**Integration Joint Board
Meeting**

Thursday, 19 December 2019 at 10:00

**Council Chambers
Ground Floor, Cunninghame House, Irvine, KA12 8EE**

1   Apologies

2   Declarations of Interest
Members are requested to give notice of any declarations of interest in respect of items of business on the Agenda.

3   Minutes/Action Note
The accuracy of the Minutes of the meeting held on 21 November 2019 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   Director's Report
Submit report by Stephen Brown, Director (NAHSCP) on developments within the North Ayrshire Health and Social Care Partnership (copy enclosed).

5   Financial Monitoring Report: Period 8
Submit report by Caroline Cameron, Chief Finance and Transformation Officer on the financial position of the North Ayrshire Health and Social Care Partnership (copy enclosed).

6   Children's Services Plan Performance Report 2017-2019
Submit report by Lauren Cameron, Policy Officer on the annual report on performance and progress against the Children's Services Plan (copy enclosed).

7   **UK Care Home Industry**
          Submit report by Louise McDaid, Staff Representative (North Ayrshire Council) on the findings and recommendations of the recent publication of a report by the Centre for Health and Public Interest on the UK Care Home Industry (copy enclosed).

8   **Auditor General - NHS Scotland in 2019**
          Submit report by Caroline Cameron, Chief Finance and Transformation Officer on the Auditor General's report on the performance of NHS Scotland in 2019 (copy enclosed).

9   **Ministerial Steering Group Update**
          Submit report by Caroline Cameron, Chief Finance and Transformation Officer on the Ministerial Steering Group update on progress in implementing the areas of action identified in the recent self-assessment (copy enclosed).

10   **Primary Care Improvement Plan**
          Submit report by Vicki Campbell, Primary Care Implementation Manager on the progress of the Primary Care Improvement Programme and proposals for further implementation over 2020/22 (copy enclosed).

11   **NAHSCP Staff Engagement Survey Results 2019**
          Submit report by Calum Webster, Senior Organisation Development Officer on the Employee Engagement Survey results for 2019 (copy enclosed).

12   **IJB Performance and Audit Committee Minutes**
          Submit the Draft Minutes of the IJB Performance and Audit Committee held on 26 September 2019 (copy enclosed).

13   **Strategic Planning Group Minutes**
          Submit the Minutes from the Strategic Planning Group meeting held on 13 November 2019 (copy enclosed).

14   **Urgent Items**
          Any other items which the Chair considers to be urgent.

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Integration Joint Board

Sederunt

Voting Members

Councillor Robert Foster (Chair)	North Ayrshire Council
Bob Martin (Vice-Chair)	NHS Ayrshire & Arran
Councillor Timothy Billings	North Ayrshire Council
Jean Ford	NHS Ayrshire and Arran
Councillor Anthea Dickson	North Ayrshire Council
John Rainey	NHS Ayrshire and Arran
Adrian Carragher	NHS Ayrshire and Arran
Councillor John Sweeney	North Ayrshire Council

Professional Advisors

Stephen Brown	Director North Ayrshire Health and Social Care
Caroline Cameron	Chief Finance and Transformation Officer
Dr. Paul Kerr	Clinical Director
David MacRitchie	Chief Social Work Officer – North Ayrshire
Dr. Calum Morrison	Acute Services Representative
Alistair Reid	Lead Allied Health Professional Adviser
David Thomson	Associate Nurse Director/IJB Lead Nurse
Dr Louise Wilson	GP Representative

Stakeholder Representatives

David Donaghey	Staff Representative – NHS Ayrshire and Arran
Louise McDaid	Staff Representative – North Ayrshire
Marie McWaters	Carers Representative
Graham Searle	Carers Representative (Depute for Marie McWaters)
Sam Falconer	(Chair) IJB Kilwinning Locality Forum
Clive Shephard	Service User Rep (Depute for Fiona Thomson)
Nigel Wanless	Independent Sector Representative
Val Allen	Independent Sector Rep (Depute for Nigel Wanless)
Vicki Yuill	Third Sector Representative
Vacancy	(Chair) IJB Irvine Locality Forum
Janet McKay	(Chair) Garnock Valley Locality Forum

North Ayrshire Health and Social Care Partnership

**Minute of Integration Joint Board meeting held on
Thursday 21 November 2019 at 10.00 a.m.**

Present
Bob Martin, NHS Ayrshire and Arran (Vice-Chair)
Councillor Timothy Billings, North Ayrshire Council
Adrian Carragher, NHS Ayrshire and Arran
Councillor Anthea Dickson, North Ayrshire Council
Jean Ford, NHS Ayrshire and Arran

Stephen Brown, Director of Health and Social Care Partnership
Caroline Cameron, Chief Finance and Transformation Officer
Dr Paul Kerr, Clinical Director
David MacRitchie, Chief Social Work Officer
David Thomson, Associate Nurse Director/IJB Lead Nurse

David Donaghey, Staff Representative (NHS Ayrshire and Arran)
Louise McDaid, Staff Representative (North Ayrshire Council)
Nigel Wanless, Independent Sector Representative
Vicki Yuill, Third Sector Representative
Janet McKay, Chair, Garnock Valley HSCP Locality Forum

In Attendance
Thelma Bowers, Head of Mental Health
Alison Sutherland, Head of Service (Children, Families and Criminal Justice)
Michelle Sutherland, Partnership Facilitator
Alison McAllister, Library and Information Service Manager
Helen McArthur, Senior Manager (Community Care Services)
Karen Andrews, Team Manager Governance
Angela Little, Committee Services Officer

Apologies for Absence
Councillor Robert Foster, North Ayrshire Council (Chair)
Councillor John Sweeney, North Ayrshire Council
John Rainey, NHS Ayrshire and Arran
Alistair Reid, Lead Allied Health Professional Adviser
Dr. Louise Wilson, GP Representative
Graham Searle, Carers Representative (Depute for Marie McWaters)
Marie McWaters, Carers Representative
Val Allen, Independent Sector Representative

1. Apologies

Apologies were noted.

2. Declarations of Interest

In terms of Standing Order 7.2 and Section 5.14 of the Code of Conduct for Members of Devolved Public Bodies there were no formal declarations of interest.

3. Minutes/Action Note

The accuracy of the Minute of the meeting held on 24 October 2019 was confirmed and the Minute signed in accordance with Paragraph 7 (1) of Schedule 7 of the Local Government (Scotland) Act 1973.

3.1 Matters Arising

The Board noted that (a) an update on the Veterans First Point Service will be provided to the January meeting; (b) an update on the Community Alarm/Telecare Services Transition from Analogue to Digital will be provided to the September meeting; and (c) all other matters arising are on track for completion by the appropriate timescales.

4. Director's Report

Submitted report by Stephen Brown, Director (NAHSCP) on developments within the North Ayrshire Health and Social Care Partnership.

The report provided an update on the following areas:-

- The Health and Social Care Scotland 2nd Annual Conference on 4 December 2019;
- Home Fire Safety visits that can be made by Scottish Fire and Rescue Service;
- The appointment of a new Communication and Engagement Officer;
- Staff Partnership Awards;
- Dementia Workshop on 27 November 2019;
- Thinking Different, Doing Better update;
- National Care Leavers' Week – a celebration of the successes of our care leavers;
- HSCP engagement events.

Members asked questions and were provided with further information in relation to:-

- The Partnership Staff Awards that will be held on 27 February 2020 in the Volunteer Rooms, Irvine; and
- The weekly staff email that provided information on Home Fire Safety Visits that can been provided by Scottish Fire and Rescue; and
- Work that will be done to ensure the referral hyperlink for Home Fire Safety Visits is operational for NHS staff.

The Board was advised that there are still places available on the Dementia Workshop on 27 November 2019 at Fullarton Connexions, Irvine.

The Board agreed (a) to note the ongoing developments within the North Ayrshire Health and Social Care Partnership.

5.   Chief Social Work Officer Annual Report

Submitted report by David MacRitchie, Chief Social Work Officer on the Annual Report of the Chief Social Work Officer to the local authority covering the period April 2018 to March 2019. Appendix 1 to the report detailed the statutory, governance and leadership functions of the role and highlighted:-

- the most recent SIMD figures (2016) which show a worsening position in North Ayrshire in the domains of Income, Employment, Education and Housing;
- the conclusion of the Audit Scotland Report of 2016 on 'Social Work in Scotland' which states that current approaches to delivering Social Work Services will not be sustainable in the long term; and
- the new Health and Social Care Partnership structures including examples of innovative service delivery approaches.

Members asked questions and were provided with further information in relation to:-

- plans that are in place to release capacity within Mental Health Services to address the waiting list; and
- difficulties in recruiting staff to specific areas within the Health and Social Care Partnership.

The Board agreed to note and endorse the Chief Social Work Officer Annual Report as set out in Appendix 1 to the report.

6.   Co-creating Libraries for Health and Well-Being

Submitted report by Michelle Sutherland, Partnership Facilitator and Alison McAllister, Library and Information Service Manager on bringing together the public, libraries, NHS and school libraries, health and social care professionals and the third sector as equal partners in a new service model to embed self-management and shared decision making in health and care. The service model and project outcomes were outlined in Appendix 1 to the report. Appendix 2 provide information on the milestones for the project that will be monitored by the local Steering Group.

Members asked questions and were provided with further information in relation to:-

- the review of community facilities that will include libraries;
- the new service model that will apply to any location or setting;
- engagement with the public to ensure all facilities are included; and
- funding for the project by the Scottish Government via the Public Libraries Improvement Fund.

The Board agreed (a) to approve the implementation of the expansion of the librarian role into the emerging locality multi-disciplinary team project until December 2020; (b) that the model focusses on mental health supports for young people and social isolation for adults as its inequalities areas; and (c) the work develops plans for sustainability across all localities thereafter.

7.   Health and Social Care Clinical and Care Governance Group Update

Submitted report by David Thomson, Associate Nurse Director in relation to an update and overview of governance and assurance activity for the period February 2019 – August 2019, reviewed by the North Ayrshire Health and Social Care Partnerships' Clinical and Care Governance Group

The report provided an update on:-

- Learning Disabilities Service;
- Adult Support and Protection;
- Child Protection;
- Multi Agency Public Protection Arrangements;
- Adverse Events;
- Opiate Replacement Therapy;
- Injecting Equipment Provision, Needle Exchange and Harm Reduction;
- Health and Safety; and
- Professional Updates from Mental Health Head of Service, Clinical Director, Lead Nurse, Interim Head of Service (Children, Families and Justice Services) and Lead AHP.

Members asked questions and were provided with further information in relation to:-

- Historic poor compliance with the completion and sign-off of Safety Action Notices being processed within 14 days and improved processes that have been put in place to ensure compliance with the Scottish Government timescales;
- Positive feedback on the arrangements put in place for GP practices in the Three Towns and West Kilbride;
- A re-run of the child count survey by the Dartington Research Unit that will be used to shape the new Children's Services Plan;
- A pro-active recruitment programme that continues to address vacancies in Child and Adolescent Mental Health Services; and
- An update on Child and Adolescent Mental Health that will be included in the report to the next meeting.

Noted.

8.   Budget Monitoring: Period 6

Submitted report by Caroline Cameron, Chief Finance and Transformation Officer on the projected year-end outturn for the 2019/20 financial year, including commitments against the available resource, explanations for the main budget variances, an

update on progress in terms of savings delivery and actions required to work towards financial balance.

Appendix A to the report provided the financial overview of the partnership position, with detailed analysis provided in Appendix B. An overview of the savings plan was provided at Appendix C. Appendix D outlined the previously approved financial recovery plan and further actions to bring overall service delivery back into line with the available resource. The movement in the overall budget position for the partnership was detailed at Appendix E.

Members asked questions and were provided with further information in relation to:-

- A year-on-year reduction that has been achieved in children's residential and community placements and a recovery plan to reduce the number of placements further;
- The roll out of the Wellness Model in the localities; and
- The projected overspend in social care services offset by a projected underspend in health services.

The Board agreed to note (a) the projected year-end overspend of £2.969m; (b) the changes in funding as detailed in Section 2.11 and Appendix E to the report; and (c) the potential impact of the Lead Partnerships.

9. Strategic Planning Group

Submitted the Strategic Planning Group (SPG) Meeting Minutes from the meeting held on 2 October 2019.

The Chair encouraged attendance at future SPG meetings.

Noted.

The meeting ended at 11.25 a.m.

North Ayrshire Integration Joint Board – Action Note

No.	Agenda Item	Date of Meeting	Action	Status	Status Date	Officer
1.	Veterans First Point (V1P) Service	21/3/19	That an update report on the long-term sustainability plan be submitted to the IJB Meeting on 29 August 2019.	Ongoing – plan to report to the January meeting	January 2020	Thelma Bowers
2.	Community Alarm/Telecare Services Transition from Analogue to Digital	26/9/19	That an update report on progress be submitted to a future meeting.	Ongoing	September 2020	Helen McArthur

Integration Joint Board
19th December 2019

Subject:	Director's Report

Purpose:	To advise members of the North Ayrshire Integration Joint Board (IJB) of developments within the North Ayrshire Health and Social Care Partnership (NAHSCP).

Recommendation:	That members of IJB note progress made to date.

Glossary of Terms	
NHS AA	NHS Ayrshire and Arran
HSCP	Health and Social Care Partnership

1.	EXECUTIVE SUMMARY
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 (NAHSCP) nationally, locally and Ayrshire wide.
2.	CURRENT POSITION
	National Developments
2.1	Climate Change Report
	The Climate Change Act 2009 introduced targets and legislation to reduce Scotland's emissions to net zero by 2045. In May 2017 the Scottish Government issued guidance to Integration Joint Boards setting out their duty to produce an annual Climate Change report. This report is submitted on the Sustainable Scotland Network (SSN) online portal by 30th November each year. All public sector reports are then published online by SSN in the form of a national annual report.
	North Ayrshire IJB submitted their annual report on 18th November 2019. As the IJB has no responsibility for employees, buildings or fleet vehicles, the IJB Climate Change report does not include detail of these, but instead refers to the two respective parent bodies plans, as they have retained responsibility for these.
2.2	Integration Event – Chief Executives/Chief Officers
	The Scottish Government hosted an event on Thursday 28th November 2019 for Chief Officers and Chief Executives in Edinburgh. The topics on the day were :- • Leading to Deliver Together • Making Change a Reality

2.3	Standards Commission for Scotland – Advice Note	
	On 6th November 2019 the Standards Commission for Scotland published an Advice Note for Members of Health & Social Care Integration Joint Boards. This aims to provide members of IJBs with an overview of their responsibilities under the ethical standards framework and assist members in recognising the dealing with potential conflicts of interest. The advice note can be accessed through this link Standards Commission Advice Note.	
	North Ayrshire Developments	
2.4	First Class	
	A few years ago the Health and Social Care Partnership took the decision to support two staff annually to undertake their social work degrees. Lynn Robertson, who has worked with us as a social work assistant for several years, not only passed her degree but was awarded a first-class honours.	
	Lynn funded some of the qualification herself and started with the Open University in 2014 balancing her studies with a full-time job and family life.	
	In 2017 she successfully applied to the first year of the partnership's funded route to continue with the BA Honours Degree in Social Work. She has continued to undertake the qualification which involves academic study and assessed work placements which for Lynn were in Justice Services and Barnardos.	
	The Health and Social Care Partnership will continue to offer this opportunity for all "budding" Social workers in the future.	
2.5	Kindness Boxes	
	This year Active Kindness will be delivering Christmas Boxes to individuals who may be lonely or isolated during the festive period. The Carers Team based in Cunninghame House, Irvine, have collected donations which will be passed on to Active Kindness to deliver. If you know someone who would benefit from a Kindness box over the festive period, please contact activekindness1@gmail.com.

Any further information contact Kerryanne Owens, Cunninghame House, Irvine on 01294 317784 or kerryowen@north-ayrshire.gov.uk | |

2.6	**Kin Conversation Cafes**
	If you are a kinship carer in North Ayrshire or work with kinship carers, Children 1st is hosting monthly 'Kin Conversation Cafés' in Ardrossan, Kilbirnie and Irvine. The sessions are really relaxed and informal with lots of conversation and tea and coffee. They also provide kinship carers some time to themselves and the chance to chat to other kinship carers, as well as seek support from staff if they need this. If you would like more information, or to confirm your attendance, contact them on 01294 214884 or email Eilidh on Eilidh.mcdonald@children1st.org.uk
2.7	**Retirals**
	Two experienced members of our mental health team retired this month. Jessie Mitchell, Head of Administration (Mental Health) retired with more than 40 years services, and Tommy Stevenson, Senior Manager (CAMHS) also retired. We wish them both a long and happy retirement!
2.8	**Mental Welfare Commission Visits**
	On 20th November 2019, The Mental Welfare Commission for Scotland published twelve new reports on its visits to NHS hospital wards and units. This included an announced visit to Woodland View on 10 September 2019.
	The report highlighted positive and negative findings from the Commission's visits, one of which was unannounced. The MWC made two recommendations for change following their visit to Woodland View, Irvine. NAHSCP will provide a response to the recommendations within the report within the MWC timescale of three months from publication of the report. The MWC report can be accessed through this link MWC Woodland View.
2.9	**Relocation of Largs Police to Brooksby Medical & Resource Centre, Largs**
	Following a consultation exercise, Police Scotland advised that Largs Police Office was no longer fit for purpose to meet the needs of the community; was in a poor state of repair and becoming too expensive to maintain.
	Police Scotland worked alongside key stakeholders to look at co-locating the Police Office in Brooksby Medical and Resource Centre, Brisbane Road, Largs.
	This work has now been completed and Police Scotland moved its operations to their new base within Brooksby Centre on Wednesday 20th November 2019.
3.	**PROPOSALS**
3.1	**Anticipated Outcomes**
	Not applicable.

3.2	**Measuring Impact**
	Not applicable
4.	**IMPLICATIONS**

Financial:	None
Human Resources:	None
Legal:	None
Equality:	None
Children and Young People	None
Environmental & Sustainability:	None
Key Priorities:	N/A
Risk Implications:	N/A
Community Benefits:	N/A

Direction Required to Council, Health Board or Both	Direction to :-	
	1. No Direction Required	√
	2. North Ayrshire Council	
	3. NHS Ayrshire & Arran	
	4. North Ayrshire Council and NHS Ayrshire & Arran	

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 IJB are asked to note the ongoing developments within the North Ayrshire Health and Social Care Partnership.

For more information please contact Stephen Brown, Director/Chief Officer on 01294 317723 or sbrown@north-ayrshire.gov.uk

Integration Joint Board
19 December 2019

Subject:	**Budget Monitoring – Month 8 (November 2019)**
Purpose:	To provide an update on financial performance to November 2019, including the projected outturn for the 2019-20 financial year.
Recommendation:	It is recommended that the IJB: a) Note the projected year-end overspend of £2.524m; b) Note the changes in funding as detailed in section 2.12 and Appendix E; and c) Note the North Ayrshire IJB position in the context of the national financial position for Integration Authorities across Scotland.

Glossary of Terms	
NHS AA	NHS Ayrshire and Arran
HSCP	Health and Social Care Partnership
MH	Mental Health
CAMHS	Child & Adolescent Mental Health Services
BRAG	Blue, Red, Amber, Green
UNPACS	UNPACS, (UNPlanned Activities) – Extra Contractual Referrals
CRES	Cash Releasing Efficiency Savings
NES	NHS Education Scotland – education and training body
NRAC	NHS Resource Allocation Committee

1.	**EXECUTIVE SUMMARY**
1.1	The report provides an overview of the financial position for the partnership and outlines the projected year-end outturn position informed by the projected expenditure and income commitments, these have been prepared in conjunction with relevant budget holders and services. This report reflects the position at the November period end and is as current and up to date as can practically be reported.
1.2	The projected outturn is a year-end overspend of £2.524m for 2019-20 which is a favourable movement of £0.445m from the previous reporting period. There is scope for this position to fluctuate due to in-year cost and demand pressures and assumptions in relation to funding and the achievement of savings. A financial recovery plan was approved by the IJB in September to work towards delivering financial balance. The plan includes actions to address the areas of overspend to help work towards financial balance this year whilst also delivering a recurring benefit to ensure financial sustainability in future years. Alongside the specific actions outlined in the financial recovery plan services will continue to deploy tight financial management controls to support bringing expenditure back into line with budget. We are in the process of meeting individually with budget managers across the partnership to help identify any further opportunities to reduce the projected overspend.

1.3	The main areas of pressure continue to be learning disability care packages, care at home, looked after children, and adult in-patients within the lead partnership. There has been a favourable movement in the position which mainly relates to updating assumptions for the future level of care at home services and plans to reduce the number of children's residential placements. Partly offsetting these reductions is a lower than anticipated level of invoice variances in Learning Disability care packages and an increase in demand for fostering services.
1.4	Whilst the financial position is improving, this is not moving at the pace required to provide assurance that financial balance can be delivered by the year-end. It will be extremely challenging to recover this overspend by this point in the financial year, there would be a significant impact of short-term decisions and actions that would require to be taken to fully recover this position. Those actions would inevitably have longer term consequences, both financially and for individual people's outcomes and would not necessarily address the areas where we continue to have financial and operational pressures.

North Ayrshire Council continue to hold £1.486m on behalf of the IJB to allow the repayment of the outstanding debt of £5.139m to the Council over the next 3-4 years. Realistically the IJB will not be in a position as planned to make this year's instalment and the IJB should focus on ensuring the final outturn position is limited to £1.5m, to ensure that there is no increase to the overall debt position at the year-end. The adjusted projected outturn position offset by the debt repayment budget is £1.038m. |
| 1.5 | Across Scotland Integration Joint Boards are facing similar financial challenges, whilst there are different individual local circumstances there are similarities with the factors contributing to financial pressures. The total budget delegated for Health and Social Care services to IJBs across Scotland is £9.3bn. The most recent collated Q2 position for 2019-20 reports that 25 out of 31 IJBs are reporting an overspend position totalling £86.3m, the main areas contributing to this are delays in delivering planned savings and demographic service pressures or increase in demand for services.

With the exception of prescribing costs which in North Ayrshire are underwritten by the Health Board, these are all pressures recognised for the North Ayrshire IJB. The partnership continue to actively engage in national networks, best practice forums and review examples of good practice and transformation from other areas. |
2.	**CURRENT POSITION**
2.1	The report includes an overview of the financial position including commitments against the available resource, explanations for the main budget variances, an update on progress in terms of savings delivery and actions required to work towards financial balance.
	FINANCIAL PERFORMANCE
2.2	Against the full-year budget of £243.165m there is a projected overspend of £2.524m (1%). An integrated view of the financial position should be taken; however, it is useful to note that this overall position consists of a projected overspend of £2.607m in social care services offset by a projected underspend of £0.083m in health services.

The Integration Scheme outlines that there is an expectation that the IJB takes account of the totality of resources available to balance the budget in year. |

		Appendix A provides the financial overview of the partnership position. The sections that follow outline the significant variances in service expenditure compared to the approved budgets with detailed analysis provided in Appendix B.
2.3	**Community Care and Health Services**	
		Against the full-year budget of £68.215m there is a projected overspend of £0.894m (1.3%) which is a favourable movement of £0.381m. The main reasons for the projected overspend are:

a) Care home placements including respite placements – projected to overspend by £0.089m (£0.001m favourable movement). Permanent placements will continue to be managed to bring the budget back into line. The projection can vary due to factors other than the number of placements e.g. the impact of interim funded places and outstanding requests for funding, this will require to be monitored closely. The overspend in permanent placements is partly offset by a projected over-recovery of Charging Order income of £0.200m which is based on income received to date and improved processes to track the charging orders. The care home budget has moved into a sustainable position and if this can be maintained over the winter period the opening position for the budget for 2020-21 will be an underspend. The IJB will be provided with an update as part of budget setting in March 2020 aligning the future resources with the Strategic Commissioning Plan for Care Homes.

b) Independent Living Services are projected to overspend by £0.265m (adverse movement of £0.035m) which is due to an overspend on physical disability care packages within the community and residential packages. There will be further work undertaken with the implementation of the Adult Community Support framework which will present additional opportunities for reviews and will ensure payment only for the actual hours of care delivered.

c) Packages of care are projected to underspend by £0.094m which is a favourable movement of £0.004m. This is due to delays in new packages offsetting the use of supplementary staffing for existing packages, this has improved from the 2018-19 position.

d) Care at home is projected to overspend by £0.530m which is a favourable movement of £0.363m. The movement is due to updating the assumptions as follows:

    i. A favourable movement due to an assumption on the number of hours potentially to be refunded following an internal review of the hours provided and an ongoing contractual issue with a commissioned provider
    ii. A favourable movement due to planned reviews to the year-end with a target for hours to reduce by 50 per week. This reduction will allow for capacity to be freed up in the internal service to facilitate hospital discharge and manage waiting lists and a reduction in cost from commissioned services.

The overspend for in-house services relates to providing additional hours to cover a service that a provider handed back and the in-house service had to increase capacity to ensure the safety of vulnerable service users within the community of the North Coast locality and also the need to facilitate patient discharges from Crosshouse Hospital. The service currently has, between hospitals and community a managed waiting list of individuals waiting on a care |

at home package or an increase in their existing care package. The additional cost of clearing this waiting list (part year costs) would be approximately £0.6m.

The planned action around reviews to reduce purchased care and maximise the capacity of the in-house service will reduce the ongoing overspend in care at home, despite this based on current plans there may remain an overspend moving into 2020-21. This will be addressed as part of the 2020-21 budget planning alongside consideration of demand pressure funding and savings to ensure a sustainable position moving forward.

e) Long Term Conditions (Ward 1), projected overspend of £0.279m (adverse movement of £0.005m) which is mainly due to an overspend in employee costs to ensure staffing levels are at a safe level. This is a recurring pressure for which funding requires to be identified. This will be reviewed during 2019-20 along with other wards. Ward 2 is projected to be £0.010m underspent (adverse movement of £0.010m) but this is subject to continuing to receive £0.504m of funding from East HSCP for their patients, East have indicated their intention to reduce the number of commissioned beds, this is not anticipated to be implemented during 2019-20.

f) Community Care employee costs are projected to overspend by £0.147m (favourable movement of £0.046m) due to supernumerary / unfunded posts and the non-achievement of payroll turnover. Some of these posts have been allocated to the care at home service and others have still to be allocated to the appropriate service to manage the costs within the delegated budget.

g) Locality services employee costs are projected to overspend by £0.153m (favourable movement of £0.008m) due to a projected shortfall in payroll turnover targets.

h) Carers Act Funding is projected to underspend by £0.268m (no movement) based on the currently committed spend. This could fluctuate depending on the number of carers' support plans undertaken and the level of demand/services identified from these plans. An allocation of £117k has previously been allocated to offset an overspend on care home respite placements.

i) Intermediate Care (excluding Models of Care) is projected underspend by £0.092m (favourable movement of £0.003m) due to vacancies.

j) Intermediate Care and Rehab Models of Care is projected to overspend by £0.247m (no movement) which represents the full year funding impact of the model. The projected overspend is based on the posts which are currently filled, with an assumption that any vacancies would be held until a longer-term decision on funding investment is taken.

k) Aids and adaptations – are projected to underspend by £0.200m per the approved recovery plan.

l) District Nursing – is projected to underspend by £0.055m due to vacancies.

| 2.4 | **Mental Health Services** |

Against the full-year budget of £76.122m there is a projected overspend of £1.308m (1.7%) which is an adverse movement of £0.448m. The main reasons for the projected overspend are:

- Learning Disabilities – projected overspend of £1.217m (adverse movement of £0.240m), of which £0.617m is in relation to community care packages, £0.330m for direct payments and £0.355m for residential placements. These overspends are partially offset by vacant posts. The projection assumes that savings of £0.289m will be made before the year end. The main reason for the adverse movement is a revision to the level of assumed invoice variations as several care packages have now been reviewed and it has become clear that the level of variation has been lower than expected and lower than in previous years. Community Learning Disability Care packages are proving to be one of the most challenging areas to address overspends, as the care packages are aligned to meet an individual's assessed needs. The recovery plan includes the prioritised review of all packages. Progress with the reviews has been slower than planned due to the implementation of the Adult Community Support Contract and also a number of packages that have been reviewed, particularly the higher cost packages, have concluded that no change is possible at this time. This work is ongoing and will continue to be a fluid position until the year-end, the financial implications for 2020-21 will require to be considered as part of the budget process for next year.

- Community Mental Health – is projected to underspend by £0.166m (favourable movement of £0.043m) mainly due to vacancy savings and an underspend in care packages.

- Addictions – is projected to be underspent by £0.104m (adverse movement of £0.006m) due to vacant posts.

- Lead Partnership for Mental Health – overall projected overspend of £0.361m (adverse movement of £0.325m) which consists of:

Overspends:

- Adult inpatients £0.620m (adverse movement of £0.020m) - mainly due to the delay in closing the Lochranza ward on the Ailsa site. The ability to close Lochranza is dependent on discharging at least two patients from South Ayrshire. South HSCP have been advised that the Lochranza ward will close, the projection also assumes subsequent redeployment costs.

- Psychiatry £0.145m (adverse movement of £0.120m) – overspend primarily due to agency costs. Agency staff are used in the absence of being able to recruit permanent posts. The adverse movement is due to the Medical Pay Award (£0.160m) which was not funded.

- UNPACS £0.399m (£0.117m adverse movement) – based on current placements which increased by one and an increased charge from the state hospital for the period April to August 2019.

- Elderly inpatients £0.200m (£0.100m adverse movement) - due to holding vacancies in relation to reconfiguring the wards. This resulted in using supplementary staff in the interim.

Underspends:

- CAMHS £0.228m (£0.042m adverse movement) – due to vacancies and delays with recruitment. This is after applying £0.150m of payroll turnover.

- Psychology £0.253m (£0.053m favourable) – due to vacancies. This is after applying £0.150m of payroll turnover.

- Adult Community Mental Health £0.100m (£0.002m favourable movement) - due to vacancies.

- MH Pharmacy £0.132m (£0.028m adverse movement) – underspend due to continued lower substitute prescribing costs.

- MH Admin £0.155m (favourable movement of £0.016m) - due to vacancies.

2.5	**Children & Justice Services**

Against the full-year budget of £35.671m there is a projected overspend of £1.260m (3.5%) which is a favourable movement of £0.155m. The main reasons for the projected overspend are:

a) Residential Schools and Community Placements – projected overspend of £1.101m (£0.285m favourable movement). The projection is based on the current number of placements and estimated discharge dates for each placement. There are currently 20 external residential placements and 2 secure placements. The reported projection assumes the secure placements end in January 2020, 4 discharges by end of December with the remaining 16 assumed to be in place until March 2020. These assumptions are based on individual plans for children. There is no provision for any increase in placements. The service are working with housing colleagues to develop alternatives for older children in care to free up local care capacity to support the reduction in external residential placements. This work ties in with future plans to further reduce the requirement for residential placements and if the planned timescales are met by March 2020 then the budget will be back into a sustainable position and on track to deliver further savings moving into 2020-21.

b) Looked After Children Placements – projected overspend of £0.203m (adverse movement of £0.120m) due to the current increased demand for fostering, adoption and kinship placements. External placements were made as there were no internal foster carers available. Unless additional internal foster carers are recruited there will be a continued need to use external foster placements. A recruitment campaign is planned to attract more in-house foster carers.

c) Children with Disabilities Employee Costs – projected overspend £0.087m (favourable movement of £0.005m) as the turnover target will not be met.

2.6	**Allied Health Professionals**

AHP services are projected to underspend by £0.069m due to vacancies.

2.7	**Management and Support Costs**

	Against the full-year budget of £8.867m there is a projected underspend of £0.690m (7.8%) which is an adverse movement of £0.055m. The underspend relates to the potential delay in commitment for pressure funding set aside in the 2019-20 budget, the most significant element of this is linked to the delay in opening of the Trindlemoss development. The requirement for this funding will need to be closely monitored and may require to be delegated to services as and when required.
2.8	**Primary Care and Prescribing** Prescribing is the responsibility for the Health Board to fund and under the terms of the Integration Scheme the Health Board continues to underwrite the prescribing position across the three Ayrshire IJBs. At month 7 prescribing is projected to be £1.383m overspent (no movement). This is not included in the projected outturn due to the NHS underwriting the risk of overspend.
2.9	**Movement in Projected Outturn Position**
	The table below shows the overall movement in the projected outturn position throughout the financial year: The partnership financial position has been challenging since the start of the year, with a significant projected overspend projected in the first reporting period. This is reflective of the challenges in delivering savings against a backdrop of continuing to prioritise and meet existing and new demand for services. The IJB approved a balanced budget for 2019-20 in March 2019. The budget was underpinned by a requirement to deliver savings of £6.1m and to manage a number of in-year unfunded pressures. Whilst the budget and savings plans are completely aligned to the IJB's Strategic Plan and ambitions within that to change how we deliver health and social care services, we have never underestimated the challenge in delivering service change across all services at pace whilst continuing to meet new demand for services. So many of the delegated services, particularly for social care, are demand led and for some services these are very specialist and high cost. This leads to a greater risk of being able to plan for and respond to in-year demands for services.

Whilst the financial position is improving, this is not moving at the pace required to provide assurance that financial balance can be delivered by the year-end. It will be extremely challenging to recover this overspend by this point in the financial year, there would be a significant impact of short-term decisions and actions that would require to be taken to fully recover this position. Those actions would inevitably have longer term consequences, both financially and for individual people's outcomes and would not necessarily address the areas where we continue to have financial and operational pressures.

North Ayrshire Council continue to hold £1.486m on behalf of the IJB to allow the repayment of the outstanding debt of £5.139m to the Council over the next 3-4 years. Realistically the IJB will not be in a position as planned to make this year's instalment and the IJB should focus on ensuring the final outturn position is limited to £1.5m, to ensure that there is no increase to the overall debt position at the year-end. The adjusted projected outturn position offset by the debt repayment budget is £1.038m.

2.10	**Savings Progress**

a) The approved 2019-20 budget included £6.134m of savings.

RAG Status	Position at Budget Approval £m	Position at Period 7 £m
Red	-	0.270
Amber / Red	-	1.683
Amber	2.980	1.002
Green	3.154	3.179
TOTAL	**6.134**	**6.134**

b) The projected year-end outturn position assumes:

i) £0.270m of the Red savings in relation to reducing LD sleepovers (£0.215m) and the roll out of MDTs (£0.055m) will not be delivered as planned and this is reflected in the overall projected outturn position; and

ii) The £0.328m risk of savings relating to Trindlemoss is partially reflected (£0.178m) in the projected overspend position as there is ongoing work to establish the deliverability of the saving given that the savings were based on the service being operational from September.

If progress is made to deliver the savings this would improve the overall outturn position or prevent the overspend increasing further.

Some savings have been reclassified as Amber / Red as the budget has been removed from the service area, but these areas are overspending.

The projected financial position assumes that all remaining savings on the plan will be delivered. Progress with savings delivery requires to be closely monitored to ensure the impact on the financial position can be assessed and corrective action taken where necessary. It is essential that if a saving cannot be achieved by the year end that there are plans in place to achieve it moving into 2020-21.

		Appendix C provides an overview of the savings plan, this highlights that at this stage a total of £3.179m of savings have been delivered successfully.

The Transformation Board is in place to provide oversight and governance to the programme of service change.   A focus of the Board is to ensure plans are in place to deliver savings and service change, with a solution focussed approach to bringing programmes back on track. |
| 2.11 | **Financial Recovery Plan** | |
| | | The Integration Scheme requires the implementation of a recovery plan if an overspend position is being projected, to take action to bring overall service delivery back into line with the available resource. The previously approved financial recovery plan is included in Appendix D.

This includes specific targeted actions with a focus on addressing the pressure areas, the actions will not only improve the projected overspend this year but will also address recurring overspends in service areas moving into future years. The plan requires the IJB support as whilst many of the actions are operational management decisions there may be some resistance from service users and communities to any changes to care packages and services.

The plan will be monitored closely and is underpinned by more detailed plans with clear actions for high risk service areas. One of the most significant risk areas is Learning Disabilities, a more detailed plan with all actions including tracking progress with reviews is co-ordinated between the service and finance and transformation team. Weekly cross-service progress meetings are being held to track progress and to ensure progress at pace.

The further actions noted below were subsequently noted to be undertaken:

1) **Care at Home** – review feedback from the Thinking Differently Doing Better sessions to identify the main 'themes' that can be taken forward to maximise capacity, including visits, assessment and review process, electronic communication with staff. Since September almost all of the communication with staff has moved to an electronic format.

2) **Learning Disability** – continue the focussed work with weekly progress updates. Hold a development session with the learning disability team to ensure that progress made to date is embedded moving forward. Progress the responder service on a geographical cluster basis with Trindlemoss being the piloted area.

3) **In house fostering –** grow the number of in-house foster carers through a recruitment campaign (advertising, radio and social media campaign). Review the terms and conditions for foster carers.   A recruitment campaign is being designed and will be launched in the coming weeks.

4) **Children's Residential Placements –** work with housing colleagues to develop alternatives for older children in care to ensure local capacity can be used to reduce the numbers of external placements. |

	The plan includes actions to address the areas of overspend to help work towards financial balance this year whilst also delivering a recurring benefit to ensure financial sustainability in future years. Alongside the specific actions outlined in the financial recovery plan services will continue to deploy tight financial management controls to support bringing expenditure back into line with budget. We are in the process of meeting individually with budget managers across the partnership to help identify any further opportunities to reduce the projected overspend.
2.12	**Financial Risks**
	The 2019-20 budget setting paper noted unfunded pressures which could present a risk to the projected outturn position. This included: a) Paid as if at work is a pressure relating to health employed staff and the payment of a holiday pay element for regular additional payments, e.g. overtime. The cost across the Health Board is estimated to be £1.4m but is unclear at this stage what the cost will be for each service, for North Ayrshire this is estimated to be around £0.15m. When the cost pressure value is known the partnership will look to services to fund from within existing resources where possible. It is anticipated that this will be paid in December. b) There is a potential pressure in relation to GP practices in difficulty. This is a dynamic pressure which we will look to manage in-year. If this cannot be achieved, then the default position would be to fund the North fair share of this (circa £0.2m) from any underspend in the Primary Care Improvement Fund (PCIF). At month 7 there are no GP practices in difficulty. In addition to these pressures there is a potential reduction to the funding available for Ward 2 in Woodland View as East HSCP are reviewing the number of beds they want to commission from the ward. It is unlikely that this will be implemented during 2019-20 due to the limited notice given re the intent to reduce.
2.13	**Budget Changes**
	The Integration Scheme states that "*either party may increase it's in year payment to the Integration Joint Board. Neither party may reduce the payment in-year to the Integration Joint Board nor Services managed on a Lead Partnership basis....without the express consent of the Integration Joint Board*". Appendix E highlights the movement in the overall budget position for the partnership following the initial approved budget. *Reduction Requiring Approval:* a) Transfer £0.010m to Communities for Youth Participatory Budgeting. *Future Planned Changes:* Further areas which are outstanding and will be included in future reports include: 1) Transfer of hub funding to the Communities Directorate (approx. £57k) 2) The transfer of the Douglas Grant and Redburn rehab wards from acute services to the North HSCP. The operational management of these wards has already

		transferred to the partnership, but the due diligence undertaken on the budget has highlighted a funding shortfall. It has been agreed with NHS Ayrshire & Arran that the financial responsibility will not transfer until balance is found. In the meantime, we are managing services and working to reduce the projected overspend prior to any transfer.
2.14	**Lead Partnerships**	
	North Ayrshire HSCP Services managed under Lead Partnership arrangements by North Ayrshire Health and Social Care Partnership are projected to be £0.361m overspent. Full detail on the underspend is given in section 2.4 above. This position is shared across the 3 partnerships on an NRAC allocation basis and is reflected in Appendix A.	
	South Ayrshire HSCP Services hosted and/or led by the South Partnership are forecast to be £0.288m overspent (adverse movement of £0.063m). The Community Equipment Store was funded with an additional £0.280m as part of the budget for this year, however it continues to be a source of pressure and represents the majority of the overspend. It should be noted that expenditure is volatile depending on the timing of purchases. This issue is being discussed by SPOG.	
	East Ayrshire HSCP Services managed under Lead Partnership arrangements by East Ayrshire Health and Social Care Partnership are projected to marginally overspent by £0.046m in total. This is a favourable movement on the month 4 projected overspend £0.288m. The overall Primary Care Lead Partnership marginal projected overspend is £0.006m (£0.266m at month 4) and this projected variance includes additional year-to-date payments within Primary Medical Services to GP practices currently experiencing difficulty (mainly practices that the NHS Board was administering due to previous GPs handing back contracts). The GP practices in difficulty issue is extremely fluid however negotiations with practices are completed with them returning to independent contractor status on 1 September 2019. Additional Ayrshire Urgent Care Services costs resulting from increased rates being paid to attract GPs over certain periods (which can prove challenging to fill without financial incentives). A non-recurring allocation of £0.370m has been included within the AUCS budget from the GP Out of Hours fund. This funding is not yet confirmed beyond 31 March 2020 and will potentially result in an additional financial pressure going forward.	
	Further work is being taken forward to develop a framework to report the financial position and impact of risk sharing arrangements across the 3 partnerships in relation to hosted or lead service arrangements. This is to ensure the IJB are fully sighted on the impact for the North Ayrshire partnership. The IJB will be kept informed of progress with this work which is being progressed by the Ayrshire Partnership Finance Leads. At month 7 the impact of the Lead Partnerships has been calculated based on the average NRAC share which is the method that was used in previous years and has been agreed by the Ayrshire Finance Leads. The NRAC shares are: North 36.6%, South 30.5% and East 32.9%	
2.15	**Set Aside**	

	The Integration Scheme makes provision for the Set Aside Budget to be managed in-year by the Health Board with any recurring over or under spend being considered as part of the annual budget setting process. The 2019-20 set aside budget for North HSCP is £30.094m, based on expenditure in 2018-19. The acute directorate, which includes the areas covered by the set aside budget, is overspent by £7.8m after 7 months. 58 additional and unfunded beds were open at the 31st March 2019. Crosshouse and Ayr hospitals have experienced a high level of demand and delayed discharges, resulting in increased operational pressures and additional expenditure. During 2018-19 the North Partnerships use of the set aside resources was £30.094m against the NRAC 'fair share' of £28.697m which is £1.127m above the 'fair share'. There is an expectation that the North Partnership will move towards its 'fair share'. The Models of Care programmes including the Intermediate Care and Rehab investment and the Palliative End of Life proposals being developed represent agreed or potential investment in community services with a view to reducing acute beds. This is in effect a mechanism to reduce the set aside resources. Currently however the funding for the ICR model is not able to be released from the acute set-aside budget due to service pressures and the overall overspend in acute services.
2.16	**National Position**
	Across Scotland Integration Joint Boards are facing similar financial challenges, whilst there are different individual local circumstances there are similarities with the factors contributing to financial pressures. The total budget delegated for Health and Social Care services to IJBs across Scotland is £9.3bn. The most recent collated Q2 position for 2019-20 reports that 25 out of 31 IJBs are reporting an overspend position totalling £86.3m, the main areas contributing to this are delays in delivering planned savings and demographic service pressures or increase in demand for services. The overview report provided to the Scottish Government is included as Appendix F. Key highlights include: - The challenge to deliver savings, in particular planned reductions in services not materialising due to increased demand being experienced - Increased activity of acute services - Additional demand for services and the increasing complexity of health and social care needs across older people, adult and children's services - The timeline to implement new models of service delivery taking longer than originally anticipated - Ongoing challenges associated with identifying further cost reduction and savings opportunities - Prescribing cost pressures; and - Staffing costs including the cost of locums. With the exception of prescribing costs which in North Ayrshire are underwritten by the Health Board, these are all pressures recognised for the North Ayrshire IJB. The partnership continue to actively engage in national networks, best practice forums and review examples of good practice and transformation from other areas.

3.	**PROPOSALS**	
3.1	**Anticipated Outcomes**	
	Continuing to implement and monitor the financial recovery plan will allow the IJB to work towards financial balance for 2019-20 whilst ensuring these plans align with securing financial sustainability in future years, thereby limiting the financial risk the funding partners, i.e. NAC and NHS AA. The transformational change programme will have the greatest impact on the financial sustainability of the partnership, the IJB require to have a clear understanding of progress with plans and any actions that can be taken to bring the change programme into line.	
3.2	**Measuring Impact**	
	Updates to the financial position will be reported to the IJB throughout 2019-20.	
4.	**IMPLICATIONS**	

Financial:	The financial implications are as outlined in the report. Against the full-year budget of £243.575m there is a projected overspend of £2.524m (1.3%). The report outlines the action being taken and proposed action to reduce the projected overspend. There are a number of assumptions underpinning the projections which could change as we progress through the year. We will continue to work with services to ensure the most accurate and reliable position is reported. The financial recovery plan details planned actions to reduce the projected overspend, delivery of the plan is being closely monitored. The main areas of financial risk which may impact on this position are highlighted in the report. North Ayrshire Council hold £1.486m on behalf of the IJB to allow the repayment of the outstanding debt of £5.139m to the Council over future years. This resource is not currently included in the projected outturn position, at this stage with the rate of financial recovery is it unlikely that the IJB will be in the position to make the planned debt repayment for 2019-20.
Human Resources:	None
Legal:	None
Equality:	None
Children and Young People	None
Environmental & Sustainability:	None
Key Priorities:	None

Risk Implications:	Within the projected outturn there are various over and underspends including the non-achievement of savings which need to be addressed on a recurring basis to ensure financial sustainability in future years. The Financial Recovery Plan is focussed on those areas which will help the current year financial position but also support ongoing future financial sustainability of the partnership.
Community Benefits:	None

Direction Required to Council, Health Board or Both	Direction to :-	
	1. No Direction Required	
	2. North Ayrshire Council	
	3. NHS Ayrshire & Arran	
	4. North Ayrshire Council and NHS Ayrshire & Arran	√

4.	CONSULTATION
4.1	This report has been produced in consultation with relevant budget holders and the Partnership Senior Management Team.

The report is shared with the Director of Finance for NHS Ayrshire and Arran and the Executive Director Finance and Corporate Support for North Ayrshire Council. |
| 5. | CONCLUSION |
| | It is recommended that the IJB:

a) Note the projected year-end overspend of £2.524m;
b) Note the changes in funding as detailed in section 2.12 and Appendix E; and
c) Note the North Ayrshire IJB position in the context of the national financial position for Integration Authorities across Scotland. |

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Partnership Budget - Objective Summary	2019/20 Budget									Over/ (Under) Spend Variance at Period 6	Movement in projected budget variance from Period
	Council			Health			TOTAL				
	Budget	Outturn	Over/ (Under) Spend Variance	Budget	Outturn	Over/ (Under) Spend Variance	Budget	Outturn	Over/ (Under) Spend Variance		
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
COMMUNITY CARE AND HEALTH	**55,103**	**55,829**	**726**	**13,112**	**13,280**	**168**	**68,215**	**69,109**	**894**	**1,275**	**(381)**
: Locality Services	25,454	25,616	162	4,561	4,435	(126)	30,015	30,051	36	140	(104)
: Community Care Service Delivery	26,081	27,164	1,083	0	0	0	26,081	27,164	1,083	1,356	(273)
: Rehabilitation and Reablement	1,765	1,548	(217)	1,946	2,043	97	3,711	3,591	(120)	(125)	5
: Long Term Conditions	1,443	1,167	(276)	4,595	4,807	212	6,038	5,974	(64)	(61)	(3)
: Integrated Island Services	360	334	(26)	2,010	1,995	(15)	2,370	2,329	(41)	(35)	(6)
MENTAL HEALTH SERVICES	**24,246**	**25,500**	**1,254**	**51,876**	**51,930**	**54**	**76,122**	**77,430**	**1,308**	**860**	**448**
: Learning Disabilities	18,427	19,727	1,300	511	428	(83)	18,938	20,155	1,217	977	240
: Commmunity Mental Health	4,454	4,392	(62)	1,611	1,507	(104)	6,065	5,899	(166)	(43)	(123)
: Addictions	1,365	1,381	16	1,345	1,225	(120)	2,710	2,606	(104)	(110)	6
: Lead Partnership Mental Health NHS Area Wide	0	0	0	48,409	48,770	361	48,409	48,770	361	36	325
CHILDREN & JUSTICE SERVICES	**32,061**	**33,278**	**1,217**	**3,610**	**3,653**	**43**	**35,671**	**36,931**	**1,260**	**1,415**	**(155)**
: Intervention Services	3,786	3,843	57	325	368	43	4,111	4,211	100	46	54
: Looked After & Accomodated Children	16,325	17,339	1,014	0	0	0	16,325	17,339	1,014	1,278	(264)
: Fieldwork	4,713	4,838	125	0	0	0	4,713	4,838	125	120	5
: CCSF	322	288	(34)	0	0	0	322	288	(34)	(20)	(14)
: Criminal Justice	2,627	2,627	0	0	0	0	2,627	2,627	0	0	0
: Early Years	394	364	(30)	2,868	2,868	0	3,262	3,232	(30)	(48)	18
: Policy & Practice	3,894	3,979	85	0	0	0	3,894	3,979	85	40	45
: Lead Partnership NHS Children's Services Area Wide	0	0	0	417	417	0	417	417	0	(1)	1
PRIMARY CARE	0	0	0	47,170	47,170	0	47,170	47,170	0	0	0
ALLIED HEALTH PROFESSIONALS				5,131	5,062	(69)	5,131	5,062	(69)	(60)	(9)
MANAGEMENT AND SUPPORT COSTS	7,034	6,516	(518)	1,833	1,661	(172)	8,867	8,177	(690)	(635)	(55)
CHANGE PROGRAMME	1,025	953	(72)	964	964	0	1,989	1,917	(72)	(50)	(22)
TOTAL	**119,469**	**122,076**	**2,607**	**123,696**	**123,720**	**24**	**243,165**	**245,796**	**2,631**	**2,805**	**(174)**
Return Hosted Over/Underspends East	0	0	0		0	(119)			(119)	(12)	(107)
Return Hosted Over/Underspends South	0	0	0		0	(110)			(110)	(11)	(99)
Receive Hosted Over/Underspends South	0	0	0		0	105			105	82	23
Receive Hosted Over/Underspends East	0	0	0		0	17			17	105	(88)
REVISED PROJECTED OUTTURN	**119,469**	**122,076**	**2,607**	**123,696**	**123,720**	**(83)**	**243,165**	**245,796**	**2,524**	**2,969**	**(445)**

	Budget £000's	Outturn £000's	Over/ (Under) Spend Variance £000's	
COMMUNITY CARE AND HEALTH	**68,215**	**69,109**	**894**	
Locality Services	30,015	30,051	36	**Older People permanent care homes** - projected overspend of £0.089m based on 816 placements. Respite care is projected to be online. **Income from Charging Orders** - projected over recovery of £0.200m' I**ndependent Living Services :** * Direct Payment packages- projected overspend of £0.105m on 65 packages. * Residential Packages - projected overspend of £0.012m based on 35 packages. * Community Packages (physical disability) - projected overspend of £0.148m based on 49 packages **NHS Packages of Car**e - projected underspend of £0.094m due to use of supplementary staffing offset by slippage in other packages. **District Nursing -** projected underpsnd of £0.055m due to vacancies.
Community Care Service Delivery	26,081	27,164	1,083	**Care at home** - in house service - projected overspend of £0.240m based on the current level of contracted costs remaining until the year end. Care at home staff have been incurring additional hours as there are moratoria on four of the purchased care providers. - Purchased Care at home - projected overspend of £0.290m. This is after reducing the budget by £0.500m to reflect the agreed 19-20 saving and assumes that the number of hours provided will reduce by 50 per week until the end of 19-20. It also assumes a refund from a provider in relation to an ongoing query on their costs. **Direct Payments** - projected underspend of £0.042m based on 31 packages continuing until the year end. **Transport costs** - projected overspend of £0.072m due to increase in staff mileage within care at home. **Admin costs** - projected overspend of £0.091m mainly due to mobile phone equipment. Supplies and Services - projected overspend of £0.133m in relation to uniforms and other supplies. **Voluntary Organisations** - projected overspend £0.088m mainly in relation to the Alzheimer service.

	Budget £000's	Outturn £000's	Over/ (Under) Spend Variance £000's	
Rehabilitation and Reablement	3,711	3,591	(120)	**Employee costs -** projected underspend £0.157m due to vacancies. **Intermediate Care and Rehab Models of Care** - projected to overspend by £0.247m which is the full year funding impact. **Aids and Adaptations** - projected underspend of £0.200m per the approved recovery plan
Long Term Conditions	6,038	5,974	(64)	**Ward 1 -** projected overspend of £0.279m due to the use of supplementary staffing. **Ward 2 -** projected underspend of £0.010m assuming £0.504m of funding transfers from East HSCP in relation to Kirklandside patients. **Elderly CMHT -** underspend of £0.061m due to vacancies. **Carers Act Funding** - projected underspend of £0.268m based on the committed spend. This could fluctuate depending on the volume of carers' assessments undertaken and the level of demand/services identified from these assessments. This underspend will be used in the first instance to cover the projected overspend on care home respite placements.
Integrated Island Services	2,370	2,329	(41)	**Outwith the threshold for reporting**
MENTAL HEALTH SERVICES	**76,122**	**77,430**	**1,308**	
Learning Disabilities	18,938	20,155	1,217	**Residential Packages-** projected overspend of £0.355m based on 41 current packages. **Community Packages (inc direct payments) -** projected overspend of £0.947m based on 296 current packages less 3.75% invoice variances. The projection assumes savings of £0.490m will be achieved (£0.201m achieved to date) and that any new packages or increases to current packages will be cost neutral. The direct payments projection is based on 41 current packages with a net increase of 2 to the year end less £0.102m recovery of unspent balances. **Employee costs -** projected underspend £0.083m mainly due to vacant posts
Community Mental Health	6,065	5,899	(166)	**Employee costs - projected underspend £0.134m mainly due to vacant posts**
Addictions	2,710	2,606	(104)	**Employee costs -** projected underspend £0.120m due to vacant posts **ADP** - projected online position as any underspend will be carried forward into 2020/21.

	Budget £000's	Outturn £000's	Over/ (Under) Spend Variance £000's	
Lead Partnership (MHS)	48,409	48,770	361	**Adult Community** - projected underspend of £0.100m due to vacancies. **Adult Inpatients**- projected overspend of £0.620m due to a delay in closing the Lochranza wards. **UNPACs** - projected overspend of £0.399m which includes the charges from the state hospital (April - August 2019). **LDS -** assumed online pending completion of the relocation of services to Woodland View. **Elderly Inpatients** - projected overspend of £0.200m due to use of supplementary staffing after ward closures. This could fluctuate pending the finalisation of the elderly mental health bed redesign. **Addictions** - projected underspend of £0.025m due to vacancies. **CAMHS** - projected underspend of £0.228m due to vacancies. **MH Admin** - projected underspend of £0.155m due to vacancies.. **Psychiatry** - projected overspend of £0.145m due the medical pay award and agency costs. **MH Pharmacy** - projected underspend of £0.132m mainly within substitute prescribing. **Psychology**- projected underspend of £0.253m due to vacancies. **Action 15** - assumed online position
CHIDREN'S AND JUSTICE SERVICES	**35,671**	**36,931**	**1,260**	
Intervention Services	4,111	4,211	100	**Employee costs -** projected overspend £0.043m due to incremental drift. **Third Party Payments** - projected overspend in relation to advocacy and functional family therapy services.

	Budget £000's	Outturn £000's	Over/ (Under) Spend Variance £000's	
Looked After & Accom Children	16,325	17,339	1,014	**Looked After Children placements - projected overspend of £0.203m based on the following:-** **Kinship -** projected overspend of £0.071m. Budget for 339 placements, currently 352 placement but projecting 356 placements by the year end. **Adoption -** projected overspend of £0.001m. Budget for 74 placements, currently 74 placements. **Fostering** - projected overspend of £0.218m. Budget for 120 placements, currently 138 placements **Fostering Xtra** - projected underspend of £0.064m. Budget for 32 placements, currently 31 placements but projecting 30 placements by the year end. **Private fostering -** projected overspend of £0.041m. Budget for 11 placements, currently 12 placements. **IMPACCT carers** - projected underspend of £0.016m. Budget for 4 placements, currently 2 placements. **Residential School placements including community packages -** projected overspend of £1.101m. The projection is based on the current number of placements and estimated discharge dates for each placement based on the support from the mainstreamed Challenge Fund project. There are currently 22 placements (inc 2 secure w3hich will end in January). The projection assumes 4 discharges in December with the remaining 16 assumed to be still in a placement at the year end. There is no provision for any increase in placements.
Fieldwork	4,713	4,838	125	**Employee costs** - projected overspend of £0.102m in relation to non achieved payroll turnover. Various minor overspends on transport and the out of hours service.
CCSF	322	288	(34)	**Outwith the threshold for reporting**
Criminal Justice	2,627	2,627	0	**Outwith the threshold for reporting**
Early Years	3,262	3,232	(30)	**Outwith the threshold for reporting**
Policy & Practice	3,894	3,979	85	**Employee costs -** projected overspend £0.087m due to the payroll turnover target not being met.
Lead Partnership (CS)	417	417	0	**Outwith the threshold for reporting**

	Budget £000's	Outturn £000's	Over/ (Under) Spend Variance £000's	
PRIMARY CARE	47,170	47,170	0	**Outwith the threshold for reporting**
ALLIED HEALTH PROFESSIONALS	5,131	5,062	(69)	**Employee costs -** projected underspend £0.069m due to vacancies.
MANAGEMENT AND SUPPORT	8,867	8,177	(690)	**Projected underspend** - this underspend relates to pressure funding awarded as part of the 2019-20 and the pressures have not yet arisen. This funding will be closely monitored and delegated to services as and when required.
CHANGE PROGRAMME & CHALLENGE FUND	1,989	1,917	(72)	**Projected underspend -** in employee costs due to vacancies and slippage in projects.
TOTAL	**243,165**	**245,796**	**2,631**	

Threshold for reporting is + or - £50,000

2019-20 Savings Tracker

Savings reference number	Description	Responsible Senior Management Lead	Deliverability Status at budget setting	Approved Saving 2019/20 £	Deliverability Status Month 7	Net Saving Achieved at Period 7 £
Health and Community Care						
SP-HSCP-19-02	Roll out of multidisciplinary teams - Community Care and Health	Helen McArthur	Amber	55,000	Red	0
SP-HSCP-19-04	Day Centres - Older People	Helen McArthur	Green	38,232	Green	38,232
SP-HSCP-19-05	Deliver the Strategic Plan objectives for Older People's Residential Services	Helen McArthur	Green	130,350	Amber	0
SP-HSCP-19-09	Care at Home - Reablement Investment	Helen McArthur	Amber	500,000	Amber / Red	0
SP-HSCP-19-12	Assessment and Self Directed Support	Isabel Marr	Green	150,000	Amber / Red	0
NHS - HSCP-9	Packages of Care	Isabel Marr	Amber	150,000	Green	150,000
Mental Health and Learning Disabilities						
SP-HSCP-19-01	Integration of the Learning Disability team	Jan Thomson	Amber	56,000	Green	56,000
SP-HSCP-19-07	Mental Health - Tarryholme / Trindlemoss (Council element)	Jan Thomson	Amber	328,000	Amber	150,000
NHS - HSCP-1	Trindlemoss (full year impact is £0.370m)* NHS element	Jan Thomson	Amber	250,000	Green	0
SP-HSCP-19-10	LD - Reduction to Sleepover Provision	Jan Thomson	Amber	215,000	Red	25,000
SP-HSCP-19-11	Reprovide Fergushill/Hazeldene at Trindlemoss & redesign commissioned services	Jan Thomson	Green	111,000	Green	0
SP-HSCP-19-06	Adult Community Support - Commissioning of Services	Jan Thomson /Julie Barrett	Green	388,000	Amber / Red	1,500
NHS - HSCP-4	UnPACs - 7% reduction*	R Ralston	Green	200,000	Amber / Red	0
NHS - HSCP-5	Substitute Prescribing - 5% reduction*	R Ralston	Green	135,000	Green	135,000
NHS - HSCP-3	Review of Elderly Mental Health Inpatients*	William Lauder	Green	727,000	Green	0
NHS - HSCP-6	See a 5th bed at Woodland View - MH inpatients*	William Lauder	Amber	90,000	Amber / Red	0

	Children, Families and Justice Services					
SP-HSCP-19-03	Fostering - reduce external placements.	Mae Henderson	**Green**	127,408	**Amber**	127,408
SP-HSCP-19-08	Children's residential placements (CF)	Mae Henderson	**Amber**	355,000	**Amber / Red**	0
	Partnership Wide					
SP-HSCP-19-13	Charging Policy	Lisa Duncan	**Green**	200,000	**Green**	200,000
NHS - HSCP-10	Reduce business admin services	Julie Davis	**Green**	50,000	**Green**	50,000
NHS - HSCP-11	ICF Project - Partnership Enablers	Michelle Sutherland	**Amber**	27,000	**Green**	27,000
NHS - HSCP-12	ICF Project - Buckreddan care home	Michelle Sutherland	**Amber**	16,000	**Amber**	8,000
NHS - HSCP-13	Uncommitted ICF Funding	Michelle Sutherland	**Green**	80,000	**Green**	80,000
SP-HSCP-19-20	Living Wage	n/a	**Green**	187,000	**Green**	187,000
NHS - HSCP-7	Resource Transfer to South Lanarkshire	n/a	**Green**	40,000	**Green**	40,000
SP-HSCP-19-14	19/20 impact of 18/19 part year savings	Stephen Brown	**Green**	113,000	**Green**	113,000
SP-HSCP-19-15	Respite	n/a	**Green**	200,000	**Green**	200,000
SP-HSCP-19-16	Payroll Turnover Target	Stephen Brown	**Amber**	500,000	**Amber**	208,333
SP-HSCP-19-17	Lean Efficiency Programme	Stephen Brown	**Green**	50,000	**Amber**	0
NHS - HSCP-2	Payroll Turnover Target - Mental Health *	Thelma Bowers	**Amber**	300,000	**Green**	300,000
NHS - HSCP-8	Payroll Turnover Target - Other Services	Thelma Bowers	**Amber**	365,000	**Green**	365,000
				6,133,990		**2,461,473**

Ref	Service Area	Action	Service Impact	IJB Support	Included in P8 Position £000's	Planned Impact £ 000's	Responsible Officer
Health and Community Care:							
1	Care at Home	**Reduction in Care at Home Provision:** - reduce weekly hours of purchased provision by between 50 and 100 hours per week, by closing cases for clients admitted to hospital. - review care packages with any reduction in hours closed to offset the overspend. - continue to review the actions of Independent Providers in the use of CM2000 for maximum efficency - further roll out and embedding of reablement approach in CAH service to allow packages to be reduced	May lead to delays in care at home packages being delivered and may impact on hospital discharges and increase delayed discharges. May have impact on waiting list. Risk of this will be mitigated by ensuring resources are used efficiently, with a risk based approach to allocating resources.		225	200	Helen McArthur
2	Care Homes - Respite Placements	**Health and Community Care Service to enforce a policy and criteria in relation to emergency respite in commissioned care home settings**: - significant increase in emergency respite where in many cases residents are placed in long term care, action taken to fund long term placements in September - change of practice for social workers in relation to use of respite - provide clairty to commissioned care home providers that respite beds will be used for short term care to ensure expectations of service, care home and service user are aligned	Action has been taken to address current placements to ensure the service delivered is equitable, that the HSCP are appropriately financially assessing residents and that the commissioned care homes are funded for long term care placements. The appropriate use of emergency respite placements will be reinforced to the social work team. The longer term commissioning and use of respite provision for older people is being considered as part of the Care Home Strategy.	√	0	-	Helen McArthur
3	Equipment & Adaptations	**Temporary reduction (2019-20 only) in the equipment and adaptations budget**. - mirrors the reduction made in 2018/19 to assist with overall financial position, would not be sustainable on a recurring basis as provision of equipment fundamental to keeping people safe at home - priority for equipment provision will be: 1. support for end of life care 2. complete adaptations started or committed to in writing prior to tightened control of expenditure 3. maintain equipment and adaptations in situ and on which service users depend 4. provide essential equipment to support avoidance of hospital admission	Potential delays to equipment and adaptations for service users, this will be kept under review together with any waiting lists and impact on delivery of community based services, including monitoring the costs of any delays in supporting individuals to be supported in the community.		200	200	Helen McArthur

Ref	Service Area	Action	Service Impact	IJB Support	Included in P8 Position £000's	Planned Impact £ 000's	Responsible Officer
Mental Health and Learning Disabilities:							
4	Learning Disabilities	**Prioritised Review of Adult Community Packages:** - targeted reviews to be carried out immediately, reviews co-ordinated on a prioritised list with a focus on individuals moving service provider following the outcome of the tender exercise and with high cost packages being prioritised - will be supported with significant additional LD social work capacity with additional professional lead, additional social workers and the employment of agency staff to accellerate planned reviews - reviews will ensure the split of personal and non-personal care is appropriate and equitable (to ensure equity of provision and charging) - direct payments to be reviewed to progress claw-back of underspends - incorporates looking at clients where the service provided has been less than than commissioned to formalise re-alignment of care packages based on need.	Service users will be reviewed by a dedicated review team, the outcome should ensure that all reviews are up to date and appropriate and equitable levels of care are being provided. This process may cause some anxiety for service users as there is an expectation that significant reductions can be made to care packages. No reduction will be made to care packages unless deemed to be safe and appropriate by the service, however there may be some resistance to change from service users, their families and advocates.	√	0	750	Thelma Bowers
5	Learning Disabilities	**Trindlemoss development finalise the financial impact of the new service (LD day service, complex care unit and supported accommodation)**: - for 2019/20 require to plan to mitigate delay in savings being achieved - opportunities to further reduce cost of amalgamating day services - identifying supports required for service users in supported accommodation - policy in relation to eligibilty and prioritisation for supported accommodation, model of care blueprint for other supported accommodation coming online	The opening of the new service at Trindlemoss (originally planned August 2019) has been delayed due to delays in the building works, this has impacted on the timescales for service users and patients transferring. The service will require to be configured around the affordability of the care and support, taking into account the positive environment and the opportunities the shared accommodation space offers in terms of reducing existing high cost care packages.	√	0	tbc	Thelma Bowers
6	Learning Disabilities	**Sleepovers - develop policy in relation to 24 hour care for Adults in the Commnunity:** - policy decision to not provide one to one 24 hour sleepover service where there are: * supported accommodation alternatives available; * opportunities for service users to share a service (will be identified by geographically mapping services); or * where technology supports can be provided supported by a responder service. - Recovery plan action and financial impact is based on a plan to deliver a responder service from the Trindlemoss supported accommodation to support removal of sleepovers in the area	This will result in the removal of one to one 24 hour support from service users, an enhanced overnight service will be provided from Trindlemoss to support capacity for response. Individual service user safety will be a priority and the one to one support will only be removed where safe to do so.	√	0	128	Thelma Bowers
7	Learning Disabilities	**Transition Cases (Adults aged 65+):** - reviews undertaken jointly with LD and Older People's service which will deliver some savings, some work outstanding in relation to these reviews where changes to care packages have been identified - further action to scrutinise outcome of reviews and equity of service provision across client groups, particularly for high cost care packages which are not equitable with community care provided in Older People's services - requires a clear policy decision in relation to transitions of care and funding for community based supports *Note that there have been several reviews undertaken which indicate that savings will be made. These savings can be limited in some of the more complex care packages as care is required on a 24/7 basis.*	Service users are being reviewed with a view to reducing the cost of packages as the clients transition to the Older People's service. Some reviews for high cost community packages have identified individuals suitable for the criteria of long term care but resistance from service users to change from current care and support. If care packages cannot be reduced the IJB will be asked to agree a policy decision on the level of care provided in such cases.		0	134	

Ref	Service Area	Action	Service Impact	IJB Support	Included in P8 Position £000's	Planned Impact £ 000's	Responsible Officer
8	Adult Community Packages	**Adult Resource Group no overall increase in care package provision:** - ARG in place for Mental Health and Learning Disability care packages for approval, ARG will no longer be permitted to approve any increase to existing or new care packages unless there has been a reduction in service elsewhere - will require social workers to proactively review caseload and use finite resource available to support whole client group - arrangements will remain in place until the service brings the overall expenditure on community care packages back into line	Service users assessed as requiring a service will have to wait until resource has been identified to fund the care package, this is equitable with waiting lists for other services where resources are limited. This may result in delays in supports being provided but will also ensure that the service is managing, directing and prioritising resources effectively.	√	0		Thelma Bowers
9	All	**Self Directed Support:** - exploring how to embed this alongside the asset based approach promoted through the HSCP *Thinking Different, Doing Better* experience into services to change how we deliver services and balance service user and community expectations - undertaking self-evaluation for North Ayrshire against good practice, this will include stakeholder engagement to develop future approach	Positive impact to embed Self Directed Support, with a view to being realistic in managing expectations of services and service users. Address a perceived inequity in how services are delivered and how embedded SDS is across social care services.	√	0	-	Stephen Brown
Children and Families:							
10	Looked After and Accomodated Children	**Children's External Residential Placements bring forward planned discharge dates:** - overspend due to delays in bringing children back from expensive external residential placements due to timescales slipping, recovery action based on pulling forward all estimated timescales by one month and moving to planned level of 14 placements by March 2020 - scrutiny of detailed plans for individual children, to be reviewed alongside the internal children's houses to free up capacity to bring children back to NA sooner - close working with Education services as shared ambition and requirements to provide educational supports within NA - formalise and reinforce governance arrangements for approval of new external children's placements	Transformation plan to support more looked after children in North Ayrshire is focussed on delivering more positive outcomes for Children. Accellerating plans to move children to different care settings is challenging for the service as these are sensitive complex cases.		286	200	Alison Sutherland

Ref	Service Area	Action	Service Impact	IJB Support	Included in P8 Position £000's	Planned Impact £ 000's	Responsible Officer
Other:							
11	All	**Recruitment freeze non-front line posts:** **-** hold recruitment to all vacant non-front line care posts, eg support services, admin support - partnership vacancy scrutiny group remains in place and will ensure posts are not approved for recruitment until the new financial year	Minimal impact on front line services but depending on where vacancies arise during the rest of the year could have an impact on the capcitay of support services, in particular to respond to service requests. The HSCP vacancy scrutiny group will ensure consideration is given to the impact on services when recruitment is delayed for individual posts.		0	200	Caroline Whyte
12	All	**Moratorium non-essential expenditure:** - communication issued to all budget holders (social care and health) with an instruction to delay or cease any areas of discretional spend (areas including supplies and services, training, third party payments etc) - finance teams will liaise with budget holders as part of regular engagement and budgets will be removed non-recurringly to allow target reduction to be met	Minimal impact on front line services but is a short term one-off approach to reducing expenditure.			184	Caroline Whyte
13	All	**Systems improvements re care packages:** - Extension of CM2000 to adult services which will enable payment to care providers based on actual service delivered, being rolled out to some providers in advance of new tender - finance working with services to review areas where service delivered differs from that commissioned to improve systems and basis of financial projections, this work also supports ongoing reviews - action plan in relation to improving projections and actions identified from recent internal audit report re Community Based Care, including streamlining systems and processes to remove duplication, scope for error and reliablity of information	Significant work requried to review systems across social care services where different approaches are used for different service areas, some areas involve duplication of information and systems. Work will result in more assurance re the information reported, including financial projections and will also ensure the partnership has assurance that we only pay for the direct care delivered.		0	-	Thelma Bowers/ Helen McArthur/ Caroline Whyte
		TOTAL			**711**	**1,996**	

2019-20 Budget Reconciliation   Appendix E

COUNCIL	Period	Permanent or Temporary	£
Initial Approved Budget			95,067
Resource Transfer			23,112
ICF Procurement Posts - Transfer to Procurement	3	T	(85)
FPC under 65's Scottish Government Funding	3	P	702
Transfer to IT WAN circuit Kilwinning Academy	4	P	(3)
Waste Collection Budget	4	P	27
CLD Officer from ADP Budget to E & C	4	T	(31)
Transfer £10k to Communities for Youth PB	7	T	(10)
Challenge Fund Drawdown from Earmarked Funds	7	T	690
Period 8 reported budget			**119,469**

HEALTH	Period	Permanent or Temporary	£
Initial Approved Budget (based on month 9 of 2018-19)			145,425
Adjustments to reflect month 10 -12 of 2018-19 including non-recurring amounts			(1,845)
Opening baseline budget for 19-20			**143,580**
Resource Transfer			(23,112)
Superannuation Uplift	3	P	2,994
Voluntary Redundancy Scheme	3	P	271
Post from acute - PA to Clinical Nurse Manager, Long Term conditions	3	P	15
Post from acute - Clinical Nurse Manager, Long Term Conditions	3	P	34
Functional Electrical Stimulation Equipment from acute			10
Pharmacy Fees	3	P	19
HPV Boys Implementation	3	P	18
Action 15 (anticipated increase)	3	P	930
Post from Acute -Specialist Pharmacist in Substance Misuse	3	T	12
Old age liaison psychiatrist from acute	3	P	108
Patient Transport Service	3	P	49
Infant feeding nurse	3	T	41
Assoc Medical Director responsibility payment to Medical Director	3	T	(24)
Associate Medical Director sessions to the Medical Director	3	T	(71)
Contribution to the Technology Enabled Care (TEC) project	3	T	(50)
Superannuation Uplift Overclaimed	4	P	(270)
Action 15 overclaimed	4	T	(485)
Prescribing Reduction	5	P	(550)
Medical Training Grade Increase	5	P	51
Admin Transfer from South HSCP	6	P	19
NMAHP Clinical Lead	6	T	16
Woodland View – Hairdressing transfer from South			12
SLA Superannuation uplift			79
Period 8 reported budget			**123,696**
GRAND TOTAL			**243,165**

CIPFA IJB CFO Section

Integration Authorities Financial Performance

Financial Year 2019/20 (Quarter 2)

OVERVIEW - BUDGET POSITION 2019/20

This is the second summary report which presents the overview of financial performance for all Integration Authorities (IA's) for quarter 2 of the financial year 2019/20. The position in respect of the NHS Highland Lead Agency arrangement is also included. The total budget for health and social care services at quarter 2 is £9,349m. This is an increase of £112m (1%) from £9,237m at quarter 1 as follows:

- 26 IAs reported an increase of £3.8m in the set-aside budget which now totals £816m.
- The NHS non-set aside budget increased by £99m to £5,708m.
- The local authority budget increased by £2.5m to £2,789m.
- The use of reserves increased by £7m to £36m.

