APPENDIX 1

Perth and Kinross Health and Social Care Partnership

Six Month Progress Report on Remobilisation and Key Strategic Performance Indicators

Our Vision

"We will work together to support people living in Perth and Kinross to lead healthy and active lives and live as independently as possible, with choice and control over the decisions they make about their care and support".

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SECTION 1: OVERVIEW OF ACTIVITY

Introduction

The COVID-19 pandemic continues to have a strong influence on Health and Social Care Services. In this respect our ReMobilisation Plan, submitted to the Scottish Government in February 2021 and shared with the Integration Joint Board members at a development session on the 7th April, serves as our annual operating plan for 2021/22. The following sections provide a comprehensive overview of progress against the actions detailed within that remobilisation plan. The actions being taken are strongly linked to the IJBs strategic priorities as set out in the Strategic Commissioning Plan and the progress made is measured in this respect.

As we move forward and continue our progress through the pandemic, we continue to develop a more strategic approach to service planning and delivery. In this respect we are currently developing Strategic Delivery Plans for:

- Community Mental Health Services
- Older Peoples Services
- Autism and Learning Disabilities

These developing strategies are inextricably linked to the IJB's strategic ambitions for Health and Social Care and will be underpinned by key performance metrics. As we move into 2022/23 and beyond, progress against the delivery of the these strategies will become core to our performance management and reporting arrangements.

Service Delivery

1. Workforce: Wellbeing, Resilience & Development

Good progress has been made on the preparation of our 3 Year Workforce Plan. A refreshed Workforce Planning Group has been established. Corporate resources have been reprioritised to support the production of the plan, Phase 1 of which has sought to identify the current and predicted gap in resources per staff grouping. Work is about to commence on Phase 2 which entails professional leads and relevant staff reviewing the data and developing proposals to address the gap on a local, regional and national level.

We committed to work with statutory partners to develop a local staff wellbeing approach. The HSCP Wellbeing Group is now established; this groups builds on the established PKC group bringing in NHST colleagues from within the partnership along with colleagues from Psychological Services. The Tayside Psychological Therapies Service Staff Wellbeing and Resilience response provision is also now in place with information and resources for staff being provided and developed further. The recent announcement of funding from Scottish Government to support wellbeing in the Primary Care and Social Care workforce was welcomed and the Wellbeing Group will support the HSCP with a considered approach to how best to allocate this funding.

Due to the ongoing pressures related to the pandemic we have continued our robust approach to workforce management ensuring resilient staffing for essential services. As part of this approach we now receive routine reports from statutory partners (Perth and Kinross Council and NHS Tayside) on staff sickness absence rates. Overall sickness absence is very low across both Health and Social Care services (4.57% and 5.67% respectively for the year to Sept/Oct).

Although these overall rates for absence are low there are isolated pockets of higher levels of absences and this routine reporting allows for further investigation to be undertaken to ensure that appropriate steps are taken to support staff back to work and to manage services accordingly.

In respect to absences which are COVID-19 related, these are not classified as sickness absence and are counted separately. Within Social Care services COVID-19 related absences are currently at 1.38% for the year to Oct. At this time it is not possible to extract COVID-19 related absences in relation to Health services due to recording practices.

2. Infection Control and Safer Working

The Perth & Kinross HSCP Infection, Prevention and Control Committee (IPCC) continues to meet regularly to monitor and scrutinise practice and to ensure local compliance with national standards on Healthcare Associated Infection Prevention and Control and the implementation of the Infection Prevention and Control Annual Work Plan across the HSCP.

COVID-19 brought a focus on ensuring that risk assessments relating to infection, prevention and control and health and safety are completed. This exercise concluded that, within our working environments, safe physical distancing can be adhered to, that PPE is appropriately utilised and that buildings are therefore appropriate to allow safe working to continue. The Risk Assessments that we have put in place continue to be monitored by operational staff and any updated guidance is shared appropriately with teams.

The PKHSCP Care Home Clinical Oversight Group continue to meet twice weekly to monitor the levels of support, guidance and expertise provided to Care Homes and to feed into the NHST Care Home Oversight and Operational Groups. We have now appointed a Senior Nurse specifically for Care Homes, who is an active participant in our Oversight Group. The regular meetings of the Group will continue until March 2022 when a review will take place.

In collaboration with NHS Tayside we have undertaken care assurance visits to all 43 Care Homes in Perth and Kinross to ensure that any improvement plans are being supported and progressed.

3. Safe Delivery of Social Care (Care Homes/Care at Home/Day Services)

Care at Home

We are continuing our review of Care at Home which is considering how best to improve, deliver or commission Care at Home to those parts of rural Perthshire where recruitment challenges limit service provision. Ongoing difficulties in securing sustainable externally commissioned Care at Home provision in rural areas particularly, is leading to further examination of options for a more blended model of service delivery.

The review process has involved a high level of stakeholder engagement in each locality, and this has concluded that in some areas there is an appetite for the HSCP to take a lead role in developing a community collaborative type approach, while in other areas where there are more established community groups, there is a desire for communities to lead these developments but to be supported to do so.

We have considered a variety of different models and explored how they could be implemented within Perth and Kinross. There is no one model that exclusively will meet the needs of our population, but through our community engagement activity the trialling of different approaches

and the learning gained from other areas we have recognised that a "Wellbeing Teams" approach would be most beneficial in both urban and rural areas.

Wellbeing Teams are small, self-managing teams that operate in local neighbourhoods they are values-led at every step, focussed on co-production, supporting people to make decisions about their life and support, committed to the wellbeing both of the people they support and the members of the team.

