards in synergy with one another.

Our Strategic Plan aims to map for you a realistic picture of a complicated landscape, and creates the conditions to share resources, maximise the potential of the totality of our assets and strive ahead with our vision, ambitions, and priorities.

In the following section we will:

- Explain why each priority is important to us
- Tell you what our Joint Strategic Needs Assessment told us in relation to each priority
- Tell you what our Community Consultation told us in relation to each priority
- Tell what we are going to do to improve and how we will know we have made a difference.
- Tell you how we will measure our success.

Target resources to where people and communities need help most.

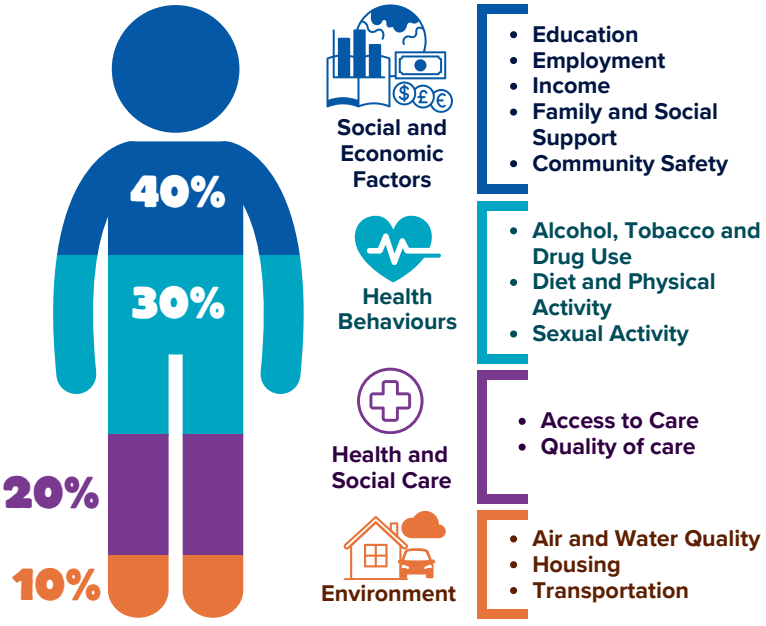
Why is this a priority for us?

NHWO 4 | NHWO 5

Health inequalities are the unjust, avoidable differences in people's health across the population and between specific population groups; there is considerable evidence that social factors have a significant influence on how healthy a person is, and across all countries there is evidence of differences in the health status of different social groups. The lower a person's socioeconomic status, the higher their chances of experiencing poor health.

There are many reasons why Health Inequalities exist, to improve the health of the whole population requires access to appropriate housing, secure and well remunerated employment, a reasonable standard of education and access to appropriate health services, these are called social determinants.

Although deprivation is inextricably tied to poorer health outcomes, the needs of populations with other protected characteristics should also be considered or they too risk being left behind. These include persons with disability, ethnic minorities, older people, children and the homeless.



This figure gives a visual representation of how health and social care services contribute only 20% of the modifiable determinants of health, with the social, economic, and environmental factors (50% collectively) being the primary drivers of our health and wellbeing. Although simplified for illustration purposes, the main message is that health and care services alone are not the solution to reducing health inequalities.

Our Joint Strategic Needs Assessment told us that:

Perth City Locality hosts the majority of deprivation within Perth and Kinross with five areas' being within most deprived Quintile (SIMD1)

equating to **16.1%** of the population, **2.6%** since 2016.

Data in relation to Perth and Kinross, indicates that alcohol- specific deaths, alcohol and drug related hospital admissions are consistently below the national average.
However, when taking a locality perspective, there are clear differences between rates in the Perth City and our other localities.

In the last 10 years Perth and Kinross deaths by suicide have had some fluctuation but have predominantly been between **20** and **27** each year with data showing that our rate of suicides is higher in Perth City and more common in men.

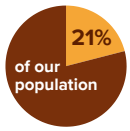
The life expectancy of people with learning disabilities is increasing, however it remains shorter than the general population.

The more complex the condition the lower the median age of death.

People with autism experience poorer mental and physical health and may be more likely to die younger than their peers without autism.

Perth City Locality has similar challenges to other urban areas in Scotland in terms of inequality, poverty and deprivation which in turn impacts on people's lifestyles and behaviours.

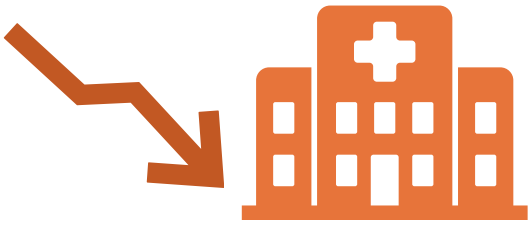
In Perth and Kinross, we have 37 data zones classed in the 10% most access deprived category in Scotland, including Rannoch and Aberfeldy, which is judged to be the most access deprived data zone in the whole of Scotland. These 37 data zones represent,



31,993 people across Perth and Kinross

and highlights the challenges of providing consistently high-quality services across such a diverse region.

Those of us with poor health literacy have the highest burden of ill health. Those of us with the lowest health literacy generally have double the rates of poor health outcomes, complications and death, compared with those who have the highest abilities.



Psychiatric hospitalisation admissions in all localities have seen a steady decline, there is a significant disparity between Perth City and the North and South localities.

What matters To You?

Our community consultation told us:

"I feel working in partnership with 3rd sector organisations is a good idea."

"I get help from an advocate which is great."

"A better understanding from professionals around cultural and religious differences."

"More choice especially employment options."

"Being able to access health and social care in one place, close to home, which would allow us to get to know the people helping us better, and we can feel more comfortable."

"Needs a more integrated approach to health and social care."

"Trauma informed staff. Non judgemental."

"Volunteers needed to support more with mental health and wellbeing."

"There needs to other options rather than digital only."

What will we do to improve?

2024 2025 2026 2027

Undertake health inequalities, equalities, human rights impact assessment with new policies, plans and investment decisions.

Our services will take a comprehensive equality, human rights, and person-centred approach always.

Adults who have multiple and complex needs, including adults at risk of harm will be identified more quickly, with targeted and well-coordinated responses.

Continue to invest in Digital Mental Health and Wellbeing Supports.

We will enhance our Suicide Prevention and co-ordination resource and promote training and information across all agencies and services.

Support all people working within the HSCPs, including the independent and voluntary sector, to increase knowledge and skills in, reducing health inequalities, including cultural competence, human rights, equality, and diversity.

Adopt a Whole Organisational Trauma Informed Approach.

The holistic needs of those most significantly impacted by mental ill health will be met as a priority.

We will prioritise prevention and early intervention of mental ill-health and suicide.

Deliver a targeted Men's Suicide Prevention Campaign in 2024.

Improve our Neurodevelopmental pathways.

Certain health conditions and caring responsibilities impact on our ability to gain employment, we will work with partners to improve availability, access and conditions within the workplace.

When we talk or write about ageing and older people, we will break away from generalisations and outdated ideas.

We will better understand the impact of inequalities on service users and demand on services using available data and feedback and comments from service users, their families and local community.

We will work closely with partners to ensure we provide welfare and money, employability, and home energy advice.

Seek to reduce the inequalities that affect the health and social outcomes for people with a physical disability, including access to opportunities for work or learning, a reasonable income and participation in wider social and cultural activities.

How do we know we are making a difference?

- Carers feel supported to be able to continue in the caring role.
- More people will agree that they live in suitable accommodation at home and in their community
- People will feel their Health and Social Care support was well communicated and accessible
- People will feel they have had a say in how the Health and Social Care support was provided
- People will feel their Health and Social Care Support is well coordinated
- People will feel that services supported them to look after their own health and wellbeing
- People experience quicker access to the right services at the right time
- People will have greater access to employment and day opportunities

How will we measure our success?

