Appendix 1

PERTH AND KINROSS HEALTH AND SOCIAL CARE PARTNERSHIP

QUARTERLY PERFORMANCE REPORT

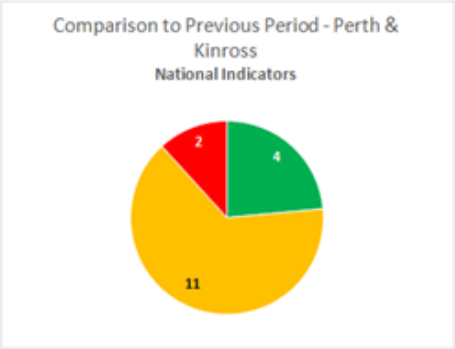
April to December 2019

Contents

Introduction

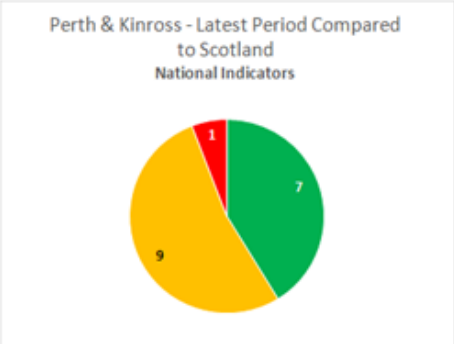
This quarterly report provides an overview of the activity being undertaken within Perth and Kinross Health and Social Care Partnership in pursuance of the objectives set within the recently approved Strategic Commissioning Plan.

This report covers the period April 2019 to December 2019 and provides a broad range of information and includes detail on partnership performance when considering the National Indicators and those for the Ministerial Strategic Group (MSG). The tables below summarise the performance indicators contained in Appendix 1.



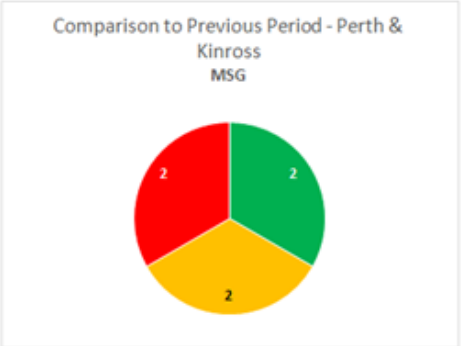
The following Indicators are highlighted as Red:

- NI 3 - Percentage of adults supported at home who agreed that they had a say in how their help, care, or support was provided
- NI 12 - Rate of emergency admissions per 100,000 population for adults



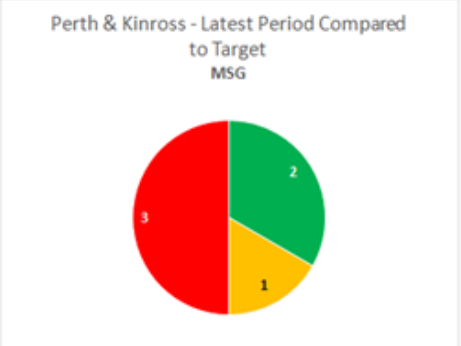
The following Indicators are highlighted as Red:

- NI 14 - Readmissions to hospital within 28 days of discharge per 1,000 discharges



The following Indicators are highlighted as Red:

- MSG 1a - Number of emergency admissions
- MSG 3a - A&E attendances



The following Indicators are highlighted as Red:

- MSG 2a - Number of unscheduled hospital bed days; acute specialties
- MSG 3a - A&E attendances
- MSG 6a - Balance of care: Percentage of population in community or institutional settings - at home (unsupported) - 65+

STRATEGIC OBJECTIVE 1

WORKING TOGETHER WITH OUR COMMUNITIES

Strategic Aim: *We want people to have the health and care services they need within their local communities and to empower people to have greater control over their lives and stronger connections in their community.*

How well are we doing?

Community Engagement
The Health and Social Care Partnership (HSCP) via Community Engagement Officers have delivered a wide range of awareness raising events, consultations, activities including co-ordinating consultation on the Strategic Commissioning Plan which received 1420 responses.

The team have run, supported or participated in a number of community projects and groups (Locality Management Groups, Wellbeing Roadshow, Carers Connect Conference 2019, SHARE Festival – Highland and Strathtay, Footwise Project, Maddoch Meet Up and many more), engaging with members of the community from across all localities.

The work of the Community Engagement Team has enabled more people to be better informed about local community information and health and social care services.

