PERTH AND KINROSS INTEGRATION JOINT BOARD

Council Building
2 High Street
Perth
PH1 5PH

30/05/2024

A hybrid meeting of the **Perth and Kinross Integration Joint Board** will be held in **the Council Chambers (Hybrid)** on **Wednesday, 05 June 2024** at **13:00**.

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

Jacquie Pepper
Chief Officer – Health and Social Care Partnership

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

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

Non-Voting Members
Jacquie Pepper, Chief Officer- Health and Social Care Partnership
Donna Mitchell, Chief Financial Officer/Head of Governance and Performance, Perth and Kinross Integration Joint Board
Arun Singh, Chief Social Work Officer, Perth and Kinross Council
Dr Emma Fletcher, NHS Tayside
Suzie Flower, NHS Tayside
Dr Sally Peterson, NHS Tayside
Dr Monica Doyle, NHS Tayside

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

Perth and Kinross Integration Joint Board

Wednesday, 05 June 2024

AGENDA

1	**WELCOME AND APOLOGIES/SUBSTITUTES**	
2	**DECLARATIONS OF INTEREST** Members are reminded of their obligation to declare any financial or non-financial interest which they may have in any item on this agenda in accordance with the Perth and Kinross Integration Joint Board Code of Conduct.	
3	**MINUTES**	
3.1	**MINUTE OF MEETING OF THE PERTH AND KINROSS INTEGRATION JOINT BOARD OF 20 MARCH 2023 FOR APPROVAL** (copy herewith)	**5 - 10**
4	**ACTION POINTS UPDATE** (copy herewith G/24/65)	**11 - 12**
5	**MATTERS ARISING**	
6	**DELIVERING ON STRATEGIC OBJECTIVES**	
6.1	**CHIEF OFFICER STRATEGIC UPDATE** Verbal Update by Chief Officer	
6.2	**TAYSIDE MENTAL HEALTH SERVICES: STRATEGIC UPDATE** Report by Chief Officer (copy to follow)	
6.3	**ALCOHOL AND DRUG PARTNERSHIP STRATEGIC DELIVERY PLAN 2024-2027 AND ANNUAL REPORTING SURVEY** Report by Chief Officer (copy to follow)	
6.4	**3 YEAR WORKFORCE PLAN UPDATE** Report by Chief Officer (copy herewith G/24/66)	**13 - 24**
6.5	**PERTH AND KINROSS INTEGRATION JOINT BOARD STRATEGIC PLAN UPDATE 2024 - 2027** Report by Chief Officer (copy herewith G/24/67)	**25 - 172**

6.6 STRATEGIC PLANNING GROUP UPDATE AND DRAFT MINUTE OF 30 APRIL 2024 173 - 178
Verbal Update (copy of minute herewith)

7 FOR INFORMATION

7.1 WORKPLAN 2024-25 179 - 180
(copy herewith G/24/68)

7.2 FUTURE IJB DEVELOPMENT SESSIONS 2024/25
(10.00am - 1.00pm)

Friday 16 August 2024
Friday 25 October 2024
Friday 20 December 2024
Friday 24 January 2025
Friday 21 February 2025
Friday 14 March 2025

7.3 FUTURE MEETING DATES 2024/25
(Council Chambers, 1.00pm - 4.00pm)

Wednesday 21 August 2024
Wednesday 2 October 2024
Wednesday 11 December 2024
Wednesday 19 March 2025

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PERTH AND KINROSS INTEGRATION JOINT BOARD

Minute of hybrid meeting of the Perth and Kinross Integration Joint Board (IJB) held in the Council Chambers, 2 High Street, Perth on Wednesday 20 March 2024 at 1.00pm.

Present:

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

Non-Voting Members
Ms J Pepper, Chief Officer/Director – Perth and Kinross Health and Social Care Partnership,
Ms D Mitchell, Chief Finance Officer/Head of Governance and Performance, Perth and Kinross Health and Social Care Partnership
Mr A Singh, Strategic Lead - Children, Families and Justice and Chief Social Work Officer, Perth and Kinross Council
Ms S Flower, NHS Tayside
Dr S Peterson, NHS Tayside
Dr L Robertson, NHS Tayside

Stakeholder Members
Ms S Auld, Service User Public Partner (from Item 7.3 onwards)
Mr D Henderson, Scottish Care Sector
Ms L Hunter, Staff Representative, NHS Tayside
Mr I McCartney, Service User Public Partner
Ms M Summers, Carer Public Partner

In Attendance:
S Hendry, L Simpson, Adam Taylor, A Brown, L Potter and M Pasternak (all Perth and Kinross Council); K Ogilvy, Z Robertson, E Devine, H Dougall, C Jolly, G Morrison, Amanda Taylor, M Grant and P Jerrard, (all Perth and Kinross Health and Social Care Partnership); V Davis and L Miller (both NHS Tayside).

Apologies:
Mr B Benson, Tayside NHS Board; Ms B Campbell, Carer Public Partner; Dr E Fletcher, NHS Tayside; and Ms S Watts, Third Sector Forum.

1. WELCOME AND APOLOGIES

Councillor C Stewart, Chair, welcomed all those present to the meeting and apologies were noted above.

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2. DECLARATIONS OF INTEREST

I McCartney declared a non-financial interest in relation to Older People Psychiatry Services.

3. MINUTE OF MEETING OF THE PERTH AND KINROSS INTEGRATION JOINT BOARD OF 14 FEBRUARY

The minute of the meeting of the Perth and Kinross Integration Joint Board of 14 February 2023 was submitted and approved as a correct record.

4. ACTIONS POINT UPDATE

The Chief Officer provided a verbal update on the status of the various action points.

Resolved:
The action points update (G/24/43) was submitted and noted.

5. MATTERS ARISING

There were no matters arising.

6. MEMBERSHIP UPDATE

The Clerk provided a verbal report updating the Board on various aspects of the membership of both voting and non-voting members of the Board.

Resolved:

(i) It be noted that with effect from 1 April 2024, Heather Dunk would replace Jacquie Jensen as a Non-Executive Member of NHS Tayside on the Perth and Kinross Integration Joint Board.

(ii) It be noted that Bob Benson would no longer be an NHS voting member on the Perth and Kinross Integration Joint Board and that NHS Tayside were currently looking to fill this vacancy.

(iii) It be noted that with effect from 1 April 2024, Sam Riddell would replace Dr Andrew Thomson as a proxy member for NHS Tayside on the Perth and Kinross Integration Joint Board.

(iv) It be noted that with effect from 1 April 2024, Beth Hamilton would become the Vice-Chair of the Perth and Kinross Integration Joint Board.

(v) It be noted that with effect from 1 April 2024, Dr Monica Doyle would replace Dr Lee Robertson as a Board Member on the Perth and Kinross Integration Joint Board.

7. DELIVERING ON STRATEGIC OBJECTIVES

7.1 CHIEF OFFICER STRATEGIC UPDATE
7.2 TAYSIDE MENTAL HEALTH SERVICES: STRATEGIC UPDATE

The Chief Officer provided a verbal update covering both Items 7.1 and 7.2 in which she highlighted the importance of the items on the agenda for today’s meeting

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detailing the level of work that has been carried out and expressed her thanks to all the authors of the relevant reports and the teams who have contributed to the significant work behind all the papers.

She further advised that the In-Patient Mental Health and Learning Disabilities in-year overspend has been met in full for 2023/24 with an agreed financial risk share and apportionment across NHS Tayside, Perth and Kinross, Dundee, and Angus IJBs. She added that following on from this agreement the three Chief Officers and the new Depute Chief Executive Officer for NHS Tayside had together commissioned a piece of work to agree a shared financial recovery plan with a clear route for agreeing, monitoring, and delivering in line with the whole system change programme with a timeline already having been shared with the Programme Board on 13 March 2024.

Resolved:
The Board noted the position.

7.3 PERTH AND KINROSS INTEGRATION JOINT BOARD STRATEGIC PLAN 2024-2027

Z Robertson, Head of Adult Social Work and Social Care / Commissioning provided the Board with a short slide-based presentation on the Perth and Kinross Integration Joint Board Strategic Plan 2024-2027.

There was also submitted a report by the Head of Adult Social Work and Social Care / Commissioning (G/24/49) providing an update on the progress made to develop the Perth and Kinross IJB Strategic Plan for 2024-27.

M Black referred to the survey response rate highlighting that 75% of the responses submitted came from women and queried whether we need to target different groups to try and get more men to respond with the overall aim of getting more equity across the responses. In response, Z Robertson stated that this was an excellent point and something they would be looking into further.

Resolved:
(i) The progress made to date to prepare the Perth and Kinross Integration Joint Board Strategic Plan, as outlined in Report G/24/49, be noted.
(ii) It be agreed that the final version of the Perth and Kinross Integration Joint Board Strategic Plan be brought to the Board for approval in June 2024.

7.4 AUTISM/LEARNING DISABILITIES STRATEGIC DELIVERY PLAN UPDATE

There was submitted a report by the Chief Officer (G/24/44) providing a progress update of year two of the Autism and Learning Disability Strategic Delivery Plan 2022-2025.

Councillor Frampton referred to Paragraph 3.3 – Independent Living highlighting the number of units either in place or in the process of being brought into place are in Perth City and queried whether in future there would be more units identified in more rural areas such as Kinross, Pitlochry, and Dunkeld. In response,

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G Morrison confirmed that it was recognised several of the sites have been around Perth City and advised that there was some work currently underway in Aberfeldy and they would be continuing to work with colleagues in the Council's Housing department when new developments to try and identify opportunities to develop clusters within them.

M Black referred to Paragraph 3.11 and specifically on the comment that people with autism are nine times more likely to die by suicide than the general population and queried how these figures in the local consultation fares against national statistics. In response, G Morrison confirmed that this data was taken from the national statistics.

A Singh referred to the transition from children to adult services and queried whether any contact was being made with parents and carers throughout the transition period to seek their views on their experiences and whether we should be looking to strengthen parts of the pathways. In response, G Morrison confirmed that this was currently happening, but it is something they would like to get better at and through the work of the Family Group Decision-Maker this was something they were looking into.

Resolved:

(i) The progress to date on the Autism and Learning Disability Strategic Delivery Plan as detailed in Report G/24/44 be noted.

(ii) An update be provided to the Board in twelve months.

THERE WAS A SHORT RECESS AND THE MEETING RECONVENED AT 2.20PM.

8. FINANCE/AUDIT AND PERFORMANCE COMMITTEE

8.1 2024-27 BUDGET

There was submitted a report by the Chief Finance Officer (G/24/45) presenting the Perth and Kinross Integration Joint Board's proposed 2024/25 Budget and 2025/26 and 2026/27 Provisional Budgets.

The Chief Officer referred to the proposal on page 58 relating to the Review of Recent Investment (Hospital at Home Service) and advised that unfortunately this was not something that the Partnership wished to do but it comes forward as a proposal after considerable consideration of all other possible options. She further advised that this model was not sustainable in the current financial context and was brought as a proposal following a risk assessment which noted that it results in minimal impact to patients, service users and staff who will remain in the employment of the Health and Social Care Partnership and NHS Tayside. She also advised that along with the Head of Health she had met with the Hospital at Home Team on 19 March 2024 to provide assurance and support to them, where it was agreed that she would provide information to the IJB that the Hospital at Home team felt related to inaccuracies within the documents previously shared with the Board. She confirmed this was carried out by email to all IJB members prior to the meeting today.

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S Auld referred to the engagement with staff and acknowledged the very recent meeting that had taken place but sought some clarification on when the engagement process with staff commenced. She also referred to the comments in the report on re-assessment around care home beds and expressed concern that with the projections of the elderly population growing the IJB were perhaps in danger of making similar decisions as those in the past and that a more medium-term view would be more beneficial for the population. In response, the Chief Officer provided assurance that the meeting held on 19 March 2024 was not the first engagement held with staff with the first engagement taking place on 8 March 2024 in advance of the papers for this meeting being made publicly available.

J Jensen referred to the hospital at home model specifically the disadvantages being the need for weekends and the focus around Perth and queried how these challenges would be eradicated in the new community model. In response, E Devine advised that it would not be a hospital at home service it will be a locality model which will provide advanced practice which will integrate with district nursing, district nursing evening service, community AHP work and the ANP Service.

Resolved:

(i) The proposed 2024/25 Budget, as set out in Appendix 1 to Report G/24/45, be approved.
(ii) The expenditure pressures, as set out in Appendix 2 to Report G/24/45, be approved.
(iii) The savings and funding proposals, as set out in Appendix 2 to Report G/24/45, be approved.
(iv) The allocation of earmarked reserves towards the 2024/25 expenditure pressures, be approved.
(v) The use of general reserves to bring 2024/25 into financial balance, be approved.
(vi) The 2025/26 and 2026/27 Provisional Budgets and the additional work required to bring these years into balance, be noted.
(vii) Directions, as set out in Section 10 and Appendix 4 to Report G/24/45, to be issued.

8.2 AUDIT AND PERFORMANCE COMMITTEE UPDATE

Councillor S McCole, Chair of the Audit and Performance Committee provided the Board with a verbal update from the last meeting of the Audit and Performance Committee that had taken place on 11 March 2024.

Audit and Performance Committee of the Perth and Kinross Integration Joint Board – 11 March 2024

Following a request from M Black, the Clerk undertook to circulate a link to the recording of the meeting to M Black and B Hamilton for their information as both had been unable to attend the meeting on 11 March 2024.

The Board noted the position.

9. GOVERNANCE

9.1 UPDATE TO IJB RESERVES POLICY

There was submitted a report by the Chief Finance Officer (G/24/46) seeking approval of the reviewed and updated IJB Reserves Policy.

Resolved:

(i) The updated IJB Reserves Policy be approved.
(ii) It be noted that the Reserves Policy will be reviewed by December 2026.

9.2 UPDATE TO IJB FINANCIAL REGULATIONS

There was submitted a report by the Chief Finance Officer (G/24/47) seeking the approval of the reviewed and updated IJB Financial Regulations.

The Chief Finance Officer acknowledged that Appendix 2 - Current Financial Regulations (2016) which was circulated as part of the document pack for this meeting should have displayed the relevant tracked changes. She advised that a revised document including the tracked changes would be circulated to Members following the meeting.

Resolved:

(i) The updated IJB Financial Regulations be approved.
(ii) It be noted that the Financial Regulations will be reviewed by March 2026.

10. FOR INFORMATION

10.1 WORKPLAN 2024/25

Resolved:

The contents of Report G/24/48, be noted.

10.2 FUTURE IJB MEETING DATES 2024/25

Wednesday 5 June 2024 at 1.00pm
Wednesday 21 August 2024 at 1.00pm
Wednesday 2 October 2024 at 1.00pm
Wednesday 11 December 2024 at 1.00pm
Wednesday 19 March 2025 at 1.00pm

10.3 FUTURE IJB DEVELOPMENT SESSIONS 2024/25

Friday 24 May 2024 at 10.00am
Friday 16 August 2024 at 10.00am
Friday 25 October 2024 at 10.00am
Friday 20 December 2024 at 10.00am
Friday 24 January 2025 at 10.00am
Friday 21 February 2025 at 10.00am
Friday 14 March 2025 at 10.00am

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ACTION POINTS UPDATE

Perth & Kinross Integration Joint Board
5 June 2024
(Report No. G/24/65)

Ref.	Meeting	Minute Ref	Heading	Action Point	Responsibility	Timescale	Status
142	20/6/23	6.4	Primary Care Strategic Delivery Plan	IJB Development Session on Primary Care Strategies to be considered.	Chief Officer	29/11/23	This is arranged for 16 August 2024.
147	29/11/23	6.8	Notice by Victoria Practice, Glover Street Medical Centre, Perth to Cease Their Methven Branch Surgery Contract	A follow up lessons learned meeting to be held on the process followed in this and previous branch closures.	Chief Officer	16/8/24	This will be included in the Primary Care Strategies Development Session being held on 16 August 2024.
148	14/2/24	9.1	Chief Officer Strategic Update	IJB Development Session on National Care Service to be held.	Chief Officer	11/12/24	In progress
149	14/2/24	7.2	Tayside Mental Health Services: Strategic Update	Further Tayside wide development session to be held (virtual)	Chief Officer	30/04/24	In progress

PERTH AND KINROSS INTEGRATION JOINT BOARD

Wednesday 5 June 2024

3-YEAR WORKFORCE PLAN UPDATE

Report by Chief Officer
(Report No. G/24/66)

PURPOSE OF REPORT

This report provides an update on progress against the actions within the 3-Year Workforce Plan for Health and Social Care in Perth and Kinross.

1. RECOMMENDATIONS

It is recommended that the Integration Joint Board (IJB):
(i) Notes the progress in the implementation of the 3-Year Workforce Plan
(ii) Requests an update in 12 months

2. BACKGROUND

The 3-year Workforce Plan for the Perth and Kinross Health & Social Care Partnership (HSCP) was approved by the IJB in June 2022. The plan sets out what is required to have a workforce of the right size, with the right skills, in the right place, at the right time. The workforce challenges are significant and are not only being experienced locally but in health and social care across the country.

The plan sets out Partnership-wide actions as well as actions required at staff group level. It should be noted that there are several actions which are not directly within our control. Where this is the case, we will raise issues to the appropriate arena, regionally or nationally.

3. GOVERNANCE ARRANGEMENTS

A Workforce Steering Group has been established consisting of Service and Professional Leads for staff groupings, Human Resources, Trade Union and Scottish Care representatives. The group meets regularly to review the action plan, resolve issues as they arise and consider whether any revisions to the plan are required.

The Terms of Reference has been reviewed and revised April 2024. Regular updates are provided to the HSCP senior management team and to the Partnership Forum.

4. PROGRESS UPDATE

4.1 Following a review of the action plan, medium term actions/priorities have been identified and aligned to the 'Five Pillars of Workforce' (Plan, Attract, Train, Employ and Nurture) Appendix 1.

Directly reporting into the Workforce Steering Group, four subgroups have been established consisting of Service and Professional Leads and key stakeholders for staffing groups:

- Education and Development
- Safer Staffing
- Recruitment/Retention and Attraction
- Staff Health and Wellbeing

4.2 The Health and Care (Staffing) (Scotland) Act 2019 was enacted from 1 April 2024, along with the commencement of monitoring and governance with first Board reports due to Scottish Government by 31 March 2025.

To meet legislative requirements where there are speciality specific Staffing Level (workload) tools, these must be applied once per financial year as a minimum along with professional judgement following Common Staffing Methodology to support workforce planning. A pan NHS Tayside Staffing Level (workload) tool run schedule is in place along with a local programme of education and training to support teams.

4.3 A Workforce Planning Programme Manager commenced in post in February 2024, to work collaboratively to develop and implement the Workforce Plan across teams and services within Perth and Kinross.

4.4 A Locality Integrated Teams Working Group has been established consisting of Locality Managers and key stakeholders. The group is focussing on engagement with teams and implementation of Six Steps Workforce Planning Methodology, to ensure a consistent response to workforce requirements. Integrated Teams consisting of professions including Social Workers, District Nurses, Allied Health Professionals (AHP) and Older People's Mental Health Nurses will be implemented in sub-localities to increase effectiveness, efficiency and reduce duplication. These teams will support older people and people with a physical disability and/or long-term condition.

4.5 In the past 12 months the Band 4 Assistant Practitioner role has been developed and implemented.

There are now 4 Assistant Practitioners in post who are working on the development of their skills in Occupational Therapy, Physiotherapy and District Nursing assessments. This has been challenging, with no pre-existing framework or training plan but their role has already proved to be invaluable in

responding to the increasing complexity of people's needs in the community, supporting more integrated models of working and mitigating the impact of hard to fill AHP and Nursing posts

4.6 Advanced Practice is developing across Perth and Kinross HSCP. We continue to define the advanced practice role across all professional groups in relation to pillars of practice. We are standardising competency frameworks and connecting into the national streams to enhance this approach. We are currently developing a HSCP Primary Care Advanced Nurse Practitioner (ANP) competency framework to support this work.

There are currently 10.4 wte ANPs and 2 wte Lead ANPs working across the HSCP. ANP role development is fundamental to complimenting existing multidisciplinary teams, supporting the delivery of new models of care and enhancing integration and co-ordination between primary and secondary care.

4.7 Occupational Therapy and Physiotherapy services within the HSCP recently completed a workforce review exercise which involved data collection on activity for a period of two weeks. This data will be used to inform a redesign of the AHP model to maximise effectiveness and efficiency.

4.8 AHPs were invited to attend Succession Planning workshops delivered by colleagues from HR, to assist in adopting a proactive approach to staff retention whilst also providing development opportunities in preparation for career succession and service stabilisation.

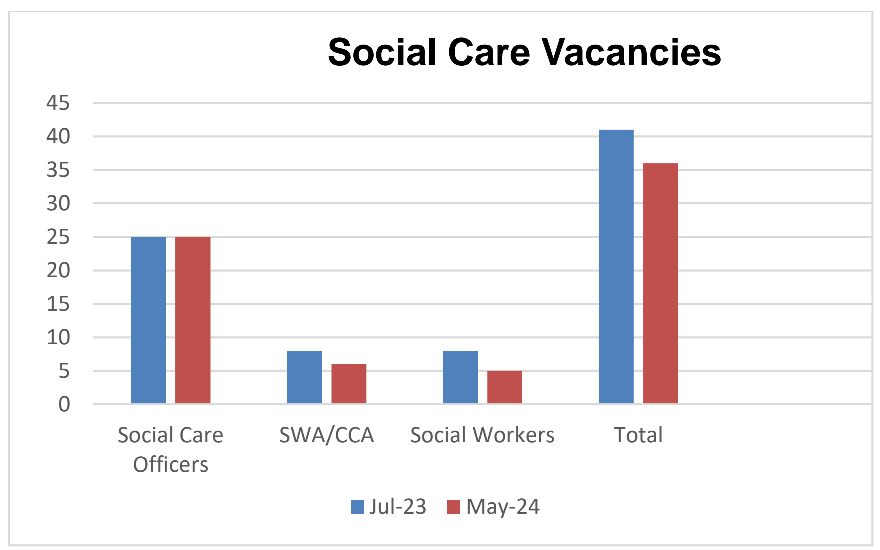
4.9 AHPs were invited to attend Succession Planning workshops delivered by colleagues from Human Resources, to help assist in adopting a proactive approach to staff retention whilst also providing development opportunities in preparation for career succession and service stabilisation.

4.10 A pan-Tayside data group has been established to co-ordinate and collate workforce information to meet the requirements of the Workforce Planning Groups and the local Workforce Strategies. This will ensure that data, analysis and benchmarks are available to support workforce planning by employers.

5. RECRUITMENT AND RETENTION

5.1 Social Care recently held a recruitment campaign which utilised multiple social media platforms and billboards, achieving a reach of 18,516, despite this, recruitment remains challenging.

Social Care vacancy data for internal posts shows a slight decrease in vacancies between July 2023 and May 2024 from 41 to 36.



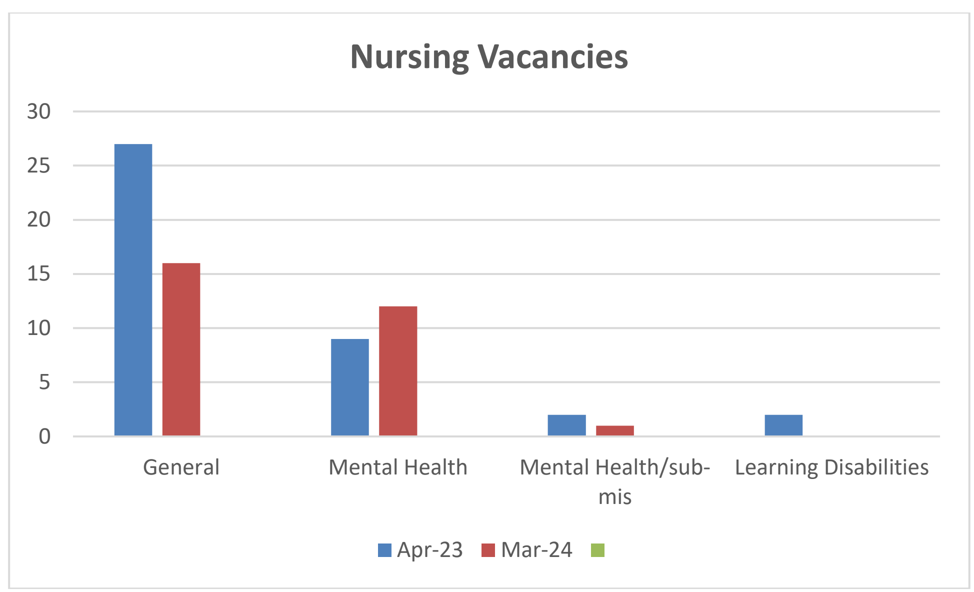
5.2 To meet the change in registration requirements for Newly Qualified Social Workers (NQSWs) from October 2024. Perth and Kinross HSCP have been one of the ten national early implementation pilot sites to test the NQSW Supported Year Framework and to evaluate its impact. At the time of applying to become a pilot site in 2021 Perth and Kinross HSCP had 13 NQSW's which has increased to 25. Funding has also successfully been secured from SSSC for Learning and Development hours within Children, Families and Justice Services to support wide implementation of the framework.

5.3 Perth and Kinross HSCP is participating in a national project being delivered by NHS Education for Scotland's Centre for Workforce Supply Social Care, Scottish Government, COSLA and Social Care Providers to identify opportunities to internationally recruit Social Care Workers. Six staff have been recruited from the Philippines and are arriving shortly. This experience has helped develop an ethical pathway for overseas recruitment which can be used in future if required.

5.4 To support workforce retention and recruitment both internal and commissioned Care at Home providers have embraced the 'What Matters to You' approach to support and encourage meaningful conversations and encourage positive behaviours between staff. Following extensive consultation with teams, improvement plans have been created to improve relationships and ensure development ideas from staff are heard and acted upon.

5.5 Combined, these actions across the Statutory and Independent Sectors have reduced the number of Care at Home hours of unmet need from 1,500 to 1,000 per week.

5.6 Nursing vacancy data shows a decrease in vacancies between April 2023 and March 2024 from 40 to 29.



5.7 Perth and Kinross HSCP will welcome and support 28 Newly Graduated Practitioners into inpatient and community teams, including for the first time Community Mental Health and Prisoner Healthcare.

5.8 Agency and bank nursing usage is monitored and shared weekly with Locality and Service Managers. This data is cross referenced against our vacancies, again to highlight hotspots in our services and provide mitigation in those areas that require high usage of bank and agency coverage. The Health and Care (Staffing) (Scotland) Act 2019 requires all health boards to report quarterly to the Scottish Ministers on the use of high – cost agency staff. This first report submission is due 31st July 2024.

5.9 There are currently 10 wte Occupational Therapy (OT) vacancies. This is a significant increase since May 2022 when the service was fully staffed. This is due to a number of issues including some vacancies being held to provide opportunities for redeployment. A whole system redesign of the operational model is proposed.

6. CONCLUSION

There has been significant progress in implementing the 3-Year Workforce Plan and the actions have had a positive impact in reducing the impact of vacancies. However, we continue to experience significant challenges regarding workforce. Progressing the actions are crucial to ensuring that we can deliver our Strategic Plan priorities and support the people of Perth and Kinross.

Author(s)

Name	Designation	Contact Details
Kenny Ogilvy	Interim Head of Adult Social Work & Social Care	tay.pkijbbusinesssupport@nhs.scot

Tracy Hunter	Workforce Planning Programme Manager	tay.pkijbbusinesssupport@nhs.scot

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

Annexe

1. IMPLICATIONS, ASSESSMENTS, CONSULTATION AND COMMUNICATION

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

1. Strategic Implications

Strategic Commissioning Plan

1.1 The development of the 3-Year Workforce Plan 2022: 2025 has been underpinned by the IJB Strategic Plans for Older People, Learning Disabilities/Autism, Community Mental Health & Wellbeing and the Primary Care Improvement Plan.

2. Resource Implications

Financial

2.1 Implementation of strategic and operational actions set out in the plan are monitored and regularly reviewed to determine where it may be necessary to provide investment in the short term to increase the sustainability of the workforce for the longer term.

Workforce

2.2 The report provides an update on the 3-Year Workforce Plan as previously set out and the review of short-medium term actions.

