North Ayrshire
Health and Social Care Partnership

North Ayrshire Health and Social Care Partnership

Annual Performance Report 2015–16

Reflections from Iona Colvin

Delivering care together is at the heart of our health and social care partnership in North Ayrshire. Our partnership of North Ayrshire Council, NHS Ayrshire & Arran, the third sector and independent care sector provides local, community health and care services (everything outside of acute hospital care) for North Ayrshire residents.

We are person-centred and we want to make sure that people's voices are heard and their needs are met. People who use our services, carers and families, staff and stakeholders work together to improve and shape the future of local health and social care services.

We published our first Strategic Plan in April 2015. This laid out our strategic priorities and where we planned to make changes.

This is our first annual performance report. It outlines what we have achieved in our first full year as North Ayrshire Health and Social Care Partnership, from April 2015–March 2016. We have worked hard to meet our priorities and you will see many examples of this in the pages that follow.

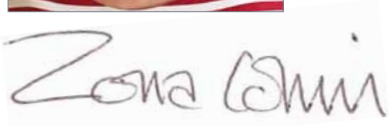
Some of our key achievements in our first year are:

- Development of new health and social care Locality Planning Forums – this new way of working is supporting North Ayrshire localities to create solutions for local health and care needs. Our aim is that partnership working in our communities will create a more equitable, healthier and better society for everyone. Locality Planning Forums give local people a voice on North Ayrshire Health and Social Care Partnership's Integration Joint Board.
- Working with peer researchers and peer support programmes to increase people's resilience, involving them in their community and helping us to better understand North Ayrshire health and social care needs – Café Solace and SMART (Self-Management and Recovery Training) programme are examples of our successful peer approach.
- Creating multi-disciplinary teams throughout many of our Partnership services – bringing together different professionals with different skills to make sure people see the right person in the right place at the right time – Irvine's new Vennel Centre (a hub space for community activities and visiting services), Brooksby's Health and Therapy Team and our new models of care for older people now use this multi-disciplinary approach.

This has been achieved with our staff; they are dedicated, professional and focussed on doing their best for the people they serve. I'd like to extend a sincere thank you to each of them.

We will publish an Annual Performance Report each year – this will show what we have achieved and the impact that this is having to ensure,

'All people who live in North Ayrshire are able to have a safe, healthy and active life.'



Iona Colvin

Director, North Ayrshire Health and Social Care Partnership
Chief Officer, North Ayrshire Integration Joint Board

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Background

North Ayrshire Integration Joint Board (IJB) was legally constituted in April 2015; North Ayrshire Health and Social Care Partnership (NAHSCP) was then able to progress on delivering its strategic priorities.

Our partnership includes Health and Community Care, Mental Health and Learning Disability Services and Children, Families and Criminal Justice. Our first annual performance report lets us look back over the past year and reflect on what we have achieved and the success we have had in a short period of time.

As set out in our Strategic Plan our vision is that

"All people who live in North Ayrshire are able to have a safe, healthy and active life".

To deliver our vision, North Ayrshire Health and Social Care Partnership will continue to focus on these five priorities:

- Tackling inequalities
- Engaging communities
- Bringing services together
- Prevention and early intervention
- Improving mental health and wellbeing

We hope you will experience our values in the way North Ayrshire Health and Social Care Partnership engage with you and how we behave:

- Person centred
- Respectful
- Efficient
- Caring
- Inclusive
- Honest
- Innovative

Structure of this report

We have measured our performance in relation to:

- Scottish Government's National Health and Wellbeing Outcomes
- Children's and Criminal Justice Outcomes
- Local measures

Financially 2015–16 has been a challenging year and we have detailed our financial position and showed how we have delivered best value.

Our Locality Planning Forums were formed in 2015–16 and we highlight the areas they are going to focus on in the coming year.

NAHSCP has lead Partnership responsibility in Ayrshire for **Mental Health and Learning Disability Services** as well as **Child Health Services** (including Immunisation, Infant Feeding and Family Nurse Partnership). This report shows some of the highlights and a few of the challenges of leading services across Ayrshire's three health and social care partnership areas.

Finally we will show how we ensure that all of our services, both internal and external, are providing high quality care and support to the people of North Ayrshire.

1. Our performance in relation to National Health and Wellbeing Outcomes

In our first year we continually focused our efforts on delivering services that improve the lives of all the people living in North Ayrshire. Our five strategic priorities link directly to the nine National Health and Wellbeing Outcomes – these provide a useful roadmap for us and we can demonstrate progress against each of these outcomes.

People are able to look after and improve their own health and wellbeing and live in good health for longer.

1.1 To support our strategic priority of prevention and early intervention, we will recognise and build on individual and local community assets, using all possible sources of support. These community-based approaches are particularly important in areas where high deprivation exists and people are less likely to proactively seek help and support at an early stage of illness.

We are piloting Community Connectors in seven local GP practices to signpost to a range of alternative community and non-medical resources, services and opportunities that can contribute to people's health and wellbeing, such as arts and creativity, physical activity, learning new skills, volunteering, mutual aid, befriending and self-help. People can also get support with issues relating to employment, benefits, housing, debt, advocacy support, legal advice or parenting. Further, Third Sector Interface Community Connectors offer interventions in Smoking Cessation and Weight Management.

Community Connector Performance

175 patients engaged

40 carers engaged

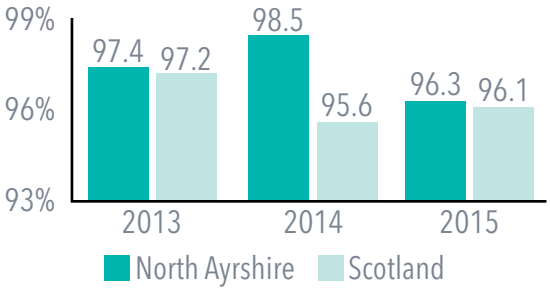
55 face to face appointments

120 telephone appointments

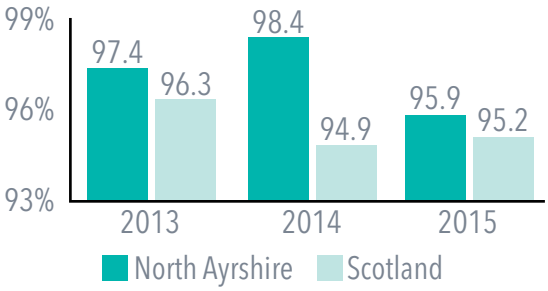
1.2 We began the process to integrate North Ayrshire Council and NHS Ayrshire & Arran addictions services into one new joined-up addictions service – North Ayrshire Drug and Alcohol Recovery Service (NADARS). The new service will give people dealing with recovery from drug or alcohol addiction seamless service and support them to improve their health and wellbeing. Much of the integration work was achieved in 2015–16 and the new service was launched in May 2016.

It is important to people that they are seen as early as possible and a national target has been set – 90% of people referring for drug and alcohol support must be seen within three weeks. We have performed above this national target, and well above the Scottish average.

Seen within 3 weeks (alcohol)



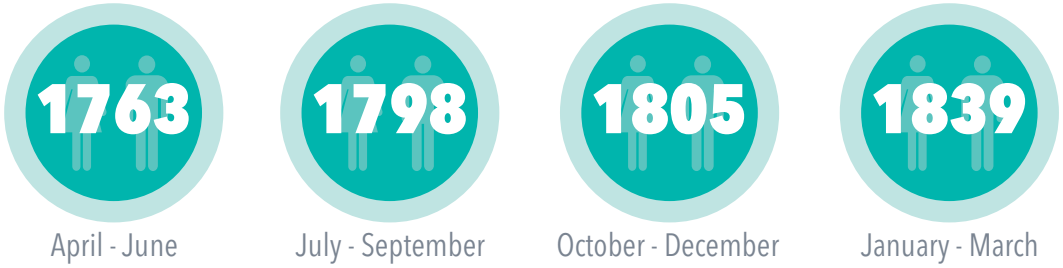
Seen within 3 weeks (drugs)



People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.

2.1 As a result of the review of Care at Home services detailed in the Strategic Plan, we have invested in and increased the capacity of our Care at Home service to meet the growing local demand – we improved Care at Home service performance too (see 6. Inspection of Services).