Each of our priorities are supported by a range of outcome focussed Delivery Plans or Strategies, all of which have their own Performance Frameworks. These frameworks use either National Indicators and or locally developed indicators, these help us to know that we are achieving what we said we would in our in individual user group delivery plans and strategies and thus the Strategic Plan.

The following plans, projects and strategies are relevant to this priority - Linked Delivery Plans, Action Plans, Transformation projects, and Strategies: Older People Delivery Plan, Carers Strategy, TEC Strategy, Primary Care Strategy. Draft Physical Disability and Sensory Impairment Strategy, Community Mental Health and Wellbeing Strategy 2022-2025, Learning Disability and Autism Delivery Plan, Suicide Prevention Plan, ADP Delivery Plan.

Measurable outcomes

C2	C3	C4	C6	LDA1	LDA3	LDA4	LDA5	LDA6
	MH1	MH2	OP3	PC4	SU4	SU5	SU6	

Good Practice Example: Suicide Prevention Campaign Perth and Kinross 2024

The national suicide prevention strategy – Creating Hope Together, was published on 29 September 2022.

In response to both the National Strategy, and our work locally to implement its vision and outcomes, and with us having seen an increase locally in probable deaths by suicide, we developed the 'Shatter the Silence' campaign.

The initial idea to have a campaign came from a meeting that our Suicide Prevention Coordinator held with several Third Sector colleagues to discuss local priorities for a small underspend in the suicide prevention budget in 2023-2024.

This led to a multi agency event which included people with lived and living experience, local third sector organisations and representation from our multi agency Suicide Prevention Steering Group and wider council colleagues. This event was the first stage in developing what the campaign should and could look like. This group will continue to support and adapt the campaign over the course of the next 6 months to a year.

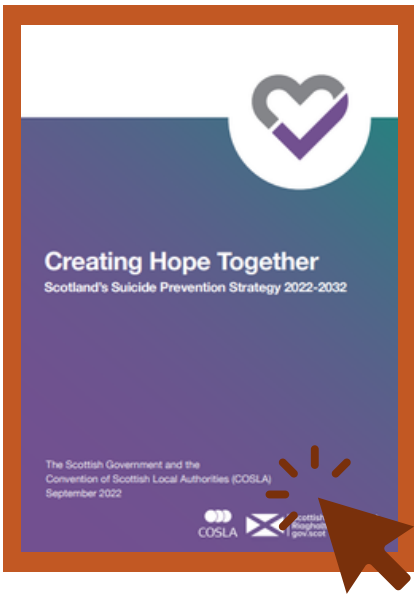
The first set of actions were to produce the graphics and messaging then have them displayed in a range of ways to allow maximum optics.

To date there has been visual adverting on buses and bus shelters and on refuse vehicles. Radio campaign was launched mid-April onwards, with a ten-week run on Radio Tay including three adverts reaching out to those with thoughts of suicide, those who are worried about someone else and those who have been bereaved by suicide.

The campaign has highlighted the Tayside suicide help website that can be downloaded to mobile devises. This has recently had a full update following a Tayside consultation that was facilitated via Perth and Kinross HSCP.

www.suicidehelp.co.uk

The Shatter the Silence campaign is aimed at tackling stigma around suicide. It is targeted at men but also aims to reflect a general message regarding hope.



Make it easier for people to understand where and how to access services

Why is this a priority for us?

NHWO 1 | NHWO 3 | NHWO 4

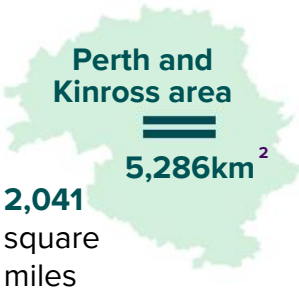
We know that getting the right help and support at the right time can help people to manage their daily lives as independently as is possible, it can support people through a crisis and is a key enabler for people in managing their own health and wellbeing. If people don't know where or how to access services, then this becomes a barrier.

The Independent Review of Adult Social Care in Scotland (2021) found that access, eligibility, and assessment were important areas for improvement. People who use social care supports told the review that things are too difficult right from the start, and they had to repeat information to lots of different people.

The pandemic also brought a pace and scale of change never experienced before and there was a departure from the usual ways of working and a shift towards doing things differently. It is important we use the learning from this experience but that we also reflect on what our communities said didn't work for them during this time.

We know that at times the language and processes of health and care services can be hard to understand, this can undermine confidence in accessing and participating in health and social care services. This can be even more challenging when faced with stressful health or life circumstances. A combination of these factors can undermine our ability to manage our own conditions safely and effectively, and this is a cause of health inequality.

Our Joint Strategic Needs Assessment told us that:



2,041 square miles

29 people per km² in comparison to the Scottish average of **70**

The relatively low population density and the urban / rural profile of Perth & Kinross has implications for the costs of providing all services, and for their accessibility to an ageing population.

Dependency ratios (the number of people over the age of 65 per 100 people below the age of 65) as are higher across the North locality followed by the South locality and with Perth City having the lowest dependency ratio. This gives us a good indication of the likely need for health and social care services to support older people across the local authority area, suggesting a greater level of need in the areas with the biggest difficulties accessing services.

Recognition of the areas of higher dependency can help to pinpoint where additional services may be needed and may also be useful when reflecting on workforce recruitment planning.

When the SIMD is broken down by domain, over **40%** of the population are in the most deprived Quintile for access to services. In the North and South localities, accessibility is the biggest issue with over half of the population in the top two most deprived quintiles.

The split in registered carers is generally a third in each locality, with the North and South having slightly higher numbers than Perth City. The highest proportion of carers across all localities are in the 66+ age group.

What Matters To You?

Our community consultation told us:

"Invest in better transport - currently poor public transport makes it difficult for social activities, going to appointments, etc".

Our Community Consultation specifically asked people via our survey to rate how important specific aspects of health and social care were to them, clear and accessible information was second top.

87% **"Clearer and accessible information about the range of support and services available and who to contact for help."**

73% **"Support more people to stay at home through better use of technology."**

67% **"Quicker access to health and social care support through use of telecare/internet."**

We asked people to tell us what challenges they faced when looking after their Health and Wellbeing.

60% said access and distance to services was a challenge for them	**30% said** knowing where to go was a challenge for them	**25% said** access to information was a challenge	**20% said** said transport was a challenge for them

What will we do to improve?

2024 2025 2026 2027

We will ensure that carers, as key partners, have improved access to support and information.

Improve information sharing between services and organisations meaning that people do not have to share the same information multiple times.

Develop clear information for patients, carers, and families to ensure that carers and families are involved and listened to by professionals in treatment and care planning.

People who have a sensory impairment or learning disability, whose first language is not English and who are older are better able to find and understand Information published by the IJB and Health and Social Care Partnership.

We will seek support from partners to improve transport within our rural localities.

Provide easy access to support at times of distress, as an example through our Improving the Cancer Journey Service.

We will work with partners to enable people with a physical disability to participate as active citizens in all aspects of daily life in Perth and Kinross.

We will develop a Health and Social Care Partnership website that provides a comprehensive overview of all services, that is engaging and easy to access.

We will focus on providing timely, high quality information which is available to children, young people, adults, families, and carers so that they can make decisions about their own mental health care and support, and about mental health services.

We will ensure that disabled people have equal access to information and are not discriminated against, by producing documents in an accessible format.

We will work to improve Mental health support pathways, which are clear with people supported to have the knowledge and confidence to take control and make decisions about their own lives.

Continue to support roles and services that act as community connectors, for example our Social Prescriber and Community Engagement teams.

We will improve access and the use of digital technology, particularly for those living in remote and rural locations and combat digital poverty where it exists.

How will we know we are making a difference?

