North Ayrshire Council
Comhairle Siorrachd Àir a Tuath

NHS Ayrshire & Arran

Cunninghame House
Irvine

06 August 2015

Integration Joint Board

You are requested to attend a meeting of the Integration Joint Board to be held on Thursday **13 August 2015 at 10.00 a.m. in the Council Chambers, Cunninghame House, Irvine**, to consider the following business.

Business

1. Apologies
Invite intimation of apologies for absence.

2. Declaration of Interest

3. Minutes / Action Note (Page 5)
The accuracy of the Minutes of the meeting held on 4 June 2015 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).

4. Matters Arising

Reports for Approval

5. Performance and Audit Committee (Page 15)
Submit report by Lesley Aird, Head of Finance, on the membership and meeting schedule for the Performance and Audit Committee of the IJB (copy enclosed).

6. Model Publication Scheme (Page 17)
Submit report by Neil McLaughlin, Information Systems Manager, on the requirement to define how information is made publically accessible (copy enclosed).

Reports to Note

7. Director's Report (Page 21)
Submit report by Iona Colvin, Director, on developments within the North Ayrshire Health and Social Care Partnership (copy enclosed).

8. GP Strategy (Page 33)
Submit report by Dr Paul Kerr, Clinical Director Health and Social Care Partnership on the document General Practice in Ayrshire and Arran: A Vision for Change (copy enclosed).

9. Care at Home Review Update (Page 65)
Submit report by David Rowland, Head of Service Health & Community Care, on the progress that has been made by Main Street Consulting in conducting a review of Care at Home Services (copy enclosed).

10. Equipment and Adaptations Project (Page 69)
Submit report by David Rowland, Head of Service Health & Community Care, on the Equipment and Adaptations Project (copy enclosed).

11. Arran Action Plan Update (Page 75)
Submit report by David Rowland, Head of Service Health & Community Care, on the progress that has been made by the Island Services Management Team in relation to the agreed Arran Action Plan (copy enclosed).

12. Financial Management Year-End Report 2014-15 (Page 87)
Submit report by Fiona Neilson, Senior Finance Manager, on the 2014-15 financial performance (copy enclosed).

13. Procurement by the Health and Social Care Partnership – Reporting Arrangements (Page 99)
Submit report by Andrew Fraser, Head of Democratic Services, on the arrangements for entering into contracts in respect of integrated functions (copy enclosed).

14. Improving Children's Outcomes (Page 111)
Submit report by Marjorie Adams, Programme Manager (Early Intervention & Prevention), on the Improving Children's Outcomes project (copy enclosed).

Consultation

15. Response to the Justice Committee's call for Evidence on the Community Justice (Scotland) Bill (Page 115)
Submit report by David MacRitchie, Senior Manager, Criminal Justice Services, on the response from North, East and South Ayrshire's Criminal Justice Social Work Services to the above Bill (copy enclosed).

16. Health (Tobacco, Nicotine etc. and Care) (Scotland) Bill / (Duty of Candour- Wilful Neglect) (Page 121)
Submit report by Derek Barron, Head of Service Health & Community Care, on the progress of the legislation and our response to the proposals in the Bill (copy enclosed).

Minutes

17. Minutes of North Ayrshire Strategic Planning Group – 25th June 2015 (Page 153)
Submit the minutes of the North Ayrshire Strategic Planning Group held on the 25th June 2015 (copy enclosed).

18. Date of Next Meeting
The next meeting will be held on **17th September 2015 at 10.00 a.m., Council Chambers, Cunninghame House, Irvine.**

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

Exempt Information

20. Exclusion of the Public
Resolve in terms of Section 50(A)4 of the Local Government (Scotland) Act 1973, to exclude from the Meeting the press and the public for the following items of business on the grounds indicated in terms of Paragraph 6 of Part 1 of Schedule 7A of the Act.

Non Disclosure of Information
In terms of Standing Order 17 (Disclosure of Information) the information contained within the following reports is confidential information within the meaning of Section 50A of the 1973 Act and shall not be disclosed to any person by any Member or Officer.

20.1 Care at Home Briefing
The board will receive a briefing from David Rowland, Head of Service Health & Community Care.

Integration Joint Board

Sederunt

Voting Members

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

Professional Advisors

Mr Derek Barron	Lead Nurse/Mental Health Advisor
Ms Iona Colvin	Director North Ayrshire Health & Social Care Partnership
Vacancy	GP Representative
Ms Lesley Aird	Section 95 Officer/Head of Finance - NAC
Mr Stephen Brown	Chief Social Work Officer- North Ayrshire Council
Ms Kerry Gilligan	Lead Allied Health Professional Advisor
Dr Paul Kerr	Clinical Director

Stakeholder Representatives

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

North Ayrshire Health and Social Care Partnership
Minute of Integration Joint Board meeting held on Thursday 4th June 2015
at 10.00 a.m., Council Chambers, Cunninghame House, Irvine

Present :
Councillor Anthea Dickson, (Chair)
Lesley Aird, Chief Finance Officer
Derek Barron, Lead Nurse
Thelma Bowers, Head of Mental Health
Stephen Brown, Head of Children, Families & Criminal Justice
Iona Colvin, Director, NAHSCP
Carol Davidson, NHS Ayrshire & Arran
David Donaghey, Staff Side Representative, NHS Ayrshire & Arran
Councillor Ruth Maguire, NAC
Bob Martin, NHS Ayrshire & Arran
Louise McDaid, Staff Side Representative, NAC
Janet McKay, NHS Ayrshire & Arran
Stephen McKenzie, NHS Ayrshire & Arran (Vice Chair)
Marie McWaters, Carers Representative
Jim Nichols, Third Sector Representative
Councillor Robert Steel, NAC
Nigel Wanless, Independent Sector Representative

In Attendance :
Melanie Anderson, Acting Committee Services Manager
Karen Andrews, Business Support Officer
Andrew Fraser, Head of Democratic Support, NAC
Jo Gibson, Principal Manager (Planning & Performance)
John Godwin, Service Development Officer, NAC
Janine Hunt, Principal Manager (Business Support)
Eunice Johnstone, Planning Manager, NHS Ayrshire & Arran
Billy McClean, Associate AHP Director, NHS Ayrshire & Arran
Fiona Neilson, Senior Finance Manager, NHS Ayrshire & Arran
Chief Inspector Tim Ross, Police Scotland
David Rowland, Head of Health & Community Care

Apologies for Absence
Kerry Gilligan, Lead AHP
Martin Hunter, Service User Representative
Paul Kerr, Clinical Director
Councillor Peter McNamara, NAC
Sally Powell, Carer Representative
Fiona Thomson, Service User Representative

1.	**DECLARATION OF INTEREST**	
	Councillor Dickson declared an interest in relation to Item 13 on the agenda.	

2.	**MINUTES/ACTION NOTE – 16th APRIL 2015**	
	Agreed without amendment.	
3.	**DEVELOPMENT AND IMPLEMENTATION OF A NORTH AYRSHIRE SOCIAL ENTERPRISE STRATEGY**	
	Submitted report by John Godwin, Service Development Officer in relation to the development and implementation of a North Ayrshire Social Enterprise Strategy.	
	The report highlighted the intention to develop a comprehensive and robust partnership based strategy to maximise the social and economic impact of social enterprises in North Ayrshire. A steering group will be established to provide strategic direction, specialist input and test developments and ideas throughout the process. It is anticipated that there will be three meetings of the Steering Group throughout this process.	
	A draft strategy will be submitted to the Steering Group on 31st August 2015. A final strategy will then be presented to the IJB, North Ayrshire Corporate Management Team and NAC Cabinet for approval.	**John Godwin** Agenda – IJB 17-9-15
	Members asked questions and received clarification in relation to :-	
	• The spend on third and independent sector projects using public funding. Iona Colvin advised that currently social enterprises and community based organisations represent 25% of total spend on contracted Health and Social Care services. It is hoped to make better opportunities for people into employment through some of the social enterprise services. The strategy is not about replacing current services in NAC/NHS.	
	• Assessing the impact of social enterprise was discussed. John Godwin advised that progress will be reviewed on a regular basis.	
	The report was endorsed by the IJB.	

4.	**INVESTMENT PROPOSALS FOR THE ADDITIONAL FUNDING AVAILABLE TO NORTH AYRSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP TO SUPPORT LOCAL RESIDENTS**	
	Submitted report by David Rowland, Head of Health and Community Care on proposals to invest additional resources to provide better care for people at home and to support individuals to return home after their acute care needs have been met.	
	IJB members commended the report, members asked questions and received clarification in relation to :-	
	• In relation to the proposal to appoint 40 additional staff on 20 hour contracts members asked how the difficulties in recruiting care at home staff have been addressed. David Rowland advised that the application process has been made easier by reverting to a paper based application form. Partnership staff are working alongside colleagues in Inverclyde to look at cross-boundary recruitment.	
	• Members asked about the flexibility on the type of contracts required, e.g., are full time hours available for those who apply. David advised that the contracts could be flexible with variations on the 20 hours if preferred.	
	• Issues around the waiting list for aids and adaptations were raised by members. David Rowland advised that it is proposed to make it easier for people to access high volume equipment. A specification for the aids and adaptations service will be brought to the IJB on 13th August 2015.	**David Rowland** Agenda – IJB -13-8-15
	• Iona Colvin advised that the aids and adaptations process is currently split across the HSCP, Housing and Building Services. Kerry Gilligan, Lead AHP will review this process.	**Kerry Gilligan**
	• Jo Gibson and her team are working with the Scottish Government ISD department to develop baseline information to measure the impact of the additional investment.	

	David Rowland advised that a progress report on the Care at Home Review, carried out by Main Street Consulting, will be tabled at the IJB meeting on 13th August 2015.	**David Rowland** Agenda – IJB – 13-8-15
5.	**IJB GOVERNANCE FRAMEWORK**	
	Submitted report by Janine Hunt, Principal Manager (Business Support) on the proposed governance framework for the delivery of the work of the IJB.	
	The report proposed draft Terms of Reference for the Health and Care Governance Group. The Terms of Reference for all the other proposed groups/committees will be developed and shared with the IJB over the coming months.	
	The proposals within the report were approved.	
6.	**PERFORMANCE AND AUDIT COMMITTEE**	
	Submitted report by Lesley Aird, Chief Finance Officer on the proposal to create a Performance and Audit Committee and proposals for the remit and powers of the committee.	
	Lesley Aird advised that the Scottish Government Guidance advised that the creation of the Audit Committee is a requirement. Lesley Aird also confirmed that the Committee will set up a programme of audit for the forthcoming year. This will be created on the advice of Internal and External Audit teams within NHS and NAC.	
	The recommendations within the paper were approved by the IJB.	
	A further report will be submitted to the IJB on 13th August 2015 with recommendations on the appointment of Board Members, including the Chair and Vice Chair. IJB to submit nominations for membership to Iona Colvin.	**Lesley Aird** Agenda – IJB – 13-8-15 **All Members**
7.	**FORMAT OF IJB MEETINGS AND ORGANISATIONAL DEVELOPMENT PROPOSALS**	
	Submitted report by Janine Hunt, Principal Manager (Business Support) on the process and format for future IJB meetings and ongoing development plan for IJB members.	
	The proposals within the report were agreed.	

8.	**HEALTHCARE IMPROVEMENT SCOTLAND (HIS) UNANNOUNCED INSPECTION OF ARRAN WAR MEMORIAL HOSPITAL (AWMH)**	
	Submitted report by Derek Barron, Lead Nurse on the recent inspection on Arran War Memorial Hospital and the action plan detailing improvement identified by the inspection team.	
	The IJB endorsed the actions contained within the action plan.	
9.	**RECOMMENDATIONS FOR THE FUTURE LEADERSHIP AND MANAGEMENT ARRANGEMENTS FOR ALLIED HEALTH PROFESSIONALS**	
	Submitted report by Billy McClean, Associate AHP Director on the recommendations for leadership and management arrangements for Allied Health Professionals across Ayrshire and Arran. This report has been approved by the South Integration Joint Board and will also be submitted to the East IJB for noting.	
	Billy McClean gave background to the recommendation within the report to adopt Option 2 which is AHP is managed through the South Ayrshire HSCP as lead partnership with a lead AHP aligned to each partnership.	
	The challenges through the process were acknowledged, and that this option was not the preferred option for either senior managers or professional and staff side representatives, but through further consultation Option 2 represented the consensus model. Billy McClean advised that work will continue with staff side representatives to strengthen this model.	
	The report was noted.	
10.	**DIRECTOR'S REPORT**	
	Submitted report by Iona Colvin, Director, NAHSCP.	
	The report was noted.	

11.	**BIG LOTTERY FUND ESF FINANCIAL INCLUSION**	
	Submitted report by David Rowland, Head of Health & Community Care in relation to discussions taking place with the Big Lottery Fund (BLF) to secure finding for financial inclusion work in North Ayrshire.	
	North Ayrshire has been selected as one of five areas to benefit from the funds should the BLF bid be successful. If successful the monies will be used to deliver an integrated programme covering financial capability, money management and debt reduction.	
	The IJB welcomed and noted the report.	
12.	**STRATEGIC PLANNING GROUP HELD ON 26TH MARCH 2015**	
	The minutes of the Strategic Planning Group meeting held on 26th March 2015 were noted.	
13.	**EXCLUSION OF PUBLIC AND PRESS**	
	The Board resolved, in terms of Section 50(A)4 of the Local Government (Scotland) Act 1973, to exclude from the meeting, the press and the public for the following item(s) of business on the grounds that it involved the likely disclosure of exempt information as defined in Paragraph 9 of Part 1 of the Schedule 7A of the Act.	
	Submitted report by Tim Ross, Chair of North Ayrshire Alcohol and Drug Partnership to seek IJB approval to extend the current contract for the Alcohol Support Service for one year. The proposals in the report were approved.	
12.	**DATE OF NEXT MEETING**	
	The next meeting will be a private briefing session on **Thursday 2nd July 2015 at 10.00 a.m., Greenwood Resource Centre, Dreghorn.**	
	The next business meeting will be held on **Thursday 13th August 2015 at 10.00 a.m., Council Chambers, Cunninghame House, Irvine.**	

NORTH AYRSHIRE INTEGRATION JOINT BOARD – ACTION NOTE

Thursday 4th June 2015 at 10.00 a.m, Council Chambers, Cunninghame House, Irvine

Present :	Anthea Dickson (Chair), Lesley Aird, Derek Barron, Thelma Bowers, Stephen Brown, Iona Colvin, Carol Davidson, David Donaghey, Ruth Maguire, Bob Martin, Louise McDaid, Janet McKay, Stephen McKenzie, Marie McWaters, Jim Nichols, Sally Powell, Robert Steel, Nigel Wanless
In Attendance :	Melanie Anderson, Karen Andrews, Andrew Fraser, Jo Gibson, John Godwin, Janine Hunt, Eunice Johnstone, Billy McClean, Fiona Neilson, Tim Ross, David Rowland
Apologies :	Kerry Gilligan, Martin Hunter, Paul Kerr, Peter McNamara, Sally Powell, Fiona Thomson

No.	Agenda Item / Summary of Discussion	Date of Meeting	Action	Status	Officer
1.	**Violence Against Women Strategy**	22-1-15	Agreed that the Violence Against Women Strategy be discussed at a future meeting of the SIB/IJB	Agenda – 13-8-15	**Stephen Brown**
2	**Strategic Planning Group Membership – Neighbourhood Representatives**	22-1-15	Jim Nichols and Jo Gibson to submit a report to the IJB on neighbourhood representatives.	Agenda – IJB – 17-9-15	**Jim Nichols/ Jo Gibson**
3.	**Criminal Justice Arrangements**	22-1-15	A report on CJS to be submitted to a future IJB meeting for consideration.	Agenda – IJB – 17-9-15	**Jim McCrae/ Stephen Brown**
4.	**Director's Report**	12-2-15	Iona to liaise with Liz Moore in relation to Acute Services representation on the IJB.	Discussion is ongoing	**Iona Colvin**

No.	Agenda Item / Summary of Discussion	Date of Meeting	Action	Status	Officer
5.	**Concerns Hub**	12-3-15	Report on the Concerns Hub to be submitted to IJB early Summer.	Agenda – IJB – 13-8-15	**Stephen Brown**
6.	**Remodelling Rehabilitation Services on Arran**	12-3-15	An interim report on the Remodelling of Service to be submitted to IJB on 13th August 2015 and the final report submitted on 8th October 2015.	Agenda – IJB – 13-8-15 Agenda – IJB – 5-11-15	**David Rowland**
7.	**Development and Implementation of a North Ayrshire Social Enterprise Strategy**	4-6-15	Draft Social Enterprise Strategy to be submitted to the IJB, NACMT and NAC Cabinet Meeting.	Agenda – IJB – 17-9-15	**John Godwin**
8.	**Investment proposals for Additional Funding Available to NAHSCP to Support Local Residents**	4-6-15	Specification for Aids and Adaptations to be submitted to IJB on 13th August 2015.	Agenda – IJB – 13-8-15	**David Rowland**
9.	**(As above)**	4-6-15	Progress report on Care at Home Review, carried out by Main Street Consulting be presented to IJB on 13th August 2015.	Agenda – IJB – 13-8-15	**David Rowland**

No.	Agenda Item / Summary of Discussion	Date of Meeting	Action	Status	Officer
10.	**Performance and Audit Committee**	4-6-15	Nominations from IJB members for membership of the Performance & Audit Committee to be forwarded to Iona Colvin, Chief Officer. A report on proposed membership for the PAC will be submitted to the IJB on 13th August 2015.	Agenda – IJB – 13-8-15	**Lesley Aird**
11.	**Date of Next Meeting(s)**				
	The next meeting will be held on **Thursday 2nd July 2015, at 10.00 a.m, Greenwood Resource Centre, Dreghorn.** **(This is a private session focussing on Children & Families)**				
	The next business meeting of the IJB will be held on **Thursday 13th August 2015 at 10.00 a.m., Council Chambers, Cunninghame House, Irvine.**				

Integration Joint Board

13th August 2015

Agenda Item No. 5

Subject:	**Performance and Audit Committee**
Purpose:	To agree the membership of and meeting schedule for the Performance and Audit Committee of the IJB.
Recommendation:	It is proposed that the IJB (a) appoints at least 6 members to the Committee from amongst the nominations received; (b) appoints a Chair from the agreed membership of the Committee, and; (c) agrees the proposed meeting schedule for the Performance and Audit Committee.

1. INTRODUCTION

1.1 On 4th June 2015, the IJB agreed the establishment of a Performance and Audit Committee, together with the remit and powers of the Committee.

1.2 It was further agreed by the IJB to invite nominations for the membership of the Committee and for the position of Chair.

1.3 The agreed Terms of Reference for the Performance and Audit Committee require that the Committee will consist of not less than six members of the IJB. The Chair of the Committee will be a voting member nominated by the IJB, noting that the Chair of the IJB cannot chair the Performance and Audit Committee.

2. CURRENT POSITION

2.1 Following the meeting on 4th June, the following nominations have been received:

- Councillor Robert Steel, (NAC)
- Councillor Peter McNamara (NAC),
- Robert Martin (NHS Ayrshire and Arran)
- Stephen McKenzie (NHS Ayrshire and Arran)
- Louise McDaid (NAC staff representative)
- Marie McWaters, Carers Representative

2.2 Robert Martin has also been nominated for the position of Committee Chair and Councillor Robert Steel has been nominated as Vice Chair.

2.3 The terms of reference for the Committee require that it should meet at least three times a year.

2.4 In order to facilitate quarterly reporting, it is considered that four meetings should be scheduled and that these should take place towards the end of February, May, August and November each year.

2.5 A fifth special meeting of the Committee will be required in June each year to consider the annual accounts of the IJB before these are presented to the full IJB for approval.

3. PROPOSALS

3.1 It is proposed that the IJB (a) appoints 6 members to the Committee from the nominations received; (b) appoints the Committee Chair, and; (c) agrees the proposed meeting schedule for the Performance and Audit Committee.

4. IMPLICATIONS

4.1 Financial Implications

None.

4.2 Human Resource Implications

None.

4.3 Legal Implications

None.

5. CONSULTATIONS

5.1 Consultations have taken place with members of the IJB in seeking nominations for the Performance and Audit Committee.

6. CONCLUSION

6.1 The establishment of a Performance and Audit Committee will enable the IJB to receive assurance that governance is sound and to scrutinise performance.

For further information please contact Lesley Aird, Head of Finance, North Ayrshire Council on 01294-324560.

Integration Joint Board

13th August 2015

Agenda Item No. 6

Subject:	**Model Publication Scheme**
Purpose:	To advise members of the Integration Joint Board of the requirement to define how information is made publically accessible.
Recommendation:	That the Integration Joint Board a) Agrees to mandate the short term option to further develop the North Ayrshire Council web site linked to NHS Ayrshire and Arran b) Agrees for an options appraisal for the long term of developing a dedicated North Ayrshire Health and Social Care Partnership web site.

