Integration Joint Board Agenda

Thursday 15 December 2016
10.00 a.m.
Council Chambers
Cunninghame House
Irvine

1. Apologies
Invite intimation of apologies for absence.

2. Declaration of Interest

3. Minutes / Action Note (Page 5)
The accuracy of the Minutes of the meeting held on 17 November 2016 will be confirmed and the Minutes signed in accordance with Paragraph 7 (1) of Schedule 7 of the Local Government (Scotland) Act 1973 (copy enclosed).

3.1 Matters Arising
Consider any matters arising from the minutes of the previous meeting.

4. Presentations

4.1 Primary Care
Receive a presentation from Pam Milliken.

4.2 Carers
Receive a presentation from Isabel Marr.

5. Director's Report (Page 17)
Submit report by Iona Colvin, Director (NAHSCP) on developments within the North Ayrshire Health and Social Care Partnership (copy enclosed).

6. Model Publication Scheme (Page 23)
Submit report by Eleanor McCallum, Partnership Engagement Officer (copy enclosed).

7. Risk Strategy (Page 25)
Submit report by Eleanor Currie, Principal Manager (Finance) on the partnership risk management strategy (copy enclosed).

8. Pan Ayrshire Sensory Impairment Update (Page 45)
Submit report by David Rowland, Head of Health and Community Care, on work that has been undertaken on behalf of the 3 Ayrshire Health and Social Care Partnerships (copy enclosed).

9. DPH Annual Report 2016 (Page 49)
Submit report by Dr Carole Davidson, Director of Public Health (NHS Ayrshire and Arran) on the Annual Report by the director of Public Health which provides a broad overview of population health information (copy enclosed).

Integration Joint Board

Sederunt

Voting Members

Councillor Peter McNamara (Chair)	North Ayrshire Council
Mr Stephen McKenzie (Vice Chair)	NHS Ayrshire & Arran
Dr Carol Davidson	NHS Ayrshire & Arran
Mr Bob Martin	NHS Ayrshire & Arran
Dr Janet McKay	NHS Ayrshire & Arran
Councillor Anthea Dickson	North Ayrshire Council
Councillor Robert Steel	North Ayrshire Council
Councillor John Easdale	North Ayrshire Council

Professional Advisors

Ms Iona Colvin	Director North Ayrshire Health & Social Care
David Thomson	Lead Nurse/Mental Health Advisor
Dr Mark McGregor	Acute Services Representative
Ms Margaret Hogg	Section 95 Officer/Head of Finance
Mr Stephen Brown	Chief Social Work Officer- North Ayrshire
Ms Louise Gibson	Lead Allied Health Professional Adviser
Dr Paul Kerr	Clinical Director
Dr Kez Khaliq	GP Representative

Stakeholder Representatives

Mr Nigel Wanless	Independent Sector Representative
Mr David Donaghey	Staff Representative - NHS Ayrshire and Arran
Ms Louise McDaid	Staff Representative - North Ayrshire
Mr Martin Hunter	Service User Representative
Ms Fiona Thomson	Service User Representative
Ms Marie McWaters	Carers Representative
Ms Sally Powell	Carers Representative
Mr Jim Nichols	Third Sector Representative

Agenda Item 3

North Ayrshire Health and Social Care Partnership
Minute of Integration Joint Board meeting held on
Thursday 17 November 2016
at 10.00 a.m., Council Chambers, Cunninghame House, Irvine

Present

Councillor Peter McNamara, (Chair)
Stephen McKenzie, NHS Ayrshire & Arran (Vice Chair)

Councillor Anthea Dickson, North Ayrshire Council
Councillor Robert Steel, North Ayrshire Council
Councillor John Easdale, North Ayrshire Council
Dr Carol Davidson, NHS Ayrshire & Arran
Dr Janet McKay, NHS Ayrshire & Arran

Iona Colvin, Director North Ayrshire Health and Social Care (NAHSCP)
Pete Gilfedder, Interim Lead Nurse/Mental Health Advisor
Margaret Hogg, Chief Finance Officer
Dr Paul Kerr, Clinical Director
Louise Gibson, Lead Allied Health Professional Adviser

Nigel Wanless, Independent Sector Representative
Louise McDaid, Staff Representative – North Ayrshire Council
Marie McWaters, Carers Representative
Sally Powell, Carers Representative
Jim Nichols, Third Sector Representative
Martin Hunter, Service User Representative
David Donaghey, Staff Representative – NHS Ayrshire and Arran

In Attendance

David Rowland, Head of Health and Community Care
Eleanor Currie, Principal Manager (Finance)
Thelma Bowers, Head of Service (Mental Health)
Paul Davies, Internal Auditor
David Hornell, Team Manager (Money Matters)
Karen Andrews, Team Manager (Governance)
Angela Little, Committee Services Officer

Apologies for Absence

Bob Martin, NHS Ayrshire & Arran
Stephen Brown, Chief Social Work Officer – North Ayrshire
Kez Khaliq, GP Representative
Dr Mark McGregor, Acute Service Representative

1.	**Apologies** Apologies were noted.	
2.	**Declarations of Interest** There were no declarations of interested in terms of Standing Order 7.2 and Section 5.14 of the Code of Conduct for Members of Devolved Public Bodies.	
3.	**Minutes/Action Note – 8 September 2016** The accuracy of the Minutes of the meeting held on 8 September 2016 were confirmed and the Minutes signed in accordance with Paragraph 7 (1) of Schedule 7 of the Local Government (Scotland) Act 1973.	
3.1	**Matters Arising** There were no matters arising.	
4.	**Review of Services for Older People and Those with Complex Care Needs** Submitted report and presentation by David Rowland, Head of Health and Community Care on the work being undertaken to meet the future needs of Older People and People with Complex Care Needs. The Interim Report was outlined at Annex A to the report and outlined the vision for the programme and a summary of the broad framework that was developed for the components of care focused around the needs of older people and people with complex needs. The presentation provided information on:- • Do we need to change? • Overarching Strategic Direction; • Developing the Strategic Vision; • Refreshing the intended outcomes; • Do the vision and outcomes take us in the right direction? • The RCOP Model; • The RCOP Pathway; • Defining a new paradigm; • Engaging others to define a new paradigm; • Redefining the Model and Pathway for a new paradigm; • Is this the correct paradigm?; and • Transitioning to a new paradigm.	-

	Members asked questions and were provided with further information in relation to:- • Education, awareness raising and a Communications Strategy that will be required to ensure the public are kept informed of the changes to services for older people and those with complex care needs; • Work that will be also be done with health professionals to raise awareness of the services that are available for older people, which will include a the Single Point of Contact and an electronic information system for professionals to access information on services; • The differentials in services across Ayrshire; and • The development of a pan Ayrshire Business Case to cost the proposals and determine affordability. The Board agreed to support the further development of the project and receive regular updates of progress.	
5.	**Chief Social Work Officer Annual Report** Submitted report by Stephen Brown, Head of Children and Families and Criminal Justice on the annual report of the Chief Social Work Officer to the local authority on the statutory, governance and leadership functions of the role, as detailed at Appendix 1, which included information in relation to:- • Partnership structures/governance arrangements; • Social Services landscape/market; • Finance; • Performance and Service Quality; • Statutory functions; • Continuous improvement; • Planning for change; • User and Carer empowerment; • Workforce Planning/Development; and • Key challenges for the year ahead Members acknowledged the tremendous work done by staff in working with the most vulnerable and disadvantaged people in the community. They also expressed their appreciation for the work done to welcome and help to settle refugees into North Ayrshire communities. The Board agreed to note and endorse the report as detailed at Appendix 1 to the report.	

6.	**Director's Report** Submitted report by Iona Colvin, Director NAHSCP on developments within the North Ayrshire Health and Social Care Partnership. The report highlighted works underway in the following areas:- • Appointment of Lead Nurse, NAHSCP; • Forensic Mental Health Unit, Ayrshire Central Hospital, Irvine; • Family Nurse Partnership Graduation Event; • Café Solace; • Care Opinion; • Partnership Staff Awards Ceremony; • "Let's Build a Carer Community in North Ayrshire; • Local Connections, Better Outcomes; • North Ayrshire GP Event; and • National Care Leavers Week. Appendix 1 to the report provided an update in relation to the feedback from the North Ayrshire Health and Social Care Provider Forum held on 5 October 2016. The Board was advised that the Carers Advisory Group are currently working on a Carers Support Package. Noted.	
7.	**Winter Plan 2016/17** Submitted report by David Rowland, Head of Service (Health and Community Care) on NAHSCP's contribution to NHS Ayrshire and Arran's Winter Plan. The Plan, which requires to be submitted to the Scottish Government, details how the local system will respond to anticipated increases in demand for services over the winter period and set out proposals to:- • Sustain capacity from winter 2015/16; • Develop capacity within existing resources; • Create additional capacity with additional resources; • Anticipate outcomes; and • Measure Impact. Members asked questions and were provided with further information in relation to:-	

	• The development of Advanced Nurse Practitioner capacity in North Ayrshire to support telehealth monitoring and lay the foundations for Hospital at Home; The Board agreed to (a) approve the contribution to NHS Ayrshire and Arran's Winter Plan; (b) endorse and support (i) the continued delivery of those service models established in 2015/16; (ii) the development of those service models that are proposed for delivery within existing resources; and (iii) subject to additional funds being made available, the creation of additional capacity with the Care at Home service; and (c) receive an interim report in January 2017 to update Members on the extent to which the anticipated benefits are being delivered through Winter 2016/17.	D. Rowlands
8.	**Financial Performance Report** Submitted report by Eleanor Currie, Principal Manager (Finance) on the overview of the 2016/17 financial position of the North Ayrshire Health and Social Care Partnership as at 30 September 2016. Appendix A to the report provided details of the Period 6 Objective Summary. The Period 6 Subjective Summary was provided at Appendix B to the report. Appendix C outlined the Change Programme Financial Summary. The mitigating action required to bring the budget on-line was provided at Appendix D. Appendix E detailed the 2016/17 Savings Tracker. Movements since the approved budget were provided at Appendix F. Appendix G gave information of the proposed Mitigation Plan for Care at Home Budgetary Pressures in 2016/17. The Principal Manager (Finance) provided an update in relation to Home Office funding that has now been confirmed for one residential school placement (£0.170m). Members asked questions and were provided with further information in relation to:- • The projected overspend in Care at home costs that includes a pressure resulting from the transfer of cases from independent sector providers to the in-house service in December 2015; • An overspend in Adult Inpatient Wards within Woodland View and Ailsa as a result of a number of factors; • The workforce tool which has assessed current numbers to determine the appropriate workforce model for delivery of wider mental health services within Woodland View; • Services that had insufficient or no funding allocated to them and unprecedented increases in demand for services for older people that has attributed to the budgetary pressures despite additional funding being provided,	

	• A Budget Seminar that will be held for IJB Members; • Discussions that will continue to take place with IJB funders and the Scottish Government; and • The timescales for budget allocations from the Scottish Government and the setting of budgets by the Council and NHS Ayrshire and Arran. The Board noted that the second sentence at 3.2(c) of the report should be have been removed. The Board agreed to (a) note the content of the report and the projected overspend of £5.054m for 2016/17; (b) approve the mitigating action identified at this stage and note that discussions are underway with all partners; (c) note that a further report will be presented to a future IJB on the Mental Health Lead Partnership recovery plan; (d) approve the virements request in section 14.1 of the report; (d) approve a new service access approach for care at home which would see implementation of a new approach to allocating capacity which would see new referrals or referrals for increases to existing care packages only receiving care when capacity becomes available due to an existing service user no longer requiring a care package; and (f) note the trial changes to existing service provision for care at home.	E. Currie
9.	**Arran War Memorial Hospital** Submitted report by Pete Gilfedder, Interim Lead Nurse/Mental Health Advisor on the unannounced inspection visit by the Healthcare Environment Inspectorate (HEI) on 26 – 27 July 2016 to the Arran War Memorial Hospital. Overall the report was positive and set out two requirements in respect of the provision of alcohol-based hand rub and the management of blood and body fluid spillages in the hospital waiting area. An Action Plan was developed to ensure compliance with the HEI's inspection. Noted.	
10.	**Improving Access to CAMHS and Psychological Therapies** Submitted report by Thelma Bowers, Head of Mental Health which provided an overview of the proposals for the use of Government funding to improve access to CAMHS and Psychological Therapies. The report also outlined proposals for Government Workforce Capacity Funding by NHS Education for Scotland (NES) which included:- • An allocation to NHS Boards to build and increase workforce capacity to deliver services (24.7m);	

	• Support for the development of the mental health workforce to enhance supply and training of workforce to deliver evidence-based therapies delivered by NHS Education for Scotland (£24.6m); and • The delivery of a Mental Health Access Improvement Support Programme delivered by Healthcare Improvement Scotland (£4.8m). Members asked questions and were provided with further information in relation to:- • A number of workforce reviews that will be undertaken to determine how the current workforce is being utilised and how to release capacity into the system. The inclusion of administrative support and Clinical Psychologist posts and salary grades within the review; • Plans to address gaps in the allocation of building workforce capacity funding; and • A progress report that will be brought back to a future meeting. The Board agreed to (a) note the content of the report; and (b) approve the proposals and plans for Government funding.	T. Bowers
11.	**Appointment to Performance and Audit Committee** Submitted report by Iona Colvin, Director (NAHSCP) on the membership of the IJB Performance and Audit Committee, the appointment of Councillor McNamara as the Chair of the Integration Joint Board and the vacancy created by the resignation of Councillor McNamara from the IJB Performance and Audit Committee. The Board agreed to appoint Councillor Anthea Dickson to the IJB Performance and Audit Committee.	A. Little
13.	**Integration Joint Board Meeting dates 2017** Submitted report by Karen Andrews, Team Manager (Governance) on proposed dates for meetings of the Integration Joint Board in 2017. The report provided information on a range of influencing factors that required to be taken into consideration, such as the budget reporting timescales and the Local Government Election on 4 May 2017. The Board agreed to approve the dates as detailed in the report.	K. Andrews

14.	**Procurement – EU Tender Plan and Contracting for Services** Submitted report by Eleanor Currie, Principal Manager (Finance) on the EU Procurement Tender Plan and the proposed tendering of health and social care contracts by North Ayrshire Council. Members asked questions and were provided with further information in relation to:- • Feedback that is awaited from other authorities in relation to contracts that have not been in place; • The appendices to the report that provided details of the spend in 2015 and has been published on the Council's website; • The extension of services into Vennel Gardens and Montgomery Court that may be examined in the future; • The creation of an Executive Group for the Providers Forum that will provide a mechanism for discussion around contracts. The Board agreed to (a) request the Council to tender for the services listed in the EU Tender Plan, as outlined in Appendix 1 to the report; (b) request the Council to contract for care services on an interim basis, as outlined in Appendix 2 to the report; (c) request the Council to go to tender for non care services, as outlined in Appendix 3 to the report; and (d) approve the appointment of two temporary Procurement Officers funded from within existing resources.	E. Currie
15.	**Social Security in Scotland** Submitted report by David Hornell, Team Manager (Money Matters) on the Council's response to the consultation on Social Security in Scotland and the implications for the Health and Social Care Partnership. The consultation is looking at what the Scottish Social Security agency will deliver in the future and is in three parts:- Part 1 – a principled approach and embedding five key principles; Part 2 – developed benefits; and Part 3 – operational policy. The report outlined the issues that may affect Health and Social Care Partnership, such as how benefits will be delivered in the future; Disability Benefits; and Carers Allowance. M. McWaters, Carers Representative provided an update following attendance at the recent Carers Parliament and advised there should not be DWP clawback on any top up.	

	The Board agreed (a) to note the North Ayrshire Council response to the consultation on Social Security in Scotland; (b) that further information and detail is required to assess the impact on citizens of North Ayrshire, including carers and those who require services commissioned by the IJB; and (c) to receive a further report following the conclusion of the consultation exercise.	
	The meeting ended at 12.10 p.m.	

North Ayrshire Integration Joint Board – Action Note

Updated following the meeting on 17 November 2016

No.	Agenda Item	Date of Meeting	Action	Status	Officer
1.	Development and Implementation of a North Ayrshire Social Enterprise Strategy	4/6/15	Draft Social Enterprise Strategy to be submitted to the IJB, NACMT and NAC Cabinet Meeting. Economic Development	Agenda – prior to end 2016 (Report going to Cabinet on 10/5/16)	John Godwin
2.	Model Publication Scheme	13/8/15	Report on progress including the outcome of the options appraisal	Agenda – prior to end 2016	Neil McLaughlin
3.	Volunteering Strategy	11/2/16		Agenda – prior to end 2016	J. Nicols
4.	Official opening of Woodland View	11/2/16	Details of official opening to be provided to IJB Members	As soon as available	T. Bowers
5.	Charter for Involvement	8/9/16	J. Nicols will report back to the next meeting on the response from the providers	October meeting	J. Nicols
6.	IJB Directions	8/9/16	Future directions to be issued to the Chief Executives of the Council and NHS Ayrshire and Arran as appropriate	Ongoing	K. Andrews

Integration Joint Board
15th December 2016
Agenda Item 5

Subject:	**Director's Report**
Purpose:	To advise members of the North Ayrshire Integration Joint Board of developments within the North Ayrshire Health and Social Care Partnership (HSCP).
Recommendation:	That members of the IJB note progress made to date.

1. INTRODUCTION

1.1 This report informs members of the Integration Joint Board (IJB) of the work undertaken within the North Ayrshire Health and Social Care Partnership both locally and Ayrshire wide.

2. CURRENT POSITION

2.1 **National Developments**

Scottish Parliament Local Government and Communities Committee.

On 23rd November 2016 I attended the Scottish Parliament Local Government and Communities Meeting to participate in the evidence session on Community Empowerment legislation. A copy of the report of the meeting can be access through the following link Official Report : Local Government & Communities Committee.

Ayrshire Developments

Visit by Sir Lewis Ritchie

Ayrshire and Arran will be receiving a Peer Review visit from Professor Sir Lewis Ritchie, Chair for the National Out of Hours Urgent Care Review on the 8th December 2016.

Sir Lewis Ritchie's report, *Pulling together, transforming urgent care for the people of Scotland*, was published on 30 November 2015. A copy of this document can be accessed by this link [Click Here]. The Review considered the current landscape and recommended actions to ensure person-centred, sustainable, high-quality out-of-hours services for the people of Scotland.

The purpose of this visit is to provide an opportunity for members of the Peer Review Group to visit Health and Social Care Partnerships. The Group will use these visits to understand the current service delivery, and see how the proposals submitted in the bids will be used to improve services in the short to medium term; and how this contributes to the Partnership's longer term vision and plans for delivering the model for out of hours urgent care recommended in Sir Lewis's Report. The visits will also give the local workforce the opportunity to give their views on how the out-of-hours service works.

The Review Team will consider common themes such as :-

- How we will work with patients
- How we intend to evaluate services
- How we intend to recruit staff to provide these services
- How we intend to sustain these services on the urgent care funding has ceased

Feedback from the visit will be presented to the IJB at a future date.

<u>New Models of Care for Older People and People with Complex Care Needs</u>

As reported at last month's IJB, the New Models of Care for Older People and People with Complex Needs Business Case is currently being developed in partnership with colleagues in East and South Ayrshire Health and Social Care Partnerships and Acute. The business case is underpinned by a simulation model of key aspects of the health and social care system in Ayrshire & Arran.

As you can imagine this work is quite complicated and therefore has taken longer than expected to complete. This has meant that the business case is not quite as far ahead as we hoped but we have made considerable progress and will develop workforce plans and more detailed budgets once this work is completed. Information on the business case to date will be going to the NHS Scrutiny Panel on the 8 December 2016.

<u>Adaptations</u>

As you are aware the Equipment and Adaptations Project has been undertaking improvement activities across many aspects of the Equipment and Adaptations processes in North Ayrshire. For the last few months the project has been working with NAC Housing colleagues to create a high level processes for the transfer of housing functions around adaptations for council tenants, private sector households and owner occupiers in line with the Public Bodies (Joint Working) (Scotland) Act 2014.

A short life working group has undertaken a review of the adaptations processes and budget with a view to transferring to the Partnership on 1 April 2017 in line with legislation. The group is currently finalising these high level processes and we hope to report how this will happen at next month's IJB.

North Ayrshire Developments

Budget Update

The budget process for 2017/18 has commenced with the Council and the Health Board. As a Partnership we are actively involved in this process to ensure that budgets are informed by our experiences of cost and demand pressures and also our plans for transformation. This process will inform the level of funding which will be made available to us for the commissioning of services in 2017-18, with the outcome likely to be known in March. Our Finance Team are currently working with our Senior Management Team to develop a medium term financial plan and we will be keen to share this with you early in the new year. Dates will be issued in due course.

Extended PSMT Session – 28th November 2016

On 28th November 2016 I hosted a session for members of the Extended Partnership Senior Management Team at Connexions, Irvine.

The focus of this half-day session with the Extended Partnership Senior Management Team was progressing multi-disciplinary teams (MDTs). The approach was a workshop session with preparatory questions for participants with an emphasis on implementation. I provided the strategic context, and presentations from ICES and MADART described examples of multi-disciplinary and multi-agency team working.

In mixed groups, senior leaders articulated the benefits of MDTs, possible models and implementation factors. The key outputs were that participants gained greater knowledge of how MDTs might best operate, proposed key design principles and underlined the importance of professional leadership and identity. The key outcome following the session was that PSMT affirmed the direction to progress MDTs.

Local Connections, Better Outcomes, our Locality Planning Forum staff sessions

As you are know we have been gradually developing our Locality Planning Forums over the last twelve months and all six forums have provided areas of local focus to inform our strategic planning process. The forums have been holding Locality Planning events to engage with people from across our Partnership – NAC, NHS, third and independent sectors – with the purpose of improving knowledge and understanding of local services as well as specific locality needs.

On Monday 21 November 2016, Irvine was our fourth locality to hold their ***Local Connections, Better Outcomes*** event and was attended by over 60 local health and care staff. The event comprised of round table discussions regarding the local areas of focus (social isolation across all ages, mental health particularly among young people and musculoskeletal issues) which were overwhelmingly supported. The discussion session was followed by a networking event to showcase local groups and services. Arran and the Three Towns will hold their ***Local Connections, Better Outcomes*** events early next year.

Asylum Seeking Children

As advised at the IJB on 17th November 2016, North Ayrshire Council agreed to accommodate young people who are unaccompanied asylum seekers. This is in response to a national commitment by Government to accommodate these young people.

Work is currently ongoing to refurbish council property at 2 Nethermains Road, Kilwinning. We have indicated to the Home Office that we would be able to take 5 young people - 16 - 18 years who could live within this property.

At present the property will be fully staffed to the same ratio as that of our Children's Units as we are currently unclear as to the specific ages of the young people who will come and their needs and issues.

The service will be regularly reviewed to ensure that it is meeting needs and work will be undertaken to assist the young people with integration into the local community and Opportunities for attainment within education and employability.

Ethical Care Charter

North Ayrshire Council become one of the first in Scotland to adopt Unison's 'Ethical Care Charter'. The Cabinet of North Ayrshire Council approved the proposal to adopt the Charter on 22nd November 2016.

The Charter provides a guarantee that appropriate employment conditions are in place for homecare workers to ensure safety, quality and dignity of the care provided is never compromised.

By signing the Charter, the Council is committed to implementing a variety of improved standards for home care services commissioned by the Council.

The first set of principles that will be implemented include:

- Care based on client need, not minutes or tasks;
- 15 minute visits should generally not be used, unless appropriate
- Homecare workers to be paid for travelling time, travel costs and other necessary expenses;
- Visits to be scheduled based on needs;
- Eligible workers should be paid statutory sick pay.

Adopting the Charter requires an immediate commitment to these.

Last month the Council also continued its fight against inequality by becoming an accredited Living Wage employer.

Although the Council has paid the Living Wage since 2011, the accreditation confirms the authority's commitment to supporting its staff. It also ensures that all Council suppliers will be encouraged to pay their staff the Living Wage, meaning that more than 500 private sector workers could benefit financially.

Change Programme Update

The Change Programme continues to support the Partnership in joining services across Health & Community Care, Mental Health Services and Children & Families. The team is currently developing the Pan Ayrshire Models of Care for Older People and Adults with Complex needs and Woodland View interface with acute and out of hours services business cases. The team has been joined by a workforce planner and mapping current staff resource to future models is now well underway.

The team facilitated a further session with the GP community and our Primary Care Development Manager will join us on the 28th November to facilitate the development of key primary care actions in each locality. This post will also finalise the production of a North Primary Care Strategy which is in draft and will be discussed at the Change Programme Steering Group in February 2017.

A review of the Integrated Care Fund (ICF) has commenced with the 'gang of four' reviewing the Ideas and Innovation projects. The Third Sector Interface is providing the monitoring support using the template agreed as part of the 'Threading the Needle' work with Scottish Government. The proposed timetable is as follows:

By 14rd November 2016	Email projects with update re timescales and to request monitoring forms
23rd November 2016	Gang of four approve criteria and review monitoring forms
23rd November – 14th December 2016	Individual Scoring
15 & 16 December 2016	Input into scoring template
TBC January 2017	Group Sift
17 January 2017	Finalised proposals to Change Programme Steering Group
4 February 2017	Information confirmed in Finance Budget Paper for IJB
12 February 2017	IJB
13 February 2017	Email Projects with feedback IJB

3. IMPLICATIONS

Financial :	None
Human Resources :	None
Legal :	None
Equality :	None
Environmental & Sustainability :	
Key Priorities :	
Community Benefits :	

4. CONSULTATION

4.1 No specific consultation was required for this report. User and public involvement is key for the partnership and all significant proposals will be subject to an appropriate level of consultation.

5. CONCLUSION

5.1 Members of the IJB are asked to note the ongoing developments within the partnership.

For more information please contact [Iona Colvin, Director] on [01294 317725] or [icolvin@north-ayrshire.gcsx.gov.uk]

Integration Joint Board
15th December 2016
Agenda Item 6

Subject:	**Model Publication Scheme (including website)**
Purpose:	To update members of the Integration Joint Board of the current position in relation to the Model Publication Scheme and the schedule/progress of the Partnership's website including the model publication scheme
Recommendation:	That the IJB agrees the proposals within this paper.