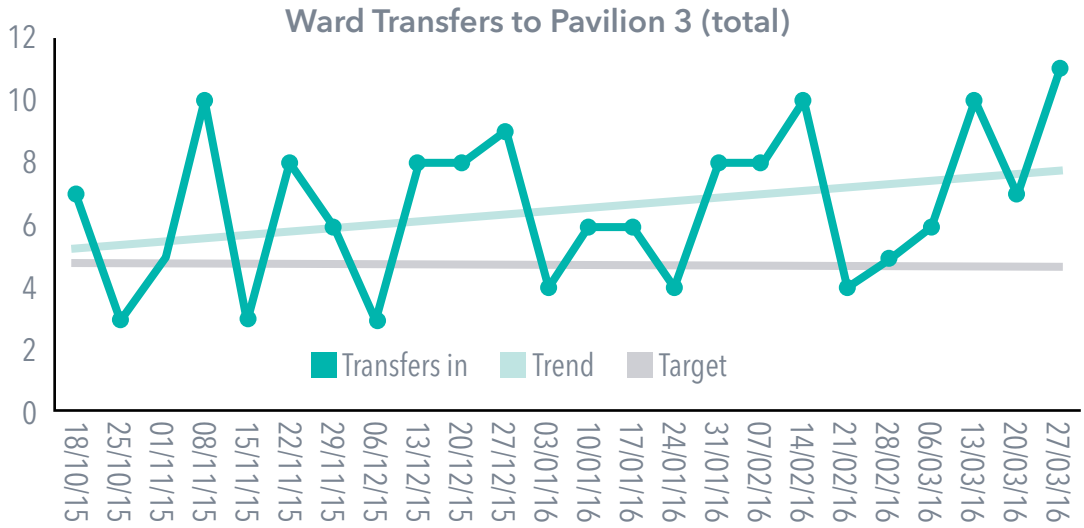
Number of people using Care at Home 2015–16



2.2 We continued to increase the use of telecare to help people stay safe and live at home for as long as possible. Our Reablement Service and our Intermediate Care and Enablement Service (ICES) have helped maintain over 2,000 people in their own homes by supporting them at a time they needed it.

2.3 During the final quarter of 2015-16 we worked to deliver the aims and aspirations in Scottish Government's Unscheduled Care: Preparing for Winter (Winter Plan). This plan set out the need for Health and Social Care Partnerships to minimise the disruption people who use our services and carers experience, provide safe and effective care and have sufficient capacity and funding to support sustainable service delivery.

Our staff demonstrated the highest levels of dedication, commitment and endeavour in supporting people to remain at home. They also ensured those who needed specialist interventions from acute hospital teams were supported home again without delay.

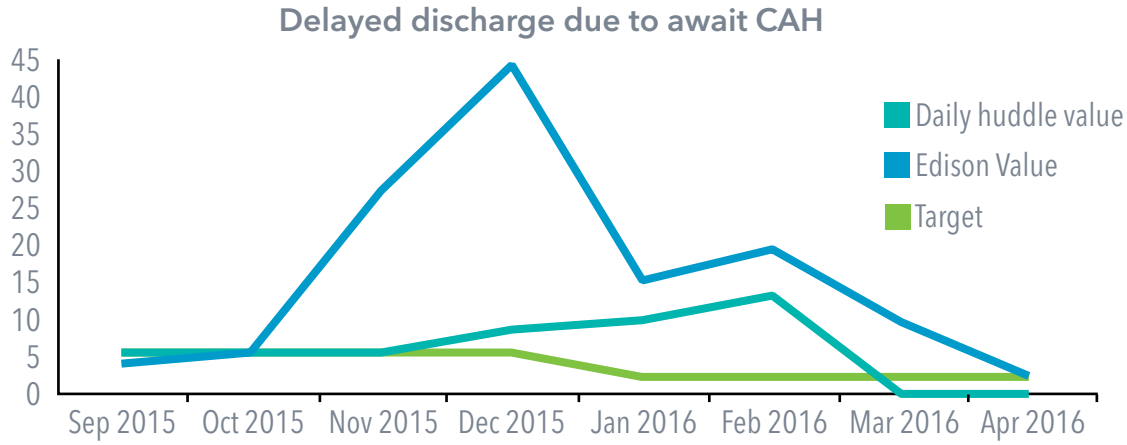


We facilitated the discharge of more people into the rehabilitation ward (Pavilion 3, Ayrshire Central Hospital) than we had pledged to achieve.

We reduced the average length of stay in Pavilion 3 from 41 days (2014–15) to 28.8 days in the same period 2015–16.

This new rehabilitation and enablement hub approach allowed more people to go home sooner.

We reduced the number of people who were delayed in hospital waiting on Care at Home package or a care home place.



2.4 We need to make sure the right levels of support are available to reduce admissions to hospital. A pilot project in Irvine successfully achieved this: our Community Alarm team, alongside colleagues from Scottish Ambulance Service responded to 999 calls. This intervention and support resulted in 50% fewer people having to be admitted to hospital.

2.5 Our Intermediate Care and Enablement Service (ICES) support people, through targeted rehabilitation, to achieve their personal goals and stay as independent as possible.

CASE STUDY

Sandra* is a 62 year old lady who had a stroke. Before this Sandra lived at home, independently as a mother, grandmother, wife, homemaker and cook. Her stroke left her with right sided weakness, reduced mobility, fatigue, low mood, reduced confidence and concentration and increased anxiety.

Working with the ICES team, Sandra agreed that she wanted to improve her mobility, increase her independence, and fulfil her role as a wife, mother and homemaker.

Sandra worked with the physiotherapist, and a programme of home exercises was developed. Sandra was also advised on safety awareness and limb positioning for pain reduction. Occupational therapists worked with Sandra on managing her fatigue and helped with daily living activities.

At the end of the ICES support period Sandra was as independent as she had been before her stroke. She had less pain in her right side and improved function in her right arm.

** Name changed*

People who use health and social care services have positive experiences of those services, and have their dignity respected.

3.1 NAHSCP helped to fund Recovery at Work's Café Solace. The community café provides a three-course evening meal, for less that £3. Café Solace is based in a local church in Ardrossan and has had approximately 3,621 customers since its launch in June 2015. It has been successful in engaging with many vulnerable people in an area of high deprivation.

Café Solace has had 27 active volunteers involved from the start; 15 of whom are currently still involved. Two volunteers have gone back into full time employment and 16 have completed or are completing further education courses. Volunteers are mainly people who have been individually affected by addictions, however Café Solace also has three volunteers who support family members and have an interest in pursuing catering careers.

3.2 As part of the End of Life project (funded by NAHSCP) a local independent sector care home provided a bed to support people at the end of their life. Its impact was positive, as reflected by the following feedback:

"My brothers and I are very grateful for the care and kindness you and your staff showed to my sister before she died. It allowed her to have a more comfortable and peaceful end to her life."

"All the staff were very helpful"

"Service excellent"

"We would like to thank everyone for all their care and kindness you gave to my dad, it was much appreciated."

All quotes from Abbotsford Care Home

Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.

4.1 Rehabilitation and enablement for frail elderly people had previously been provided in Pavilion 3 (P3), Ayrshire Central Hospital. With the planned move to the new community hospital, Woodland View, we had an opportunity to test a new model of person-centred care.

A new GP led approach, supported by a multi-disciplinary team was established. This new way of working supports rehabilitation for frail elderly people and will help us to ensure the most vulnerable people in our communities are safe and receive the support they need. This approach allows for early discharge from acute hospital and, by intervening early and by providing rehabilitation services such as physiotherapy or occupational therapy, can prevent conditions from deteriorating, which may result in acute hospital admissions.

CASE STUDY

Pavilion 3 was a rehabilitation ward in Ayrshire Central Hospital that served as a community rehabilitation ward from acute hospital wards. Many people were transferred to P3 before they were ready and subsequently became unwell and had to be re-admitted to acute hospital wards, others would remain in the ward for too long after they were ready to be discharged.

Outcomes for patients were generally poor and the morale of staff was low. Many staff members felt 'the service could do better'.

From 1–5 June 2015, a rapid test of change week took place; a new model of work was implemented and tested over a short period. This new model included a multi-disciplinary team, new leadership and clear, regular communication between all staff members.

Over the course of the week, improvements were evident with patient assessments and decisions being made more quickly. Using the multidisciplinary team approach meant that all specialities were available on ward and reduced the need for lengthy and numerous phone calls to external services.

Overall the test of change made improvements in two key areas: the new process was more effective at admitting people from acute hospital wards, who would benefit from rehabilitation, and people began to be discharged from hospital to home, or homely setting, more quickly. These improvements lead to better outcomes for people and lead to greater staff satisfaction.

4.2 The Flexible Intervention Service (FIS), funded by NAHSCP and provided by The Richmond Fellowship Scotland, aims to provide early intervention and/or crisis prevention for people with mental health issues, for a period of up to 12 weeks. Our Flexible Intervention Service (FIS) has supported 104 people in 2015–16 to retain their independence and maintain their quality of life.

CASE STUDY

Gill* has experienced a long history of depression and anxiety, and has a mild learning difficulty. This affected her ability to cope with living on her own and looking after herself.

Gill is a very private, determined and independent person who, despite her long periods of depression, has not been hospitalised or known to social services. Gill experienced difficulties establishing routine at home and potentially could have lost her tenancy agreement because of her living conditions.

Gill was very apprehensive about engaging with new people. Despite this, she progressed well with the support provided by FIS. The support helped Gill to complete household chores and also prompt her about caring for her self. Gill recognised that she wanted to change and improve her skills around the home by keeping her kitchen clean and learning basic cooking skills.