In addition to the above the HSCP has further engaged with our communities, and collaborated with our community planning partners to deliver a range of community based services, for example:

- Across Perth and Kinross there are now 6 recovery cafes each with a community focus and being led by people in recovery or with an interest in recovery. They are supported by staff and mentors from Perth & Kinross Alcohol & Drug Partnership (ADP), Hillcrest Futures and NHS Tayside, as well as local community volunteers.
- Loch Leven Advice Hub in partnership with "Broke Not Broken" (Foodbank Support based in Kinross) is a local drop-in facility based at the Loch Leven Health Centre to support people with community connections, signposting to benefits services, foodbank support and community organisations.
- More information in respect to the development and availability of services in each locality is available through regular Locality Newsletters.

  https://yourcommunitypk.org/2019/01/latest-health-and-wellbeing-newsletters/

Contributes to National Health and Wellbeing Outcome 4

Carers
In relation to the Carers (Scotland) Act, HSCP consulted with its Stakeholders to produce the Adult Carers Eligibility Criteria and the Short Breaks Services Statement, this assisted in the development of the Joint Carers Strategy which was approved at the December 2019 meeting of the IJB.

During the consultation exercise we received feedback from carers in different localities across Perth and Kinross. This was the most successful consultation of the views of carers undertaken in this area. Responses were received from carers and their families from a wide variety of backgrounds, cultures and community groups, such as gypsy/traveller carers, carers of people with drug and alcohol use issues, and ethnic minority carers.

Contributes to National Health and Wellbeing Outcome 6

Mental Health
A further public consultation exercise was undertaken, concluding in October 2019. A key finding from this exercise was that 40% of responders expressed a level of satisfaction about the mental health support they had received but a further 25% expressed a level of dissatisfaction which shows that improvements are needed. Additionally, concern was raised about services being based within Perth City with relatively limited services in rural areas. There was however some positive acknowledgement that online and social media related support had been helpful and that information was also available to help people find mental health services for their needs.

Combined with other developments in the provision of Mental Health Service the HSCP, in response to this identified gap, has invested significantly in "Mindspace" to provide counselling services throughout Perth and Kinross, with a particular focus in rural areas. This service now extends to include Auchterarder, Crieff, Kinross and Blairgowrie with in excess of 140 sessions per week being provided. Further developmental work is needed to support the further extension of this service to more rural areas.

Contributes to National Health and Wellbeing Outcome 6

Keys to Life Strategy
In developing the refreshed Keys to Life Strategy, we carried out a consultation exercise (March and October 2019) with our stakeholders; private; third sector; voluntary; and with professionals. This has included service users in the Making Where We Live Better group supported by the Centre for Inclusive Living Perth & Kinross and Independent Advocacy Perth & Kinross. Responses to our consultation, further feedback, and an analysis of areas which require support, enabled us to identify 7 priority Themes which will inform the content of our Keys to Life Strategy as it develops. Themes included:

Short Breaks	*Transition Points*	*Homes/Where you live*	*Increased Independence*
Out & About	*Reduce Inequalities*	*Workforce Development*	

Contributes to National Health and Wellbeing Outcome 2

What we will do next

In the upcoming period the HSCP will:

- Consult on the future model of care which will focus on support being delivered in the right place for an individuals need.
- "Jump into Wellbeing" (North Perth)
- "Community Partnership Wellbeing Day" (South Perthshire and Kinross-shire)
- "Big January Get Together" (Eastern Perthshire)
- Social Work Contributions Policy Consultation (covering all Perth and Kinross)

National and MSG Performance Indicators related to Objective/National Outcomes

NI 03 - % of adults supported at home who agree that they had a say in how their help, care or

support was provided (HACE)

NI 04 - % of adults supported at home who agree their health and care services seemed to be well co-ordinated (HACE)

NI 07 - % of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life (HACE)

NI O8 Carers - % of carers who feel supported to continue in their caring role (HACE)

STRATEGIC OBJECTIVE 2

PREVENTION AND EARLY INTERVENTION

Strategic Aim: *We will aim to intervene early, to support people to remain healthy, active and connected in order to prevent later issues and problems arising.*

How well are we doing?

Intermediate Care
The HSCP is implementing Locality Intermediate Care community based services to rapidly respond to patients with an unstable long term condition or exacerbated episode of poor health.