1. EXECUTIVE SUMMARY

1.1 North Ayrshire Integration Joint Board has a legal obligation to 'make certain classes of information routinely available' as per the model publication scheme laid out by Information Commissioner Office.

1.2 NAHSCP has scoped, tendered and awarded a contract for the design and build of a new Partnership website. This will host NAHSCP information and IJB information, including the Model Publication Scheme.

1.3 Designs will be presented to IJB by the end of February 2017. The new website should be live for April 2017.

2. BACKGROUND

2.1 North Ayrshire Integration Joint Board has a legal obligation to 'make certain classes of information routinely available' as per the model publication scheme laid out by Information Commissioner Office. This information is currently held on North Ayrshire Council public website.

2.2 Public facing service information is available via NAC (Health and Social Care pages) and NHS Ayrshire & Arran (services listings). Having a Partnership website will create a joined-up integrated picture of health and social care in North Ayrshire.

2.3 NAHSCP is creating its own individual culture – integrated teams, use of Appreciative Inquiry, change programme, branding and social media. A partnership wide working group with cross sector expertise reviewed and discussed a partnership website.

3. PROPOSALS

3.1 Creating a website for NAHSCP will establish an organisational presence and make integration visible (including third and independent sectors), will help promotion of services and is key to engaging with the public (consultations etc). It addresses the need for increased digital communication routes and engagement. We will adopt a user-journey approach that ensures relevant public-facing information.

3.2 **Anticipated Outcomes**

- Website will be published April 2017.
- North Ayrshire Integration Joint Board will publish the Model Publication Scheme on North Ayrshire Health and Social Care Partnership website.

4. IMPLICATIONS

Financial :	NAHSCP website (domain, design and training) approx. £3000 Maintenance, support and hosting approx. £400 per year Additional development service (ad hoc basis) approx. £35 p/h
Human Resources :	Task & Finish Working Group established to steer the design and content of website, membership includes carers and service users. Existing resource will manage website (after initial build/design and launch)
Legal :	As per IJB report 13.08.15
Equality :	Website will be easy to read and will conform to visual accessibility requirements. Audio accessibility will also accommodated.
Environmental & Sustainability :	n/a
Key Priorities :	n/a
Community Benefits :	n/a

5. CONSULTATION

5.1 Consulted across the Partnership (NAC/NHS/third and independent sectors) and with North Ayrshire Council IT and Web teams and agreed by the Partnership Senior Management Team.

6. CONCLUSION

6.1 The development of the Partnership's website as host for the Partnership model publication scheme will provide means for the residents of North Ayrshire to be directed to and seamlessly access relevant and available information relating to North Ayrshire Health and Social Care Partnership.

For more information please contact Eleanor McCallum on 01294 317812 or EleanorMcCallum@north-ayrshire.gcsx.gov.uk

Integration Joint Board
15th December 2016
Agenda Item 7

Subject:	**Risk Management Strategy**
Purpose:	To outline the partnership risk management strategy
Recommendation:	To approve the partnership risk management strategy and note the key areas of risk identified to date

1. INTRODUCTION

1.1 The partnership's Risk Management Strategy outlines the process established to identify risk, evaluates its potential consequences and determines the most effective method of controlling or responding to it. To ensure that the management of risk is integrated within the partnership, the process forms part of the partnership's governance framework.

2. CURRENT POSITION

2.1 This will be the first Risk Management Strategy of the partnership.

2.2 The strategy has been developed jointly across the three Ayrshire Health and Social Care Partnership and NHS Ayrshire and Arran.

2.3 A strategic risk register is being compiled based on the strategy and will be reported to the IJB in January 2017. Initial discussion within the senior management team has identified the following areas of risk:

- Safe Delivery of Services including financial risk
- Infrastructure
- Culture and Practice
- Delivery of the Change Programme
- Governance
- Procurement
- Demography and Inequality Pressures

3. PROPOSALS

3.1 It is proposed to approve the risk management strategy detailed in Appendix 1.

3.2 **Anticipated Outcomes**

The primary objectives of this strategy will be to:

- promote awareness of risk and define responsibility for managing risk within the IJB;
- establish communication and sharing of risk information through all areas of the IJB;
- initiate measures to reduce the IJB exposure to risk and potential loss; and,
- establish standards and principles for the efficient management of risk, including regular monitoring, reporting and review.

This strategy takes a positive and holistic approach to risk management. The scope applies to all risks, whether relating to the clinical and care environment, employee safety and wellbeing, business risk, opportunities or threats.

3.3 **Measuring Impact**

3.3.1 Monitoring will include review of the IJB's risk profile at Senior Management Team level. The PSMT is responsible for providing assurance to the IJB that the Risk Management Strategy is being applied effectively across the Partnership.

3.3.2 Key Perfomance Indicators (KPIs) will be linked where appropriate to specific risks to provide assurance on the performance of certain control measures. For example, specific clinical incident data can provide assurance that risks associated with the delivery of clinical care are controlled, or, budget monitoring PIs (Performance Indicators) can provide assurance that key financial risks are under control.

3.3.3 Reviewing the IJB's risk management arrangements on a regular basis will also constitute a 'Plan/ Do/ Study/ Act' review cycle that will shape future risk management priorities and activities of the IJB, inform subsequent revisions of this policy and strategy and drive continuous improvement in risk management across the IJB.

4. IMPLICATIONS

4.1 **Financial Implications**

The implementation of the strategy will initiate measures to reduce the IJB exposure to risk and potential loss.

4.2 **Human Resource Implications**

None

4.3 **Legal Implications**

None

4.4 **Equality Implications**

None

4.5 **Environmental Implications**

None

4.6 **Implications for Key Priorities**

Appropriate and effective risk management practice will deliver better outcomes for the people of North Ayrshire, protecting the health, safety and wellbeing of everyone who engages with the IJB or for maximising opportunity, delivering innovation and best value, and increasing performance.

5. CONSULTATIONS

5.1 None.

6. CONCLUSION

6.1 That the IJB approve the Risk Management Strategy outlined in Appendix 1

For more information please contact Eleanor Currie, Principal Manager – Finance on Tel. No 01294-317814 or email to eleanorcurrie@north-ayrshire.gcsx.gov.uk

Appendix 1

Integration Joint Board

Risk Management Strategy

Version No:	
	1.0
Prepared By:	
	NHS and Local Authority Risk Leads
Effective From (replacing version 5.1):	
	xx/xxx/xx
Review Date:	
	xx/xxx/xx
Lead Reviewer:	
	Iona Colvin Chief Officer NA H&SCP
Dissemination Arrangements:	

"This Strategy underpins the commitment to robust risk management across the three Ayrshire Health and Social Care Partnership and must be read in conjunction with NHS Ayrshire & Arran and Council Risk Management Strategies" – CE Officer

CONTENTS

Policy – the risk management approach

Integration Joint Boards (IJB's) are committed to a culture where their workforce is encouraged to develop new initiatives, improve performance and achieve goals safely, effectively and efficiently by appropriate application of good risk management practice.

Appropriate and effective risk management practice will be embraced throughout the IJB as an enabler of success, whether delivering better outcomes for the people of Ayrshire, protecting the health, safety and wellbeing of everyone who engages with the IJB or for maximising opportunity, delivering innovation and best value, and increasing performance.

Key benefits of effective risk management:

- risk 'aware' not risk 'averse' decisions are based on a balanced appraisal of risk and enable acceptance of certain risks in order to achieve a particular goal or reward;
- high achievement of objectives and targets;
- high levels of morale and productivity;
- better use and prioritisation of resources;
- high levels of user experience/ satisfaction with a consequent reduction in adverse incidents, claims and/ or litigation; and
- a positive reputation established for the IJB.

In doing so the Joint Boards aims to provide safe and effective care and treatment for patients and clients, and a safe working environment within the IJB and others who interact with the services delivered under the direction of the IJB.

The Joint Boards purposefully seeks to promote an environment that is risk 'aware' and strives to place risk management information at the heart of key decisions. This means that the IJB can take an effective approach to managing risk in a way that both address significant challenges and enable positive outcomes.

Risk appetite is the amount of risk which is judged tolerable and justifiable. It is the amount of risk that any organisation is prepared to tolerate, or be exposed to at any one point in time. A formal risk appetite statement requires to be agreed annually by each IJB.

The Joint Board promotes the pursuit of opportunities that will benefit the delivery of the Strategic Plan. Opportunity related risk must be carefully evaluated in the context of the anticipated benefits for patients, clients and the IJB.

The Joint Board will receive assurance reports from their Partnership Senior Management Team (PSMT) not only on the adequacy but also the effectiveness of its risk management arrangements and will consequently evaluate the contribution that risk management makes to the wider governance arrangements of the IJB.

The Joint Boards, through the following risk management strategy, has established a Risk Management Framework, (which covers risk policy, procedure, process, systems, risk management roles and responsibilities).

This document represents the risk management framework to be implemented across the Joint Boards and will contribute to the IJB's wider governance arrangements.

Strategy - Implementing the policy

Introduction

The primary objectives of this strategy will be to:

- promote awareness of risk and define responsibility for managing risk within the IJB;
- maximise opportunity to improve service delivery;
- establish communication and sharing of risk information through all areas of the IJB;
- initiate measures to reduce the IJB exposure to risk and potential loss; and,
- establish standards and principles for the efficient management of risk, including regular monitoring, reporting and review.

This strategy takes a positive and holistic approach to risk management. The scope applies to all risks, whether relating to the clinical and care environment, employee safety and wellbeing, business risk, opportunities or threats.

Strategic/Corporate[1] risks represent the potential for the IJB to achieve (opportunity) or fail to meet (threat) its desired outcomes and objectives as set out within the Strategic Plan, and typically these risks require strategic leadership in the development of activities and application of controls to manage the risk.

Operational risks represent the potential for impact (opportunity or threat) within or arising from the activites of an individual service area or team operating within the scope of the IJB's activities. Parent bodies will retain responsibility for managing operational risks as operational risks will be more 'front-line' in nature and the development of activities and controls to respond to these risks can be led by local managers and team leaders. Where an operational risk impact across multiple service areas or, because of interdependencies, require more strategic leadership, then these can be proposed for escalation to 'strategic/corporate risk' status for the IJB and where required the parent organisation.

All risks will be analysed consistently with an evaluation of risk as being **very high/high/moderate/low & red/amber/yellow/green**. Further information can be found at Appendix 1.

Risk management process

Risk Management is about the culture, processes and structures that are directed towards realising potential opportunities whilst managing adverse effects[2] It is pro-active in understanding risk and uncertainty, it learns and builds upon existing good practice and is a continually evolving process that has an important role in ensuring that defensible and beneficial decisions are made.

The IJB embeds risk management practice by consistent application of the risk management process shown in the diagram on the right, across all areas of service delivery and business activities. Further information in relation to the Risk Managment Process can be found at Appendix 1.

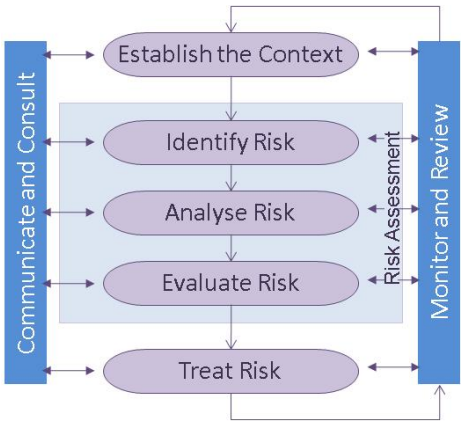

Figure 1 Risk Management Process

[1] Differences in terminology of risk currently exists, Strategic is used with the LA whilst Corporate is used with NHS.
[2] Australia/ New Zealand Risk Management Standard, AS/NZS 4360: 2004

Application of good risk management across IJB activities

The following standard procedures will be implemented across all areas of activity that are under the direction of the IJB in order to achieve consistent and effective implementation of the Risk Managment Strategy.

Implementation of the risk management process. This means that risk management information should (wherever possible) be used to guide major decisions in the same way that cost and benefit analysis is used.

Identification of risk using standard methodologies, and involving subject experts who have knowledge and experience of the activity or process under consideration.

Categorisation of risk under the headings below:

- Strategic / Corporate Risks: such as risks that may arise from Political, Economical, Social, Technological, Legislative and Environmental factors that impact on the delivery of the Strategic Plan outcomes.
- Operational Risks: such as risks that may arise from or impact on Clinical Care and Treatment, Social Care and Treatment, Customer Service, Employee Health, Safety & Well-being, Business Continuity/ Supply Chain, Information Security and Asset Management.

Appropriate ownership of risk. Specific risks will be owned by/ assigned to whoever is best placed to manage the risk and oversee the development of any new risk controls required.

Consistent application of the agreed risk matrix. Necessary to analyse risk in terms of consequences and likelihood of occurrence, taking into account the effectiveness of risk control measures in place. The risk matrix to be used is attached in Appendix 1.

Consistent response to risk that is proportionate to the level of risk. This means that risk may be terminated; transferred elsewhere (ie to another partner or third party); tolerated as it is; or, treated with measures to bring it to a level where it is tolerable for the IJB in keeping with its appetite/ tolerance for risk. In the case of opportunities, the IJB may 'take' an informed risk in terms of tolerating it if the opportunity is judged to be (1) worthwhile pursuing and (2) the IJB is confident in its ability to achieve the benefits and manage/ contain the associated risk. Further information can be found at Appendix 1.

Implementation and maintenance of risk registers. Used as a means of collating risk information in a consistent format allowing comparison of risk evaluations, informed decision-making in relation to prioritising resources and ease of access to information for risk reporting.

Reporting of strategic/corporate risks and key operational risks to the IJB on a six monthly basis. Operation of a procedure for movement of risks between strategic and operational risk registers that will be facilitated by the PSMT.

Routine reporting of risk information. Required within and across teams and a commitment to a 'lessons learned' culture that seeks to learn from both good and poor experience in order to replicate good practice and reduce adverse events and associated complaints and claims.

Risk leadership and accountability

Governance, roles and responsibilities

This section should be read in conjunction with Ayrshire and Arran Integrated Health and Social Care Partnerships Health and Care Governance Framework

Integration Joint board

Members of the Integration Joint Board are responsible for:

- Oversight of risk through the Performance and Audit Committee;
- Seeking assurances from the Partnership Senior Managment Team that effective risk management arrangements are in place;

- Receipt and review of reports on strategic/corporate risks and any key operational risks that require to be brought to the IJB's attention; and,
- Ensuring they are aware of any risks linked to recommendations from the Chief Officer concerning new priorities/ policies/ emerging risks, opportunities and the like.

Chief Officer

The Chief Officer has overall accountability for the IJB's risk management framework, ensuring that suitable and effective arrangements are in place to manage the risks relating to the functions within the scope of the IJB. The Chief Officer will keep the Chief Executives of the IJB's partner bodies and members of the IJB informed of any significant existing or emerging risks that could seriously impact the IJB's ability to deliver the outcomes of the Strategic Plan or the reputation of the IJB

Chief Financial Officer

The Chief Financial Officer will be responsible for promoting arrangements to identify and manage key business risks, risk mitigation and insurance.

Partnership Senior Management Team

Members of the Senior Management Team are responsible (either collectively, or by nominating a specific member of the team) for:

- supporting the Chief Officer and Chief Financial Officer in fulfilling their risk management responsibilities;
- arranging professional risk management support, guidance and training from partner bodies;
- receipt and review of regular risk reports on strategic/corporate, shared and key operational risks and escalating any matters of concern to the IJB;
- ensure the impact of decisions made in terms of risk and opportunities do not have a negative impact on insurance and self insurance arrangments. Key specialist advisors should be involved in decision making processes at the earliest opportunity where practicable; and
- ensuring that the standard procedures set out in this doucment and supporting documentation are actively promoted across their teams and within their areas of responsibility.

Individual Risk Owners

It is the responsibility of each risk owner to ensure that:

- understand their responsibiliy in relation to the managment of risk;
- risks assigned to them are analysed in keeping with the agreed risk matrix;
- measure effectivness of existing controls;
- risk mitigation are in place to manage the risk are proportionate to the context and level of risk;.
- monitor the timely implementation of additional mitigation where required;
- risk is reviewed not only in terms of likelihood and impact of occurrence, but takes account of any changes in context that may affect the risk; and
- risks are defined clearly to make explicit the scope of the challenge, opportunity or hazard and the consequences that may arise.

All persons working under the direction of the IJB

Risk management should be integrated into daily activities with everyone involved in identifying current and potential risks where they work. Individuals have a responsibility to make every effort to be aware of situations which place them or others at risk, report identified hazards and implement safe working practices developed within their service areas. This approach requires everyone to understand:

- the risks that relate to their roles and activities;
- how their actions relate to their own, their patients, their services users / clients and public safety;

- their accountability for particular risks and how they can manage them;
- the importance of flagging up incidents and/ or near misses to allow lessons to be learned and contribute to ongoing improvement of risk management arrangements; and,
- that good risk management is a key part of the IJB's culture.

Partner Bodies

It is the responsibility of relevant specialists from the partner bodies, (such as internal audit, external audit, clinical and non clinical risk managers and health and safety advisers) to attend meetings as necessary to consider the implications of risks and provide relevant advice. It is the responsibility of the partner bodies to ensure they routinely seek to identify any residual risks and liabilities they retain in relation to the activities under the direction of the IJB.

Resourcing risk management

Resourcing the risk management framework

The work on developing and leading the ongoing implementation of the risk management framework and accociated training for the IJB and employeeswill be resourced through the Partnership Senior Management Team's arrangements.

Training, learning and development

Risk management training and development opportunities

To implement effectively this strategy, it is essential for staff to have the competence and capacity for managing risk and handling risk judgements with confidence, to focus on learning from events and past experience in relation to what has worked well or could have been managed better, and to focus on identifying malfunctioning 'systems' rather than people.

Training is important and is essential in embedding a positive risk management culture across all activities under the direction of the IJB and in developing risk management maturity. The PSMTwill regularly review risk management training and development needs and source the relevant training and development opportunities required.

Monitoring activity and performance

Monitoring risk management activity and performance

A suitable system is required to ensure risk managment activity and performance is monitored. Monitoring will include review of the IJB's risk profile at Senior Management Team level.

The PSMT is responsible for providing assurance to the IJB that the Risk Managment Strategy is being applied effectively across the Partnership.

Key Perfomance Indicators (KPIs) will be linked where appropriate to specific risks to provide assurance on the performance of certain control measures. For example, specific clinical incident data can provide assurance that risks associated with the delivery of clinical care are controlled, or, budget monitoring PIs (Performance Indicators) can provide assurance that key financial risks are under control.

The performance data linked to the Strategic Plan will also inform the identification of new risks or highlight where existing risks require more attention.

Reviewing the IJB's risk management arrangements on a regular basis will also constitute a 'Plan/ Do/ Study/ Act' review cycle that will shape future risk management priorities and activities of the IJB, inform

subsequent revisions of this policy and strategy and drive continuous improvement in risk management across the IJB.

It is expected that partner bodies will use IJB risk reports to keep their own organisations updated on the management of the risks, highlighting any IJB risks that might impact on the partner organisation.

Communicating risk management

Communicating, consulting on and reviewing the risk management framework

Effective communication of key risk management information across the IJB is essential to developing a consistent and effective approach to risk management.

Copies of this policy and strategy will be widely circulated via the Partnership Senior Management Team and will form the basis of any risk management training arranged by the IJB.

This strategy will be reviewed every three years or earlier if required to ensure that it reflects current standards and best practice in risk management and fully reflects the Integration Joint Board's business environment.

Appendix 1 Risk Management – A Quick Guide

Risk Management – A Quick Guide

What is Risk Management and why do we have to do it?

Risk is something that may have an impact on the achievement of our objectives. This could be an opportunity as well as a threat. Good risk management means that we have a better understanding of what risks and opportunities an IJB may face and how it can best manage them.

This quick guide provides basic details on the risk management process more detailed information in relation to using risk register software, directorate risk registers, peer review process, etc can be found in the supporting Management of Risk Guidance document.

Understanding and managing threats or risks comes down to four very simple questions:

1. What are the worst things that could happen to us?
2. What is the likelihood of them happening?
3. What would be the impact?
4. What can we do about it? (How can we prevent it from happening, or what can we put in place to manage it if it should?)

There are several tools which can be used to answer these questions. For simplicity and ease of understanding our approach is to use a simple 4 stage process of identification, assessment, management and review to ensure our risks are recorded and effectively managed. This approach is shown in Figure 2 and described in the four sections below.

Figure 2 – Four Steps to Managing Risk

1. Identifying risks

To identify risks think through the things that could prevent or hinder your team from achieving its business objectives. There are three parts to a risk – an event that has a consequence that leads to an impact on our objectives. Typical risk phrasing could be:

Loss of… ***Failure of…..*** ***Failure to...*** ***Lack of…*** ***Development of…*** **Opportunity for**	***lead to ……***	***results in……***

You will also need to identify whether the risk is:

- Strategic/Corporate: risks that are significant in size and duration and will impact on the reputation and performance of the IJB and parent organisations as a whole and in particular its ability to deliver Board objectives;
- Operational: risks specific to the delivery of individual services/service performance/project.

2. Assessing risks

Residual/Net risk = the level of risk remaining after managing it through treatment and/or control measures.

To identify the Residual/Net Risk we simply identify the consequence score from the appropriate domain listed in Table 2 after we have identified the control measure. We then multiple the consequence score by the likelihood of the event occurring. The likelihood score is taken from the matrix at Table 3.

Multiplying the consequence x likelihood then provides us with the Residual Risk. The Residual risk score helps to make decisions about the significance of risks to the IJB and how they will be managed, the controls required and the treatment of the risk. This can be found in Table 4.

***SEVERITY CONSEQUENCE MATRIX* - Description and definition of the** CONSEQUENCE / IMPACT of the risk should it occur (these are a guide)

Severity

"Domains"	**1** **Insignificant**	**2** **Minor**	**3** **Moderate**	**4** **Major**	**5** **Extreme**
Objectives and projects	▪ Barely noticeable reduction in scope / quality / schedule	▪ Minor reduction in scope / quality / schedule	▪ Reduction in scope or quality, project objectives or schedule.	▪ Significant reduction in ability to meet project objectives or schedule.	▪ Inability to meet project objectives, reputation of the organisation seriously damaged and failure to appropriately manage finances.
Injury (physical and psychological) to patients/staff.	▪ Adverse event leading to minor injury not requiring first aid.	▪ Minor injury or illness, first-aid treatment needed. No staff absence required.	▪ Significant injury requiring medical treatment and/or counselling.	▪ Major injuries or long term incapacity/ disability (loss of limb), requiring medical treatment and/or counselling.	▪ Incident leading to death or major permanent incapacity.
Patient experience / outcome	▪ Reduced quality of patient experience / clinical outcome not directly related to delivery of clinical care.	▪ Unsatisfactory patient experience / clinical outcome directly related to care provision – readily resolvable	▪ Unsatisfactory patient experience / clinical outcome, short term effects – expect recovery < 1Wk	▪ Unsatisfactory patient experience / clinical outcome, long term effects - expect recovery > 1Wk	▪ Unsatisfactory patient experience / clinical outcome, continued ongoing long term effects.
Complaints / claims	▪ Locally resolved complaint	▪ Justified complaint peripheral to clinical care	▪ Below excess claim. ▪ Justified complaint involving lack of appropriate care.	▪ Claim above excess level. ▪ Multiple justified complaints.	▪ Multiple claims or single major claim.
Staffing and competence	▪ Short term low staffing level (< 1 day), where there is no disruption to patient care.	▪ Ongoing low staffing level results in minor reduction in quality of patient care	▪ Late delivery of key objective / service due to lack of staff.	▪ Uncertain delivery of key objective / service due to lack of staff.	▪ Non delivery of key objective / service due to lack of staff. ▪ Loss of key staff.

		▪ Minor error due to ineffective training / implementation of training.	▪ Moderate error due to ineffective training / implementation of training. ▪ Ongoing problems with staffing levels	▪ Major error due to ineffective training / implementation of training.	▪ Critical error due to insufficient training / implementation of training.
Service / business interruption	▪ Interruption in a service which does not impact on the delivery of patient care or the ability to continue to provide service	▪ Short term disruption to service with minor impact on patient care.	▪ Some disruption in service with unacceptable impact on patient care. ▪ Temporary loss of ability to provide service.	▪ Sustained loss of service which has serious impact on delivery of patient care resulting in major contingency plans being invoked.	▪ Permanent loss of core service or facility. ▪ Disruption to facility leading to significant "knock on" effect.
Financial	▪ Negligible organisational financial loss (£< 1k).	▪ Minor organisational financial loss (£1-10k).	▪ Significant organisational financial loss (£10-100k).	▪ Major organisational financial loss (£100k-1m).	▪ Severe organisational financial loss (£>1m).
Inspection / assessment / audit	▪ Small number of recommendations which focus on minor quality improvement issues.	▪ Minor recommendations made which can be addressed by low level of management action.	▪ Challenging recommendations but can be addressed with appropriate action plan.	▪ Enforcement Action. ▪ Low rating. ▪ Critical report.	▪ Prosecution. ▪ Zero Rating. ▪ Severely critical report.
Adverse publicity / reputation	▪ No media coverage, little effect on staff morale.	▪ Local Media – short term. ▪ Minor effect on staff morale / public attitudes.	▪ Local Media – long term. ▪ Impact on staff morale and public perception of the organisation.	▪ National Media (< 3 days). ▪ Public confidence in the organisation undermined. ▪ Usage of services affected.	▪ National Media (> 3 days). ▪ MP / MSP Concern (Questions in Parliament).
Organisational / Personal Security, and Equipment	▪ Damage, loss, theft (£< 1k).	▪ Damage, loss, theft ▪ (£1-10k).	▪ Damage, loss, theft ▪ (£10-100k).	▪ Damage, loss, theft ▪ (£100k-1m).	▪ Damage, loss, theft (£>1m).