The challenges we continue to experience in sustaining effective delivery of Care at Home to our more rural areas through externally commissioned services, is encouraging us to explore the potential for developing an in-house Care at Home service.

Care Home Support
To provide proactive care centred on the needs of individual residents, their families and staff we established the Enhanced Care Home Support Team. A team leader was recruited early in the year to the team and is leading the recruitment of other posts and the design and implementation of the team. There are delays in the recruitment process and this has meant that we have not been able to fill posts as planned, however, Nursing posts are now expected to be advertised in the coming weeks and an Enhanced Care Home Social Worker is now in post. Engagement with the Care Home sector has commenced and will be vital to our ongoing development of the team and their remit.

Day Services
Following the relaxation of the COVID-19 restrictions buildings-based support has resumed. Initially there were reduced numbers, but they have now increased to capacity. Virtual support is still available for those wishing to access it.

4. Third Sector/Commissioned Services

We continue to engage with third sector providers to support them to reflect on the past year and consider what their future delivery model will look like. We are committed to working with third sector providers to ensure that they are able to adapt to new delivery models, are aligned to the HSCP priorities and to consider where we can support future development.

During the pandemic we have seen small organisations flourish and gain significant levels of volunteer and community response. The value of these local and community-led organisation should not go unrecognised and we will endeavour to provide any support we can, while looking to replicate best practice across Perth and Kinross. Providing a swift response has been key and we will continue to look to promote organisations who are actively intervening earlier and delaying or avoiding the need for statutory services.

We plan to collaborate with some particular providers to consider services that support people who are experiencing Long COVID-19. Live Active Leisure and RVS are commissioned to work with and complement statutory services in relation to Long COVID-19, to encourage activity in a variety of settings: inpatient, community-based, within care homes and into service users' own homes.

We also continue to support and work with our Independent Care at Home/Care Home providers to ensure the impact of Long COVID-19 is recognised and activities to counteract its impact are embedded in day to day practice.

5. Hospital and Community Care

In June 2021, we collaborated with senior clinicians and operational managers across NHS Tayside to instigate a system wide Resilience Plan to stabilise the Medical, AHP and Nursing Workforce. An action plan with key priorities for the short, medium and long term has been agreed with a weekly Operational Group, who are working at a fast pace to stabilise the MFE (Medicine for the Elderly) workforce and make best use of community pathways to support capacity and flow.

As part of the above contingency plan, a test of change has commenced between the Frailty team in PRI, Advanced Nurse Practitioners and Perth City Locality Integrated Care Team. This has focussed on providing support to people with more complex needs on arrival at PRI, to support them to return home without the need for admission/readmission, if it is appropriate to do so. Where admission is unavoidable the team support timely discharge through a holistic approach to meeting their health and care needs.

This test of change is in addition to the assessment, care and treatment support provided by Advanced Nurse Practitioners and the Locality Integrated Care Services to people with deteriorating conditions at home. These are people who are at risk of hospital or care home admission and this service is ensuring they are able to stay at home safely, for longer. Further improvements are being taken forward to enhance the Locality Integrated Care Team to provide a 7-day service including increased overnight care.

To further support the shift from traditional bed-based services to care for people with more acute healthcare needs at home, we have been successful in a bid to Healthcare Improvement Scotland to test a Hospital at Home Service over the Winter Period. We are currently recruiting the required workforce and developing the model. This will provide hospital-level care for acute conditions in a person's own home for a short episode that would normally require an acute hospital admission. This will be delivered through a multi-disciplinary team and will complement existing community services such as Advanced Nurse Practitioners and Locality Integrated Care Teams.

In collaboration with NHS Tayside Unscheduled Care Board for Winter Planning we have commenced the establishment of resilience and response arrangements to cope with the expected winter pressures. Despite the demands of the pandemic, we aim to maintain 'business as usual' and prevent deterioration in health and corresponding escalation in necessary care where possible. Business Continuity Plans across the Partnership are being reviewed with contingency planning for adverse weather commenced. Plans are also in place to build resilience for winter period into the Locality Integrated Care Team capacity and Integrated Discharge Hub to provide additional assessment and transition support capacity.

6. Primary Care

Primary Care covers a broad range of service and has seen significant development of new ways of working recently, both in relation to the pandemic but also in respect to the further implementation of our Primary Care Improvement Plan.

We are continuing to develop our Care and Treatment Services which support people to access a range of routine appointments, mainly focussed on Chronic Disease Management, which relieves the need for an appointment within a GP practice. It has been challenging to fully establish this service, particularly in Perth City, given the difficulties of securing permanent/long-term premises. Work continues however in this regard with support from statutory partners and we are developing

a Premises and Clinical Strategy which sets out the needs of the Health and Social Care Partnership for the medium to long-term.

We are continuing to work closely with GP practices to integrate primary care services with localities. An example of this continues the work referenced above in respect to Chronic Disease Management. Working with GP colleagues we are taking opportunities to link with localities based services to better manage patients' conditions within the community. This is particularly the case for people who have not presented to their GP for routine monitoring.

We have also tested the introduction of ANPs as the first point of contact for Nursing Home visits rather than it being the GP. Having completed a successful pilot of this approach within the Perth City locality we are taking the learning from this exercise to further test the approach within Care Homes, linking closely with the LInCs model and the Falls pathway.