In the last reporting period the service specification, the clinical pathways and design and make-up of the multi-disciplinary teams have been produced and in some areas the service has been rolled out. This work will continue in the coming months to establish this valuable service sustainably across Perth and Kinross.

It is expected that this service will lead to better outcomes by supporting those most in need to:

- Better look after their health and well-being at home
- Bring a greater level of coordination in respect to the services delivered via the multi-disciplinary teams
- Reduce the need for emergency admissions and readmissions to hospital

Contributes to National Health and Wellbeing Outcome 2

Primary Care
The Primary Care Improvement Plan is in year 2 of a 3 year implementation period. This programme is progressing in respect to the establishment of multi-disciplinary teams connected to GP practices so that patients can see the right health professional at the right time in the right setting, in particular:

- 6 Primary Care Mental Health Nursing posts, 2 per locality, have been established to support the provision of Mental Health services early. Additional mental health capacity has been brought in to support these posts with the introduction of a further 3 well-being support workers. This allows patients to see a mental health professional within their GP practice rather than waiting for a referral. It can be seen from early activity data that 71% of available appointments have been utilised and user feedback has been positive. Example comments include:
  - *"This is a fab service, it takes so long to speak to someone, and this speeds the service up", "[The mental health nurse] was friendly, understanding and put me at ease straightaway. She was encouraging and because of this the session was helpful to me."*
  - *"Great to have some time to discuss my issues. Helped me identify best next steps and get lots of material/website/advice on how to help myself."*
- 3 Community Link Workers/Social Prescribers have now been secured in permanent positions again bolstering support within GP practices. These posts form part of a wider group which includes Healthy Communities Project Officers and MoveAhead Project Officers which the HSCP is seeking to take forward under an overarching strategy which will see a greater level of coordinated activity in respect to this valuable service. Funding under Action 15 is progressing a further three Social prescriber positions to expand the service availability. This service has seen a month on month increase in the number of service user interactions and feedback from service users and those connected to the service is very positive.
- Quotes from service users and those connected with the service.

- *"Very many thanks, what a prompt and caring service!" (General Practitioner)*
- *"I have found the Social Prescribing service invaluable in my role as an assessing worker specifically when clients are at risk of isolation but do not fit the criteria for care services. The positive impact that the service has had on some of my client's wellbeing has been immeasurable and I have found the Social Prescribing service in Perth another effective tool for engaging and signposting service users." (HSCP Community Care Assistant)*
- *"Without support we would never have applied for our benefit and carer entitlements. My husband now has PIP and I have respite. I didn't classify myself as a carer before our discussions. I feel someone is listening and I feel better informed." (Client)*

- Physiotherapists are now providing dedicated "First contact" physio services (FCP). This again sees patients accessing services and treatment earlier, rather than via traditional referral routes. The roll out of the service is still early in its development but it can be seen from the activity detailed below that good progress has already been made:
  - As at January 2020, 7 clinics are located in Perth City and 3 in the South Locality (Kinross)
  - On average 80 patients per month were seen between January - November 2019
  - Outcomes included: 73% of patients discharged, 15% were referred to Physio, 7% for follow up with FCP and 4% Onward referral
  - Feedback from patients: 97% of people were either satisfied or very satisfied with the overall quality of physiotherapy assessment and advice received. Comments included *"I do not have any negative comments, it is a brilliant service" and "The physio made me feel at ease and spoke in clear simple terms."*

Contributes to National Health and Wellbeing Outcome 1 and 4

Care About Physical Activity (CAPA)
Care About Physical Activity (CAPA) is a programme between Scottish Social Services Council (SSSC), Care Inspectorate and Care Homes which has focused on improving the health and wellbeing of residents through physical activity by improving balance, fitness and strength for older people which will reduce falls.

In 2018 "Paths For All" in partnership with the HSCP successfully secured funding from the Spirit of 2012 Changing Lives Sport and Physical Activity Fund (2 year fund from Jan 2019 to Dec 2020). This was used to develop dementia friendly walking resources to support 5 care homes in 2019 and a further 5 in 2020. These resources enable care home residents to walk more both within the care home and outdoors, and to take part in strength and balance exercises.

The work is very bespoke with each care home identifying different ideas and interventions to make walking more accessible for residents. This work has involved the residents, their carers, family members and children taking part in multigenerational projects. During 2019, 5 Care Homes based in Crieff, Auchterarder and Blairgowrie have successfully carried out works to support residents which included erecting strength and balance exercise panels in care homes, external exercise panels in care home grounds and dementia friendly raised sensory areas.