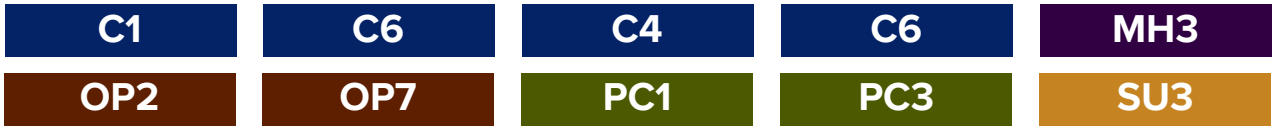
- People will feel their Health and Social Care support was well communicated and accessible
- People will feel they have had a say in how the Health and Social Care support was provided
- People will feel their Health and Social Care Support is well coordinated
- People will feel that services supported them to look after their own health and wellbeing
- People experience quicker access to the right services at the right time

How will we measure our success?

Each of our priorities are supported by a range of outcome focussed Delivery Plans or Strategies, all of which have their own Performance Frameworks. These frameworks use either National Indicators and or locally developed indicators, these help us to know that we are achieving what we said we would in our in individual user group delivery plans and strategies and thus the Strategic Plan.

The following plans, projects and strategies are relevant to this priority - Linked Delivery Plans, Action Plans, Transformation projects, and Strategies: Draft Physical Disability and Sensory Impairment Strategy, Community Mental Health and Wellbeing Strategy 2022- 2025, Learning Disability and Autism Delivery Plan, Older People Delivery Plan and Carers Strategy.

Measurable outcomes



Provide health and social care supports close to home.

Why is this a priority for us?

NHWO 2 | NHWO 3 | NHWO 4 | NHWO 5 | NHWO 9

Perth and Kinross extends over an area of 5,286sq km and encompasses 1 city, 6 towns and over 100 smaller settlements of all sizes, and some of the UK's most diverse landscapes. The diversity of our landscape and our urban/rural mix can bring challenges as well as opportunities.

The HSCP has teams and services based within our North and South localities and this ensures staff understand the needs of the area in which they work and can respond accordingly, there will always be limitations to what we can provide therefore our work with partners is vital to ensure those living in rural areas are not disadvantaged by inequitable provision.

We do however have gaps in provision in our most rural areas, it is financially unsustainable for our commissioned providers to deliver a small number of packages within small, remote, and rural areas. This causes an issue for us; it means that we are unable to offer all Self-Directed Support Options in all areas of Perth and Kinross and has led to health inequalities.

Our Joint Strategic Needs Assessment told us that:

Majority of the population live predominantly in a rural area **67.8%.**
20.5% of this population live in very small, dispersed places throughout the local authority area.

32.2%
live in urban areas

Dependency ratios (the number of people over the age of 65 per 100 people below the age of 65) are higher across the North locality followed by the South locality and with Perth City having the lowest dependency ratio.
Dependency ratios give us a good indication of the likely need for health and social care services to support people across the local authority area.

Perth and Kinross have a higher proportion of people over 65 than the Scottish average

24.1% Perth and Kinross

19.6% Scotland

our North and South localities face greater challenges in relation to this ageing population.

Perth and Kinross have a smaller proportion of people of working age compared to Scotland as a whole.

60.2% Perth and Kinross

63.8% Scotland

Our ageing population will change demand for housing, this population are also more likely to live alone and to be under-occupying homes, increasing the risk of isolation and loneliness.

These factors in combination present logistical difficulties for us and therefore mean the way in which we deliver services needs to adapt, to take cognisance of our rurality, ageing population and workforce issues.

In Perth and Kinross, we have 37 data zones classed in the 10% most access deprived category in Scotland, including Rannoch and Aberfeldy, which is judged to be the most access deprived data zone in the whole of Scotland.
These 37 data zones represent,
31,993 people across Perth and Kinross

Falls are the most common reason for admission to hospital. This data does not identify individuals who have had multiple falls.

What Matters To You?

Our consultation activity told us that the following were highly important to our population:

- **89%** **"I can access all health and social care support in one place, close to home."**
- **83%** **"More opportunities to support health and wellbeing in my local community."**
- **73%** **"Support more people to stay at home through better use of technology."**
- **55%** **"Support for more volunteering/peer support as safe alternatives to services."**
- **"Meaningful respite opportunities that meet the outcomes of carers - improve availability and opportunities".**
- **"People want to invest their time in local communities".**
- **"Lack of affordable housing for key workers, hard to attract talent and entice professionals to move to the area".**

Very clear messages were consistently being fed back through all forums and methods used during our consultation. People are clearly saying they want to access support in their own communities where possible, and that having access to multi-disciplines in the one building would be preferable.

Our services are predominantly based within Perth City, this can mean that access for those living in our more rural areas is limited, this is particularly relevant within our older people, Learning Disability, and deprived populations.

We asked people to tell us what challenges they faced when looking after their Health and Wellbeing.

60% said access and distance to services was a challenge for them	**38% said** said finding the time to attend was a challenge	**24% said** finance or money was challenge for them
20% said said their caring responsibilities created a challenge for them	**20% said** said transport was a challenge for them	**12% said** said need to support to attend was a challenge

What will we do to improve?

2024 2025 2026 2027

Move away from a Perth centric approach, by developing services closer to people homes.

We will better understand where need exists in our communities and plan services around them.

We will work with communities to develop bespoke care and support models of delivery, develop new models of rural service provision to develop a sustainable solution.

We will make sure that Perth and Kinross have a rich variety of high-quality providers working within it.

Ensure more people are supported to achieve their personal outcomes through low level, early interventions provided by community-based care and support services.

Offer personalised, locally based support, including optimising the use of Technology Enabled Care (TEC), across Perth and Kinross to reduce reliance on institutional care.

If hospital admission is required, we will support people to return home as soon as possible, ensuring their home circumstances are safe and that any carers have all they require to support their loved one.

Intervene 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.

Develop our Age Friendly Communities work, strive to ensure older people feel less isolated and lonely.

Continue to invest in our Care at Home and Care Home services, ensuring they can meet the needs of our population.

Design and implement safe, sustainable, patient outcomes focused systems of urgent care access, pathways, and treatment for Perth & Kinross residents.

Continue to work closely with our partners in the Third and Independent sector.

Invest in systems that allow us to understand where need is and how we efficiently respond.

Refresh and renew our Care at Home contract, asking providers to work together, to work across previously rigid geographical boundaries and to collectively provide a Care at Home service within Perth and Kinross.

Work to ensure fewer people need help and support from formal health and social care services and instead access earlier help and support from the third sector (voluntary and community organisations).

Work with our Housing colleagues to ensure housing is fit for purpose and meets the need of our ageing population, this will be key in enabling people to remain in their own home.

Continue to develop our Overnight Responder service, enabling rapid remote responses and enhancing independent living.

We will analyse the root cause of admission to hospital, look at preventative measure that could be implemented and keep people in their own homes and communities wherever possible.

How will we know we are making a difference?

- Carers feel supported to be able to continue in the caring role.
- More people will agree that they live in suitable accommodation at home and in their community
- People will feel their Health and Social Care support was well communicated and accessible
- People will feel they have had a say in how the Health and Social Care support was provided
- People will feel their Health and Social Care Support is well coordinated
- People will feel that services supported them to look after their own health and wellbeing
- People experience quicker access to the right services at the right time
- There will be a reduction in unnecessary admissions and readmissions to hospital
- We will see a reduction in Long Term Hospital stays
- People will have greater access to employment and day opportunities

How will we measure our success?

Each of our priorities are supported by a range of outcome focussed Delivery Plans or Strategies, all of which have their own Performance Frameworks. These frameworks use either National Indicators and or locally developed indicators, these help us to know that we are achieving what we said we would in our in individual user group delivery plans and strategies and thus the Strategic Plan.

The following plans, projects and strategies are relevant to this priority - Linked Delivery Plans, Action Plans, Transformation projects, and Strategies: Community Mental Health and Wellbeing Strategy 2022-2025, Learning Disability and Autism Delivery Plan, Older People Delivery Plan and Carers Strategy.

Measurable outcomes

C1 C3 C4 LDA1 LDA3 LDA4

MH1 MH2 OP3 OP6 PC1 PC2 SU6

Work with communities to design the health and social care supports they need.