3. Assessments

Equality Impact Assessment

3.1 Our Workforce Plan was prepared taking account of our duties to promote equalities and human rights. It includes action to promote our public sector equality duties and to provide appropriate support for people who are protected under the Equality Act. This includes people with protected characteristics within our current workforce and also to attract people with protected characteristics to take up work in health and social care who might not otherwise consider or be able to pursue a career in this sector. The following are some of the actions which have been assessed as relevant with positive outcomes expected following implementation:

- Improving our equalities data
- Advancing equality of opportunity and inclusive workplaces
- Developing non-registered roles and career pathways to support people into a career in health and social care
- Developing young workforce initiatives to make working in health and social care an attractive career option for young people
- Considering flexible working opportunities
- Ensuring competitive rates of pay for social carers employed in the Third and Independent sector

Risk

3.2 The IJBs Strategic Risk Register identifies insufficient workforce as a red risk. The implementation of our 3-Year Workforce Plan is the key improvement action required to mitigate this.

4. CONSULTATION

Internal

The Workforce Plan has been developed through several working groups representing the range of professions in the HSCP. The plan has been discussed and commented on in a range of locality and professional fora including the HSCP Staff Partnership Forum. Trade Unions have also had the opportunity to comment.

2. APPENDICES

Appendix 1: 5 Pillars Workforce Plan

Appendix 1

Summary of Short-Medium Term Actions across the Five Pillars of Workforce

Plan	Attract	Train	Employ	Nurture
To meet the terms of Health & Care (Staffing) (Scotland) Act 2019, speciality specific Staffing Level (workload) tools should be used annually alongside the application of Common Staffing Methodology (CSM) Set up systems and processes for gathering and reporting workforce data for planning and monitoring purposes. This should	Review recruitment and retention pathways in Health and Social care Continue to develop and explore new models of employment into health and social care roles Increase the number of employment programmes such as foundation, modern and graduate apprenticeships, 'earn as	Engage with all partners including Higher Education, Local Colleges, Practice Professional Developments, NHS Education in Scotland, and the Scottish Social Services Council (SSSC) to ensure a comprehensive approach to training at all levels, with new developments/programmes aligned to strategic priorities and service design	Develop succession pathways that reflect integration Review skill set, roles, remits within the workforce 'right staff, right skills, right place, right time' Review measures to support retention of staff in Health and Social Care	Develop current/future leaders by supporting the implementation of Excellence in Care and Leading Excellence in Care Framework across HSCP Implement learning from our workforce from 'What Matters to You' Continue to provide and encourage learning and development for new ways

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include the necessary preparation to introduce real time staffing data collection, risk escalation and mitigation across HSCP, Third and Independent sectors	you learn', Princes Trust including in the third/independent sector Targeted recruitment with young people in schools/youth groups through engagement with key stakeholders. Further explore international recruitment programme to attract overseas workforce	Continue to promote and grow new roles such as Advanced Practice and Band 4 Health Care Support Workers Develop career pathways and succession planning to create a culture of continuous improvement and development 'grow our own'	Continue to work in partnership with employers across statutory, third and independent sector	of working across the partnership

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Sub-Working Groups

Education and Development	Safer Staffing	Recruitment/Retention/ Attraction	Staff Health and Well-being
Pillars: Attract, Train, Employ, Nurture **Remit/Actions:** • 'Grow our own' undertake training needs analysis • Review job descriptions • Develop/implement succession planning pathways • Further development of roles • Continue to develop advanced practice roles • Ensure mandatory training undertaken • Robust induction for new staff	**Pillars:** Plan, Attract, Train, Employ, Nurture **Remit/Actions:** • Implement Staffing Level Tools annually as per legislation • Implement Common Staffing Methodology where applicable • Develop Standard Operating Procedures (SOPs) to support governance and legislative reporting requirements • Roll out of e-rostering and SafeCare across professional groups	**Pillars:** Attract, Train, Employ, Nurture **Remit/Actions:** • Review of recruitment and retention pathways • Are exit interviews completed • Explore new models of employment into health and social care roles • Engage with schools, youth groups (Youth Academy) • Explore other avenues such as Princes Trust, earn as you learn schemes with partner organisations	**Pillars:** Train, Employ, Nurture **Remit/Actions:** • Staff participate in I Matter/What Matters to You • Promote well at work and other services • Health and Well-being champions • Focus on positive stories and shared learning • Implementation of Leading Excellence in Care Framework • Implementation of Succession Planning Toolkit

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• Completion of annual appraisals • Clinical supervision/restorative supervision	• Develop local decision-making processes and recording mechanisms for any disputes • Ensure all staff aware of Health and Care (Staffing) (Scotland) Act 2019 through programme of education • Develop a reporting structure/process following staffing level tool runs • Engagement with Care Inspectorate	• Explore international recruitment further across HSCP	

DRAFT

PERTH & KINROSS INTEGRATION JOINT BOARD

5 June 2024

PERTH AND KINROSS INTEGRATION JOINT BOARD STRATEGIC PLAN UPDATE 2024 – 2027

Report By Chief Officer
(Report No. G/24/67)

PURPOSE OF REPORT The purpose of this report is to seek the IJBs approval of the refreshed Strategic Commissioning Plan.

1. RECOMMENDATION(S)

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

- Approves the final version of the Perth and Kinross IJB Strategic Plan as set out in Appendix 1.
- Agree that directions in relation to the Strategic Plan are delivered via the mechanism of Delivery Plans.

2. SITUATION/BACKGROUND

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; and

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

A review may result in the integration authority making any necessary changes by replacing its strategic commissioning plan.

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.

3. Joint Strategic Needs Assessment

We undertook a Joint Strategic Needs Assessment over the course of 2023 with its purpose being 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, to create a picture of service needs now (and in the future) to support the decision-making process within the Partnership and underpin the need for more integrated working.

The findings from the JSNA are not entirely unexpected and articulate what we know to be areas of significant demand now and as we move forwards see Appendix 2. By way of high-level summary and overview, see the underlying:

- The majority of Perth and Kinross population live predominantly in a rural area 67.8% with 32.4% living 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, the North and South localities face greater challenges in relation to an ageing population.

- Perth and Kinross have a smaller proportion of people of working age compared to Scotland as a whole, and this is likely to continue.
- In P&K council, the split in registered carers is generally a third in each locality, with both 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.
- 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 *(this is National data; local data is not available).*
- 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 hosts most of the deprivation within Perth and Kinross with five areas' being within most deprived Quintile (SIMD1) equating to 16.1% an increase of 2.6% since 2016
- Perth City also hosts the most affluent proportion of the population with 27% of people living in the least deprived Quintile (SIMD5) an increase of 1.3%.
- When the SIMD is broken down by domain over of 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 ageing population will change demand for housing. They are also more likely to live alone and to be under-occupying homes, increasing the risk of isolation and loneliness.
- Perth City Locality has more people suffering alcohol and drug related harms and ill health than the other PKHSCP 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.
- Falls are the most common reason for admission to hospital.
- In Perth and Kinross, the leading cause of death for females in 2021 was Dementia and Alzheimer's disease (11.1% of all female deaths) and was the second leading cause for males (7.7%). Projections estimate an extra hundred cases year in year.
- Perth city locality have the highest number of unscheduled bed days. Most of the unscheduled beds are for the over 65 age group, but Perth City has the lowest over 65 demographics in comparison to the North and South locality.
- Post Covid there has been an increase in Delayed Discharge across all localities with Perth City returning to pre-2017 levels.
- 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.
- Projections indicate a requirement for an increase in Care Home placements year on year.

4. Consultation and Involvement

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 committed 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.

In undertaking the consultation on the Strategic Commissioning Plan (SCP) for Perth and Kinross HSCP, we applied the 7 National Standards for Community Engagement (2016) https://www.scdc.org.uk/what/national-standards and were guided by 'Planning with People' (Community engagement and participation guidance) https://www.gov.scot/publications/planning-people/ which clarified our responsibilities in relation to Community Engagement and involving people meaningfully.

The aims of the consultation on the strategic commissioning plan were to:

- Involve people in shaping the future of health and social care services.
- 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?
- Provide a range of opportunities for people to engage with the consultation on the development of the strategic plan.

To maximise public involvement and participation a mixed approach to engagement was adopted. By using both quantitative and qualitative methods it provided a more comprehensive and holistic understanding of the issues, needs and experiences of individuals and communities. To ensure that a wide range of voices was heard, a participation programme was agreed which offered participants a range of accessible opportunities to engage, locality drop in events, targeted focus groups and an online survey.

A bespoke animated video https://www.youtube.com/watch?v=b4h9PRfqRcM "Planning a Better Future Together - Have your say" was prepared and distributed to 944 community groups/people and 70 key stakeholders and highlighted through social media channels, with a reach of 85,000 followers. The Community Engagement Team distributed 378 posters throughout our three localities and to support accessibility we developed an easy read detailing the locality drop in sessions https://www.pklearning.org.uk/Planning-A-Better-Future-Together-Easy-Read/

Targeted Focus sessions supported the involvement of groups with protected status and people who are excluded from participating due to disadvantage relating to social or economic factors and received over 163 responses from 12 sessions.

An online survey provided an additional method and did not require attendance in person, with 366 responses.

Key Themes

Following the collation of data from all localities Drop ins, Questionnaires and Targeted Focus Group sessions, the following information was recurringly articulated and was highly pertinent to the formation of our new Strategic Commissioning Plan.

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

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

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

60% access and distance to services was a challenge for them
30% knowing where to go was a challenge for them
38% said finding the time to attend was a challenge
25% access to information was a challenge
24% finance or money was challenge for them
12% said need to support to attend was a challenge
15% said that the relationship they had with professionals was a challenge
20% said their caring responsibilities created a challenge for them
20% said transport was a challenge for them

We asked how you feel about the support or service you accessed in the last 12 months, and then further if you were dissatisfied, what were the reasons. 49% of participants said they were either satisfied of very satisfied with a further 20% saying they were neither satisfied nor dissatisfied. 14% specifically commented that they were dissatisfied or very dissatisfied with 18% not answering.

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.

People were clear that they wanted to be involved in the planning and design of how services are delivered.

Of the 14% who were dissatisfied 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.

Workforce Feedback

We used our August 2023 Strategic Planning Group meeting to coordinate a Workforce Consultation event, where staff had the opportunity to convey their worries and wishes for the future of the Health and Social Care Partnership.

The workforce identified key themes when they were asked to consider “What Matters to You”.

1. Increased integration of services to support partnership working leading to improved service delivery.
2. Ensure we have the right services, in the right place and people know how to access them.
3. We need to consider a range of approaches to improve time efficiency for social care workers moving between appointments.
4. Continuous feedback is important and valued by the workforce.

Joint SPG/IJB consultation

A joint session in September offered the opportunity for the Strategic Planning Group and Integrated Joint Board membership to consider high level information gathered from both the JSNA and the Consultation activity and to gather further feedback that would inform the refreshed plan.
Examples of Strategic Commissioning Plan Priorities from across Scotland were provided, and members were asked to consider which priorities they felt were valuable and therefore what should be in our Strategic Commissioning Plan.

An update paper was brought to the November 2023 IJB which proposed that the data gathered via the Joint Strategic Needs Assessment, combined with existing intelligence including the Public Health Annual report, our Locality profiles, consultation feedback gathered during the formation of delivery plans and strategies and the feedback from our Communities, Workforce and Joint IJB/SPG session consultation was now used to develop a first draft of our Strategic Commissioning Plan and that we bring this to the IJB meeting scheduled for the 20th February 2024.

The Strategic Planning Group met 8/3/24 to discuss the first draft, each Priority within the plan has been considered and a range of comments have

been collated and will be applied to the plan. The group were very positive regards the first draft, the group felt the language used was accessible and that they could hear the voices of our community throughout the document. Comments gathered were wide ranging and encapsulated multiple of aspects of delivery that they would like to see strengthened in the final draft. Examples of comments made were that the group would like to see a more explicit reference to:

- The input from Third Sector Partners
- Technology Enabled Care
- Extreme rural focus
- Supporting carers with their role when someone is discharged from hospital
- Only telling your story once
- Iterative community engagement
- Shared resources/assets
- Transitions at all points in life
- An ask for a pictorial representation of what good looks like/case study
- Continued Learning and Development support for our Care at Home and Care Home sectors
- Good practice examples from the Third sector
- Training for our workforce in specialist areas of delivery more widespread

A first draft was presented to the IJB in a development session and subsequently an abbreviated presentation was delivered to the Integrated Joint Board on the 20th of March, and with agreement that a final draft would be brought to the June meeting.

5. CONTENT OF PLAN

The vision of the plan 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 will risk over promising and under delivering.

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.

The plan opens by articulating 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 and doing the things that matter most to them.*"

The plan describes its statutory responsibilities within the Public Bodies (Joint Working) (Scotland) Act 2014, on Integration Authorities, either Integration Joint Boards or Health Boards and Local Authorities acting as lead agencies to create a strategic plan for the integrated functions and budgets that they control.

The plan moves on to articulate our priorities, ambitions, and underpinning principles of Early and Intervention and Prevent, Person Centred Approaches and Best Value:

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

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

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.

The priorities are applicable to us all no matter what type of service we are accessing, and 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 three years.
Each of the seven priorities are codependent on one another, 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.

The plan provides a high-level overview of our population profile, with the full Joint Strategic Needs Assessment and an overview of our Community Consultation, both included as an appendix to the plan.

The Plan describes how it is supported by our linked transformational projects, whose objectives are to transform services to meet current and future demands and how 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.

We have referenced our use of the National Framework for Community and Social Care Integrated Services to inform the development of our transformation plans, and to measure performance by assessing the extent to which the characteristics within the Framework are evident in local services.

The plan discusses Performance Measurement, our statutory obligations, including our duty to measure the progress we are making against the 9 National Health and Wellbeing Outcomes, but have also referenced the Public Health Strategyhttps://publichealthscotland.scot/our-organisation/a-scotland-where-everybody-thrives-public-health-scotland-s-strategic-plan-2022-to-2025/ and our commitment to ensuring we play a part in the successful delivery of these priorities. We further go on to discuss local arrangements, and our intention to publish a Performance Framework in 2024.

6. FINANCIAL IMPLICATIONS

There are no financial implications arising directly from this report however financial implications will continue to be considered on an annual basis and as the strategy develops.

The 2024/25 budget and 2025/26/27 provisional budget was approved by the IJB in March 2024. Recognising the significant gap within the provisional budgets for 2025/26 and 2026/27, the Budget Review Group will continue to meet throughout 2024/25. It will consider additional funding solutions and reductions in expenditure required and how this can be achieved with minimal impact on the strategic plan and to the population's health and care needs. The proposed 2024/25 budget has been developed and considered with IJB members via Budget Review Group meetings held in January & February and at Budget Development Sessions on 12 December 2023 and 23 February 2024.

7. CONCLUSION

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

We ask that the plan is approved by the IJB and agree that directions in relation to the Strategic Plan are delivered via the mechanism of user Delivery Plans and or Strategies.

Updates on the implementation of the plan will be provided via our Annual Performance Report and updates on our delivery plans, strategies, and transformation projects.

Author(s)

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

ANNEX

1. IMPLICATIONS, ASSESSMENTS, CONSULTATION AND COMMUNICATION

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

1. Strategic Implications

Strategic Commissioning Plan

1.1 This report is a refresh of the existing Strategic Commissioning Plan.

2. Resource Implications

Financial

2.1 As referenced in the body of the report. There are no financial implications arising directly from this report however financial implications will continue to be considered on an annual basis and as the strategy develops.

Workforce

2.2 Workforce Implications will follow during the implementation of the plan

3. Assessments

Equality Impact Assessment

3.1 Equality Impact Assessment completed.

4. Consultation – Patient/Service User first priority

External & Internal

4.1 A full external and internal consultation process has been carried out and has underpinned the writing of this report and the Draft IJB Strategic Plan.

Impact of Recommendation

4.2 No adverse impact considered.

5. Legal and Governance

5.1 There are no known legal implications.

6. Directions

Directions in relation to the Strategic Plan are delivered via the mechanism of user Delivery Plans or Strategies.

7. Communication

7.1 A full communication plan will follow.

2. BACKGROUND PAPERS/REFERENCES

No background papers

3. APPENDICES

Appendix 1: Strategic Plan
Appendix 2: JSNA

Appendix 1

IJB Strategic Plan 2024 -27

AMBITION

COMPASSION

INTEGRITY

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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

- By intervening early.
- By working efficiently and achieving best value.
- By providing outstanding Health and Social Care Support.
- By supporting people to live their lives better, on their terms.
- By ensuring we improve wellbeing (social, emotional, physical and mental health).
- By creating simple pathways, clear points of entry to an integrated offer from Health and Social Care.

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;

Compassion Integrity

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.

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	**Health**	**Hospital**	**Pan Tayside**

• 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
	• 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
		• 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
			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.

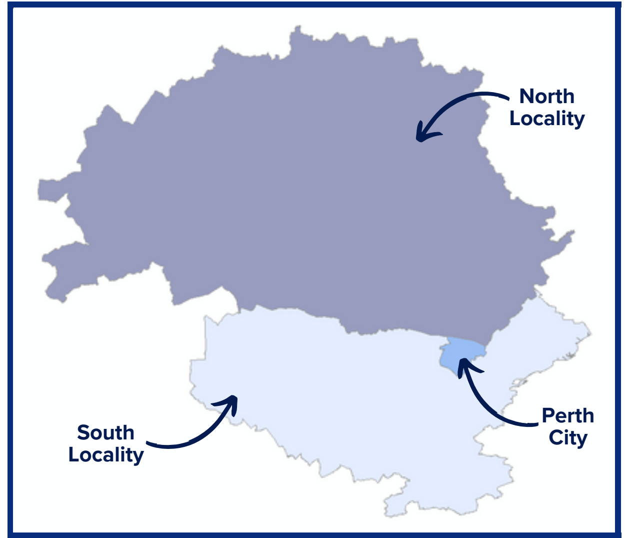
Population

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

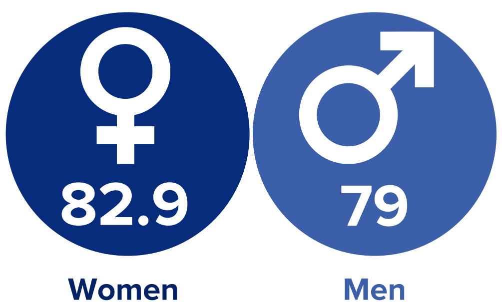
65+ (%) in each locality

North - 26%

City - 22%

South - 24%

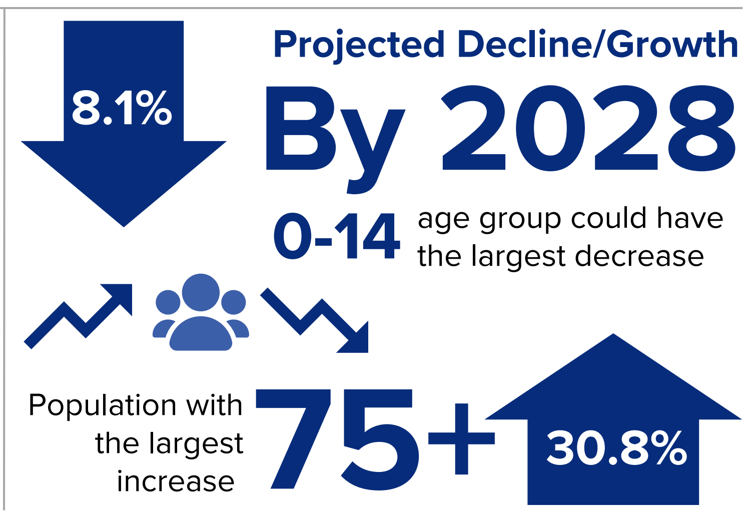
Average Life Expectancy



Women **Men**

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

Projected Decline/Growth

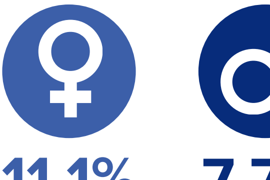


By 2028

0-14 age group could have the largest decrease

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

Dementia



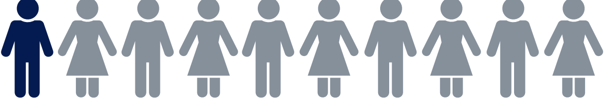
11.1% 7.7%

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:

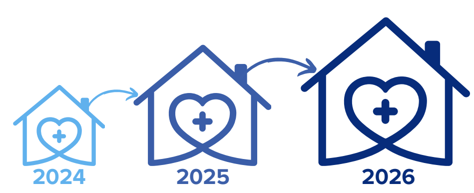
- Cancer
- Arthritis
- Coronary Heart Disease
- Asthma
- Diabetes

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.

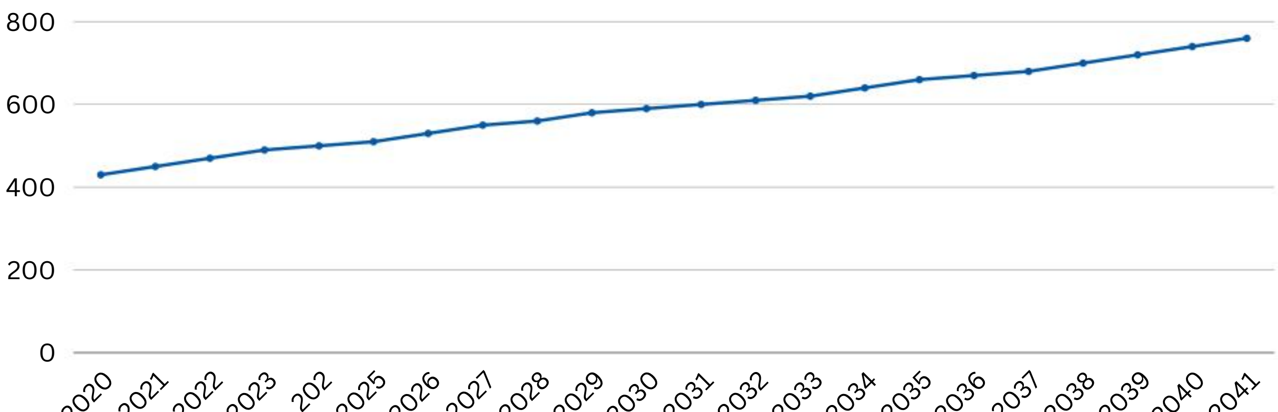


The life expectancy of people with learning disabilities is increasing, however it remains shorter by some 20 years.

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.

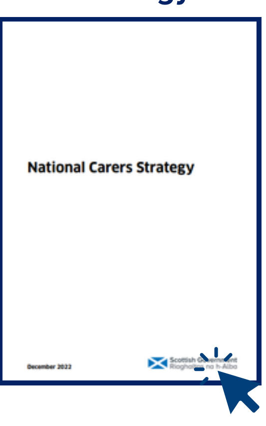
C3 Carers are supported to have a life alongside caring, with their emotional/physical wellbeing supported by flexible and personalised support.

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.

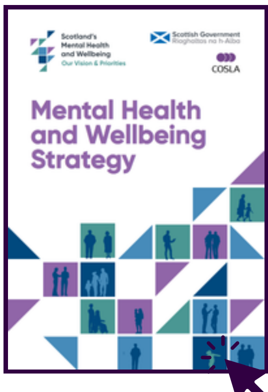
LDA5 Improved access to quality and meaningful employment opportunities.

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

Related National Strategies

Mental Health and Wellbeing Outcomes

Related National Strategy



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.

Older People Strategic Outcomes

Related National Strategy

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.

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.

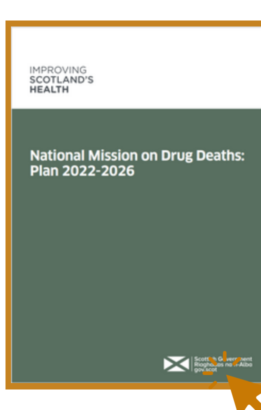
SU3 People at most risk have access to treatment and recovery.

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."

"Less red tape. Less tick boxing."

"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."

'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."

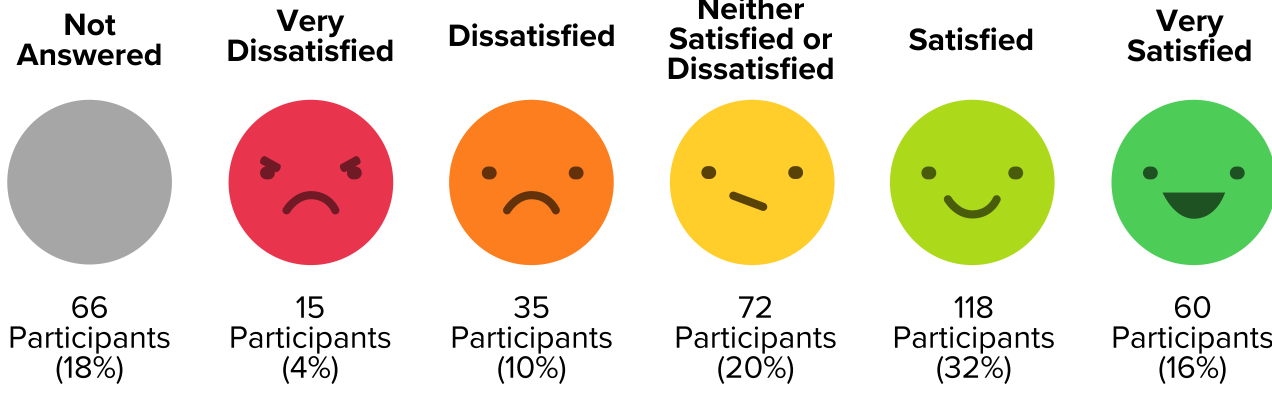
"There needs to other options rather than digital only. Repeat prescriptions are ordered online but some of them aren't online and other options aren't given."

"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:

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.

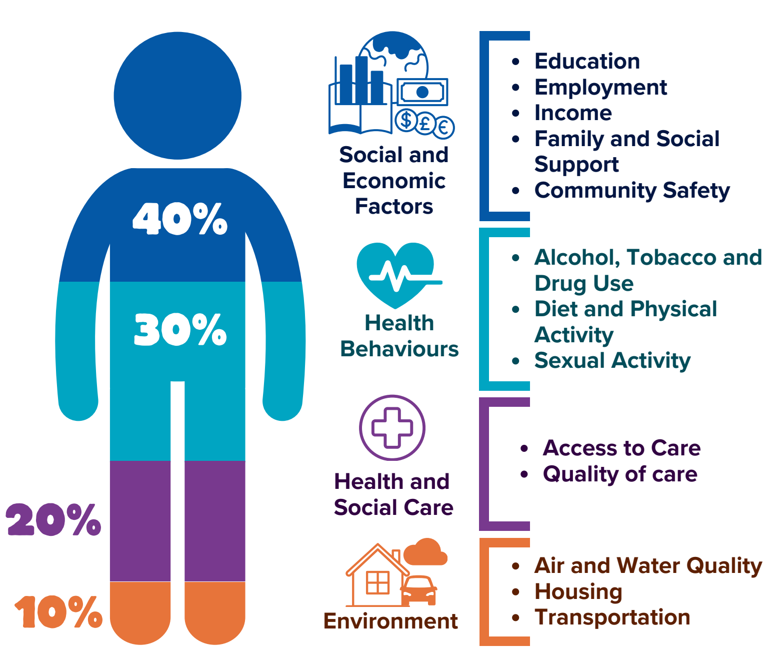
Target resources to where people and communities need help most.

Why is this a priority for us?

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)

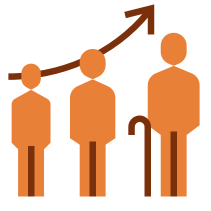
equating to **16.1%** of the population, **2.6%** since 2016.

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.

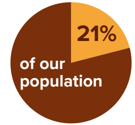


The more complex the condition the lower the median age of death.

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.

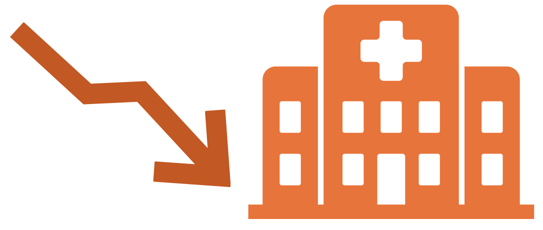
In Perth and Kinross, we have 37 data zones classed in the 10% most access deprived category in Scotland, including Rannoch and Aberfeldy, which is judged to be the most access deprived data zone in the whole of Scotland. These 37 data zones represent,



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?

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.