FINANCIAL VARIANCES 2019/20 – YEAR-END OUTTURN AND YEAR TO DATE

IAs have different reporting approaches. At this stage of the financial year, 28 IAs report projected outturns for the year-end and 3 IAs report year to date (second quarter) positions.

Of the 28 IAs, representing £8,117m of the total budget, a year end overspend of £66.4m is projected. Projected outturns across these IAs vary as follows:

- 23 IAs are projecting overspends totalling £82.9m
- 1 IA is projecting a break-even position
- 4 IAs are projecting underspends totalling £16.5m

This is the position before additional financial support from partners, the impact of financial recovery plans and the further use of reserves is taken into consideration.

Year-end Projected Outturns

- £41m non delivery of savings
- £15m demographics
- £10m staffing pressures
- £7m prescribing
- £3m price increases
- £6.9m other net cost pressures

Projected cost pressures - £82.9m

Of the 3 IAs, representing £1,233m of the total budget, a year to date overspend of £2.8m is reported at the end of quarter 2. The year to date positions across these IAs vary as follows:

- 2 IAs are reporting overspends totalling £3.4m
- 1 IA is reporting an underspend of £0.6m

SIGNIFCANT FACTORS 2019/20

The factors contributing to the variances reported by IAs are detailed on the schedule which accompanies this covering report.

The key highlights, which were reported at quarter 1, remain relevant and are summarised as follows:

- the challenge to deliver savings, in particular planned reductions in services not materialising due to inceased demand being experienced
- increased activity of acute services
- additional demand for services and the increasing complexity of health and social care needs across older people, adult and children's services
- the timeline to implement new models of service delivery taking longer than originally anticipated
- ongoing challenges associated with identifying further cost reduction and savings opportunties
- prescribing cost pressures; and
- staffing costs including the cost of locums.

As part of their financial strategies, 14 IAs are relying on the planned use of reserves totalling £36m at this stage of the financial year. As reported previously, the increase in costs is partly offset by underspends as a result of staff vacancies and slippage in the implementation of new funding. Both of these provide non-recurring financial relief.

Work continues to be progressed to develop the set-aside monitoring arrangements.

IMPACT ON FUNDING 2019/20

It is currently estimated that the projected overspend totalling £69.2m will be addressed as follows:-

- Anticipated additional funding from NHS Boards   £28.8m
- Anticipated additional funding from Local Authorities   £6.8m
- Agreed financial recovery plan with no impact for partners   £12.8m

The funding impact of £20.8m remains 'not yet determined' or has still to be publicly reported in respect of 12 IAs.

A total of 4 IAs remain in repayment arrangements with partners (£14.7m).

2

UPDATE ON RESERVES

The IA's reserves have reduced by £3.2m at quarter 2 to £110m (Earmarked £77m; Contingency £33m). The contingency reserve continues to represent 0.4% of the total financial envelope of £9,349m. 8 IAs do not have a reserve. 5 IAs do not have a contingency reserve. 2 IAs have a negative reserve. For 16 IAs, the contingency reserves range from 0.03% to 3.8% of their available funding.

FUTURE REPORTS

IA's will continue to standardise presentation.

Integration Joint Board
19 December 2019

Subject:	**'Getting it Right for You' North Ayrshire Children's Services Plan – Performance Report 2017-2019**
Purpose:	To consider and note the 'Getting It Right For You', North Ayrshire Children's Services Plan Performance Report 2017-2019
Recommendation:	The North Ayrshire HSCP IJB is asked to note and support the contents of the 'Getting It Right For You', North Ayrshire Council's Children's Services Plan Performance Report 2017-2019

Glossary of Terms	
Act	Children and Young People (Scotland) Act 2014
CSP	Children's Services Plan 'Getting it Right for You'
NACPP	North Ayrshire Community Planning Partnership

1.		**EXECUTIVE SUMMARY**
1.1		North Ayrshire Community Planning Partnership has overall responsibility for the annual report on its Children's Services Plan 'Getting it Right for You' 2016-2020. In response to Part 3, Section 13 of the Act, an annual report on performance and progress against the Plan must be published, as soon as practicable after the end of each one-year period.
1.2		This paper outlines some key achievements contained within North Ayrshire Children's Services Plan (CSP), 'Getting it Right for You' – Performance Report 2017-2019.
2.		**BACKGROUND**
2.1		North Ayrshire Community Planning Partnership (NACPP) has overall responsibility for the annual report on its Children's Services Plan (CSP) 'Getting it Right for You'. The plan was published in March 2016, one year in advance of the expected statutory publication date.
2.2.		The key aims of the CSP are as set out in the Act. The North Ayrshire CSP is ambitious and is written in a style which has the 'young reader' in mind. The Statutory Guidance ensures that the CSP can 'tell a story'. The North Ayrshire CSP originally contained 36 'Promises' that were split into 3 life stages; Early Years (0-5), Primary Years (5-12) and Secondary Years (13-18). In 2018 the Children's Services Strategic Partnership (CSSP) revised the Promises which led to 32 promised which were mainly relevant to all ages.

2.3.	The 2017-2019 Getting it Right for You' North Ayrshire Children's Services Plan – Performance Report 2017-2019 is attached as appendix 1. This report covers the reporting periods 2017/18 and 2018/19 due to timings. The 2016/17 report was published in October 2018.
2.3.	Some of our Key Achievements detailed in the annual report are shown below:
	- Our Year of Young People Ambassadors' focussed on suicide prevention and were awarded a **National YouthLink Award** for Health and Wellbeing for their [Thirteen Ways Suicide Prevention work](.). 9,515 activities, programmes and learning events which support **participation in democracy** were accessed by Young People in 2018/19. - Over 90% our schools have become **Rights Respecting Schools (RRS)** and are accredited to Bronze level - RRS Committed. - We continue to support mental health and wellbeing. **Place2Be** counselling has continued within 6 North Ayrshire schools which are located in North Ayrshire's areas of highest deprivation. - Targeted **nurture approaches** have been further embedded in North Ayrshire schools. This is having a significant impact on social and emotional wellbeing in 7 secondary schools, 20 primary schools and 9 early learning and childcare establishments. - The Education Service's **Family Learning Team (FLT)** had 425 initiatives and programmes which have supported over 4000 families since the team was established. Our evidence shows that families have increased knowledge, confidence and understanding in how to support your learning at home and in school. - Through its whole systems approach to Active Communities, North Ayrshire and NHS Ayrshire and Arran have been selected to be an "Early Adopter" site for the new **Public Health priority relating to diet and healthy weight.** This will involve a focus on children and young people, physical activity and food environments. North Ayrshire will also be one of four local authorities who will have a "special partnership" status with sportscotland and this will link with and complement the Early Adopter work. - On the 14th March 2019 a Peer Research event took place called 'Who am I?'. This event was facilitated by North Ayrshire Council's modern apprentices and members of the North Ayrshire's Champions Board. The aim of the project was to bring together Care Experienced Young People and Professionals to start a conversation around the **Language** used in the 'care system', the **Stigma** often associated with the language that is used and the resulting **Behaviours** of Care Experienced young people and professionals. Approximately 20 care experienced young people with various care experiences and approx. 30 practitioners from front line practitioners to those in management positions were involved. - Our **Active Schools programmes** provide support for extracurricular sport and activity after school. Compared to the 2017/18 academic year, the number of individuals taking part in activities has increased by 12.9% to 8,774. - The gap between the **attainment of leavers** from the 20% most deprived areas and those from the rest of the areas (80%) has reduced in 2018 to 37%, from 44% the previous year and is much smaller than the corresponding gap for all leavers in Scotland (46%). - A new **integrated Infant Feeding Team** has been established, bringing together maternity and health visiting services, infant feeding team and peer supporters from the Breastfeeding Network. The team is dedicated to supporting mothers to breastfeed their newborn babies in a way that reflects their individual experiences

	and needs. The service has focussed on babies born by Caesarean Section initially, as well as supporting mums and babies in the Neonatal Unit. • Universal Early Years staff and children and families Social Work staff are now successfully **co-located in Kilwinning Academy**.
3.	**PROPOSALS**
3.1	**Publication of the Children's Services Plan Annual Report 2017-2019** The final draft Children's Services Plan Performance Report 2017-2019 will be submitted to the North Ayrshire CPP Board for approval on 5 December 2019. It is proposed that the North Ayrshire HSCP IJB support the content of the report. In addition, an info-graphic will be published with the annual report in January 2020.
3.2	**Anticipated Outcomes** Compliance with Part 3, Section 13 of the Children and Young People (Scotland) Act 2014 and providing a report on progress of the Children's Services Plan.
3.3	**Measuring Impact** Ongoing assessment of impact will be monitored by the Children's Services Strategic Partnership
4.	**IMPLICATIONS**

Human Resources:	None
Legal:	None
Equality:	None
Children and Young People	The report contains performance information relating to services provided to children and young people and their families.
Environmental & Sustainability:	None
Key Priorities:	Supports the Local Outcomes Improvement Plan Theme - A Thriving North Ayrshire. To meet the requirements of Part 3 Section 13 of the Children and Young People (Scotland) Act 2014
Risk Implications:	None
Community Benefits:	None

Direction Required to Council, Health Board or Both	Direction to :-	
	1. No Direction Required	X
	2. North Ayrshire Council	
	3. NHS Ayrshire & Arran	
	4. North Ayrshire Council and NHS Ayrshire & Arran	

5.	**CONSULTATION**
5.1	Key partners and contributors to the Children's Services Plan are consulted on an annual basis to provide updates on progress. These updates form the basis of the annual report. The Children's Services Strategic Partnership meets quarterly.

6.	CONCLUSION
6.1	The HSCP IJB is asked to note and support the contents of the Children's Services Plan 'Getting it Right for You' Performance Report 2017-2019.

For more information please contact Lauren Cameron, Policy Officer on 01294 324160 or at laurencameron@north-ayrshire.gov.uk or Stephen Brown on 01294 317804 or at sbrown@north-ayrshire.gov.uk

NORTH AYRSHIRE Children's Services Plan

Annual Performance Report
2017-18 to 2018-19

How we are doing

GETTING IT
RIGHT
FOR YOU

NORTH AYRSHIRE
CHILDREN'S SERVICES
STRATEGIC PARTNERSHIP

What we set out to do

Here at North Ayrshire Council, we aim to ensure that you, our children and young people, experience the best start in life. We want you to think that North Ayrshire is the best place to grow up in Scotland. This vision is at the heart of everything we do for you.

In 2015, to help us achieve this vision, we asked for your views. Then, using what you told us, we wrote the Children's Services Plan: Getting it right for you (2016-2020). We were also guided by a new law that has strengthened your rights, called The Children and Young People (Scotland) Act 2014. With all that in mind, we made you some Promises, which you can find here.

In 2016 we began to make some changes to our services to help us keep our Promises and deliver better outcomes for you.

We have worked together with our friends in the Children's Services Strategic Partnership (CSSP) to focus on the top 4 issues that were important to you.

These 4 priorities you asked us to consider were to:

- Improve how you engage with school
- Help you to be physically active and be at a healthy weight
- Prevent smoking, drinking and taking substances at an early age age
- Support your social and emotional development.

We also asked you to help us by keeping your own promises too. For example:

- We promise to tell an adult we trust if we are worried about something
- We promise to eat food that is good for us
- We promise to take part in physical activity
- We promise to speak out about the things that matter to us so that they can change

We also promised to report on our progress and we are pleased to give you our next annual report on how we are doing.

Contents

Structure of this report

We want this report to be easy to read and understand. It matches the work we did in *Getting it right for you: North Ayrshire Children's Services Plan 2016–2020*.

In this report we have revised some of our promises to make them more relevant to you. This means that many of the promises now relate to all ages and stages. Each promise is under a heading to show what stage they are relevant to.

Within each section we will tell you some of our achievements, backed up by the results from our Performance Framework (important points to focus on). This Performance Framework has helped us measure how well we are keeping our Promises. When we made our Promises, we set high standards because we want the best outcomes for all our children, young people and families.

We will also tell you what we are still aiming to achieve in our Next steps section. We know that this report affects real lives, so where possible, we use case studies and include quotes from people like you and your families, who have experienced the services we have provided.

We have tried to keep this report as clear as possible. The online version has many embedded hyperlinks (underlined) that relate to our work. These will give you more online information that might be of interest to you. The website addresses are all collated within the Appendix (see page 54).

As you will see from this annual report, we have made steady progress towards our overall promises and our action plan.

Our Promises to you *and our achievements*

Overarching Promises

We promised to
work on the Children's Services Plan priorities to improve your outcomes.

Early Years (0-5 years)

Primary Years (5-12 years)

Secondary Years (12-18 years)

This is our Second report. Getting it right for you: North Ayrshire Children's Services Plan 2016–2020 is being used and reviewed on a daily basis by workers across the Children's Services Strategic Partnership (we'll call it the "Partnership" from now on). Our Promises are linked into all the work that we do. We're keeping track of our progress every single day.

We promise to
consult with you and your family about your needs to inform the services we deliver.

Early Years (0-5 years)

Primary Years (5-12 years)

Secondary Years (12-18 years)

In the 2018 Year of Young People (YOYP) we hosted the Scottish Youth Parliament sitting, Brexit event and National Awards, welcoming people from all around Scotland to make decisions at a national level. A first of its kind, Joint Cabinet Live featured digital representation from all secondary schools in North Ayrshire. Key partnerships were created with the Police and NHS to ensure young people have the information they need to make informed decisions. Our YOYP Ambassadors' also focussed on suicide prevention and were awarded a National YouthLink Award for Health and Wellbeing for their Thirteen Ways Suicide Prevention work.

The YOYP Legacy Report was approved in March 2019 and will deliver further significant innovation in how you, as young people, influence the Council's work, Poverty and Inequality, Health and Well-being and in particular mental health and Young Peoples Voice and rights.

The Scottish Youth Parliament Elections took place across North Ayrshire until Friday 29th March 2019. We had 17 candidates standing for 4 places.

These young people will represent you, young people from across the area for the next 2 years nationally and locally. Any young person aged 12-25 in North Ayrshire could vote online via the Young Scot website.

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Highlights of local events which took place in the Year of Young People included:

• A unique '**Joint Cabinet Live**' which brought together young people from all over North Ayrshire via a live video link, to interact with the Council's Cabinet members on the issues faced by young people living in the area.

• A special **YoYP Participatory Budgeting** exercise that saw those aged 8-26 voting on projects, either organised by or for the benefit of young people, that they wanted to see happen during 2018. The winning bids received up to £1,000 to help deliver their projects.

• The 65th sitting of the Scottish Youth Parliament took place in March and was hosted in Saltcoats. This annual event and national awards ceremony was attended by people from across Scotland and attracted high levels of media interest.

• There are a number of YOYP activities of which the Young Ambassadors and young people in North Ayrshire are particularly proud. These activities are already creating a powerful legacy and include:

  - **Unfearties**: the signing up of elected members (Councillors), council employees, partners and organisations as unfearties. Unfearties are individuals who are courageous in discussing children's issues, are making a difference in children's lives, and who are willing to speak up for, and stand alongside, children. Over 300 have been signed up to date.

  - **Right Here Right Now Training**: Working with MSYPs to roll out a programme of training on young people's rights for pupils across our primary and secondary schools.

  - **Care Experienced Young People's and Young Carers Participation**: Working with Corporate Parenting Team and North Ayrshire Young Carers to set up participation groups that will feed directly into the participation structure, and actively encourage young people to participate in the Youth Council Executive.

  - **Peer research projects** across the Council and developing proposals for shadowing Cabinet members.

The Scottish Youth Parliament's (SYP) National Sittings are when SYP meets as a full parliament. Sittings are an opportunity for Members of Scottish Youth Parliament (MSYPs) to meet with other MSYPs from across Scotland to discuss and take action on issues that are important to the young people they represent. At Sittings, MSYPs take part in workshops, debates, training sessions, and, most importantly, set SYP's policy agenda.
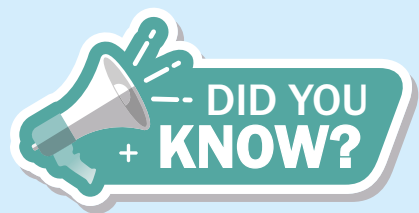
DID YOU + KNOW?

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- **Intergenerational Community Planting**: Young people worked with the Three Towns Growers and Streetscene to plant potatoes for community food which will provide free sustainable food for the community.

- **Work with young Syrians**: Working with key staff and the young Syrian communities to ensure their voice is represented in the youth participation structure and encouraging them to participate in the YOYP activities throughout the year and beyond.

- **School Leavers Toolkit**: Creating a resource online in partnership with Young Scot that has signposting to local and national organisations that will assist young people leaving school. All school leavers have been issued with promotional material to signpost them to this.

- **V in The Park**: Working in partnership with The Ayrshire Community Trust (TACT), a YOYP theme was developed for Volunteer Week. This included an event at Eglinton Park with 150 young people participating. All YOYP ambassadors are signed up for their Saltire award to receive recognition for all of the volunteering they have done as part of their role.

- **"13 Reasons Why" Suicide Prevention Online Campaign**: Working with Choose Life the Young Ambassadors have written a number of Blogs and Vlogs around positive mental health and suicide prevention messages throughout the summer and beyond, in partnership with Young Scot, and to national acclaim. This initiative won the National YouthLink Award for Health and Well being

- **#Kindness Rocks**: Placing messages of kindness around North Ayrshire – hand painted rocks shared on YOYP Facebook page to promote positivity and positive mental health messages, in partnership with Carnegie UK.

- **Health Foundation – Young People's Enquiry**: Working with the Health Foundation to create a young people's enquiry team from across North Ayrshire. North Ayrshire was the only Scottish site and the young people were given training to consult with young people across Ayrshire to gather opinions on what it is like to live and grow up in North Ayrshire.

- **Period Poverty Campaign**: The Young Ambassadors worked to help launch the promotional campaign highlighting the free sanitary products that will now be available across all council and community buildings.

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We promise that where we can, we will put all our children's services into local areas so that all of our staff can work more closely together for you.

Early Years (0-5 years)

Primary Years (5-12 years)

Secondary Years (12-18 years)

We have developed our Universal Early Years Teams to include Health Visitors, Early Years Social Workers, Family Nurturers, Health Visitor Support Workers, Health Care Support Workers, a Speech and Language Therapist and a peri-natal Mental Health Nurse who can all respond to your needs and your parents' needs.

Universal Early Years staff and children and families social work staff will be co-located in Kilwinning Academy and the transition will begin at the end of July/ early August 2019. All staff will be successfully co-located by early September 2019.

A Challenge Team have been created in two schools, Greenwood Academy and Elderbank Primary. The team includes four Social Workers, three Family Care Workers, three Mentors and a Registered Nurse. The Challenge Teams work in partnership with a range of other services.

This new model of a schools-based team approach will enhance and develop our current ways of working to support children to remain living at home with their families. The team will also identify concerns within families at an earlier stage and, through working together with families and the wider school community, increase the likelihood of remaining with family and therefore ultimately improving children's outcomes.

The Challenge Team are visible to children at school, family and educational staff and have been welcomed within both schools to operate as part of the wider school staff team. The team are proactive, with relational ways of working, seeking to intervene at the earliest point of any difficulties being identified. This prevents escalation, where possible, for children through the care system. Social workers are allocated to support specific children and their families, who attend these schools – these being the children who are at greatest risk of becoming looked after or accommodated away from home. The team has case management responsibility, which includes reporting to the Children's Hearings and Looked After and Accommodated Reviews.

The support offered by the Challenge Teams has been recognised as making a significant difference to the outcomes for children, young people and their families. The new ways of working have had a significant impact on how support is delivered to those most in need, but also the outcomes experienced by those receiving support.

This model has seen a more intensive targeted response to families in need, being delivered. In order to achieve this, workers have been given a smaller caseload to allow them to increase their availability to support.

Moving to localities will help staff to plan and deliver better services to improve local health and wellbeing and will ensure that the services provided in each locality are meeting your specific needs.

We promise to make sure that your rights are protected.

Early Years (0-5 years)

Primary Years (5-12 years)

Secondary Years (12-18 years)
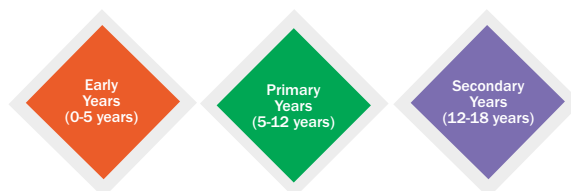
Almost all (over 90%) of our schools have become Rights Respecting Schools (RRS) and are accredited to Bronze level – RRS Committed. There are now around 30% at Silver Rights Aware, whilst three schools have attained gold level ambassador status.

Most of our schools have been on their journey towards formal Rights Respecting School Status. This award is not compulsory but is a structured way to undertake this work in schools. The remaining schools (as do all schools) consider children's rights due regard wellbeing work and rights are at the heart of their vision, values and aims. This forms the basis of all policy work including anti bullying, restorative practice, nurture and promoting positive relationships.

Following on from the introduction of this work on rights, all schools are now subject to revised and updated quality improvement measures in this area and an annual report on the impact of this work will be compiled ensuring all schools consider children's rights in their work with you and your families.

Child Rights Education (CRE) involves learning about rights, throughout your education. The Rights Respecting School approach helps you as "rights holders" to claim your rights. It also helps adults as "duty bearers" to be responsible for you. Child Rights Education helps all of us, young and old, to work together. When we encourage each other and give each other space to thrive, we create meaningful friendships and work well in school – and in the wider world!

We promise to work closely with our partners, you and your family to make sure that North Ayrshire is a more secure place to live so that you are safe, protected and not at risk of intentional or unintentional harm.

Early Years (0-5 years)

Primary Years (5-12 years)

Secondary Years (12-18 years)

12
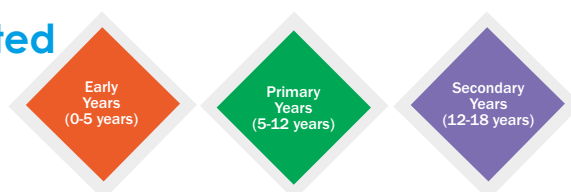
MAASH (Multi Agency Assessment Screening Hub) continues to receive referrals relating to Domestic Incidents, and Child Concerns from Police Scotland.

Our CareFirst system indicates that from the period of April 2017 to March 2018, MAASH received 393 referrals relating to Domestic incidents, and 634 referrals relating to Child Concerns. This equates to 1027 annually, and approximately 86 referrals monthly. In relation to domestic incidents, it is noted that 85% of victims were female, 15% were male.

Irvine is noted to have had the highest numbers of domestic incidents. Approximately one third of victims were aged 16 to 26. Two thirds were over 26.

Less than 3% of Child Concerns referrals resulted in a referral to the Scottish Children's Reporter Administrator (SCRA). Similarly, approximately 3.5% resulted in referrals to the respective Area Teams.

In addition to assessing Police Concern referrals, MAASH continue to participate and contribute to MATAC (Multi Agency Tasking and Co-ordinating) meetings, and Decision Making Forums in respect of DSDAS (Disclosure Scotland Domestic Abuse Scheme).

case study

To help you keep yourself safe online we have listened to you, your parents and professionals and created a co-ordinated approach to online safety. Young people in North Ayrshire told us their definition of Online Safety is;

"Being Switched on when using websites and social media and being able to use them confidently, happily and safely."

Young people and professionals have worked together to create a pledge to help keep you safe in online, whilst helping you to enjoy the benefits of the digital world.

You should be able to see this pledge displayed across North Ayrshire and find access to the online directory in schools, libraries and community facilities.

To help the adults who support you improve their knowledge and understanding we have developed a co-ordinated approach to training and provided an easily accessible guidance for young people and adults in the form of an Online Safety Directory.

The new North Ayrshire Online Safety Directory is available here – http://www.northayrshire.community/get-involved/youngpeople/

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The percentage of families previously registered on the Child Protection Register who have been re-registered following a period of less than one year was 4.9% in 2018/19 and 3.9% in 2017/18.

DID YOU + KNOW?

We promise to make sure that you move from stage to stage as smoothly as possible for you.

Early Years (0-5 years)

Primary Years (5-12 years)

Secondary Years (12-18 years)

Child Protection

From October 2018, the number of children on the Child Protection Register has dropped from 156 to 117. Monthly case audits are undertaken by the Senior Manager(s) and Chief Social Work Officer reviewing current registration and placement status while providing essential professional risk and decision-making judgements appropriate for each case.

Development & Piloting of the Early Years Planning Framework

A new planning tool has been developed to help you move from Early Years to Primary school. This has involved rolling out additional training to establishments by September 2018. There has been a greater focus on the use of your developmental milestones and transitional planning.

Our **Family Learning Team (FLT)** has developed programmes for your primary and secondary transition. The primary programme is 'Supporting Transition Into Primary' (**STIP**) and the secondary programme is 'Supporting Transition After Primary' (**STAP**).

The **Supporting Transition into Primary (STIP)** Programme saw an increase in parent participation levels in 2017/18. The total number of participating families has increased to 570 in 2017/18. 146 families were supported in 2016/17 and 395 have been supported in 2018/19.

Some sample statements from parents who participated in the STIP programme are noted below:

Supporting Transition into Primary: Feedback from Parents/Carers

"Really enjoyed having this quality time together I learnt to see different ways to encourage learning."

Informative fun and easy going. Examining books through play and imagination. Brought to life by puppets and characters from the book i.e. fox, mouse etc. most helpful in the aspect of time spent together with our child learning how to hold his interest, transferring skills learned by parent and child and implement these at home.

"I enjoyed spending quality time with my child and spending time doing various activities. Both myself and my daughter enjoyed attending the sessions. We will continue to work on skills we have learned e.g. numbers, letters, pencil skills, story time and make these times fun. The sessions were fun and varied which my child enjoyed."

"We learned a lot of stuff, I will be doing it all at home, most of all it was fun"

The **Supporting Transition after Primary (STAP)** Programme was newly established in 2017/18 with 121 families participating in this programme in its first year. This rose to 197 families in 2018/19. Some sample statements from participating parents are noted below:

**Supporting Transition after Primary: Feedback from Parents/Carers**

"It was good to be able attend the local primary school instead of travelling to the academy – it works very well. The academy staff were able to answer questions and ease anxiety."

"Good to get to know some staff from the Academy before children start in S1."

We promise to care for your needs if you have any health needs or disability.

Early Years (0-5 years) **Primary Years (5-12 years)** **Secondary Years (12-18 years)**
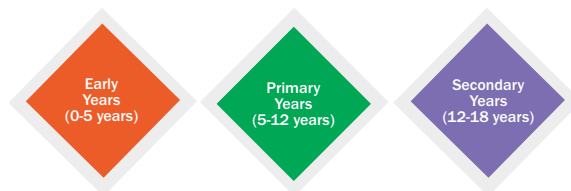
If you have a health need or disability and are moving to adult services, we will have a Child's Assessment and Plan (CAP) in place for you.

A short life working group has been set up to look at the ASN transitions pathways as part of the Children's Services Improvement Board. This will help to improve transition planning from mainstream or ASN Education to Adult Services.

We promise to ensure that your mental health and wellbeing are a priority.

Early Years (0-5 years) **Primary Years (5-12 years)** **Secondary Years (12-18 years)**
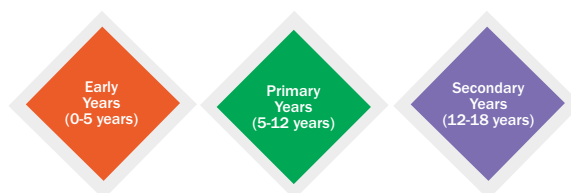
Work has started to build a new Additional Support Needs School alongside a Respite and Residential (R&R) Facility. The project is a first of its kind in Scotland and will provide a unique learning and living environment for young people. The new school will provide modern, fully accessible facilities for 200 young people from ages 2 to 18 with a range of additional needs. The school will include sensory spaces, a swimming pool, an hydrotherapy pool and enhanced outdoor learning spaces including an outdoor rebound area and external classrooms.

It will include facilities for health and social care colleagues to access, incorporating first-aid, therapy and treatment facilities.

And the R&R facility will incorporate an eight-bedroom respite facility for young persons with additional support and health needs, along with an eight-bedroom residential facility which will provide a specialist environment for young people with severe and complex needs.

In primary and secondary schools, we continue to improve the access for you to get support with your emotional wellbeing. Examples include: Kitbags for primary schools; Mindfulness in the classroom; Connecting with Mental Health Glow tile; Heartstone Project; Reflections emotional wellbeing resource; Safe Spot mental health advice and support app for secondary schools.

Secondary school counselling has supported 558 young people from the beginning of the service in mid-2017 to February 2019, and this has had a positive impact on mental wellbeing, reducing barriers to learning and improving social skills. This has been demonstrated by improvements in Strengths and Difficulties Questionnaire scores.

Some information on some of our interventions and programmes is provided below under each learning stage.

No.1

No.1 PRIORITY   TEACHER

16

Primary school support

Kitbag was researched, promoted and purchased for all North Ayrshire primary schools in the 2017/18 session. This is a resource which is designed to be used with small groups of learners and initial feedback indicates children have a greater understanding and awareness of positive relationships, building resilience and strategies to support their mental and emotional wellbeing.

These specially developed 'bags' give you a safe space to talk about any worries or fears you might have. Children have really enjoyed the finger puppets – Wolfy and Robin – as well as calming oil, strengths cards and a talking stick.

An evaluation of kitbag was conducted with small groups of P4 and P7 pupils in four schools in the 2017/18 academic session.

In general there had been improvements following the use of Kitbags.

Playback Ice's ICEPack primary resource to help your mental and emotional wellbeing was also used to support the health and wellbeing curriculum in the 2017/18 academic session. This resource is now being widely used in schools. Over 394 staff have completed IcePack training and 99% felt this training was relevant and useful as practitioners and also in supporting you.

An initial pilot programme of "**Mindfulness in the Classroom**" was piloted for staff in primary and secondary schools within the Irvine Royal cluster. Following this initial pilot, we have a clearer understanding of school requirements for the roll out of a mindfulness resource in the 2018/19 academic year.

Place2Be counselling has continued within 6 North Ayrshire schools which are located in North Ayrshire's areas of highest deprivation. Support is offered in the form of one to one counselling sessions and Place2Talk group sessions. 1880 group sessions were held in 2017/18 with 228 boys and 404 girls attending. In addition, 86 children accessed one to one counselling, with 1568 individual sessions throughout the 2017/18 academic year.

There were also 213 Parent Partnership sessions held involving parents and carers in sessions with pupils. Evidence gathered from teacher and parent SDQs (Strengths and Difficulties Questionnaires) in all six primary schools have reported Place2be has had a positive impact. 67% reported an improvement in mental health. We have gathered information from Place2be's 'Child's view' approach. These have shown it is having a positive impact.

A **Primary Pupil Mental Health Survey** was completed by 820 children in 5 schools located in North Ayrshire's most deprived areas. The survey focused on feelings about school and 94% of you who took part, indicated you felt there was an adult who you could go to if you had a worry or something was upsetting you. This suggests a high proportion of you are confident accessing support for emotional wellbeing.

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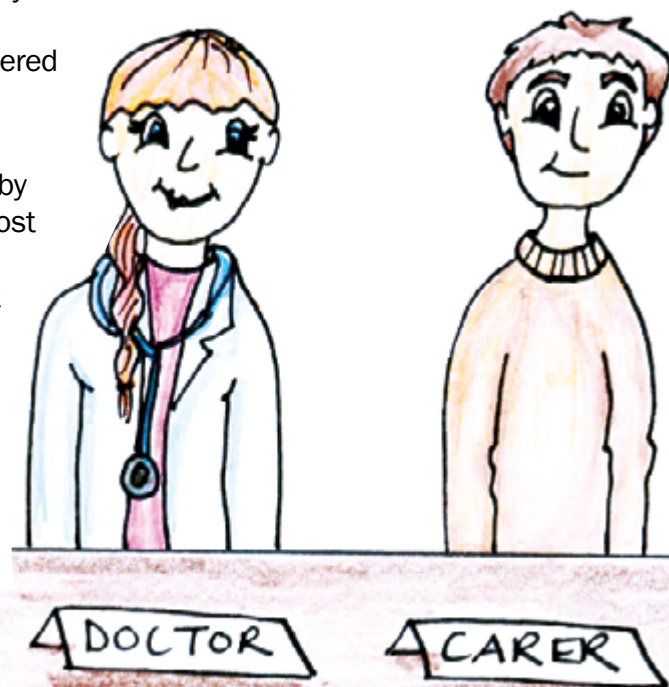
Secondary school support

We launched the '**Connecting with Mental Health' Glow tile** in November 2017. This can be used by all secondary pupils and staff to access a range of supports for mental health and emotional wellbeing. Usage figures show that the site has had approximately 1000 hits to date.

To support further development of the Glow tile, the Health and Wellbeing team recently conducted a **Secondary Pupil Mental Health Survey** of over 650 pupils.

This enabled the Health and Wellbeing team to direct you to sections of the Glow tile that identified common mental health concerns. Obtaining your views in secondary schools has supported the service to identify key priorities in the 2018/19 academic session. As an example, you reported exam stress as a key issue and in response additional support in this area will be provided through partnership working with the Educational Psychology Service.

Following a pilot of **Secondary Wellness Recovery Action Plan training**, through partnership working with the NHS Health Improvement Team in the 2016-17 academic session, the health and wellbeing team have developed and piloted a new secondary emotional wellbeing resource titled '**Reflections**' with a group of thirteen S3 pupils in Ardrossan Academy. All participating pupils reported improvements in their understanding of mental health, factors that negatively affected their mental health and supports which worked for them after completing the programme. Based on feedback from participating pupils, the programme has been revised and training and support will be offered to staff in other secondary schools to further roll this out in 2018/19 academic session.

Through Scottish Attainment Challenge Funding, a **secondary school counselling service** was introduced in the 2017/18 academic session. One full time counsellor is now in each of the 9 secondary schools. As of June 2018:

- 350 of you have accessed this service
- 39% of pupils self-referred
- 61% were referrals from pastoral staff
- S3 students were the most frequent users of this service
- The three most common reasons for attending counselling were – low mood (65%), stress (62%) and anxiety (58%).

From the evaluation of the counselling service there has been a positive impact for those of you who have attended. You told us that attending school counselling had a positive impact on your mental wellbeing, reducing barriers to learning and improving social skills.

In addition, there are at least 20 Scottish Mental Health First Aid trained Mental Health Ambassadors in each secondary school. These are S5/S6 pupils.

We promise to provide you with the best education possible through high quality teaching and to encourage and celebrate your achievements.

Early Years (0-5 years)

Primary Years (5-12 years)

Secondary Years (12-18 years)

Our Professional Learning Academy (PLA) is there to improve the quality of learning and teaching across your schools and early years establishments. In December 2018 the Learning Academy won a Scottish Public Service Award in the category of Employee Development and Skills. This recognised our PLA team who have displayed excellence in promoting skills development across teams and operational units.

This year the PLA has worked with 95% of our schools and nurseries in North Ayrshire and has delivered twilight training sessions to 1,293 teachers and practitioners. The key focus is to improve literacy and numeracy for you as learners. Training and intervention programmes delivered in-school during the day have impacted directly upon 3,196 learners. There have been 14 interventions which have taken place over 8-20 weeks depending on the nature of the support and there have been 94 twilight events covering 28 different topics. Twilight training events were very positively received with almost all participants either agreeing or strongly agreeing that courses were professionally relevant and of a very high standard.

Nine schools, 54 teachers and 1,200 learners participated in the Coaching Approach to Maths over the course of the year. Assessments of learners' skills, understanding and knowledge in numeracy at primaries 1, 2, 3 and 4 showed an average increase in scores of 46%.

The Literacy Strategy is now in its final stages of development and has listened to the views, ideas and experiences of staff, families and you, as learners, as well as research into what works. The strategy outlines the key approaches taken in developing literacy skills throughout the Broad General Education and its implementation will be fully supported by the professional learning programmes offered by the PLA.

Reading Recovery has been a key focus this session and a member of the team is one of only three accredited Reading Recovery Teacher Leaders in Scotland. 12 primary schools have taken part in this year-long programme and now each has a qualified Reading Recovery Teacher. 48 children have completed the programme so far and have, on average, increased their reading age by 2 years. This has also improved skills in writing and spelling with most increasing their spelling age by 8 months. High quality training for classroom assistants has complemented our approach to supporting reading skills, with the introduction of 'Boosting Reading at Primary & Secondary'. There are currently 15 schools who have trained these staff to deliver this 10 week intervention. Early results have been positive so far.

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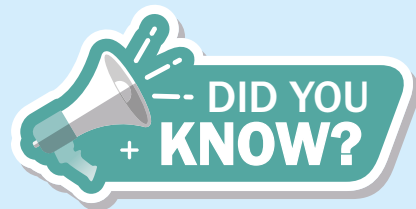
We promise through our nurturing schools approach to build your confidence and to help you attain the highest standards you can.

Early Years (0-5 years)

Primary Years (5-12 years)

Secondary Years (12-18 years)

Targeted nurture approaches have been further embedded in North Ayrshire schools. This is having a significant impact on social and emotional wellbeing in 7 secondary schools, 20 primary schools and 9 early learning and childcare establishments. The Early Years Family Nurturer role has developed during 2018/19. 105 families and often wider family members, have been supported by the Family Nurturers for areas such as social/ community integration, routines and home conditions.

Evidence collected in the last academic session shows positive changes at early years, primary and secondary, which strongly suggests that nurture group intervention is both needed and impactful at different stages.

Early Years Nurture

In the 2017/18 academic session, there were 9 early years nurture provisions to help you. Each early years nurture provision supports a small number of children, who will benefit from receiving more intensive nurturing and restorative work. To date 40 children have now completed this intervention. Results, based on Boxall assessment and through SDQ (strengths and difficulties questionnaires), show:

- Almost all children show an improvement from attending nurture
- 95% of children show improvement in their developmental strand
- 88% of children show improvement in their diagnostic strand
- Parent and key workers indicate a significant reduction in total difficulties and an increase in pro-social skills of learners

Primary Nurture

There are now 20 primary nurture groups in North Ayrshire that are funded through the Scottish Attainment Challenge. 137 of you in primary stages have completed primary nurture morning group intervention. Results, based on Boxall assessment and through SDQ (strengths and difficulties questionnaires), show:

- 76.6% of children have improved their developmental strand
- 75% of children have improved their diagnostic strand
- Teacher evaluations show a 57% increase of pro-social skills and 68% reduction in total difficulties experienced by learners.
- Parent evaluations show a 72% reduction in total difficulties and a 52% increase in pro-social skills of children at exit of nurture provision.

As an example, one Head Teacher commented:

"The difference between how they were when they came into school and now is considerable. This isn't a quick fix however progress has been made. The children sometimes struggle when they are without the support from the nurture staff and back in class in the afternoon."

Secondary Nurture

There are currently 7 secondary nurture groups in North Ayrshire and 114 young people received this intervention as of July 2018.

86.8% of children improved on the Boxall development strand, while 71.7% of children improved on the Boxall diagnostic strand. The positive impact of secondary nurture was recorded in all aspects of Boxall assessment.

Positive impact of secondary nurture, is also indicated through SDQ (strengths and difficulties questionnaires) completed by young people, teachers and parents. All groups who completed SDQs reported a reduction in young people's total difficulties. Over 50% of pupils who have accessed this provision have now transitioned back to learning full time in their mainstream secondary schools.

The third summative whole school annual nurture survey for all staff across North Ayrshire schools was completed in May 2018 of the 2017/18 academic session. The 922 respondents, included class teachers, promoted post teaching staff, classroom assistants and early years practitioners. 74% of staff indicated that they have participated in nurture training on the nurture principles and practice, which is a significant increase from results obtained from the 2015/16 (43%) and 2016/17 (67%) academic sessions.

This survey also showed that staff are far more likely now to strongly agree that children have a good relationship with each other than in previous years. This evidence suggests that practitioners have an enhanced understanding of the principles and practice of nurture.

North Ayrshire's commitment to the on-going professional learning of all nurture practitioners has been particularly successful in the 2017/18 academic session. This is evidenced by the high quality of the professional learning being recognised by the GTCS through awarding the Nurture workstream a GTCS "Excellence in Professional Learning Award."

We promise that
if your parents (or carers) have
problems we will be there to
support you all through it.

Early Years
(0-5 years)

Primary Years
(5-12 years)

Secondary Years
(12-18 years)

21
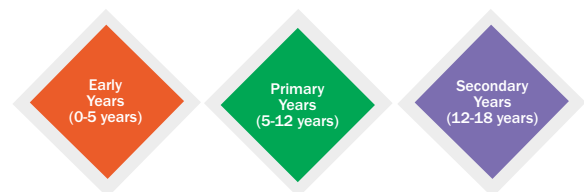
Early Years Social Workers who work with your Health Visitor can provide support if your family is experiencing difficulties with relationships. We now have four Early Years Social Workers who are there to support you.

The Family Learning Team works closely with schools and are available to support and signpost families where needed. The Family Learning Team have a range of programmes available that target aspects of health and wellbeing for example, Families Connect, KitBag, and Parents in Partnership.

Support may also be available through drop in sessions and form filling surgeries. Other programmes look at Budget Busting Cooking, foodbank voucher distribution and funding grants for accredited learning.

We promise to help your parents (or carers) get the best information on money, benefits and employment to help make sure that you have food to eat and a safe, dry and warm house to live in.

Early Years (0-5 years)

Primary Years (5-12 years)

Secondary Years (12-18 years)

Health Visitors, Family Nurses and Early Years staff ask about your family's financial situation to make sure that support is provided. The 'We Work for Families' programme team supported 183 families to access education, training and employment, whilst maximising income through relevant benefits. Early Years Social Workers and Family Nurturers supported 21 families with budgeting skills.

Money Matters provides advice to anyone living in North Ayrshire on welfare rights, assistance or representation in relation to benefits. Our service and the advice we offer is free, impartial and confidential.

During 2018/19, a significant number of families were supported by Money Matters to access welfare rights advice, ensuring they received their full, legal entitlement to state benefits. We have worked in partnership with Money Matters and Home Energy Scotland to develop a formal Financial Inclusion pathway. This will ensure that your parents have an opportunity to discuss any money worries and can be offered support to help address these.

The Education Service's Family Learning Team (FLT) works to support your family. As of March 2019, there have been 425 initiatives and programmes which have supported over 4000 of your families since the team was established. Our evidence shows that families have increased knowledge, confidence and understanding in how to support your learning at home and in school.

Family Learning Team

Our work in this area has been highlighted on the National Improvement Hub (https://education.gov.scot/improvement/practice-exemplars/family-learning-in-north-ayrshire).

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We promise to
help your parents (or carers) to
support you in your learning.

Early Years (0-5 years)

Primary Years (5-12 years)

Secondary Years (12-18 years)

Our Family Learning Team (FLT) approach to family learning for both primary and secondary schools is consistent and fair in all areas. This approach allocates family learning team resource to each school based on the schools levels of deprivation. Twenty-six primary schools in North Ayrshire's areas of highest deprivation receive 1 day equivalent family learning worker support per week.
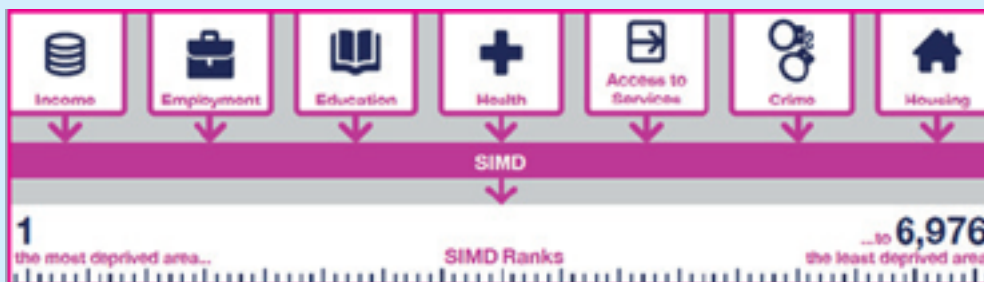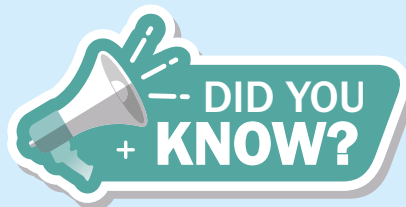
A similar model is adopted in family learning support provided to secondary schools in North Ayrshire. Five secondary schools with highest levels of deprivation receive 2 days equivalent support while schools with the lowest levels of deprivation receiving a ½ day's equivalent per week.

The number of children in receipt of Free School Meals in North Ayrshire is 22.3% compared to 15.6% in Scotland as a whole

The percentage of Children living in low income families is 23.3% in North Ayrshire compared to 16.3% in Scotland as a whole.

Scottish Index of Multiple Deprivation (SIMD) is:

- The official tool to find the most deprived areas in Scotland
- It compares the levels of deprivation across small areas in Scotland

DID YOU KNOW?

Income · Employment · Education · Health · Access to Services · Crime · Housing

SIMD

1
the most deprived area...   SIMD Ranks   ...to 6,976
                                                        the least deprived area

Deprived doesn't just mean 'poor' or 'low income'.
It can also mean people having fewer resources and opportunities, for example in health and education.

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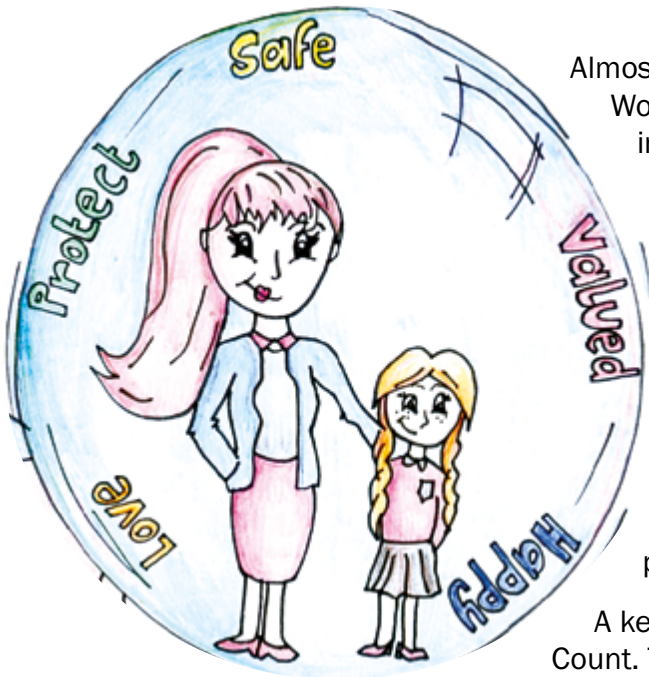
Almost all schools reported that having a Family Learning Worker on the same day every week has helped to increase their capacity to help families. The FLT team has been working with your schools and Head Teachers to make sure that everyone knows how our work can help you. The FLT help schools identify which programmes are most appropriate to their learners and families.

The number of primary schools working with the Family Learning Team has increased from 22 in 2016/17 to 44 in 2017/18.

In secondary schools, the FLT worked in partnership with 8 out of 9 schools in 2017/18.

A key Family Learning Team initiative is Read Write Count. The Read Write Count programme is focused on improving literacy skills of those of you in P2 and P3 through family based learning. This used free family book bags provided by the Scottish Book Trust. The initial feedback indicated it had a positive impact on learning.

The success of this programme is in part due to the high quality resources which are free, as well as the Family Learning Worker's role in leading Read Write Count, in schools which identified this as a family learning opportunity for P2 and P3 families. A variety of follow-up sessions for counting, reading and writing are offered to encourage the use of the materials at home.

The FLT's process engaged and involved school practitioners in a variety of programmes. Through an increase in the number of programmes delivered, there has been an increase in the number of school practitioners involved in family learning opportunities (12 full time equivalent practitioners). This has enabled schools to have a clearer understanding of the importance of family learning as a contributing factor to wider attainment and achievement.

Impact of Read Write Count – Comments from Parents/Carers:

- Good experience reading the stories and playing the games to help encourage learning.
- Spending time with my child in the class made us both happy.
- Really enjoyed working along with S. He loves his bag. We are looking forward to sharing the stories with his brothers.
- Bags are a great idea! Looking forward to using them at home. Coming into the school was really useful and interesting.
- We had great fun with the story telling dice, tropical triumph was a great way to introduce counting.
- The materials that the children have to take home are great and I look forward to reading together.
- The game was a nice way to explore numbers and practice number skills
- Great ideas provided for home time learning.
- Enjoyed the Read Write Count. It's good to get small tips on how to help my child at home.

We promise to
help your parents (or carers) learn what is important to be a supportive and confident parent and engage your wider family members as they will be a great support to you.

Early
Years
(0-5 years)

Primary
Years
(5-12 years)

Secondary
Years
(12-18 years)
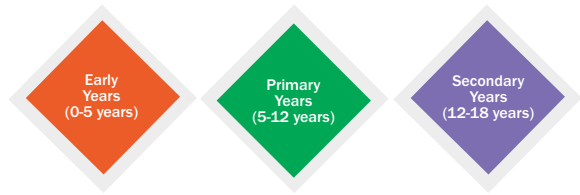
Health Visitors and Family Nurses can request support from a number of different professionals. They do this by making a request through North Ayrshire's Named Person Service. During 2018/19, almost 3,000 requests for support were made for children under the age of 5. Almost half of these were for early intervention and prevention support.

Staff within Universal Early Years' (UEY) service offer home-based parenting support to your family from the period before you're born up until you start school. Staff include six Health Visiting Support Workers, four Early Years' Social Workers, two Family Nurturers, two Healthcare Support Workers, a Perinatal Mental Health Nurse, Infant Feeding Nurse and an Early Years Speech and Language Therapist. We work across North Ayrshire to make sure support is available where you live.

We can support you and your family with breastfeeding, baby massage, behaviour, toileting, sleep routines, making sure your home is safe and allows you to play and develop and helping you and your family find out what is happening in your local area.

We also offer support to make sure your language and communication skills are developing well. In 2018/19, we developed a new programme of support for families led by our Early Years Speech and Language Therapist. This means that wherever you live in North Ayrshire, you can access the same support to help you communicate. We supported 250 families with language and communication.

Triple P: 5 groups with 40 families starting and 24 finishing

Incredible Years: 4 groups with 39 families starting and 15 completing

Triple P discussion groups have been introduced to provide parents with a shorter "access" route to Triple P programme

Some parents could not complete the course as they had to go back to work.

We have a huge variety of parenting programmes so that your mums and dads or carers can get the right support for them at the right time, in the right place if they need it. A parenting co-ordinator and two new members of the team are part of the Education service's early years team and have been recruited to support this.

Our targeted parenting programmes include Scotland-wide Psychology of Parenting Project (PoPP) programmes: Triple P and Incredible Years (for 3–7 year olds). These are available in all localities in North Ayrshire. Trained early years group leaders work with up to 12 parents on strengthening relationships with their children over 8 or 14 weeks.

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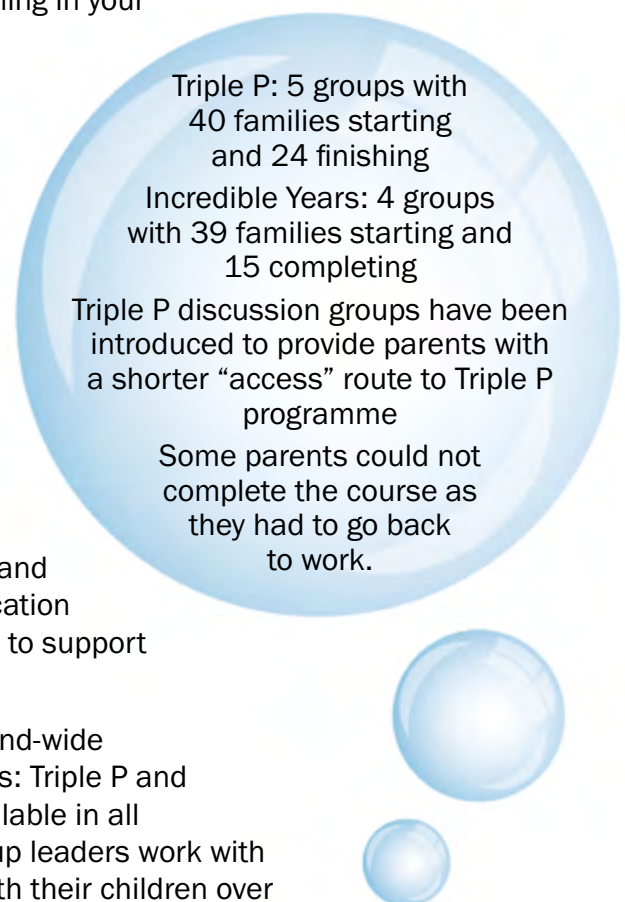
Mellow Parenting is another Scottish-wide set of programmes to help your mum and dad and carers to look after you.

Mellow Parenting (MP) is a programme designed to promote sensitive parenting. It aims to improve parental-child attachment and address parental mental health as well as developing better relationships between parent and child.

In North Ayrshire, Mellow Parenting (including Mellow Bumps and Mellow Dads) is offered alongside our local partners Barnardo's (Kilwinning) and Women's Aid. Dads are actively recruited into all parenting programmes.

We are also developing an annual training programme on the Solihull Approach including refresher training. The training is now offered to Health & Social Care (HSCP) staff. Last year 80 HSCP staff were trained in Solihull Approaches. This enables them to deliver 2 hour workshops to parents as required. The Solihull Approaches are about emotional health and wellbeing and provide training and resources to staff working with you.

Our universal parenting programme is open to all parents from the Parent Early Education Partnership (PEEP). These programmes focus on helping your parents to learn together to develop your learning.

There are 60 staff from early years' centres, childminders, private and voluntary sector were trained in Parent Early Education Partnership (PEEP). This programme encourages parents to interact and develop learning through play. Parents who attend these sessions have children birth to five years. This programme is being delivered on a weekly basis in all nursery centres and classes which are located in North Ayrshire's areas of highest deprivation. In addition we are delivering community PEEP in Ardrossan (x2), Beith, Dalry, Irvine (x2), Kilwinning and Largs. Over the period of 2017/18, 424 families have attended PEEP sessions and 49% of these families were within SMID 1 & 2 areas. PEEP has been used as part of a transition programme in 68% of nurseries in our most deprived areas.

The PEEP Progression Pathway is a 12 or 16 week training course for your parents. This work goes towards SQA units that allow parents to apply to Ayrshire College for agreed courses such as Education and Social Care. Our staff from various teams work collaboratively to deliver Incredible Years and Triple P programmes.

Early years practitioners deliver baby massage in all localities with referrals coming from HSCP colleagues.

The SNAP (Stop Now and Plan) Programme, is an evidence-based, cognitive- behavioural model powered by the minds at Child Development Institute (CDI). SNAP helps you and your parents learn how to effectively manage emotions and 'keep problems small'.

DID YOU + KNOW?

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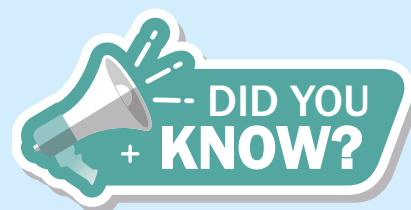
The SNAP Boys and SNAP Girls programmes are designed for children ages 8 to 11 engaging in aggressive and anti-social behaviour at school or in the community. Experienced and highly trained staff work with each family to assess challenges and problems and develop an action plan. Children and families may participate in interventions that aim to prevent future anti-social behaviour and reduce the chances of conflict with family, friends and authority figures.

Our follow up statistics at 6 months and 12 months show that parents and children have learned new methods of managing behaviours from the SNAP Parenting and Kids Groups. This all helps to build good parent and child relationships as well as at home and in school.

All our programmes help build strong family relationships and these form part of our renewed Positive Family Partnership Strategy and its action plan. This plan involves working with our partners in the NHS, North Ayrshire Health and Social Care Partnership and the voluntary sector. Our actions cover 4 main areas:

- Parenting Programmes
- Communication with Parents
- Parental Involvement
- Parental Support

We promise to
offer you lots of sport and physical activity opportunities to keep you fit and healthy.

Early Years (0-5 years)

Primary Years (5-12 years)

Secondary Years (12-18 years)

We support your family to play with you and encourage you to be active from the moment you are born. Health Visitors and Family Nurses will gift your parents and carers Play@Home books when you are a baby, toddler and pre-schooler. These have great ideas for playing and exploring. This helps encourage physical activity for you and your family as you grow up.

Almost all (98%) of our schools are involving you in quality Physical Education for two hours or more in a week. All schools have healthy active activities supplemented through active play and lunchtime/ after school sports and activity clubs.

Through our Active Schools Programme, we have close links between schools and 486 local sport clubs. Our Active Schools co-coordinators provide support for extracurricular sport and activity after school, with 8,774 residents taking part last year. We try to encourage you and your family to take part in activities at local clubs and through KA Leisure provision.

27

We promise that when it is not possible to stay with your family, we will make sure that you are looked after as quickly as possible in a new caring home, to keep your moves to a minimum and to tell you about the reasons for these decisions.

Early Years (0-5 years)

Primary Years (5-12 years)

Secondary Years (12-18 years)

North Ayrshire is a national "Early Adopter" site

DID YOU KNOW?

Through its whole systems approach to Active Communities, North Ayrshire and NHS Ayrshire and Arran have been selected to be an "Early Adopter" site for the new Public Health priority relating to diet and healthy weight. This will involve a focus on children and young people, physical activity and food environments.

North Ayrshire will also be one of four local authorities who will have a "special partnership" status with sportscotland and this will link with and complement the Early Adopter work.

Conflict
Care
Support

We are committed to children remaining in the care of their parents and when this is not possible the wider family is explored as an alternative and the first option to prevent children being accommodated.

The UN Guidelines for the Alternative Care of Children clearly state that the family is the 'fundamental group of society and the natural environment for the growth, well-being and protection of children' and that 'efforts should primarily be directed to enabling the child to remain in or return to the care of his/her parents, or when appropriate, other close family members'.

We have a kinship care policy which sets out the processes for assessment, approval, review and support to Kinship Carers within North Ayrshire's Health and Social Care Partnership within the context of legislation and national policy. The policy was revised due to changes in legislation and the implementation of the Children & Young People (Scotland) Act 2014 and to ensure that the policy met the requirements outlined by the Scottish Government and COSLA (Convention of Scottish Local Authorities).

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The Kinship Service is an integral part of The Heath and Social Care Partnership's strategy to support children to remain within their family and community. The outcomes for children placed within Kinship arrangements are generally known to be better than for children in other care settings.

The Looked after Children (Scotland) Regulations 2009 reinforce this requirement. Every child has the right to have their family and friends explored as carers if they need to leave the care of their parents. 'Unless there are clear reasons why placement within the wider family would not be in the child's best interests the care within the wider family or community circle will be the first option for the child' (Scottish Government 2009).

We have over the years been working to reduce the number of unnecessary moves that you may experience if you are in care by developing our Assessment and Plan and have developed a Kinship Care Panel.

We have developed a multi-disciplinary team of Health and Social Care staff to support you if you have experienced Care.

We have set up a separate Corporate Parenting Continuing and Aftercare Group who are now at the stage of implementing our Continuing Care policy.

We have a Corporate Parenting Plan in place and we worked with children and young people to seek their views and thoughts. This was accomplished by having groups of young people coming together from foster care, residential care, kinship and looked after at home. The groups were facilitated by operational staff. The Corporate Parenting Plan reflects some of their views and the plan quotes these children and young people throughout the document.

The percentage of children or young people having 3 or more moves is substantially lower than the National average of 5% and 6% for comparator authorities. In North Ayrshire there were 18 children with three or more moves, this equates to 3%.

Champions Board

North Ayrshire Champions Board have been together for 1 year. They are a group of care experienced young people who work with corporate parents to create change in the care system.
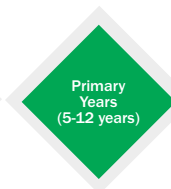The group meet once a week and focus on key themes, such as mental health, housing, language and stigma. Depending on what the group are focusing on they will invite a corporate parent in to have a discussion about this. Our young people are the ones driving the change and continue to work with corporate parents to make this happen.

29

We promise to give you and your family help if you are above a healthy weight.

Early Years (0-5 years) | **Primary Years (5-12 years)** | **Secondary Years (12-18 years)**

There were 9 Looked After and Accommodated Children who have had three or more moves as at Quarter 4, 2018/19. This figure was 12 at the same period for 2017/18

The number of moves before a permanent placement was 3.6 in 2018/19 and 2.2 in 2017/18

Early Years' staff will discuss with your parents and carers what a healthy diet looks like for you at all stages of your development. You will be weighed and measured at various points to make sure that you are at a healthy weight. Our Health Visiting Support Workers can support your family with feeding (including breast and bottle feeding), weaning, portion sizes, cooking skills and tips for when you are being a bit "fussy" with your food!

We are looking at developing a more targeted support for families when there are concerns about your weight.

We have delivered a huge variety of programmes to help you to have a healthy lifestyle. We have been continuing with the JumpStart programme.

The main aim of the programme is to slow the weight gain for children and young people to allow them to grow into a healthy weight. This is done by encouraging and supporting positive health behaviour changes. The programme works with families to increase physical activity, encourage healthier eating habits, increase positive self-esteem and reducing screen time amongst others. In 2018/19:

- 27 children completed the JumpStart programme

- 17 Children reduced their BMI on completion of the programme

case study

Peer Research Project

On the 14th March 2019 a Peer Research event took place called 'Who am I?'. This event was facilitated by North Ayrshire Council's modern apprentices and members of the North Ayrshire's Champions Board.

The aim of the project was to bring together Care Experienced Young People and Professionals to start a conversation around the Language used in the 'care system', the Stigma often associated with the language that is used and the resulting Behaviours of Care Experienced young people and professionals.

Approximately 20 care experienced young people with various care experiences and approx. 30 practitioners from front line practitioners to those in management positions were involved.

The outcomes and recommendations from this project can be seen here.
http://girfecna.co.uk/wp-content/uploads/2019/08/Peer-research-event-report.pdf

30

- 17 Children increased their physical activity levels to meet their 60 minutes per day of moderate intensity activity

- 14 Children increased their fruit consumption per day, 10 remained the same, 3 decreased

- 9 Children increased their vegetable intake per day, 15 remained the same, 3 decreased

JumpStart Choices:

- 1 school

- 3 classes

- 93 children completed the programme

- 21 were above the 91st centile (above a healthy weight)

Active Schools

Our Active Schools programmes provide support for extracurricular sport and activity after school, helping to keep you active. Compared to the 2017/18 academic year, the number of individuals taking part in activities has increased by 12.9% to 8,774. This is supported by a 35% increase in the number of activity sessions which has led to our young people taking part in a total of 197,641 sessions in the 2018/19 academic year.

The key differences that have allowed these increases are –

- Introduction of individual school delivery plans to identify spread of activity as well as any gaps in provision.

- Having a Continuous Professional Development calendar for teachers which has increased our pool of volunteers who are qualified.

- Introduction of the both a Primary and Secondary events calendar which are authority wide allowing schools to work towards specific events – resulting in an increase of extracurricular activity sessions.

- Increase in the number taking part in the year long programme North Ayrshire Sports Academy (NASA) from 30 in year 2017/18 to 50 in year 2018/19 has resulted in more extracurricular clubs being run.