1.	**INTRODUCTION**
1.1	Section 23 of the Freedom of Information (Scotland) Act 2002 requires Scottish public authorities to produce and maintain a publication scheme. Health and Social Care Partnerships are under a legal obligation to: • Publish the classes of information that they make routinely available • Tell the public how to access the information and what it might cost.
1.2	The Partnership has a requirement to inform the public of how information is handled in order to: • allow the public to see what information is available (and what is not available) in relation to each class, • state what charges may be applied • explain how to find the information easily • provide contact details for enquiries and to get help with accessing the information • explain how to request information we hold that has not been published.

2.	**CURRENT POSITION**
2.1	North Ayrshire Council and NHS Ayrshire and Arran have distinct publication schemes. The integration of social care with NHS Ayrshire and Arran requires the development of a unique publication scheme to inform and direct the public to available information contained under the Partnership.
2.2	There is a web page attached to North Ayrshire Council (NAC) web site providing available information in relation to the Partnership; however, this is limited as it only links to the available North Ayrshire Council information.
2.3	The NHS Ayrshire and Arran web site has links to information relating to the Integration Joint Board meetings and associated meetings only which is accessible to the public.
2.4	Charges currently apply for access to information on members of the public. If the information is stored electronically or in paper file format the charges can range from £20 - £50 dependant on the size of the request in NHS. For the NAC if it is personal information the fee is £10, but is not requested from what was social services.
2.5	Currently Freedom of Information enquiries are dealt with separately by the NHS and Local Authority. For 2014 figures for NAC there were 141 enquiries for 'social services'. For the NHS it was 33 enquiries for community health services or mental health services for the financial year 14/15.
3.	**PROPOSALS**
3.1	A defined Publication Scheme is required to offer the public specific and robust information in relation to each of the classes listed above. There are 2 options available to the Partnership: *Short to Medium Term* Develop the North Ayrshire Council web site further including all necessary links to the NHS Ayrshire and Arran web site and ensure that the NHS Ayrshire and Arran web site contains connecting links to the NAC web site. These can only be developed by the corporate web teams, therefore, initial content needs to be defined and development timescales negotiated. *Long Term* Undertake a feasibility study to develop a bespoke Partnership website which meets the needs of the Act and also provides an identity for the Partnership. This development will be contingent on agreement across both NAC and NHS to build the shared infrastructure and communication across both organisations.
4.	**IMPLICATIONS**
4.1	**Financial Implications** For the long term option, there will need to be a full tender approach to the development of an external Partnership web site.
4.2	**Legal Implications** By agreeing to these developments, the Partnership is enabled to develop the mechanisms to be legally compliant. The publication scheme will finally need to be approved by the Scottish Information Commissioner.

5.	**CONSULTATIONS**
5.1	None required. However to note that a pan-Ayrshire meeting has been set for all Freedom of Information coordinators to discuss a unified approach, between the three Ayrshire Partnerships and NHS Ayrshire and Arran to coordinating and providing information to the public that cross organisational boundaries. This is an important step in ensuring the processes are put in place to build the information architecture and the scale of the work is yet unquantified.
6.	**CONCLUSION**
6.1	The development and publicising of the Partnership model publication scheme will provide the means for the residents of North Ayrshire to be directed to and seamlessly access, relevant and available information relating to the Partnership.

For more information please contact Neil McLaughlin, Information Systems Manager (HSCP) on 01294 310398 or NMcLaughlin@north-ayrshire.gcsx.gov.uk

Integration Joint Board
13th August 2015

Agenda Item No. 7

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

1.	**INTRODUCTION**
1.1	This report presents a high level overview for members of the Integration Joint Board (IJB) of the work undertaken within the North Ayrshire Health and Social Care Partnership, both locally and with the other Ayrshire partnerships.
2.	**CURRENT POSITION**
2.1	The Strategic Planning & Operational Group (SPOG) continue to meet weekly. The current Chair, Allan Gunning has now left NHS Ayrshire & Arran on 31st July 2015 and Iona Colvin, Director, NAHSCP will take over as Chair of the group from 7th August 2015.
	National Developments
2.2	Iona Colvin, Director attended the Local Government and Regeneration Committee on 10th July 2015 to give evidence on the complaints process within the HSCPs. The Committee has since asked for further detail and clarification on a number of areas. A follow up session on progress will be held on 23rd September 2015.
	The SPOG have established a complaints workstream to look at the complaints process across the partnerships, local authorities and NHS.
	Derek Barron, Associate Nurse Director/Lead Nurse attended a Mental Health Summit at the Scottish Parliament on 30th July 2015. The summit sought views and real life experiences on the main challenges in mental health services and asked the undernoted questions :-

	• What are the main challenges in improving mental health provision in the NHS? • How can we make social care and health integration work for mental health care? • What are the shortcomings of the legislative framework for supporting mental health services in Scotland? • What needs to change to improve patient access to mental health services?
	Ayrshire Developments
2.3	John Burns, Chief Executive, NHSAA and Elma Murray, Chief Executive, NAC agreed to participate in the delivery of a West of Scotland Health & Social Care Integrated Transport Hub. Iona Colvin, Director has been asked to lead on this across Ayrshire and attend the West of Scotland Programme Board. A meeting was held on 9th June 2015, attended by representatives from NAC, NHS, East and South Ayrshire and the Scottish Ambulance Service to take this forward. Following that meeting, SPT appointed a consultant to work alongside each partner organisation to establish a workstream on Data Gathering and Development of Monitoring and Financial Framework. The first meeting with the consultant is planned for August 2015.
2.4	A pan Ayrshire meeting to discuss the implications of the Children & Young People (Scotland) Act 2014 and its implementation will be held on 2nd October 2015. This will be attended by all partner agencies including, NHS Ayrshire and Arran, local authorities, Children's Report Administration and Police Scotland.
	North Ayrshire Partnership Developments
2.5	Change Programme Projects within Phase 1 of the Change Programme are underway. Two of these projects have achieved important milestones recently :-
	Care at Home Review At the IJB on 4th June 2015, members approved investment of £2m in the care at home service to ensure our staff are supported fully in delivering high quality care. This investment will enable the partnership to secure jobs within vital caring roles, develop a career pathway in care and grow the capacity of our service to ensure we are much more responsive to the current level of demand, positioning us to better support individuals at home for longer and reduce avoidable emergency admissions. Recruitment is underway, however, it vital to ensure services are sustainable into the future as demand grows. Mainstreet Consulting have been asked to engage with staff and service users to understand the current and likely future pressures. This will allow us to explore potential models that will ensure local people are fully supported in the future. A working group, including representation from the service, will review Mainstream Consulting's work in August and propose some recommendations for further exploration to the IJB in September.

	Rehabilitation and Enablement Hub at Pavilion 3 Ayrshire Central Hospital A 'test of change' week was held at the beginning of June to allow teams to test small changes, such as referral routes, care plans and supported discharge approaches in a safe and supported environment, across Crosshouse Hospital and East and South Health & Social Care Partnerships. This week highlighted areas for improvement and changes are planned to improve service user's experience.	
	The other three Phase 1 projects are moving towards their milestones:	
	Integrated Addiction Services The team has worked to ensure processes are joined up and will undertake a 'test of change' week at the beginning of August to ensure these processes are effective for patients, users, carers and the staff involved.	
	Woodland View (North Ayrshire Community Hospital) The Capital build is due to be completed on target. Iona Colvin, Director now chairs the Woodland View Programme Steering Group. At the Programme Steering Group on the 16th July 2015 the work around defining the final models of care on the new site and an organisational development programme for staff and stakeholders was approved.	
	Ideas and Innovation Fund The 26 projects monitored by the Third Sector Interface all commenced at the start of June 2015.	
	At the Change Programme Steering Group on 16th July 2015, the following Phase 2 projects were approved and lead officers identified :-	
	Project Name	**Lead**
	• Pan Ayrshire Bed Review (inc. continuing care, residential, nursing and community hospitals).	Iona Colvin
	• Arran Rehabilitation and Enablement Model and Equipment & Adaptations Service Review.	David Rowland
	• CAMHs Neurodevelopmental pathways for children with ADHD/ASD.	Thelma Bowers
	• Tier 4 Commissioned Learning Disabilities Services including the future role of Arrol Park and an Opiate Replacement Therapy Review.	Thelma Bowers
	The Steering Group also agreed to include the following additional projects :-	
	• Revision of Adult Learning Disabilities sleepovers.	Thelma Bowers
	• Psychological Services Review	Thelma Bowers
	• Mental Health Innovation work (once funding from Scottish Government approved).	Thelma Bowers
	• Pan Ayrshire Transforming Care after Cancer Project	Stephen Brown

	(exploring employability options for patients on completion of treatment).	
	• Development of a Pan Ayrshire Police Concern Hub supporting both adults and children identified with support & protection issues.	Stephen Brown
	• Review of the Business Support functions to create service which facilitates and meets the need of health and social care services.	Janine Hunt
	At present the programme is within timescales and budget. The programme has also identified risks. Common risks across all projects are the challenges of using a range of IT systems and the lack of shared accommodation. A full risk assessment and mitigation plan will be put in place.	
	A Performance, outcomes and evaluation framework is also being developed for both the projects and the impact of the overall programme.	
2.6	Locality Planning The Scottish Government has released the final version of its Localities Guidance. The partnership are working with North Ayrshire Community Planning Partnership colleagues to align this with their Localities Approach (formerly the Neighbourhood Approach) to reduce both bureaucratic and engagement overload in our local communities.	
2.7	Strategic Planning Group The Terms of Reference for the Strategic Planning Group are under review to allow the group to undertake a more professional advisory role. The format of each meeting has been changed to focus on one of the five strategic priorities. Strategic Planning Group meeting on 25th June 2015 focussed on Mental Health and Well-being. The group welcomed a number of staff from the Mental Health directorate as well as members of the Mental Health Reference Group. The agenda included interesting discussions and presentations from the four service areas; Learning Disabilities, Mental Health, Addictions and CAMHs. The next meeting on 6th August 2015 will focus on the Tackling Inequalities priority.	
2.8	Senior Management Team	
	The final structures across the three partnerships have now been approved and will be circulated across all staff and partner agencies. A copy is attached at Appendix 1.	
	Within the North Ayrshire Partnership an induction session for new managers was held on 8th July 2015.	
	Following opening remarks from Iona Colvin, this initial induction provided information on professional advisory structures, finance, governance, support structures and the change programme. Other follow up induction sessions are being planned to include HR and people management information.	

	An extended partnership senior management team event was held on 26 June 2015. This event brought together around 100 people from the across the Partnership to receive a personal welcome to the Partnership and strategic overview from the Director. The agenda also included an update on the change programme and key projects from Heads of Service and Senior Managers. Participants also spent time in other mixed groups, articulating their hopes and aspirations for the Partnership. A clear message from participants was their shared desire to collaborate to deliver enhanced outcomes for service users and communities.
2.9	<u>Aspire Meetings (All Service Performance Information Review & Evaluation)</u>
	The Partnership Senior Management Team agreed to establish ASPIRE meetings to create a dynamic discussion with each care group in order to: • Ensure visibility of frontline services and performance at Chief Officer and SMT level. • Share best practice and celebrate success. • Identify and remove barriers to improving performance. • Ensure objectives and key performance indicators are met.
	The ASPIRE meetings will take place quarterly with the first meetings looking at the baseline report based on Q4 2014-15 data. Two of the three care group meetings were held by the end of July with the third taking place in early August.
	The meetings allow each care group the opportunity to highlight the areas of service which are performing well and identify where the challenges lie in the areas where performance is modest. It also gives each care group the opportunity to identify where further data could be drawn from to fill gaps in performance information and will be a forum to raise issues e.g. IT systems.
	The review panel is chaired by the Chief Officer (Iona Colvin) who will discuss with each care group specific areas of performance. This will allow open discussion and gives the opportunity for each care group to identify ideas to improve performance.
	Following each meeting an Action Plan is prepared, which will be recorded on the Covalent Performance Management system. These actions will be progressed by the care group and be measured using the Covalent system. Progress will also be reviewed at the subsequent ASPIRE meetings.
	A corporate performance report for the whole Partnership will be considered by the Performance and Audit Committee.
2.10	<u>IJB Development Sessions</u>
	Following on from the IJB development sessions in March and May 2015, IJB members were asked to consider areas for their personal development and identify particular areas of interest. Karen Andrews, Business Support Officer will contact individual IJB members to facilitate the identified development need and/or area of interest.

	The first of the private briefing sessions for IJB members took place on 2nd July 2015 and focussed on children and families.
	The next session will be held on 8th October 2015 and will focus on Mental Health and Addiction services.
2.11	<u>Mental Health Services</u>
	An initial 1½ day Mental Health Senior Management Development event is scheduled to take place in the last week of August. Facilitated by Calum Webster, the team (Head of Service, five Senior Managers, Interim Project Manager and Head of Psychology) will scope the opportunities provided by the Partnerships. Team members will affirm their individual and collective aspirations and leadership responsibilities in delivering enhanced pan-Ayrshire services. The event will examine progressing priorities such as Mental Health & Wellbeing strategy, governance and key projects. The outcomes of the session will help inform future team and OD interventions.
2.12	<u>District Nursing Services</u>
	Queen's Nursing Institute Scotland is funding £4000 to a 'catalyst for change' 6 month project to enable Dalry district nursing team to lead in the provision of an integrated health and social care approach to care delivery. This pilot project will focus on person centred planning and delivery of care, support and advice, working as partners with individuals and families to improve outcomes from early, intermediate through to end of life stages of dementia.
	Implementation will facilitate a 'team around the person' approach as highlighted by the Dementia Carers Voices Survey (2015), with an identified named community nurse, ensuring coordination and access to a hub of support and expertise across health, social care and third sector services.
	This project will have four primary drivers; pathway for post diagnostic support is clear and understood, provision of education for staff, integration of health, social care and third sector staff assessment and care planning with an outcome focused approach to care. Formative and summative evaluation will be quantitative and qualitative including focus groups, auditing number of referrals, minutes recorded from hub meetings and actions, assessment and care planning processes, anticipatory care planning, staff training status and health and social and third sector engagement.
2.13	<u>Appreciative Inquiry Development Session</u>
	The Partnership Senior Management Team (PSMT) underwent Appreciative Enquiry training on 9th July 2015. Appreciative Inquiry is an approach for creating and sustaining organisational change. This approach builds on an organisation's core strengths rather than focusing on how to overcome or minimise its weaknesses. It engages people in building the kinds of organisations and practice that people are enthusiastic about and proud to be a part of.

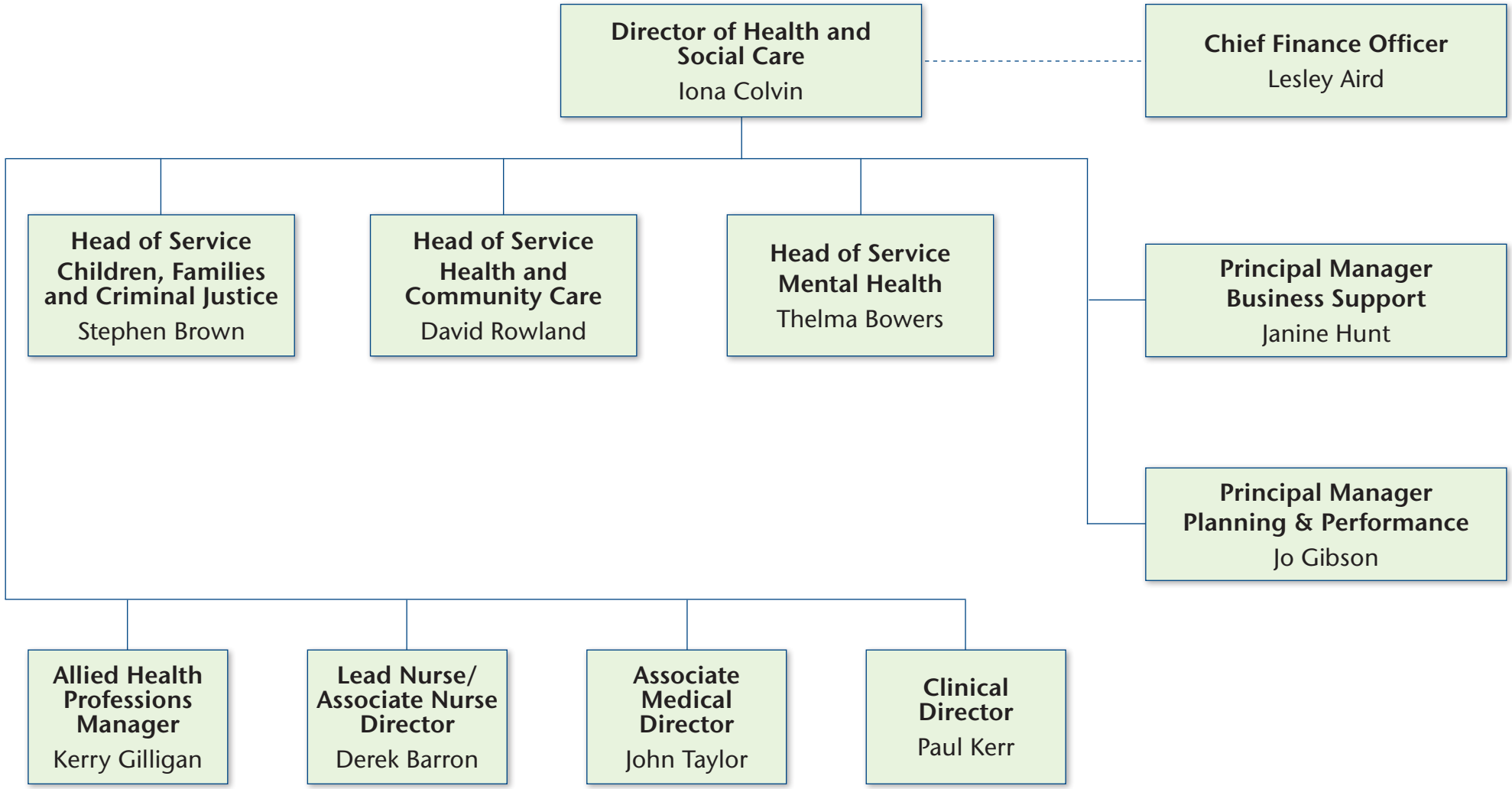
2.14	Making the Connections Event
	Over 500 Partnership staff (all sectors) attended the Making Connections… and having a blether event on 8th June 2015. Almost 90 services exhibited. North Ayrshire Health and Social Care Partnership people talked, listened, caught up old friends and met new colleagues, shared stories, learned about our new organisation … and had a cuppa. Our first all staff event at The Magnum was a resounding success; **96%** of staff who responded felt Making Connections met their aims and objectives, **96%** of staff who responded felt their Partnership knowledge had increased because of attending Making Connections,**100%** of staff who responded thought the seminars were useful.
2.15	Ministerial openings – Dirrans Centre and Montrose House/Stronach Day Service, 15 June
	The official opening, by Shona Robison MSP, Cabinet Secretary for Health, Wellbeing and Sport, of Dirrans Centre, Kilwinning and Montrose House/Stronach Day Service, Arran showcased new builds and joint partnership working at its best. Ms Robinson and invited guests chatted with service users and toured the facilities, including Dirrans Centre training kitchen and Montrose House step-up step-down facilities. The weather was kind and Provost Sturgeon, assisted by residents and service users, buried the Montrose House time capsule, which will be opened in 40 years' time.
3.	**IMPLICATIONS**
3.1	**Financial Implications**
	There are no financial implications arising directly from this report.
3.2	**Human Resource Implications**
	There are no human resource implications arising directly from this report. The human resource implications for each proposal for the Partnership will be considered as they are developed.
3.3	**Legal Implications**
	There are no legal implications arising directly from this report.
3.4	**Equality Implications**
	There are no equality implications.
3.5	**Environmental Implications**
	There are no environmental implications.

3.6	**Implications for Key Priorities**
	The NAHSCP will continue to work to the delivery of the five objectives within the Strategic Plan.
4.	**CONSULTATIONS**
4.1	No specific consultation was required for this report. User and public involvement is key for the partnership and all significant proposals will be subject to an appropriate level of consultation.
5.	**CONCLUSION**
5.1	Members of the IJB are asked to note the ongoing developments within the partnership.