The six-hour weekly support over a period of 12 weeks allowed Gill to be able to sustain her tenancy agreement and increase her confidence and morale. Gill was supported to acheive the outcomes she wanted by improving her quality of life through being as healthy as she could and staying safe.

** Name changed*

4.3 Invigor8 is a falls prevention initiative for older people, delivered by KA Leisure. There are 12 classes operating each week across North Ayrshire; Postural stability (PSI), strength and balance, and chair based exercise classes.

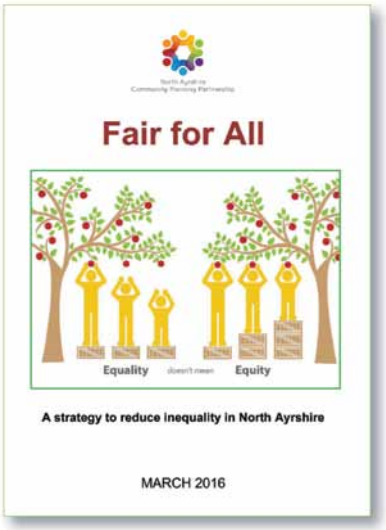
During 2015–16, 214 people referred to Invigor8, 552 classes took place with 5290 attendances at classes.

Health and social care services contribute to reducing health inequalities.

5.1 We will work to help people deal with their financial difficulties. Our Money Matters team has advised and supported the most vulnerable people in our communities to access more of the benefits they are entitled to. This has led to an additional £7,614,130 of household income across North Ayrshire.

£7,614,130

5.2 NAHSCP was a key partner in developing the North Ayrshire Community Planning Partnership's (CPP) Inequalities Strategy, *Fair for All*. This will ensure that partner organisations across North Ayrshire will work together to reduce inequalities and increase opportunities for people in North Ayrshire.



People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being.

6.1 We prioritise the need to support those who care for others and take their needs into consideration. NAHSCP is currently progressing the recommendations of the North Ayrshire Carers Strategy 2014–18. The Carers Advisory Group is made up of 60% carers. We are supporting carers to develop a new carer's assessment form.

6.2 To showcase Partnership services, we held the Care and Support North Ayrshire (CareNA) exhibition in October 2015. Over 135 providers exhibited. Almost 1000 people attended from across North Ayrshire (public and staff). People met and talked with providers and learned more about the services that were available to support them in their local areas.

6.3 We prioritised the need to provide opportunities for carers' breaks. We are working with partners and colleagues to ensure individuals are aware of the opportunities available to them to have a break from their daily caring roles.

Respite is offered across all service areas and age groups – day respite, as well as overnight respite. Our young carers, in particular, experienced respite breaks from their caring role in conjunction with our partner, Unity Trust Carers Centre.

> "Respite week away from caring role was a fantastic break… away from any responsibilities we have at home."

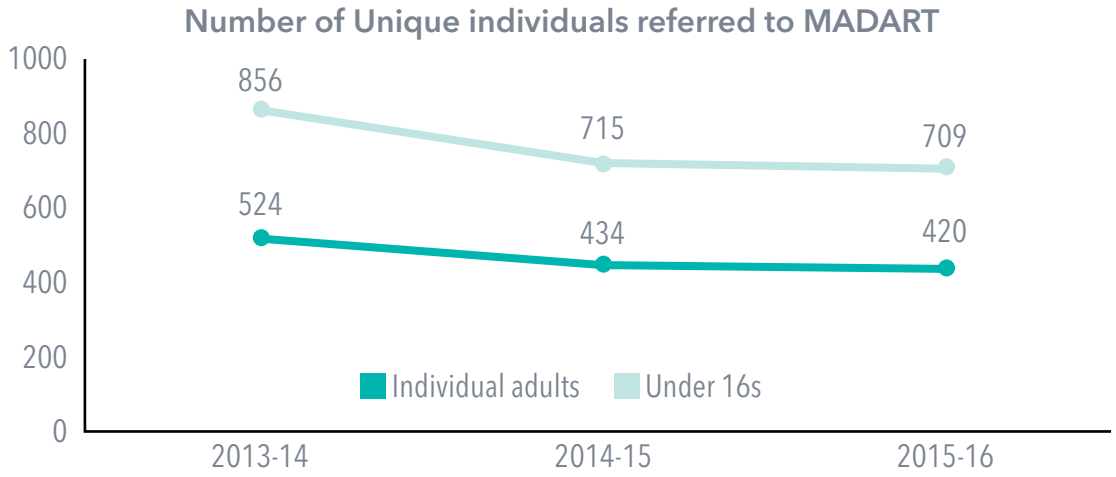
> "Time away from your caring role, lets you see you're not on your own… meet new friends."

Quotes from Unity Trust Young Carers promotional DVD

People who use health and social care services are safe from harm.

We will provide support to help keep people safe. We are continuing to work on this action together with people who use our services. Here are some examples:

7.1 We have increased the effectiveness of MADART (Multi-Agency Domestic Abuse Response Team) in reducing reported domestic abuse in North Ayrshire by 0.4%. This is in contrast to the trend across Scotland where domestic abuse rates increased by 2.5%. We continue to work towards keeping people safe from domestic abuse.



7.2 Our Strategic Plan prioritised the need to promote good health and wellbeing. Across Mental Health Services we continue to prioritise assessment and support for the most vulnerable people. Many people with mental health problems are being supported through the immediate delivery of the Flexible Intervention Service. Adult protection processes are used to keep people safe from harm whenever it is required.

7.3 Our Adult Support and Protection (ASP) service works hard to make sure that all adults age 16 and upwards are protected and kept safe from harm. In 2015–16 our ASP received 724 referrals, of these 80 progressed to full investigations. We are working hard to make sure we respond to protection concerns quickly and we are improving our response rate all the time – over 50% of referrals are now being completed within five working days.

OUTCOME 8

People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.

8.1 Employee engagement surveys were undertaken by North Ayrshire Council and NHS Ayrshire & Arran. Encouragingly high levels of engagement were recorded from staff who responded, with a positive increase across all areas. This is encouraging at a time of change for many staff.

North Ayrshire Council	Positive response)
Relate (identified with organisation)	88.1%
Say (speak positively)	68.6%
Stay (intend to stay)	81.3%
Strive (prepared to go above and beyond)	60.2%

NHS Ayrshire & Arran	Positive response
Free from discrimination	94.1%
Health and safety training	92.4%
Going the extra mile	91.8%
Job clarity	88.5%
Confidence/trust in line manager	85.6%

8.2 Positive staff engagement has also been identified as a highlight from events held for Woodland View, Addictions, Aids and Adaptations and Pavilion 3. The commitment and enthusiasm to develop a joined-up approach to support better care for people is evident.

8.3 We hosted 'Making Connections', a staff event at the Magnum Centre in June 2015. This event showcased the work of Partnership services and projects and gave Partnership staff an opportunity to get to know each other. The programme for the day included five service specific seminars and a Question Time style discussion forum. Overall, 84 services exhibited and 527 members of staff attended.

Some staff quotes from Making Connections:

"The seminars were a great opportunity to hear from the new senior management teams about their vision for the HSCP"

"Learned what services are available"

"Looking forward to making new friends/ colleagues and taking strategy forward"

"Already feel connected but realised just how much I am part of the bigger team."

8.4 SMART (Self-Management and Recovery Training) Recovery for Family and Friends provides support and tools for people who are affected by the addictive behaviour of someone close to them. The programme aims to help participants develop more effective coping strategies and find a greater sense of fulfilment in their own lives. There are two meetings per week for friends and families and the feedback received is very positive.

"Since being trained in SMART, I have enjoyed facilitating different groups. I enjoy learning how SMART helps others with their addiction and how participants help each other within the group."

Resources are used effectively and efficiently in the provision of health and social care services.

9.1 Additional Delayed Discharge Funding monies were made available to invest in Care at Home services and care home provision. The aim was to reduce the length of time people had to wait for care packages before leaving hospital. This allowed us to provide better services that are effective, safe and good value for money.