- Enhanced partnerships with schools and community clubs which have resulted in a higher number of deliveries, both curricular and extracurricular across the authority.
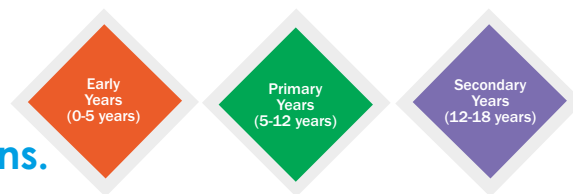
The most popular activities were football, multi-sport, basketball, netball and badminton.

Percentage of children with a healthy weight in Primary 1 was 75.4% in 2017/18, 71.8% in 2016/17

We promise to
provide you with access to opportunities that value you as an individual and your aspirations.

The 'Read, Write, Count' initiative continues with 25 schools in deprived areas participating during term 2 and 3. Up to this point, 355 of your families have been supported to use the resources at home.

The number of young people leaving school to enter a positive destination has positively increased to **95.6%,** against a target of 95.7% and benchmark of 92.3%.

There has been an increasing number of employers in the local area offering work placements to young people with Additional Support Needs. There have been two successful transition events involving employers and training providers aimed at ensuring young people and their parents have the best information to inform their post-school decisions. We are working collaboratively with the council's employability and skills team to ensure that their new supported employment service will include an offer to school leavers.

For some of North Ayrshire's more vulnerable young people, Education provides continued support through Activity Agreement programmes. Activity Agreements provide 1:1 support to help young people overcome barriers they may face when taking the next step to employment, training or further education. At any one time there are approximately 25 young people participating in Activity Agreements in North Ayrshire. Almost 70% of participants move onto an immediate positive destination with the remaining young people continuing to have appropriate support and signposting by the most relevant post-school agency.

The completion of a small-scale programme with local employers to offer pupils a one-year work experience placement with a view to them considering offering a modern apprentice place has been a mutually positive experience.

Skills for Learning, Life and Work are embedded in North Ayrshire's school curriculum. Trips to workplaces, as well as school visits from professionals from a variety of sectors, are regularly featured as part of the school curriculum.

We promise to
provide you with skills for life, learning and work, including financial education.
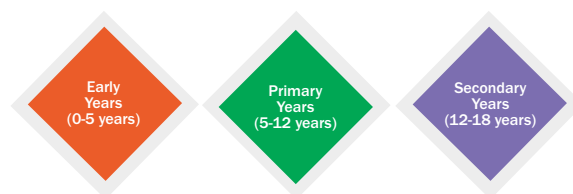
This encourages discussion around routes to employment and the right career path for you. These experiences vary throughout education and ensure when you take your first steps into work, training or further education you have had an opportunity to gain relevant experience or begin to cultivate skills which are valued by employers.

Financial education is a component of Curriculum for Excellence, delivered in all of our schools. There is a growing need to ensure all young people understand personal finance and money management and plans are in place to review practice in this area.

We promise to
address differences in educational attainment so that you can achieve your full potential.

Early Years (0-5 years)

Primary Years (5-12 years)

Secondary Years (12-18 years)

The gap between the attainment of learners from the most deprived and least deprived areas in literacy and numeracy (from Primary up to S3) continues to decrease and is consistently smaller than the corresponding figure on a national level.

Leavers' Attainment (S4-S6)

Similarly, attainment in literacy and numeracy for our school leavers is also steadily improving. Performance of North Ayrshire school leavers in attaining Literacy at Level 4 (96%) and Level 5 (84%) in 2018 has been the highest recorded to date. Numeracy continues to improve at Level 5, with 70% of all school leavers achieving this in 2018.

The average total tariff score of the lowest attaining 20% of leavers has remained well above the Virtual Comparator and above National performance in four of the last five years. The performance of the middle attaining 60% of school leavers from North Ayrshire has steadily improved over the last 5 years. The performance of the highest attaining 20% of leavers has remained broadly consistent over the last three years, exceeding the corresponding performance of the Virtual Comparator.

The virtual comparator consists of a sample group of school leavers from schools in other local authorities who have similar characteristics to the school leavers from your school.
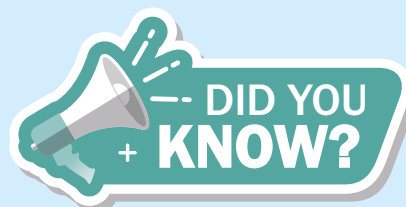
For each school leaver, ten matching school leavers are randomly selected based on gender, additional
support needs, stage of leaving school (S4, S5 or S6) and the social context in which they live (Scottish Index of Multiple Deprivation).
These characteristics were selected due to their significance in explaining differences in the attainment and destinations of school leavers in Scotland.

DID YOU + KNOW?

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The gap between the attainment of leavers from the 20% most deprived areas and the ones from the rest of the areas (80%) has reduced in 2018 to 37%, from 44% the previous year and is much smaller than the corresponding gap for all leavers in Scotland (46%).

A range of targeted supports have been put in place through the Education Service's Scottish Attainment Challenge workstreams and school identified Pupil Equity Fund interventions. This has supported the gap in literacy and numeracy attainment gap between learners (from Primary up to S3) living in North Ayrshire's most and least deprived areas to consistently decrease and remain below the corresponding national figure.

We promise to work with you and your family to encourage and support positive family relationships.

Early Years (0-5 years)

Primary Years (5-12 years)

Secondary Years (12-18 years)
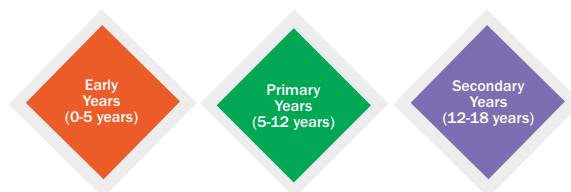
Functional Family Therapy (FFT) is a specialist family service team based within North, South and East Ayrshire and is run in partnership with Action for Children. Functional Family Therapy is a highly successful programme designed to train staff to work with your family if they are in crisis. It helps families to work together to overcome significant issues like substance abuse and violence and to find ways to work together and adapt.

Functional Family Therapy is a short-term intervention working with some parents and carers or others who are important to you. The intervention can last for a 3 to 5 month period and the age range is 11-17 years of age.

The Functional Family Therapists will focus on engagement, motivation and relational assessment and behaviour change.

I SHOULD HAVE A SAY IN THIS...

Functional Family Therapy has been available in North Ayrshire since January 2019 with around 30 referrals. At the time of writing this report we were working with 7 families. There is agreement is that FFT will continue to be available until at least March 31st 2022. This timescale will provide an opportunity to understand the positive impact of the Service at a local level.

All families who are referred to FFT have quick and regular contact from the FFT Team. Introductory visits are arranged and where FFT is explained. Families are involved with FFT for a maximum of five months. Ongoing engagement is important and the introductory meeting helps to encourage engagement and motivation at an early stage.

Of the families we are working with currently none have dropped out. We have been able to engage all of them in their home environment. The therapists are also offering a flexible service of late night working to meet the needs of the families.

34

Referring professionals have begun to give positive feedback which is being collated:

"I went out to see John* last week and noticed a really nice and relaxed atmosphere in the house. There was good positive conversation between John and his mum. When leaving the house, Stephanie asked John to come off his phone which he did with no issue and Stephanie praised him for this. I have noticed a definite positive improvement in their relationship with more calm and encouraging interactions. The support and advice received by yourself has been extremely beneficial for the family and has brought them back from the brink of John potentially being received into local authority care." – *name has been changed

Parenting Style Assessments from the Cognitive Centre Foundation (CCF) are used with parents or carers at the start and end of each programme. These help everyone involved in measuring how useful the programme has been. This could mean a parent having a better understanding or being able to use a variety of parenting styles and techniques to help in difficult family situations.

Family therapy – The Happy Families resource can be used in groups who share common issues relating to parenting. The resources provide practical ways to start talking. One team member is qualified at foundation level in Family Therapy and Systemic Practice, and this brings an additional point of view and area of expertise to our approaches.

Developing parental support programmes

In addition to Family Learning initiatives, there are a variety of parenting programmes available to parents across all geographical areas in North Ayrshire. The Parenting Team support the delivery of these programmes and deliver extensive staff development opportunities.

The Parenting Team are continuing to work in partnership with Parent Network Scotland and parents in the Stevenston and Kilwinning area are currently attending the Parenting Matters Course.

Parents In Partnership is a programme for parents to attend their child's secondary school for 6 weeks. They attend once a week to follow a timetable of their child as well as some life skills. The aim of the programme is to reduce both parental and pupil anxiety and promote positive relationships between home and school.

The programme was developed by CELCIS (Centre for Excellence for Chidlren's Care and Protection) and all secondaries, apart from Arran High, have delivered this programme.

We promise to support you to build and maintain healthy sexual relationships free from coercion and harm.

Early Years (0-5 years)

Primary Years (5-12 years)

Secondary Years (12-18 years)
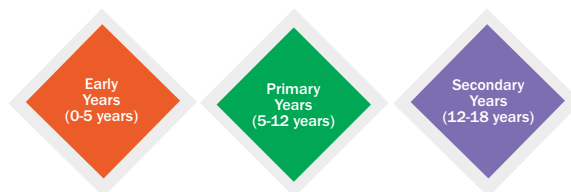
A Relationships, Sexual Health and Parenthood (RSHP) Framework has been developed in partnership by Health and Social Care, Education colleagues and school nursing staff. This element has been included within the wider North Ayrshire Council Health & Wellbeing Framework 2018.

Supportive meetings and two education sessions have been delivered to P6 and P7 teaching staff in relation to "Puberty" and "Conception and Birth" lesson plans. Corresponding teaching presentations and Guidance continues to be circulated and developed.

Our Health Improvement Team continue to support and attend the LGBT (lesbian, gay, bisexual, and transgender.) Education Events as hosted by staff from Ayrshire Colleges and East Ayrshire Council. These events provide an opportunity to share best practice and facilitate any additional learning for staff and students.

CCard

CCard is a service in Ayrshire and Arran offering access to free condoms with minimum embarrassment or fuss. Condoms offer protection against some of the sexually transmitted infections such as chlamydia, gonorrhoea and HIV. The Ccard is available via the Ccard app.

DID YOU KNOW?
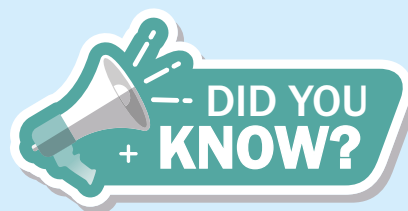
NHS Ayrshire and Arran's CCard App has been successfully launched and the scheme continues to be delivered across Ayrshire. During 2018/19, a total of 17 young people under the age of 16 registered for the CCard via the original paper scheme, 94 people over the age of 16 registered this way and there was a total of 155 downloads of the CCard App. The App also provides further information and signposting to sexual health services.

A total of 28 staff and partners have received training in the delivery of the CCard scheme.

LGBT Awareness training has been delivered to 26 members of staff across the authority, including staff working within Addictions Services and staff who work with Care Experienced Young People.

A total of 7 sexual health awareness sessions and workshops were delivered to 105 young people in North Ayrshire.

The Health Improvement Team provided support at the following health events aimed at young people:

- Freshers Fayre (Ayrshire College, Kilwinning) (approx. 160 participants)
- Freshers Fayre (Irvine Royal) (approx.. 30 participants)
- "Healthy you" (Kilbirnie) (approx. 15 participants)
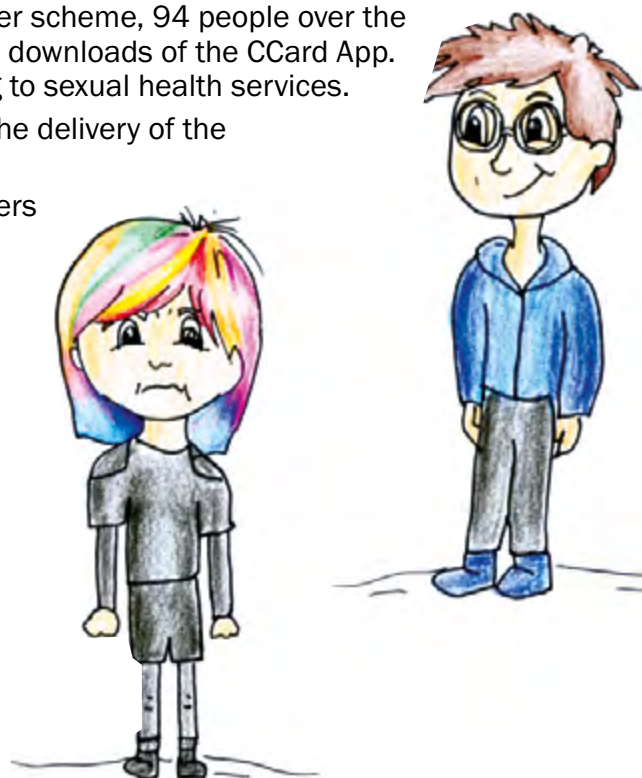
Our Promises to you
Early Years (0-5 years)

**We promise that
if your mum smokes, drinks alcohol or
takes substances when she is pregnant
with you that we will offer her a
programme to help her stop.**

Early
Years
(0-5 years)

The rates of women smoking
in pregnancy
in 2017/18 was 24.3% in
the North Ayrshire Health and
Social Care Partnership. This
compares to 20.6% in NHS
Ayrshire and Arran area and
14.8% nationally.

We have a combined addictions maternity clinic which runs monthly within North Ayrshire Drug and Alcohol Recovery Service (NADARS). This is a monthly outpatient clinic which gives any women who are on a substitute prescription with the service to be reviewed by a Consultant Psychiatrist in Substance Misuse, their keyworker, and one of the Safeguarding Midwives. The purpose is to improve outcomes for mother and baby during and after pregnancy by ensuring that treatment is optimised and mums have the opportunity to meet regularly with an addictions consultant and midwife to ensure that all their needs are being addressed.

Community midwifery staff in North Ayrshire carry out a carbon monoxide breath test with all pregnant women. If the reading is 4 or over an automatic referral is sent to the Quit Your Way Team who will endeavour to make contact to discuss the correct support for cessation. Nicotine replacement therapy is safe to use in pregnancy and is provided free of charge in conjunction with support from the Quit Your Way Officer.

Pregnant women may choose to use an e-cigarette, which Quit Your Way cannot provide but will support the use of, as this is safer than continued smoking.

Many pregnant smokers do not engage with the service because they are not ready to stop smoking or decide to stop by themselves without support from Quit Your Way. Quit Your Way have tried alternative approaches in North Ayrshire to increase uptake of support such as using text messages instead of phone calls, but this has failed to improve uptake.

From 1st April 2017 to 31st March 2019, 449 pregnant women who smoked were referred from maternity staff in North Ayrshire. Out of the 448 women, 85 (19%) engaged with Quit Your Way for support with smoking cessation.

We promise to help your mum if she wants to breastfeed, as this is best for you.

Health Visitors discuss feeding intention at pre-birth contact with mum at around 32-36 weeks gestation and if mum chooses to breastfeed, will ensure that additional home based support is available. Parents have access to local resources, for example, Parent and Baby cafes.

Additional support for breastfeeding is provided through Health Visiting Support Workers and Healthcare Support Workers for early, low level support, and through the pan-Ayrshire Infant Feeding Nurse, where more specialist assistance is required. During 2018/19, 87 antenatal visits were made by the Health Visiting Support Workers/ Healthcare Support Workers to support breastfeeding and 49 requests for breastfeeding assistance were made in the post-natal period.

A new integrated Infant Feeding Team has been established, bringing together maternity and health visiting services, infant feeding team and peer supporters from the Breastfeeding Network. The team is dedicated to supporting mothers to breastfeed their newborn babies in a way that reflects their individual experiences and needs. The service has focussed on babies born by Caesarean Section initially, as well as supporting mums and babies in the Neonatal Unit.

The percentage of babies mixed fed or solely breastfed at 6/8 weeks old was 26.27% in 2018/19 and 20.88% in 2017/18

The percentage of babies exclusively breastfed at 6/8 weeks was 19.51% in 2018/19 and 14.29% in 2017/18

case study

Integrated Infant Feeding Team /Peer Support for Breastfeeding

Mum delivered baby number 3 by elective section. She has previously breastfed both her other children for over 2 years. She had had a problem previously with a low milk supply with her first two children and had to top both up with formula till after 6 months until they were on solids. When Peer Supporter Caroline first visited Mum she told her that baby was sleepy but feeding frequently. She was worried that baby did not seem to get to the end point of a feed. The baby had not regained her birth weight and the Mum was feeling upset and worried.

When Caroline returned to Ayrshire Maternity Unit (AMU) she spoke to Cara, from AMU infant feeding team about the situation, with the mum's permission. Caroline saw this mum weekly and spoke to her in

between visits by phone and by text. Caroline reassured her regularly that she was doing an amazing job. Mum started to find finding topping up very hard as baby was sleepy after she feeds her and it was hard to get her to take Expressed Breast Milk (EBM) or formula, she was also finding the cycle of feeding: topping up; expressing and sterilising exhausting.

This Mum with the Support of the Infant Feeding Team in AMU and the Peer Support Service continues to breastfeed her baby, she has given up pumping as this became exhausting and she continues to top her baby up with formula but is happy in the knowledge her baby is still getting her breast milk. Working as part of the Integrated Infant Team and communicating together meant we could offer this mum the support she needed without her having to work with several teams.

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**We promise that
you are offered a developmental growth
assessment by your health visitor
(named person) when you reach 27-30 months
and at pre-school age, with a focus on
growth, wellbeing, communication
and language development.**

Early
Years
(0-5 years)

All children within North Ayrshire are routinely offered a developmental and growth review at 27-30 months and 4 years as part of the Universal Pathway for Health Visiting (2015); this is inclusive of a full assessment of need and health promotion advice. The Universal Early Years' service in North Ayrshire is committed to assessing the health and wellbeing of our children in correlation with local and National policies; as well as intervening early to ensure the best possible outcomes for our children and families.

We also offer support to make sure your language and communication skills are developing well. In 2018/19, we developed a new programme of support for families led by our Early Years Speech and Language Therapist. This means that wherever you live in North Ayrshire, you can access the same support to help you communicate. We supported 250 families with language and communication during the last year.

Almost all of the Early Years Education Centres now have **Communication Champions**, who have had additional training and support from the Speech and Language (SPIN) team. The Communication Champions and Early Years staff are working together and will be delivering speech and language workshops for parents.

**We promise that
we will offer all children aged 3 or 4 years
old early learning to help you learn,
develop social skills and meet
other young children.**

Early
Years
(0-5 years)

Bookbug Baby and Toddler Bags continue to be delivered with additional support from the Bookbug Co-ordinators to gift to families not reached by Health Visitors. During the course of the year,1487 Bookbug Explorer Bags were gifted through the Early Years Classes in May/ June to all Ante Pre Schools (3 year old) children. Primary 1 bookgifting was completed in November 2018 and planning is in hand for P1 Family Bag to be gifted through the Library Class Visits Programme again during Bookweek Scotland in November 2019.

The number of children with Speech and Language concerns at 27-30 month review was 156 in 2018/19 and 190 in 2017/18

In partnership with Scottish Book Trust, North Ayrshire hosted the Bookbug Explorer pan-Ayrshire Training for Early Years Staff in February. North Ayrshire has been selected to host the P1 Family Bag Training in September 2019 for Teachers and Library Staff.

The annual delivery agreement with Scottish Book Trust is currently being reviewed.

In early years, there has been a steady increase over time in the proportion of children meeting their developmental milestones at the point at which they start school from 2014 to 2017 rising from 69% in 2014 to 77% in 2018. This has been supported by a successful quality improvement project on communication friendly environments in partnership with NHS Ayrshire and Arran. Early learning and childcare practitioners and parents and carers are reporting the positive impact that the project has had on them and their children.

To continue to support your learning, each early years centre and class records information on the progress of your development. These are called developmental milestones. These milestones include health and wellbeing, listening, talking, reading, writing, numeracy and maths. This information is used to help identify any gaps in your development, discover any needs you might have and plan the next steps for you. It also provides information on moving up to Primary 1 and helps us to improve our practices for the coming year.

**DID YOU
+ KNOW?**
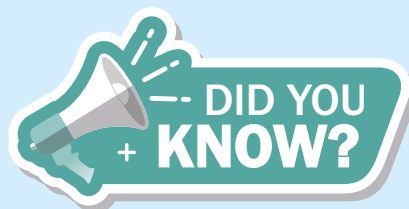
Early Years Expansion

Our Vision

North Ayrshire aims to lead the way in early learning and childcare by providing all children with excellent learning experiences in nurturing and inspiring environments. We want to provide all parents with a flexible and responsive service that meets their needs and, with them, build the foundation for a bright future for all our children.

From August 2020, the number of hours of early learning and childcare that children receive will increase from 600 hours per year, (which is about 16 hours per week during term time) to 1140 hours per annum (which is about 30 hours per week during term time).

To get prepared for August 2020, the increased hours are already available across many of the Council's early years classes, centres and partner nurseries. Children and families are reporting many benefits of the new entitlement with some families being able to access new work, training and education opportunities.

The extended hours mean that children are also entitled to a free lunch at nursery. This has proved to be very popular amongst the youngest children who say that chicken curry is their favourite nursery lunch! Parents also report on the many benefits of their children having the funded meal as part of the early learning experience.

Another benefit of the expansion in hours is the work that has been taking place to refurbish and extend our early learning and childcare buildings. This means that our early learning environments are inspiring and nurturing places of learning for our children and families.

The percentage of children achieving their developmental milestones at the time the child starts primary school was 78% in 2018/19 and 77.2% in 2017/18

DID YOU + KNOW?

**We promise that
in your early years experience we will
provide daily physical activity, that
you will be able to play outside and,
that all snacks provided will be of
nutritional value.**

Our Early Learning and Childcare Team have senior early years practitioners available to provide advice and support in developing outdoor environments for you to use Loose Parts to develop fun learning experiences. Loose Parts are materials within our play spaces that can be moved, carried, combined, redesigned, lined up, and taken apart and put back together in multiple ways. This allows you to be creative while playing outside.

Our early learning centres, primary schools and nurseries are using the Setting the Table guidelines to plan your snack menus. These include using practical activities to encourage healthy food and looking at lots of recipes with good nutritional value. As part of the 1140 Expansion Programme, free school meals are provided for all of you in early years. This is helping with your health and wellbeing as well as on your families finances.

In North Ayrshire, all our primary schools and early years centres take part in **Fit Fifteen**. This was launched in April 2016 with the idea that everyone, every day, everywhere, should be active through providing more opportunities for daily physical activity. This plan strives to get you to take part in at least 15 minutes of fitness each school day.

The most recent figures produced show that the percentage of Primary 1 children in North Ayrshire who were overweight, obese or clinically obese had fallen to 16.8% in 2017/18. This is the lowest rate since 2008/19.
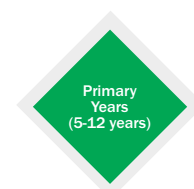
100% of Early Years Centres and Primary Schools take part in Fit Fifteen

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Our Promises to you
Primary Years (5-12 years)

We promise that
we will support you to be able to read,
write and count before leaving
Primary school.

Primary
Years
(5-12 years)

Primary/Secondary – Achievement of Curriculum for Excellence Levels

Raising attainment in numeracy remains broadly in line with the national average. Teacher professional judgement data shows that there is an improving trend overall in numeracy attainment levels most notably in the proportion of pupils achieving third or fourth level by S3, and for the percentage attaining second level by P7.

Attainment in literacy has increased at each of the main stages from P1 through to S3, from 2015 to 2017, for reading, writing and listening and talking.

Overall, attainment in both literacy and numeracy at both primary (P1-P7) and secondary stages (S1-S3) has continued to improve over the last three years. This is illustrated in the graphic below:

Percentage of primary pupils (P1/P4/P7) who achieved nationally expected levels of attainment:

	Literacy	Numeracy
2016	64%	74%
2017	70%	77%
2018	72%	80%

Percentage of secondary pupils (S3) who achieved nationally expected levels of attainment:

	Literacy	Numeracy
2016	70%	82%
2017	86%	81%
2018	91%	92%

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Our Promises to you
Primary Years (5-12 years)

**We promise that
you will have an allocated named person
(normally Health Visitor, Head Teacher,
or Pastoral Support Teacher) and we will
tell you who they are and be there for you
and your family.**

Primary Years (5-12 years)

Secondary Years (12-18 years)

Primary and Secondary

On 1st September 2019, John Swinney, Depute First Minister, made a statement to the Scottish Parliament and announced that the *Scottish Government would no longer pursue legislation to make the provision of a named person for every child a statutory entitlement*. He has made it clear that this does not mean that the named person policy has been scrapped. Children in North Ayrshire are benefitting from a key point of contact who can offer help and support to children and families when they need it.

The DFM's announcement should have little impact on the functions of the current Named Person Service in North Ayrshire, or the processes that have been developed, or the support given to children and their parents. Even though the legislation was never enacted, North Ayrshire Health & Social Care Partnership and Education made the decision to take forward the role of the Named Person and the Named Person service in line with its Getting it Right for Every Child policy. Going forward we must ensure the named person role and named person service is being delivered in line with existing laws and guidance on data protection, confidentiality, human rights and other relevant rules of law.

Whilst we will need to review terminology we continue to be committed to the principles of Getting it Right for Every Child and the delivery of a high quality service supporting children, young people and families.

In the very near future, we will review the functions, processes and governance of the Named Person Service and review our documentation, processes and procedures around the named person.

In relation to information sharing, whilst awaiting further guidance, we will continue to support the proportionate sharing of necessary Information and be governed by the General Data Protection Regulation (GDPR) and the Data Protection Act (2018) and guided by North Ayrshire Data Protection and Information sharing protocols.

We have continued to focus on **Getting it Right for Every Child (GIRFEC)**, as well as supporting the Named Persons and Lead Professionals via our Named Person Service –

We have done this by:

1. Expanding our service directory to help Named Persons and Lead Professionals find the right type of support for your needs. Services can be provided by a range of partner organisations, including the Council, the NHS, the Health and Social Care Partnership or perhaps a charity.

2. Using a Request for Assistance process, form and guidance that ensures a consistency of practice across staff who may be working with you and your family. This was introduced to make sure that the right support is provided as quickly as possible and to fill any gaps in services.

3. Continuing to share GIRFEC newsletters with practitioners and managers, keeping them up-to-date and providing links to useful websites and resources. Over the past year, named persons and practitioners have received training in a variety of areas including:

   - Children's Rights
   - The role of the Named Person
   - AYRshare

4. Providing a Pan Ayrshire website to provide information about services and developments across the whole of Ayrshire and Arran. Our GIRFEC Pan AYRshire guidance has also been updated.

All of this means that Named Persons will be better able to identify your family's wellbeing needs, taking your views into account every step of the way.

Where your parent or carer is in touch with certain adult services, such as alcohol and drug services or the homeless service, we have a new way of notifying your Named Person. This allows them to make sure you are supported through the process as well.

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**We promise,
wherever possible, to place a number
of professionals in schools so that
"a team around children" can make sure
you get the right support at the right time.
This will include your named person.**

Primary Years (5-12 years)

Secondary Years (12-18 years)

The work of building teams around the child and family continues to develop.

Work with our partners continues to develop the locality model of care approach to build a team of people including your Named Person, who can in consultation with you carry out an assessment of your wellbeing and where necessary and in agreement with you and your family, agree how best to provide support for any identified needs.

We have worked with our colleagues across Ayrshire to ensure we have clear pathways to help you, or at times, your family access supports.

Where your parent or carer is in touch with certain adult services, such as alcohol and drug services or the homeless service, we have a new way of notifying your Named Person. This allows them to make sure you are supported through the process as well.

Secondary Years

**We promise to
work with you and your family
to help you feel safe from drugs,
alcohol and domestic abuse.**

Secondary Years (12-18 years)
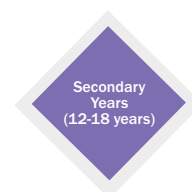
A wide range of supports are available to keep you safe from harm from drugs and alcohol abuse.

Substance Misuse

All Secondary School pupils will have access to a PSE programme of education which includes a focus on four key themes; use of substances, informed choices, risk taking behaviour and action in unsafe situations. This education is often delivered in partnership with police and third sector agencies. The PASS (Prevention of Alcohol and Substance Misuse Sessions) resource is widely used in North Ayrshire schools. Pupil learning includes information on current laws, how media and peer pressure affect their own attitudes and behaviours. They learn how to identify and select the skills/qualities required to make positive choices in challenging situations, for example, confidence, resilience, assertiveness. In addition, they should develop positive coping strategies when dealing with stressful and challenging situations. In terms of protection pupils learn how substance misuse can affect judgement and impair ability to make responsible decisions and what actions to take in an emergency relating to substance misuse.

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Domestic Violence

All secondary school pupils have access to a PSE programme of education focussing on Relationships, Sexual Health and Parenthood. One theme of learning is devoted to the development of healthy relationships and how to recognise the signs of unhealthy relationships. There is a focus on consent within relationships and pupils learn how to distinguish between a balance of power and abuse of power in relationships, for example, respect, trust, coercion, consent. Pupils are signposted to sources of help and support.

Young Persons Support Team

The Young Persons Support Team continues to deliver the CHARLIE Programme which is a 30-week programme specifically designed to support you if you are 8-11 years old.

The CHARLIE Programme can support you if you are living with or have experienced the impact of parents substance misuse. In 2019 the North Ayrshire Alcohol and Drug Partnership (ADP) funded a range of interactive tools and equipment to support the ongoing development and work of the Charlie programme.

C.H.A.T.

The North Ayrshire Alcohol and Drug Partnership have identified funding to train over 50 staff from across Children and Families Services in the Children Harmed by Alcohol Toolkit (C.H.A.T.) The C.H.A.T. resource pack and training has been developed by Alcohol Focus Scotland and aims to build resilience and protective factors in children and families. In addition, C.H.A.T assists children and young people to understand the recovery journey, develop social skills and emotional intelligence whilst encouraging them to talk to someone about their experiences.

The C.H.A.T. training is a one day course and will be delivered by Alcohol Focus Scotland. Once staff have completed the training there will be an expectation that the learning and application of the Children Harmed by Alcohol Toolkit is embedded into practice. The implementation, impact and evaluation of C.H.A.T will be subject to the existing ADP reporting and monitoring processes to ensure that ADP Core Outcomes are being meet.

To date three session have taken place with a further two sessions scheduled before the end of 2019.

CAPSM SUB Group

The North Ayrshire Children Affected by Parental Substance Misuse Group (CAPSM) continues to work to improve the quality and accessibility of services for you if you are at risk due to the harmful effects of parental/ care giver alcohol or drug use.

The CAPSM Group is a recognised sub-group of the North Ayrshire Alcohol and Drug Partnership (ADP) and the Child Protection Committee (CPC), which links with other strategic Community Planning groups, including Safer North Ayrshire Partnership (SNAP). The CAPSM Subgroup meets regularly to strengthen understanding across agencies of your needs if you have been affected by parental substance misuse. The CAPSM subgroup also supports partners in developing an effective inter-agency response and to strengthen communication links and joint working between adult and children's services.

Rosemount Project

A Family Worker (Alcohol Support) is based within the Rosemount Crisis Intervention team. This post is funded by the North Ayrshire Alcohol and Drug Partnership to support you if you are Looked After and Accommodated / Looked After at Home and have been affected by alcohol and substance misuse.

Interventions are tailored to your individual needs and levels of risk and are delivered via both group work and individual sessions to raise awareness and help you to gain a better understanding of drugs and alcohol and how links can be made to other areas in your lives such as health, relationships etc.

case study

Rosemount Project

The Family Worker (Alcohol Support) has been leading on a project with the National Galleries of Scotland. This project involved young people in Kinship placements and is called "Beings Hearts + Minds". This exhibition explored young people's wellbeing, through their emotional response to powerful works of art and was displayed in the National Portrait Galleries from January 2019 until April 2019. The North Ayrshire Alcohol and Drug Partnership has supported the Beings exhibition to come to North Ayrshire. The Beings Exhibition was displayed in the Racquet Hall in Eglinton Country Park from 26th of July 2019 until the 26th of August 2019. The exhibition featured a surreal 'Wedding Ceremony' photographic display, created by young people from the local area, alongside other artworks and videos exploring different ways into young people's minds.

From April 2018 and March 2019, 363 children and young people were supported by the Rosemount Crisis Intervention Service with 94% remaining within their family home on a long term basis. During the same period 87% of our young people went on to positive training, employment and education destinations. Furthermore, from April 2018 – September 2018 78% of young people reported a reduction in their drug and alcohol use.

Work with National Galleries – Quotes from Young People

"At first it was weird, but it was really cool"

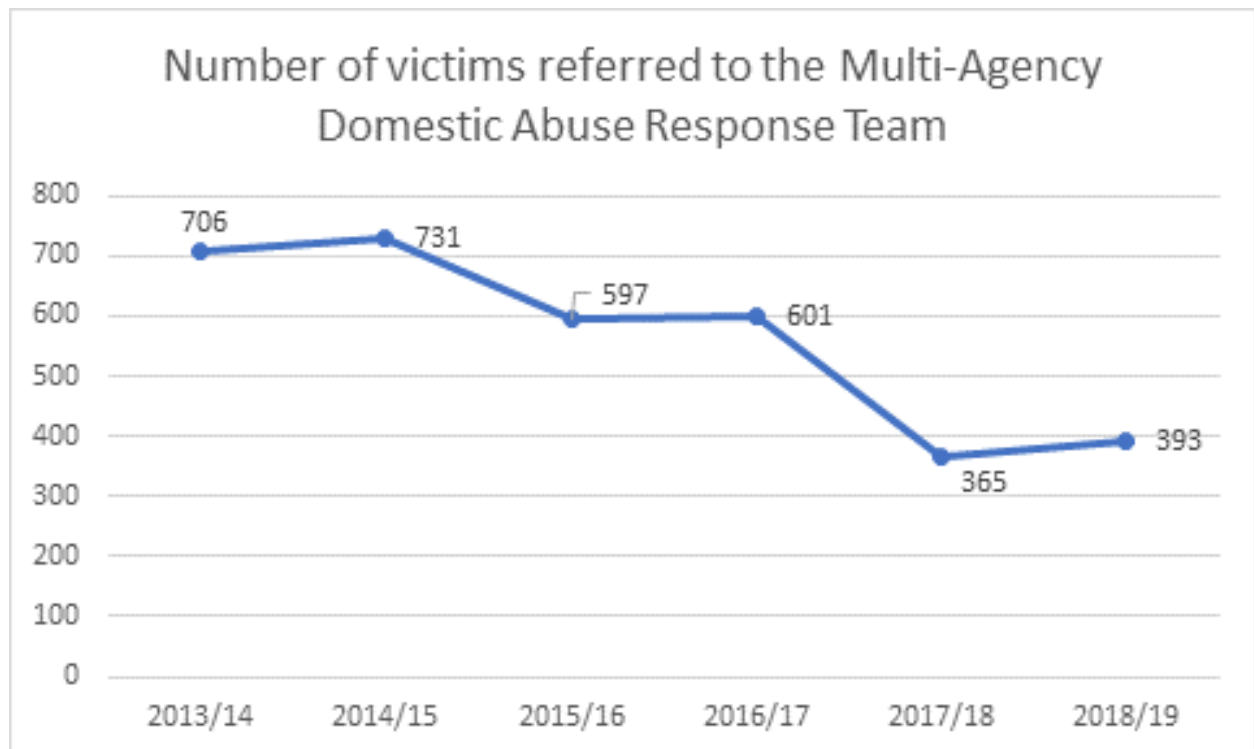*"Very fun, educational and great working with other groups"*

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NADARS

A process to share information between adult services and children's services was developed and tested during 2018/19. North Ayrshire Drug and Alcohol Recovery Service (NADARS) together with the HSCP Universal Early Years' service and Education services, tested a process to notify the Named Person where an adult with parenting responsibilities was engaged with the service. The process could also be used where a staff member had concerns over the wellbeing of any children or young people in the family. Consideration is now being given to how the process can be rolled out to other adult services.

34 children presented
to Emergency department due to
alcohol misuse
in 2018/19

35 children presented
to Emergency department due to
alcohol misuse
in 2017/18

Domestic Abuse

The Young Persons Support Team, Intervention Services (YPSTIS) continues to work with families across all of the localities within North Ayrshire, in a targeted manner, to discuss relationships, domestic abuse and personal safety issues. The ongoing work of MADART (Multi Agency Domestic Abuse Response Team) continues to ensure that you are receiving support at a much earlier stage. Information from MADART shows that the number of victims being referred is continuing to decrease, indicating that work in this area is having an impact.

Number of victims referred to the Multi-Agency Domestic Abuse Response Team

Year	Number
2013/14	706
2014/15	731
2015/16	597
2016/17	601
2017/18	365
2018/19	393

The 'Twilight Basketaball' programme continues to be run in Dalry and Irvine on a Friday evening for 11-21 year olds. The national scheme provides basketball sessions filled with education and life skills.

The Ayrshire Alcohol and Drugs Partnership provided funding to Barnardos to allow the sharing of learning from the "Voices of Emoji" group with professionals to help them understand how young people feel living with alcohol/drug use in their family.

An Ayrshire Alcohol and Drug Partnership funded project 'Funky Films' worked with North Ayrshire's Women's Aid on a project – "Expect, Respect". It involved students from City of Glasgow College and the Glasgow Acting Academy to produce a film to raise awareness of domestic abuse in young people's relationships. The film was screened at the North Ayrshire gender based violence and young people conference where there were representatives from local secondary schools. It also had a screening within the Harbour Arts Centre where members of the community, police and local councillors were in attendance.

https://www.youtube.com/channel/UCcVOJLuIz90i-_twR9oQhbw?app=desktop

We promise to enable you to move from school and beyond towards a job, further education or training course.

All North Ayrshire schools are broadening the range of wider qualifications and experiences available to you in secondary schools. This is part of North Ayrshire's Developing the Young Workforce approach which builds on skills for learning, life and work. In addition to the traditional subjects our schools are offering a wide range of opportunities for you to achieve wider accreditation that reflects your personal aspirations and skills. There are 62 different wider achievement opportunities and the numbers of you participating in those is rising year on year.

Working in partnership with Ayrshire College a range of vocational programmes are also on offer to you in the Senior Phase. These include construction, engineering, hair and beauty, and motor mechanics. Ayrshire College also offer a new Foundation Apprenticeship and 25 pupils from North Ayrshire schools are working towards an FA qualification in Engineering for children and young people.

For some of North Ayrshire's more vulnerable young people, who have no positive destination on leaving school, Education and Youth Employment provides continued support through Activity Agreement programmes. Activity agreements provide 1:1 support to help you overcome barriers you may face when taking the next step to employment, training or further education.

The completion of a small-scale programme with local employers to offer pupils a one-year work experience placement with a view to them considering offering a modern apprentice place has been a mutually positive experience.

case study

Jess* is a care experienced young person and she has had a few placements within North Ayrshire. Jess and her brother were returned to their parents and this was successful.

Jess attended mainstream school however she lacked confidence and self-esteem. Jess signed up for the Activity Agreement, this was not a smooth transition at first however Jess was supported and her attendance, confidence and self-esteem improved greatly. Jess became confident enough to apply by herself for a modern apprenticeship. Jess attended the interview and gained a place. Jess struggled with this however she was supported and completed this.

Jess then went onto apply for college and gained a place, Jess is currently attending college and she is also taking driving lessons. Jess is wanting to work within the care sector as she feels her journey will give her a good insight to support others.

– *name has been changed

Quotes from young people
Activity Agreement

"It's good"

"It helps with confidence. You feel part of the group. Everyone helps each other"

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Local Employability Partnerships

North Ayrshire's Local Employability Partnership is a key driver in the coordination of Youth Employment activity across Local Authority services. The Directorate of Education and Youth Employment is an active member of this group and promote opportunities available throughout North Ayrshire. One example has been promoting and supporting young people to engage with North Ayrshire's Employability Hubs.

Skills Development Scotland

Secondary schools in North Ayrshire enter into an annual partnership agreement to plan the delivery of Career Management Skills across the curriculum. An adviser in every secondary school offers Career Information and Guidance, aligned to the Career Education Standard, Curriculum for Excellence and Developing Scotland's Young Workforce.

The proportion of Pupils entering Positive Destinations was 95.6% in 2017/18 and 93.4% in 2016/17

case study

Positive Destinations

In conjunction with the Council's Business Growth team and Ayrshire Chamber of Commerce, schools were given the opportunity to identify pupils who may benefit from a flexible work experience placement. Although many pupils already do extended or more flexible placements, we specifically targeted local employers who had indicated that they may consider recruiting young people in the foreseeable future. Two pupils have successfully completed a full year with local employers. The time was built into the pupils' timetables so their learning on placement was an integral part of their school curriculum. This allowed them to gain valuable experience of the workplace while still completing their school studies. Their attendance at the workplaces has been excellent and their motivation has impressed the employers so much that this has led to offers of post-school employment. One of these is an engineering apprenticeship. The other is an offer of employment to a young person for whom making a successful post-school transition would have presented challenges. It is envisaged that this model, which has been small in scale, will grow and be one of a suite of opportunities matching pupils' aspirations to the recruitment plans of local businesses.

Next Steps

In this section we will tell you some of the things that we still want to achieve.

We will be working on a new version of our Children's Services Plan to cover 2020 to 2023. This will involve talking to you to find out what your priorities are for the future.

We also are going to:

- Co-produce the refresh of the Young Peoples Citizenship and participation strategy for North Ayrshire, ensuring the strategy is informed by your rights and that you are at the heart of the development.

- Implement the actions of the National Youth Work Strategy for Scotland, in partnership with you the young people of North Ayrshire, providing youth work opportunities in your localities based on need.

- Support the legacy of the year of young people via the three workstreams of Poverty, Health and Well Being and Youth Voice.

- Continue our corporate commitment to ensuring that we are a Child Centred Council, ensuring that we are focused on putting our children and young peoples, views and aspirations at the centre of our decision-making processes.

- Support your active participation at national Youth Citizenship structures, with a focus on the Scottish Youth Parliament and support to the North Ayrshire elected Members of the SYP.

- Develop an action plan for the whole systems Early Adopter diet and healthy weight priority with Scottish Government and share our findings with other local authorities.

- Create the conditions for you to access the highest quality learning experiences from ages 3-18.

- Support you to become successful learners, confident individuals, effective contributors and responsible citizens.

- Offer opportunities to you and your families to play a more active role in school life and encourage more participation in learning.

- Work with you to build your resilience, supporting your mental health and physical well-being.

Appendix 1
Useful websites

Children's Services Plan – 'Getting it right for you' (2016-2020)

https://www.north-ayrshire.gov.uk/Documents/SocialServices/childrens-services-plan.pdf

The Children and Young People (Scotland) Act 2014

https://www.cypcs.org.uk/policy/children-young-people-scotland-act

Children's Services Strategic Partnership (CSSP)

https://www.north-ayrshire.gov.uk/Documents/CorporateServices/ChiefExecutive/CommunityPlanning/cssp-structure.pdf

UN Convention on the Rights of the Child

https://www.unicef.org.uk/what-we-do/un-convention-child-rights/

Carers (Scotland) Act

http://www.gov.scot/Topics/Health/Support-Social-Care/Unpaid-Carers

Getting it Right for Every Child

http://www.girfecna.co.uk/

Stop to Listen

https://www.children1st.org.uk/what-we-do/speaking-up-for-scotlands-children/stop-to-listen/

Foetal alcohol syndrome (FAS)

http://www.nhs.uk/conditions/foetal-alcohol-syndrome/Pages/Introduction.aspx

Psychology of Parenting Project (PoPP) programmes

http://www.nes.scot.nhs.uk/education-and-training/by-discipline/psychology/multiprofessional-psychology/psychology-of-parenting-project.aspx

All 6 areas in North Ayrshire

http://www.northayrshire.community/your-community/

Mellow Parenting

http://www.mellowparenting.org/our-programmes/

Mellow Bumps

http://www.mellowparenting.org/our-programmes/mellow-bumps/

Mellow Dads

http://www.mellowparenting.org/our-programmes/mellow-dads/

PEEP Progression Pathway

https://www.peeple.org.uk/parent-qualifications

The Family Nurse Partnership

http://www.gov.scot/Topics/People/Young-People/early-years/parenting-early-learning/family-nurse-partnership/background

Speech and Language (SPIN) team

https://ayrshirehealth.wordpress.com/2015/08/26/its-all-about-spin-by-alison-gooding/

Universal Health Visitor Pathway

http://www.gov.scot/Publications/2015/10/9697

Bookbug Bags

http://www.scottishbooktrust.com/bookbug/bookbug-bags

Explorer Bags

http://www.scottishbooktrust.com/bookbug/bookbug-bags/bookbug-explorer

Baby Bags

http://www.scottishbooktrust.com/bookbug/bookbug-bags/bookbug-baby

Family Bag

http://www.scottishbooktrust.com/bookbug/bookbug-bags/bookbug-primary-1-family-bag

The Children and Young People Improvement Collaborative (CYPIC)

http://www.gov.scot/Topics/People/Young-People/early-years/early-years-collaborative

Loose Parts

http://www.letthechildrenplay.net/2010/01/how-children-use-outdoor-play-spaces.html

PLAY@Home

http://www.healthscotland.com/documents/20735.aspx

Save the Children Read on Get On campaign

https://www.savethechildren.org.uk/sites/default/files/images/Read_On_Get_On_Scotland.pdf

National Improvement Framework

http://www.gov.scot/Resource/0049/00491758.pdf

Active Schools Co-ordinators

https://www.north-ayrshire.gov.uk/education-and-learning/active-schools.aspx

Family Learning team on Facebook

https://www.facebook.com/pg/Family-Learning-Team-North-Ayrshire-Council-1599378163405978/posts/

Tapestry Partnership

http://www.tapestrypartnership.com/

The Scottish Youth Parliament

http://www.syp.org.uk/

Leader of the Council (Councillor Joe Cullinane)

https://north-ayrshire.cmis.uk.com/North-Ayrshire/-ayrshire.cmis.uk.com/north-ayrshire/Councillors/CurrentCouncillors/tabid/98/ctl/ViewCMIS_Person/mid/437/id/17/ScreenMode/Ward/Default.aspx

Scottish Minister for Health (Shona Robison)

http://www.parliament.scot/msps/currentmsps/Shona-Robison-MSP.aspx

Follow North Ayrshire's Youth Council on Twitter

https://twitter.com/search?q=north%20ayrshire%20youth%20council&src=typd

Throughcare Services

https://www.north-ayrshire.gov.uk/health-and-social-care/children-and-families/throughcare.aspx

Place2Be

https://www.place2be.org.uk/what-we-do/where-we-work/where-we-work/north-ayrshire/

Stop Now And Plan (SNAP)

http://www.carena.org.uk/providers/care-support/snap-project/

Child and Adolescent Mental Health Service (CAHMS)

http://www.nhsaaa.net/services-a-z/c-child-and-adolescent-mental-health-services.aspx

The ICE Pack – Knowing Me, Knowing You

http://playbackice.com/

The CHARLIE Programme

http://www.carena.org.uk/providers/care-support/charlie-programme/

Child Protection Committee

http://childprotectionnorthayrshire.info/cpc/children-and-young-people/

Children Affected by Parental Substance Misuse Group

http://childprotectionnorthayrshire.info/cpc/committee/capsm/

Alcohol and Drugs Partnership (ADP)

http://naadp.com/who-are-we.aspx

Funky Films on Facebook

https://www.facebook.com/funkyfilmsnaadp/

Health Improvement Team

http://www.nhsaaa.net/services-a-z/h-health-improvement.aspx

National Attainment Challenge

https://www.education.gov.scot/improvement/Pages/
sac1tosac11scottishattainmentchallenge.aspx

Developing the Young Workforce

http://www.gov.scot/Publications/2014/12/7750

Activity Agreement

http://www.gov.scot/Topics/Education/edandtrainingforyoungple/16pluslc/
activityagreements

North Ayrshire Council's Modern Apprenticeship

https://www.north-ayrshire.gov.uk/jobs-and-training/modern-apprenticeships.aspx

Functional Family Therapy

http://fftllc.com/

Cognitive Centre Foundation (CCF)

https://www.cognitivecentre.com/

Positive Family Partnership Strategy

https://www.north-ayrshire.gov.uk/Documents/CorporateServices/ChiefExecutive/
CommunityPlanning/positive-family-partnership-strategy.pdf

Alcohol Focus Scotland

http://www.roryresource.org.uk/

Integration Joint Board
19th December
Agenda Item No.

Subject:	**The financial crisis in the Care Home sector**

Purpose:	To highlight the findings and recommendations of the recent publication of the report 'Plugging the Leaks in the UK Care Home Industry' by the Centre for Health and the Public Interest'
Recommendation:	It is recommended that the IJB:

(a) Welcomes the findings and recommendations of the report by CHPI.

(b) Recognises that recent local Care Home closures have occurred as a result of some of the very business practices uncovered through the CHPI research.

(c) Given the devolved status of Health and Social Care in Scotland, asks that the Chief Officer writes to the Cabinet Secretary for Health and Sport calling for the introduction of a Care Home Transparency Act and greater financial regulation of providers in Scotland.

(d) Directs North Ayrshire Council and the NHS Ayrshire and Arran to consider the building of local care home facilities as part of their ongoing capital planning programmes.

Glossary of Terms	
CHPI	Centre for Health and Public Interest
HSCP	Health and Social Care Partnership
IJB	Integration Joint Board

1.	EXECUTIVE SUMMARY
1.1	In November 2019, the Centre for Health and Public Interest, published a report 'Plugging the Leaks in the UK Care Home Industry – Strategies for resolving the financial crisis in the residential and nursing home sector'. The research was partly funded by Unison, following the collapse of a number of care homes across the UK, significantly impacting on residents and staff.
1.2	One of the key findings of the report is that an estimated £1.5 billion of public money (10% of the total spend across the UK) is being leaked out of the care home industry annually. Instead of going towards direct frontline care, £1.5 billion goes to rent, dividend payments, net interest payments, directors' fees and profits before tax.

1.3	The report highlights a variety of questionable business practices by some providers to ensure that, particularly within those organisations run for profit, those profits are maximised often in ways specifically designed to avoid paying tax. The report makes recommendations to bring greater transparency and regulation to the sector.
1.4	Over the last 18 months, two privately-owned for-profit care homes have closed in North Ayrshire with the owner of one of those homes facing criminal charges. In both instances, significant numbers of residents and staff were affected.
2.	**BACKGROUND**
2.1	In addition to the two recent care home closures in North Ayrshire, across the UK there have been well-publicised Care Home collapses that illustrate the fragility of the sector and the complex business models underpinning many operators. In 2011, the collapse of Southern Cross affected care home residents and staff across the country.
2.2	Most recently, Four Seasons Healthcare remains in administration with a recent potential sale falling through. This means that risks remain to the 17,000 residents and 22,000 staff who currently reside in, or work in, Four Seasons Healthcare homes throughout the UK. It is worth noting that Cumbrae Lodge in Irvine is part of the Four Seasons Healthcare group.
2.3	The CHPI report explored the business models of the 26 largest providers in the Care Home industry, looking at business models, structures and income and expenditure. These 'Big 26' providers include for-profit and not-for-profit providers. The research undertaken found the following – • There are significant levels of leakage across the care home sector and the type of care home business impacts the amount leaking out • There are significant differences in the level of leakage among the largest ('Big 26') providers • Some of the Big 26 care home providers use complex company structures to maximise leakage and hide profit extraction • The Big 26 providers pay out significant amounts in rent payments each year, often to related companies which are based outside the UK's tax jurisdiction • Debt repayments are a significant area of leakage for some of the Big 26 providers • Much of the debt loaded onto the care homes by large for-profit providers is owed to related companies that are often based offshore and at high rates of interest i.e. a form of hidden profit extraction which also avoids tax • Splitting the care home business into separate operating and property companies raises other public interest concerns, including the ability of a care home operator to pay compensation for causing harm, and potential tax avoidance • Leakage is also occurring through management fees and related company transactions
2.4	Whilst there are undoubtedly many Care Home providers who are operating legitimate, ethical, tax-paying operations both across North Ayrshire and the UK, the findings of the CHPI report gives significant cause for concern. Given the local

	experience in North Ayrshire, and the findings of the report relating to the 'Big 26' providers, the IJB should consider the recommendations contained within the report.
3.	**PROPOSALS**
3.1	The report makes three key recommendations as outlined in the following sections.
3.2	**Recommendation 1 -** A Care Home Transparency Act – care home providers should be mandated to disclose where their income goes. All the money which goes into the care home industry in the UK should be treated as public money and should be accounted for as such. For anyone purchasing care home services, it is currently impossible to know how much of it goes on front line care and how much of it leaks out to investors. Irrespective of the mix of sources of a care home's income, whether from a local authority, the NHS, or from private individuals, there should be full transparency about how its income is spent.
3.2	**Recommendation 2 -** A new form of care regulation is required to prevent care home companies with unsatisfactory financial models from providing care in the UK. Companies which are registered outside the UK for tax purposes, or which have high levels of debt and/or make large payments to related property companies or pay large management fees, are not providing good value for money. There is a significant public interest in ensuring that the state only contracts with companies which can demonstrate that an acceptable proportion of their income goes to frontline care and have a sustainable financial model. With regard to the finances of a licensed care home provider these requirements should include: • tax registration in the UK of the ultimate controlling parties of the company providing the service; • full transparency in line with the requirements of the proposed Care Home Transparency Act; • minimum equity and net assets requirements to ensure that they can be held financially liable for any care malpractice in their homes; • an agreed proportion of income to be spent on staffing costs and non-staff operating costs; and • an agreed limit to the proportion of income to be spent on profit, debt repayment, and property costs.
3.3	**Recommendation 3 -** Capital should be made available by the government for the provision of new care homes. Generally, the current capital investment in new care homes is being provided by the larger for-profit care home providers and is being directed towards building large homes which are primarily focused on the more profitable part of the market, namely residents who fund their care out of pocket. In addition, the funding model of these new care homes is liable to lock in high rental and borrowing costs. In order to avoid locking these high costs into the care home infrastructure, and to ensure that there are different types of care home provision – including smaller care

| | homes – the government should make available low-cost capital in the form of loans to small and medium sized care home operators too in order to encourage the development of a range of home sizes and care models.

Alternatively, both local authorities and the NHS could build and own the new care home infrastructure. A decision could then be made about whether to operate these homes themselves or lease them out to other public, private, or not-for-profit providers. This would limit the opportunities for the type of extraction and leakage that we have identified in the form of rental payments and debt repayments. Public ownership of the care home infrastructure would also offer protection for residents against the risks associated with the financial collapse of a care home company. |
|---|---|
| **4.** | **Anticipated Outcomes** |
| 4.1 | The following outcomes are anticipated –

• Greater transparency on where money is spent and greater assurance around the spending of the public pound.
• Greater stability for the Care Home sector, and better security for residents and staff working within the sector. |
| **5.** | **Measuring Impact** |
| 5.1 | Ultimately, this will be measured in fewer Care Home closures. |
| **6.** | **IMPLICATIONS** |

Financial :	The financial implications of future Care Home failings remain significant.
Human Resources :	Previous Care Home closures have impacted on HSCP staff and management time to ensure effective and sensitive decommissioning of failing Homes.
Legal :	There are no Legal implications arising directly from this report, albeit the recommendations call for legislative change.
Equality :	The recommendations within this report are designed to address a situation which adversely impacts predominantly upon Older People.
Environmental & Sustainability :	There are no Environmental & Sustainability implications.
Key Priorities :	Ensuring that people can live at home or in a homely setting.
Risk Implications :	The current risks associated with a lack of transparency and the questionable business practices of some providers operating within the Care Home sector will be addressed through the actions being called for.
Community Benefits :	Greater stability within the Care Home sector will help protect local employment.

Direction to :-	

Direction Required to Council, Health Board or Both	1. No Direction Required	
	2. North Ayrshire Council	
	3. NHS Ayrshire & Arran	
	4. North Ayrshire Council and NHS Ayrshire & Arran	X

7.	**CONSULTATION**
7.1	This report has been produced in consultation with Trade Union and Staff Side colleagues.
8.	**CONCLUSION**
8.1	It is recommended that the IJB: (e) Welcomes the findings and recommendations of the report by CHPI. (f) Recognises that recent local Care Home closures have occurred as a result of some of the very business practices uncovered through the CHPI research. (g) Given the devolved status of Health and Social Care in Scotland, asks that the Chief Officer writes to the Cabinet Secretary for Health and Sport calling for the introduction of a Care Home Transparency Act and greater financial regulation of providers in Scotland. (h) Directs North Ayrshire Council and the NHS Ayrshire and Arran to consider the building of local care home facilities as part of their ongoing capital planning programmes.

For more information please contact Louise McDaid, Trade Union Representative (Local Government) IJB on (01294) 553802.

Plugging the leaks in the UK care home industry

Strategies for resolving the financial crisis in the residential and nursing home sector

November 2019

CHPI | Centre for Health and the Public Interest

The author

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Vivek previously worked as a manager in Monitor and NHS Improvement analysing and reporting on the operational and financial performance of the provider sector. Before that he worked for 4 years as a management consultant at Deloitte. He holds a BSc Economics (Hons) from the LSE, a MSc Economics, and is a chartered accountant.

Acknowledgements

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Key Facts

£1.5bn   Out of a total annual income of £15bn, an estimated £1.5bn (10%) leaks out of the care home industry annually in the form of rent, dividend payments, net interest payments out, directors' fees, and profits before tax, money not going to front line care. This is equivalent to the £1.5bn of additional funding for social care promised by the government in the September 2019 Spending Review.

£7   Out of every £100 put into small to medium-sized care home companies goes to profit before tax, rent payments, directors' remuneration, and net interest paid out.

£15   Out of every £100 put into the 18 largest for-profit care home providers goes to profit before tax, rent payments, directors' remuneration, and net interest paid out.

£261m   Of the annual income received by the largest 26 care home providers goes towards paying off their debts. Of this £117m (45%) are payments to related, and often offshore, companies.

£102   The aggregate amount paid per bed per week in interest costs by the 5 largest private equity owned or backed care home providers. This is equivalent to 16% of the weighted average weekly fee (£622) paid for a residential care bed in the UK.

59%   The proportion of the £2.5bn of long-term debt owed by the largest 13 for-profit care home providers to related companies.

15 – 32%   The proportion of annual income spent by 7 of the 18 largest for-profit providers on rent payments, totaling £264m a year. In comparison, the 8 largest not-for-profit providers spent 2% of their income on rent payments, totaling £25m a year.

6   Of the largest 26 providers have owners based in a tax haven. This includes 4 out of the 5 largest private equity owned or backed providers and 2 of the 13 largest non-private equity for-profit care home providers.

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Executive Summary:
Key Findings and Recommendations

The UK care home crisis – is it just about underfunding?

1. The UK care home industry is in crisis. The sector, which is almost entirely provided by independent companies, is frequently said to be on the brink of collapse. Since 2011 two major care home providers, Southern Cross and Four Seasons, who between them provided care to 45,000 residents, have either exited the industry or gone into administration.

2. Without doubt the financial model underpinning the UK care home industry is unsustainable. In addition the government's preparations for a No Deal Brexit forecast that an increase in inflation could, at worst, lead to the collapse of both small and large care home providers in the 6 months after a No Deal Brexit.[1]

3. The cause of this crisis is unclear – the prevailing view is that there is insufficient money going into the system and that the government in England needs to increase the amount it pays the independent sector to look after state-funded residents.[2]

4. Yet news reports also detail large amounts of profit being extracted from the care home industry, either in the form of dividends or as loan repayments to investors.[3] Detailed investigations of the Four Seasons care home group and similarly structured US nursing home chains also find large amounts of hidden profit extraction, casting doubt on the view that the industry's crisis is solely due to a lack of funding.[4] [5]

5. So where does all the money end up? In an ideal scenario, most of the money which goes into the sector would go directly to looking after the care home residents. This would mean enough staff with the right training to provide high quality care and good facilities, entertainment, food, and other services for the residents.

6. Despite the billions which go into the care home sector, care home workers are amongst the lowest paid workers in the country with high turnover rates (39.5%). Quality in care homes in England is also poor, with one in every five homes rated 'inadequate' or 'need improvement'.[6]

7. There is a growing consensus across the political parties that social care in England should receive a meaningful increase in state funding in order to provide free personal care in care homes to most of those who are in need.[7] However, there are significant concerns that the injection of billions of pounds of additional funding into an industry which is beset by structural difficulties is unlikely to deliver either an improved level of care or value for money for the taxpayer.

8. In addition, given the increasingly tight restrictions on local authority-funded social care, 51% (£7.7bn) of the total annual income (£15.2bn) for independent care homes now comes from individuals and their families. The lack of financial transparency within the care home industry is therefore as much a consumer rights issue as it is a value for money issue for taxpayers.

Our approach to measuring the leakage out of the UK care home industry

9. This report is based upon a forensic study of the accounts of 830 adult care home companies, including the 26 largest providers. Collectively these companies represent 68% (£10.4bn) of the total estimated annual revenue (£15.2bn) for independent adult social care home providers.

10. Our analysis seeks to explain where the money going into the care home sector ends up and the nature of the structural problems which lie at the heart of the care home crisis.

11. It does this by quantifying the amount of money which 'leaks' out of the sector, and by examining the businesses practices and financial structures which enable this leakage for the 26 largest providers of care home services in the UK.

What do we mean by leakage?

12. When public services are provided by for-profit companies there is a public interest in ensuring that the level of profit made is reasonable. A balance needs to be struck between ensuring that as much of the money which goes into the care sector goes towards providing care, and the need to fairly reward the companies providing care so that they can continue to operate and grow.

13. Ideally, the profitability of a business can be measured by looking at its profit before tax figure. In accountancy terms, this measures the amount of income left over after all costs have been deducted apart from tax, and ordinarily this measure gives a good indication of the amount of income which leaks out.

CHPI | Centre for Health and the Public Interest

14. However, previous reports into large care home providers in both the UK and the US have found difficulties in tracking the money which goes into the larger care home companies. This is because the complex nature of their corporate structures meant that "profits were hidden in the chain's management fees, lease agreements, interest payments to owners, and purchases from related-party companies."[8]

15. Similarly in the UK, a detailed analysis of the Four Seasons care home chain found "cash extraction tied to opportunistic loading of subsidiaries with debt; and tax avoidance through complex multi-level corporate structures which undermine any kind of accountability for public funding".[9]

16. The highly varied and complex nature of some of the large care home companies now operating in the UK and the US means that using this standard measure understates the true profitability of these businesses and fails to capture the true level of leakage from the sector.

17. This is because the complexity and opacity of the company structures allows profit to be extracted in hidden ways, such as through property costs, management fees, and debt repayments.

18. To assess the true profitability of care home companies we therefore need to look not only at profit before tax but also at expenditure on rent, interest and repayments of debt, and directors' remuneration, areas where hidden profit extraction occurs. Collectively they represent the total potential leakage out of the sector.

19. In this report we track the leakage rate for the 4 different types of provider by examining their business costs which are not directly related to the provision of care to residents. These 4 provider types are as follows:

    • Small and medium-sized care home companies
    • Large not-for-profit or employee-run providers
    • Large for-profit (Private Equity owned or backed) providers
    • Large for-profit (Non-Private Equity) providers

20. The small and medium-sized care home companies operate around 70% of the registered beds in the care home market, whilst the other 3 types comprise 26 large providers ('the Big 26') which operate the remaining 30%.

Key findings

The report finds the following:

Finding 1: There are significant levels of leakage across the care home sector and the type of care home business impacts the amount leaking out

21.　There are big differences between the Big 26 providers (operating 30.8% of all registered beds) and all other (784) small to medium-sized care home companies identifiable in the sector, in the way in which income is allocated to various business costs. This is particularly true for those categories of business cost which include potential leakage.

22.　For the Big 26, £13.35 of every £100 put in goes to profit before tax, rent payments, directors' remuneration, and net interest paid out.[i] In total this amounts to £653m a year out of a total income of £4.9bn.

23.　For the 784 small to medium-sized care home companies, £7.07 of every £100 goes to profit before tax, rent payments, directors' remuneration, and net interest paid out. This amounts to £390m a year out of a total income of £5.5bn.

24.　In total, across both the Big 26 providers and the small to medium-sized care home companies, we therefore estimate that £1.0 billion goes on profit before tax, rent payments, directors' remuneration, and net interest paid out, an average leakage rate of 10%.

25.　Around £15.2 billion is spent each year on independent care homes for older people. Assuming that there is an average leakage rate of 10%, we estimate that a total of £1.5 billion leaks out of the UK care home sector in the form of profit before tax, rent payments, directors' remuneration and repayments on loans.

26.　This is a significant potential loss of resources for the care home industry, equivalent to the additional £1.5 billion a year allocated to the social care sector in the Spending Review Statement in September 2019.

Finding 2: There are significant differences in the level of leakage among the largest ('Big 26') providers

27.　For the 8 large not-for-profit providers the level of leakage is £8.60 out of every £100 received, and amounts to £93m a year

28.　For the 5 large for-profit providers (Private Equity) the level of leakage is £9.06 out of every £100 received, and amounts to £159m a year.[ii]

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i　Net interest paid out is interest paid out (e.g. on loans) minus any interest paid in (e.g. on bank deposits).

ii　This is lower than the aggregate leakage across the industry (£10.00) and significantly less than the leakage for the 13 other for-profit providers (£19.49). This is due to an aggregate loss before tax, which is mostly caused by a combined £159m loss by just two of the providers.

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29. For the 13 large for-profit providers (Non-Private Equity) the level of leakage is £19.49 out of every £100 received, and amounts to £401m a year.

Finding 3: Some of the Big 26 care home providers use complex company structures to maximise leakage and hide profit extraction

30. Our review of the accounts and company structures of the Big 26 providers identified that many of the large for-profit companies have adopted structures which avoid tax, limit their liabilities if they are sued, and increase the amount of hidden profit which goes to their owners, investors, and related companies.

31. The Big 26 providers are part of large corporate groups totalling over 2,500 companies. Within this complex web, profit from the care home business can be funnelled out in the form of rental payments, debt repayments, and payments for services.

32. Table 1 shows how large care home companies use different structures which can disguise profit extraction and increase different forms of leakage.

Table 1 – The numbers of large care home companies of different types which use structures which can disguise profit extraction

Company Type	Offshore owner in tax haven	Split of operating and property companies	Sale and leaseback	Purchase services or supplies from a related company
5 large for-profit providers (Private Equity)	4/5	5/5	2/5	4/5
13 large for-profit providers (Non-Private Equity)	2/13	12/13	6/13	5/13
8 large not-for-profit providers	0/8	1/8	1/8	3/8

Finding 4: The Big 26 providers pay out significant amounts in rent payments each year, often to related companies which are based outside the UK's tax jurisdiction

33. Across the large for-profit providers it is common for rental payments to be made to separate companies which own the care home assets, which are either part of the same company group or an external company. As a result, one of the main areas of leakage for the Big 26 providers is the high cost of rent paid to landlords for using care home buildings.

34. Conversely the large not-for-profit providers tend to own most of their care home buildings. This explains why the 8 large not-for-profit providers pay out £2.34 out of every £100 of income on rent, compared to the 18 for-profit providers which spend £11.07 out of every £100 received.

35. The collapse of the care home provider, Southern Cross, was in part due to unaffordable rents. Whilst no company in the Big 26 has been as risky in its rental obligations, transparency over all these debts is a matter of public interest.

    - 7 of the 18 large for-profit providers spend between 15% and 32% of their revenue on rent payments, totalling £264m a year.

    - The 9 providers with sale and leaseback arrangements paid the highest average rent: £14.32 out of every £100 of income received.

    - 5 of the 9 sale and leaseback arrangements amongst the Big 26 providers were with related companies (shares or has the same owners).

    - For those companies for which we were able to identify sufficient information we discovered that rental payments would often rise annually with inflation (RPI) plus a margin of usually around 2-4%. This puts pressure on fees to rise in tandem, to cover these costs.

36. When rental payments are paid between related companies it becomes hard to identify the true profitability of the underlying care home business and hence the true level of leakage, because rental charges may be levied by related companies at rates far higher than would be set by the market.

37. In addition, the offshore location of some of these related companies means that UK taxes can be avoided, which is another form of leakage from the system, although one that we have not been able to quantify.

Finding 5: Debt repayments are a significant area of leakage for some of the Big 26 providers

38. Our analysis reveals that a significant amount of debt has been loaded on to each of the care home beds by the Big 26 providers

    - The 8 large not-for-profit providers have borrowed £21,069 for each care bed they own, and pay interest costs of £19 per bed per week.

    - The 13 large for-profit (Non-Private Equity) providers have borrowed £21,546 for each care bed they own, and pay interest costs of £14 per bed per week.

