PERTH & KINROSS INTEGRATION JOINT BOARD

6 November 2015

Perth and Kinross Strategic Plan/Joint Commissioning Plan – *Draft for Consultation*

Report by Chief Officer

1. PURPOSE OF THE REPORT

1.1 This report presents the draft joint strategic plan/commissioning plan for Perth and Kinross for approval to circulate for formal consultation. It includes an outline of the sections of the plan, including the case for change, key themes and strategic priorities, and a summary of needs and resources. The main draft document is attached as an appendix. The covering report also outlines the process and timetable for consulting on the draft strategic plan from November 2015 to January 2016.

2. RECOMMENDATIONS

2.1 The Integrated Joint Board is asked to approve the draft strategic plan for formal consultation in Appendix 1 and the process for consulting on the plan in Appendix 2.

3. BACKGROUND

3.1 The Public Bodies (Joint Working) (Scotland) Act requires integration authorities to prepare strategic plans which set out their integration arrangements to achieve or contribute to national health and well being outcomes. These plans should divide the area into at least two localities.

3.2 A key part of this process is the development of a detailed joint strategic needs assessment (current and projected, activity, demand, gaps) which is used to plan and redesign services to deliver better personal outcomes and address key policy priorities.

3.3 Strategic plans should reflect the important role of informal community capacity building to deliver more effective preventive and early interventions. They should also deliver improved outcomes through better aligning investment to what we know about the needs of people in local communities, available resources and support, and what is working to deliver better outcomes.

4. STRATEGIC JOINT COMMISSIONING PLAN

4.1 The draft strategic plan has being developed based on an assessment of need and agreement of key strategic priorities so that the planning partners can focus and plan effort and resources on where they are needed most. It is based around 5 key themes and the agreed actions and priorities to be delivered through localities, with local management teams developing and implementing their local strategic plan. The draft plan includes information on:

- The case for change – having services and support available to meet people's needs and aspirations, managed with reduced public finances
- Current and projected populations, health and wellbeing, target populations
- Resources: consumption of services, balance of care, assets
- Feedback from local people, service users
- Models of good/innovative practice - what models currently work
- 5 key themes
- Strategic priorities and key actions for localities which will reflect the specific needs and challenges of local areas.

5 NEXT STEPS

5.1 This draft plan will be widely circulated as part of the formal consultation process. Details of the method of consultation are included in Appendix 2 where it is noted that The Visioning Outcome in Community Engagement (VOICE) toolkit will be used to record, plan, monitor and evaluate consultation activities.

6. CONCLUSION AND RECOMMENDATIONS

This report attaches the first draft strategic plan for approval by the Board to be circulated for formal consultation and details the process by which it will be widely consulted over the next 8 weeks. A summary version will also be circulated. Following formal consultation, a final draft will be presented to the Board for approval in February 2016.

The Integrated Joint Board is asked to:

- Approve the draft strategic plan for formal consultation;
- Approve the method of consultation;
- Request a revised plan which incorporates the consultation feedback for final discussion in February 2016.

Appendix 1

Perth and Kinross Health and Social Care Partnership

Draft Strategic and Joint Commissioning Plan 2015 - 2018

For Integration Joint Board meeting 6th November 2015

Name	Position
Lorna Cameron	Head of Housing and Care Commissioning Strategy
Eileen McMullan	Service Manager, Planning and Commissioning
V7	30 Oct 2015

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Strategic Commissioning Plan

1. Introduction: commitment and challenge

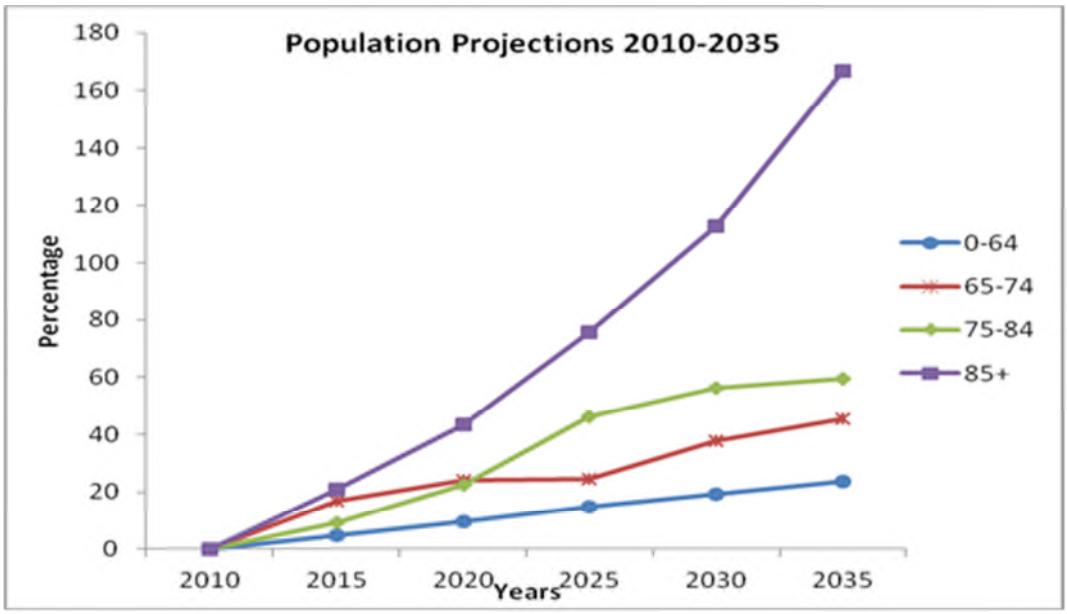
Health and Social Care is changing and from April 2016 community based health and social care services will be provided through the Perth and Kinross Health and Social Care Partnership. This documents sets out how these services will work together to meet people's needs now and into the future. Our aim is to improve the wellbeing and outcomes of people, particularly those who have complex needs and need the support of health and social care at the same time. In Perth and Kinross, we recognise that people who are ill, vulnerable or have disabilities, often need support from a number of services to enable them to live as independently as possible and to prevent unnecessary stays in hospital or in residential care.

We will work together to make sure people are supported to lead as independent, healthy and active lives as possible in their own homes. Our challenge is to find innovative and creative ways of doing this at a time of increased demand and expectations and reducing public finances.

Perth and Kinross

Perth and Kinross has a population of 147,740 living and working across its expansive 5,000 square kilometres. Over the coming decades the area is expected to experience significant demographic change, especially in relation to older people, the majority of whom are increasingly fit and active until much later in life and are an important and significant resource, with a great contribution to make in their local communities. Advances in health care and healthier lifestyles mean that people are living longer generally and the vast majority of older people aged 65+ live healthily at home. We know, however, that the need for support from health and social care services increases with age and the challenge for services and communities will be to ensure that people are supported to be able to lead healthy, fulfilling lives at home for as long as possible.

The projected population of people aged 65-74 (+26%), 75-84 (+48%) and 85 plus (+80%) over the next fifteen years is summarised below.



- Those aged 75+ are projected to double over the next 15 years, from 14,406 to 27,250
- Those aged 85+ are projected to more than double from 4,027, to 10,651 by 2037

- Based on current dementia prevalence rates for Scotland, people with dementia are expected to double over the next 25 years
- Other vulnerable people, including those with learning or physical disabilities, require the support of health and/or social care services to live as independently as possible and people with mental health needs or substance misuse problems who need support on their journey to recovery.
- There is a small number of people with learning disabilities with specialist care needs who require high levels of care and a growing number of young people with learning disabilities
- People with multiple morbidities, complex needs will be targeted by our partnership services, particularly with early support and intervention
- The needs of the population who are affected by poverty and health inequalities will also need to be targeted by partnership services

The case for change

We believe growing numbers of people in Perth and Kinross who have complex care needs or are growing older will benefit from better joined-up care, better anticipatory and preventative care and a greater emphasis on community-based care. We know that people want to have any care and support they need delivered to them in or as near to their own homes and communities and are a rich resource of innovation, support and intelligence about what is needed, what works and what role they can play in supporting community members.

We already know from the success of some of the projects we have tested out in recent years with funding from the Change Fund that working in partnership with the third sector and with communities we can make a difference to people's quality of life. Community based and third sector initiatives have demonstrated improved outcomes for a whole range of vulnerable and older people in our community. Since 2013 there appears to be a levelling in the number of people aged 65+ being admitted to hospital as an emergency and it is believed that investment in innovation through funding streams such as the Change fund has had a part to play in this, supporting early intervention. Our approach to reablement has led to significant improvements in independence for older people following a period in hospital. A Homeless Voice Boxing project in Perth City aimed at some of the most vulnerable and deprived people in the community has demonstrated significant health and wellbeing improvements for the people who participate and time banking projects which developed in some of the most isolated rural communities have demonstrated many positive impacts including members feeling more supported by their neighbours and more valued by their communities, increasing their community participation.

We are learning from these achievements. We also know that the way we deliver services at the moment is not sustainable. The population changes and other significant challenges face the partnership over the next five years and make a strong case for fundamental changes in the way we deliver health and social care services.

Rising demand and pressures on services

In Perth and Kinross, as with other areas, health and social care services are seeing an increase in demand for key services.

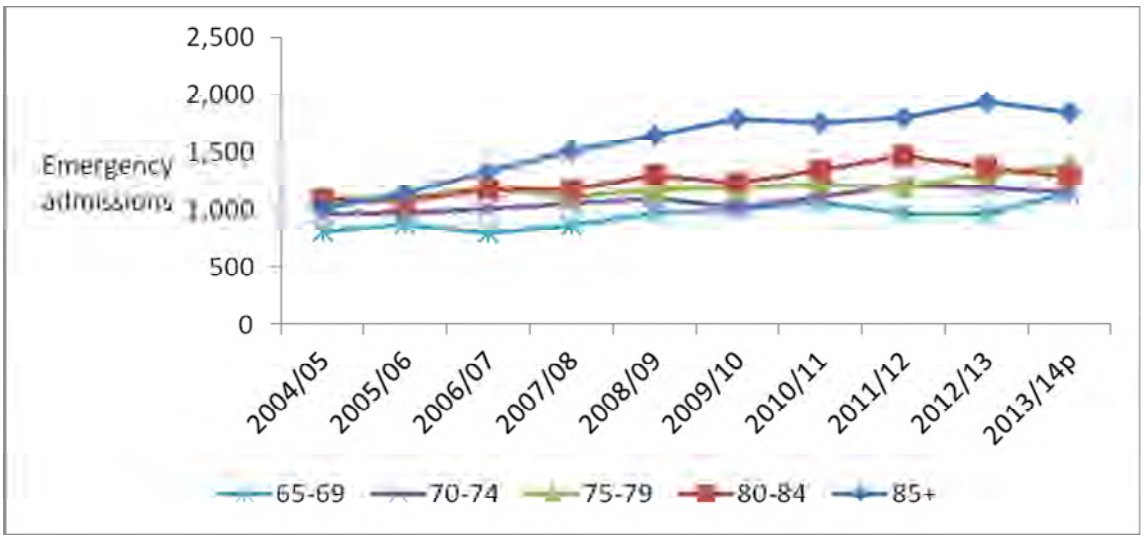
Unplanned hospital admissions are increasing, particularly for the older age group, as are the number of re-admissions, including people readmitted within 7 days of discharge. The pressures of people waiting to be discharged from hospital to appropriate community or residential setting remain; and the number of people entering residential care is increasing and projected to continue

to increase if we do nothing. In addition, there is pressure on home care services, with rising demand and waiting lists for services.

Some of our pressures are highlighted below. These need to be seen across the continuum of health, care and support and creative solutions found to address them:

- Between 2004 -2013 there was 38% increase in unplanned hospital admissions of people aged 65+ admitted as an emergency admission
- The increase in unplanned admissions for those aged 85+ is higher than other age groups
- We are experiencing an increase in the numbers of people being readmitted to hospital within 28 days of discharge.
- Rising emergency admissions create pressure both within the acute sectors and across the health and social care system with knock-on effects of delayed discharge, social work assessment and care at home services.

Figure 2 – Emergency Admissions for 65+ population by age group – Source ISD



- Crisis placements into care homes have risen from average of 5 to 15 per month, many of which result later in permanent placements
- Numbers of people experiencing delayed discharges, largely as a result of emergency admissions are increasing and our analysis indicates that people aged 85+ are most likely to be delayed in hospital
- There is increased demand for home care services causing pressure on the current budget of £9.57m
- People receiving home care services are more frail, which is reflected in an increase in the average hours each new person receives, particularly in the last year, from 8 (April 2014) to 9 in March 2015
- The number of people supported in care homes had been reducing since 2010 (918) but has recently been on the increase, with 875 people supported in March 2015, resulting in pressure on the care home budget for older people (£14.6m).

Health inequalities

Deprivation is a major factor in health inequalities with people in more affluent areas living longer and having significantly better health. Many of the people suffering the greatest negative health effects relating to mental health, obesity and long term disease are those experiencing poverty and social disadvantage. Whilst Perth and Kinross has a relatively affluent population compared with the rest of Scotland, there are significant areas of deprivation and in our rural communities there are inequalities in relation to access to services.

Income Deprivation, Employment Deprivation, Access Deprivation, and Child Poverty

When we look at deprivation and poverty across the areas, Perth City had higher levels of income deprivation and employment deprivation than North and South Perthshire in 2013. Just under half of those living in North and South Perthshire were 'access deprived'. Levels of childhood poverty varied considerably between the localities in 2012, 12.4% of the population in Perth City, compared with 9.6% and 6.4% in North and South Perthshire respectively. A number of people who are affected by poverty have multiple and complex needs, which need to be dealt with early and appropriately.

We also know that:

- There is a proportionately greater use of acute hospital services by patients from deprived communities
- Substance misuse disproportionately affects the most vulnerable and socio-economically deprived in our community.
- People with mental health problems are at greater risk of poor physical health and of dying at a younger age.
- The 2011 Census asked respondents whether they have a mental health condition that is expected to last and the rate of self-reported mental health conditions across Scotland shows that mental health needs are more prevalent among those living in deprived areas.
- There is clear evidence that those with chronic physical illnesses are more likely to suffer from mental health problems, particularly depression and that those with co-occurring chronic physical health problems and mental illness have poorer outcomes.
- There are stark health inequalities faced by people with learning disabilities (LD) –
    - significantly shorter life expectancy,
    - increased risk of accompanying sensory and physical impairments
    - Poorer physical and mental health than the general population. For example, the average
    - Number of health co-morbidities in the population of people with LD at aged 20 is the same as for the general population at age 50. (The Keys to Life ten-year strategy)

All of the people described above will be targeted by the partnership for services and support.

High costs, increasing demand and reduced budgets

All this emphasises the need for a change in the way health and social services are planned, commissioned and delivered. Unless we embrace a radical, new and collaborative way of working, embedded in a new culture throughout our public services, both budgets and provision of services will buckle under the strain. By using our resources in a different way we aim to put an **emphasis on prevention and anticipatory care** which could result in the reduction in unplanned admissions to hospital or long-term care, improving quality of life for individuals by maintaining independence for longer and minimising support needs.

Many areas across the UK and internationally are facing the same challenges in relation to increasing demands for health and social care, alongside declining public expenditure. Research indicates that countries facing similar challenges of an ageing population, people living with multiple and complex needs, a lack of co-operation between health and social care providers, fragmentation of health and social care systems and providing services to rural and remote areas[1], will often be the stimulus to integrated working arrangements. So the ambition of integration is not new and we can learn from examples across the UK and around the world to support our plans to improve the lives of all people in Perth and Kinross.

Sweden - for example, Sweden was one of the first countries to recognise the limitations of hospital delivered care and the importance of primary care and prevention care strategies, especially for older people. Hospital reforms in the 1990s focused on 2 main objectives: increased specialisation and concentration of services. Smaller hospitals provided more specialised care such as outpatient and community services whilst 24/7 emergency services were concentrated in larger hospitals. National reforms over the last decade have strengthened primary and preventative care models and an RCN policy briefing (2013) highlights some of the lessons we could learn from including:

- ✓ Need to focus on quality and system improvements
- ✓ Promoting a person centred approach
- ✓ Delivering integrated care
- ✓ Strengthening the workforce

Torbay - closer to home, the success of Torbay's integrated health and social care teams is an example of the positive results of integration. The teams work closely with GP's to support older people at home. This is achieved through increased spending on a wider range of intermediate care services, thereby avoiding inappropriate hospital admissions.