For more information please contact Iona Colvin, Director on (01294) 317723 or icolvin@north-ayrshire.gcsx.gov.uk

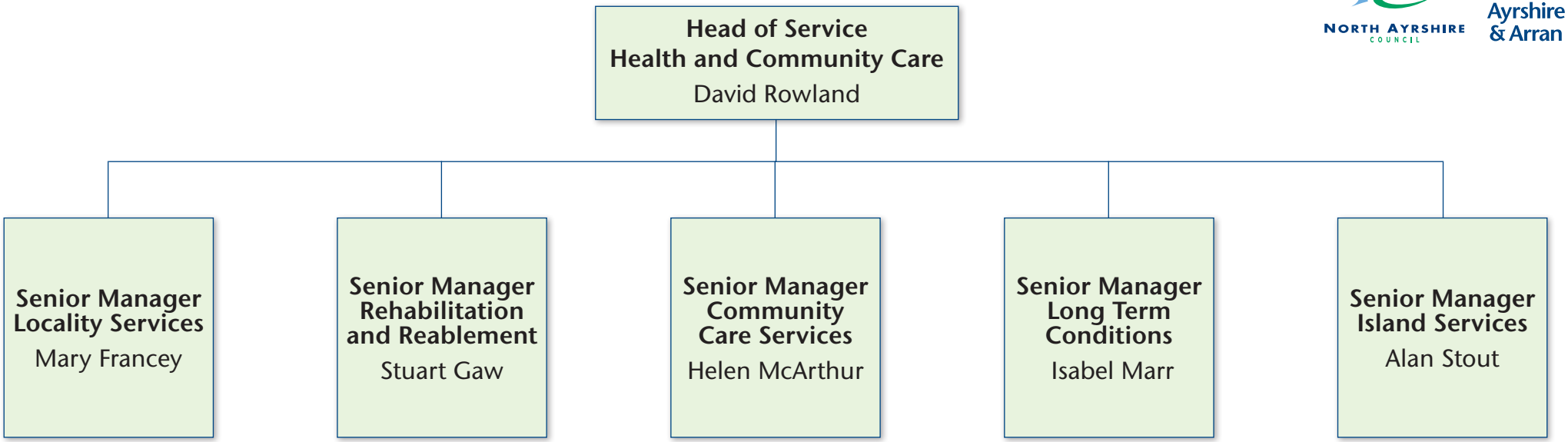
Appendix 1

North Ayrshire Health and Social Care Partnership

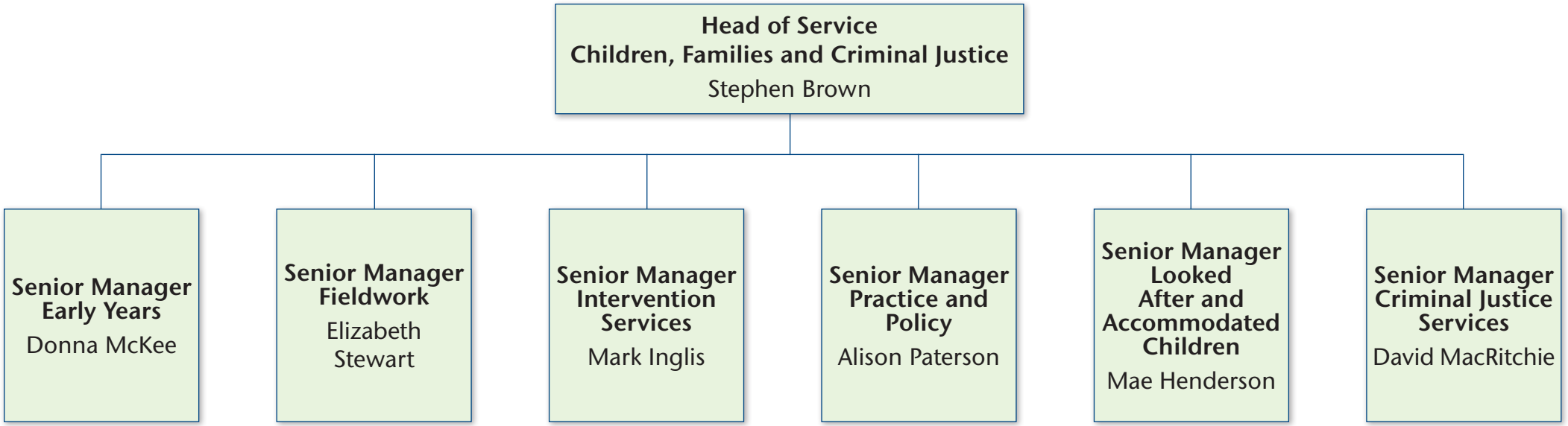


In partnership with

North Ayrshire Health and Community Care



North Ayrshire Children, Families and Criminal Justice



North Ayrshire Mental Health Services

Head of Service Mental Health Services
Thelma Bowers

Senior Manager CAMHS
Tommy Stevenson

Interim Service Manager CAMHS
Eileen Bray

Senior Manager Addictions
Peter McArthur

Joint Service Manager Addictions
Anne Lee

Senior Manager Learning Disabilities
John McCaig

Interim Service Manager Learning Disabilities
Jan Thomson

Senior Manager Inpatients
William Lauder

Clinical Nurse Managers
Lynne Murray - Adult Acute Inpatients
Stuart McKenzie - Rehab and Forensic Services
Margaret Rooney - Elderly Mental Health
One x vacancy

Senior Manager Community
Dale Meller

Interim Service Manager Community
Sharon Hackney

Interim Programme Manager Woodland View
Linda Boyd (seconded from EAHSCP)

Head of Psychology Psychology and Psychological Services
Cathy Kyle

North Ayrshire Professional Leadership Nursing

Associate Nurse Director / Lead Nurse
Derek Barron

Senior Nurse MHS Inpatients
Pete Gilfedder

Senior Nurse MHS Community
Karen McDowall

Senior Nurse Community
Ann Reid

Integration Joint Board
13th August 2015
Agenda Item No. 8

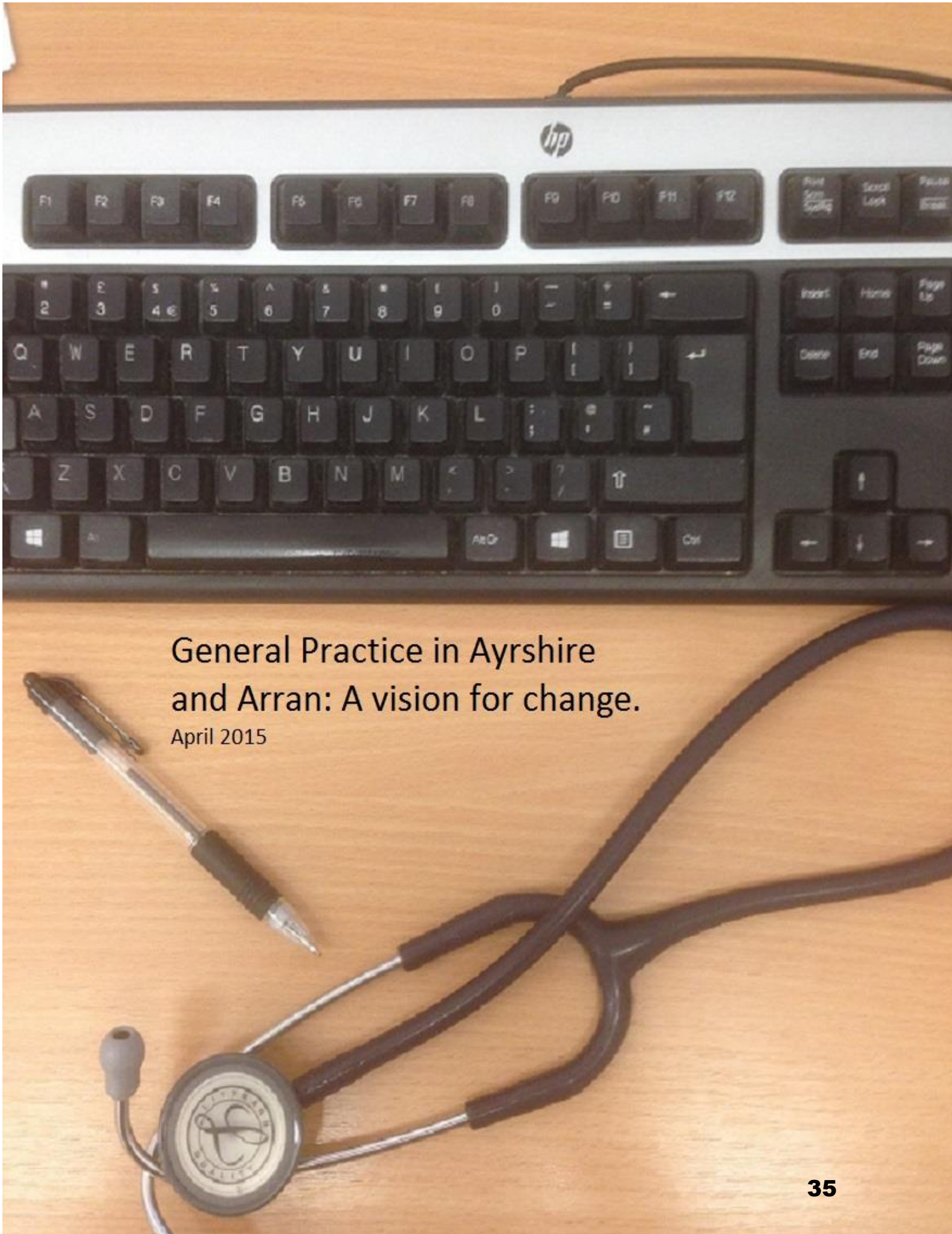
Subject: **GP Strategy**

Purpose:	Review of the document General Practice in Ayrshire and Arran: A Vision for Change
Recommendation:	IJB members are asked to consider the content of this document and endorse the proposal to work with our local GPs.

1.	**INTRODUCTION**
1.1	The Ayrshire and Arran LMC have produced a document called General Practice in Ayrshire and Arran: A Vision for Change. (Appendix 1)
1.2	This document gives an overview of the current GP system pressures and suggested solutions for moving forward.
1.3	GP recruitment is a significant problem at present and likely to become more significant in the long to medium term.
2.	**CURRENT POSITION**
2.1	The document has been reviewed by the management team on the NA H&SCP. It contains useful suggestions for future change, many of which are embedded in the NA H&SCP current outcomes and strategies.
3.	**PROPOSALS**
3.1	The IJB will review this document and consider the suggestions included.
4.	**IMPLICATIONS**
4.1	There are no implications to date.

5.	**CONSULTATIONS**
5.1	Iona Colvin, Director NA H&SCP, David Rowland Head of Service, Health and Community Care and Dr Paul Kerr Clinical Director NA H&SCP attended the LMC meeting held on the 28th April 2015 where this document was presented and discussed by the GP Sub Committee.
6.	**CONCLUSION**
6.1	The IJB to note the contents of the report.

For more information please contact Dr Paul Kerr, Clinical Director Health and Social Care Partnership on 01294 317705 or paulkerr@north-ayrshire.gcsx.gov.uk



General Practice in Ayrshire and Arran: A vision for change.

April 2015

Contents

Executive Summary

The NHS and General Practice in Scotland is at a crossroads. Since the inception of the NHS in 1948, general practice has been the bedrock of the service with 90% of patient journeys starting and finishing in primary care[1]. The NHS is under pressure with the changing demographics of the population[2], a change in the disease profile affecting the population, and advances in treatments and the management of disease which invariably add to cost and workload across the service. There is increasing patient expectation and demands often led by politicians who do not back up their promises with resources and funding.

General Practice has changed. The traditional model of the registered patient population is still at the heart of the service. Practices still accept the risks attached to a demand led service with the potential of having to provide unlimited services to patients who are ill or perceive themselves to be ill. General Practitioner access remains available twenty four hours per day, seven days per week. The division of the GP contract in 2004 resulted in General Practitioners losing the *responsibility* for providing evening and weekend services and this heralded significant service redesign. The clear decision of Government and Health Boards to shift work away from hospitals has created substantial extra work for General Practice. The move within hospitals to more specialisation now often leaves the General Practitioner as the only doctor able to take a holistic view of the patient. Hard won victories (for patients) to embed community nurses and health visitors as integral part of the practice team have been lost and the demographic change of the General Practice workforce now presents a challenge as working patterns both for male and female General Practitioners evolve.

The General Practitioner has developed from the role of simply being the "Family Doctor" to that of the "Family Doctor" managing a larger team caring for patients with increasingly multiple and complex needs at home.

Change continues apace both for the NHS in Scotland and General Practice with the *integration agenda* and the development of Health and Social Care Partnerships (HSCP). To meet the challenges identified in the NHS and to meet the Government's continued wish to move more care away from hospitals, General Practice realises it must continue to evolve to ensure it can still address the needs of patients.

General Practice however is under considerable pressure. Despite the increasing workload and the rise in number of patients contacts within each practice, General Practice funding has reduced in the proportion of NHS spend from 10.75% to 8.4% over the period 2006-2012 as evidenced by RCGP[3]. Practices are facing a significant workforce crisis with the bulge in general practitioner numbers recruited in the early 1980s now reaching retirement age with an inadequate number of young doctors available to replace them as general practice is now not perceived as a good career option.

This document is the outcome of discussions within the LMC and sets out to describe some of the current issues within primary care in Ayrshire and Arran along with some

suggested solutions. It is set out in a similar way to the BMA policy document *The Way Ahead* (2012) as the same areas are pertinent today with sections on Access, Health Inequalities, Balance of Care, Workforce, Infrastructure, Information Technology and Out of Hours provision[4].

List of Recommendations

1. **Increase capacity within primary care to meet current needs and future predictions.**

2. **To develop mechanisms including the use of new technology to explore access to primary care services.**

3. **Support all areas of the health and social care services to understand complexities and impact on others as well as solutions.**

4. **Support promotion of self-care through public education programmes on use of NHS services including consequences of inappropriate demand on services.**

5. **Transfer work from GPs to other health professionals where evidence has shown positive evaluation.**

6. **Review distribution of community and primary care services to ensure that needs associated with higher levels of deprivation are adequately met.**

7. **The Health Board and councils should identify what they collectively spend on reducing health inequalities locally and work together to ensure that resources are targeted at those with the greatest need.**

8. **Agree a programme of work which addresses the identified issues affecting practices where health inequality impacts on registered patients of that General Practitioner.**

9. **Healthcare professionals should lead the development of Health and Social Care Partnerships.**

10. **There should be an agreed process for all service redesign involving a shift in the balance of care which includes the identification of resources (whether new money or a reallocation) prior to the implementation of the change.**

11. **General practitioners and practices need to have identified time and funding which needs to be resourced by Health and Social Care Partnerships to engage and participate in this agenda.**

12. **Work needs to be undertaken to allow general practitioners to engage in integration without necessarily attending meetings utilising IT, virtual meetings and web- based decision making tools.**

13. **We would propose a move towards the development of a community hub model of care to deliver a comprehensive community service.**

14. **Submit an application to NES to initially increase the number of training posts which will be filled each year to twenty five.**

15. **Undertake an assessment of the number of training posts needed in Ayrshire and Arran and if the result is greater than twenty five to either encourage more practices to seek training status or encourage existing practices to increase the number of doctors in training they can accommodate.**

16. **Submit a bid to NES to set up a post MRCGP fellowship scheme in Ayrshire and Arran using the "rural fellowship scheme" as a template to encourage doctors on completion of training to spend time in Ayrshire and Arran building up experience.**

17. **Review the recruitment processes locally to make it more attractive for prospective General Practitioners to want to come and live and train in Ayrshire and Arran.**

18. **Develop a marketing strategy to attract General Practitioners to the locality.**

19. **To introduce measures to deal with local workforce / workload issues i.e.**
    - **New financial resource for primary care**
    - **Increase appointment times**
    - **Introduce a robust policy to review secondary care practices that unnecessarily impact on primary care**
    - **Develop and promote the skills of the Primary Care Health team.**
    - **To provide support for scheduled and unscheduled general practitioner absence from practice**
    - **Introduce formal childcare support for General Practitioners and GP trainees**

20. **The Health Board should give greater priority to premises funding and a return to ring-fenced funding should be supported.**

21. **GP-owned premises development must be maintained as a viable option where suitable for local needs.**

22. **The Health Board should establish local arrangements for ensuring new premises are built where they are needed.**

23. **An urgent task force including representatives from the Health Board, Health and Social Care Partnerships, Primary Care Development and the Local Medical Committee should be set up to identify the priorities for surgery development in Ayrshire and Arran.**

24. **The Health Board should instruct the *Information and Clinical Support Service* to undertake a review of Health Board owned premises occupied by General Practitioners to identify problems and to agree a plan with the practice to make them "fit for purpose" in the twenty first century. Dedicated funding will need to be identified by the Health Board to allow this to happen within a reasonable timescale.**

25. **The Health Board needs to use the same vigour as happened when agreeing recent secondary care developments in identifying sustainable funding streams to cover the capital costs of surgery developments**

26. **The Health Board needs to review the current funding models for the on-going costs of General Practitioner premises in Ayrshire and Arran and identify the funding which will be required to sustain surgery development in the era of integration and prioritising.**

27. **An urgent review of IT provision to GP practices in Ayrshire and Arran to ensure that each practice has hardware and software which is fit for purpose.**

28. **The acceptance by the Health Board that failure to provide robust, working, fit for purpose IT for practices is a contractual breach which requires immediate remediation.**

29. **A review of those practices where problems exist, an urgent identification of potential solutions and an agreed program of work with the practice to ensure an early resolution of both hardware and software problems.**

30. **A review of practice training needs to enable practices to better utilise their IT systems with an agreed program of work to ensure this is delivered.**

31. **An urgent review of practices with branch surgeries with any necessary program of work undertaken swiftly to remedy problems to ensure that all clinicians on all sites can access the patient record equally quickly at all times.**

32. **The urgent rolling out of remote access to GP IT systems, which does not require the use of equipment which practices are pressurised into buying, to enable clinicians to access patients records during consultations away from the surgery and to allow remote working in the evening and weekends.**

33. **A review of data-sharing and conditional access to enable practice team members to contribute to the GP record.**

34. **The full implementation of the ADOC out of hour's working party report.**

Access

Patients want timeous and appropriate access to their GP or a member of the primary health care team. One of the challenges facing general practice as in other parts of the NHS has been rising demand. It is widely recognised that around 90% of NHS contacts occur in a primary care setting[1] with an estimated 24.2 million patient contacts with GPs and practice nurses in Scotland during 2012/2013[5]. This is an increase of around 11% since 2003/2004. Added to that has been the change in the complexity of consultations with each consultation requiring more time to meet the expectation of patients. Most GPs admit they now cannot undertake a patient consultation in ten minutes, the norm for the last twenty years.

In Ayrshire, which mirrors Scotland, there has been little rise in the general practitioner workforce with the GP population locally increasing from 298 in 2004 to 334 in 2014 (headcount numbers – not full time equivalent)[6]. In Scotland the equivalent numbers are 3970 and 4320 (again headcount numbers)[7]. Given the changing profile of the general practice workforce with more and more GPs working less than full time, the whole time equivalent number has not changed, in fact it may have even declined.

Compare this to the change in the national consultant workforce in the same timeframe. The consultant workforce nationally grew from 3368 in 2004 to 4984 in 2014 (whole time equivalent numbers). The GP community has always been supportive of consultant colleagues and understands the reasons why there has been an expansion of their workforce to meet patient's needs. It cannot understand why government has not attached the same importance to GP numbers given its rhetoric.

Pressure on access is caused by increasing demand and a static (at best) workforce. There are many contributing factors.

- The ageing population and multi-morbidity with increasing pressure to manage care at home. It is well documented that there is an increasingly elderly population and this trend will continue in the years to come. These patients wish to be cared for at home and there is greater political drive to achieve this. The impact on access and workload in primary care is difficult to measure, but it is clear that these patients will inevitably require increased medical services in the community. Some of the areas where impact exists are: the increasing requirement for appointments in the surgery; the increasing requests for home visits inevitably rising as the population becomes older, frailer and increasingly housebound; the increased impact on practices of nursing/residential homes which essentially now are "step down hospitals in the community"; the increasing management of complex patients with two or more medical problems and the move towards more primary care investigation and interpretation of results.
- The increasing prescribing with resultant monitoring as more treatments become available. As patients live longer with multi-morbidity, so too comes the inevitability of increased prescribing. Polypharmacy results in challenges for the patient and a financial and workload burden both for the practice and for the system as a whole. Many of the treatments require monitoring of some description which has an inevitable impact on the general practitioner and the team.
- The increasing burden of administrative tasks that impacts upon GP time and thus upon time a GP has available for direct patient contact. We are not arguing this is not important work, but highlighting that it takes away from direct patient care.

- The increasing demand and expectation with media campaigns encourages early attendance at GP with new symptoms, a good example being the current campaign asking patients to see their GP if they have had a cough for three weeks. Whilst every GP is keen to encourage proactive care, it comes at a cost and currently the increasing demand for services is outstripping supply. Due to the pressures / demands of the last few years, General Practice has become a finite resource which inevitably impacts on access.
- The limitation of the ten minute appointment is now an issue. For the last twenty years, the ten minute consultation has been the norm in most practices but now with more complex multi- morbidity and patients not only attending their general practitioner to discuss medical problems but often also to discuss social, situational problems affecting themselves or their families. This model needs to change as longer consultations times are needed. The days of the morning and afternoon surgery with perhaps up to fifteen patients per surgery or sometimes even more are coming to an end and a new model needs to be agreed.

Access to General Practice is currently seen as a national priority and work is ongoing to trial different mechanisms for access in pilot projects throughout Scotland. Some consideration needs to be taken to address this locally and so the following are the Local Medical Committee's recommendations that may help to address access within Ayrshire and Arran:

1. **Increase capacity within primary care to meet current needs and future predictions** – We need to increase the capacity of primary care to deliver services to patients either directly by funding practices to increase appointments as happened in East Ayrshire with the investment in primary care funding (Susan Deacon funding) in 2001 or indirectly by attaching appropriate professionals to practices to allow general practitioners to skill mix to enable them to see those patients who most need their skills.