    - The 5 large for-profit (Private Equity) providers have borrowed £35,072 for each care bed they own, and pay interest costs of £102 per bed per week.[iii]

39. The cost of the debt per bed owed by the 5 large for-profit (Private Equity) providers is especially high, amounting to around 16% (8 weeks of care) of the weighted average weekly fee of £622 paid for residential care in the UK, and 12% of the weighted average fee for nursing care of £856 per week.

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iii Despite having similar levels of long-term debt the 8 large not-for-profits and the 13 large for-profits (Non-Private Equity) have far lower interest charges than the 5 large for-profits (Private Equity) companies. This is in part due to the higher interest rates charged on the loans to private equity owned or backed companies. However, whilst the 13 large for-profits also have high interest rates on some of their intercompany debts these are often only repayable in one lump sum at the end of the loan. This means that they are not paying out as much in interest payments each year, but still face a high burden overall.

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Finding 6: Much of the debt loaded onto the care homes by large for-profit providers is owed to related companies that are often based offshore and at high rates of interest i.e. a form of hidden profit extraction which also avoids tax

40. The Big 26 providers vary in how much of their long-term debt and interest payments are to related companies:

     - For the 8 large not-for-profit providers, loans from related companies comprise 1.4% (£7.5m) of their long-term debts and 0.0% (£0m) of their interest payments.

     - For the 5 large for-profit (Private Equity) providers, loans from related companies comprise 58.6% (£755.1m) of their long-term debts and 53.4% (£104.3m) of their interest payments.

     - For the 13 large for-profits (Non-Private Equity) their funding from related companies comprises 59.9% (£713.8m) of their long-term debts and 30.9% (£12.7m) of their interest payments.

41. The interest rates on these loans range between 7% and 16%, which is considerably higher than the cost of borrowing money from external investors or banks.

42. These debt arrangements may reasonably be seen as designed to generate extra hidden profit for the owners of the company – the debt repayments made to related companies leave these businesses before their pre-tax profit figure is calculated.

43. In addition, interest payments on loans are tax deductible and the related company paid is often offshore, so tax is saved at both ends – representing a double leakage for the taxpayer. This may explain why the Big 26 providers with an offshore owner paid out £9.09 of every £100 of income on net interest payments out, compared to £2.86 for all other large providers.

44. Overall, these arrangements make it hard to understand how much profit some of these companies are generating from providing care home services.

Finding 7: Splitting the care home business into separate operating and property companies raises other public interest concerns, including the ability of a care home operator to pay compensation for causing harm, and potential tax avoidance

45. Eighteen of the twenty-six largest providers had corporate structures where the operating company (which runs the care home) was split from the property company (which owns the home).

46.   This leaves operating companies with few assets (since they no longer own care home buildings). These companies are responsible for providing safe care, and if they fail to do so they can be sued. But the only assets the company will have available to pay out any compensation are cash in the bank and any equipment it owns.

47.   This means that the split can be seen as a way to protect valuable property assets from being at risk. Indeed, 5 out of the 18 companies with this split had negative assets (in 2017, or the latest available year) meaning that their liabilities (what they owed in total over time) were greater than the value of their assets. This is a public interest issue, since those providing care need to be able to be held financially responsible for any harm they may do.

48.   Additionally, when these property companies are owned by related companies or based offshore there are concerns over hidden profit extraction and tax avoidance.

Finding 8: Leakage is also occurring through management fees and related company transactions

49.   Twelve of the Big 26 companies had significant purchases from, or other transactions with, related companies. These ranged from consultancy services provided by another company owned by the same directors to the charging of high management and performance fees.

50.   When transactions between related companies exist it is harder to determine how legitimate the prices set are, and the necessity of the services provided.

51.   Many companies were charged management fees which went to related companies which had few or even no staff, making it seem to be a way to funnel profit out of the company (and often out of the UK).

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Recommendations

52. In order to redress these significant deficiencies within the UK care home industry we make the following recommendations:

Recommendation 1:
A Care Home Transparency Act – care home providers should be mandated to disclose where their income goes

53. For anyone purchasing care home services, it is currently impossible to know how much of it goes on front line care and how much of it leaks out to investors. Irrespective of the mix of sources of a care home's income, whether from a local authority, the NHS, or from private individuals, there should be full transparency about how its income is spent.

54. Similar measures have been introduced in the US. In 2009 The Nursing Home Transparency and Improvement Act was passed as part of the Affordable Care Act. As in the UK, the complex management, ownership, and financial structures of large care home chains was found to impede the ability of federal and state governments to hold nursing home chains to account for their use of public money. This legislation requires nursing homes which are in receipt of public funding (Medicaid or Medicare) to report detailed information on ownership, staffing levels, other costs, complaints, and expenditure categories.

55. However unlike in the US, all the money which goes into the care home industry in the UK should be treated as public money and should be accounted for as such. Those individuals and family members who pay for care out of their own pockets are often required to do so because they are denied access to funding by the state, and as taxpayers they are entitled to know where their money goes.

Recommendation 2:
A new form of care regulation is required to prevent care home companies with unsatisfactory financial models from providing care in the UK

56. It is not in the interest of care home residents, their families, or the taxpayer for some types of company to own and run residential and nursing care homes. Companies which are registered outside the UK for tax purposes, or which have high levels of debt and/or make large payments to related property companies, or pay large management fees are not providing good value for money.

57. Moreover, as the government has recognised, companies which owe significant amounts of debt or who have high property costs are at risk of financial collapse. This creates an unnecessary risk of harm to care home residents and if it occurs it requires the state to pick up the pieces. There are currently no regulations in place to prevent a care home collapse, merely a mechanism for forewarning local authorities that this is likely to happen.

58. If, as seems likely, a future government commits to substantially increasing the amount of taxpayer money which goes into social care, there is a significant public interest in ensuring that the state only contracts with companies which can demonstrate that an acceptable proportion of their income goes to frontline care and have a sustainable financial model.

59. This will require a significant shift in how care is regulated in the UK, away from simply regulating the quality of care according to a series of output measures, to specifying that certain requirements are in place before a care home company is licensed. This is similar to current arrangements for defence contractors.

60. With regard to the finances of a licensed care home provider these requirements should include:

    - tax registration in the UK of the ultimate controlling parties of the company providing the service;
    - full transparency in line with the requirements of the proposed Care Home Transparency Act;
    - minimum equity and net assets requirements to ensure that they can be held financially liable for any care malpractice in their homes;
    - an agreed proportion of income to be spent on staffing costs and non-staff operating costs; and
    - an agreed limit to the proportion of income to be spent on profit, debt repayment, and property costs.

61. Based upon our findings in this report we consider it likely that a significant proportion of the care home companies providing services in the UK would be able to meet these requirements as their expenditure on debt and rental payments is not significant, nor are their profit margins.

62. However, in the event that some care home providers are not able to meet these requirements the state should facilitate the restructuring of the companies so that they are able to achieve a licence to operate. Alternatively, they will need to be enabled to exit the market and the service re-provided by either the state or another company.

63. Whilst we anticipate that there will be significant concerns about the impact of such a regulatory regime on the viability of a number of the large care home companies, it should be borne in mind that the risks of insolvency, bankruptcy, and corporate collapse are current features of the existing care home market. Data provided by Company Watch shows that the percentage of the care home companies with a 1 in 4 chance of going into insolvency or in need of major restructuring in the next 3 years has increased from 24% in March 2014 to 30% in September 2019.[10]

64. As a result, a restructuring of some parts of the care home industry will be necessary at some point and it is preferable that this is undertaken in a managed way and in line with a clear set of public interest objectives.

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Recommendation 3:
Capital should be made available by the government for the provision of new care homes

65. The UK's current capital investment in new care homes is being provided by the larger for-profit care home providers and is being directed towards building large homes which are primarily focused on the more profitable part of the market, namely residents who fund their care out of pocket. In addition, the funding model of these new care homes is liable to lock in high rental and borrowing costs and there is evidence that larger care homes are associated with a worse quality of care.

66. In order to avoid locking these high costs into the care home infrastructure, and to ensure that there are different types of care home provision – including smaller care homes – the government should make available low-cost capital in the form of loans to small and medium sized care home operators too in order to encourage the development of a range of home sizes and care models.

67. Alternatively both local authorities and the NHS could build and own the new care home infrastructure. A decision could then be made about whether to operate these homes themselves or lease them out to other public, private, or not-for-profit providers. This would limit the opportunities for the type of extraction and leakage that we have identified in the form of rental payments and debt repayments. State ownership of the care home infrastructure would also offer protection for residents against the risks associated with the financial collapse of a care home company.

Introduction

68. Nearly all the care homes in the UK are now in private hands (94% of all beds). Whilst a substantial number of them are owned by small businesses a large number of them are owned by international private companies.

69. In total this means that 2,316 care homes in the UK (30.8% of the total number of registered beds) are owned by the 26 largest companies, whose investors see them as a source of income and profit.

70. Each year, independent care homes for older people receive £15.2bn in income. £7.4bn (49%) of this comes from local authorities (LAs) and the NHS whilst the majority, £7.7bn (51%), comes from individuals and their families, who are often forced to pay privately because of the tight restrictions governing access to state-funded care.[11]

71. But where does all this money end up? In an ideal scenario, most of the money which goes into the sector would go directly to looking after the care home residents. This would mean enough staff with the right training to provide high quality care and good facilities, entertainment, food, and other services for the residents.

72. Yet, despite the billions which go into the care home sector, care home workers are amongst the lowest paid workers in the country with very high turnover rates. Quality in care homes in England is also poor, with one in every five homes rated 'inadequate' or 'need improvement'.[12]

73. Investors, naturally, view care homes as a business and have expectations on how much profit they can make. They will seek a share of the money which goes into the care home sector. Any income which goes to these investors will not go towards care workers or the residents of the care homes.

74. The care home industry is frequently said to be in crisis due to a lack of funds. But it is not clear how much of this extra funding is needed to provide good quality care, and how much will become unnecessary extra profit for the care homes' investors.

75. As a result we undertook a forensic study of the accounts of over 830 adult care home companies, including the 26 largest providers, to identify where each pound which goes into the care home industry actually goes. These companies have a combined income of £10.4bn, representing 68% of the total estimated market value for independent providers in 2017.

76.   Our analysis of this sector finds 4 main types of company running care homes. They differ in how much of their income is spent on staff, rent, debt (e.g. loans) repayments, and profit. In other words, giving more money to some types of company will lead to more potential 'leakage' out as extra profit for the owners, and so less spent on residents, compared to others. The four main types of company are:

- Small and medium-sized care home companies
- Large not-for-profit or employee-run providers
- Large for-profit (Private Equity owned or backed) providers
- Large for-profit (Non-Private Equity) providers

77.   There is a noticeable variation in where the income is spent between (and sometimes within) these 4 types of company. Some of these types have financial structures which provide demonstrably worse value for money for society (i.e. more hidden profit extraction) and potentially a worse quality of care. Driving these differences are some behaviours and business structures which prioritise quick and frequent profit extraction, and can threaten financial sustainability.

78.   Adult social care is a critical public service, with ultimate responsibility lying with local authorities and government, so there is a strong public interest in only allowing financially sustainable providers (with a reasonable level of profitability) to operate in this low risk and stable income industry.

79.   Furthermore, the adult care home industry needs to build more homes to meet the extra demand in the coming decades, but only the larger operators are able and willing to do so. Our examination of their financial structures not only tells us how they spend the money that they currently receive, but also what future costs are being locked into the price of new beds. For example, expensive loans taken out to build new homes will ultimately have to be repaid by those (the government and the individuals) who wish to use the new beds.

80.   The rest of this report will look at the leakage of funds and the differences in the financial structure of these 4 types of company in the care home industry, with both current spending and future care costs in mind.

SECTION A: The creation and development of the adult residential care and nursing home market for older people in the UK

Unlike NHS hospitals, the provision of nursing and residential care has never been seen as part of the state's infrastructure

81.   The provision of residential and nursing care for older people in the UK has never been entirely provided by the state, in contrast to health care which is now mainly delivered in NHS hospitals and other NHS facilities. Instead, under the welfare settlement of the 1940s, social care – the delivery of personal care such as bathing, dressing, and feeding people who are in need – was not covered by the NHS and has remained the responsibility of local authorities and private individuals.

82.   Even during periods in the 1970s when local authorities started to build their own care facilities, they have always arranged this type of care with voluntary, independent, and third sector providers, and as a result the state has never played a dominant role in this part of the national infrastructure either by owning the assets or by providing capital for new care homes to be built by public bodies. This history has meant that there has always been the potential for the provision of residential and nursing care services to be treated as a source of income and profit for investors.

Governments in the 1980s and 1990s created opportunities for large corporations backed by international investors to enter the UK care home market

83.   It was only in the 1980s and 1990s that there was a significant increase in opportunities for international investors to build or purchase care homes in the UK. A combination of state subsidies for investors (via the social security budget) coupled with an expectation from central government that local authorities should not provide any services directly, meant that for-profit care home chains were created and the sector increasingly became corporatized.[13]

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84. And whilst the NHS had previously provided long term care in NHS hospitals for older people – on the basis that they were meeting healthcare needs – the 1980s saw a large number of these old-style 'geriatric' wards being closed with the expectation that older people would instead be looked after in the community, or in purpose-built residential care facilities, and would also be subject to the means test associated with social care provision. With local authorities unable to provide these facilities themselves and with a growing population of older people, a new market opportunity was created for investors.[14]

Since the 1980s local authorities have been denied the resources to invest in residential and nursing care provision, creating further opportunities for the private sector to expand

85. A key reason why local authorities were unable to build care homes was not unwillingness on their part but because central government denied them the ability to borrow to invest in them. This approach to limiting public investment in the care home sector survived the Conservative governments of the 1980s and 1990s and was continued by the Labour and Coalition governments up to the present day, resulting in further opportunities for the private sector to expand.

86. Thus in the early 2000s those local authorities which wished to keep hold of their care home stock, in order to avoid being entirely reliant on the market, were prevented from doing so. And when new regulatory requirements relating to the quality of facilities were introduced, local authorities either had to borrow to invest in their remaining care homes to bring them up to these new standards – which they couldn't – or they had to sell or transfer them to the independent sector.[15] In the mid-1990s it was estimated that 12 percent of all independent residential care homes were homes which had either been transferred from or sold by local authorities because of central government policy.[16]

The creation of a private market coincided with a drive to keep the cost of care for older people as low as possible

87. The introduction of a new regulatory regime – now overseen by the Care Quality Commission in England – also meant that many small providers had to close because they also did not have access to the finance needed to bring their homes up to the required standard. This in turn led to further growth in the share of the market owned by large investors.

88. As a result, since the 1980s the provision of residential and nursing home care has changed dramatically. From 1980 to 2018 the number of publicly provided (local authority) residential care beds fell from 141,719 to 17,100, a fall of 88%. In their place have grown independent sector operators (for and not-for-profits) who over the same period went from providing 76,811

residential care beds to 243,000, an increase of over 200%. Similarly for nursing care beds, independent providers have grown from providing 25,523 beds to 194,100 beds, an increase of over 660%.[17]

Figure 1: UK Capacity (beds) for older people (65+) in a residential setting by provider and care type.
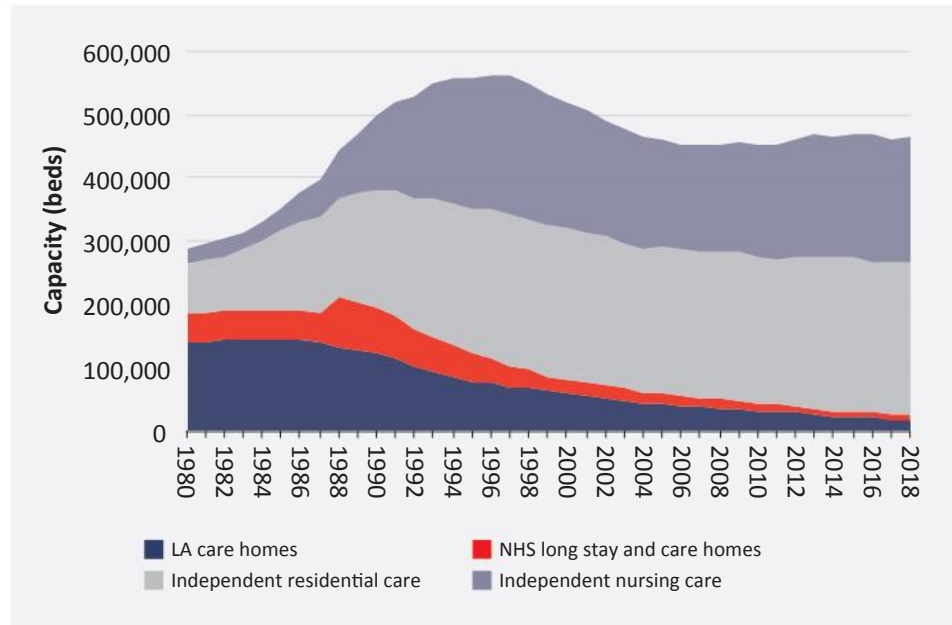
Source: LaingBuisson 'Care Homes for Older People UK Market Report' 29th edition 2018.

The move from a cottage industry to corporate chains and the involvement of Private Equity funds and Real Estate Investment Trusts in the ownership of residential and nursing care homes

89. Although it has been the policy of successive governments to open up the care home sector to private companies there has never been a public debate about the type of private providers which should be involved in this aspect of care provision. Instead six main types of providers were identified during the initial market opening in the 1980s:

1 **traditional owner/managers** – either new entrants with training in a caring profession, predominantly nursing, or those involved in a career change.

2 **colonizer chains** – over time some of the smaller care home providers were transformed into 'colonizer chains' by business people seeking new areas of investment.

3 **hotel and leisure interests** – companies with subsidiaries in gambling and brewing.

4 **construction and property groups**

5 **private for-profit health care groups** – particularly UK and US corporations.

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6 **private not-for-profit health care groups** – including BUPA, Nuffield Hospitals, and GM Healthcare.[18]

90. However, in a climate in which the government was committed to keeping the cost of residential and nursing care as low as possible, this range of providers whittled down to 3 main types:

   • the large private for-profit groups
   • the large not-for-profit groups
   • the smaller traditional owner/manager

91. The large for-profit and not-for-profit groups were able to expand as they had access to the necessary finance, management, and marketing expertise, whilst smaller traditional owner/managers continued to provide services in a challenging market environment so long as they were content to generate smaller returns.[19]

92. As a result, the independent care home industry is now very fragmented, with a wide variety of firm sizes. The ten largest care home groups provide 21.4% of the UK's total bed capacity, 33% is provided by small operators (who run less than 3 care homes), with the remainder (45.6%) provided by other large or medium-sized groups.[20]

93. For the large for-profit and not-for-profit chains, the care home sector is potentially lucrative because of the income which comes from providing a care service with growing demand, due to an ageing population, and because of the stability afforded by the fact that the state provides a significant share of the revenue. But it is also lucrative because of the value of the property – the homes themselves – which are central to the delivery of the service. From the perspective of investors, therefore, the care home industry both in the UK and in the US is seen as much as a property business as it is a care business.[21]

94. Thus the beds in care homes which are funded (whether by the state or by private individuals) generate steady and reliable income streams which can be used to pay a return to investors or lenders. And any company which owns the physical asset can generate income from renting it back to a company providing the care service, or can sell the property when its value rises.

95. The development of this way of thinking about care homes as a source of income and profit, as well as the lack of regulations regarding the types of companies that are allowed to provide care home services, saw the growing involvement of Private Equity funds and Real Estate Investment Trusts (REITs) in both the UK and the US care home markets from 2000 onwards.

96. The term Private Equity refers to a range of investments which are not traded on public stock markets so individual retail investors cannot buy shares in them. In general Private Equity funds tend to buy large commercial companies using a combination of capital raised from private investors (rather than on the stock market) and borrowed from lenders.[22] In many cases a Private Equity fund will purchase a company using a loan which

is secured against the assets of the company being acquired. This means that a proportion of the income which is generated by the company will need to go towards repaying the original loan used to buy the company. The funds aim to invest in a company for up to 7 years and then sell it on for an increased price.

97. A study of the introduction of private equity into the care home market in the US described the approach taken by Private Equity funds as follows:

"A typical transaction in what analysts term a "real estate play" is a deal where investors buy a company, use the real estate assets to help finance the deal (for example, leasing the properties to help pay off debt assumed in the acquisition), and hire a separate operating company to manage the assets. In addition to paying rent, the operator tenant usually pays all expenses of the properties, including operating expenses, property taxes, and capital improvements" [23]

98. In this scenario the care homes are often placed as assets in property investment companies such as Real Estate Investment Trusts (REITs), which both in the UK and in the US have a special tax status: they pay no corporation tax on the profits of their rental business.[24] Separating off the assets of the care home company into a separate REIT has led to concerns in the US that this may reduce the likelihood of the care home company being the subject of successful litigation, because the assets are separated from the care home operating companies and could therefore be beyond the reach of any claimant who has suffered injury or harm due to malpractice.[25]

The funding of residential and nursing care has shifted away from the state and back to private individuals

99. In the UK there has been a significant shift away from local authority funding to funding by the NHS and by private individuals. In 2018 46% of residents in independent sector care homes were funded by local authorities, down from 54% in 2008. In contrast, the number of residents who pay for their own care (self-funders) increased from 42% in 2008 to 45% in 2018, whilst the number funded by the NHS increased from 4% in 2008 to 9% (2016).[26] [iv]

100. The fall in the number of care home residents funded by local authorities is due to a number of factors, including the financial constraints on local authorities, and the preference for older people to be cared for in their own homes, but most importantly the fact that it has become much more difficult for individuals to access local authority funding for residential care.

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iv   The increase in the number of care home places funded by the NHS is mainly down to the introduction of new guidelines regarding Continuing Healthcare and Personal Care with Nursing. For many years the NHS refused to accept responsibility for funding much of the nursing care in care homes as it was not formally classed as 'healthcare'. Due to a number of high profile court cases and the introduction of new guidelines the number of people receiving NHS funding has grown on average by 6.4% a year. For more information on this see: National Audit Office (2017) – Investigation into NHS continuing healthcare funding. Available at: https://www.nao.org.uk/report/nhs-continuing-healthcare-investigation/

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101. Local authority-funded social care in England is currently only available to people with assets (including housing wealth) and savings of less than £23,250. Even if individuals meet this 'means test' – which is becoming harder to meet, due to the increasing market value of houses – they may fail to be eligible for state funding because free local authority care is increasingly only available also to those with what are called 'substantial' care needs.

102. In terms of the total amount of revenue which goes into the independent care home industry, less than half – 49% (£7.4bn) – comes from local authorities or the NHS, whilst the majority, 51% or £7.7bn, comes from self-funders. The share paid by private individuals has grown rapidly (up from 45% in 2008) because of the growth in the number of older people needing care, the restrictions on accessing local authority-funded care, and the fact that care homes charge self-funders more than they do local authorities (an average of 36% more).[27]

103. Local authorities, in particular, have often cut the price that they pay for care, due to the pressures on them to also provide a wide range of non-care services. The effect has been that the average (inflation-adjusted) spend per person in England fell from £345 (2010/11) to £310 per person (2015/16), whilst in Wales and Scotland the amount spent had fallen less dramatically but is still over £400 per head.[28]

Figure 2: Market value for nursing, residential, and long stay care for older people (including those with dementia) by payer type.
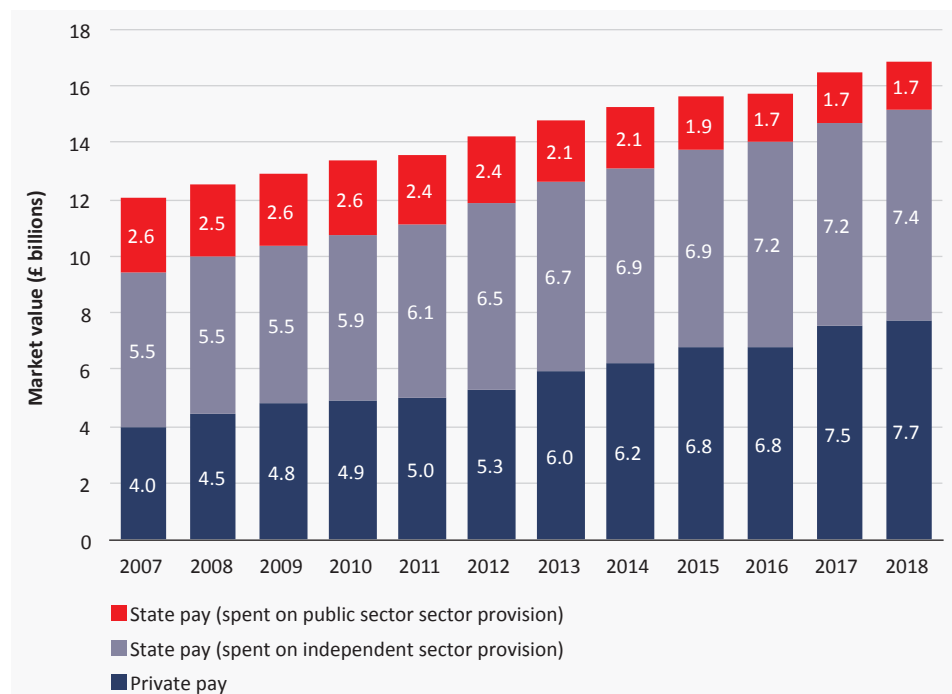
Source: LaingBuisson (2018) – Care Homes for Older People – UK Market Report – 29th edition.

The future demand for care

104. The demand for social care is expected to grow as the proportion of the UK's population that is elderly rises along with life expectancy. Between 2018 and 2028 the proportion of those aged 85 and older (the most likely demographic to go into a care home) is projected to grow by 31% to 2.1m, compared to only 5% growth for the overall population.[29] At the same time, at age 65, a citizen is expected to live in poor health for, on average, 44% (male) or 47% (female) of the rest of their life, which suggests the need for social care during those years.[30]

105. It is estimated that 1.2 million people (in 2016) didn't receive the help that they needed for essential daily tasks ('unmet needs').[31] At the same time, around 8% of the UK's households were informal (unpaid) carers for someone, usually an elderly relative.[32] There have been concerns that the ability of these informal carers to meet the growing levels of unmet needs will become increasingly unsustainable. Together with a rising proportion of elderly people these suggest that there will be a growing demand for social care services, including more care home beds.

Summary

It is important to note that the current state of the market for the provision of care home services in England is the result of a number of policy decisions taken by successive governments over the past three decades.

These include:
- treating the provision of care home services as separate from the NHS;
- using the market as a means to keep the cost of caring for older people down;
- transferring the cost of care home services from the state to private individuals;
- restricting the ability of local authorities to borrow to build state-run facilities;
- providing subsidies to the private sector to attract investment; and
- allowing any type of private company to run a care home business, including overseas investors and Private Equity funds.

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SECTION B: Measuring leakage out of the care home sector – Key Findings

What we mean by leakage and why it is more than just profit before tax

106. Ideally, most of the income received by a care home company would be spent directly on caring for residents, through expenditure on care staff, facilities, food, laundry, entertainment, and other services for residents. Any money which does not go to these areas is less clearly legitimate, meriting critical analysis, and should therefore be treated as potential 'leakage'.

107. There is a strong public interest in minimising the level of leakage in order to ensure that as much of the money which goes into the care sector goes towards providing care and is therefore value for money. This is balanced by the need to fairly reward the companies providing care so that they can continue to operate and grow.

108. When public services are provided by for-profit companies there is a public interest in ensuring that the level of profit made is reasonable. In some instances – such as when the government contracts with the Defence Industry – there are regulations, designed to avoid leakage, governing the amount of profit which can be made by the defence contractor.[33]

109. In accountancy terms, profit before tax measures the amount of income left over after all costs have been deducted apart from tax, and ordinarily this measure gives a good indication of the amount of income which leaks out.

110. However, the highly varied and complex nature of some of the large care home companies now operating in the UK and the US means that using this standard measure understates the true profitability of these businesses and fails to capture the true level of leakage from the sector. This is because the complexity and opacity of the company structures allows for profit to be extracted in hidden ways.

111. For example, in the US a 2015 study of a major nursing home chain found that "profits were hidden in the chain's management fees, lease agreements, interest payments to owners, and purchases from related-party companies".[34] Similarly in the UK, a detailed analysis of the Four Seasons care home chain found "cash extraction tied to opportunistic loading of subsidiaries with debt; and tax avoidance through complex multi-level corporate structures which undermine any kind of accountability for public funding".[35] In the US the policy response to financial complexity and hidden profit extraction in the care home industry was the 2009 Nursing Home Transparency Act which mandated greater transparency regarding where taxpayer funds were spent.[36]

Additional sources of leakage in addition to profit in the care home sector

112. It is therefore important to look for other less obvious sources of profit extraction. These can often be found in the following types of business cost in addition to profit before tax:

   - **Property costs** – this includes rent for using the care home which may be paid to an external company or to a related company (one which shares or has the same owners).

   - **Debt repayments** – this includes payments to cover the interest and value of a loan used to buy, improve, or extend a care home, and in some cases to pay back a loan used to buy the company in the first place. These can be payments to banks, bondholders, or other investors, and can be at high interest rates.

   - **Directors' remuneration** –payments made to the directors of a company for managing the business and its finances.

   - **Management fees and central overhead costs** – these are costs charged to the company by a parent company for managing its finances and business functions such as payroll, HR, and legal services. These are discretionary sums and are often used by a parent company to extract money out of a subsidiary business.

Strategies used by companies to increase the amount of hidden profit extraction

113. Some common strategies are employed by care home companies to enable the extraction of profit through such business 'costs'. These strategies are built into the way in which some care home companies are structured and organised, and some companies employ them more than others.

114. In essence each of these strategies involves shifting profit out of the company which provides the care to other related companies in a corporate group. Shifting profit does not affect the overall profitability of the care business, but it allows the profit shown by the care home company to be reduced. This can lower the tax paid and obscure how profitable the care home business is. Having care home companies which look barely profitable is beneficial when you are publicly lobbying for more money from the government and from self-paying care home residents.

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115. These strategies include:

- **Offshore ownership** – this allows tax to be avoided when money is paid to related companies that are based overseas. This is often achieved through repaying large loans which have been made to the care home business from a related offshore company. Expenditure on interest repayments is not usually subject to tax.

- **Splitting up the company** – care home businesses are often split into multiple companies with some companies in the group providing care in the homes, while other companies in the group own the properties or provide supplies and management services. The care home company is then charged rent or billed for supplies or management fees by the other companies. This reduces its pre-tax profit but not that of the overall business. The fees and prices charged can be at above-market rates, so that profits are moved out of the care home company, making it look less profitable than it actually is.

- **Sale and leaseback** – many of the large companies sell their care home premises to a buyer and then agree to rent them back over a number of years. In some cases the care homes are sold to and then rented back from a related company. These rental agreements are often opaque so it is hard to determine whether the rent paid by the care home company is reasonable or not. If the rent charges are set deliberately high then the profit of the care home company is reduced, although the profit of the overall business is not.

Summary

In an ideal situation most of the income which goes into the care home sector would go to caring for the care home residents. When care home services are provided by businesses rather than directly by the state there will always be some level of leakage. The aim for policy makers should be to minimise this leakage, to a reasonable level, in order to deliver value for money for the taxpayer.

Due to the complex financial structure of some of the care home companies which are currently providing care services, in the UK and the US, it is not possible to measure leakage just by looking at the amount of declared profit which these companies make. Some companies structure their businesses to extract hidden profits and to maximise the amount of money which leaks out. The policy response in the US has been to require greater transparency about where the money going into the care home sector ends up.

Methodology

The companies' accounts that we examined

116. We constructed two data sets for our analysis. For the largest 26 providers of adult social care we separately reviewed each of their accounts (group and where possible individual homes / care businesses), and recorded critical information about their financial and operational structures.[v] This is referred to as the '**Big 26 data set'** or the 'large providers' and totals **£4.9bn** of income (2017) and **30.8%** of all registered care home beds.

117. To look at industry-wide trends we collected financial information from the accounts of all UK-registered companies which list their primary business as residential nursing care or residential care for the elderly and disabled.[vi] Of these 11,928 companies we looked at those which had been trading from 2012-2017 (to ensure comparability), and which were not part of the corporate groups of the Big 26 providers.[vii] This left us with **784 companies**. This is referred to as the '`**Smaller trading companies data set'**, and consists of small to medium-sized care home companies with a total of **£5.5bn** of income (2017).

118. The group of 'large' providers consists of 26 care home providers which account for 30.8% of the total number of registered care home beds in the sector. These are set out in Table 2.

Table 2: The large (Big 26) care home providers split by ownership type (2017, or latest year)

8 Large not-for-profit providers	5 Large for-profit providers (Private Equity)	13 Large for-profit providers (Non-Private Equity)
Total revenue: £1.1bn	Total revenue: £2.1bn	Total revenue £1.8bn
Number of residential and nursing beds: 24,964	Number of residential and nursing beds: 36,755	Number of residential and nursing beds: 55,330
Anchor Sanctuary Housing Association Methodist Homes Orders of St John Care Trust Abbeyfield Society Shaw Healthcare Quantum Care Somerset Care	HC-One Four Seasons Health Care Care UK Orchard Care Homes Akari Care	Barchester Healthcare Bupa Care Homes Runwood Homes Maria Mallaband and Countrywide Group Avery Healthcare Advinia Health Care Sunrise Senior Living Caring Homes Larchwood Care Minster Care Group Priory Group Excelcare Healthcare Homes

v   See Appendix for a list of the main companies examined for each.

vi   UK SIC primary and secondary codes: 871 and 873.

vii   Specifically companies that were not dormant and had at least £1,000 of revenue across all years and for individual years of analysis their revenue was greater than £100,000.

How representative are our data sets

119. Together the two data sets represent an annual income of £10.4bn in 2017. This amounts to 68% of the total estimated market revenue (£15.2bn) for independent adult social care homes.[37]

120. We couldn't identify all the companies and hence where all the market's revenue went due to two factors: firstly, there may be private or public companies providing adult social care which do not appear in Companies House, or which do not list adult social care as their primary or secondary industry codes. Secondly, for some of the largest twenty-six providers we could not precisely isolate the income that they derived from adult social care from their other business activities, which leads to some under and over estimates.

What our data sets can and cannot tell us

121. We can look at trends in the financial performance of companies which have been in the industry for a few years and identify different types of financial and business structures. We have more detailed information on the largest twenty-six companies and their strategies.

122. We cannot easily identify differences in region, the ratio of resident types (LA-funded or self-funded), types of care (e.g. nursing or residential), or new entrants using the Smaller trading companies data set. For the Big 26 data set we have more of this information.

123. We also do not have financial information for each individual care home run by these providers. These are hard to access in a systematic way because the results of multiple care homes are often presented together in a company's accounts. However, for this report we are interested in the financial and business structure of the companies running care homes and not the performance of individual care homes themselves.

124. Viewing this industry from the perspective of its companies and groups can reveal other forms of profit making (e.g. high management fees) that are not apparent at the care home level and reveal operational priorities.

There are significant levels of leakage across the care home sector and the type of care home business impacts the amount leaking out

125. To assess the true profitability of care home companies it is necessary to look not only at profit before tax but also at expenditure on rent, interest and repayments of debt, and directors' remuneration, areas where hidden profit extraction may occur. Collectively they represent the total potential leakage out of the sector.

126. We initially looked at how the income received by all care home providers was spent in aggregate. We examined a total of 830 individual companies that accounted for 68% of the total estimated market revenue for independent adult social care homes in 2017 – i.e. £10.4bn, out of a total revenue of £15.2bn.

127. Table 3 provides a breakdown of how this £10.4 billion of income is spent. It also shows how the amount spent on each area of expenditure differs between the small to medium-sized companies and the largest (Big 26) providers in the industry.

Table 3: Costs of adult social care home operators as percentage of revenue (2017 or latest year available, excluding exceptional items)

Costs as a % of revenue (aggregate)	Small to Medium-sized care home companies	Large care home providers
	Every £100 of income is spent as follows	
Staff costs	£58.02	£56.10
Non-staff operating costs[viii]	£31.82	£25.07
Rent	£1.44	£9.14
Net Interest paid out[ix]	£1.27	£5.04
Directors remuneration	£0.62	£0.41
Depreciation and Amortization	£3.09	£5.47
Profit Before Tax	£3.74	-£1.24
Total potential leakage	**£7.07**	**£13.35**
Proportion of total estimated industry revenue	36%	32%
Number of companies	784	26 – but part of groups with >2,500 companies

Sources: Big 26 data set, Smaller trading companies data set – this analysis excludes exceptional items.

viii These include other costs of running a business such as care supplies and utilities.

ix Net interest paid out is interest paid out (e.g. on loans) minus any interest paid in (e.g. on bank deposits).

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128. Unsurprisingly expenditure on staff costs is similar across the industry. Social care is a labour-intensive business and all company types generally pay their basic care workers the national living wage. This is becoming increasingly unsustainable as staff with their skills levels are in shorter supply and have better-paid opportunities in other industries.

129. There are big differences between the Big 26 providers (operating 30.8% of all registered beds) and all other (784) small to medium-sized care home providers identifiable in the sector, in how income is allocated to various business costs. This is particularly true for those categories of business cost which include leakage.

130. For the Big 26, £13.35 of every £100 put in goes to profit before tax, rent payments, directors' remuneration, and net interest paid out. In total this amounts to £653m a year out of a total income of £4.9bn.[x]

131. For the 784 small to medium-sized care home companies, £7.07 of every £100 goes to profit before tax, rent payments, directors' remuneration, and net interest paid out. This amounts to £390m a year out of a total income of £5.5bn.

132. In total, across both the Big 26 providers and the small to medium-sized care home companies, we estimate that £1.0 billion goes on profit before tax, rent payments, directors' remuneration, and net interest paid out; an aggregate leakage rate of 10%.

133. A lot of the difference in the amount of leakage between the Big 26 providers and the small to medium-sized companies is due to their different company structures and their histories.

134. For example, a large number of the small to medium-sized companies are family-run businesses or small charitable bodies providing services in from one to three properties which they own outright, so they pay little to no rent. Out of every £100 in income received they spend £1.44 on rent, compared to the Big 26 providers which spend £9.14 out of every £100 received.

135. The Big 26 operate tens to hundreds of care homes each and they have often grown by renting new properties, so their rent costs are higher. However more of their rent payments are to related companies and so are, in part, a form of hidden profit extraction, which will be explained later.

. . . .

x   This total leakage figure is reduced by the overall negative profit before tax (i.e. loss) by the Big 26 providers, which is due to losses by 7 of the 26 companies. Over 83% (£159m) of these losses are due to just two companies which continue to operate in the industry. This suggests that they are either more profitable than they appear to be or that they see future profits outweighing any current losses. The largest loss is by Elli Investments Limited (Four Seasons Health Care), which has been identified as a company which "would be robustly profitable" without opaque and potentially discretionary charges levied on the company by its group management. (See Burns, D. et al. (2016) – Where does the money go? Financialised chains and the crisis in residential care, CRESC Public Interest Report). This again illustrates why it is not possible to rely on profit before tax figures to tell whether and by how much a company is profitable.

136. Similarly, the amount of income spent on repaying debt is much lower in the small to medium-sized companies – £1.27 of every £100 in income received, compared to £5.04 for the Big 26 providers. This difference is probably due the fact that many of the small to medium-sized companies own their properties outright and are not borrowing in order to expand. The Big 26 providers include newer entrants and those that have expanded through borrowing. However, there is a large variation within the Big 26 providers.

137. Interestingly, the profit before tax of the small to medium-sized companies is far higher than for the Big 26 providers – £3.74 out of every £100 received ends up as a profit before tax compared to a loss of £1.24 per £100 for the Big 26 providers. Because of their relatively simple corporate structures the amount of profit before tax generated by the small to medium-sized companies is likely to be a more accurate representation of their underlying profitability than is the case for the Big 26 providers.

Estimated total leakage out of the care home sector

138. Around £15.2 billion is spent each year on independent care homes for older people. Assuming that there is a leakage rate of 10%, we estimate that a total of £1.5 billion leaks out of the UK care home sector in the form of profit before tax, rent payments, directors' remuneration and repayments on loans.[xi]

139. This is a significant potential loss of resources for the care home industry, equivalent to the additional £1.5 billion a year allocated to the social care sector in the Spending Review Statement in September 2019.[38]

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xi   A recent study by the Competition & Markets Authority (CMA) looked at the financial performance and sustainability of care home providers. As part of this work they produced an aggregated income statement for the largest twenty-six care home providers. Using the CMA's figures for the largest 26 providers, £20.00 of every £100 put in goes to profit before tax, rent payments, management fees, and interest paid out. This amounts to £864m a year out of a total income of £4.3bn. This estimate of potential leakage is a lot higher than the one based upon our Big 26 data set. The reason why is because the CMA were able to identify management fees (including central costs) as a separate cost, whilst for us these are included with 'Non-staff operating costs'. The CMA's analysis suggested that this cost is "significant" and the bulk of this fee was likely payments to shareholders, usually private equity funds, for management services. In 2016 these fees totalled £221m, a growth of 9.0% from 2015 despite overall revenue growing by only 4.3%. Management fees are discretionary and can be used to extract hidden profit out of a business. This suggests that our total leakage figure for the Big 26 providers is likely an underestimate. If we assume, in line with the CMA, a management fees cost of 5.1%, then our overall estimate of leakage out of the Big 26 providers rises from £653m to £902m a year (i.e. 18.85% of revenue). See Competition & Markets Authority (2017) – Care homes market study: final report. Appendices and glossary.

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There are significant differences in the level of leakage among the largest ('Big 26') providers

140. We broke down further the Big 26 providers by ownership type, giving us 4 different types of care home business.

- Small and medium-sized care home companies
- Large not-for-profit or employee-run providers
- Large for-profit (Private Equity owned or backed) providers
- Large for-profit (Non-Private Equity) providers

141. The analysis set out in Tables 4 and 5 shows that there are also significant differences in the level of leakage among the large (Big 26) providers. Firstly, there are large differences between the not-for-profits and for-profits (Table 4), and then within the for-profits there are further differences (Table 5). In summary:

- For the **8 large not-for-profit providers** the level of leakage is £8.60 out of every £100 received, and amounts to £93m a year
- For the **5 large for-profit providers (Private Equity)** the level of leakage is £9.06 out of every £100 received, and amounts to £159m a year.[xii]
- For the **13 large for-profit providers (Non-Private Equity)** the level of leakage is £19.49 out of every £100 received, and amounts to £401m a year.

Table 4: Costs of the large (Big 26) providers split by ownership type as a % of revenue (2017 or latest year available, excluding exceptional items)

Costs as a % of revenue (aggregate)	Large for-profit	Large not-for-profit
	Every £100 of revenue in is spent as follows:	
Staff costs	£56.51	£54.65
Non-staff operating costs	£24.32	£27.73
Rent	£11.07	£2.34
Net Interest	£5.88	£2.07
Directors remuneration	£0.42	£0.39
Depreciation and Amortization	£4.47	£9.01
Profit Before Tax	-£2.67	£3.80
Total potential leakage	**£14.70**	**£8.60**
Number of providers	18	8

Source: Big 26 data set

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xii This is lower than the aggregate leakage across the industry (£10.00) and significantly less than the leakage for the 13 other For-profit providers (£19.49). This is due to an aggregate loss before tax, which is mostly caused by a combined £159m loss by just two of the providers.

142. The not-for-profits mostly provide residential care beds whilst the for-profits offer more nursing beds. Nursing beds receive higher fees but also require nursing staff, who are increasingly scarce. The higher fees may be in part offset by the higher cost of staff but it shouldn't impact the financial structure i.e. where they allocate their costs (e.g. rent) and how they choose to fund themselves (e.g. who they borrow from).

143. As state funding growth has become limited all providers have been put under pressure to control or reduce their labour costs. Both not-for-profits and for-profits rely on a poorly paid workforce, paid at the statutory minimum wage rate. As social care is staff-intensive this means that 'costs' are reduced by sweating the staff e.g. working them harder without increasing pay, limiting annual leave, or not paying for handover meetings. These practices are common across all of the Big 26. Indeed, of the 5 Big 26 providers which spend less than 50% of their income on staff, two are not-for-profits.

144. The not-for-profits have far simpler corporate structures. They didn't have many subsidiary companies (ones that they own and control) or parent companies which had lent them money, so their profit before tax figures more accurately reflect their true profitability.

145. Both the large for-profits and not-for-profits are looking to expand the number of care homes and are following similar strategies:[39]

146. **Diversification**: they are often expanding out of their core residential and nursing care businesses to provide specialist dementia care homes, integrated care, and intermediate care (care for those well enough to leave hospital but who can't return home yet).

147. **Restructuring**: a large number had closed down care homes and handed back contracts to LAs. A few cited difficulties with making a profit on domiciliary care services. A number of the for-profits were reducing their borrowings and trying to buy more of their new or existing properties as opposed to renting. This reflects an uncertainty for some over whether they can maintain such high rental costs given fee rates.

148. **Selective expansion**: Almost all the Big 26 providers aimed to increase the number of self-funders they have in their care homes. Many were also building new homes in areas and to specifications aimed at wealthy individuals. Aside from two not-for-profits, none were keen to build or refurbish homes for LA-funded residents.

149. Within the for-profits there was more variation in leakage by ownership type.

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Table 5: Costs of the large (Big 26) providers split by ownership type as a % of revenue (2017 or latest year available, excluding exceptional items)

Costs as a % of revenue (aggregate)	Large for-profit (Private Equity)	Large for-profit (Non-Private Equity)	Large not-for-profit
	Every £100 of revenue in is spent as follows:		
Staff costs	£57.18	£55.95	£54.65
Non-staff operating costs	£28.76	£20.55	£27.73
Rent	£7.32	£14.26	£2.34
Net Interest paid out	£10.83	£1.66	£2.07
Directors remuneration	£0.15	£0.65	£0.39
Depreciation and Amortization	£5.00	£4.01	£9.01
Profit Before Tax	-£9.24	£2.92	£3.80
Total potential leakage	**£9.06**	**£19.49**	**£8.60**
Number of providers	5	13	8
Proportion of total annual revenue of Big 26	35.8%	42.1%	22.0%

Source: Big 26 data set

Summary

Tables 3–5 show that there are variations in how much the different types of care home company spend on their costs. These differences are particularly noticeable in costs where hidden profit extraction does occur, such as rent and interest paid out.

Within the large (Big 26) providers, the not-for-profits spend relatively consistent proportions of their revenue on each area of costs. The for-profits show more variation on these costs, even when split into further categories i.e. Private Equity or non-Private Equity ownership. These variations are explainable through a deeper analysis of the different corporate structures employed by providers.

SECTION C: Some of the Big 26 care home providers use complex company structures to maximise leakage and hide profit extraction

150. Some of the differences among the Big 26 providers can be explained by the nature of their company structure and how money flows to different investors and companies that have claims on the care home company's revenues. Table 6 shows how large care home providers use different structures to disguise profit extraction and increase different forms of leakage.

Table 6 –The numbers of large (Big 26) care home providers of different types which use structures which can disguise profit extraction.

Company Type	Offshore owner in tax haven	Split of operating and property companies	Sale and leaseback	Purchase services or supplies from a related company
5 Large for-profit providers (Private Equity)	4/5	5/5	2/5	4/5
13 Large for-profit providers (Non Private Equity)	2/13	12/13	6/13	5/13
8 Large not-for-profit providers	0/8	1/8	1/8	3/8

Leakage in the form of rental payments and the impact of 'Sale and Leaseback'

151. One of the reasons why leakage in the form of rental payments is so high for some of these providers is due to who owns the care home premises and in particular, the use of sale and leaseback arrangements, i.e. when a company sells an asset (in this case a care home building) to a buyer and then leases (rents) back the building (from the buyer) on a long-term contract.

152. It is estimated that amongst medium to large care home operators around 50% of all bed capacity is covered by sale and leaseback.[40] Our review of the Big 26 providers' accounts identified 9 companies which had used sale and leaseback as a way of financing the expansion of their companies; 8 were large for-profit companies and one was a large not-for-profit company.

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153. In general the large not-for-profit providers have not relied on sale and leaseback because they mainly consist of older companies which initially started out providing housing and other services for older people. As charities, the level of financial risk that they are willing to take is lower. Therefore they own most of their care homes and buildings and so their rent payments are low, while consequently their (non-cash) depreciation payments are higher because they own their assets (buildings).

154. These arrangements explain why the 8 large not-for-profit providers pay out £2.34 out of every £100 of income on rent compared to the 18 for-profit providers which spend £11.07 out of every £100 received.

155. However, there are also significant differences within the large for-profit group of providers. The 5 for-profit (private equity) care home providers spend £7.32 out of every £100 received on rent; while for the other 13 other large for-profit providers £14.26 out of every £100 received is spent on rent.

156. The 9 providers with sale and leaseback arrangements paid the highest average rent: £14.32 out of every £100 of income received.

157. Sale and leaseback is popular amongst the Big 26 providers because it provides cash for expansion (buying new homes) whilst allowing them to still use the care homes they have sold. However, it also means that any rise in value of the property is forgone, and it is harder to dispose of businesses if they are locked into long-term rental contracts. For many for-profit providers, sale and leaseback may be one of the only ways that they can raise cash to expand, as banks are less willing to lend to businesses without a significant number of properties or other assets available as security.

158. For the buyers of the care home assets the purchase allows them to receive a steady stream of income (along with any rise in property values) without the risks involved in providing the care services. Investment companies (such as Welltower Inc and Impact Healthcare REIT plc) have been keen to buy and rent back care homes, usually securing a 5-7% return on their investment for little risk.[xiii]

159. However, it is not always the case that the sale and leaseback arrangements are with separate property companies. We found that 5 of the 9 sale and leaseback arrangements amongst the Big 26 providers were with related companies or individuals.

160. In the situations where sale and leaseback arrangements exist within a large corporate group, the care home company will have split their business into an operating company and a property company.

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xiii Some REITs now also own stakes in operating companies too (i.e. companies which actually provide adult social care).

The Big 26 providers pay out significant amounts in rent payments each year, often to related companies which are based outside the UK's tax jurisdiction

161. When rental payments (via sale and leaseback or otherwise) are paid between related companies it becomes hard to identify the true profitability of the underlying care home business and hence the true level of leakage, because rental charges may be levied by related companies at rates far higher than would be set by the market.

162. In addition, the offshore location of some of these related companies means that UK taxes can be avoided, which is another form of leakage from the system, although one that we have not been able to quantify.

High rental payments reduce the money available to look after care home residents and lock in high fee rates

163. Even if the rental payments for the care homes are not to a related company there are legitimate concerns about the growth in rental payments and the impact that this has on care home fees. Seven of the 18 large for-profit providers currently spend between 15 and 32% of their revenue on rent payments, totalling £264m a year.

164. For those companies for which we were able to identify sufficient information we discovered that their rental or leaseback payments would often rise annually with inflation (RPI) plus a margin of usually around 2-4%.

165. This means that for any company with these arrangements their fee rates must increase yearly by an amount higher than the rate of inflation or cuts will need to be made to other areas of the business – such as staffing costs or investment in facilities or entertainment for residents.[xiv] If the fee rates do not increase, or if cuts to other areas are not possible to meet the increased cost of growing rental payments, the company is put at risk of financial difficulties.

166. For the funders of the care of residents – whether the local authority or the NHS or individual residents and their families –these high rental costs, and their dependence on care home providers with these arrangements, puts pressure on them to continually increase the fees that they pay. As a result there is a significant public interest in transparency over the costs that are locked into these long-term rental agreements and in minimising increases in rental charges.

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xiv For example, one Big 26 provider that we reviewed had annual rental increases of up to 2.5%, but had managed to increase their annual fees by 5.2%. These yearly inflation plus rental increases lock in a minimum fee increase for the users of their care homes for the coming years.

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167. The collapse of the care home provider Southern Cross was in part due to unaffordable rents on sale and leaseback care homes. Whilst no company in the Big 26 has been as risky in its rental obligations, transparency over all these debts is a matter of public interest. But it is a matter of concern that the group of Big 26 providers which have sale and leaseback transactions have an above average level of gearing of 578.4% – in other words their debts are almost six times greater than the assets they have available to pay them off.

168. For the purchasers of care home premises, a sale and leaseback transaction can quickly provide a return on their investment, leaving little downside risk for them if the business fails. This type of profit extraction via the selling off a company's assets is ill-suited for a low risk industry where returns are expected to be steady and yearly. It is especially against the public interest if it leads to higher debts which must be covered by care home fees.

Summary

Significant amounts of money leak out of the care home sector in the form of rental payments to companies which own care home buildings. Some care home providers have sold their assets to property investors and are often locked into paying high rents over a long period of time.

These high rental payments are not often seen as leakage out of the care home system, but because they are so significant for some providers they can eat into the into the money available to look after care home residents and lock in high fee rates which local authorities, the NHS, and private individuals have to pay.

This arrangement is especially problematic where a care home group has split its structure into an operating company and a property company, and rental payments are made by one company to lease the care home premises from another, both of which they own. These rental payments can include hidden profits, if the rental payments are artificially high.

Leakage in the form of debt repayments and the impact of inter-company loans

169. The amount of income which leaks out in the form of debt repayments is also highly variable across the Big 26 providers, and is again a product of the way in which the companies are structured and how their loans are financed.

170. For the 8 large not-for-profits, the amount spent on debt repayments amounts to £2.07 of every £100 of income received compared to the 18 large for-profit providers, which spend £5.88 on debt for every £100 of income received.

171. However, it is the 5 large for-profit (Private Equity) providers whose debt repayment as a percentage of income is highest – across these five providers £10.83 of every £100 income received goes towards debt repayments. This is far higher than it is for the 13 large for-profit (Non-Private Equity) providers (£1.66), the 8 large not-for-profits (£2.07), and the 784 small to medium-sized companies (£1.27).

172. As a group the 8 large not-for-profits are more conservative with their finances (partly due to the requirements imposed by their charitable status) and do not borrow much to expand, instead preferring to grow by reinvesting any surplus funds they have generated. Any borrowing they do is mostly from banks, using their care home properties as security. This means that their loan terms are very favourable, with interest rates as low as LIBOR + 1.5%.

173. This stands in contrast to the large for-profit providers where over half their interest payments and almost 60% of their long-term debt is owed to related companies (i.e. companies with shared or the same owners).

174. The 18 large for-profit providers also borrow from banks at low interest rates (LIBOR + 1.5%-4% being common), using their properties as security. This is less common because many don't have enough freehold properties (to offer as security) to borrow as much as they would like. However, they also receive significant funding from parent or other related companies. They tend to be part of larger groups of companies (comprising a total of over 2,500 companies across all Big 26 providers). This is because they are owned by investors, or are parts of businesses, which are operating in other industries too, and this means that they are also more likely to be funded out of loans from parent and related companies.

175. The Big 26 providers vary in how much of their long-term debt and interest payments are to related companies:

- For the 8 large not-for-profit providers, loans from related companies comprise 1.4% (£7.5m) of their long-term debts and 0.0% (£0m) of their interest payments.

- For the 5 large for-profit (Private Equity) providers, loans from related companies comprise 58.6% (£755.1m) of their long-term debts and 53.4% (£104.3m) of their interest payments.

- For the 13 large for-profits (Non-Private Equity) their funding from related companies comprises 59.9% (£713.8m) of their long-term debts and 30.9% (£12.7m) of their interest payments.

176. The interest rates on these loans typically ranges between 7% and 16%, which is considerably higher than the cost of borrowing money from external investors or banks.

177. Ordinarily a company will seek to borrow as cheaply as possible in order to keep the cost of debt repayments as low as possible, and to maximise their profit. Because most of the debt in the large for-profits is owed to related companies at rates which are higher than would be available from external lenders, these debt arrangements may reasonably be seen as designed to generate extra hidden profit for the owners of the company, a sum which leaves these businesses before their profit before tax figure is calculated.

178. In addition, interest payments on loans are tax deductible and often the related company to which they are made is offshore, so tax is saved at both ends – representing a double leakage for the taxpayer. This may explain why the Big 26 providers with an offshore owner paid out £9.09 of every £100 of income on net interest payments out, compared to £2.86 for all other large providers.

179. The high levels of debt repayments by these companies also helps explain their low pre-tax profit figures. The fact that large for-profit (Private Equity) providers have very high interest payments going to related companies may explain why their owners are happy for them to keep on making apparent losses.

180. Overall, these arrangements make it hard to understand how much profit some of these companies are generating from providing care home services.

The impact of the debt loaded on to care home beds and the effect on care home fees

181. Care home companies view the beds that they own as the basis for generating income – they sell the use of a bed at a weekly price to local authorities, the NHS, or private individuals. Because these income streams are relatively stable they can borrow against them, with lenders knowing that they will have an almost guaranteed income to cover interest and repayments.

182. One way of comparing the impact of debt on the operation of a care home company is therefore to look at how much debt has been loaded onto each of the care beds owned by the company, and the weekly cost of repaying the debt and interest. Our analysis reveals the following aggregate figures:

- The 8 large not-for-profit providers have borrowed £21,069 for each care bed they own, and pay interest costs of £19 per bed per week.

- The 13 large for-profit (Non-Private Equity) providers have borrowed £21,546 for each care bed they own, and pay interest costs of £14 per bed per week.

- The 5 large for-profit (Private Equity) providers have borrowed £35,072 for each care bed they own, and pay interest costs of £102 per bed per week.[xv]

183. The cost of the debt per bed owed by the 5 large for-profit (Private Equity) providers is especially high, amounting to around 16% of the weighted average weekly fee of £622 paid for residential care in the UK, and 12% of the equivalent fee for nursing care at £856 per week.[41]

184. However it should also be noted that the rental payments due over the lifetime of some their lease arrangements are not necessarily included in the long-term liabilities in the care home companies' accounts.[xvi] Consequently these debt per bed figures are likely to be an understatement of the amount of debt borrowed on these care beds, the cost of which funders ultimately have to shoulder.

185. Regardless of who ultimately receives the money, an aggregate interest cost of £102 per bed per week is an extremely high leakage out of the fees paid by local authorities, the NHS, or private individuals and is a substantial resource which could be going directly towards the care of residents.

Summary

The large for-profit providers owe a substantial amount of their debt to related companies. On top of this the interest rates on these loans are very high, compared with the rates paid by the not-for-profits, and with external borrowing rates. This suggests that a substantial amount of the leakage in this area is hidden profit extraction.

The particularly high aggregate interest costs per bed per week for for-profit (Private Equity) providers is especially concerning as it places a large pressure on funders to shoulder these costs or accept cuts to other areas of care costs.

xv   Despite having similar levels of long-term debt the 8 large not-for-profits and the 13 large for-profits (Non-Private Equity) have far lower interest charges than the 5 large for-profits (Private Equity) companies. This is in part due to the higher interest rates charged on the loans to Private Equity owned or backed companies. However, whilst the 13 large for-profits also have high interest rates on some of their intercompany debts these are often only repayable in one lump sum at the end of the loan. This means that they are not paying out as much in interest payments each year, but still face a high burden overall.

xvi   This will change in accounts from periods after 1st January 2019 following the implementation of IFRS 16.

Splitting the care home business into separate operating and property companies raises other public interest concerns, including the ability of a care home operator to pay compensation for causing harm, and potential tax avoidance

186. There are other concerns with splitting up the care homes business into separate operating companies (those that provide the care) and property companies (those that own the home). Firstly, it leaves operating companies with few assets (since they no longer own care home buildings). These companies are responsible for providing safe care, and if they fail to do so they can be sued. But the only assets the company will have available to pay out any compensation is cash in the bank and any equipment it owns.

187. This means that the split can be seen as a way to protect valuable property assets from being at risk. Indeed, 5 out of the 18 companies with this split had negative assets (in 2017, or the latest available year) meaning that their liabilities (what they owed in total over time) were greater than the value of their assets. This is a public interest issue, since those providing care need to be able to be held financially responsible for any harm they may do.

188. Secondly, in many cases the property company was owned by a related company. This hinders transparency because it obscures how profitable the care home business is when the rent is going to the same overall owner.

189. Thirdly, there are property companies in the Big 26 which are offshore. Yet again, this means that the tax paid in the UK falls (rental payments are a cost that reduces the tax due), without necessarily a corresponding rise in UK tax paid by the property company.

Summary

There is a public interest in ensuring that those providing public services can be held accountable for malpractice. Placing the assets in separate companies raises concerns over the ability of care home operating companies to pay out sufficient compensation, and creates opportunities for tax avoidance.

Leakage through management fees and purchasing supplies from a related company

190. Twelve of the Big 26 had significant purchases or other transactions with related companies. These ranged from consultancy services provided by another company owned by the same directors to the charging of high management and performance fees.

191. When transactions between related companies exist it is harder to determine how legitimate the prices set are, and the necessity of the services provided.

192. Many companies were charged management fees which went to related companies which had few or even no staff, making it seem to be a way to funnel profit out of the company (and often out of the UK). The Competition and Market Authority's (CMA) aggregated income statement for the largest twenty-six care home providers found the charging of management fees and central costs consumed 5.1% (£221m) of the annual revenue of the Big 26 providers, most of it going to private equity investors.[42]

193. It is important to note that these fees are discretionary – the amounts paid are the choice of the parent company. They reduce the profits before tax in the care home business's accounts, but still amount to leakage from the sector. Yet again, such inter-company purchases and management fee payments make the profitability of care home businesses less transparent.

Summary

A lot of the variation and differences in the cost allocations of the Big 26 for-profit providers can be explained with the behaviours and business structures listed above.

This section makes clear that these are behaviours that hinder public scrutiny of how profitable or sustainable a care home business is. They also allow for more profit extraction and undermine our ability to measure the profit actually made by looking at care homes and their operators in isolation.

Just as importantly, some behaviours and financial structures increase financial fragility and lock in high future costs.

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Conclusion and Recommendations

194. This report demonstrates that the care home sector is in crisis, partly because of the financial structures present in sections of the industry and not just because there are insufficient amounts of money going into it.

195. The current financial structure of many of the largest providers hinders public accountability and hides the true extent of profits being made at the expense of front line care.

196. Care homes are capital and labour-intensive businesses. When rental costs and debt repayments are high (because investors expect a certain level of returns) this puts pressure on care home businesses to squeeze labour costs by overworking and underpaying staff. This partly explains why the turnover rate for care workers is 39.5% a year as workers can get similar pay (at national minimum wage) and better working conditions in other industries such as retail.[43]

197. Reducing the excessive and often hidden leakage of some of the big companies in the care home industry could free up funds to pay staff higher wages and offer them improved career progression. Re-directing the money which leaks out of the UK economy to off-shore investors and towards frontline care could also be used to help revitalise the declining economies of those English regions with ageing populations and provide attractive jobs for younger people.[44]

198. But policy makers also need to consider how the financial structure of the care home industry and the investment decisions taken will impact on the care homes that are being built to meet future demand.

199. Whilst research shows that smaller care homes tend to have the highest satisfaction scores and that the larger the care home the worse the quality of care, it is also the case that many of the family businesses which run smaller care homes are leaving the sector as their owners retire.[45] [46]

200. In addition, the larger for-profit care home companies are not interested in either purchasing or building smaller homes but instead prefer to build or invest in very large homes with 60-120 beds. These facilities - which have the potential to generate large amounts of income - are also increasingly being built to attract the growing private pay market rather than to meet the planned needs of specific communities.

201. Both the high levels of debt which are loaded onto these new facilities and the high cost lease arrangements which underpin them means that this is an expensive way to finance new facilities for older people. The use of private finance to build public infrastructure such as schools and hospitals can lock taxpayers into repaying the high cost loans which have been used to finance them.[47]

202. Because the state has rarely invested directly in care homes in the UK - instead leaving it to private investors or charities - policy makers do not consider them to be part of the essential national infrastructure like schools or hospitals. Yet, the rising number of older people in the UK population means that there is a growing imperative to provide new care facilities which are affordable, high quality, and meet the needs of care home residents rather than being built in order to provide a set return to investors.

203. As a result, resolving the care home crisis will require policy makers to both address the amount of money currently leaking out of the care home sector and to develop a capital investment strategy which ensures that the future provision of care home facilities is in the public interest.[xvii] On this basis we make the following recommendations:

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xvii A strong case for changing how we view the benefits of public and private infrastructure investments can be found in: Foundational Economy Collective 'Foundational Economy: The infrastructure of everyday life' Manchester University Press 2018.

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Recommendation 1
A Care Home Transparency Act – care home providers should be mandated to disclose where their income goes

204. For anyone purchasing care home services, it is currently impossible to know how much of it goes on front line care and how much of it leaks out to investors. Irrespective of the mix of sources of a care home's income, whether from a local authority, the NHS, or from private individuals, there should be full transparency about how its income is spent.

205. Similar measures have been introduced in the US. In 2009 The Nursing Home Transparency and Improvement Act was passed as part of the Affordable Care Act. As in the UK, the complex management, ownership, and financial structures of large care home chains was found to impede the ability of federal and state governments to hold nursing home chains to account for their use of public money. This legislation requires nursing homes which are in receipt of public funding (Medicaid or Medicare) to report detailed information on ownership, staffing levels, other costs, complaints, and expenditure categories.

206. However, it is important to learn from the US experience when framing a UK Act. Whilst the US regulations have improved transparency, they only require individual nursing homes to provide details of their finances, but not the corporate groups which now operate many care homes.[48] This means there is less transparency about the money which goes to the property and management companies which make up these groups.[49]

207. In addition, the US Act only provides data in relation to care home services funded by Medicare and Medicaid. Again this is a limitation which should be addressed in a UK Care Home Transparency Act. All the money which goes into the care home industry in the UK should be treated as public money and should be accounted for as such. Those individuals and family members who pay for care out of their own pockets are often required to do so because they are denied access to funding by the state, and as taxpayers they are entitled to know where their money goes.

Recommendation 2
A new form of care regulation is required to prevent care home companies with unsatisfactory financial models from providing care in the UK

208. It is not in the interest of care home residents, their families, or the taxpayer for some types of company to own and run residential and nursing care homes. Companies which are registered outside the UK for tax purposes, or which have high levels of debt and/or make large payments to related property companies, or pay large management fees are not providing good value for money.

209. Moreover, as the government has recognised, companies which owe significant amounts of debt or who have high property costs are at risk of financial collapse. This creates an unnecessary risk of harm to care home residents and if it occurs it requires the state to pick up the pieces. There are currently no regulations in place to prevent a care home collapse, merely a mechanism for forewarning local authorities that this is likely to happen.[50]

210. If, as seems likely, a future government commits to substantially increasing the amount of taxpayer money which goes into social care, there is a significant public interest in ensuring that the state only contracts with companies which can demonstrate that an acceptable proportion of their income goes to frontline care and have a sustainable financial model.

211. This will require a significant shift in how care is regulated in the UK, away from simply regulating the quality of care according to a series of output measures, to specifying that certain requirements are in place before a care home company is licensed.

212. It is not unusual for the state to make requirements of private companies regarding their finances before contracting with them. The Defence Reform Act 2014 for example permits the Single Source Regulations Office to determine both profit rates and allowable costs for non-competitive defence contracts.[51]

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213. With regard to the finances of a licensed care home provider these requirements should include:

- tax registration in the UK of the ultimate controlling parties of the company providing the service;

- full transparency in line with the requirements of the proposed Care Home Transparency Act;

- minimum equity and net assets requirements to ensure that they can be held financially liable for any care malpractice in their homes;

- an agreed proportion of income to be spent on staffing costs and non-staff operating costs; and

- an agreed limit to the proportion of income to be spent on profit, debt repayment, and property costs.

214. Based upon our findings in this report we consider it likely that a significant proportion of the care home companies providing services in the UK would be able to meet these requirements as their expenditure on debt and rental payments is not significant, nor are their profit margins.

215. However, in the event that some care home providers are not able to meet these requirements the state should facilitate the restructuring of the companies so that they are able to achieve a licence to operate. Alternatively, they will need to be enabled to exit the market and the service re-provided by either the state or another company.

216. Whilst we anticipate that there will be significant concerns about the impact of such a regulatory regime on the viability of a number of the large care home companies, it should be borne in mind that the risks of insolvency, bankruptcy, and corporate collapse are current features of the existing care home market. Data provided by Company Watch shows that the percentage of the care home companies with a 1 in 4 chance of going into insolvency or in need of major restructuring in the next 3 years has increased from 24% in March 2014 to 30% in September 2019.[xviii]

217. As a result, a restructuring of some parts of the care home industry will be necessary at some point and it is preferable that this is undertaken in a managed way and in line with a clear set of public interest objectives.

xviii For more information see: https://www.companywatch.net/platform/scores-definition

Recommendation 3
Capital should be made available by the government for the provision of new care homes

218. Given the ageing population there is a need for new care homes, in a range of sizes and formats and at an affordable cost. The UK's current capital investment in new care homes is being provided by the larger for-profit care home providers and is being directed towards building large homes which are primarily focused on the more profitable part of the market, namely residents who fund their care out of pocket. In addition, the funding model of these new care homes is liable to lock in high rental and borrowing costs and there is evidence that larger care homes are associated with a worse quality of care.[52]

219. In order to avoid locking these high costs into the care home infrastructure, and to ensure that there are different types of care home provision – including smaller care homes – the government should make available low-cost capital in the form of loans to small and medium sized care home operators too in order to encourage the development of a range of home sizes and care models.