- The appointment of ward-based health and social care co-ordinators was a key factor in the success in Torbay, acting as the main point of contact for all referrals and the liaison with other team members.
- A close working relationship was developed with nurses, allied health professionals and social care staff to put in place appropriate care packages and support, alongside the sharing of information to support positive outcomes for individuals.

Outcomes Achieved:

- ✓ Reduced use of hospital beds;
- ✓ Low rates of emergency hospital admission for people aged over 65 and minimal delayed transfer of care;
- ✓ A fall in the use of residential and nursing home care;
- ✓ Increase in home care services and direct payments.

So, what will a successful Perth and Kinross health and social care system look like in future?

The Swedish and Torbay examples demonstrate that in spite of the challenges, it is possible to improve outcomes for people through changes in the emphasis of services and the way we work

1 SPICe The Information Centre, "The Integration of Health and Social Care: International Comparisons", Scottish Government, 16 July 2012

together. We want to learn from these and build on and develop the progress we have made in many areas, transforming the health and social care system. We want to have:

- ✓ Varied and responsive community-based services and support that will enable people to live as independently at home as possible with a better quality of life
- ✓ High numbers of people supported through re-ablement and recovery, with no need for further care
- ✓ Reduced emergency re-admissions
- ✓ Reduced non-elective admissions
- ✓ Reduced delayed discharges
- ✓ Reduced admissions to residential care, and none from acute hospitals
- ✓ Reduced numbers of people needing longer term care
- ✓ Reduced health inequalities and increased health and well being

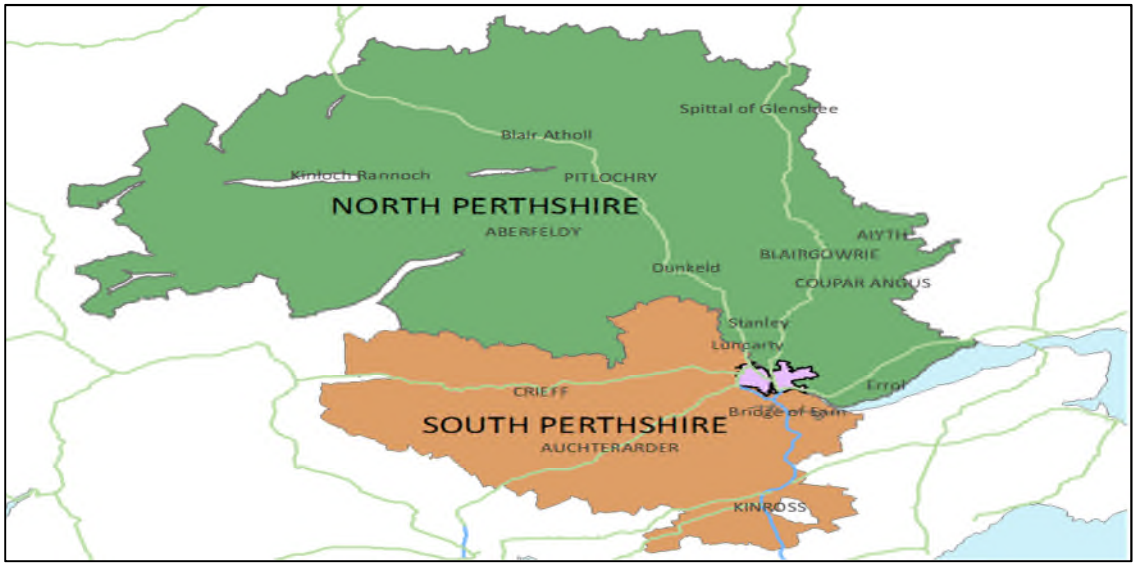
Working and delivering locally

To support our planning and delivery of local services, we have divided Perth and Kinross into 3 broad areas or localities as outlined in the map below:

- North Perthshire
- South Perthshire, and
- Perth City.

Our services will integrate work around GP practices, community pharmacy, dentistry, third sector providers, statutory health and social care services and communities to focus on early intervention and prevention.

Figure 1: Map of Perth and Kinross 3 localities



Developing our workforce

To deliver effective locally based integrated services we will need a **confident, competent professional workforce** who feel supported and valued. We need to ensure that across the health and social care sector, the workforce is engaged and involved in all of our planning and

development. We experience a high turnover and shortages of suitably skilled staff in key areas across the health, care and support sector and recruitment and retention of high quality health and social care staff across the sector is a key challenge for the partnership.

Through our Joint Organisational Development Plan we will promote a positive culture and encourage integrated working, based on a common purpose, to deliver the best possible outcomes for our communities. We will continue to create opportunities for our people to offer their best, in service of the communities of Perth and Kinross. The plan will support staff in three key ways:

- Providing accessible information, and raising awareness, understanding and participation around integrated working
- Providing access across our Health & Social Care workforce to the development programmes of partner organisations.
- Further develop specific development opportunities focused on supporting Health & Social Care Integration.

It is crucial to recognise the role played by a range of organisations beyond NHS and local authority and that services are and will be delivered by a range of professionals, including from third sector organisations and bodies such as GPs, pharmacists, dentists and others. We will need to work in partnership to make sure staff are available across all professional groups to deliver high quality care that is person centred and delivered flexibly according to the needs of all vulnerable residents.

Preparing for the Future

We want to improve outcomes and ensure that people get the health and services they need by providing support and services in local communities, empowering people to have greater control over their lives and managing their health and care where appropriate. This means:

- ✓ Citizen and community empowerment and capacity building
- ✓ Partnership with the voluntary and independent sectors
- ✓ Developing locally based integrated teams to drive and manage health and social care locally
- ✓ Working with primary care integrating community health services that work with GP practices, community pharmacists, dental practitioners and optometrists
- ✓ Expanding our use of technology, particularly in rural areas
- ✓ Using local community hospitals to provide planned care
- ✓ Tackling the rise in unscheduled hospital admissions - 2% of people use 50% of hospital and prescribing expenditure. 73% of total is unplanned admissions.
- ✓ Reducing delayed discharges from hospital
- ✓ Ensuring equitable access to services from all sections of the community
- ✓ Allocating resources to support prevention and early intervention.

2. Next section

- Vision
- Principles

- National context
- National outcomes
- Our strategic plan
- Locality planning
- Care groups and target populations
- Housing and homelessness

Our Vision

Our commitment to the Public Service Reform agenda is articulated in our Community Plan/Single Outcome Agreement 2013-2023. This sets out a vision of a confident and ambitious Perth and Kinross, to which everyone can contribute and in which all can share. Through our strategic objectives we aim to maximise the opportunities available to our citizens to achieve their potential, at every life stage.

For the Health and Social Care Partnership this supports our vision that:

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

We will do this by:

- ✓ Developing an integrated health and social care system focusing on prevention, anticipation and supported self-management
- ✓ Developing integrated locality teams at local level, so that all clinical, professional and non-clinical staff can work together in a coordinated way to improve access, the journey of care and the quality of services.
- ✓ Ensuring that people are at the centre of all decisions, which will include carers
- ✓ Delivering joint health and social care services to provide whole systems of care to meet the range of needs of people who require care and those who care for others, by combining staff and resources to assemble packages of care, deliver a wider range of care within communities and supporting people to be cared for at home.
- ✓ Improving the health of people and communities through wider partnership working to identify the health and care needs of their communities, focus on health promoting activity; take action to improve well-being, life circumstances and lifestyles and to actively address health and care inequalities.

Our Principles

Our vision can only become a reality through actions and the principles which underpin our approach. We will make sure the services and support we offer people are:

- Are planned and led locally in a way which engages with the community and local professionals
- Developed in partnership
- Integrated from the point of view of individuals, families and communities
- Take account of the particular needs of individuals and families in our different localities
- Best anticipate people's needs and prevent them arising
- Make the best use of available facilities, people and resources
- Maintain quality and safety standards as the highest priority

National Context

The Government's 2020 Vision

Our '2020 Vision'

Our vision is that by 2020 everyone is able to live longer healthier lives at home, or in a homely setting.
We will have a healthcare system where we have integrated health and social care, a focus on prevention, anticipation and supported self-management. When hospital treatment is required, and cannot be provided in a community setting, day case treatment will be the norm. Whatever the setting, care will be provided to the highest standards of quality and safety, with the person at the centre of all decisions. There will be a focus on ensuring that people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission.

The Public Bodies (Joint Working) (Scotland) Act 2014 provides the legislation for integrating health and social care services and requires local integration authorities to create a strategic plan for the areas it controls. The key purpose of integration is to improve the wellbeing and outcomes of people who use health and social care services, particularly those whose needs are complex and involve support from health and social care at the same time:

- to provide seamless integrated quality health and social care services, and
- To ensure resources are used effectively to deliver services that meet the needs of increasing numbers of people with long term conditions and complex needs.

National Outcomes

A national outcomes framework has been developed to assess the progress made towards achieving these outcomes. In Perth and Kinross we see the integration of health and social care as a vehicle to improve the wellbeing of people who use services. By involving people and their communities in decisions which affect them and through more joined up working and delivery of services earlier to prevent ill health, it is intended we will meet the 9 national outcomes for integration set out below and in detail as appendix 1 .

The services currently provided by the new partnership to achieve these outcomes will include services provided by Perth and Kinross Council and NHS Tayside as set out in the table below. A key challenge for the partnership will be to ensure services are integrated and meet the needs of people and communities in our localities and make the shift towards prevention and early intervention.

Services currently provided by Perth and Kinross Council	**Community services currently provided by NHS Tayside**	**Hospital Services currently provided by NHS Tayside (for planning purposes)**
• Social work services for adults with physical disability and older people • Services and support for adults with learning disabilities. • Mental Health Services • Drug and Alcohol Services • Adult Protection and Domestic Abuse • Carers Support Services • Health Improvement Services • Housing Support Services (in Sheltered Housing) • Aids and adaptations equipment and telecare • Residential care homes / nursing care home placements • Care at Home	• District nursing services • Substance misuse services • Primary medical services • General dental services • Ophthalmic services • Community geriatric medicine • Primary medical services to patients out-of-hours • Community Palliative care services • Community learning disability services • Community mental health services • Community continence services • Community Kidney dialysis services • Public Health promotion	• Accident and Emergency services provided in a hospital • Inpatient hospital services relating to the following areas: ▪ general medicine; ▪ geriatric medicine; ▪ rehabilitation medicine; ▪ respiratory medicine; and ▪ Psychiatry of learning disability. • Palliative care services provided in a hospital • Inpatient hospital services provided by GP's

Services currently provided by Perth and Kinross Council	Community services currently provided by NHS Tayside	Hospital Services currently provided by NHS Tayside (for planning purposes)
• Reablement services • Respite and day care		• Services provided in a hospital in relation to an addiction or dependence on any substance • Mental health services provided in a hospital, except secure forensic mental health services • Pharmaceutical services

The following services are currently planned and delivered on a pan-Tayside basis, and are included in the Integrated Functions. The **Perth and Kinross Integration Joint Board** will host these services on behalf of the other Tayside Integration Joint Boards:

- Learning Disability inpatient services
- Substance misuse inpatient services
- Public Dental Services/Community Dental Services
- General Adult Psychiatry (GAP) Inpatient services
- Prisoner Healthcare
- Podiatry

✓ The Perth and Kinross Partnership will develop agreements with the Dundee and Angus Integration Joint Boards to make sure we work together to plan and deliver changes that may impact on any of the hosted services.

Our Strategic Plan

This Strategic Plan sets out how we will achieve our vision and priorities over the next three years, targeting money where it's needed most. It is based on

- an analysis of the needs of our population to be able to target those populations and areas accordingly now and in the future
- relevant legislation and guidance on services to meet the needs of the populations and areas most in need
- feedback from individuals, communities and other key stakeholders
- current and potential services and available resources and the extent to which they are likely to meet our future population and community needs
- Research and innovative practice
- Reviews of the strengths and limitations of our current services and the changes needed to meet the growing and varying needs of our population

What are aiming to do?

Through joint strategic commissioning we will plan and deliver services and support for people in a new way. This includes identifying the needs of individuals and communities, across Perth and Kinross and at local level, empowering communities to decide what will best address those needs and working together with agencies to put the right services and support in place – at the right time. In practice, this means that, instead of different agencies working separately, all services (Health, Local Authority, Third and the Independent sectors) will all work in partnership together and with people, to plan, purchase and deliver services. We need to ensure:-

- A better matching of an individual's needs with the right services to meet those needs
- More prevention and early intervention to reduce the demand for complex and expensive health and care services
- Engagement and partnership with voluntary & private sectors, individuals & communities
- Reconfiguring of public services to meet the overall needs of individuals, families and communities

Planning and Commissioning

Planning, review and commissioning will be at the heart of effective service delivery. Our approach is informed by the current legislative and policy environment and is developed in partnership with professionals from the statutory sector, third sector and communities investing to focus on and achieve positive and better outcomes for individuals and communities over the long term.

Our aim is to:

- focus on commissioning which will achieve positive outcomes for those who use services
- promote 'co-production' to make services more effective and bring in new resources, by working in partnership with the people using their services
- promote social value by placing social, environmental and economic outcomes at the heart of commissioning

We will aim to commission service in partnership to ensure taking account of the needs and wishes of our local populations.

Our vision, principles and priorities will be at the heart of our strategic plan and joint commissioning arrangements as we decide:

- What do we need for the future?
- What will we continue to invest in/disinvest?
- How to make sure commissioning is based on the outcomes we want to achieve?

✓ Over the next 3 years we will develop a plan to review existing health and social care provision and decide how to transform services to ensure that all, irrespective of their sector, enhance the quality of life for the individuals and their carers now and in the future.

Our overarching aim is to ensure services are integrated and that we shift the balance of care to ensure that our focus is on community based outcomes focussed preventative services.

Locality Planning

We recognise the need to take account of the needs of different communities. The legislation clearly stipulates that integration authorities need to plan services at a locality level, taking account of the needs of people in different areas, and identifying at least 2 localities.

With a population density of 28 people per square kilometre, Perth & Kinross is the 8th least densely populated local authority area in Scotland and a relatively high proportion of residents are classed as being in some way 'access-deprived'. This means that issues of financial cost, time and inconvenience of having to travel may affect access to basic health and social care services. 29.6% of Perth & Kinross's older population (65+ years) live in areas classed as being among the '15% most access-deprived' in Scotland, well above the national average of 15%. This presents some particular challenges in the delivery of health and social care services and we need to plan to ensure equity of access.

Taking account of these differences, our plans will be developed and based on the different needs of the three localities of North Perthshire, Perth City and South Perthshire.

Care groups and target populations

Locality planning and the development of integrated locally based teams will change the way we deliver care to groups with different needs. A person centred approach will ensure that the needs individuals are what drive the planning and delivery of services. However, we need to understand the different needs of the population and the specialist needs of individuals who need care and support.

We already have key joint strategies in place for particular groups of people and the priorities and actions set out in the care group strategies will form part of our strategic plan. NHS clinical care strategies will complement our plans and are primarily focussed on the quality of care that people can expect to receive. Our strategy will be underpinned by strong clinical and professional governance, with adult support and protection a key priority across the partnership.