During the pandemic it has not been possible to continue our Quality, Safety and Efficiency in Prescribing programme. Work has however now started to re-establish this programme again. The programme seeks to support GPs in respect to their prescribing practice and creates opportunities for a greater number of medication reviews to be undertaken and this leads to opportunities to improvements in the quality, the safety or the efficiency of the medication prescribed.

In recognition of the critical role that primary care plays in maintaining and improving the health of our population and having identified key risks to its sustainability we have developed a model for primary care resilience. In preserving the role of the GP as the expert medical generalist in the delivery of holistic primary care services, this model bolsters the Health and Social Care workforce to support GPs in that role and in doing so provides a greater level of sustainability in the support provided to patients. Having developed the model we are engaged in the HR processes in order to progress to recruitment.

7. Urgent Care

Our approach to Urgent Care (the Urgent Care pathway) continues to develop with a test of change underway in North Perthshire and Perth City Locality. This is assisting in the refinement of the pathway before rolling out across other localities. The current Test of Change are being clinically lead in a collaborative approach between Lead General Practitioners, Consultant Nurse Urgent Care, Advanced Nurse Practitioners and wider multidisciplinary locality teams. Further discussions are underway on how we enhance the urgent care approach across all localities.

We are beginning to collaborate with the Scottish Ambulance Service in the planning and development of the approach to ensure it is as seamless and integrated as possible. This links together wider developments via our LInCS model of care, our Advance Nurse Practitioners and how we manage Minor Injuries across Perth and Kinross, and which is now delivered effectively via our Community Care and Treatment Service.

8. Mental Health & Wellbeing

Several key priorities have been identified within the draft Mental Health Strategy for implementation and these include the recruitment of a Lead GP for Mental Health. A successful applicant has been appointed and they should commence post before the end of the calendar year. We have also recruited a Mental Health Advanced Nurse practitioner who will work in Community Mental Health Teams.

The Distress Brief Interventions (DBI) model is due to commence within Perth and Kinross in December, following a successful tendering process. A DBI is a time limited and supportive problem-solving contact with an individual in distress. This is a two-level approach:

- DBI level 1 is provided by front line staff and involves a compassionate response, signposting and offer of referral to a DBI level 2 service.
- DBI level 2 is provided by commissioned and trained third sector staff who would contact the person within 24-hours of referral and provide compassionate community-based problem-solving support, wellness and distress management planning.

Work is ongoing regarding establishing a Mental Health and Wellbeing Hub to focus on all aspects of health and wellbeing. This is a key theme which has been identified within the draft Mental Health and Wellbeing Strategy and discussions are taking place with other services and planning groups as to how this can best be taken forward.

We have continued our collaboration with 'The Neuk' Crisis and Distress Hub and its affiliated partners. In this regard we have located Registered Mental Health Nurses within the hub, working within the Early Intervention and Prevention Service. This enhances service provision around crisis and distress and improves accessibility to services.

We are also recruiting a Senior Suicide Awareness and Prevention Co-ordinator to enhance suicide awareness, prevention co-ordination and service delivery. Alongside this, work is continuing at Tayside level around future training and skills development for the workforce.

Our plans to explore the possibility of having a Single Point of Contact for access to Mental Health services have been delayed due to contingency measures currently in place. We are reviewing our current processes to determine the preferred model as we move forward.

Stakeholders within P&K continue to be heavily involved in pathway re-design work across Tayside and progress is reported back into the Mental Health and Wellbeing Strategy Group. The Mental Health strategic lead is liaising on a regular basis with the community Planning Partnership and Strategic Planning group.

9. Older People's Mental Health

The Older People Mental Health In-patient wards in Murray Royal Hospital have continued to remain COVID-19 free. This has been achieved through methodical use of PPE, routine surveillance testing for patients over 70 and the implementation of Asymptomatic Testing for staff where there has been excellent compliance.

Our Older Peoples Mental Health Teams have worked closely with other health and social care colleagues through our Locality Integrated Care Service model to provide an enhanced, integrated and co-ordinated approach for people with physical health needs, dementia and cognitive impairment.

Older Peoples Mental Health In-patient areas have been supported to increase the staffing complement to respond to COVID-19 incidence in the wards. This includes one to one support on admission whilst awaiting negative confirmation of COVID-19 testing, as well as ensuring that meaningful activity is promoted to reduce stress and distress caused by the isolation period. This successful approach has been carried forward into 2021/22, to enable us to sustain this good practice example, emerging from the pandemic

The In-patient area has significant challenges in delayed discharge given patients' complex health and care needs and there remains a significant challenge around capacity across the Tayside POA In-patient estate. To address this we have created a Band 6 Transition Nurse post to work alongside in-patient services, care homes and care home liaison teams across Perth and Kinross. This has successfully supported patients with complex care needs to be offered placements in a more homely setting. Remobilisation funding has been secured until July 2022 to ensure this Transition Nurse can continue to provide essential support. It is acknowledged that this is a vital role in bridging the gap between inpatient services and Community Mental Health Teams (CMHT) . Additional posts will be required to support this model, and this will be taken forward, along with the need to review our Care Home liaison function and our Dementia and COVID-19 action plan, within our developing service transformation proposal.

We are reviewing whether there is a need to develop specialist, complex inpatient beds for older people with mental health issues similar to the Intensive Psychiatric Care Unit model offered to young adults.