2. **To develop mechanisms including the use of new technology to explore access to primary care services** – Through the new Health and Social Care Partnership structure and the nascent locality groups, there may be an opportunity to discuss access options and plan new services with patient groups utilising new technologies. An example of this could potentially be investment in "tele-pods" " for basic healthcare monitoring in surgeries e.g. BP, weight etc. with individualised advice provided. Another example would be the development of the tele medicine project in place for those recently discharged from hospital. The development of IT to interface between the practice and the patient through practice web-sites, emails and electronic ordering of prescriptions has started in Ayrshire and Arran although care must be taken with these new developments to ensure this does not create even more new work for practices struggling to cope.

3. **Support all areas of the health and social care services to understand complexities and impact on others as well as solutions** – The Health and Social Care Partnership will have a crucial role to improve co-ordination between health and social care and also between primary and secondary care. Demand is often created unintentionally by other areas of the wider team particularly by shifting work around the system. No changes in this area should be made until there is a full impact assessment on all partners. We would suggest that there should be assistance in providing appropriate education to try to eliminate unintentional consequences. An example being the

provision of a fit note for a patient post operatively whilst the patient was in hospital for all of their expected absence from work to reduce the need for the patient to have additional contact with the practice and streamline patient care.

4. **Support promotion of self-care through public education programmes on use of NHS services including consequences of inappropriate demand on services** – There must be a move towards the promotion of self-management in those patients with long term conditions ensuring greater understanding of the condition and how and when to access NHS services along with a better public awareness campaigns of the management of simple self-limiting illness and greater education about the most appropriate person e.g. direct care, *right person right place* and minor illness clinicians. HSCPs need to encourage debate and health education at schools and colleges. New training of carers both employed and voluntary in the management of minor ailments and recognition of illness needs to be developed. The Health Service needs to support new parents in the understanding of the use of the NHS and recognising and managing minor illness.

5. **Transfer work from GPs to other health professionals where evidence has shown positive evaluation** – There has been a huge shift of work into primary care in the last ten years and now GPs do not have the capacity to cope with this themselves. Work needs to flow to other health care professionals as part of the extended primary health care team. When a clinician takes on a role, they need to have the skills to undertake all of the role to ensure holistic care for the patient and must not simply cherry pick attractive elements leaving the areas they do not wish to cover with the GP. Examples of using other health care professionals include: embedding pharmacists within practice to improve poly pharmacy review/medication reconciliation which has been shown to reduce admission rather using the Chronic Medication Service (CMS) with no proven benefit; using the skills of midwives who have taken on maternity care to provide all of the service via independent prescribing and delivery of appropriate prescriptions and immunisations to patients ensuring holistic care; supporting health visiting teams to deliver all of the childhood immunisation programme; supporting community nursing teams via independent prescribing to provide complete services for wound care and continence management and enabling direct access to mental health teams and allied health professionals without need for GP referral.

Health Inequalities

The *2020 vision*[8] sets out the challenging agenda "everyone will be able to live longer healthier lives at home, or in a homely setting and that Scotland will have a healthcare system where there is integrated health and social care and a focus on prevention, anticipation and supported self-management." This continues to be a significant challenge both locally in Ayrshire and Arran and nationally across Scotland. The problem exists throughout the Health Board area. It is most obvious in defined communities where there is recognised levels of deprivation, but there are less obvious pockets with equally deserving needs which require support and resourcing. This is both an urban and rural problem here in Ayrshire and Arran.

The introduction of Health and Social Care Partnerships is the beginning of a more integrated approach to health and social care and gives us the opportunity to help address some of the existing pressure areas:

- Social Deprivation
- Addictions
- Alcohol
- Young parents
- Patient education
- Emotional and behavioural issues in young people including the increasing problem of self-harming.
- Child protection
- Adult protection

More figures to illustrate the challenges:

- Death rates from CHD in the most deprived areas run at 150% of those least deprived.
- Alcohol related deaths are 6 to 7 times higher in the most deprived areas.
- Smoking prevalence is about 4 times higher in the most deprived areas.
- Drug related deaths are around 16 times higher in the most deprived areas.
- The overall cancer incidence is around a third higher in the most deprived areas.
- Anxiety related consultations are almost double the rate in the most deprived areas.
- Around a third of women in the most deprived areas can be classified as obese compared to a fifth in the least deprived.
- Type 2 diabetes increases with deprivation level.
- Uptake for screening considerably lower in deprived areas.

We need to ensure that we have the right services in the right place and that the identified needs of patients are met by the NHS.

Measure	Least Deprived	Most Deprived
Female Life Expectancy	84.2 years	76.8 years
Male Life Expectancy	81 years	70.1 years
Alcohol Related Admissions (per 100,000)	214	1,621
Smoking Prevalence	11%	40%
GP consultations for anxiety (per 1000)	28	62
Breastfeeding at 6 weeks	40%	15%

Better access is needed to reduce inequalities. For most people GPs are the first point of access.

Findings from the Deep End Project show that GPs in deprived areas treat patients with higher levels of multiple problems than GPs working in less deprived areas. This is reflected in the local Ayrshire and Arran statistics. In Ayrshire and Arran the average percentage of the patient population with 5 or more chronic diseases is 1.26%, this compares with 2.34% of the practice population in the most deprived area.

Recent public sector budget cuts have been shown to increase patient visits to GPs particularly in deprived areas where reduced benefit payments result in increased consultation rates.

The Deep End Project[9] recognised the constraint of a 10-minute consultation time in general practice and clearly advocated more resource to increase consultation times in order to deal with the complexity of the problems presented.

Audit Scotland[10] have recognised the good work that practice nurses do in prevention but have also noted that there is a lack of information about numbers and distribution of practice nurses. In addition to GP staff we need to consider the role of community staff and community families, dentists also provide a valuable resource in deprived areas.

It should be recognised that policies designed to improve the health of the whole population can indeed increase inequalities as uptake is lower in deprived areas.

Better access to specialist services may help to alter outcomes. There is clear evidence that there are fewer cardiology interventions in deprived groups

Present measures used underestimate the impact of deprivation and the challenges of drug abuse, alcoholism, domestic violence, child protection and single parents.

The Local Medical Committee recognises the challenges involved in better managing

health inequalities and we have based our recommendations on an Audit Scotland report from December 2012.

6. **Review distribution of community and primary care services to ensure that needs associated with higher levels of deprivation are adequately met -** Some of this responsibility will now pass to Health and Social Care Partnerships. Audit Scotland has stated that shifting resources to deal with consequences of health inequalities to effective intervention and access to preventative services is essential to tackling health inequalities. They give clear advice that the Scottish government should introduce national indicators to specifically monitor progress in reducing health inequalities. NHS boards should monitor the uptake of preventative and early detection services and take action to enable more targeted approach.

7. **The Health Board and councils should identify what they collectively spend on reducing health inequalities locally and work together to ensure that resources are targeted at those with the greatest need -** The Government takes account of deprivation, rurality and remoteness in funding Health Boards. What is less clear is how the Health Board then targets resources at local areas with greatest need. Three Health and Social Care Partnerships have been set up in Ayrshire and Arran but it would appear that budgets have been set taking no account of this guidance and have been set with historic spend embedded into base-lines. Indeed the Partnerships have been set up with in-built deficits which will make the needs assessment work across the Health Board area much more difficult to achieve.

8. **Agree a programme of work which addresses the identified issues affecting practices where health inequality impacts on registered patients of that General Practitioner -** This would include:
    - Moving to fifteen minute appointments as a matter of urgency which was a recommendation from the Deep End project of the 100 most deprived practices.
    - Undertaking work to address accommodation and staffing issues in these practices
    - Working with the NHS board to find a marker for deprivation for practices in larger towns to make it easier to identify unmet need; this may be looking at things like teenage pregnancy rates, free school meal and uniform grant allocation as well as Keep Well postcode information
    - Shift the model of consultant care from secondary care model to a community based consultant model working with General Practitioners with patients with deprivation issues to target Diabetes, CHD, COPD and Mental Health.
    - Funding advanced nurse practitioners or practice nurses in deprived areas to release GP's to deal with longer, more complex appointments.
    - Having a better allocation of community nursing staff in line with need.
    - Attaching or having a hub provision of counsellors, alcohol and drug workers, benefit advisors and citizens advice with immediate or soon access
    - Building in funded professional development time for those working in deprived areas to try and attract the best GPs to area of need.

Balance of Care

The shift in the balance of care from secondary to primary care has been established for many years and continues to be the aspiration of the *2020 Vision*[8]. This is good for patients, it is often good for the Health Service but comes at a cost for practices. Work flows into primary care in a haphazard fashion, often it is opportunistic but comes with no attached resource. This contributes significantly to the pressures that exist in general practices which include:

- Secondary Care Workload – there is a substantial amount of work done in Primary Care on behalf of Secondary Care, one example being phlebotomy services
- Funding – Whilst enhanced services offer resource to practices to deliver non GMS services, all too often these are short term minimal funding streams.
- Impact of efficiency savings in Secondary Care.

Any business needs to be able to plan ahead and this is based on an understanding of potential workload and available resource to deliver services within a defined budget. It needs to be realised throughout the Health and Social Care structure that independent contractors such as General Practice are small businesses and as such the GP partners receive no income from the Health Board other than practice funding which pays for the infrastructure and staffing costs in the practice. Practices need to have business plans to ensure they remain viable. Providing short term funding pots for new Enhanced Services is no longer a sustainable model for service delivery. Practices are already overstretched, under staffed, lacking suitable premises, they are struggling to embrace new services all on a background of increasing expenses and falling profits.

To 'business plan', substantive funding needs to be offered to practices at the beginning of the agreement for a minimum of a three year term if not longer and the service specification needs to be agreed within the budget constraints of the funding stream.

To deliver any new service, the impact of such a service must first be measured, resource implications discussed and agreed and then added to the financial package to be made available at the beginning of the new financial year. This approach would ensure that new services are given adequate time for discussion and agreement with the GP community. Practices will have time to plan for additional services and to resource any additional staff required to deliver those services.

Whilst this would be the ideal way of providing additional services within General Practice, we recognise that funding is not currently available to employ additional GPs, Practice Nurses etc. and therefore Practices are not in a position to take on additional workload. To address the increasing shift in workload from Secondary Care to Primary Care and the desire to care for more complex patients at home, an alternative model of community care needs to be developed.

The Scottish GP Committee published a proposal for the future of general practice in Scotland in 2012[4] and three of its recommendations in this area are still relevant:

- **The Scottish Government and NHS Scotland should promote clinical leadership in the redesign of services.**

- **The Scottish Government and NHS should encourage and support joint working between primary and secondary healthcare professionals on the redesign of patient pathways to achieve the optimum balance of care.**
- **The impact of shifting the balance of care developments on primary care services should be anticipated and monitored by the Scottish Government and NHS Scotland to assess the quality and benefit to patients and ensure that the necessary capacity and resources are available.**

The Local Medical Committee also would recommend

9. **Healthcare professionals should lead the development of Health and Social Care Partnerships**

10. **There should be an agreed process for all service redesign involving a shift in the balance of care which includes the identification of resources (whether new money or a reallocation) prior to the implementation of the change**

11. **General Practitioners and practices need to have identified time and funding which needs to be resourced by Health and Social Care Partnerships to engage and participate in this agenda.**

12. **Work also needs to be undertaken allow General Practitioners to engage in integration without necessarily attending meetings utilising IT, virtual meetings and web-based decision making tools.**

13. **A proposal to move towards the development of a community hub model of care to deliver a comprehensive community service**.

The primary function of the Community Hub is to coordinate the care of patients with complex care needs, multiple co-morbidities, high SPARRA scores etc. This coordinated care approach will require an integration of available services and will need GP clinical leadership from within the hub to provide successful co-ordination of care. This model supports the GP Clinical Lead with an extended team which could include advanced nurse practitioners, community nurses, palliative care nurses, heart failure nurses, community respiratory nurses, community SPARRA advanced nurse practitioners etc.

The Hub Team will work closely with GP Practices to deliver a level of care appropriate to the patient's needs and Hub team members need to be embedded within practice teams, attending team meetings when appropriate and they need to provide services at practice level when it is in the interests of the patient.

To deliver this coordinated care approach, the hubs will need to be resourced. All staff will be employed by the NHS or council.

At present the current Community Wards offer a basic Hub service with the GPs and advanced nurse practitioners having access to EMIS patient records. No additional resource would be required to start this basic level of service; however, given recent changes further recruitment may be required. There is also current variance across localities which would have to be addressed.

Services coordinated by the Hub which could be accessed by Practices and Secondary care via a single point of contact could include (these services could also be developed individually):

- Community COPD SPARRA advanced nurse practitioners - these advanced nurse practitioners will work closely with Practices and the Community Hub. They will meet weekly with Practices and discuss 'escalating' COPD patients with a practice clinician. The advanced nurse practitioners will then visit the patients and provide a holistic care approach, anticipatory care planning, poly-pharmacy review etc. This will provide an improved level of care for patients, reduced admissions to hospital, more 'homely' care, reduced house visits for GPs, reduced telephone consultations etc. An advanced nurse practitioner dedicated to this role working closely with the Practice is imperative to the success of this model.
- Community Heart Failure Nurses - No resource implications as the posts already exist. There may however be a need to expand the service. A data collection e.g. audit of heart failure admissions could provide substantive data for analysis to determine if additional Heart Failure nurses are needed. They will be accessible to the community hub GP/ advanced nurse practitioners to provide an integrated approach to patient care. Primary Care will be able to refer patients into this service also. Secondary Care Clinicians will continue to refer patients on discharge from hospital. Any escalating patients will be discussed with the community hub team.
- Community Diabetic Nurses. These nurses will meet with Practices on a regular basis and discuss complex patients. They will visit the patients, providing a holistic assessment, anticipatory care planning, polypharmacy review etc. They will liaise with secondary care clinicians if specialist advice is required. Any 'escalating' patients will be discussed with the community hub team.
- Community Phlebotomy Service - Community phlebotomists will provide locality / sub-locality based services for both primary and secondary care. Referrals will be received from hospital wards, out-patient department and from GP practices. Out-patient bloods will be requested directly by the out-patient clinician who will be responsible for communicating the result to the patients and acting on the result thus reducing the burden on primary care. Primary Care will provide sessional accommodation to the phlebotomist for phlebotomy services for both secondary care and primary care requests which may need to be resourced. GPs will refer patients directly to the community phlebotomist and not the community nursing team. This will release community nursing DN time and thus increase community nursing resource.
- Community Hub Social Worker - Social workers dedicated to the Community HUB within each locality will be appointed. Social workers will be attached to practice to facilitate closer working and will also be accessible within the hub via a single point of contact. The social worker will provide a service to both primary and secondary care. Referrals will be accepted from hospital wards, outpatient departments, hospital discharge coordinators, GPs, Community Hub Team etc. The social worker will have a close working relationship with practices along with a good knowledge and understanding of the existing services and resources accessible for patients.
- Community based pharmacist. An existing resource. The pharmacist will be accessible via the community hub and will be aligned with practices. They will have an agreed programme of work and could undertake poly-pharmacy reviews, discharge medicines reconciliation, medicines monitoring and cost saving projects.
- Tele health Services - The Community Hub team will be able to access tele health Services for COPD and Heart Failure. Careful coordination and integration of services

such as COPD advanced nurse practitioners, Hub GP/ advanced nurse practitioners, respiratory consultants with Tele health facilities, will result in a more comprehensive level of care, more homely care, reduced admissions etc.

- ICES – Better coordination of the existing resource with clinical leadership provided by the Hub GP.
- SPOC – A single point of contact for both primary and secondary care that would have knowledge of local services and into which referrals can be made on the understanding that appropriate action can be taken.
- Crisis Beds – Step Up/Down beds providing an additional resource for the local GPs thus potentially avoiding inappropriate direct admission to secondary care services.
- Secondary Care Prescriptions/Fit Notes - No new resource required. Out-patient services should be patient centred. Patients currently attending hospital out-patients appointments are issued with a hand written script which the patient then has to deliver to the GP practice. The practice then has to provide a GP10 Prescription within a predefined time scale. The patient then has to return to collect the prescription before it can be dispensed by a local pharmacist. Likewise, advice is given to patients by hospital Clinicians to avoid work and patients then have to attend the GP for the issue of Form Med 3. This is not a patient centred service and causes an unnecessary burden on Primary care. Out-patient clinicians will provide patients with suitable prescriptions that can be accepted and dispensed by community pharmacies or a Med 3 for patients to submit to their employer.

Workforce

There has been no increase in the General Practice Workforce in Ayrshire and Arran in the last ten years. There may have been a 12% increase in the headcount but given the change in career patterns for general practitioners in the same period, this will have resulted in a static or perhaps even a declining "full time equivalent" workforce[6]. This is mirrored across Scotland. It seems strange that the decision makers at a political and at a strategic managerial level have not sanctioned an equal rise in the GP work-force to meet the goals set out in the *2020 Vision*[8] to shift the balance of care from hospital to community. It will be impossible to meet the targets set with the current GP work-force.

Not only does Ayrshire and Arran have a static workforce, there is a bigger problem developing. A local survey carried out last year jointly by the board and the LMC revealed that 37% of the workforce were aged 50 or over with 22% being over 55. Most of these doctors will retire on or before their sixtieth birthday. Given the workforce pressures of twenty first century general practice and the perverse disincentives of the government's pension changes there is no incentive, in-fact there are penalties, to remain in practice. In addition, there is a shortage of GPs. A recent BMA survey showed that around 17% of Scottish practices currently have an unfilled vacancy.

There has been difficulty with recruiting to general practice training within Ayrshire and Arran in recent years and a wider recognition of a reduction in trainee applications. Ayrshire currently has twenty five training practices but potentially only eighteen doctors commence their general practice training each year leaving seven practices fallow. In recent years, Ayrshire and Arran has not managed to recruit eighteen doctors per year. Given the workforce projections over ten years, say ten general practitioners reach retirement age each year, add to these general practitioners who move for family / partner reasons, also add the accepted ratio that it takes circa 1.6 general practitioners entering the workforce to replace those general practitioners retiring and the increasing requirements for locum / sessional general practitioners to cover locality duties / maternity leave etc. then Ayrshire and Arran is not able to stand still and certainly is not able to meet the increased number of general practitioners needed to meet the strategic requirements over the ten years "in hours" or "out of hours"

BMA Scotland has made various recommendations in relation to Primary Care Workforce. At a National level the BMA has recommended that the Scottish Government regularly reviews primary care workforce data and trends to inform planning. This may help to create the workforce capacity required to cope with the demand for GPs in the future, however despite the Scottish Government maintaining GP trainee numbers, Ayrshire practices have experienced significant difficulty attracting new partners, locums (including maternity) and GP trainees. There has also been difficulty attracting sufficient GPs able and willing to work during the OOH period.

BMA Scotland has made various recommendations in relation to Primary Care Workforce.

- **The Scottish Government should continue to regularly review primary care workforce data and trends to inform planning**
- **NHS Education for Scotland should support practices to further develop and promote the skills of the primary healthcare team.**

- **The Scottish Government should establish reliable information about locum GPs working in Scotland.**
- **The Scottish Government should create a working group to consider measures, such as contractual incentives, to encourage practices to take on more partners.**
- **NHS Education for Scotland should create more training places in remote and rural practices.**
- **NHS Education for Scotland should review contractual arrangements for the employment of GP Specialty Trainees in their general practice placement.**

The Local Medical Committee would support all of these recommendations being implemented locally.

Ayrshire and Arran needs to develop a strategy to increase general practitioner numbers in the locality. The problems are not specific to Ayrshire and Arran and it seems inevitable that Ayrshire and Arran will be in competition with other health board areas for what is likely to be a limited resource (of general practitioners) for some years to come.

Ayrshire and Arran has to be able to adapt quickly to the changing face of Primary Care. The BMA states that the Scottish Government Health Department must take the lead in considering and helping NHS Boards introduce more innovative ways to recruit GPs into remote and rural areas, but it is the Ayrshire and Arran Health Board that needs to take action as soon as possible if it wishes to avert a workforce crisis. While it is clear that the Scottish Government will have to support Primary Care by increasing the number of training general practitioners, at locality level , Ayrshire and Arran needs to ensure that we are able to attract enough general practitioners to work in the locality and needs to consider how best to retain its current cohort of general practitioners.

Recent trends and experience would suggest that Ayrshire and Arran is regarded as being increasingly remote and rural by training GPs and by those wishing to secure a permanent post. To attract and retain the number of GPs required to maintain and enhance a quality service, Ayrshire and Arran has to take the opportunity to invest, innovate and develop capacity in primary care. Ayrshire and Arran needs to consider how to make General Practice an attractive option for those wishing to start a career as a partner but it also needs to consider how to retain its current workforce by the continued development of tangible and robust support for those already working as GPs in the area.

Ayrshire and Arran Health Board needs to work with the LMC to analyse locality workforce data and national workforce data to come up with a Primary Care workforce strategy. Workforce analysis needs to take into account the increasing trend towards part time working. The type of clinical staff that practices employ is also changing and this needs to be incorporated into any strategy that hopes to ensure that the clinical workforce in Ayrshire and Arran fit for purpose in the coming years.