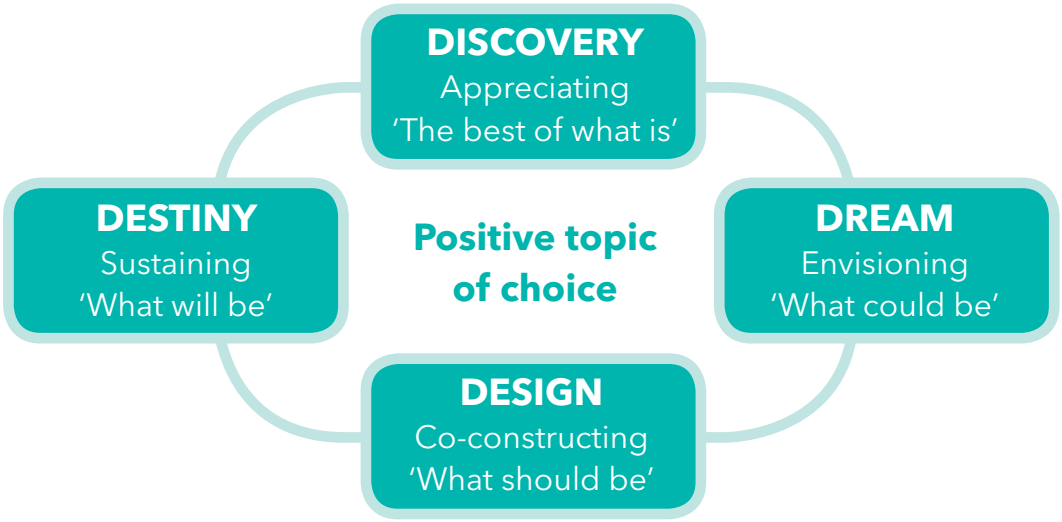
9.2 Care at Home hours are a resource that the Partnership cannot afford to waste. Over the course of our first year we have worked with our colleagues in acute hospitals to try and reduce the number of cancelled discharges. However, there is still a great deal of work to do.

3,658hrs
lost due to discharges being cancelled (2015–16)

9.3 A well-motivated and engaged staff group is a key resource to delivering effective and efficient services that are person-centred and improve people's wellbeing. NAHSCP has used an Appreciative Inquiry (AI) approach within organisational development. This strength and values based approach, brings together people who use our services, carers and staff to vision and design the future direction of care and support. Here are some staff comments, after they have participated in an AI event:

> "We are a strong, dynamic, flexible team."

> "We are weaving all our strengths and skills into all we do as a partnership."



9.4 Our Intermediate Care and Enablement Service (ICES) supports people to regain their independence by supporting them when they are either discharged from hospital or to prevent admission to hospital. During 2015–16, this early intervention and prevention service has saved the equivalent of 3,082 unnecessarily hospital bed days.

ICES aims to see new referrals within one day of receiving the referral. In 2015–16 their achievement was 82.1%

3,082
ICES bed days saved

9.5 Through various approaches, including increasing Care at Home capacity, increasing occupancy at Pavillion 3, and the pilot project between Community Alarm and Scottish Ambulance services, the Partnership has reduced the number of occupied bed days in acute hospitals.

On average a person admitted to an acute ward will spend 5 days in acute hospital. Further, a frail elderly adult is likely to spend 11.3 days in hospital.

Between October 2015 and January 2016, NAHSCP recorded 6,749 unrequired bed days in acute hospital wards and 13,276 unrequired bed days in frail elderly hospital wards. Our work is enabling more people who use our services to be effectively supported in their own home, or homely setting.

Total of 20,025
Bed days saved in acute and frail elderly wards

National Health and Wellbeing Indicators

Scottish Government identified 23 indicators that were felt evidenced the nine national health and wellbeing outcomes. 14 indicators will evidence the operation of NAHSCP and the data for these will come from NHS Information Services Division (ISD). The other 9 indicators were taken from responses in the biennial Health and Care Experience Survey and NAHSCP results are detailed in the table below.

Health and Social Care Experience Indicators	North Ayrshire 2013/14	North Ayrshire 2015/16	Scottish Av % Diff	Rank against Family Group
1 I am able to look after my own health	93%	93%	-0	3
2 Service users are supported to live as independently as possible	80%	82%	-2	8
3 Service users have a say in how their help, care or support is provided	80%	77%	-2	7
4 Service users' health and care services seem to be well coordinated	79%	78%	+2	5
5 Rating of overall help, care or support services	80%	79%	-2	7
6 Rating of overall care provided by GP Practices	86%	84%	-3	6
7 The help, care or support improves service users' quality of life	80%	82%	-1	8
8 Carers feels supported to continue caring	39%	43%	+2	6
9 Service users feel safe	80%	79%	-5	8

To support service improvement, the Scottish Government has identified benchmarking families. These family groups are made up of eight local authorities that share similar social, demographic and economic characteristics. We can meaningfully compare our performance information with similar areas, engage with colleagues across Scotland and encourage learning. North Ayrshire is partnered in its family group with: East Ayrshire, Dundee, Eilean Siar (Western Isles), Glasgow, Inverclyde, North Lanarkshire and West Dunbartonshire.

We performed at, or better, than the Scottish average in three indicators out of nine.

Compared to 2013–14 survey data, we have improved in four out of nine indicators.

Benchmarking against our family group we rank in the bottom quartile in five out of nine indicators.

Local Indicators

As well as the National Health and Wellbeing Indicators we regularly report on local indicators to help us to evidence the National Health and Wellbeing Outcomes and also our strategic priorities. A full list of indicators can be found at Appendix 1.

2. Our performance in relation to Children's Outcomes and Criminal Justice Outcomes

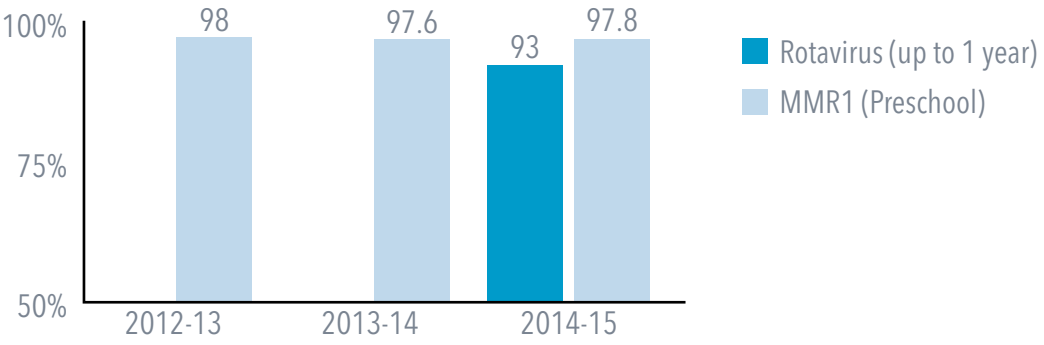
OUTCOME 1

Our children have the best start in life and are ready to succeed

1.1 Looking after your own health starts as early in life as possible. NAHSCP performs well in childhood immunisation programmes.

Both Rotavirus and MMR 1 have very high uptake percentages as seen in the chart.

Child immunisation uptake (3 year trend)

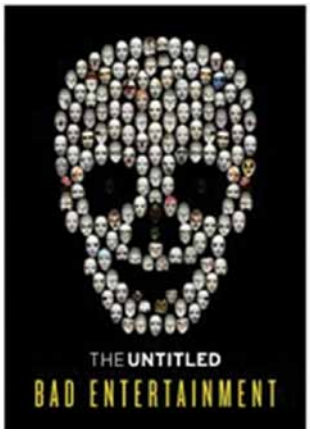


The Childhood Flu Schools Programme is a nurse led service that successfully achieved an uptake of 75.4% in 2015–16. This was above the national target of 75% and higher than the Scottish average of 71.1%.

OUTCOME 2

Our young people are successful learners, confident individuals, effective contributors and responsible citizens

2.1 Our Strategic Plan said we would maximise the potential for people to work, with a particular focus on vulnerable young people. Rosemount project, in collaboration with a range of partners (North Ayrshire Council's Education & Youth Employment, Place and Economies & Communities teams, along with National Galleries Scotland) had devised a collaborative approach to developing employability programmes for vulnerable and disadvantaged young people who are not ready to move from school to employment or further education. Through their engagement with National Galleries Scotland a group of North Ayrshire young people created and exhibited The UNTITLED: Bad Entertainment art installation in Edinburgh's Scottish National Portrait Gallery from January to May 2016.



This was a positive life-changing experience for the young people involved; 75% have secured positive destinations either in Activity Agreements or moving info further education.

We have improved the life chances for children, young people and families at risk

3.1 The Family Nurse Partnership (FNP) is a voluntary home visiting programme for first time young mums, aged 19 years or under. The programme supports young mums from the early stages of pregnancy and aims to enable them to; have a healthy pregnancy, support their child's health and development and to positively plan for their future. The first cohort of young mums in North Ayrshire are close to completing their time with FNP programme. This first cohort supported 71 new-born children and their mothers and families. The FNP programme is ongoing and is now signing up new mums and mums-to-be.

CASE STUDY

Louise* was 17 years old when she became pregnant.
She was homeless when she came into contact with the Family Nurse Partnership (FNP), having recently left an abusive relationship with the baby's father and was sleeping on a friend's sofa. Louise had been with various foster carers since a young age. She had low confidence and little trust in professionals.

The family nurse worked hard in encouraging Louise to engage with the programme. The family nurse employed respectful, strength based approaches to assure Louise that the programme would provide a consistent, safe space, to explore her difficulties.

After Louise's baby was born she moved into a supported accommodation tenancy with the support of the FNP and through further support moved into her own tenancy within six months.