10. Alcohol and Substance Use Services

Our local Drug and Alcohol Services have continued to develop their approach to service users. We have received additional funding from the Scottish Government to reduce Drug Deaths and although some of this funding has been ring fenced for residential rehabilitation we are developing a mobile Buvidal clinic and bids to implement recommendations from the Recovery Community review are being considered. We have implemented the Non-Fatal Overdose pathway which seeks to identify and provide support to people as quickly as possible after a non-fatal overdose. In addition, we are seeking to recruit two Assertive Outreach Workers who will provide outreach to individuals who have experienced or who are at risk of overdose. Complementing these developments, we have continued to implement the Recovery Orientated System of Care (ROSC) with the Recovery Community, and this is being reviewed in partnership with the Scottish Recovery Consortium.

We have enhanced our use of Technology Enabled Care (TEC) where possible; virtual supports are in place such as Recovery Cafes and we are scoping the potential use of TEC to reduce the risk of people overdosing.

We plan to enhance the medical prescribing provision to ensure that people have access to the appropriate medicines at the right time and work is ongoing to implement the Medication-Assisted Treatment (MAT) Standards.

Increased funding has been awarded to Tayside Council on Alcohol (TCA) for alcohol counselling and the ADP has also supported and participated in a number of 'safer drinking' promotional campaigns to support people who have increased their alcohol intake due to lockdown restrictions.

11. Digital Innovation

Our ambition is to ensure our workforce have access to the technological tools and services they need to increase their resilience and enable new, more efficient and effective ways of joint working across health and social care. We need also to continue to roll out digital solutions to the people who use our services so that they can access the support they need effectively and efficiently.

To progress our digital agenda we have completed the roll out of 'Total Mobile' the Home Assessment and Reablement Team. This solution streamlines processes through the replacement

of paper submissions by electronic forms that support automation at many points of the process. The automation reduces duplication of work, standardisation of data input, and enhanced reporting. Following this success we are moving to the next stage of system implementation which will improve the scheduling of client visits which is a resource intensive manual process. Given the success of the Total Mobile solution we have started scoping the potential for this solution to be used across wider Health and Social Care Services.

We have reviewed the National Digital Citizen Delivery plan against existing Digital/TEC projects to ensure our outcomes are aligned and supporting the delivery plan. This is evident in areas such as the transition from analogue to digital telephony systems by working closely with the Local Government Digital Office. We are also active participants in the PKC Participation Group to engage with citizens, staff, and services in supporting and promoting access to digital services and equipment to reduce digital poverty and inclusion.

12. Carers' Support

We committed to develop new supports and alternative services for people in collaboration with carers and providers. Additional staff have been recruited and we will develop the befriending service which was established as part of the COVID-19 response. To assist in responding to increased referrals we have provided additional funding to PKAVS. We are also working with commissioned service providers to continue developing community-based supports across Perth & Kinross, particularly in rural settings.

We are promoting the use of TEC support for service users, including the publication of available support via PKAVS email newsletter and Failte, the new HSCP magazine. We have also worked with the Carers Strategy Group to develop training and to promote the use of TEC. This has also been taken forward with support from external partners, such as Vision PK and Hearing Loss UK.

We have reviewed (are reviewing?) the Hospital Discharge process to ensure that carers are supported and involved in discharge planning and that their perspective is considered. We have recruited a Social Care Officer who works in collaboration with the Hospital Discharge Team to improve the experience for the unpaid carer. We are now seeking to develop this further with colleagues across Tayside to improve the discharge process from Ninewells hospital.

We have recruited a Palliative Carer Support Worker to provide additional capacity within localities and to ensure compliance with new legislative guidance on supporting people who are terminally ill. Processes have been put in place to ensure that carers are supported appropriately, within the specified timescales.

To enable carers to be empowered to inform the development of our programmes, plans and strategies we have trained eight unpaid carers to participate in working groups ensuring that carers are represented in the planning and shaping of services for carers and those they care for. A Carers Reference Group has been established and further communication with strategic leads will be undertaken to ensure that carers are represented across all strategies. Young carers continue to be involved via the Young Carer Strategy Monitoring Group, the development of mental health support for young carers, and also young carers champions in schools.

In recognition of the additional support required, we have boosted our resources to PKAVS to allow them to support an increasing number of young carers to access normal life experiences, to get respite and where needed 1-1 tuition. All of this is aimed at allowing young carers to achieve their life potential and reduce the attainment gap. PKAVS have also been resourced to ensure

that support is available for parent carers to access respite allowing them to get the short breaks from their caring role.

13. Complex Care

Complex Care relates to the support provided for people with complex needs to enable them to live their daily lives. It includes a range of health and social care supports, accommodation and access to employment, further education and leisure activities.

People from any client group can have complex needs, however the vast majority have autism and/or a learning disability.

The Complex Care Transformation Programme aims to improve support for people with complex needs. An integrated, multi-disciplinary team (SCOPE) is being developed which will support people with autism and/or a learning disability and enable the implementation of a consistent, Positive Behavioural Support model which will identify and address individual's behaviours that services find challenging rather than trying to alleviate the impact by providing excessive amounts of social care. The recruitment of this multi-disciplinary team is currently being taken forward.

An overnight responder service and eight Core and Cluster developments are being implemented and day care/opportunities, respite and the transitions processes for people with complex care needs are being reviewed and improved. The tender for the TEC element of the Overnight Responder Service has now been completed. Procurement challenges have however prompted the need to consider alternative options.

In addition we have progressed the Transitions Pathway consultation exercise which is focussed on improving our approach to ensuring that young people transition as seamlessly as possible, at the appropriate time, from children's services.