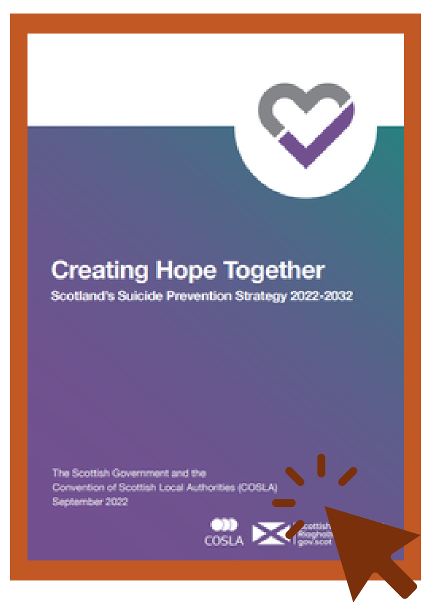
The first set of actions were to produce the graphics and messaging then have them displayed in a range of ways to allow maximum optics.

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.



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:

Perth and Kinross area = 5,286km^2

2,041 square miles

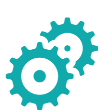
29 people per km^2 in comparison to the Scottish average of 70

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

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Measurable outcomes

C1	C6	C4	C6	MH3
OP2	OP7	PC1	PC3	SU3

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.

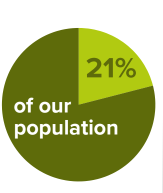
60.2% **Perth and Kinross**

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

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.

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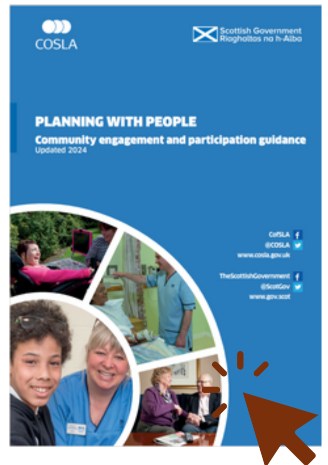


Measurable outcomes

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.

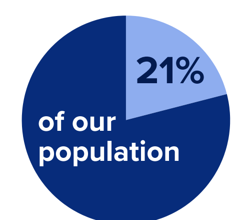
Integrated community teams based in neighbourhoods or localities are a core element of our care models being developed in Perth and Kinross. Integrating our core locality teams involves providing a multi-disciplinary response by GPs, Advanced Nurse practitioners, district nurses, physiotherapists, occupational 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

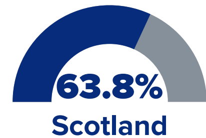
our North and South localities face greater challenges in relation to this ageing population.

Falls are the most common reason for admission to hospital.

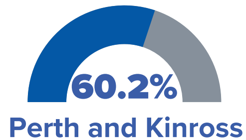
Dependency ratios (the number of people over the age of 65 per 100 people below the age of 65) are higher across the North locality followed by the South locality and with Perth City having the lowest dependency ratio.

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.

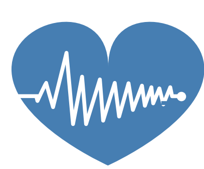


Scotland



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

What will we do to improve?

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

LDA2 | MH3 | OP3 | OP4

PC2 | PC4 | SU1 | SU4 | SU6

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:

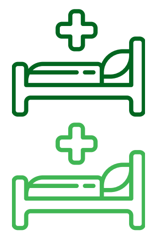
Cancer	Arthritis	Coronary Heart Disease	Asthma	Diabetes

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).

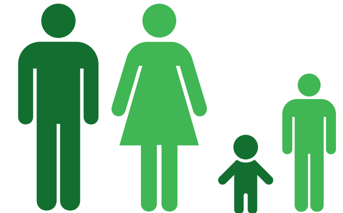
Of this population group, **17%** of those under the age of 65 were living with more than one LTC compared to **50%** of those aged **over 65.**

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.
- People experience quicker access 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.

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.

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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:

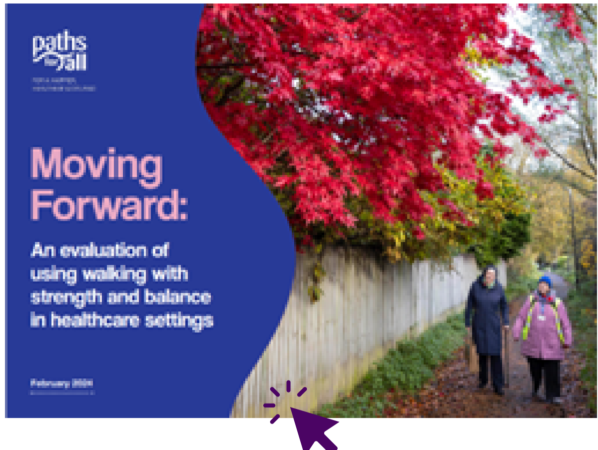
- Care homes,
- Care at home,
- Hospitals.

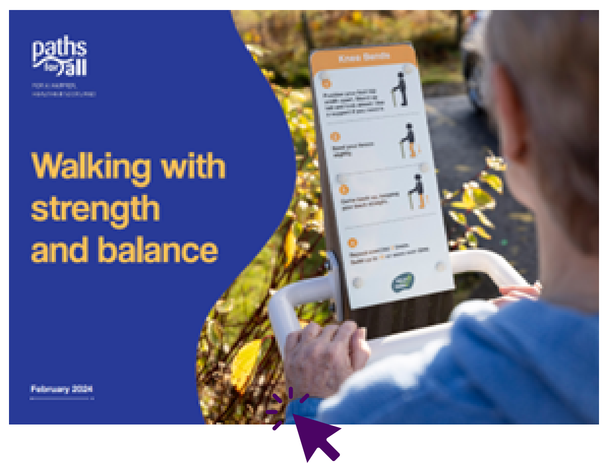
The aim of the evaluation of the walking with strength and balance programme is to:

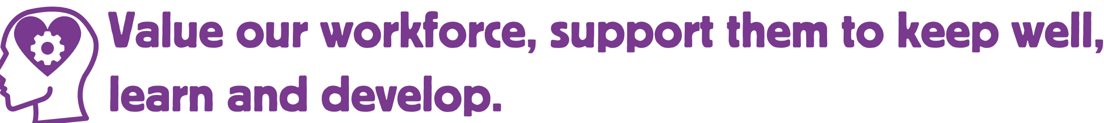
- Summarise the timeline and development.
- Identify key drivers and enablers which supported the development of the programme.
- Identify the challenges and difficulties.
- Share success stories.

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.







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:

Employed Staff Age Profile

Age	Health	Adult Social Work & Social Care
<25	40	33
25-34	197	101
35-44	229	132
45-54	338	205
55-59	195	105
60+	90	82

Female	1,529 (88%)
Male	218 (12%)

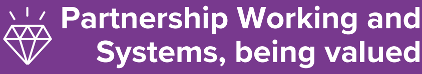
Part Time	911 (52%)
Full Time	836 (48%)

Third & Independent Sector Age Profile

Age	Care Homes (Private & Voluntary)	Care at Home/ Housing Support (Private & Voluntary)
Unknown Age	150	70
<25	200	110
25-34	330	210
35-44	300	170
45-54	330	210
55-59	340	260
60+	70	50

Our consultation with our workforce told us:

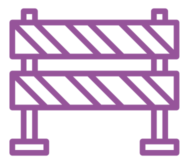
Main Wishes



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.

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.



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

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

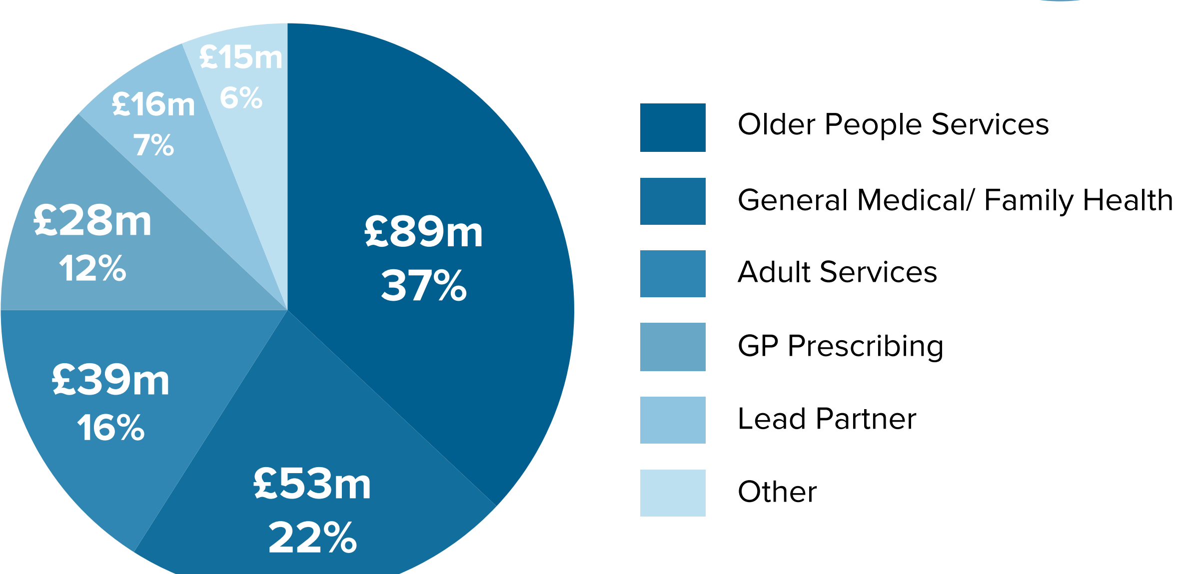
Perth and Kinross IJB commission a range of health and adult social care services. These services are funded through budgets delegated from both Perth & Kinross Council and NHS Tayside.

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

Total HSCP Budget = £239m

£82m
34%
£157m
66%

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."

Joint Strategic Needs Assessment

Perth & Kinross

Perth & Kinross Health & Social Care Partnership

February 2023

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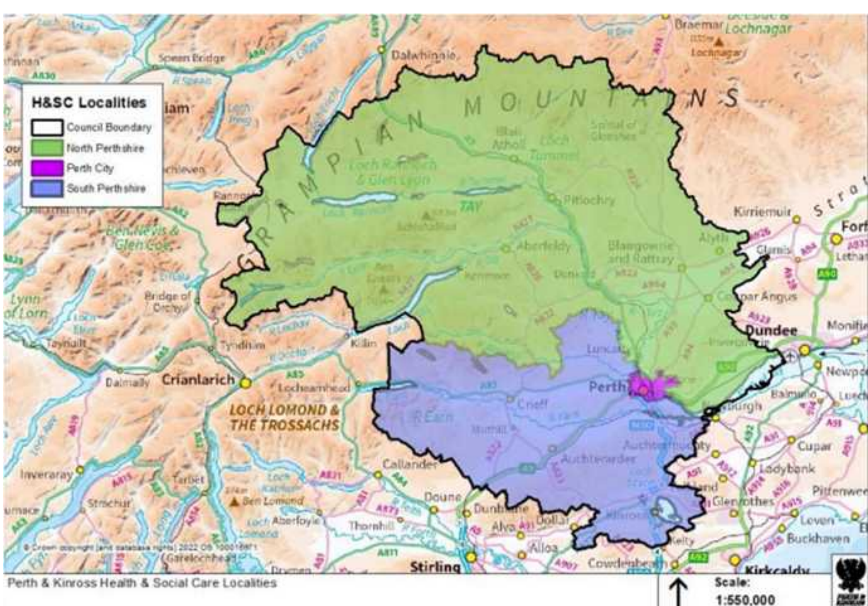
1 INTRODUCTION

1.1 Background

In order for the Strategic Commissioning team within Perth & Kinross Health and Social Care Partnership (PKHSCP) to commission and deliver services that best meet the needs of its local communities now and in the future (and to be able to intervene at an early stage to address emergent health problems), we need a clear understanding of the health and social care needs of our local population.

The purpose of this Joint Strategic Needs Assessment (JSNA) is to provide this clear understanding. It brings together information and data (both qualitative and quantitative) on the health and care needs of the adult population of Perth & Kinross in one place, to create a picture of service needs now (and in the future) to support the decision making process within the Partnership and underpin the need for more integrated working.

Map 1 : Perth and Kinross Localities



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There are three locality areas within Perth & Kinross – North Locality, South Locality and Perth City Locality – with variation in population density and socioeconomic circumstances, population patterns of health and wellbeing, and use of (and experiences of using) health and social care services; there is a need to understand more about this to plan services and support effectively and sustainably. Where possible, the data in this report will reference the three localities individually to better highlight the similarities and differences between them; in turn, these will influence planned service provision.

1.2 Existing Local and national strategies

This JSNA is an evidence based document, underpinned by a range of national and local strategies and policies. The local strategies referred to are the result of partnership consultation and working, and this document is not intended as a replacement or revision of them. Where appropriate, however, more up to date data and information are referenced, where these have become available since the strategies and policies referred to were published; this is particularly relevant for documents which reference 2011 Census data and / or National Records of Scotland mid-year population estimates.

1.2.1 National strategies / policies

A mapping exercise to define the themes foregrounded in national strategy documentation (Appendix 1) identified a strong focus on healthcare provision, including access to healthcare for those living with long term conditions, disabilities and frailty as they age. The focus on social care was less well defined, with few suggestions around how to support older people to remain engaged with their communities; although there is a lot of good work being undertaken at local level across Scotland to support people to get out and about socially and to mitigate the worst effects of poverty and the cost of living crisis, this is not well reflected in national strategic documents. Interestingly, the national strategies do not explicitly commit to making social care a well remunerated and satisfying career path; nor do they touch on the need to utilise scarce resources in an effective, sustainable, equitable and person centred way.

1.2.2 Local strategies / policies

A mapping exercise to define the themes foregrounded in local strategic documentation (Appendix 1) found a much stronger focus locally on the patient point of view, and in particular the need to recruit and retain engaged and well-motivated staff to ensure service sustainability. There is also a strong focus on prevention, early intervention and integrated working to support people to live independently at home, and – if they are unwell – to treat them as close to home as possible in non-acute settings where this is appropriate. People are supported to remain active in their communities, taking part in activities that interest them and retaining and strengthening their social connections. Underpinning all of this is a strong focus on how services can be developed, adapted and enhanced to ensure they are available and accessible at the point of need.

1.3 Next steps

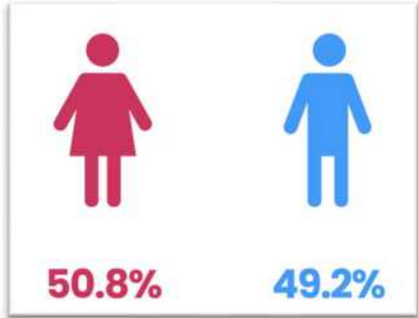
To support the Strategic Commissioning Plan (SCP), this needs assessment has to be sufficiently broad as to reflect the entire system of adult health and social care, yet succinct enough that the key messages are easily understood.

The first draft of the SCP document will be subject to a consultation process; feedback and comments from the consultation process will be incorporated into the next draft. The vision of the Strategic Commissioning Plan is to support our population to lead healthy and active lives, and to live as independently as possible, with choice and control over their support.

2 DEMOGRAPHICS

2.1 Current population

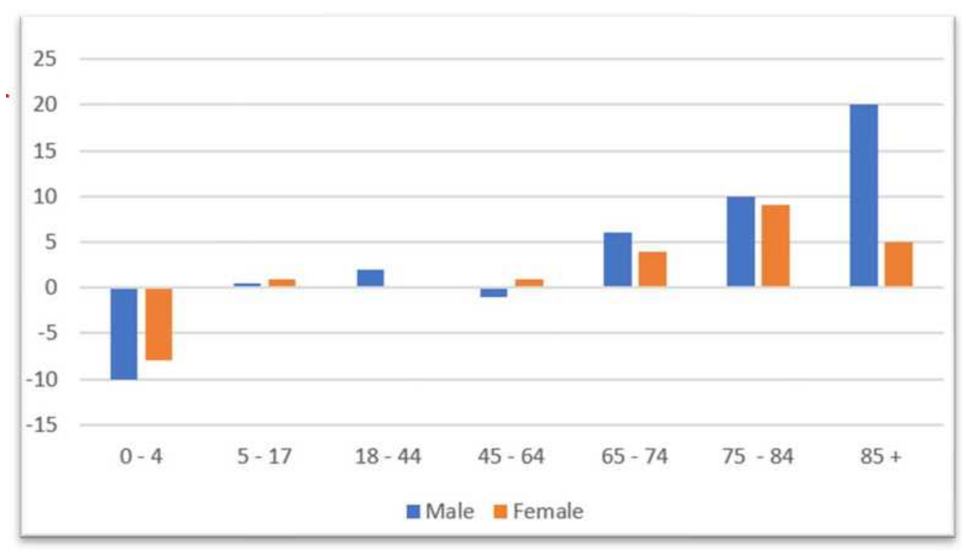
Figures provided by Public Health Scotland indicates Perth and Kinross population is **153,810.**



The population is evenly distributed between the three localities. It has been rising over the past 10 years with an estimated growth of 0.3%. Perth City locality contains the only urban area in Perth and Kinross, leading it to being more densely populated with 270 people per km^2 in comparison to the rural localities of 29 people per km^2.

In Perth and Kinross, the predominant population is of working age. However, as highlighted in Figure 1, there has been a significant increase in the over 65 age group and a substantial decline in birth to 4 yrs.

Figure 1 : Percent change in population from 2016 – 2021 by age and sex in Perth and Kinross



Source: NRS Mid-Year estimates 2020

The data below highlights the percentage of people over 65. Perth and Kinross have higher levels in comparison to Scotland. The North and South localities face greater challenges in relation to an ageing population.

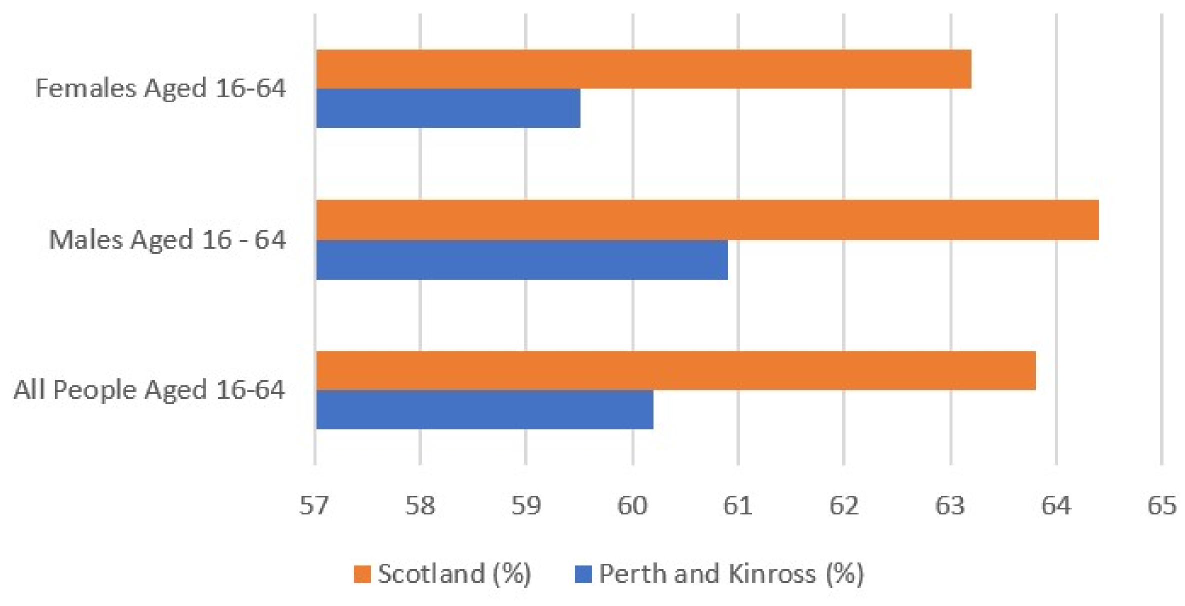
Table 1 : Percentage of population over 65

	North Locality	Perth City Locality	South Locality	Perth & Kinross	Scotland
Percentage of the population over 65 (2021)	26.2	21.8	24.1	24.1	19.6

Source: PHS Locality Profiles

Figure 2 highlights that Perth and Kinross has a smaller proportion of people of working age compared to Scotland as a whole, and this is likely to continue. Consequently, workforce capacity may become an increasing challenge year on year.

Figure 2 : Population aged 16 – 64



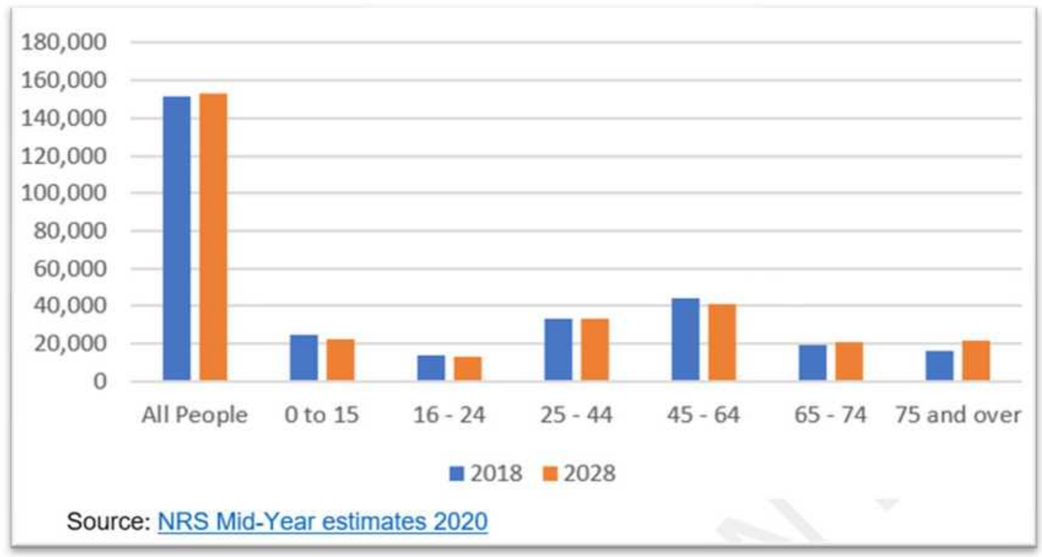
Source - [Labour Market Profile - Nomis - Official Census and Labour Market Statistics (nomisweb.co.uk)]

2.2 Future Population Projections

In 2018, National Records of Scotland (NRS) predicted that by 2028 the population of Perth & Kinross would have increased to around 152,779; this figure had been exceeded by the time of the 2022 Census. The anticipated rise in the average age of Perth and Kinross's population is attributed to the aging of the baby boomer generation and the expectancy of increased longevity among residents.

Over the ten year period to 2028, the 0-15 age group is projected to see the largest percentage decrease (-8.1%) and the ≥75 age group is projected to see the largest increase (+30.8%) (Figure 3). In terms of size, 45 – 64 is projected to remain the largest group; all of which underlines the increasingly elderly population, with fewer younger people coming through to be able to take care of them. This has substantial implications for potential levels of need for health and social care support in Perth & Kinross in the coming years.

Figure 3: Projected change of population by age group in Perth and Kinross, 2018 and 2028.



2.3 Life Expectancy

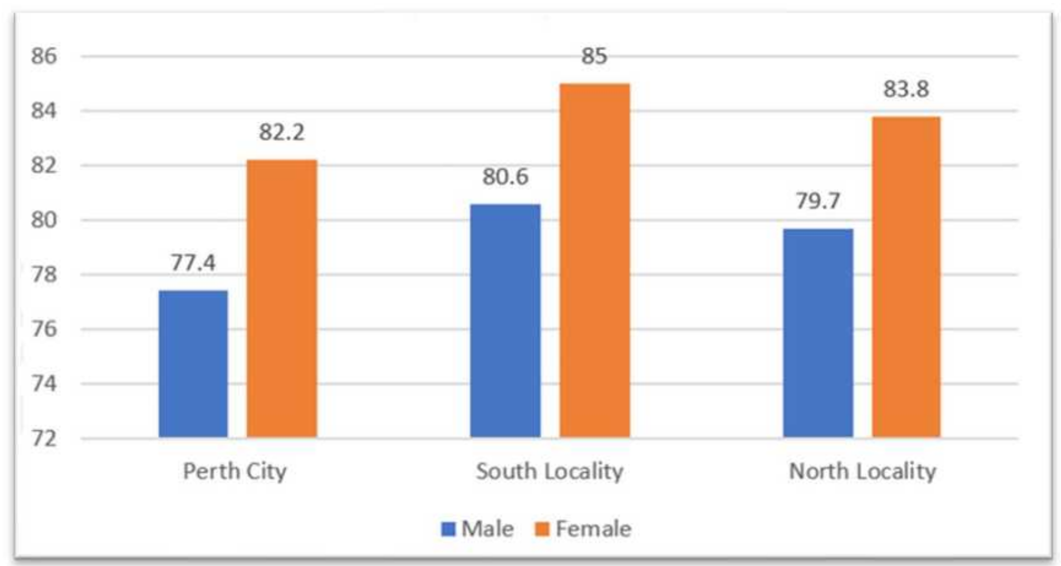
Over the last decade Scotland's life expectancy rates have begun to stagnate or reduce. Currently, Perth and Kinross average life expectancy rates are above the national average at 79 years for males and 82.9 years for females. In comparison to other HSCPs, Perth and Kinross have the 7th highest rate of life expectancy. However, Figure 4 highlights a potential decline and plateau of male life expectancy and a recent decline for females.

Figure 4 : Average life expectancy in men and women over time.

Source : NRS Life Expectancy - Datasets - Perth and Kinross - Open Data (pkc.gov.uk)

Figure 5 highlights the disparities between localities with the South Locality experiencing the highest life expectancy rates with the Perth City Locality, which has greater levels of deprivation, having the lowest.

Figure 5 : **Life expectancy in Perth and Kinross Localities**



Source : [NRS Life Expectancy - Datasets - Perth and Kinross - Open Data (pkc.gov.uk)]

2.4 Migration

Perth and Kinross figures on migration are the 4th highest with a net migration increased from **4.7** people per 1,000 population in 2019-20 to **16.4** in 2020-21 which was significant considering the total for Scotland only increased by 2%. Migration and particularly seasonal workers are a crucial component of the business model for agricultural, food and drink, hospitality and tourism sectors and are essential to the health and social care sector. Seasonal workers are mainly located in the rural localities of Perth and Kinross and levels spike in the summer season.

7,930

People migrated to Perth and Kinross a 49.5% increase from 2019-20

5,400

People migrated out of Perth and Kinross a 18.2% increase from 2019-20

Inflow of migration primarily came from within Scotland at 79% followed by the rest of the UK at 13% and international migrants at 8%.

67% of migrants are of working age, with the 30 – 34 age group being the greatest number. 23% are under 19 and 10% are over 65/

Source : Perth and Kinross Council Area Profile (nrscotland.gov.uk)

Perth and Kinross support a range of refugees who have fled ongoing conflict in their own area on a temporary or a resettling basis primarily through the Vulnerable Persons' Relocation Scheme. This support is mainly based in Perth City Locality. There is an increased possibility that their health and wellbeing may have been significantly impacted by their past experiences of trauma .

The New Scots Refugee integration strategy states 'everyone resident in Scotland' is entitled to access health care on the same basis[1]'. The demand for health and social care services, including specialist mental health services and trauma informed care will continue to be impacted, leading to increased need and concentrated demand on the Perth City Locality. Refugees and asylum seekers face barriers to accessing service. It is vital that the HSCP continues to work closely with them and key organisations to help understand their need and how best to support them.

[1] Scottish Government, *New Scots: Refugee Integration Strategy 2018-2022*

2.5 Ethnicity

Ethnicity has been defined as "the social group a person belongs to, and either identifies with or is identified with by others, as a result of a mix of cultural and other factors including language, diet, religion, ancestry and physical features traditionally associated with race"[2].

Figure 6: Ethnicity of Perth and Kinross

Source : Census 2011

According to the 2011 Census, Perth and Kinross population comprises primarily of **81.8%** 'White-Scottish'. We have a varied and well established ethnic minority communities which totals **1,852**, including **585** Indian, **461** Chinese and **331** Pakistani. It is also home to the highest individual local Gypsy/Traveller population with **415** people classifying themselves as Gypsy/Traveller.