Table 2 – Consequence/Impact Matrix

Likelihood

	1 **Remote**	**2** **Unlikely**	**3** **Possible**	**4** **Likely**	**5** **Almost Certain**
Probability	▪ Will only occur in exceptional circumstances.	▪ Unlikely to occur but definite potential exists.	▪ Reasonable chance of occurring – has happened before on occasions.	▪ Likely to occur – strong possibility.	▪ The event will occur in most circumstances.

Table 3 – Likelihood Matrix

Risk Rating

LIKELIHOOD	SEVERITY				
	1 Insignificant	2 Minor	3 Moderate	4 Major	5 Extreme
5 Almost Certain	**5**	**10**	**15**	**20**	**25**
4 Likely	**4**	**8**	**12**	**16**	**20**
3 Possible	**3**	**6**	**9**	**12**	**15**
2 Unlikely	**2**	**4**	**6**	**8**	**10**
1 Remote	**1**	**2**	**3**	**4**	**5**

Table 4 – Risk Rating

Level of Risk	Risk	How the risk should be managed
Very High (20-25)	Immediate Action Required Intolerable	Requires active management to manage down and maintain the exposure at an acceptable level. Escalate upwards. The activity or process should not be started or allowed to continue until the risk level has been reduced. While the control measures selected should be cost-effective, legally there is an absolute duty to reduce the risk. Review every 3 months.
High (10-16)	Immediate Action Required Unacceptable	Contingency plans may suffice together with early warning mechanisms to detect any deviation from the profile. Escalate upwards. If a new activity or process, it should not be started until the risk has been reduced. Considerable resources may have to be allocated to reduce the risk. Where the risk involves an existing activity or process, the problem should normally be remedied within one to three months. Review every 6 months.
Moderate (4-9)	Action Required	Efforts should be made to reduce the risk, but the cost of reduction should be carefully measured and limited. Risk reduction measures should normally be implemented within three to six months. Re-assess frequently
Low (1-3)	Acceptable	No further preventative action is necessary, but consideration should be given to more cost-effective solutions or improvements that impose no additional cost burden. Monitoring is required to ensure that the controls are maintained. Review periodically to ensure conditions have not changed.

Table 5 – How Risks should be managed

3. Managing and controlling risks

THE FOUR T's

The level of the inherent risk will help determine the best treatment for a risk, whether strategic, corporate, partnership or operational. Once the type of risk has been determined, consideration must be given to the most appropriate to treat the risk, action plan will be require to be drawn up and implemented. The rating and prioritisation of the risk will determine the speed with which the risk action plan should be implemented and at which level of the organisation the risk needs to be reported.

Tolerating	The IJB may tolerate a risk where: • the risk is effectively mitigated by internal controls, even if it is a high risk • the risk cannot be mitigated cost effectively • the risk opens up greater benefits These risks must be monitored and contingency plans should be put in place in case the risks occur.
Treating	This is the most widely used approach. The purpose of treating a risk is to continue with the activity which gives rise to the risk, but to bring the risk to an acceptable level by taking action to control it in some way through either: • containment actions (these lessen the likelihood or consequences of a risk and are applied before the risk materialises) or • contingency actions (these are put into action after the risk has happened, thus reducing the impact. These must be pre-planned)
Terminating	Doing things differently and therefore removing the risk. This is particularly important in terms of project risk, but is often severely limited in terms of the strategic risks of an organisation.
Transfer	Transferring some aspects of the risk to a third party, e.g. via insurance, or by paying a third party to take the risk in another way. This option is particularly good for mitigating financial risks, or risks to assets. However it is a limited option.

Table 6 – The Four T's

CONTROLS

Any action, procedure or operation undertaken to either contain a risk to an acceptable level (the impact), or to reduce the likelihood. Where future actions are planned these should have a date by which they will be implemented.

4. Monitor and Review Risks

REPORTING RISK

Nothing stays the same forever. By talking to your staff and monitoring incident rates and control measures, you will be able to judge whether your risk control measures are effective. Managers and staff must be given responsibility to oversee the process and

develop reporting procedures, discussing and helping to implement solutions, as well as monitoring the solutions for effectiveness.

Your risks should be reviewed regularly to ensure that the risk has not changed and that no further control measures are needed. A risk should also be reviewed if any changes occur that may increase the risk of an adverse event occurring.

There is no legal time frame for when you should review your risk assessment. However, the IJB has adopted the process that it is at your discretion to decide when a review is deemed necessary, but the risk assessment is a working document and, as your business experiences change, this information should be recorded and updated. As a guide, it is recommended that risk assessments be reviewed on an annual basis.

Integration Joint Board
15th December 2016
Agenda Item 8

Subject:	**Pan Ayrshire Sensory Impairment Update**
Purpose:	To provide the IJB with an updated account of the work that has been undertaken on behalf of the 3 Ayrshire Health and Social Care Partnerships. To advise the Integration Joint Board of the need to create a "Policy Officer" post for up to three years to further support and coordinate the implementation of the Pan Ayrshire Sensory Impairment Plan.
Recommendation:	It is recommended that the Integration Joint Board notes the contents of the report and approves the proposal by the 3 Ayrshire Health & Social Care Partnerships to create a jointly funded "Policy Officer" post for up to three years to further support and coordinate the implementation of the Pan Ayrshire Sensory Impairment Plan.

1. PURPOSE OF REPORT

1.1 The purpose of this report is to:

- Give an updated account of the work that has been undertaken on behalf of the 3 Ayrshire Health and Social Care Partnerships.
- To advise the Integration Joint Board of the need to create a "Policy Officer" post for up to three year to further support and coordinate the implementation of the Pan Ayrshire Sensory Impairment Plan.

2. RECOMMENDATION

2.1 It is recommended that the Integration Joint Board notes the contents of the report and approves the proposal by the 3 Ayrshire Health & Social Care Partnerships to create a jointly funded "Policy Officer" post for up to three years to further support and coordinate the implementation of the Pan Ayrshire Sensory Impairment Plan.

3. BACKGROUND INFORMATION

3.1 "See Hear" published in 2014 is the first ever Scottish Government Sensory Strategy. It outlines a comprehensive and partnership based vision for the delivery of a more integrated sensory loss service. It endorses a number of approaches to delivering an integrated Sensory Impairment Service, notably:

- The importance of developing and utilising sensory care pathways across health and social care services.
- The key role of third sector organisations working in partnership with statutory agencies.
- The growth in demand for services which demand more of a community based approach and an increased focus on early intervention / diagnosis, and preventative measures.
- The increasing need to address the issue of Sensory Impairment through training and awareness raising for staff working in a variety of health and social care settings.
- The need to address the wider lifestyle impacts of sensory loss, and to provide emotional support, alongside clinical interventions.
- The key link between the sensory strategy and the wider reshaping care for older people agenda.

3.2 A Pan Ayrshire and Arran Sensory Locality Plan was developed. This plan was produced in response to new statutory requirements on local partners, and links directly to the recommendations of the "See Hear" strategy. The Ayrshire and Arran Plan was the first plan of its type developed in Scotland and has developed as a template plan now being used in many other areas.

3.3 The locality plan is an ambitious and radical document rooted in the stark realisation the demographic trends allied to budgetary pressures mean the "status quo in service delivery is not an option". Due to a sharply ageing population profile in Ayrshire over the next 15 – 20 years, the number of people with sight loss could double, and those with hearing loss increase by 50%: significant service redesign is therefore essential. This should be linked to a shift from a "deficit" to an "asset" based approach – focussing on how the quality of life for people with a sensory loss can be maximised, rather than primarily focussing on the condition.

3.4 The plan covers all of Ayrshire and Arran, encouraging geographic service integration where practical, but recognising the need for area sensitivities. It contains a clear commitment to the creation of an integrated Pan Ayrshire and Arran Sensory delivery of service – maximising the effectiveness of a strongly rooted partnership approach between the statutory and third sector and voluntary organisations. The plan details 8 priority areas of action, notably:

- The need for learning and training of frontline staff on sensory loss.
- The need for accessible and locally provided services on a "hub and satellite" model.
- The need for a "decisive shift" to prevention and anticipatory care, linked to community based services and tele-care.
- An outcomes focus – linked to co-production and wider information provision to service users on available supports.
- The importance of clear and effective sensory loss care pathways.
- The development of more integrated and localised health and social care supports.

- Services designed to be “flexible, adaptable and fit for the future” – cognisant of demographic realities, and the need to increase volunteer inputs.
- A continued focus on improving practice and performance.

4. REPORT

4.1 To date, in order to advance the Pan Ayrshire Sensory Impairment Locality Plan we have:

- Developed a Pan Ayrshire Sensory Impairment Action Plan.
- Set up an Operation Leads Meeting compromising officers from the 3 Ayrshire Health and Social Care Partnerships and colleagues from the voluntary and third sector.
- Set up a “Programme Board” to oversee and support the implementation of the strategy and action plan.

4.2 Further work is being undertaken in a number of key areas, namely:

- Identifying / actioning a management system for reporting on Key Performance Indicators across both statutory and non-statutory services.
- Developing an integrated Pan Ayrshire training matrix / schedule.
- Setting up a service user focus group to inform and consult on the work carried out to date and the proposed work relating to the Pan Ayrshire Sensory Impairment Plan.
- Developing an outcome focussed framework for users of the Pan Ayrshire Sensory Impairment Service.
- Developing a “traffic light” system to assist in the implementation of the Sensory Impairment Action Plan.

4.3 In order to ensure that these actions are realised, the Strategic Planning and Operational Group (SPOG) has agreed the creation of a “Policy Officer” to take forward this agenda in the short – medium term covering the next 3 years.

5. STRATEGIC CONTEXT

5.1 The Pan Ayrshire Sensory Locality Plan and Action Plan link to the following Partnership Strategic Plan objectives:

- We will work to reduce the inequality gradient and in particular address health inequality.
- We will protect children and vulnerable adults from harm.
- We will ensure children have the best possible start in life.
- We will support people to live independently and healthily in local communities.
- We will prioritise preventative, anticipatory and early intervention approaches.
- We will proactively integrate health and social care services and resources for adults and children.

6. IMPLICATIONS

Financial Implications

6.1 The Policy Officer post will be funded equally by the 3 Ayrshire Health and Social Care Partnerships. In North Ayrshire it is proposed that funding will be provided through the Integrated Care Fund. The postholder will be employed through South Ayrshire Council on behalf of the South Ayrshire IJB as the Lead Partnership for Sensory Impairment. The post will be created initially for up to three years. It is expected that the full year cost of the appointment, including on-costs and travel will be in the order of £44,500 and £47,500 in the first year, including set up. The final cost of the post will be determined through job evaluation. The full year cost to the North Ayrshire IJB in the first year will be £ 15,800 and in future years £14,800.

Human Resource Implications

Human Resource Implications

6.2 The Director of Health and Social Care will specify and evaluate the duties of the proposed Policy Officer post and recruit to the position in liaison with HR staff in South Ayrshire Council.

Legal Implications

6.3 There are no legal implications arising from this report.

Equalities Implications

6.4 There are no equalities implications arising directly from the contents of this report.

Sustainability Implications

6.5 There are no sustainability implications arising directly from the contents of this report.

7. CONSULTATION AND PARTNERSHIP WORKING

7.1 There has been considerable partnership working across Ayrshire and across the sectors on sensory impairment.

8. CONCLUSION

8.1 This report contains details relating to the background to the Pan Ayrshire Sensory Impairment locality and action plan and identifies work streams to progress the same.

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Integration Joint Board
15th December 2016
Agenda Item 9

Subject:	**Director of Public Health Annual Report 2016**
Purpose:	The Director of Public Health Annual Report is an independent report which provides a broad overview of population health information for decision makers and planners on the key health priorities that need to be addressed within Ayrshire and Arran.
Recommendation:	The Integration Joint Board is asked to consider and note the contents of the Director of Public Health Report 2016.

1. EXECUTIVE SUMMARY

1.1 The Director of Public Health (DPH) Report is an important vehicle for informing those on the NHS Board, Health & Social Care Partnerships (H&SCPs), Local Authorities and other partner organisations, as well as local people themselves, about the health of their community. It is an independent report which provides a broad overview of population health information for decision makers and planners on the key health priorities that need to be addressed within Ayrshire and Arran.

2. BACKGROUND

2.1 In Ayrshire and Arran, there has been a continuous rise in life expectancy over the last decade of around three years for men and two years for women. This in part contributes to the projection of a 49% rise in men aged 80 years and over by 2025 and a projected 31% rise in women aged 80 years and over. When combined with a projected fall in the number of people aged 40 to 49 years over the same time period, this raises the possibility of some future challenges with informal care provision.

2.2 Alcohol remains a public health priority in Scotland and in Ayrshire and Arran. Our death rates are still high and it is causing harm through physical illness (including cancers) and the impact on mental health, violence, abuse and social and emotional wellbeing in individuals, families and communities. Although consumption of alcohol and deaths related to alcohol have been falling in recent years, these remain well above the levels seen twenty to thirty years ago.

2.3 Tobacco use remains a public health priority although smoking rates are reducing across Scotland. The smoking rates in Ayrshire and Arran are among the highest in Scotland and smoking is an important risk factor for the commonest cancers (trachea, bronchus and lung cancer). Smoking rates among pregnant women have not declined as much as in the general population, which is an important factor in the health of newborn babies.

2.4 Obesity and diabetes are still on the increase and we need a much stronger drive to ensure people, particularly parents, have the information and support they need to choose healthier diets and increase physical activity; but we also need action by government, employers and manufacturers to develop our environments, including workplaces, and food supply to make healthy choices the easy choice.

2.5 Mental health and wellbeing is our fourth priority for improving population health and it is encouraging that there is now a much more open attitude in society to talking about mental health issues and providing support to people who require it. Suicide rates are the lowest they have been for decades although loneliness and social isolation continue as important issues to address particularly with an ageing population.

3. PROPOSALS

3.1 The Integration Joint Board is asked to consider and note the contents of the Director of Public Health Report 2016.

3.2 **Anticipated Outcomes**

Improving population health and reducing inequalities.

3.3 **Measuring Impact**

Through reporting of performance against actions on each of the priorities through Covalent.

4. IMPLICATIONS

4.1 It is intended that the population health information in this report will inform planning, contribute to strategies and aid decision-making.

Financial :	There are no significant resource implications from the publication of the plan. It will mainly be available online. Copies will be made available on request.
Human Resources :	There are no significant workforce implications from the publication of the plan.
Legal :	-
Equality :	Equality Impact Assessments (EQIA) has been carried out on the work streams highlighted to address the population health priorities.
Environmental & Sustainability :	The report will mainly be disseminated online
Key Priorities :	Improving and protection population health
Community Benefits :	-

5. CONSULTATION

5.1 Lead officers from Public Health will be involved and are discussing the DPH Report with the relevant committees in East, North and South Ayrshire H&SCPs.

6. CONCLUSION

6.1 The Integration Joint Board is asked to consider and note the contents of the Director of Public Health Report 2016.

For more information please contact Dr Carol Davidson, Director of Public Health, NHS Ayrshire & Arran on 01292 885882 or carol.davidson@aapct.scot.nhs.uk

Appendix 1

NHS Ayrshire & Arran

Director of Public Health Annual Report 2016

Working together to achieve the healthiest life possible for everyone in Ayrshire and Arran

Foreword

I am delighted to present my 2016 report on the health of the people of Ayrshire and Arran. The interesting period of political history has continued since my last report with the referendum on the European Union following so closely behind the referendum on Scottish independence. In addition, the financial challenge for public services has become more acute in the wake of global recession. Along with the financial and workforce challenges we now face, however, come new opportunities to try and test different ways to organise and provide services and work with people in new and exciting ways. Our new Health and Social Care Partnerships are now well established and beginning to reach out and develop closer relationships with the communities they serve; locality arrangements are in place, 'community connector' projects are being tried and 'asset based approaches' are being developed . Changes are happening within primary care too, with new clusters of GP practices being formed and quality leads being identified. Strategic cohesion is being maintained by the efforts of all parts of Ayrshire and Arran's health and care system (acute care, primary care, community health and social care). Wider partnerships with all Community Planning Partners continue to be vital, particularly in the current economic climate, so that all partner organisations can collaborate on the most productive and efficient way to work together with our population to improve health and wellbeing.

In this report, I provide an overview of the health of the people of Ayrshire and Arran using the most recently available data. I also report on what we are doing to try to prevent health problems from developing in the first place (primary prevention); early detection of disease (for example through screening programmes); preventing or slowing the progress of disease once it has developed (secondary prevention) and reducing the impact that disease and disability have on people's health and wellbeing (tertiary prevention). The health status section describes trends in the main causes of poor well-being, illness and death. Life expectancy is an overall indicator of how healthy our population is and it continues to improve for both men and women in all parts of Ayrshire and Arran. The decrease in smoking, and better recognition and treatment of risk factors for circulatory disease, has reduced this as the main cause of death. Although cancer is becoming the main cause of death as people survive to older ages, new cancer treatments have also meant that many cancers are now able to be treated more like chronic illnesses.

I have previously identified our top four priorities for improving population health as ATOM (Alcohol, Tobacco, Obesity and Mental Health & Wellbeing). Updates are provided on progress achieved through our strategies to address these priorities. Although there are improvements to note, progress is slow for issues where more intensive individual help or cultural change is required to support people to adopt healthier behaviours and therefore I recommend that these ATOM topics remain as our top priorities.

I want to make particular mention of alcohol as data on trends indicate we have seen the peak of alcohol related deaths and admissions and we might expect to see further falls in these rates. However alcohol should remain a priority as our rates are still high and it is still causing harm through physical illness, including cancers, and impact on mental health, violence, abuse and social and emotional well being in individuals, families and communities. The UK Chief Medical Officers have recently published updated guidance on low risk drinking. This guidance now says **"to keep health risks from alcohol to a low level it is safest not to drink more than 14 units a week on a regular basis"**. The advice for women who are pregnant or think they could become pregnant is that **the safest approach is not to drink alcohol at all**. Further details on this advice can be obtained from https://www.gov.uk/government/consultations/health-risks-from-alcohol-new-guidelines.

As I discussed in my last report, although rates of smoking continue to reduce gradually nationally and locally, rates in Ayrshire and Arran are among the highest in Scotland, particularly for women smoking during pregnancy. We need to increase our efforts to reduce these rates.

Obesity and diabetes are still on the increase and we need a much stronger drive to ensure people, particularly parents, have the information and support they need to choose healthier diets and increase physical activity; but we also need action by government, employers and manufacturers to develop our environments, including workplaces, and food supply to make healthy choices the easy choice.

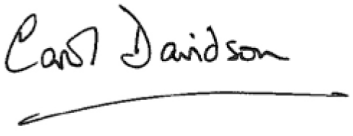
Mental health and wellbeing is our fourth priority for improving population health and it is encouraging that there is now a much more open attitude in society to talking about mental health issues and providing support to people who require it. Suicide rates are the lowest they have been for decades although loneliness and social isolation continue as important issues to address. Locally in Ayrshire and Arran we are seeing lots of change and innovation in our mental health services. We now have a well developed 'recovery' rather than a 'maintenance' approach to support people with addictions and care in the community and minimising any hospital stays for mental health problems is usual practice.

In my 2013/14 report, I called for an increased focus on children and young people's health and I would like to emphasise that again. We could see significant improvements in the health of future generations within a relatively short timescale of five to fifteen years if we can reduce smoking and alcohol consumption in pregnancy; reduce parental smoking; increase knowledge, understanding and support for breastfeeding, healthy diets and increased physical activity in families with young children; and increase early intervention and support for families in relation to housing, finance, safety, parenting and reducing social isolation. I know that those working with

children and young families are working hard on these issues and they need support and encouragement to make the visible difference we would all like to see.

Although the preceding paragraphs describe the priority of health topics and behaviours we need to keep working on, that does not diminish the crucial nature of the work we all need to continue on the social and economic determinants of health and inequalities through our local Community Planning Partnerships. The importance of politics and national policy change for improving health and reducing inequalities is also clear, and behind that is the power and influence of the views of people. On many issues, society's views have to change before there is a political will to introduce legislation that has clear benefits for health, such as drink driving and smoking legislation; and sometimes political drive and the introduction of legislation leads to a change in societal views such as with the seat belt law. We know that income, power and resources (such as education) are the main determinants of inequality in society and that inequality in these determinants leads to inequalities in health. So in order to improve health and reduce inequalities in health, in addition to taking action at an individual level in terms of our own health behaviours and health and care staff adopting inequalities sensitive practice and policies, we can also influence and use our democratic political system to achieve change. Together, through a balance of legislation, policy change and social movements, we can make greater and faster improvements in health that will benefit everyone.

I would like to acknowledge the contribution of all those who have been involved in the production of this report, but would particularly like to thank colleagues in health, social care and Community Planning Partnerships for working with our population to achieve ' the healthiest life possible for everyone in Ayrshire and Arran.



Dr Carol Davidson
Director of Public Health
NHS Ayrshire & Arran
August 2016

Contents

List of figures

List of tables

Chapter 1 • Health of the People in Ayrshire and Arran

This section of the Director of Public Health Report provides an overview of the population and main health issues in Ayrshire and Arran and in the three Health and Social Care Partnership (H&SCP) areas that lie within it. The Health and Social Care Partnerships (H&SCPs) formally came in to being in April 2015, as a result they are a focus for this section of the report. Later in this section, more detailed data is provided on a range of health issues, through a series of tables and graphs and some commentary around these. Because of space constraints in this report, the amount of detailed data provided is necessarily limited; more information can be obtained by contacting the author of this section of the report.

The main emphasis of the information provided is on numbers and rates of birth, numbers and rates of death, deaths in the first year of life, immunisations, population projections, life expectancy, hospital admissions and the main causes of death. However there are also references to available information on smoking, alcohol, benefits, employment, and other factors that influence health in a number of ways. The data are laid out in a way that facilitates comparison between the Health and Social Care Partnerships (H&SCPs) where possible and some comparison with Ayrshire and Arran and with Scotland. This is intended to assist with understanding health issues and to inform planning and decision-making at a number of levels.

Health of the population of Ayrshire and Arran

National Records for Scotland (NRS) estimated the 2015 mid-year population of NHS Ayrshire & Arran to be 370,590. Of the three Health and Social Care Partnership areas in Ayrshire and Arran, East Ayrshire accounts for 33 per cent (122,060) of the total population, North Ayrshire 37 per cent (136,130) and South Ayrshire 30 per cent (112,400). Population projections in Ayrshire and Arran for 2015 to 2025 shows that males aged 80 years and over are projected to increase by 49 per cent and females aged 80 years and over by 31 per cent. The largest projected decrease is for both males and females aged between 40 and 49 and this has potential implications for the number of formal and informal carers available in the future.

Overall life expectancy in Ayrshire and Arran for both men and women has continued to increase and is similar to the Scottish average. In the last decade average male life expectancy in Ayrshire and Arran increased from 73.7 years to 76.8 years. For females during the same decade, average life expectancy increased from 79.0 years to 80.6 years.

There were 3,593 live births in the year ending March 2015. Ayrshire and Arran has a higher birth rate at 55.4 per 1000 women aged 15 to 44 compared to the Scotland rate of 51.9 per 1000 women. There were 4,644

deaths in Ayrshire and Arran in 2015. The three major causes of mortality (cancer, heart disease and stroke) accounted for 57 percent of all deaths in Ayrshire and Arran during 2014. Ayrshire and Arran has slightly higher rates of premature mortality (deaths under the age of 75) than Scotland.

What follows is a description of some of the key health issues in the East, North and South Ayrshire H&SCPs, which is based on the population health indicators used by the Scottish Public Health Observatory (ScotPHO). For many of these indicators, information will also be available at locality level, which can be obtained from the author of this section.

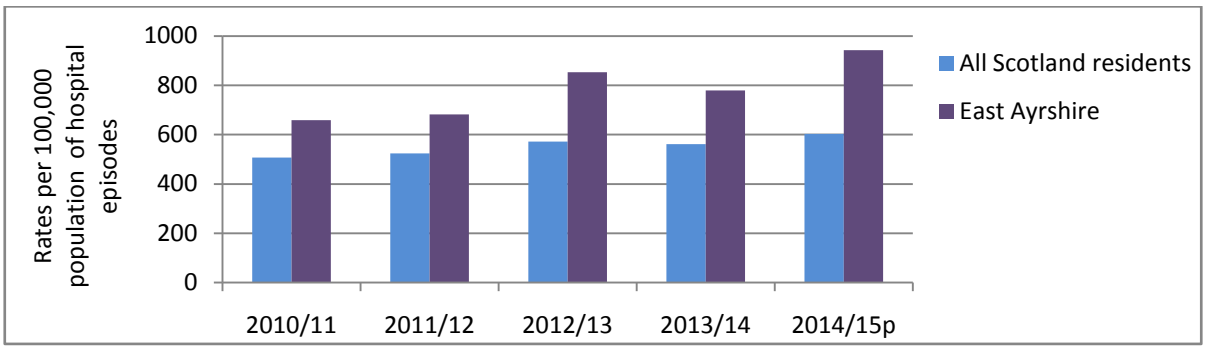
Health of the population of East Ayrshire

Overall life expectancy in East Ayrshire for both men and women has continued to increase and is similar to the Scottish average. In the last decade average male life expectancy in East Ayrshire increased from 73.5 years to 75.9 years. For females during the same decade, life expectancy increased from 78.4 years to 79.7 years. The following are some key points about health and related issues in East Ayrshire:

- the rate of early deaths from coronary heart disease (under 75 years) in East Ayrshire is currently above the Scottish average but overall has continued to decrease from 129 per 100,000 population in 2002-04 to 67 per 100,000 in 2013-15
- the rate of patients hospitalised with coronary heart disease in East Ayrshire has also decreased over the last ten years but is still above the Scottish average
- early deaths from cancer (under 75 years) in East Ayrshire are similar to the Scottish average and show a decline over the decade but less so when compared to coronary heart disease
- the rates of patients registered with cancer are similar to the Scottish average and have remained steady over the last decade
- the number of deaths from alcohol conditions is small relative to cancer and CHD and therefore a 5-year average annual figure is used to measure it. In East Ayrshire the rates peaked at 28 per 100,000 population for 2006-10 and have gradually declined to 24 per 100,000 for 2009-13
- in East Ayrshire the rates of alcohol related hospital stays are significantly higher than the Scottish average. These were highest in 2007-08 at 1,087 per 100,000 population, but they have decreased to 801 per 100,000 for 2013-14
- the estimated smoking attributable deaths in East Ayrshire are 427 per 100,000 people, considerably higher than the Scottish average rate of 367.