14. Public Protection/ Adult Support & Protection

One of our Adult Support and Protection (ASP) key priorities is to improve referral routes to enable an effective, multi-disciplinary response to vulnerable people referrals. To progress this we have secured dedicated NHS ASP advisers to enhance the identification and referral of adult concerns from within the health sector.

The Inter-agency Referral Discussion (IRD) process was introduced into Perth and Kinross in December 2020. This further enhances the multi-agency approach to ASP taken in Perth and Kinross.

A key learning from recent audits relates to the improving use of chronological histories during case conferences, particularly when multiple agencies are involved. A 'test of change' has been taken forward in Perth City in this regard and will be reviewed in December 2021.

As we continue to develop our multi-agency approach to adult support protection, Third Sector colleagues have become core members of the ASP Committee and the supporting subgroup. Their involvement is allowing greater opportunities to identify ASP concerns particularly in relation to adults with mental health or substance use issues.

15. Inequalities

It is clear that many groups have been disproportionately affected by COVID-19 and its impact on communities. We remain committed to developing a targeted approach to those groups that have been affected to ensure they have information and access to appropriate support, care and treatment.

We are working with community planning partners to ensure that a human rights-based approach is developed. The Chief Officer and Heads of Adult SWSC sit on the Community Planning Partnership (CPP) Board with both Heads of Service as members of a CPP short life working group whose focus is to develop a joined up and targeted approach to tackling the priorities within the Local Outcomes Improvement Plan.

Out with this activity we are commencing our 'Community Brokerage' pilot with Support Choices. This model supports people to identify the social care support which is right for them and promotes greater choice and control in their own social care. Trained and accredited Community Brokers help people plan and organise their own support arrangements and make maximum use of local support and activities within the community, even if they are not eligible for formal support. We expect this to include people in a range of locations and circumstances, including Highland Perthshire, Crieff/Comrie and Perth City

We had planned to develop an Integrated Resource Framework (IRF) to enable us to understand health and social care inequalities across each locality and enable informed strategic decision making. However it has not been possible to progress the development of this as yet due to management capacity issues.

16. Working with Communities

A Connected Scotland strategy for tackling social isolation and loneliness and building stronger social connections was published in December 2018 and is the Scottish Government's national strategy for tackling social isolation and loneliness and building social connections. This strategy identifies 4 priority areas for action, we are adopting these within Perth & Kinross and establishing work streams with a focus on:

Empower Communities and build shared ownership

Our intention is to invest in and expand the use of Brokerage within Perth and Kinross. There are currently only a small number of brokers available primarily within North Perthshire, we are seeking to ensure brokerage is widely available within all localities. The intention of Brokerage is to intervene at the earliest possible stage and prevent long term impact, it can avoid the use of statutory services and as a model drives us towards an outcome focussed and co-produced approach to our community-based support or ultimately care planning. We have commissioned a local provider to undertake a pilot for the delivery of a Test of Change project to develop Community Brokerage in Perth and Kinross, commencing November for a period of six months.

As we continue to review our Care at Home delivery model, we are trialling specific elements of a "self-managed team approach" in our HART team, and this will allow us to gain local learning around this approach. The outcomes of this trial will be shared with our external partners and within our Community Collaborative groups with the intention of delivery models being developed, bespoke to the community in which they live.

Promote positive attitudes and tackle stigma
We have undertaken a review of current delivery and are clear that a change in delivery model would be of benefit to the Partnership. Further work is being undertaken with regard these proposals, but the proposed changes including an increase in number of social prescribers and a centralised management function will provide:

- GP practices and other agencies with access to a one door referral point for non-clinical social support.
- Community Groups and communities will be supported to engage in developing local approaches to the need being identified by the staff working with the individuals referred.
- A clarity and common role for the Social Prescribers will be established alongside a robust performance framework
- The HSCP will have made an explicit strategic commitment backed by a visible structural intent to deliver an integrated and coordinated preventative resource to work alongside individuals and communities to deliver the aspirations of the HSCP Strategic plan.

Support and Infrastructure that fosters connections:
There is an ongoing need for engagement as part of a continuous cycle of strategic planning, key to this is understanding and considering the views of localities, we need to harness the skills of local people, the power of local associations and the supportive functions of local institutions and services in order to build stronger, more sustainable communities.

As a vehicle for ensuring this continuous engagement the Strategic Planning Group and its membership were refreshed to ensure representation was inclusive of people who use health and care services, unpaid carers, commercial providers of healthcare, non-commercial providers of healthcare, commercial providers of social care, non-commercial providers of social care, social work and social care professionals, health professionals, non-commercial providers of housing and third sector bodies carrying out activities related to health and social care. Two meetings have been held with another due in late November. We have presented a variety of papers to the group including our latest remobilisation plan, the draft Mental Health Strategy, and a National Care Service Consultation presentation.

The SPG will oversee the development and monitoring of the Partnership's Strategic Plan and Strategic Commissioning Plan and provides a reporting structure for all service user strategy Groups.

The Communication, Engagement and Participation group and membership has been refreshed and the first meeting held, with an opportunity for stakeholders to contribute to future agendas. This group will coordinate all engagement activity across Perth and Kinross. Each of our localities has an up-to-date Participation and Engagement Plan that is overseen by the Locality Management Group. This document plays a key role in coordinating engagement by all agencies and organisations with a Health and Social Care focus in the areas, representation from each local management group now sit on the Communication, Participation and Engagement Group.

The aforementioned meetings will ensure engagement at all levels and across all agencies, meaning our Strategic Planning and thus service delivery is informed and co-produced by all relevant stakeholders.