Health varies according to a range of characteristics, including ethnicity and migration status; the health patterns between ethnic groups and the white population differ significantly. Public Health Scotland states 'there are significant inequalities

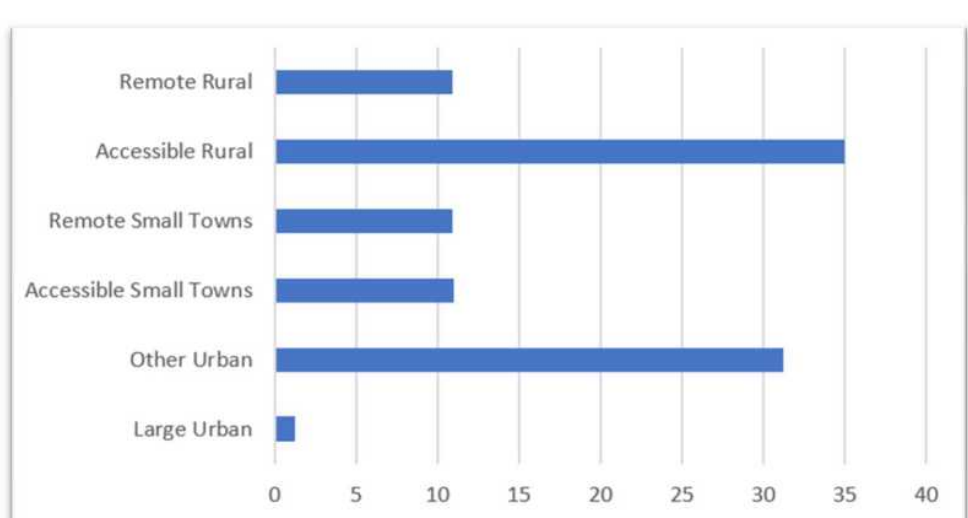
[2] Bhopal R. *Glossary of terms relating to ethnicity and race: for reflection and debate.* J Epidemiol Community Health 2004:58:441-445

between ethnic groups in Scotland when it comes to health needs and outcomes[3].' It is important that support is in place to ensure these groups can access the health and social care support and services they need at the right time and in the right place.

2.6 Rurality

The Scottish Government Urban Rural Classification 2020 provides a consistent way of defining urban and rural areas based on population and accessibility (See Appendix 2). The majority of Perth and Kinross population live predominantly in a rural areas **67.8%** with **32.4%** living in urban areas.

Figure 7 : Percent of population in each 6 fold Urban Rural Category



Source [Scottish Government Urban Rural Classification 2020 (www.gov.scot)]

The Perth & Kinross geographic area covers 5,286km^2 (2,041 square miles). In terms of population density, it is one of the most sparsely populated regions of Scotland at 29 people per km^2 compared to the Scotland average of 70.

[3] Public Health Scotland *Ethnic Groups and Migrants* 2021

Map 2 shows that Perth and Kinross comprise of 37 settlements, defined 'as groups of adjacent, densely populated postcodes that add up to 500 or more people'. It has the fourth highest number of settlements in Scotland with 79.5% of its population living within them. However, it also means 20.5% of its population live in very small, dispersed places throughout the local authority area. This is important as it has an impact on how we plan and deliver services across the area.

Map 2: Perth and Kinross settlements

Source [Settlements and Localities 2020 (shinyapps.io)]

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 highlighted in Figure 8 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.

Figure 8 : Dependency ratios across all three localities

Locality	Area	Dependency ratio
North	Stanley	34.17
North	Luncarty	37.57
North	Coupar Angus	39.99
North	Burrelton	40.89
North	Bankfoot	43.18
North	Aberfeldy	44.82
North	Dunkeld and Birnam	46.56
North	Alyth	48.78
North	Murthly	49.26
North	Blairgowrie	55.14
North	Pitlochry	55.53
City	Perth	32.37
City	Scone	59.59
South	Forgandenny	10.40
South	Aberuthven	24.84
South	Inchture	28.14
South	Blackford	30.07
South	St Madoes and Glencarse	31.76
South	Glenfarg	33.87
South	Errol	34.34
South	Longforgan	34.77
South	Crook of Devon	36.86
South	Abernethy	37.35
South	Methven	38.64
South	Braco	40.12
South	Bridge of Earn	41.62
South	Milnathort	42.46
South	Kinross	42.90
South	Auchterarder	45.02
South	Dunning	45.04
South	Almondbank	45.23
South	Kinnesswood	46.23
South	Crieff	48.57
South	Muthill	50.38
South	Comrie	74.53

Source: HSCP

2.7 Scottish Index of Multiple Deprivation

The Scottish Index of Multiple Deprivation (SIMD) is a nationally used model that measures multiple domains of deprivation to arrive at an estimate of how deprived an area is. Domains include income, employment, health, education, housing, crime and geographic access; however, there are limitations to SIMD in rural areas. Deprivation can be less easy to spot in an area where, for example, geographic access is limited for everyone.

In comparison to other Local Authorities, Perth and Kinross has the 7th lowest local share of deprivation[4]. As Table 2 highlights, the majority of Perth and Kinross population live in and above SIMD 3.

[4] Scottish Government *Introducing The Scottish Index of Multiple Deprivation* 2020

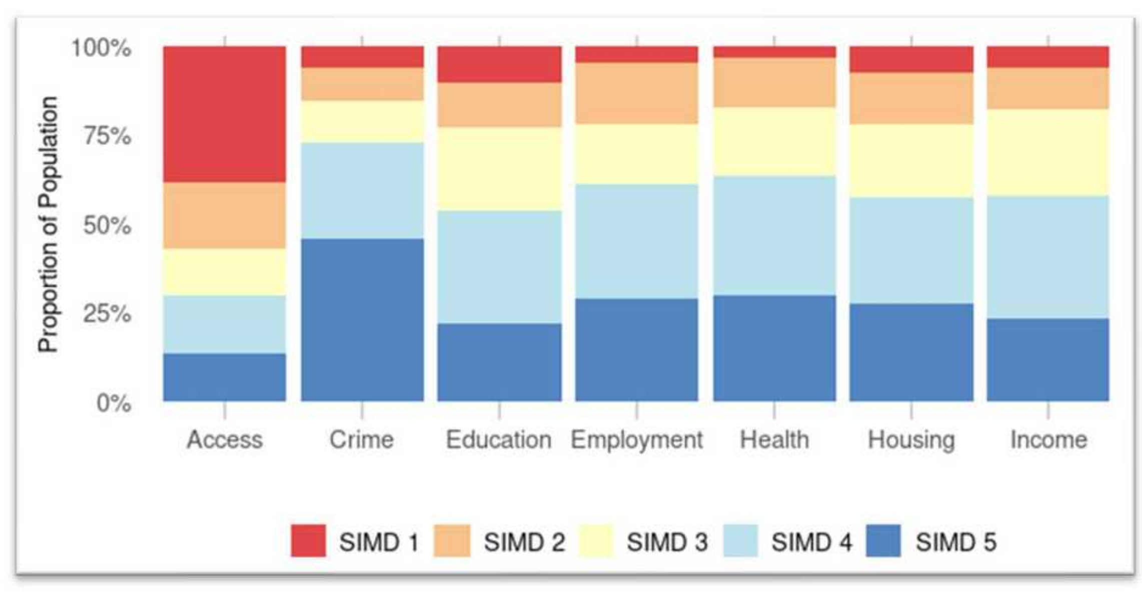
Table 2 : Percent of the Perth and Kinross population living in the 2016 and 2020 SIMD Data zone Quintiles in 2016 and 2021 respectively.

Quintile	Percent of 2016 Population (SIMD 2016 Ranking)	Percent of 2021 Population (SIMD 2021 Ranking)	Difference
SIMD 1	5.4%	6.0%	0.6%
SIMD 2	11.3%	12.5%	1.1%
SIMD 3	23.8%	21.5%	-2.3%
SIMD 4	41.3%	36.8%	-4.5%
SIMD 5	18.1%	23.3%	5.1%

Source: Scottish Government, Public Health Scotland, National Records

When the SIMD is broken down by domain over 40% of the population are in the most deprived Quintile for access to services (Figure 9). In the North and South localities, accessibility is the biggest issue with over half of the population in the top two most deprived quintiles.

Figure 9 : Proportion of the population that reside in each 2020 SIMD quintile by domain in 2021.

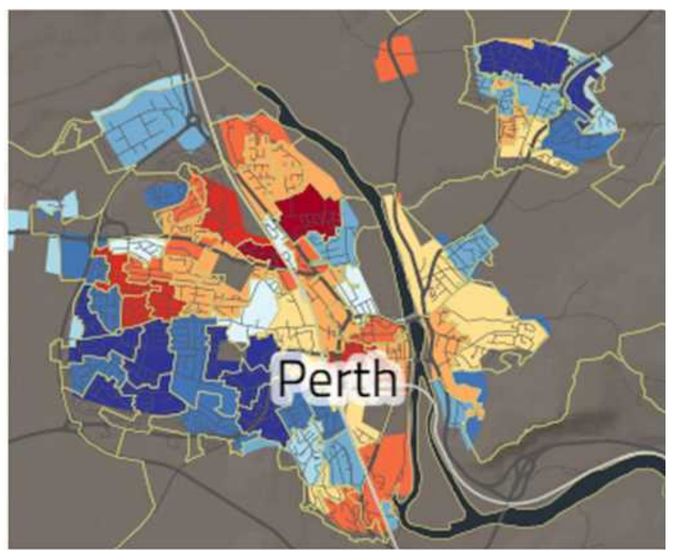


Source: Scottish Government, Public Health Scotland, National Records Scotland.

This is in stark contrast to the other domains: crime, education, employment, health, housing and income, where at least two thirds of the South and North populations live in the top two least deprived quintiles. Generally, primary care, care home and A&E services are most concentrated in Perth City and dotted around the bigger towns around Perth and Kinross. Leaving large areas of the rural population with limited access to services. The impact of this is that early intervention and preventative care is compromised in rural areas, which increases the risk of higher rates of hospitalisation.

Perth City is the only urban setting within Perth and Kinross and like other cities it brings opportunities, jobs and services to optimise its citizens health and quality of life but at the same time it can lead to concentrated areas of risk and hazards leading to adverse health outcomes.

Map 3: Levels of deprivation in Perth City locality

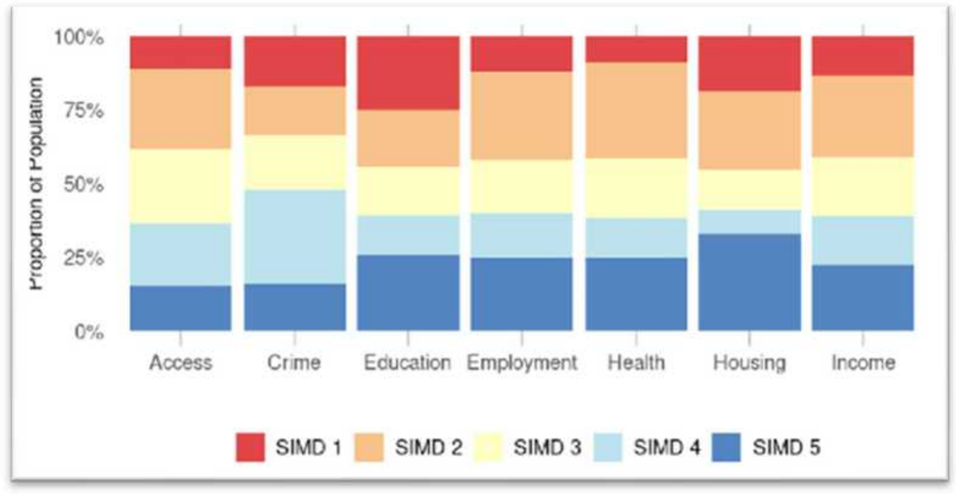


SIMD (Scottish Index of Multiple Deprivation)

Perth City Locality hosts the majority of deprivation within Perth and Kinross with 5 area's being within most deprived Quintile (SIMD1) equating to 16.1% an increase of 2.6% since 2016 (Map 3) . This locality also hosts the most affluent proportion of the population with 27% of people living in the least deprived Quintile (SIMD5) and increase of 1.3%. These increases within both SIMD 1 and SIMD 5, highlight an increasingly polarised community in terms of affluence and deprivation which in turn

is likely to have a significant impact on need for health and social care services in Perth City.

Figure 10 : Proportion of the population that reside in each 2020 SIMD quintile by domain in 2021.



Source: Scottish Government, Public Health Scotland, National Records Scotland.

When SIMD 1 is broken down into domains it highlights education as the main factor driving deprivation in Perth with housing and crime also being major contributors (Figure 10). Education matters for health as it influences future income, employment and social networks. SIMD 2 has the highest percent of population at 28.5% and this group face multiple challenges across several domains with access to health care and employment opportunities impacting on them the most.

2.8 Housing

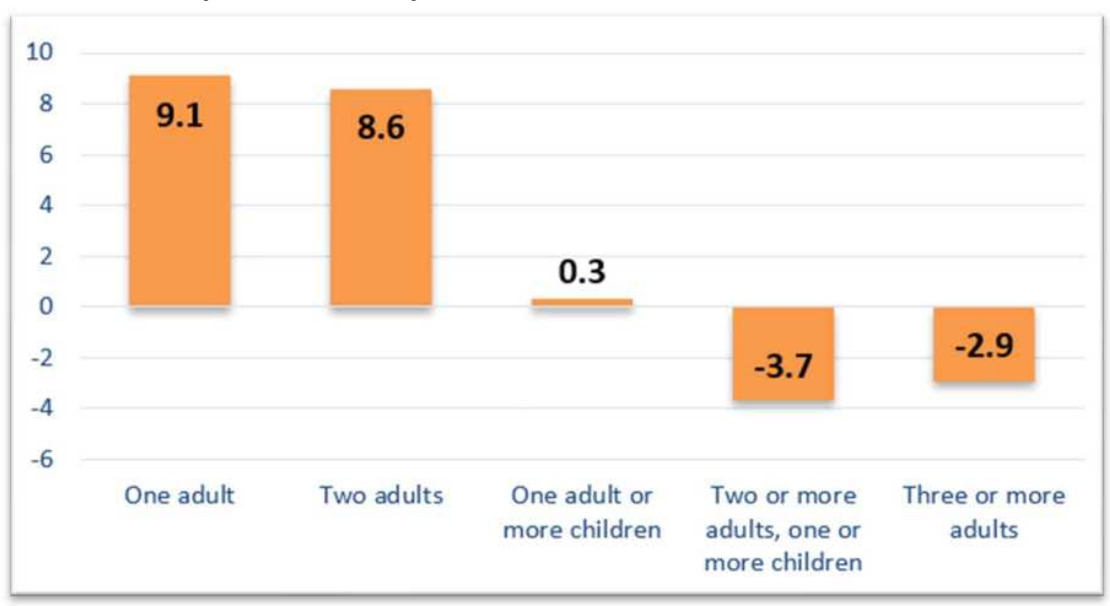
Housing is an important determinant of health. Substandard housing is a social driver of health inequalities, which can greatly impact a person's physical and mental health. The housing sector plays a key role in ensuring the health and well-being of communities and is pivotal in supporting PKHSCP to 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"[5]

In the post-covid landscape and with an increasingly elderly population, we are facing unprecedented challenges in relation to the prevention of hospital admissions, enabling people to be discharged from hospital in a timely manner and being able to access care close to home.

The National Record of Statistics have projected that between 2018 and 2028, the household type "Two or more adults, one or more children" is projected to see the largest percentage decrease and the household type "One adult" is projected to see the largest increase.

Figure 11 : Perth and Kinross percentage change in projected number of households by household type, 2018 and 2028

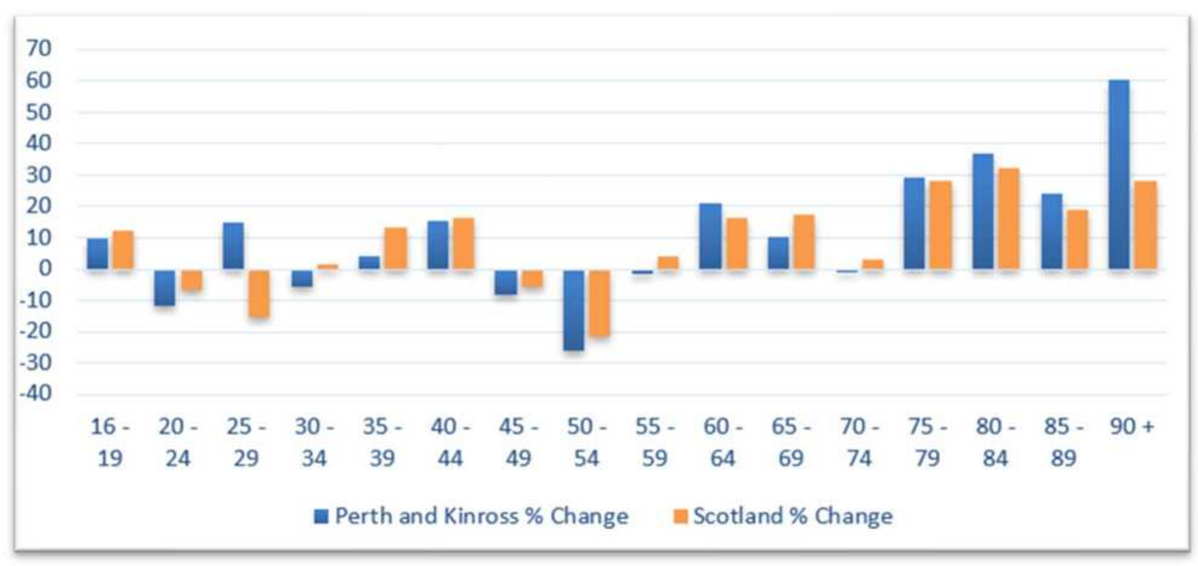


Source : NRS Perth and Kinross Profile

[5] Perth and Kinross Council, *Local housing strategy framework 2022 - 27,* 2022

Projections in relation to number of household by age group also indicates a significant rise in households for the over 65. Figure 12 provides a comparison to Scotland's average which highlights the specific challenges associated to Perth and Kinross.

Figure 12 : Percent change in projected number of households by age group of Household Reference, 2018 and 2028.



Source : NRS Perth and Kinross Profile

The ageing population will change demand for housing. They are also more likely to live alone and to be under-occupying homes, increasing the risk of isolation and loneliness. The need for more adaptable and specialised housing is critical, combined with accessible health and social care community provisions, will be key to enabling people to remain in their own homes as they age.

At present, there are 74,586 dwellings in Perth and Kinross with the majority tenure being owner-occupied.

Table 3 : Housing tenure in Perth and Kinross

	Owner Occupied	Private Rental Sector	Social Housing Sector	OTHER
Type of Tenure	63%	16%	16%	5%

Source : LHS Framework

This presents challenges for low income families in Perth and Kinross, as it limits the range of affordable housing options. Compounding the situation further is the cost of private rent in Perth and Kinross, which is out of reach for low income families.

As previously acknowledged, 67% of Perth and Kinross' population live in rural areas. There are complexities associated with rural living, including limited availability of affordable homes with demand outweighing availability, **30%** of rural dwellings were built before 1919 and **57%** of homes are 'off gas grid', leading to challenges with energy efficiency, maintenance and adapting them to respond to changing need either as a result of health difficulties, disability or ageing.

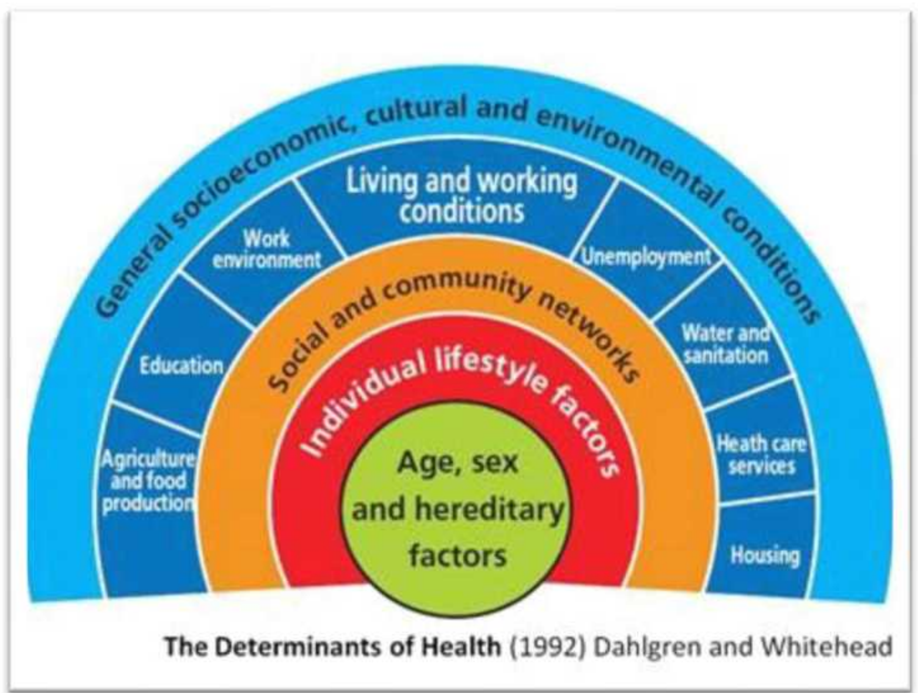
Factors associated with tenure and rurality has a direct impact on the recruitment and retention of health and social care staff. The Health and Social Care Partnership will need to consider new models of rural service provision in order to develop a sustainable solution.

3. INEQUALITIES

3.1 Health inequalities

Health inequalities are the unjust, avoidable differences in people's health across the population and between specific population groups[6]; 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 systematic differences in the health status of different social groups. The lower a person's socioeconomic status, the higher their chances of experiencing poor health[7]. Health inequalities are multifactorial; it has long been known that, in addition to the promotion of positive health behaviours, action must be taken to reduce exposure to the full range of social determinants of health, as illustrated in Figure 13. 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.

Figure 13 : Dahlgren & Whitehead's illustration of the determinants of health[8]



[6] Public Health Scotland *What are health inequalities?* 2021
[7] World Health Organisation *Health inequities and their causes* 2018
[8] Dahlgren G & Whitehead M *Policies and strategies to promote social equity in health: background document to WHO strategy paper for Europe* Institute for Future Studies, 1992.

An important component of prevention, therefore, relates to wider strategies and interventions to address and reduce the impact of socioeconomic inequalities on health.

3.2 Substance Use

Alcohol and drug use is an important public health issue in Scotland, with higher rates of both alcohol and drug-related deaths compared to other countries. In 2020, 27% of deaths in Scotland were avoidable with drug and alcohol related disorders being one of the leading causes of avoidable deaths[9]. The prevalence of harmful and hazardous alcohol consumption and drug use is highest in the most deprived areas. It presents both short and long term risks to health, which is compounded further due to prolonged usage and an ageing population which increases the risk of co-morbidity.

In Perth and Kinross, there are presently **693** active clients receiving support from NHS Tayside for substance misuse. **68%** of people seeking treatment are male with largest age group being 25 – 45 year olds with **417** receiving treatment.

Figure 14 : Number of patients per age group

Source : NHS Tayside "Number of People Receiving Services By Age in Perth and Kinross", 2023

[9] Miall N, Fergie G, Pearce A *Health Inequalities in Scotland: Trends in deaths, health and wellbeing, health behaviours, and health services since 2000,* 2022.

This number only reflects individuals who are actively engaged in treatment, hence the volume of drug and alcohol misuse within Perth and Kinross will be greater.

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, Table 4 highlights stark differences between rates in the Perth City Locality and other localities and Scotland.

Table 4 : Alcohol related Hospital Admissions and Mortality Rates

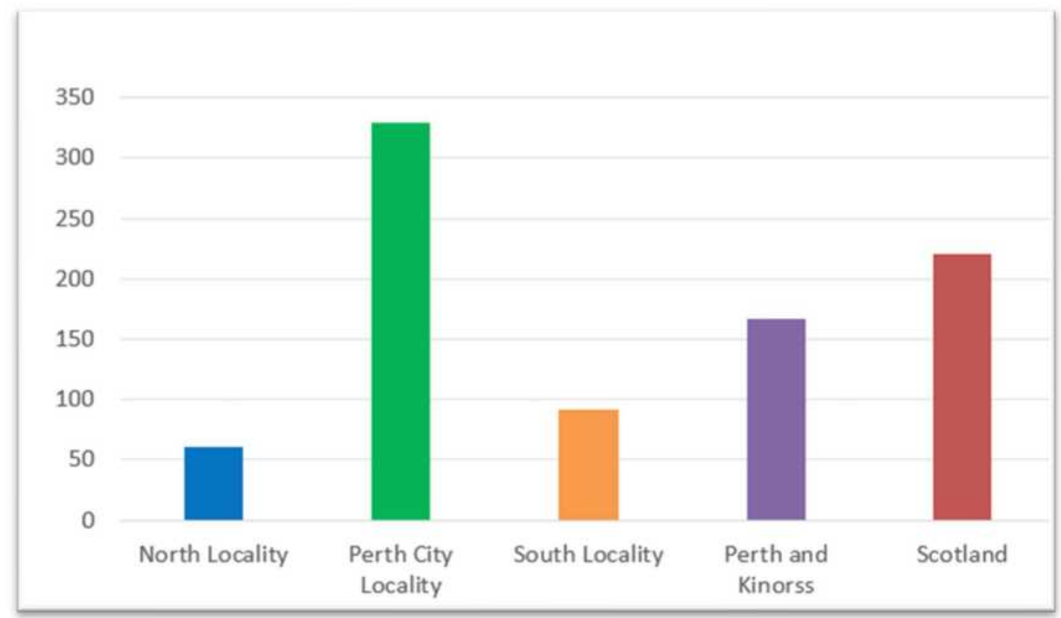
	North Locality	Perth City Locality	South Locality	Perth & Kinross	Scotland
Alcohol- related hospital admissions per 100,000	279	666.5	335.4	426.2	621.3
Alcohol- specific mortality per 100,000	10.9	20.9	12.2	14.4	20.8

Source: Public Health Scotland Profiles, Perth and Kinross, 2020/21

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.

The trend for drug related admissions began to increase in the time period 2014/15 – 2016/17 and has increased by **74.1%.** Figure 15 highlights the disparities of these admissions between localities.

Figure 15 : Drug-related hospital admissions per 100,000 by locality 2017/18 – 2019/21.



Source: PHS Locality Profiles “Drug related hospital admissions rates by area for the latest period available” 2023

This coincided with different type of drugs becoming accessible and a changing demographic of users. Traditionally people mainly used opiates but since 2016, ‘legal highs’ (new psychoactive substances) became prevalent and latterly cocaine. A further complication is polysubstance use, which has detrimental effects on people’s physical and psychological health more rapidly. Specialist alcohol services report a significant increase in their caseloads post covid, levels remain high but have begun to stabilise.

The Perth City Locality has more people suffering alcohol and drug related harms and ill health than the other PKHSCP localities and the NHS Tayside and Scottish populations as a whole. This is indicative of a considerable level of unmet need to support people to reduce their reliance on alcohol and drugs to cope with their life circumstances. Current services are geared towards supporting those affected by alcohol and opiate misuse, leading to an unmet need to support the impact of different types of drug misuse.

Increased early education and prevention on substance misuse and associated risk factors could be considered to prevent drug use from becoming normalised, especially within youth culture. Substance misuse is multifactorial, hence the needs of those impacted by substance misuse can rarely be solved by one service. The Integrated Drug and Alcohol Recovery Team is seeking to develop a person centred approach which includes a multi-agency response. However, there is a recognition that systems still present the biggest challenge to this approach, increasing the risk of people continuing to bounce back into health and social care services.

3.3 General health and premature death

As part of the 2011 Census[10], Scotland's population was asked to self-assess their general state of health. The highest proportion of Perth and Kinross population stated their health was very good, which was above the national average.

3.3.1 Anxiety, depression and psychosis prescriptions

Perth and Kinross have a smaller proportion of its population being prescribed medication normally used to treat anxiety, depression or psychosis (17.3%) compared to the rest of Scotland (19.3 %). As Figure 16 highlights, all localities have seen an increase of over 30% over the last ten years, with the North Locality increasing the most at 39.9%.