Some of the target client care groups include:

- people with learning disabilities
- physical disability and/or sensory impairment
- people with mental health needs
- people with substance misuse problems
- adult carers
- Older people
- people with one or more long term conditions
- homeless people
- offenders

For people with **learning disabilities** our priorities are informed by the government's Keys to Life Strategy and include:

- Effective support through life's transitions at all stages and ages and improving these pathways: (1) from school to adulthood, (2) into parenthood, (3) from adulthood to older age (4) from older age or illness to dying and death;
- Supporting carers and families to maintain their own health and wellbeing;
- Supporting better lives in older age;
- Personalised support that ensures people are supported to
    - live a nice home
    - be healthy, happy, occupied, enjoying friendships and relationships
    - Attend further education, training courses, volunteering and getting a job

For **physically disabled people or those with a physical or sensory impairment** we want to make sure they have access to accessible and appropriate

- Housing
- Employment
- Appropriate health care to support their physical and mental well-being and encourage healthy lifestyles
- Information to fully participate in all aspects of life

For people with **mental health needs** our Joint Mental Health Strategy (2012-2015) is being updated and an action plan developed which will ensure we deliver services which are person-centred, accessible, integrated and comprehensive by

- Supporting initiatives and services which promote good mental health and wellbeing in our local communities.
- Enabling access to services for those with mental health needs and poor mental wellbeing.

Recovery is **central** to the Strategy and defined by the Scottish Recovery Network as "being able to live a meaningful and satisfying life, as defined by each person, in the presence or absence of symptoms..." It encourages us to work within a wellness concept, not illness.

Our **Drug and Alcohol Strategy 2015-2020** focuses on a preventative approach to reduce the adverse impact of alcohol and drug use and is similarly focussed on recovery. We will:

- actively promote health, well-being
- Encourage recovery by supporting and promoting prevention approaches to substance misuse and a healthy and responsible attitude to alcohol consumption.

We recognise the contribution that **adult carers** make to the health and wellbeing on the people they care for. Our Joint Strategy for **Adult Carers (2015-2018)** is an ambitious plan to improve the lives of carers in Perth and Kinross and, as a consequence, support more people to live independently in their communities.

For **older people** our vision is to promote the independence and wellbeing of older people at home or in a homely setting. Our Integrated Care Fund supports work with communities to achieve positive outcomes for older people, such as delivering or enabling personalised care and support, independence and a good quality of life. We still have work to do to embed some successful models of care to support older people successfully in the community and this strategic plan will support our ambition to create integrated services that support older people to live successfully in the community, avoiding unnecessary prolonged periods in hospital. Our key priorities are set out in the Older People's Action plan and include:

- Development of Technology Enabled Care (TEC) as a resource to contribute to maintaining people's safety and independence to support people to remain at home for longer.
- Commission a care at home service which is personalised, flexible and works in an integrated way to support people to live independently at home
- Promote Anticipatory Care Planning (ACP) across agencies and ensure those individuals who require an ACP have one in place.
- Encourage community empowerment, engagement and participation in all localities to enable communities to do more for themselves and to encourage people to have their voices heard in the planning and delivery of services.

Housing and homelessness

Housing and housing support services play a crucial role in supporting people to live independently at home or in a homely setting and make a vital contribution to the 9 national health and wellbeing

outcomes. The vision for housing set out in the council's local housing strategy (2011-2016) is that "Perth and Kinross is a place where everyone will have access to good quality housing that they can afford that is in a safe and pleasant environment. People will have access to services that will enable them to live independently and participate in their communities". Our housing strategy will set out key outcomes and play a central role in meeting our key priorities for integration. Currently we provide or support:

- care and repair services, aids and adaptations and to ensure that people are supported to stay at home or able to move to suitable alternative accommodation
- specialist housing (sheltered, very sheltered, extra care) for older people
- housing with additional support in sheltered housing units to support people in the community
- specialist supported accommodation for homeless households and people with a range of support needs
- preventative 'floating' housing support services to a wider range of people, including older people, homeless people, people with disabilities, people with mental ill-health and those with substance misuse issues
- prevention and alleviation of homelessness through the development and implementation of our homelessness strategy

Integration and the need to shift the balance of care to support more people in the community for longer will increase the need to ensure that housing plays a central role in the strategic planning process. We will work in partnership with housing to ensure that together we support the achievement of the national health and well-being outcomes.

3 Needs and resources

- Needs of the population
- Target populations
- Partnership resources

- How health and social care services are consumed
- Feedback from community engagement
- Good practice and innovative models

Needs of the population

We have used a wide range of information to inform our priorities, including:

- the joint strategic needs assessment (JSNA)
- feedback from community engagement

- the national and local strategies including the Tayside NHS plan and local joint care group strategies

The JSNA provides us with good information about the local populations, issues that can impact in the need for health and social care services as well as the use of current services. It is published as a separate document and some of the key messages are set out below.

Perth and Kinross

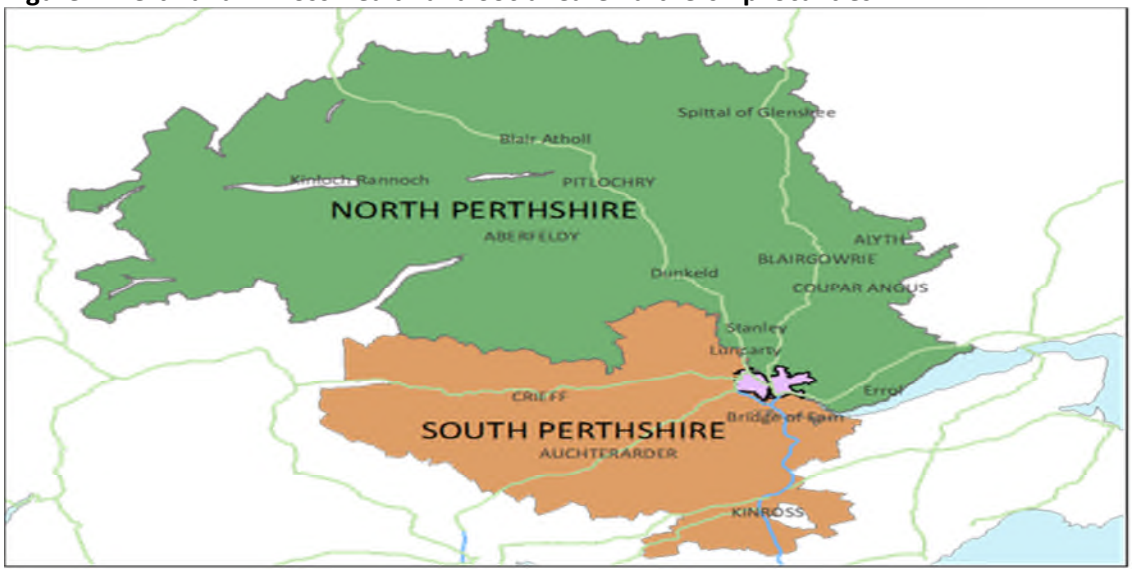
Perth & Kinross has a diverse mix of urban and rural communities and has a population of 148,880 (2014) living across the area's 5,268 square kilometres. The geographical distribution of the population is important as it brings challenges for the delivery of services to some rural and remote communities.

On average health and well-being in Perth and Kinross is better than that of other places in Scotland, although there is some variation in need across the different localities. However, evidence also suggests that health inequalities are more pronounced for older people in rural areas than for their contemporaries in urban settlements (Locality Profiles 2015).

Recognising the need to take account of the needs of different communities, this plan provides information for 3 localities or areas and our planning will increasingly be delivered on this area basis:

- **North Perthshire** locality consists of three distinct areas: Highland Perthshire, Strathmore and Carse of Gowrie
    - With an overall population of 50,338 residents, it has the highest number and proportion of people aged 65+, and the lowest number and proportion of children.
- **Perth City locality** is the largest settlement in Perth & Kinross and includes the sub-localities Perth City North and Perth City South.
    - It has the largest population of the 3 localities, 50,814 with the highest number of individuals of working age, and the lowest number people aged 65+.
- **South Perthshire** consists of the distinct areas of Strathearn and Kinross.
    - With the smallest population of the 3 localities with 46,598 residents, the population also has the lowest number of working age individuals of all 3 localities.

Figure ….Perth and Kinross Health and Social Care Partnership localities



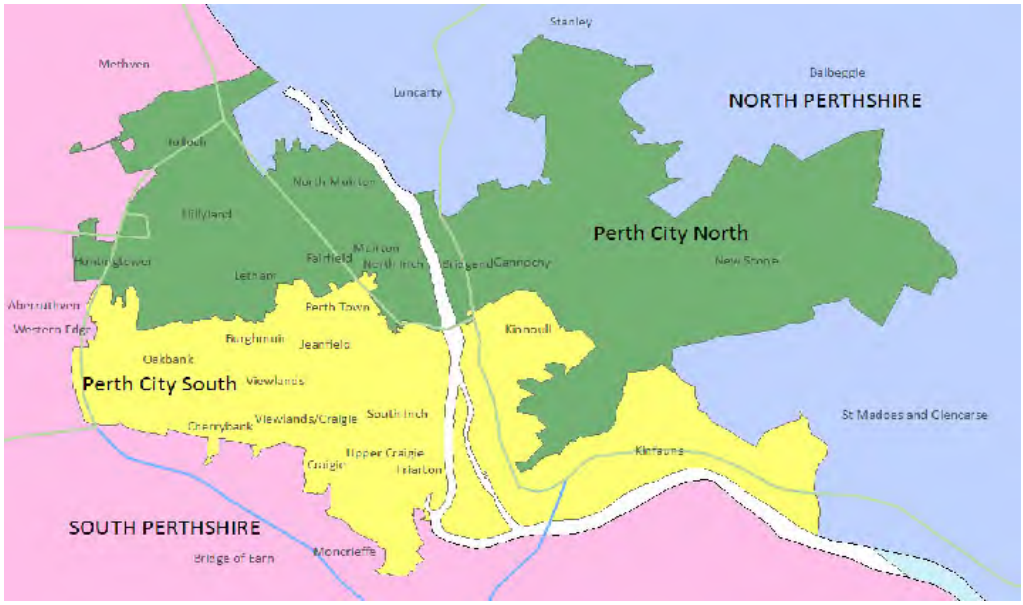


Table ….Perth and Kinross Adult Population by Age

Age Group	Current Population (2012 MYE)	Projected Population 2017	Projected Population 2027	Projected Population 2037	% Change Current - 2037
16-64	91,795	94,880	99,054	102,781	11.97%
65-74	16,567	18,463	19,828	21,962	32.57%
75-79	5,949	6,470	8,363	9,260	55.66%
80+	8,457	9,753	13,813	17,990	112.72%
Total	147,740	154,101	168,904	183,468	24.18%

Source: Mid-Year Estimates (MYE) NRS 2012-based population projections

The adult population is relatively evenly spread across the 3 localities although the biggest concentration of the population is in Perth City. There are some concentrations of the population in the main settlements of North and South Perthshire but the populations are spread over a larger rural area and in villages and smaller towns.

Table ….Perth and Kinross Adult Population by Locality

Age Band	North Perthshire	South Perthshire	Perth City	Perth and Kinross
18-24	3,395	3,126	4,491	11,012
25-34	5,114	3,710	7,267	16,091
35-44	6,067	5,352	6,240	17,659
45-54	7,929	7,443	7,348	22,720
55-64	7,524	6,474	6,229	20,227
65-74	6,605	5,579	4,971	17,155
75-84	3,940	3,241	3,309	10,490
85+	1,387	1,290	1,413	4,090
Total	***41,961***	***36,215***	***41,268***	**119,444**

Ethnicity

The population is predominantly white Scottish but there is a small but significant number of the population from different ethnic backgrounds and we need to ensure our services meet the needs of everyone in the community. The 2011 census shows that 98% of Perth and Kinross residents self-reported that they were of white ethnicity, above the Scottish average of 96.1%. Furthermore, 81.8% of Perth and Kinross residents consider themselves to be white Scottish. Of all three localities Perth City has the most diverse ethnic population, with 3.2% of residents self-reporting to be non-white, compared to just 2.0% of the population of Perth and Kinross overall. Perth City has the highest prevalence of people identifying as white Polish, at 2.8%. This is twice as high as in North Perthshire (1.4%) and over three times the rate in South Perthshire (0.8%).

ETHNIC POPULATIONS IN PERTH & KINROSS (SOURCE: NATIONAL CENSUS, 2011)

Ethnicity	Perth & Kinross	Scotland
White- Scottish	81.8%	84.0%
White- Other British	11.3%	7.9%
White- Irish	0.8%	1.0%
White- Polish	1.7%	1.2%
White- "Other"	2.4%	2.0%
Asian, Asian-Scottish or Asian-British	1.3%	2.7%
"Other" Ethnic Groups	0.8%	1.3%

An often hidden population is the Gypsy/ Traveller population and Perth and Kinross has traditionally been an area that Gypsy/Traveller community members have lived in or travelled through. However exact figures are difficult to quantify, particularly if individuals live in mainstream housing or do not 'identify' themselves as Gypsy/Travellers for possible fear of discrimination. The Scottish Census figures for 2011 included "Gypsy/Traveller" as a classification for the first time and the results were released in September 2013. Nationally 4,212 people were recorded as such with the highest individual local authority population being 415 in Perth and Kinross. Whilst numbers may be small, the gypsy/Traveller Strategy 2013-18 identifies that this group has faced discrimination and have not always received services to standards expected. The community themselves, identified a need for better healthcare in a survey conducted between 2012 and 2013.

Multiple Deprivation

The table below show Perth & Kinross's population according to the Scottish Index of Multiple Deprivation (SIMD) quintiles. Almost two thirds of Perth & Kinross's population are in Quintiles 4 and 5 (i.e. the two 'least deprived' quintiles) but there is significant variation between the localities, with Perth City having the highest level of deprivation at over 40%.

	SIMD Quintiles				
Locality	**1**	**2**	**3**	**4**	**5**
Perth & Kinross	5.8%	12.8%	19.0%	40.9%	21.6%
North Perthshire	2.5%	5.0%	19.9%	62.0%	10.6%
South Perthshire	0.0%	0.0%	27.2%	45.7%	27.2%
Perth City	14.4%	32.2%	10.6%	15.5%	27.3%

Figure: Percentage of residents per SIMD quintile for Perth and Kinross and each locality (2012)

Target population

While the majority of the population use health care services, such as GPs, pharmacy and dental services, our focus in this section is those people whose needs may be complex, who may be at risk of developing long term conditions or who sometimes require the intervention of social care and other support services.

Analysis, demographics:

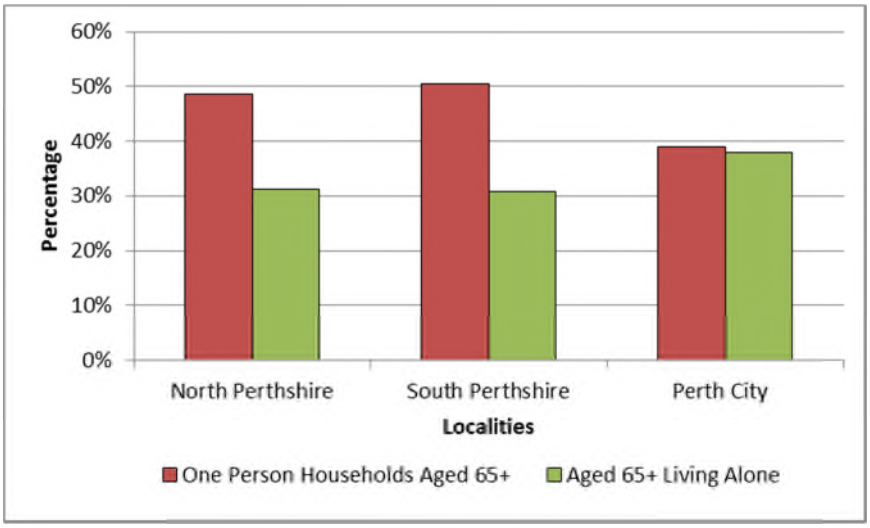
Our needs assessment tells us that our population is living healthier and longer lives. We compare favourably with the rest of Scotland in key areas relating to health and deprivation, but the analysis tells us that there are some key challenges across and within the three localities relating to deprivation, age, prevalence of long term conditions, substance misuse, mental health and learning disability. In addition a particular challenge for service planning is the nature of the dispersed and rural population of Perth and Kinross and a relatively high proportion of residents are classed as being access deprived (31.3% compared with 15% nationally) which means that compared with an urban population they face particular challenges in being able to access services easily. Interestingly, feedback from the community engagement confirms that transport and access to services is a key issue in the rural communities of Perth and Kinross.