Create opportunities for people to connect
The Partnership are investing in App based technology to promote and coordinate elements of our Volunteer workforce. This approach will allow ease of access to volunteering opportunities, it will

ensure volunteer activities are matched to skill, matched to location and will allow complete flexibility in regularity of volunteer work. The Volunteers will be trained and supported by an already commissioned local volunteer organisation.

We are investing in Remote Responder Technology, and we are currently tendering for the necessary IT equipment and software. Once this is completed, TEC units will be provided to people currently receiving overnight support and a Social Care Officer will be on shift overnight to monitor and respond virtually to calls through the TEC unit. Some existing overnight staff will be assigned to provide a physical response if this is required.

Our service users will be consulted before this service commences and risk assessments will be carried out. In each situation there will be a transition period during which existing supports will remain in place to ensure the new service is appropriate

17. Hosted Services

Public Dental Services

The pandemic reduced dental activity significantly however throughout 2021/22 the Public Dental Service has continued to try to increase clinical activity again to meet the needs of all patient groups. The service is however constrained by higher than average rates of sickness absence, and the continuing additional precautions in place as a result of COVID-19. Further demand pressures are being experienced in respect to patients not being able to access routine dental care within the independent sector. This is leading to increases in presentations of unregister patients and dental emergencies to the PDS.

We have made further progress in the last six months in our Dental Outreach activity and additional dental sessions (funded via NHS Education Scotland, University of the Highlands and Islands and Dundee Dental School) are in place to increase support for Aerosol Generating Procedures (AGPs). The current Outreach cohort comprises final year undergraduate dentists and dental therapists from Dundee University, and undergraduate dental therapists from University of Highlands and Islands, attending Broxden, Kings Cross and Springfield.

For patients with special care needs who require General Anaesthetic (GA), we have improved access to dental treatment in Stracathro Hospital but the cohort suitable for this hospital is limited and the most complex patients are however unable to access care anywhere in Tayside.

PDS continue to work with NHS Tayside Estates Department to improve physical infrastructure in relation to ventilation issues across Tayside Dental premises to reduce fallow time and allow for more treatments to take place.

Podiatry

Recruitment and retention of Podiatrist remains a challenge at a time when demand is increasing in terms of volume and complexity. This is largely due to a reduction in presentation during the pandemic as well as the redeployment of staff to support other critical services.

The implementation of Podiatry Assessment Hubs is enabling the service to restore the balance between demand and capacity in line with eligibility criteria and supporting improved patient flow.

In order to support requests for lower risk assistance, the Podiatry service continues to offer advice and signposting to wider resources which support enablement and bolster health resilience.

Prison Healthcare
Within HMP Perth, through close working relationships with the Scottish Prison Service and the Vaccination Teams we have ensured that a comprehensive vaccination programme has been rolled out. This has been complemented by an effective approach to Infection Control and Safer Working which has assisted in managing COVID-19 infections within Prison Healthcare.

New admissions to the prison environment are tested on the day of admission and again on day 7 and where appropriate they are offered vaccination. By taking this approach in parallel with offering vaccination to the wider prison population, over 444 first dose vaccinations and 290 second doses vaccinations have been administered within HMP Perth. Within HMP Castle Huntly 134 first dose and 130 second dose vaccines have been administered.

18. Mental Health Medical Staffing and Demand Contingency

We have experienced significant difficulties in respect to the staffing levels within Mental Health Services. To mitigate against pressures raised through medical staffing vacancies we have established urgently a Contingency Hub to maximise the effectiveness of medical staffing and ANP input to mental health assessments with a supporting infrastructure including dedicated accommodation, service management and administrative support. This is being reviewed on a weekly basis with amendments being made accordingly.

The medical workforce is beginning to stabilise with additional locum support and working with key stakeholders we are seeking to reduce the level of contingency and to normalise working practices. Further to this we aim to increase staffing provision to help alleviate pressures by securing additional Registered Mental Health Nurses, Occupational Therapists and Mental Health Advanced Nurse Practitioners.

19. Premises

As services continue to remobilise and we consider new ways of delivering the support our patients and service users need, consideration is equally being given to the best locations from which our services should be delivered. Although the post COVID-19 model of working is still to be finalised, it is likely to be a form of blended working for some services. Many other HSCP services cannot however be delivered in a virtual manner and there will be an ongoing requirement for office and clinical space.

We currently face a number of pressing premises issues across a range of services and with new and developing services coming in we need to establish our core premises requirements urgently.

To progress this with the necessary pace we have engaged with statutory partners and are also seeking opportunities to procure external support via a contractor or consultant.

20. Vaccination/Flu Programme

We have worked in collaboration with NHST Central Vaccination Programme to deliver annual flu and COVID-19 booster programme. The local delivery model has however changed due to accommodation issues and the model will now be delivered through a centre in Perth with Pop-up clinics in rural areas across Perth and Kinross.

Care Home residents and staff vaccination is progressing well with housebound and long stay inpatient vaccination to follow. Health and social care staff clinics are running at PRI and the centre at Dewar's continues to provide vaccination for both flu and COVID-19. GP practices are continuing to support the delivering flu vaccination to the over 70 age group and the Clinically Extremely Vulnerable.

A Short Life Working Group has been established with partner agencies to consider mass vaccination clinics from December 2021 until March 2022. Risks to this programme exist in respect to premises however and these are being worked through with partners.