Why is this a priority for us?

NHWO 1 | NHWO 2 | NHWO 3 | NHWO 4 | NHWO 7 | NHWO 9

Active involvement of the community plays a pivotal role in driving the transformation of health and social care and improving outcomes for communities. Perth and Kinross Health and Social Care Partnership is dedicated to fostering collaborative relationships with individuals and communities. We place significant importance on actively seeking the input and feedback from those who access our services to co-create and shape future service delivery.

> "A purposeful process which develops a working relationship between communities, community organisations and public and private bodies to help them to identify and act on community needs and ambitions. It involves respectful dialogue between everyone involved, aimed at improving understanding between them and taking joint action to achieve positive change."

What Matters To You?

Our consultation activity told us:

- **83%** "More opportunities to support health and wellbeing in my local community."
- **77%** "Provide opportunities for local communities to influence how health and social care budgets should be spent."
- "Community hubs fostering collaborative partnerships and enabling local decision-making".
- "Empower communities to create their own local solutions".
- "Volunteering opportunities provide members of various communities with a sense of pride, keeping them active and connected thus feeling they have a fulfilled, meaningful life."

Listening to the views of people who use services, and actively involving them throughout the process of planning care delivery, is a key improvement recommendation of the recent Independent Review of Adult Social Care in Scotland.

A wide range of national policies and strategies set out how health and social care services and supports should be delivered in the future. This includes changes to the way existing services are delivered and new types of support to be provided.

Planning with People https://www.gov.scot/publications/planning-people/ supports public bodies that plan and deliver health and social care services in Scotland, including integration authorities, to effectively undertake community engagement and participation. The guidance, which is co-owned by the Scottish Government and the Convention of Scottish Local Authorities (COSLA), outlines statutory requirements for public bodies, presents information on community engagement, and promotes good practice.

In addition, HIS has produced operational examples of engaging with communities, including a checklist for involving people with lived experience in service design https://www.hisengage.scot/equipping-professionals/how-to-engage/

In 2022-23 we undertook a self-evaluation of our Community Engagement and Participation work, we used the Quality Framework for Community Engagement and Participation: Supporting the delivery of meaningful engagement in health and social care Self-evaluation tool.

This has been designed to support NHS Boards, Health and Social Care Partnerships and Local Authorities to meet their statutory duties with regard to public involvement and community engagement in the planning and provision of health and social care. We considered three domains and have used the feedback from this activity to help develop a refreshed Co-design and Engagement Strategy for Perth and Kinross, this will be published in 2024.

Domain 1 - Ongoing Engagement and Involvement of people
Domain 2 - Involvement of people in service planning, strategy, and design
Domain 3 - Governance and leadership - supporting community engagement and participation

What will we do to improve?

2024 2025 2026 2027

Ensure meaningful and effective engagement with community, individuals, and individual service users to understand community needs and to inform the development and implementation of strategic plans. Influencing and having conversations with the wider community about inequalities.

Provide appropriate and relevant support, including the use of technology, for people to engage meaningfully in planning services.

We are committed to ensuring that carer and public partner engagement is fully resourced, that our strategic planning group represents the views of local carers and public partners and that this representation is meaningful and effective.

Ensure support services in Perth and Kinross are designed and delivered to support all people with a physical disability to live the life they choose, to have control, to make informed choices and to have support to communicate this when needed at every stage of their lives.

We will embed Co-design principles into our day-to-day work and support staff to learn and understand the principles involved in using this approach.

Produce a new Co-design and Engagement Strategy – this will outline our commitment to involving all partners and ensuring all strategic decision making is influenced by those who use services.

Continue to embed and learn from Care Opinion feedback.

How do we know we are making a difference?

- People will feel their Health and Social Care support was well communicated and accessible
- People will feel they have had a say in how the Health and Social Care support was provided
- People will feel their Health and Social Care Support is well coordinated
- People experience quicker access to the right services at the right time
- Our communities will see their thoughts and ideas in our service delivery.

How will we measure our success?

Each of our priorities are supported by a range of outcome focussed Delivery Plans or Strategies, all of which have their own Performance Frameworks. These frameworks use either National Indicators and or locally developed indicators, these help us to know that we are achieving what we said we would in our in individual user group delivery plans and strategies and thus the Strategic Plan.

The following plans, projects and strategies are relevant to this priority - Linked Delivery Plans, Action Plans, Transformation projects, and Strategies: Older People Delivery Plan, Carers Strategy, Primary Care Strategy, Community Mental Health and Wellbeing Strategy 2022-25, TEC Action Plan, Community Action Plans.

Measurable outcomes

C4 | LDA6 | MH4 | OP2 | PC1

Good Practice Example: Learning Disability Day Support Collaborative Project

The Learning Disability Day Support Collaborative focussed on exploring opportunities for transforming services to best meet the needs of supported people and their unpaid carers/families.

Perth and Kinross Health and Social care Partnership was chosen to be part of the Learning Disability Day Support Collaborative Project and worked alongside Falkirk, North Ayrshire and Lothian Health and Social Care Partnerships and with support Healthcare Improvement Scotland iHub.

People from across Perth & Kinross gathered to explore ways to create better day opportunities for people with Learning Disabilities. Some of those taking part are themselves people who use these services, along with people who work in Health, Social Care, Third sector and Higher Education. In teams they tested how they could work together, designing services that matter to the people who use them.

This gathering was called a Jam and was a collaborative co design process which emphasises relationships, empathy and a deep understanding of the needs & perspectives of everyone involved.

The Jam identified areas for improvement, an environment in which we could co create solutions, and build trust, using a range of tools & techniques, such as user research, journey mapping and prototyping.

The Jam is part of a wider co-design exploration in Perth & Kinross with the aim of transforming the way we do things, to create equitable and inclusive spaces, for collaborative and joyful experiences.

In so doing, we hope to enable, imagine, and develop opportunities that support our unique and beautiful lives... joining together for a good life.

https://youtu.be/y1cPCHkqJno

Improved Integrated Working

Why is this a priority for us?

NHWO 2 | NHWO 3 | NHWO 4 | NHWO 9

Health and social care services do not operate in isolation, the workforce regularly works across a variety of settings that require collaboration, with a wide range of bodies. This requires the commitment and engagement of workers and management across all health and social care providers to implement change successfully with the people who use services, their carers and families remaining central to all aspects of our work.

Our linked Transformation projects will play a vital role in moving towards a sustainable health and social care system for the future, a central focus for many of these models is integrating services to improve how people experience care. This will be achieved by making sure services are more joined-up, by promoting better working between clinical and community-based services and by beginning to blur the lines of long-established roles and their boundaries.

Integrated community teams based in neighbourhoods or localities are a core element of our care models being developed in Perth and Kinross. Integrating our core locality teams involves providing a multi-disciplinary response by GPs, Advanced Nurse practitioners, district nurses, physiotherapists, occupational therapists, Older People Community Mental Health Team, pharmacists, social workers, social care officers and the third and independent sector and who will all work together to provide community-based support.

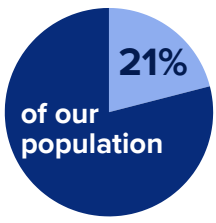
We know that where we have already integrated teams that it promotes closer working relationships and provides care tailored to the needs of the people in our localities, Perth and Kinross HSCP want to role out this approach on a whole system basis. Thus ensuring, regardless of where you live in Perth and Kinross, you can access services where not only are there a rich range of skills available but also a sharing of those skills, ensuring person centred and timeous responses to your health and social care needs.

Our Joint Strategic Needs Assessment told us that:

In Perth and Kinross, we have 37 data zones classed in the 10% most access deprived category in Scotland, including Rannoch and Aberfeldy, which is judged to be the most access deprived data zone in the whole of Scotland. These 37 data zones represent,

31,993 people

across Perth and Kinross



and highlights the challenges of providing consistently high-quality services across such a diverse region.