- East Ayrshire has the highest rate in Scotland of patients hospitalised with chronic obstructive pulmonary disease (COPD). Figure 1 presents trend data from 2010/11 to 2014/15 comparing East Ayrshire rates with Scotland rates.

Figure 1: Rate per 100,000 population of hospital episodes for COPD in East Ayrshire compared to Scotland



Source: http://www.isdscotland.org/Health-Topics/Hospital-Care/Diagnoses/

- adults claiming incapacity benefits/severe disability allowance/employment and support allowance in East Ayrshire is considerably higher than the Scottish average and is showing a gradual downward trend each year since 2009
- the proportion of the working age population in East Ayrshire claiming out of work benefits in 2015 was 14 per cent compared to the Scottish average of 11 per cent

Early Years

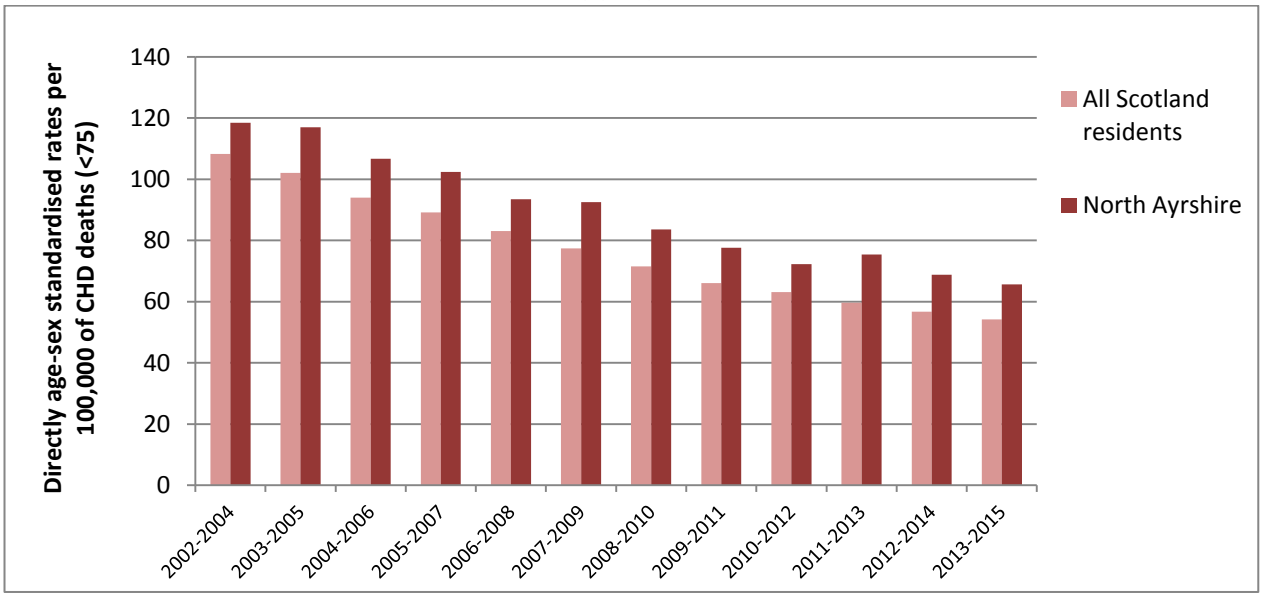
- immunisation uptake at 24 months in East Ayrshire was 99.4 per cent in 2014/15, the highest uptake in Scotland – this refers to the 5 in 1 vaccine (Diphtheria, tetanus, pertussis, haemophilus influenza B, and polio)
- in 2012, 15.3 per cent of children in Scotland were living in poverty and in East Ayrshire the figure was 19.4 per cent
- the rate of children looked after by East Ayrshire local authority is 18 per 1000 people aged 0-18 years, the Scottish average is 14 per 1000

Health of the population of North Ayrshire

Overall life expectancy in North Ayrshire for both men and women has continued to increase and is similar to the Scottish average. In the last decade male life expectancy in North Ayrshire increased from 73.2 years to 76.5 years. For females during the same decade, average life expectancy increased from 79.1 years to 81.0 years. The following are some key points about health and related issues in North Ayrshire:

- the rate of early deaths from coronary heart disease (under 75 years) in North Ayrshire is higher than the Scottish average, but overall has decreased from 118 per 100,000 population in 2002-04 to 66 per 100,000 in 2013-15. Figure 2 shows three-year aggregated age and sex standardised rates of premature deaths (under 75 years) from coronary heart disease in North Ayrshire compared to Scotland from 2002-04 up to 2013-15
- the rate of patients hospitalised with coronary heart disease has gradually decreased over the last ten years but is still above the Scottish average
- early deaths from cancer (under 75 years) in North Ayrshire are similar to the Scottish average and show a decline over the decade but less so when compared to coronary heart disease
- the rates of patients registered with cancer are similar to the Scottish average and have remained steady over the last decade
- the number of deaths from alcohol conditions is small relative to cancer and CHD and therefore a 5-year average annual figure is used to measure it. In North Ayrshire the rates peaked at 33 per 100,000 population for 2002-06 and have gradually declined to 23 per 100,000 for 2009-13
- in North Ayrshire the rates of alcohol related hospital stays are significantly higher than the Scottish average. These were highest in 2007-08 at 1,166 per 100,000 population, decreasing to 923 per 100,000 for 2013-14
- the estimated smoking attributable deaths in North Ayrshire are 422 per 100,000people, considerably higher than the Scottish average rate of 367
- North Ayrshire has the third highest rate in Scotland for patients hospitalised with chronic obstructive pulmonary disease (COPD)
- the proportion of adults claiming incapacity benefits/severe disability allowance/employment and support allowance in North Ayrshire is considerably higher than the Scottish average, but is showing a gradual downward trend each year since 2009
- the proportion of the working age population of North Ayrshire that is claiming out of work benefits is 16 per cent compared to the Scottish average of 11 per cent

Figure 2: Rate per 100,000 population of early deaths from CHD (< 75 years) in North Ayrshire compared to Scotland (3-year aggregates)



Primary Source – National Records of Scotland (NRS)

Early Years

- immunisation uptake at 24 months in North Ayrshire is 98.7 per cent for the 5 in 1 vaccine (Diptheria, tetanus, pertussis, haemophilus influenza B, and polio)
- in 2012, 15.3 per cent of children in Scotland were living in poverty and in North Ayrshire the figure was 21.5 per cent.
- the rate of children looked after by North Ayrshire local authority is 22 per 1000 population aged 0-18 years, the Scottish average is 14 per 1000.

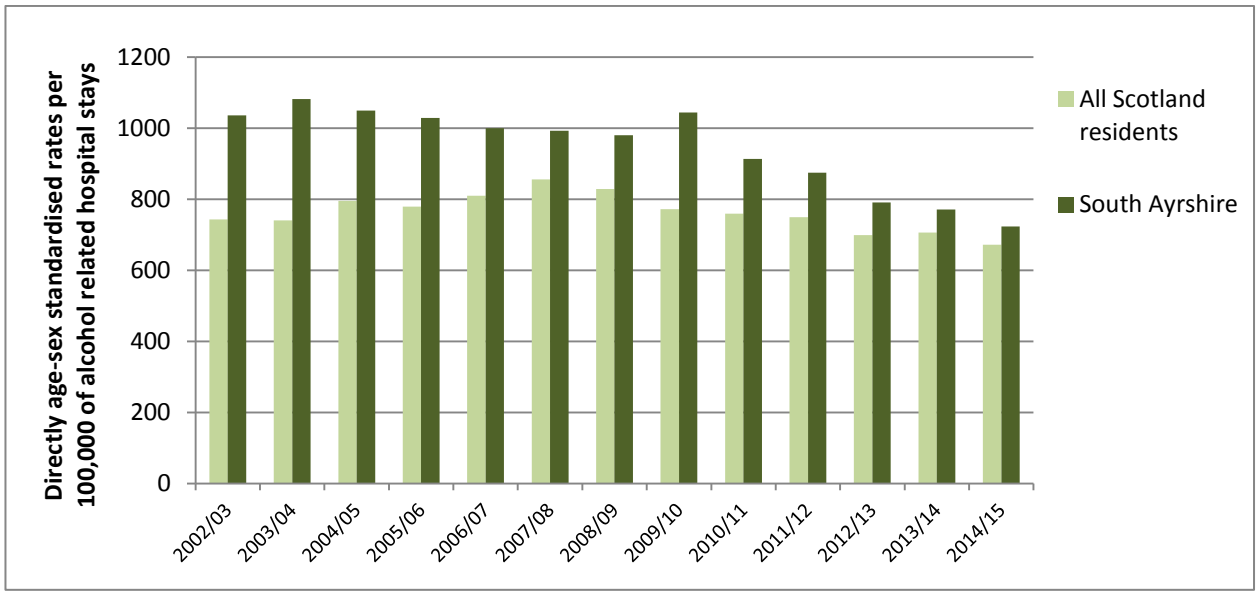
Health of the population of South Ayrshire

Overall life expectancy in South Ayrshire for both men and women has continued to increase, male life expectancy is above the Scottish average and female life expectancy is similar to it. In the last decade male life expectancy in South Ayrshire increased from 74.4 years to 78.2 years. For females during the same decade, average life expectancy increased from 79.6 years to 81.0 years. The following are some key points about health and related issues in South Ayrshire:

- the rate of early deaths from coronary heart disease (under 75 years) in South Ayrshire is similar to the Scottish average and has continued to decrease from 105 per 100,000 population in 2002-04 to 54 per 100,000 in 2013-15

- the rate of patients hospitalised with coronary heart disease has also decreased over the last ten years in South Ayrshire but is still above the Scottish average
- early deaths from cancer (under 75 years) in South Ayrshire are similar to the Scottish average and show a decline over the decade but less so when compared to coronary heart disease
- the rates of patients registered with cancer are similar to the Scottish average and have remained steady over the last decade
- the number of deaths from alcohol conditions is small relative to cancer and CHD and therefore a 5-year average annual figure is used to measure it. In South Ayrshire the rates peaked at 27 per 100,000 population for 2002-06 and have gradually declined to 21 per 100,000 for 2009-13
- in South Ayrshire the rates of alcohol related hospital stays are slightly higher than the Scottish average. These were highest in 2009-10 at 1,041 per 100,000 population and have decreased to 773 per 100,000 for 2013-14. Figure 3 shows the trend in rates of alcohol related hospital stays in South Ayrshire compared to Scotland from 2002/03 up to 2014/15

Figure 3: Rates per 100,000 population of alcohol related hospital stays in South Ayrshire compared to Scotland



Primary Source - ISD Scotland (SMR01, Linked Database)

- the estimated smoking attributable deaths in South Ayrshire are similar to the Scottish average
- the rate of patients hospitalised with chronic obstructive pulmonary disease (COPD) in South Ayrshire is similar to the Scottish average and has remained stable over the last decade

- the rate of adults claiming incapacity benefits/severe disability allowance/ employment and support allowance overall in South Ayrshire is lower than the Scottish average and is showing a gradual downward trend each year since 2009.
- The proportion of the working age population in South Ayrshire that is claiming out of work benefits is 11.9 per cent, similar to the Scottish average rate of 11.0 per cent

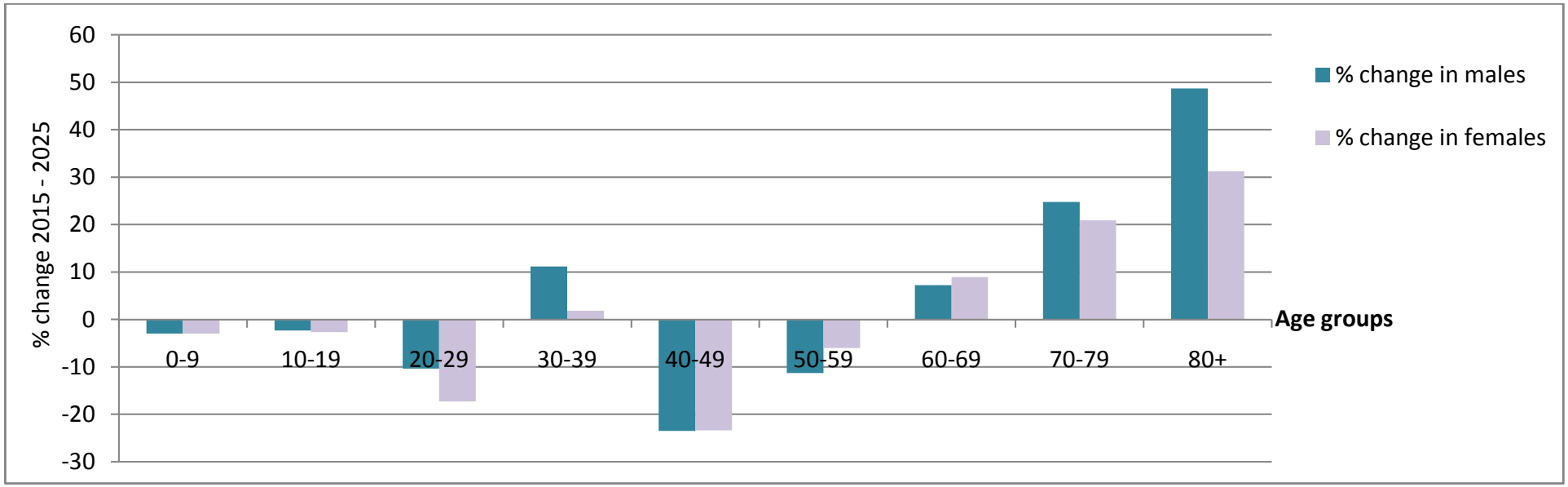
Early Years

- immunisation uptake at 24 months in South Ayrshire was 99 per cent in 2014/15, the second highest uptake after East Ayrshire in Scotland – this relates to the 5 in 1 vaccine (Diptheria, tetanus, pertussis, haemophilus influenza B, and polio)
- in 2012, 15.3 per cent of children in Scotland were living in poverty and in South Ayrshire the figure was 15.4 per cent
- the rate of children looked after by South Ayrshire local authority is 15 per 1000 people aged 0-18 years, similar to the Scottish average rate of 14 per 1000.

Population projections for males and females in Ayrshire and Arran between 2015 and 2025 (2012 based)

Figure 4 shows that males aged 80 years and over are projected to increase by 49 per cent and females aged 80 years and over by 31 per cent in Ayrshire and Arran. The largest projected decrease is for both males and females aged between 40 and 49 and this has implications for the number of formal and informal carers that may be available in the future (dependency ratio). Table 1 provides projected changes in the population for all those aged 75 years and over between 2015 and 2025. Ayrshire and Arran and each of the H&SCPs have a higher percentage increase in the period than Scotland as a whole, with North Ayrshire having the largest increase.

Figure 4: Percentage change in projected population by age and sex between 2015 and 2025 Ayrshire and Arran



Source: http://www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/population/population-projections

Table 1: Population projections 2015 to 2025, all persons over 75 years of age in Ayrshire and Arran

	2015 population >75 years	2025 population >75 years	Number change	Percentage change
Scotland	443,241	588,913	145,672	33 per cent
East Ayrshire	10,330	14,051	3,721	36 per cent
North Ayrshire	12,637	17,565	4,928	39 per cent
South Ayrshire	12,205	16,330	4,125	34 per cent
Ayrshire and Arran	35,172	47,946	12,774	36 per cent

Source: http://www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/population/population-projections

Childhood Immunisations (up to 24 months of age) in Ayrshire and Arran

Currently children are immunised against diphtheria, tetanus, pertussis (whooping cough), polio, and haemophilus influenzae type b (Hib) combined in a '5 in 1 vaccine'. They also receive pneumococcal conjugate vaccine (PCV) and meningococcal group C vaccine (MenC) in the first year of life. Booster doses of Hib/MenC and PCV are given in the second year of life, along with a primary course of measles, mumps and rubella vaccination (MMR) around the age of 13 months.

The national target for uptake of childhood immunisation is for 95 per cent of children to complete a primary course of immunisation by the age of 24 months. In 2014-15 uptake rates in NHS Ayrshire & Arran remained consistently high, exceeding the 95 per cent target and also were above the Scottish average, while the increase in uptake of the first dose of MMR vaccine at 24 months to its highest level of 97 per cent in 2013-14, has been maintained (Table 2).

Table 2: Annual immunisation rates (per cent) at age 24 months for 2009/10 to 2014/15; NHS Ayrshire & Arran (and Scotland figure in brackets).

Year	DTP/Hib/Polio	Men C*	PCV	MMR 1	Hib/MenC booster	PCV Booster
2015	99 (98)	99 (97)	99 (97)	97 (95)	97 (95)	97 (95)
2014	99 (98)	98 (96)	98 (97)	97 (96)	98 (96)	98 (96)
2013	99 (98)	98 (96)	98 (97)	96 (95)	97 (96)	97 (96)
2012	99 (98)	98 (96)	98 (97)	95 (94)	97 (95)	96 (95)
2011	99 (98)	98 (96)	98 (97)	94 (93)	96 (94)	94 (94)
2010	99 (98)	98 (97)	98 (97)	94 (94)	95 (94)	94 (93)

Figures in brackets are for Scotland during the same time period (Source: ISD Scotland)

Uptake of immunisations in children aged 24 months in East, North and South Ayrshire are above target and the Scottish average with the exception of MMR uptake in North Ayrshire which is just below the 95 per cent target (Table 3).

Table 3: Immunisation uptake rates (per cent) at age 24 months, 2014-15, by H&SCP

Area	DTP/Hib/Polio	MenC	PCV	MMR1	Hib/MenC Booster	PCV Booster
Scotland	98.1 (98.2)	97.1 (96.0)	97.1(96.9)	95.4(95.6)	95.4(95.7)	95.4(95.5)
East Ayrshire	99.5 (99.6)	99.7 (98.7)	98.9(99.0)	98.5(97.9)	98.5(98.2)	98.2(98.1)
North Ayrshire	98.2 (98.3)	98.3 (97.6)	97.9(97.7)	94.8(96.6)	95.9(97.1)	95.2(97.4)
South Ayrshire	99.3 (98.9)	99.0 (97.8)	98.9(98.0)	96.5(96.5)	97.7(97.3)	97.4(97.5)
NHS A&A	98.9 (99.0)	98.9 (98.0)	98.5(98.3)	97.0(97.0)	97.3(97.6)	96.8(97.7)

Source: ISD Scotland. Figures in brackets are for 2013-14

Perinatal and infant mortality

Stillbirths and deaths in the first year of life are thankfully rare and the rate varies considerably from year to year. Therefore table 4 presents 4-year average rates for each of the categories of perinatal and infant mortality along with the total number of deaths. Perinatal deaths occur in the first week of life, neonatal deaths in the first 28 days of life and infant deaths occur before the first birthday of the child. The stillbirth rate in Ayrshire and Arran is higher than the Scotland rate but the Ayrshire and Arran rates for perinatal deaths (excluding stillbirths) and for infant deaths are similar to the Scottish rate. East Ayrshire has higher rates across all categories and South Ayrshire has higher rates than North Ayrshire for all except stillbirths.

Table 4: Estimated stillbirths, perinatal, neonatal and infant deaths, numbers and rates (4-year averages) for Scotland, Ayrshire and Arran and East, North and South Ayrshire, 2012-2015

	4-Year totals and averages							
	Stillbirths[a] Total Number	Average rate per 1000 total births	Perinatal deaths[b] Total Number	Average rate per 1000 total births	Neonatal deaths[c] Total Number	Average rate per 1000 live births	Infant deaths[d] Total Number	Average rate per 1000 live births
Scotland	948	4.2	1332	5.9	528	2.3	785	3.5
East Ayrshire	34	6.4	46	8.6	18	3.4	25	4.7
North Ayrshire	32	6.1	37	7.0	-	1.3	12	2.3
South Ayrshire	23	5.6	34	8.4	13	3.2	14	3.5
Ayrshire & Arran	89	6.1	117	8.0	38	2.6	51	3.5

Source: http://www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/vital-events/general-publications/births-deaths-and-other-vital-events-preliminary-annual-figures/archive

a. child born after the 24th week of gestation and did not breathe or show any sign of life

b. stillbirths and deaths in the first week of life

c. refers to all deaths in the first four weeks of life

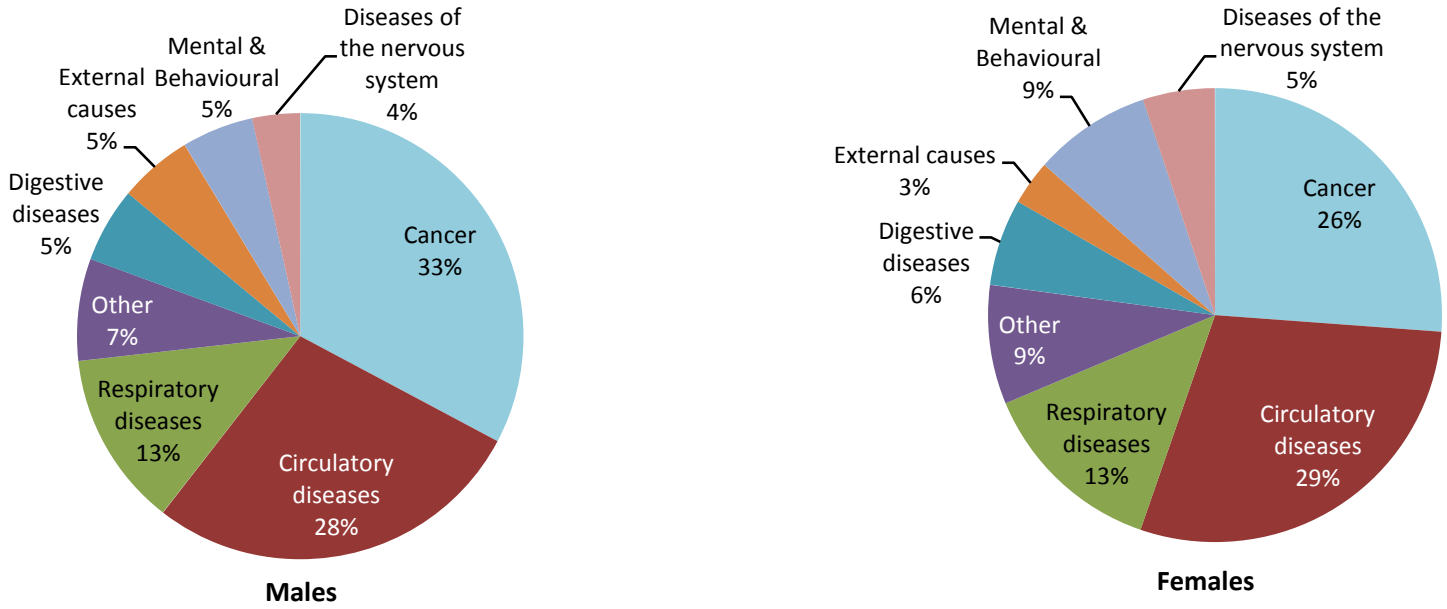
d. refers to all deaths in the first year of life.

Main causes of death in adults

The three major causes of adult mortality (cancer, heart disease and stroke) accounted for 57 percent of all deaths in Ayrshire and Arran during 2014. There were 1,273 deaths from cancer accounting for 29 per cent of all deaths, and heart disease and stroke combined accounted for a further 28 per cent of all deaths in Ayrshire and Arran in 2014.

Using broad classifications of the main causes of death, diseases of the circulatory system account for the largest number of deaths in women (671, males 568) and cancer was the main cause of death for men (671, females 602). Respiratory disease was the third highest cause of death for males and females (260 and 307 respectively). There were more female than male deaths from mental and behavioural causes (193 and 106 respectively) and more men died from external causes (accidents and violence) compared to women (109 and 73 respectively) as shown in Figure 5.

Figure 5: Main causes of death in males and females, all ages, NHS Ayrshire & Arran, 2014

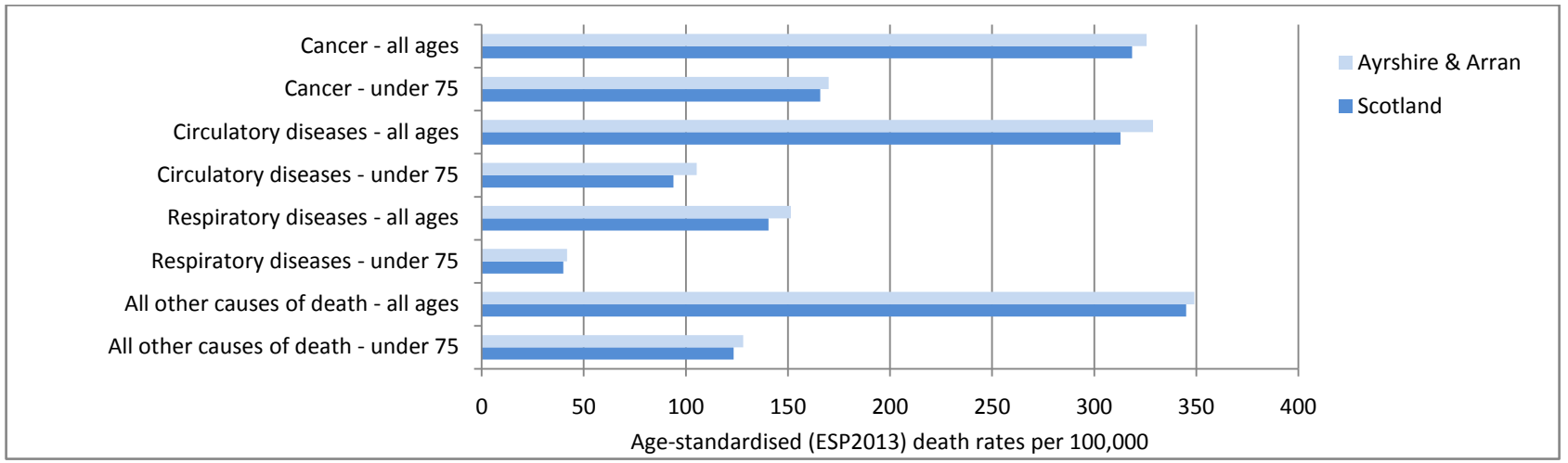


Source: http://www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/vital-events/deaths

Premature mortality

Premature mortality is defined as death from all causes under the age of 75 and it is considered to be an important overall indicator of health in the population. Figure 6 shows that overall mortality rates and premature mortality rates in Ayrshire and Arran are similar to Scotland for all the main causes of death (cancer, circulatory diseases and respiratory diseases). Lifestyle issues such as smoking, drug and alcohol misuse, poor mental wellbeing and obesity all increase the risks for the main causes of mortality.