220. Alternatively both local authorities and the NHS could build and own the new care home infrastructure. A decision could then be made about whether to operate these homes themselves or lease them out to other public, private, or not-for-profit providers. This would limit the opportunities for the type of extraction and leakage that we have identified in the form of rental payments and debt repayments. State ownership of the care home infrastructure would also offer protection for residents against the risks associated with the financial collapse of a care home company.

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Appendix

The Big 26 providers consisted of the following:

- HC-One Ltd
- Four Seasons Health Care (Elli Investments Ltd)
- Barchester Healthcare Ltd
- Care UK (Care UK Health & Social Care Holdings Ltd)
- Bupa Care Homes (results of 9 companies)
- Anchor (The Anchor Trust)
- Sanctuary Housing Association (Sanctuary Care Limited)
- Methodist Homes (MHA)
- Runwood Homes Ltd
- Maria Mallaband and Countrywide Group (MMCG Holdings Ltd)
- Avery Healthcare Holdings Ltd
- Orders of St John Care Trust
- Advinia Health Care Limited
- Sunrise Senior Living (Sunrise UK Operations Limited)
- Caring Homes (Myriad Healthcare Holdings Ltd)
- Larchwood Care (Larchwood Holdco Limited)
- Orchard Care Homes (Cortina Race LLP)
- Minster Care Group Limited
- Priory Group (results of 13 companies)
- Excelcare (Excelcare Holdings Ltd)
- Abbeyfield Society Limited
- Akari Care (AK (SPV) Ltd)
- Shaw Healthcare (Group) Ltd
- Healthcare Homes (Healthcare Homes Holdings Ltd)
- Quantum Care Ltd
- Somerset Care Ltd

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CHPI | Centre for Health and the Public Interest

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Integration Joint Board
19th December 2019

Subject:	**Auditor General – NHS Scotland in 2019**
Purpose:	To allow the IJB to review the findings of the Audit Scotland report, produced in October 2019, on the NHS in Scotland and to note the current actions in place within the HSCP to support sustainability.
Recommendation:	The IJB is asked to note the findings of the Auditor General's report and to note the current actions in place which support sustainability. A further update will be provided when the Scottish Government provide updated HSCP guidance in 2020.

Glossary of Terms	
HSCP	Health and Social Care Partnership
Auditor General	Lead for Audit Scotland
MSG	Ministerial Steering Group

1.	EXECUTIVE SUMMARY
1.1	The Auditor General's produced a report in October 2019, on the NHS in Scotland. A full copy of the report is available at https://www.audit-scotland.gov.uk/report/nhs-in-scotland-2019
1.2	The report contained five key messages which have been summarised below: 1. Health remains the biggest area of Scottish Government funding but is facing continuing pressure from rising demand and costs, which is resulting in waiting time failures and an estimated £1.8 billion shortfall in the projected funding for health and social care by 2023/24. So far, the pace of change to address this, particularly through the integration of health and social care, has been too slow. 2. The Scottish Government has started to put in place foundations to support boards make the changes required. These include the publication of the Health and Social Care: Medium-Term Financial Framework, the Waiting Times Improvement Plan and the introduction of a national leadership development project. It is, however, too soon to assess the impact of these initiatives. 3. Despite the existing pressures, patient safety and experience of hospital care continues to improve. Drugs costs have stabilised, and we have seen examples of new and innovative ways of delivering healthcare that involve a range of partners. 4. Achieving financial sustainability remains a major challenge for NHS boards. There have been increases in predicted deficits and additional financial support provided by the Scottish Government, and a continued reliance on one-off savings. 5. The ambitions within the Scottish Government's 2020 Vision, will not be achieved by 2020.

1.3	The Auditor general had provided a range of improvement recommendations for:
	• The Scottish Government in partnership with NHS boards and integration authorities, • the Scottish Government specifically and • the Scottish Government in partnership with NHS boards
1.4	The North Ayrshire Health and Social Care Partnership recognises many of the challenges identified in the Auditor General's report on NHS Scotland and has as result of the recent Ministerial Steering Group (MSG) action plan, already begun work to increase the pace of transformation and integration of services to support sustainability.
1.5	The IJB is asked to note the findings of the Auditor General's report and to note the current actions in place which support transformation and sustainability.
2.	**BACKGROUND**
2.1	The Auditor General's produced a report in October 2019, on the NHS in Scotland. A full copy of the report is available at https://www.audit-scotland.gov.uk/report/nhs-in-scotland-2019
2.2	The report contained five key messages: 1. Health remains the single biggest area of government spending, at £13.4 billion in 2018/19. This was 42 per cent of the 2018/19 Scottish Government budget and is growing. The healthcare system faces increasing pressure from rising demand and costs, and it has difficulty meeting key waiting times standards. Without reform, the Scottish Government predicts that there could be a £1.8 billion shortfall in the projected funding for health and social care by 2023/24. So far, the pace of change to address this, particularly through the integration of health and social care, has been too slow. 2. The Scottish Government has started to put in place foundations to support boards make the changes required. These include the publication of the Health and Social Care: Medium-Term Financial Framework, the Waiting Times Improvement Plan and the introduction of a national leadership development project. The new requirement for NHS boards to develop three-year financial and performance plans enables them to more effectively plan how services will be delivered in the longer term. It is, however, too soon to assess the impact of these initiatives. 3. Despite the existing pressures, patient safety and experience of hospital care continue to improve. Drugs costs have stabilised, and we have seen examples of new and innovative ways of delivering healthcare that involve a range of partners. These aim to increase the care provided in the community and expand multidisciplinary working, to improve access to care and treatment. 4. Achieving financial sustainability remains a major challenge for NHS boards. There have been increases in predicted deficits and additional financial support provided by the Scottish Government, and a continued reliance on one-off savings. Capital funding from the Scottish Government has decreased by 63 per cent over the last decade and the level of backlog maintenance remains high, at £914 million. High-profile, newly-built hospitals have come under significant scrutiny because of health and safety concerns.

	5. The ambitions within the Scottish Government's 2020 Vision will not be achieved by 2020. The Scottish Government should work with NHS staff, partners and the public to develop its new strategy for health and social care. It should set out priorities that support large-scale, system-wide reform to increase the pace of change. Collaborative leadership is needed to focus on better partnership working, staff engagement and promoting positive workplace behaviours. Staff are at the heart of the NHS and it is vital that more is done to support them so that they can care for people in a safe, fulfilling and respectful environment.

	The Scottish Government should:
	• finalise and publish as a matter of urgency, the national capital investment strategy to ensure that capital funding is strategically prioritised and report publicly on progress against the health and social care delivery plan. This should provide an update, and include measures of performance, on how services are being delivered differently to allow more people to be cared for closer to home
	• develop a single annual staff survey that relates to behaviours, culture and staff experience, to identify areas for improvement and address behaviour that is contrary to NHS Scotland values.
	
	The Scottish Government in partnership with NHS boards should:
	• Make sure that NHS boards' three-year plans are approved in time for the start of each financial year. The plans should be routinely managed and monitored and should include details of how boards intend to reduce their reliance on non-recurring savings
	• Ensure that the NHS Scotland A Blueprint for Good Governance is implemented in full and that areas for improvement are addressed, particularly around strengthening risk-management arrangements
	• Continue to monitor the effectiveness of the Scottish Government's NHS leadership development project and its impact on recruitment, retention and the support of senior healthcare leaders
	• Ensure that all NHS boards:
	    o provide evidence that they actively promote positive workplace behaviours and encourage the reporting of bullying and harassment
	    o have action plans in place to improve culture, address any issues identified and use the findings of the Sturrock review to inform their plans for cultural improvement.

3.	**PROPOSALS**
3.1	From the recommendations for Scottish Government in partnership with NHS boards and integration authorities', the North HSCP has already put in place:
	• A Strategic Plan which will be updated in 2020 supports large-scale, system-wide reform, with clear priorities that identify the improvement activities most likely to achieve the reform needed building on the previous transformation programme. • A North Ayrshire HSCP workforce plan which will be updated to reflect the new national, integrated health and social care workforce plan and guidance. • Using the MSG Action Plan North Ayrshire HSCP is working to Improve the quality and availability of data and information. This will now be enhanced to show primary and community care to enhance how patient information is shared across health and social care services.

		• The North Ayrshire HSCP has already signed up to and uses the principles of the Community Empowerment Act within communication and engagement strategies and engagement work. • Engaging or Supporting as a NHS Board caring for Ayrshire Programme.
3.2	**Anticipated Outcomes**	
	The Auditor General report builds on the MSG review of integration action plans and enables further improvement, which should increase the pace of health and social care integration.	
3.3	**Measuring Impact**	
	The HSCP has undertaken a MSG Integration review self-assessment and provided and action plan to Scottish Government. It is expected that new HSCP guidance will be made available in 2020, which will include the Auditor General recommendations and a further review of progress towards integration will be undertaken at that time.	
4.	**IMPLICATIONS**	

Financial:	The improvements highlighted in the Auditor Scotland report are being actioned in the MSG integration review action plan. It is expected that the Scottish Government will produce new HSCP guidance in 2020, which will include the recommendations, and these will form part of the HSCP medium term financial plan.
Human Resources:	N/A
Legal:	N/A
Equality:	N/A
Children and Young People	N/A
Environmental & Sustainability:	The improvements highlighted in the Audit Scotland report are being actioned in the MSG integration review action plan. It is expected that the Scottish Government will produce new HSCP guidance in 2020, which will include the recommendations, and these will form part of plans to ensure HSCP sustainability.
Key Priorities:	The sustainability of HSCPs
Risk Implications:	Failure to integrate, transform and achieve financial sustainability may destabilise Health and Social Care Partnerships and reduce the delivery of positive outcomes for the people of North Ayrshire.
Community Benefits:	N/A

Direction Required to Council, Health Board or Both	Direction to :-	
	1. No Direction Required	x
	2. North Ayrshire Council	
	3. NHS Ayrshire & Arran	
	4. North Ayrshire Council and NHS Ayrshire & Arran	

5.	CONSULTATION
5.1	Not Applicable.

6.	CONCLUSION
6.1	It is expected that the Scottish Government will produce new HSCP guidance in 2020, which will include the Auditor General recommendations, and the North Ayrshire HSCP will implement this guidance as part of the new Strategic Plan refresh. .

For more information please contact Caroline Cameron on ccameron@north-ayrshire.gov.uk or Michelle Sutherland on msutherland@north-ayrshire.gov.uk on 01294 317751

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NHS in Scotland 2019

Auditor General for Scotland

The Auditor General's role is to:

- appoint auditors to Scotland's central government and NHS bodies
- examine how public bodies spend public money
- help them to manage their finances to the highest standards
- check whether they achieve value for money.

The Auditor General is independent and reports to the Scottish Parliament on the performance of:

- directorates of the Scottish Government
- government agencies, eg the Scottish Prison Service, Historic Environment Scotland
- NHS bodies
- further education colleges
- Scottish Water
- NDPBs and others, eg Scottish Police Authority, Scottish Fire and Rescue Service.

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Audit Scotland is a statutory body set up in April 2000 under the Public Finance and Accountability (Scotland) Act 2000. We help the Auditor General for Scotland and the Accounts Commission check that organisations spending public money use it properly, efficiently and effectively.

Contents

Links

⊕ PDF download

⬀ Web link

Exhibit data

When viewing this report online, you can access background data by clicking on the graph icon. The data file will open in a new window.

Audit team

The core audit team consisted of:
Leigh Johnston, Fiona Watson, Eva Thomas-Tudo, Agata Maslowska, Veronica Cameron and John Kirkwood with support from other colleagues and under the direction of Claire Sweeney.
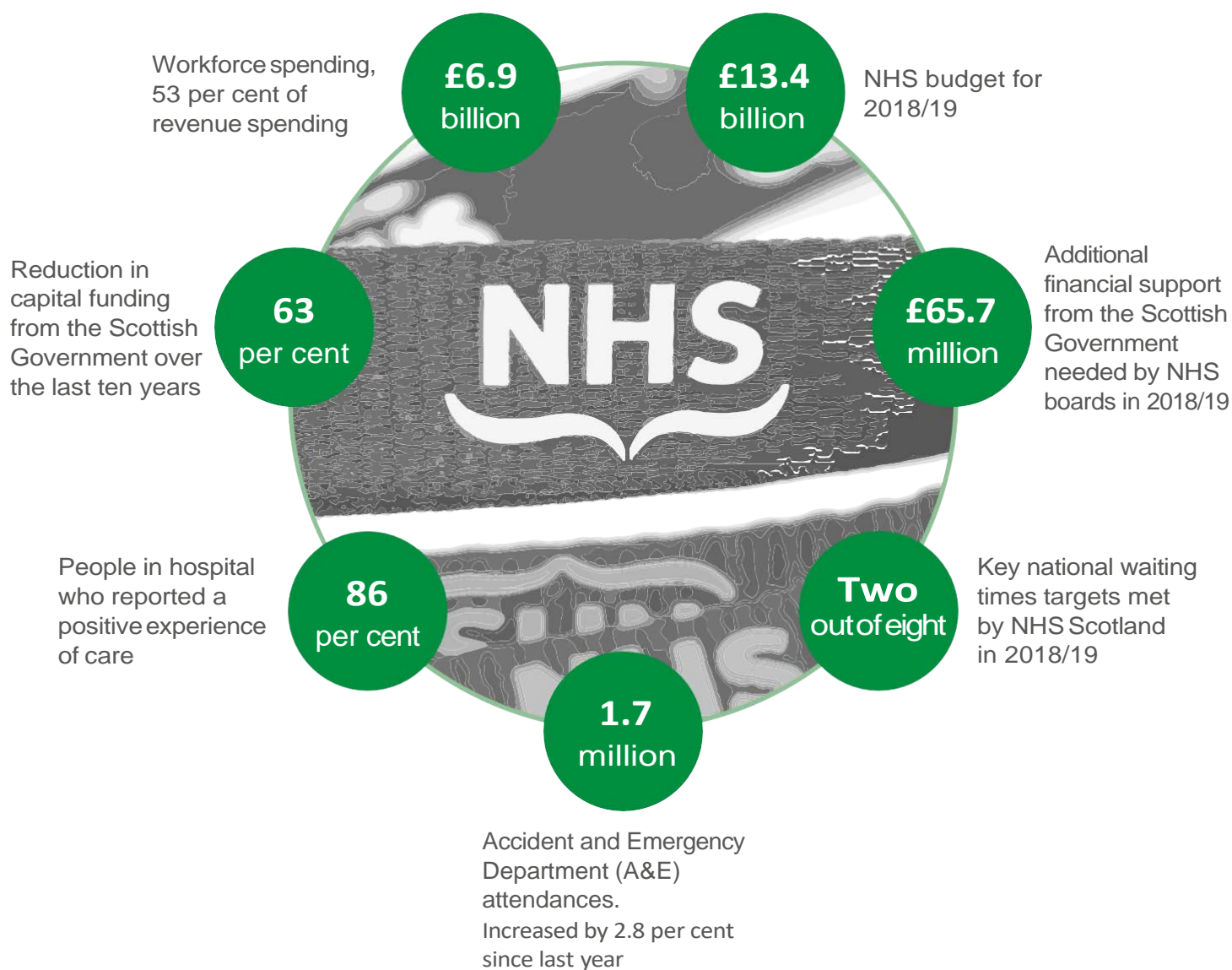
Key facts

£6.9 billion
Workforce spending, 53 per cent of revenue spending

£13.4 billion
NHS budget for 2018/19

63 per cent
Reduction in capital funding from the Scottish Government over the last ten years

£65.7 million
Additional financial support from the Scottish Government needed by NHS boards in 2018/19

86 per cent
People in hospital who reported a positive experience of care

Two out of eight
Key national waiting times targets met by NHS Scotland in 2018/19

1.7 million
Accident and Emergency Department (A&E) attendances. Increased by 2.8 per cent since last year

Summary

Key messages

1 Health remains the single biggest area of government spending, at £13.4 billion in 2018/19. This was 42 per cent of the 2018/19 Scottish Government budget and is growing. The healthcare system faces increasing pressure from rising demand and costs, and it has difficulty meeting key waiting times standards. Without reform, the Scottish Government predicts that there could be a £1.8 billion shortfall in the projected funding for health and social care of £18.8 billion by 2023/24. So far, the pace of change to address this, particularly through the integration of health and social care, has been too slow.

2 The Scottish Government has started to put in place foundations to support boards make the changes required. These include the publication of the *Health and Social Care: Medium-Term Financial Framework*, the *Waiting Times Improvement Plan* and the introduction of a national leadership development project. The new requirement for NHS boards to develop three-year financial and performance plans enables them to more effectively plan how services will be delivered in the longer term. It is, however, too soon to assess the impact of these initiatives.

3 Despite the existing pressures, patient safety and experience of hospital care continue to improve. Drugs costs have stabilised, and we have seen examples of new and innovative ways of delivering healthcare that involve a range of partners. These aim to increase the care provided in the community and expand multidisciplinary working, to improve access to care and treatment.

4 Achieving financial sustainability remains a major challenge for NHS boards. There have been increases in predicted deficits and additional financial support provided by the Scottish Government, and a continued reliance on one-off savings. Capital funding from the Scottish Government has decreased by 63 per cent over the last decade and the level of backlog maintenance remains high, at £914 million. High-profile, newly-built hospitals have come under significant scrutiny because of health and safety concerns.

5 The ambitions within the Scottish Government's 2020 Vision will not be achieved by 2020. The Scottish Government should work with NHS staff, partners and the public to develop its new strategy for health and social care. It should set out priorities that support large-scale, system-wide reform to increase the pace of change. Collaborative leadership is needed to focus on better partnership working, staff engagement and promoting positive workplace behaviours. Staff are at the heart of the NHS and it is vital that more is done to support them so that they can care for people in a safe, fulfilling and respectful environment.

Recommendations

The Scottish Government in partnership with NHS boards and integration authorities should:

- develop a new national health and social care strategy to run from 2020 that supports large-scale, system-wide reform, with clear priorities that identify the improvement activities most likely to achieve the reform needed

- develop and publish the national, integrated health and social care workforce plan and guidance, to inform future workforce planning

- improve the quality and availability of data and information, particularly in primary and community care. This will allow better performance monitoring, inform service redesign and improve care coordination by enhancing how patient information is shared across health and social care services

- incorporate the principles of the Community Empowerment Act within communication and engagement strategies.

The Scottish Government should:

- finalise and publish as a matter of urgency, the national capital investment strategy to ensure that capital funding is strategically prioritised

- report publicly on progress against the health and social care delivery plan. This should provide an update, and include measures of performance, on how services are being delivered differently to allow more people to be cared for closer to home

- develop a single annual staff survey that relates to behaviours, culture and staff experience, to identify areas for improvement and address behaviour that is contrary to NHS Scotland values.

The Scottish Government in partnership with NHS boards should:

- make sure that NHS boards' three-year plans are approved in time for the start of each financial year. The plans should be routinely managed and monitored and should include details of how boards intend to reduce their reliance on non-recurring savings

- ensure that the *NHS Scotland A Blueprint for Good Governance* is implemented in full and that areas for improvement are addressed, particularly around strengthening risk-management arrangements

- continue to monitor the effectiveness of the Scottish Government's NHS leadership development project and its impact on recruitment, retention and the support of senior healthcare leaders

- ensure that all NHS boards:

    – provide evidence that they actively promote positive workplace behaviours and encourage the reporting of bullying and harassment

    – have action plans in place to improve culture, address any issues identified and use the findings of the Sturrock review to inform their plans for cultural improvement.

Introduction

1. The NHS provides vital health services to the people of Scotland. People are living longer, many with chronic health conditions. There are greater expectations for the NHS to provide high-quality, timely and technologically advanced care. Pressures on the NHS in Scotland continue to be substantial and demand for services is at an all-time high. Between 2017/18 and 2018/19 the NHS in Scotland saw:

- an increase of 2.2 per cent in people waiting for outpatient appointments

- an increase of 2.8 per cent in Accident and Emergency Department (A&E) attendances

- an increase of 6.1 per cent in people waiting for inpatient appointments.

2. Wide-scale reform is necessary to address the increasing pressures on the NHS and reduce demand for acute services. The Scottish Government has had a long-term commitment to delivering care closer to home. To achieve this, the successful integration of health and social care is vital. Effective collaboration with community partners will support better planning, design and coordination of patient-focused care and services.

3. In 2018/19, the NHS in Scotland received £13.4 billion from the Scottish Government. This funding is needed to support the increasing cost of healthcare delivery and to meet national policy directives such as integration and reducing waiting times. *The Health and Social Care: Medium-Term Financial Framework* (MTFF), published in October 2018, sets out the reforms required to ensure the financial sustainability of the NHS in Scotland. Without reform the Scottish Government predicts that there will be an increase in spending across health and social care in Scotland to around £20.6 billion by 2023/24.

4. Despite the significant challenges, the NHS in Scotland has a committed workforce that continues to provide high-quality, safe care. There have been significant improvements in key patient safety indicators, such as mortality rates in hospital, and patients' experiences of healthcare has also improved.

5. This report provides an overview of the NHS in Scotland and the realities of delivering healthcare in Scotland. It draws on a wide range of intelligence, interviews and data, to help understand the context, challenges and performance. It sets out the financial performance of the NHS in 2018/19, and the financial outlook for 2019/20 and beyond. This includes the new approach to longer-term financial planning and the new MTFF, and progress towards achieving the objectives of the Health and Social Care Delivery Plan (HSCDP). We report on the workforce, leadership and culture, governance and performance against national targets.

Part 1
How the NHS in Scotland is performing

Key messages

1 The NHS budget for 2018/19 was £13.4 billion, an increase of one per cent in real terms since 2017/18. Four NHS boards required a total of £65.7 million in additional financial support from the Scottish Government to break even. The NHS achieved £390.4 million in savings, less than one per cent below its target, but remains reliant on one-off savings. Fifty per cent of all savings were non-recurring.

2 The Scottish Government has started to put in place foundations to support financial sustainability. The introduction of new three-year financial and performance plans and break-even arrangements is an important step towards more effective longer-term planning.

3 The NHS in Scotland is facing growing pressures from population changes and increasing costs of delivering healthcare. NHS boards and the Scottish Government have implemented a range of initiatives to manage these pressures. Some progress has been made. For example, spending on drugs has stabilised.

4 The NHS capital budget decreased by 63 per cent over the last decade. The level of backlog maintenance remains high, at £914 million, with nine per cent being classified as high risk. High-profile new builds have come under significant scrutiny because of health and safety concerns.

5 Patient safety is continuing to improve, with a significant reduction in hospital mortality rates. People's experience of hospital care is also improving. However, boards continue to struggle to meet key waiting times standards, with only two of eight national standards being met. But in seven of the eight standards, the number of people that were seen and treated on time increased. The Scottish Government has introduced several initiatives to improve access to care, such as the *Waiting Times Improvement Plan* (WTIP).

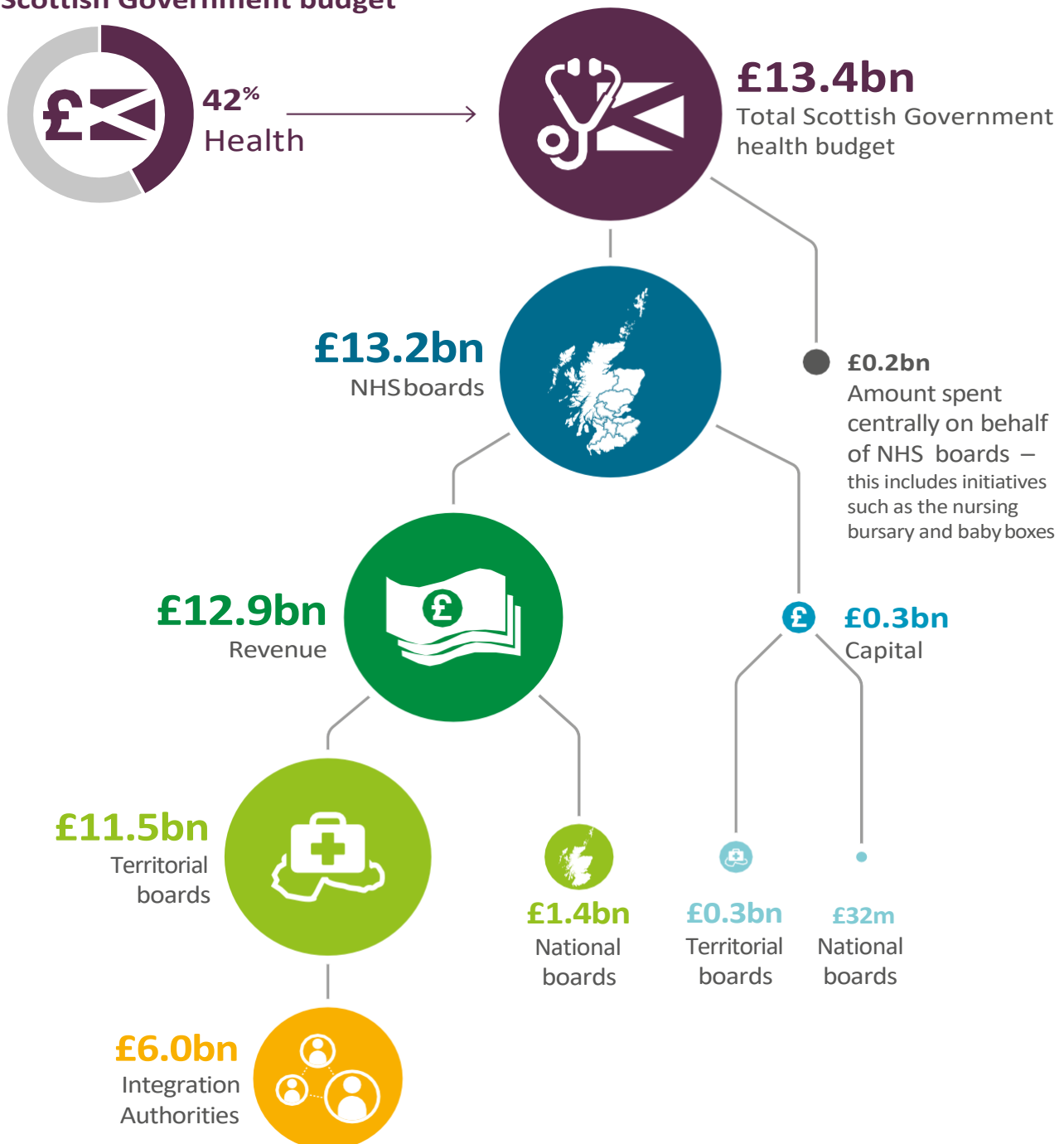### The NHS is starting to address some of its financial pressures, but major risks remain

6. In *NHS in Scotland 2018* , we reported that the NHS was not in a financially sustainable position. This meant that it was unlikely to be able to continue delivering services effectively or change how services are delivered with the available resources. NHS boards continue to struggle with financial pressures, which makes it harder to reform the health and social care system.

7. The Scottish Government health budget in 2018/19 was £13.4 billion. This was one per cent higher than the previous year, taking inflation into account. Of this, the amount allocated to NHS boards was £13.2 billion. The total revenue budget, for day-to-day spending, allocated to NHS boards was £12.9 billion. This has increased by 0.6 per cent in real terms since 2017/18 (Exhibit 1).

Exhibit 1
A breakdown of NHS funding in 2018/19

Scottish Government budget

42% Health

£13.4bn Total Scottish Government health budget

£13.2bn NHS boards

£0.2bn Amount spent centrally on behalf of NHS boards — this includes initiatives such as the nursing bursary and baby boxes

£12.9bn Revenue

£0.3bn Capital

£11.5bn Territorial boards

£1.4bn National boards

£0.3bn Territorial boards

£32m National boards

£6.0bn Integration Authorities

Source: Audit Scotland using NHS Consolidated Accounts

8. Health accounted for 42 per cent of the Scottish Government's budget in 2018/19. NHS boards delegate a significant proportion of their budgets to Integration Authorities (IAs) to fund health services such as primary and community care. In 2018/19, territorial boards delegated £6 billion to IAs, 52 per cent of their budget.

9. Over the last ten years, the health budget has increased by six per cent in real terms. Most of this increase has been in the last five years, with an increase of 5.8 per cent (Exhibit 2). Funding per head of population has increased at a slower rate. In 2018/19, health funding in Scotland was £2,471 per person. This compares to £2,424 in 2009/10, a two per cent increase in real terms.[1]

10. The Scottish Government's draft budget for 2019/20 states that health funding will increase to £14.2 billion, an increase of 5.4 per cent in cash terms. Revenue funding is planned to increase by 5.6 per cent and capital funding is set to decrease by 1.5 per cent in cash terms.[2]

Exhibit 2
Health funding trend since 2009/10
Health funding has increased in both real terms and cash terms since 2009/10.
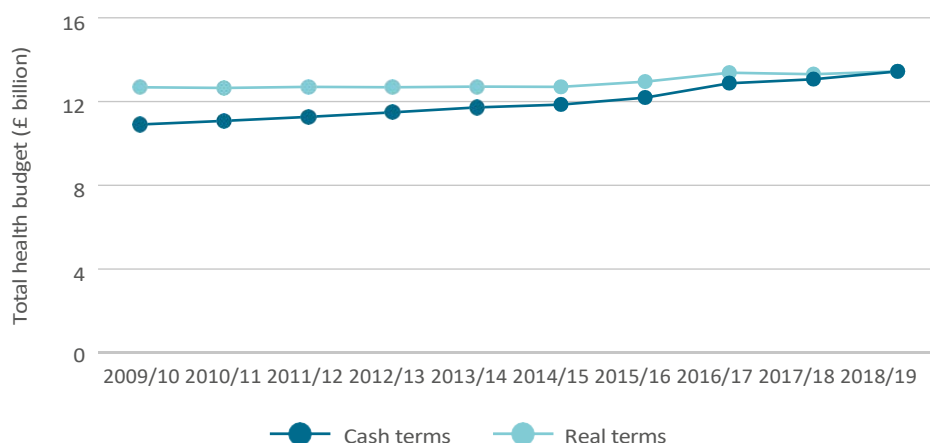
Source: Scottish Government budgets

Without ongoing reform, there could be a rise in spending across health and social care services to around £20.6 billion by 2023/24

11. Last year, we reported that the publication of the MTFF aimed to better address the financial challenges of integrating the delivery of health and social care services. The framework acknowledges that there will be increases in demand for services, workforce pay and the cost of delivering healthcare services. It predicts that without reform there will be a £1.8 billion shortfall in the projected funding of £18.8 billion by 2023/24.[3]

12. In 2016, the Scottish Government published its five-year **HSCDP** (i). It set some ambitious targets intended to drive the integration of health and social care across the NHS in Scotland to help achieve the 2020 Vision.[4] Last year, we recommended that the Scottish Government should publish a report on progress

Exhibit 13

A timeline of major Scottish Government health and social care policies and publications (page 31)

against the HSCDP. This has not yet been published and we recommend the Scottish Government do so as soon as possible. Further work is required to achieve the reform needed across health and social care. This work will not be completed in time to achieve the 2020 Vision.

13. NHS boards delegate funding to IAs for certain health services. This funding has increased each year since 2016/17, when IAs were established. In 2018/19, NHS territorial boards delegated 52 per cent of their budgets to IAs. This represents a 4.1 per cent increase in real terms from 2016/17.[5] IAs aim to shift spending and services from hospitals to community and social care. There is little evidence to date that this is happening.

At the beginning of 2018/19 the number of boards predicting a year-end deficit increased

14. Last year, we reported that the number of boards predicting year-end deficits had increased. These boards needed to make additional savings to offset any predicted overspend against their budget. There is a risk that boards will be unable to break even and will require additional financial support from the Scottish Government:

- In 2015/16, all territorial NHS boards predicted that they would break even or record a surplus by the end of the year.

- By 2016/17, three territorial boards predicted a year-end deficit, which increased to seven in 2017/18 and nine in 2018/19.

- The number of boards that required additional financial support from the Scottish Government, to break even at year end, were: one (2016/17), three (2017/18) and four (2018/19).

- The size of the predicted deficit also increased for 2018/19, from £99 million to £150 million, but decreased to £116 million for 2019/20. For 2021/22, however, the deficit is predicted to be significantly larger, at £207 million. Most of this deficit relates to NHS Lothian, which predicts a deficit of almost £90 million, and NHS Greater Glasgow and Clyde, which predicts a deficit of £61.5 million.[6]

The NHS in Scotland met its financial targets in 2018/19, but required £65.7 million in additional financial support from the Scottish Government to achieve this

15. In 2018/19, all NHS boards broke even, staying within the limits of their revenue and capital budgets, and delivered a surplus of £4.6 million.[7] However, this was only possible because four boards received additional financial support from the Scottish Government, totalling £65.7 million.[8] This was an increase from £50.7 million in 2017/18, but was £8.8 million lower than initially forecast. The four boards that required additional support were:

- NHS Ayrshire and Arran – £20 million

- NHS Borders – £10.1 million

- NHS Highland – £18 million

- NHS Tayside – £17.6 million.

16. The Scottish Government announced that territorial boards would not have to repay any outstanding loans owed at the end of 2018/19. This totalled almost £150 million.[9] It is unclear what the Scottish Government's approach will be if boards require additional financial support in future years.

The NHS almost achieved its savings target for 2018/19, but remains reliant on one-off savings

17. In 2018/19, the NHS achieved £390.4 million in savings. This was 0.3 per cent below its savings target of £391.1 million. This was a significant improvement compared with the previous year, when it achieved savings seven per cent below its target of £480.8 million. Exhibit 3 shows the savings achieved against targets for all NHS boards.

Exhibit 3
Savings achieved against targets in 2018/19
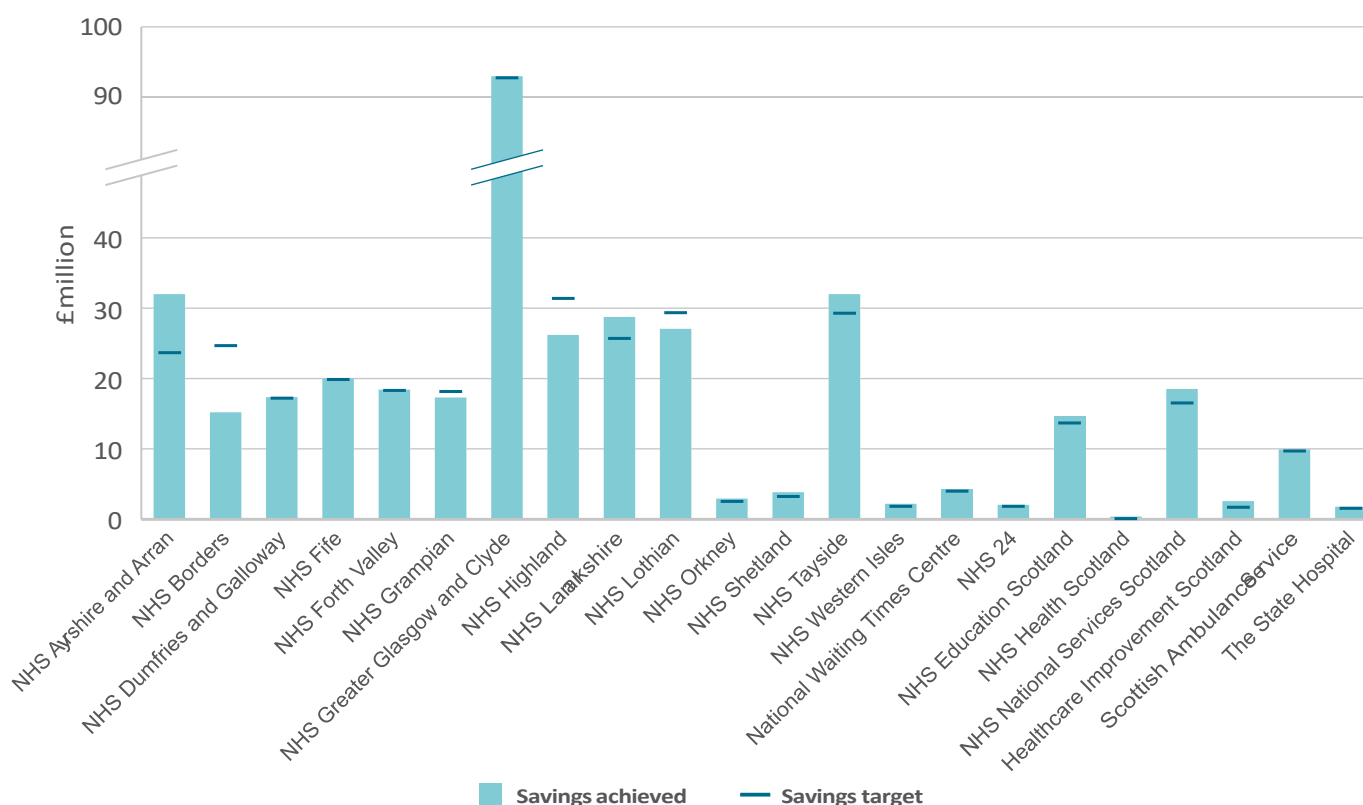
Source: NHS boards' annual audit reports and financial performance reports, 2019

18. In 2018/19, 50 per cent of all savings were non-recurring, up from 35 per cent in 2016/17. Non-recurring savings are not sustainable. They can improve a board's in-year financial position, but they do not reduce the cost of running the organisation and cannot necessarily be repeated in subsequent years. An example of a non-recurring saving is delaying recruitment for a vacant position. Recurring savings can be made in one year and can continue to save money in future years, for example by changing the way a service is delivered, to become more efficient. Boards varied significantly in their reliance on non-recurring savings, with territorial boards being more reliant than national boards (Exhibit 4, page 13).

Exhibit 4
The percentage of savings achieved that were non-recurring in 2018/19
Boards varied significantly in their reliance on non-recurring savings.
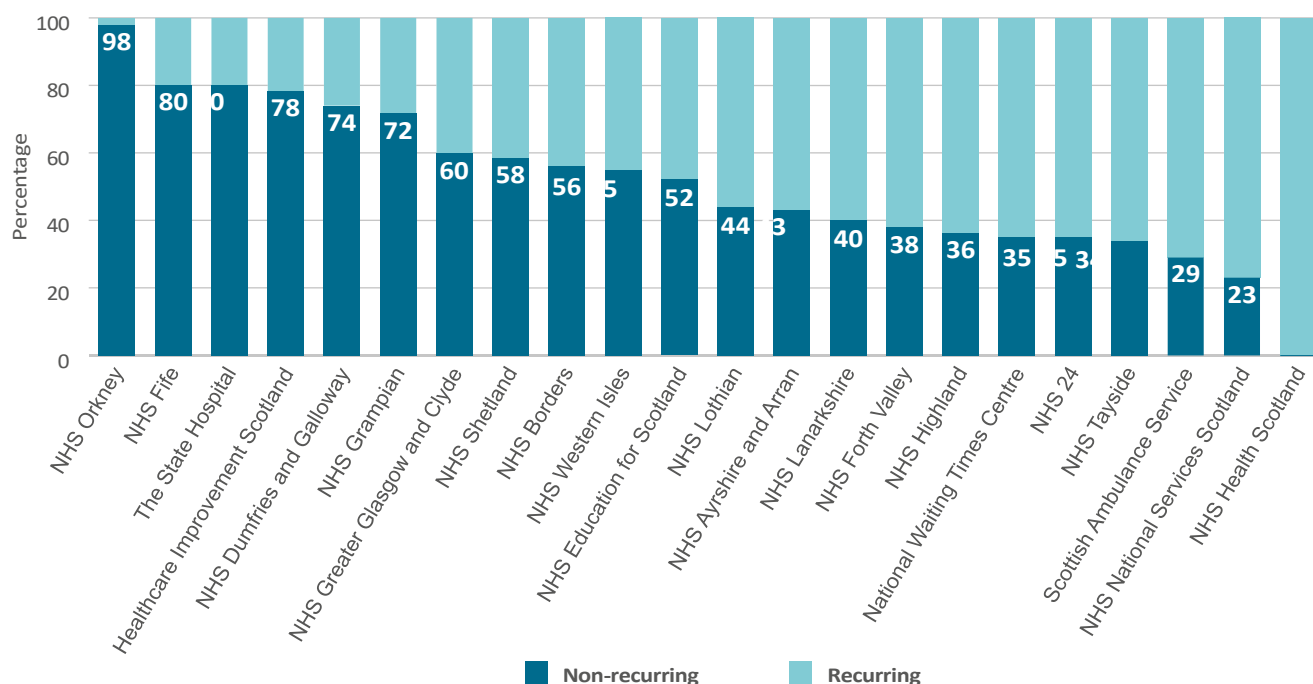
Source: Audit Scotland using annual audit reports and month-13 financial performance reports

The level of planned savings that are high risk has increased

19. In their annual plans for 2018/19, NHS boards categorised their planned savings as high, medium or low risk, depending on the likelihood that the savings would be realised. In 2018/19, the NHS in Scotland classified their planned savings as follows:

- 32.0 per cent as high risk

- 28.5 per cent as medium risk

- 39.5 per cent as low risk.

20. The proportion of high-risk savings was significantly higher in 2018/19 than in previous years (13.1 per cent in 2017/18). There was wide variation among boards. For example, NHS Greater Glasgow and Clyde classified all its planned savings as high risk, which had a significant impact on the total proportion of savings classified as high risk.

21. However, NHS boards vary in how they assess savings. For example, only some boards include unidentified savings as high risk. To improve transparency and consistency, NHS boards should ensure that any unidentified savings are classified as high risk.

Boards were able to better identify where future savings will come from

22. There was a significant improvement in the proportion of unidentified savings in boards' plans for 2018/19. Last year, boards were unable to identify where 28 per cent of planned savings would come from. This year, nine per cent of required savings were not yet identified in boards' plans, a reduction of 19 percentage points (Exhibit 5, page 14).

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Exhibit 5
Trends in unidentified planned savings, 2013/14 to 2018/19
The level of unidentified savings in all boards' plans decreased significantly in 2018/19.
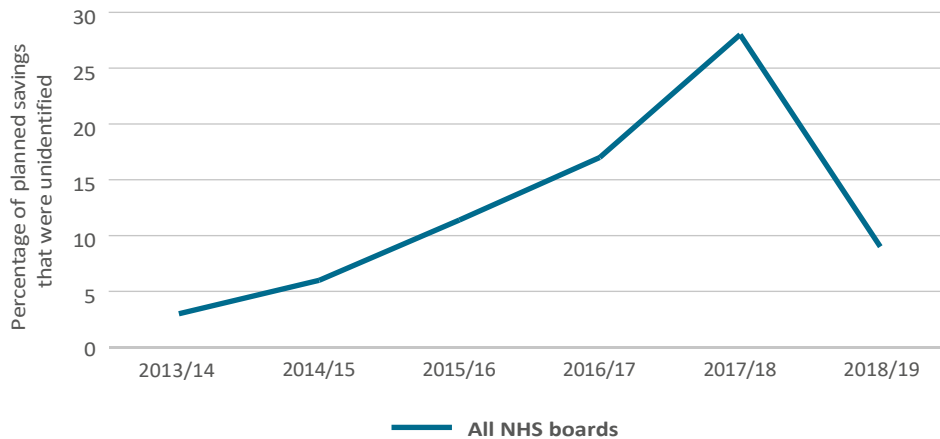
All NHS boards

Source: Audit Scotland using NHS boards' local delivery plans/annual operational plans 2013/14 to 2018/19

The Scottish Government has started to put in place the foundations to support financial sustainability

23. In October 2018, the Scottish Government published its MTFF. This was an important step towards supporting improvements to achieve financial sustainability of the NHS in Scotland. It outlines the scale of the financial challenges ahead and acknowledges that reform is necessary if the NHS is to be sustainable.

24. The MTFF sets out the activities required to support the reform needed. It also sets out the intention to invest more in primary, community and social care. The aim is for approximately 50 per cent of savings released from the hospital sector to be redirected to these areas through:

- increases in efficiency savings

- reductions in attendances at A&E, and the numbers of inpatients and outpatients

- regional working and public health prevention strategies.

25. Alongside the publication of the MTFF, the Scottish Government announced that boards will no longer be required to break even at the end of each financial year. Instead, they will be required to break even over a three-year period. This should provide greater flexibility in planning and investing over the medium to longer term.

26. NHS boards were required to produce three-year financial plans for the first time for 2019/20. This is an important step towards the NHS developing more effective longer-term planning. The Scottish Government developed guidance with boards to support the development of these plans, but this was not released until late February 2019. This gave them limited time to develop plans before the start of the financial year in April, and some were not approved until August 2019.

27. The Scottish Government held briefing sessions for boards during September 2019 and intends to release guidance in December 2019, to support them in developing next year's plans. In the first year of this new approach to financial planning, most boards included some information for the next three years, but the level of detail provided varied. Some boards, including NHS Borders and NHS Lanarkshire, did not include full details for all three years.

28. We expect the level of detail in boards' financial plans to improve next year, following the release of further guidance by the Scottish Government. The Scottish Government and NHS boards should work together to make sure that plans are in place and approved in time for the start of each financial year.

Five boards are receiving external support because they are struggling to meet financial and performance targets

29. The Scottish Government has a five-stage escalation process to provide boards with additional support when they are unable to meet financial or performance targets. Most boards are at stage one, which means that they are deemed to be performing steadily and are reporting normally. Stage five means that the Scottish Government deems that a board's organisational structure is unable to deliver effective care. Case study 1 and Case study 2 (page 16) describe the external support being provided to help two boards achieve financial balance. At October 2019, no boards were at stage five, but **five boards were at stage three or four** ⓘ.

ⓘ

Escalation at October 2019:

Stage three:
– NHS Ayrshire and Arran
– NHS Lothian

Stage four:
– NHS Borders
– NHS Highland
– NHS Tayside

Case study 1

NHS Borders receives external support to help it achieve financial balance

In November 2018, NHS Borders moved to escalation stage four in the Scottish Government's performance escalation framework. Boards at stage four face a significant risk to service delivery, quality, financial performance or safety, and senior-level external support is required.

In 2018/19, the board was unable to achieve financial balance and needed £10.1 million in additional financial support from the Scottish Government to break even. This was mainly to alleviate cost pressures at the Borders General Hospital and offset efficiency savings that were not achieved.

The Scottish Government Health and Social Care Directorate Board Recovery Team has been providing support since December 2018. NHS Borders created a new Financial Turnaround Programme to replace its previous transformation programme. The programme aims to achieve a more sustainable improvement in the board's finances. The Financial Turnaround Programme is in its early stage, and its success will depend on the pace of change and the resources made available.

The board has also developed a new project management office (PMO) structure. In the short term, the PMO director will be supported by a turnaround team with experience of successfully delivering similar financial recovery programmes elsewhere.

Source: Audit Scotland, 2019

Case study 2

NHS Ayrshire and Arran is further developing its improvement plan

In October 2018, the Auditor General published a report to draw Parliament's attention to the scale of the challenge that NHS Ayrshire and Arran was facing in meeting its financial targets. The report concluded that some of the cost pressures were not wholly within the control of the board, such as pay increases and the apprenticeship levy. However, the board's operating costs remained too high.

In 2017/18, PwC reviewed NHS Ayrshire and Arran's Transformational Change Improvement Plan (TCIP). It found that the TCIP was not substantial enough to achieve long-term financial sustainability and that greater transformational change would be required. During 2018/19, the PMO strengthened the governance and oversight of the TCIP. The board's internal auditors concluded that this provided only a partial level of assurance for the board and made several recommendations. These focused on improving governance for the implementation of the plan and a better understanding of dependencies between specific projects. Progress is reported regularly to the Corporate Management Team and the Performance Governance Committee.

In 2018/19, the board needed to make savings of £23.8 million. To support this, 143 improvement initiatives were identified. These initiatives achieved recurring savings of £18.4 million. This was £3.7 million more than in 2017/18. The board achieved £32 million of savings in total. Work will continue to implement the recommendations of the internal audit review, to improve the success of the TCIP in achieving recurring savings.

Source: Deloitte, 2019

Capital funding from the Scottish Government has decreased by 63 per cent over the last decade, and there are signs of strain

30. The NHS capital budget, that is, money for new buildings and equipment, can fluctuate as new projects are approved or completed. There has been a trend of reducing funding over the last decade. In 2018/19, capital funding from the Scottish Government was £334 million, a reduction of 63 per cent in real terms since 2009/10 .

31. Demand for capital funding outweighs what is available for the next two years. This will limit boards' ability to invest in their infrastructure. The Scottish Government is prioritising several infrastructure investments over the next two years. These include:

- an elective centres programme to create additional procedural and diagnostic capacity across Scotland[10]

- the new Baird Family Hospital and the Anchor Centre at Foresterhill Campus in Aberdeen

- new community hospitals in Aviemore and Broadford

- the replacement of St Brendan's Hospital, Barra, with a new health and social care hub.

32. NHS boards can use their revenue budget, which is allocated for day-to-day spending, to support additional capital investment. One way of doing this is to enter into contracts where the private sector finances the initial construction costs for the buildings and maintains them for a specific period, usually 25-30 years. NHS boards make annual payments from their revenue budgets for the length of the contract. Investment in these types of projects across the public sector in Scotland will be covered in more detail in our upcoming report on revenue funding of assets.

Exhibit 6
Capital funding from the Scottish Government since 2009/10
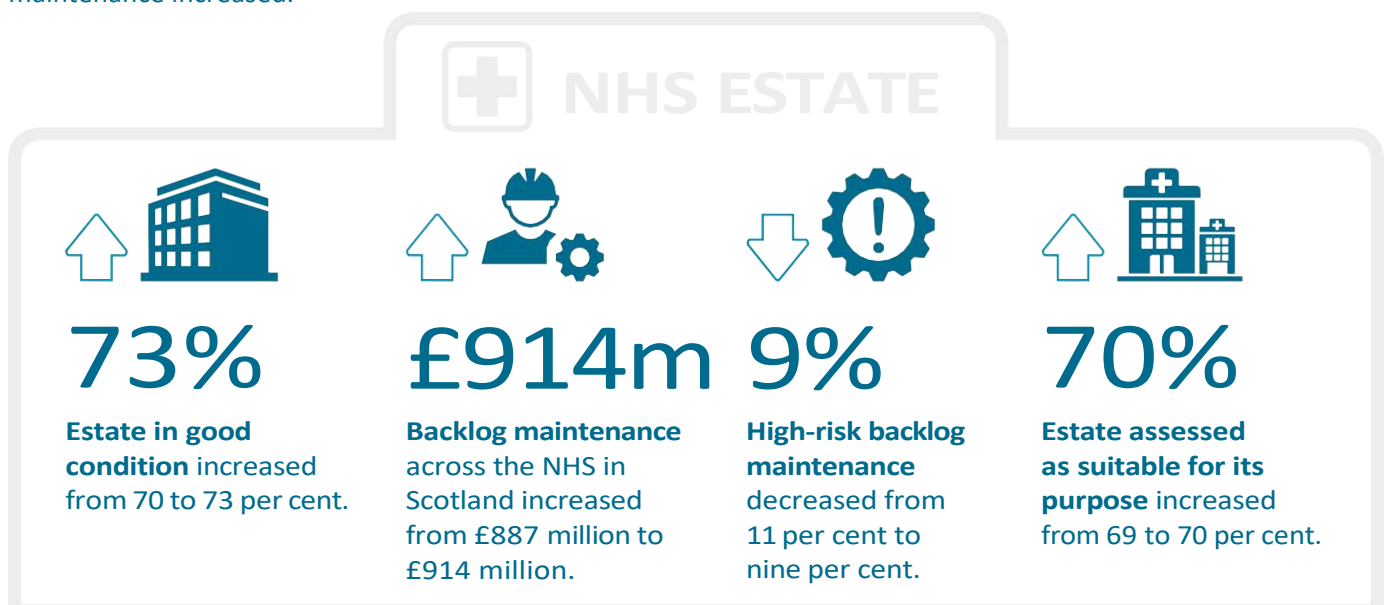Capital funding has decreased in real terms.
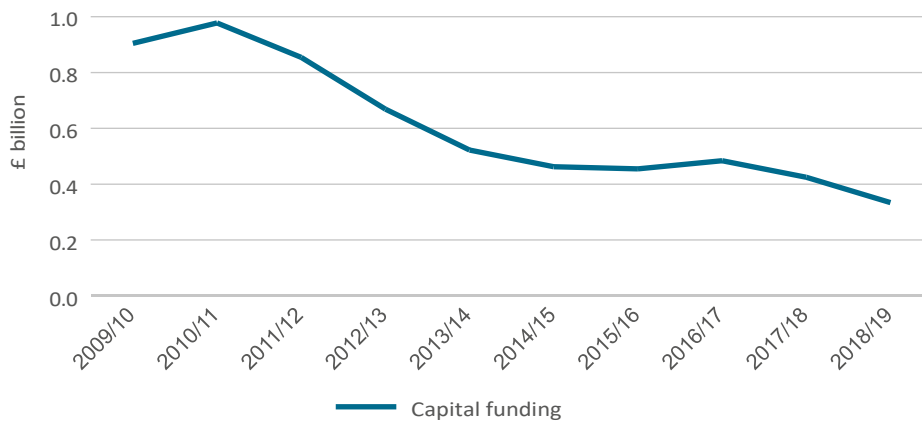
Source: Audit Scotland using NHS Consolidated Accounts

33. The condition of the NHS estate has improved, but there is still a significant maintenance backlog (Exhibit 7). Nine per cent of the backlog is classified as high risk, the majority of which (55 per cent) relates to electrical work required at Ninewells hospital in NHS Tayside. The Scottish Government has committed to fund the work required to resolve this. As recommended in _NHS in Scotland 2018_ , ⊕ the Scottish Government has been developing a national capital investment strategy to ensure that capital funding is strategically prioritised. This strategy should be finalised and published as a matter of urgency.

Exhibit 7
The condition of the NHS estate 2016 to 2018
The condition of the NHS estate has improved slightly over the last three years, but the level of backlog maintenance increased.

NHS ESTATE

73%
Estate in good condition increased from 70 to 73 per cent.

£914m
Backlog maintenance across the NHS in Scotland increased from £887 million to £914 million.

9%
High-risk backlog maintenance decreased from 11 per cent to nine per cent.

70%
Estate assessed as suitable for its purpose increased from 69 to 70 per cent.

Source: Scottish Government, 2019

Major capital projects face significant challenges

34. New hospitals have recently been built in Glasgow and Edinburgh. These major new-build projects have come under considerable scrutiny as a result of significant health and safety concerns (Case study 3 and Case study 4, page 18). In September 2019, the Scottish Government committed to carrying out a public inquiry into the issues at the Queen Elizabeth University Hospital in Glasgow and the Royal Hospital for Children and Young People in Edinburgh. The inquiry will look at how the problems with the ventilation systems happened, and what steps can be taken to prevent these problems in future. It is essential that the Scottish Government and NHS boards learn from these projects when planning new healthcare facilities.

35. Delays in opening a new healthcare facility can mean that an older site must be operational for longer than expected. This can result in additional expenditure to make sure that the older site remains fit for purpose for longer. In these circumstances, the relevant NHS board and the Scottish Government should provide assurance that any risks to patient and staff safety have been addressed.

Case study 3

Queen Elizabeth University Hospital, Glasgow

In January 2019, Healthcare Improvement Scotland carried out an unannounced inspection of the Queen Elizabeth University Hospital, including the Institute of Neurosciences and the Royal Hospital for Children. The focus of the inspection was infection control, specifically considering the following standards:

- leadership in the prevention and control of infection

- infection prevention and control policies, procedures and guidance

- decontamination.

The inspection report published in March 2019 included 14 requirements and one recommendation. Nine of these were classed as urgent and had to be implemented within one week. The board developed an improvement plan to address the inspection findings.

The Cabinet Secretary for Health and Sport has also commissioned an independent review of the Queen Elizabeth University Hospital. As well as covering the infection control issues, this review will consider:

- the design of buildings

- the process for commissioning and constructing new healthcare facilities

- the scale of health problems acquired from the healthcare environment

- wider implications for healthcare facilities across Scotland.

The independent review is in its early stages. Two chairs have been appointed, and the terms of reference are under development. There is no timescale for the review to be completed or published.

Source: *Unnanounced Inspection Report – Safety and Cleanliness of Hospitals, Queen Elizabeth University Hospital (including Institute of Neurosciences and Royal Hospital for Children)*, Healthcare Improvement Scotland, 2019; Scottish Government, 2019

Case study 4

Royal Hospital for Children and Young People, Edinburgh

The opening of the new Royal Hospital for Children and Young People (RHCYP) in Edinburgh was delayed after final safety checks of the building found that the ventilation system in the critical care department did not meet national standards.

NHS National Services Scotland (NSS) reviewed all buildings systems in the new hospital that could have health and safety implications for patients and staff. The review assessed the water, ventilation and drainage systems and set out a timeframe for the opening of the hospital. NSS will also assess all current and recently completed new-builds and major refurbishments, to provide assurance that they comply with national standards.

KPMG carried out an independent review of the governance arrangements for the RHCYP. It identified the factors that led to the decision to delay the move to the new hospital, including communication and timescales. It found that a document produced by NHS Lothian during the tender stage of the project in 2012 was inconsistent with guidance, and that opportunities to rectify the error were missed. It also found that there was confusion over the interpretation of technical guidance and standards.

The Scottish Government has asked NHS Lothian to develop a recovery plan with clear milestones and responsibilities. The Cabinet Secretary for Health and Sport also announced that a package of tailored support measures would be made available to the board to support improvements.

Source: Scottish Government, 2019; *Review of: water, ventilation, drainage and plumbing systems*, NHS National Services Scotland, 2019; *Independent assessment of governance arrangements*, NHS National Services Scotland and KPMG, 2019

The NHS in Scotland is facing significant pressures from population changes and increasing demand for services

36. Certain factors, such as demographic changes, rurality and deprivation, can affect demand for services and can make it more costly for boards to deliver services. The Scottish Government uses a formula developed by the NHS Scotland Resource Allocation Committee (NRAC) to assess how much funding each board should be allocated. The NRAC formula considers the demographics of each board area, including population size, deprivation levels and unavoidable geographical variations in the cost of providing services.

37. In 2018/19, all NHS boards received allocations within 0.8 per cent of what the NRAC formula determined they should receive, known as parity.[11] This was an improvement from the previous year, where all boards received allocations within one per cent of parity. This required an additional £30 million investment. To maintain this position for 2019/20, £23 million additional investment was required.[12]

38. NHS Highland was the only board to move slightly further from parity in 2018/19, moving from 0.7 per cent below parity in 2017/18 to 0.8 per cent. NHS Western Isles has historically received an allocation that was significantly above parity; in 2018/19, it was 11.3 per cent above.

39. In 2018/19, demand for hospital care continued to grow with increases in attendances at A&E and the number of people waiting for inpatient and outpatient appointments. At the same time, more people were admitted to hospital for both emergency and planned care, and on average, their stay in hospital was slightly shorter than in 2017/18. The average length of stay in hospital reduced from 6.2 days in 2017/18 to 6.0 days in 2018/19, despite increases in delayed

discharges. Fewer operations were cancelled and there was a small increase in the number of outpatient appointments held, following significant decreases in 2017/18. Exhibit 8 (page 21) shows national trends across selected indicators of demand and activity for acute services in 2018/19. The quality and availability of health and social care data need to improve. This will help boards better understand the reasons for trends in demand and activity and how to make best use of existing capacity.

40. We have consistently reported the lack of data and information available to measure performance and outcomes, especially in primary and community care. It is crucial that this is addressed as a matter of urgency. The establishment of Public Health Scotland is another opportunity to provide boards with more useful data from across the health and social care system. This will allow NHS boards and IAs to make informed decisions when planning and designing services.

41. The Scottish Government has committed to increasing investment in primary care by £500 million by 2021/22. This should provide at least £1.28 billion by 2021/22 to support the new GP contract and primary care reform. This aims to free up capacity in acute hospitals to reduce waiting times and improve access to services. In addition, a whole-system partnership programme to reform adult social care started in June 2019. This work is being carried out in partnership with people with lived experience of social care, unpaid carers and people who deliver the services. The programme aims to create additional capacity in the community to better meet the needs of people, their carers and the workforce.

Boards continue to struggle to achieve key national standards

42. The NHS in Scotland met two of the eight key national waiting times standards in 2018/19 (Exhibit 9, page 22). This is a small improvement from 2017/18, when the NHS met only the drug and alcohol waiting times standard. The standards that were met were:
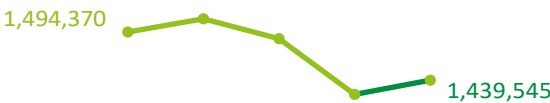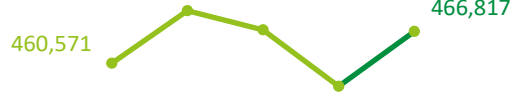
- patients starting cancer treatment within 31 days (decision to treatment)

- drug and alcohol patients seen within three weeks.

43. National performance declined for six out of the eight standards in 2018/19. Performance improved for outpatients waiting less than 12 weeks following first referral and for patients starting cancer treatment within 31 days of the decision to treat. Appendix 1 (page 42) shows performance against the national standards by NHS board for 2018/19, including the percentage change since the previous year and over the last five years.

44. It is important to acknowledge the impact of rising demand on waiting times. In 2018/19, the number of people seen on time increased for seven of the eight standards. This means that the waiting times targets were met for more people in 2018/19 than in 2017/18. However, demand for services increased at a higher rate, so the percentage of people for whom the targets were met declined.

Exhibit 8
National trends in demand and activity for acute services in 2018/19

Demand	Trend 2014/15– 2018/19		Change since 2017/18
Number waiting for outpatient appointment	255,061 → 311,503	↑ 22.1% since 2014/15	↑ 2.2%
Number waiting for inpatient appointment	55,973 → 76,832	↑ 37.3% since 2014/15	↑ 6.1%
A&E attendances	1,639,991 → 1,691,952	↑ 3.2% since 2014/15	↑ 2.8%
Activity			
New outpatient attendances	1,494,370 → 1,439,545	↓ 3.7% since 2014/15	↑ 1.1%
Return outpatient attendances	3,035,662 → 2,848,272	↓ 6.2% since 2014/15	↑ 0.9%
Emergency admissions	576,328 → 593,543	↑ 3.0% since 2014/15	→ 0.0%
Daycase admissions	460,571 → 466,817	↑ 1.4% since 2014/15	↑ 2.4%
Elective admissions	186,055 → 146,365	↓ 21.3% since 2014/15	↓ -2.8%
Number of procedures	1,465,847 → 1,440,249	↓ 1.7% since 2014/15	→ 0.0%
Trend 2016/17 – 2018/19			
Cancelled planned operations	7,288 → 6,788	↓ 6.9% since 2016/17	↓ -16.4%
Bed days occupied by delayed discharges	408,351 → 420,157	↑ 2.9% since 2016/17	↑ 9.0%

Note: 'Number waiting for outpatient appointment' and 'Number waiting for inpatient appointment' refer to the number of patients on the waiting list at the end of March in each year. 'Cancelled planned operations' refer to operations that have been cancelled for capacity or non-clinical reasons. The definition of bed days occupied by delayed discharges changed in June 2016, so the 2016/17 figure has been adjusted for comparability with subsequent years.

Source: Accident & Emergency Activity and Waiting Times Statistics, ISD Scotland, September 2019; Number on inpatient waiting list, ISD Scotland, August 2019; Number on new outpatient waiting list, ISD Scotland, August 2019; Cancelled planned operations, ISD Scotland, September 2019; Bed days occupied by delayed discharges, ISD Scotland, September 2019; Annual acute hospital activity and hospital beds, ISD Scotland, September 2019

Exhibit 9

NHS Scotland performance against key national waiting times standards, 2017/18 to 2018/19

NHS Scotland met two of the eight waiting times standards in 2018/19.

Performance %

2017/18 2018/19 Standard

Measure

⊘ **Standard met**

0   20   40   60   80   100

Change in the number of people seen on time 2017/18–18/19

👤 Number of people seen on time 2018/19

18 weeks referral to treatment time
↑ **0.8%**
👤 944,630

A&E attendees seen within 4 hours
↑ **1.8%**
👤 1,543,558

CAMHS patients seen within 18 weeks
↑ **8.7%**
👤 12,504

Day case or inpatients who waited less than 12 weeks for treatment
↓ **-8.1%**
👤 202,994

Drug and alcohol patients seen within 3 weeks
↑ **2.5%**
👤 42,323

Outpatients waiting less than 12 weeks following first referral
↑ **3.3%**
👤 237,029

Patients starting cancer treatment within 31 days (decision to treatment)
↑ **7.2%**
👤 23,815

Patients starting cancer treatment within 62 days (referral to treatment)
↑ **4.0%**
👤 12,312

Note: Figures are annual aggregated performance figures for all standards, apart from 'Outpatients waiting less than 12 weeks following first referral' (census date at 31 March 2018 and 31 March 2019). CAMHS = child and adolescent mental health services.

Source: See Appendix 3 for sources

The Scottish Government and NHS boards have recently introduced initiatives that aim to improve access to care

45. The Scottish Government has been working to improve waiting times and, in October 2018, introduced the WTIP.[13] The Scottish Government is investing more than £850 million over two and a half years. Of this, £535 million will be spent on frontline services and £320 million on capital projects.

46. As part of the WTIP, the Scottish Government introduced new monitoring arrangements for NHS boards that require them to report quarterly on their performance. This enables the Scottish Government to hold boards to account and to provide additional support to those that are not on track to meet their phased improvement goals. So far, £102 million of WTIP funding has been allocated for 2019/20. It is too soon to assess whether this additional funding will help boards to meet the phased improvement goals set out in the WTIP.

47. The Scottish Government has also developed a national independent-sector contract to provide additional capacity and reduce waiting times. This contract is designed to cap private-sector charges for treatment. It is planned to be used as a short-term measure, while elective centres are being set up.

48. The National Theatre Productivity Group is a collaboration between the National Waiting Times Centre (NWTC) and some NHS territorial boards. They are working together to share good practice and introduce new ways of working, to improve efficiency and reduce waiting times. At a recent event, the Golden Jubilee Hospital shared information about an initiative to reduce patient waiting times for cataract surgery. This work focused on improving theatre use by calling patients from a pre-assessment clinic to fill late cancellations. NWTC reported that on average, around 18 per cent of patients who cancelled late were replaced with other patients. There has been very positive feedback from patients. This is a model that has clinical support, has been approved by the General Medical Council and has the potential to be tested in other specialties.

Inpatients' experiences of care and patient safety are improving

49. In 2018, the Scottish Government published its report on a survey of inpatients' experiences of quality of care.[14] It showed that 86 per cent of inpatients had a positive experience of care, an improvement of two percentage points since 2016. There was a consistent picture of positive experience in many areas.

50. Results in relation to arrangements for leaving hospital remained consistent, with 78 per cent of inpatients rating this experience as good or excellent. Only 30 per cent of people reported being delayed on the day of leaving hospital, an improvement of nine percentage points since 2016. The most common reason for such delays continued to be waiting for medications.

Patient safety is improving across a range of measures

51. Despite the financial and demand challenges, staff are working hard across all health and social care settings to provide safe, high-quality care. Recently published data on the NHS Performs website shows improvement across a range of indicators over the past ten years. The Scottish Patient Safety Programme, established in 2008, has successfully improved patient safety.[15] This programme has contributed to the following significant reductions:

- Post-surgical mortality rates have decreased by 36.6 per cent since 2008, following the introduction of the World Health Organization Surgical Safety Checklist.[16] The checklist promotes a culture of teamwork and communication in operating theatres, helping to improve surgical care and safety.

- The number of deaths from sepsis has been reduced by introducing a structured response to, and treatment of, sepsis. Since its launch in 2012, the sepsis programme has contributed to a 21 per cent reduction in mortality rates.[17]

- The Hospital Standardised Mortality Ratio for Scotland has decreased by 14 per cent since 2014 because of improvements in the recognition of, and response to, acutely unwell patients. This means that the number of recorded deaths decreased compared to the number of deaths predicted.

52. In November 2016, the Scottish Ambulance Service (SAS) introduced a new system to prioritise patients. To create the system, over half a million 999 incidents were reviewed to determine what factors had the biggest impact on patient outcomes. This new system better prioritised incidents and matched the timing and type of ambulance response to the needs of the patient. In its first year of operation, there was a 43 per cent improvement in 30-day survival rates for patients in the most urgent category.