Quotes from residents
- *"I have Parkinson's and have to move every day, it is so important to me. I enjoy the posts and getting out and I do sit to stand exercises daily and am improving well. Some days are better than others, but exercise is great for me."*
- *"Since the start of this initiative my health has improved with the walking and exercise that I have been doing, I have lost weight and I have been able to come off my diabetic medication which I am pleased about."*

Contributes to National Health and Wellbeing Outcome 1 and 4

Mental Health
The Mental Health and Suicide Prevention training programme continues to run in Perth and Kinross. This feeds into the wider awareness raising projects which in 2019 included Mental Health Awareness Week in May, Suicide Prevention Week in September and Mental Health Awareness Day in October. These campaigns support early intervention and prevention by creating informed communities within Perth and Kinross.

Contributes to National Health and Wellbeing Outcome 5 and 7

What we will do next

- Extend CAPA to a further 5 Care Homes throughout 2020
- Continue the expansion of multi-disciplinary teams linked to GP practices
- Establish and roll out the enhancement to the Locality Integrated Care Teams to provide faster access to comprehensive complex assessment and support at home (LINCS)

National and MSG Performance Indicators related to Objective/National Outcomes

NI 01 - % of adults able to look after their health very well or quite well (HACE)

NI 02 - % of adults supported at home who agree that they are supported to live as independently as possible (HACE)

NI 07 - % of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life (HACE)

NI 09 - % of adults supported at home who agree they felt safe (HACE)

NI 11 – Premature mortality rate per 100,000

NI 12 – Rate of emergency admissions per 100,000 population for adults

NI 13 – Rate of emergency bed day per 100,000 population for adults

NI 16 – Falls rate per 1,000 population age 65

MSG 1a – Number of emergency admissions

MSG 2a – Number of unscheduled hospital days; acute specialties

MSG 3a – A&E attendances

STRATEGIC OBJECTIVE 3

PERSON-CENTRED HEALTH, CARE AND SUPPORT

Strategic Aim: *By embedding the national Health and Care Standards we will put people at the heart of what we do*

How well are we doing?

Single Handed Care
To improve person centredness the HSCP is implementing "Single Handed Care", this enables people to be supported by one carer, utilising appropriate equipment, instead of two carers. It better enables the development of bespoke packages of care for the individual and also creates carer capacity to provide personalised support to others. Occupational Therapists are integral to the implementation of "Single Handed Care" and the move towards a truly integrated Occupational Therapy service has been pivotal to its success.

Single handed care training has been rolled out to a wider staffing group as follows:

- 16 Delegates attended the single handed care training in October 2019 and obtained Royal Society for the Protection of Accidents (RoSPA) Level 4 accreditation.
- 14 X Occupational Therapists completed the course for the first time – those completing this course came from locality teams, community hospital(s) and the Access Team.
- 1 x Occupational Therapist and 1 x moving and handling trainer completed their annual refresher training.

Contributes to National Health and Wellbeing Outcome 2 and 9

Mental Health Services
In 2019 new "Action 15" funding, under the Scottish Government Mental Health Strategy, has been utilised to create a new post of co-ordinator for the Lighthouse project. This service assists in supporting people in distress out of hours and at weekends.

Additionally, by utilising Action 15 funding to create a Mental Health Practitioner (MHP) position within the Access Team person-centred care has improved for individuals in crisis. This post provides new support to individuals who come into contact with the service but do not necessarily meet the eligibility criteria for social work services. It is however recognised that intervening early to provide appropriate support at this stage provides great benefit to the individual.

Contributes to National Health and Wellbeing Outcome 4

Care at Home/Home Assessment and Recovery Team
The transformation of the Reablement and Internal Care at Home service to the Home Assessment and Recovery Team (HART) is supporting people to retain as much independence as possible. An average of 37% of people who are supported by HART Reablement do not require Care at Home.

Although recruitment has been challenging, all posts within the service have been filled and sickness absence within the Team has reduced by 19% from the previous year.