Majority of the population live predominantly in a rural area **67.8%.**

20.5% of this population live in very small, dispersed places throughout the local authority area.

32.2%
live in urban areas

Perth and Kinross have a higher proportion of people over 65 than the Scottish average

24.1% Perth and Kinross **19.6%** Scotland

our North and South localities face greater challenges in relation to this ageing population.

Falls are the most common reason for admission to hospital.

Dependency ratios (the number of people over the age of 65 per 100 people below the age of 65) are higher across the North locality followed by the South locality and with Perth City having the lowest dependency ratio.

Dependency ratios give us a good indication of the likely need for health and social care services to support people across the local authority area.

Perth and Kinross have a smaller proportion of people of working age compared to Scotland as a whole, and this is likely to continue.

63.8%
Scotland

60.2%
Perth and Kinross

In Perth and Kinross, 21% of the population who had contact with NHS Services had at least one physical long-term condition (LTC). Of this population group, 17% of those under the age of 65 were living with more than one LTC comparedto 50% of those aged over 65.

In Perth and Kinross, the leading cause of death for females in 2021 was Dementia and Alzheimer's disease and was the second leading cause for males.

11.1% **7.7%**

Projections estimate an an extra hundred cases year on year.

2025 2026 2027

What Matters To You?

Our consultation activity told us that the following were highly important to our population:

89% **"I can access all health and social care support in one place, close to home."**

87% **"Clearer and accessible information about the range of support and services available and who to contact for help."**

83% **"More opportunities to support health and wellbeing in my local community."**

"Listen to people who live in the area. Make services more efficient - carers are going between areas unnecessarily".

“ We would like an Integrated hub for support and care/questions/information etc”.

“Information in one place and accessible in various formats would be really helpful”.

We asked people to tell us what challenges they faced when looking after their Health and Wellbeing.

60% said access and distance to services was a challenge for them.	**30% said** knowing where to go was a challenge for them.	**20% said** said their caring responsibilities created a challenge for them.	**20% said** said transport was a challenge for them.	**15% said** that the relationship they had with professionals was a challenge.

What will we do to improve?

2024 2025 2026 2027

Our aim is to develop integrated locality bases across our North and South localities ensuring integrated working across our Health and Social Care teams.

Ensure the workforce work flexibly to provide high-quality, person-centred support, avoiding working in silos or being limited by defined role remit.

Provide a rapid, multi-disciplinary response for people if their health deteriorates to prevent admission to hospital or a care home.

Value the role of each profession, community, or organisation – better understand what each partner brings.

Align our Third and Independent sector to locality Integrated structures.

Further develop trusting relationships between NHS and third sector partners, allowing more people to be signposted to these community services.

Ensure people can access the community-based help and support that they need in the evenings, overnight and at weekends.

Ensure all partners understand what is available within our localities, all assets. Continue the work of the JSNA to include, community asset mapping, which is matched to need.

Continue on our work to Integrate our specialist services, such as IDART, Learning Disabilities/SCOPE and Primary Care Mental Health.

How will we know we are making a difference?

- Carers feel supported to be able to continue in the caring role.
- More people will agree that they live in suitable accommodation at home and in their community
- People will feel their Health and Social Care support was well communicated and accessible
- People will feel their Health and Social Care Support is well coordinated
- People will feel that services supported them to look after their own health and wellbeing
- People experience quicker access to the right services at the right time
- There will be a reduction in unnecessary admissions and readmissions to hospital
- We will see a reduction in Long Term Hospital stays

How will we measure our success?

Each of our priorities are supported by a range of outcome focussed Delivery Plans or Strategies, all of which have their own Performance Frameworks. These frameworks use either National Indicators and or locally developed indicators, these help us to know that we are achieving what we said we would in our in individual user group delivery plans and strategies and thus the Strategic Plan.

The following plans, projects and strategies are relevant to this priority - Linked Delivery Plans, Action Plans, Transformation projects, and Strategies: Older People Delivery Plan, Carers Strategy, TEC Strategy, Primary Care Strategy, NHST Integrated Clinical Strategy, Community Action Plans, Community Mental Health and Wellbeing Strategy 2022-2025, Learning Disability and Autism Delivery Plan.

Measurable outcomes

Promote Self-management and Living Well

Why is this a priority for us?

NHWO 1 | NHWO 2 | NHWO 4 | NHWO 7

People living with long-term conditions live with them 24 hours a day, the input from professionals represents only a small proportion of that time. Self-management is about enabling people to live more independently, confidently and with greater quality in the things that matter to them.

Data shows that not only are people living longer; they are living longer with long term conditions. It is also reported that an increasing number of people in the middle age group are developing, or at high risk of developing, a long-term condition.

There are many benefits for people who have the tools and support to enable them to live well. Increased self-esteem, enabled to take control, feeling connected, less isolated, reduced anxiety, improvement in mood, feeling empowered to challenge and question health professionals, recognised as experts in their condition, able to provide peer support, are just some examples of benefits.

NHS services generally treat people when they are ill, a reliance on this medical model alone won't fully support people to live well. More and more services can be delivered in communities by a variety of partners, including the third and independent sector. Self-management does not have to be complicated, for example, giving people the right information at the right time, treating people as individuals, recognising the impact of their condition on their day-to-day life, and ensuring they can access support all allow people to take control.

Supporting people to manage their conditions and live well has the potential to impact on demand for HSCP services. People who are managing their health better are less likely to need these services.

Our Joint Strategic Needs Assessment told us that:

Under 65 Years Old

1.1 in 10 people aged under 65 have at least 1 LTC

65 - 74 Years Old

4.1 in 10 people aged 65 tom 74 have at least 1 LTC

75 - 84 Years Old

6.2 in 10 people aged 75 to 84 have at least 1 LTC

Over 75 Years Old

7.9 in 10 people aged over 85 have at least 1 LTC

The main Long Term Conditions are:

Cancer	Arthritis	Coronary Heart Disease	Asthma	Diabetes

this pattern is consistent across all localities.

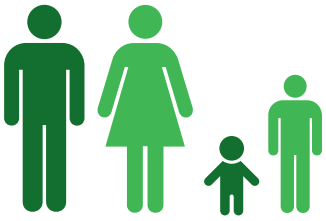
In Perth and Kinross, **21%** of the population who had contact with NHS Services had at least one physical long-term condition (LTC).

Of this population group, **17%** of those under the age of 65 were living with more than one LTC compared to **50%** of those aged **over 65.**

Perth city locality have the highest number of unscheduled bed days. Most of the unscheduled beds are for the over 65 age group.

Perth City has the lowest over 65 demographics in comparison to the North and South locality.

Those of us with lower levels of health literacy: have higher rates of emergency admission and have difficulty managing our own health an wellbeing, that of out children, and anyone else we care for.



How does poor health literacy affect people's health?

- Are generally 1.5 to 3 times more likely to experience a given poor outcome
- Have poorer health status and self-reported health
- Wait until we're sicker before we go to the doctor
- Find it harder to access services appropriate to our needs
- Find it harder to understand labelling and take medication as directed
- Are less able to communicate with healthcare professionals and take part in decisions
- Are less likely to engage with health promotional activities, such as influenza vaccination and breast screening
- Are at increased risk of developing multiple health problems
- Have higher rates of avoidable and emergency admissions
- Have higher risks of hospitalisation and longer in-patient stays
- Have difficulty managing our own health and wellbeing, that of our children, and of anyone else we care for
- Have greater difficulty looking after ourselves when we have long-term conditions

Why is addressing health literacy important?

Because whenever our health literacy needs are not met, the safety, effectiveness and person-centredness of our care is undermined:

Ineffective communication undermines our capacity to be in the driving seat of our care, which is the cornerstone of self-management, and key to person-centred care.

When our health literacy needs are met, we are better able to work with our health care professionals to safeguard our own care and live well.

What Matters To You?

Our consultation activity told us:

"Enable individuals to self-manage and practice self-care by providing easy accessible information to assist in informed decision-making right from the outset".