Utilising the range of tools available to the FNP programme, the family nurse used motivational techniques to support Louise learn about trust, love, baby cues and attachment. Louise was able to use this learning to care for her baby.

As well as learning about caring for her baby, Louise gained insight into her previous patterns of negative relationships through the FNPs approach to building confidence and self-esteem. Louise was then able to e-engage with her foster family. With the support of the family nurse and her newly developed social support network, Louise moved into a new home that was a safe and warm environment for both her child and herself. Louise has also moved into employment and has started college.

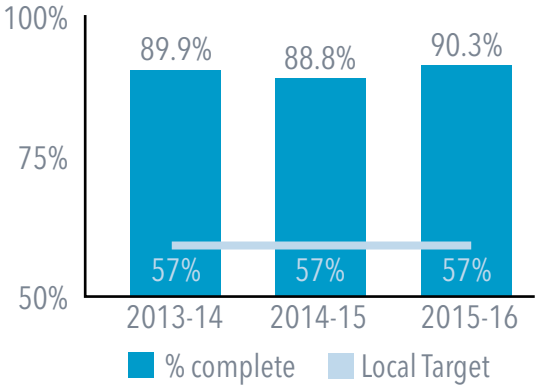
** Name changed*

3.2 Our Youth Justice Service had a target to reduce the number of young people in secure remand during 2015–16 to a maximum of five young people. This target was achieved and our aim would be to reduce this further in subsequent years.

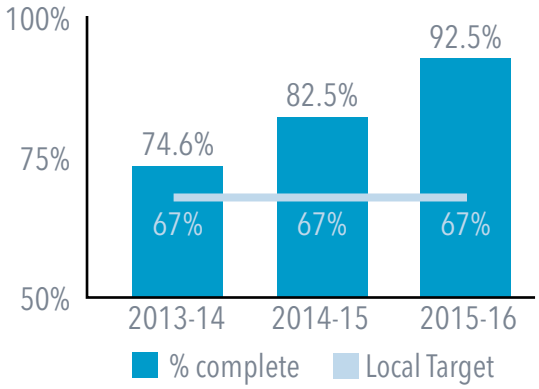
Community safety and public protection

1.1 The Criminal Justice Service continues to a have positive impact on the local community through the delivery of the Community Payback Order scheme. The Community Payback service has achieved continuous improvement with both level 1 and level 2 Community Payback Orders performing well above national targets.

Level 1 CPO unpaid work completed within 3 months



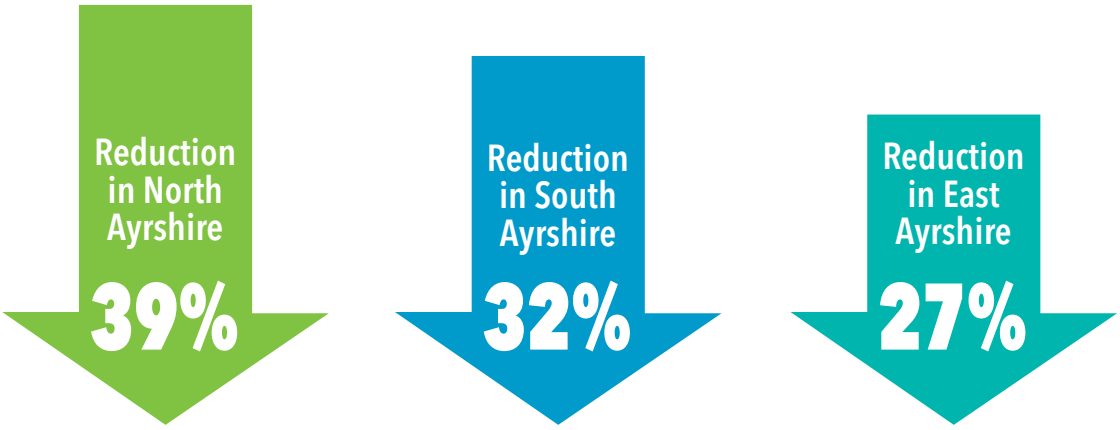
Level 2 CPO unpaid work completed within 6 months



1.2 Throughout the year, the Community Payback Service held a number of Sale Days at Smithstone House in Kilwinning. Goods on sale included a range of garden products, such as hanging baskets, planters, garden furniture and herbs. All items were grown or built by those on a Community Payback order and all proceeds – over £1000 were donated to local good causes, including Women's Aid and North Ayrshire Foodbank.

The reduction of re-offending

2.1 In our Strategic Plan we said our Criminal Justice and Youth Justice would work closer together to reduce reoffending. As a result, we continue to reduce recorded crime in our local authority area through the prevention and early intervention services of our Youth Justice and Criminal Justice services. Recorded crime in North Ayrshire has reduced by 39% from 2005/6 to 2014/15. The compares favourably with a 32% Reduction in South Ayrshire and 27% Reduction in East Ayrshire. In line with these reductions, the South West Scotland, Criminal Justice Authority now has the third lowest reconviction rate across Scotland.



Social inclusion to support desistance from offending

3.1 Criminal Justice Services successfully accessed NAHSCP funding via Integrated Care Fund (ICF) monies to appoint a worker to provide immediate short term support to women released from custody or released on bail, with a particular focus on linking them with existing health and support services. Early feedback on this approach has been positive and the service will continue to embed the programme to improve outcomes for those accessing support.

3.2 The Women Offenders Groupwork continues to provide mentoring and support to those accessing the service, which is delivered in partnership with Barnardo's Scotland's SHINE service. The service also has strong links with other support services, such as; Addaction, The Ayrshire Community Trust, Venture Trust and Money Matters.

3. Change programme - our approach to change

When North Ayrshire HSCP was first established we decided to do things slightly differently with the finances supplied by Scottish Government. We embarked on a change programme that has seen us radically transform major areas of local health and social care provision and hence improve our local performance measures.

In Health and Community Care we:
- Reviewed Care at Home services to increase capacity and efficiency
- Remodelled rehabilitation and enablement services to develop a multidisciplinary hub
- Established community connectors in GP practices to enable the move from primary care to community supports.

In Children, Families and Criminal Justice we:
- Progressed work to redesign services to create 'Teams around children'
- Reviewed co-location of multi-disciplinary teams including education, social workers, early year's health, money matters, Child and Adolescent Mental Health services (CAMHS) and educational psychology
- Developed Getting it Right for You: North Ayrshire Children's Services Plan.

In Mental Health and Learning Disability Services we:
- Redesigned our Addictions Service by bringing together two services (North Ayrshire Council and NHS Ayrshire & Arran) and developing them into one team – North Ayrshire Drug and Alcohol Recovery Service (NADARS).
- Prepared to move all in-patient mental health staff and patients to Woodland View throughout 2015–16. This was successfully completed early 2016–17.

The Transforming Care after Treatment programme provided targeted support to local employers advising them of how they can support their staff who have been affected by cancer. Since this Pan-Ayrshire programme began, 18 business seminars have been organised. Initial feedback indicates that many of those who attended have actively reviewed their HR policies.

We started work on four development areas:
- Build Teams around Children
- Develop Primary Care services in local communities
- Support the needs of Older People and Adults with Complex Care Needs
- Develop and deliver a new strategy Mental Health and Learning Disability

These are detailed more thoroughly in our Strategic Plan: The way ahead 2016–18 www.north-ayrshire.gov.uk

Through all of these ambitious and achievable reviews and projects we will continue to performance manage and monitor to ensure we are meeting the National Health and Wellbeing Outcomes as well as our five strategic priorities.

4. Reporting on Localities

North Ayrshire is home to over 136,000 people.

People from different local communities experience life in North Ayrshire differently, with a wide range of contrasting health outcomes.