[10] Scottish Government "Scotland's Census" 2011

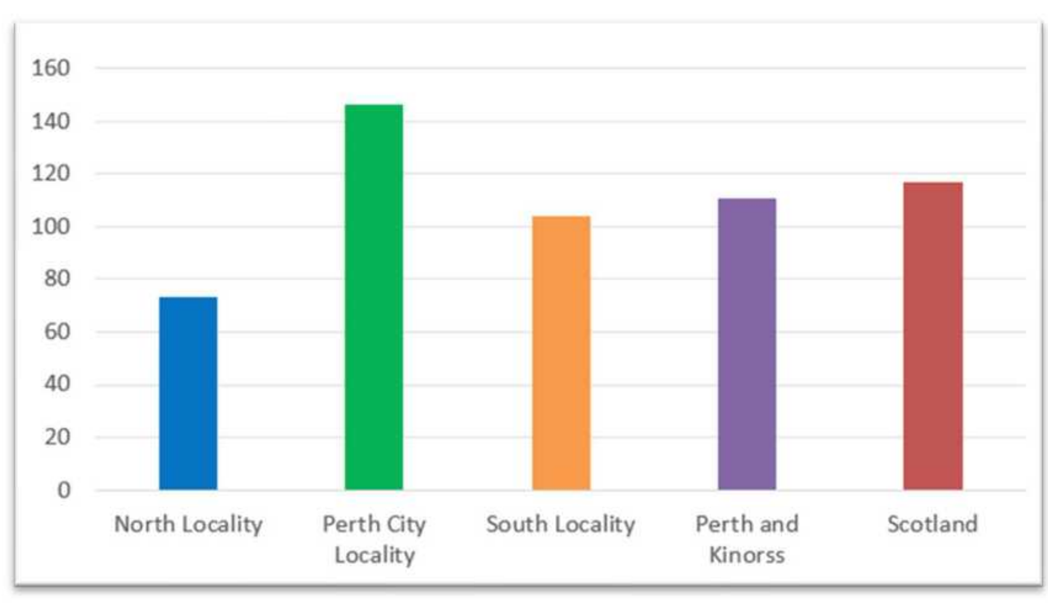
Figure 16 : Population prescribed drugs for anxiety/depression/psychosis.

Source: [ScotPHO profiles (shinyapps.io)]

Please note that these medications can also be used to treat non-mental health conditions in certain circumstances, so this should not be taken as the rate of anxiety, depression or psychosis among these locality populations.

3.3.2 All-cause mortality

Figure 17 : Deaths Aged 15 – 44 per 100,000 by locality 2019 – 2022.

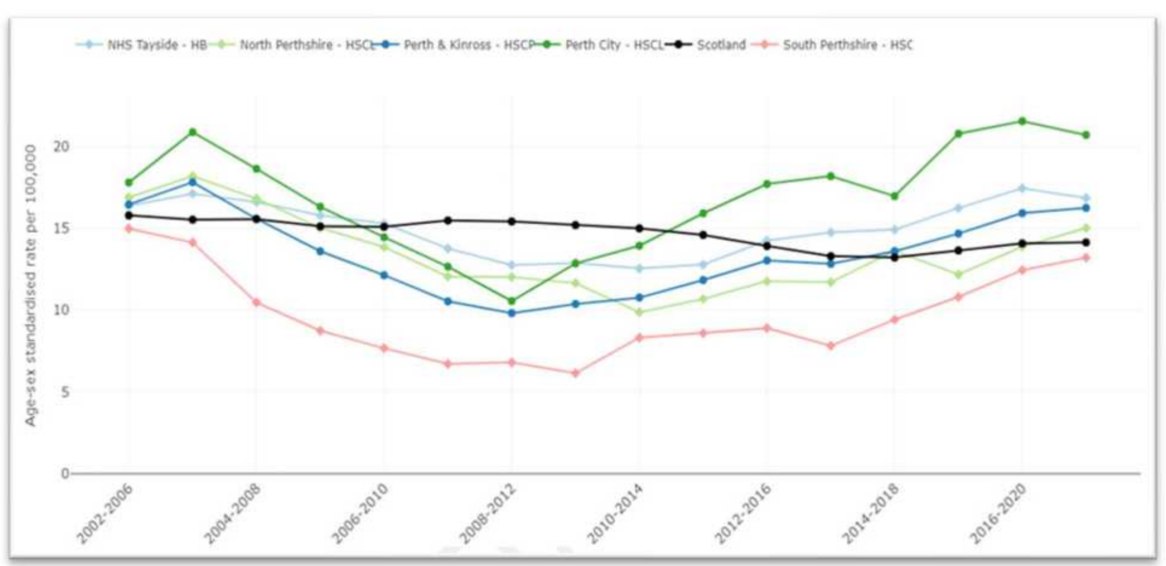


Source : Public Health Scotland, Perth and Kinross Locality Profile

Figure 17 highlights the premature death rate (deaths among those aged 15-44 years) for Perth City Locality is considerably higher than for North and South Locality and partly reflects the greater problems with alcohol and drug related illness and harm experienced in this locality.

3.3.3 Suicide

Figure 18 : Deaths from suicide



Source : ScotPHO profiles (shinyapps.io)

In 2021 there were 753 probable suicides in Scotland, a decrease of 52 (6%) on the previous year. This is the lowest number of suicides registered in a year since 2017. The rate of suicide in males was 3.2 times as high as the rate for females. The rate for probable suicide mortality was higher than the Scottish average in Highland, Tayside and Ayrshire and Arran at health board level for the 2017 to 2021 average.

It is most helpful to look at the rates and breakdowns over a five-year period or longer rather than isolate one-year figures due to the complexity and range of influencing factors. The statistics are published annually by the national records of Scotland[11].

[11] National Records of Scotland, *Probable Suicides, 2023*

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. Locally the numbers for each locality have also fluctuated over time. Perth City rates are particularly high. The local figures vary in relation to the national average and breakdown of demographics. However, our data shows that our rate of suicides in males is also higher than the rate for females.

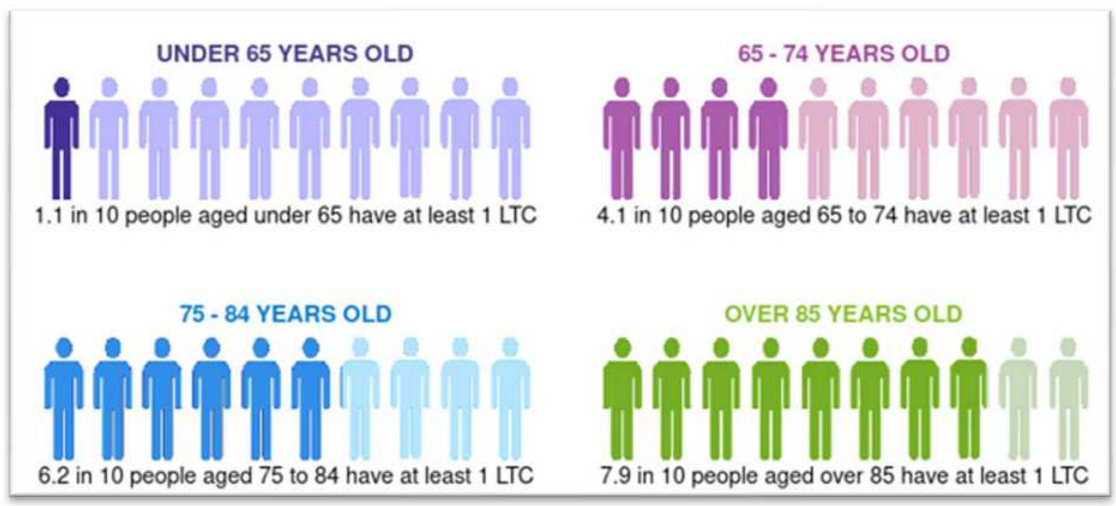
There are a wide range of factors that can contribute to suicide. Mental health remains an aspect that requires focus and resources. However, we also need to look at how local resources can best address and support the range of other factors and needs for example deprivation is a significant influencing factor along with higher risks for specific groups.

There is an ongoing need to understand the complexity of suicide and look at service provision to meet the needs for prevention, early intervention, crisis and postvention (bereaved by suicide) aspects across the different locality areas. We also need to look at our local data, pathways, and resources for those who have attempted suicide to ensure people in crisis are given a trauma informed response based on the time, space compassion approach promoted by the national strategy for suicide prevention[12].

[12] Scottish Government *Creating Hope Together: suicide prevention strategy* 2022

3.4 Living with illness: Long Term Physical Conditions & Multimorbidity

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



Source : Public Health Scotland, Perth and Kinross Locality Profile

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. The main LTCs are cancer, arthritis, coronary heart disease, asthma and diabetes and the pattern is consistent across all localities.

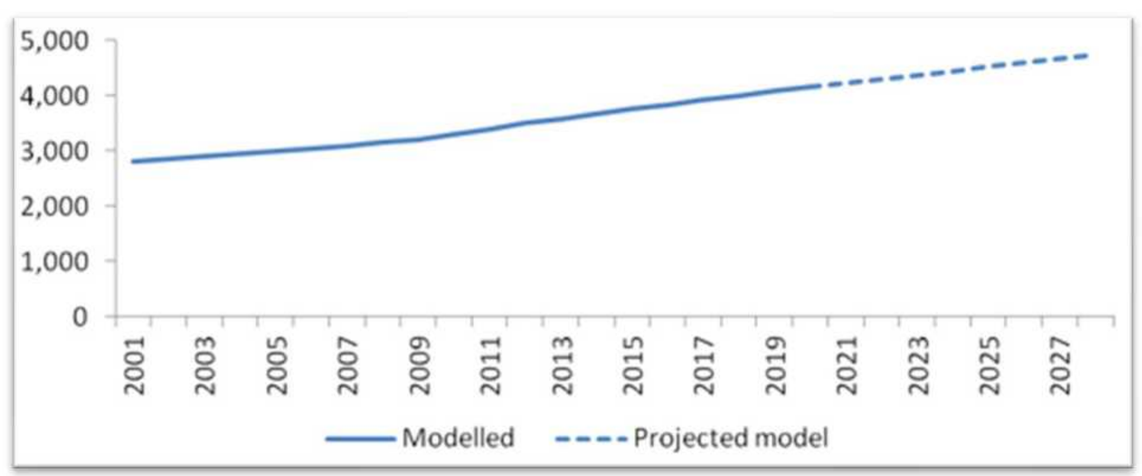
Multi-morbidity, the co-occurrence of two or more conditions, is more prevalent amongst the over 65 age group, 25.7% have 1 LTC, 14% have 2, 7.4% experience 3 and 6.8% have 4 one more LTC.

The data indicate that living with multiple LTCs is more of an issue for older people who are likely to need increased health and social care support to be able to live independently within their communities. The data for those aged under 65, however, 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. A major challenge facing health systems is how best to support people with LTC'S. In Perth and Kinross, this challenge will increase due to the demographic projections of an ageing population

3.5 Frailty

Perth & Kinross has one of the highest proportions of older people in our total population of any local authority in Scotland; as such, providing safe, sustainable, effective and person centred care for people living with frailty is a significant priority.

Figure 19 : Perth and Kinross moderate to severely frail population (modelled)



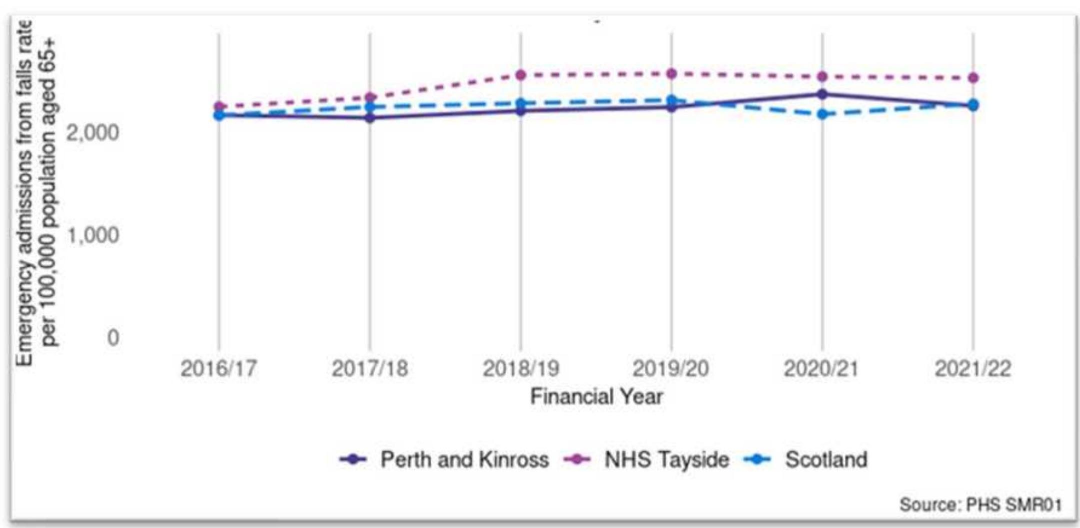
Source : HSCP

Figure 19 suggests a steadily increasing frailty/complexity burden of need. Early intervention to prevent hospital or care home admissions continues to be an important facet of our work, which is underpinned by taking a locality approach to ensure people can access care and support as close to home as possible at the point of need.

Falls are a common reason for admission and account for a high proportion of hospital admissions especially in the older age groups[13]. Figure 20 highlights current rates in Perth and Kinross which have been relatively stable. The limitation of this data is that it does not identify individuals who have multiple falls.

[13] IDS Scotland, *Unintentional Injuries – Falls – Hospital admissions,* 2019

Figure 20 : Falls in population aged 65+ by geographical area.



Even though the North and South localities have a greater percentage of people over 65, Table 5 highlights that Perth City locality has higher rates in comparison to Scotland average.

Table 5 : Emergency hospital admissions from falls by locality

	North Locality	Perth City Locality	South Locality	Perth & Kinross	Scotland
Emergency hospital admissions from falls per 100,000 per population 65+	2,094	2,559	2,185	2,262	2,281

Source: Public Health Scotland Profiles, Perth and Kinross, 2022

3.6 Dementia

Dementia is an umbrella term used to refer to a group of symptoms experienced by people with a degenerative neurological illness or condition. Dementia related conditions cause damage to the brain which can impact on communication, memory, and decision-making skills, and for some people, personality, and behaviour. These symptoms are not a part of the normal ageing process, and they can disrupt functions of daily living and social relationship. These diseases disproportionately

affect older people and the risk of dementia increases exponentially above the age of 60 years.

Public Health Scotland acknowledge that here is limited research into social inequalities and dementia. However, they acknowledge that "health inequalities persist into old age and that many of the risk factors for dementia are associated with socio-economic disparities in mortality and morbidity."[14]

In Perth and Kinross it is estimated that 3,350 people are living with dementia. The proportion between the localities is consistent with the age and total population demographic (Figure 21).

Figure 21 : Estimated number of people living with dementia.

1250
1200
1150
1100
1050
1000
Perth City Locality
North Locality
South Locality

Source: HSCP

In Perth and Kinross, the leading cause of death for females in 2021 was Dementia and Alzheimer's disease (11.1% of all female deaths) and was the second leading cause for males (7.7%)[15].

Prevalence rates for dementia are predicated to increase as a result of the rise in number of people over 65 and more people in the oldest age groups. Figure 22

[14] Public Health Scotland, *Dementia, 2021*
[15] NRS Scotland, *Perth and Kinross Council Area Profile,* 2022

shows projections for Perth and Kinross and it is estimated that it will equate to an extra hundred cases year on year. We face greater challenges in comparison to other local authorities due to our ageing population.

Figure 22 : Dementia prevalence projection for Perth and Kinross

Prevalent cases
7,000
6,000
5,000
4,000
3,000
2,000
1,000
0
2016 2019 2022 2025 2028 2031 2034 2037 2040

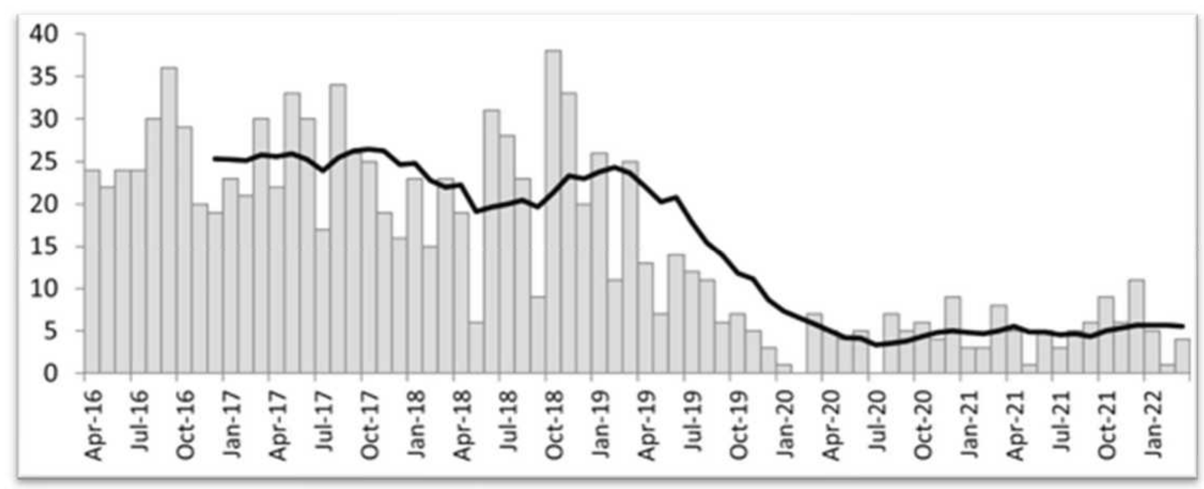
65+ prevalence rate
30%
25%
20%
15%
10%
5%
0%
2016 2019 2022 2025 2028 2031 2034 2037 2040

(a) Projected prevalent cases *(b) projected prevalence rate for 65+ population*

Source : EUROCODE prevalence applied to NRS 2016 age/gender-specific population projections

An increased prevalence will place a sustained pressure on health and social care services, including those relating to diagnosis and post diagnostic support, community based services and hospital care (Figure 23). As we plan for the future, ensuring the delivery of co-ordinated, integrated, timely services to support people with dementia, their families and carers will be key to improving outcomes.

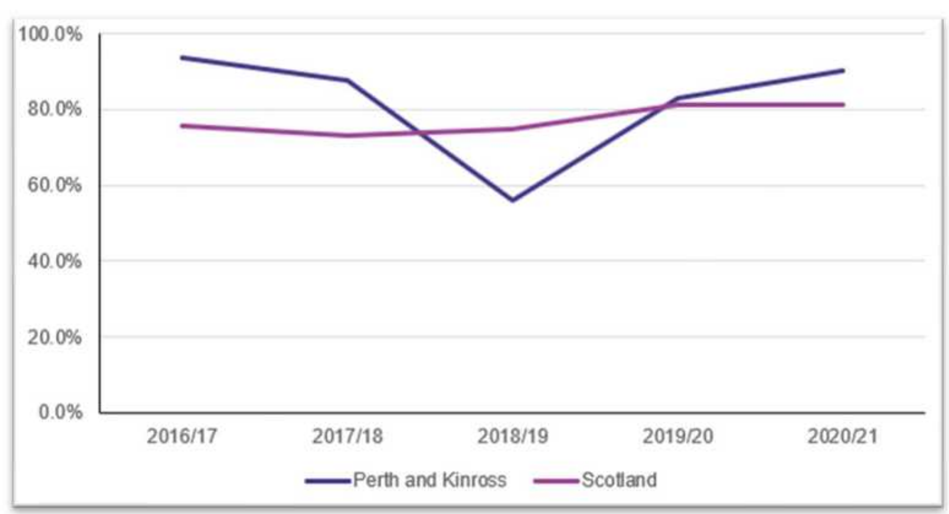
Figure 23 : Individuals diagnosed and referred for Post Diagnosis Support in Perth and Kinross.



Source : PHS Quarterly PDS Management Report.

The above Public Health Scotland performance management data on the numbers of diagnosis per quarter, shows a strong decline in diagnosis rates and referrals for PDS since January 2019. This may have been a consequence of Covid-19 but there is a concern that the referrals have not increased post Covid. It is unclear whether this is a result of increased waiting times, a reduction in number of people displaying early-onset of dementia or a lack of understanding of the condition. In relation to post diagnostic support, Figure 24 highlights an improvement with 90% of people referred for post-diagnostic support receiving a minimum of one year's support.

Figure 24 : Percentage of people referred for dementia post-diagnostic support who received a minimum of one year's support.



Source : Public Health Scotland, Dementia post-diagnostic support : Local Delivery Plan Standard 2020/21

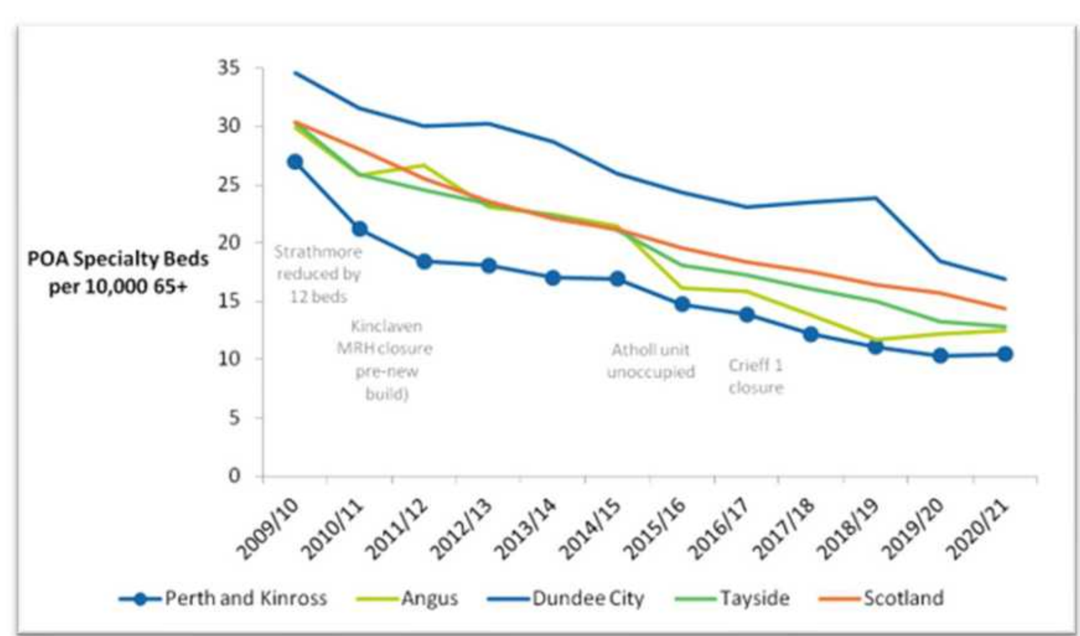
The Scottish Government reported that the main reasons for admissions to specialist dementia hospital care were[16];

1. *Increase in distressed behaviour in the person with dementia.*
2. *Carer distress*
3. *Failed discharge to a care home.*
4. *Risk behaviours that meant care could not be safely managed at home.*
5. *Lack of a care package to support the person with dementia to remain at home.*

[16] Scottish Government, *Transforming specialist dementia hospital care: independent report 2018*

Current guidance suggests a specialist dementia hospital capacity of 1% of the dementia population[17]. This equates to 33 beds specifically for patients with severe psychological symptoms of dementia or the combined influence of a co-morbid mental health condition. Over the past decade, average-staffed inpatient Psychiatry of Old Age(PoA) beds have halved to the current complement of 24 organic, and 14 functional beds. This represents the lowest per-capita 65+ PoA bed complement in Tayside, and almost one-third less than that for Scotland as a whole. (Figure 25)

Figure 25 : Average staffed POA beds per 10,000 65+

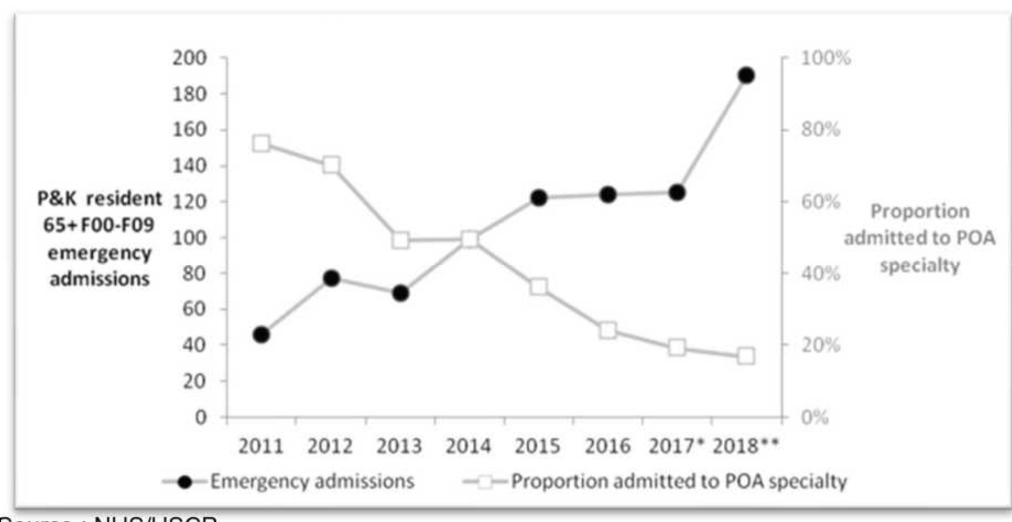


Source : Beds data: ISD, Population data: NRS

Utilisation of remaining beds is high, with the median occupancy around 93%. Overutilisation is exacerbated in delays in the discharge process and the lack of Intensive Home Treatment and early supported discharge over the weekend and out of hours for this patient group. Between the three Murray Royal Hospital wards, around 17% of occupied bed days are taken up by patients experiencing delayed discharge.

[17] Edvardsson, D., Winblad, B., & Sandman, P. O. *Person-centred care of people with severe Alzheimer's disease: Current status and ways forward* 2008

Figure 26 : Emergency Admissions for mental health conditions for 65+ Perth and Kinross residents. The proportion of these admissions to POA is overlayed.



Source : NHS/HSCP

The reduction of PoA specialty beds has (by definition) been accompanied by a reduction in PoA inpatient admissions and bed days. However, unplanned admissions for organic mental health disorders have been increasing. At the start of the 2010-2020 decade, around 80% of such admissions were to PoA specialty beds; this has now reduced to less than 20%, with most cases being admitted to general acute beds.

There is an ongoing capacity issue in relation to facilities to accommodate patients with advanced stages of dementia who experience high levels of stress and distress. Presently, many care homes throughout Perth and Kinross have low thresholds for patients experiencing these symptoms resulting in patients tending to be in hospital for long stays (12 months or more). Hospital settings are not designed to meet the needs of people with a long term basis and as such contribute to ongoing stress. This indicates an unmet need in relation to community provisions for those who experience Behavioural and Psychological Symptoms of Dementia (BPSD) or display distressed behaviour, making it more difficult to remain or return to a homely setting.

Transitional support and co-ordination of care using a collaborative approach, families working with specialist multi-disciplinary teams to plan for next steps, could prevent re-admission to hospital and placement/carer breakdown. Ensuring we have a skilled and knowledgeable workforce specific to dementia care within community and hospital services, especially for those supporting people with advanced dementia and other co-morbidities, is also a key aspect of prevention to hospitalisation.

4. SHIFTING THE BALANCE OF CARE

A key priority for the Scottish Government is to ensure that people receive ‘the right care, in the right place, from the right person’. Over the past three years there has been an increase in Accident and Emergency(A&E) attendances suggesting a high degree of unmet need in accessing care close to home. Research suggests that this is partly due to a ‘lack of understanding of what services are available and challenges accessing appropriate services’[18].

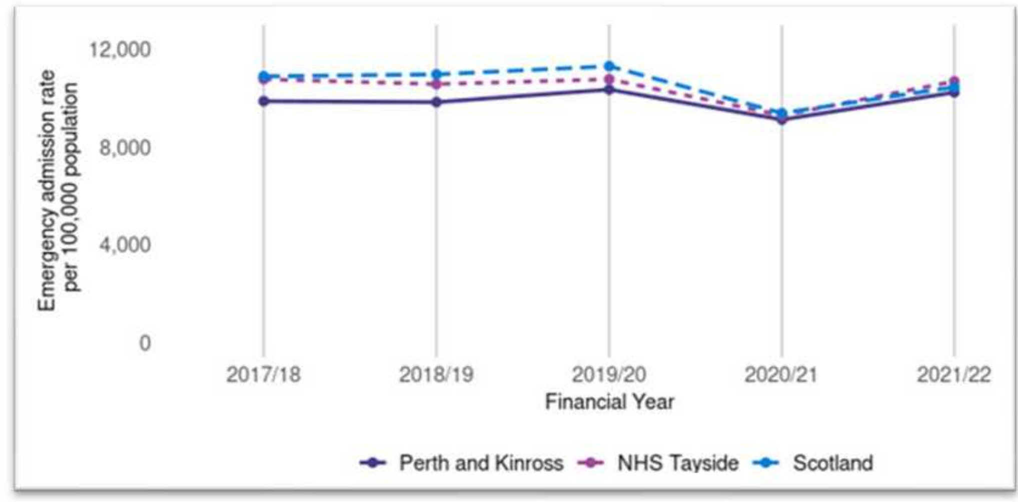
Research indicates that some people also experience barriers or disadvantage when accessing urgent care, such as people from minority ethnic communities, people with disabilities and those living in rural areas. Evidence suggests that those from deprived areas are 2.5 times more likely to attend A&E with a preventable emergency admission[19].