Some key demographics

- There are 31,735 people aged 65+, 21.5% of the population
- The number of individuals aged 75+ is projected to increase by the greatest proportion by 2037, at 58.9%. While the growth of a comparatively small population will invariably result in a large proportional increase, this is important due to the high health and social care costs associated with individuals aged 75+ and over.
- The number of people aged 65-74 is also expected to increase between 2012-2037 by one third (32.6%), which will likely add further pressures to service delivery. Hence older people (aged 65+) are a specific target group for the purposes of our strategic plan.

People Living Alone

- There are 20,875 one-person households in Perth and Kinross. Approximately 45% (n=9,404) of these are occupied by people aged 65+. There are 28,337 households with residents aged 65+, so nearly 1 in 3 (33.1%) of people aged 65+ in Perth and Kinross live alone.
- A higher percentage (37.9%) of people aged 65+ live alone in Perth city, compared with North Perthshire (31.1%) and South Perthshire (30.8%).



Substance misuse

In 2013, alcohol misuse was identified as the underlying cause of 11.2 deaths in every 100,000 in Perth & Kinross. This is well below the national average (21.4) but over the last 3 years there has been an increase of 3% in the number of deaths directly attributable to alcohol misuse.

- Residents of the most deprived areas of Perth & Kinross were five times more likely to die of an alcohol-related condition than those living in the least deprived areas.
- Around 2% (national average: 2.4%) of males and 0.5% (national average: 1%) of females in Perth & Kinross were estimated to be 'problem drug users' in 2012. Though these prevalence-levels fall below the levels nationally, in 2012/13, 961 new individuals across Tayside were reported to the Scottish Drug Misuse Database (SDMD), an increase of 17% on the number of new clients from the previous year.
- As with alcohol misuse, there is a clear deprivation factor with regard to drug-related A&E presentations in Perth & Kinross. Those registered to the least deprived Deprivation Quintiles are significantly less likely to present at A&E as a result of drug misuse.

Mental Health

- Around 1 in 4 adults experiences a mental health episode in a year, ranging from anxiety and depression to more acute symptoms.
- Perth city is the locality with the highest referral rate to the Community Mental Health team compared to the other 2 localities.
- The percentage of Perth & Kinross residents prescribed drugs for anxiety/depression/psychosis in 2013 was 14.9%, below the national average of 17%
- However, in 2013/14 there were 1,373 (0.96%) patients who had a serious mental illness such as schizophrenia, bipolar affective disorder or other psychoses, higher than the average of 0.88% for Scotland overall.
- 0.9% (n=1,385; three-year rolling average, 2011/12-2013/14) of Perth & Kinross population (based on 2013 estimates) were the subject of a psychiatric hospitalisation.
    - Perth City: 1.7%
    - North Perthshire: 0.5%
    - South Perthshire: 0.6%
- However all three localities registered a decrease over the period.

People with Long term Conditions

8,000 adults in Perth and Kinross are identified as having one or more long term condition and of these a significant number, 5,282, have 2 or more conditions. In the 2011 census, 18.1% of the population of Perth and Kinross considered their day to day movement in some way limited by a condition that was expected to last more than a year.

- 4% of the population have been diagnosed with diabetes – slightly below the Scottish average of 5% but a condition that is expected to rise as the population gets older.

At least one long-term condition

According to SPARRA (Scottish Patients at Risk of Readmission and Admission) data at August 2014, 8,000 individuals in Perth & Kinross had at least one long-term condition, 44.6% of whom lived in Perth City.

Table: Number of individuals with at least one long-term condition (01/08/14) (SPARRA)

Individuals with long-term conditions	Perth & Kinross	North Perthshire	South Perthshire	Perth City
1+ Long-term condition	8,000	2,416	2,014	3,570
Multimorbidities (2+ conditions)	5,282	1,607	1,332	2,343

In registers kept by GP practices, a number of specific long term conditions report higher prevalence rates in Perth & Kinross than in Scotland as a whole. These include Hypertension (15.0% vs 13.9%), Hypothyroidism (5.6% vs 3.8%), Coronary Heart Disease (4.6% vs 4.3%), Cancer (2.5% vs 2.2%) and dementia (1.1% vs 0.8%). In part this is likely to be a result of the older population.

Based on the recent Scottish cross-sectional study, prevalence estimates indicate that, similar to Perth and Kinross as a whole, around 24% of the Perth and City population have two or more long term health conditions. The estimated prevalent cases for specific age groups are shown in Figure….for Perth City, and for the North and South Perthshire localities.

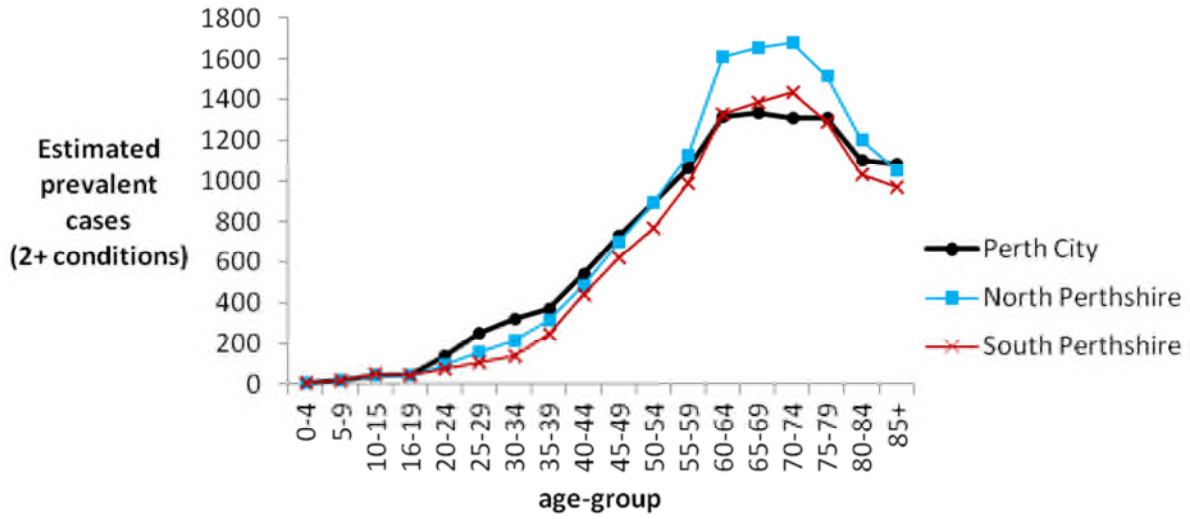


Figure 2. Estimated prevalent cases of two or more long term conditions for Perth and Kinross localities

The lower number of estimated multi morbidity cases in Perth City and South Perthshire above working age is driven by the relatively young population compared with North Perthshire. It is notable, however that the total numbers under 60 years are higher in Perth City compared with both of the rural areas.

The issue of long term conditions affects all parts of society. On the one hand there is a strong connection between poverty and long term health problems. On the other hand, those who live longer may spend many years dealing with the complexities associated with these conditions. We need to proactively support people who are affected by, or who may go on to develop, long term conditions and the complex problems that accompany them. This means recognising multiple underlying causes, the accumulation of risk with age, and the impact of disease. People with symptomatic conditions need effective clinical and support management. But targeted and effective prevention is also necessary to prevent future need, and to address the increasing health gap. This requires a coherent range of approaches across the breadth of prevention, care and support.

Learning Disability

The locality with the highest number of adults registered with a learning disability is North Perthshire, with 191 individuals. However, it is in the Perth City North sub-locality where the highest proportion of adults registered with a learning disability live, 95 out of 156 people.

Locality	Number of adults registered with a learning disability
North Perthshire	191
South Perthshire	124
Perth City	156
Total	471

However, there will be higher numbers of people known to health services and the 2011 Census, shows that 683 individuals reported having a learning disability in Perth and Kinross. This is 0.5% of the population.

Whilst the numbers known to the local authority may be small, a number of people with learning disabilities have very complex conditions that require high levels of care and support.

Summary

Our population profile information by locality presents us with a picture of differences across the three areas of Perth & Kinross and highlights the need to ensure a local response to the different needs of the population. Further examination of data connected to how people use our existing services will highlight different patterns of service provision and use which will need further exploration as health and social, care integration becomes embedded across the area.

Partnership total resources

The section below summarises the budget available to the partnership to plan and deliver health and social care services: **£193.4m.** This includes elements transferred from Tayside NHS and Perth and Kinross Council to the new integration body.

	Adult Social Care	Community Health	Presc. & FHS	Hosted Services	Hospital Set Aside	Total
Older people's services	£35M	£17M				£52M
Adult Mental Health	£3M	£3M		£8M		£14M
Addictions	£1M	£1M		£3M		£5M
Learning disabilities	£15M	£1M		£7M		£23M
Prescribing			£25M			£25M
Family Health Services			£35M			£35M

	Adult Social Care	Community Health	Presc. & FHS	Hosted Services	Hospital Set Aside	Total
Other	(2M)	£12M		£5M	£25M	£40M
TOTAL	£52M	£34M	£60M	£23M	£25M	£194M

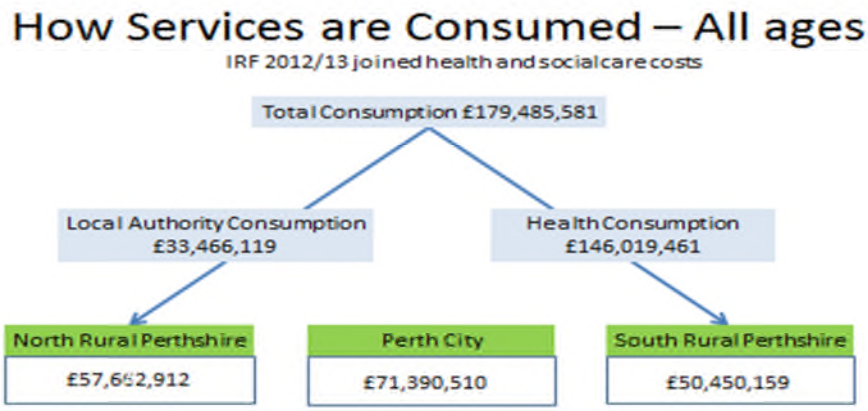
The figures above are a provisional representation of the resources available to the Integrated Joint Board. Some services identified earlier (hosted services) will be delivered for the whole of Tayside and are delivered by one of the three health and social care partnerships and arrangements for the funding of these services are still under discussion.

Like all public services across the country, Perth and Kinross expects significant financial pressures over the next three years. The Council will have to save 12% of its budget and the Health Board is facing similar pressures. This further reinforces the need to review our model of delivery across health and social care. This will mean a shift from a high resource institutional response to crisis to an approach which is targeted, works with communities is preventative and asset based.

The Partnership will publish a financial statement by April 2016 outlining the total resources available to the Integration Joint Board and plans to manage the financial pressures facing the partnership over the next three years.

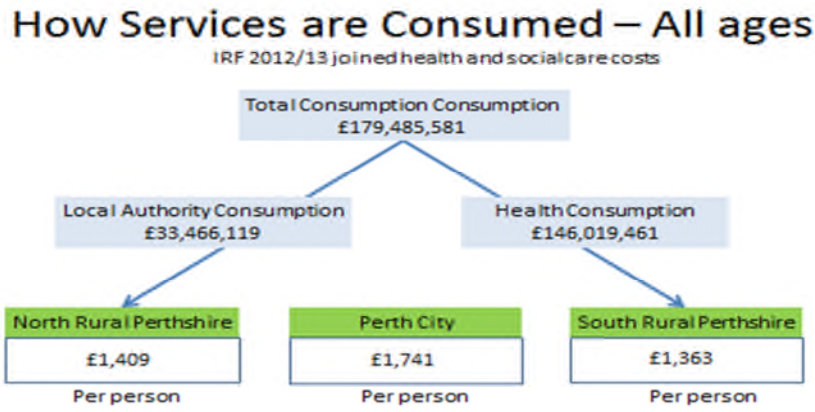
How health and social care resources are consumed

The section below looks at the way health and social care service are consumed by the public. The information is analysed using the Integrated Resource Framework (IRF) which enables us to examine expenditure across the majority of local health and social care services, totalling almost £180m worth of services. The data allows us to examine activity, equity, efficiency, variation and quality across the three localities of Perth and Kinross. The tables below give us an indication of how our current health and social care resources are spent.



The chart above shows that overall expenditure on health and social care is greater in Perth City than in the less densely populated areas of North and South Perthshire. The table below also shows

us that expenditure per person is much higher in Perth City although there will be variation across age and client group.



Further analysis of the data highlights some key issues that will need further examination as we plan, review and develop services in the three localities.

Deprivation

Analysis of the (IRF) and the NHS Information Services Division (ISD) datasets both demonstrate examples of service consumption bias towards least deprived individuals and communities. However, although the most deprived communities consume far greater resources than least deprived communities, this is simply as a result of the greater numbers of the most deprived populations in services compared with other populations.

The analysis shows that the per person spend of a “least deprived individual” compared to a “most deprived individual” the least deprived person will nearly always consume more services than the most deprived, sometimes up to 4 times the consumption.

Multi-morbidities

For Multimorbidity (2 or more Long Term Conditions), we identified the 50-64 age group as the largest consumers of health services, and again when the same data is analysed at a per person level, then the “least deprived individual” is a typically higher consumer than the “most deprived”.

Locality Behaviour 98% Indicator

Analysis of the (IRF) dataset for the 98% indicator (i.e. 98% of our 65 and over population are living safely at home) has shown a greater % of the 65 + population resident in Care Homes is from an urban area. (1.2% of rural localities v 2.7% in urban localities)

Locality Behaviour Re-admission to hospital

- Analysis of the ISD “Age Sex Standardised Rates of 7 & 28 day emergency readmissions” identified that the **average** re-admissions **per 100 discharges** from hospital over a **7 year** period were:
- Scotland wide : 3.81 re-admissions within 7 days and 8.33 re-admissions within 28 days

- Perth City :4.35 re-admissions within 7 days and 9.29 re-admissions within 28 days (urban locality)
- Perth City 2014/15 4.45 re-admissions within 7 days and 9.17 re-admissions within 28 days
- North and South Perthshire localities are below the yearly numbers and the national averages

We do not yet have a clear explanation for the differences, but do know that there are higher levels of income and employment deprivation in Perth City, more older people who live alone and higher numbers of the population with mental health needs and issues with substance misuse. We also know that access to services is likely to be easier in Perth City than in the more remote and rural areas and that there is greater availability of services. Whilst these issues do not offer an explanation of the higher spend person, the information suggests a need to better understand how access to services is organised by staff and service users.

- ✓ We will further explore how we can use the information highlighted by the data in order to support our planning of health and social care services.

Community Engagement

During 2015 an extensive programme of community engagement was undertaken involving health, social care and the voluntary sector umbrella body – PKAVS - who set out to achieve a number of objectives:

- To have a meaningful discussion with health and social care planning and communities, service users, carers and their representatives.
- To increase the involvement of all community stakeholders in developing community profiling and planning
- To deliver effective engagement that will help us meet the National Health and Wellbeing Outcomes.
- To support the capacity of all involved to take forward effective engagement

This revealed a lot about how individuals and communities experience health and social care services as well as insights into the priorities of communities. Over 4,000 people 'joined the conversation' and feedback from this has been used to influence our priorities and actions. Feedback from our local community engagement is fairly consistent with key messages from national information about service users and community experience of the health and social care system.