HART regularly consult service users in the quality of the service provided and the following examples provide an overview of the most recent survey:

- 100% - Personal care is carried out in a dignified way, with my privacy and personal preferences respected
- 100% - I am treated as an individual by people who respect my needs, choices and wishes
- 95% - I am enabled to independent and as in control of my life as I want and can be

Contributes to National Health and Wellbeing Outcome 1, 3 and 4

Care Homes
Engagement with Care Home providers has improved over the last year with quality improvement being a key focus. Within 2 care homes a national trial to support providers in developing their own improvement plans has been undertaken. This work is supported by the Care Inspectorate, Improvement Service and Scottish Care. The staff and services involved in this trial have found it to be a very positive experience and it has given teams the ownership of their improvement plan.

Additionally, the Scottish Care lead is working with 5 Care Homes on an individual basis to assist with, care planning, improvement planning and peer support, working closely with the Care Inspectorate.

Contributes to National Health and Wellbeing Outcome 3 and 4

Floating Housing Support and Hostels (FHS)
Floating Housing Support (FHS) services enable vulnerable individuals at risk of losing their tenancy to live independently and maximise their independence. The aim is to provide short-term personal outcomes focussed support, on both a practical and emotional level, to support people to live independently in their own home. A new service specification for Floating Housing Support and Hostel service(s) was developed during 2019. Providers are working alongside clients to agree and achieve person led outcomes that maintain focus on being self-sustaining and improving their quality of life in their chosen community.

From October 2019 service users have been transitioned from outgoing providers with 157 new referrals allocated to the new FHS providers. In this initial period, the new providers have been very responsive with the aim of providing client support within 7 days of receipt of referral.

Contributes to National Health and Wellbeing Outcome 2

What we will do next

Learning Disability
- Develop the Learning Disability "Keys to Life Strategy" for Perth and Kinross.

Care at Home
- Improve discharge process, returning to Care Homes
- Continue working closely with the Scottish Care Lead
- Develop a one stop shop online portal of information for older people services
- Improve and increase the use of TEC within Care Homes
- Two new Care Homes being developed (potentially inclusive of intermediate care)

Floating Housing Support and Hostels
- We are committed to using the "Better Futures Outcomes Framework" to allow for consistent monitoring and reporting of service provision.

Bringing People Back Home (Out of Area)
- Benchmark against best practice, to establish new models of service provision to support clients to access services locally rather than requiring daily travel out of area.

National and MSG Performance Indicators related to Objective/National Outcomes

NI 02 - % of adults supported at home who agree that they are supported to live as independently as possible (HACE)

NI 03 - % of adults supported at home who agree that they had a say in how their help, care or support was provided (HACE)

NI 06 - % of people with positive experience of care at their GP Practice (HACE)

NI 07 - % of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life (HACE)

NI 08 - % of carers who feel supported to continue in their caring role

STRATEGIC OBJECTIVE 4

REDUCING INEQUALITIES AND UNEQUAL HEALTH OUTCOMES AND PROMOTING HEALTHY LIVING

Strategic Aim: *Our services and plans will seek to reduce health inequalities, to increase life expectancy, increase people's health and wellbeing and to reduce the personal and social impact of poverty and inequality.*

How well are we doing?

Equalities Outcomes

In June 2019, a report went to the IJB providing details on the continuing joint equalities activity in relation to the IJB Equality Outcomes and how these activities are contributing to the Equalities Agenda within the HSCP. Examples of the developing work in support of the reduction of health inequalities includes the following:

- The interpretation and translation service has noted an increase in the level of support required. Additional resources have been deployed to cater for this need including an increase in the number of available British Sign Language (BSL) interpreters. Additionally, BSL interpreters now have the opportunity to engage patients using new video call facilities this is assisting in the rearrangement of cancelled/missed appointments.

- The Perth and Kinross Gypsy Traveller Strategy was approved in 2018 and a one year progress report in respect to its implementation was considered and approved by Perth and Council Housing and Communities Council on 21st August (link **here).** Following this the annual Gypsy/Traveller community wellbeing event was held in October and attracted 112 attendees.

- We continue to provide dedicated resource embedded within the Moveahead service with a remit for targeting Health Inequalities across Perth and Kinross.

- There is also ongoing development around Physical Health Check monitoring for individuals who are accessing Adult Mental Health services, Psychiatry of Old age services and Learning Disability services.

- To support people suffering with social isolation in rural areas Recovery Cafes throughout Perth and Kinross continue to assist people in reducing health inequality by supporting them to reach their potential. In particular Recovery Cafes are now in the process of developing additional support mechanisms, for example Chatty Cafes and Fitness Programmes. This is being supported by LiveActive, Letham4All and Hillcrest Futures.