4.1 Emergency and Unscheduled Admissions

In Perth and Kinross the main emergency department is located at Perth Royal Infirmary with five small hospitals/health centres, two in the South Locality and three in the North, which carry out emergency department related activity.

[18] Scottish Government, *Health Standards,* 2023
[19] NHS 75 Digital, *People in most deprived areas were almost twice as likely to visit A&E as those in least deprived, 2020*

Figure 27 : Emergency admissions by geographical area.



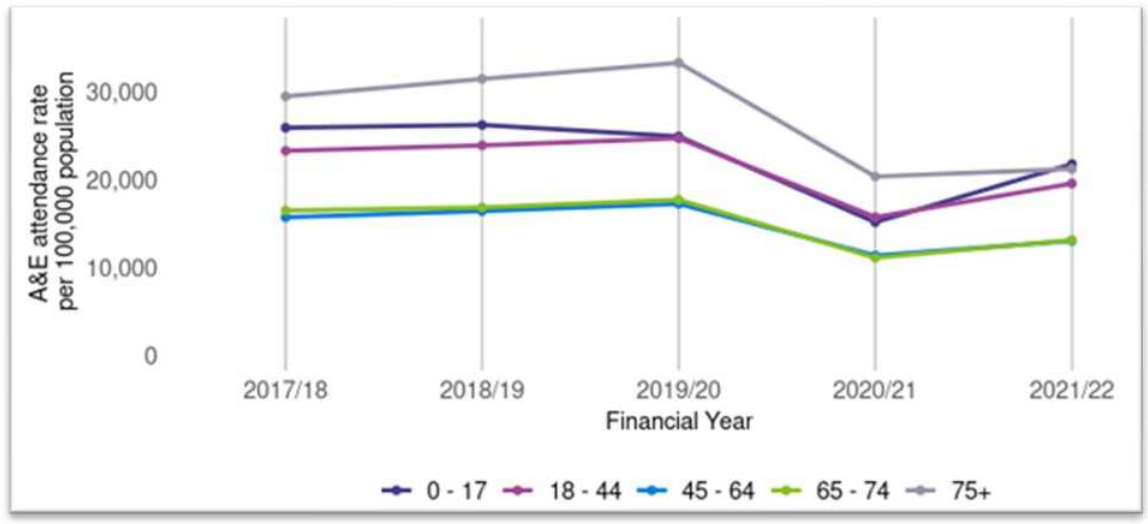
Perth and Kinross rates of emergency admissions is comparative to Scotland (Figure 27). In all localities, the age group of attendees is primarily the over 65 age group with the highest rates associated with the 75+ age group. Table 3 demonstrates disparities in localities with Perth City locality exceeding the national average.

Table 6 : Emergency admissions in each locality.

	North Locality	Perth City Locality	South Locality	Perth & Kinross	Scotland
Emergency Admissions per 100,000	9,773	11,359	9,554	10,218	10,434

In relation to Accident and Emergency (A & E) attendances, Perth and Kinross is significantly below the national average. A significant drop in rates occurred in 2020 – 21 due to pandemic, but figures are beginning to increase but are still below previous levels. Figure 28 shows that the youngest and oldest age groups accessed A & E at an increased comparable to other age groups.

Figure 28 : A & E attendances by age group



Source : PHS A & E Datamart

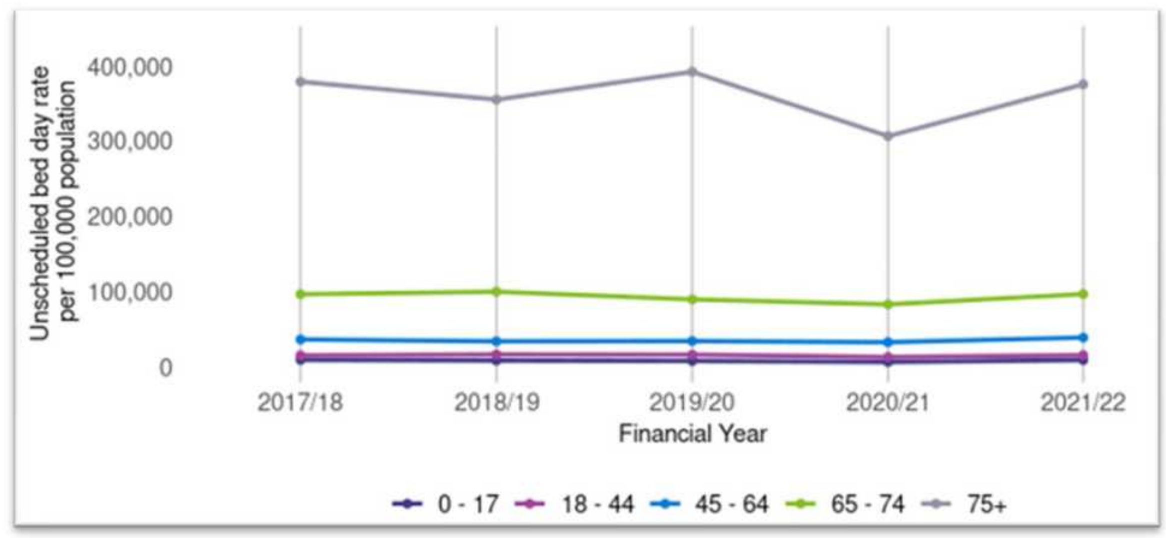
A similar pattern occurs in relation to localities, 41 % of attendances are from the Perth City locality. (Table 7)

Table 7 : A & E attendances by geographical area.

	North Locality	Perth City Locality	South Locality	Perth & Kinross	Scotland
A & E attendances per 100,000	14,909	21,977	15,576	17,443	25,791

Perth and Kinross rate of unscheduled acute bed days is comparable to Scotland (Figure 29). Once again, the over 75+ demographic have the greatest number of unscheduled bed days.

Figure 29 : Unscheduled acute bed days by age group.



Source : PHS SMRO1

A consistent finding as shown in Table 8 indicates that the Perth City locality has the highest number of unscheduled bed days, even though they have the lowest over 65 demographic in comparison to the North and South Locality.

Table 8 : Unscheduled acute bed days by geographical area.

	North Locality	Perth City Locality	South Locality	Perth & Kinross	Scotland
Unscheduled bed days per 100,000	68,502	76,354	69,787	71,500	71,792

The data suggests that urgent care for older people is sufficiently robust for this demographic to avoid hospitalisation and continue to be cared for at, or close to, home. Perth City Locality shows higher rates. Reducing unscheduled admissions through the development of sustainable and robust urgent care approach remains a key priority.

4.2 Preventable Hospital Admissions

Potentially Preventable Admissions(PPA) are hospital admissions that could have been prevented with better co-ordinated care. In Perth and Kinross, Perth City Locality has higher rates of PPA than other localities at **1,588** PPA per 1000 and in comparison, to Scotland **1,464**.

Current readmission rate (28 days) has increased across all localities within Perth and Kinross (Table 6).

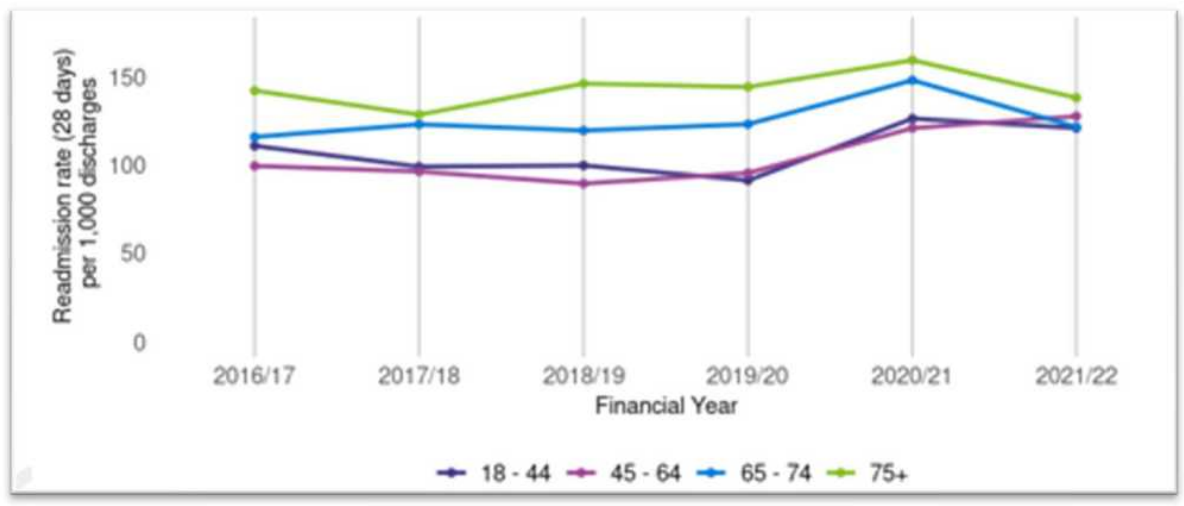
Table 9 : Readmission rates (28 days)

	North Locality	Perth City Locality	South Locality	Perth & Kinross	Scotland
Emergency readmissions (28 day) per 1,000 discharges	122.5	140.6	122.3	128.7	106.5

Readmission rates (28 days) for 2021/22 show an increase across all localities within Perth and Kinross and is above of national average. There had been a steady decline in readmissions since 2016, but a spike in rates occurred in 2019 – 21 and they have not returned to previous levels.

Older people are at greater risk of readmission. The over 65 age group rates peaked in 20-21 and have begun to reduce. However, as the Figure 30 highlights, the 45-64 age group appears to be continuing to increase since 2019-20,suggesting that there is a level of unmet need within this age group in relation to the availability of immediate family support, accessing community support and services to prevent readmission.

Figure 30 : Readmission rate (28 days per 1,000 discharges by age group for Perth and Kinross).



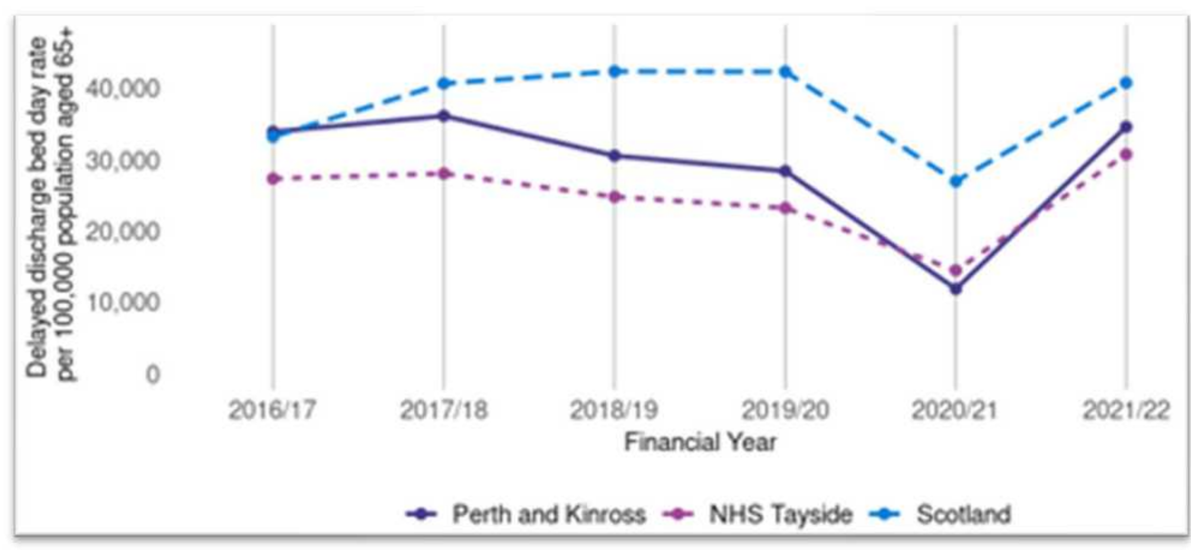
Source: PHS SMR01

4.3 Delayed discharges from hospital

Delayed discharges occur when a patient is clinically fit to be discharged from hospital but is unable to return home due to factors out with their control; for example, they need additional care and support at home which cannot be provided at the point of discharge. Evidence indicates that prolonged periods of unnecessary bed rest can have an extremely detrimental effect on a person's health and wellbeing and lead to early admission to long term care[20].

[20] Scottish Government, *Healthcare standards,* 2022

Figure 31 : Delayed discharge bed days per 100,000 population aged over 65 over time by residence.



Source: PHS Delayed discharge

Perth and Kinross levels of delayed discharge remain below national average (Table 10). Between 2017 - 18 and 2020-21, rates in the North and Perth City localities underwent a sustained fall, with the South Locality rates remaining stable at 2017-18 levels. Covid – 19 most likely accelerated the fall as people were more reluctant to attend hospital and doctors admitted less people to hospital. However, Perth City locality rates are now in excess of 2017-18 numbers and the South Locality has returned to previous levels with the North being below, indicating unmet need in relation to social care in the community.

Table 10 : Delayed discharge (65+)

	North Locality	Perth City Locality	South Locality	Perth & Kinross	Scotland
Delayed Discharge (65+) per 100,000	27,432	44,695	34,418	34,580	40,774

Following Covid- 19, the health and social care sector faced unprecedented challenges in relation to workforce capacity with many leaving the profession at all levels. This has continued to be the trend which is having the most direct impact on the availability of care and support in the community and care homes. The cost of

living crisis is compounding these challenges further. Specific attention may be required within Perth City and South Locality to assess the availability of appropriate care or services within these communities and consider initiatives which will support care at home and care home staff to be able to live close to their places of work.

4.3 Mental health

In terms of psychiatric patient hospitalisations all localities have seen a steady decline in admissions. However, Figure 32 highlights a significant disparity between Perth City locality and the North and South localities.

Figure 32 : Psychiatric patient hospitalisations (per 100,000)

Source: ScotPHO

A similar trend is apparent in relation to unscheduled speciality bed days, with Perth City locality showing significantly higher rates. In Perth and Kinross, the over 75 age group have the most unscheduled bed days, followed by the 18 – 44 age group.

Table 11: Unscheduled mental health speciality bed days.

	North Locality	Perth City Locality	South Locality	Perth & Kinross	Scotland
Unscheduled bed days per 100,000	12,867	32,365	15,384	20,086	18,672

A range of factors may impact on the Perth City Locality position in comparison to North and South Perthshire Localities. In particular there are a number of core groups that are more likely to require hospital admission. These include

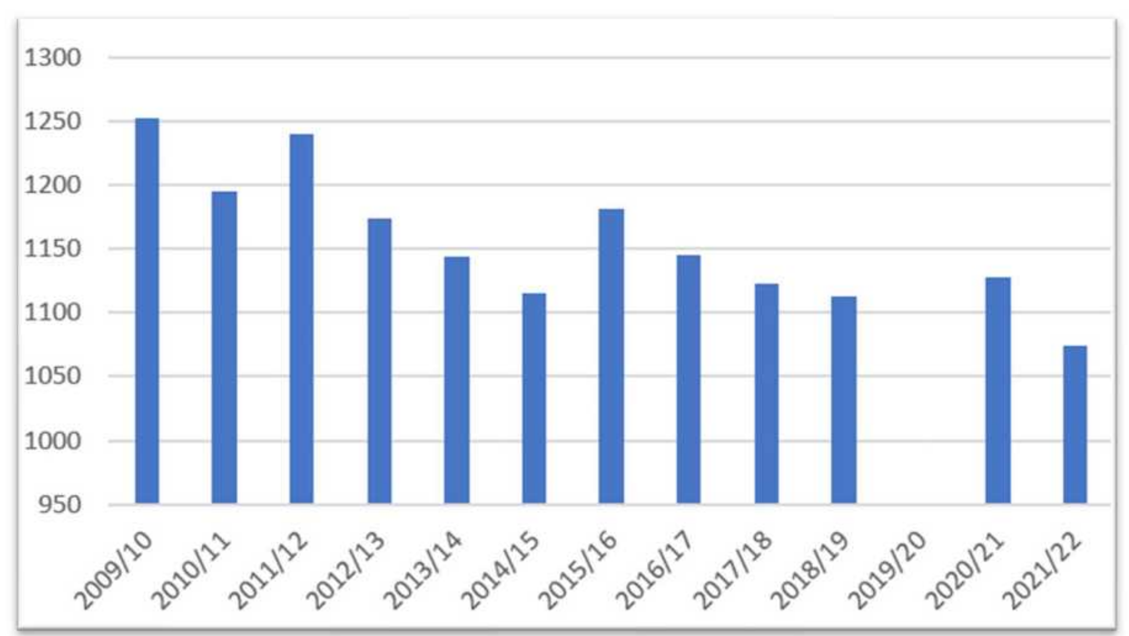
- University student population who tends to experience higher levels of mental health morbidity.
- People living in areas of high of deprivation.
- The centralisation in Perth City of Supported Accommodation Projects for people with highly complex mental illness.
- The centralisation in Perth City of Homeless Projects and interim settlement placements for refugees.
- Prisoners from Perth Prison choosing to resettle in Perth City, who also have an increasing trend in substance misuse.
- Pressure on supported accommodation and Elderly Mentally Infirm beds resulting in people's discharge from hospital being delayed.

The data indicates a high degree of unmet need in relation to specialised community mental health services to prevent hospital admissions, especially for those over 75. Whilst there is an interplay of complex factors, given national comparable data, this area warrants further scrutiny and is a key component of the Whole System Change Programme for Tayside's Mental Health and Learning Disability Service. The Programme is underpinned by the National Mental Health Indicators which include both areas identified and involves a range of whole system change activities to achieve the best possible care and treatment for people with mental illness.

4.3 Care homes

Care homes for adults are designed to care for adults with high levels of dependency and need 24 hour care[21]. Figure 33 indicates present levels of admissions to care homes, which shows a 4% reduction in permanent placements for over 65s. This reduction is predominantly due to the reduction in respite/short breaks but other factors include; improvements in care at home, reduction in respite and short breaks, workforce capacity in care homes, continued Covid-19 restrictions and fear associated with care homes, due to Covid -19.

Figure 33 : Perth and Kinross older People (Over 65) admissions to care homes.

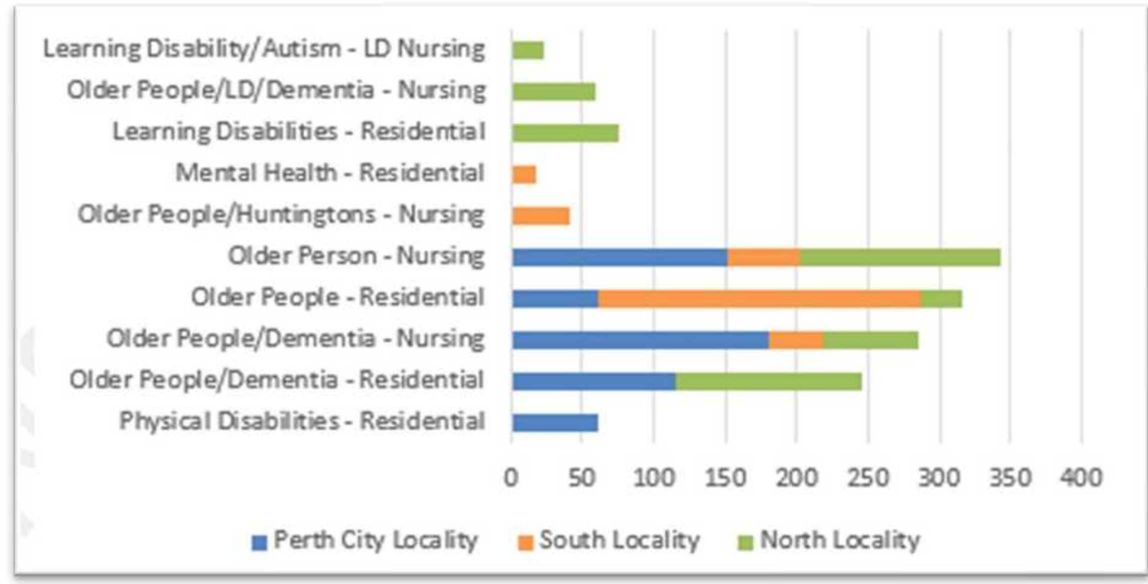


Source: HSCP

In Perth and Kinross there are **42** care homes comprising of **1469** beds with Figure 34 showing the type of beds available. In the South locality, there are **373** beds available between **13** providers, North locality has **525** beds provided by **16** providers and Perth City locality has **571** beds between **13** providers. However, bed occupancy fluctuates considerably and presently it is recorded at **12%** underoccupancy due to large scale enquiries and challenges with workforce capacity.

[21] Public Health Scotland, *Care Home Census for adults in Scotland,* 2022

Figure 34: Number of care home beds in each locality

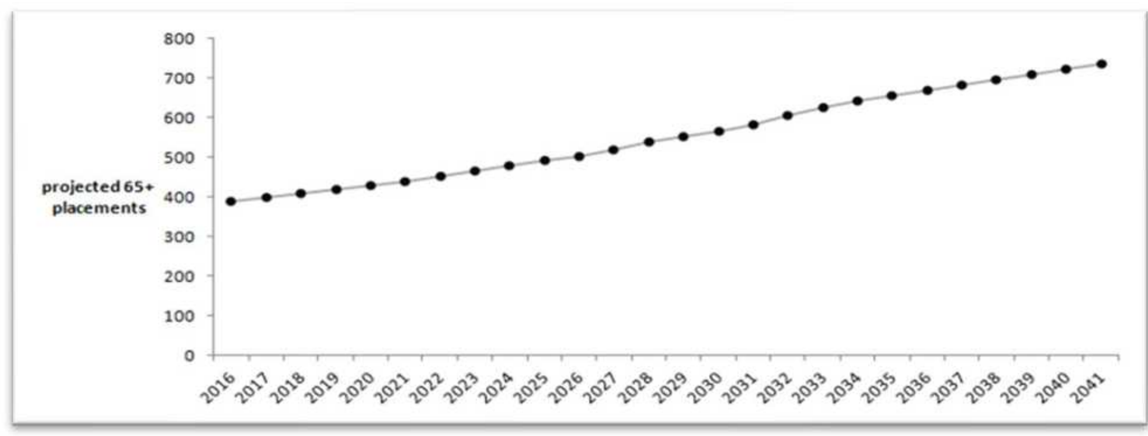


Source: HSCP 'Occupancy Care Homes" 2023

It is important to note that residential care homes may offer placements to people with dementia. Nursing care homes may also take residential placements. Care homes described as supporting older people and people with dementia have a dedicated unit/beds for people with dementia. The majority of people in care homes are in the over 75 age group with the average length of stay for older people aged 65 + being 2.4 years.

Figure 35 highlights a requirement for approximately 15 more placements year on year, with an approximate increase of 90% by the year 2041.

Figure 35: New placement projections (excludes crisis and physical disability)



Source: HSCP/NHS Data

Perth City and the North Locality have a high number of placements for those suffering from dementia at both a nursing and residential level. However, the South has high levels of residential support but limited nursing and specific dementia placements, increasing the likelihood of people experiencing a delayed discharge or accessing care out with their locality or community in which they live. 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.

As previous data highlights, there is a shift in the pattern of disease towards long-term conditions, particularly with growing numbers of older people with multiple conditions and complex needs such as dementia. However, people are often denied placements in care homes due to a perceived 'inability to meet their needs' leading people becoming delayed in hospital. We need to shift the balance of care back into communities and recognise that care homes are a vital resource in achieving this.

In order to meet this unmet need, the HSCP need to continue to work closely with care homes to improve staff knowledge and training, supporting them to be able to offer high quality care to patients with complex needs whose day to day behaviour may be perceived as challenging. The Enhanced Care Home Team plays a key role in bridging this gap but we need to ensure that it is robust enough to cope with present and continuing demand.

Perth and Kinross HSCP have been working collaboratively with care home providers to divert hospital admissions and assist discharge through the purchase of additional interim care facilities, like care home beds. The sustainability of this approach may well be a challenge when the need for permanent care home placements will increase as a result of an ageing population and Scottish Government funding ends.

Given that we are losing considerable bed days to delayed discharges, it potentially indicates a need for placement support that falls between the high intensity level of an inpatient ward and that of a general care home, coupled with the upskilling of staff and increase of staff complement and skill mix in residential and nursing care home settings.

4.6 Home care service

Our home care services provide regular support to people in their homes to assist them with everyday activities. The main mechanism for delivering this is through Care at Home. The aim of care at home is to help vulnerable people of all ages live independently and securely in their own homes by providing practical and personal support. The success of care at home is evident through the reduction in permanent placements as people are being supported to remain at home for longer. At present there 16 different Care at Home providers commissioned by Perth and Kinross Council HSCP to provide care at home. The HSCP HART Team is presently the largest provider of care at home.

The number of P&K residents, of all ages, that were assessed as requiring Homecare services in 2021/22 was 3,174 for a total of 1,754,030 Homecare hours[22]. 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. Capacity within this service is at 90% with approximately 1200 – 1500 hours of unmet need, primarily relating to Self-Directed Support (SDS) Option 3 for the over 65 age group, with double ups presenting one of the biggest challenges to resource.

[22] PKC Source return 2021/22

Table 12: Total number of care home clients.

	No. Home Care Clients	% Total
0-17	6	0.2%
18-64	672	21.2%
65+	2,495	78.6%
Total Home Care clients	**3.173**	

Table 1: Total home care clients by age group (2020/21)

4.6.1 By Locality

Based on the annual source return for 2020/21, by HSCP Locality, 36% of Home Care clients resided in Perth City.

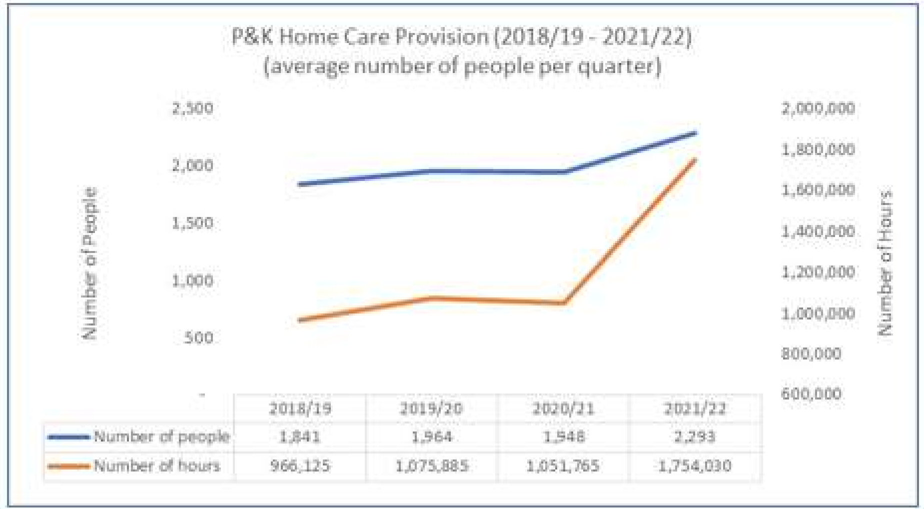
Table 13: Number of care home clients by locality.

North Perthshire	995	31%
Perth City	1158	36%
South Perthshire	943	30%
Not mapped	77	2%
Total Home Care clients	**3.173**	

Table 2: Total home care clients by locality (2020/21)

According to the published Public Health Scotland data, the *average* number of people assessed as requiring Home Care services by PKC increased by 18% from 2020/21 to 2021/22, with the total hours increasing by 67% (Figure 36). As a rate per 1,000 population, Homecare provision has increased from 12.2 in 2018/19 to 12.9 in 2021/22. Covid-19 had a significant on this type of service and it is still recovering leading to a level of current unmet need. However, following positive recruitment by the Partnership to a range of key services and by working in partnership with the provider Avenue, who provide an 'Early Support Discharge Service', levels of delay discharges are continually reducing and fewer admissions to hospital are occurring.