Issues highlighted include:

- The need for clear information about who to contact and how to access services.
- Caring and understanding attitudes - being treated with respect and dignity.
- Care delivered as close to home as possible.
- Safe, effective services that provide the right care, support and information at the right time.
- Information and support to live well for people with a long term condition.
- Equitable access to services irrespective of area.
- How a joint approach between families, communities and services was the way forward

- (Kings Fund 2014) :

Additional themes from 'join the conversation' include:

- A sense that people struggle to make the system work for them and have the necessary information available to them to make this work. This was a strong theme throughout as well as frustration about the number of times people have to tell their story to professionals as they travel through a pathway and transfer between services
- Knowing how to access services: people don't know what is available of how to access services and staff also struggle to support people to navigate the system. There is a feeling that services aren't joined up, well-co-ordinated or personalised and some positive views that people and communities can do more to support themselves.
- Delays in accessing care at home, lack of continuity of staff and lack of time make it a negative experience for a lot of service users
- Experience of GP services varied: there was some very good feedback about GP practices and very high public expectations about the role of GPs as a gateway for all health and wellbeing issues
- A feeling that services are designed to suit service requirement. A good example would be the length of travel time from rural areas for very short hospital appointment and suggestions that perhaps better use of new technology might help resolve this

These and other issues highlighted will inform some of the changes want to make to our health and social care system to ensure it is more personalised and is designed to meet the needs of individuals and communities.

What is working well/innovative practice, models of care?

We have already highlighted some examples of what works and how this will inform our journey towards an integrated health and social care system. Locally, lessons from the Change Fund Projects and emerging practice from the integrated care fund suggest integrated ways of working that will support our vision for change to support more people to live healthier lives at home. Some examples of practice are outlined below:

Rapid Response*, *PERTH AND KINROSS

The Rapid Response Team was set up to provide an alternative to admission to a hospital or care home for people during a time of crisis. The service provides coordinated support from a range of professionals from health and social care including GPs, District Nurses, Social Workers, Social Care Officers, Occupational Therapists and Physiotherapists. The service is available throughout Perth and Kinross and is accessed through a telephone Single Point of Contact, with the aim to support people to remain in their own home.

Outcomes Achieved:

- ✓ 84% of people receiving the service remained in their own homes
- ✓ 88% of GP practices have referred to Rapid Response
- ✓ The service is valued by 84% of GPs as an alternative to admitting people to hospital or a care home (2012/2013 data)

"*I just wanted to say thank you, I appreciated so much, everything you did for my Mum. Your care enabled me to keep her at home and to be with her at the end and for that I will always be grateful."* Feedback from a family member

Reablement, PERTH AND KINROSS

The Reablement Team helps people live safely and as independently as possible in their own homes. Support can be given if people need help to live at home, or help or support to return home from hospital. People will be given the opportunity to regain the skills they need to feel confident about living independently at home.

Outcomes Achieved:

- ✓ 1/3 of people required no further ongoing social support and returned to their previous level of independence
- ✓ 40% regained their full independence

"If the reablement service was not in place, I would have been in hospital for a lot longer as I couldn't manage on my own"

Enhanced Community Support, (ECS), BLAIRGOWRIE & PERTH CITY [2]

Enhanced Community Support (ECS) aims to ensure healthcare professionals are in a position to provide prompt identification and appropriate, timely responses to adult and older people's health care needs, helping to avoid crisis management and unnecessary or prolonged hospital or care home admissions. The Enhanced Community Support model will support more people in their own homes and people will receive care coordination at a practice level by the primary care team.

Delivery of the right amount of care, delivered by the right service, at the right point in the continuum of care, especially at the interfaces of illness, recovery and independence is essential to facilitate appropriate multidisciplinary healthcare planning. This in turn will allow us to enable people to maintain their health, independence and wellbeing for as long as possible. *Early indications suggest the model is delivering good outcomes for patients and some development work will be required to deliver the model as a fully integrated care service.*

Summary of key findings

Through our community engagement work, analysis of the population of Perth and Kinross and understanding of the challenges facing the partnership there are a number of key issues we will have to address. We know that:

- There is a proportionately greater use of acute hospital services by patients from deprived communities
- The population is ageing and although most people are living healthy and active lives, the need for health and social care services increases with age
- There is a growing older population in North Perthshire , a remote rural area where services are difficult to access

[2] Perth and Kinross CHP, Enhanced Community Support Project, Project Initiation Document, 2014.

- There are significant pockets of income and employment deprivation in North Perthshire and Perth city
- Substance misuse disproportionately affects the most vulnerable and socio-economically deprived in our community.
- People with mental health problems are at greater risk of poor physical health and of dying at a younger age.
- There are stark health inequalities faced by people with learning disabilities
- The partnership is facing significant budget pressures at a time when there is growing need for services
- There are patterns of service use in relation to unplanned admissions, use of care homes and other issues that require further investigation and there is some indication that the people who are most deprived are not accessing support at an early stage
- There appears to be inequality in access and use of services with the most deprived individuals using fewer health and social care services with much higher patterns of consumption in urban areas when compared with rural areas.
- Part our of planning will be to understand these issues better so that we can shape our health and social care system to better meet people's needs

Our plan will help us to address these issues building on some of the good work already being developed across the partnership and we intend to use the lessons learned from the ICF projects and from models established through the Change Fund to inform our future service delivery models and commissioning plans. The initial evaluation of projects and lesons learned from elsewhere will begin to inform our plans to shift the balance of care through:

- a greater focus on prevention and early intervention,
- the delivery of integrated health and wellbeing outcomes for individuals and communities, and
- Contribute to our wider work designed to tackle health inequalities.

It is early in the process and our expectation that as the projects begin to evidence outcomes, the later evaluation of ICF activity will provide good basis of learning from what works and help inform local commissioning priorities

Based around 5 priority themes

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

Strategic priorities, future plan

A radical approach is needed to transform our health and social care system to prevent the avoidable use of health and social care and respond flexibly and appropriately to people who are vulnerable and need care and support.

We already have many strong, effective, person-centred services and support so need to build on these to continue to shift the balance of care towards locally, community based services, adapting to the specific needs of communities in the different areas of Perth and Kinross.

Based on our vision for health and social care, our knowledge and understanding of population, themes identified from community and stakeholder engagement and lessons learned from local initiatives and elsewhere we have identified 5 priority areas :

1. Prevention and early intervention
2. Person centred health, care and support
3. Work together with communities
4. Inequality, unequal health outcomes and healthy living
5. Making the best use of available facilities, people and resources

1. Prevention and early intervention

A focus on prevention and early intervention will help us make the changes needed cross health and social care to:

- improve outcomes for people
- provide services which reduce health inequalities
- promote independence
- deliver more personal health and care services closer to home
- reduce unplanned hospital admissions and delays in discharge
- Anticipating what people need and intervening early to prevent future, costly and unnecessary interventions.

Prevention is at the heart of public service reform with integrated preventative approaches including anticipatory care, promoting physical activity and introducing technology and rehabilitation interventions to prevent or delay functional decline and disability.

With this approach, we aim to have a positive impact on the health and wellbeing of individual's people's lives by preventing deterioration in health, dependency on health and social care services and delay in recovery and loss of independence.

We want to shift our resources to prevent harm rather than continually responding to acute needs and problems that could have been avoided. Successful prevention and early intervention measures should mean that we will see a reduction in unplanned hospital admissions, more people with mental health or drug alcohol problems in recovery and more people supported to live independently at home.

Developing preventative services and anticipatory care

We will look at prevention on three levels:

- ✓ **Primary prevention/promoting wellbeing** –aimed at people who have little or no health or social care needs; or symptoms of illness. The focus is on maintaining independence and good health, and promoting wellbeing through information advice and community engagement.

- **Secondary prevention/early intervention** - we need to identify people at risk, stop or slow down any deterioration, and actively seek to improve their situation. This includes working more effectively with primary care to identify those at greatest risk of ill health.

- ✓ **Tertiary prevention** –aimed at minimising disability or deterioration from established health conditions or complex social care needs. The focus here is on maximising people's independence, and on preventing inappropriate use of more intensive services for people whose needs could be met by lower cost interventions

Primary Prevention

We recognise that community and other local services can have a significant role in prevention and we want to ensure that people with health and social care needs benefit from access to universal services. There are many services and activities which have a direct positive impact on wellbeing, particularly cultural, educational, recreational, and sports and community groups. These activities are open to everyone and we need to make sure services support and encourage access to universal services to help people to retain independence.

Resources in the community, such as primary health care, housing, information, support and advice, will also have central role is supporting our vision to support more people to live at home independently.

Consistent feedback from communities was that we needed to **improve information** about access to services as many people said they didn't know how to access information about health and social care services or what local activities were available to them. We recognise these concerns and want to improve access to information and help communities and people to support themselves though improved access to universal services and community resources in the locality.

- ✓ We will improve information through the development of a virtual health and social care market place to improve information about services and how to access them and that people with low to moderate needs can access information about universal services or lunch clubs, befriending and other supports without having to engage with statutory services

People felt there were significant benefits of local community groups in maintaining people's health wellbeing and independence and there are some very good examples of where this is already happening. For example, five Time Banks were established across Perth and Kinross. They coordinate informal volunteering and a flexible framework for community members to offer each other some form of help or service, in direct response to expressed needs. Amongst many positive impacts, members reported feeling more supported by their neighbours, feeling more valued by their communities, feeling more comfortable asking for help, increasing their community participation and making new friends.

- ✓ We will continue to work with local communities to support initiatives to build community capacity and support volunteering

Solutions - Housing

Housing is key to supporting people to live as independently as possible in their homes and has a major impact on people's health and wellbeing. Based on the 2011 census we know that:

- almost 65% on people living in Perth and Kinross are owner occupiers.
- 17.6% are in social housing
- 13.1% the private rented sector
- Waiting lists for social housing continue to be high, with over 3,600 people waiting currently (March 2015) and an annual turnover of only 830 lets; 63% on the list are looking for 1 bedroom properties

Feedback from communities in North Perth and in Perth City suggests that affordable housing is an important area of concern for people. Shortages of affordable housing impacts on people's ability to live independently and impacts on people who work in the health care and support sector who struggle to afford to live locally.

High cost and poor quality housing impacts on the health and wellbeing of vulnerable people in a number of ways and we need to work with housing colleagues to ensure that there is a good supply of affordable mainstream and supported housing that with services attached.

We will work closely with partners to ensure:

- that where possible existing accommodation can be adapted to support people to remain at home and where this is not possible support people to move into suitable alternative accommodation
- the provision of specialist housing (sheltered, very sheltered, extra care) for older people is available in local communities for people who need it most
- the provision of specialist supported accommodation for people with a range of support needs is available to support people to live as independently as possible at home or in homely setting
- that preventative 'floating' housing support services support older people, homeless people, people with disabilities, mental health and addiction issues for a short period to ensure they are able to maintain their accommodation and prevent homelessness

Secondary prevention/early intervention and tertiary prevention

There is clear trend that indicates a higher level of need for health and social care services across all client groups and for older people with long terms conditions in particular. We are seeing an increase in unplanned hospital admissions, delayed hospital discharge and greater use of residential care. We know that lengthy stays in hospital produce poor outcomes for people and this highlights the need to improve co-ordination and integration of care.

During community engagement events it became apparent that the transition from hospital to home was not seamless. Feedback suggested that this appeared to be a result of unclear communication and a delay in care packages being set up which people reported was distressing for individuals and their families/friends.

"*It can be a complicated process being discharged from hospital with care package in place. Ensuring goals are wisely set and getting medications sorted with doctors. The patient needs support with this if no family/friends present.*"

Solutions - Primary care

It has long been recognised that 90% of all healthcare begins and ends in primary care. This is predominantly with a GP, traditionally the first point of contact a patient has with the health service, who also acts as a gatekeeper to a range of other services provided throughout Perth & Kinross and beyond. Primary care, and in particular care delivered by general practice is viewed by communities as the gateway to health and social care services and over the next few years, GP practices will be faced with new challenges in terms of demand as a result of the changing population, increasing health and wellbeing needs and public expectations. Feedback from communities across Perth and Kinross about GPs was very positive and people have very high expectations about the role of GP s within their communities.

The partnership has already established GP cluster groups within the localities and these will be integral to the development and delivery of health and social integration. The aim of the clusters is to:

- share information between partners
- explore different and improved ways of working together
- to support practices to enable consistent and sustainable changes and improvements in the delivery of healthcare

We see the development of enhanced community support and an integrated team approach based in local areas as crucial to the success of integration through designing support around primary care. We have already successfully piloted an Enhanced Community support model and plan to roll this out across Perth and Kinross. Teams will be based around GP practices work with people with complex needs to prevent unplanned hospital admission and support people to remain independent in the community. In addition a locally based, integrated approach will ensure that third sector organisations, as well as public health and social care providers will work together to support individuals where they are all involved in the delivery of care and support. We will need to support the workforce to develop new ways of working and build on good practice that already exists. Independent sector providers of residential care, care at home, GPs, pharmacies and the voluntary sector currently do play and will continue to play a key role in the delivery of health and social care and we will ensure that they are fully involved with local integrated teams.

We will:

- ✓ ensure that a good quality primary care service is provided in every locality and that GP practices are supported to meet the health and care needs of their patients.
- ✓ ensure that people are sign posted to appropriate services away from GP practices where this is appropriate
- ✓ Create integrated locality teams, working in partnership with GPs to facilitate opportunities for personalised, planned care and support targeted particularly at frail older people and other adults living with long term conditions or with multi- morbidity.
- ✓ Make sure teams working in each locality are integrated, with key components in place:
  - ✓ a move to community-based multi-disciplinary teams based around GP practices that include generalists working alongside specialists
  - ✓ a focus on intermediate care, case management and support to home-based care
  - ✓ joint care planning and coordinated assessments of care needs
  - ✓ named care coordinators who act as navigators and who retain responsibility for patient care and experiences throughout the patient journey
  - ✓ clinical records that are shared across the multi-disciplinary team.

Example

Complex Case Integrated Group (CCIG), PERTH AND KINROSS

The Complex Case Integration Group (CCIG) is a multi-agency group focusing on adults aged 16 and over who have complex needs. Each locality has an established core group of CCIG members who meet monthly to discuss referrals from their locality.

People referred to CCIG will be those who are not supported through another formal system and the group aims to build on the successful and innovative integrated work of the Homeless Integration Team (HIT) and Equally Well model of practice. An individual with complex needs is defined as a person who has inter-related health and social care needs which impact on their physical, social and emotional wellbeing. These circumstances limit their ability to participate in society and can result in homelessness and social exclusion.

The core agencies involved in CCIG includes locality social work teams, the Access Team (Adult Care Services), Housing Service, Community Mental Health Team, Drug and Alcohol Services, Criminal Justice Services, Tayside Police. Other relevant agencies who are involved with a person who has been referred will be invited to attend a CCIG meeting. If the agency has had previous involvement then a summary of this involvement will be requested.

Outcomes Achieved:

Some of the outcomes for individuals referred to CCIG include:

- ✓ Improved health and wellbeing
- ✓ Reducing the number of re-referrals of adults with significant mental health problems
- ✓ Sustaining tenancy safely
- ✓ Reduction in reoffending
- ✓ Reducing and stabilising substance misuse
- ✓ Stabilising financial wellbeing

We will build and develop these examples and others to embed as integrated ways of working and support innovation across Perth and Kinross, adapting successful models to meet local needs.

We know that there are high levels of need for support for people with long term conditions. There is evidence to suggest that self-management programmes can be successful in reducing unplanned hospital admissions and improve the experience and health outcomes of some patients with long term conditions (Kings Fund).

- ✓ We will ensure that condition-based self-management programmes are supported for people with long term conditions where there is evidence that people can benefit from this approach.

Secondary prevention in health such as detecting the early stages of disease and intervening early has been shown to be cost effective and can reduce the gap in life expectancy and health outcomes.

- ✓ The partnership will work with GP practices and community and voluntary sectors to engage with people who are hard to reach and less likely to be in touch with mainstream health services.

Solutions - Pharmacy services

Community pharmacies are a significantly unrecognised as a community resource and offer great potential to support more people to live as independently as possible at home. We will work in partnership with public health to ensure that all *patients, regardless of their age and setting of care,*

receive high quality pharmaceutical care from clinical pharmacist independent prescribers. ..... so that every patient gets the best possible outcomes from their medicines, and avoiding waste and harm".