Figure 6: Premature (under 75s) age-standardised death rates compared to all ages, for cancer, circulatory and respiratory disease, Scotland and NHS Ayrshire & Arran, 2014



Source: http://www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/vital-events/deaths/age-standardised-death-rates-calculated-using-the-esp

Please note - The 'age-standardised' death rates presented here were calculated using the 2013 European Standard Population (ESP2013), and are not directly comparable to rates calculated prior to 2014. Also the data for specific causes of death for the NHS Board should be used with caution, particularly the figures for under 75s, or for areas which have relatively small populations, or for some specific causes of death. This is because, if the underlying numbers of deaths are relatively small, they and the calculated death rates may be affected by relatively large percentage year-to-year fluctuations. More information about this is available from the Fluctuations in, and possible unreliability of death statistics page on the NRS website.

Table 5 shows that for the commonest cause of death in Ayrshire and Arran (cancer), 49 per cent of all mortality is premature, occurring under the age of 75 years. For mortality from circulatory disease and respiratory disease, 31 per cent and 27 per cent respectively is premature.

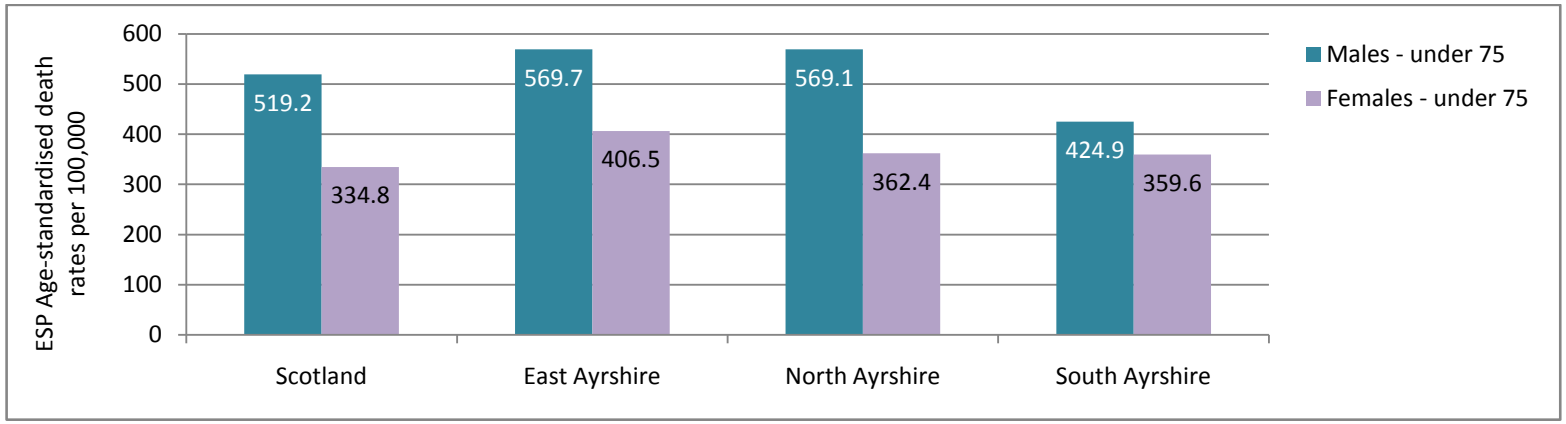
Table 5: Numbers and percentages of deaths from specified causes for NHS Ayrshire & Arran 2014

	All ages	Under 75 years of age	Percentage of premature deaths
Cancer	1273	630	49.5
Circulatory diseases	1239	387	31.2
Respiratory diseases	567	154	27.2
All other causes of death	1303	450	34.5
All causes of death	4382	1621	37.0

Source: http://www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/vital-events/deaths/age-standardised-death-rates-calculated-using-the-esp

Age-standardised death rates adjust the number of deaths for the age profile of the population – you would expect more deaths in an older population. Figure 7 shows that age-standardised death rates are noticeably higher in males compared to females. However women in East Ayrshire have a particularly high age-standardised death rate compared with women in North and South Ayrshire and compared with women in Scotland – this will be investigated further within the Public Health Department.

Figure 7: Age standardised death rates under 75 years (all causes) for males and females in Scotland compared to East, North and South Ayrshire for 2014

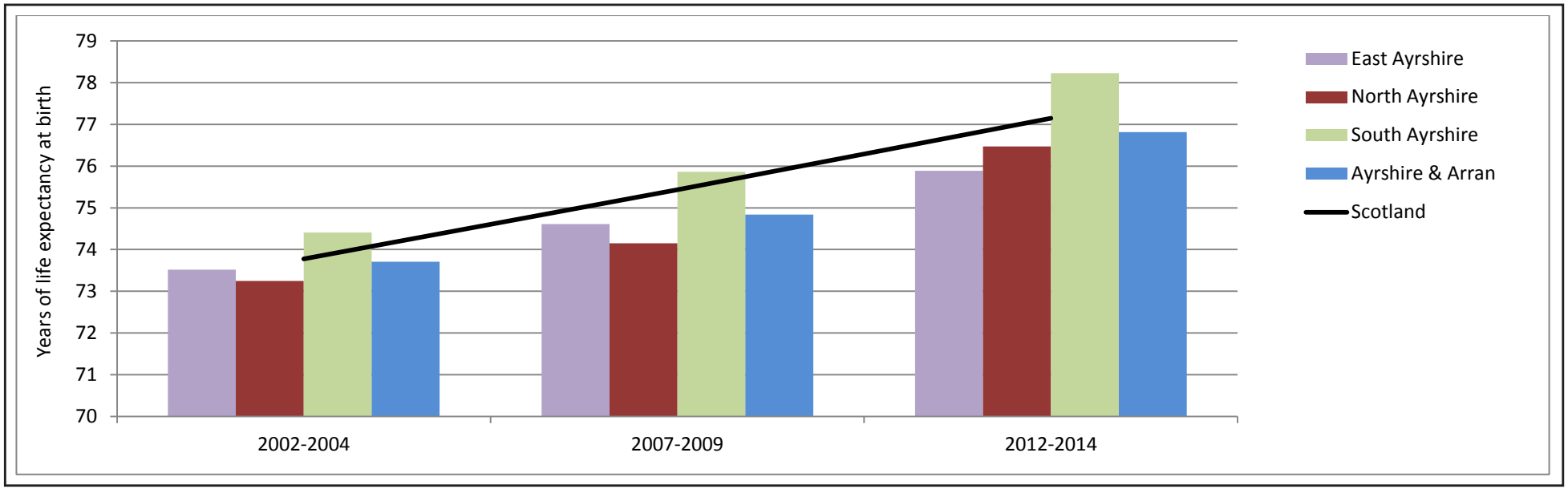


Source: http://www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/vital-events/deaths/age-standardised-death-rates-calculated-using-the-esp

Life expectancy at birth

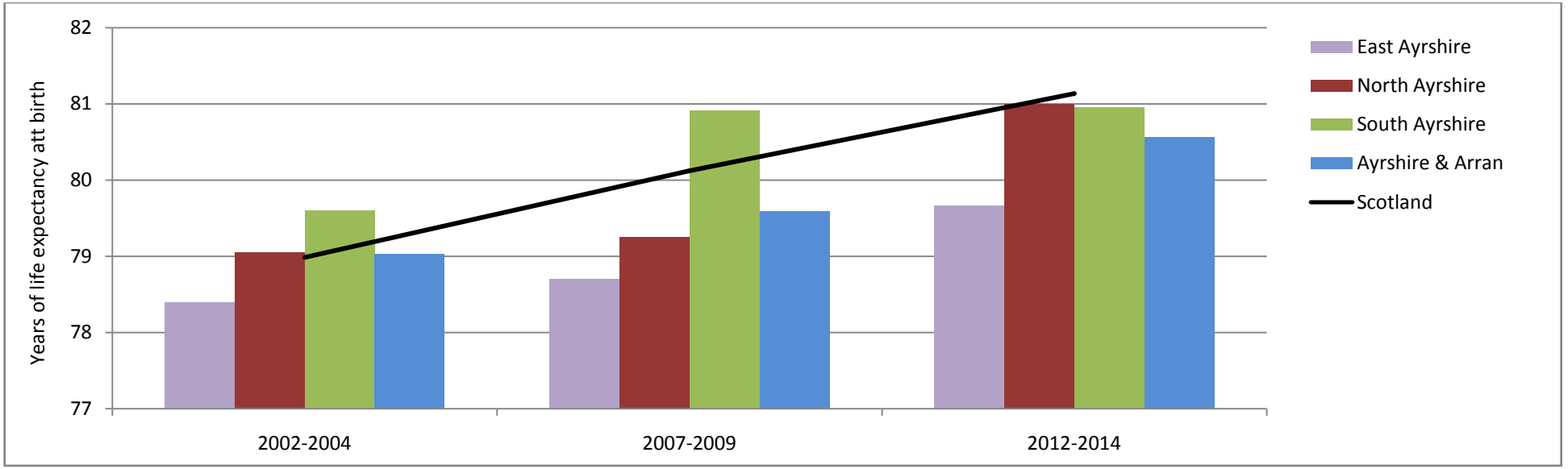
Life expectancy at birth is the mean number of years a baby born today can expect to live if the current age and sex specific mortality rates are applied throughout the baby's life. It should not be used as a predictor of individual length of life but more to compare health across populations and within populations over time. Figures 8 and 9 show that for men and women life expectancy has increased noticeably between 2002-04 and 2012-14 in Ayrshire and Arran, in each Health and Social Care Partnership, and in Scotland. However life expectancy in Ayrshire and Arran still lags behind Scotland and East Ayrshire lags behind North and South Ayrshire for both men and women.

Figure 8: Life expectancy at birth in Scotland, 2002-04 to 2012-14, by East, North and South Ayrshire councils and NHS Ayrshire & Arran (males)



Source: http://www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/life-expectancy

Figure 9: Life expectancy at birth in Scotland, 2002-04 to 2012-14, by East, North and South Ayrshire councils and NHS Ayrshire & Arran (females)

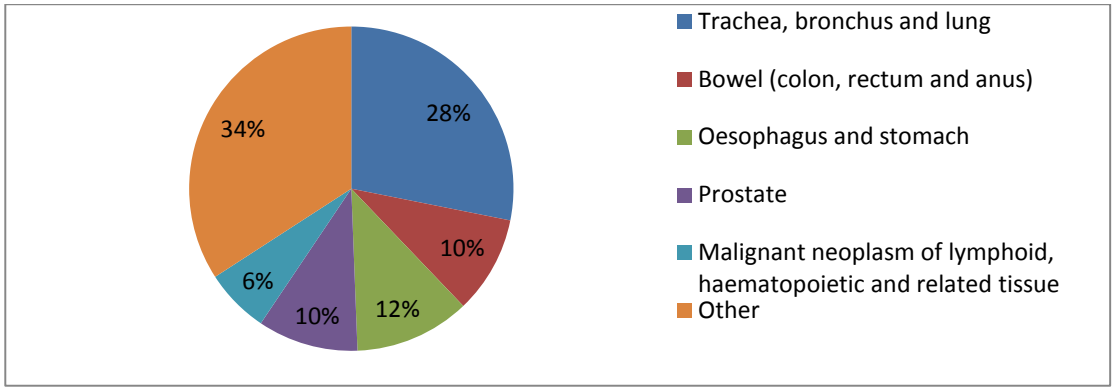


Source: http://www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/life-expectancy

Cancer

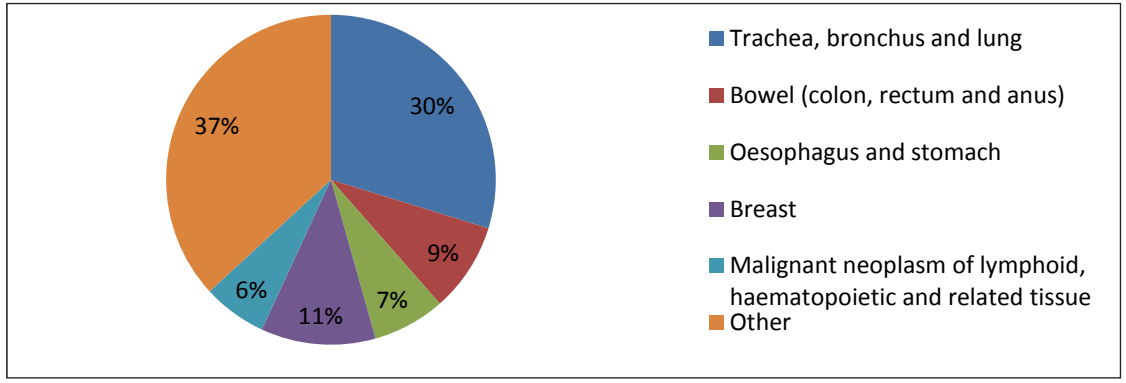
The types of cancer with the largest numbers of deaths in Ayrshire and Arran in 2014 included cancers of the trachea, bronchus and lung (368 deaths), bowel cancer (118 deaths), cancers of the oesophagus and stomach (120 deaths), breast cancer (68 deaths), prostate cancer (67 deaths) and cancers of the lymphoid haematopoietic and related tissue (81 deaths). More detail on the main types of cancer deaths in males and females in Ayrshire and Arran are provided in Figure 10 and 11.

Figure 10: Male cancer deaths in Ayrshire and Arran, 2014



Among males, the largest single cause of cancer in Ayrshire and Arran is of the trachea, bronchus and lung accounting for over a quarter of all cancer deaths in 2014. Cancer of the oesophagus and stomach is the second most common type of cancer death in men (Figure 10).

Figure 11: Female cancer deaths in Ayrshire and Arran, 2014



Among females the largest single cause of cancer in Ayrshire and Arran is of the trachea, bronchus and lung accounting for almost a third of all cancer deaths in 2014. Cancer of the breast was the second most common single cause of cancer deaths in women (Figure 11).

Source: http://www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/vital-events/general-publications/vital-events-reference-tables/2014/section-6-deaths-causes

Chapter 2 • Update on Priority Areas of Work from previous Director of Public Health (DPH) Report

Update on Alcohol

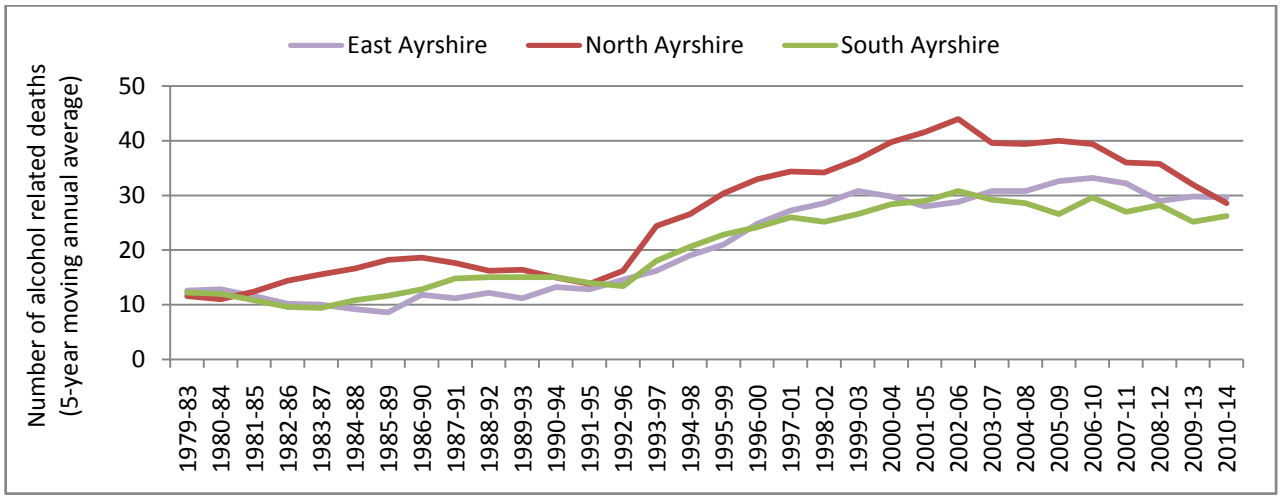
Overview

Alcohol continues to cause significant harm to people across Scotland. On average 22 people in Scotland die every week from alcohol related causes[1]. The Scottish Health Survey report for 2014 noted that there has been little change in consumption of alcohol across the population[2]. 41 per cent of men reported drinking more than the recommended 3-4 units on their heaviest drinking day in the past week, a reduction from 45 per cent in 2003. A third (33 per cent) of women drank more than their recommended 2-3 daily units, down from 37 per cent in 2003. Therefore the 2013 and 2014 figures are not significantly different.

Alcohol related deaths

Since the last DPH report was produced for 2013/14, there has been a continuation of a downward trend in alcohol-related deaths across Scotland. Analysis at national level has found that most of the increase and then gradual decline in deaths, affected men living in the most deprived areas of Scotland[1]. The pattern of increasing death rates followed by a gradual fall is also seen across East, North and South Ayrshire (Figure 12). While encouraging, it is worth noting that the number of alcohol related deaths reported remains significantly higher than reported in the early 1980's across both Scotland and Ayrshire[1].

Figure 12: Alcohol-related deaths East, North and South Ayrshire, 1979-83 to 2010-14



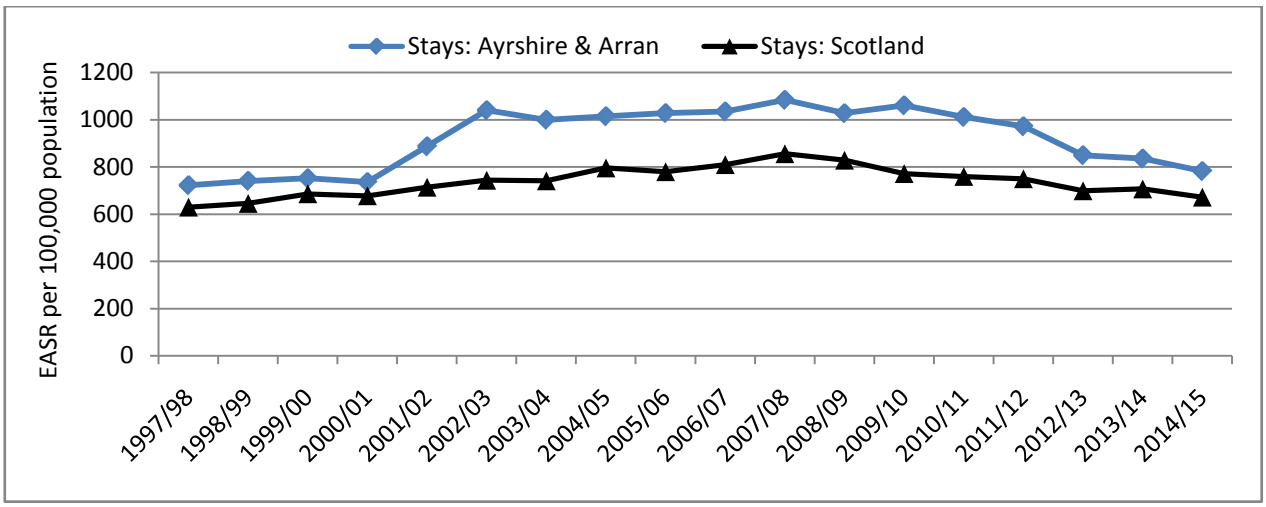
Source: http://www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/vital-events/deaths/alcohol-related-deaths

Hospitalisation rates because of alcohol

Standardised admission rates for alcohol related hospital admissions show a similar pattern in Ayrshire to the rest of Scotland. Although hospitalisation rates have declined since 2008/09, the rate of decline has slowed in recent years. Alcohol admission rates have remained higher in Ayrshire in comparison to Scotland as a whole.

Across Scotland in 2014/15, alcohol-related stays in general hospitals were nearly eight times more frequent for individuals living in the most deprived areas compared to the least deprived areas[1].

Figure 13: Alcohol related General Acute hospital stays (SMR01) for NHS Ayrshire & Arran; 1997/98 to 2014/15

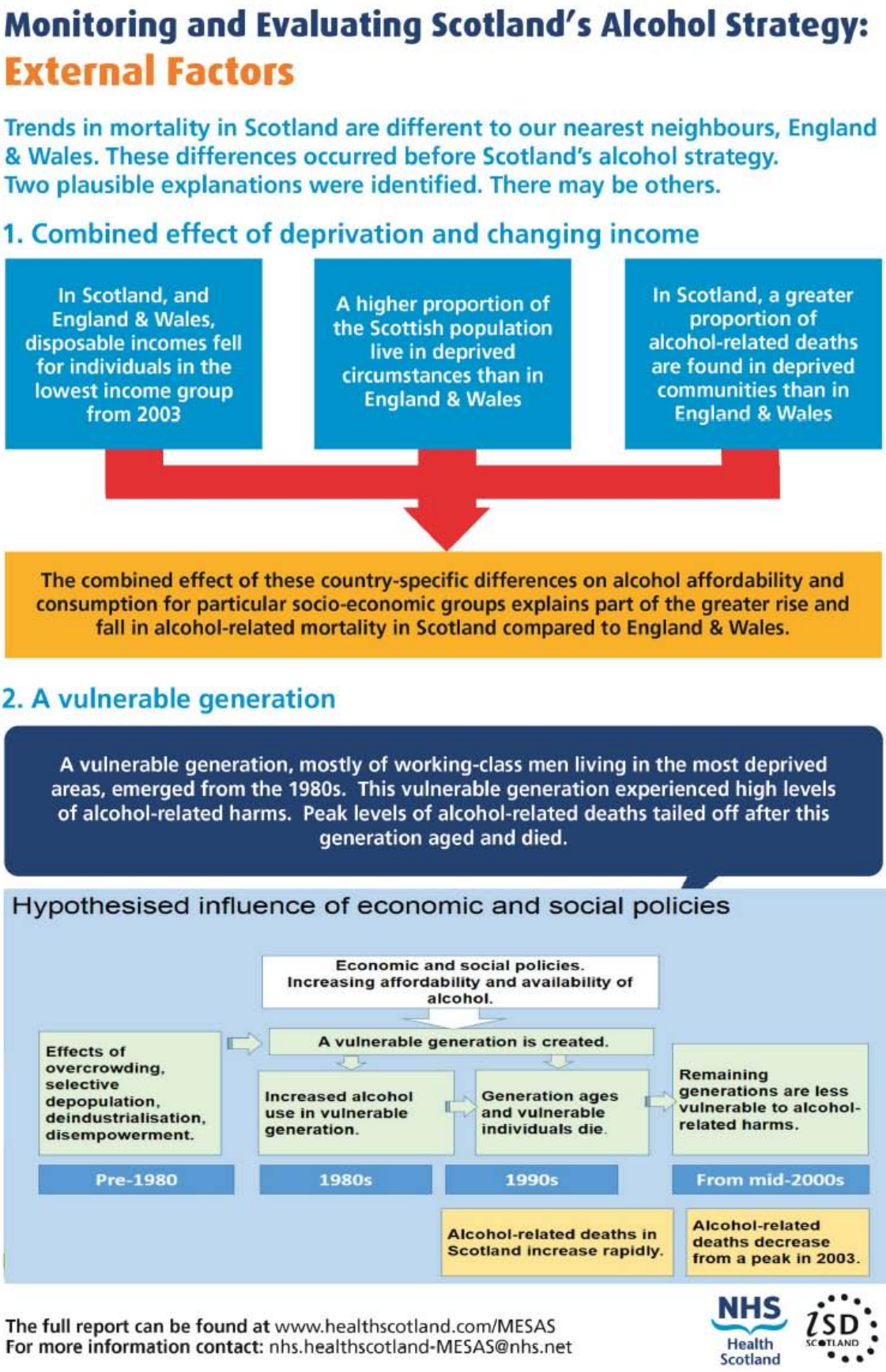


Source: https://www.isdscotland.org/Health-Topics/Drugs-and-Alcohol-Misuse/Publications/2015-10-13/2015-10-13-ARHS2014-15-Report.pdf

Learning from national analysis

The recently published report "Monitoring and Evaluating Scotland's Alcohol strategy", considered the likely impact of Scotland's strategic approach to alcohol[1]. Most of the data on trends in alcohol mortality and hospitalisation rates pre-date implementation of the above strategy. Therefore in the strategy, possible external factors were reviewed, which could explain the rise and fall in mortality rates in recent years, leading to the conclusions contained in the following extract:

"Two factors external to the strategy were considered to have made a contribution to the mortality trends: falling disposable income (and hence alcohol affordability) for people living in the most deprived areas, and a vulnerable cohort responsible for a wave of alcohol-related mortality, that increased in the 1990s and decreased from the mid-2000s as the cohort aged and died."



The report recommends that Scottish Government should continue to focus efforts on implementing evidence based interventions to reduce alcohol related harm. Among the most important factors are those influencing price, availability and exposure to marketing.