Figure 36: Perth and Kinross Home Care Provision

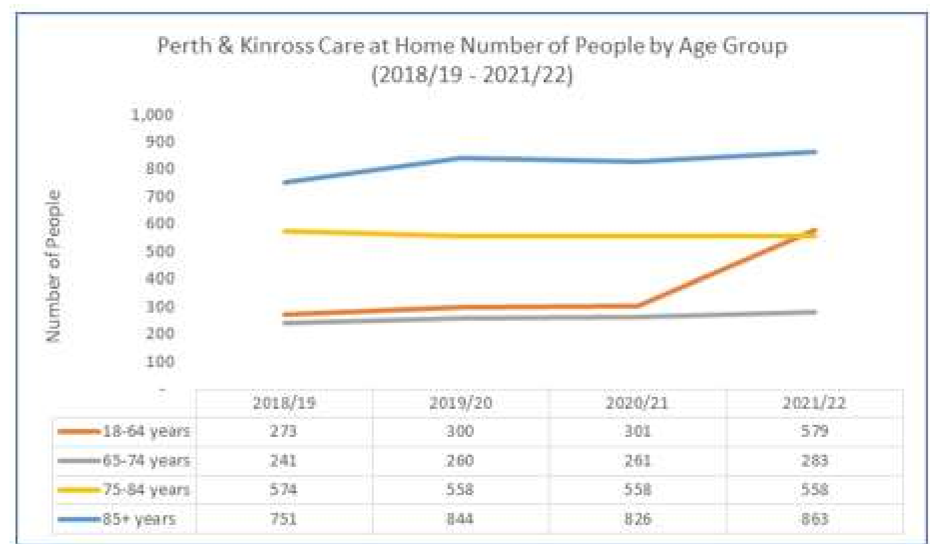


Source: PHS PKC average quarterly number of home care clients and total hours per year.

4.6.2 By Age Group

Based on the published PHS data as highlighted in Figure 37, there has been an 18% increase in clients from 2020/21 to 2021/22 is driven by the 18-64 age group, which increased by 92.1% from 301 to 579 (based on an average across all 4 quarters each year).

Figure 37: Perth and Kinross Care at Home Number of People by Age Group



Source: PHS PKC home care clients by age (average across quarters)

Complex needs around Learning Disability, Autism and Mental Health accounts for the majority of the increase in the 18 – 64 age group and these packages of care tend to be greater than those for the over 65. Retention in this group is lower due to frequency of behaviour that challenges. Hence, ensuring we have a skilled workforce who have access to specialist training, education and high levels of support is key to retention.

Due to our ageing demographic, there will be a continual increase in demand for this service as we strive to support people to remain at home. In response, new social care models are being developed and trialled. 'Living Well Care' is currently being piloted which offers a holistic person-centred approach to Care at Home by working flexibly and creatively to improve the personal and non-personal care outcomes of individuals living in the community.

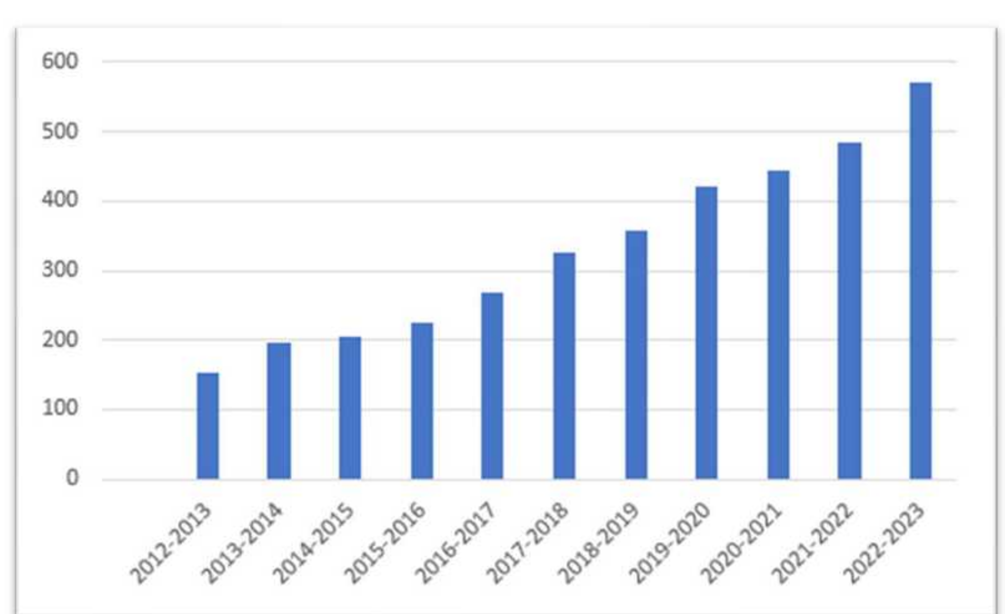
A significant majority of the over 65 reside in rural locations, where there is a limited workforce. We are presently working with the Rannoch Community Trust to explore different models of care to allow for increased care at home support. Community engagement is central to our work as move forward. Involving local communities in the designing and implementation of health and social care initiatives can lead to more effective and sustainable care.

Care at home relies heavily on health and social work, especially colleagues in Allied Health Care and Community Rehabilitation Teams for timely response to care and support needs. To ensure sustainability, it's essential to continue to work towards a well-integrated and efficient system with a continued focus on person centred care.

4.6.3 SDS Option 1 – Direct Payments

Self-directed support (SDS) is a way of providing support that means people are given choice and control over what kind of support they get.[23] Option 1 is known as Direct Payments, this is where the supported person receives money from their Local Authority, which allows them to arrange their own support or purchase a service from a care agency to fulfil an individual's outcomes. This is the only option where Personal Assistants (PAs) can be employed.

Figure 38: Perth and Kinross Number of Option 1 clients 2012 – 2023



Source: HSCP "Actual Option 1 clients" 2023

Figure 38 shows a continually increase in requests for Option 1 since 2012 with the greatest rise in numbers occurring between 2021/22 to 2022/23. This is primarily due to this option being as a default option due to reduced capacity from providers. However, this option faces similar recruitment challenges. Data from mid-May 2023 provides a 'snapshot' of current levels of unmet need of 169.5 hours, comprising of 19 clients trying to source a PA or self-employed carer. Table 14 highlights the South Locality as accessing this option at a higher level across all client groups.

[23] Scottish Government, *"Self-Directed Support Guide"*, 2014

Table 14: Option 1 by Locality .

Client group	North	South	Perth City
OP /PD	96	111	60
LD	8	35	22
MH	8	5	2
CARERS	28	59	27
SUB TOTAL	**140**	**210**	**111**
TOTAL	**461**		

Source: HSCP “Actual Option 1 clients” 2023

4.6.4 Recruitment and Retention

There is a recognition that continual recruitment is required to prevent a crisis in workforce levels. Promoting social care as a career is essential within Perth and Kinross and the HSCP it currently working with Developing the Young Workforce and local secondary schools to raise awareness and opportunities within this sector.

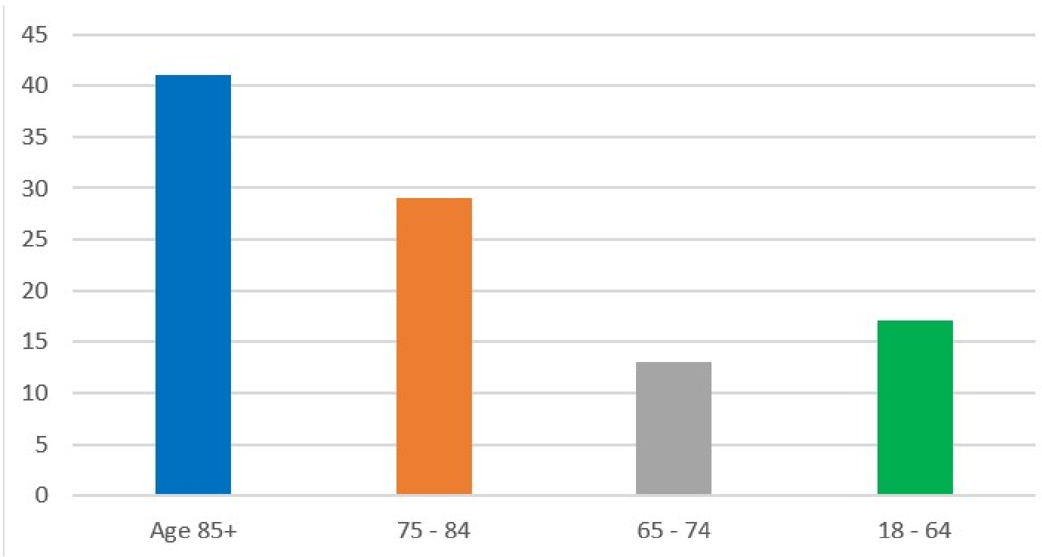
To support retention, flexible working conditions and investment in learning and development is offered to help people feel valued and to promote loyalty. Creating cohesive small teams in local contexts could also contribute to greater consistency and efficacy in their role.

National conversations are currently taking place on pay and employment conditions within the sector. Presently, private providers offer more competitive terms and conditions pay. Consequently, if we don’t achieve standardisation of these aspects across the entire sector, we will persistently encounter difficulties in retaining staff.

4.7 Technology enabled care

The Community Alarm & Telecare Service is designed to enable people to live safely, securely and independently in their own homes. It is accessed primarily by the over 65 age group, with the over 80’s age group benefitting from it the most (Figure 39). Staff are available 24 hours a day, 365 days a year, to respond to any alerts. The service currently has **4001** registered clients across Perth and Kinross, a decline of 73 service users from 2021 -22.

Figure 39: Number of clients by age group



Source: HSCP Care & Professional Governance Forum - Annual Assurance Framework, 2023

Between the period April 2022 and March 2023 there was 1,362 referrals in total, a decrease from the previous year of 245 referrals per annum. However, there has been an increase in the total number of calls received by the Community Alarm and Telecare Service over the last year. Between the period of April 2022 and March 2022, **192,703** calls were handled by the service, an increase of 23.5% from 2021/22.(See Table 15)

Table 15: Number of referrals and calls per month

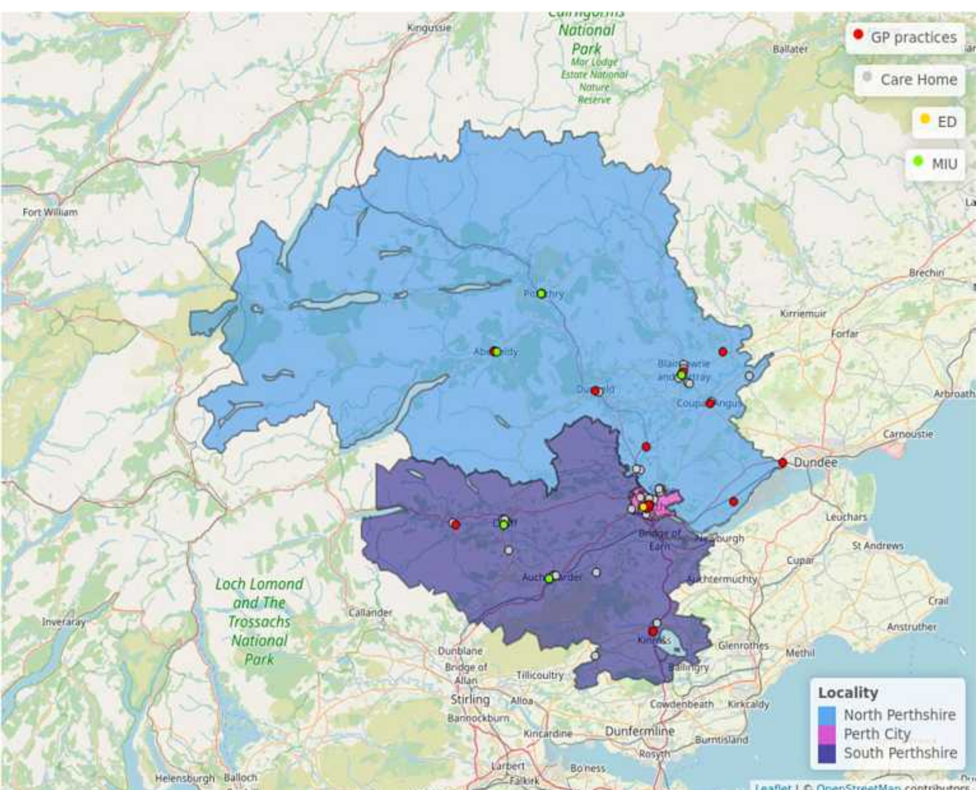
2022 - 2023	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April
Number of Referrals	215	109	197	90	92	108	104	91	72	104	81	
Number of Calls	12,983	13,663	13,758	14,537	15,172	17,061	16,959	17,433	16,676	16,545	23,199	25,762

Recent reports have indicated that on average, 73.22% of calls were responded to within 45 mins, and 87.06% within 60 mins. It is apparent that these averages fall slightly below the expected standard defined by Telecare Services Association (TSA), which could be due to the geographical nature of Perth and Kinross. The TSA has advised it is unlikely that we could consistently meet these targets due to square mileage of Perth and Kinross. This highlights the challenges for the HSCP in relation to providing a timely, equitable service to its remote and rural population.

The Technology Enabled Care Team continues to manage the transformation of the Alarm Receiving Centre from analogue to digital until all service users across P&K are migrated to a fully digital end to end service. The expansion of digital cross all health and social care settings is fuelling innovation from home health monitoring through the ConnectMe project which is funded nationally and managed by NHS and the array of client assessment tools entering the market. Both these areas are slowly transforming the service to being more proactive in its approach. Whilst TEC continue to deliver support to applications such as Brain in Hand and the Respiratory App, we continue to investigate opportunities in the use of TEC to promote independence through the use of self-learning tools and video technologies. The challenges facing TEC have been the promotion and encouraged use of TEC through service providers and this is a challenge we continue to tackle via face to face community and service engagement events.

5 PRIMARY CARE

Map 4 : Services by locality in Perth and Kinross HSCP



Primary care is an individual's most frequent point of contact with the NHS. Its influence on population outcomes and the function of the wider health and social care system is significant, acting as both a first point of contact and a gateway to a wide variety of services. Most of the time, people use their own personal and community assets to manage their health and wellbeing and achieve the outcomes that matter to them. Primary care professionals enhance this by providing accessible health care and support to individuals and families in the community, when it is needed, at whatever stage of life.

There are currently 23 GP Practices in Perth & Kinross, with a small number of practices operating separate and part time branch surgeries. There were 5 branch surgeries, however Blair Atholl branch surgery was closed last year following decision at NHS Tayside board in December 2022. This leaves 4 branch surgeries which are still operating, Methven and Scone, Dunning and Kinloch Rannoch.

There are 5 clusters; Perth City, Strathearn, Strathmore, South and North-West Perthshire. Each cluster has a Cluster Quality Lead to represent the practices within each geographically aligned cluster and each practice has a Practice Quality Lead.

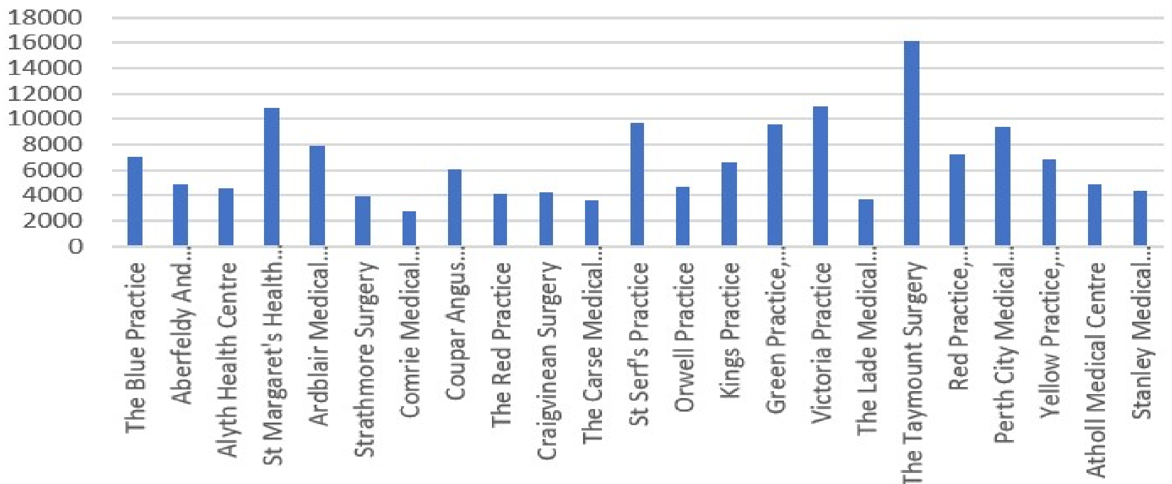
Since 2018, we have seen the closure of Bridge of Earn, Blair Atholl and most recently Invergowrie surgeries. Figure 40 demonstrates the significant impact that an unplanned GP practice closure can have on neighbouring practices.

Figure 40: Change in Practice Populations April 2017 to 2019

Source : ISD Data

Currently in Perth and Kinross, we have 2 practices in Perth City area operating with closed lists due to inability to recruit, although both have now been successful and are awaiting new GPs to start in September when lists will re-open. There is a further application to close a list by a rural practice.

Figure 41: Current Practices and List Sizes October 2023



Source: [GP Practice Contact Details and List Sizes - GP Practices and List sizes October 2023 - Scottish Health and Social Care Open Data (nhs.scot)]

Reforms to the General Medical Services (GMS) contract in 2018 established a re-focused role for GPs and enhanced the multi-disciplinary team to take on many of the frontline healthcare tasks previously co-ordinated by GPs. This has led to an increase in the numbers of multi-skilled healthcare professionals situated within GP practices and making a significant contribution to the improvement of health outcomes for the people in their communities.

As independent contractors, GPs have significant concerns around sustainability in terms of workforce and workload, premises and support for the wellbeing of themselves and their staff. Perth & Kinross HSCP continue to work collaboratively with GP practices to identify opportunities to increase resilience and to improve recruitment and retention, making practices sustainable within their communities to face the challenges posed by rapidly changing population characteristics including an increase in older, more frail and more complex patients.

5.2 Community Health Services

The broader Community health services can cover an extensive and diverse range of health and social care activities. Services are delivered in a wide range of settings – including in people's own homes as well as in community clinics, community centres and schools – so are less visible than services delivered in hospitals and GP surgeries.

The precise range and configuration of services vary between local areas. They commonly include adult community nursing, specialist long-term condition nursing, therapy services, preventive services such as sexual health and smoking cessation clinics, and child health services including health visiting and school nursing. Some providers also deliver specialist and targeted services.

Community health services provide support across a range of needs and age groups but are most often used by children, older people, those living with frailty or chronic conditions and people who are near the end of their life. Community services often support people with multiple, complex health needs who depend on many health and social care services to meet those needs. They therefore work closely with other parts of the health and care system, such as GPs, hospitals, pharmacies and care homes. The increasing numbers of people living with long-term conditions means that more people are likely to need support from community health services in the future and our progressively ageing population will increase the demands disproportionately in P&K.

5.3 Urgent care

Urgent care is defined as care for any non-life threatening illness or injury which nevertheless needs urgent attention[24]. While we maintain and progress an overall focus on prevention and early intervention, sometimes there is no alternative to an admission to hospital. Where this is the case, work is progressing to improve the

[24] Scottish Government *Reshaping unscheduled care services* Scottish Government 2022

inpatient experience, ensuring people have access to the right care in the right time and in the right place, enabling them to return home as soon as possible.

A redesign of urgent care services has been identified as a key workstream for the HSCP; it requires an integrated, whole system approach across health and social care in partnership with the third and independent sectors to provide a range of community based, short-term, targeted specialist care and support services. These services will also support timely discharge from hospital where admission cannot be avoided, and support people to continue to live as independently as possible for as long as possible in the heart of their communities.

6. CARERS

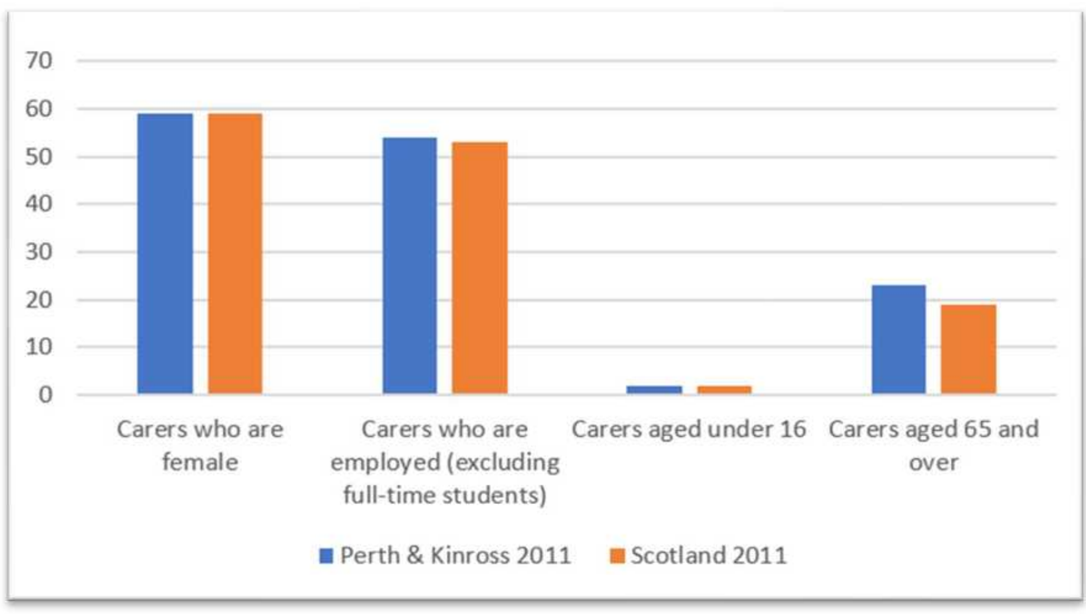
Unpaid carers of all ages play a vital role in the lives of the people they care for and in the wider community. Supporting carers to continue caring for as long as they wish and are able, not only helps keep families together, reduces the need for formal or statutory services, but also saves the economy money (Carers UK estimates the saving to be about £132 billion per year).

An unpaid carer can be a child or an adult who gives help and support to someone else who has a disability, illness, health condition, a mental health or substance misuse issue, and/or who is elderly or frail. The person being cared for may be a spouse, parent, child, sibling, a relative, neighbour or a friend of the carer.

Unpaid carers can also be parent or kinship carers who provide care to an ill or disabled child to a greater extent than would be expected in a parenting role. Unpaid carers may have paid or voluntary work other than their caring role, be in education, retired, or be unemployed. They may be in receipt of welfare benefits, pensions or be earning wages unrelated to their caring role.

The most recent national census that we have data for was in 2011. We are currently waiting for the availability of the census information from 2022, which will provide a more up-to-date picture.

The 2011 Census asked people who provided unpaid care to give details regarding the amount of time they spent caring each week. In 2011, 13,308 (9%) of the 146,652 people who responded to the census in Perth & Kinross identified themselves as carers, of which:



Source: Census 2011

Of the carers aged over 16, 5% reported that their health is 'bad' or 'very bad' and 79% reported that their health is 'good' or 'very good'. However, where the carers provide at least 20 hours of care per week, the proportion reporting that their health is 'bad' or 'very bad' increases to 9% and those reporting that their health is 'good' or 'very good' decreases to 70%. This suggests a negative impact to health related to an increased amount of care provided.

It is estimated that the number of carers has increased since the covid-19 pandemic. In fact, Carers UK estimated in June 2020 that an additional 4.5 million people had become unpaid carers across the UK since the pandemic began, bringing the total to 13.6 million.

The Scottish Carers Census 2021-22 shows there were 42,050 unique carers identified. This data also indicates that adult carers were slightly less likely to live in the least deprived areas; however, on the contrary, young carers were more likely to live in the most deprived SIMD deciles in 2021-22. In terms of support needs, more than 6 in 10 carers were recorded as most commonly requiring advice and information and short breaks and respite out of all the different categories in 2021-22.

Locally, the number of carers supported in Perth and Kinross through PKAVS Carers Centre have doubled from 2020 to 2023 and the number of carers supported through P&K council have remained fairly consistent. The increase at PKAVS may be due to them being predominantly the point of entry for support and information for carers. While it is positive that the number of identified carers in P&K have grown, helping to close the gap of 'hidden carers' between the census figures and the carers known to services, as we also know that the number of people becoming carers have also grown since the pandemic, this might mean that the gap is still as, or more, substantial as before. We are currently waiting for updated census data for more information on these numbers.

In PKAVS, the split in registered carers is generally 2:1 in both North and South against Perth City. Of this, just under a third of the carers supported is a young carer (5-17) and two thirds an adult carer (25+), the rest being young-adult carers (18-24).

In P&K council, the split in registered carers is generally a third in each locality, with both 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.

7. COMPLEX CARE

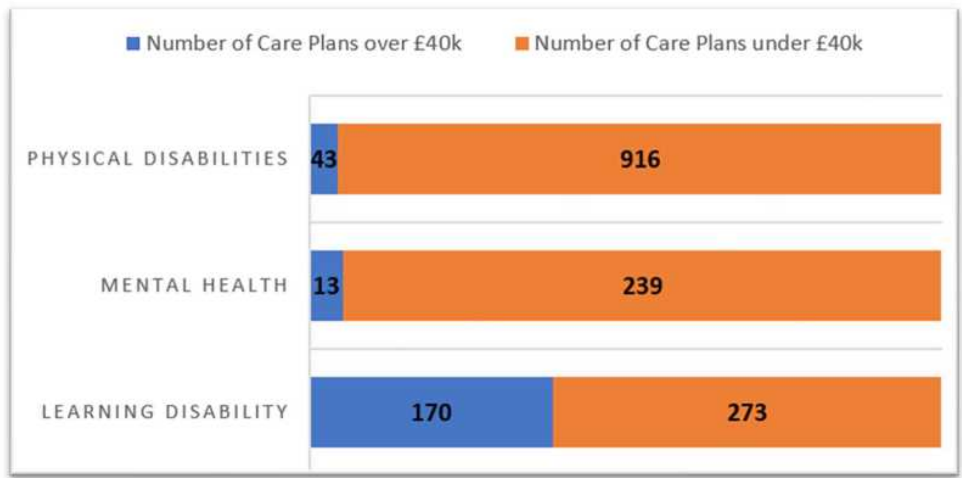
Research completed by the Scottish Learning Disability Observatory (SLDO) indicates that more people with a learning disability are now living into older age, with many presenting with a diverse range of complex and multi interrelated health conditions. The life expectancy of people with learning disabilities is increasing, however it remains shorter by some 20 years when compared to the general population. Research indicates that these deaths are avoidable, treatable and manageable[25]. SLDO also state that people with autism experience poorer mental and physical health and may be more likely to die younger than their peers without autism[26].

The term Complex Care is used to describe people with learning disabilities who require more intensive support and includes people with behaviour which challenges, autism spectrum disorder, mental health needs, people with profound and multiple disabilities, offending behaviour, or a combination of these. Those meeting this criteria will have a care package above £41k.

In 2019, there was 5723 care plans across a number of Client Category Groups with 301 care plans over £41k and 226 relating to complex care (Figure 42). There was 5422 under this costing threshold with 1428 clients assigned as complex care.

[25] Scottish Learning Observatory *Life expectancy and causes of death of people with learning disabilities, 2020*
[26] Scottish Learning Observatory *Multi-morbidity in adults with autism, 2020*

Figure 42: Number of care plans over and under £41,000



Source: HSCP 'Transforming Complex Care' 2019

Note – These figures do not include autism

Perth and Kinross HSCP undertook a transformation of complex care in 2019 due to significant financial and resource pressures specific to Learning Disability and Mental Health packages equating to £2.8m. The ambition of this programme is to 'help people live independently, at home for as long as possible with as high a quality of life as possible'.

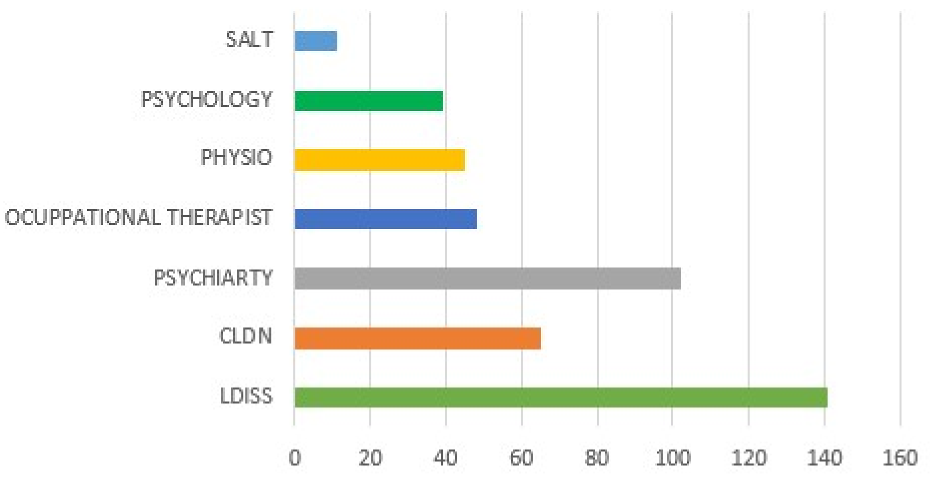
To achieve this, the SCOPE Team has evolved, a Perth and Kinross Health and Social Care multi-disciplinary team, which will provide a life-long support to individuals with a learning disability and/or autism whose needs are complex from the age 14 and upwards. This team will work towards the prevention and reduction of hospital admissions, carer and/or placement breakdowns and out of area placements.