"Wellbeing extends beyond just services; we must actively promote and safeguard the use of other interventions such as gardens and greenspaces, being connected and faith".

"Access to transportation plays a vital role in helping individuals maintain their well-being".

"Information in one place and accessible in various formats".

What will we do to improve?

2024 2025 2026 2027

We will promote self-management, prevention, and early intervention within the primary care services.

Disadvantaged communities will benefit from more targeted investment to support self-care and prevention.

We will build knowledge, understanding, skills and confidence in service users to use health information, to be active partners in their care, and to navigate health and social care systems. This is known as health literacy.

We will establish a culture of anticipatory forward care planning within our community teams to promote and support self-management and enable best management of crises. Change anticipatory to forward, apparently no longer called the latter.

We will optimise the use of digital and mobile technologies to enable people to self-manage their health, to enable monitoring, diagnostics, advice, and access which aims to enhance ongoing care and decision making closer to home wherever possible.

We will enable people to connect with the service and supports that they need at an earlier stage using a social prescribing approach.

We will ensure all service provision adopts a reablement approach.

Continue to support our third sector providers in developing and rolling out programmes that improve physical and mental wellbeing.

We will further develop our Age Friendly Work.

How will we know we are making a difference?

- Carers feel supported to be able to continue in the caring role.
- More people will agree that they live in suitable accommodation at home and in their community.
- People will feel their Health and Social Care support was well communicated and accessible.
- People will feel they have had a say in how the Health and Social Care support was provided.
- People will feel their Health and Social Care Support is well coordinated.
- People will feel that services supported them to look after their own health and wellbeing.
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Measurable outcomes

C3	C5	LDA3	LDA4	MH4
OP1	OP2	OP3	PC3	SU3

Good Practice Example: Moving forward: An evaluation of using walking with Strength and Balance in healthcare settings.

A detailed summary of the work between Paths for All and Perth and Kinross Health and Social Care Partnership to develop, pilot, and embed a whole systems approach to increasing physical activity opportunities for people in receipt of care, and in particular, people living with dementia.

Paths for All is a national walking charity with the aim to support everyone to be active in Scotland every day. Since 2018, the Dementia Friendly Walking team has been supporting care homes, community hospital settings and care at home services to implement a walking with strength and balance programme across Perth and Kinross.

Paths for All commissioned Outside the Box to evaluate and summarise the programme in Perth and Kinross to help other care settings, NHS and Health and Social Care Partnerships set up and implement their own programme.

The evaluation explores experiences in three different healthcare settings:

- Care homes,
- Care at home,
- Hospitals.

The aim of the evaluation of the walking with strength and balance programme is to:

- Summarise the timeline and development.
- Identify key drivers and enablers which supported the development of the programme.
- Identify the challenges and difficulties.
- Share success stories.

The evaluation was carried out between February and May 2023 and based upon conversations and visits with the following:

- Attendance and discussion at the Care Home Activity Network (CHAN).
- Conversations with key staff at Paths for All and Perth and Kinross HSCP.
- Visits, conversations, and garden tours with staff and residents at Beech Manor Care Home, Richmond House, and Muirton House Care Home.
- Participating in a gentle movement Live Active Leisure session.
- Conversations with staff at Glenhelenbank Residential Home.
- Conversations with staff from Blairgowrie Community Hospital.
- Workshop with staff from the Home Assessment Recovery Team (HART).
- Conversation with Dr Grant Gibson, the University of Stirling.
- Reviewing the resources produced by Paths for All.

Value our workforce, support them to keep well, learn and develop.

Why is this a priority for us?

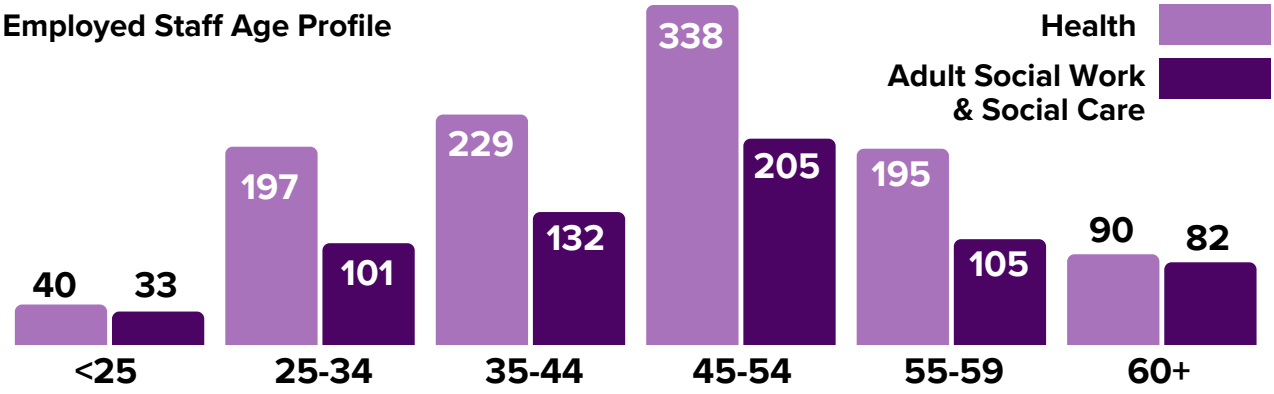
NHWO 3 | NHWO 4 | NHWO 8 | NHWO 9

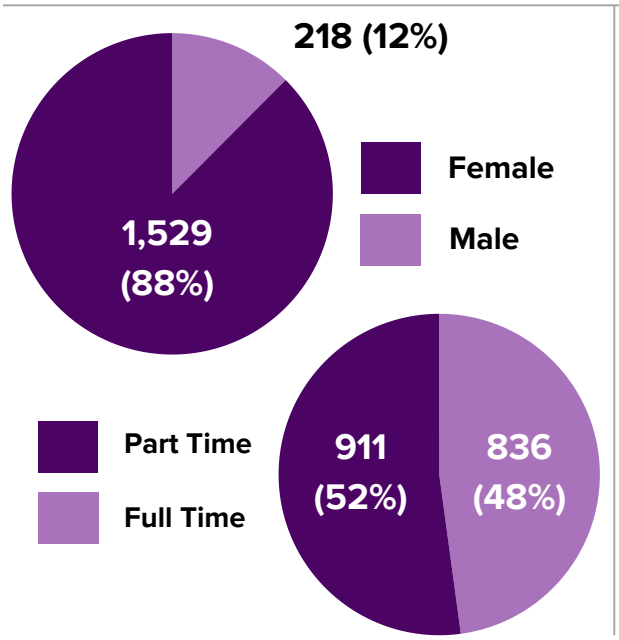
We want the Health and Social Care Partnership to be viewed as a rewarding and fulfilling place to work for everyone, with the best possible staffing and expertise levels in place. Our workforce whether employed by a statutory Health and Social Care organisation, independent provider, or as partners in the voluntary and community sector, are the organisation's greatest asset and are working harder than ever to provide the care and support needed by our communities.

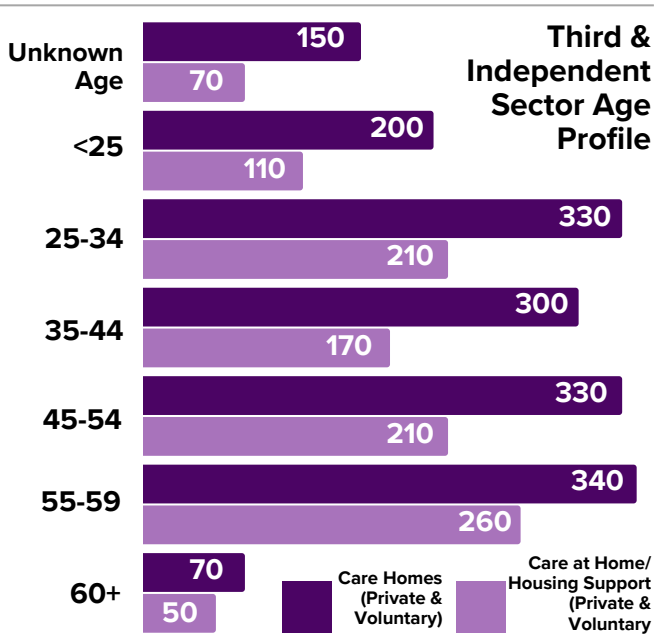
The system could not run without the skill, dedication, and commitment of our talented, hard-working colleagues, across all disciplines, professions, and levels.