We will

- ✓ work to ensure that pharmacy service are integrated within the locality teams and are able to develop their role to support people with complex needs in their communities

Solutions – technology enabled care

The vast majority of users of telecare services in Perth and Kinross are aged 75+ years and in comparison with Scotland and most other local authorities, a relatively low proportion of the 75+ population use telecare services. We know that technology enabled care services have the potential to transform the lives, support independence and improve the health of vulnerable people with a range of needs. Feedback from the community suggest there is an appetite to explore how this can be used to support independence and manage a range of long term conditions and we will improve our use of technology enabled care to provide care closer to a person's home, in their own homes or local communities.

We will:

- ✓ Increase the uptake of technology enabled care across our three localities
- ✓ Work with partners to design low level floating support for people most at risk of losing their independence
- ✓ Keep people informed through a virtual health and social care market place to improve information about services available to people in the community
- ✓ Develop this tool by building the 'Well Connected' site to enable people to access universal and health care and support services

- ✓ Continue to work with housing partners to ensure that people are supported to live as independently as possible in housing that is suitable for their needs:
  - o Expand care and repair services to ensure access to adaptations for people in private sector accommodation
  - o Review the use of aids and adaptations in social housing
  - o Increase use of technology enable care to compliment support for carers and to reduce the need for care at home where this is appropriate
  - o Plan new social housing developments to ensure that people are able to live at home as independently as possible

- ✓ Develop integrated services based around GP practices to ensure accessible and effective support at times of crisis to reduce the incidence of unscheduled and unplanned care.
  - o Roll out the delivery of Enhanced Community Support model (ECS) in GP practices to prevent and respond to crisis
  - o Through our locality based teams, promote integrated approach to health and social care where more than one service is involved with and individual
  - o Work across services within primary and secondary care, social care and the third sector to provide rehabilitation at home or in the community
  - o Review the pathways between hospital and the community to make sure patient care is provided at the right time and in the right place
  - o Review existing services and pilot an enhanced role for community pharmacy, dentistry and optometry services to ensure closer integration with locality teams

- ✓ Implement falls prevention initiatives, falls education, and establish effective falls pathways in all three localities which encompass falls assessment, treatment and rehabilitation.
- ✓ Reduce the number of people delayed in hospital by improving pathways from hospital to community
- ✓ Evaluate the Integrated Care Fund projects to inform our future service delivery models and commissioning plans. The evaluation will be used to inform our plans to shift the balance of care through a greater focus on prevention and early intervention.

2. Key theme 2 – Person centred health, care and support

Involving people in decisions about their care is a key priority for the partnership and the Scottish Government. We need to see and treat people as partners in their own health, care and support, able to self-manage their conditions, putting the person at the centre of the process. There is a strong body of evidence that involving people in health and social care planning leads to improved outcomes and there remains gaps practice in taking on board the needs and wishes of individuals receiving care. Research by Themessl-Huber (2006) compared the perception of professional and older people on preventing hospital admissions and the use of care services. There were significant differences in perceptions: older people felt that emergency admissions were an inevitable part of growing older, whereas professionals largely attributed this to social isolation and didn't consider improved interventions as a way of reducing unscheduled care. Older people often deliberately did not use health and social care services because of fear of losing independence, whilst professionals interpreted this as difficulties in accessing services or lack of trust in the services already being provided. Involving people in decisions about care will minimise risks and help people manage their care and we need to ensure that we listen to people; taking on board what they think will work for them.

What do communities tell us?

We have made much progress, but feedback from our local communities through 'Join the Conversation' suggests that there is still work to do. The most common themes identified from community engagement events across the three localities of Perth and Kinross raised concerns about quality and consistency of care across the health and social care system; issues about access to services, proximity, timing and availability of appointments.

People told us about their concerns that information sharing between services, patients and community groups could be done better in order to prevent crisis and better support people.

What does the needs assessment say?

Our needs assessment highlighted access issues in the rural areas of Perth and Kinross and significant issues of "access deprivation" in areas of rural North and South Perthshire. Access to services was a consistent theme during the community engagement with people highlighting transport to appointments and travel time as issues that hindered their ability to get timely appointments close to home.

What are our priorities?

- ✓ Develop a joint work force strategy to support the workforce to:
  - o empower people to make the most of their lives through participation in decisions about their health care and support

- encourage and support a person centred approach which supports people to maximise personal assets and supported self-management for long term conditions.

✓ Through our commissioning plans ensure that a person-centred approach to the provision of health care and support services is embedded across statutory, voluntary and private sector
  - All newly commissioned services will be focussed on outcomes to ensure a person centred and outcome focussed approach in our services

✓ Continue to transform our care at home services to ensure they are person centred and outcomes focussed
✓ Increase the number opportunities for people to be able to exercise choice through self-directed support and commission and control their own care.
✓ Transform our nursing services and move towards models of care and outcome focussed assessments
✓ Review care pathways between hospital and the community for people in their last years of life in order to ensure that they are supported to be at home or in a homely setting with support appropriate to their level of need.
✓ Review Minor injury & illness units to ensure provision of clinical care is an appropriate alternative to hospital care

Key theme 3 – Work together with communities

We are committed to working in partnership with people in our communities ('co-production') to build on the skills, knowledge, experience and resources of individuals and communities. In response to the challenges facing the partnership we need to encourage an approach which is targeted, supports the development of personalisation, and works within communities.

Through this we need to develop a shared understanding with our communities which sets out what they can expect in terms of high quality health and care services alongside their shared responsibility for their own health and the health of the local community. Our community engagement suggests that some people believe that we encourage dependency and could do more to plan for a health and social care system that encourages personal responsibility for health and wellbeing.

We need to look at what is already in our local communities, build on existing relationships and invite and be open to new relationships, where individuals, families, communities and service providers have a reciprocal and equal relationship. This is an approach where services *'do with, not to'* the people who use them and who also act as their own catalysts for change[3].

Through our Communities First Review we will work alongside our communities to co-produce and provide more choice and control for individuals in their localities. We want ensure that the most vulnerable individuals receive responsive quality care that is delivered locally, and in a personalised way. We will build upon the principle that community resilience and empowerment as key to further developing and supporting people to live as independently as they can. This will enable a shift in public expectation from a needs led model to one which is preventative and asset based, resulting in individuals accessing services only when they need them. For a relatively small investment through the Integrated Care Fund (ICF) we are supporting a number of initiatives that developed opportunities for individuals and local communities, supported self-reliance at an

[3] "Co-Production of Health and Wellbeing in Scotland", JIT, p.14,

individual and community level and developed sustained and meaningful engagement across communities. Through our evaluation, we will learn from these projects and work to create opportunities for service models that deliver alternative support provision including social enterprise at local level.

Our priorities are to:

- ✓ Develop a *Communities First Initiative* to work alongside our communities to co-produce and provide more choice and control for individuals in their localities. This will build upon the principle that community resilience and empowerment are key to further developing and supporting people to live as independently as they can
- ✓ Make sure community development and capacity building is recognised and will work with partners across the council and in the voluntary sector to support initiatives in this area
- ✓ Embed community development teams in all three localities to support individuals groups and communities to work with us as partners in planning and delivering services in the three localities of Perth and Kinross
- ✓ Build on the lessons learnt from community initiatives tested through the Change and Integrated Care funds.
- ✓ Explore opportunities for Participatory Budgeting , involving local communities and special interest groups to take more control over the way our resources are spent We will jointly plan develop and deliver services in each locality which compliment local community activities
- ✓ Work across Perth and Kinross to reshape the market place through an approach which supports local enterprise and provides greater choice for people who need care and support
- ✓ Explore opportunities for Participatory Budgeting , and increase opportunities for people involving local communities and special interest groups to take more control over the way our resources are spent

Participatory Budgets
We are launching a new exciting way of involving carers in how money is spent to benefit them. We're doing this through Participatory Budgeting and piloting this in Perth and Kinross. An event will take place in February 2016 where carers themselves will vote on how they want the money to be spent.

TImebanking Perth and Kinross

The Time Bank project aims to support older people by providing services on an informal basis, reduce isolation by extending friendship networks, involving people in their communities and keeping them as active and supported as possible. It was introduced to Perth and Kinross in 2011 though the Change Fund and a Co-ordinator was employed by the local voluntary sector umbrella body, PKAVS. Time Banks are a means of exchange used to organise people around a purpose or area or interest. Time is the commodity of exchange. Members are signed up to exchange one hour of their time to gain 1 hour of time credits that can be exchanged for services from other Time Bank members. Membership can include individuals, businesses, and public services.

5 time banks have been established across Perth and Kinross and an evaluation found the following

Outcomes predicted:

1. An increase in community wellbeing
2. Simple solutions to support the over 65s living at home independently
3. Increased capacity within communities
4. Additional volunteering opportunities

Unexpected outcomes evidence through the SROI:

5. Increase in social networks – new friendships and reconnecting old friendships
6. Giving members a purpose in life and their communities.

Key theme 4 – Reduce inequalities and unequal health outcomes and promote healthy living

Tackling health inequalities is challenging: health inequalities are influenced by a wide range of factors, including access to education, employment and good housing, equitable access to healthcare and individual circumstances and behaviours. Reducing health inequalities will help increase life expectancy, increase the health of disadvantaged groups and will also help reduce the direct statutory costs and wider societal costs. Reducing health inequalities is vital to achieving sustainable economic growth – particularly among those whose lives are currently cut short due to deprivation or other inequalities.

Health inequalities are highly localised and vary widely within individual areas. Deprivation is a major factor in health inequalities with people in more affluent areas living longer and having significantly better health. Conversely, many of the people suffering the greatest negative health effects relating to mental health, obesity and long term disease are those experiencing poverty and social disadvantage. We need to encourage and support individuals and communities to look after and improve their health and wellbeing, resulting in more people living in good health for longer, with reduced health inequalities.

Using early intervention and preventative approaches we believe there is much we can do to promote healthier lifestyles and tackle the health inequalities that exist between different groups and communities in Perth and Kinross. The biggest killers are heart disease, stroke and cancers. Some of the contributing factors to these diseases are beyond the influence of the individual or of health services but we can encourage healthier lifestyles and prevent disease through early detection and screening. After smoking, obesity is the biggest underlying cause of ill health. It can lead to high blood pressure, heart disease, stroke, diabetes, cancer and early death. It also increases immobility and makes any other disability more severe than it would otherwise be.

Some risk factors for these, such as smoking, are strongly linked to deprivation. We recognise that there are a large number of vulnerable or marginalised groups within the Perth and Kinross area. Some of this inequality is down to geographical location, e.g. living within an area of deprivation where communities experience higher levels of households living on benefit and poorer health

status than Perth and Kinross overall. Interventions targeted at these communities are being tested through projects such as Equally Well, Keep Well and Evidence2 Success.

What does the needs assessment say?

Figure… : Percentage of population income, employment, and access deprived in Scotland, Perth and Kinross, and each locality (2013)[4]

Deprivation Type	Scotland	Perth & Kinross	North Perthshire	South Perthshire	Perth City
Income Deprived (2013)	13.2%	8.7%	7.8%	6.6%	11.4%
Employment Deprived (2013)[5]	12.2%	8.3%	7.3%	6.1%	11.0%
Access Deprived (2013)[6]	15.0%	31.3%	45.2%	45.2%	4.7%
Child Poverty (2012)	15.3%	9.4%	9.6%	6.4%	12.4%

42% of people in Perth & Kinross have a BMI score that categorises them as overweight (compared to 37% in Scotland), while 27% are also classed as obese (compared to 25% nationally).

What are our priorities

We will :

- ✓ Develop health interventions for people who are at the highest risk of ill health, to prevent illness and reduce health inequalities including:
  - o Smoking
  - o Alcohol and drug use
  - o Oral health
  - o Sexual health
- ✓ Focus Health Improvement services on those who are most at risk of health inequalities and difficult to engage and will primarily work with the most deprived individuals who fall across the whole of Perth and Kinross. This will be achieved through community and partnership engagement, early intervention including health promotion and direct clinical interventions.
- ✓ Create health and wellbeing hubs across the localities
- ✓ Explore opportunities for community hospitals as local community hubs for health, social care and third and independent sector with a range of services and facilities to support health and wellbeing in local communities
- ✓ Roll out the use of community pharmacy technicians and develop care pathways to enable engagement between patients, community pharmacists, locality pharmacist and general practitioner
- ✓ Reduce health inequalities for people who have a learning disability through the development of a SMART Action Plan
  - o Increase take up of Health Screening & Health promotion activities for people with learning disabilities.
  - o Prepare information for other agencies to inform them of the specific needs of people with learning disabilities e.g. health inequalities agenda/ accessible information agenda)

[4] Ibid
[5] Of working age population (16-64)
[6] Population living in 15% most "access deprived" areas

- ✓ Develop recovery models of care, including the development of mutual aid groups within each of the 3 the localities in which change is initiated and driven by the individual is supported by family and community

Work with partners to help achieve the Scottish Government aims of having a higher proportion of people in a normal weight range. The partnership will work to make the area an environment where healthy life choices become easier.

Key theme 5 – making the best use of available facilities, people and resources

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As we prepare for integration both the council and the NHS are facing financial challenges at a time when demands for services are increasing due to a rising population, some of whom have complex health and social care needs. We need to look at our joint health and social care resources, how we use our joint resources to improve the health and well- being outcomes of the local populations them and what we need to change in order to focus our funding on delivering health care and support for local people.

There will always be a need for hospitals and care homes, particularly as people get older, and we need to ensure that specialist services are used appropriately to meet people's needs. As we begin to develop our locality planning model there will be a need to focus on realigning resources to provide more community based delivery. This will develop over the life of the strategy at a time when public finances are reducing and requires a radical look at how we deliver services. The need for any service redesign should not require additional or new funding but to be "redesigned" from existing budgets and services.

Facilities

We will look at the best use of the health and social care estate and what service models are best delivered from where. We currently have x number of hospitals in Perth and Kinross and x number of community hospital facilities, day centres and a large number of residential and nursing homes. A key theme emerging from our community engagement highlighted transport, long journeys for appointments for hospital services and transport more generally as an issue in the more rural communities. The availability and choice of services in North and South Perthshire is very different from Perth city. In some of the rural communities there is inequality in access health, social care and other services.

Our priorities - we will:

- ✓ Assess the best use of our facilities in each locality and consider models that deliver care in our local communities and bring care closer to home.
- ✓ Redesign Community Hospitals to ensure better use of local community hospital beds. This will support our work to reduce the number of people being admitted as an unplanned admission to the acute sector.
- ✓ Improve use of technology enabled care to compliment support for carers and to reduce the need for care at home where this is appropriate

People

The success of our journey towards integration will be reliant on staff across the health social care sector in statutory health and social care services and in the third sector.

Quality and professional standards need to be at the core of everything we do to ensure safe and effective practice and positive outcomes for people who use out services To ensure this quality, people who are providing care and support must be appropriately skilled, qualified and have the personal attributes to be in a role that has dignity and respect as an essential requirement.

Our staff and care providers will operate within the relevant professional frameworks and with regulatory bodies such as the Care Inspectorate, Quality Improvement Scotland.

We want to ensure that care and support provision complies with the essential standards of care and will work collaboratively to ensure best practice and continuous improvement

Staff employed across the statutory, voluntary and private sectors will be supported to take person-centred approaches to working with people who use services and improving the care they provide.

Our priorities – we will:

- ✓ Engage, support and develop staff across all sectors and develop an integrated workforce development plan
- ✓ Through the monitoring and implementation of Clinical and care governance standards and adult protection measures we will ensure that vulnerable people remain safe and are protected from harm from others, themselves and the community.
- ✓ Through commissioning plans ensure that services across the statutory, voluntary and private sectors, are designed and delivered to be safe effective and sustainable; building high quality services which improve health and wellbeing across Perth and Kinross .
- ✓ Work with partners to make sure care is evidence-based, incorporates best practice and fosters innovation, achieving seamless and sustainable pathways of care.
    - ✓ Continue to develop and deliver the Scottish Patient Safety Programmes, to reduce mortality, harm and avoidable injury in a variety of care settings including Acute Adult Care, Maternity, Neonatal, Paediatrics, Mental Health and Primary Care settings
    - ✓ Complete the integration of Occupational Therapy Services.