7.1 Specialist Teams

7.1.1 The Learning Disability Specialist Team

The Learning Disability Specialist Health Team provide support to over 450 people. Figure 43 shows the services that people are currently accessing. Health colleagues have estimated that there are potentially 1,611 individuals in Perth and Kinross with learning disabilities who are not known to services.

Figure 43: Number of people accessing learning disability specialist services.



Source: NHS Tayside LDISS 'Annual Health Check Proposal', 2023

Data in relation to learning disabilities in Perth and Kinross is based on people who receive services, which does not give a true measure of current prevalence. Public Health Scotland are working with GPs to gather this data but to date it is not available.

According to the 2011 Census, people with learning disabilities rated their health very low in comparison the general population.

In response, the Scottish Government has set out directions to all Scottish Health Boards to ensure all patients with a learning disability have an **annual health check.** This came into force in May 2022. Within Tayside a short-life working group (SLWG) has been looking at how to implement this, potentially adopting a blended approach between primary care and the learning disability specialist team. A number of practices in NHST (one of which is in P&K) is piloting the assessment methodology & approach.

The aim of this new service will be to help address health inequalities and ensure that people in this group are able to have any health issues identified and treated as quickly as possible.

The Learning Disability Intensive Support Service(LDISS) recognised that people with learning disabilities faced challenges when accessing good quality health care and need changes to healthcare to make things better, known as reasonable adjustments. They analysed data in relation to non-attendance for appointments and introduced a hybrid approach, comprising of clinics within LDISS and an outreach service. This has led to health checks being completed at the right time, in right place, by the right person. It is vital that the workforce and services recognise the need to make reasonable adjustments to reduce barriers to healthcare and improve health outcomes.

People with learning disabilities are living longer. They also have a different pattern of health conditions from the general population and different causes of death[27]. They are more likely to develop dementia and those who develop a dementia related condition will usually do so at a younger age, for example, up to three quarters of people aged 50 years or older with Down's Syndrome develop dementia. Efforts should commence to work in collaboration with housing, community services and care providers across all localities to address future need to ensure people continue to live in their own home within their local community with access to the right care and support.

7.1.2 Tayside Adult Autism Consultation Team

The National Autistic Society indicated to the Scottish Government in 2023 that more than 1 in every 100 people in Scotland has an Autism Diagnosis[28]. The demographic has changed considerably since the 2011 Census, with more women, girls and non-binary people being diagnosed as autistic.

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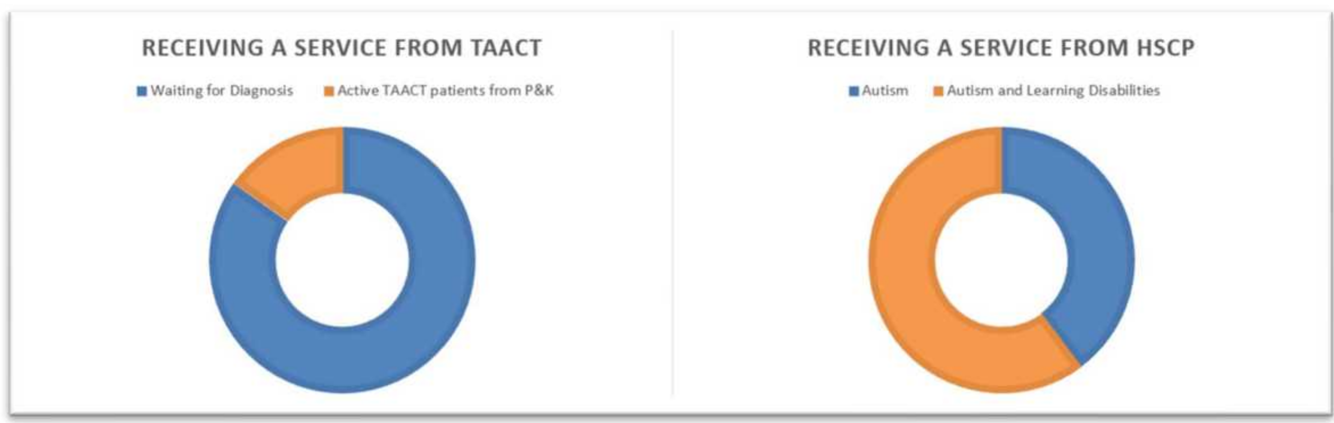
[27] Scottish Learning Disabilities Observatory, *Causes and rates of death in adults with learning disabilities,* 2020.
[28] Scottish government *Celebrating Autism* 2023

Autistic people also self-assessed their health as poorer than the general population.

Similarly to learning disabilities, data in relation to autism in Perth and Kinross is based on people who receive services. Public Health Scotland are working with GPs to provide more accurate data in relation to numbers of people with a diagnosis. There is a recognition that a number of people with autism will remain undiagnosed or choose not to be diagnosed.



There are presently 37 autistic people and 56 autistic people with a dual diagnosis of a learning disability who are receiving an HSCP service. The HSCP commission support from our local One Stop Shop, Autism Initiatives who currently support 637 autistic people, which is an increase of 65 referrals this year alone.

The Tayside Adult Autism Consultation Team (TAACT) is a multi-disciplinary team who provide diagnostic and consultancy services. At present, there are 167 patients from Perth and Kinross who are waiting for diagnostic assessments and they are presently supporting 30 patients.

In a recent HSCP consultation, contributors highlighted mental health as a key priority. They identified difficulties in accessing mental health services, lack of understanding of autism within the workforce and availability of specific resources and treatment for autistic people. People commented that their interaction with community mental health teams at times compounded their situation rather than actively improve it. As an HSCP we need to ensure that we support our workforce to develop a greater understanding and knowledge of autism to ensure they can support autistic people towards recovery.

Employability was also identified as a key priority. Data provided by The Office for National Statistics[29] highlighted that 'disabled people were among those disabled people with the lowest employment rate' with only 22% of autistic adults being in any kind of employment. Unemployed people are five times more likely to have poor health than employees[30]. This issue also resonates with people who have learning disabilities or those with a mental illness.

Presently, Perth and Kinross HSCP and PKC are working on a government initiative in partnership with Perth Autism Support to increase understanding of neurodiversity within the workforce and improve the support that autistic employees receive.

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[29] Office for National Statistics *Outcomes for disabled people in the UK - Office for National Statistics (ons.gov.uk), 2020*

[30] The Health Foundation *How employment status effects our health 2022*

7.1.3 Employment Support Team

The HSCP's Employment Support Team (EST) delivers a supported employment service to people with health conditions or disabilities to prepare for, find and maintain paid employment. The team supports with early intervention and prevention and in work crisis management providing a quick response and also supporting individuals and employers with job retention.

The EST is currently working with 103 people seeking employment or being supported with job retention. The staff team is at capacity with average caseloads of 25+ people each. There are 28 people waiting for a service with a current wait time of at least 4 months. The team is currently in the process of recruiting a full time member of staff and are hoping this person is in post for September 2023. Team members cover Perth and Kinross localities ensuring service users from all areas are assured of a supported employment service.

Since the end of the pandemic there has been an increase in demand for the service and referrals submitted. The majority of referrals are for people with mental health conditions referred by the community mental health teams who recognise the benefits, value and long-term economic savings of people being in meaningful employment.

From April 2023 the EST also facilitated a Supported Volunteering opportunity for service users interested in working in hospitality, which was undertaken in collaboration with the Salvation Army. More employability opportunities to support people into volunteering would aid with helping individuals into volunteering which is both valuable to the community as well as the individuals themselves. Funding seems to be prioritised into supporting people into paid employment and not volunteering therefore opportunities for people needing support to access volunteering will be missed.

In 2022, to meet demand for referrals from people with physical disabilities and people with sensory loss, the team secured short term funding through the Challenge Fund – (No-one Left Behind) to be able to support 10 people through the service. When funding ended in March 2023 the team absorbed these job seekers into their current caseloads; however, as expected referrals continue to be received from these client groups. This process impacted on the team's ability to progress individuals on the waiting list. This underlines the need for an ongoing supported employment service to be available for job seekers with physical disabilities or sensory loss which the EST are offering but this will need to be reviewed in line with the capacity of the team.

Additionally, the end of (No-one Left Behind) Challenge Fund monies in March 2023 added staff resource pressure to the EST due to other employability partners looking to signpost service users to EST as partner agencies were unable to continue to support individuals without the funding for staff resources. This highlights the need for robust and sustainable supported employment services to be available for individuals with health needs looking to get into work.

8. PALLIATIVE AND END OF LIFE CARE

The essence of health and social care is to support people to live and die well, on their own terms with whatever health conditions they have[31]. This will become more critical in Perth and Kinross due to our ageing population, increasing the demand on palliative and end of life services.

The diagram below highlights people's feelings about palliative and end of life care[32].

It is critical that the HSCP strives to ensure consistency and a responsive service to meet people's palliative care needs.

A report completed by Marie Curie, indicates that 'community settings may replace hospital as most common place to die by 2040'[33]. Figure 44 highlights that the majority of people in Perth and Kinross have died in a community setting, either at home, in a care home or hospice.

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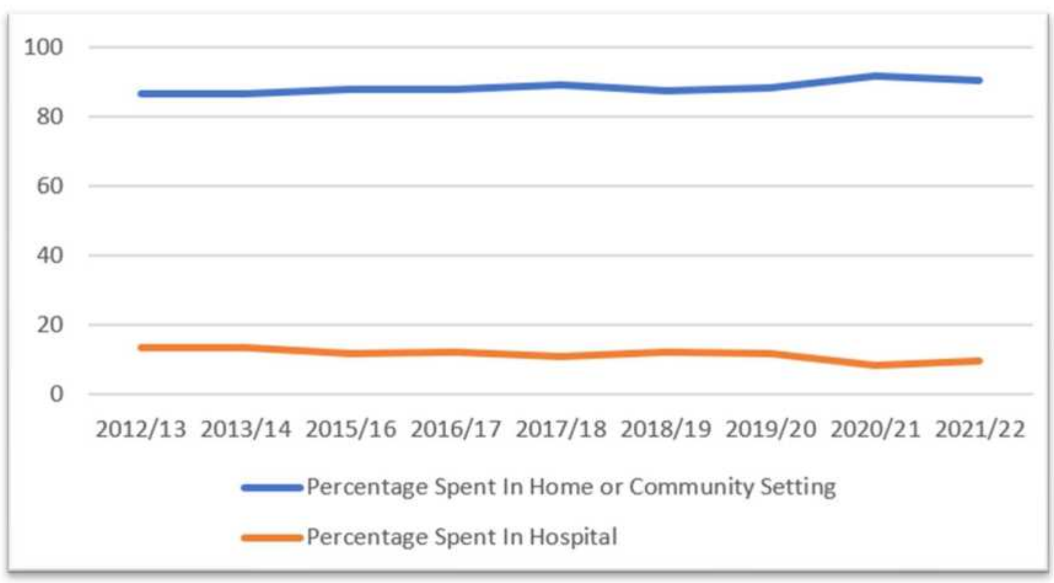
[31] Scottish Government *Palliative and end of life care: strategic framework for action* 2015
[32] Scottish Government *Palliative and end of life care : care opinion* 2015
[33] Marie Curie

Figure 44: Percentage of last six months of life spent in community or hospital in Perth and Kinross



Source: [Palliative and End of Life Care - By HSCP - Scottish Health and Social Care Open Data (nhs.scot)]

The complexities associated with older age such as frailty, dementia and the increasing likelihood of multi-morbidity mean that palliative and end of life care is becoming more intricate. A priority for the HSCP must be to ensure we have robust community provisions in place to ensure that people can plan with the certainty that support will be delivered in the setting of their choice.

In preparation for this increase in demand we need to ensure that;

- We have a workforce in the community that is upskilled to support palliative and end of life care.
- Care providers are able to be dynamic and responsive to changing need.
- The necessary volume of care home places.
- We build community care capacity through informal carer support and community engagement.

APPENDIX 1

230220_Strategy Thematic Mapping

APPENDIX 2

Population shares (%) by urban / rural area, 2023 Classification

Category	Description
1 – Large urban areas	Populations of 125,000 or more
2 – Other urban areas	Populations of 10,000 to 124,999
3 – Accessible Small towns	Populations of 3,000 to 9,999 within 30 minutes drive of a settlement of ≥ 10,000 people
4 – Remote small towns	Populations of 3,000 to 9,999 more than 30 minutes drive of a settlement of ≥ 10,000 or more
5 – Accessible rural areas	Areas with a population of less than 3,000 within 30 minutes drive of a settlement of 10,000 or more
6 – Remote rural	Areas with a population of less than 3,000 more than 30 minutes drive from a settlement of 10,000 or more.

Minute

Perth & Kinross Health & Social Care Partnership

P & K HSCP Strategic Planning Group Minute

Minute of the above meeting held on 30 April 2024 at 1pm via Microsoft Teams
(Recorded for Minute purposes only)

Present

Ian McCartney	Service User Representative (Chair)
Kenny Ogilvy	Interim Head of ASWSC/Operations
Evelyn Devine	Head of Health
Donna Mitchell	Interim Chief Finance Officer
Angie Ferguson	Perth Autism Support CEO/Autism Rep
Sandra Auld	Service User Representative
Christopher Lamont	Senior Service Manager - Mental Health services
Maureen Taggart	Alzheimer Scotland/Older People
Raymond Jamieson	Young Carers' Rep (PKAVS)
Alison Fairlie	Service Manager
Bernie Campbell	Carer Representative
Valerie Davis	Lead Nurse
Jillian Milne	Chief Executive, Mindspace/Third Sector Forum
Karyn Sharp	Service Manager
Angie McManus	AHP Lead
Kathryn Baker	TCA
Angela Milne	North Locality Manager
Christopher Jolly	Service Manager Business Planning & Performance
Charlie Cranmer	Alcohol and Drug Partnership Co-ordinator (Item 2)
Alison Gallacher	Business Improvement Officer (Item 3)
Tracy Hunter	Workforce Planning Programme Manager (Item 4)
Ben Wilson	Planning & Housing Strategy Manager (Item 5)
Elliot Williamson	Project Management Officer (Item 5)
Carlyn Morilly	Transportation Development Officer (Item 5)
Shara Lumsden	(Minutes)

Apologies

Sandra Young	Tayside Services Manager, Supporting Mind Scotland
Amanda Taylor	Senior Service Manager for Older People, Palliative and Urgent Care
Dave Henderson	Scottish Care – Independent Sector Lead
Ingrid Hainey	Hillcrest Futures/Substance Use Rep
Jacquie Pepper	Chief Officer, P&K Health & Social Care Partnership
Zoe Robertson	Interim Head of ASWSC/Commissioning (Vice Chair)
Evelyn Devine	Head of Health
Lisa Milligan	Service Manager, Primary Care
Julie Hutton	Chief Executive of Independent Advocacy
Tia Dixon	Locality Manager
Maureen Summers	Chair of Carers' Voice & Carers'

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1. WELCOME AND APOLOGIES

IM welcomed everyone to the meeting.

2. ADP Delivery Plan Presentation

Draft ADP Strategic Delivery Plan is out to the ADP Strategy Group for comments. The plan will go to the ADP Strategy Group for final sign off next month. Perth and Kinross ADP are a multi-agency partnership responsible for tackling alcohol and drug issues for individuals, families and communities throughout Perth and Kinross.

Previous ADP Strategic Delivery Plan was signed off before the pandemic therefore part of the original plan had to be reworked.
Drug Death crisis and the challenges associated led to several Scottish Government papers, plans and frameworks. Significant revisions in 2020 to deal with what was happening both locally and nationally. Progress was made across all priorities:

- Establishment of Near-Fatal Overdose Pathway
- Establishment of Residential Rehabilitation Pathway
- Formation of iDART (Integrated Drug and Alcohol Recovery Team)
- Implementation of MAT Standards
- Support for projects utilising a Whole Family Approach to service design
- Development of a new Voluntary Throughcare model for people returning to communities from prison

This work has resulted in several key performance improvements:
- A reduction in drug deaths
- A reduction in near-fatal overdose incidents
- An increase in the number of approved residential rehabilitation places
- An improvement in treatment waiting times
- An increase in the number of Naloxone kits distributed

The new Strategic Delivery Plan will cover a 3-year period. Consultation was undertaken with a wide range of partners and individuals from statutory, third sector, living/lived experience, and carers groups e.g. EPICS, recovery cafes, people accessing treatment services.

The **STRATEGIC PLANNING GROUP:**
- Noted the overview provided.
- Acknowledged the improvements made.

3. Carers Strategy Update

The Joint Carers Strategy was approved in August 2023. There are 7 outcomes in the strategy. Outcome 7 is related to Education and Children's Services. KS will obtain a written update from Sharon Cooper, Service Manager, ECS and sent it round the group. **KS**

There are 3 phases for the Carers Act Awareness Training:
- Phase 1 - ongoing from 2021 – Statutory Social Work/Social Care & Education Social Work workforce

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- Phase 2 - from April 2024 – roll out of specific materials for health partners
- Phase 3 – Carer training

Carers Champions are across all 5 localities. Independent representatives and associated members Carers Voice, 9 HSCP Carer Support Workers and funding for 11 posts in PKAVS Carers Centre.

In 2023 a presentation to registered managers from Commissioned Services on the benefits of Carer Positive https://carerpositive.org with one expressing interest in progressing this.

Young Carers continue to be supported through transition to Young Adult and then Adult Carers through arrangements with PKAVS Carers Centre (due January 2025).

Ongoing Carer Experience Survey collated and under review, Carers Trust survey in 2023 carried out by PKAVS Carers Centre.

Promoting Variety project concluded in September 2023 – created by PKAVS Carers Centre of regular supportive meetings and activities for Parent Carers in Perth & Kinross.

- Project actions were the result of co-production work by PKAVS Carers Centre, Parent to Parent, Ship and Perth Autism Support; activities included wild swimming, coffee and chat, summer picnic
- 53 parent carers and their families attended at MacCrosty Park
- Family day at Perth Races with 119 attendances (supported by Perth Racecourse)

Challenges:

- 2 Risk Workshops – December 2023 and January 2024
- 9 Risks identified
- Availability of respite options – Statutory Support (6 months Test of Change has been approved)

BC asked for more information around respite for carers to allow for feedback to their groups.

MS paid tribute to Mel Gibson (who has now stepped down from his Carer Rep role) for his voluntary time supporting carers and advocating on their behalf. Improvements required to both hearing and responding to carer voice were noted.

The **STRATEGIC PLANNING GROUP:**

- Noted the Carer Strategy update

4. Workforce Plan update

TH discussed the key points from the Workforce Plan and the 5 Pillar Approach:
Plan – Attract -Train - Employ - Nurture

Working groups have already been set up but there needs to be alignment into the Workforce Steering Group to ensure all the actions and processes feed into each other for the reporting and governance structure.

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The suggested Sub-Working Groups need to be set up and working:

- Education and Development
- Safer Staffing
- Recruitment/Retention/Attraction
  Staff Health and Wellbeing

JM advised progression pathways within the Third sector are experienced differently and although they can bring people in and train them, provide a nurturing environment for people, career progression is more challenging, with less progression options within smaller organisations and staff leave because they are good and ambitious. More work needs to be done around opportunities for development in the Third Sector.

IM asked if Universities or College can provide a partnership to provide medical skills. IM advised that a Medical School has been created in Wigan in all levels of skills and linking it with Wigan College. IM will make contact and provide further information to TH.

The **STRATEGIC PLANNING GROUP:**

- Noted the overview provided.

IM

5. Draft Transport Strategy and Action Plan - Ben Wilson, Elliot Williamson, and Carlyn Morilly

Ben Wilson, Planning, Housing & Strategy Manager and covers 3 strategy areas:
Planning Strategy – long term growth and change, new housing for Perth and Kinross
Housing Strategy – Affordable Housing Programme, new builds along with Housing Association and Council's own programme
Transportation & Development Strategy – transport strategy and planning i.e. Cross Tay Link Road

BW ensures all 3 strategies are aligned as part of the Corporate Plan to provide sustainable, inclusive places.

The first draft Transportation and Development Strategy will be going out for public consultation.

MS raised the issue of Stagecoach changing bus routes and the proposal to withdraw the bus service between PRI and Ninewells. Raising concerns regards the potential impact on patients and on staff using the buses.

BW advised that Perth & Kinross Council do provide subsidies for most of the bus routes in Perthshire. The Public Transport Unit handle the subsidy arrangements.

Elliot Williamson, Lead Officer for the local transport strategy and action plan described how it was Perth and Kinross Council's vision to manage and develop the transport network over a period of 15 years. The Strategy will consider all modes of transport, for the movement of transport, for the movement of goods and people.

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The Transport Strategy is structured across 5 headings to show the purpose, organisational vision, and objectives in line with appropriate national guidance. Following a robust evidence-led process, 11 unique Transport Planning Objectives were produced to address locally identified problems. Perth and Kinross Council has adopted the 'Avoid, Shift, Improve' Framework to communicate the types and scale of actions required to provide an improved transport experience for users of the transport network.

The Action Plan originally had over 200 actions although this was reduced to 164 actions of which 44 are the strategic actions are split across the 8 themes. An 8-week public consultation will be facilitated through the PKC Consultation hub.

- 6 supporting promotional stalls around Perth and Kinross within staff resource
- Target business community and children & young people

EW will send the presentation and links to the consultation to the group.

AF discussed their Supporting Autistic parents and carers in Independent Travel Programme for young people. AF asked if there was anything they can do to help with the consultation and will connect with EW/BW after the meeting.
BW advised that Taktran covers the wider area will be more involved in the funding available for this type of programme of work.

Discussion followed regards cycle use, with a range of work being carried out with use of cycle paths and roads in and around Perth City Centre. Aiming to improve people's physical health and mental health for accessibility into towns and villages.
KB commented on the width of the cycle lanes in and around Perth. Sometimes there are cars parked which makes the cycle lanes useless. KB is interested to know how space will be made for bikes.

IM asked if it is possible to get together outwith this meeting to discuss ways to work together which could impact on the Transport Strategy and vice versa. BW is happy to meet further or what works for the Strategic Planning Group.

The **STRATEGIC PLANNING GROUP:**

- Noted the overview provided.
- Requested further involvement in the development of this strategy.

6. **A.O.C.B**

No items discussed.

Date of Next Meeting: 6 February 2024 13.00- 16.00pm

DRAFT

PERTH & KINROSS INTEGRATION JOINT BOARD
WORKPLAN 2024-25

(Report No. G/24/68)

This work plan outlines the major items the Integration Joint Board has to consider as part of its schedule of work for the year. This plan will continue to be kept under review throughout the year.

Item	Standing Item	Non Standing Item	Responsibility	14 Feb 2024	20 Mar 2024	5 June 2024	21 Aug 2024	2 Oct 2024	11 Dec 2024	19 Mar 2025	Comments
Minute of Meeting	✓		Chief Officer	✓	✓	✓	✓	✓	✓	✓	
Action Points Update	✓		Chief Officer	✓	✓	✓	✓	✓	✓	✓	
Matters Arising	✓		All	✓	✓	✓	✓	✓	✓	✓	
Membership Update		✓	Clerk to the Board	✓	✓						
Delivering on Strategic Objectives											
Chief Officer Strategic Update	✓		Chief Officer	✓	✓	✓	✓	✓	✓	✓	
Tayside Mental Health Services: Strategic Update		✓	Chief Officer	✓		✓		✓	✓	✓	Written Report
Tayside Mental Health Services: Strategic Update (*Verbal*)		✓	Chief Officer		✓		✓				Verbal Update
Perth & Kinross Older People's Strategic Delivery Plan		✓	Head of Health					✓			Annual Update
Perth & Kinross Autism / Learning Disabilities Strategic Delivery Plan		✓	Head of Adult Social Work Operations		✓					✓	Update on SDP
Perth & Kinross Primary Care Strategic Delivery Plan		✓	Associate Medical Director					✓			Annual Update
Perth & Kinross Primary Care Premises Strategy		✓	Associate Medical Director					✓			Annual Update
Perth & Kinross Carers Strategy		✓	Chief Officer				✓				Annual Update
Participation & Engagement Strategy		✓	Chief Officer					✓			For approval
3 Year Workforce Plan		✓	Head of Adult Social Work Operations			✓					Annual Update
Alcohol & Drug Partnership Strategic Delivery Plan 2024-2027		✓	Head of Adult Social Work Operations			✓					For approval June 24. Annual Update October 24
Strategic Planning Group Update and Minute	✓		Head of Adult Social Work Commissioning	✓		✓	✓	✓	✓		
Perth & Kinross Community Mental Health & Wellbeing Strategy 2022-2025		✓	Senior Service Manager						✓		Annual Update
Perth & Kinross IJB Strategic Commissioning Plan		✓	Head of Adult Social Work Commissioning		✓	✓					Update March 2024. Approval June 2024.
Chief Social Work Officer Annual Report		✓	Chief Social Work Officer	✓						✓	For noting
Winter Planning Across Perth & Kinross 2024-25		✓	Chief Officer					✓			For approval
NHS Tayside Director of Public Health Annual Report 2024		✓	Chief Officer							✓	
Perth & Kinross Adult Protection Committee Annual Report		✓	Chief Officer	✓					✓		Report and Presentation
Perth & Kinross Adult Support & Protection Biennial Report 2022-24		✓	Interagency Adult Protection Coordinator						✓		For noting & endorsement
Finance / Audit and Performance											
2024-2027 Budget		✓	Chief Finance Officer		✓					✓	For approval
Audit and Performance Committee Update		✓	Chair of A&PC	✓	✓	✓	✓	✓	✓	✓	
Audit and Performance Committee Annual Report		✓	Chair of A&PC				✓				
Governance											
Strategic Risk Management Annual Report 2023-24		✓	Chief Officer					✓			
Review of Standing Orders		✓	Clerk to the Board				✓				
Reserve Policy		✓	Chief Finance Officer		✓						
Financial Regulations		✓	Chief Finance Officer		✓						
Public Sector Equalities Duty		✓	Chief Officer					✓			
Strategic Risk Appetite		✓	Chief Finance Officer				✓				For approval
For Information											
Future Meeting Dates	✓		For information	✓	✓	✓	✓	✓	✓	✓	
Future Development Sessions	✓		For information	✓	✓	✓	✓	✓	✓	✓	
Work Plan	✓		For information	✓	✓	✓	✓	✓	✓	✓	
Annual Performance Report		✓	For information				✓				
Tayside Winter Planning Report 2024-25		✓	Chief Officer						✓		
Audited Annual Accounts		✓	For information					✓	✓		

PERTH & KINROSS INTEGRATION JOINT BOARD
DEVELOPMENT SESSION WORKPLAN 2024-25

This development sessions work plan outlines the major items the Integration Joint Board has to consider as part of its schedule of work for the year. This plan will continue to be kept under review throughout the year.

Item	**Responsibility**	**24 May 2024**	**16 Aug 2024**	**25 Oct 2024**	**20 Dec 2024**	**24 Jan 2025**	**21 Feb 2025**	**14 Mar 2025**
Participation & Engagement Strategy	Chief Officer	✓						
Roles and Responsibilities	Chief Officer							
Digital Innovation/Technology	Head of Adult Social Work Operations		✓					
Budget/Finance	Chief Finance Officer				✓	✓	✓	
Walking with Strength & Balance - Evaluation & Toolkit	Chief Officer (Kayleigh Lytham)	✓						
National Care Service	Chief Officer							
Tayside Mental Health Services Strategic Update	Chief Officer							
Care Home Activity & Partnership Working	Head of Adult Social Work Commissioning		✓					
Primary Care Strategies	Evelyn Devine			✓				
Risk Appetite	Chris Jolly/Phil Jerrard	✓						
Public Dental Services				TBC				
Podiatry Services				TBC				
Prison Healthcare Services				TBC				