Contributes to National Health and Wellbeing Outcome 5 and 7

Carers

At the Carers Connect event in 2019, carers participated in a mapping exercise which enabled carers and HSCP to identify the availability of peer and community support groups for carers across Perth and Kinross. This exercise identified 46 local groups and organisations. Further work will now be undertaken with Carer Support Workers, Community Engagement Team and Perth and Kinross Association of Voluntary Service (PKAVS) to better enable carers to access local community support wherever they live.

To assist Health and Social Care professionals to learn about the identification of unpaid carers a digital training resource has been produced by NHS Education for Scotland and Scottish Social Services Council. This updates previous materials to reflect changes following the introduction of the Carers (Scotland) Act 2016. This new resource is now available for all health and care professionals

including those in the Third Sector.

In relation to mitigating inequalities in the provision of support to carers from all groups, we have commissioned Minority Ethnic Carers of People Project (MECOPP) to provide support to carers from the gypsy traveller community and have commissioned the PKAVS Minorities Communities Hub.

Contributes to National Health and Wellbeing Outcome 6

Diabetes

Work has progressed in taking forward proactive preventative work around the wider Diabetes Agenda. The following is an update from work that has been taken forward in relation to the Type 2 Diabetes (T2D) Prevention, Early Detection and Early Intervention Framework which is being delivered pan Tayside.

- Reviewed current state for all pathways – pre-diabetes (Pre-DM), type 2 diabetes (T2D) and Gestational Diabetes (GDM)
- Work stream priorities have been agreed for 2020/21
- Adult Weight Management data has been interrogated and results suggested that there was a need for re-design. This will be taken forward via DHI design led and co-produced workshops during 2020 (funded separately from T2DP Framework monies).
- Digital ways of working have been identified and procurement of Oviva and Inhealthcare platforms is underway.

Contributes to National Health and Wellbeing Outcome 5

What we will do next

Carers

- Develop information and guidance material to support training to health and social care and wider partners to better identify and support carers as well as to help carers to better self-identify and to seek support.
- Develop Carers Champions to share knowledge about the support available to carers.

National and MSG Performance Indicators related to Objective/National Outcomes

NI 07 - % of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life (HACE)

NI 08 - % of carers who feel supported to continue in their caring role

STRATEGIC OBJECTIVE 5

MAKING THE BEST USE OF PEOPLE, FACILITIES AND RESOURCES

Strategic Aim: *We will use our combined health and social care resources efficiently, economically and effectively to improve health and wellbeing outcomes for the people of Perth and Kinross.*

How well are we doing?

Review of Inpatient Rehabilitation

The HSCP are reviewing the provision of inpatient rehabilitation beds to ensure equity of access to all Perth & Kinross adult residents and to ensure that beds are placed where the most need and demand is. This review will also consider the new community models being introduced to support and maintain people at home for longer (Locality Intermediate Care and Respiratory services). A review of Perth & Kinross performance when benchmarked against our best performing neighbouring Health & Social Care Partner demonstrated that Perth & Kinross have similar number of beds but with changes in population need, not all the beds are in the right place to meet the needs of the current and projected population of frail older people.

Inside of this transformation, the HSCP has been focusing on developing and enhancing community-based infrastructures to support more people at home or in homely environments. These evolving services will support the Partnership's objective to shift the balance of care by providing earlier intervention and prevention approaches to care, which allow effective management of more acute care needs in the persons own home effectively reducing the reliance on the use of hospital beds.

Contributes to National Health and Wellbeing Outcome 2 and 9

Specialist Community Respiratory (Telecare)

The HSCP recognised a gap in providing specialist community respiratory services to adults living with long term respiratory conditions (mostly housebound COPD, chronic asthma, bronchiectasis or Interstitial Lung Disease). There are around 3,200 people registered with a P&K GP Practice with a diagnosis of COPD. There were around 1,400 respiratory emergency admissions to hospital in 2019. Many people struggle with chronic respiratory conditions and this will have a major impact on their lives. It is also common for people with respiratory conditions to have additional long-term conditions. The proposed new service development will align with the evolving Locality Intermediate Care service. The service will provide earlier intervention/prevention assessment and self-management for people living with COPD and asthma living in their own homes. In order to facilitate, support and sustain self-management approaches, SMART technology is being explored to provide patient specific education and information links to community services.