To make General Practice more attractive and to increase number of GPs we would recommend that the Health Board should consider the following:

14. **Submit an application to NES to initially increase the number of training posts which will be filled each year to twenty five**

15. **Undertake an assessment of the number of training posts needed in Ayrshire and Arran and if the result is greater than twenty five to either encourage more practices to seek training status or encourage existing practices to increase the number of doctors in training they can accommodate**

16. **Submit a bid to NES set up a post MRCGP fellow-ship scheme in Ayrshire and Arran using the "rural fellowship scheme" as a template to encourage doctors on completion of training to spend time in Ayrshire and Arran building up experience.**

17. **Review the recruitment processes locally to make it more attractive for prospective general practitioners to want to come and live and train in Ayrshire and Arran.**

18. **Develop a marketing strategy to attract general practitioners to the locality -** Ayrshire and Arran should support a marketing campaign to attract new general practitioners. The Health Board should use the opportunity brought about by changes to the "Golden Hello" scheme to invest in activities to encourage general practitioners to come to the Health Board area. A website to market Primary Care in Ayrshire could be developed.

19. **To introduce measures to deal with local workforce / workload issues i.e.**

- **New financial resource for primary care -** In Ayrshire and Arran, like many areas, the proportion of NHS spend on primary care has decreased. For many years there has been a push to shift the balance of care towards primary care from secondary care and workload has continued to increase. Despite this there has been little evidence of any attached resource. If this continues then increasing workload within primary care will make it increasingly unsustainable. This will result in GPs retiring as early as they feel able to and it will mean that fewer trainees are likely to want to work within General Practice within Ayrshire and Arran. Ayrshire and Arran need to anticipate the difficulties with recruitment and retention that it will have in the next few years and it urgently needs to address the real need to invest in Primary Care. Health and Social Care Partnerships also need to prioritise funding and resource to directly support practices and work with practices to reduce general practitioner workload while also (in whatever way possible) trying to support general practitioners practices so that they attract additional resources/clinical staff.
- **Appointment times -** In order to attract and retain GPs, Ayrshire and Arran needs to support practices who wish to or are able to provide increased appointments times. If Ayrshire and Arran is seen to proactively develop, financially support and be at the forefront of initiatives to increase appointment times, it will attract new GPs to the locality. It will also help to make an increasingly unsustainable workload more tolerable for those GPs within 10 years of retiral. Ayrshire and Arran and the Health and Social Care Partnerships should consider resourcing and investing in practices with a new/ additional funding stream specifically to fund the enhanced quality and patient safety that would be provided by longer consultations.
- **Introduce a robust policy to review secondary care practices that unnecessarily impact on primary care -** There has been a trend for initiatives that reduce workload for Secondary Care at the expense of Primary Care. Any new work that Primary Care does takes resource away from practices and should be appropriately funded. There

should be robust agreements in place to develop and maintain system wide efficiencies and accurate assessment of impact of any new service development.

- **Develop and promote the skills of the Primary care Health team -** Ayrshire and Arran should consider directly supporting practices by re-introducing a properly funded training scheme for practice employed and attached staff. This would allow clinical staff within each practice to increase the quality of care that it provides for its patients and it would help to support GPs in the work that they do. Ayrshire and Arran Health Board and the Health and Social Care Partnerships should consider supporting education and skill development. This would be facilitated by financial support or manpower support (in the form of locum cover). In addition, GPs should be supported to maintain areas of special interest e.g. minor surgery, dermatology, diabetes care, family planning with funding retained to support activities in practices.
- **To provide support for scheduled and unscheduled general practitioner absence from practice -** Ayrshire and Arran needs to fully fund payments for maternity, paternity and adoption leave in an equitable fashion to other boards. Ayrshire and Arran also needs to assess the availability of sickness cover especially for practices that may be put under significant pressure by any long term absence.
- **Childcare Support for general practitioners and general practitioner trainees -** The Health Board should consider how it might support working parents with young families. Consideration also needs to be given to the working hours of GPs which can extend from before 8am until after 6.30pm and how the Health Board can help with child care solutions to help cover this time.

Infrastructure

To provide safe, effective and high quality care for patients, practices must have premises that are fit for this purpose. The premises need to be well equipped and they need to have adequate accommodation for all of the members of the primary health care team who need to use them. Premises themselves can have a direct impact on quality at practice level and inadequate premises can limit actions which can be taken to improve quality care[11]. Fit for purpose infrastructure and robust information and technology services are fundamental to fulfilling aspirations outlined in this document.

Traditionally GPs worked from practice owned premises, privately rented premises or Health Board owned premises. All of these offered benefits and risks both to the practice and the Health Board. The introduction of the PFI scheme with the disproportionate incentives which were given at an initial stage to private developers skewed the market and latterly this was the only method practices could use to ensure a premises development scheme was approved and completed. The "cost rent" scheme has been wound up and now there is no improvement grant scheme for smaller improvements or developments. This loss of ring fenced funding both at a local level and also at a national level has been devastating for practices with accommodation problems and as a result patients often are accessing primary care services in buildings not fit for purpose.

The Primary Care Directorate has a premises strategy for General Practice surgery development which has been reviewed and updated on a number of occasions. There appears to be limited coordination with other parts of primary care as any premises developments for community based staff fall within the remit of *Information and Clinical Support Service.* The issue of funding in recent years has been an issue with PFI falling out of favour with changes in government and the replacement *Hubco* model not taking off despite previous promises. It is interesting to compare primary and secondary care with evidence of significant development at a secondary care level with the £22 million developments (including a direct contribution of £6.5 million form Health Board funding) at the "front door" of both Crosshouse and Ayr Hospitals but very little activity at a primary care level.

The emergence of Health and Social Care Partnerships promises a new era of integration of health and social care at a patient level. To make this work, patients will need access to health and social services based in the same buildings. There is evidence that this model works with previous joint working culminating in successful bids for national funding. Unfortunately this funding stream seems to have dried up and some of the previous projects have outgrown their buildings. The Health Board needs to show the same enthusiasm in meeting this agenda, backing action with similar levels of funding as they did when addressing the perceived problems in secondary care when approving and starting the developments at Crosshouse and Ayr Hospitals.

In addition to capital funding of projects the Health Board needs to address the on-going costs of premises funding with primary care facing the challenges of appropriately funding the on-going costs in this area. Until 2004, this budget was ring fenced although some virement was allowed but now this forms part of the cash limited GMS allocation from central government which does not meet all of the costs it needs to bear.

Within Ayrshire and Arran many practices currently struggle to optimise their potential due to unfit premises, however, more worryingly is the number of practices who currently struggle to deliver current services in buildings that are not fit for purpose. With the trend towards partnership working, expanding practice teams and visionary community-based services, it will require further investment in primary care facilities to make them fit for multi-disciplinary care provision and for future delivery of services.

Investment plans need to take account of evolving needs of future general practice. The Local Medical Committee encourages the Health Board and the Primary Care Management Team to urgently review the premises within the region and address the current situation.

The opportunity to explore unconventional financing where there is appetite from local practices could also potentially exist. One example of such development is Bromley by Bow Centre which over time has evolved from a health centre into an innovative community organisation supporting families, young people and adults of all ages to learn new skills, improve their health and wellbeing, find employment and develop the confidence to achieve their goals and transform their lives[12].

It is also essential that for premises owned by partnerships the notional rent benefits are reviewed regularly to ensure contemporaneous entitlements and that suitable arrangements are in place for compensation of overhead costs of the practices.

It must be recognised that Ayrshire and Arran practices are diverse in their premises arrangements and each would require individually tailored solution according to their needs.

The Scottish GP Committee published a proposal for the future of General Practice in Scotland in 2012 and three of its recommendations in this area are still relevant[4]:

20. **The Health Board should give greater priority to premises funding and a return to ring-fenced funding should be supported.**
21. **GP-owned premises development must be maintained as a viable option where suitable for local needs.**
22. **The Health Board should establish local arrangements for ensuring new premises are built where they are needed.**

At a local level, the Local Medical Committee would recommend:

23. **An urgent task force including representatives from the Health Board, Health and Social Care Partnerships, Primary Care Development and the Local Medical Committee should be set up to identify the priorities for surgery development in Ayrshire and Arran**
24. **The Health Board should instruct the *Information and Clinical Support Service* to undertake a review of Health Board owned premises occupied by general practitioners to identify problems and to agree a plan with the practice to make them "fit for purpose" in the twenty first century. Dedicated funding will need to be identified by the Health Board to allow this to happen within a reasonable timescale.**
25. **The Health Board needs to use the same vigour as happened when agreeing recent secondary care developments in identifying sustainable funding streams to cover the capital costs of surgery developments**

26. **The Health Board needs to review the current funding models for the on-going costs of general practitioner premises in Ayrshire and Arran and identify the funding which will be required to sustain surgery development in the era of integration and prioritising.**

Information Technology

The eHealth Strategy 2011-17 sets out the Scottish Government's vision for eHealth in 2017[13]. Six new strategic e-Health aims have been developed which will be the focus of all eHealth activity in this period. They are to use information and technology in a coordinated way to:

- maximise efficient working practices, minimise wasteful variation, bring about measurable savings and ensure value for money;
- support people to communicate with the NHSS, manage their own health and wellbeing, and to become more active participants in the care and services they receive;
- contribute to care integration and to support people with long term conditions;
- improve the availability of appropriate information for healthcare workers and the tools to use and communicate that information effectively to improve quality;
- improve the safety of people taking medicines and their effective use; and
- provide clinical and other local managers across the health and social care spectrum with the timely management information they need to inform their decisions on service quality, performance and delivery.

What Ayrshire and Arran practices need is much more mundane, it is a functioning computer system which works efficiently at all times in all surgeries (main or branch) with no hang-ups, hiccups or other barriers preventing clinicians using the system for the benefit of their patients.

Now that practices are either paper-less or paper-lite, having a functioning computer system is as important as any other piece of medical equipment. If the IT system is down, clinicians cannot manage their patients safely.

Sadly, within Ayrshire and Arran, practices are struggling to achieve high quality patient care as a result of deficiencies in IT services and in some areas IT could be considered to be unfit for purpose. The key challenges are unstable internet access, issues with server and migration to the SWAN system, issues with backups, difficulties with remote access, inadequate bandwidth for practices and telecom infrastructure. Current NHS Ayrshire and Arran IT procurement strategies force practices to work with outdated systems. A consequence is poor interface with non-NHS platforms and expensive updates within short time to keep systems compatible with the rest of the world.

A key issue identified time and time again by Ayrshire and Arran GPs is poor quality or complete lack of remote access. Modern GPs are faced with many conflicting demands on their time and remote access is now considered essential. At the very least Ayrshire and Arran GPs will wish to receive services comparable to other health board regions. This is an area we strongly support and urge Ayrshire and Arran to address.

Moving towards integration of health and social care services, there is an urgent need for a system that allows for sharing of information with variety of stakeholders. The system should allow for easier integration and sharing of information, remove unnecessary duplication, exploit existing assets and get the best long-term value. One of the proposed solutions is Emis Web and the Local Medical Committee urges the Heath Board to pursue access to this as a matter of urgency so that as a minimum community nursing teams, ICES and other community services can share information on a day to day basis.

Modern IT services provide for faster communications which must be exploited for better patient care. The LMC recommend that the Health Board urgently develop new communication pathways such as clinical mailbox for clinical advice, picture-sharing for clinical opinion, discharge summaries follow up.

Similarly further developments need to take place for ECS and KIS to be available to Scottish Ambulance services and where relevant to local authority teams.

With the introduction of the nGMS contract 2004, provision of IT – both hardware and software was taken over by NHS Boards. NHS Ayrshire and Arran have a contractual obligation to ensure that each practice has IT which is fit for purpose.

The Local Medical Committee would recommend:

27. **An urgent review of IT provision to GP practices in Ayrshire and Arran to ensure that each practice has hard-ware and soft-ware which is fit for purpose**
28. **The acceptance by the Health Board that failure to provide robust, working, fit for purpose IT for practices is a contractual breach which requires immediate remediation.**
29. **A review of those practices where problems exist, an urgent identification of potential solutions and an agreed program of work with the practice to ensure an early resolution of both hard-ware and soft-ware problems**
30. **A review of practice training needs to enable practices to better utilise their IT systems with an agreed program of work to ensure this is delivered.**
31. **An urgent review of practices with branch surgeries with any necessary program of work undertaken swiftly to remedy problems to ensure that all clinicians on all sites can access the patient record equally quickly at all times.**
32. **The urgent rolling out of remote access to GP IT systems, which does not require the use of equipment which practices are pressurised into buying, to enable clinicians to access patients records during consultations away from the surgery and to allow remote working in the evening and weekends.**
33. **A review of data-sharing and conditional access to enable practice team members to contribute to the GP record.**

Out of hours

The responsibility for provision of Out of Hours care passed to NHS Ayrshire and Arran in 2004 with the new GMS contract. The existing Ayrshire Doctors on Call, a not for profit company owned by the general practice community was subsumed into NHS ADOC and ownership and management responsibility passed to the NHS Health Board.

General Practitioners in Ayrshire have always supported the work of Ayrshire Doctors on Call. It is in the interests of every patient and every practice that an efficient well organised out of hours provider which has an adequate work-force is available and working when surgeries are closed.

Traditionally the work-force who undertook sessions for Ayrshire Doctors on Call were local GP along with a cohort of experienced Ayrshire GPs whose primary role was working out of hours. Over recent years the number of Ayrshire GPs undertaking sessions has reduced for a number of reasons e.g. increased work "in hours", difficulty in finishing "day time" work in time to undertake out of hours sessions, no pay rise for ten years and the changing demographics of the workforce.

One of the more noticeable issues seen within Ayrshire and reflected throughout Scotland over the last few years has been the increasing difficulty in filling all required sessional shifts. This problem became critical about two years ago. Ayrshire Doctors on Call undertook some work to understand the reasons why fewer Ayrshire GPs were choosing to work for Ayrshire Doctors on Call and as a result shift patterns were changed and fifteen minute consultations were introduced to recognise the particular issues facing GPs attending patients out of hours and the health board set up a working party which included members of the Local Medical Committee to review the service.

The out of hour's working party made a number of recommendations which the Local Medical committee support. Ayrshire Doctors on Call would:

- Continue to be predominantly delivered by GPs with support where appropriate by other clinical colleagues
- Continue to be delivered from three sites in Ayrshire.
- Would appoint and train more advanced nurse practitioners to support and work alongside GP colleagues
- Would implement new pay rates for all sessions and commit to uprating them each year following the review body report.

Ayrshire Doctors on Call continues to deliver the service for Ayrshire patients although the recruitment remains a concern. Further problems created by the recent HMRC decision do not help although the full impact is as yet unknown.

The Local Medical Committee would recommend:
34. The full implementation of the out of hour's working party report.

Conclusion

General Practice has been the back-bone of the NHS since 1948. GPs and their teams continue to deliver more than 90% of patient contacts and most of the patients that GPs attend start and complete their journey within a primary care setting without recourse to other parts of the health system.

General Practitioners value their role within the NHS structure as generalist, as the first point of contact for most patients seeking professional help and as gate keepers to the wider health care system. They appreciate the pressure being faced by secondary care, they want and feel they can be part of the solution.

General Practice is also under pressure, probably they face the biggest pressures since the inception of the NHS, certainly since the contractual changes of 1966. This ***Vision*** conveys in its different sections the problems and pressures that Ayrshire and Arran General Practitioners and their teams face. More importantly, it describes a pathway to giving General Practice the tools which will enable it not only to give a high quality service to patients today, but will also equip it to play a major role in allowing the Health Board to achieve the goal of integration and meeting the targets set out in the *2020 Vision*.

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Integration Joint Board

13 August 2015

Agenda Item No. 9

Subject:	**Care at Home Review – update.**
Purpose:	To provide the Integration Joint Board with an update on the progress that has been made by Main Street Consulting in conducting a review of Care at Home Services.
Recommendation:	The Integration Joint Board (IJB) is asked to note the current position and timescale for delivery of recommendations.

1.	**BACKGROUND**
1.1	On 12 March 2015 the Shadow Integration Board endorsed a thorough review of Care at Home services incorporating external expertise and advice from a management consultancy.
1.2	In doing so, it was agreed that the Consultancy Team would work closely with the Health and Social Care Partnership (HSCP) Change Team to identify potential models that would secure safe, dependable and sustainable Care at Home services into the future.
1.3	To progress this, a Project Team was established to shape and inform the review, ensuring the work was underpinned by expertise drawn from all service delivery and business scoping functions, as well as from service users and carers.
1.4	Main Street Consulting were subsequently awarded the contract to undertake the Care at Home Review and commenced in Spring 2015.
2.	**CURRENT POSITION**
2.1	To date, Main Street Consulting carried out: • interviews with over 100 individuals within Care at Home, wider North Ayrshire HSCP professionals and service users; • a desktop review of relevant service financial, performance and population data in North Ayrshire; and • research into Care at Home innovation across the UK, Europe and internationally.

2.2	Initial predictions from Main Street Consulting suggest that, in the absence of a shift to greater prevention, new ways of managing demand and greater emphasis on reablement across Health and Social Care systems, the demand for Care at Home Services is likely to increase exponentially. Indeed, the level of this demand could increase by 21.23% by 2024, equating to approximately £6.5 million more spend required to sustain this.
2.3	The findings of Main Street Consulting suggest that this rising demand should be addressed through a three stage approach – • Short-term – work with services users, families and local communities to develop a clearer understanding of roles & responsibilities with greater emphasis on enablement and reablement approaches that maximise independence and reduce long-term dependency on service provision. • Medium-term – reduce costs of delivery by encouraging innovations and creating community resilience. This should be done alongside redesigning how services are secured and delivered to ensure that Care at Home is stable whilst being flexible and responsive to need. • Longer-term – Prevention and earlier intervention becomes embedded across health and social care systems that allows for traditional service delivery approaches to be supplemented by extensive area and society-wide interventions on behaviour change.
2.4	The provision of Care at Home services over the coming years will be crucial for truly shifting the balance of care and for supporting more people at home and in their communities safely for longer. A range of options now require to be explored to ensure that the mixed economy of care that delivers the service is balanced appropriately. Fundamental to this will be the placement of a career in care and supporting staff through continuous personal development.
2.5	These options are currently being finalised in conjunction with MainStreet Consulting on the basis of their findings and research.
3.	**PROPOSALS**
3.1	While it had been anticipated that the final recommendations from this Review would be presented to this meeting of the IJB, it is recognised that further engagement in the final stages of the process will ensure the level of involvement and ownership necessary to support the resulting change programme.
3.2	To that end, it is proposed that: • The initial findings from the Care at Home Review be shared with Trade Union colleagues on 10 August 2015; • A detailed assessment of these findings be conducted with a wide range of stakeholders at an event on 19 August 2015; • A follow-up session with Trade Union colleagues to share the findings from this assessment will be scheduled for the end of August / beginning September 2015; and • The recommendations from the Review will be presented to IJB on 17

	September 2015.
4.	**IMPLICATIONS**
4.1	**Financial Implications** There are no financial implications from the content of this update report.
4.2	**HR Implications** There are no HR implications from the content of this update report.
4.3	**Legal Implications** There are no legal implications from the content of this update report.
4.4	**Equality Implications** There are no equality implications from the content of this update report.
4.5	**Environmental Implications** There are no environmental implications from the content of this update report.
4.6	**Implications for Key Priorities** There are no implications for key priorities from the content of this update report.
4.7	**Community Benefit Implications** There are no community benefit implications from the content of this update report.
5.	**CONCLUSION**
5.1	The IJB is asked to note the progress of the work to date and agree the revised timescale for delivery.

For more information please contact either David Rowland, Head of Service Health & Community Care on 01294 317797 or davidrowland@north-ayrshire.gcsx.gov.uk or Helen McArthur, Senior Manager, Community Care Services on 01294 317783 or hmcarthur@north-ayrshire.gcsx.gov.uk

Integration Joint Board
13th August 2015
Agenda Item No. 10

Subject:	**Equipment and Adaptations Project**
Purpose:	The purpose of this paper is to provide the IJB with an overview of the Equipment and Adaptations Project.
Recommendation:	The IJB notes and agrees the proposals.

1.	**INTRODUCTION**
1.1	Equipment and adaptations play a vital role by allowing people to live independently in their own homes. Interventions vary from simple devices, such as grab rails, to major adaptations, such as stair lifts and bespoke bath and shower rooms.
1.2	The demographic impact of people living for longer, resulting in more people living at home with complex and multiple needs and this has created a growth in demand for equipment. Around a third of all households (34%) contain at least one person with a long-standing limiting illness, health problem or disability. Just over a third of this population use equipment or have had adaptations to their homes. Furthermore, the number of older people is set to rise by around 31 % by 2031 (over 74s by 81%).
1.3	The provision of equipment and adaptations, including the opportunities provided by innovative technology, should be an integral part of mainstream community care assessment and service provision and should enable Service Users to live as independently and safely as possible within their own home for as long as they wish to do so.
1.4	In addition, the demand on equipment and adaptations has grown in line with the drive for early intervention and prevention. This is underpinned by Outcome 2 of the National Health and Wellbeing Outcomes which acknowledges the important role which independence and choice of environment plays in people's lives: "People, including those with disabilities, 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."
1.5	As one of the North Ayrshire Health & Social Care Partnership's five strategic priorities, which was selected due to being one of the Christie reports four pillars of reform; a decisive shift towards prevention. It is also in line with the themes of the Single Outcome Agreement; reducing local inequalities of outcome, Building community capacity, Prevention and early intervention.