Perth and Kinross IJB does not directly employ any staff. The health and social care workforce is employed through Perth and Kinross Council, NHS Tayside and organisations in the third and independent sector.

Workforce demographics:







Our consultation with our workforce told us:

Main Wishes

Improvements in Service Design

Staff would like to see an improvement in how they are communicated with, they want to be involved in improvement work and the design of future services.

A lack of information and understanding about services and roles was highlighted as a significant barrier.

Partnership Working and Systems, being valued

There is uncertainty around the impact of national care service.

Staff felt there had been positive progress in relation to partnership working and opportunities for how this could be further strengthened.

Increase to Staff and Resources

Staff want to see improvements in relation to discharge planning and inconsistencies in approach.

Universally staff agreed that providing care in a person's home or in their own community was a priority, that a hospital setting is not always the right environment for people but to do this we need a range of different community approaches with well trained staff.

Our Workforce and COVID 19

There is no denying that the COVID 19 pandemic has placed additional pressures and stress on the Health and Social Care workforce. They have experienced sustained, high levels of demand, with constant changes to working practice in order to adapt to the challenges of a global pandemic.

The pandemic has also brought a pace and scale of innovation never experienced before. Changes in how we delivered services were accelerated within very tight timescales; we embraced a more lean, light, and agile approach to governance and regulation, and we adopted a wealth of new technologies, service innovations and ways of working that were rolled out across a range of different settings.

The experience of COVID has brought into sharp focus the importance of our core value of compassion. Our greatest asset is our people who give inspiring support for the health, happiness and wellbeing of our citizens and communities. We recognise the importance of collective, compassionate leadership in nurturing the workforce and enabling innovation and high-quality care. We understand the importance of an inspiring vision, positive inclusion and participation, enthusiasm for team working and cross-boundary working and support for autonomy and innovation.

What Matters to You (WMTY)?

Is a movement which supports our localities to embed this collaborative and collective approach across Perth and Kinross, it places a high importance on nurturing and developing the way we as individuals and within teams work, emphasising the importance of relationships and trust.

The WMTY approach advocates respect, innovation, and action to improve outcomes for colleagues and in turn the people and communities we serve. This approach encourages open and honest discussion about the whole system, this enables clarity and consistency of vision, direction and purpose across our localities and an embedding of our values ambition, compassion and integrity.

The WMTY movement is ongoing and should become the default approach within our organisation.

Workforce Plan

We are currently experiencing, and foresee ongoing, recruitment issues within our Health and Social Care sector. We have an ageing population in Perth and Kinross where the proportion of older people is increasing, and the proportion of younger people is decreasing. This, compounded by the impact of the COVID 19 Pandemic has led to extreme difficulties in recruiting skilled, and experienced staff within multiple areas of our delivery.

The need to grow and upskill our workforce at the same time as transforming how we further work to improve quality and increase capacity are consistent themes. We need to transform by expanding existing roles, developing new roles, and building the skills of our workforce to continue to achieve safe, integrated, high quality and affordable health and social care services for people residing in Perth & Kinross.

We will develop our workforce to embed a human rights approach to assessment, treatment, care, and support. Our relentless focus will be on integration, locality working, co-production, prevention, early intervention and tackling inequalities.

To improve staff retention, succession planning, and recruitment we will equip the workforce with adaptable skills and enable staff to practice at the higher end of their remit. This will enable staff to retain core skills and exercise flexibility to respond to a wider range of needs and circumstances.

We will ensure that our approach to learning and development is integrated and supports professional development and improves career pathways.

In parallel to redesign of services, PKHSCP will require to oversee implementation of the Health & Care (Staffing) (Scotland) Act 2019. This places a legal duty for HSCPs/NHS Boards to be appropriately staffed to provide safe, high-quality care which improves outcomes for service users and puts patient safety at the fore.

What will we do to improve?

2024 2025 2026 2027

Ensure that staff are well informed. We will work collaboratively to embed this shared vision within staff teams, supporting and developing staff from all organisations to respond appropriately, putting people first.

Recognise that our people are our greatest asset, and it is through their talents and ambitions that real improvement will continue to be made.

Support staff to understand the importance of the communities we service and develop positive approaches to engage, listen and act.

Provide staff with a continually improving and safe working environment, promoting the health and wellbeing of staff.

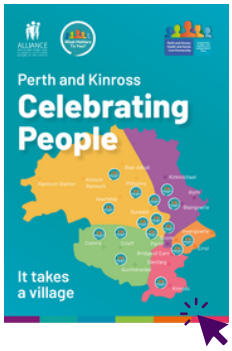
Treat staff fairly and consistently with dignity and respect in an environment where diversity is valued.

Support staff to learn from and build on best practice, ensuring that they are appropriately trained and developed.

Ensure managers and teams who welcome international recruits maintain their own cultural awareness to create inclusive team cultures that embed psychological safety.

Ensure Perth and Kinross is an attractive and forward-thinking place to work, continue to invest in our student workforce, modern apprentices, and graduate apprentices.

How will we measure our success?



Each of our priorities are supported by a range of outcome focussed Delivery Plans or Strategies, all of which have their own Performance Frameworks. These frameworks use either National Indicators and or locally developed indicators, these help us to know that we are achieving what we said we would in our in individual user group delivery plans and strategies and thus the Strategic Plan. The following plan is relevant to this priority - Workforce Plan 2023-26, Celebrating People Document.

Additionally we use Care Opinion. Care Opinion is a place where you can share your experience of health or care services, and help make them better for everyone. Care Opinion makes it safe and simple to share stories online and see other people's stories too.
These collated stories are leading to change, feedback gathered lets us and our staff know what is and what is not working well. Care Opinion gives our staff valuable feedback, to date and in the majority feedback has been positive but where it hasn't, services use this feedback to improve.

Measurable outcomes

LDA2	MH4	OP7	PC2

Good Practice Example: Peer Learning

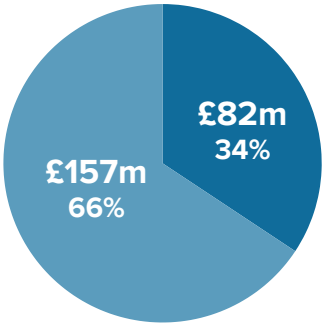
The peer learning group provides all social work students placed across Perth and Kinross from both statutory and third sector settings to learn together about key practice themes. There are ten sessions in total that cover all social work disciplines that are all facilitated by different front-line practitioners and professionals from across Perth and Kinross Council. The group promotes peer wellbeing support, maximises learning available across the service, supports critical reflection and provides opportunities for social work staff to contribute to student learning and develop their mentoring and facilitation skills. The sessions provide students with the opportunity to learn about social work teams and services out with their placement setting and has inspired six individuals to undertake their dissertation research projects about areas that have been of particular interest and that can support improvements and innovation in practice at a cultural and structural level. It has also given students the confidence to apply for social work posts across the council and so far, seven individuals have been successful in obtaining employment. The peer learning model has been endorsed by Stirling and Dundee University and Perth and Kinross Council have been invited to a national event to share our experiences.