Key points

- there has been little evidence of change in the drinking patterns among the wider population in recent years
- although there has been a downward trend in alcohol related deaths and hospitalisations since around 2008/9, both remain significantly higher than they were in the 1980's
- at national level, Scottish Government has announced that there will be a refresh of the national alcohol strategy
- minimum Unit pricing has not yet been implemented. This has significant potential to reduce alcohol consumption, particularly amongst those who drink most heavily

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References

1. Monitoring and Evaluating Scotland's Alcohol Strategy Final Report. NHS Health Scotland. Published March 2016.http://www.healthscotland.com/scotlands-health/evaluation/planning/MESAS/Publications.aspx
2. The Scottish Health Survey 2014: Vol 1. National Statistics Publication. http://www.gov.scot/Topics/Statistics/Browse/Health/scottish-health-survey

Update on Tobacco

In line with the recommendations contained in the previous DPH Report in 2013/14, work on tobacco control has been progressing in partnership across a number of agencies, including the NHS, Local Authorities, Health and Social Care Partnerships, Fire and Police Services. A report on the 2012-2015 Tobacco Control Action Plan is now available http://athena/publichealth/Documents/201215TCS Full Report and Action Plan 201518.pdf

An example of this partnership working is an event which took place in North Ayrshire when one of the Fresh Air-shire team spent time providing smoking related advice and support to young people in the area. They worked alongside Police, Trading Standards and Youth Workers. The aim was to weave the health message into initiatives to address the use of illicit cigarettes and cigarettes being purchased by or for those under 18. This initiative received a very positive response from partners.

Members of the Tobacco Control Strategy Group have contributed to consultations on tobacco control related issues e.g. smoking in cars containing children. In this way we have endeavoured to influence national policy and legislation.

Health and Social Care Partnerships offer an opportunity for both health and social care staff to raise the issue of smoking and signpost people to appropriate services, and we are currently working with the partnerships to ensure that they have the correct training and resources to allow them to take this forward.

Within the three main aspects of the strategy: prevention, cessation and protection, a great deal of work has been progressing. In respect to preventing children and young people from taking up smoking, we have introduced a programme called “Assist” which involves training students to be peer supporters within schools. In respect to cessation, we continue to offer clinics in primary care, communities, prison, hospitals, and in some pharmacies, always seeking to target these services to areas of greatest need. A significant amount of work has also been undertaken within maternity services to reduce the number of pregnant women who smoke. Finally in respect to protection, the NHS smoke-free grounds policy has now been in place for a year and compliance has been generally good.

Work at both local and national levels requires to continue at pace, if we are to reach the agreed target of less than 5 per cent prevalence by 2034.

Key points:

- work on tobacco control has been progressing in partnership across a number of agencies
- a significant amount of work has been undertaken within maternity services to reduce the number of pregnant women who smoke
- the NHS smoke-free grounds policy has been in place since 2015 and compliance has been good
- the ambition across Scotland is to reduce smoking prevalence to less than 5 per cent by 2034

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Update on Healthy Weight

In line with the recommendations contained in the previous DPH Report in 2013/14, an Ayrshire Healthy Weight Strategy has been developed by representatives from NHS Ayrshire & Arran, the three local authorities and the North Ayrshire Public Partnership Forum. The vision for the Healthy Weight strategy is to achieve 'the healthiest weight possible for everyone in Ayrshire and Arran'. Its aim is to halt the rise in the levels of overweight and obesity among children and adults by 2024, and ultimately reduce them.

The strategy has been developed in two phases. The first phase has focused on obesity and the second on addressing issues related to underweight. It is a 10 year strategy with an initial three year action plan. Over the first three years, actions contained in the action plan focus on those where the NHS and local authorities have direct control.

2015/16 was the second year of the initial three year action plan. During the year, good progress has been made on actions such as:

- local authorities are providing incentive schemes for children and young people through cashless school meals systems; for adults as part of exercise on referral programmes; and for older people as part of the Invigor8 falls prevention programme
- training is available to staff in a range of settings on food for good health and physical activity
- information on healthy eating and physical activity for parents is provided on the CARIS (Childcare and Recreation Information Service) website
- there are now over 100 premises signed up to the 'Breastfeed Happily Here' scheme demonstrating their support to women who wish to breastfeed while visiting the respective businesses
- the National Healthy Living Award has been implemented in the majority of community planning partner's workplaces, where appropriate. Over 100 local convenience stores are taking part in the Scottish Grocer's Federation Healthy Living programme

- cycling action plans are being implemented in each area and the development of an Active Travel Strategy is being developed by Ayrshire Roads Alliance
- child and adult weight management programmes continue to be delivered throughout Ayrshire
- the JumpStart Choices, school based healthy living programme, was delivered to over 1500 school pupils during 2015/16.

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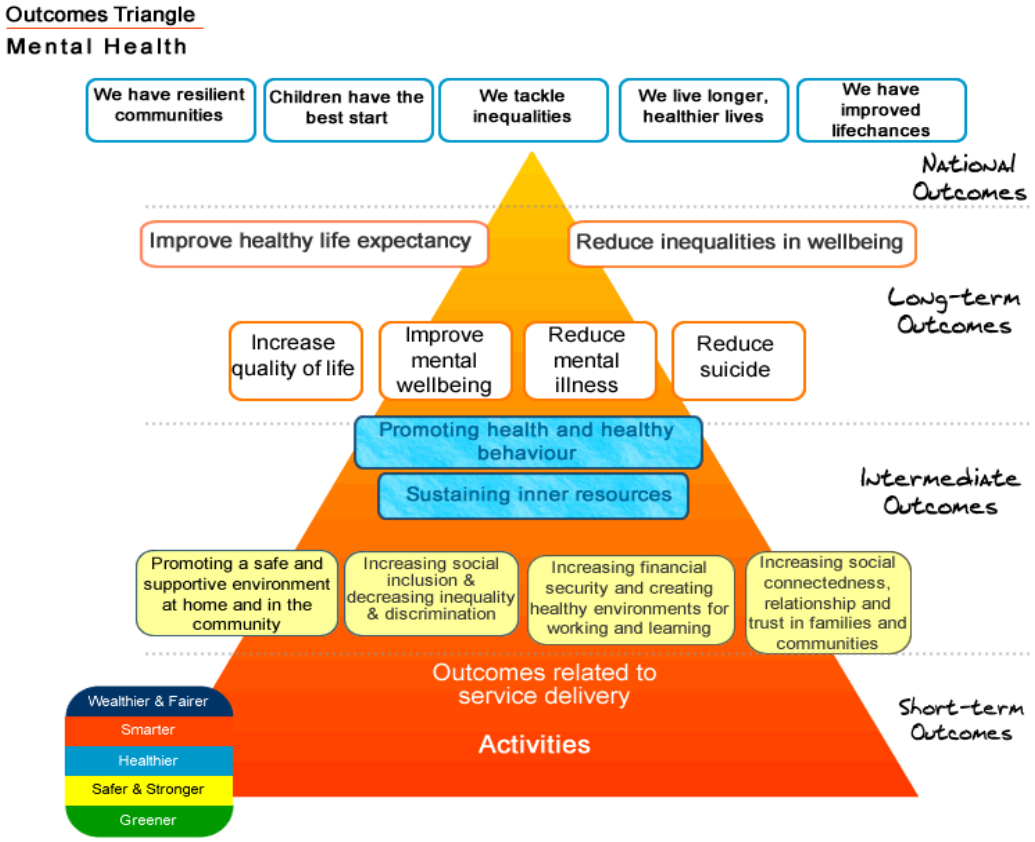
Update on Population Mental Health

The Mental Health and Wellbeing Strategy for Ayrshire and Arran 2015-2027 (Mental Health and Wellbeing Strategy 2015-27) recognises that decreasing social isolation, developing and nurturing inner resources and having a sense of meaning and purpose are all fundamental to sustaining good mental health.

NHS Health Scotland has described how all this fits together (Figure 14, below). The strategy focuses on the achievement of the intermediate outcomes (six boxes in the lower section of the triangle).

Figure 14



One route to addressing some of these issues is to increase community connections and activity. The mental health strategy has an underpinning, evidence-based outcomes framework, which, along with research from other areas, such as Go Well gave confidence that this approach merited exploration. This framework also underpins the rationale for the Theory of Change that supports the asset-based approach to community development that is described in the next chapter. Working together, Community Planning partners developed a proposal which was submitted successfully to NHS endowments funds.

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The following five chapters relate to Health Improvement.

Chapter 3 An asset-based approach to community development: AHEAD project

The factors which influence health and wellbeing largely sit outwith the traditional remit of the health system. Asset-based approaches demand partnership working so that contributing circumstances such as education, living and working conditions, and the wider environment can be influenced. Thus it is crucial that this work is clearly positioned within Community Planning Partnerships and the developing health and social care agenda.

Working in an asset based approach allows communities (and communities of interest) to:

- Identify what their priorities are for action and control the development of that activity
- Work together, to get to know each other and to understand each other better. This leads to an increase in social cohesion and a reduction in social isolation. It is generally well known that there is a significant risk of increased morbidity amongst isolated people, particularly elderly people, and communities working together can contribute to reducing isolation

This approach has been identified as creating and developing "health assets" which are the resources that individuals, groups, communities and populations have (for example, knowledge, skills and capacities), which can be harnessed in the ways described above to protect against the consequences of life and used to promote health and wellbeing. These assets exist at individual level (e.g. resilience) as well as at community level (e.g. social, economic and environmental factors that influence health and wellbeing).

There is growing evidence which confirms the contribution the asset based approach has to improving health and wellbeing both at individual level and community level[1]

So, with funding from NHS Endowment Funds, community planning partners in Ayrshire and Arran have embarked on a four year programme (until March 2018) to implement asset based approaches to improving health and wellbeing. Such an approach is consistent with both the national social policy context and the strategic priorities of local Community Planning Partners and the NHS Board.

Work started in April 2014 with the employment of (initially) four Community Builders (now seven part-time Community Builders). Working with partners, areas for activity were identified in North and South Ayrshire: Dalmilling,

Wallacetown and Lochside in South Ayrshire and Fullarton, Harbourside and Castlepark in North Ayrshire. East Ayrshire, as part of the Vibrant Communities approach, has an allocation from the AHEAD (AyrsHirE Asset Development) funding stream to facilitate capacity development in asset-based working.

The role of the Community Builders is to identify individual community connectors who are residents within the local areas and who know the communities well. The community connectors help engage people and identify what assets can be used in their communities.

Partners are supporting the implementation of this programme. The programme is led by the Department of Public Health; operational management of the Community Builders and their associated activity is the responsibility of the respective Local Authority. A third sector organisation (Access to Employment) is the employing organisation for the staff. Learning from the initiative, combined with an evaluation, has been commissioned and Social Marketing Gateway is undertaking that work. The Glasgow Centre for Population Health provides an advisory role and Scottish Government (which part funds the evaluation) is a key source of support. An "end of first year" report has been produced. (Learning from the AHEAD Project in Ayrshire Report).

Asset based work in the various communities is going well. The Community Builders (CBs) are becoming well established in their environments and are being accepted as part of the fabric of the community. It has taken time for the CBs to be accepted and the pace is inevitably slow as local communities develop trust with the CBs. The CBs provide monthly updates about activity, which is varied, ranging from sports based activity, to garden maintenance, to sprucing up the local area, to the creation of community gardens to arts and crafts based activity. All age groups are engaged.

There are also a number of organised events where the CBs link with other professionals in the area, or where they host a community "asset mapping" session. The CBs are working with a wide range of agencies: libraries, schools, Department of Work and Pensions, faith communities, parks/leisure, community safety, community learning and development and many third sector agencies.

One of the most important pieces of learning that has been identified by the evaluation team thus far and shared with those working in AHEAD is that this work can only go at the pace that it takes to build trust. It simply cannot be rushed; trying to force the pace results in initiatives that are CB led, not community led, and which may lack community commitment. These initiatives are not so successful.

At the half-way point in the work, much has been achieved in relation to the short-term outcomes in the Theory of Change. However, at this point, some work needs to be progressed to consider how the Health & Social Care Partnerships (HSCPs) can tap into this approach. The models of delivery are very different and further exploration is needed to find ways to reduce the gap between the approaches.

At the same time, many new posts are being created within the HSCPs that work in a similar way to the CBs, so there is hope that there is potential for future developments.

Key Points and Recommendations

- public sector agencies could further explore the potential to adopt asset based approaches in localities to help the move towards more co-produced services in communities

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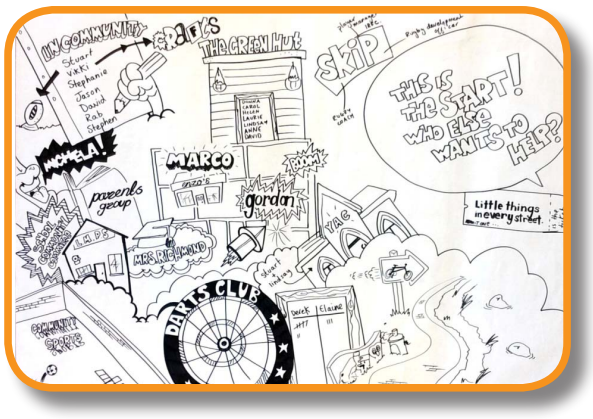

An asset map made with local artist Tragic O'Hara, Cormac Russell and a few residents – discussing who makes a good life for kids in Fullarton.

Coast watch annual beach clean organised by a local community group.

Chapter 4 Health Issues in the Community

Introduction

Health Issues in the Community (HIIC), is a training programme aimed at increasing community capacity and community participation, whilst establishing and consolidating community development approaches to tackling inequalities in health. The programme was developed in partnership between Health Scotland and the Community Health Exchange (CHEX) and is split into two parts: – Health and Society and Ideas into Action. HIIC aims to raise awareness and increase understanding of the social model of health; health inequalities, and how community development approaches can help reduce these inequalities.

Activity

In collaboration with South Ayrshire Council's Community Learning and Development team, a Health Issues in the Community course was delivered for the first time within a secondary school setting in Ayrshire and Arran. The programme was offered to Girvan Academy in response to the school's desire to enhance subject options available to senior pupils as the school looks to promote wider achievement. A request for contributions from partners was sent out through the South Carrick Learning Community Partnership (LCP), at which NHS Ayrshire & Arran is represented by a Health Improvement Officer.

The delivery of the HIIC course at Girvan Academy was included within the South Carrick LCP's improvement plan. These plans are aligned to South Ayrshire's Single Outcome Agreement, with this work incorporated under the 'Supporting our Children and Families' priority. The intermediate outcome of this priority is 'more children and young people are successful learners and achieve more widely'. The course is also closely linked to Curriculum for Excellence, and has been mapped to the relevant experiences and outcomes of the health and wellbeing, social studies and languages curriculum areas.

Ahead of the course, a presentation was delivered at the senior-school assembly before interested pupils were invited to take part in a taster session to gain further insight into the content of HIIC. From this, five pupils elected to participate in the course.

The Part 1 course – Health and Society – comprises eight units:

- What Health Means to Me
- Different Ways of Thinking about Health
- Poverty, Inequality and Health

- Different Experiences, Common Problems
- Power and Participation
- Community Development and Health
- The Group Project
- Reflection and Review of Learning

The units are delivered using a variety of different learning methods with the aim of developing the participants' understanding of the range of factors that affect their health as an individual and the health of their community, before exploring how these issues can be tackled through community development approaches.

The course is accredited at SCQF Level 6, and all five pupils put themselves forward for accreditation as they were keen to add to their portfolio of qualifications with a view to their post-school options. To achieve this, pupils were required to complete learning logs for each unit, a written assignment, and full participation in the group project. The group presented their project to the school's senior management team and community learning and development staff, demonstrating what they had learned and how they could use that knowledge to influence key health issues within their community. At the time of writing, all four portfolios that were submitted and marked have passed, with the final portfolio still to be assessed.

As part of their submission for accreditation, pupils are required to complete a self-evaluation. All five pupils reported that following their participation they:

- had a better understanding of the health issues that affect their community
- felt more able to influence factors affecting their health

One pupil also made note of how much more confident they were following their participation, particularly in relation to the group project, whilst another commented how much they enjoyed the different style of learning – remarking that it allowed them to contribute their ideas effectively.

Feedback from Girvan Academy supported the pupils' comments, stating that they found the content and relaxed learning style interesting and enjoyable. The staff member also remarked how impressed both they and their colleagues were at the group's presentations, which formed part of the pupil's portfolios. Following the success of this course, Girvan Academy has requested a further delivery in the 2016/17 school session.

Some quotes from participants

> *"I loved every moment of the class and wouldn't hesitate to recommend it - I already have several times. I learned more than I expected to and it has changed my perception of my community and those within it, for the better."* ***Pupil 1***

> *"I really enjoyed the HIIC course it helped me gain my unconditional for college as I put it into my personal statement. I would highly recommend the course to future students as it's an easy structure to follow with interesting topics."* ***Pupil 2***

Key Points

Health Issues in the Community is a training course that equips participants with knowledge of the social model of health, health inequalities, power and participation and community development approaches to health.

- the course was delivered within a secondary school in Ayrshire and Arran for the first time and all five participants have submitted portfolios for accreditation. Four pupils have received a pass at SCQF Level 6, with one portfolio still to be assessed
- there was a self-reported increase in the participant's knowledge and understanding, as well as some of the group noting that their confidence had also increased
- the pupils responded to the content and style of learning very well, whilst the delivery would not have been possible without the collaborative working between Health Improvement, Community Learning and Development and Girvan Academy
- Girvan Academy has requested the programme is delivered again in the next school session and it has been agreed that South Ayrshire's Community Learning and Development team will lead this delivery with support from Health Improvement.

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Chapter 5 Gender Based Violence

The term "Gender Based Violence" (GBV) is an umbrella term which includes, but is not limited to, domestic abuse, rape and sexual assault, childhood sexual abuse, sexual harassment, stalking, commercial sexual exploitation, female genital mutilation, forced marriage and so-called 'honour' crimes.

The term is unfamiliar to many people. 'Gender' refers to the attitudes and behaviour that society expects of men and women. Despite great progress, many inequalities still exist between the sexes. A fundamental inequality is the level of fear and harm experienced mainly by women and perpetrated mainly by men. The United Nations defines gender-based violence as:

violence that is directed against a woman because she is a woman, or violence that affects women disproportionately. It includes acts that inflict physical, mental or sexual harm or suffering, threats of such acts, coercion and other deprivations of liberty[1].

Using this term also helps to make the connections between the different forms of abuse, particularly since many women experience more than one type of violence.

Domestic abuse affects between 1 in 3 and 1 in 5 women over the course of their lives (although not all women are equally at risk).[1]

In 2014-15, there were 59,882 incidents of domestic abuse recorded by the police in Scotland, an increase of 2.5 per cent from 2013-14. Incidents of domestic abuse recorded by the police in Scotland with a female victim and a male perpetrator represented 79 per cent of all incidents of domestic abuse in 2014-15, where gender information was recorded. The 26-30 years old age group has the highest incident rate per 100,000 population for both victims (2,615 incidents recorded per 100,000 population) and perpetrators (2,766 incidents recorded per 100,000 population)[2].

What is domestic abuse?

Domestic abuse is abuse perpetrated by partners or ex-partners and it can include physical abuse (assault and physical attack involving a range of behaviours), sexual abuse (acts which degrade and humiliate and are perpetrated against the victim's will, including rape) and mental and emotional abuse (such as threats, verbal abuse, withholding money and other types of controlling behaviour such as isolation from family and friends). It is characterised by a pattern of coercive control which escalates in frequency and severity over time. It can be actual or threatened violence

and can happen occasionally or often. It can begin at any time, in new relationships and after many years. Pregnancy is often a trigger point.

Causes of domestic abuse

Many people believe that domestic abuse is caused by poverty, alcohol misuse or witnessing abuse as a child. Although each of these can be contributing factors, they are not the sole or primary causes of domestic abuse. Domestic abuse occurs in every social class and across boundaries of age, ethnicity, disability and religion. Alcohol is involved in about half the incidents of domestic abuse[3].

Who is at risk of gender-based violence?

Being female is the key risk factor for gender-based violence[4]. While no woman is immune from it, not all women are equally at risk. Factors such as age, financial dependence, poverty, disability, homelessness, and insecure immigration status can heighten women's vulnerability to abuse or entrap them further in it. Young women are at high risk of all forms of abuse, yet often this can be overlooked or minimised, particularly in their teenage years.

Whilst men are at much less risk from gender-based violence, some men are abused in similar ways by other men and, sometimes, by women.

Impact of abuse

The NHS spends more time dealing with the impact of abuse against women than almost any other agency. Physical and sexual abuse have direct health consequences and are risk factors for a wide range of long-term health problems.

More women suffer rape or attempted rape than have a stroke each year, and the level of domestic abuse in the population exceeds that of diabetes by many times[5]

Policy Context

"Equally Safe, Scotland's strategy for Preventing Violence Against Women and Girls"[6] was refreshed in February 2016. It provides a framework and standard for policy, interventions, and service design in Scotland. The overall aim of the strategy is to prevent and eradicate violence against women and girls, creating a strong and flourishing Scotland where all individuals are equally safe and respected and where women and girls live free from such abuse - and the attitudes that help perpetuate it.

Routine Enquiry

Within the context outlined above and given the prevalence of abuse, its adverse health impacts and the reluctance of survivors to disclose without direct questioning because of the stigma surrounding abuse, the NHS has been asked to undertake Routine Enquiry (RE).

RE is *"asking direct questions in relation to abuse of a specified population group when they present to a service. This can be at a particular point in their use of a service, or on all occasions at which they present. It does not matter whether there are any signs or indications of abuse"*[7].

The aim of RE is to support diagnosis and assessment of patients to ensure early, appropriate intervention and care. A disclosure of abuse also means that the therapeutic intervention will be more meaningful and will be specific for that individual.

RE of domestic abuse is applicable to all women accessing particular services (and men in some services). Research suggests that RE by trained staff during pregnancy can increase disclosures by three-fold and that the act of disclosure can reduce children's experience of violence and lessen its impact[8].

Activity

There are three active Violence Against Women (VaW) Partnerships in Ayrshire, all of which report to the Community Safety strand of the respective Community Planning Partnership. There is also a multi-agency group, which sits within the South West Scotland Community Justice Authority. NHS Ayrshire & Arran also has an internal steering group, principally to progress RE, but it also addresses other forms of violence against women and ensures that NHS A&A fulfils its role in this regard as an employer. The three VaW partnerships are represented on this group and there is close partnership working.

There is a three year action plan for GBV which specifically identifies activity that the NHS needs to undertake: this ranges from capacity building for front-line staff, to data and intelligence gathering, developing guidance for NHS staff on issues such as human trafficking or female genital mutilation (FGM) to working with education on issues such as healthy relationships and FGM.

Key points and Recommendations

- gender based violence continues to be a significant issue in the lives of many women in Ayrshire
- the impact on victim's physical and mental health is considerable and can have life-long consequences
- many front-line NHS staff are routinely asking about people's experience of abuse with a view to providing more appropriate support and therapeutic interventions
- partnership working is essential to progress all four strands of Equally Safe, the Scottish strategy for gender-based violence.
- as the NHS deals with the impact of abuse more than any other agency, NHS staff should continue to implement and roll-out Routine Enquiry of abuse and respond appropriately to disclosures of abuse
- the three Violence Against Women partnerships in Ayrshire, alongside the NHS, should further develop close working relationships to progress Equally Safe in Ayrshire

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Chapter 6 Health in the Workplace

Introduction

It is well recognised and documented that being in good employment is good for employees' health and mental wellbeing. The workplace is also an ideal setting to reach a wide range of people who may not usually be accessible through the normal healthcare routes, for example, men who don't routinely access health services. People from various backgrounds with a range of health needs can be found in workplaces across Ayrshire and Arran and the Healthy Working Lives agenda aims to support people of working age to live healthier, more productive and more content lives.

Policy context

The importance of being in 'good' employment is also highlighted within the "Marmot Review of Health Inequalities (2010)". The need for employers to provide a working environment that helps to promote and protect their employees' physical health, safety and psychological wellbeing is key to motivating and retaining their workforce. This can be achieved through the following examples; ensuring employees receive a living wage, employees feeling that they have control over aspects of decision making relating to their employment, working within a safe and protective environment and employees being supported during times of sickness or ill health.

NHS Health Scotland's "Good Work for All" (2015) briefing paper also discusses the importance of 'good' work which helps in reducing health inequalities within the local population and wider community through social and financial benefits. In tackling the widening gap between individuals with the best and worst health, it is crucial that employers ensure their workforce have equal access to policies and practices that support good health, therefore ensuring all benefit from 'good' work. The Healthy Working Lives Team support employers in developing and implementing a range of workplace policies and procedures to ensure the health, safety and wellbeing of employees.

Activity

NHS Ayrshire & Arran's Workplace Team provides free and confidential advice to employers of local companies and businesses and is responsible for delivering the Healthy Working Lives Award programme. The principal purpose of Healthy Working Lives is to work with employers to help them to better protect and promote the health, safety and wellbeing of their employees. These deliver positive business outcomes for employers and

for the economy as a whole, and maximise the contribution of employers to tackling inequality and improving the health and wellbeing of the local population.

There are three levels to Healthy Working Lives awards programme - Bronze, Silver and Gold: with each level offering particular challenges to participating organisations. The Award Programme supports employers and employees to develop health promotion and safety themes in the workplace in a practical, logical way that is beneficial to all.

In 2016, across Ayrshire and Arran, more than 63 companies and businesses are involved with the Healthy Working Lives programme. 35 workplaces within Ayrshire have achieved a Healthy Working Lives Award at either Bronze, Silver or Gold level, with a further 28 registered workplaces currently working towards the Bronze award. This has resulted in over 40,000 employees working in safer and healthier workplaces. For NHS Boards, the Chief Executive's Letter CEL 01 (2012) states that Boards should continue to work to attain Healthy Working Lives Awards for all acute services, working towards the Gold Award. The local Workplace Team is currently supporting NHS Ayrshire & Arran to progress through the Healthy Working Lives award programme.

Photograph of Healthy Working Lives Award winners - 2015/16:

Left to right

Amy Govan (VOCA); Joanne Hanley (VOCA); Jan McCulloch (Barns Medical Practice); Aileen Emerson (Belmont Academy); Jane McKie (East Ayrshire Council); and David Doran (East Ayrshire Council).

The Workplace Team also provide a wide range of training opportunities to workplace managers and their employees to raise their knowledge and skills in topics such as mental health and wellbeing in the workplace, drugs and alcohol policy support for workplaces, supporting staff attendance and risk assessment. In 2015/16, the Workplace Team provided training to 108 employers (242 employees) in Ayrshire and Arran.