1.6	There is a range of benefits both in terms of their impact on quality of life for both service users and carers by the appropriate provision of equipment and adaptations, in conjunction with a programme of rehabilitation. In many cases, a significant reduction in the demand for care can be achieved through the avoidance, or delay in the onset, of the need for health and social care services and have a positive impact of delayed discharge levels.
1.7	More recently, the Scottish Government published the "Adaptations, Aids and Equipment Advice Note" in relationship to the role of Health & Social Care partnerships. In addition, in March 2015, the Scottish Government issued advice to Health Boards and local authorities on their statutory responsibilities in relation to the provision of equipment to meet the identified wellbeing needs of disabled children and young people in the community. DL 01 (2015) "Providing equipment to children and young people with disabilities".
1.8	This guidance and the launch of North Ayrshire Health & Social Care Partnership provides an excellent opportunity to review requirements around aids adaptions and equipment and develop more integrated processes and systems accordingly.
2.	**CURRENT POSITION**
2.1	The OT Equipment Store Staff, based in Irvine, delivers and installs a variety of simple to complex equipment within Service Users homes. These can range from minor equipment such as grab rails, handrails and lever taps, to major alterations such as showers, stair lifts, and ramps. In recent years increased demand has resulted in increased volume of work and therefore waiting time.
2.2	The volume of referrals for equipment and telecare referrals is increasing year on year. • Increase in volume of equipment referrals • Year 2011 – average 17 referrals per day • Year 2014 – average 35 referrals per day Increase in number of service users • Year 2012/2013 - 76% increase in spend for Telecare • 3500 Service Users using Telecare as at year 2014 and predicted to continue to increase in year 2015 onwards Number of referrals • 2011 to 2012 = 4018 referrals • 2012 to 2013 = 5796 referrals • 2013 to 2014 = 5947 referrals
2.3	Current processes have not been designed to deliver such a high volume work. In addition, we need to promote self-care and well-being, increase choice and control and improve quality of life by maximising the benefits of independent living for service users and their families.
2.4	Currently the delivery and fitting of both simple devices to complex equipment is undertaken by technicians. If high volume low level equipment that does not require assessment was moved to a direct access basis, this would free technicians to focus on more complex equipment. Often assessment of low level equipment costs more than the actual provision of equipment.

2.5	Equipment and adaptations are provided to adults and younger people in North Ayrshire via a number of referral sources: council employed occupational therapists; health employed occupational therapists; other allied health professions; nursing; and the ICES team. The existing provision is uncoordinated from the perspective of people who use services, and their carers, and this can be evidenced by service user interviews, complaints, and staff interviews.
2.6	An exercise is underway to develop a business case for a pan Ayrshire equipment service, however it is anticipated that North Ayrshire HSCP will require to undertake a review of the existing service provision in preparation for implementation. No date is currently set for this, therefore we have an opportunity to improve people's experience in the short to medium term.
3.	**PROJECT DESCRIPTION**
3.1	In preparation and in conjunction with the Pan-Ayrshire Equipment Store we will undertake a review of the integrated community equipment service in North Ayrshire, with a view to creating single management of the service and identification and pooling of existing resources and budget. Ensuring measures are in place to ensure the most effective use of existing resources • to improve recycling, cleaning and maintenance of equipment to meet the national standards • to determine the types of aids and equipment necessary for each individual • to ensure the right equipment is given to the right person at the right time • to provide a direct access service for users, carers and their families • increasing access to aids, adaptations and equipment to increase independence of users and carers
4.	**SERVICE OBJECTIVES**
4.1	The following service objectives will be covered: • Ensure service user needs are better understood and planned for; • Make it easier for stakeholders to find out about the options available • Review store processes to ensure they meet new business requirements • Simplify access to equipment and minor adaptations; • Capture better information about performance of the service, including outcomes to enable improved financial planning in future. • Services users confident and trusted to manage their own needs • Providing service users and carers with more choice and control over how their needs are met • Promotion of independence and enabling self-help where possible by improving access to community equipment services for a broader section of the local population • The process will be transparent, equitable and offer informed choice to the service user/carer • A form is developed that is accessible for all users • Improved communication to all parties • Quicker responses and lesser waiting times for all stakeholders • Service User and OT service satisfaction would be improved • Electronic Loans Management System (ELMS) used to full potential • Increase the capacity of technicians to improve the turnaround of complex equipment needs

	• Potential to develop community capacity through small aids delivery service by social enterprise or through volunteers • Create an awareness programme for all staff to ensure a shared understanding of how equipment may benefit individual users • Develop and undertake a range of training programmes for staff and volunteers to ensure the safe provision and fitting of equipment • Development of service standards so that stakeholders can monitor performance of the service • Development of monitoring and evaluation systems to ensure performance feedback
5.	**OUTCOMES**
5.1	The following outcomes will be met: • To ensure readiness for the Pan-Ayrshire Equipment Store • Reduce bureaucracy and streamline access to aids, adaptations and equipment to make it more accessible to all stakeholders • Better value for money through more efficient processes and more effective use of resources • Greater consistency and equity in service provision • A quicker and more appropriate response to need - the right service at the right time. • Improve and promote choice and control for service users • Simplifying the arrangements for adapting homes regardless of tenure • Service users supported to promote self-care and early intervention and prevention • Accessibility of and access to equipment for all stakeholders • Development of online and manual forms • Improve the speed, efficiency and effectiveness of equipment provision • Reduce dependence on service provision and support service users to promote their own well-being • Reduce stress on carers and families
6.	**PROPOSALS**
6.1	It is proposed the project is divided into a phased approach as follows: <u>Stage One - Analyse</u> • Map all services within North Ayrshire who provide aids, adaptions and equipment • Analyse the types of equipment service users are requesting • Undertake service user projections to ascertain future service requirements • Analyse equipment and adaptations suitable for differing levels of service <u>Stage 2 – Assess As-Is</u> • Map existing referral pathways • Map existing processes for assessment, supply and fitting of equipment • Identify current Electronic Loans Management System (ELMS) processes <u>Stage 3 – Develop To-Be</u> • Develop business requirements from stakeholders • Develop referral pathways for new integrated service • Develop process for Direct Access

- Develop processes for assessment, provision and delivery of aids, and adaptions through different service levels
- Develop requirements for Electronic Loans Management System (ELMS) and additional software/equipment
- Identify workforce requirements

Stage 4 - Implement

- Undertake test or pilot
- Training for staff in new processes
- Awareness training for all staff
- Roll out of new processes and systems

6.2 It is proposed that this work will be undertaken across 4 workstreams:

- Minor adaptations and equipment (Lean Six Sigma)[1]
- Children's Equipment
- Complex equipment and major adaption
- Equipment Store
- Finance
- Workforce

6.3 The following timescales are proposed for the project:

Milestone Dates	Description	Responsibility
July 2015	Begin Lean Six Sigma Review for Minor Aids & Adaption	Helen McArthur/ Kerry Gilligan
August 2015	First project team meeting	Helen McArthur/ Kerry Gilligan
September 2015	Phase 1	Helen McArthur/ Kerry Gilligan
November 2015	Phase 2	Helen McArthur/ Kerry Gilligan
March 2016	Phase 3	Helen McArthur/ Kerry Gilligan
June 2016	Phase 4	Helen McArthur/ Kerry Gilligan

6.4 It is proposed the project is undertaken by the Equipment and Adaptations Project Team and governed through the Change Programme Steering Group.

7. IMPLICATIONS

7.1 **Financial Implications**

The Personal Social Service Research Unit in their paper " Building a business case for investing in adaptive technologies in England" modelled potential saving from equipment and adaptive technologies whilst recognising that the costings around this are complex generate estimates of the overall costs and benefits associated with adaptive technologies as follows:

- optimistic scenario - reductions in the demand for health and social care are

[1] This will involve introducing direct access to low cost, high volume equipment to release assessment capacity thereby supporting those with more complex needs.

	estimated at £1,079 per recipient per year • conservative scenario - reductions in the demand for health and social care equate to £261 per recipient per year Therefore results suggest that equipment and adaptations lead to reductions in the demand for other health and social care services worth on average £579 per recipient per year.
7.2	**Human Resource Implications** There are currently no human resource implications.
7.3	**Equality Implications** There are currently no implications for equality.
7.4	**Environmental Implications** There are currently no implications for the environment.
7.5	**Implications for Key Priorities** While much work reports the cost benefits arising from adaptations in terms of offsets to health and social work services, it also needs to be borne in mind that there are other benefits. Adaptations can significantly enhance independence and increase quality of life. In addition adaptations can also deliver tangible benefits to relatives who are acting as full time carers. Adaptations can lessen the demands on carers' time and reduce the levels of stress that they are exposed to. This project therefore directly impacts on our strategic priorities around early intervention and bringing services together.
8.	**CONSULTATIONS**
5.1	This paper was developed in consultation with David Rowland, Kerry Gilligan, Helen McArthur and Louise Gibson. Wider consultation will be undertaken throughout the lifecycle of the project.
9.	**CONCLUSION**
6.1	The Equipment and adaptations project will undertake a review of the integrated community equipment service in North Ayrshire, with a view to creating single management of the service and identification and pooling of existing resources and budget.

For more information please contact David Rowland, Head of Service Health & Community Care on 01294 317797 or davidrowland@north-ayrshire.gcsx.gov.uk, or Helen McArthur, Senior Manager (Community Care Services) on (01294) 317783 or hmcarthur@north-ayrshire.gcsx.gov.uk, or Kerry Gilligan, Lead AHP on (01294) 317806 or Kerry.gilligan@aapct.scot.nhs.uk

Integration Joint Board

13 August 2015

Agenda Item No. 11

Subject:	**Arran Action Plan Update.**
Purpose:	To provide the Integration Joint Board (IJB) with an update on the progress that has been made by the Island Services Management Team in relation to the agreed Arran Action Plan.
Recommendation:	The IJB is asked to note the current position and proposed plans to progress areas of slippage.

1.	**BACKGROUND**
1.1	In November 2014 work began on the development of proposals for new models of rehabilitation on Arran aligned with the proposed step-up step-down facility at Montrose House.
1.2	It was quickly recognised that greater benefit would be derived from considering the future of these services as part of a wider review of health and care provision on Arran.
1.3	This review was endorsed by IJB for inclusion in the Partnership Change Programme for 2015/16 and work commenced on the development of a formal Project Initiation Document (PID) and formation of the Project Team.
1.4	Recognising the need to maintain momentum in exploring opportunities for innovation and integration on Arran, the IJB agreed an action plan to progress the development of a new model of care and this report provides an update on the progress made to date.
2.	**CURRENT POSITION**
2.1	The action plan and a summary of progress to date are set out at ***appendix 1***.
2.2	The reported progress demonstrates that, of the 28 actions specified within this plan: • 12 have been completed or are being actively pursued; • 10 have been subject to slippage; and • 6 have yet to commence.

2.3	The main reasons for slippage and failure to commence have been identified as: • Delays in establishing the new integrated management arrangements required to support delivery; • Delays in formalising the wider PID and establishing the Project Team required to provide on-island leadership to support this change programme; and • The inter-relatedness of certain actions.
2.4	The new management arrangements now in place. It is therefore anticipated the PID will be finalised and the Project Team will be established by the end of August 2015.
2.5	This will, in turn, provide the clarity of purpose, operational leadership and accountability framework for the Change Programme Steering Group to discharge its responsibilities in ensuring delivery within timescale, thereby mitigating the risk of further slippage.
3.	**PROPOSALS**
3.1	It is proposed that the IJB endorse the proposals contained within appendix 1, which are designed to ensure momentum is maintained in terms of dialogue and engagement around opportunities for change while the PID is finalised and Project Team established.
3.2	It is further proposed that IJB should receive a further performance report in November 2015 confirming the full action plan for the Arran Health and Care Review, progress against this and timescale for further delivery.
4.	**IMPLICATIONS**
4.1	**Financial Implications** There are no financial implications from the content of this update report.
4.2	**HR Implications** There are no HR implications from the content of this update report.
4.3	**Legal Implications** There are no legal imp lications from the content of this update report.
4.4	**Equality Implications** There are no equality implications from the content of this update report.
4.5	**Environmental Implications** There are no environmental implications from the content of this update report.
4.6	**Implications for Key Priorities** There are no implications for key priorities from the content of this update report.

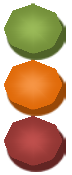
4.7	**Community Benefit Implications** There are no community benefit implications from the content of this update report.
5.	**CONCLUSION**
5.1	The IJB is asked to note the progress of the work to date and agree the revised timescale for delivery.

For more information please contact either David Rowland, Head of Service Health & Community Care on 01294 317797 or davidrowland@north-ayrshire.gcsx.gov.uk or Alan Stout, Senior Manager, Island Services on 01770 601303 or A.Stout@aapct.scot.nhs.uk

Appendix 1

Action Plan updated July 14, 2015.
Alan Stout, Senior Manager
To provide a creative, responsive asset based approach to service delivery within Montrose House, with the right staff, in the right place, at the right time to meet the needs of the local community

'S.M.A.R.T' Action Plan
(Specific, Measureable, Achievable, Realistic, Time bound)

Recommendation	Action	Target Date For Completion	Desired Outcome, Evidence of Progress and Effective Implementation / Final Outcome	Action Status	R/A/G 	Update / Remedial Action
1. **Agreement of vision for rehabilitation service provision within the Arran Locality of North Ayrshire Health & Social Care Partnership**	Development day " Arran Appreciative Enquiry, Excellence in Care"	Dec 2014	• Development implemented & report produced	Closed		
	Analysis of results from " Arran Appreciate Enquiry, Excellence in Care"	Feb 2015	Development implemented & report produced	Open		
	Comparison of results against existing Arran Service Plan	Mar 2015	• Duplicate actions identified • Actions within ASP updated to reflect proposed outcomes of Development Day	Closed		

	Development of time bound action plan to address recommendations above	May 2015	• Actions and recommendations now 'dove tail' with existing Arran Service Plan	Open		
			• Service leads and Team Leaders to support the Responsible Officer in development and implementation of agreed actions.	Slippage		The transition to the new management arrangements has delayed the start of this work. This will now be progressed from mid-August 2015.
			• These actions will be incorporated in the Covalent Action plan for Arran Service Plan	Slippage		This will flow from the work above.
2. **Clarification of desired service provision within Montrose House**	Clarification from Care Commission regarding use of Residential areas vs 'rehabilitation area'	Jan 2015	• Clarity surrounding service design and provision	Closed		
	Assessment of available facilities within Montrose House and 'on island'	Mar 2015	• Service provision must not stand in isolation from Arran Locality development	Open		
			• Identification of appropriate environment for service	Slippage		The Project Initiation Document for the

			provision including interrelatedness of other service provision			Arran Review is being finalised and a Project Team will be formed in August 2015 to progress this assessment as part of the review.
	Engagement and discussion with local staff to identify high level Rehabilitation service model	Mar 2015	• Agreement with outcomes • Agreement in 'direction of travel'	Slippage		Discussions underway with AHP & Clinical Managers, no discussion with front line staff yet – this will now be progressed as a matter of urgency through the Project Team.
	Definition of Detailed Rehabilitation Service Model	May 2015	• Clear indication of service needs to address agreed care provision • Service needs will be delivered in a safe and reliable manner	Slippage Slippage	 	Initial discussion and data sourcing underway. Initial review of accommodation undertaken. This will now be co-ordinated by the Project Team.

	Development of detailed Action plan to deliver desired service model	Jun 2015	• Action plan development • Action plan held within Covalent Arran Service Model	Slippage		High level action plan will be finalised within the Project Initiation Document with detailed plan to be developed by Project Team.
3. **Development of model of care for 10 bedded step-up/step down/rehabilitation unit within Montrose House**	Discussion with multidisciplinary team regarding options for care provision	Mar 2015	• Initial discussions with John Dennis (Team Leader Physiotherapist), Linsey Stobo (Principal OT), Ailsa Weir, SCN	Slippage		Initial discussions have been held with the formal definition and exploration of options being progressed through the Project Team in line with the Project Initiation Document when finalised.
	Secure agreement for model of care clarifying limitations of use	May 2015 May 2015 Jun 2015 July 2015	• Facilitate early hospital discharge • Prevent avoidable hospital admission • Identification, development and provision of services that are focused on enablement • Palliation **Early discussion underway**	Open Open Open Not started		

			o Level of care provision to be agreed o Staff skill set to be agreed			
	Development of agreed multiagency pathways of care to ensure appropriate care delivery in appropriate environment	Jun 2015 (on going)	• Identification of need • Development of options for care • Pathways of care eg (ASP01.01.01)	Not started		
	Identify and develop skill set required to deliver agreed model of care	Jun 2015	• Agree care delivery • Agree skill sets required • Bench mark requirement against that already available within the locality	Slippage		This will proceed in line with the model of care proposed by the Project Team
	Training to satisfy skill set to be identified and sourced	Aug 2015	• Training provided locally • Identify alternative means of providing training eg., rotating through specialist areas • Identified support and actions from clinical & mental health teams	Not started		

4. **Development of staffing model for Montrose House including residential, 'step-up unit' and day care**	Assess current staffing model for appropriateness within Montrose House	Mar 2015	Current staffing structure to be remodelled to satisfy safe levels of care and Care Inspectorate requirements	Open		
	Identification of overarching staffing model to provide safe and reliable care to residents in all areas of Montrose House	Apr 2015	• Development of integrated staffing model within Montrose House and utilising 'in reach' from partner agencies • Agreement of staffing model from all partners • Develop costed staffing model to satisfy agreed overall provision of care for Montrose House Recruitment as required • Agreement for Arran Locality integrated staffing model	Slippage		Staffing model is subject to review for the residential units with further workforce planning being progressed through the Project Team in line with the agreed service model.
	Develop staffing model to satisfy implementation of agreed care model for step-up/down unit	May 2015	• Agreement of specific staffing model to provide safe care related to this area • Identify and assess inter relatedness with current service providers • Assess service models in alternative areas for application. • Identify costed staffing model	Not Started		This will be progressed by the Project Team when the model of care has been agreed.

			to provide safe care related to this area • Deficits in costed staffing model to be communicated to the SIB/JIB			
	Consultation with key stakeholders regarding service provision, staffing model and intended outcomes	May – Aug 2015	• Broad agreement will be achieved amongst key stakeholders regarding services to be provided within Montrose House • Stakeholders will agree staffing model to satisfy service provision • Consultation will take place with extended multiagency teams • Consultation will take place with local population.	Open		
	Recruitment to new / vacant posts	Apr - Jul 2015	• Job descriptions will be developed and agreed for 'integrated' posts • Recruitment will take place to 'integrated' posts • Due cognisance will be given to rotational opportunities within the Arran Locality to offer a broad range of service delivery opportunities	Not started Open	 	

	Identification of skill set and training model to satisfy agreed model of care	Aug 2015	• As above	Not started		

Integration Joint Board

Agenda Item No. 12

Subject:	**Financial Management Year-End Report 2014-15**
Purpose:	To provide an overview of the 2014-15 financial performance
Recommendation:	That the Board notes the content of this report, including specific key actions on significant variances and the actions being taken to bring the budget back into line in 2015-16.

1.	**INTRODUCTION**
1.1	This report provides an overview of the 2014-15 financial performance of the North Ayrshire Health and Social Care Partnership. The report reflects the full year expenditure and income for 2014-15 and has been prepared in conjunction with relevant budget holders.
1.2	The total annual budget allocation reported at period 10 to end January 2015 was £197.020m. This has increased to £197.051m. The changes are noted in section 3.2 of this report.
2.	**CURRENT POSITION**
2.1	Against the revised full-year budget of £197.051m there is an overspend of £5.416m.
2.2	Summary of main movements since last report The overall position has improved from a projected overspend of £5.666m at the end of January to a full year actual overspend of £5.416m, a positive movement of £0.250m. The main movements are as follows:
2.2.1	Level One – Core – final outturn overspend of £2.762m (favourable movement of £0.436m from Period 10)
2.2.2	Learning Disabilities, full year underspend £0.178m, favourable movement from period 10 of £0.375m. The movement from period 10 is mainly due to a reduction in care package costs as a result of packages starting later and ending earlier than anticipated and the in-year recovery of unspent direct payment balances.