SECTION 2: PERFORMANCE AGAINST NATIONAL INDICATORS

National Indicators Overview

The following narrative provides an overview and commentary on our performance to date when considering a range of national performance measures. These measures are linked closely to the National Health and Wellbeing outcomes and all KPIs for which data exists at the time of writing have been provided. Please note that data is not currently available for National Indicators NI 11, 17, 18 and 20.

Emergency Admissions (NI12)

The rate of emergency admissions per 100,000 population has increased by 3.53% in the year to date compared to the 2020/21 value (10,395 to 10,762 July 2021). However, this increase is lower than that for Scotland overall, which increased by 5.48% over the same period. This means that when compared to Scotland the rate of emergency admissions in Perth and Kinross remains 4.90% lower.

The rise in emergency admission needs to be interpreted in the context of an exceptionally low comparator period, 2020/21. When compared to 2019/20 (immediately prior to the pandemic) we can see that emergency admissions currently remain lower (10,762 compared to 11,395).

			2019/20		2020/21		Latest Data for 2021/22			Comparison		
ID	Indicator	measure	Scotland	Perth & Kinross	Scotland	Perth & Kinross	Scotland	Perth & Kinross	Period	How we compare to 2020/21	Scotland latest compared to 2020/21	How we compare to Scotland
NI-12	Rate of emergency admissions per 100,000 population for adults (18+ all specialities)	Rolling 12 month rate	12,408	11,395	10,670	10,395	11,289	10,762	Jul-21	3.53%	5.48%	-4.90%

Emergency Bed Days (NI13)

The number of emergency bed days increased by 3.62% in the year to date compared to the 2020/21 value (93,569 to 96,958 June 2021). Across the same period, Scotland overall reported a slightly smaller increase of 3.03%. Despite this, the figure for Perth and Kinross remains 6.58% lower than the value for Scotland overall.

The increase in emergency bed days reported since 2020/21 should be understood within the context of particularly low number of emergency bed days reported for the 2020/21, due in part to the impact of COVID-19 and our pandemic response. When compared to 2019/20 Perth and Kinross recorded a 12.51% reduction in emergency bed days (110,828 to 96,958 June 2021).

			2019/20		2020/21		Latest Data for 2021/22			Comparison		
ID	Indicator	measure	Scotland	Perth & Kinross	Scotland	Perth & Kinross	Scotland	Perth & Kinross	Period	How we compare to 2020/21	Scotland latest compared to 2020/21	How we compare to Scotland
NI-13	Rate of emergency bed day per 100,000 population for adults (18+)	Rolling 12 month rate	118,474	110,828	100,201	93,569	103,334	96,958	Jun-21	3.62%	3.03%	-6.58%

Note: This indicator is linked to NI 12 above and NI 19 detailed below.

Readmissions to Hospital within 28 days of discharge (NI14)

The rate of readmission to hospital after discharge reduced by 6.66% in the year to date compared to 2020/21 (129 to 121 June 2021). Readmissions also reduced across Scotland overall across the same period, however, at a slower rate of 4.09%. Wider direct comparisons of current performance against Scotland are not however valid as recording practices vary significantly within Tayside to the rest of Scotland.

Current performance when compared to previous year's can be viewed within the context of Perth and Kinross's continuous improvement, with the rate of readmission having reduced by a 6.52% between 2019/20 and 2020/21 (138 to 129).

			2019/20		2020/21		Latest Data for 2021/22			Comparison		
ID	Indicator	measure	Scotland	Perth & Kinross	Scotland	Perth & Kinross	Scotland	Perth & Kinross	Period	How we compare to 2020/21	Scotland latest compared to 2020/21	How we compare to Scotland
NI-14	Readmissions to hospital within 28 days of discharge per 1,000 discharges (18+)	Rolling 12 month rate	138	138	112	129	108	121	Jun-21	-6.66%	-4.09%	10.98%

Proportion of last 6 months of life spent at home or in a community setting (NI15)

The proportion of the last 6 months of life spent at home or in a community setting has increased by 0.72% in the year to date compared to 2020/21 (90.33% to 91.05% July 2021). Within the same period, Scotland has demonstrated a slight reduction of 0.06%. Accordingly, Perth and Kinross recorded the proportion of the last 6 months of life spent at home or in a community setting at a rate 0.92% above that of the Scottish average.
Increasing performance rates in this measure have been maintained throughout the COVID-19 pandemic, with a 0.66% reduction recorded between 2019/20 and 2021 (89.67% to 90.33%).

			2019/20		2020/21		Latest Data for 2021/22			Comparison		
ID	Indicator	measure	Scotland	Perth & Kinross	Scotland	Perth & Kinross	Scotland	Perth & Kinross	Period	How we compare to 2020/21	Scotland latest compared to 2020/21	How we compare to Scotland
NI-15	Proportion of last 6 months of life spent at home or in a community setting	Rolling 12 month rate	88.24%	89.67%	90.19%	90.33%	90.13%	91.05%	Jul-21	0.72%	-0.06%	0.92%

Falls rate (NI16)

The falls rate reduced by 0.81% in the year to date when compared to 2020/21 (23.74 to 23.54 July 2021). This contrasts to a Scottish increase of 2.42% reported over the same period. Despite this relative improvement, the falls rate for Perth and Kinross is 6.52% higher than Scotland.

In 2019/20, which captures a significant period of pre-pandemic data, the falls rate was 7.37% lower when compared to 2020/21 (22.11 to 23.74).