The Workplace Team works with local Ayrshire and Arran partners including the Chamber of Commerce, Business Gateway and The Ayrshire Hospice. These joint partnerships contribute to the important work of closing the health inequality gap for the local workforce within the local population.

Key points and Recommendations

- Ayrshire and Arran employers are aware of the range of support, advice and services offered by the Healthy Working Lives Team; 809 Ayrshire and Arran employers have accessed services in 2015/16
- within Ayrshire, 35 workplaces currently have a Healthy Working Lives Award at either Bronze, Silver or Gold level, covering over 40,000 employees across Ayrshire and Arran
- supporting the reduction of health inequalities in the local workforce population through improved and supportive working conditions, environment and culture. For example in 2015/16 three local employers were supported in undertaking stress risk assessments
- improving the healthy life expectancy of the local workforce population through education, training and awareness raising campaigns; with 242 employees trained in 2015/16
- support in developing policies and practices to protect and improve the physical, emotional and mental health and wellbeing of the local workforce population. 24 policies were supported and reviewed in 2015/16
- contributing to positive long-term employer and employee behaviour changes, creating a healthier and safer and more productive workforce through a structured and supportive framework adaptable to an employer's needs
- the Healthy Working Lives Team should continue to facilitate capacity building within Ayrshire and Arran workplaces to increase their health improvement knowledge and activity via a suite of nationally developed training opportunities

Logic Model - Logic Model link – http://www.healthscotland.com/uploads/documents/21378-HWLStrategicLogicModel.pdf

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Chapter 7 Health Promoting Care Homes

Scotland has an ageing population, with the number of over 75's set to increase by over 25 per cent in the next 10 years[1]. Healthy ageing is of great importance whether living at home or in a care home setting. "Scottish Government, Reshaping Care for Older People - A Programme for Change 2011-2021"[2] states that:

"Older people in Scotland are valued as an asset, their voices are heard and older people are supported to enjoy full and positive lives in their own home or in a homely setting." [2]

A care home is a place where individuals can reside, either permanently or for a fixed period and have their needs met by trained staff. Care homes are inspected and regulated by the Care Inspectorate to ensure that appropriate standards are being met[3]. One way of demonstrating effective care and health promotion activity within a care home is through use of the Health Promoting Care Home (HPCH) Framework.

The framework was developed by a multi agency partnership group from NHS Ayrshire & Arran, Scottish Care, third sector, care homes and the three local authorities - North, South and East Ayrshire. It was developed to ensure the residents and their families can participate and have greater choice in improving health. Care home managers identify a HPCH Co-ordinator who co-ordinates all the health promoting activity within the care home and will be the key contact with partner organisations. Action plans are created to build on good practice and identify gaps relating to health promoting activity within care homes. A toolkit was developed to accompany the framework containing relevant information, contacts and support.

Care Homes are guided through the use of the framework by NHS Ayrshire & Arran's Health Improvement staff. The HPCH co-ordinators are invited to quarterly learning forums with an input from a range of organisations and this allows the opportunity to share knowledge and practice. The HPCH co-ordinators provide valuable feedback on topics they would like to see included in future forums.

The framework developed using a multi-agency approach and aims to provide a structure from which health promotion activity can be directed. The objectives are to:

- build on good practice and identify areas for development in relation to health
- highlight areas where successful health promotion activity has taken place and share this with other service providers

- encourage consideration of health in its widest context.
- help secure the best possible outcomes for people living in care homes
- encourage the involvement of families, residents and carers in health improvement activities
- focus on prevention by recognising the sources of health, not just disease or illness
- promotes the importance of staff health and wellbeing

A certificate is provided for display to demonstrate the care home is participating in the framework.

Results and Outcomes

- Following a successful six month pilot, the framework was rolled out to care homes across Ayrshire and Arran
- 33 homes are participating in the framework
- Positive anecdotal feedback has been received from care home managers, staff, residents and families

Conclusion

Care homes can use the framework as a tool to identify areas for development, to highlight successful health promotion activity and to share good practice with other service providers. Overall, the HPCH framework supports care homes to evidence the successful work that is happening within their care home, and is used to provide evidence to the Care Inspectorate. Anecdotally, care homes have reflected positively on the impact of the Framework for their residents.

Key points and Recommendations

- healthy ageing is of great importance whether living at home or in a care home setting
- the Health Promoting Care Home Framework provides care homes with structure and direction for health promoting activity
- health improvement staff should raise awareness of the HPCH Framework, linking with partners, carrying out guidance sessions, supporting learning forums and reviewing the toolkit to ensure information remains relevant and up to date

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The following four chapters relate to Health Protection.

Chapter 8 Update on Protecting the Health of the Population

The Public Health etc (Scotland) Act 2008 requires NHS Boards to protect their populations from communicable diseases, contamination or other hazards which constitute a risk to health. The NHS Ayrshire & Arran Health Protection Team (HPT) works collaboratively across the NHS and other statutory and voluntary agencies, to prevent and control communicable diseases and environmental hazards.

The team deals with a wide range of communicable diseases and environmental risks, both in hours and out-of hours. This includes managing outbreaks of disease and other incidents which threaten the health of the public, and responding to individual cases of communicable disease which have wider implications for the community. Preparedness for a range of eventualities is important, so the team participates in exercises to rehearse responses to a range of health threats, including terrorist activity and natural major incidents of various types. The most recent national exercise involved responding to an imported animal case of rabies.

The Health Protection Team receives infectious disease notifications, reports and enquiries from a number of sources including microbiology laboratories, GPs, Environmental Health Officers, schools, care homes, nurseries and hospital wards. The following table provides a summary of the cases notified during 2015-16.

Table 6 - Notifiable diseases and infections within Ayrshire and Arran (1st April 2015-31st March 2016)

Infection/disease notified	2015-2016
Campylobacter	345
Cryptosporidium	62
E.coli O157 and other VTECs	27
Giardia	10
Haemophilus Influenzae type B (Hib)	0
Hepatitis A	1
Hepatitis B	10
Invasive Group A Streptococcal Infection	14
Legionella	2
Measles	2
Meningococcal Infection	11
Mumps	16
Pertussis	40
Rubella	0
Salmonella	54
Shigella	2
Tuberculosis	16
Total	613

In 2015/16, the team was involved in managing 51 outbreaks of infection within Ayrshire and Arran. Of these, 86 per cent were outbreaks of gastrointestinal infections and the rest were single outbreaks of pseudomonas, chickenpox, scabies, respiratory tract infection and Hepatitis C. Most gastrointestinal outbreaks were caused by norovirus (93 per cent), with two outbreaks of E-coli O157, two outbreaks of clostridium perfringens, and one of astrovirus. Most of the outbreaks occurred in care homes and hospital wards. Six school outbreaks and two nursery outbreaks were reported. Two were household outbreaks and the remaining nine included a hotel, restaurants, and day care centres.

During the same period, 2015/16, 111 situations were managed by the Health Protection Team. Situations include a wide range of issues requiring public health management and monitoring over an extended period of time. These often involve environmental issues such as problems with drinking water quality. Public Health is routinely notified of breaches affecting drinking water quality, and will provide any necessary health advice. Other situations notified included a chemical spillage, concerns about a biomass boiler, and an 'outbreak' of rhabdomyolosis.

Patient notification exercise: infection control breaches in local dental practice

A large patient notification exercise was undertaken following alleged infection control breaches in an East Ayrshire dental practice. An incident management team (IMT), including experts from Health Protection Scotland (HPS) was convened to examine the alleged breaches and assess any risk to patients. Control measures were put in place and 5,100 patients were informed by letter that risk of infection was very low and testing was not recommended. In response to this notification exercise more serious allegations about the practice emerged from another source. A further risk assessment was carried out using this new information. Patients had to be contacted again and blood borne virus (BBV) testing was offered as a precaution. A patient helpline was set up. Approximately 2,250 BBV tests were carried out. No Human Immunodeficiency Virus (HIV) or Hepatitis B cases were identified. Less than five new cases of Hepatitis C were identified. There is no evidence indicating that a dental patient who underwent BBV testing as part of the patient notification exercise acquired a BBV in the dental practice. However, BBV transmission within the dental practice cannot be ruled out given that only half of the practice patients were tested. The IMT informed the General Dental Council (GDC) of all allegations and findings. The GDC held a hearing resulting in the dentist and practice manager both being struck off. Public Health contacted the Chief Dental Officer for Scotland to share concerns about these breaches not being picked up during announced practice inspections. Scottish health boards have recently been given new powers to conduct unannounced inspections of dental practices if they have concerns. Lessons learned from this incident are being disseminated throughout Scotland in an effort to prevent future incidents of this sort.

Key points

- the NHS Ayrshire & Arran Health Protection Team, located in the Public Health Department, works collaboratively across the NHS and other agencies to prevent and control key threats to health
- between April 2015 and March 2016 the Health Protection Team dealt with over 600 individual disease notifications, 51 outbreaks, and 111 incidents
- Public Health respond to a range of threats to health, including infection control breaches affecting the local community

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Chapter 9 Meningitis and Septicaemia

Meningococcal infection, despite now being relatively rare, still causes a great deal of public anxiety, particularly among parents of young children. This is evident from the overwhelming response to a recent petition to make Men B vaccine much more widely available for children.

Meningococcal infection is a spectrum of disease caused by the Neisseria Meningitidis bacterium. Infection may present as meningitis, septicaemia or both. Meningococcal infection is the most common cause of bacterial meningitis in the UK. In 2015/16 there were seven separate (unrelated) confirmed cases of meningococcal infection in Ayrshire and Arran. There have been no outbreaks locally in recent years.

Meningococcal infection is of public health importance for four reasons:

1. severity of disease with a 10 per cent case fatality rate and 15 per cent of cases experience serious complications including deafness, loss of limbs and convulsions
2. intensity of public anxiety associated with meningococcal disease. Although the disease is now relatively rare, it can be very serious and primarily affects babies, children and teenagers
3. ability of the disease to occur among small clusters of people (where everybody in the cluster becomes ill). Since the introduction of Men C vaccine, clusters and outbreaks are far less common. However, the potential for clusters of disease remains
4. available vaccines only cover some of the 12 sub-types of meningococcal disease including Meningococcus A, B, C, W and Y.

For prevention of sporadic cases of meningococcal infection, vaccination is the only option. Early identification and treatment leads to better outcomes and prognosis, so public awareness of the signs and symptoms is important as is early detection and treatment by clinicians.

Common early symptoms of meningococcal infection include fever (sometimes with cold hands and feet), headache, neck stiffness, sensitivity to bright light, vomiting and muscle pain. Presentation can vary but typically illness progresses rapidly.

Public Health response to a case

Meningococcal infection is spread from person-to-person via droplet secretion during prolonged and close contact (usually within a household

or closed setting). Infectivity is low so public health action focuses mostly on contacts within the household setting and any intimate contacts (sexual partners/kissing partners). The aim of antibiotic prophylaxis to close contacts is twofold:

1) to eradicate carriage within the close group of contacts, one of whom is likely to be the source of the infection, in order to prevent further spread of disease

2) to prevent further cases or reduce the severity of infection within this close group, where some people may already have picked up the infection

Close contacts must be made aware of the signs and symptoms of meningococcal infection and the importance of seeking medical advice promptly. Risk of secondary cases occurring is highest among close contacts.

Epidemiology of meningococcal disease

The epidemiology of meningococcal disease has changed markedly in the UK in recent years. During the 1990s there was a significant increase in number of cases. The increase was mainly due to clusters of Meningococcus C infection. Meningitis C is now increasingly rare due to the success of the Men C vaccination programme. Now most cases of meningococcal infection are sporadic, with the occasional cluster in closed settings (eg.military, nursery). The age groups most commonly affected are around five months of age and teenagers. Vaccinations target these age groups who are deemed to be most 'at risk'. Worldwide, there is much geographical variation. Outbreaks of infection sometimes occur among people making the Hajj pilgrimage to Mecca. Travel vaccination is sometimes required to endemic areas, including the 'meningitis belt' in Africa.

Introduction of Meningitis B vaccine

The introduction of Men B vaccine into the UK childhood immunisation schedule in May 2015 has caused some controversy, with a petition calling for age of eligibility to be extended. The aim of the programme is to provide direct protection against invasive Men B disease. The vaccine will help to prevent cases of Men B in those at highest risk. The rationale for vaccinating children at the ages selected i.e. infants aged five months and younger at the start of the programme on 1st May 2015 is as follows:

1. the need to prevent Men B disease in infants and young children
2. the need to achieve protection by five months of age, before the age of highest risk

3. the need to ensure children are protected into their second year of life

The age groups most at risk of Men B are those aged five months old, followed by one and two year olds.

As a result of routine vaccination in Scotland now including Meningococcus sub-types ACW135Y and B, it is anticipated that a significant reduction in cases caused by these subgroups will occur.

Key Points

- Meningococcal disease can present as meningitis, septicaemia, or both and the illness often progresses rapidly with a 10 per cent case fatality rate and a 15 per cent chance of a serious complication
- the total number of new cases of meningococcal disease arising each year has declined substantially since the 1990's, largely due to the increased availability of vaccines. Only seven confirmed cases were notified in Ayrshire and Arran in 2015/16.
- timely public health action to identify, advise and offer antibiotic prophylaxis to contacts of a case is important to prevent its onward transmission within closed groups (usually household contacts).

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Meningococcal Rash Glass Test
Source: Meningitis Now

Chapter 10 Progress Towards Improving Sexual Health

NHS Ayrshire & Arran has been implementing a five year sexual health strategy (2011-16). The vision for this strategy was 'Working together to promote well-being in sexual health and deliver excellence in the services we provide.'

The strategic priorities are to:

- increase the awareness and knowledge of the factors that affect sexual health and wellbeing
- reduce the levels of unplanned teenage pregnancies
- increase the uptake of screening opportunities for sexually transmitted infections
- increase the uptake of testing for sexually transmitted infections.

The first Sexual Health and Blood Borne Virus (BBV) Framework was published by the Scottish Government in 2011 and updated in August 2015. The Framework brought together policy on sexual health and wellbeing, HIV and viral hepatitis for the first time. Intended outcomes include a reduction in new BBVs, sexually transmitted infections and unintended pregnancies; a reduction in the health inequalities gap in sexual health and BBV; and longer healthier lives for those affected by BBVs.

What did the strategy deliver?

Some of the achievements of the local strategy are outlined in this chapter.

Training and public awareness

During the past year (2015/16) a total of 25 specific training sessions were offered within the sexual health training brochure with an uptake of 19 sessions being delivered to 118 multi-agency participants. In addition, 22 bespoke training sessions were delivered to a total of 436 multi-agency participants including vulnerable groups. The training on offer is available to anyone working, living or studying within Ayrshire and Arran, free of charge, with the overall aim to increase the knowledge and skills of attendees on sexual health and wellbeing. This includes general awareness on sexually transmitted infections and the sexual health needs of distinct population groups eg. learning disabilities.

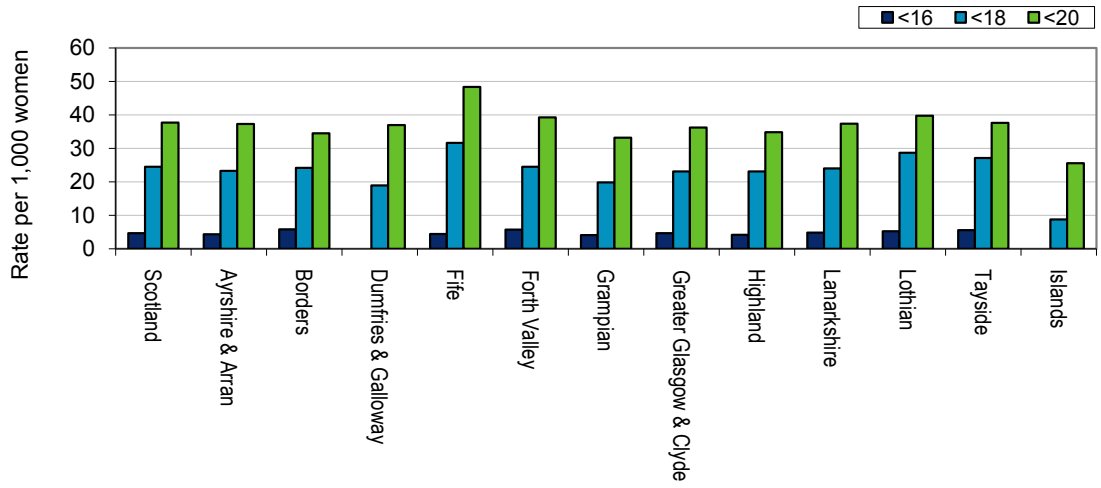
Targeted STI prevention work

Young people (particularly women) aged less than 25 are the age group most at risk of being diagnosed with a sexually transmitted infection (STI). In 2013, 77 per cent of genital chlamydia and 72 per cent of gonorrhoea diagnoses in women were in those aged under 25. The sexual health improvement team target young people across our local community where they meet to socialise. The sexual health improvement team attend health events in workplaces, colleges, HMP Kilmarnock and the University of the West of Scotland (and freshers fairs at further education establishments). During the last year a total of 25 health events within 18 different venues across Ayrshire and Arran were attended, with a total of 1331 individual interactions achieved.

Teenage Pregnancies

Between 2000 and 2012, Ayrshire and Arran experienced a decline in teenage pregnancy rates, as did Scotland as a whole. There were 664 deliveries in the under 20 age group within NHS Ayrshire & Arran during 2000, reducing to 505 in 2012. There is a significant inequalities component to teenage pregnancy. 252 teenage deliveries took place in the 20 per cent most deprived areas and 29 in the least deprived areas. The Sexual Health Improvement Team recently consulted with a variety of young people on teenage pregnancy, the findings of which have contributed to the development of a new Teenage Pregnancy Action Plan. Figure 15 illustrates how NHS Ayrshire & Arran had a slightly lower teenage pregnancy rate than the Scottish average in 2013.

Figure 15: Teenage pregnancies by NHS Board of residence, 2013



Source: NRS registered births and stillbirths & Notifications (to the Chief Medical Officer for Scotland) of abortions performed under the Abortion Act 1967.

<16 yrs includes all pregnancies in women aged under 16. the rate is calculated using the female population aged 13-15.

<18 yrs includes all pregnancies in women aged under 18. the rate is calculated using the female population aged 15-17.

<20 yrs includes all pregnancies in women aged under 20. the rate is calculated using the female population aged 15-19.

Contraception

The sexual health improvement team actively promotes long acting reversible contraceptive (LARC), complementing the work of sexual health services and primary care. The number and rate per 1,000 women (15-49) of the contraceptive implant prescribed in primary care by NHS Ayrshire & Arran continues to increase. The prescription rate increased from 29.2 per 1,000 women (2013/14) to 31.1 per 1,000 women (2014/15). The CCard (NHS Ayrshire & Arran's free condom scheme) has been in operation since 2007 and during that time over a million condoms have been distributed to the public. Shayr.com, NHS Ayrshire & Arran's public facing sexual health website, provides a wealth of information on how to access sexual health services and also provides up to date information on all areas of sexual health. Access to www.shayr.com from local authority venues such as schools has improved and the site can now be accessed from all schools and local authority premises throughout Ayrshire and Arran. The site use continues to increase with 33,719 users visiting the site 49,048 times.

Community pharmacists within NHS Ayrshire & Arran continue to demonstrate commitment to developing their role in supporting good sexual health by providing Emergency Hormonal Contraceptive (EHC) where appropriate, to women aged 13 years and above. Community pharmacists have also been providing postal dual chlamydia and gonorrhoea testing kits to those at risk, providing treatment and signposting to services as required.

Gay Men's service

NHS Ayrshire & Arran commission a dedicated gay men's service, providing one to one support, outreach support for men who frequent public sex environments, as well as internet outreach. This is a valuable service to prevent the spread of disease among men who have sex with men and who do not access specialist sexual health services. The service also provides free condoms by post to men who have sex with men.

Lesbian, Gay, Bisexual & Transgender issues

NHS Ayrshire & Arran is committed to equality and diversity and achieved the Lesbian, Gay, Bisexual & Transgender (LGBT) Charter Foundation Award in February 2016. This Charter helps organisations meet their legislative obligations in the context of LGBT equality. By displaying the LGBT Charter of

Rights it sends a positive message to LGBT people that they are included, valued, supported and will be treated fairly when they access services. The sexual health improvement team support the pan-Ayrshire multi-agency LGBT development group, which aims to improve the lives and experiences of LGBT people living, working or studying across Ayrshire. This is achieved by ensuring that Ayrshire has a more confident and skilled workforce who are better equipped to meet the needs of LGBT people.

Key points and Recommendations

- teenage pregnancy rates in Ayrshire and Arran have reduced in recent years
- Public Health continues to work with partners to raise awareness of the risks of sexually transmitted infections with young people
- a new Teenage Pregnancy Action Plan is being implemented
- work is ongoing to reduce the stigma of those who identify as LGBT.

It is recommended that NHS Ayrshire & Arran further develops partnership working with the Local Authorities, Health and Social Care Partnerships, and the voluntary sector to build on achievements to date and aim for better sexual health outcomes for the people of Ayrshire and Arran.

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Chapter 11 Public Health Screening Programmes

Introduction

The UK National Screening Committee defines screening as:

"...a process of identifying apparently healthy people who may be at increased risk of a disease or condition. They can then be offered information, further tests and appropriate treatment to reduce their risk and/or any complications arising from the disease or condition."

Cancer screening

Cancer is most common in older people because advancing age is a major risk factor. As our older population continues to grow, there will be an increase in the incidence of cancer in Scotland. It is vital that cancer prevention work continues to prevent cancers from developing in the first place. Half of all cancers are preventable with changes to lifestyle including not smoking, reducing alcohol consumption, healthy eating, physical activity and avoiding exposure to carcinogens.

Inequalities and cancer

Late detection of cancer is much more of a problem among particular population groups, and there are vast health inequalities in cancer detection and survival. In Ayrshire and Arran, as well as across Scotland, the following inequalities exist:

- bowel screening uptake is low among men living in the most deprived areas (particularly working age men)
- women defaulting from cervical screening in Ayrshire and Arran are more likely to live in more deprived areas
- younger women who have received an abnormal smear are less likely to attend for follow-up than those in older age groups.
- Women living in deprived areas are less likely to respond to an invitation for breast screening and more likely to have breast cancer detected later.

The public health team uses a range of methods to engage with local communities and to help raise awareness of the importance of cancer screening among those with lowest uptake. Examples include promoting the bowel screening message to men at local football matches and the bookies offices, and to men and women through social clubs, local companies and other venues.

New developments in bowel screening

Two key developments in bowel screening during 2017 will be:

- the launch of the Faecal Immunochemical Test (FIT) test. This test only requires screening participants to provide one stool sample, compared to the three samples required with current FOB (Faecal Occult Blood) test. In pilot studies, the FIT test led to an increase in screening uptake of 5 per cent in absolute terms (almost 10 per cent in relative terms). The increased uptake was proportionately greater in areas of deprivation, where screening uptake is traditionally lower
- the launch of new bowel screening standards, which place an even greater emphasis on the quality of the colonoscopy service that is provided to those that are screen-positive. Quality of colonoscopy is critical to the overall effectiveness of the bowel screening programme.

Changes to the cervical screening programme

There will be significant changes to eligibility for cervical screening from June 2016. All women in Scotland between the ages of 20 and 60 years are currently routinely invited for a cervical screening test every three years. From June 2016, the age-range of eligible women will change to 25-64 years plus 364 days. The frequency of cervical screening will continue to be every three years for women aged 25 to 50 years old, but will change to be every five years for women age 50 to 64 years plus 364 days. Any young woman (under 25 years) already in the screening programme will continue to be invited for screening on a three yearly basis regardless of age.

Since 2008, all 12-13 year old girls in Scotland have been offered routine vaccination against Human Papilloma Virus (HPV). The vaccine offers protection against the two types of HPV that cause 75 per cent of cases of cervical cancer. The HPV vaccine also protects against other types of HPV that cause about 90 per cent of genital wart cases. Women who have undergone HPV immunisation will still need to attend for cervical screening as these two interventions together will minimise the chance of cervical cancer developing.

A decision is awaited from the Scottish Government on the plan to introduce HPV testing as the primary cervical screening tool. This will mean using different approaches to screen women depending on their HPV status. This change will most likely result in the concentration of cytology services in a smaller number of centres. The uncertain timescale for this decision is causing significant workforce challenges for the local programme.

Developments in the breast screening programme

The breast screening programme is subject to ongoing developments and improvements. Since June 2015, all units have been equipped with digital mammography equipment. Nationally, there is ongoing development of the new IT system. In response to ongoing debate about the effectiveness of breast screening, a UK independent breast screening review was initiated in October 2011. This reported in October 2012. In response to its findings, a new leaflet was developed nationally in order to help women understand the potential benefits and risks of breast screening. The aim is to enable women to make a fully informed decision about participation.

Pressures resulting from a greater number of women eligible for screening, staff shortages, training and the introduction of digital screening units have impacted on the ability of the service to screen women timeously every three years. The service is addressing this through offering extended screening days and maximising appointment availability.

Circulatory screening programmes

Abdominal Aortic Aneurysm Screening

Abdominal Aortic Aneurysm Screening (AAA screening) launched in Ayrshire and Arran in 2013. The programme offers a one-off ultrasound scan to all men after their 65th birthday in order to measure the size of the aorta (a critical blood vessel that comes down from the heart to deliver blood all around the body). In older men the aorta sometimes 'balloons' out into an aneurysm. Depending on its size, this increases the risk of rupture of the aorta, which carries a 50 per cent risk of death.

On screening, over 95 per cent of 65 year old men are expected to have a normal size aorta and will be discharged from the programme after one scan. The other men enter a programme of regular measurements of their aorta. If it increases beyond 5.4cm in diameter, the man will be referred to

vascular surgery to be considered for treatment. The aims of the screening programme are to reduce the number of men that have an aortic rupture and to increase the proportion of aorta repairs that are carried out electively (in a planned way) against those carried out as emergencies.