2.2.3	Mental Health Community Teams, full year underspend £0.340m, a decreased underspend from period 10 of £0.086m. The movement was due to a £0.145m carry forward to 15/16 for Early Intervention project partially offset with £0.040m less than expected voluntary organisations expenditure.
2.2.4	Resource Transfer, full year underspend of £0.133m, favourable movement from period 10 of £0.081m. The movement was due to an increase in the allocation of resources overheads against the section 27 grant within criminal justice, this now reflects the actual expenditure incurred.
2.2.5	In addition there have been slight favourable movements totalling £0.117m in Older People, Addictions, Community Nursing and General Medical Services and slight adverse movements totalling £0.051m in Physical Disabilities and Community Prescribing.
2.2.7	Level Three – Hosted Services – final outturn overspend of £1.723m (favourable movement of £0.086m from Period 10) Ayrshire wide mental health services have a favourable movement of £0.088m due to a slight decrease in external referrals unplanned activity and a reduction in psychiatry locum expenditure.
2.2.8	Level Four – Children's Services – final outturn overspend of £0.835m (adverse movement of £0.152m from Period 10) An adverse movement of £0.179m within Children and Families Services mainly due to an increase in residential schools placements £0.119 due to: • additional respite costs £0.065m, • one new placement £0.009m • an increase in provider rates due to a variation in packages £0.013m • a projected recharge to education of £32k that did not materialise, and • one new residential package for children with disabilities £0.031m from end January.
2.2.9	Direct Overheads and Support Services – final outturn underspend of £0.193m (reduced underspend of £0.127k from Period 10) The reduced underspend was due to a change in VAT advice around joint management posts, redundancy costs incurred as part of the initial management restructure carried out during 2014/15 and the purchase of additional Carefirst licences not previously projected. Level Two – Non District General Hospitals – final outturn overspend of £0.289m (favourable movement of £0.007m from month 10).
2.3	**Detailed Actual vs Budget Analysis to 31st March 2015** The summary in Appendix 1 details the projected expenditure within the Health Board and North Ayrshire Council. The key variances for the year were:

2.3.1	**Level One Core (full year overspend £2.762m - 2.4% variance against budget)** Learning disabilities underspent by £0.178m by the end of the financial year. During the year the service delivered £139k of future year efficiency savings earlier than anticipated through review of care packages. In addition, residential and community care packages were underspent by £33k, Income was £80k greater than budgeted, £23k turnover savings within the NHS community learning disabilities team due to a delay in filling of a vacancy at the beginning of the year, and respite care was underspent by £14k. These underspends were partially offset by Direct Payments which were overspent by £62k, an overspend in payments to voluntary organisations of £34k and a general overspend of £13k.
2.3.2	Older Peoples services were overspent by £2.469m by the end of the financial year. This was due mainly to:
2.3.2.1	Older People's Care at home services £1.169m overspend: • Employee Costs – additional temporary staffing and overtime costs required to cover additional workloads, as a result of increased demand and some work being handed back by external providers, and sickness absence. Full year additional cost £563k. • Purchased care at home services –overspend of £606k due to an increase in both the number of service users and overall service user needs and the need to support individuals home from acute care at a time when the hospital was under significant pressure. A review of resource utilisation is being carried out to maximise the use of existing resources in order to ensure that the service is running as efficiently as possible to help to offset increasing demand linked costs. The report is expected to go to the IJB in August 2015 At the same time, the Care at Home Action Plan is being reinvigorated to ensure the current service is optimised to meet local need and work has recently begun to review the models of service delivery to ensure these are safe and sustainable into the future. The financial benefits of this for 2014-15 were limited but this work will help underpin budgeted activities for future years. The Council agreed in December 2014 to increase the Care at Home budget to address the demand pressures on the service experienced during 2014/15 and meet anticipated pressures in 2015/16.
2.3.2.2	Older People's residential and nursing care homes had an overspend of £1.195m. At the end of the financial year there were 890 placements, against a budget of 848. The service started the year with 36 placements more than budget which has contributed to the current projected overspend. Some of this higher than anticipated demand can be attributed to assessment criteria and practice from some time ago that resulted in individuals entering long-term care at a much earlier stage than they would now. In year, the profile of admissions and discharges differed significantly against the budgeted activity profile which added to the overall overspend. The Council agreed in December 2014 to increase the Older People budget for 2015/16 to address the increased demand levels experienced during 2014/15 and meet anticipated pressures in 2015/16.

2.3.2.3	In previous years the admissions policy to nursing and residential homes led to a high number of long term residents staying in excess of 5 years. For the past couple of years the service has been seeking to address this through enhancing reablement services in order to help more people stay independent and in their own houses for as long as possible and to reduce long term home admissions. To further develop this concept Nursing, allied health professionals (AHP) and Social Work staff are working together from Pavilion 3 at Ayrshire Central Hospital within the new, integrated Rehabilitation and Reablement Hub, through which patients are being supported to attain the level of independence required for them to successfully return home with an appropriate Care at Home package. The financial benefits of this for 2014-15 were limited but this work will help underpin budgeted activities for future years.
2.3.3	There was an overspend of £0.095m in Physical Disabilities mainly due to increases in residential care packages and direct payment packages.
2.3.4	An underspend of £0.340m in Community Mental Health Teams due mainly to delays in recruiting for vacancies at the start of the year (£0.095m), and recurring vacancies (£0.081m) lower than budgeted demand for residential packages (£0.107m) and community packages (£0.012m). An underspend in voluntary organisations expenditure (£0.112m) and in minor variances totalling (£0.005m) offset within an increase in direct payments £0.051m and legal expenses £0.021m. Within Addictions services (£0.085m) underspend, mainly due to employee vacancies (£0.130m) partially offset with overspends in other budgets.
2.3.5	Community Nursing was overspent by £0.060m. A review of the use of supplementary staffing was undertaken to address this emerging overspend and the financial position is beginning to improve as a consequence.
2.3.6	The full year overspend in Primary care prescribing was £0.788m, primarily resulting from the cost per item prescribed being higher than the original estimate. The pharmacy team is reviewing the use of high cost drugs which should help to reduce spending. The increase in the cost of drugs has been taken into account in setting the anticipated spend for 2015-16.
2.3.7	General Medical Services were overspent of £0.086m as the demand for enhanced services exceeded the funding available e.g. anti-coagulation monitoring. The overall enhanced services commissioning plan is being reviewed with the potential for services to be removed.
2.4	**Level Two – Non District General Hospitals (full year overspend £0.289m – 4.6% variance against budget)** The frail elderly wards at Ayrshire Central Hospital continued to exceed budget despite additional funding being provided during 2014/15. The full year overspend is £0.234m due to high occupancy, patients being more frail and high staff sickness levels. Sickness absence in these wards averaged about 16% for 2014/15. Absence will be addressed in 2015/16. The development of the Rehabilitation and Reablement Hub described earlier in this report may also help to reduce the overspend for 2015/16. Arran War Memorial Hospital staffing was overspent by £0.050m to ensure a safe level of nursing cover is available within the unit.

2.5	**Level Three – Lead Partnership Services (full year overspend £1.723m – 4.0% variance against budget)** Lead Partnership mental health services were overspent by £1.730m due to: • overspend of £1m in employee costs within the adult inpatient wards, due to high levels of constant observations and high sickness absence. • Cost of unplanned activity (UNPAC) eg. placement of patients in private facilities for low secure and specialist mental health services was much greater than experienced in the past. An increase of 60% from the previous financial year. In some cases, the increased UNPAC activity was the direct consequence of limited availability of NHS places, resulting in an underspend in the Service Level Agreement which partially offset the additional costs. Reviews have been undertaken on all UNPACs activity and as a result of this there have been some discharges in recent months. It is anticipated that once services move to the new North Ayrshire Hospital in April 2016 the level of overspend will reduce. A low secure forensic inpatient unit will be developed that will reduce the reliance on private providers. It is expected that the design of the wards in the new hospital will reduce the level of staffing required for constant observations. Since North provides this service on a Lead Partnership basis for the whole of Ayrshire any ongoing budget issues would have to be resolved on a pan-Ayrshire basis. The three Ayrshire partnership Finance Teams are working with the Performance & Data Teams to establish baseline and ongoing activity and cost reporting mechanisms for all Lead Partnership and Set Aside budgets. This will allow for more robust in year monitoring and tracking across the three partnerships of any risks or opportunities associated with Lead Partnership Services.
2.6	**Level Four – Children's Services (full year overspend of £0.835m – 3.2% variance against budget)** Social work Children's Services overspent by £0.850m due mainly to: • Overspend of £0.387m on Residential and Remand Schools due to an increase in the number of Residential placements required during the year. • Children with Disabilities care packages overspent by £0.667m due to an increase in the number of care packages. Resource allocation meetings have been re-established to address this. Reviews are being undertaken of 25 care packages, these packages relate to 88% of the total projected cost. • The above overspends are partially offset by the underspend on Employee Costs - £0.215m due to delays in recruiting staff at the start of the year.
2.7	**Direct Overheads and Support Services (full year underspend of £0.193m – 2.6% variance against budget)** General reduction in support service employee costs across Social Services.

3.	**BUDGET REVIEW**
3.1	**Efficiency Update**
3.1.1	Social Services are continuing the roll out of the new CM2000 system which, once fully implemented, should reduce the costs of Older People services. In addition, a staffing review has been undertaken to address the projected overspend on staffing for Older People.
3.1.2	Action taken to reduce the level of overspend in 2014/15 and for 2015/16 on Lead Partnership Services includes: • Minimisation of the use of agency nurses • Review patients on constant observations regularly to ensure that the need for the level of care continues • Ensure compliance with the Promoting Attendance Policy. • Consider whether there are in-house solutions to the use of the private sector which could be appropriate. • Negotiate with private provider to secure a reduction in fees.
3.1.3	Adult care package costs were targeted with efficiencies of £0.830m, £0.750m, 90% of the target was achieved during 2014/15. Work will be ongoing to review care packages and to consider alternative supported accommodation models during 2015/16.
3.1.4	Older People Services were targeted with efficiency savings of £1m in relation to reablement. This was not achieved. Other efficiencies within older people included £0.150m in relation to workforce review and £0.594m to be achieved through costs of care packages. The workforce review saving, was achieved through the restructure of social services in November 2013. Within 2014/15 demand for older people care at home exceeded budget, therefore efficiencies in care packages were not achieved. Demand for care at home increased by 2% and the average hours per week per service user increased by 5%. Pressure funds of £1.929m were awarded in 2015/16 budget process to address the increase in demand for care at home services during 2014/15 together with further anticipated demand in 2015/16.
3.1.5	Efficiency savings of £0.088m were identified for income received from older people service users, actual additional income received from older people for 2014/15 was £0.225m.
3.1.6	Elderly mental health wards were targeted with efficiency savings of £0.2m, but this was not achieved as planned. Some beds have now closed and the savings will be released in 2015-16.
3.2	**Budget Movements**
3.2.1	Within the Council budgets have been amended in respect of:- • £29k transferred to Children and Families residential units for inflationary increases in relation to food purchases • £30k transferred to Children and Families in relation to consultancy costs for the Dartington project • £126k transferred from the Council's change fund to Older People's services to fund review team and CM2000 Project Manager

	• £106k transferred from the Partnership to the budget in respect of pre planned savings from contracts in relation to the wide area network (WAN).
3.2.2	Within Health budgets have been adjusted in respect of:- • £12k increase in resource transfer for ADP funding • £60k budget decrease for lead mental health services for the transfer of ADP funding to primary care
3.2.3	Virement Within Health budgets have been adjusted in respect of:- • £201k virement from support services to lead mental health services.
4.	**IMPLICATIONS**
4.1	Further action needs to be taken by budget managers during 2015-16 to bring overspending services into financial balance. Overspends were met by North Ayrshire Council and NHS Ayrshire & Arran for 2014-15 for the services that they funded. This arrangement will continue into 2015-16 in terms of baseline budget corrections, however both organisations will expect the HSCP to work within agreed budgets. Any projected overspends in year need to be identified early and the Partnership will have to work with Health and the Council to agree action plans to address issues arising.
5.	**CONSULTATIONS**
5.1	This report has been produced in consultation with relevant budget holders and the Director of Finance for NHS Ayrshire and Arran and the Executive Director Finance and Corporate Support for North Ayrshire Council.
6.	**CONCLUSION**
6.1	The full year overspend in 2014-15 was £5.416m The main areas of overspend were Older Peoples services, Community Prescribing, lead Mental Health services and Children's Services. It is recommended that the Health and Social Care Partnership note content of this report, including specific key actions on significant variances and the actions being taken to bring the budget back into line in 2015-16. The 2015/16 monitoring reports will closely track in year financial performance and highlight any ongoing financial risks together with the impact of corrective actions taken.

For more information please contact Fiona Neilson, Senior Finance Manager on 01292-513301 or Lesley Aird, Head of Finance, North Ayrshire Council on 01294 324560

Indicative Health & Social Care Partnership Budgets: North
Report as at 31st March 2015

Objective Summary	2014/15 Budget Council			2014/15 Budget Health			2014/15 Budget Aligned			Notes		Aligned	
	Budget	Outturn	Variance	Budget	Outturn	Variance	Budget	Outturn	Variance			Variance Period 10	Movement from Period 10
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000			£'000	£'000
Level One Core													
Learning Disabilities	15,200	15,045	(155)	491	468	(23)	15,691	15,513	(178)			197	(375)
Older people	37,880	40,349	2,469	0	0	0	37,880	40,349	2,469			2,480	(11)
Physical Disabilities	4,132	4,227	95	0	0	0	4,132	4,227	95			84	11
Mental Health Community Teams	3,219	2,960	(259)	2,122	2,041	(81)	5,341	5,001	(340)			(426)	86
Addiction	1,388	1,340	(48)	1,062	1,025	(37)	2,450	2,365	(85)			(45)	(40)
Community Nursing		0	0	3,554	3,614	60	3,554	3,614	60			102	(42)
Prescribing		0	0	27,205	27,993	788	27,205	27,993	788			748	40
General Medical Services		0	0	16,750	16,836	86	16,750	16,836	86			110	(24)
Resource Transfer, Change Fund, Criminal J	(10,749)	(10,876)	(127)	12,392	12,386	(6)	1,643	1,510	(133)			(52)	(81)
Total Level One	**51,070**	**53,045**	**1,975**	**63,576**	**64,363**	**787**	**114,646**	**117,408**	**2,762**	1		**3,198**	**(436)**
Level Two - Non District General Hospitals													
Ayrshire Central Continuing Care				4,192	4,426	234	4,192	4,426	234			240	(6)
Arran War Memorial Hospital				1,498	1,548	50	1,498	1,548	50			52	(2)
Lady Margaret Hospital				553	558	5	553	558	5			4	1
Total Level Two	**0**	**0**	**0**	**6,243**	**6,532**	**289**	**6,243**	**6,532**	**289**	2		**296**	**(7)**

Indicative Health & Social Care Partnership Budgets: North
Report as at 31st March 2015

Objective Summary	2014/15 Budget Council			2014/15 Budget Health			2014/15 Budget Aligned			Notes		Aligned	
	Budget	Outturn	Variance	Budget	Outturn	Variance	Budget	Outturn	Variance			Variance Period 10	Movement from Period 10
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000			£'000	£'000
Level Three - Hosted Services													
Mental Health Services				42,673	44,403	1,730	42,673	44,403	1,730			1,818	(88)
Family Nurse partnership				472	465	(7)	472	465	(7)			(9)	2
Total Level Three	**0**	**0**	**0**	**43,145**	**44,868**	**1,723**	**43,145**	**44,868**	**1,723**	3		**1,809**	**(86)**
Level Four - Children's Services													
Community Paediatrics				460	470	10	460	470	10			30	(20)
C&F Social Work Services	23,894	24,744	850	0	0	0	23,894	24,744	850			671	179
Health Visiting				1,645	1,620	(25)	1,645	1,620	(25)			(18)	(7)
Total Level Four	**23,894**	**24,744**	**850**	**2,105**	**2,090**	**(15)**	**25,999**	**26,834**	**835**	4		**683**	**152**
Direct Overheads & Support Services	6,235	6,047	(188)	**783**	**778**	(5)	7,018	6,825	(193)	5		(320)	127
Partnership Total	**81,199**	**83,836**	**2,637**	**115,852**	**118,631**	**2,779**	**197,051**	**202,467**	**5,416**			**5,666**	**(250)**

Report as at 31st March 2015

Subjective Summary	2014/15 Budget Council			2014/15 Budget Health			2014/15 Budget Aligned			2014/15 Budget Aligned	
	Budget	Outturn	Variance	Budget	Outturn	Variance	Budget	Outturn	Variance	Variance Period 10	Movement from Period 10
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Employee Costs	41,136	40,805	(331)	50,624	51,622	998	91,760	92,427	667	712	(45)
Property Costs	485	407	(78)	16	56	40	501	463	(38)	(16)	(22)
Supplies and Services	2,187	2,513	326	1,844	1,718	(126)	4,031	4,231	200	144	56
Prescribing Costs		0		27,205	27,993	788	27,205	27,993	788	748	40
Primary Medical Services		0		16,750	16,836	86	16,750	16,836	86	110	(24)
Transport and Plant	524	601	77	0	0	0	524	601	77	26	51
Admin Costs	954	962	8	3,217	3,136	(81)	4,171	4,098	(73)	(48)	(25)
Other Agencies & Bodies	51,972	55,162	3,190	7,279	8,338	1,059	59,251	63,500	4,249	4,060	189
Transfer Payments	1,672	1,934	262	8,917	8,932	15	10,589	10,866	277	397	(120)
Other Expenditure	300	179	(121)	0	0	0	300	179	(121)	(213)	92
Capital Expenditure		0		0	0	0	0	0	0	0	0
Income	(18,031)	(18,727)	(696)	0	0	0	(18,031)	(18,727)	(696)	(254)	(442)
Partnership Total	**81,199**	**83,836**	**2,637**	**115,852**	**118,631**	**2,779**	**197,051**	**202,467**	**5,416**	**5,666**	**(250)**

Integration Joint Board

13th August 2015

Agenda Item No. 13

Subject:	**Procurement by the Health and Social Care Partnership – Reporting Arrangements.**
Purpose:	To consider arrangements for entering into contracts in respect of integrated functions.
Recommendation:	To note the proposed reporting arrangements.

1.	**INTRODUCTION**
1.1	The Council and NHS Ayrshire & Arran have delegated certain functions (integrated functions) to the Integration Joint Board (IJB) as set out in the Integration Scheme. This report deals with the arrangements which apply to procurement by North Ayrshire Council and NHS Ayrshire and Arran in relation to procurement for such integrated functions.
1.2	The IJB is responsible for the distribution of funding to the Health and Social Care Partnership (HSCP) and scrutiny of its performance. While the IJB is a legal body in its own right it cannot contract; the HSCP is not a legal body.. Any contracts would be entered into by the Council or NHS Ayrshire & Arran rather than the IJB with the Chief Officer signing off as the Director of Health and Social Care on behalf of the Council or NHS Board., This reflects the fact that the IJB funds the Council and NHS (albeit operating in a partnership as HSCP) to provide or procure the services. Nevertheless the IJB needs to be able to scrutinise performance, including the performance of services which have been procured.
2.	**CURRENT POSITION**
2.1	In terms of both the Council Scheme of Delegation and the IJB Scheme of Delegation relating to Council derived functions, the Director of Health and Social Care is authorised "to enter into contracts for the supply of goods and materials, the execution of works and the provision of Services where there is adequate provision in the estimates and the estimated expenditure is less than £100,000 or let in terms of a framework to which the IJB, the Council or the NHS is a party" Moreover the Director of Health and Social Care can also enter into contracts higher than this in the case of emergency involving danger to life or property subject to subsequently reporting the expenditure.