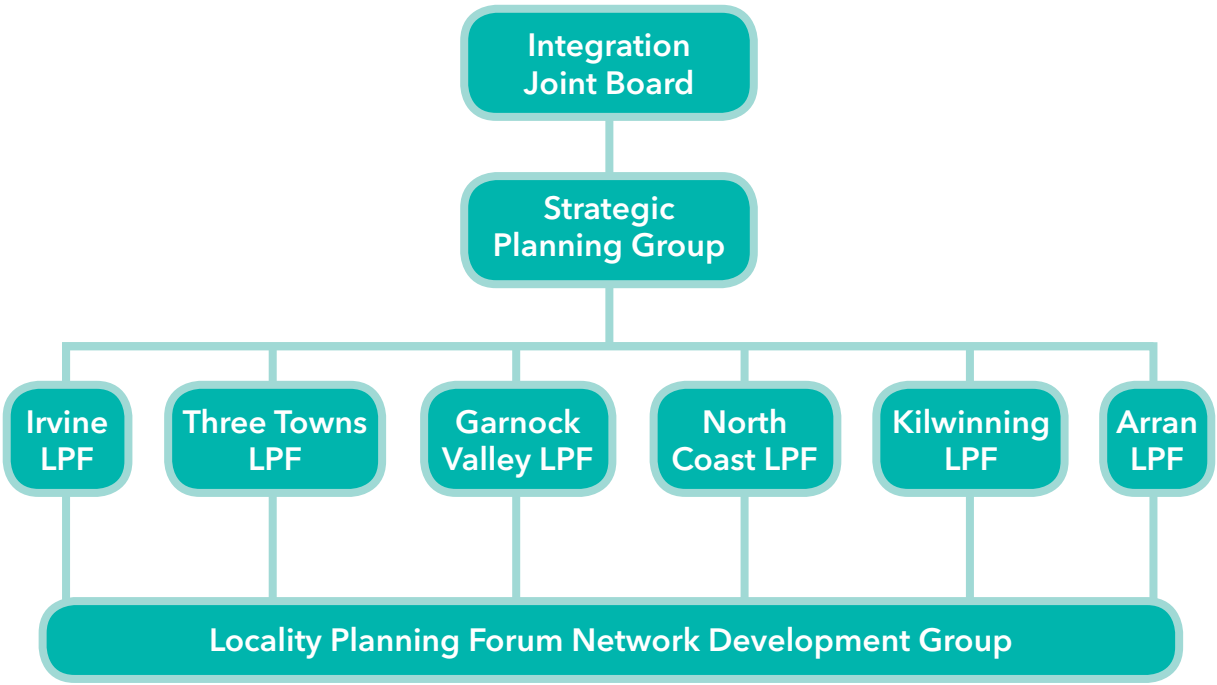
Over 2015–16, the Partnership developed six Locality Planning Forums (LPF).

- Arran
- Garnock Valley
- Irvine
- Kilwinning
- North Coast and Cumbrae
- Three Towns

These forums will be the key link between local communities and North Ayrshire Health and Social Care Partnership. The priorities identified by the forums will be channelled into the Partnership's strategic planning process for action. Each locality began with a core membership of three individuals:

- Chairperson – a member of the Integration Joint Board
- Lead Officer – a Senior Manager from NAHSCP
- Local GP – a locality based GP

The forums are supported by the Locality Network Development Group. The purpose of this group is to provide support to enable the forums in their continued development.



Localities Development

In line with national guidance, locality chairpersons are able to co-opt members onto their Forum. These members can include representatives from health and social care, carers and patient organisations, housing, third and independent sectors.

Each forum has taken into account the key issues, such as inequalities and poverty, which face each locality. Through use of local information, forums have identified key priorities for delivery in the forthcoming year

Priorities identified by Locality Planning Forums are included in the Partnership's updated Strategic Plan for 2016–18. As action plans are developed it is anticipated that a suite of performance measures will be identified to measure the improvements in their local areas.

Localities priorities are:

Three Towns

- Care at Home access
- Young men – wellbeing/ mental health
- Social isolation

Garnock Valley

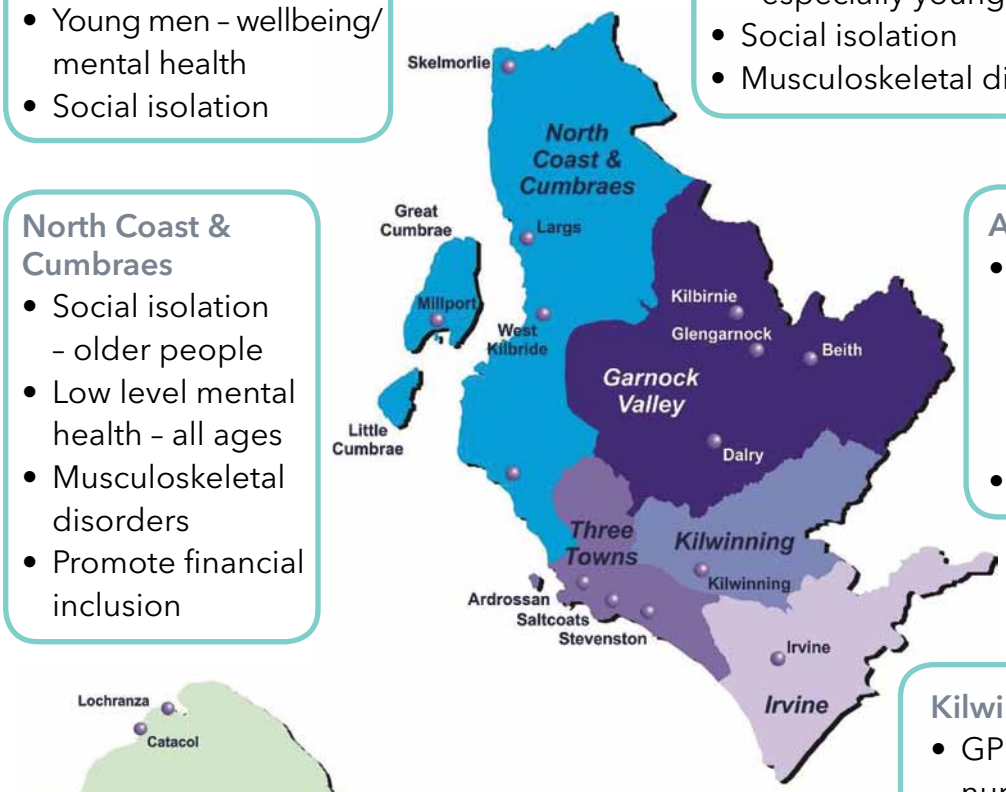
- Mental health and wellbeing – especially young people
- Social isolation
- Musculoskeletal disorders

North Coast & Cumbraes

- Social isolation – older people
- Low level mental health – all ages
- Musculoskeletal disorders
- Promote financial inclusion

Arran

- Social isolation, particularly older people with complex care needs
- Transport



Irvine

- Social isolation – all ages
- Low level wellbeing/mental health – especially young people
- Physio access re musculoskeletal disorders

Kilwinning

- GP sessions in nursing homes
- Occupational Therapy advice in pharmacies
- Engage with community
- Engage with Early Years centres

5. Reporting on Lead Partnership responsibility

North Ayrshire HSCP is the lead partnership for **Mental Health Services** as well as some **Early Years Services** for North, East and South Ayrshire. This means we are responsible for the strategic planning and operational budget of all Mental Health in-patient services, Learning Disability Assessment and Treatment Service, Child and Adolescent Mental Health Services, Psychology Services, Child Health Service, Children's Immunisation Team, Infant Feeding Service and Family Nurse Partnership.

Mental Health Services

In 2015–16 we worked towards the completion of Woodland View, the new state of the art Mental Health and Community Hospital in Irvine. Inpatient services will move from old, outdated accommodation (across two sites) to a modern, purpose built single-site facility.

In addition, a number of Community Mental Health services have started the process of joining together health and social care staff into integrated teams.

Primary Care Mental Health Teams (PCMT) work with those who have mild to moderate mental health issues and offer up to a maximum of 12 sessions of treatment. During the service year, Primary Care Mental Health teams across Ayrshire accepted 6,267 referrals into the service:

Community Mental Health Teams (CMHT) work with those with more complex, lifelong conditions and treatment can be anywhere from 12 sessions and more. These teams had 2,944 accepted referrals throughout the service year:

Child and Adolescent Mental Health Service (CAMHS) is a multidisciplinary service including psychiatry, psychology, nursing, speech and language therapy and occupational therapy and psychotherapy. Within North, South and East Ayrshire there are dedicated CAMHS teams linking to local education, social work and health teams. They have had great success in meeting the 18 week Referral to Treatment target, but challenges still remain including trying to develop alternative models of service delivery and achieving integration across agencies.

CAMHS, across Ayrshire, had a total of 1,679 referrals accepted.

CAMHS commenced 97% of treatments within the service year, exceeding the service standard of 90%. At the end of March 2016, the pan-Ayrshire service had a waiting list of 298 people. Of this, 5 (2%) had exceeded the 18-week maximum standard.

Throughout the service year, Psychological Services commenced 76.8% of treatments and interventions (this is the aggregated total of the twelve specialist teams). This was under the HEAT target of 90%. Further, as at year end, Psychological Therapies across Ayrshire had a waiting list of 2,570 people, with 580 (23%) having already exceeded the 18 week maximum standard. NAHSCP is undertaking a full review of Ayrshire-wide Psychological Services to better understand the challenges and constraints to delivery.

In relation to acute hospital Mental Health wards, 810 people were admitted during the service year:

251 admitted within East Ayrshire HSCP

331 admitted within North Ayrshire HSCP

228 admitted from South Ayrshire HSCP.

North Ayrshire Drug and Alcohol Recovery Service (NADARS) was the first truly integrated team in NAHSCP. Their journey to a single joined-up team encountered and overcame many issues, including using different IT systems, telephony, information security and governance issues (where and how we will store and share service user information). See Alcohol and Drug waiting times on page 8.