			2019/20		2020/21		Latest Data for 2021/22			Comparison		
ID	Indicator	measure	Scotland	Perth & Kinross	Scotland	Perth & Kinross	Scotland	Perth & Kinross	Period	How we compare to 2020/21	Scotland latest compared to 2020/21	How we compare to Scotland
NI-16	Falls rate per 1,000 population (65+)	Rolling 12 month rate	22.35	22.11	21.47	23.74	22.01	23.54	Jul-21	-0.81%	2.42%	6.52%

People aged 75+ spend in hospital when ready to be discharged (NI19)

The days people aged 75+ spend in hospital when ready to be discharged increased by 26.96% in the year to date when compared to 2020/21 (197 to 250 August 2021). Across Scotland performance against this measure has also reduced albeit at a lower rate of 17.73%. Despite this movement in relative performance, the rate in Perth and Kinross remains significantly lower than Scotland overall, by 135.30%.

The increase in days people aged 75+ spend in hospital when ready to be discharged needs to be interpreted in the context of an exceptionally low comparator period, 2020/21. When compared to 2019/20 (immediately prior to the pandemic) we see the rate of delayed discharges remain 49.7% lower (497 compared to 250 August 2021).

			2019/20		2020/21		Latest Data for 2021/22			Comparison		
ID	Indicator	measure	Scotland	Perth & Kinross	Scotland	Perth & Kinross	Scotland	Perth & Kinross	Period	How we compare to 2020/21	Scotland latest compared to 2020/21	How we compare to Scotland
NI-19	Number of days people aged 75+ spend in hospital when they are ready to be discharged per 1,000 population	Rolling 12 month rate	768	497	484	197	589	250	Aug-21	26.96%	17.73%	-135.30%

A&E Attendances (MSG 3)

The number of A&E attendances have increased 9.69% when compared to 2020/21 (14,268 to 15,651 per 100,000 July 2021). Across the same period for Scotland this measure increased by 11.07%. As such, Perth and Kinross attendances at A&E are currently a significant 46.62% lower than for Scotland overall.

The increase in attendances should be understood within the context an abnormally low comparator period, 2020/21. When compared to the period immediately prior to the pandemic (2019/20) a 30.90% reduction has been realised (22,650 to 15,651 July 2021)

			2019/20		2020/21		Latest Data for 2021/22			Comparison		
ID	Indicator	measure	Scotland	Perth & Kinross	Scotland	Perth & Kinross	Scotland	Perth & Kinross	Period	How we compare to 2020/21	Scotland latest compared to 2020/21	How we compare to Scotland
MSG 3	A&E attendances per 100,000 population	Rolling 12 month rate	28,504	22,650	20,408	14,268	22,948	15,651	Jul-21	9.69%	11.07%	-46.62%

NATIONAL INDICATOR TABLES

APPENDIX 1

			2019/20		2020/21		Latest Data for 2021/22			Comparison		
ID	Indicator	measure	Scotland	Perth & Kinross	Scotland	Perth & Kinross	Scotland	Perth & Kinross	Period	How we compare to 2020/21	Scotland latest compared to 2020/21	How we compare to Scotland
NI-11	Premature Mortality Rate per 100,000	Rolling 12 month rate	430	332	460	363	na	na	na	na	na	na
NI-12	Rate of emergency admissions per 100,000 population for adults (18+ all specialities)	Rolling 12 month rate	12,408	11,395	10,670	10,395	11,289	10,762	Jul-21	3.53%	5.48%	-4.90%
NI-13	Rate of emergency bed day per 100,000 population for adults (18+)	Rolling 12 month rate	118,474	110,828	100,201	93,569	103,334	96,958	Jun-21	3.62%	3.03%	-6.58%
NI-14	Readmissions to hospital within 28 days of discharge per 1,000 discharges (18+)	Rolling 12 month rate	138	138	112	129	108	121	Jun-21	-6.66%	-4.09%	10.98%
NI-15	Proportion of last 6 months of life spent at home or in a community setting	Rolling 12 month rate	88.24%	89.67%	90.19%	90.33%	90.13%	91.05%	Jul-21	0.72%	-0.06%	0.92%
NI-16	Falls rate per 1,000 population (65+)	Rolling 12 month rate	22.35	22.11	21.47	23.74	22.01	23.54	Jul-21	-0.81%	2.42%	6.52%
NI-17	Proportion of Care Services rated good or better in Care Inspectorate inspections	Rolling 12 month rate	81.80%	86.39%	82.00%	86.00%	na	na	na	na	na	na
NI-18	Percentage of 18+ with intensive social care needs receiving Care at Home	Rolling 12 month rate	63.0%	59.3%	62.1%	60.7%	na	na	na	na	na	na
NI-19	Number of days people aged 75+ spend in hospital when they are ready to be discharged per 1,000 population	Rolling 12 month rate	768	497	484	197	589	250	Aug-21	26.96%	17.73%	-135.30%
NI-20	Percentage of health and care resource spent on hospital stays where the patient was admitted as an emergency	Rolling 12 month rate	24.08%	26.6%	25.95%	24.9%	na	na	na	na	na	na
MSG 3	A&E attendances per 100,000 population	Rolling 12 month rate	28,504	22,650	20,408	14,268	22,948	15,651	Jul-21	9.69%	11.07%	-46.62%

Performance Key

Colour	Meaning
Green	We are within 3%, or are meeting or exceeding the number we compare against
Amber	We are between 3% and 6% away from meeting the number we compare against
Red	We are more than 6% away from meeting the number we compare against