<u>Resources</u>

As part of our priority to shift the balance of care so that we provide care closer to home, we want to maximise resources within communities, including the whole range of universal and voluntary services. A number of transformation programmes initiated by the Council and NHS partners have begun the process of challenge and review supporting out vision to support more people to live as independently at home for longer. This will form part of our response to the financial challenges set out earlier enabling us to maximise our joint resources to deliver high quality, efficient health and social care services.

Transformation programmes

We have a number of planned reviews that will help the partnership transform community care and health services and will :

- ✓ Work with partners through the Procurement Reform Review to achieve savings from procurement activities through more collaborative procurements, closer management of suppliers, reducing demand, and avoiding unnecessary expenditure

- ✓ Review community care day services to increase locally based service opportunities for individuals to access support relevant to their identified outcomes through the rationalisation of current day care provision and development of more community based models across localities.
- ✓ Review Older People's Residential Care Services to outline how we will meet the demands of an increasing older population, manage the current and future financial constraints, as well as enabling us to manage the shift in the balance of care.
- ✓ In partnership with housing, review of homeless service – to provide options for direct access to settled accommodation for homeless people
- ✓ Review Community Care Packages for Adults to developing models of practice which enhance the individual's, their families, and community's assets to create more resilience and which is financially sustainable.
- ✓ Health Improvement - we will amalgate the Health Improvement team (currently comprises of the Central Healthcare, Healthy Communities Collaborative and Keep Well Teams) to become known as the Community Health & Wellbeing Team.
- ✓ Dementia services -develop and roll out an enhanced dementia service to provide support, both directly to people in their own homes and in their communities.
- ✓ Community Hospitals - move towards community hospitals becoming local community hubs for health, social care and third and independent sector with a range of services and facilities to support health and wellbeing in local communities.

Example
Aberfeldy
A new model of care is being developed at Aberfeldy which aims to integrate care and support for older people who need care in a community hospital or care home. The vision is one of a community hub, integrating the community hospital and community services, primary care social work and a range of associated local health and social care services. The aim is to create a hub of services around the GP practice in the town by moving the community hospital to combine with a local authority care home. Neither the local the community hospital or care home is fully utilised and the new model will improve continuity of care along side better use of facilities within the community. Local people have been fully engaged in the process through "Your Community, your voice, your future".

Strathmore Dementia Pilot

The Strathmore Enhanced Community Based Older People's Mental Health Service delivers community based dementia services to older people and their carers in their own homes. The move from a ward based dementia service to a Community based service with health and social care professionals working with the third sector such as Alzheimer Scotland was made possible by decommissioning the bed establishment within the Strathmore dementia unit. In the year prior to the closure of the unit, only 40 patients were admitted for assessment or intervention. The Strathmore Dementia Service now provides a community based service for 700-800 people living with dementia in the Strathmore locality. Evaluation of the pilot showed that the move from a ward based service to a community based service reduced admissions to the hospital catering for

Psychiatry of Old Age and that significantly more patients and cares received dementia care within their own home environment.

The success of the pilot has led to similar services being developed in North West Perthshire, South Perthshire and Perth City. Better partnership working between health, social care and the voluntary sector has meant that more people and their carers can be supported in a person centred way.

Outcomes achieved:

- Older people living at home with dementia; or a mental illness are receiving person centred care better suited to their needs
- People with mild and moderate presentations are not being admitted to hospital and are being supported to live at home for longer
- Positive feedback from patients and cares about the new model of care which providers greater flexibility and choice

In summary

We have set out an ambitious plan to integrate our health and social care system to improve the health and wellbeing of people living and working in Perth and Kinross. We have a lot of work to do and at the end of the 3 years' strategy will see a health and social care landscape transformed to keep more people living independently at home for longer leading healthier lives. We will know we are successful by through monitoring our progress on performance towards the national outcomes and are developing a framework to help us to do this.

5. Action Plan

Whole area – Perth and Kinross

The actions set out below will apply across Perth and Kinross and in some areas will be adapted to meet the needs of each of the three localities. This will require a joint approach by all partners and across the relevant areas. The locality management and planning structure is currently in development and some priorities have already been identified for each locality. Throughout the process the locality planning teams will further develop specific plans relevant to the local area and community.

National outcome	Key theme	Key action	2016 /2017	2017 /2018	2018/ 2019
1	Prevention and early intervention	✓ Keep people informed through a virtual health and social care market place to improve information about services available to people in the community o We will develop this tool by building the Well Connected site to enable people to access universal and health care and support services ✓ Continue to work with our partners in housing to ensure that people are supported to live as independently as possible in housing that is suitable for their needs: o Expand care and repair services to ensure access to adaptations for people in private sector accommodation o Review the use of aids and adaptations in social housing o Increase use of technology enable care to compliment support for carers and to reduce the need for care at home where this is appropriate o Plan new social housing developments to ensure that people are able to live at home as independently as possible ✓ Develop integrated services based around GP practices to ensure accessible and effective support at times of crisis to reduce the incidence of unscheduled and unplanned care. ✓ Roll out the delivery of Enhanced Community Support model (ECS) in GP practices to prevent and respond to crisis. ✓ Through our locality based teams ensure an integrated approach to health and social care where more than one service is involved with and individual ✓ Work across services within primary and secondary care, social care and the third sector to provide rehabilitation at home or in the community ✓ Review the pathways between hospital and the community to ensure that patient care is provided at the right time and in the right place	✓		

National outcome	Key theme	Key action	2016 /2017	2017 /2018	2018/ 2019
		✓ Review existing services and pilot an enhanced role for community pharmacy, dentistry and optometry services to ensure closer integration with locality teams ✓ Implement falls prevention initiatives, falls education, and establish effective falls pathways in all three localities which encompass falls assessment, treatment and rehabilitation. ✓ Reduce the number of people delayed in hospital by improving pathways from hospital to community ✓ Evaluate the Integrated Care Fund projects to inform our future service delivery models and commissioning plans. The evaluation will be used to inform our plans to shift the balance of care through a greater focus on prevention and early intervention.			
2, 3	**Person centred health and social care**	✓ Develop a joint workforce strategy to support the workforce to: o empower people to make the most of their lives through participation in decisions about their health care and support o encourage and support a person-centred approach which supports people to maximise personal assets and supported self-management for long term conditions. ✓ Through our commissioning plans ensure that a person-centred approach to the provision of health care and support services is embedded across statutory, voluntary and private sector o All newly commissioned services will be focussed on outcomes to ensure a person centred and outcome focussed approach in our services ✓ Continue to transform our care at home services to ensure they are person centred and outcomes focussed ✓ Increase the number opportunities for people to be able to exercise choice through self-directed support and commission and control their own care. ✓ Transform our nursing services and move towards models of care and outcome focussed assessments ✓ Review care pathways between hospital and the community for people in their last years of life in order to ensure that they are supported to be at home or in a homely setting with support appropriate to their level of need. ✓ Review Minor injury & illness units to ensure provision of clinical care is an appropriate alternative to hospital care			
6, 4	**Work with communities**	✓ Embed community development teams in all three localities to support individuals groups and communities to work with us as partners in planning and delivering services in the three localities of Perth and Kinross ✓ Explore opportunities for Participatory Budgeting and			

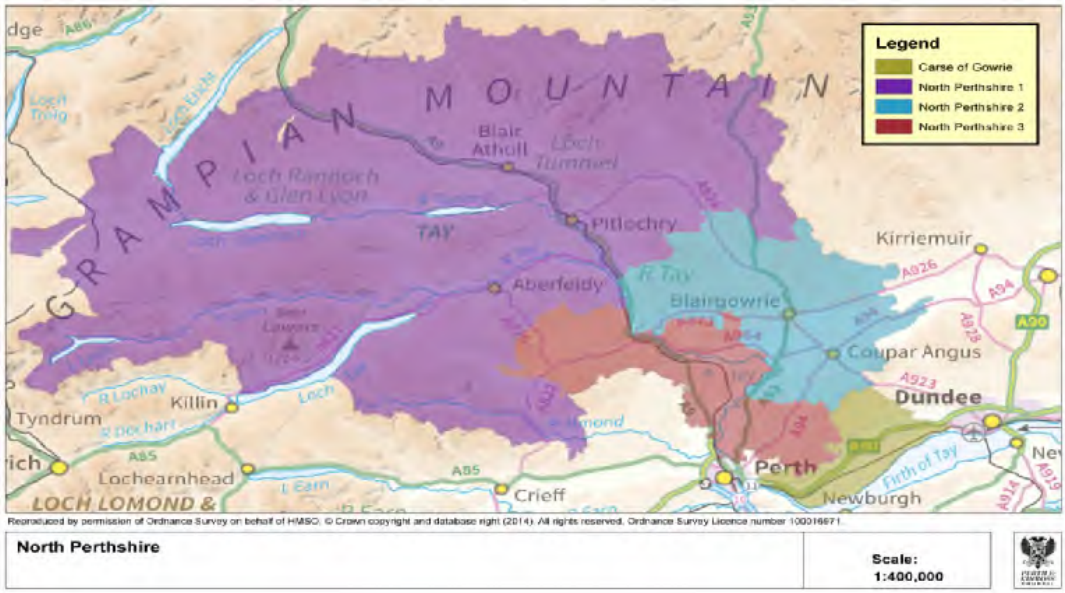
National outcome	Key theme	Key action	2016 /2017	2017 /2018	2018/ 2019
		increase opportunities for people involving local communities and special interest groups to take more control over the way our resources are spent ✓ Develop a Communities First Initiative to work alongside our communities to co-produce and provide more choice and control for individuals in their localities. This will build upon the principle that community resilience and empowerment are key to further developing and supporting people to live as independently as they can.			
5	**Reduce inequalities**	✓ Develop health interventions for people who are at the highest risk of ill health, to prevent illness and reduce health inequalities including: o Smoking o Alcohol and drug use o Oral health o Sexual health ✓ Focus Health Improvement services on those who are most at risk of health inequalities and difficult to engage and will primarily work with the most deprived individuals who fall across the whole of Perth and Kinross. This will be achieved through community and partnership engagement, early intervention including health promotion and direct clinical interventions. ✓ Create health and wellbeing hubs across the localities ✓ Explore opportunities for community hospitals as local community hubs for health, social care and third and independent sector with a range of services and facilities to support health and wellbeing in local communities ✓ Roll out the use of community pharmacy technicians and develop care pathways to enable engagement between patients, community pharmacists, locality pharmacist and general practitioner ✓ Reduce health inequalities for people who have a learning disability through the development of a SMART Action Plan o Increase take up of Health Screening & Health promotion activities for people with learning disabilities. o Prepare information for other agencies to inform them of the specific needs of people with learning disabilities e.g. health inequalities agenda/ accessible information agenda etc.) ✓ Develop recovery models of care, including the development of mutual aid groups within each of the 3 the localities in which change is initiated and driven by the individual is supported by family and community ✓ Work with partners to help achieve the Scottish Government aims of having a higher proportion of people in a normal weight range. The partnership will work to make the area an environment where healthy			

National outcome	Key theme	Key action	2016 /2017	2017 /2018	2018/ 2019
		life choices become easier.			
9	**Best use of facilities**	✓ During 2016/17 we will review our facilities and develop plans for the best use of local facilities to deliver integrated models of care in local communities. ✓ We will redesign Community Hospitals to ensure better use of local community hospital beds and use as local community hubs. This will support our work to reduce the number of people being admitted as an unplanned admission to the acute sector.			
4, 8, 7	**Best use of people**	✓ We will engage, support and develop staff across all sectors and develop an integrated workforce development plan ✓ Through the monitoring and implementation of Clinical and care governance standards and adult protection measures we will ensure that vulnerable people remain safe and are protected from harm from others, themselves and the community. ✓ Through commissioning plans make sure services across the statutory, voluntary and private sectors, are designed and delivered to be safe effective and sustainable; building high quality services which improve health and wellbeing across Perth and Kinross . Work with partners to make sure care is evidence-based, incorporates best practice and fosters innovation, achieving seamless and sustainable pathways of care. ✓ Continue to develop and deliver the Scottish Patient Safety Programmes, to reduce mortality, harm and avoidable injury in a variety of care settings including Acute Adult Care, Maternity, Neonatal, Paediatrics, Mental Health and Primary Care settings ✓ Complete the integration of Occupational Therapy Services.			
9	**Best use of resources**	We have a number of planned reviews that will help the partnership transform community care and health services and will : ✓ Work with partners through the Procurement Reform Review to achieve savings from procurement activities through more collaborative procurements, closer management of suppliers, reducing demand, and avoiding unnecessary expenditure ✓ Review community care day services to increase locally based service opportunities for individuals to access support relevant to their identified outcomes through the rationalisation of current day care provision and development of more community based models across localities. ✓ Review Older People's Residential Care Services to outline how we will meet the demands of an increasing older population, manage the current and future			

National outcome	Key theme	Key action	2016 /2017	2017 /2018	2018/ 2019
		financial constraints, as well as enabling us to manage the shift in the balance of care. ✓ Review care at home to assist people to remain at home for longer in their localities, and shift the balance from traditional services to community focussed services ✓ In partnership with housing, review of homeless service – to provide options for direct access to settled accommodation for homeless people, r ✓ Review Community Care Packages for Adults to developing models of practice which enhance the individual's, their families, and community's assets to create more resilience and which is financially sustainable. ✓ **Health Improvement -** We will amalgamate the Health Improvement team (currently comprises of the Central Healthcare, Healthy Communities Collaborative and Keep Well Teams) to become known as the Community Health & Wellbeing Team. ✓ **Dementia services - d**evelop and roll out an enhanced dementia service to provide support, both directly to people in their own homes and in their communities.			

Locality actions 2016/17 -2018/19

LOCALITY 1 – NORTH PERTHSHIRE



The North Perthshire locality consists of three distinct areas: Highland Perthshire, Strathmore and Carse of Gowrie. Most of its settlements are located on or close to the main transport corridors (A9, A93 and A90) but access to services remains a strong issue for residents. North Perthshire comprises of the following major settlements of: Aberfeldy, Alyth Blair Atholl, Blairgowrie, Coupar Angus, Dunkeld, Errol, Invergowrie, Pitlochry.

Population

With an overall population of 50,338 residents, it has the highest number and proportion of individuals 65 years old+ years, and the lowest number and proportion of children. Its population can be summarised as below:

- 25,685 (51%) females, and 24,653 (49%) males.
- 7,919 (16%) under the age of 16. This is the lowest number and proportion of all 3 localities.
- 30,603 (61%) working age (16 to 64).
- 11,818 (23.5%) 65 +years .

Key issues

- Highest number and proportion of over 65s of all 3 localities.
- North Perthshire has 45% of its population living in the 15% most access deprived[7] datazones in Scotland.
- The percentage of dependent children under the age of 20 in families that receive Child Tax Credits or income support/jobseekers allowance is 9.6%. This is seen as a proxy for children living in poverty. The figure for the whole of Perth & Kinross is 9.4%.
- Higher numbers of people with learning disabilities compared with South Perthshire and Perth City

Meets national outcome	**Key theme**	**Key actions – *identified by Integrated Leadership Group and Strategic Planning Group planning sessions***	
People are able to look after and improve their own health and wellbeing and live in good health for longer	Prevention and Early intervention	• Embed social prescribing model to support change in culture and increase referrals to mainstream services in the community • Identify a range of community champions and deliver support to enable them to help people self manage and find the support they needs • Develop and embed role of 'link workers/ super conductors in GP surgeries. Roll out across all GP practices • Identify a range of community champions and other key people and support / train them to help people and self-manage and find support they need • Promote prevention and a self-reliant culture through education in schools and other community spaces • Through development of technology enable care strategy, develop app for accessing info / services • Ensure information is provided in accessible formats • Develop specific strategies for health promotion, made relevant to local communities	
People, including those with disabilities,		• Create co-ordinated care pathways and link to the development of integrated and enhanced care teams • Ensure co-location of teams where this possible • Look to develop a health and well-being 'hub' in	

[7] The Geographic Access domain was introduced in SIMD 2004 to capture the issues of financial cost, time and inconvenience of having to travel to access basic services from different locations in Scotland. It consists of two sub-domains. The first relates to journey times via private transport to the nearest GP, retail centre, petrol station, school (primary and secondary), and post office. The second sub-domain regards public transport (bus, train, metro, and ferry) journey times to the nearest GP, retail centre, and post office only.