The Learning Disability Service has undergone a substantial review this year targeting the delivery of services to those needing complex care, specialist support and sleepover provision, amongst others.

The Crisis Team is working on a pilot pathway with Police Scotland to prevent those people experiencing crisis having to attend the emergency department in order to have a mental health assessment. The work looks very promising and could save many hours and improve outcomes for people.

Child Health Services

The Child Health Service is responsible for the comprehensive immunisation, screening, health review programmes and fail-safe aspects delivered to the eligible population across Ayrshire. This service is hosted by NAHSCP, with a consistent approach being implemented across the three partnerships. The Child Health Service is governed by Scottish Government legislation and protocols.

The Children's Immunisation Team provides an Ayrshire wide provision with NAHSCP as lead. The team delivers the Ayrshire school-based immunisations programme. The immunisations delivered are Human Papilloma Virus, Diphtheria Tetanus & Polio, Meningitis ACWY and Measles, Mumps & Rubella. This programme is offered to 16,833 young people between the cohorts of S2 to S6. The annual influenza vaccine is offered to 24,553 children from Primary 1 to 7. The success of Primary School flu immunisation programme and catch up Meningitis ACWY campaign for school pupils in S3 to S6, highlight excellent pan Ayrshire services. See immunisation performance on page 25.

The Infant Feeding Service promote the benefits of breastfeeding to families and provide specialist support to those families that have complex feeding issues. Over the year, interviews with mothers show a high quality of care is being delivered. There has been a continued increase in the number of venues that have signed up to the 'Breastfeed Happily Here' scheme. However, breastfeeding rates remain low in Ayrshire.

The Family Nurse Partnership (FNP) has been working in Ayrshire since February 2013 and has supported over 250 young women. The programme has achieved many positive outcomes such as; increasing positive attitudes to breastfeeding, uptake in immunisations, increase in the number of children born at a healthy weight, and a reduction in smoking during pregnancy. Integration has presented a challenge to the programme due to differing processes and travel across the three authorities. Going forward, a move to locality based working should lead to further improvements.

6. Inspection of Services

External Services

Within NAHSCP our contract management officers are responsible for ensuring that any care deficiencies reported are recorded and cross referenced with other information, for example Care Inspectorate reports. If there are issues of concern we act in accordance with the contract management framework. We take action where services fail to meet ongoing standards or where there is breach of contract.

The provider is responsible for developing and delivering an action plan that satisfies the Council and Care Inspectorate (if they are involved) and that there are steps to improve services. Where there is no evidence of improvement, NAHSCP's Head of Service takes decisions about any required action. This could involve reductions in rate, increased monitoring activity such as on site visits and imposing conditions on the service such as a moratorium (no further referrals) until issues resolve or the contract is terminated.

Any action to address service deficiencies will attempt to do so in ways that prioritise outcomes for people who use our services and ensures safety and wellbeing.

We will regularly visit the provider to ensure the action plan is progressing, including liaison with care managers and other bodies and gathering evidence about service improvements.

This level of contract monitoring activity will continue until such times as NAHSCP is satisfied that the service has made the necessary improvements to ensure the care, safety and wellbeing of residents.

Internal Services

Internal services undergo inspection from the Care Inspectorate.

In 2015–16, 11 internal services were inspected and the table (overleaf) shows the care grades awarded.

One of Scottish Government's suite of National Indicators is the proportion of care services graded 'good' (4) or above in Care Inspection Grades. As at 31 March 2016, 92.5% of NAHSCP inspected services were graded 4 or above.

Base / Care Inspectorate No.	Insp Date	Quality Theme Care Grades (out of 6)
Children & Families		
Achnamara, Saltcoats / CS2007142322	7 Aug 2015	5 Support 5 Environment 5 Staffing 5 Management
Mount View, Dreghorn / CS2003003327	8 Jun 2015	5 Support 5 Environment 5 Staffing 5 Management
Abbeycroft, Kilwinning / CS2003001163	21 Apr 2015	5 Support 5 Environment 4 Staffing 5 Management
The Meadows, Irvine / CS2007142325	29 Apr 2015	5 Support * Environment * Staffing 5 Management
Canmore, Kilwinning / CS2003001160	2 Jul 2015	5 Support 5 Environment 4 Staffing 5 Management
Older People Services		
Anam Cara, Kilbirnie / CS2008177877	27 May 2015	4 Support 4 Environment 4 Staffing 4 Management
Montrose House, Arran / CS003001167	24 Sep 2015	3 Support 5 Environment 3 Staffing 3 Management
Stronach Day Service, Arran / CS2003034609	10 Aug 2015	4 Support 5 Environment 4 Staffing 4 Management
Care at Home, Irvine & Garnock Valley / CS2008192553	30 Mar 2016	4 Support * Environment 4 Staffing 5 Management
Care at Home, Three Towns & Arran / CS2008192560	30 Mar 2016	4 Support * Environment 4 Staffing 5 Management
Adult Services		
Community Based Services, Kilwinning / CS2003053166	9 Oct 2015	4 Support 4 Environment 4 Staffing 4 Management

**Grade not available*

7. Financial performance and best value

Financial information is part of our performance management framework with regular reporting of financial performance to the Integration Joint Board (IJB).

This section summarises the main elements of our financial performance for 2015–16.

Partnership Revenue Expenditure 2015–16

All Partnership services experienced continued increasing demand, particularly in Children and Families, Learning Disability and Physical Disability services. The Partnership was able to reduce the cost of care services across all services but in some areas the increased demand led to in-year overspends against the original approved 2015–16 funding. These were partially offset by early delivery of future savings around Older People services and income generation.

The Integration Joint Board (IJB) approved a financial recovery plan on 10 March 2016. Following this the Council agreed to fund £1.255m of the 2015–16 cost pressures on a one-off basis. However, the final outturn in respect of the Partnership increased to £2.109m, which the Council has agreed to fully fund. Table 1 details performance by service for 2015–16.

Table 1: Financial performance for 2015–16

	Budget £000	Actual £000	Variance (Fav)/Adv £000	Notes (overleaf)
Learning Disability	15,625	15,844	219	(1)
Older People	41,483	41,320	(163)	
Physical Disability	5,405	5,734	329	(2)
Mental Health Community Teams	5,436	5,437	1	
Addictions	2,362	2,253	(109)	
Community Nursing	3,754	3,761	7	
Prescribing	30,049	30,699	650	(3)
General Medical Services	17,344	17,163	(181)	
Resource Transfer, Change Fund, Criminal Justice	2,194	2,209	15	
Non District General Hospitals	6,561	6,496	(65)	
Lead Partnership Services – Mental Health	46,678	46,577	(101)	
Children and Families	26,669	28,346	1,677	(4)
Direct Overheads and Support Services	7,298	7,127	(171)	
Total net expenditure	210,858	212,966	2,108	
North Ayrshire Council Funding	84,674	86,783	(2,109)	
NHS Ayrshire & Arran Funding	126,184	126,183	1	
Total income	210,858	212,966	(2,108)	
Surplus/(deficit)	0	0	0	

Note: The budget above reflects the budget managed by the IJB during the year, and excludes the Large Hospital Set Aside Budget that was allocated to the IJB at the end of the year.

A number of services experienced significant in-year budget pressures during 2015–16:

1. **Learning Disability £0.219m overspend**

   This overspend mainly relates to increased demand for services that was partially offset by a reduction in the cost of care services. The overspend has been further offset by increased income generation and management of vacant staff posts.

2. **Physical Disability £0.329m overspent**

   This overspend mainly relates to spend on equipment necessary to keep people safe in the community. There was an increased demand for services during 2015–16 that has been partially offset by a reduction in the cost of care services that are reflective of individual need and management of vacant staff posts.

3. **Prescribing £0.650m overspent**

   This overspend is due to the increased average cost of drugs due to lack of some items and price increase of some high cost drugs. Per the Integration Scheme, any overspends in this budget are funded by NHS Ayrshire & Arran and additional funds have been provided by NHS Ayrshire & Arran to cover this expenditure.

4. **Children and Families £1.677m overspend**

   This service began 2015–16 with a baseline budget pressure of £0.770m linked to Children with Disability Services. The increase to £1.089m reflected the increase in demand for services. New legislation during the year, increased the fees payable to Kinship Carer, which created a further in-year pressure of £0.250m.

This pressure on budgets has been recognised as part of the 2016–17 revenue budget and additional investment has been targeted at this service area.

Reporting on Integrated Care Fund

NAHSCP received a total of £2,890,000 from the Integrated Care Fund (ICF) from Scottish Government.

The main driver for the ICF was to support our strategic priorities.

We embraced the challenge of doing things differently by allocating some of the finances to develop the **Ideas and Innovation Scheme** – projects within local communities. After a screening process by a panel made up of NAC, NHS, Third and Independent sector members (which was highlighted as an example of best practice by Scottish Government) we funded 26 projects ranging from Foodtrain (delivering shopping to those less mobile) to On Yer Bike (community project that refurbishes bikes and lends them out to underprivileged children and their families). A detailed list of the projects and funding allocation can be found in Appendix 2.