53. Minimising healthcare associated infections is a priority for the NHS. It has achieved consistent improvement in two key measures – Clostridium difficile (C. diff) infection rate and meticillin-resistant Staphylococcus aureus (MRSA)- associated bacteraemia rate. Between 2014 and 2018, a decreasing year-on-year trend has been seen in the incidence rate of:

- C. diff, which has decreased by 7.5 per cent in patients 15 years and older

- MRSA, which has decreased by 17.1 per cent between 2014 and 2018.[18]
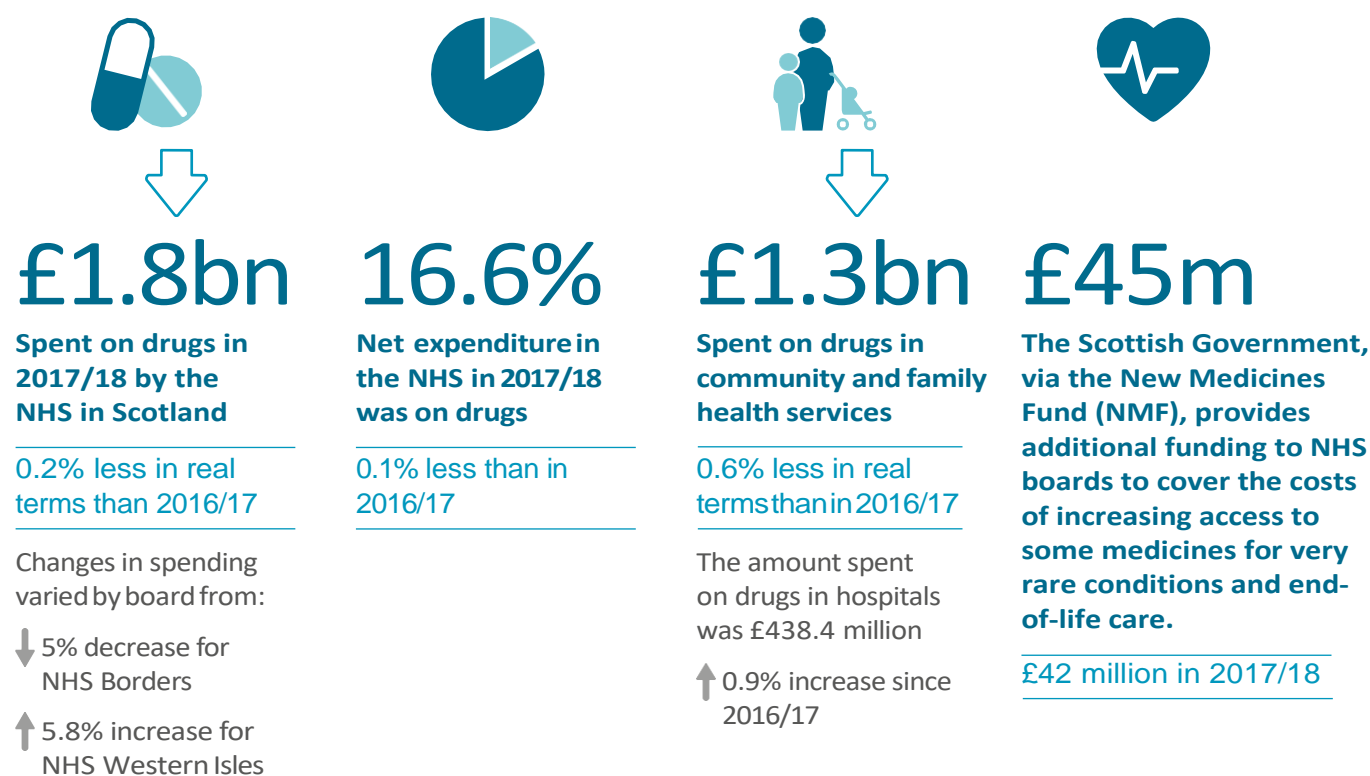
The amount spent on drugs stabilised in 2017/18

NHS boards and the Scottish Government have implemented a range of initiatives to manage prescription costs

54. The NHS in Scotland spent almost £1.8 billion on drugs in 2017/18, a reduction of 0.2 per cent in real terms since 2016/17 (Exhibit 10, page 25). Good progress continues to be made in the proportion of generic medicines prescribed. This increased from 83.9 per cent in 2017/18 to 84.3 per cent in 2018/19.[19] Generic medicine is usually cheaper, sometimes significantly, compared to branded medicine. Some initiatives that boards have been working on include:

- increasing the use of generic medicines in secondary care

- reducing the amount of drugs dispensed in primary care by more regularly reviewing the medicines that are being prescribed

- switching from high-cost drugs to cheaper alternatives that are chemically similar to the original drugs and close enough to achieve the same results. These are referred to as biosimilars.

Exhibit 10
Expenditure on drugs stabilised in real terms, in 2017/18

£1.8bn

Spent on drugs in 2017/18 by the NHS in Scotland

0.2% less in real terms than 2016/17

Changes in spending varied by board from:

↓ 5% decrease for NHS Borders

↑ 5.8% increase for NHS Western Isles

16.6%

Net expenditure in the NHS in 2017/18 was on drugs

0.1% less than in 2016/17

£1.3bn

Spent on drugs in community and family health services

0.6% less in real terms than in 2016/17

The amount spent on drugs in hospitals was £438.4 million

↑ 0.9% increase since 2016/17

£45m

The Scottish Government, via the New Medicines Fund (NMF), provides additional funding to NHS boards to cover the costs of increasing access to some medicines for very rare conditions and end-of-life care.

£42 million in 2017/18

Source: R600: pharmacy – drugs expenditure, ISD Scotland costbook data, November 2018; Volume and Cost (NHS Scotland), ISD Scotland, July 2019; Scottish Government NHS allocations, March 2019

55. Ten boards have reduced their expenditure on drugs in real terms. An example of a successful approach for reducing drug expenditure is the three-year medicines' efficiency programme launched by NHS Fife in 2016. This has delivered £12 million in savings across health and social care services. The programme included three priorities. These were to restrict the list of medicines available for prescribing, to reduce medicines waste and to review more regularly the medicines that are being prescribed. NHS Grampian also reduced its prescribing budget by £3.5 million compared with last year, mainly through switching to biosimilars.

56. The Scottish Government effective prescribing team supported improvements to reduce costs including by:

- implementing electronic prompts for prescribers, to encourage them to use generic medicines and lower-cost alternatives

- emphasising the importance of carrying out medicines reviews, to safely reduce the number of medications being taken at the same time.

The NHS in Scotland continues to face significant workforce challenges

57. The NHS is reliant on its workforce to deliver healthcare services. However, it is increasingly challenging to recruit enough people with the right skills, particularly in some rural areas. outlines some important

198

figures relating to the NHS workforce in 2018/19.

Exhibit 11
NHS workforce 2018/19

Headcount

164,114

March 2019

↑ 0.6 % since last year
↑ 3.4% over five years

Full-time equivalent

140,881

March 2019
(excluding some primary care staff)

↑ 0.7 % since last year
↑ 3.9% over five years

Staff costs

£ = **53%** of revenue

£6.9bn

in 2018/19

↑ 2.5% in real terms
since last year

Vacancy rates

Consultants

7.7%

↑ from 7.5% in 2017/18
Highest: **44.2%** Orkney
Lowest: **1.9%** Lothian

54%
Vacancies open
for at least 6 months
↓ from 60% in 2017/18

Nursing and midwifery

4.9%

↑ from 4.5% in 2017/18
Highest: **8.4%** Highland
Lowest: **0.7%** Ayrshire and Arran

28.5%
Vacancies open for
at least 3 months
↓ from 30.3% in 2017/18

Allied health professionals

4.7%

↑ from 4.4% in 2017/18
Highest: **9.1%** Grampian
Lowest: **0.4%** Ayrshire and Arran
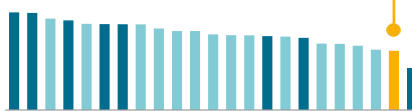
32%
Vacancies open for
at least 3 months
↑ from 29.4% in 2017/18

Sickness absence

5.4%
same as 2017/18

Territorial boards
Highest: **5.9%** NHS Forth Valley
Lowest: **4.3%** NHS Shetland

National boards
Highest:
8.6% NHS 24
8.3% State Hospital
7.8% Scottish Ambulance Service

Staff turnover

6.4%
down from 6.6% in 2017/18

Territorial boards
Highest: **9.8%** NHS Shetland
Lowest: **6.5%** NHS Ayrshire and Arran

National boards
Highest: **10.5%** NHS Health Scotland
Lowest: **4.5%** Scottish Ambulance Service

Workforce aged over 55

55+ **22%**
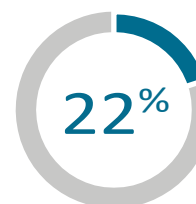
Source: Audit Scotland using ISD workforce data and Scottish Government consolidated accounts, 2019

58. The Scottish Government's ambition is for the NHS to provide more care in the community than in acute hospitals. To support this ambition, the way that care and treatment is delivered will change, and therefore the way that NHS staff work will change too. There are examples of where roles have changed to support different ways of working (Case studies 5 and 6).

Case study 5

Pharmacy First has been a success at NHS Forth Valley

NHS Forth Valley has evaluated its Pharmacy First service. This service aims to improve patients access to treatment for certain conditions without the need to see a GP. This service is now available at all community pharmacies, many of which are open at the weekend or evenings, when most GP practices are closed.

Results found that between April 2017 and March 2019, pharmacists were able to provide treatment for 83 per cent of consultations. Pharmacists referred just ten per cent of patients to their GP. The remaining seven per cent of patients were given advice.

Service users were asked for feedback on the service and, of those who responded, 88 per cent said that the pharmacist was able to help them fully, and 100 per cent rated the service excellent or good. Pharmacists in Forth Valley also provided positive feedback on the service and, of the GPs who responded, 53 per cent said that there had been a decrease in the number of patients seeking treatment, as many conditions were covered by the Pharmacy First service.

Source: *Evaluation of the pharmacy first extension service*, NHS Forth Valley, April 2019

Case study 6

The Scottish Ambulance Service is helping to reduce demand for GP appointments

The Scottish Ambulance Service has been testing new ways of working as part of multidisciplinary teams in primary care, to help safely reduce the demand for GP appointments. Paramedics assess patients with urgent symptoms that need to be addressed before the next available GP appointment.

Initial results found that paramedics could safely assess and treat more than 65 per cent of requests for GP home visits, reducing demand for GP appointments. Patient feedback has been very positive. It also found that paramedics involved in this work brought additional expertise back to their 999 calls, with more patients being treated at the scene, which reduced hospital admissions. The Scottish Ambulance Service now plans to further develop this work and roll it out across the country.

Source: Scottish Ambulance Service, 2019

59. In 2018, the Scottish Government published the new General Medical Services Contract, also known as the GP contract. It included plans to expand the role of multidisciplinary teams in primary care, to ease GPs' workload and improve patient access to appropriate care. These teams will be based in GP practices and involve pharmacists, advanced nurse practitioners, physiotherapists and others. It aims to increase the role that GPs have in planning and delivering new health and social care services. It also aims to increase the amount of time that they have available to care for patients, particularly those with complex or difficult to diagnose conditions.

60. Our report *NHS workforce planning - part 2* found that because of a lack of primary care data, it is difficult to assess whether these aims are on track to be achieved. Increasing the primary care workforce as planned will be a significant challenge and any changes are likely to have an impact on other parts of the system.

Temporary staffing costs remain significant, and there is a wide variation between boards

61. As a result of recruitment and retention issues, sickness absence and pressures to meet waiting time targets, NHS boards supplement their workforce by using temporary staff. In 2018/19, NHS boards spent £169.5 million on agency staffing. This was a real-terms increase of 0.3 per cent since 2017/18 (Exhibit 12, page 29).

Boards are working to reduce temporary staffing costs

62. The cost of temporary staffing is significant. Boards have carried out a range of initiatives to reduce temporary staffing costs:

- In 2018/19, NHS Greater Glasgow and Clyde developed a refreshed campaign to recruit graduate nurses. It took a proactive approach to meeting students and promoting the board. It provided graduates with the opportunity to speak to senior nursing staff to learn more about the organisation. The board recruited 458 newly qualified nurses through this recruitment exercise, which filled most of its nursing vacancies. The board saw a real terms reduction of 23.4 per cent in agency spending in 2018/19 compared with 2017/18.[20]

- NHS Grampian has expanded its recruitment to alternative roles. The board has funded a considerable number of additional clinical development fellow, advanced nurse practitioner and physician associate posts. These posts can support areas that are struggling to recruit enough junior doctor posts and can help to reduce the reliance on medical locums. The board also recruited more than 100 nurses from Western Australia and is planning to develop a more formal partnership with Western Australia. It has also been promoting research and development opportunities, to attempt to attract more people to work at NHS Grampian.

Withdrawing from the European Union is likely to exacerbate existing workforce and cost pressures

63. There is considerable uncertainty around the potential impact of the UK's withdrawal from the European Union (EU). The immediate areas of potential impact for NHS boards include reduced access to medicines for certain patient groups and increased costs of medicines and supplies. Higher costs will compound the financial pressure on the NHS. In the longer term, there is uncertainty about future immigration rules and the impact that this may have on being able to attract applicants for vacancies. Professional bodies consider that the number of applicants to the NHS from other EU countries has already declined. This will place further strain on the NHS workforce.

64. The UK and Scottish Governments are leading and coordinating most of the preparations. NHS National Services Scotland has played a central role in contingency arrangements. In line with guidance from National Procurement, NHS boards have not been holding increased stocks of drugs or medical equipment. This is being managed at a UK-wide level.

65. Some boards have acted to strengthen their local arrangements to increase resilience. Several boards, with their partners, have established assurance groups to coordinate preparations, address risks where possible and keep their staff and board members updated. NHS boards should factor any known workforce and cost implications into their financial plans.

Exhibit 12
Temporary staffing costs in 2018/19

In real terms, several boards reduced their spending on temporary staff. Spending on medical agency locums has decreased but spending on agency and bank nurses continues to increase.

Medical locum

2014/15 − £72.8 million
2018/19 − £98.0 million

Peaked in 2016/17 at £114 million and has reduced year-on-year since

Nursing agency
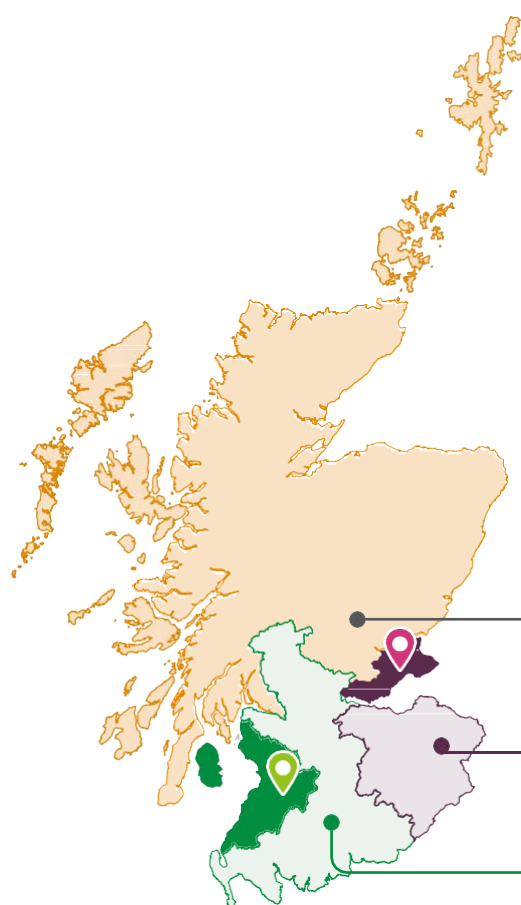
2014/15 − £17.1 million
2018/19 − £26.2 million

Decreased in 2017/18 but has reached its highest so far in 2018/19

Nursing bank

2014/15 − £138.8 million
2018/19 − £161.9 million

Continuing to rise year-on-year.

This is a more cost effective option for health boards than agency nurses

Compared with 2017/18 costs:

7 **territorial boards** reduced their agency spending in 2018/19, in real terms

NHS Fife saw the largest percentage increase in spending

20.6%
£1.8 million

NHS Ayrshire and Arran saw the largest percentage decrease in spending

26.1%
£3.0 million

Spending on agency staffing varied significantly across NHS boards and varied by region:

North region
£43 per 1,000 population

East
£27 per 1,000 population

West
£23 per 1,000 population

Note:
North: Grampian, Highland, Orkney, Shetland, Tayside and Western Isles.
East: Borders, Fife and Lothian
West: Ayrshire and Arran, Dumfries and Galloway, Forth Valley, Greater Glasgow and Clyde and Lanarkshire

Sources: NHS Consolidated Accounts for the financial year 2018/19, Scottish Government, 2019; NHS Scotland workforce, ISD Scotland, June 2019; Mid-year population estimates, National Records of Scotland, April 2019

Part 2
Achieving a sustainable NHS

Key messages

1 The Scottish Government's 2020 Vision is to change the way health and social care services are delivered. The successful integration of health and social care is essential for achieving this, but progress has been slow and the aims of the 2020 Vision will not be achieved on time. NHS boards are working on a significant number of local improvement initiatives, but there is scope to consolidate this activity to achieve larger-scale, system-wide reform. The Scottish Government should identify and prioritise the initiatives that are most likely to achieve the reform needed. It should use this information to develop its new strategy for health and social care for 2020 onwards. Much more work is also required to engage with local communities to inform and co-design changes to services.

2 Reforming health and social care also means that changes to the NHS workforce are required. To support this, the Scottish Government needs a national, integrated, health and social care workforce plan. This is overdue.

3 There has been significant turnover in senior leadership positions across the NHS in Scotland, with 26 new appointments in 2018/19. The Scottish Government has introduced a series of changes to improve its approach to senior leadership recruitment and development. This is a medium- to longer-term solution, and it is too soon to determine the impact of these changes on stabilising senior leadership in the NHS.

4 The NHS needs to improve workplace culture. Following reports of bullying and harassment and an independent review, the Scottish Government has committed to implementing a series of improvements. Boards are now required to provide assurance that they are aware of the culture and behaviours in their organisation and have plans to address any issues identified.

There has been long-term and consistent national policy direction for health and social care integration, but progress has been slow

66. Since 2005 there have been several strategies and frameworks published by the Scottish Government that aim to reform health and social care services across Scotland (Exhibit 13, page 31). To achieve the Scottish Government's vision to change the way services are delivered, successful integration of health and social care is urgently required and is a major priority across the whole system.

Exhibit 13
A timeline of major Scottish Government health and social care policies and publications, 2005–16

2005 **The Scottish Government published** *Delivering for Health*
This first set out the aim to provide care that is quicker, more personal and closer to home. It aimed to support more integrated working across health and social care, improve patient pathways and develop a culture of teamwork and co-operation.

2009 **The Scottish Government and COSLA published** *Improving Outcomes by Shifting the Balance of Care Improvement Framework*
It proposed ways that NHS boards and local authority partners could make better use of resources across the health and social care system. It aimed to help them to better manage the impact on acute hospitals of population growth, increase in the number of older people and long-term conditions.

2011 **The Scottish Government published its** *2020 Vision*
It set out the aim that by 2020 'everyone is able to live longer, healthier lives at home, or in a homely setting'. Ambitions were to shift care from acute to community care, increase integrated working focusing on prevention, anticipate care needs and support self-management of long-term conditions. It aimed to ensure people are discharged from hospital as soon as appropriate with minimal risk of readmission.

2014 **Integration legislation passed and introduced the mandate for change with the establishment of Integration Authorities (IAs)**
NHS boards need to work in close partnership with IAs and local authorities to plan together how services that were once provided in hospital can be moved to the community. IAs are responsible for planning, designing and commissioning primary care services. They are also responsible for developing primary care improvement plans, in collaboration with NHS boards and local GP subcommittees.

2015 **The Scottish Government published the** *National Clinical Strategy*
This highlighted areas where improvements would be necessary over the next five to ten years across primary and acute care. Significant changes were required to ensure the NHS could adapt to meet the needs of the population in the future.

2016 **The Health and Social Care Delivery Plan set the direction required to make hospital services more sustainable and available for those who need them in the future**
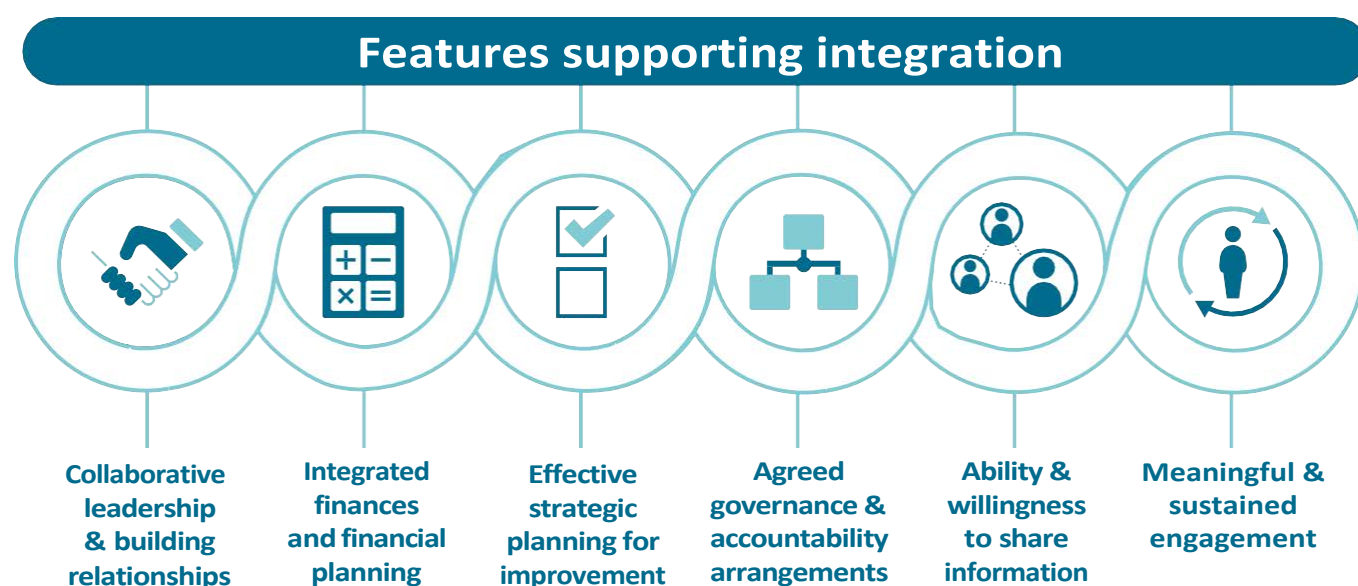It provided more guidance for health and social care services to change the way services are delivered. It intended to increase the number of people that can be treated and cared for closer to their home, where it is safe and appropriate to do so.

67. Changing how healthcare services are accessed and delivered has been too slow. In September 2018, the Scottish Government, NHS Scotland and COSLA released a joint statement setting out a shared commitment to integration. It clearly stated that the pace of integration needs to be stepped up. In our report, *Health and Social Care Integration: update on progress* ⊕, we identified six areas that IAs and their NHS and council partners need to address (Exhibit 14).

Exhibit 14
Features central to the success of integration

Features supporting integration

| Collaborative leadership & building relationships | Integrated finances and financial planning | Effective strategic planning for improvement | Agreed governance & accountability arrangements | Ability & willingness to share information | Meaningful & sustained engagement |

Source: *Health and social care integration: update on progress*, Audit Scotland, November 2018

68. In 2018/19, NHS boards' external auditors reported on a range of challenges to the progress of integration. These included the following:

- Several boards reported IA overspends, including NHS Ayrshire and Arran, NHS Fife and NHS Forth Valley.

- There is a variation in the way that NHS boards work with IAs to plan services and budgets. Some reported that agreements are not yet fully implemented or are being renegotiated.

- There are workforce pressures, including the availability of key roles and having the right skills and experience.

- There is difficulty in finding time to support reform and integration while maintaining acute services.

69. As a result of concerns about the pace of health and social care integration, the Cabinet Secretary for Health and Sport commissioned a review of progress. This was conducted in late 2018. The Ministerial Strategic Group for Health and Community Care (MSG) published their findings in February 2019 and set out proposals for ensuring the success of integration.[21] It set out its proposals under the headings identified in Exhibit 14.

70. Following publication of their review, the MSG issued a self-evaluation template to be completed by health boards, councils and IAs. This aimed to evaluate their current position in relation to the findings of the review. This exercise will be repeated to demonstrate any progress made across the country. Work needs to continue to implement the recommendations highlighted in our report and the MSG review. The Scottish Government has appointed a dedicated lead for this work.

There are examples of NHS boards working with partners to successfully change the way that services are delivered

71. There are numerous innovative and successful examples of partnership working across health and social care to change the way that services are delivered. For example, NHS 24 works with Police Scotland and SAS to improve the pathway for people in distress who contact these three organisations. It also engaged with service users and those delivering services, to develop a mental health hub, based on similar models in London and Cambridgeshire. The hub aims to reduce the proportion of people experiencing mental health issues that are referred to emergency services. Early results show that it has been successful, with less than ten per cent of these cases being referred on to emergency services. Case study 7 shows how SAS is working with NHS 24 to reduce the demand on emergency departments.

Case study 7

SAS is collaborating with NHS 24 to improve patient triage

SAS has been working with NHS 24 to improve the way patients are assessed and treated. Many people making 999 calls are experiencing symptoms relating to long-term conditions that may not always require hospital care or admission. SAS and NHS 24 worked with NHS boards and IAs to develop new pathways of care. These pathways are designed to deal with the immediate issue and minimise the risk of future emergencies.

As a result, more patients are being safely managed either within the ambulance control centre or in the community by paramedics, without having to attend A&E. In June 2019, 37 per cent of incidents were managed by paramedics or through the control centre. This compares with 32 per cent of incidents in April 2017.

Good progress is being made, but there is variation across Scotland in the rate of patients being taken to emergency departments. SAS is focusing on reducing this variation. It is working with IAs and GP clusters to develop local solutions with local communities, in line with the principles of realistic medicine.

Source: Scottish Ambulance Service, 2019

The potential of digital technology is not yet being maximised

72. In April 2018, the Scottish Government published a new digital health and care strategy.[22] The strategy sets out national digital priorities for the next decade that aim to support the transformation of health and social care delivery. These include making use of new technologies to:

- share patient information across health and social care boundaries
- improve patient safety and the coordination of care
- support the redesign of services
- build workforce capability.

73. The Scottish Government is developing a new health and social care digital platform. The platform intends to improve access to health records where and when they are needed across acute, primary and community care. New ways of working using new technologies will also be tested, such as virtual clinics and the remote monitoring of chronic illnesses.

74. Work to implement the strategy is at an early stage. It requires collaboration between the Scottish Government, NHS boards and local government, and governance arrangements are being established to monitor progress. We will continue to monitor developments as part of our ongoing work programme.

75. There are examples of good work across Scotland to make the most of the technology that is currently available to improve patient care. The implementation of the electronic frailty index tool is an example of this (Case study 8).

Case study 8

The Living Well in Communities (LWiC) team is improving the identification and management of people with frailty

The LWiC team in Healthcare Improvement Scotland's improvement hub has developed preventative support for people with frailty in the community. It uses an electronic frailty index (eFI) to identify people with frailty before they reach crisis point. The eFI is available to GP practices through a national IT (information technology) system known as the Scottish Primary Care Information Resource (SPIRE). GP practices using SPIRE can now identify their frail population enabling them to better direct and manage their healthcare needs. During the summer of 2019, the LWiC team supported 19 health and social care partnerships across Scotland to implement the eFI. This could lead to more care being provided in the community rather than in acute hospitals and improve the quality of life of people with frailty.

Source: Healthcare Improvement Scotland, 2019

More work needs to be done to engage with local communities when making changes to health and social care services

76. We have previously reported that the NHS in Scotland needs to be more open, by improving public reporting and the way that the community is involved in planning and designing changes to services.

77. In 2019, NHS boards completed the blueprint for good governance self-assessments.[23] These identified that engagement with stakeholders required further development across several boards. It found that boards need to develop more effective communication and engagement strategies. The approach to community engagement was inconsistent, with some boards reporting that they needed more clarity around expectations. Some boards reported that improved guidance was needed to support better dialogue and inclusion of the community in decision-making.

78. The Community Empowerment (Scotland) Act 2015 sets the requirement for all public bodies to work alongside their stakeholders when making decisions about what services are delivered and where.[24] Working in partnership with the community aims to support the co-design of services and improve outcomes. This is particularly important for marginalised community groups. There is still much work to be done to meet the requirements of the Act with many boards still developing engagement strategies.

79. The Place Principle, recently introduced by the Scottish Government and COSLA, aims to support collaboration and co-design of places in the community.[25] It supports inclusiveness and sustainable outcomes. Planning and working together with the community is vital to ensure a positive, shared understanding and agreement on future community developments.

80. In November 2018, the Scottish Government commissioned an independent review of how NHS Lanarkshire had planned for the redevelopment of Monklands Hospital. Concerns had been raised by elected representatives and members of the public about the level of community engagement and consultation. There were also concerns about the quality of the information used in the planning process, particularly around identifying possible new sites for the hospital. The review found that NHS Lanarkshire had carried out their planning and consultation process well, and in line with existing guidance. Nonetheless, to restore public confidence and trust, it recommended that for the redevelopment, they should follow the Place Principle to create a shared vision with the local community.[26]

81. NHS boards should incorporate the Community Empowerment Act principles into their communication and engagement strategies.[27] This will enable a more mature approach to involvement and improve trust and confidence within the community. Providing a range of community groups with a voice will allow a more informed and open conversation about the design and delivery of public services to meet local needs.

The development of a national, integrated health and social care workforce plan is overdue

82. Between June 2017 and April 2018, the Scottish Government published three workforce plans, covering the NHS, social care and primary care.[28,29,30] It also intended to develop, with COSLA, a national integrated health and social care workforce plan. This was due to be published in 2018 but has been delayed until 2019.

83. IAs have been expected to provide health and social care workforce plans since 2017/18. These should include information about the existing workforce across their health and social care partnership, the expected workforce required in the future and an analysis of workforce supply and demand trends. Not all IAs, however, have produced a plan.

84. Health and social care reform incudes changes in the way that care is delivered and by whom. To support planning for a different type of workforce, broader analysis is required. This should identify:

- what roles will be needed and how many

- where they are needed and what skills and training are necessary

- what these changes to the workforce will cost.

85. Acute hospitals and primary and community care services continue to face increasing workforce shortages. It is unclear if commitments to increase the number of GPs and create new multidisciplinary primary care teams can be achieved in the timescales expected. This is in addition to maintaining acute hospital services and establishing new elective centres. The Scottish Government needs to publish the national, integrated health and social care workforce plan and guidance to inform workforce planning.

The Scottish Government should develop a new strategy for health and social care that identifies priorities to support large-scale, system-wide reform

86. The Scottish Government's 2020 Vision is to provide more care closer to home and reduce demand for acute hospital services. This aims to improve patient experience and help achieve the longer-term financial sustainability of the NHS. The successful integration of health and social care is essential for achieving this vision. However, progress has been slow, and the aims of the 2020 Vision are unlikely to be achieved by 2020. NHS boards have been working on a significant number of local improvement projects that may or may not have contributed to these aims.

87. The Scottish Government should identify and prioritise which initiatives are most likely to achieve the level of large-scale reform needed. It should use this information to develop a new strategy for health and social care for 2020 onwards. Spreading successful improvements to support the delivery of a new strategy is not always straight forward. NHS boards need to consider how these initiatives will fit within their local circumstances. This can include the need for additional skills and the development of new relationships. Cultural change may also be required to accept new ways of working.[31] NHS boards should be able to demonstrate how they are meeting the priorities of the new strategy and should report progress regularly to the Scottish Government.

The Scottish Government and boards still have work to do to improve NHS governance

88. Each NHS board is responsible for ensuring that health services are delivered safely, efficiently and effectively. To support this, NHS boards must have good governance arrangements in place that provide sufficient scrutiny and assurance of financial and operational performance. This year, external auditors found that most NHS boards had adequate governance arrangements in place but found recurring areas of concern. These included the capability and capacity of board members, commitment to transparency, and the quality and timing of information provided for board committee meetings. The Scottish Government is carrying out a range of work aimed at strengthening governance arrangements in NHS boards. This includes piloting a standardised review of corporate governance – NHS Scotland's *A Blueprint for Good Governance* – published in February 2019.[32]

89. The blueprint for good governance intends to provide support for NHS board directors to better fulfil their oversight and decision-making role. It aims to create stronger systems and processes for effective scrutiny of performance. The first step in the framework was for NHS boards to conduct a self-assessment to provide a baseline of performance and to identify where improvements were needed. The self-assessment covered five functions of good governance. These are setting the direction, holding to account, assessing risk, engaging stakeholders and influencing culture.

90. Results showed that most boards scored themselves as performing well or exceptionally well across all five functions. Boards have developed action plans to address areas for improvement. NHS boards will provide six-monthly reports to the Scottish Government on progress against their agreed action plans. Themes for improvement include:

- board member induction, skills and ongoing training and development

- strengthening risk management arrangements

- standardising corporate governance documents

- improving the timing and quality of reports that are submitted to the board.

91. The national-level work to support improvement is being managed via three workstreams:

- corporate governance systems

- attraction and recruitment

- retention and development.

92. The blueprint recommends the independent validation of NHS boards in addition to the self-assessments. It is expected that all boards will be independently reviewed over a three-year period. The Scottish Government is currently considering options for the most appropriate way for this to be conducted. The Scottish Government Corporate Governance Steering Group is overseeing activity relating to the framework and workstreams.

The lack of stable leadership in the NHS is impeding reform

93. There has been a significant turnover of senior leadership positions during 2018/19. Exhibit 15 outlines some of these key changes.

Exhibit 15
Changes in senior leadership appointments across the NHS in Scotland 2018/19

22 NHS board

26 new appointments
senior leadership positions

5 chief executives
NHS Grampian, Highland, Orkney, Tayside, and National Waiting Times Centre

9 board chairs
NHS Borders (interim), Grampian, Highland (interim), Shetland, Tayside (interim), Western Isles, Scottish Ambulance Service, NHS Education for Scotland and National Waiting Times Centre

6 new directors of finance
NHS Forth Valley, Highland (interim), Orkney (interim), Tayside, Western Isles and Scottish Ambulance Service

6 new medical directors
NHS Fife, Lanarkshire, Shetland (interim), Tayside (interim), National Services Scotland and NHS 24

Source: NHS boards' annual audit reports, 2019

94. At October 2019, over half of NHS boards in Scotland have senior leaders holding dual positions. Typically, this involves only one member of each board's senior leadership team, although three members of the NHS Grampian Executive Team held positions at NHS Tayside during 2018/19. At NHS Shetland, auditors were concerned that three members of the leadership team found managing dual roles challenging, as responsibilities continue to increase.

95. NHS boards are finding it difficult to recruit future leaders. It often takes a long time to appoint people to these positions. Vacancies, interim roles and short tenure can lead to short-term decision-making. This can affect the level of reform and the effective working relationships needed across NHS Scotland. The NHS Leadership Academy suggests that chief executives should stay in post for at least five years, to give organisations the stability they need for effective strategic planning. It is also considered that new chief executives can take 15-32 months to transition into their role.[33]

The Scottish Government has improved its approach to senior leadership recruitment and development

96. Greater collaboration and partnership working are needed to support health and social care integration and to improve staff engagement and workplace culture. The Scottish Government recognised that to achieve this, a different style of leadership was required. This was an important factor in the creation of its new leadership development programme called Project Lift.

97. Project Lift has introduced a series of changes that have been progressed over the past two years.[34] Project Lift focuses on building positive relationships, respect and kindness. It intends to help people work together more effectively across health and social care services, communities, local authorities and the third sector to improve outcomes. The changes include the following:

- Values-based recruitment: this is a multi-stage recruitment process that includes a competency-based application form, and psychometric tests that are independently analysed and used to set questions for interview and role play. A one-year evaluation is under way and will include feedback from candidates. This process has been extended from only the recruitment of board chairs to now include board members and executive directors.

- A new approach to appraisal: for chairs and deputy chairs, this aims to include 360-degree appraisal by March 2020. The Scottish Government is planning to extend this to non-executive directors. This process aims to support improvements recommended in *A Blueprint for Good Governance* and the Sturrock review.

- A stronger process for induction and professional development: this has been introduced for new non-executive directors and chairs, and NHS Education for Scotland provides mentoring and coaching opportunities.

- A new talent management process: this has been established to help identify and develop future leaders. Individuals complete an online self-assessment and are invited to participate in a supported process of personal and leadership development. Over 1,500 staff from across Scotland have registered with this programme since its launch in 2018.

- Improved engagement across health and social care and the wider public sector: this has included leadership learning events and support to build relationships and cross system, collaborative working.

98. Project Lift aims to resolve future recruitment challenges. The Scottish Government should continue to monitor the effectiveness of the initiatives and their impact on recruitment and retention of senior healthcare leaders. However, this is a medium- to long-term solution and there is an immediate need to fill existing senior leadership vacancies on a substantive basis.

The NHS needs to improve its workplace culture

99. In 2013, the Scottish Government published its *Everyone Matters: 2020 Workforce Vision*. It set out the commitment to put people at the heart of delivering high-quality care, to value the workforce and to treat people well ⓘ.

100. In September 2018, four senior doctors from NHS Highland publicly reported problems with bullying and harassment. They reported a long-standing culture of fear and intimidation and an environment where concerns could not be raised in an open and transparent way. As a result of this the Cabinet Secretary for Health and Sport commissioned an independent review to further explore the matters raised.

101. John Sturrock QC published his review in April 2019.[35] There was extensive engagement, with input from around 300 NHS Highland staff. Many reported that they had experienced some form of bullying, harassment or inappropriate behaviour that was considered significant and harmful. The review made important immediate and longer-term recommendations that also have wider implications for the NHS in Scotland. We expect all boards and the Scottish Government to respond actively and positively. The recommendations included:

- a requirement for person-centred leadership

- working in partnership and engaging with staff at all levels

- improvements in governance

- improvements in the management of human resources processes.

102. The Scottish Government has committed to supporting improvements across NHS Scotland as a result of the Sturrock review.[36] Several initiatives are being put in place to support a safe, open and honest workplace culture. These include the following:

- The establishment of a ministerial-led short-life working group to ensure that the recommendations from the report are implemented.

- A review of all workplace policies, including bullying and harassment, conduct, and grievance and the development of a single workforce investigation policy.

- The formation of new legislation to establish an Independent National Whistleblowing Officer for NHS Scotland. This will form part of the Scottish Public Services Ombudsman role and will have the authority to investigate the way that whistleblowing complaints are handled and will make recommendations and report to the Scottish Parliament.

- Each NHS board appoints a whistleblowing champion as part of the role of one of their non-executive directors.

NHS Scotland values

– Care and compassion

– Dignity and respect

– Openness, honesty and responsibility

– Quality and teamwork

103. The Scottish Government is seeking assurance that all boards are considering the outcomes and recommendations from the Sturrock review. Given the importance of this issue across NHS Scotland, the Scottish Government should ensure that all NHS boards:

- provide evidence that they actively promote positive workplace behaviours and encourage reporting of bullying and harassment

- have action plans in place to improve culture, address any issues identified and use the findings of the Sturrock review to inform continual cultural improvement.

104. The Scottish Government should consider what it can do to support NHS boards with this and whether a national cultural reform programme is required.

Senior leaders should consider how they can improve engagement with front-line staff

105. The everyone matters: 2020 workforce vision led to the introduction of the iMatter survey in 2015.[37] This staff experience survey was designed to help individuals, teams and health boards understand the extent to which employees feel motivated, supported and cared for at work.

106. The response rate for the 2018 survey was 59 per cent.[38] This was less than the response rate in 2017, at 63 per cent. An employee engagement index (EEI) score is provided when there is a response rate of 60 per cent. Therefore, a national EEI score for health and social care was not published as part of the national report. In 2018, 13 boards, only five of which were territorial, received an organisational EEI score compared with 19 in 2017. The Scottish Government has commissioned an independent academic review to identify reasons for the reduction in response rate and to recommend ways to improve participation.

107. The results of the 2018 national report showed that staff were clear about their work and had confidence in their line manager. Areas that were rated lower included how well staff were involved in decision-making and the visibility of senior leaders. The areas where responses scored lowest align with some of the important leadership and cultural issues discussed in this report.

108. The iMatter survey does not contain questions specifically relating to culture such as bullying and harassment. This is covered in the biennial Dignity at Work Survey, last conducted in 2017.[39] Those results showed an increase in the proportion of staff experiencing bullying. Nine per cent of staff experienced bullying from their manager compared with eight per cent in 2015. Fifteen per cent of staff experienced bullying from a colleague compared with 13 per cent in 2015.

109. The Scottish Government should consider incorporating questions relating to organisational culture and behaviour within a single annual staff survey. This will enable the Scottish Government to monitor staff experience and the status of organisational culture and behaviour across the NHS. This will also avoid the requirement to conduct, analyse and report on two separate surveys. There are examples of public-sector surveys that include a combination of such questions.

Endnotes

1   Audit Scotland using the draft budget for 2019/20, Scottish Government, December 2018; Mid-year population estimates, National Records of Scotland, April 2019.

2   *Draft budget for 2019/20,* Scottish Government, December 2018.

3   *Scottish Government Medium-Term Health and Social Care Financial Framework,* Scottish Government, October 2018.

4   The 2020 Vision published by the Scottish Government set out the aim that everyone is able to live longer and healthier lives at home or in a homely setting.

5   Audit Scotland using NHS consolidated accounts for financial years 2016/17-2018/19, Scottish Government, 2019.

6   NHS board local delivery plans and annual operational plans 2015/16-2019/20.

7   NHS consolidated accounts for financial year 2018/19, Scottish Government, 2019.

8   *NHS Scotland 2018-19 consolidated financial reporting to 31 March 2019,* Scottish Government, May 2019.

9   Based on data reported in *NHS in Scotland 2018* ⊕, Auditor General, October 2018.

10 New facilities will be established in Golden Jubilee National Hospital, NHS Highland, NHS Lothian, NHS Grampian, NHS Tayside and NHS Forth Valley.

11 NRAC parity status, Technical Advisory Group on Resource Allocation, 2019.

12 Scottish Budget 2019-20: Level 4 data, Scottish Parliament Information Centre (SPICe).

13 *Waiting Times Improvement Plan,* Scottish Government, October 2018.

14 *Inpatient Experience Survey,* Scottish Government, January 2019.

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30 *National health and social care workforce plan: part 3,* Scottish Government, April 2018.

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35 *Report to the Cabinet Secretary for Health and Sport into cultural issues related to allegations of bullying and harassment in NHS Highland,* John Sturrock QC, April 2019.

36 *The Scottish Government response to the Sturrock Review into cultural issues related to allegations of bullying and harassment in NHS Highland,* Scottish Government, May 2019.

37 *Everyone matters: 2020 workforce vision,* Scottish Government, 2013.

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39 *Health and social care staff experience: report 2017,* Scottish Government, March 2018.

Appendix 1
Audit methodology

This is our annual report on how the NHS in Scotland is performing. Our audit assessed how well the NHS managed its finances and performance against targets in 2018/19 and how well the NHS is adapting for the future.

Our findings are based on evidence from sources that include:

- the audited annual accounts and auditors' reports on the 2018/19 audits of the 22 NHS boards

- Audit Scotland's national performance audits

- NHS boards' Annual Operational Plans which set out how boards intend to deliver services to meet performance indicators and targets, and indicative spending plans for the next three years

- activity and performance data published by ISD Scotland, part of NHS National Services Scotland

- publicly available data and information on the NHS in Scotland including results from staff and patient surveys

- interviews with senior officials in the Scottish Government and a sample of NHS boards.

We reviewed service performance information at a national and board level. Our aim was to present the national picture and highlight any significant variances between boards. We focused on a sample of key targets and standards, covering some of the main activities of the NHS. Where we have used trend information, we have selected a time period where information is most comparable. Information about the financial performance of the NHS is included in .

Appendix 2

Financial performance 2018/19 by NHS board

Board	Core revenue outturn (£m)	Total savings made – Annual Audit Report (£m)	Non-recurring savings in Annual Audit Report (%)	NRAC: distance from parity (%)	
Ayrshire and Arran	796.6	32.0	43	-0.8	
Borders	237.7	15.2	56	1.1	
Dumfries and Galloway	343.2	17.3	74	2.8	
Fife	706.8	20.0	80	-0.8	
Forth Valley	568.8	18.4	38	-0.8	
Grampian	1,035.1	17.3	72	-0.8	
Greater Glasgow and Clyde	2,404.3	93.0	60	1.8	
Highland	714.6	26.2	36	-0.8	
Lanarkshire	1,271.9	28.8	40	-0.8	
Lothian	1,535.1	27.1	44	-0.8	
Orkney	58.7	2.9	98	-0.4	
Shetland	59.3	3.8	58	-0.4	
Tayside	848.7	32.0	34	-0.8	
Western Isles	83.8	2.2	55	11.3	
National Waiting Times Centre	71.1	4.3	35		
NHS 24	65.0	2.1	35		
NHS Education Scotland	464.4	14.6	52		
NHS Health Scotland	19.5	0.4	0		
NHS National Services Scotland	466.9	18.5	23		
Healthcare Improvement Scotland	29.4	2.6	78		
Scottish Ambulance Service	251.8	9.9	29		
The State Hospital	32.8	1.8	80		

Source: Scottish Government Consolidated accounts, 2019. Annual Audit Reports and Financial Performance Reports, 2019. Information on NRAC parity by board, Technical Advisory Group for Resource Allocation, 2019

Appendix 3

Annual performance against key waiting times standards in 2018/19 by NHS board

Health board	18 weeks referral to treatment time	A&E attendees seen within four hours	CAMHS patients seen within 18 weeks	Patients starting cancer treatment within 31 days of decision
	standard = 90%	standard = 95%	standard = 90%	standard = 95%
Ayrshire and Arran	⊗ 79.0	⊗ 92.2	✔ 92.3	98.9
Borders	✔ 90.4	⊗ 93.6	⊗ 56.9	100.0
Dumfries and Galloway	⊗ 89.0	⊗ 92.6	⊗ 85.1	96.8
Fife	⊗ 79.0	✔ 95.2	⊗ 76.0	95.6
Forth Valley	⊗ 83.4	⊗ 86.1	⊗ 70.8	96.8
Grampian	⊗ 65.0	⊗ 94.4	⊗ 44.3	⊗ 91.6
Greater Glasgow and Clyde	⊗ 84.4	⊗ 90.3	⊗ 80.7	⊗ 94.6
Highland	⊗ 80.7	✔ 96.5	⊗ 82.3	⊗ 93.9
Lanarkshire	⊗ 85.7	⊗ 90.8	⊗ 70.9	98.6
Lothian	⊗ 72.0	⊗ 85.9	⊗ 62.8	⊗ 94.3
Orkney	✔ 93.1	✔ 95.7	✔ 95.0	96.2
Shetland	⊗ 83.6	✔ 96.3	✔ 95.0	98.5
Tayside	⊗ 76.3	✔ 97.5	⊗ 43.5	⊗ 92.7
Western Isles	✔ 90.7	✔ 98.9	✔ 95.0	100.0
Scotland	**80.2**	**91.2**	**70.7**	**95.0**

✔ Standard met   ⊗ Standard missed

Health board	Patients starting cancer treatment within 62 days of referral	Outpatients waiting less than 12 weeks following first referral	Day case or inpatients who waited less than 12 weeks for treatment	Drug and alcohol patients seen within three weeks
	standard = 95%	standard = 95%	standard = 100%	standard = 90%
Ayrshire and Arran	⊗ 84.6	⊗ 82.4	⊗ 83.9	✓ 98.6
Borders	⊗ 93.3	✓ 96.8	⊗ 78.4	✓ 95.3
Dumfries and Galloway	⊗ 92.0	✓ 95.9	⊗ 83.7	✓ 94.6
Fife	⊗ 85.4	✓ 98.2	⊗ 70.5	✓ 96.5
Forth Valley	⊗ 81.8	⊗ 88.2	⊗ 60.3	✓ 98.4
Grampian	⊗ 78.9	⊗ 64.9	⊗ 54.7	✓ 91.4
Greater Glasgow and Clyde	⊗ 77.1	⊗ 74.6	⊗ 77.3	✓ 94.8
Highland	⊗ 80.3	⊗ 84.7	⊗ 57.7	⊗ 87.8
Lanarkshire	✓ 95.9	⊗ 89.7	⊗ 63.3	✓ 97.9
Lothian	⊗ 81.0	⊗ 65.1	⊗ 77.2	⊗ 80.5
Orkney	⊗ 89.2	⊗ 78.9	⊗ 83.0	✓ 97.9
Shetland	⊗ 78.2	⊗ 71.2	⊗ 88.1	✓ 96.0
Tayside	⊗ 84.8	⊗ 62.7	⊗ 67.5	✓ 90.6
Western Isles	⊗ 83.3	⊗ 91.6	✓ 100.0	⊗ 89.3
Scotland	**82.5**	**75.0**	**72.2**	**93.6**

✓ Standard met   ⊗ Standard missed

Sources: Child and Adolescent Mental Health Services: waiting times, workforce and service demand, ISD Scotland, June 2019; National drug and alcohol treatment waiting times, ISD Scotland, June 2019; 18 weeks referral to treatment: ISD Scotland, May 2019; New outpatient appointment: waiting times for patients waiting at month end, census date at 31 March 2019, ISD Scotland, May 2019; Inpatient or day case admission: waiting times for patients seen, ISD Scotland, May 2019; Accident and emergency: attendances and time in department, ISD Scotland, June 2019; Performance against the 62-day standard from receipt of an urgent referral with suspicion of cancer to first treatment by NHS board, ISD Scotland, June 2019; Performance against the 31-day standard from date decision to treat to first cancer treatment by NHS board, ISD Scotland, June 2019

NHS in Scotland 2019

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**Integration Joint Board
19th December 2019**

Subject:	**Ministerial Steering Group – Review of Integration Progress report**
Purpose:	To allow the IJB to review the progress of implementing the areas of action identified in the recent self-assessment of progress towards integration.
Recommendation:	The IJB is asked to note the recent progress and to expect a further update once the Scottish Government has provided updated guidance to Health and Social Care Partnerships in 2020.

Glossary of Terms	
HSCP	Health and Social Care Partnership
MSG	Ministerial Steering Group

1.	**EXECUTIVE SUMMARY**
1.1	The North Ayrshire IJB submitted its MSG Review of Integration self-assessment, which highlighted areas of both good practice and improvement to the Scottish Government in May 2019.
1.2	The Scottish Government MSG integration review identified the following key areas, with sub proposals, to both enable and improve the effectiveness and pace of integration: ➤ Collaborative Leadership and Relationship Building ➤ Integrated finance and financial planning ➤ Effective strategic planning for improvement ➤ Governance and accountability ➤ Ability and willingness to share information ➤ Meaningful and sustained engagement
1.3	In April 2019 the HSCP undertook a self-assessment using the Scottish Government template, against the sub proposals, which generated the following assessment: ➤ Collaborative Leadership and Relationship Building - **Established** ➤ Integrated finance and financial planning - **Established** ➤ Effective strategic planning for improvement - **Established** ➤ Governance and accountability - **Established** ➤ Ability and willingness to share information - **Established** ➤ Meaningful and sustained engagement - **Exemplary**
1.4	Since May 2019 a wide range of work has been undertaken across service areas to address identified areas of improvement, which will improve the pace of integration and these improvements are noted in section 2 of this report. These areas also correlate to the recently published Audit Scotland report on the NHS Scotland in 2019.

1.5	The IJB is asked to note the recent progress and to expect a further update once the Scottish Government has provided updated guidance to Health and Social Care Partnerships in 2020.
2.	**BACKGROUND**
2.1	The HSCP submitted its MSG Review of Integration self-assessment, which highlighted areas of both good practice and improvement to the Scottish Government in May 2019. This section of the report will highlight the action taken to deliver the sub actions, against each of the key areas. Many of these areas also correlate to the recently published Audit Scotland report on the NHS In Scotland 2019.
2.2	**Collaborative Leadership and Relationship Building**: All this work is focussed on improving collaboration and building positive relationships. The development of a partnership Workforce Development Strategy has been completed, and the monitoring of progress is updated to both PAC and the Staff Partnership Forum. Work continues with NHS Ayrshire & Arran and North Ayrshire Council on reviewing support arrangements and developing formal agreements for support services and additional cross-party meetings to establish better relationships. The Third and Independent sector teams are represented as part of Thinking Different: Doing Better and the independent sector is involved in the development of the new Care Home Commissioning Strategy.
2.3	**Integrated finance and financial planning**: Work continues to improve the budget setting arrangements in the short and longer term through the development of the Medium Term Financial Plan in 2020. The support for a section 95 officer and the HSCP reserves policy has been approved. A significant piece of work is the development of IJB Directions and workshops have been held pan-Ayrshire to discuss consistent approach to Directions, this has included discussion about moving forwards a fair share methodology.
2.4	**Effective strategic planning for improvement**: The actions from the Joint (adults) Inspection have been taken forward as part of this area of work and include succession planning and on-going IJB development sessions. Further work continues to review governance processes, budget setting arrangements and the links to succession planning.
2.5	**Ability and willingness to share information**: Improvements around improving performance information, benchmarking and reporting information to the Performance & Audit Committee continues. There is also a drive to make information more accessible to the public and delivery of an accessible Annual Performance Report continues as a priority.
2.6	**Meaningful and sustained engagement**: A new approach of working directly with communities and key groups in their settings has been developed. Each of the Locality Planning Forums, have updated their priorities and have agreed to hold public event. Strategic Planning Group agreed a 2020 vision for engagement in November 2019 and this was agreed. The integrated LPF/LP pilot on Arran has now also commenced. The HSCP presented to the National Planning and Commissioning Managers network about our LPF and engagement approach and it was noted that our approach was further ahead than other areas. Using a new range of methods, the HSCP has delivered a visible engagement approach to approximately 3000 people in the last 5 months. The Partnership has also submitted three best practice examples to the National HSCP conference in December 2019.

2.7	The overall assessment is that local issues are being taken forward effectively. Those issue that remain outstanding are as a result of these requiring either a pan-Ayrshire e.g. Directions or require national solutions e.g. third sector funding to be involved in IJBs.
3.	**PROPOSALS**
3.1	The IJB is asked to note the recent progress and to expect a further update once the Scottish Government has provided updated guidance rand a follow up self-assessment to HSCP's in 2020. The full list of actions and progress is noted at **Appendix 1.**
3.2	**Anticipated Outcomes**
	The review of integration has been enabling improvements to increase the pace of health and social care integration across Scotland. The self-assessment and NA IJB improvement plan allows us to demonstrate the progress in North Ayrshire.
3.3	**Measuring Impact**
	The IJB has undertaken a self-assessment and provided and action plan to Scottish Government. It is expected that new HSCP guidance will be made available in 2020 and a further review of progress towards integration will be undertaken.
4.	**IMPLICATIONS**

Financial:	Improvements are being actioned.
Human Resources:	N/A
Legal:	N/A
Equality:	N/A
Children and Young People	N/A
Environmental & Sustainability:	The MSG integration review seeks to improve the pace and effectiveness of integration to support sustainable partnership working. The improvement areas also align to the recently published Audit Scotland report on the NHS in Scotland in 2019.
Key Priorities:	The sustainability of IJB's.
Risk Implications:	Failure to integrated effectively will destabilise Health and social care partnerships.
Community Benefits:	N/A

Direction Required to Council, Health Board or Both	Direction to :-	
	1. No Direction Required	x
	2. North Ayrshire Council	
	3. NHS Ayrshire & Arran	
	4. North Ayrshire Council and NHS Ayrshire & Arran	

5.	**CONSULTATION**
5.1	Progress with actions identified as part of the self-assessment has been monitored though PAC.
6.	**CONCLUSION**
6.1	The IJB is making positive progress, working with partners to improve the pace of integration of health and social care.

For more information please contact Caroline Cameron on ccameron@north-ayrshire.gov.uk or Michelle Sutherland on msutherland@north-ayrshire.gov.uk on 01294 317751

North Ayrshire Health and Social Care Partnership

MSG Review of Integration Actions (including Joint Inspection (Adults) Action Plan)

MSG Reference number	Tree	Action	Lead	Support	Self Evaluation	start	Planned Timescale	Status	Comment on Progress
1	**Theme**	**Collaborative Leadership and building relationships**							
1.1	**Key Action**	**All leadership development will be focussed on shared and collaborative practice**			**Complete**	April 2019			
1.1.1	Sub-action	NAHSCP Workforce Development Strategy includes an action for the partnership to develop succession planning for key leadership positions (also noted in action 3)	Michelle Sutherland	Calum Webster		April 2019	March 2020	🟢	Draft succession planning arrangements reviewed by PSMT and EPSMT in October 2019. A plan to be present to the HSCP Partnership Forum in January 2020.
1.1.2	Sub-action	Review of support arrangements, including opportunities to bring support within HSCP and to the formalise support arrangement between NHS/Council	Stephen Brown	Caroline Whyte		April 2019	September 2020	🟡	Discussions ongoing with partner organisations
1.2	**Key Action**	**Relationships and collaborative working between partners must improve**			**Established**	April 2019			

North Ayrshire Health and Social Care Partnership

MSG Review of Integration Actions (including Joint Inspection (Adults) Action Plan)

MSG Reference number	Tree	Action	Lead	Support	Self Evaluation	start	Planned Timescale	Status	Comment on Progress
1.2.1	Sub-action	Establish more routine cross party meetings HB/Council out with the budget process	Stephen Brown	Karen Andrews		April 2019	September 2019	🟢	Quarterly elected member sessions in place and coordinated by NAC Chief Executive department. NAC and NHS executive teams have been invited to TDDB. Senior Officer meetings take place with Council and NHS Chief Execs and IJB Chief Officer, scheduled in out with budget process.
1.3	**Key Action**	**Relationships and partnership working with the third and independent sectors must improve**			**Established**	April 2019			
1.3.1	Sub-action	Third & Independent sectors to be allocated dedicated space in the partnerships organisational development programme 'Thinking Different; Doing Better'	Stephen Brown			April 2019	July 2019	🟢	Complete
1.3.2	Sub-action	Actions aligned to Joint inspection (adults) - Noted in MSG review action 1.1.1,3.1.4,3.4.1,3.4.5,3.5.4,3.5.5,4.5.1,4.5.2,5.5.1,5.1.2,6.2.2	Stephen Brown			April 2019	April 2020	🟢	Actions aligned - complete

North Ayrshire Health and Social Care Partnership

MSG Review of Integration Actions (including Joint Inspection (Adults) Action Plan)

MSG Reference number	Tree	Action	Lead	Support	Self Evaluation	start	Planned Timescale	Status	Comment on Progress
1.3.3	Sub-action	Greater involvement of the Third & Independent sectors in commissioning strategies, starting with the older People's Care Home Strategy	Caroline Whyte	Michelle Sutherland		April 2019	March 2020	⬤	Both 3rd and Independent sectors are involved in the Care Home Commissioning Strategy. Third and Independent Sector leads chair HSCP provider forum groups.
1.3.4	Sub-action	Scottish Government requested to consider the longer-term sustainability of Independent & Third Sector representation on IJBs and a funding model to support this	Stephen Brown	Michelle Sutherland		April 2019	April 2020	⬤	Further work required
2	Theme	Integrated finances and financial planning							
2.1	Key Action	Health boards, local authorities and IJBs should have a joint understanding of their respective financial positions as they relate to integration (by 1st April 2019 and each year by end March)			Established	April 2019			
2.1.1	Sub-action	Medium term financial plan 2019-22 to be developed by summer 2019, followed by longer-term financial plan.	Caroline Whyte	Eleanor Currie		April 2019	September 2019	⬤	Work has started on MTFP, however due to uncertainty around future funding levels the MTFP will not be presented unitl early 2020. Work has progressed on the pressures and savings for the period 2020 - 2023.

North Ayrshire Health and Social Care Partnership

MSG Review of Integration Actions (including Joint Inspection (Adults) Action Plan)

MSG Reference number	Tree	Action	Lead	Support	Self Evaluation	start	Planned Timescale	Status	Comment on Progress
2.1.2	Sub-action	Clarity to be developed for NHS budget setting timescales to allow any financial risk to be built in to IJB budget setting timescale	Caroline Whyte	Eleanor Currie		April 2019	September 2019	🟠	Agreements in principle reached through Ayrshire Finance Leads and also with NHS DoF. Timing is dependent on SG finance settlement
2.1.3	Sub-action	Scottish government finance directorate to review in-year funding allocations to HB as these do not form part of IJB baselines and rising costs negatively impact IJBs in future years (examples are ADPs , Action 15 monies and PCIF)	Caroline Whyte	Eleanor Currie		April 2019	December 2019	🟠	Issues raised through IJB CFO Network and also with NHS DoF
2.2	**Key Action**	**Delegated Budgets for IJBs must be agreed timeously (by end March 2019 and thereafter each year by end March) (specific actions captured section 2.1)**			**Established**	April 2019			
2.2.1	Sub-action	Medium term financial plan 2019-22 to be developed by summer 2019, followed by longer-term financial plan. (also action 2.1.1)	Caroline Whyte	Eleanor Currie		April 2020	September 2019	🟠	Work has started on MTFP, however due to uncertainty around future fudning levels the MTFP will not be presented unitl early 2020. Work has progressed on the pressures and savings for the period 2020 - 2023.

North Ayrshire Health and Social Care Partnership

MSG Review of Integration Actions (including Joint Inspection (Adults) Action Plan)

MSG Reference number	Tree	Action	Lead	Support	Self Evaluation	start	Planned Timescale	Status	Comment on Progress
2.2.2	Sub-action	IJB led budget process for 2020-21 onwards, planning will commence earlier and concurrently for both social care and health to enable an integrated approach to resource allocation and to ensure the IJB will be in a position to approve a balanced budget by 31 March each year (similar action 2.1.2)	Caroline Whyte	Eleanor Currie		April 2020	March 2020	🟠	Planning process for 2020-21 budget is underway, and resource pressures have developed alongside draft savings proposals. IJB development session in October and a further session planned for the new year.
2.2.3	Sub-action	Scottish government finance directorate to review in-year funding allocations to HB as these do not form part of IJB baselines and rising costs negatively impact IJBs in future years (examples are ADPs , Action 15 monies and PCIF) Same as action 2.1.3	Caroline Whyte	Eleanor Currie		April 2020	December 2019	🟠	Issues raised through IJB CFO Network and also with NHS DoF
2.3	**Key Action**	**Delegated hospital budgets and set aside budget requirements must be fully implemented**			**Partly Established**	April 2019			

North Ayrshire Health and Social Care Partnership

MSG Review of Integration Actions (including Joint Inspection (Adults) Action Plan)

MSG Reference number	Tree	Action	Lead	Support	Self Evaluation	start	Planned Timescale	Status	Comment on Progress
2.3.1	Sub-action	Ayrshire and Arran as the pilot site for set aside. Timescales to be developed for SPOG	Stephen Brown	Caroline Whyte		April 2020	April 2020	⬤	Directions workshops have been held pan-Ayrshire to discuss consistent approach to Directions, this has included discussion re moving forwards a fair share methodology. Work is ongoing.
2.4	**Key Action**	**Each IJB must develop a transparent and prudent reserves policy**			**Established**	April 2019			
2.4.1	Sub-action	Reserves Policy to be reviewed as part of the routine review of governance documents, expectation that earmarked reserve balances will be established at the end of 2018-19	Caroline Whyte	Eleanor Currie		April 2020	November 2020	⬤	Complete - presented to PAC in September for approval and approved by the IJB in October 2019.
2.5	**Key Action**	**Statutory partners must ensure appropriate support is provided to IJB S95 officers**			**Exemplary**	April 2019			
2.5.1	Sub-action	Delegation of operational NHS finance function	Caroline Whyte			April 2020	October 2020	⬤	Local discussions have commenced.

North Ayrshire Health and Social Care Partnership

MSG Review of Integration Actions (including Joint Inspection (Adults) Action Plan)

MSG Reference number	Tree	Action	Lead	Support	Self Evaluation	start	Planned Timescale	Status	Comment on Progress
2.6	Key Action	**IJBs must be empowered to use the totality of resources at their disposal to better meet the needs of their local populations (from 31 March 2019 onwards) (captured by action 2.1.1 & 2.3.1)**			**Partly Established**	April 2019			
3	Theme	**Effective strategic planning for improvement**							
3.1	Key Action	**Statutory partners must ensure that Chief Officers are effectively supported and empowered to act on behalf of the IJB**			**Complete**	April 2019			
3.1.1	Sub-action	Review of support arrangements, including opportunities to bring support within HSCP with Council/NHS (also action 1.1.2)	Stephen Brown	Caroline Whyte		April 2019	September 2020	🟠	Discussions ongoing with partner organisations
3.1.2	Sub-action	More clarity of partnership role in partner body governance structures to avoid duplication and maximise impact and input of chief officer	Stephen Brown	Karen Andrews		April 2019	April 2020	🟠	PSMT governance arrangements workshop in September 2019. Further work required to take forward.

North Ayrshire Health and Social Care Partnership

MSG Review of Integration Actions (including Joint Inspection (Adults) Action Plan)

MSG Reference number	Tree	Action	Lead	Support	Self Evaluation	start	Planned Timescale	Status	Comment on Progress
3.1.3	Sub-action	Develop succession planning for key leadership roles (Also Action 1.1.1)	Stephen Brown	Michelle Sutherland		April 2019	April 2020	🟢	Draft succession planning arrangements reviewed by PSMT and EPSMT in October 2019. A plan to be present to the HSCP Partnership Forum in January 2020.

North Ayrshire Health and Social Care Partnership

MSG Review of Integration Actions (including Joint Inspection (Adults) Action Plan)

MSG Reference number	Tree	Action	Lead	Support	Self Evaluation	start	Planned Timescale	Status	Comment on Progress
3.1.4	Sub-action	Develop the use of data to support the chief officer in decision making and service improvement (Inspection recommendation 2 also see 1.3.2)	Caroline Whyte	Neil Mclaughlin		April 2019	April 2020	🟠	Review of PAC data process has commenced.Performance support structures are now alligned to each service area. Performance team will be in attendance at each service SMT to present, capture and discuss quartely performance progress for attributing improvements to operational practice with further support offered to provide further data analysis. Operational changes are factored into and highlighted in quarterly PAC updates. Further discussion with PAC has resulted in a refocus of the quarterly report on measures not meeting targets. This will assist discussion on: reasons for measures being outwith set targets; the actions to be put in place to being measures in line plus a proposed timescale see the improvement. Further work required to incorporate wait times information.