The uptake rates for AAA screening in the first year of the programme in Ayrshire and Arran were over 86 per cent, which is well above the level that was initially expected. Up to June 2015 a total of 12 men had been referred to vascular surgery from screening, and 8 of these have had a surgical procedure carried out. The numbers of men detected with aneurysms and referred on to vascular surgery in Ayrshire and Arran have been much lower than was initially expected. This has also been the case across Scotland and is thought to be related to a decline in the overall occurrence of aneurysms, linked to the fall in smoking rates in the population over the last 20-30 years.

Diabetic Retinopathy Screening

The Diabetic Retinopathy Screening (DRS) programme has been in operation in Ayrshire and Arran since 1st August 2006. Diabetes presents a serious health challenge for Ayrshire and Arran, with 22,231 people known to be diagnosed with diabetes as at the end of 2014. Diabetic retinopathy represents a serious risk for people with diabetes, and may lead to blindness if it remains undetected and untreated. The DRS programme offers annual digital retinal screening to all individuals diagnosed with diabetes who are over the age of 12 years. In Ayrshire, the programme is delivered through accredited community optometrists, allowing people to be screened closer to home and often by their own optometrist. Uptake has historically been very good, exceeding the national target of 80 per cent. In 2014/15 and 2015/16, uptake in Ayrshire and Arran dropped very slightly to 78.3 per cent and 78.9 per cent respectively, reflecting the national trend.

Developments in Diabetic Retinopathy Screening

Further work is underway locally to examine population groups or areas with poorer uptake, and a targeted campaign will be planned accordingly. This campaign may be tied in with the anticipated national communication campaign regarding the expected change from annual to biennial screening for some low-risk patients. Other developments include the integration of a new screening technique (optical coherence tomography) into the screening pathway, which it is hoped will reduce the number of unnecessary referrals to ophthalmology. Work is underway to better match provision of screening locations with the need for screening.

Table 7: Public Health Screening Programmes in Ayrshire and Arran (cancer and circulatory)

Screening Programme	Target population	Time frame	Uptake	Outcomes
Cancer				
Cervical screening	All eligible women in Ayrshire and Arran aged 20 to 60 years	2013-14	80.2 per cent uptake	15 cases of invasive carcinoma 486 referrals for colposcopy
Bowel screening	All adults in Ayrshire and Arran aged 50 to 74 years	1/11/12 to 31/10/14	57.5 per cent	2.2 per cent positivity rate; 96 people had screen detected colorectal cancers
Breast screening	All eligible women in Ayrshire and Arran aged 50 to 70 years. Women aged over 70 can self refer	2013-14	Women invited 18,638 Women who attended 13,756 (73.8 per cent)	118 Women referred for breast surgery. The cancer detection rate in 2014 was 8.6 cancers per 1000 women screened.
Circulatory				
Diabetic retinopathy screening	People over the age of 12 with diabetes	1/4/14 to 31/3/15	78.3 per cent	3.4 per cent of those screened require referral to an ophthalmologist, of which approximately one third do not require treatment.
Abdominal aortic aneurysm (AAA) screening	Offered to all men in their 65th year. Men over this age can self refer	1/6/13 to 31/04/2014	86.2 per cent	75 men under surveillance. 8 men have had surgical procedures carried out (up to June 2015).

Key points

- inequalities are evident in uptake of screening programmes. The Public Health Department strives to reduce such inequalities where possible
- screening programmes are constantly being developed and evaluated to ensure they are effective and evidence-informed.

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The following four chapters relate to improving health services and disease prevention.

Chapter 12 Oral health in children

Introduction

Good oral health is a key part of overall health and wellbeing. Dental Public Health seeks to place oral health improvement in a wider arena of health improvement by using the "common risk factor" approach. The key messages of limiting intake of sugar, as well as reducing tobacco and alcohol use, have broader health benefits too. There have been recent significant improvements in the oral health of children, but dental extraction still remains as a common reason for admission of a child to hospital. Dental decay causes pain and suffering, leading to loss of sleep and time off school.

Policy context

The Scottish Dental Action Plan (2005) provided significant investment and initiated the Childsmile Programme. Locally, NHS Ayrshire & Arran has an Oral Health Strategy (2013-23) and action plan, which include activities for children. The recently published *Outcomes Framework from Scottish Government (2016)* gives new targets for oral health. Other legislation, such as the *Children and Young People's Act, Scotland (2014)* will impact on activity. Dental decay can become established at an early age, and may be used as an indicator of "concern". There have been several pilots within NHS Ayrshire & Arran dental services looking at this issue.

Activities

The main oral health improvement activities for children are delivered through the Childsmile Programme (nationally directed) and the Oral Health Promotion (OHP) team, whose activity is determined locally by the Oral Health Strategy. The Childsmile Programme is evaluated nationally and has several components:

- The Core Programme
  - every child provided with dental pack containing toothbrush and fluoride toothpaste
  - every three and four year old child attending nursery offered free, daily, supervised tooth brushing
  - supervised tooth brushing also offered to Primary 1 and Primary 2 children in targeted schools

- Childsmile School and Nursery Programme
  - children in the most deprived areas are offered biannual fluoride varnish application at primary school and nursery
- Childsmile Practice Programme
  - Health Visitor reinforces key oral health messages, including the benefit of child registration at a local dentist
  - for the most vulnerable families, a Dental Health Support Worker provides home support, preventive advice and assistance in attending dentist.

The OHP Team delivers school-based programmes for older children in primary and secondary schools, including "Search for a Smile" and "Gleam – Embrace!". The team has won several awards for their innovative approach.

The Childsmile and OHP Teams are based with the Public Dental Services in East Ayrshire Health and Social Care Partnership (HSCP), the Lead Partnership for Primary Care, and they maintain their links with Public Health through the Consultant in Dental Public Health. Targets for oral health improvement in Primary one children are included in the HSCP and Community Planning Partnership plans. The National Dental Inspection Programme collects information on Primary one and Primary seven children on alternate years and gives data for the whole of Ayrshire and Arran, as well as East, North and South Ayrshire separately.

The detailed inspections on random samples of Primary one and Primary seven children provide estimates of the prevalence and burden of dental decay in the population. The oral health of children in Primary one indicates the effectiveness of pre-school preventive programmes including home care, diet, parenting, Childsmile interventions and uptake of dental services.

Table 8 shows that all areas in Ayrshire and Arran now exceed the national standard of 60 per cent of children in P1 with no obvious decay experience. However, the new target to achieve 76 per cent free from decay by 2022 will be a challenge.

Table 8 Percentage of children in Primary 1 with no obvious decay

Location	Year					
	2004	2006	2008	2010	2012	2014
Scotland	50.7	54.1	57.7	64.0	67.0	68.2
East Ayrshire	-	45.8	61.4	64.1	69.2	63.9
North Ayrshire	-	44.5	60.2	56.4	62.8	68.4
South Ayrshire	-	62.0	79.3	68.8	64.1	66.8
Ayrshire and Arran	53.3	50.9	63.1	62.7	65.5	66.3

Source: http://www.isdscotland.org/Health-Topics/Dental-Care/Publications/2014-10-28/2014-10-28-NDIP-Report.pdf

Table 9 indicates that while the majority of children in Primary one had no obvious decay, for those children with obvious decay experience, the level of decay experience could be high.

Table 9 Obvious decay experience in Primary 1 children in 2014, by area

Location	per cent of children with no obvious decay	Mean number of teeth with obvious decay	
		Primary 1 children whole population	Primary 1 children with obvious decay
East Ayrshire	63.9	1.4	4.0
North Ayrshire	68.4	1.1	3.6
South Ayrshire	66.8	1.4	3.7

Source: http://www.isdscotland.org/Health-Topics/Dental-Care/Publications/2014-10-28/2014-10-28-NDIP-Report.pdf

Data are available for the prevalence of no obvious decay in Primary seven children (Table 10) and for the burden of disease (Table 11). Again, there is a new and challenging target to achieve 90 per cent free from decay by 2022.

Table 10 Percentage of children in Primary 7 with no obvious decay

Location	Year					
	2005	2007	2009	2011	2013	2015
Scotland	52.9	59.1	63.6	69.3	72.8	75.3
East Ayrshire	56.4	63.9	69.9	77.6	81.0	75.4
North Ayrshire	48.0	61.7	67.7	69.7	77.4	81.4
South Ayrshire	59.3	65.2	72.4	82.0	84.2	82.5
Ayrshire and Arran	54.0	63.5	70.4	76.3	80.2	80.0

Source: http://isdscotland.org/Health-Topics/Dental-Care/Publications/2015-10-27/2015-10-27-NDIP-Report.pdf

Table 11 Obvious decay experience in Primary 7 children in 2015, by area

Location	per cent of children with no obvious decay	Mean number of teeth with obvious decay	
		Primary 7 children whole population	Primary 7 children with obvious decay
East Ayrshire	75.4	0.5	2.1
North Ayrshire	81.4	0.4	2.0
South Ayrshire	82.5	0.3	1.9

Source: http://isdscotland.org/Health-Topics/Dental-Care/Publications/2015-10-27/2015-10-27-NDIP-Report.pdf

While there have been significant improvements in children's oral health, these appear to be slowing. Current oral health activity may have reached the limit of what it can achieve and additional measures will be required to achieve further improvements. There is evidence at a national level that there have been reductions in oral health inequalities, but data are not available locally. Targeted activities will be required to address the continuing oral health disparities.

Key points and Recommendations

- good oral health is of key importance to overall general health
- oral health improvement programmes have been shown to reduce inequalities in oral health
- there have been significant improvements in the oral health of children over recent years, but there are still challenges remaining for a "hard-to-reach" group of children
- the previous rapid progress shown has slowed and additional targeted activities are now needed to address the continuing oral health disparities.
- actions focussed on improving oral health should continue in order to maintain the achievements so far, with additional activities targeted at those in hard-to-reach groups in order to make further improvements

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Chapter 13 Reducing Hospital Admissions in Children

A rapid needs assessment aimed to identify the key actions required to reduce serious adverse events from taking place in childhood. This chapter gives a brief summary of the findings relating to avoidable admissions - a full report, with full referencing is available on request.

The objectives were to:

- Quantify avoidable admissions
- Identify models of care (1): review of systematic reviews on models of care for preventing/avoiding/reducing hospital admissions

Quantifying Avoidable Admissions

There were 10,434 admissions of children and young people resident in Ayrshire and Arran to hospital in 2013/14. 62 per cent of these admissions were for periods of less than 12 hours, reflecting good practice in observing children. Socioeconomic deprivation and young age of the child were the main drivers of admission rates.

The primary analysis of avoidable emergency admissions to hospital focused on Ambulatory Care Sensitive Conditions (ACSC) as identified by Purdy et al (2009)[1] based on ACSC coding used in NHS England and a review of international literature on ACSCs.

Table 12 shows that 41.4 per cent of emergency conditions were amenable to management in primary or ambulatory care. The five most common groups of ACSC admissions were: ENT, dehydration or gastrointestinal conditions, asthma, constipation and dyspepsia.

Table 12: All child emergency admissions and ACSC admissions for NHS Ayrshire & Arran residents aged 0-19, attending hospital in 2013/14 (source SMR01).

	All emergency admissions	ACSC admissions
Number of admissions	6838	2834
Percentage of emergency admissions	100 per cent	41.4 per cent
Number of patients	5113	2236
Number of bed days	9487	3363
Percentage of admissions with 0 bed days	51.6 per cent	54 per cent

Table 13 shows that children admitted for ear, nose and throat problems were the most common of the ACSC conditions, closely followed by dehydration and gastro-intestinal conditions.

Table 13: Most common ACSC diagnoses for children and young people

	Number of admissions with these diagnoses	per cent ACSC admissions	Number of admissions with this in primary position	per cent of all emergency admissions
ENT	767	27	660	11
Dehydration and Gastrointestinal	699	25	575	10
Asthma	394	14	170	6
Constipation	198	7	123	3
Dyspepsia & perforated ulcer	187	7	120	3

Reducing the most common causes for emergency department attendance

- Ear, nose and throat

Interventions with evidence of effectiveness included pneumococcal immunisation [2,3]. In addition, senior medical specialist review in the emergency room [4], as well as the use of short stay observation arrangements were of value.

- Dehydration and Gastroenteritis

Rotavirus vaccine has contributed to a significant reduction in the incidence of rotavirus gastroenteritis and the significant reduction in emergency hospital admissions [5,6,7]. (This was introduced as a national immunisation programme for all babies in Scotland born after 1st May 2013). Breastfeeding was shown to significantly reduce hospital admissions from gastrointestinal and respiratory infections in infants aged under one year. Antiemetics are useful in the emergency department to reduce vomiting, allow oral rehydration as opposed to intravenous rehydration and reduce avoidable admissions. There is no evidence that education programmes or primary care follow-up soon after emergency department visits for gastroenteritis are associated with a lower rate of subsequent visits [8].

- Asthma

Well-designed asthma education programmes that foster continuity, target socio-economically deprived parents and children and enhance self-management and the management of an exacerbation may reduce the need for hospital care [9]. Continuity of care, smoke free homes and cars, early identification of allergies and not being overweight are all important in reducing avoidable admissions in children with asthma [10, 11].

- Constipation and Dyspepsia

Hospital use may be avoidable if primary care interventions are offered early and thereafter maintained. These include dietary interventions, laxative therapy, cow's-milk-free diet, probiotic yogurt, water intake, lifestyle modifications, not being overweight and increased physical activity. All of these increased the likelihood of constipation being managed in the community [12,13,14]. There was little literature relating to dyspepsia. Several studies found that the identification and eradication of Helicobacter pylori in children presenting with non-ulcer dyspepsia demonstrated long term improvements [15].

Key points

- 41.4 per cent of emergency conditions were amenable to management in primary or ambulatory care
- socioeconomic deprivation was a significant driver of the rate Ambulatory Care Sensitive Conditions
- the five most common groups of ACSC admissions were ENT, dehydration or gastrointestinal conditions, asthma, constipation and dyspepsia
- interventions with evidence of effectiveness to reduce ENT admissions include pneumococcal immunisation and senior medical specialist review in the emergency room
- rotavirus vaccine has contributed to a significant reduction in the incidence of rotavirus gastroenteritis and the significant reduction in emergency hospital admissions
- well-designed asthma education programmes that foster continuity, target socio-economically deprived parents and children and enhance self-management and the management of an exacerbation may reduce the need for hospital care
- hospital use for constipation may be avoidable if primary care interventions are offered early and thereafter maintained; these include dietary interventions, laxative therapy, and lifestyle changes etc.

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Chapter 14 Reducing Hospital Admissions in Adults

A rapid Joint Strategic Needs Assessment was carried out by the Public Health Department in 2014. The aim was to support East, North and South Ayrshire Health and Social Care Partnerships with evidence based information that had the potential to reduce emergency hospital admissions. The objectives were to:

- Quantify avoidable admissions
- Identify models of care [(1)]: review of systematic reviews on models of care for preventing/avoiding/reducing hospital admissions
- Identify models of care [(2)]: focused literature search for condition-specific admission-avoidance models of care for top five Ambulatory Care Sensitive Condition (ACSC) diagnoses.

Quantifying Avoidable Hospital Admissions

The primary analysis of avoidable emergency admissions to hospital focused on Ambulatory Care Sensitive Conditions (ACSC) as identified by Purdy et al (2009)[1] based on ACSC coding used in NHS England and a review of international literature on ACSCs. This definition incorporates 36 categories of conditions for which admission could be avoided by interventions in primary, community or social care.

Table 14: Top five ACSC categories (1st position), number of emergency admissions in Ayrshire and Arran residents during 2013/14, of all ages*

	Frequency	Percentage of all emergency admissions	Percentage of all ACSCs
Angina	4,174	8.6 per cent	24 per cent
Urinary Tract Infection (UTI)/pyelonephritis	1,759	3.6 per cent	10 per cent
Chronic Obstructive Pulmonary Disease (COPD)	1,652	3.4 per cent	9 per cent
Dehydration / gastroenteritis	1,295	3.0 per cent	7 per cent
Influenza/pneumonia	1,092	2.3 per cent	6 per cent

*frequency of top five ACSC differed in children and young people (<19 years)

Summary of the Evidence for models of care to prevent avoidable hospital admissions

There is evidence that a number of interventions are successful in reducing avoidable admissions, including:

- interventions at Accident and Emergency: review by senior clinician and GP-led assessment units for urgent referrals from community GPs [2,3]
- integrated clinical care programmes for heart failure, chronic obstructive pulmonary disease (COPD), asthma and diabetes, and exercise-based rehabilitation for coronary heart disease (CHD) and COPD [4],
- case management for heart failure [5],
- home visits (plus telephone support) for heart failure patients; pregnant women with hypertension and/or diabetes, and inpatients with mental health conditions [5],

- self-management, including practitioner review, in asthma and COPD patients [5,6],
- specialist clinics for heart failure patients [5,6],
- assertive community treatment for patients with mental health conditions[7],
- Managed Clinical Networks (MCN) in patients with angina and diabetes; and
- tele-related health care in older people and in people with heart failure, CHD, hypertension and diabetes [8].

The evidence to date is inconclusive with respect to two models of care which are relevant to HSCPs. Evidence on the impact of hospital at home and horizontal integrated care on emergency admissions is emergent, complex and as yet inconclusive:

- a Cochrane review of admission avoidance hospital at home found a non significant increase in admissions compared to inpatient hospital care. Systematic reviews have found that, for specific patients and particular conditions, hospital at home has varying degrees of success in reducing admissions or readmissions. However, hospital at home may be achieving other important patient outcomes [9]
- a comprehensive evaluation of 16 heterogeneous pilots of health and social care integration initiatives in England did not provide evidence that

horizontal integration reduces emergency admissions. It may not have been realistic to expect such outcomes to emerge in the short term [10].

The literature review highlighted several key points for consideration in developing models of care locally. These include:

Key points

- more than 70 per cent of avoidable admissions are significantly associated with measures of deprivation, so interventions must reflect this
- as most avoidable admissions are due to a range of factors, no single model or intervention will be effective in reducing admission rates, therefore a whole-systems approach will be required
- there is a clear need to develop robust evaluation, both local and national if possible, when introducing any new models of care without a robust evidence base.

A full list of interventions, including those that were not shown to affect admissions and those as yet unproven, is available in the full report – this can be obtained by contacting the chapter author

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Chapter 15 Greening the NHS Ayrshire & Arran Estate

The Contribution of Greenspace and Natural Environments to Public Health and Wellbeing

There is growing evidence demonstrating the positive relationship between quality, accessible greenspace and mental and physical health and wellbeing; although the mechanisms by which these benefits occur are not yet fully understood.[1]

People of all ages who use green spaces regularly are more likely to be physically active; and urban dwellers who use outdoor spaces such as woodland for physical activity have a lower risk of poor mental health than those who exercise in the gym or the streets.[2] Studies consistently show a positive relationship between levels of stress and increasing time spent in outdoor green spaces, regardless of age, gender and socioeconomic status.[3] This is likely to result from the individual or combined restorative effects of outdoor activity and exercise; natural daylight, stimulation of the senses and the aesthetic experience. There is some evidence to suggest that greenspace can also contribute to reducing health inequalities, with studies in Scotland demonstrating a link between men living in deprived urban areas with higher amounts of local greenspace and lower risk of mortality.[4] A number of studies have demonstrated positive clinical outcomes resulting from contact with the natural environment which include: lowered heart rate and blood pressure; reduced experience of pain; and improved post-operative recovery.[5]

Social interaction and wellbeing is consistently reported as a significant outcome which can be gained from using greenspace. However, opportunities for quiet contemplation and for some, the spiritual dimension of connecting with the outdoors, are also key. Greenspaces are seen as one of the few remaining neutral spaces that are available to all and tend to be highly valued by communities.[1] Greenspace creation also has a positive impact on other aspects of the physical environment linked to climate change such as reducing flooding, air pollution and global warming which, in turn, have an impact on population health.

Strategic/ Policy Context

A strong, cross-sectoral policy framework is emerging which now sees the links between greenspace and health recognised in health and environment as well as transport, planning and education policy. Examples include Good Places, Better Health (2008), and the Scottish Biodiversity Strategy (2013). Greening the NHS Estate also fits with the Scottish Government's 2020 Vision by helping to better focus the healthcare system on upstream prevention.

In 2007 the Green Exercise Partnership (GEP), a joint venture between Forestry Commission Scotland, Scottish Natural Heritage and NHS Health Scotland, was formed. A key objective of this work was to support NHS Boards to make better use of their outdoor estate as a resource for health and wellbeing.

Greening the NHS Ayrshire & Arran Estate

NHS Ayrshire & Arran has been working in partnership with the GEP since 2011. A Public Health led joint strategic review of the NHS Ayrshire & Arran estate was carried out. A total of 86 sites were assessed against criteria including: size; potential for improving health and wellbeing and enhancing biodiversity; how accessible, connected, attractive and appealing they were; and opportunities to involve communities. Seven sites were prioritised for possible future development and Landscape Assessment and Development Reports were prepared to inform action. These sites are:

- University Hospital Ayr/Ailsa
- Ayrshire Central Hospital/ Woodland View
- University Hospital Crosshouse
- Girvan Community Hospital
- Arrol Park Resource Centre
- Biggart Hospital
- Arran War Memorial Hospital

National Demonstration Project- University Hospital Ayr/ Ailsa

A GEP National Demonstration project was established at University Hospital Ayr and Ailsa in South Ayrshire to showcase the health and wellbeing benefits that can be gained from positive investment in and management of the NHS estate. Funding was secured from Scottish Government, GEP (Forestry Commission Scotland), NHS Endowments and Sustrans Scotland to develop a landscape master plan and carry out improvement works.

The project has brought neglected woodland back into sustainable management and given the extensive area of woodland, meadow and grassland (approximately 28 hectares) a clear purpose as a health improvement asset for patients, staff, visitors and the local community. Approximately 3.6 km of new paths network has been created in the hospital grounds including: 1km of a new Sustrans cycle route which will ultimately connect to the A77; and a network of woodland walks. These are supported

by new signage and interpretation. In addition, approximately 2,500 new trees have been planted and 26 new seats and perches have been installed, all in native green oak. A new teaching circle has also been created in one of the meadow areas.

The new network of paths and greenspace developments were officially opened by the Chairman of the NHS Board on 5 October 2015. Footfall counters are beginning to show an increase in the volume of people using the new paths. Staff report that they are using the grounds for walking and relaxation and they are reporting mental health benefits from taking time away from busy wards to 'de-stress and unwind'. Some staff also report using the paths for 'walk and talk' meetings with colleagues. Patients have commented that they find the paths and the spaces 'peaceful and therapeutic'. In addition to benefits to public health, infrastructure improvements are supporting the NHS Board to meet its corporate objectives relating to climate change, biodiversity, sustainability and good corporate citizenship.

Work is now required to promote engagement with, and use of, the outdoor space. Funding has been secured for a Greenspace for Health Senior Project Officer who will liaise with patients, clinicians, staff and wider community groups to support and enable green exercise, recovery programmes and outdoor learning on site. The Conservation Volunteers (TCV) have been commissioned to deliver this project.

Mainstreaming Beyond the Demonstration Site

The demonstration site has acted as a catalyst for greening projects at other sites prioritised in the strategic review. At Ayrshire Central Hospital/ Woodland View in North Ayrshire, there was an opportunity to consider how we use and adapt the greenspace infrastructure for health and wellbeing whilst the new hospital was being built. Further joint working with, and grant funding from, Sustrans Scotland has led to the upgrade of a footpath linking Woodland View and the neighbouring community of Castlepark to dual use pedestrian/ cycle path status. Work is also progressing with North Ayrshire Council to create an active travel hub on site. This will complement the existing paths infrastructure being implemented within the hospital grounds as part of the new build developments. A woodland management plan and access proposals have also been produced to inform the development of a significant section of the existing woodland on site and the creation of woodland walks and useable green spaces. Proposals are also being developed to improve and develop the more limited greenspace at University Hospital Crosshouse in East Ayrshire.

Key Points

- much has been achieved in bringing together the health and environment sectors in this programme and we are beginning to reap the benefits of NHS greenspace as an asset and an opportunity for upstream prevention rather than an underutilised, unmanageable liability
- we have benefited greatly from partnership funding to unlock the potential of the estate; and greenspace development is being integrated into NHS policy and strategy and is influencing operational practice. However, incorporating and funding this work as a core element of estate management remains challenging given the current service pressures
- there is some way to go to mainstream the use of the outdoor estate as a key element of prevention, treatment, care and recovery. It is recognised that this will take time and will only be achieved though continued partnership working, longer term planning and enhanced engagement and ownership of patients, visitors, staff and the wider community.

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The following are: an extract from the woodland walk leaflet showing the paths infrastructure at University Hospital Ayr and Ailsa; a few before and after shots from the site; and a photograph of our newly completed teaching space.

Woodland Walks and Greenspace Infrastructure University Hospital Ayr/ Ailsa

Evergreen Way Pre Development

Evergreen Way Completed

Woodland Wynd Before

Woodland Wynd After

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Glossary

AAA	Abdominal Aortic Aneurysm
ACSC	Ambulatory Care Sensitive Conditions
AHEAD	AyrsHirE Asset Development
A&E	Accident & Emergency
BBV	Blood Borne Virus
CB	Community Builders
CHD	Coronary Heart Disease
COPD	Chronic Obstruction Pulmonary Disease
CPPs	Community Planning Partnerships
DPH	Director of Public Health
DRS	Diabetic Retinopathy Screening
DWP	Department of Work and Pensions
ED	Emergency Department
FIT	Faecal Immunochemical test
FOB	Faecal Occult Blood
GDC	General Dental Council
GEP	Green Exercise Partnership
HIV	Human Immunodeficiency Virus
HPS	Health Protection Scotland
HPT	Health Protection Team
HPV	Human Papilloma Virus
H&SCPs	Health and Social Care Partnerships
IMT	Incident Management Team
IT	Information Technology
LARC	Long acting reversible contraception
LGBT	Lesbian, Gay, Bisexual and Transgender
MCN	Managed Clinical Network
OHP	Oral Health Promotion
PPF	Patient, Public Forum
UK	United Kingdom
UTI	Urinary Tract Infection

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