Part of the ICF was used to continue to fund the nine legacy projects from the **Reshaping Care for Older People Project**. These projects continue to perform well and a business case is being developed to mainstream fund them within the next two years.

Our **Change Programme** in 2015–16 was very ambitious and involved the review of large parts of the service. It was broken into three phases.

	Allocation for 2015–16	Total year spend	(Over)/ Underspends
Ideas and Innovation Scheme	£1,040,788	£852,000	£190,000
Reshaping Care for Older People Legacy	£993,478	£1,134,000	(£141,000)
Change Programme	£802,448	£688,000	£114,000
Contingency	£103,836	£10,000	£94,000
Care at Home		£197,000	(£197,000)
Equipment		£60,000	(£60,000)
Total ICF spend to date (2015–16)	£2,941,559*	£2,941,559*	£0

**Includes Resource Transfer monies to exceed ICF allocation*

Phase one started in February 2015 covering services from all directorates including the integration of Addiction Services, Intermediate Care and Rehabilitation hub at Pavilion 3 Ayrshire Central Hospital, construction of Woodland View Mental Health and Community Hospital, Review of Care at Home services, contact centre for accommodated children.

Phase two commenced in October 2015 and continued the projects started in phase one but added in additional projects including the review of Arran services, creating Teams around the Child, review of Learning Disability services for people with complex care needs who require specialist supports, review of models of care for older people and people with complex care needs.

Finally **phase three** commenced in December 2015 and incorporated the review of Cumbrae, joint forensic services and integrating community mental health teams.

A detailed report of the impact of the ICF has been submitted to Scottish Government. Please contact us if you'd like a full copy of the ICF report.

Financial outlook

It is important moving forward that expenditure is managed within the financial resources available and a full action plan has been developed to improve financial management for the future.

Scottish Government has announced additional funding of £250m for Health and Social Care Partnerships for 2016/17, to help address social care pressures. Although this has been welcomed, significant challenges remain moving forward. The most significant risks faced by the IJB over the medium to longer term can be summarised as follows:

- the socio-economic and health inequalities prevalent in North Ayrshire
- the increased demand for services alongside reducing resources
- the wider financial environment, which continues to be challenging
- the impact of Welfare Reform on the residents of North Ayrshire
- the impact of demographic changes
- the impact of the Living Wage and other nationally agreed policies
- the Change Programme does not meet the desired timescales or achieve the costs associated

These risks mean that money is tighter than ever before. It is therefore crucial that we focus on early intervention, prevention and recovery if we are to work within the total annual Partnership budget of just over £200m.

Moving into 2016–17, we are working to proactively address the funding challenges while, at the same time, providing high-quality services for the residents of North Ayrshire.

Best value

NHS Ayrshire & Arran and North Ayrshire Council delegate budgets to the Integrated Joint Board (IJB). The IJB decides how to use these resources to achieve the objectives of the strategic plan. The IJB then directs the Partnership to deliver services in line with this plan.

The governance framework is the rules and practices by which the IJB ensures that decision making is accountable, transparent and carried out with integrity. The IJB has legal responsibilities and obligations to its stakeholders, staff and residents of North Ayrshire.

NAHSCP ensures proper administration of its financial affairs by having a Chief Financial Officer (section 95 of the Local Government (Scotland) Act 1973).

To strengthen governance arrangements and oversee the IJB's significant change programme, the Change Programme Steering Group was established during 2015–16. It is chaired by Iona Colvin, IJB Chief Officer with senior representation from all NAHSCP services as well as third and independent sector partners.

Evidence of transformational change taking place at strategic and operational levels, includes:

- Woodland View – Mental Health and Community Hospital
- North Ayrshire Drug & Alcohol Recovery Service (NADARS)
- Redesign of Care at Home Services
- Winter Planning
- Review of Children's Services
- Review of Island Services

Financial reporting on Localities

The 2015–16 financial information is not split into localities as this level of financial reporting will be developed during 2016–17.

Appendices

Appendix 1 Local Indicators Table

PI description	Last update	Current value	Target	Status
Number of learning disability service users in voluntary placements	2015-16	78	43	✔
Number of people receiving Care at Home	2015/16	1,839	1,703	✔
Care at Home capacity (number of hours) lost due to cancelled hospital discharges	2015/16	3,657.94	Baseline Year	
Number of bed days saved by ICES providing alternative to acute hospital admission	2015-16	3,082	3,060	✔
Percentage of people referred to ICES seen within 1 day of referral	2015-16	82.1%	Baseline Year	
Number of secure remands for under 18s	2015-16	5	5	✔
Number of children completing SNAP who have been sustained within their local school	2015-16	100%	100%	✔
Preschool children protected from disease through % uptake of child immunisation programme (Rotavirus)	2015-16	93%	92.2%	✔
Preschool children protected from disease through % uptake of child immunisation programme (MMR1)	2015-16	97.8%	98.2%	✔
Percentage uptake of Child Flu Programme in schools	2015-16	75.4%	75%	✔
Addictions referrals to treatment within three weeks (alcohol)	2015-16	96.3%	90%	✔
Addictions referrals to treatment within three weeks (drugs)	2015-16	95.9%	90%	✔
Number of people attending Café Solace	2015-16	3,621	Baseline Year	
Number of volunteers working with Café Solace	2015-16	27	Baseline Year	
Number of Unique Individuals referred to MADART (under 16)	2015-16	709	Baseline Year	

PI description	Last update	Current value	Target	Status
Number of re-referrals to MADART	2015-16	103	Baseline Year	
Number of referrals to MADART	2015-16	598	Baseline Year	
Percentage of people indicating an improvement in their recovery capital following the introduction of the Recovery Capital Questionnaire	2015-16	61.22%	Baseline Year	
Percentage of individuals subject to level 1 Community Payback Order Unpaid Work completed within three months	2015-16	90.32%	57%	
Percentage of individuals subject to level 2 Community Payback Order Unpaid Work completed within six months	2015-16	92.45%	67%	

Appendix 2 Ideas and Innovation Scheme

Projects	Sector	Total amount
Health promoting care homes	Indep.	£11,000
Post diagnostic dementia support	NHS	£60,000
Ayrshire Home from Hospital	Third	£62,292
Café Solace	Third	£30,000
Food Train	Third	£45,000
Talking Mats	NHS	£13,089
Callcare 365	Third	£24,000
Medicine Mgt	NHS	£20,000
End of life facility	Indep.	£39,000
ICES Pharmacy	NHS	£25,000
Positive connections	Third	£7,550
Custody support (women)	NAC	£45,000
Staying connected	Third	£38,610
What's on guides	Third	£17,619
On Yer Bike	Third	£51,552
3 town growers	Third	£44,500
GP establishment	Third	£15,600
Services to Fullerton	NHS	£50,000
Community Connectors	Third/NAC [1]	£133,500
Weigh to go	NHS	£16,725
Talking about diabetes	NHS	£2,811
Hep C Peer support	NHS	£41,000
Self-management support	NHS	£2,600
Food, Fluid and Nutrition	NHS	£42,599
Services to Redburn	NHS	£12,000
Multimorbidity HARP	NHS	£190,741
Ideas and Innovation Total		£1,041,788
Contingency		£103,836

[1] *£73,000 for Third Sector Interface and £60,500 for North Ayrshire Council.*

RCOP Legacy	Sector	Total amount
ICES	NHS/NAC	£433,401[2]
Falls Training	NAC	£14,000
OOH Care at Home	NAC	£222,000
Community Capacity	Third	£90,000
Dementia Training	NAC	£39,189
Care home development worker	Indep.	£21,000
Telecare	NAC/NHS	£41,000[3]
LOT resource workers	NAC	£71,298
Carers Strategy	Third	£10,000
RCOP Legacy Total		£941, 888

Change Team	Sector	Total amount
Adult Mental Health		£89,437[4]
Child and Adolescent MH services		£64,437
Addiction Services		£60,400[5]
Rehab and Enablement		£53,592[6]
Care at home review		£51,000
Programme Support		£483,581[7]
Change Team Total		£802,447
Grand Total		£2,889,959

[2] *£185,000 for North Ayrshire Council and £248,401 for NHS Ayrshire & Arran.*
[3] *£26,000 for North Ayrshire Council and £15,000 for NHS Ayrshire & Arran.*
[4] *£64,437 for North Ayrshire Council and £25,000 for NHS Ayrshire & Arran.*
[5] *£30,200 for North Ayrshire Council and £30,200 for NHS Ayrshire & Arran.*
[6] *£26,796 for North Ayrshire Council and £26,796 for NHS Ayrshire & Arran.*
[7] *£158,764 for North Ayrshire Council and £324,817 for NHS Ayrshire & Arran.*

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