North Ayrshire Health and Social Care Partnership

MSG Review of Integration Actions (including Joint Inspection (Adults) Action Plan)

MSG Reference number	Tree	Action	Lead	Support	Self Evaluation	start	Planned Timescale	Status	Comment on Progress
3.4	**Key Action**	**Improved strategic planning and commissioning arrangements must be put in place**			**Partly Established**	April 2019			
3.4.1	Sub-action	Develop a clear commissioning strategy for older adult services, starting with the Care Home Commissioning Strategy (Inspection Action point 3 also see 3.1.2)	Caroline Whyte	Michelle Sutherland		April 2019	March 2020	🟢	A number of sessions have taken place with the provider Reference Group, presentation to care home forum, SPG and EPSMT on progress. Plan to present Strategy to IJB in time to inform 2020-21 budget planning.
3.4.2	Sub-action	Engage with the local LIST analysts, performance team and support from Scottish Government to develop commissioning plans for unscheduled care (has to be pan-Ayrshire)	Caroline Whyte	Neil Mclaughlin		April 2019	April 2020	🔴	ISD analysts involved in MSG baseline, projection and targets. This work is ongoing and remains an area for further development.
3.4.3	Sub-action	Internal audit review of lead partnership services will inform improvement plan	Caroline Whyte	Eleanor Currie		April 2019	March 2020	🟡	A number of recommendations made as part of the internal audit, many of these are pan-Ayrshire and link with the work to develop Directions and commissioning plans.
3.4.4	Sub-action	Clearer links to be evidenced between the strategic plans and financial plans	Caroline Whyte	Eleanor Currie		April 2019	March 2020	🟡	Work on-going linked to MTFP, Strategic Plan and TB processes

North Ayrshire Health and Social Care Partnership

MSG Review of Integration Actions (including Joint Inspection (Adults) Action Plan)

MSG Reference number	Tree	Action	Lead	Support	Self Evaluation	start	Planned Timescale	Status	Comment on Progress
3.4.5	Sub-action	Integrated workforce plan to be presented to IJB for approval (Inspection action 6 also see 3.1.2)	Caroline Whyte	Michelle Sutherland		April 2019	September 2020	🟢	Complete
3.4.6	Sub-action	Further develop performance reporting, with frequent updates on progress with delivery of strategic plan objectives	Caroline Whyte	Neil McLaughlin		April 2019	April 2020	🟠	Review of PAC data process has commenced and performance reporting now established with SPG.Further discussion with PAC has resulted in a refocus of the quarterly report on measures not meeting targets. This will assist discussion on: reasons for measures being outwith set targets; the actions to be put in place to being measures in line plus a proposed timescale see the improvement.
3.5	**Key Action**	**Improved capacity for strategic commissioning of delegated hospital services must be put in place**			**Partly Established**	April 2019			
3.5.1	Sub-action	Ayrshire and Arran as the pilot site for set aside. Timescales to be developed for SPOG (also 2.3.1)	Stephen Brown	Caroline Whyte		April 2019	April 2020	🟠	Pan Ayrshire meetings with Scottish Government underway

North Ayrshire Health and Social Care Partnership

MSG Review of Integration Actions (including Joint Inspection (Adults) Action Plan)

MSG Reference number	Tree	Action	Lead	Support	Self Evaluation	start	Planned Timescale	Status	Comment on Progress
3.5.2	Sub-action	Look to other areas and the Scottish government for examples where this has been implemented successfully	Stephen Brown	Eleanor Currie		April 2019	April 2020	⬤	Pan Ayrshire meetings with Scottish Government underway
3.5.3	Sub-action	Establish process for ongoing monitoring of set-aside arrangements and progress	Caroline Whyte	Eleanor Currie/Neil McLaughlin		April 2019	April 2020	⬤	Pan Ayrshire meetings with Scottish Government underway
3.5.4(i)	Sub-action	Develop preventative services and SDS as an asset based approach. (Inspection action 5)	Stephen Brown	Isabel Marr		April 2019	March 2020	⬤	New SDS group established to undertake a self-evaluation and consultation exercise. Workshops undertaken and savings issued.
3.5.5(i)	Sub-action	All health and social care services delivered by external providers should take account of the national health and social care standards (Inspection action 5)	Stephen Brown				September 2019	⬤	Standards in place and audited by Scottish Government return on 13/08/19
4	**Theme**	**Governance and accountability arrangements**							
4.1	**Key Action**	**The understanding of accountabilities and responsibilities between statutory partners must improve**			**Established**	April 2019			

North Ayrshire Health and Social Care Partnership

MSG Review of Integration Actions (including Joint Inspection (Adults) Action Plan)

MSG Reference number	Tree	Action	Lead	Support	Self Evaluation	start	Planned Timescale	Status	Comment on Progress
4.1.1	Sub-action	Standing orders, and key governance documents to be updated, including financial regulations, reserves policy	Caroline Whyte	Karen Andrews		April 2019	March 2020	🟠	Work underway to review key documents. Reserves policy appproved. Financial regulations are drafted for approval at future IJB.
4.1.2	Sub-action	Induction programme to be developed for IJB members	Caroline Whyte	Michelle Sutherland		April 2019	December 2019	🟠	Initial scoping has been undertaken.
4.1.3	Sub-action	Ongoing development programme for IJB members based on skills gap	Caroline Whyte	Michelle Sutherland		April 2019	April 2020	🟠	Initial scoping has been undertaken to be informed by a needs assessment.
4.2	**Key Action**	**Accountability processes across statutory partners will be streamlined**			**Established**	April 2019			
4.2.1	Sub-action	Explore ways of making performance information more publicly available and accessible (current integrated report reviewed at non-public performance and audit committee)	Caroline Whyte	Neil McLaughlin		April 2019	April 2020	🟠	Performance reporting and information has been an iterative process, when the PAC are content with the report a proposal will be brought re publishing the information.With the recent appointment to the Communications Officer postion, the HSCP web site is going through a review with a dedicated page for the quarterly PAC performance.

North Ayrshire Health and Social Care Partnership

MSG Review of Integration Actions (including Joint Inspection (Adults) Action Plan)

MSG Reference number	Tree	Action	Lead	Support	Self Evaluation	start	Planned Timescale	Status	Comment on Progress
4.3	Key Action	**IJB chairs must be better supported to facilitate well run boards capable of making effective decisions on a collective basis**			**Established**				
4.3.1	Sub-action	Ongoing development programme for IJB members based on skills gap (also 4.1.2)	Caroline Whyte	Michelle Sutherland		April 2019	December 2019	⬤	Initial scoping has been established
4.3.2	Sub-action	Improve planning for meetings to ensure a whole system approach to decision making	Stephen Brown	Karen Andrews		April 2020	March 2020	⬤	PSMT scoped a review of governance arrangements in September. Further work required to identify any potential delays.
4.4	Key Action	**Clear directions must be provided by IJB to health boards and local authorities**			**Partly Established**	April 2019			
4.4.1	Sub-action	Ayrshire and Arran HSCP Directions workshops have been established, looking to progress Primary Care and acute set-aside directions first	Stephen Brown	Caroline Whyte		April 2019	March 2020	⬤	Pan Ayrshire meetings with Scottish Government underway
4.4.2	Sub-action	North Ayrshire HSCP will develop an approach for mental health services which we lead, and take forward sample Directions for approval at the pan Ayrshire workshops	Thelma Bowers	Caroline Whyte		April 2020	December 2019	⬤	Draft will be presented for consideration at the Directions workshop

North Ayrshire Health and Social Care Partnership

MSG Review of Integration Actions (including Joint Inspection (Adults) Action Plan)

MSG Reference number	Tree	Action	Lead	Support	Self Evaluation	start	Planned Timescale	Status	Comment on Progress
4.4.3	Sub-action	NAHSCP will engage in any SG consultation on revised statutory guidance	Caroline Whyte	Michelle Sutherland		April 2021	September 2019	🔴	Draft guidance has been issued in December for consultation changes inspired by SG work with Ayrshire on directions and set aside.
4.5	**Key Action**	**Effective, coherent and joined up clinical and care governance arrangements must be in place**			**Established**	April 2019			
4.5.1	Sub-action	Improvements to link strategic commissioning and also to note any actions taken to address formal overspends, for example more reporting of impact on waiting times for services, being clear about statutory and non-statutory targets (inspection action 3 also see 1.3.2)	Caroline Whyte	Neil McLaughlin		April 2019	December 2019	🟡	Any plans to address financial overspends include the risks or impact on service delivery, more work is required to routinely report the impact of waiting lists etc to PAC as part of performance reporting. Work has commenced to review operationally available information on waiting lists for consistency of reporting, potential impact to service commissioning and overspend. Waiting list information inclusion is being prepared as a core element of the quarterly PAC report from 2020-21.

North Ayrshire Health and Social Care Partnership

MSG Review of Integration Actions (including Joint Inspection (Adults) Action Plan)

MSG Reference number	Tree	Action	Lead	Support	Self Evaluation	start	Planned Timescale	Status	Comment on Progress
4.5.2	Sub-action	Feedback from performance reports to inform and direct areas of improvement (also inspection action 3 also see 1.3.2)	Caroline Whyte	Neil McLaughlin		April 2019	December 2019	🟠	Review of PAC data process has commenced and issues to be escalated, where improvements required.Performance support structures are now alligned to each service area. Performance team attendance at each service SMT to present, capture and discuss quartely performance progress for attributing improvements to operational practice with further support offered to provide further data analysis. Operational changes are factored into and highlighted in quarterly PAC updates.
5	**Theme**	**Ability and willingness to share information**							
5.1	**Key Action**	**IJB annual performance reports will be benchmarked by chief officers to allow them to better understand their local performance data. (by publication of reports in July 2019)**			**Established**	April 2019			

North Ayrshire Health and Social Care Partnership

MSG Review of Integration Actions (including Joint Inspection (Adults) Action Plan)

MSG Reference number	Tree	Action	Lead	Support	Self Evaluation	start	Planned Timescale	Status	Comment on Progress
5.1.1	Sub-action	Reflect on local actions required following any review or benchmarking undertaken by the chief officers group (also inspection action 1 see 3.1.2)	Caroline Whyte	Neil McLaughlin		April 2019	April 2020	🔴	APR published at the end of July, benchmarking not yet been undertaken. Best practice shared at HSCP conference
5.1.2(i)	Sub-action	Improve systems for measuring individual service user outcome and have a system of reporting to IJB and other stakeholders, at locality level, to show the impact of delays and inform improvements in service delivery. (Inspection Action 2)	Caroline Whyte	Neil McLaughlin		April 2019	April 2020	🔴	Review of PAC data process has commenced to collate service user views for performance and IJB reports. There remain challenges with reporting performance at locality level.Further discussion is required to determine the most effective means for operational teams to capture service users views. The mechanism to analyse this data will be created at the same time.
5.2	**Key Action**	**Identifying and implementing good practice will be systematically undertaken by partnerships**			**Exemplary**	April 2019			
5.2.1	Sub-action	Evaluate the impact of inspection report and agree action plan (see action 3.1.2)	Caroline Whyte	Michelle Sutherland		April 2020		🟢	Complete - actions now built in to MSG approach.

North Ayrshire Health and Social Care Partnership

MSG Review of Integration Actions (including Joint Inspection (Adults) Action Plan)

MSG Reference number	Tree	Action	Lead	Support	Self Evaluation	start	Planned Timescale	Status	Comment on Progress
5.2.2	Sub-action	Consider adopting a systematic approach to canvass IJB reports to allow evaluation and identification of good practice	Caroline Whyte	Michelle Sutherland		April 2021	April 2020	●	Examples of best practice have been presented to IJB and are being presented to the National HSCP conference. Best practice examples are being collated for the annual performance report.
6	Theme	Meaningful and sustained engagement							
6.1	Key Action	Effective approaches for community engagement and participation must be put in place for integration			Exemplary	April 2019			
6.6.1	Sub-action	Communities will be invited to HSCP OD programme TDDB	Stephen Brown	Caroline Whyte		April 2019	December 2019	●	Staff sessions, foundation apprentices and student sessions are underway. Pilot community sessions were delivered in October and this approach is being explored further for a wider roll out into new year.

North Ayrshire Health and Social Care Partnership

MSG Review of Integration Actions (including Joint Inspection (Adults) Action Plan)

MSG Reference number	Tree	Action	Lead	Support	Self Evaluation	start	Planned Timescale	Status	Comment on Progress
6.6.2	Sub-action	Further consideration will be given to how we engage meaningfully with hard to reach/less visible populations	Caroline Whyte	Michelle Sutherland		April 2019	September 2019	●	LPFs and presented a 2020 vision for engagement to the SPG in November as a way forward. The HSCP presented to the National Planning and Commissioning Managers network and it was noted that our approach was further ahead than other areas. Using a new range of methods the HSCP has delivered a visible engagement approach to 3000 people in the last 5 months.
6.2	**Key Action**	**Improved understanding of effective working relationships with carers, people using services and local communities is required**			**Exemplary**	April 2019			
6.2.1	Sub-action	Build on examples of best practice and joint working	Caroline Whyte	Michelle Sutherland		April 2019	March 2020	●	Examples of best practice have been presented to IJB and are being presented to the National HSCP conference. Best practice examples are being collated for the annual performance report.

North Ayrshire Health and Social Care Partnership

MSG Review of Integration Actions (including Joint Inspection (Adults) Action Plan)

MSG Reference number	Tree	Action	Lead	Support	Self Evaluation	start	Planned Timescale	Status	Comment on Progress
6.2.2	Sub-action	Ensure governance and support for key messages and communication support to deliver consistency (Inspection Action 7 also see 3.1.2)	Karen Andrews	Comms Lead		April 2019	March 2020	⬤	New communications and engagement officer in partnership to take forward front facing communications.
6.3	**Key Action**	**We will support carers and representatives of people using services better to enable their full involvement in integration**			**Exemplary**	April 2019			
6.3.1	Sub-action	Benchmark HSCP against other partnerships	Caroline Whyte	Michelle Sutherland		April 2019	March 2020	⬤	Examples of best practice have been presented to IJB and are being presented to the National HSCP conference. Best practice examples are being collated for the annual performance report.

North Ayrshire Integration Joint Board
19th December 2019

Subject:	**Ambitious for Ayrshire Implementation of the 2018 General Medical Services Contract**
Purpose:	To present the Integration Joint Board a progress report on the Primary Care Improvement Programme and proposals for further implementation over 2020/22.
Recommendation:	**IJB are asked to :** • confirm assurance with progress of the Primary Care Improvement Plan to date • Note the continued pan Ayrshire collaboration to develop the updated PCIP 2020 / 2022 • Agree the outline Commissioning proposals in respect of delegated North Ayrshire resources for 2020 / 22 • Direct NHS Ayrshire & Arran to progress to implementation the 2020/22 North Ayrshire Commissioning Proposals • Note that detailed Directions will be proposed when the 2020/21 North Ayrshire IJB Budget is confirmed in March 2020

Glossary of Terms	
NHS AA	NHS Ayrshire and Arran
HSCP	Health and Social Care Partnership
EMG	Expert Medical Generalist
GP	General Practitioner
GMS	General Medical Services
MoU	Memorandum of Understanding
SGPC	Scottish GP Committee
BMA	British Medical Association
IJB	Integration Joint Boards
CTAC	Community Treatment and Care
MDT	Multi-Disciplinary Team

1.	**EXECUTIVE SUMMARY**
1.1	The new 2018 Scottish GMS Contract came into effect from 1 April 2018. The overall aim of the contract is to ensure patients access the right person, at the right place, at the right time.
1.2	The contract facilitates a refocusing of the GP role as Expert Medical Generalist (EMG). The aim is to enable GPs to use their skills and expertise to do the job they train to do.

1.3	This refocusing of the GP role will require some tasks currently carried out by GPs to be carried out by additional members of a wider primary care multi-disciplinary team. Integration Authorities, the Scottish GP Committee (SGPC) of the British Medical Association (BMA), NHS Boards and the Scottish Government have agreed through a Memorandum of Understanding, priorities for transformative service redesign in primary care in Scotland over a three year planned transition period**.**

The report attached at Appendix 1
- presents an update on progress within Ayrshire and Arran for 2018 / 20
- Outlines the future plans across Ayrshire and Arran for 2020 / 2022
- Seeks approval of proposed implementation arrangements for North Ayrshire HSCP. |
| **2.** | **BACKGROUND** |
| 2.1 | It is widely recognised that there is sustained pressure on Health and Care services through increasing demand and complexity and that General Practice is pivotal in delivering national policy of providing access to high quality healthcare as close to home as possible through professionals who can provide continuity of care.

The 2018 GMS contract supports national policy for the modernisation and stabilisation of Primary Care. The aim is to achieve this through the refocusing of the GP role as Expert Medical Generalist (EMG), building on the core strengths and values of General Practice. By investing in new workforce and infrastructure to support General Practice the aim is to free up time to enable GPs to use their skills and expertise to do the job they train to do.

In early 2018 a single Primary Care Improvement Plan 2018/21 was endorsed by the 3 Ayrshire IJBs, the NHS Board and the GP Sub Committee / Local Medical Committee. At that time it was indicated that further endorsement would be required as the Programme progressed and national resources were made available and a commitment given to return to partner agencies to seek that endorsement. This report fulfils that commitment.

In line with the Public Bodies (Joint Working) (Scotland) Act 2014) it reinforces that IJBs are responsible for the planning and commissioning of primary care services. Within Ayrshire and Arran, each of the IJBs delegated planning and redesign of Primary Care services through the NHS Board to the East HSCP as the lead HSCP for Primary Care |
| **3.** | **PROPOSALS** |
| 3.1 | **PRIMARY CARE IMPROVEMENT PLAN 2020 / 2022**

The second phase Ayrshire and Arran Primary Care Improvement Plan is attached as Appendix 1 of this report. It has been developed in a collaborative approach across the 3 Ayrshire IJBs the NHS Board and the local GP sub-committee / Local Medical Committee. This inclusive collaboration has been essential in presenting a report that outlines the ambition of all parties to develop our Primary care services to be both sustainable and meet the future needs of our communities.

The Memorandum of Understanding between Integration Authorities, the Scottish GP Committee (SGPC) of the British Medical Association (BMA), NHS Boards and the Scottish Government have agreed priorities for transformative service redesign in primary care in Scotland over a three year planned transition period. These priorities include: |

- vaccination services,
- pharmacotherapy services,
- community treatment and care services,
- urgent care services and
- Additional professional services including acute musculoskeletal physiotherapy services, community mental health services and community link worker services.

The implementation programme in Ayrshire and Arran has focused around these priorities and the report gives both an update on progress and proposals for future investment and development.

1. **PHARMACOTHERAPY SERVICES –** this priority area is described in Chapter 8 of the report and has seen the most significant investment to date with over 100 staff being recruited and deployed in General Practice. The implementation process has provided significant learning about skill mix, culture and governance and this is invaluable as we progress all the priorities.

2. **COMMUNITY TREATMENT AND CARE (CTAC) –** Chapter 9 of the report describes progress to date. This has included recruitment of 9 graduate Primary Care nurses who have been deployed to General Practices, to support the testing of models of care and how this will integrate with Practice employed staff and community based staff.

    At this time it is evident this will be a priority area for investment in 2020/22. We estimate that approximately 90 wte staff, Nurses and Health Care Support Workers will be required to fulfil the MOU commitments. As with pharmacotherapy the issues of skill mix, governance and culture will be key.

3. **VACCINATION TRANSFORMATION PROGRAMME -** Within Ayrshire and Arran whilst recognising the need for clarity of governance, we have recognised the interdependencies between the Vaccination programme and CTAC. These programmes are therefore aligned and good progress is being made particularly in relation to Pregnant Women, Preschool children and School Programme. Further progress with the Adult, Flu and Travel programmes are planned over 2020/22.

4. **URGENT CARE SERVICES -** Chapter 10 of the report describes proposals for implementation over 2020/22. A number of stakeholder events with HSCPs and GP Practices took place throughout 2019 with the aim of reaching an agreed vision for an Urgent Care service Feedback on largest areas of demand were:
    - Home visits
    - On the day assessment
    - Frailty patients (including anticipatory care planning)
    - Mental Health presentations

Financial planning to address these areas of demand have been based on an assumption that 34 Advanced Practitioners will be recruited. There is a risk of the availability of these numbers of skilled staff within the timescale. There is significant learning to be taken from early implementation of Advance Nurse Practitioners in GP practices that evidences a cross dependency with Community Treatment and Care. It is also recognised that the interaction with wider Multi-Disciplinary workers will have an impact. These will all be factors during implementation.

	5. **MULTI-DISCIPLINARY TEAMS IN GENERAL PRACTICE –** the MOU is clear in the transfer of task in the preceding priorities but is less clear in respect of this final area. In terms of impact this does not mean this is any less valuable and Chapter 11 of the report describes progress and proposals in respect of Physiotherapy, Mental Health Workers and Community Connectors being deployed to support General Practice. The community connector / link worker programme is well advanced and in North Ayrshire is deployed across all GP practices. Physiotherapy has been a more recent roll out of service and is closely linked to the full Musculoskeletal pathway with additional intended to be both recruited and integrated form existing services. Mental Health support available to patients in General Practice is identified as the largest need for investment. There are 20.8 wte mental health workers attached to GP practices and a need for a further 23 is identified. This programme is closely linked to the Mental Health Strategy Action 15 investment programme and is dependent on this. Leadership and management of the new MDTs will be critical to successful implementation of the programme and realisation of the benefits for patients. Chapter 12 of the report reflects the MOU and the Clinical Leadership role of MDTs, the management responsibilities of HSCPs and the future role of the wider practice team including the Practice Managers in co-ordination of the team. Within Ayrshire and Arran we have agreed a "Guiding Principles" document about how we intend to work together respecting all these roles. 6. **PRIMARY CARE PREMISES and INFRASTRUCTURE –** the successful implementation of the MOU and delivery of the wider priorities is highly dependent on the availability of appropriate premises and the ability of professionals to record, access and share information. Chapter 14 of the report describes progress and priorities in these areas.
3.2	**Anticipated Outcomes**
	Successful implementation will require General Practice to be fully integrated within a network of health and social care providers in local communities. This includes an expanded multidisciplinary team within or attached to Practices, as well as links to community health and social care teams, and voluntary sector organisations
3.3	**Measuring Impact** Implementation of the actions set out in Primary Care Improvement Plan 2020 -2022 will be monitored through the implementation workstreams who have responsibility for overseeing the transfer of tasks and new services embedding As service models develop and integrate, these will be supported by an evaluation framework to measure the impact of the change based on people, quality, service and finance.
	These will be monitored throughout the implementation phase and reported through the governance structure to IJBs, NHS Board, Local Medical Committee and Scottish Government

4.	IMPLICATIONS

Financial:	Chapter 15 of the report provides detail of the Primary Care Improvement Fund, deployment to date and projections for 2020/22. The Scottish Government has committed to invest £250million in supporting General Practice over a 4 year period. Of this sum, subject to annual budget setting decisions, it is anticipated £11.484m will be allocated to Ayrshire and Arran and as a delegated function £4,260,119 to North Ayrshire IJB. This report outlines the anticipated utilisation of the delegated resources over the period for North Ayrshire. At a local and national level there is emerging risk in respect of the sufficiency of resource to fully meet the commitments of the Memorandum of Understanding.
Human Resources:	The Primary Care Improvement Programme is a significant workforce development to enable delivery of the policy. To date the recruitment strategy in Ayrshire & Arran supported by the Implementation team has been a particular strength of the programme. The joint social media communications across NHS, IJBs and local GPs has been exemplary. For implementation working across services with the support of Human Resources and confidence of Finance to recruit against planned income has been key to keeping Ayrshire & Arran at the forefront of the programme. In the next phase of commissioning there will be a number of Human Resource Implications. Each of the report sections outline workforce opportunities and any challenges. The opportunity to bring an expanded workforce to meet the needs of local communities is the principal opportunity. The availability of sufficient qualified and experienced staff across the priorities will be a challenge, as will the management of any TUPE arrangements as services transition from General Practice to HSCPs. The most significant workforce challenge will be culture and the shift to MDT working, part of a local team around a defined population, whilst remaining feeling professionally secure in practice.
Legal:	This report presents for IJB proposals for local implementation of the Memorandum of Understanding between Integration Authorities, the Scottish GP Committee (SGPC) of the British Medical Association (BMA), NHS Boards and the Scottish Government.
Equality:	The implementation of the Primary Care Improvement Plan has at its core taken a "Once for Ayrshire" approach, seeking to ensure that all our residents, regardless of any of the protected characteristics or locality have equality of access to primary care services. Within this we recognise the accountability of IJBs to meet these standards through their commissioning plans on a local level and seek to support this.

Children and Young People	N/A
Environmental & Sustainability:	N/A
Key Priorities:	General Practice is at the core of primary care and through the implementation of the new contract, General Practice in Ayrshire and Arran will be supported to deliver, in a sustained way, the 4C guiding principles outlined to ensure patients access the right person, at the right place, at the right time. These are described in the Scottish Government Primary Care Vision and Outcomes as: • **Contact** – maintain and improve access • **Comprehensiveness** – introducing a wider range of health professionals to support the expert medical generalist • **Continuity** - enabling more time with the GP for patients when it is really needed • **Co-ordination** – providing more information and support for patients
Risk Implications:	Section 16 of the report outlines the risks to implementation. It should be emphasised that all risks are being actively managed. In summary risks to the programme are: It is recognised that there remains risk that even with the planned level of investment the full ambition of the MoU for Pharmacotherapy may not be deliverable. The new for Community Treatment and Care workforce will be a balance of qualified nurses and Health Care Support Workers. Further work is required with practices and HSCP teams to confirm skill mix, professional governance and management/oversight arrangements of staff at a practice level. This agreement remains a risk to the programme. The pace of delivery of IT systems that communicate and Information Sharing agreements remains a risk to MDT working. The availability of and pace of transfer of sufficient GP Premises to facilitate the transfer of MOU tasks to the HSCPs remains a risk to the programme. There is a financial risk to the overall delivery of sufficient MDTs to meet the requirements of the MOU. Further clarity is required in respect of funding of these posts. If Mental Health Action 15 monies are applied then the overall risk to funding of the programme as outlined is mitigated.
Community Benefits:	Only applies to reports dealing with the outcome of tendering or procurement exercises.

Direction Required to Council, Health Board or Both	Direction to :-	
	1. No Direction Required	
	2. North Ayrshire Council	
	3. NHS Ayrshire & Arran	x
	4. North Ayrshire Council and NHS Ayrshire & Arran	

5.	CONSULTATION
5.1	In developing the PCIP consultation has taken place across various leadership forums within the NHS Board and HSCPs along with the local GP Sub Committee and Area Professional Nursing Committee.
6.	**CONCLUSION**
6.1	IJB members are asked to: • confirm assurance with progress of the Primary Care Improvement Plan to date • Note the continued pan Ayrshire collaboration to develop the updated PCIP 2020 / 2022 • Agree the outline Commissioning proposals in respect of delegated North Ayrshire resources for 2020 / 22 • Direct NHS Ayrshire & Arran to progress to implementation the 2020/22 North Ayrshire Commissioning Proposals • Note that detailed Directions will be proposed when the 2020/21 North Ayrshire IJB Budget is confirmed in March 2020

For more information please contact Vicki Campbell on vickicampbell1@nhs.net Primary Care Implementation Manager

Ambitious for Ayrshire

Implementation of 2018 General Medical Services Contract

2020-2022

Ambitious for Ayrshire – Our Aim
To deliver safe, effective, person centred, sustainable Primary Care Services at the heart of the healthcare system for the people of Ayrshire and Arran

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East Ayrshire Integration Joint Board		
North Ayrshire Integration Joint Board		
Ayrshire & Arran NHS Board		
South Ayrshire Integration Joint Board		

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Contents

Foreword

In 2018 Ayrshire and Arran set out an ambitious and forward looking Primary Care Improvement Plan (PCIP) to implement a Once for Ayrshire programme transformation plan to deliver the new General Medical Services contract.

There has been significant progress in a number of areas since the development of the first PCIP in June 2018 as we strive towards introducing new ways of working that will require innovation and new models of care to be delivered across General Practice. This has involved recruiting a number of additional staff as well as carrying detailed scoping work with GP Practices and Health and Social Care Partnerships (HSCPs) to understand the scale of work and actions required to deliver against the Memorandum of Understanding and new contract.

This second plan, PCIP 2020-22, for Ayrshire and Arran continues to represent the collaborative working between our clinicians, Integration Authorities, NHS Board, and other stakeholders to build on the work to date to find solutions to the current challenges within primary care, supporting the healthcare within our communities.

In the developing the plan there has been extensive engagement with a range of health and social professional bringing them together in a programme of large scale change workshops to design service models.

We will continue to work with patients, GPs and other health, social care and voluntary sector providers on a locality basis through the next steps for development of community based services.

Eddie Fraser
Director of East Health and Social Care Partnership
Lead Partnership for Primary Care
Ayrshire & Arran

Hugh Brown
Chair of the GP Sub Committee
Ayrshire & Arran

Executive Summary

This Primary Care Improvement Plan (PCIP) is a follow up plan that has been produced setting out how the three Health and Social Care Partnerships (HSCP) work alongside General Practice and the NHS Board to deliver the implementation of the new 2018 General Medical Services (GMS) Contract.

The intention of the new contract is for GPs to become better embedded in HSCPs as senior clinical leaders working collaboratively with a multidisciplinary team and HSCP managers to achieve better outcomes for patients. To help ensure visible change in the context of the new contract the Memorandum of Understanding (MoU) focuses on a number of specific services to be reconfigured. These include:

- Vaccination Services
- Pharmacotherapy Services
- Community Treatment and Care Services
- Urgent Care Services
- Additional Professional clinical and non-clinical services including musculoskeletal physiotherapy services, community mental health services, and community link worker services

The plan describes the work that has taken place under the strategic framework of PCIP 2018-21(linked) that was developed in May 2018 to support delivery until 2021. This updated strategic plan sets out how Ayrshire and Arran will respond to local and national challenges whilst focussing on developing realistic trajectories that have been signed up to by operational teams. As with the previous PCIP, high level delivery actions have been agreed with key stakeholder groups, and been supported with the understanding that further discussion with General Practice, service providers and the public is required as implementation arrangements evolve and mature.

In developing the plan, key actions and recommendations from stakeholders and subject experts have been considered to understand the action required, ensuring these are in line with the MoU and local strategic priorities, offering a solid platform to transform how services are delivered across general practice and primary care.

We will continue to work with HSCPs and local communities to understand how our initiatives to improve quality[1] of care and access are being experienced on the ground and how we can continue to enhance the use of new technology to improve access to General Practice. Our objective to improve access not only relates to access to GP appointments, but also equity of access to extended services that are provided within General Practice.

Chapter 1: National Policy

The Scottish Government Strategic Primary Care Vision and Outcomes focuses on the modernisation of primary care to deliver a safe, effective and person-centred healthcare service in line with the 2020 vision, the National Clinical Strategy and Health and Social Care Delivery Plan 2016.

The new 2018 Scottish GMS Contract came into effect from 1 April 2018. The overall aim of the contract is to ensure patients access the right person, at the right place, at the right time. To achieve this, the contract facilitates a refocusing of the GP role as Expert Medical Generalist (EMG). This role builds on the core strengths and values of General Practice. The national aim is to enable GPs to use their skills and expertise to do the job they trained to do.

This refocusing of the GP role will require some tasks currently carried out by GPs and practices, to be undertaken by additional members of a wider primary care multi-disciplinary team – where it is safe, appropriate, and improves patient care. Integration Authorities, the Scottish GP Committee (SGPC) of the British Medical Association (BMA), NHS Boards and the Scottish Government have agreed priorities for transformative service redesign in primary care in Scotland over a three year planned transition period. These priorities include vaccination services, pharmacotherapy services, community treatment and care services, urgent care services

and additional professional services including acute musculoskeletal physiotherapy, community mental health and community link workers. GPs will retain a professional leadership role in these services in their capacity as EMGs.

The funding of general practice in Scotland has been reformed and a phased approach was agreed to implement the contract fully. The new funding formula designed to better recognise workload was accompanied by an additional £23 million investment in GMS to improve services for patients. This was implemented nationally in 2018/19.

The Memorandum of Understanding (MoU) with the new contract requires NHS Boards and local Integration Joint Boards to have a PCIP in place to set how they will deliver the priorities over a three year period (April 2018-March 2021). The final year of funding allocated through the Primary Care Improvement Fund (PCIF) will be available in 2021/22 therefore all plans set out in the PCIP will be due to implement by 2021/22.

Chapter 2: Local Context
Our Primary Care Development Plan has been developed in the context of the current national policy and what we know about the needs of our local population

In Ayrshire and Arran there was agreement in 2018 that there should be one co-ordinated PCIP produced for Ayrshire and Arran, with a focus on local priorities and delivery where services are commissioned within the HSCPs based on population need. This builds on the Lead Partnership arrangements for Primary Care where the three Ayrshire IJBs commission primary care services through EAHSCP, but still retain the overall delegated accountability for primary care in their local area. The aim of the initial PCIP was to set out a clear direction of travel, and outline the key characteristics of successful, high quality General Practice. As implementation progressed throughout 2018 and 2019 plans became more detailed with a large number of staff now transitioning into GP Practices

As well as delivering against the requirements set out in the new contract and national MoU, NHS Ayrshire & Arran and the three HSCPs have worked collaboratively to define a model of care that links closely with wider locality teams to form a fully integrated health and care system. As anticipated, the introduction of multi-disciplinary teams (MDT) working is complex and the scale of change required across professions whilst challenging, is a unique opportunity to progress a longer-term strategy of transformational change to deliver the vision for Primary Care.

Locally the PCIP was developed to sustain general practice and even with new ways of working embedding into General Practice, there continues to be increasing demand for services both within community care and within the acute care facilities. It is recognised that continuing to provide services in the current way is not a sustainable model going forward.

We have made significant progress within the delivery of the new contract. At this time there remain barriers to full realisation of the potential of the contract mechanisms. Increased investment is required in premises, digital infrastructure, software and our community workforce, to fully realise transformational change in our communities.

NHS Ayrshire and Arran are undertaking a whole system transformational programme of activity, Caring for Ayrshire, as part of our 10 year vision to reform how health and care services are delivered, including a review of current systems and infrastructure. The work carried out to date in Primary Care along with the vision and actions set out in this PCIP provides a foundation for developing a whole system health and care model which focuses on individuals, families and communities with general practice and primary care providing accessible, continuing and co-ordinated care. The aim is to empower people to take control of their own health and care as far as possible, enabling self-management, promotion of wellbeing and prevention of ill health, use of telecare and telehealth and maximising care provided in and around communities, general practices, community optometrists, general dentists and community pharmacists.

Chapter 3: Our Vision
Sets out a vision which sees GPs and GP-led multi-disciplinary teams manage a wide range of health problems, providing both systemic and opportunistic health promotion, diagnoses and risk assessments, dealing with multi-morbidity, coordinating long term care, and addressing the physical, social and psychological aspects of patients' well-being throughout their lives.

Ambitious for Ayrshire – Our Aim

To deliver safe, effective, person centred, sustainable Primary Care Services at the heart of the healthcare system for the people of Ayrshire and Arran

General Practice is at the core of primary care and through the implementation of the new contract, General Practice in Ayrshire and Arran will be supported to deliver, in a sustained way, the 4C guiding principles outlined to ensure patients access the right person, at the right place, at the right time. These are described in the Scottish Government Primary Care Vision and Outcomes as:

- **Contact** – maintain and improve access
- **Comprehensiveness** – introducing a wider range of health professionals to support the expert medical generalist
- **Continuity** - enabling more time with the GP for patients when it is really needed
- **Co-ordination** – providing more information and support for patients

Successful implementation will require General Practice to be fully integrated within a network of health and social care providers in local communities. This includes an expanded multidisciplinary team within or attached to Practices, as well as links to community health and social care teams, and voluntary sector organisations.

Over the next two years a combination of additional investment, service redesign and increased capacity will allow for workload to evolve, increasing the time available for GPs to focus on the most complex patients with sufficient time to meet their care needs, as well as increase the time for professional development.

Using the additional investment through the Primary Care Improvement Fund, the HSCPs will invest in and support General Practice to:

1. Transform how practices work to allow them to manage workload, improve access, and provide high quality services
2. Improve population health, particularly amongst those at greatest risk of illness or injury
3. Manage and coordinate the health and care of those with long-term conditions
4. Manage urgent episodes of illness or injury
5. Manage and coordinate care for those who are at the end of their lives
6. Support practices to work together in their clusters to improve quality of care and share resource, developing more resilient services to their locality based population
7. Fully integrate with community and healthcare service providers in the communities, wrapping services around people in the community

Chapter 4: Governance Framework to Support Delivery
This framework describes the programme management and governance arrangements intended to provide a foundation of good corporate governance enabling the Primary Care Transformation Programme to implement the changes outlined and agreed

The ambition, size, scale and financial investment of the pan Ayrshire Primary Care Transformation Programme required a temporary flexible organisation structure to be established to coordinate, direct and oversee the implementation of all related projects and activities in order to deliver required outcomes. This is supported by the Implementation Support Team.

The arrangements in place ensure that the programme operates to deliver its role and functions. Having a robust governance structure around the programme also provides clarity on the decision-making process delegated from the Integration Joint Boards (IJBs), NHS Board, and GP Sub Committee to the Programme Board and associated Implementation Groups set out in the structure. The structure is set out in Appendix A.

For each area of the programme there is delegated involvement, responsibility and accountability from representatives across the three HSCPs, NHS Board, and GP Sub Committee within Ayrshire and Arran.

The national MoU represents a landmark statement of intent, recognising the statutory role (set out in the Public Bodies (Joint Working) (Scotland) Act 2014) ("the Act") of Integration Authorities in commissioning primary care services and service redesign to support the role of the GP as an expert medical generalist.

The pan Ayrshire Primary Programme and implementation of the new GMS contract are governed by the following documents:

- The new GMS (2018) contract which sets out the requirements on GPs, IJBs, and NHS Board to comply with the contract.
- The national MoU between The Scottish Government, the Scottish General Practitioners Committee of the British Medical Association, Integration Authorities and NHS Boards which builds on the statutory role (set out in the Public Bodies (Joint Working) (Scotland) Act 2014) ("the Act") of Integration Authorities in commissioning primary care services and service redesign to support the role of the GP as an expert medical generalist.
- Ayrshire & Arran PCIP 2018 – 2021
- A Governance and Programme Framework to support implementation of the General Medical Services Contract (2018) in Ayrshire and Arran which describes the decision making process
- The local Ayrshire and Arran Guiding Principles to describe the relationship between the practices and services delivered at practice level by HSCPs and NHS Board.

In line with the Public Bodies (Joint Working) (Scotland) Act 2014) it reinforces that IJBs are responsible for the planning and commissioning of primary care services. Within Ayrshire and Arran, each of the IJBs delegated planning and redesign of Primary Care services through the NHS Board to the East HSCP as the lead HSCP for Primary Care.

There are four overarching Workstream Implementation Groups in place aligned to the MoU priorities, for delivery that have a series of actions and projects within them. The groups are led by a clinical lead, pan Ayrshire management lead, and a GP Sub Committee Executive Member along with dedicated project support.

Membership of all groups and subgroups developed include representation pan Ayrshire to ensure the leads responsible for delivery in each HSCP area are represented. The PCIP 2018-2021 and this PCIP 2020-22 was developed through the Implementation Groups under the oversight and scrutiny of Writing Group that was established with progress being monitored through the Oversight Group and Primary Care Programme Board

Since the introduction of PCIP 2018-2021 and as implementation has progressed there has been governance and oversight from each of the IJBs, GP Sub Committee and NHS Board at the following stages:

After the initial sign off in June 2018, a 6-month update report on progress has presented to each IJB and NHS Board twice between November 2018 and June 2019.

The Primary Care Programme Board and GP Sub Committee have been provided with a detailed progress update at every meeting, with the local Oversight Group monitoring progress of the actions and timescales, providing linkages with the National GMS Implementation Oversight Group and other national groups to progress work in line with the national direction of travel.

The Writing Group has met bi-monthly from March 2018-October 2019 to provide oversight, leadership, and direction on work required to take the high levels action set out within the PCIP to more focussed project work through the Implementation Groups.

The Implementation Groups continue to have pan Ayrshire memberships and co-chaired by a pan Ayrshire lead along with a member of the GP Sub Committee Executive. Until January 2019 the Groups met monthly, with 3 of the 4 Groups now meeting bi-monthly due to detailed work now being taken forward through project subgroups that report into the Implementation Groups.

The Implementation Progress Tracker from the Scottish Government National Oversight Group is required to be submitted every 6 months. The first report was returned in May 2019 (period October 2018- March 2019) signed off by Programme Board and Local Medical Committee. The second report was completed and returned in November 2019 (period April 2019 – September 2019) signed off by the Oversight Group, the Writing Group and Local Medical Committee.

The 7 key principles below were outlined in the PCIP, linked to the West of Scotland regional principles that underpin the transformation programme, and align to IJB Strategic Plans. These principles have been referred to during all decision making process to ensure any changes or developments are in line with the underpinning aims of the new contract.

1. **We will encourage and empower our citizens and carers to take control of their own health and wellbeing within our communities and Services.**

2. **We aim to deliver outcome-focused and responsive services for the population of Ayrshire and Arran.**

3. **Service developments will aim to improve patient health and the patient journey aligned with the goal of supporting the continuous improvement and sustainability of Primary Care.**

4. **Development of service delivery will, where practical, have clear alignment to the requirements stated within the Memorandum of Understanding and General Medical Services Contract (2018), striving to ensure continuity of team members to allow teams to develop and grow.**

5. **Service changes will, by default, be delivered to meet local needs and make best use of services available within localities and neighbourhoods recognising there will be times when, for good practical and clinical/financial governance sense, will remain pan Ayrshire.**

6. **Seek to ensure a balance between operating as a consistent, equitable service across Ayrshire and Arran alongside appropriate local flexibility to include the aspirations of local communities and professionals.**

7. **Within the context of a pan-Ayrshire improvement plan, we will support a reasonable, proportionate and consistent approach across each of the Health and Social Care Partnerships within Ayrshire and Arran**

Chapter 5: Progress So Far: Proving an update on the work undertaken during 2018/2019 as committed within the Primary Care Improvement Plan 2018-2021

A full update against each of the priority areas of the contract can be found under each relevant section later in the plan. Where advantageous, there was agreement that implementation would be taken forward on a Once for Ayrshire model that delivers a core framework across Ayrshire and Arran. It is anticipated that alongside the core framework for delivery, different areas across Ayrshire and Arran will deliver at different times, and at a different pace depending on their starting point.

It has been essential that local teams and professionals were involved as members on the Implementation Groups and key subgroups in developing detailed plans based on what works best for that HSCP community. As specific projects commenced to develop the actions set out within the original PCIP these were progressed using a detailed project specification agreed by the Implementation Groups. All projects continue to be programme managed through to implementation using the tools and methodologies in place.

Through innovative successful recruitment campaigns there have been a large number of additional workforce recruited in support of implementation across each of the workstreams from July 2018-October-2019. These include:

- Midwives to deliver vaccinations
- Primary Care Nurses
- Training Advanced Nurse Practitioners (ANPs)
- GP Clinical Pharmacists
- Pharmacy Technicians
- Pharmacy Support Workers
- Trainee Pharmacy Technicians
- Advanced Muscular Skeletal (MSK) Physiotherapists
- Mental Health Practitioners
- Community Link Workers

These new staff have been embedding in GP Practices since summer 2018 with all Practices now having access to Pharmacotherapy Support. Development of the other services is progressing with a large number of practices and patients now having access to an Advanced MSK Physiotherapist and Mental Health Practitioner to see patients as first point of contact. Initial experience demonstrates that these additional professionals in the multi-disciplinary teams are making a positive impact for both patients and practices.

With the amount of resource that has become available at the different phases throughout the implementation so far there has been a reality that the numbers of new staff with current available funding will not spread across all practices. The Framework Allocation document agreed in Ayrshire and Arran outlines the principles and processes for allocating new resource fairly and transparently. This has included involving clusters and practices in discussions with HSCP teams to allocate resource in the most effective way possible taking a range of factors into account including, demand, demographics, accommodation available, along with the appropriate mentorship and supervision can be put in place.

This is a new way of working for HSCPs, service teams, and staff within the GP Practices. It is recognised that each will require support in developing these new ways of working over the next 2 – 3 years. A range of education and engagement sessions have taken place across 2019 with all staff to understand what is required to ensure we can support services and GP Practices to embed and support new MDTs effectively.

The key element identified by all staff across the Health and Care system was effective functioning MDTs in community with the availability of specialist supports, providing confidence to local practitioners that alternatives to hospital presentation were realistic and clinically safe.

Framework to support GMS contract

In our emerging model of care the teams within General Practice will link closely with the wider locality teams as shown in the Health and Social Care Diagram below and will be supported by a range of specialist support. From the perspective of the patient this requires to be integrated and seamless support.

Ayrshire and Arran's Integrated Health and Care System

Framework to support GMS contract
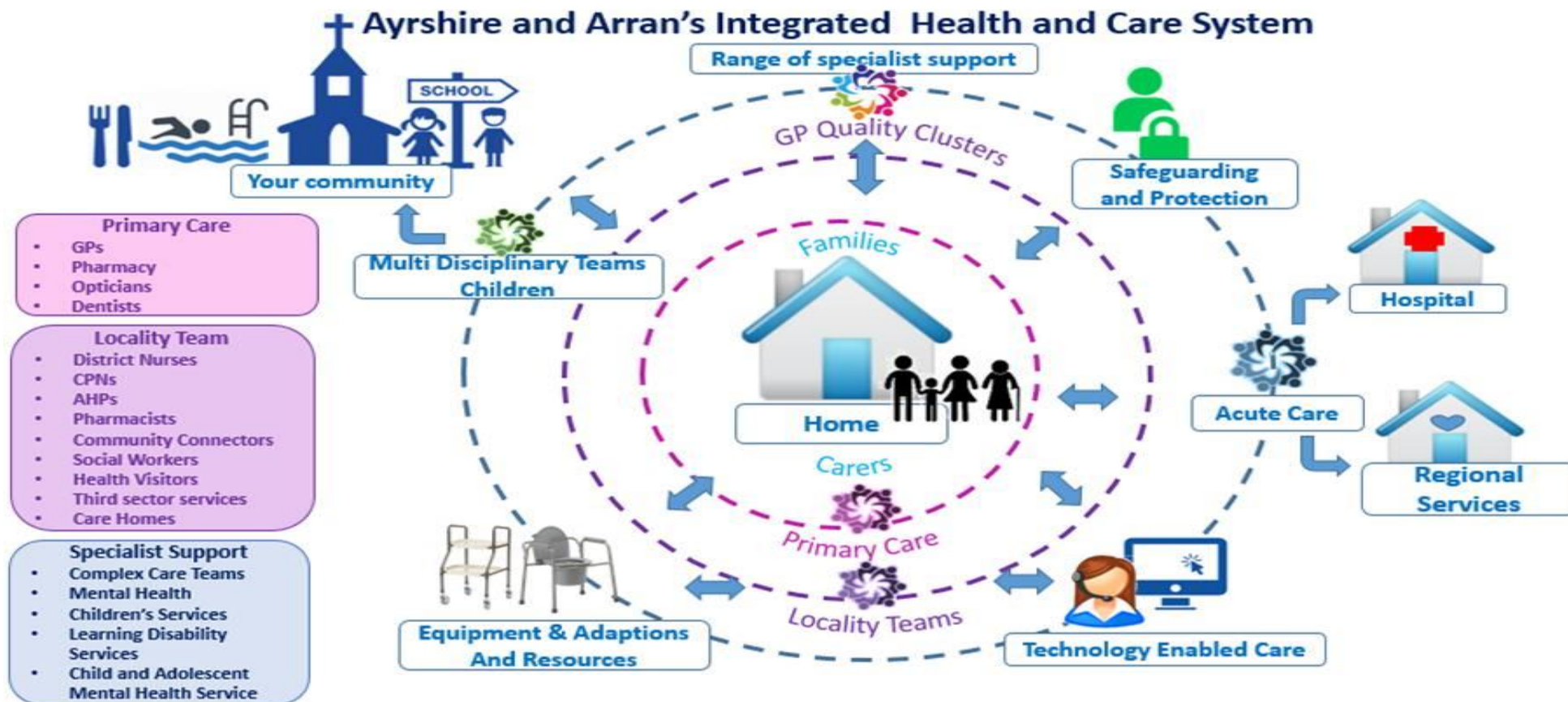
Chapter 6: Forward Plan for Ayrshire and Arran Understanding our population and current demand to plan the most efficient and effective services for the future

There are 53 General Medical Practices in Ayrshire and Arran with approximately 386,000 patients registered. 147,000 of these patients have been diagnosed with at least one lifelong chronic disease. In total there are 298,000 incidences of chronic disease with many patients suffering from multi-morbidity who require multiple clinical inputs and are on multiple medications requiring regular monitoring.

Building on our progress to date, HSCPs, NHS Board and the GP Sub Committee have considered the future requirements and next steps in our journey as we strive to meet the challenges ahead. Our focus over the initial phase has been to support and sustain General Practice maintaining high quality care and supporting our GP workforce whilst putting in place the foundations to achieve our right place, right person and right time ambition.

This two-year phase 2 plan locally sets out the steps to work towards implementing the new GMS Contract by 2021/22 focussed heavily on partnership working, integration, quality and efficiency. In developing the plan there is recognition of the range of diversity and increasing demands, expectations, and challenges in the years ahead whilst partners come together as a system to meet our local population's health and care needs.

Due to a large proportion of funding still to be allocated by Scottish Government to IJBs through Health Boards in 2020/21 and 2021/22, new service models will require phasing in across the final two years of implementation. This requires detailed workforce planning for recruitment, training, deployment and integration into practices.

Phasing choices can be agreed at an HSCP level between services and GP Practices based on priorities and should be made with an awareness of potential impact on other areas should there be a delay to certain services.

The PCIP 2018-21 was developed using a Once for Ayrshire approach with a focus on local priorities and delivery where services are commissioned within the HSCPs based on population need. There remains an ambition to deliver the new contract on a pan Ayrshire basis ensuring equitable access for patients to all services.

Key Principles for Progressing
- Once for Ayrshire
- Open and transparent as models of care continue to develop
- Equity of service and access
- Plan for what we can deliver within the current funding envelope
- A balance between spread across individual practices and practice population
- We will only truly see the benefit of the contract through implementation of effective MDT working in and around the GP Practice
- Continuity of staff to build trust within practices focussing on inter-professional relationships
- Realisation of the money we have in the PCIF assigned to delivering the new contract. The implementation of the contract is only part of the overall wider change programme – Caring for Ayrshire will allow further improvements to community led care

Framework to support GMS contract

Chapter 7: Engagement and Communication Our approach to communicating with our public and staff, as well as engaging widely in the design of services and pathways.

There is an ongoing commitment to redesign our Primary Care services, engaging fully with GP colleagues, HSCPs, the public, along with all other stakeholders and partners. Since the development of the PCIP there have been a series of engagement events with GP Practices, Clusters and discussions at HSCP GP Locality Forums, where there has been opportunity to involve GP Practices in plans and decision making.

Following the approval of PCIP 2018-21 a joint event with local GP Sub Committee took place in October 2018 with all GP Practices and HSCPs to discuss the content of the plan, explain implementation steps and seek information from practices on priorities.

In May 2019 a wide social media campaign commenced through various platforms to inform the public of the changes and new ways of working within GP Practices. This material was created working closely with GP Practices and has also been supported and shared with a variety of patient and public involvement groups, stakeholder groups and self - management groups across Ayrshire and Arran.

Three events took place in June 2019 with all GP Practices, Estates, Digital and HSCP teams to discuss current challenges with MDT working. This was an opportunity to identify where there could be solutions in the immediate future, but also to look towards a whole system clinical model wrapped around the population and GP Practices maximising digital solutions and reviewing the estate across Ayrshire and Arran.

As part of the development of PCIP 2020-22 there was a follow up event with all GP Practices and HSCPs in October 2019 to review progress of PCIP implementation and discuss proposed models and ways of working for the remaining parts of the contract not agreed. Discussions at and feedback from this event has contributed to the actions and timelines proposed.

The pan Ayrshire Engagement and Communication Group, chaired by the Head of Primary Care and Out of Hours Community Response Services, have produced an Engagement and Communication Plan for the duration of the PCIP. The programme has a plan of engagement with stakeholders to provide information on the new ways of working and what changes the public can expect to see in their GP Practice. This has not only been helpful for the public, but in attracting staff and GPs to work in the area. Feedback from local community and planning groups is that the public are feeling well informed of the changes ahead.

A schedule of individual GP Practice visits have taken place and have been planned between September 2018 – January 2019 with senior leaders in the relevant HSCP and Primary Care Team to understand how each individual practice is feeling in relation to the new contract and wider changes across their HSCP. This has been an opportunity to listen to what's important to practices to facilitate most impact from the new contract as well as how we can continue to support them during this period of transformation.

Framework to support GMS contract

Chapter 8: Pharmacotherapy Service Implementation Provides an overview of the service and actions that have agreed through the Implementation Groups and overarching Writing Group.

The GP contract includes an agreement that every GP practice will have access to a pharmacotherapy service.

The MoU states that GP Clinical Pharmacists and Pharmacy technicians will take on responsibility for:
- Core elements of the service, including: acute and repeat prescribing, medicines reconciliation, monitoring high risk medicines
- Additional elements of the service, including: medication and polypharmacy reviews and specialist clinics (e.g. chronic pain)

Ayrshire and Arran committed to a three-year trajectory from April 2018 to April 2021, to establish a sustainable pharmacotherapy service which would include pharmacist and pharmacy technician support to the patients of every practice. The vision set out was for the staff to become embedded members of core practice clinical teams and, while not employed directly by practices, the day-to-day work of pharmacists and pharmacy technicians, will be co-ordinated by practices and targeted at local clinical priorities. The implementation of the pharmacotherapy service is being led by Director of Pharmacy during the implementation period through the Pharmacotherapy Service Implementation Group. A critical success factor to the provision of pharmacotherapy services is the take up of serial prescribing and dispensing which is the subject of national enabling work. This is being rolled out through an implementation plan across all areas by March 2020 with 27 out of 53 GP Practices now signed up and operating the service. The plan is on track for all GP Practices to be using the service by March 2020 with a focussed piece of work to increase patient numbers signed up and make any further refinements required to ensure more effective and efficient use of the service.

Since June 2018 the recruitment plan has been progressed with a view to front load the service in terms of recruitment and training of the eventual required workforce. This set out an aim to have the projected number of staff in post by 2020. Approaching the workforce recruitment in this way allowed a contingency for adjustment and refinement to the provision of level one, two and three pharmacotherapy services across all practices by the last half of 2020/21.

Following the recent round of recruitment, there are now over 100 staff working to deliver a pharmacotherapy service across Ayrshire and Arran.

Allocations to date have been based on practice population size as an indicator of how much resource was required, as well as to ensure all GP Practices received access to some resource during initial roll out. Further work will take place throughout the rest of 2019/20 to ensure allocations of these staff are fairly distributed in each locality and cluster in order that practices have equitable access to pharmacy support. The level of support assigned to each practice going forward will depend on various factors including practice size, demographics and practice population need.

Through developing the Pharmacotherapy Service since June 2018, it became evident in early 2019 that a large proportion of work within practices could be carried out safely by a Pharmacy Technician or Pharmacy Support Worker, therefore reducing the need to have such a high compliment of GP Clinical Pharmacists across practices. It is recognised that a significant number of pharmacy workers are required across Scotland to deliver Pharmacotherapy in every Board area. With this in mind, Ayrshire and Arran have developed training placement models including extra rotational pharmacist roles working between acute hospital and community workplaces along with Trainee Technician roles in every area with a clear career pathway.

The service are in the process of developing standard operating procedures, protocols and other support tools for the team to ensure there is a consistent approach to pharmacotherapy work and ensure a safe, consistent and reliable service can be delivered. A recent audit carried out in all GP Practices was able to demonstrate that there are a number of practices who are making good progress with implementing the service.

A key factor of this success is having efficient, robust, and safe prescribing processes in place along with close working relationships with GPs within the practice to integrate and support the team with the new ways of working.

It is recognised that implementing new prescribing processes and procedures in Practices will require intense support from the Pharmacotherapy Team in the early stages which may be more support than what will be required on an ongoing basis to run the service. The table below shows the comparison in workforce that was projected in PCIP 2018 -21 to workforce now in post due to maximising skill mix and learning from best practice. Detailed below is the investment of finance and overview workforce.

It is recognised that there remains risk that even with this level of investment the full ambition of the MoU for Pharmacotherapy may not be deliverable.

2018- 20 Plan	Planned	In Post 2018	Gap
GP Clinical Pharmacists (Band 7)	53.4 wte	34.5 wte +=5wte rotational Pharmacists	18.9 wte
Pharmacy Technicians (Band 5)	21.4 wte	16.4 wte	5 wte
Total service	74.8 wte	55.9 wte	23.9 wte
Total estimated cost	£3,880,163		

Where we are now 2019	Staff in post Nov19	Total in Post 2019
GP Clinical Pharmacists (Band 7)		43.8 wte + 5 rotational pharmacists
Pharmacy Technicians (Band 5)		16.4 wte
Pharmacy Support Workers (Band 3)		10 wte
Student Trainee Technicians (Band 2)		3 wte
Total service	78.2 wte	
Total Projected Cost	£3,309,638	

Framework to support GMS contract

Chapter 9: Primary Care Nurse Service Implementation Provides an overview of the service and actions that have been agreed through the Implementation Groups and overarching Writing Group.

Community Treatment and Care Service

We set out in PCIP 2018-21 to scope and establish a sustainable Community Treatment and Care (CTAC) service model for Ayrshire and Arran by 2020. The 2018 GMS contract states that the responsibility for providing CTAC will pass from GP practices to Health and Social Care Partnerships (HSCPs) by 2021. These services will be commissioned by HSCPs and delivered in collaboration with NHS Boards who will employ and manage the associated nursing and HCSW workforce.

CTAC within the MoU includes but is not limited to:
- management of minor injuries and dressings
- phlebotomy
- ear syringing
- suture removal
- chronic disease monitoring and related data collection.

A Primary Care Nurse Implementation Group was set up with subject experts from General Practice, HSCPs and Primary Care to scope current arrangements, consult with key stakeholders, develop and cost a proposed model and support implement of these arrangements.

A scoping exercise was undertaken in December 2018 to establish existing CTAC interventions and current workforce data across Ayrshire and inform requirements to establish and deliver a sustainable CTAC Service in the HSCP areas.

As part of collaborative working across primary care and HSCP in the design phase, representation was sought across these areas with the aim to discuss and consider in more detail the service requirements and possible models of delivery.

The main outcomes and priorities identified from the scoping and service design work was to ensure:

- All CTAC related tasks were transferred from Practice Nursing staff to the CTAC service
- CTAC service was delivered at a practice or cluster level
- Model to interlink with wider community nursing models

Following various engagement sessions with stakeholders the principles below were agreed as priority must do for an Ayrshire and Arran CTAC Service.

1. Transfer of all tasks safely and effectively

2. Needs to deliver primary care first, whilst recognising a potential with further investment to encompass additional services, however the MoU commitment is to remove tasks from Practices first.

3. Operate with very clear professional and managerial responsibilities across Primary Care and the HSCPs.

4. Co-ordinated by the Practice – in order that day to day work is managed appropriately and has oversight.

5. Continuous – if staff member off sick the practice cannot take all the workload back on. Someone other than the Practice Manager should have responsibility for rescheduling.

Proposal for CTAC Service

To develop and grow a sustainable primary care nursing workforce, and taking into consideration the age profile of the current nursing teams, there was agreement to develop nine newly qualified nurses into the Ayrshire Graduate Nurse Development Programme (A-GRAND) offering an early career choice within General Practice as well as testing what the new Primary Care Nurse role could look like to deliver the CTAC service.

This has been a unique opportunity to develop a training programme for the newly qualified nurses who have trained in Ayrshire and Arran, offering them the chance to work closely with General Practice experts to provide a wide range of nursing interventions. The nurses are currently working in Practices across North, South and East Ayrshire undertaking a structured development programme supported by the Senior Nurse for Primary Care including higher education to complete specific learning.

Potential CTAC models have been scoped from January – October 2019 through various stakeholder workshops and design sessions with subject experts whilst also liaising with national colleagues to understand other potential models for implementation. Through all design stages there has been broad agreement that CTAC should be practice based and seamless for patients accessing the service.

As part of the scoping and design, audit work carried out with practices on current clinics and nursing interventions, undertaken was used to estimate a projected workforce that will continue to be refined working alongside practices as the service develops and embeds into practice.

Discussions have been ongoing in relation to the banding and skill mix of nurses required to deliver CTAC interventions within practice, with a recognition that multiple clinicians and levels of staff are currently employed in practice to carry out this workload.

To be able to fully understand the CTAC demands and requirements for each GP Practice to design a model to deliver this service efficiently there has been agreement that a phased approach to implementation is essential. This will enable the new models of care to be tested and evaluated in some areas and then, once the learning from the initial sites is shared and reviewed models can be adapted these can then be rolled out to other areas.

It is estimated that approximately 90 wte staff members will be required to deliver CTAC across Ayrshire and Arran based on information to date. This number also includes nurses to deliver adult at risk immunisations such as shingles, pneumococcal, hepatitis B and other groups associated with increased risk.

This new workforce will be a balance of registered nurses and Health Care Support Workers. Further work is required with practices and HSCP teams to confirm skill mix, professional governance and management/oversight arrangements of staff at a practice level. This agreement remains a risk to the programme.

In the implementation phase we also recognise the reality that the same staff may deliver different elements of the MoU for instance CTAC, Urgent Care, and immunisations.

The action plan for implementation of the CTAC service is detailed in Appendix C.

Framework to support GMS contract

Vaccination Transformation Programme

Vaccination programmes in Ayrshire & Arran have been embedded within General Practice over many years and this model of delivery has proved highly successful, however changes have to be made in light of the increasing levels of complexity of vaccination programmes and pressures across Primary Care. The MoU states that by 2021, vaccinations will have moved away from a model based on GP delivery, to one based on NHS Board delivery through dedicated teams. We have been empowered to develop local solutions to meet local needs in a planned way, progressing at a pace that ensures safe and sustainable delivery continues.

The Vaccination Transformation Programme has nationally been divided into five different work streams shown below with an update on current progress along with proposed actions to implement by 2021.

Programme	Progress 2019/20	Plans for 2020/21
1. Pre-school	• Clinical delivery model agreed along with adding additional capacity to each of the childhood nursing teams across each of the HSCPS. • It was also agreed that additional resource for delivery of childhood flu would be invested in through local HSCP childhood nursing teams.	Service will be transferred early 2020
2. School based	No changes required to current delivery model	No changes required to current delivery model
3. Travel Vaccinations and Travel Health Advice	• After scoping and discussions with current service, agreement of additional capacity of 1wte travel health nurse at travel hub clinic Ayrshire Central Hospital to assist current travel consultant and nurse. • Agreement to develop hub and spoke model in line with the approach other Boards have taken which will be chargeable service to patients requiring travel advice and immunisations.	• Recruit to the 1wte which will be two part time roles to allow cover arrangements • Continue to develop hub and spoke model with other contractors such as local pharmacies and interested GP Practices.
4. Adult influenza	• Agreement to deliver flu clinic based on current practice models where possible using additional seasonal workforce and bank staff.	• Aim to set out detailed plans to have in place for flu season 2020 delivering through local HSCP arrangements.
5. At risk and age group programmes	• Model implemented October 2018 through midwifery service for delivery of pertussis and flu vaccinations for pregnant women. • Adult Immunisations - proposed delivery of through CTAC with ongoing additional capacity in service	• To transfer adult immunisations through delivery of CTAC late 2020.

Framework to support GMS contract

Chapter 10: Urgent Care Service Provides an overview of the service and actions that have been agreed through the Implementation Groups and overarching Writing Group.

We are continuing to see high demand from patients seeking urgent care about their physical, mental health and wellbeing which can be stressful and complex to navigate, as well as putting additional workload onto practices. Our vision is to enable the population of Ayrshire and Arran to get the right care they need in the right place, at the right time, which is not always through the GP Practice. Currently urgent care is delivered:

- In GP Practices
- In partnership with the HSCPs
- Through other community contractors including pharmacies and dental practices
- Third sector
- Partners such as NHS24 and NHS Inform, by enabling informed self-care, self-management and supportive and connected communities.

As we continue to implement our new multi-disciplinary teams in practices including professionals such as Advanced Nurse Practitioners, Nursing, AHPs, Pharmacists and Community Link Workers or Connectors, Advanced MSK Physiotherapists, and Mental Health workers will often be the first point of care assessing and treating individuals presenting with urgent care needs. This approach will enable GPs to have the time to develop their role as Expert Medical Generalists focusing on caring for individuals who present with undifferentiated, chronic and complex illness.

People often know what care they need and through our local approach to signposting patients to the most appropriate person we are seeing

evidence of patients feeling more informed about services available locally or within their GP Practice. The role of administrative staff in GP practices is key to directing patients and supporting them to navigate care. Over 200 staff from across Ayrshire and Arran have undertaken triage training at different levels to support how they appoint patients or signpost them onto other services. There has also been targeted sign posting work carried out working closely with clusters in each HSCP to promote community working and approach with other community assets.

A number of stakeholder events with HSCPs and GP Practices took place throughout 2019 with the aim of reaching an agreed vision for an Urgent Care service Feedback on largest areas of demand were:

- Home visits
- On the day assessment
- Frailty patients (including anticipatory care planning)
- Mental Health presentations

The contract made particular reference to home visits as an area where other professionals and Advanced Practitioners, could provide input and release GP time to provide greater focus and continuity of care for individuals with complex health needs. The Urgent Care Implementation Group agreed as a first action in 2018 to review the existing pattern of home visit provision across Ayrshire and Arran, seeking to learn from good practice.

Framework to support GMS contract

Proposal for Urgent Care Service

A review of home visit activity was undertaken to identify demand and to project the total number of advanced practitioners that would be required to meet demand. This information was cross-referenced with feedback from clusters and it was projected that approximately 34 advanced practitioners would be required over the next 2 years to deliver an urgent care service based on this home visit activity across Ayrshire. Following discussions with GP Practices, there has been feedback that Practices would prefer to use the advanced practitioner resource for home visits and also on the day assessment depending on practice need. It has been agreed that the workload and use of the practitioner will be defined by the practice.

There are a number of programmes ongoing across Ayrshire and Arran in relation to frailty, anticipatory care planning, and single point of contact. It is recognised that further work is required to link these areas of working with urgent care pathways in General Practice. This will be taken forward in a structured way with key colleagues across the whole system.

As outlined earlier in the plan, it is anticipated that new and existing members of staff will work to deliver across a number of elements of the MoU. For instance MDT members (Mental Health Practitioners and Advanced MSK Physiotherapists) will contribute to the urgent care response within practices. Developing the Urgent Care Model will also be an opportunity to work with practices to train, develop current staff, and 'grow our own' workforce who aspire to become advanced practitioners with a structured funded training programme.

There is a risk that there is insufficient workforce available to recruit to the advanced practitioners required to deliver the Urgent Care Model. We anticipate General Practice Nurses and the Primary Care Nurses as they gain experience they will be well placed to develop into these roles, providing a resource that is experienced in Primary Care and local networks.

Links to Other Urgent Care Services

Through the Minor Ailment Service (MAS) community pharmacies are increasingly becoming the first port of call for eligible patients for a range of common clinical conditions. The Scottish Government is committed to extending and expanding MAS so that it was available to everyone – this will launch in April 2020. Ayrshire and Arran has added to the range of common clinical conditions treatable by community pharmacists under the Pharmacy First Ayrshire service. Women between 16 and 65 can now be treated for uncomplicated urinary tract infections and patients aged two years and over, can also be treated for impetigo. Both conditions previously required prescriptions through GP practices or Out of Hours services.

Locally we have also expanded on this format by adding other skin infections and shingles and intend to further expand on this. Expanding the range of common clinical conditions treated will improve outcomes for patients and reduce the workload for GPs and other health and social care professionals. A number of community pharmacists are qualified as Independent Pharmacist Prescribers, providing clinics from their community pharmacy, in conjunction with local GP practices. These clinics include respiratory clinics, as well as hypertension and sexual health clinics. Further training and development of this workforce will unlock a further resource that can play a role in the multi-disciplinary team and promote patient self-management of long-term conditions, improving outcomes for people.

Community optometrists provide a comprehensive eye examination service model to care for an aging population. The eye examination is universally funded and therefore free of charge to all eligible patients. Geographical access to eye care at optometrist practices across Ayrshire and Arran is good. Community Optometrists in Ayrshire and Arran also provide a first point of treatment for minor eye ailments through Eyecare Ayrshire

Framework to support GMS contract

Chapter 11: Multi-disciplinary Teams in General Practice Provides an overview of the service and actions that have been agreed through the Implementation Groups and overarching Writing Group.

The introduction of MDT working is complex and the scale of change required across professions is a unique opportunity to progress a longer-term strategy of transformational change to deliver the vision for Primary Care. The teams within General Practice will also link closely with the wider locality teams as shown in the Health and Social Care Diagram on Page 10. For the purposes of the implementation of the contract, the Implementation Group has focussed only on the GP Practice based team as outlined in the MoU.

The ambition of the MDT is to deliver care to the patient in a seamless way, reducing the number of visits and number of professionals working with a person and their family. As outlined in the contract and MoU, the introduction of these services relies on the establishment of new workforce that will be part of the practice teams, but not employed by them.

Additional MDT staff should, where appropriate, be attached to GP practices to provide direct support to these practices under the oversight of GPs as senior clinicians. Trusting and continuity of professional relationships will be key to the effectiveness of MDTs. A guiding principles document has been developed to support this team working. Some MDT members will be attached exclusively to a single GP practice while others may be required to work across a group of practices (e.g. Clusters). Workforce arrangements will be determined locally and agreed as part of the HSCP delivery plans.

Many of the MDT staff deployed into HSCPs will be employed by the NHS Board and work with local models and systems of care agreed between the HSCP, local GPs and other key stakeholders within services.

Staff will work as an integral part of local MDTs. NHS Boards, as employers, will be responsible for the pay, benefits, terms and conditions for these staff.

Existing practice staff will continue to be employed directly by practices unless there is a transfer of task through TUPE arrangements. Practice Managers, receptionists and other practice staff will have important roles in supporting the development and delivery of local services. Practice Managers should be supported and enabled to contribute effectively to the development of practice teams and how they work across practices within Clusters and in enabling wider MDT working arrangements.

Key to achieving efficient joint working between professionals will be the implementation of the new GP IT system being led nationally. The new systems aim to be more intuitive and user friendly. They will be quicker, more efficient, with increased functionality allowing more efficient working across professions in the MDT, underpinned by strong service levels and performance management, with clear lines of responsibility and accountability, providing, overall, a more professional GP IT Service. It is expected this will begin to roll out winter 2020.

Scottish Government are leading on the Joint Data Controller agreements for data to be shared more easily across various professional groups and GP Practices ensuring more efficient and joined of working to support patient journeys. It is anticipated this agreement will be in place by the end of 2019/20.

The pace of delivery of IT systems that communicate and Information Sharing agreements remains a risk to MDT working.