Contributes to National Health and Wellbeing Outcome 2 and 9

Primary Care

As part of the Primary Care Improvement Plan a range of new services have been developed and are currently being implemented. The following provides some examples of where this work is making best use of resources and giving better access to patients so that they can be treated by the right professional in the right location at the right time.

- The urgent care service is being developed to shift service provision away from GPs in appropriate circumstances. This sees advanced practice professionals providing care to patients in order to facilitate GPs having more time to deal with complex cases. This service also interfaces closely with the developing LINC service.
- The first contact Physiotherapy service provides access for patients, via their GP, to specialist physiotherapists. This swift access is reducing the patient pathway to specialist services and is making best use of resources by relieving the need for onward referral to traditional services.

Contributes to National Health and Wellbeing Outcome 3,4, 9

Service Level Agreements
We are supporting our commissioned service providers by utilising our resources to support them in accessing external funding. This alleviates the need for statutory funding and supports the providers to gain confidence the external funding streams available. Our service level agreements combine this comment to support along with details of the expectations placed on providers.

Contributes to National Health and Wellbeing Outcome 9

What we will do next

Carers:
- *Take forward Participatory Budgeting*
- *Through our support of PKAVS, from January 2020 we will be participating in a Coalition of Carers pilot project to develop unpaid carers from Perth and Kinross to take an active role in representing their peer group in the public sphere and to participate in developing services.*

Older People
- Implementation of new stroke model
- Implementation of Test of Change Discharge to Assess

National and MSG Performance Indicators related to Objective/National Outcomes

MSG 1a – Number of emergency admissions

MSG 2a – Number of unscheduled hospital bed day; acute specialities

MSG3a A&E attendances

MSG 4 Delayed Discharge bed days

MSG 5 Proportion of last 6 months of life spent at home or in a community setting

MSG 6a – Balance of Care: Percentage of population in community or institutional settings – at home (unsupported) 65+

Performance Key – we have used the following definitions to set the colour and arrows:	We are meeting or exceeding the target or number we compare against		We are within 3% of meeting the target or number we compare against		We are more than 3% away from meeting the target or number we compare against	*An arrow indicates the direction that numbers are going in*

ID	Indicator	Previous period comparator	Latest period available	Previous period Figure Perth & Kinross	Latest period Figure Perth & Kinross	Comparison to Previous Period Perth & Kinross	Latest period Figure Scotland	Perth & Kinross - Latest Period Compared to Scotland
NI-1	Percentage of adults able to look after their health very well or quite well	2015/16	2017/18	95.39%	94.64%	↓ 1%	93.00%	↑ 2%
NI-2	Percentage of adults supported at home who agreed that they are supported to live as independently as possible	2015/16	2017/18	81.43%	82.96%	↑ 2%	81.00%	↑ 2%
NI-3	Percentage of adults supported at home who agreed that they had a say in how their help, care, or support was provided	2015/16	2017/18	81.82%	77.71%	↓ 4%	76.00%	↑ 2%
NI-4	Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated	2015/16	2017/18	75.53%	74.54%	↓ 1%	74.00%	↑ 1%
NI-5	Total % of adults receiving any care or support who rated it as excellent or good	2015/16	2017/18	83.36%	81.25%	↓ 2%	80.00%	↑ 1%
NI-6	Percentage of people with positive experience of the care provided by their GP practice	2015/16	2017/18	91.34%	88.42%	↓ 3%	83.00%	↑ 5%
NI-7	Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life	2015/16	2017/18	83.63%	80.64%	↓ 3%	80.00%	↑ 1%
NI-8	Total combined % carers who feel supported to continue in their caring role	2015/16	2017/18	40.30%	40.89%	↑ 1%	37.00%	↑ 4%
NI-9	Percentage of adults supported at home who agreed they felt safe	2015/16	2017/18	79.74%	84.95%	↑ 5%	83.00%	↑ 2%

The Health and Care Experience Survey (HACE) is undertaken every two years and is due to be carried out in 2020.

Comments:

- It can be seen that significant community engagement activity has been undertaken. This work supports the achievement of improvements in National Indicator 4 (Objective 1).
- National Indicators 1, 2, 3, 5, 7 and 9 (Objective 1, 3 and 4) relate to how service users feel about the services they receive and how well those services meet their needs. The work being carried out in connection with these objectives (detailed in the body of this report) is assisting the HSCP to better shape services. Although still in development this work will ensure that people are supported in ways which best meet their needs.