PKLearning | Community of Practice

Resources and Risks

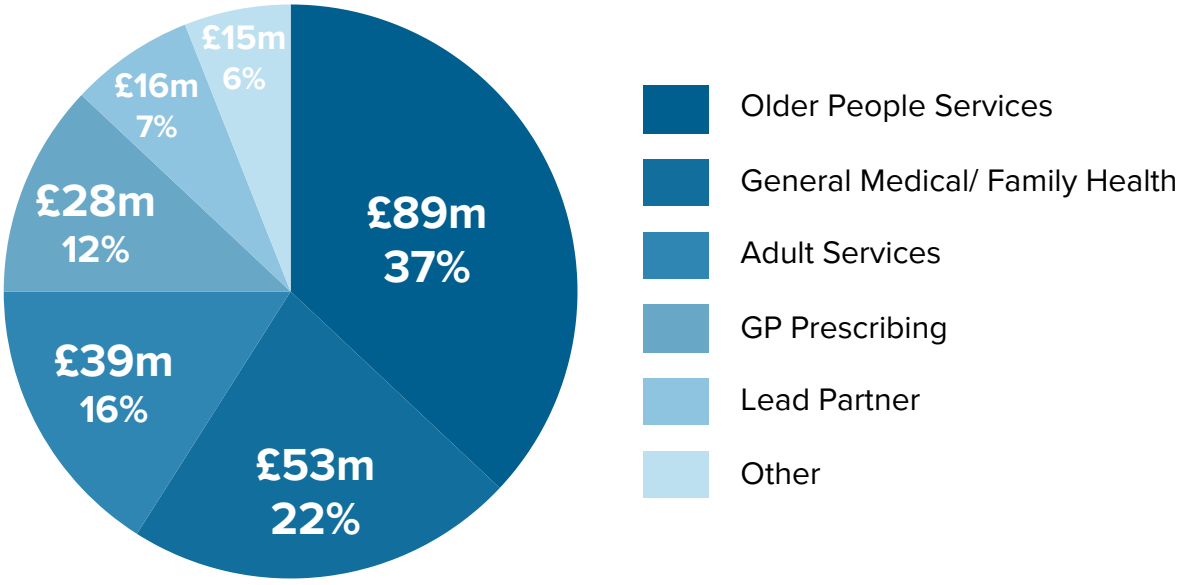
Perth and Kinross IJB commission a range of health and adult social care services. These services are funded through budgets delegated from both Perth & Kinross Council and NHS Tayside.

For 2023/24 the contributions to Perth & Kinross IJB were:



Total HSCP Budget = £239m

Health and Social Care - Total Recurring Budget 2023/24



The IJBs Financial Plan 2024/25 – 2026/27 recognises that the IJB is facing significant financial challenge over the coming years and will need to be realistic about what can be delivered with the funding available.

The IJB is required to set a balanced budget where funding matches expenditure, but funding is not keeping pace with increasing needs and costs. This requires the IJB to prioritise investment and disinvestment in line with a financial strategy that supports the delivery of the strategic plan.

The IJB is committed to planning services within the financial resources that are available, but to achieve this it will mean significant transformation and efficiency savings are required and it may mean some developments have to progress at a slower rate than desired.

A programme of transformation has been agreed which spans the entirety of the Partnership's business and seeks to deliver transformational change and sustainable services for the people of Perth and Kinross, shift the balance of care and realise financial savings to support a balanced budget.

We cannot provide services in the way we have before - we don't have enough money to do so. With growing demand for support and less money available we want to work with individuals and neighbourhoods to find ways to better support people in our communities.

The Third and Independent Sector

The Independent and Third sector is commissioned to play a number of different roles within Perth & Kinross, providing either direct service (for example: care homes, care at home, supported accommodation and day care services) or support services helping people to navigate services; support (advice, information, buddying); providing opportunities for people to lead active and health lives; provide social opportunities; non health related practical support (repairs, shopping, transport); providing a voice for particular groups or communities; providing specialist knowledge of a particular condition.

It is vital that the full extent of the third sector's knowledge, expertise, and information, both in relation to communities and the sector itself, is brought to bear upon strategic commissioning and locality planning to achieve the outcomes of health and social care integration. This will require all parties to work with trust and mutual respect.

Commissioned services represent a wide and varied level of provision, essential to achieving the Health and Social Care Partnerships objectives. The Social Care gross budget is £108.6m, of this there is £79.9m budgeted for services commissioned externally. This equates to just under 74% of all our IJB Social Care budget.

We highly value our Third and Independent sector's work, they are essential partners, who are uniquely placed within the overall delivery of services, they are able to build strong long-lasting relationships, foster trust and offer support out with a statutory setting.

We monitor each provider that we commission, but we do so on an individualised basis, ensuring the bespoke nature of their delivery and the outcomes to be achieved are measured. More generically we ask our providers to work to the five principles set out in the Health and Social Care Standards. We work in partnership with the Care Inspectorate and share local intelligence which in turn is used to improve standards of care support across the sector.

Everyone who receives a service should experience the following:

- I experience high quality care and support that is right for me.
- I am fully involved in all decisions about my care and support.
- I have confidence in the people who support and care for me.
- I have confidence in the organisation providing my care and support.
- I experience a high-quality environment if the organisation provides the premises.

Our Strategic Commissioning Plan places a significant level of emphasis on the need for services and support to intervene early to prevent later, longer term issues arising. It aims to enable people to manage their own care and support by taking control and being empowered to manage their situation, this is where the Third Sector excel.

Where this is not possible, our aim is for services to target resources where they are needed most, reducing ill health and deterioration, and ultimately reducing health inequalities Perth & Kinross.

We ensure that through effective planning, commissioning, and monitoring of key services, people can lead healthy, active lives and live as independently as possible in the community.

The Housing Contribution Statement

The 'Housing Contribution Statement' (within the Strategic Commissioning Plan) sets out how the Local Housing Strategy can support the delivery of the Health and Social Care Partnership aims, ensuring people have access to suitable housing and support to enable them to live as independently as possible. This includes:

- Working with housing developers to build sustainable housing which can be easily adapted to meet changing household needs.
- Continuing to work in partnership with a range of services to meet the housing requirements of people with particular needs.
- Providing a range of housing options for older people, including sheltered housing with on-site housing support.
- Intervening early to prevent and respond to homelessness effectively.
- Ensuring suitable housing and housing support is available to prevent admissions and prolonged stays in hospital and engage early with partners to deliver a seamless service for people discharged from hospital.
- Ensuring residents and tenants have access to services which allow their current home to be adapted to meet their medical and support needs.
- Supporting residents to live in warm, dry, energy efficient and low carbon homes which they can afford to heat.

The Housing Service is a key contributor to the development and implementation of the priorities set out within the Health and Social Care Strategic Commissioning Plan and a range of governance and operational arrangements ensure the achievement of these priorities.

The Health and Social Care Partnership is responsible for providing the Perth and Kinross Community Planning Partnership (CPP) with updates on the relevant actions within the Community Plan and for reporting on the outcomes achieved through the delivery of the Strategic Commissioning Plan and social care locality teams to support the delivery of housing, health and social care outcomes within our communities.

Challenges

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

Key challenges include:

- Changing demographics in Perth and Kinross, particularly in relation to an ageing population profile.
- Increasing demands for complex adaptations to existing homes.
- Increasing demands for specialist housing and support for people with particular needs.

- Responding appropriately to the specific housing and support needs of vulnerable groups such as homeless people, older people, people with mental health issues, people with learning disabilities and people with drug and alcohol issues.
- Responding to the challenges that the rural nature of the Local Authority area can bring in relation to the provision of support and suitable accommodation.
- Continuing to identify households in fuel poverty or at risk so that appropriate support and assistance is provided.

Housing is an important determinant of health. Substandard housing is a social driver of health inequalities, which can greatly impact a person's physical and mental health. The housing sector plays a key role in ensuring the health and well-being of communities and is pivotal in supporting PKHSCP to realise its vision for its citizens to live as independently as possible. Guaranteeing affordable, accessible and sustainable housing is the vision of the new Local Housing Strategy vision for Perth and Kinross;

"Everyone in Perth and Kinross has access to the right home, in the right place and at the right cost."