Framework to support GMS contract

Through innovative successful recruitment campaigns there have been a large number of additional workforce recruited in support of implementation across each of the workstreams from July 2018-May-2019. These are described in more detail under each of the professions noted below.

Mental Health Practitioners (MHPs)
Since March 2019, there has been a roll out of a new model for MHPs being based in General Practice as first point of contact practitioners. These roles are funded through PCIF and Mental Health Action 15 monies using a pan Ayrshire model. The MHPs are currently only assessing patients and signposting on to other services if required. By increasing the number of MHPs available for GP Practices, there would be opportunity for the role to support and treat patients following assessment without the need to refer onto other mental health services if possible.

Early data for the first 6 months of having these roles in GP Practices shows:
- a high number of patients are requesting to see an MHP or being triaged by practice reception staff as first point of contact
- 92 % of those being assessed were not known to Mental Health Services
- Only 16% of people assessed required a prescription for medication
- 7% of total presentations were referred onto to community mental health services for ongoing treatment

Further work is required to understand overall patient journeys and longer-term benefits, however patients and GP Practices are reporting the early benefits of having a first point of contact MHP role available in practices for patients to self-refer to or be signposted to. This has been requested by all GP Practices as a priority. Capacity and current service models within Community and Primary Care Mental Health teams does not allow for this level of resource to be based in General Practice.

There are now 20.8 wte MHPs based across 34 GP Practices with the roll out plan proposing a further 23 wte across Ayrshire and Arran to cover all GP Practices. If Mental Health Action 15 monies are applied then the overall risk to funding of the programme as outlined on page 24 is mitigated.

There is a risk to recruiting to all the required roles and oversight of recruitment across all HSCPs and other Mental Health Services will be needed to ensure there is not a knock on impact to other services.

Advanced MSK Physiotherapists Practitioners (APP)
There was agreement in previous PCIP to invest in an additional 7 wte first point of contact APP roles to provide this specialist care in the right place at the right time in GP Practices. Due to the reduction in demand to core MSK services during the initial test with these roles, there was an aim to create a shift from all MSK Physios being based within acute services to a more blended model with General Practice. There are now currently 11 wte physios employed, as well as a MSK Lead role providing professional leadership across 26 practices.

The number of patients seeing the MSK Physiotherapists in GP Practices continues to rise each month with demand now much higher than first anticipated in previous reports. Early results from May 2019 show that:
- 67% of patients are signposted as a first point of contact with the Physiotherapist
- Only 1.7% of these required to be redirected to a GP
- 75% of these patients were given self-management advice

Recent evaluation of the service and referral rates to core MSK Service has highlighted that, although there continues to be a reduction in referrals to core service from some General Practices, this is not consistent and at the rate originally projected. This requires closer review, but early findings indicate that when a GP Practice only has a small of amount of MSK Physio time in practice (for example 1 day) this is not having any impact on referrals or how MSK demand is managed in practices.

It has been acknowledged that further additional resource will be required to enhance the service provision in some areas. On this basis the roll out plan includes proposal for an additional 3 wte MSK Physio roles with an expectation that an additional 3 wte MSK roles will transfer from core MSK service over 19/20 and 20/21. If the predicted ongoing reduction in demand to core MSK service is achieved, there is a commitment to the transfer of further posts.

There are a range of ways to be referred into core MSK Services and there is a risk that, although GP Practice referrals may reduce, close scrutiny will have to be given to other referral sources throughout the redesign of how this service is delivered.

ANP Academy

The Primary Care ANP Academy was established in September 2017 to develop a new workforce of Primary Care Advanced Nurse Practitioners.

This programme offers Practice Nurses working in General Practice in Ayrshire and Arran, the opportunity to develop into the role of an Advanced Nurse Practitioner whilst maintaining their salary and contract of employment.

Cohort 3 of ANP Academy Commenced in September 2019 with 22 nurses in total projected to complete training by 2021.

No proposals have been put forward for future cohorts at this stage and the aim is to blend the ANP Academy approach with the 'grow your own' CTAC and Urgent Care Service model therefore funding for training will be available through this route.

Community Link Workers

The new GMS contract recognises the place of 'Community Link Workers' functioning as part of a broader Multi-disciplinary Team whilst not being prescriptive regarding the role and function and local operational arrangements.

The new contract defines the Community Links Worker as a non-clinical practitioner based in or aligned to a GP practice or cluster who works directly with patients to help them navigate and engage with wider services. They often serve a socio-economically deprived community or assist patients who need support because of for example, the complexity of their conditions

Across Ayrshire and Arran there are 25.5 wte Community Link Workers across 49 Practices. Some are funded through the PCIP and others through HSCP resources.

Whilst East and North HSCP have now fully recruited to meet planned resources, South Ayrshire HSCP have reported they require a further 1.5wte workers to ensure full practice coverage. This will be included within detailed implementation plan.

Full details of the roll out numbers within the MDT are included within Appendix E. It should be noted that the GP Clinical Pharmacist role is included as part of the Pharmacotherapy Service within Appendix B.

Chapter 12: Leadership and Management of New Multidisciplinary Teams

The new GMS contract establishes GPs as Expert Medical Generalists whose responsibilities include local and whole system quality improvement, and local clinical leadership for the delivery of general medical services under GMS contracts.

The national MoU identifies that EMGs "will strive to ensure robust interface arrangements, connection to and coherence with other parts of the wider primary care team (e.g. nurses physiotherapists), health and social care community-based services and with acute services where required. The EMG will be supported by a MDT; maximising the contribution of both clinical and non-clinical staff in medicine, nursing, allied health professions, links workers, practice management, administration and others."

There is an explicit understanding that part of this role will be senior clinical leadership of the multi-disciplinary teams. Line management of much of the primary care multi-disciplinary team staff will be provided through the employing authority (usually NHS Boards). The purpose of the line management is to support staff in their role as a member of the primary care multi-disciplinary team attached to one or more practices and their patient lists. While all professionals involved in patient care have a leadership role to play, the senior clinical leadership role of doctors will be outlined in the GP role in Primary Care Improvement Plans.

Practice Managers have a key role in the management and co-ordination of the MDT teams, working with various service leads within HSCP arrangements to ensure appropriate service provision within the practice through having oversight of patient access and leave arrangements as well as service commissioning arrangements to the practice. Practice Managers will require ongoing support in this new way of working which is being led by the local Centre of Excellence Team who provide development to Practice Managers.

Leadership which is intended to improve outcomes for patients will clearly require collaborative working with a wide variety of professionals who will be involved in primary care multi-disciplinary teams. Various members of these teams will also undertake leadership roles to achieve changes and improvements. There are many examples of effective teams whose membership have different employers. Many GPs will have had experience of this with district nurses and other professionals not directly employed by their practice. The MOU is a clear statement of intent to deliver this form of team working. We have agreed shared principles to ensure these teams operate in optimum ways to the benefit of patient care. Some of these primary care multi-disciplinary team members will be attached to individual practices but inevitably, in some cases, resources may have to be shared between different practices. GP clusters will have an important role in facilitating cross practice working including developing common working practices and pathways. We believe that the best way to deliver the 4Cs and relationship-based care to patients is through the effective relationships between the members of these primary care multi-disciplinary teams.

There is an agreed Ayrshire and Arran Guiding Principles document which works within the specifications of the national contract MoU to further explore the agreed ways of working between Ayrshire & Arran General Practice, North Ayrshire Health and Social Care Partnership (H&SCP), South Ayrshire Health and Social Care Partnership, East Ayrshire Health and Social Care Partnership and NHS Ayrshire & Arran. It focusses on the delivery of the key priorities of the national MoU to promote collaborative working across clusters and with wider health and social care.

IJBs have the responsibility for the planning of health and social care services for their local population and commission delivery from the HSCPs, NHS Ayrshire & Arran, third and independent sector providers.

Chapter 13: -Feedback on New Ways of Working

Over the last 18 months GP Practices have adapted to the new changes within the contract along with additional staff being based in practices. Feedback and comments have been received throughout the implementation. This section also sets out specific examples of the benefits to having these new roles based in General Practice for patients and the practices.

Advanced MSK Physiotherapist
Patient Feedback

Patient 1 -As someone who regularly suffers from lower back problems, I reluctantly called my GP for a routine appointment in despair weeks after my back had went, receptionist advised a physio was starting in 2 days! He gave me great reassuring advice which got me straight back into work and back to being more mobile everyday! Also ensuring I receive the right follow up treatment. I had tried every stretch I could Google, Yoga and chiropractors! If I had to wait 3 weeks for a routine appointment and then a referral to a physio I honestly do not know how I would have managed and would have had to take more time off work. Cannot praise this service enough

Patient 2 - My mum has Achilles tendonitis. I printed her some exercises off from MSK website but it failed to settle. She'd previously waited 1 year for physio to her knee so was despairing at thought of long wait yet again. Mum was delighted to be triaged see a physio, few days later who gave additional advice and plan of action. As a GP myself I wholeheartedly endorse the concept of multidisciplinary working and look forward to surgery I work at having a CPN join the team shortly

Patient 3 – I want to commend the decision to have practice based MSK Physiotherapists. I have recently used the service and found the advice and support provided to be very helpful indeed. I believe the service has helped me understand my condition and take the appropriate exercises which will prevent more serious problems at a later date. Importantly this allows me to continue to have a good health and exercise regime which is a key preventative measure at the age of 66 which will hopefully lessen the need for me to make demands on the wider system. In my view the provision of a physiotherapy service in the GP Practice is a very proactive positive decision.

Mental Health Practitioner

Patient Feedback - I hadn't been sleeping well for a few months and phoned my GP practice to see if I could get an appointment with my GP. When I was asked to describe my symptoms to the receptionist, I felt a bit embarrassed but when she explained that it was so that she could refer me to the most appropriate person I told her how I'd been feeling. She asked me if I'd like an appointment with the Mental Health Practitioner that day and explained that the appointment slot would be 45 minutes. The MHP was really understanding; I had time to talk about how I was feeling and she listened patiently, provide re-assurance that my feelings were normal and suggested some techniques that would help me to unwind and relax prior to going to bed. I felt better for just talking about how I was feeling and was able to put the techniques in place and get back to a normal sleeping pattern. I didn't even know my GP practice had an MHP but I think this is a really good service for patients.

GP Practice Staff Feedback

(GP): When asked how he felt about the new MHP service, he replied "I think it is great having MHP here, but I feel it would be more useful if you could see patients back for reviews".

(Receptionist): When asked how she felt about the new MHP service, she replied "The benefits are self-explanatory, I have patients calling and actually asking for triage call from mental health practitioner, it is taking loads of pressure away from the GP triage in the morning".

(ANP): When asked how she felt about the new MHP service, she replied "Well put it this way, we hate it when you are off, it has definitely enhanced the service that this practice provides".

Primary Care Nurse

The nine newly qualified nurses have been working in General Practice since January 2019 integrating to the teams and working to the top of their competence framework in a short space of time. Practices have embraced the new role in practices reporting the support the Primary Care Nurse role has had in supporting the general practice nursing team.

The development of this role has encouraged support and mentorship from nurses employed by the practice, building up trust and confidence although the Primary Care Nurse is not directly employed by the practice, but through the HSCP/NHS Board. This joint working to support the patient journey and share the workload in practices aligns fully with the aim of the new contract and MoU.

We are seeing emerging examples of culture change. At a recent GP Practice visit meeting which took place with the HSCP Director and GPs, the Primary Care Nurse interrupted the meeting to seek advice from the GP regarding a patient. The GP immediately responded to support the nurse and returned a short while later to the meeting. This demonstrated that Primary Care nurse felt comfortable to interrupt the GP for advice and also that the GP trusted the nurse's assessment of the situation with the patient.

Pharmacotherapy Service

A GP Practice with 10,509 patients serving a deprived population with high levels of health and care need have been working closely with the pharmacotherapy team of 1 wte GP Clinical Pharmacist and 0.2 wte Pharmacy Technician to support and integrate them into the practice team. They have worked collaboratively to implement robust and efficient prescribing processes, utilising limited repeat function meaning there are fewer acute prescriptions and workload is more manageable. All medication reviews are up to date and they have full confidence in their prescribing systems.

The Pharmacotherapy Team are doing the majority of the prescribing work in the practice with the practice and team hopeful that with a small amount of additional workforce going into the team, they will be in a good position to achieve the requirements of the MoU. Feedback from the team and GP Practices is if we get the systems and processes right then a high

quality safe prescribing can be guaranteed, reducing acute numbers and allowing a planned approach to medicine management in each practice.

Practice Staff Feedback - To have a member of the (pharmacy) team available in the back office works really well as you have the opportunity to refer any queries that are pharmacy related directly which is more efficient than passing to a GP and waiting for a response.

Community Link Worker

Patient feedback

Patient 1 - I attended GP as felt I was not coping with my husband, who has terminal cancer – I was always a very active, sociable and happy person – but recently feel isolated, agitated, etc. After discussion with GP, who thought I was on the verge of depression, I was referred onto the Community Link Worker (CLW)

I had good long discussion with the CLW she was very patient and advised that I should be looking after myself and discussed the possibility of a local walking group, arts and crafts, etc. I have now joined the local walking group and have joined local knitting club. I attended my GP for follow-up and said how much better I was and I am enjoying the time to myself without feeling guilty and feel I am coping better with my husband and his illness and feel if I had not had the chat with the Leona I may have ended up taking meds that I did not want to and feel that this is an excellent service.

Patient 2 - I think that the CLW service is great – for the following reasons:-

- Time to talk
- Time to get all feelings out about things I am worried about
- Offers different options
- It is like "sitting chatting to pal" – The CLW puts you at ease and seems genuinely interested in me
- Don't feel under pressure and anxious like I have done in the past going to CPNs, Psychiatry appointments – get worked up going to these places – feel they don't have the same time

Chapter 14: Primary Care Premises Introduces a number of measures designed to manage the risks of GPs carrying the responsibility for premises

One of the overarching aims of reforming General Practice is to improve infrastructure and reduce risk in areas such as ownership of premises, IT and information sharing. These areas are being taken forward and explored on a national basis with a view to transitioning new arrangements by 2020

The National Code of Practice for GP Premises was published on 13 November 2017. Following the acceptance of the GMS contract offer by SGPC, Scottish Government and Health Boards are working to implement the Code of Practice. The Code sets out plans to offer interest-free secured loans to GPs who own their premises. It sets out the steps that GP contractors who lease their premises privately must take if they wish their Health Board to take on the lease.

GP Owned Premises
New interest-free sustainability loans will be made available, supported by £30 million investment over 2019/22. There were 12 loans submitted and approved from Ayrshire and Arran.

GP Leased Premises
The Scottish Government's long-term strategy is that no GP contractor will need to enter a lease with a private landlord for GP practice premises. NHS Boards will gradually take on the responsibility from GP contractors for negotiating and entering into leases with private landlords and the subsequent obligations for maintaining the premises. NHS Boards will ensure that GP contractors are provided with fit-for-purpose accommodation which complies with the standards set by the Premises Directions.

If a lease expires before 1 April 2023, the most likely course of action is for the NHS Board to negotiate a new lease or provide alternative accommodation.

If the lease expires after 1 April 2023, NHS Boards will take on the existing lease from GPs where:
- The practice has ensured that its premises are suitable for the delivery of primary care services and are sufficient to meet the reasonable needs of its patients
- The practice has met its statutory obligations regarding the premises
- The practice has provided all relevant information to its NHS Board
- The practice has given sufficient notice to its NHS Board of its need for assistance
- The practice has registered the lease with the NHS Board
- The practice has the agreement of the landlord to the assignation of the lease (and the other necessary conditions)
- The practice has complied with its obligations under its existing lease
- The rent represents value for money

The availability of sufficient space in GP Premises to facilitate the transfer of MoU tasks to the HSCPs remains a risk to the programme.

Chapter 15: Primary Care Improvement Fund
Provides a financial summary of the overall investment from each IJB against the funding required against of the implementation programmes.

Funding Allocation

The Integration Joint Boards and NHS Board have received confirmation from Scottish Government of the allocated Primary Care Improvement Fund for 2018/19 and 2019/20 which will be used by IJBs to commission primary care services and is allocated on an NRAC basis through Health Boards to IJBs.

To assist with preparation of the PCIP, Scottish Government has announced its commitment to increase the overall funding to £250 million by 2021-22. Strictly as a planning assumption, and subject to amendment by Ministers without notice, the IJBs have been advised that it is expected that the Primary Care Improvement Fund (PCIF) increased to £55 million in 2019-20, and will further increase to approximately £110 million in 2020-21, and £155 million in 2021-22. This will, as this year, be distributed on an NRAC basis. This has allowed early planning assumptions for investment to be made within the PCIP.

All PCIF in-year allocations should be considered as earmarked recurring funding. It should be assumed therefore that staff may be recruited on a permanent basis to meet the requirements set out in the MoU. Scottish Government will engage with the IJBs and NHS Boards over the three years on any plans to baseline these funds.

Investment Required

Through each of the Implementation Groups initial work has been carried out to understand the investment required from now until 2022.

Due to a large proportion of funding still to be allocated to Health Boards in 2020/21 and 2021/22, new service models will require phasing in across the final two years of implementation. Phasing choices can be agreed at an HSCP level between services and GP

Practices based on priorities and should be made with an awareness of potential impact on other areas should there be a delay to certain services.

For example the delivery of adult vaccinations and adult flu will rely on the introduction of CTAC services in all areas no later than September 2020. Projections of staff have been made on this basis to support HSCPs with decisions and ensure there is no knock on impact to vaccination delivery.

The service models projected are based on all GP Practices having access to every service described within this plan. At present this remains a financial risk to delivery of the programme. Where there is overspend highlighted as a result of ensuring equity of access to all practices, work will continue to mitigate this be refining models and skill mix during 2020/21 before the final PCIF allocation in 2021/22.

In line with legislation and accountability. The required investment detailed in the implementation action plans has been divided into IJB area for each year, along with WTE share, based on that IJB's NRAC share of the funding. As noted earlier in this document, the aim is to deliver a core pan Ayrshire service delivery model where possible in General Practice, with the recognition that there may be slight variation in delivery models based on the HSCP local delivery plans and population need.

Changes or adjustments to the PCIP as it develops and matures will require to be signed off by the LMC. Any discussions on variation of service delivery models should take place through the Implementation Groups in the first instance and then escalated to the Writing Group or Oversight Group where required

Summary of Investment Primary Care Improvement Fund – East Ayrshire Integration Joint Board

	2018/19	2019/20	2020/21	2021/22
Allocation (NRAC 33%)	£839,378 (70% of allocation)	£1,332,761	£2,689,500	£3,789,720
Funding Available from previous years		£277,555 (30% with SG) £213,000	£296,442	£47,956
Total Available	£839,378	£1,823,316	£2,985,942	£3,837,676
Pharmacotherapy	£278,975	£855,000	£1,123,000	£1,123,000
Primary Care Nurse	£50,130	£153,000	*£930,752	£1,264,721
Urgent Care	£61,973	£74,847	**£336,378	£792,581
MDT	£190,788	£369,027	£474,856	£845,800
Programme Delivery	£36,735	£73,000	£73,000	£36,500
Total Spend	£618,601	£1,526,874	£2,937,986	£4,062,602
Balance	£220,596	£296,442	£47,956	-£224,926 + 36, 500 (prog delivery) = 188,426 gap

*CTAC Nurses – 9 month of spend (August 19 – March 20)
**Urgent Care/Home Visit Service – 7 months of spend for additionality (Sept 19 – March 20)

Note – any slippage shown is from agreed roles/services that have been phased in to make affordable in year for each HSCP
- **Any planned underspend will be carried forward to support the service in future years on a recurring basis.**
- **Each budget will be closely monitored and discussed with HSCP if more than the originally planned underspend begins to show**

Summary of Investment Primary Care Improvement Fund – North Ayrshire Integration Joint Board

	2018/19	2019/20	2020/21	2021/22
Allocation (NRAC 36.7%)	£941,120 (70% of allocation)	£1,493,895	£3,015,500	£4,249,080
Funding Available from previous years		£311,000 (30% with SG) £29,799	£2,812	£10,839
Total Available	£941,120	£1,834,694	£3,017,812	£4,260,119
Pharmacotherapy	£492,096	£940,000	£1,176,530	£1,176,530
Primary Care Nurse	£56,292	£172,578	*£956,053	£1,419,343
Urgent Care	£69,188	£61,000	**£211,000	£884,640
MDT	£240,691	£585,000	£585,000	£955,944
Programme Delivery	£41,103	£73,304	£78,390	£39,195
Total Spend	£899,370	£1,846,882	£3,006,973	£4,475,652
Balance	£41,750	£2,812	£10,839	-£215,533 +£39,195 (prog delivery) = 176,338 gap

* CTAC Nurses - only 7 months of CTAC service (Sept 19 – March 20)

** Urgent Care/Home Visit Service – only 5 months of Urgent Care Model (Nov 19- March 20)

Note – any slippage shown is from agreed roles/services that have been phased in to make affordable in year for each HSCP
- Any planned underspend will be carried forward to support the service in future years on a recurring basis.
- Each budget will be closely monitored and discussed with HSCP if more than the originally planned underspend begins to show

Summary of Investment Primary Care Improvement Fund – South Ayrshire Integration Joint Board

	2018/19	2019/20	2020/21	2021/22
Allocation (NRAC 30%)	£763,071 (70% of allocation)	£1,240,500	£2,445,000	£3,445,200
Funding Available from previous years		£258,000 £13,523	£33,023	£36,338
Total Available	£763,071	£1,512,023	£2,478,023	£3,481,538
Pharmacotherapy	£398,735	£848,000	£1,001,689	£1,001,689
Primary Care Nurse	£46,691	£161,000	*£799,432	£1,203,578
Urgent Care	£57,410	£69,000	**£218,535	£729,687
MDT	£212,620	£328,000	£349,029	£726,605
Programme Delivery	£34,092	£73,000	£73,000	£36,500
Total Spend	£749,548	£1,479,000	£2,441,685	£3,698,059
Balance	£13,523	£33,023	£36,338	-£216,521 +£36,500 (prog delivery) = £179,021 gap

*CTAC Nurses – includes 8 months of cost (Aug 19 – Mar 20)

** Urgent Care/ANP service – includes 7 months of cost (Sept 19 – March 20)

Note – any slippage shown is from agreed roles/services that have been phased in to make affordable in year for each HSCP
- **Any planned underspend will be carried forward to support the service in future years on a recurring basis.**
- **Each budget will be closely monitored and discussed with HSCP if more than the originally planned underspend begins to show**

Chapter 16: Summary of Risks Provides an overview of risk identified throughout each of the contract areas and actions that are being progressed to mitigate against these.

Pharmacotherapy
It is recognised that there remains risk that even with this level of investment, the full ambition of the MoU for Pharmacotherapy may not be deliverable. In Ayrshire and Arran we have strived to develop the Pharmacotherapy Service as a priority with practices, testing skill mix to ensure best value, as well as designing the most efficient processes and systems to make delivery more achievable. As we move forward and continue to support practices with this new way of working with the funding and workforce plan outlined, the service will continue to monitor implementation closely, providing additional support where required and revising skill mix and models where appropriate to do so.

By taking this approach the service will be able to identify during 2020 which additional support is still required to achieve the ambition of the MoU.

Community Treatment and Care (CTAC)
This new workforce will be a balance of qualified nurses and Health Care Support Workers. Further work is required with practices and HSCP teams to confirm skill mix, professional governance and management/oversight arrangements of staff at a practice level. This agreement remains a risk to the programme. With a view to implement this service by September 2020, there will be opportunity to explore different ways to deliver the most efficient service in practices safely, using a blend of skill mix and expertise before confirming the final agreed workforce numbers. The funding profile committed for this area allows for a blend of skill mix between agenda for change Band 3 and Band 5, along with provision to support to HSCPs with management and professional leadership. There will be ongoing oversight and updates provided as to how this model develops in conjunction with HSCP teams and GP Practices.

Vaccination Transformation Programme
The delivery of adult immunisations and adult flu by winter 2020 relies on the implementation of CTAC by September 2020. Any delay to this service being agreed and delivered through HSCP teams will delay the transfer of these vaccinations. The delivery of adult flu vaccinations in winter 2020 will also require staff to agree to sign up to extra hours as well as the use of bank staff to carry out the number of flu clinics needed.

The travel advice hub and spoke model will be designed and implemented 2020/21 – 2020/22 due to the training and development needs to deliver this service safely.

Urgent Care Service
There is a risk that there is insufficient workforce available to recruit to the advanced practitioners to deliver the Urgent Care Service Model. We anticipate as the Primary Care Nurses gain experience they will be well placed to develop into these roles, providing a resource that is experienced in Primary Care and local networks.
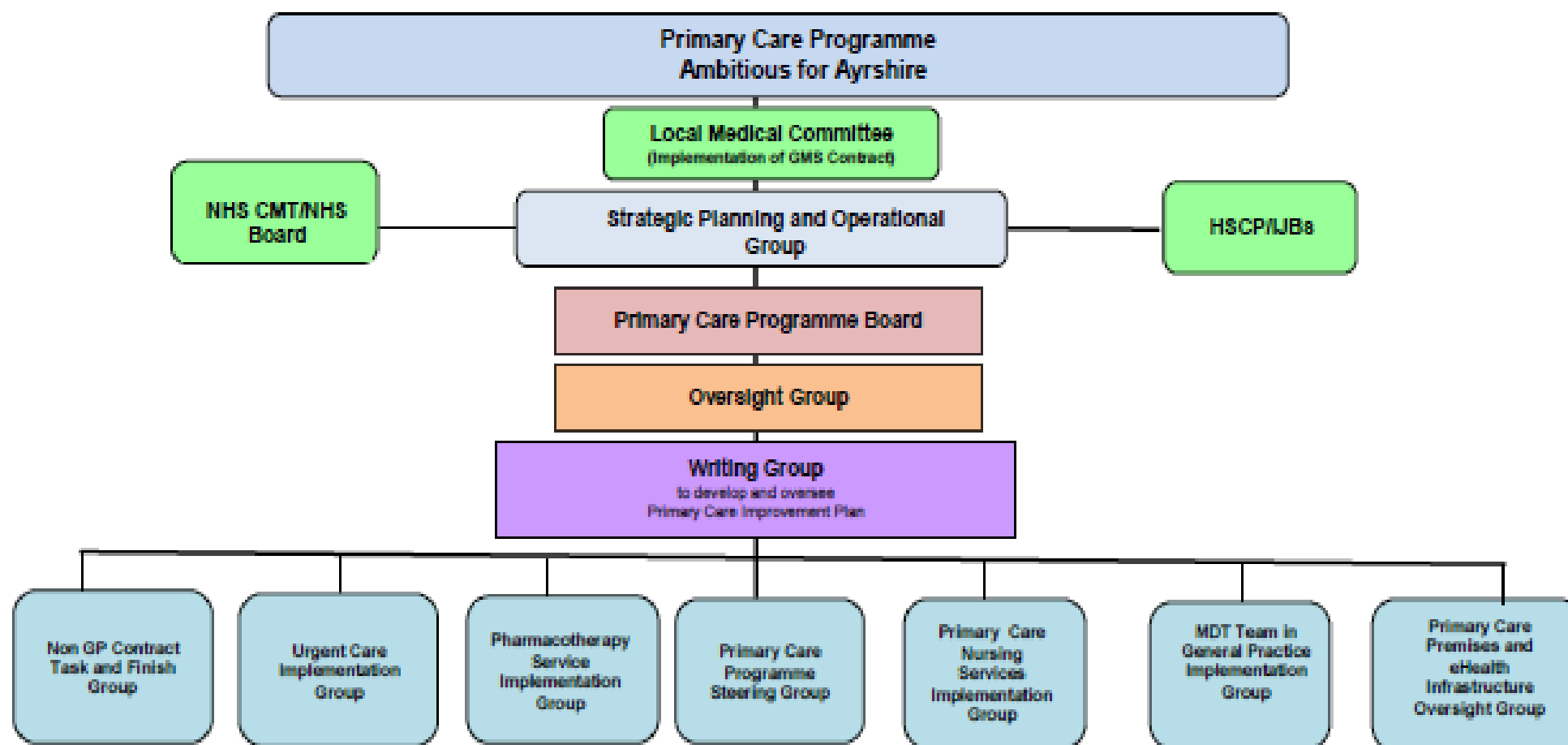
Effective Multi-disciplinary Teams in General Practice

The pace of delivery of IT systems that communicate and Information Sharing agreements remains a risk to MDT working. We will continue to provide work-around solutions in practices where possible until another solution is implemented.

The availability of sufficient GP Premises to facilitate the transfer of MoU tasks to the HSCPs remains a risk to the programme whilst a number of additional staff are already taking up posts in practices. We have worked with 42 practices to arrange the removal of case notes from practices to create space and supported practices with small improvement grants to make adaptations to accommodate more members of staff. This has not been possible for all practices due to space being available but we continue to look at hosting arrangements or other ways of working to ensure practices and patients still gain access to the services available.

There is a financial risk to the overall delivery of sufficient MDTs to meet the requirements of the MoU for all Practices. Further clarity is required in respect of funding of these posts. If Mental Health Action 15 monies are applied then the overall risk to funding of the programme as outlined on pages 28 -30 is mitigated.

Throughout the report we have developed our planning and investment proposals to deliver the task transfer of the MoU jointly between, GP profession, HSCPs and NHS Board. At this time we are confident that this will substantially deliver towards the contract agreement. We have also highlighted a number of significant risks in terms of the sufficiency of resource both human and financial to fully deliver all tasks for all practices. This is an area that will require transparent review as we progress the plans.

Primary Care Programme Ambitious for Ayrshire

Local Medical Committee (Implementation of GMS Contract)

NHS CMT/NHS Board

Strategic Planning and Operational Group

HSCP/IJBs

Primary Care Programme Board

Oversight Group

Writing Group
to develop and oversee
Primary Care Improvement Plan

- Non GP Contract Task and Finish Group
- Urgent Care Implementation Group
- Pharmacotherapy Service Implementation Group
- Primary Care Programme Steering Group
- Primary Care Nursing Services Implementation Group
- MDT Team in General Practice Implementation Group
- Primary Care Premises and eHealth Infrastructure Oversight Group

Membership Agreed for Implementation Structure to Date

Oversight Group	Writing Group
Director of East HSCP (Accountable Officer) Chair GP Sub Committee Secretary GP Sub Committee Associate Medical Director for Primary Care (Professional Lead)	The Head Primary Care and Out of Hours (co-chair) Secretary GP Sub Committee (co-chair) Associate Medical Director Primary Care Associate Nurse Director Primary Care Director of Pharmacy Director of Public Health (Children's Services Lead also) Three Representatives from GP Sub Committee North HSCP Representative – Clinical Director South HSCP Representative – Partnership Facilitator Programme Manager

Urgent Care Implementation Group	Pharmacotherapy Service Implementation Group	Primary Care Nurse Service Implementation Group	MDT Implementation Group
Associate Medical Director Primary Care – Co Chair GP Sub Exec Member – Co Chair Head Primary Care and Out of Hours Community Response Services ANP Clinical Lead – Out of Hours SAHCP – AHP Consultant Practice Manager x 2 NAHSCP Senior Manager Senior Nurse for Primary Care	Director of Pharmacy Co-Chair Chair GP Sub – Co-chair GP Stakeholder NAHSCP – Primary Care Mental Health Services Lead SAHSCP – Clinical Director Lead Pharmacists x 2 Lead Community Pharmacists Practice Manager x 2	Associate Nurse Director –Co-Chair Secretary GP Sub – Co-Chair Chair VTP Implementation Group Clinical Lead Phlebotomy Management Lead Phlebotomy Director of Public Health Senior Primary Care Nurse SAHSCP – Associate Nurse Director NAHSCP – Head of Service, Children and Families, Senior Nurse, Team Leader for MHS Lead Community Pharmacist Practice Managers x 2	AHP Lead EAHSCP – Co-Chair GP Sub Exec Member – Co Chair NAHSCP Rep – Team Leader Mental Health & Senior Manager Locality Services SAHSCP – Partnership Facilitator Senior Primary Care Nurse Clinical Nurse Manager ANPs Clinical Lead MSK Physio Lead Pharmacist Practice Manager x 2

Priority: Pharmacotherapy Service		Appendix B
Objective	**How do we get there**	**Timescale**
Arrangements to establish a sustainable pharmacotherapy service by 2021	Establish project structure and governance arrangements with planning team to focus on meeting objective testing staffing level assumptions through pilot working	2018/19
Rollout serial prescribing and dispensing	Establish a systematic and standard approach for initial identification and take-up of suitable patients; documentation templates; phased implementation and roll out plan	2018/19
	Roll out on track for all Practices to be signed up to service in March 2020 with a focussed piece of work over next 12 months (March 2021) to maximise uptake.	2019-21
Leadership and Training Academy	Establish a Pharmacotherapy/Education and Training leadership structure along with a refreshed management structure to reflect eventual model of pharmacotherapy service.	2018/19
Workforce Recruitment	Recruit to projected workforce for Band 8b Leadership role x 1 wte Band 7s x 18.9 wte + Band 5s 5 wte	2018 - 2020
	To reflect changes in skill mix projections and provide greater resilience to service recruit extra 3 wte Band 7 GP Clinical Pharmacists	2020/21
Monitor Implementation for Readiness of Task Transfer	Once all practices have access to some pharmacotherapy resource carry out audit to create baseline data for tasks that cannot be counted using extracts from practice systems	2019/20
	Look for unusually high numbers of acute prescribing compared to other practices with a similar list size. This will enable us to work with the practice to look at improving systems and processes to reduce numbers.	2019/20
	Create policies and procedure to maximise on all systems and processes where high quality safe prescribing can be guaranteed, reducing acute numbers and allowing a planned approach to medicine management in each practice.	2019/20
	Adjust skill mix to enable delivery completion of tasks in a timely manner	2019 - 2021
	Work with team to proactively manage workload on a week to week basis accounting for leave and cover arrangements	2020/21
	Continuously evaluate service for readiness of transfer in March 2021	2019 -2021
	Provide regular reports on state of readiness and advise of formal position in October 2020	2020/21

Priority:	Primary Care Nurse Service Community Treatment and Care Services & Vaccination Transformation Programme	Appendix C

Key Action set out in Memorandum of Understanding	How do we get there	Timescale
• Management of minor injuries and dressings • Ear syringing • Suture removal • Chronic disease monitoring and related data collection	1. Group established to carry out full scoping exercise to understand the current workforce and requirements with an aim to propose model Oct 19	May -2018 – October 2019
	2. Test Primary Care Nurse model with new graduates – providing training and development in community and primary care nursing	2018/19
•	3. Further refine CTAC model and detailed service specification with HSCP Leads to allow recruitment and ready to roll out service by September 2020.	Nov 19 – May 20
Phlebotomy	Secondary Care Blood Requests	
	1. Phase 1 – test site renal and urology	June 2018– October 2018
	2. Phase 2 – Extend to other specialties	October 2018 – March 2019
	3. Phase 3 – Provide Phlebotomy Service for General Practice	September 2020/21
Vaccination Programme		
Pre-school Programme	1. Scope and cost a pan Ayrshire model for agreement	August 2019
	2. Implement new model (including flu)	January 2020
School based Programme	1. No changes	
Travel vaccinations and travel health advice	1. Develop hub and spoke model with current travel health clinic within Ayrshire	2019/20-2020/21
Influenza Programme	1. Agreement to deliver via nurse bank/primary care nurse development roles	October 2020
At risk and age group programmes (pregnant women shingles, pneumococcal, hepatitis B	1 Pregnant Woman to be delivered by midwife at 20 week scan within Ayrshire Maternity Unit. A cost of up to 2.5 wte midwives to expand the service will be required.	October 2018
	2. All other adult age group vaccinations to be delivered via Community Treatment and Care Service	September 2020

Priority:	Urgent Care Service	Appendix D

Key Action set out in Memorandum of Understanding	How do we get there	Timescale
Advanced Practitioner Resource to assess and treat urgent or unscheduled care presentations and home visits within an agreed local model or system of care	**Access Multi-Disciplinary Team (MDT) Practitioner Resource to assess and treat urgent care presentations by:**	
	1. Link to MDT workstream to establish standardised pathways for Advance Practitioner Resource to assess and treat urgent or unscheduled care presentations	2018-20
	2. Develop signposting algorithms / pathways linked to clinical decision making 2018-20 in line with MDT development	2018-20
	3. Provide infrastructure /pathways for consistent signposting / navigation across A&A in line with MDT development (signposting training, NHS24 / H&SCP directories, Linkworkers / Community connectors)	2018-19
	4. Scope Remote and Rural specific requirements and solutions	2018-19
	5. Support implementation for NHS24 Practice Websites where add value	2019/20
	6. Maintain Eyecare Ayrshire and continue to promote	2018-21
	7. Maintain existing Pharmacy First and promote	2018-21
	8. Maximise the uptake of community pharmacy as a first port of call for common clinical conditions by utilisation of the Minor Ailment Service (MAS)	2018-21
	9. Support the development of Independent Pharmacist Prescribers (IPPs) for common clinical conditions	2018-21
	10. Undertake social media / communication campaign for right care, right person, linking to national work as appropriate – scoping and planning	2018-21
	11. Create a local collaborative with clusters to undertake quality improvement activity including minimising home visits	2018/19
	12. Scope home visit activity, demography, ANP involvement and practice protocols across practices, learning from good practice	2018/19
	13. Create Urgent Care Service linking to MDT and Primary Care Nurse workstream to enable continuing development of community teams.	2020-2021
	14. Develop 'grow our own' approach to training advanced practitioners to achieve required 34 wte advanced practitioners across all GP Practices.	2020-2021

Priority:	Multidisciplinary Team in General Practice	Appendix E
Key Action set out in Memorandum of Understanding	**How do we get there**	**Timescale**
Advanced MSK Physio	1. Recruited to 7 additional MSK Physio posts (11 wte in total)	2018/19
	2. Recruit to additional 3 wte to further enhance service (1wte per HSCP)	2020/21
	3. Present plan to show additional resource phasing out from core MSK service to GP Practices	2020/21
Primary Care Mental Health Services	1. Testing of MHP role in General Practice concluded that an additional 23 wte Band 6 MHPs were required. **East – 8 wte, North – 8 wte, South 7 wte** These roles will be phased in as funding allows within IJB allocated funding, including any funding from Mental Health Action 15	2020-2021
Community Link Workers	1. Group established with HSCP Leads to review number of Link Workers in post and scope current roles.	
	2. Initial scoping identified South Ayrshire required 1.5wte to ensure full coverage across all practices in line with other HSCPS	2020/21
Development of ANPs	1. Development of 12 ANPs through ANP Academy – includes academic study and mentoring/supervision in their place of work. Cohort 1 of 14 commenced September 2017	Committed
	2. Cohort 2 – 3 students and spread across additional GP Practices. Reduced number due to evaluation taking place and learning to take place on cohort 1	September 2018
	3. Cohort 3 – 7 students	September 2019
	4. Future development of ANPs will be through the Urgent Care Service model	

Integration Joint Board
19th December 2019

Subject:	**NAHSCP Staff Engagement results 2019**
Purpose:	To report key findings from the staff engagement tools iMatter and Our Voice, which shows comparatively high levels of engagement across the Partnership
Recommendation:	IJB to note the findings of the staff engagement iMatter and Our Voice and to note that ongoing work to continuously support engagement improvement is being taken forward using team improvement action plans.

Glossary of Terms	
HSCP	Health and Social Care Partnership
iMatter	A team-based engagement process used in H&SC Partnerships and the NHS - sponsored and monitored by the Scottish Government
Our Voice	North Ayrshire Council Staff Survey
NAC	North Ayrshire Council
NHS AA	NHS Ayrshire and Arran

1.	EXECUTIVE SUMMARY
1.1	In 2019 NAHSCP staff engagement scored comparatively highly, as measured by the Scottish Government's iMatter team process (79%) and Our Voice – the North Ayrshire Council's Staff Survey (72.5%). A copy of the full analysis is noted at **Appendix 1**. Results indicate specific areas of strengths: • Generally high levels of engagement: NAHSCP attained comparatively higher engagement scores in the iMatter survey and in three of the four components measured by the NAC survey. • NAHSCP attained a 67% engagement improvement action plan upload (compared with an average of 53% for NHS Ayrshire and Arran). Ongoing work to continuously support engagement improvement with staff is being taken forward using this team improvement action plan approach. • Both surveys recognise that the partnership is a positive place to work with 79% rate for iMatter (compared to 76% NHSAA) and 76.5% for Our Voice NAC staff wishing to remain working for the organisation (compared to 75.41% other NAC staff).

1.2	Possible areas identified for improvement are: • Encouraging more teams to take part in the iMatter process - not all teams reached their target response rates and consequently received no team-specific reports ("no reports") or uploaded a team improvement action plan. • Encouraging continuous improvement in all aspects of engagement and team-specific improvements in engagement. • Continuing to improve workload management, demands and opportunities to influence transformational change.
2.	**BACKGROUND**
2.1	This year, NHS and NAC staff (1474 staff in 204 teams) responded to the iMatter questionnaire and 548 NAHSCP Council staff responded to the NAC Our Voice survey. NAHSCP contributes to the aggregate iMatter results for NHSA&A (reported nationally).
2.2	The iMatter questionnaire is aimed at all Partnership staff and is a tool to help improve staff engagement. The iMatter questionnaire does not collect written comments.
2.3	Our Voice is a NAC staff survey which this year covered engagement, health and wellbeing plus Health and Safety. There is an ability for staff to leave written comments.
2.4	This IJB paper comments only the engagement results of the NAC survey alongside the iMatter results.
3.	**PROPOSALS**
3.1	IJB is asked to note the proposed areas of strength and proposed areas for improvement stated as stated in section 1.2.
3.2	**Anticipated Outcomes**
	IJB has evidence that individuals and teams in the Partnership continue to be engaged and the managers in the Partnership promote engagement. The evidence includes: • The comparatively high levels of engagement in the Partnership and how these compare with the rest of NHS A&A and the Council. • Our contribution to NHS A&A KPIs (we have comparatively higher response rates, engagement levels and action plan uploads) • Our contribution to NAC engagement levels (we have a comparatively higher overall engagement level)
3.3	**Measuring Impact**
	Staff engagement is seen as an enabler to individual and team performance and so Partnership performance. Through monitoring measurements and activities to enhance staff engagement NAHSCP can get the best for its staff and in as a result of this work, for its service users and patients.

4.	IMPLICATIONS	
Financial:	N/A	
Human Resources:	Higher engagement can lead to greater job satisfaction and better performance. Teams have identified how to continuously enhance engagement using service improvement action plans.	
Legal:	N/A	
Equality:	N/A	
Children and Young People	N/A	
Environmental & Sustainability:	N/A	
Key Priorities:	These staff engagement interventions support the strategic priorities and strategic plan 2018 – 2021, the Participation and Engagement Strategy and the Workforce Plan.	
Risk Implications:	N/A	
Community Benefits:	N/A	

Direction Required to Council, Health Board or Both *(where Directions are required please complete Directions Template)*	Direction to :-	
	1. No Direction Required	x
	2. North Ayrshire Council	
	3. NHS Ayrshire & Arran	
	4. North Ayrshire Council and NHS Ayrshire & Arran	

5.	CONSULTATION
5.1	Sheena Stewart (L&OD Advisor) provided Our Voice data and Craig Robertson (Planning and Performance Assistant, NAHSCP), who is a member of the Our Voice Working Group, provided support with interpretation of the results for the Partnership. iMatter and Our Voice staff engagement results will be presented to the Strategic Planning Group, which has previously noted the engagement work with our communities through 'What Matters to You' analysis and our developing 2020 engagement vision.
6.	CONCLUSION
6.1	IJB is asked to note the contents of the report. Ensuring on-going and positive staff engagement enhances the effectiveness of the Partnership as an organisation and strengthens the message that our staff tell our communities about health and social care.

For more information please contact [Michelle Sutherland or Calum Webster] on [Tel. No. [01294 31 7751 OR 01294 31 7815.] or [MSutherland@north-ayrshire.gov.uk or calumwebster@north-ayrshire.gov.uk]

Appendix 1: Staff Engagement results NAHSCP 2019

Summary

In 2019 NAHSCP staff engagement scored comparatively high, as measured by The Scottish Government's iMatter process and NAC's Staff Survey:

- NAHSCP scored higher in terms of employee engagement (79%) when compared with NHS Ayrshire and Arran combined scores (76%).

- NAHSCP scored higher in terms of employee engagement (72.5%) when compared with the combined scores for services in NAC (70.67%).

Possible areas of strength suggested by the results:
- There are generally high levels of engagement: NAHSCP attained generally high engagement scores in iMatter and in three of the four components measured by the NAC survey.

- Follow through: NAHSCP attained 67% action plan upload (an indicator of follow through) compared with an average of 53% for NHS Ayrshire and Arran.

Possible areas of improvement suggested by the results:
- Encouraging more teams to take part in the iMatter process (not all teams reached their target response rates and consequently received no team-specific reports ("no reports") or uploaded an action plan).

- Encouraging continuous improvement in all aspects of engagement and team-specific improvements in engagement.

- Continuing to improve workload management, demands and influencing change.

Engagement in NAHSCP

Two mechanisms we use to measure and develop engagement in the Partnership are iMatter and the NAC Our Voice staff survey. This year, NHS and NAC staff (1474 staff in 204 teams) responded to the iMatter questionnaire and 548 NAHSCP Council staff responded to the NAC Our Voice survey.

The iMatter process

iMatter is a team-based process to developing engagement where team members individually complete a questionnaire, collectively develop an action plan and fulfil the actions they agreed. This process is repeated on an approximately annual cycle. The iMatter questionnaire is not a staff survey but a measuring tool to stimulate focus on what each team in the Partnership does well and what could be better in terms of engagement.

Each team member completes the 29-item questionnaire that looks at the individual's engagement in their role, the team (including line manager) and the person's engagement

with the Partnership. If a team's response rate threshold is reached, a team-specific report provides an anonymised and collective view of team members to inform their action plan. Assuming the Partnership receives the necessary response rate, the collective scores of teams are compiled into a team report for the Partnership which also provides a "staff survey" profile. iMatter uses only a numerical rating scale and, because it is not a staff survey, collects no written comments.

The Scottish Government commissioned Webropol Ltd to undertake the work to report staff experience in Health and Social Care. The iMatter questionnaire, portal and reporting are administered by Webropol. The Scottish Government monitors four iMatter KPIs of questionnaire response rate, employee engagement index (EEI - described later), action plan uploads and number of "no reports". NAHSCP contributes to the results (and KPIs) of NHS North Ayrshire and Arran.

Our Voice - The NAC Staff Survey
The NAC staff survey has numerical ratings of questions and collects written comments. Managed by NAC's Learning & Organisation Development, the survey is issued to all services in the Council including the HSCP. In addition to staff engagement, the survey covered other areas such as health and wellbeing plus health and safety. Engagement is examined in a different way to iMatter. The NAC survey uses eight questions to consider four variables:

- Identification (Relating to the Council aims)
- Advocacy (Speaking positively about NAC)
- Retention (Desire to remain working with the Council)
- Commitment (Going above and beyond the role)

By combining the scores for the questions on these four aspects, it is possible to get an indication of engagement across the Council and across the Partnership.

What does iMatter tell us about engagement in the Partnership?
Engagement scores are comparatively high.
This is evidenced by the response rate to the questionnaire, the resultant scores and the number of action plans uploaded into the iMatter portal.

The iMatter report presents results for all 29 items (questions) and gives three "high level" results that are useful indicators of engagement:

- Response rate – ie the overall response rate to complete the questionnaire (for teams greater than four members, 60% response rate is needed to generate a team-specific report)
- EEI (Employee engagement index – a number compiled from 28 of the 29 questions)
- An "Overall" question, q29, known as "The Thermometer score" ("On a scale from 0 to 10, Overall working in my organisation is a . . .")

Additionally, the number of action plans agreed and uploaded is an important indicator of engagement (and engagement with the iMatter process). Completing the questionnaire takes fewer than five minutes – it is the discussion on how to improve engagement that demands the time of the manager and the team.

The results for this year's iMatter are:

2019	NHS Ayrshire and Arran	NAHSCP*
Response rate	60%	61%**
EEI	76%	79%**
Thermometer score	6.94	7.12**
Action plans uploaded	53%	67%

* NAHSCP results contribute to the NHS Ayrshire and Arran results
** NAHSCP scored higher (better) on every questionnaire item compared with the composite results for NHS Ayrshire and Arran.

From the iMatter perspective, where might we get better?

This report recommends two areas for improvement.

1. Encouraging team-specific improvements

   Partnership-wide, our lowest scoring items are around visibility of senior leaders and involvement in decisions about the Partnership. However, our scores here compare favourably with scores for these questions in comparison groups. It is not a recommendation of this report that we necessarily take action on these scores but it may be a consideration.

   Our scores are very consistent year on year (eg EEI is up 1% since 2017).
   In terms of engagement as measured by iMatter, while there is definitely room for improvement in every item, our engagement is generally high and there is no obvious area of specific weakness across the Partnership.

   Key areas of improvement are generally team-specific so improvement is best done through encouraging teams to take part in activities that improve engagement and to take a continuous improvement approach.

2. Encouraging participation in the iMatter process

   - Although our number of action plans uploaded is relatively high, it is not 100%. The iMatter process is not a "measuring process" - its primary focus is taking action to improve engagement.

   - Not all teams got the required response rate – 33% of the teams in the Partnership did not reach the required response level this year (NHS A&A was 34%) and consequently received no team-specific report. We do not know what engagement is like in these teams so it is important that we encourage participation in the process from all teams.

What does the NAC staff survey tell us about engagement in the Partnership?

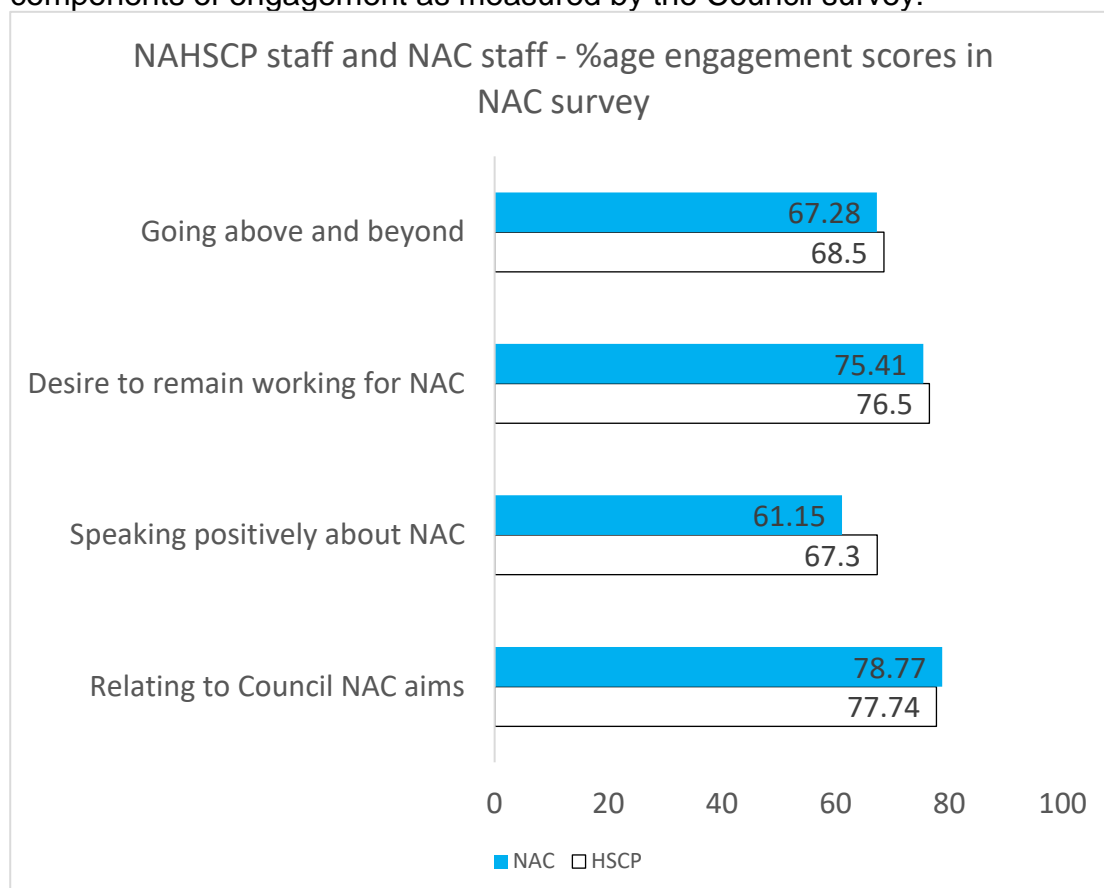Our engagement scores are generally comparatively high.

In terms of the overall engagement score, NAHSCP scores higher than the Council as a whole although our average response rate was lower than the Council overall average.

2019	NAC	NAHSCP*
Overall engagement	70.67%	72.5%
Response rates	46.2%	44.8%**

*NAHSCP scores contribute to the overall NAC engagement score and response rates.
** The NAC survey followed iMatter which had a 61% response rate.

Furthermore, the Partnership scores higher or slightly higher on three of the four components of engagement as measured by the Council survey:

NAHSCP staff and NAC staff - %age engagement scores in NAC survey

Component	NAC	HSCP
Going above and beyond	67.28	68.5
Desire to remain working for NAC	75.41	76.5
Speaking positively about NAC	61.15	67.3
Relating to Council NAC aims	78.77	77.74

Note: The NHSCP scores contribute to the total scores for NAC.

From the NAC Our Voice perspective, where might we get better?

- Work pressures and transformational change

The NAC survey suggests that around 20% of staff who responded are not engaged (NAC average is a little over 21%) and around 7% of respondents are actively disengaged (NAC average is 8%). This might be due to variables highlighted in our lower scoring items around having too much to do at work and that there were too many demands on staff by different people. Additionally, it may be around having insufficient opportunities to influence change or not being clear on how changes will work in practice.

**North Ayrshire Health and Social Care Partnership
Performance and Audit Committee**

**Thursday 26 September 2019 at 11.40 a.m.
Council Chambers, Cunninghame House, Irvine**

Present
John Rainey, NHS Ayrshire and Arran (Chair)
Councillor Timothy Billings, North Ayrshire Council (Vice-Chair)
Louise McDaid, Staff Representative, North Ayrshire
David Donaghey, Staff Representative, NHS Ayrshire and Arran

In Attendance
Stephen Brown, Director of the North Ayrshire Social Care Partnership
Caroline Whyte, Head of Finance (HSCP)
Paul Doak, IJB Chief Internal Auditor
Eleanor Currie, Principal Manager - Finance
Neil McLaughlin, Manager (Performance and Information Systems), NAHSCP
Angela Little, Committee Services Officer, NAC

Apologies for Absence
Jean Ford, NHS Ayrshire and Arran
Marie McWaters, Carers Representative

1.	**Apologies**	
	The Committee noted apologies from Jean Ford and Marie McWaters.	
2.	**Declarations of Interest**	
	There were no declarations of interest 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**	
	The accuracy of the Minutes of the meeting held on 27 June 2019 were confirmed and the Minutes signed in accordance with Paragraph 7(a) of Schedule 7 of the Local Government (Scotland) Act 1973.	

4.	**2019-20 Performance Report – Quarter 1**	
	Submitted report by the Neil McLaughlin, Performance and Information Systems Manager on the reformatting of the IJB Quarterly Performance Report. The Quarter 1 Performance Report was attached at Appendix 1 to the report and provided a high-level overview of the progress being made in delivering the strategic priorities as set out in the HSCP 3-year strategic plan.	
	Members asked questions and were provided with further information in relation to:-	
	• Work that continues with the owners of systems and data to support the needs of the Partnership's reporting requirements; • Data collected from several systems and missing period information as a result of systems not being available or developed to meet the required outputs; • The move away from residential care for young people and the recruitment of new in-house foster carers; • Further development of Self-Directed Support to ensure it is underpinned within the organisation; • Work that has been done to replicate East Ayrshire processes within the acute setting, monitoring and accurately recording delayed discharges and work with East Ayrshire in analysis of interrogated data to better understand the outputs; • A future report to the Committee on completion of the Commissioning Strategy that is being developed with Care Home providers; • Reporting of a number of mental health national indicators that does not reflect the effectiveness of treatment; • Mapping information that will be undertaken in 2020 and the use of ISD data to compare data on drug deaths; and • A planned audit of the Integration Joint Board, in 2020, that will include performance reporting.	Neil McLaughlin
	Noted.	
5.	**Internal Audit Reports Issued**	
	Submitted report by the IJB Chief Internal Auditor on the findings of relevant Internal Audit work. The findings from audit work carried out within North Ayrshire Council in services areas that fall within the remit of Health and Social Care was attached at Appendix 1 to the report. Appendix 2 detailed the relevant audit work completed within NHS Ayrshire and Arran.	

	The IJB Chief Internal Auditor provided details of the audits which have been carried out:-	
	Limited assurance was obtained around the arrangements for NAC Community Based Support. The audit generated 7 high, 6 medium and 2 low priority actions.	
	A partial level of assurance was provided by the audit of NHS GP Sustainability Arrangements, with 2 medium and one low recommendation ratings.	
	The audit of the Medical Workforce Planning provided a partial assurance rating, with 2 medium and one low recommendation ratings.	
	Members asked questions and were provided with further information in relation to:-	
	• A follow up report to the Audit and Scrutiny Committee on the progress of actions to ensure community-based support processes and controls are fit for purpose; • A report to the Health Board's Audit Committee on GP Sustainability Arrangement and difficulties in obtaining financial information on GP contracts.	
	The Committee agreed to (a) receive a follow up report on the progress of community-based support actions; (b) invite Vicky Campbell to the next meeting to discuss implementation of the action plan relating to GP Sustainability; and (c) otherwise note the report.	Stephen Brown and Paul Doak
6.	**MSG Review Progress Report**	
	Submitted report by Caroline Whyte, Chief Finance and Transformation Officer on the MSG Review of Integration Actions, including Joint Inspection (Adults) Action Plan, highlighting the key actions for each theme, those actions established, the planned timescale, status and comments on progress of those yet to be completed. The Committee agreed to (a) receive an update report to the next meeting; and (b) otherwise note the report.	Caroline Whyte
7.	**Finance Improvements Action Plan**	
	Submitted report by the Caroline, Whyte, Chief Finance and Transformation Officer on the Financial Projection Improvements Action Plan, which detailed the improvement actions, an update on progress, as at September 2019, action status and the anticipated timescale for completion.	

	Members asked questions and were provided with further information in relation to recruitment that is required to progress accurate and up to date service agreements on care first.	
	The Committee agreed to (a) receive an update report on the care package information for children with disability to the next meeting; and (b) otherwise note the report.	Eleanor Currie
8.	**IJB Reserves Policy**	
	Submitted report by Caroline Whyte, Chief Finance and Transformation Officer on a review of the Reserves Policy. The Reserves Policy provided information on: - the statutory/regulatory framework for reserves; - the operation of reserves; - the role of the Chief Finance Officer; - adequacy of reserves; - reporting framework; and - accounting and disclosure. The Committee agreed to approve the draft Reserves Policy; and (b) remit the Policy to the Integration Joint Board for approval.	Caroline Whyte
9.	**Quarterly MSG Finance Return for all Integration Authorities – Q1 2019/20**	
	Submitted report by Caroline Whyte, Chief Finance and Transformation Officer on the financial performance for all Integration Authorities for quarter 1 of the financial year 2019/20. The report detailed the financial variances 2019/20 and year-end outturn and year to date, significant factors contributing to the variances reported by Integration Authorities, the impact on funding for 2019/20 and an update on reserves. Noted.	
	The meeting ended at 1.00 p.m.	

Minutes of North Ayrshire Strategic Planning Group Meeting
Held on Wednesday 13ᵗʰ November 2019, 10:00am
Greenwood Conference Centre, Dreghorn, Irvine

Present:
Councillor Anthea Dickson (Vice Chair)
Caroline Cameron, Chief Finance and Transformation Officer, NAHSCP
Michelle Sutherland, Strategic Planning & Transformational Change Lead, NAHSCP
Elaine Young, Public Health Representative
Louise McDaid, Staff Representative
Val Allen, Independent Sector Lead
Lynne McNiven, Public Health
Clive Shephard, Confederation of North Ayrshire Community Associations
Theresa Potter, Engagement Officer, NAHSCP with Alannah ?
Louise Gibson, Dietetic lead, Integrated Services, NHS A&A
Scott Bryan, Strategic Planning, Policy and Inequalities Officer, NAHSCP
Lawrence McMahon, Governance Assistant (Minutes) NAHSCP
Val Allan, Independent Sector Lead
Christine Speedwell, Carers Centre
David MacRitchie, Chief Social Work Officer & Senior Manager, Justice Services, NAHSCP
Dr Paul Kerr, Clinical Director, NAHSCP
Sharon Bleakley, Scottish Health Council
David Bonnellie, Optometry Representative
Sam Falconer, Pharmacy Representative
Fiona Comrie, KA Leisure

In Attendance:

Russell Scott, NHS Ayrshire and Arran

Apologies Received:
Bob Martin (Chair)
Alison Sutherland, Head of Service, Children and Families & Justice Services, NAHSCP
Thelma Bowers, Head of Service, Mental Health Services, NAHSCP
David Thomson, Associate Nurse Director/Lead Nurse, NAHSCP
Lorna McGoran, Primary Care Development Manager
Vicki Yuill, Arran CVS & Arran Locality Lead
Andrew Keir, GIRFEC MANAGER
Gerard Clancy, GA Representative

1.	**WELCOME & APOLOGIES**	
1.1	Councillor Anthea Dickson welcomed all to the Strategic Planning Group and thanked all for attending. Apologies were noted and accepted.	
2.	**MINUTES/ACTION NOTE OF PREVIOUS MEETING (02 October 2019)**	
2.1	Minutes of the previous meeting dated 02 October 2019 were approved as accurate with no amendments required.	
3.	**MATTERS ARISING**	
3.1	All matters arising actioned.	
Focus on: Strategic Planning		
4.	**Caring for Ayrshire – 10-year strategy**	
4.1	Russel Scott, Senior Programme Manager, provided an overview of the Caring for Ayrshire 10-year strategy.	
4.2	The presentation covered the following areas: - Initiation - Scoping - Planning & Development - Implementation - Process - Organisation - Technology - Information - Stakeholder Engagement - Caring for Ayrshire- Models of Care - Key milestones and Indicative Timescales Russell agreed to share the stakeholder engagement paper with the group for their information.	**R.Scott**
4.3	A group discussion took place following the presentation: • Louise McDaid raised concern regarding the suitability and the availability to the public highlighting that a large proportion of North Ayrshire residents do not have access to the internet at home. Acknowledge the importance of understanding the needs & environment of North Ayrshire residents. • Sharon Bleakley highlighted the engagement plan has a potential impact on whole population of Ayrshire and questioned the plan to maximise figures. Russel advised the stakeholder engagement group will review this to ensure a plan is developed. • Dr Paul Kerr emphasised the importance in creating awareness to all GP's and health care employees.	
Focus on: Gambling		
5.	**Understanding Gambling Addiction**	
5.1	The representative from Gamblers anonymous was unable to attend the meeting therefore presentation was not delivered. Suggestion that a small group attend a meeting with Gamblers Anonymous and feedback information to the stakeholders of the SPG. SPG members that have an interest to attend the meeting with Gamblers Anonymous to inform Michelle Sutherland or Scott Bryan.	
6.	**Strategic plan 2018-21- Actions Update**	
6.1	Scott Bryan provided a brief update on progress of actions for the Strategic Plan 2018-21.	

	The presentation covered the following areas: - Current Status - By Strategic Priority - Tackling inequalities - Engaging communities - Prevention & Early intervention - Improving Mental Health & Wellbeing - Bringing Services Together - Action Timescales 2018-19 & 2019-2021	
	A group discussion took place following the presentation: • Scott Bryan to compile a report to highlight ongoing actions including those that are progressing and those with delays identified. Scott to provide updated report and disseminate to group for reading.	**S.Bryan**
Focus on: Community Engagement		
6.	**What Matters to You? 2019**	
6.1	Alannah provided a brief update on the outcome of the 'What Matters to You?' engagement for 2019.	
6.2	The presentation covered the following areas: - Number of responses per locality - Comments generated per locality - Sentiment scale - Content analysis - Primary Themes - Social & Community - Accessibility - Availability - Active Healthy Lifestyle - Outdoor/ Green Space - Supporting the most vulnerable - Next steps Next steps report to be sent out to group for information.	
6.3	A group discussion took place following the presentation: • Michelle Sutherland advised the 'What Matters to You?' team have requested commitment from the Garnock Valley LPF area to review the planning for next year's project to ensure its success. • Val Allan emphasised staff must take responsibility of asking the public what matters to them and in their community. • Sharon Bleakley questioned if there is anything in place to consider feedback provided and what is being done differently to address feedback.	

	Theresa Potter- Creating a 20/20 Vision	
	The presentation covered the following areas: - Review membership and structure of the Local Planning Forums - Typology of Engagement - Balance - Methods & Techniques - Partnerships - Impact - Asset Based Community Development Approach to Public Engagement	
	A group discussion took place following the presentation: • Theresa highlighted there will be a networking event taking place on the 2nd December 2019 for each Locality Planning Forum to come together to provide progress updates, review membership of their forums and review their structures.	
Focus on: Locality Updates		
7.	**Update from LPF Leads**	
7.1	**Arran** Vicki Yuill not in attendance – advised there has been no meeting held since last SPG meeting, therefore no update to provide.	
7.2	**Garnock Valley** Theresa Potter provided a brief update on current work ongoing in the Garnock Valley area. Theresa informed the group the Garnock Valley Locality Planning Forum have established a sub group to target social isolation and loneliness within the community. Theresa advised the forum group has organised a Christmas gathering which will be held on the 4th December 2019 for individuals living within the Garnock Valley. Christmas lunch will be provided which has been sponsored by a local entrepreneur. Mental & Physical wellbeing of those who attend will be reviewed. A mini impact assessment, social action and research will be undertaken.	
7.3	**Kilwinning** Sam Falconer provided a brief update on current work ongoing in the Kilwinning area. Sam informed the group the Kilwinning Locality Planning Forums priorities were recently discussed, and the following priorities were agreed to be taken forward: • Improving local knowledge of HSCP services • Addressing mental health • Promoting physical activity Sub group has been created to host an event for the local community to come together to address mental health concerns. Sam highlighted an issue that was raised at a recent Locality Planning Forum regarding the Eglinton garden project. Sam advised there are	

	current funding issues, ongoing concerns regarding the future of this project. Michelle Sutherland has met with Ann Wilson from TACT and advised Ann of persons to link with in the Mental Health management team. Ann is looking at other options in terms of resources that could bring forward further volunteering. Issue has been flagged and work is ongoing to address this.	
7.4	**Irvine** No replacement for Barbara Conner as Irvine Locality Chair has yet been identified. Further update pending. Theresa Potter advised the Irvine Locality Planning Forum have created a working sub group to target mental health and wellbeing within the community. On Friday 10th October 2019 (Mental Health day) there was an open day held at the portal which involved recovery work , gyms, Mental Health wellbeing. Elderly forums programme of activities to enhance wellbeing with KA leisure. Scott Bryan advised Irvine are currently without a chair therefore a request will be tabled at future IJB to appoint a new chair. The Irvine Locality Planning Forum members have advised they are happy for the Community link workers to share the role of chair as suggested at a recent meeting. Scott noted this is a potential short-term solution however agreement is required from the IJB, to establish permanent solution. Theresa Potter conveyed she is happy to carry out a capacity session with the community link workers on how to chair meetings etc if this short-term solution is agreed by the IJB.	
7.5	**North Coast** Louise McDaid provided a detailed update in regards to ongoing work within the North Coast community. • Ongoing work involving the Mental Health ambassadors based at Largs Academy. They are working to produce an information leaflet on Mental Health Supports to go to all P7 and High School pupils in the North Coast. A number of groups have been created to address the following: • Social Isolation and Mental Health. • Bereavement • Bullying • Breathing choir • Health and Wellbeing for elderly (Cycling with age) • Addictions recovery • Anxiety Louise conveyed the Minister from Cumbrae has suggested the Locality Planning Forum create and share a calendar of events being held within the North Coast.	

7.6	**Three Towns**	
	Three towns have a working sub group also looking at social isolation and loneliness. Mental & Physical Wellbeing event being held in January 2020 on an intergenerational basis. Purpose of the event is to capture voices of the young people within the community as well as the elderly.	311
8.	**AOCB**	
8.1	Group informed that next month's SPG meeting is cancelled due to anticipated apologies on the lead up to festive period. Scott Bryan to send group the link for the partnership awards for nomination requests. Future Agenda Items Any agenda items to be forwarded to Scott Bryan or Louise Harvie for inclusion within future agenda.	
8.2	There was no other business to be discussed, therefore the meeting was closed.	
9.	**Next Meeting**	
9.1	Tuesday 28th January 2019, Greenwood Conference Centre at 10am.	