National Performance Indicators **Appendix 1**

ID	Indicator	Previous period comparator	Latest period available	Previous period Figure Perth & Kinross	Latest period Figure Perth & Kinross	Comparison to Previous Period Perth & Kinross	Latest period Figure Scotland	Perth & Kinross - Latest Period Compared to Scotland
NI-11	Premature Mortality Rate per 100,000 population*	2017 calendar year	2018 calendar year	367	346	↓ 6%	432	↓ 25%
NI-12	Rate of emergency admissions per 100,000 population for adults	Year up to Oct-18	Year up to Oct-19	10,251	10,741	↑ 5%	11,574	↓ 8%
NI-13	Rate of emergency bed day per 100,000 population for adults	Year up to Sep-18	Year up to Sep-19	80,824	78,340	↓ 3%	83,690	↓ 7%
NI-14	Readmissions to hospital within 28 days of discharge per 1,000 discharges	Year up to Oct-18	Year up to Oct-19	110	109	↓ 1%	98	↑ 10%
NI-15	Proportion of last 6 months of life spent at home or in a community setting	Year up to Oct-18	Year up to Oct-19	89.80%	90.17%	↑ 0%	88.32%	↑ 2%
NI-16	Falls rate per 1,000 population (65+)	Year up to Oct-18	Year up to Oct-19	22.81	23.38	↑ 2%	23.37	↑ 0%
NI-17	Proportion of care and care services rated good or better in Care Inspectorate inspections **	2017/18	2018/19	88.11%	87.04%	↓ 1%	82.17%	↑ 5%
NI-19	Number of days people aged 75+ spend in hospital when they are ready to be discharged per 1,000 population	Year up to Nov-18	Year up to Nov-19	617	447	↓ 38%	786	↓ 76%

*Premature mortality rates are based on calendar years, as reported by National Records of Scotland (NRS). 2019 update will be available around August 2020
** Data is collected annually for the Care Inspectorate. 2019/20 will not be available until late 2020

ID	Indicator	Previous period comparator	Latest period available	Previous period Figure Perth & Kinross	Latest period Figure Perth & Kinross	Comparison to Previous Period Perth & Kinross	2019/20 MSG Target	Perth & Kinross - Latest Period Compared to Target
MSG 1a	Number of emergency admissions	Year up to Oct-18	Year up to Oct-19	12,664	13,270	↑ 5%	14,592	↓ 10%
MSG 2a	Number of unscheduled hospital bed days; acute specialties	Year up to Sep-18	Year up to Sep-19	99,853	96,783	↓ 3%	85,547	↑ 12%
MSG 3a	A&E attendances	Year up to Oct-18	Year up to Oct-19	33,148	34,176	↑ 3%	32,888	↑ 4%
MSG 4	Delayed Discharge bed days	Year up to Oct-18	Year up to Oct-19	16,176	11,066	↓ 32%	12,731	↓ 15%
MSG 5	Proportion of last 6 months of life spent at home or in a community setting	Year up to Oct-18	Year up to Oct-19	89.80%	90.17%	↑ 0%	91.30%	↓ 1%
MSG 6a	Balance of care: Percentage of population in community or institutional settings - at home (unsupported) - 65+	2017/18	2018/19	92.13%	92.32%	↑ 0%	96.61%	↓ 5%

Comments on National Indicators 11-19 and MSG 1a – 6a:

- In relation to the indicators for which there is available and up to date data, overall performance is largely good or stable. In particular performance in respect to delayed discharge (NI-19) has improved by 38% and is 76% better than Scotland.

- Considering indicators NI-12, NI-14, MSG1a, MSG3a where performance has declined, these indicators relate to unscheduled hospital admission and resultant bed day numbers. Work to reduce this flow into hospital settings is being taken forward in respect the introduction of Specialist Community Respiratory and Locality Integrated Care Services. As these services become established and are rolled out an increase in performance against these indicators can be expected.

National Health and Well-being outcomes

Appendix 2

No.	Descriptor
1	People are able to look after and improve their own health and wellbeing and live in good health for longer
2	People, including those with disabilities or long-term conditions, or who are frail, are able to live, as far as reasonably practicable, independently, and at home or in a homely setting in their community
3	People who use health and social care services have positive experiences of those services, and have their dignity respected
4	Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services
5	Health and social care services contribute to reducing health inequalities
6	People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing
7	People using health and social care services are safe from harm
8	People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide
9	Resources are used effectively and efficiently in the provision of health and social care services