Meets national outcome	Key theme	Key actions – *identified by Integrated Leadership Group and Strategic Planning Group planning sessions*	
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		Pitlochry • Examine capacity of drop in services to improve access for people living in rural areas	
People who use health and social care services have positive experiences of those services and have their dignity respected		• Explore options to reduce the number of different people providing care • Build in regular evaluation/feedback for all services • Review issues of access and transport including scope for services to be delivered locally • Review issues of quality, governance and workforce development	
		• Identify sub localities issues for health and social care in terms of community engagement	
		• Assess the best use of facilities and consider models that deliver care in our local communities. • Redesign Community Hospitals to ensure better use of local community hospital beds. This will support our work to reduce the number of people being admitted as an unplanned admission to the acute sector. • Improve use of technology enabled care to compliment support for carers and to reduce the need for care at home where this is appropriate	

LOCALITY 2 – SOUTH PERTHSHIRE

The South Perthshire locality consists of the distinct areas of Strathearn and Kinross. Its main settlements are mostly found on or close by the main transport corridors (M90, A9 and A85).

Population

- 23,636 (51%) females and 22,636 (49%) males.
- 8,269 (18%) under the age of 16. This is the highest proportion of under 16s in all the 3 localities, though the number of under 16s is greater in Perth City.
- 28,103 (60.3%) working age (16 to 64). This is the lowest number and proportion of all 3 localities.
- 10,226 (21.9%) 65 years old and above, this is slightly above the proportion for Perth & Kinross as a whole (21.5%).
- For both income and employment deprivation, South Perthshire has the lowest percentages of all 3 localities.

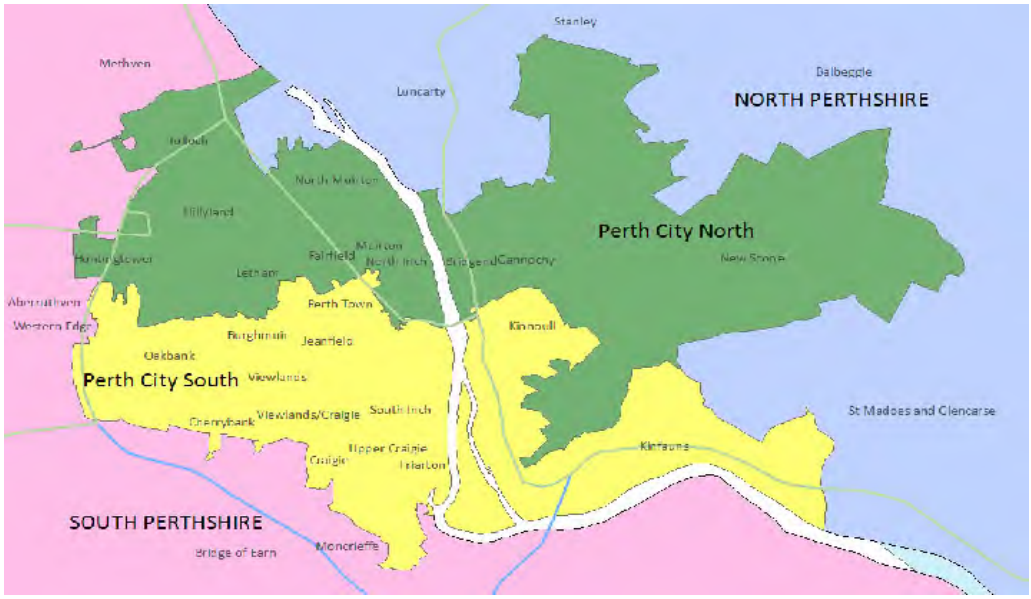
Key issues

- Similar levels of access deprivation to North Perthshire – level of rurality a key factor
- Low level of deprivation compared with the rest of Perth and Kinross

Meets national outcome	**Key theme**	**Key action – *identified by Integrated Leadership Group and Strategic Planning Group planning sessions***	
People are able to look after and improve their own health and wellbeing and live in good health for longer	1,	• Increase access to Technology enabled care; Including the development of wellbeing self-help apps • Embed social prescribing model to support change in culture and increase referrals to mainstream services in the community	
People, including those with disabilities, long term conditions or who are frail, are		• Develop integrated care teams to provide a seamless care approach • Develop 24hr support at home using independent providers in a different way • Increase/promote the use of technology	

Meets national outcome	**Key theme**	**Key action – *identified by Integrated Leadership Group and Strategic Planning Group planning sessions***	
able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community		enable care including Skype, video conferencing with patients and GPs and hospital staff • Explore Nurse led Discharge and Admission to hospital • Encourage Community resilience e.g. upskill volunteers to support people at home and signpost to other services	
Health and Social Care Services are Centred on Helping to Maintain or improve the quality of life of service users		• Develop and Single Shared Referral process and one person centred plan • Explore the develop of a community wellbeing centre including mobile options • Develop a joint organisational development plan	
Health and Social care services contribute to reducing health inequalities		• Develop one-stop health and social care wellbeing centre • Improve awareness of the use of pharmacy services and broaden range of services / referrals that can be made by community pharmacy • Increase engagement with community independent providers • Map local services and pathways to reduce duplication	
People who work in Health and Social Care Services are supported to continuously improve the information, support, care and treatment they provide and feel engaged with the work they do		• Explore opportunities for joint training and learning opportunities • Share good practice and examples of what is working across all localities; •	

LOCALITY – PERTH CITY NORTH and SOUTH



Perth City comprises of the following residential areas of: Bridgend, Fairfield, Gannochy, Hillyland, Hillyland & Tulloch, Huntingtower, Kinnoull, Letham, Muirton, North Inch, North Muirton, Perth Town, Scone, Tulloch, Burghmuir, Cherrybank, Craigie, Friarton, Kinfauns, Moncrieffe,Oakbank Perth Town, South Inch, Upper Craigie, Viewlands, Viewlands/Craigie, Western Edge.

Population

Perth City locality is the largest settlement in Perth & Kinross and includes the sub-localities Perth City North and Perth City South.

It has the largest population of the 3 localities, 50,814 with the highest number of individuals of working age, and the lowest number 65 and older. Its population can be summarised as below:

- 8,460 (17%) under the age of 16. This is the highest number of under 16s of all 3 localities, though the proportion is greater in South Perthshire.
- 32,661 (64%) working age (16 to 64). This is the highest number and proportion of all 3 localities.

- 9,693 (19%) 65 years old and above. This is the lowest number and proportion of all 3 localities.
- The highest proportion of its population in the most deprived SIMD quintiles 1and 2, at 46%. Perth City also has the highest percentage of its population in the least deprived quintile, with 27%.
- For both income and employment deprivation Perth City has the highest proportions of all 3 localities.
- The percentage of dependent children under the age of 20 in families that receive Child Tax Credits or income support/jobseekers allowance is 12%. This is seen as a proxy for children living in poverty. This is the highest for the 3 localities and the figure for the whole of Perth & Kinross

Key Issues

- High levels of income and employment deprivation
- High numbers of older people (over 65) living alone

Meets national outcome	**Key theme**	**Key action** – ***identified by Integrated Leadership Group and Strategic Planning Group planning sessions***	
2	1,	• Enhanced Community Support teams to be rolled out across Perth city • Develop Integrated Care teams linked to zones using existing premises in the City e.g. Letham Centre • Invest in Community in sub localities. For example men's sheds • Develop community engagement and learn from good practice elsewhere e.g. Aberfeldy consultation as a model • Develop role of Community pharmacy in relation to prevention and early intervention • Develop support structure for GPs to divert people to other resources in the community	
3		• Explore options to improve GP coverage in the Letham area • Develop Discharge to Home Model to Assess from Acute care • Continue with the redesign of District Nurse role and remit • Redesign Care At Home service to increase capacity within rapid response and crisis services • Undertake process mapping to reduce duplication and streamline services and systems of referral within and between agencies • Make sure service users also have a voice in the development of localities and to inform what is required in their community.	
1		Promote the use of apps and link with SMART city to support self- management	

Meets national outcome	Key theme	Key action – *identified by Integrated Leadership Group and Strategic Planning Group planning sessions*	
8		• Develop an organisational/workforce development plan within the locality plan, encompassing a joint structure across all sectors in the locality to promote shared ownership e.g. NHS, PKC, independent/third/voluntary sectors; • Develop a shared training plan across all agencies within the locality; • Develop and enhance peer support models within agencies and across agencies; • Promote the relevance of the strategy with operational frontline staff within workforce development plans to encourage and motivate staff to take ownership of the work they do	

ANNEX A: DRAFT NATIONAL INDICATORS FOR INTEGRATION OF HEALTH AND SOCIAL CARE

This annex sets out the core suite of indicators currently being developed to support integration. These indicators have been developed where possible from national data sources so that the collection is consistent across areas. Further work will be taken forward with stakeholders before the final set of indicators is confirmed.

(a) Outcome indicators based on survey feedback:

1. Percentage of adults able to look after their health very well or quite well

2. Percentage of adults supported at home who agree that they are supported to live as independently as possible.

3. Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided.

4. Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated

5. Percentage of adults receiving any care or support who rate it as excellent or good

6. Percentage of people with positive experience of their GP practice

7. Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life

8. Percentage of carers who feel supported to continue in their caring role

9. Percentage of adults supported at home who agree they felt safe

10. Percentage of staff who say they would recommend their workplace as a good place to work

(b) Outcome indicators based on administrative data:

11. Premature mortality

12. Rate of emergency admissions for adults (including proposal to also look at rate of emergency bed days for adults)

13. Readmissions to hospital within 28 days

14. Proportion of last 6 months of life spent at home or in community setting

15. Falls rate per 1,000 population in over 65s

16. Proportion of care and care at home services rated 3 or above in Care Inspectorate Inspections

17. Delayed discharge – 14 days, 72 hours, bed days lost

18. Percentage of adults with intensive needs receiving care at home

ANNEX B **National outcomes and key indicators**

National Health and Wellbeing Outcome 1	What people can expect
People are able to look after and improve their own health and wellbeing and live in good health for longer.	▪I am supported to look after my own health and wellbeing ▪I am able to live a healthy life for as long as possible ▪I am able to access information

SG Core indicators

1. Percentage of adults able to look after their health very well or quite well
11. Premature mortality rate
12. Emergency admission rate

National Health and Wellbeing Outcome 2	What people can expect
People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently at home or in a homely setting in their community.	▪I am able to live as independently as possible for as long as I wish ▪Community based services are available to me ▪I can engage and participate in my community

SG Core indicators

2. Percentage of adults supported at home who agree that they are supported to live as independently as possible
12. Emergency admission rate
14. Percentage of adults with intensive care needs receiving care at home
15. End of Life Care
21. Percentage of people admitted to hospital from home during the year, who are discharged to a care home
22. Percentage of people discharged from hospital within 72 hours of being ready

National Health and Wellbeing Outcome 3	What people can expect
People who use health and social care services have positive experiences of those services, and have their dignity respected.	▪I have my privacy respected ▪I have positive experiences of services ▪I feel that my views are listened to ▪I feel that I am treated as a person by the people doing the work – we develop a

SG Core indicators

3. Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated
4. Percentage of adults receiving any care or support who rate it as excellent or good
5. Percentage of people with positive experience of accessing their GP practice
15. End of Life Care
17. Proportion of care services graded 'good' or above in Care Inspectorate inspections
22. Percentage of people discharged from hospital within 72 hours of being ready

National Health and Wellbeing Outcome 4	What people can expect
Health and social care services are centered on helping to maintain or improve the quality of life of people who use those services.	•I'm supported to do the things that matter most to me •Services and support help me to reduce the symptoms that I am concerned about •I feel that the services I am using are continuously improving •The services I use improve my quality of life

SG Core indicators

6. Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life
12. Emergency admission rate
19. Delayed discharge bed days

National Health and Wellbeing Outcome 5	What people can expect
Health and social care services contribute to reducing health inequalities.	•My local community gets the support and information it needs to be a safe and healthy place to be •Support and services are available to me •My individual circumstances are taken into account

SG Core indicators

11. Premature mortality rate

12. Emergency admission rate

National Health and Wellbeing Outcome 6	What people can expect
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 well-being.	•I feel I get the support I need to keep on with my caring role for as long as I want to do that •I am happy with the quality of my life and the life of the person I care for •I can look after my own health and wellbeing

SG Core indicators

7. Percentage of carers who feel supported to continue in their caring role

14. Percentage of adults with intensive care needs receiving care at home

National Health and Wellbeing Outcome 7	What people can expect
People using health and social care services are safe from harm.	•I feel safe and am protected from abuse and harm •Support and services I use protect me from harm •My choices are respected in making decisions about keeping me safe from harm

SG Core indicators

8. Percentage of adults supported at home who agree they felt safe

10. Suicide rate

12. Readmission to hospital within 28 days

18. Falls

National Health and Wellbeing Outcome 8	What people can expect
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.	•I feel that the outcomes that matter to me are taken account of in my work •I feel that I get the support and resources I need to do my job well •I feel my views are taken into account in decisions

SG Core indicators

10. Percentage of staff who say they would recommend their workplace as a good place to work

National Health and Wellbeing Outcome 9	What people can expect
Resources are used effectively and efficiently in the provision of health and social care services.	▪I feel resources are used appropriately ▪Services and support are available to me when I need them ▪The right care for me is delivered at the right time

SG Core indicators

12. Readmission to hospital within 28 days

19. Delayed discharge bed days

20. Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency

23. Expenditure on End of Life Care

Appendix 2

Consultation on the Health and Social Care Integrated Partnership Strategic and Commissioning Plan

Background

In preparation for developing the Health and Social Care Integrated Partnership Strategic and Commissioning Plan a wide scale community engagement programme 'Join the

Conservation', was undertaken across Perth and Kinross, led by Perth and Kinross Association of Voluntary Services. Engagement also took place with a range of people and representative bodies identified by the Scottish Government, to also help inform and shape this plan.

Now these engagement activities have concluded, the Joint Integration Board is ready to formally consult on the draft Health and Social Care Integrated Partnership Strategic and Commissioning Plan, before submission to the Scottish Government by 31st March 2016.

Proposal for Consultation

The overall support for the consultation on the draft Health and Social Care Integrated Partnership Strategic and Commissioning Plan will come from members the Health and Social Care Integration Community Engagement Steering Group and will be implemented by a small working group which is open to Steering Group Members and agreed partners.

To make sure adherence to a range of engagement quality standards, The Visioning Outcome in Community Engagement, (VOICE), toolkit will be used to record, plan, monitor and evaluate consultation activities.

The following milestones have been identified as part of an early scoping activity and if approved by the Board will be actioned by the working group

- Create VOICE Record (November 6th 2015)
- Agree and draft communication and consultation strategy, including key messages (6th November 2015)
- Agree consultation questions (10t November 2015)
- Prepare Summary and easy read version of the draft plan (10 November 2015)
- Launch formal consultation period 16 November 2015 to 25 January 2016
- Analyse feedback and make relevant changes to draft plan if required (14th February 2016)
- Progress sign off/approval governance prior to submission to Scottish Government (March 31st 2016)

Progress on the consultation will reported back through the Health and Social Care Integration Community Engagement Steering Group and regular updates will be available through the existing reporting structure. Existing approval and sign off procedures for press releases and publications will be used.

For further information please contact Suzie Burt, Team Leader Customer and Community Engagement Team on **01738 476771** or email **sburt@pkc.gov.uk**