2.2	Neither the Council nor IJB Scheme of Delegation relating to Council functions authorises officers to exercise delegated powers "where any decision would represent a departure from Board (IJB) policy or procedure, would represent a departure from the Strategic Plan or would be contrary to a standing instruction of the Board (IJB) (or committee), or would itself represent a significant development of policy or procedure. The only exception to this is in the case of urgency where the officer may, after consultation with the relevant Chairperson of the Board (IJB), exercise delegated powers. Should such powers be exercised in urgent circumstances, a report will be submitted to the next appropriate meeting for noting".
2.3	In respect of NHS functions delegated to the IJB, the NHS Scheme of Delegation as adopted by the IJB gives wider powers to the Director of Health and Social Care. Procurement on behalf of NHS Ayrshire and Arran by the Director of Health and Social Care is subject to the NHS Board Standing Financial Instructions, a copy of the section on procurement is attached as Appendix 1. With the exception of tenders in excess of £4,000,000, where NHS Board approval is required, providing expenditure is within approved budget and properly tendered there is no need to obtain the approval of the NHS Board, albeit the NHS Audit Committee receives information on tenders which have not gone through the usual tender process.
2.4	Both Schemes advise caution before exercising delegated powers where a matter is likely to be controversial.
3.	**PROPOSALS**
3.1	It is recommended that the following reporting arrangements are adhered to:- Where a procurement by the Council is less than £100,000 or is let in terms of a framework agreement, the Director of Health and Social Care can enter into the contract under delegated powers. There is no need to report to either the IJB or Council, although equally there is nothing to stop the Director of Health and Social Care reporting to the IJB, if a particular contract might be controversial.
3.2	Where the contract is in excess of £100,000 or not let in terms of a framework agreement, if it is to be let on behalf of the Council, then Council's Cabinet are required to authorise the procurement. Where the contract procurement is by NHS Ayrshire and Arran it requires NHS Board approval if it exceeds £4,000,000 otherwise, it does not need to be reported to either the Health Board or IJB providing it is within budget and complies with the terms of the NHS Board's Standing Financial Instructions.
3.3	As regards oversight by the IJB the following is recommended: a. In recognition of the fact the Council and NHS have delegated their decision making functions to the IJB (except in procurement), and the IJB would set the policy framework for the services to be procured, the Chief Officer would, for contracts likely to be in excess of £100,000 seek the approval of the IJB to the required budget commitment. In turn this allows the Council's Cabinet, or for Contracts let by the NHS, the Director of Health and Social Care to progress to tender.

	b. In the case of Pan-Ayrshire contracts the approval of each IJB should be sought prior to the tender process and authority sought from each IJB to authorise a specific Council or the NHS to tender and let a contract for defined services.
	c. Reporting on contracts let - these should be included in a regular (say twice per annum) report to the IJB regarding external contracts let by the Council and NHS on behalf of the Health and Social Care Partnership. This assists the IJB to scrutinise services let under such contracts. These reports might be considered by the IJB's Audit Committee.
4.	**IMPLICATIONS**
4.1	**Financial Implications**
	There are no financial implications arising from this report, but it supports the Integration Joint Board's financial governance.
4.2	**Human Resource Implications**
	There are no human resource implications arising from this report.
4.3	**Legal Implications**
	There are no legal implications arising from this report.
4.4	**Equality Implications**
	There are no equality implications arising from this report.
4.5	**Environmental Implications**
	There are no environmental implications arising from this report.
4.6	**Implications for Key Priorities**
	Effective oversight of procurement ensures the priorities of the Strategic Plan are being met.
4.7	**Community Benefit Implications**
	There are no community benefit implications arising from this report.
5.	**CONSULTATIONS**
5.1	There has been consultation between the Integration Joint Board's Chief Officer, the Council's Chief Financial Officer, the NHS Board's Planning Manager and the Council's Head of Democratic Services.

6.	**CONCLUSION**
6.1	It is recommended that the reporting arrangements detailed in this paper apply to procurement of Integrated Services.

For more information please contact Andrew Fraser, Head of Democratic Services on: 01294 324125 or andrewfraser@north-ayrshire.gov.uk

18 PROCUREMENT

18.1 All goods and services relevant to Ayrshire & Arran Health Board must be processed by utilising an official buying order. The key principles outlined in CEL05 (2012) should be complied with, with the exception being a purchase order is not required where a contract or binding agreement is already in place.

18.2 It should be especially noted that NHS Ayrshire & Arran Staff are prohibited from ordering or obtaining goods for their personal use through NHS Ayrshire & Arran's ordering system or in such a way as to take advantage of NHS Ayrshire & Arran's discounts or other privileged purchasing arrangements. Thus, all goods obtained through the Board's auspices shall be for the official use of NHS Ayrshire & Arran.

18.3 No company should be given any advantage over its competitors, such as advance notice of NHS requirements, which might hinder fair competition between prospective contractors or suppliers.

18.4 As part of the Board's Procurement Policy all orders must be considered in total value and not be taken as individual items where the supply/work is to be phased.

18.5 Board procedures must be followed at all times concerning the buying and receipt of goods ie a separate officer should order and receive goods.

18.6 The foregoing sets out the general principles in relation to Procurement. More detailed guidance to be used by individual departments is contained in NHS Ayrshire & Arran's Procurement Operating Procedure Link

(a) National Contracts

Where supplies and services of the type and quantity required are available on national contract, the order must be placed with the supplier designated in that contract. Only in exceptional circumstances and with the authority of the Director of Finance, will supplies and services available on contract be ordered outwith central contract.

(b) Competitive Tendering

Competitive tenders will be invited from providers in the NHS and/or independent sector, from among companies equipped to

meet NHS standards and requirements for the supply of goods, materials and manufactured articles, for the rendering of services, for building and engineering works of construction and maintenance, and for disposals where the expenditure/income will exceed £25,000. Procedures will be in accordance with the relevant EU/World Trade Organisation on Procurement, formerly referred to as GATT Directives on public procurement. Also all contracts over £25,000 will be advertised on the Public Contracts Scotland Advertising Portal.

(c) Quotations

Competitive quotations will be obtained in writing (including electronic data) wherever possible from a minimum of three suitable firms where the expenditure will be not less than £10,000 and not more than £25,000. For quotations not less that £3,000 and not more than £10,000 one written quotation should be obtained.

(d) Competitive tenders and Quotations will not be required in the following circumstances:

Patient-specific procurements:

- Unplanned procurements for individual patients due to timescales involved and confidential nature of patient health care.

Emergencies

- Major incident: When a major incident is declared, given the extreme urgency of the situation, to support taking necessary action.

Sole source

- Procurement: in a few cases there may only be one supplier of a produce that provides a specific functionality – eg innovative developments. Robust evidence, independent of the supplier, for sole supplier status must be provided.

- Maintenance and/or repair: Where the maintenance and/or repair can only be carried out by the manufacturer or designated contractor.

- Where a contractor's specialist knowledge is required.

Standardisation

- Medical equipment management governance requires standardisation to help ensure clinical staff competence in equipment use and to facilitate maintenance and the supply of consumables and accessories. Standardisation should, however, not be used to resist change. The standardisation provision only applies where the number of items to be procured is a low proportion of the inventory for those items. It should also take into account life-cycle replacement planning.
  (Medicines Healthcare products Regulatory Authority (MHRA) Device Bulletin DB2006 (5): Managing Medical Devices; Audit Scotland, Better Equipped to Care, (2004).

  Where goods and services are supplied on this basis, it shall only be with the approval of the Director of Finance and the Assistant Director of Finance (Governance & Shared Services) and be separately and formally recorded and reported to the Audit Committee. Approval will only be given based on evidence submitted in a Tender Waiver Request Form (attached).

(e) Form of Contract, an official Purchase Order or a Letter of Acceptance shall be issued for every Contract resulting from a successful, accepted invitation to tender or quote for the supply of goods and services.

(f) Management Consultants - where it is deemed necessary to engage management consultants, the principles outlined in the NHS MEL 1994(4) must be applied, and the engagement of management consultants must follow the guidance contained within the Board's Procurement Operating Procedure Link

Note: In the case of both (d) and (f), all such approvals will be formally reported to NHS Ayrshire & Arran's Audit Committee.

(g) Retention of Documents

Successful – 6 years after the end of the financial year in which the agreement contract expires.

Unsuccessful – 3 years after the financial year to which they relate.

(h) Standards of Business Conduct – NHS Staff

In any circumstances where an officer has an interest, pecuniary or otherwise, in the outcome of a tender or quotation, the officer concerned must declare his/her interest and withdraw from all contracting/procurement arrangements concerning that item.

Visits by officers at suppliers' expense to inspect equipment etc. must not be undertaken without the prior approval of the Chief Executive or the Director of Finance.

All staff should be made aware of, and comply with, the requirements of 1989(GEN)32 as re-stated and reinforced by NHS MEL(1994)48 "Standards of Business Conduct for NHS Staff" with regard to acceptance of financial assistance, gifts, hospitality and declaration of interest.

(i) Receipt and Safe Custody of Tenders and Records

All tenders will be addressed to the Chief Executive or their designated officer, unless otherwise specified on their behalf.

- Tenders will be submitted in plain sealed envelopes addressed to the Chief Executive. The envelope will be marked "Tender for ….", but will not bear the name or identity of the sender.

- Tender envelopes will be date stamped and held unopened in a secure place until after the closing date or time.

- Tenders will be opened as soon as possible after the stated closing date or time by the Chief Executive's nominated representatives in the presence of an independent witness. Officers will initial each tender received.

- Details of tenders received will be entered in a Register of Tenders, which shall be signed by both the attending officers.

- Where it is clearly in the interests of NHS Ayrshire & Arran, late, amended, incomplete or qualified tenders may be considered. In such circumstances, a full report will be made to the Chief Executive who will have authority to admit such tenders. Where a company invited to tender requests a delay in the submission, any deferment approved will be notified to all the companies concerned.

- Where it is the intention not to award the business to the lowest tender a written statement must be submitted to the Assistant Director of Finance (Governance and Shared Services) giving reasons for choice. The Assistant Director of Finance (Governance and Shared Services) will review the request and recommend approval or not to the Director of Finance. The Director of Finance will give final approval and then advise the Operational Manager concerned. The Director of Finance will also report this exception formally to the Audit Committee.

- Tenders received electronically will be opened bv two members of staff who will jointly produce a tender report which will be forwarded for inclusion in the formal Register of Tenders.

- Further guidance on tendering procedures is contained in the Board's Procurement Operating Procedure Link.

(j) Other Controls

The Assistant Director of Finance (Governance & Shared Services) will be responsible for ensuring that lists are maintained of authorised ordering officers. Limits will vary according to their limit of delegation.

- Details of all orders placed shall be available to the Director of Finance, either in paper form or accessible through a computerised procurement ledger system.

- The Director of Finance will ensure that appropriate delegation arrangements are in existence to ensure that all orders comply with the Board's Financial Plan. Orders not complying with the Board's Financial Plan must be authorised by senior officers and approved by the Chief Executive or Director of Finance.

- Orders shall not be placed in a manner devised to avoid the financial limits specified by NHS Board.

- Contracts shall only be entered into by officers of the Board who are properly designated to do so (Designated Purchasing Officers). All contracts should have appropriate terms and conditions, which limit the Board's liabilities and minimise the risk of any adverse litigation. Where

appropriate, standard forms shall be used and where contracts are not of a standard form, the Procurement Department and/or Central Legal Office should be consulted.

18.7 These instructions must be read in conjunction with NHS Ayrshire & Arran's Procurement Operating Procedure Link.

TENDER WAIVER REQUEST REVIEW FORM

TENDER N0:-

Request From:		Date:
Summary of Request:		
Review Points/Bob Brown:		
Recommendation/(Approved/Not Approved): Bob Brown:		Date:
Authorisation: (Approved/Not Approved)		Date:

Integration Joint Board

Agenda Item No. 14

Subject:	**Improving Children's Outcomes**
Purpose:	To provide an update on the Improving Children's Outcomes project.
Recommendation:	It is recommended that the Integration Joint Board note the progress being made in developing the Improving Children's Outcomes project which will inform the next North Ayrshire Children's Services Strategic Plan.

1.	**INTRODUCTION**
1.1	North Ayrshire Community Planning Partnership has been working with the Scottish Government and the Dartington Social Research Unit (SRU) over the last year to develop an evidence-based approach to improving children's services. This has involved gathering evidence on the needs of the child population through a community and a schools survey, including an analysis of how services meet that need.
1.2	There were 7951 children and young people who completed the survey carried out in 9 Secondary and 50 Primary Schools. Less than 4% of parents withdrew consent to participate and less than 2% of children declined to participate. There was a response rate of 93% of all children eligible for the survey within North Ayrshire. The community survey was carried out with 635 families with children aged between 0 and 8 years from across North Ayrshire.
1.3	Reports have been produced for each school cluster and for each secondary school, as well as summary reports for all primary and all secondary schools.
2.	**CURRENT POSITION**
2.1	The findings from the community and school surveys were considered at Development and Strategy Days held in January and February 2015. Prior to the events, there was some local interpretation on the risk factors and key developmental outcomes. At the events there was wider consideration of what the survey data shows and how it can be interpreted, drawing on the knowledge and experience of those who participated. This allowed for discussion on what North Ayrshire's priorities should be in addressing the needs of children and young people in future.
2.2	The results from the school's summary reports show this data in more detail highlighting the key developmental outcomes and associated risk factors. The key developmental outcomes are aspects of children's development that are predictive of later outcomes.

2.3	At a Strategy Day in February where the results were reviewed, it was agreed that North Ayrshire's priorities are: • Poor Engagement with School. • Obesity. • Early Initiation of substance use. • Social and Emotional Development (6-12 years). •
2.4	Information is being gathered on the funding of children's services and Focus Groups have been held on the priority themes to establish current arrangements.
2.5	The fund mapping exercise will result in a better understanding of investment in children's services in North Ayrshire.
2.6	The Scottish Government has indicated recently that it is extending its support of this project and its work with Dartington SRU up to December 2015. Additional funding of £50,000 has been set aside to provide further comparative research and dissemination of the learning from this project. This will be done with the three sites currently involved, Dundee, Angus and North Ayrshire, along with Renfrewshire and Perth and Kinross which were involved in the earlier stages.
2.7	A session for children's services managers was held on 1 May to consider the evidence from Dartington and other websites on 'what works' in terms of universal and targeted interventions, drawing on the best available evidence in order to address the priorities coming out of the survey data.
2.8	At this session there was discussion on what more could be done, using the driver diagrams from the Early Years Collaborative's improvement methodology, in order to identify new activity to address the priority areas.
3.	**PROPOSALS**
3.1	The Children's Services Strategic Partnership has considered the results and agreed that there should be close involvement with communities in testing if the results meet with their understanding of children's needs. It will also be vital that children, parents and the wider community are closely involved in identifying what more could be done to address them.
3.2	At the Children's Services Strategic Partnership event there was discussion on possible developments in relation to each of the priorities as follows:
	Poor Engagement with School • Share learning from the Early Years Centres about how to engage with parents and get them involved in learning activity. • Build parental confidence in schools so that parents have a better understanding of the importance and benefits of education. • Establish "Teams around the Child" in schools were staff e.g. from the Health and Social Care Partnership are located in the school building and provide a community hub, improving the accessibility of services.

	Obesity • In addition to Healthy Start, weaning and breastfeeding initiatives, more could be done using social marketing and advertising to change attitudes towards food and healthy eating. • Address community and parental perceptions e.g. about weaning and solid foods, but this must be done together with communities using co-production techniques. • Develop interventions at key times e.g. during pregnancy or in the early years to maximise impact. • Identify more activity to tackle obesity across age groups in primary and secondary school.
	Early Initiation of Substance Use • Build capacity of parents to prevent the early initiation of substance use. • Engage more with young people to find out what they consider are the best means of tackling this issue. • Increase existing universal preventative initiatives e.g. Lila, Rory, etc. • Develop targeted resources for young people engaging in substance use as well as experiencing parental substance misuse.
	Social and Emotional Development (6-12 years) • Develop more nurture and restorative approaches across all CPP partners services, building on the nurturing school developments in Education. • Develop counselling services in schools and ask young people more about what they would find helpful to support their emotional wellbeing. • Increase the accessibility of diversionary activity e.g. leisure activities, community groups, involvement in community life. • Expand evidence based initiatives such as Positive Alternative Thinking Strategies (PATHS) and Stop Now and Plan (SNAP).
3.3	The Children's Services Strategic Partnership is responsible for directing this work in future. The priorities from this project, along with others, will form the basis of the next North Ayrshire Children's Services Strategic Plan which will guide the commissioning of children's services in the future.
3.4	The Communications Plan on the outcome of the survey has been implemented. A press release has been issued and a Head Teachers' briefing was held on 1 June. A CPP Lunchtime briefing was held on 2 June. Parent and pupils were invited to briefing sessions at each secondary school to discuss the survey findings.
3.5	A session was held with the Youth Council on 12 June to obtain their views about what can be done in response to the priorities and this was also discussed with the Joint Youth Cabinet. The 45 young people at the Youth Council event participated in workshops to test out their estimate of the results from the survey e.g. on poor engagement. They consistently overestimated the results, assuming that the results would be worse than they are from the survey.

3.6	There have been discussions with Connected Communities regarding wider community engagement on the results through Straight Talking sessions in each neighbourhood area. Their views will be important in developing proposals to address the priorities and on the proposals in the next North Ayrshire Children's Services Strategic Plan 2016/20 which is now being drafted.
4.	**RECOMMENDATION**
4.1	It is recommended that the Integration Joint Board note the progress being made in developing the Improving Children's Outcomes project which will underpin the next North Ayrshire Children's Strategic Services Plan.

For more information please contact Marjorie Adams on 01294 317801 or madams@north-ayrshire.gov.uk.

Integration Joint Board
13th August 2015
Agenda Item No. 15

Subject:	**Response to the Justice Committee's call for Evidence on the Community Justice (Scotland) Bill**
Purpose:	To inform the Integration Joint Board of the response from North, East and South Ayrshire's Criminal Justice Social Work Services (report attached) to the above Bill.
Recommendation:	That the Integration Joint Board notes and supports the comments in the report.

1.	**INTRODUCTION**
1.1	The Scottish Parliament's Justice Committee is seeking views on the general principles of the Community Justice (Scotland) Bill, which was introduced in the Scottish Parliament on the 7th May 2015.
1.2	The objectives of the Bill are: "to help create a stronger community justice system based on local collaborative strategic planning and delivery, with national leadership, support and assurance". The Bill therefore abolishes the eight existing regional community justice authorities and proposes a new model for community justice services with responsibility being given to the 32 Community Planning Partnerships (CPP's) across Scotland. These proposals follow reports published in 2012 by the Commission on Women Offenders and by Audit Scotland which highlighted concerns about the current model for community justice, and two subsequent Scottish Government consultations which identified support for the introduction of a new model.
1.3	Community Justice is defined by the Scottish Government as *"The collection of agencies and services in Scotland that individually and in partnership work to manage offenders, prevent offending and reduce reoffending and the harm that it causes, to promote social inclusion, citizenship and desistance."*
2.	**CURRENT POSITION**
2.1	Currently, community justice services are delivered through eight regional Community Justice Authorities (CJAs). The role of CJAs is to plan, co-ordinate, monitor and report on the delivery of offender services and to produce a strategic plan for their area in consultation with statutory and non-statutory partner bodies. The membership of CJAs includes elected members from each constituent local authority. North Ayrshire is part of the South West Scotland Community Justice Authority along with East and South Ayrshire and Dumfries and Galloway.

2.2	A Criminal Justice Joint Committee, also with elected member representation, is the overview body for Criminal Justice Social Work Services across the three Ayrshire local authority areas.
3.	**PROPOSALS**
3.1	The Bill proposes that the responsibilities of the eight Community Justice Authorities are taken on by the 32 CPP's across Scotland. The Bill also proposes the creation of a new national body, Community Justice Scotland, to provide strategic leadership and oversight of the services. It is envisaged that Community Justice Scotland will also provide independent assurance to Ministers on the successes of community justice partners in tackling re-offending. This is intended to give community justice the leadership it needs to continue the progress towards tackling crime and making communities safer.
4.	**IMPLICATIONS**
4.1	The implications are addressed within the attached response to the Justice Committee. Issues around the governance of community justice services and criminal justice social work services is being considered on a Pan-Ayrshire basis and final decisions also need to be made locally and across Ayrshire about the relationship between CPP's and HSCP's in regard to community/criminal justice.
5.	**CONSULTATIONS**
5.1	The attached response to the Justice Committee has been prepared following various meetings and discussions with CJA and CPP partners as well as Criminal Justice managers across the three Ayrshires.
6.	**CONCLUSION**
6.1	Community Justice in Scotland is undergoing a major reform. It is planned that the eight CJA's will be formally dis-established on the 31st March 2017 and the new model for community justice in Scotland will come into effect on the 1st April 2017. The Integration Joint Board is requested to note and support the comments made by Criminal Justice Social Work Services within the Health and Social Care Partnership to the Justice Committee in regard to the proposals in the Community Justice (Scotland) Bill.

For more information please contact David MacRitchie, Senior Manager, Criminal Justice Services on 01294 317781 or dmacritchie@north-ayrshire.gcsx.gov.uk

North Ayrshire's Health and Social Care Partnership's Response to the Justice Committee's call for Evidence on the Community Justice (Scotland) Bill

Introduction:

North, East and South Ayrshire are part of the South West Scotland Community Justice Authority (SWSCJA) along with Dumfries and Galloway. Over the last nine years of available data, SWSCJA has moved from having one of the highest reconviction rates in Scotland to being amongst the lowest.

The responsibility for Criminal Justice Social Work Services sits within the Health and Social Care Partnerships (HSCP) of North, East and South Ayrshire. A Criminal Justice Joint Committee, with Elected Member representation, is the overview body for Criminal Justice Social Work Services across the three Ayrshire local authority areas.

Criminal Justice Social Work Services in North, East and South Ayrshire have jointly planned and developed a range of services which are shared across the three HSCP's.

1. **Will the proposals of the Bill transform the community justice system in the way envisaged by the Commission on Women Offenders in its 2012 report, such as addressing the weaknesses identified in the current model, tackling reoffending and reducing the prison population?**

1.1 We feel that it is not entirely accurate to refer to the Commission on Women Offenders as providing a justification for the Bill's proposals. The Commission on Women Offenders does not recommend any structural reform at all. There is also no mention in the Commission on Women Offenders of a new national improvement and assurance body being established such as Community Justice Scotland.

1.2 The structural reforms proposed by the Bill are no guarantee of realising the improvements sought by the Commission on Women Offenders in terms of governance, accountability, leadership, reducing offending and reducing the prison population.

1.3 Reference has already been made to the success of the SWSCJA in contributing to the reduction of reoffending rates over the last nine years. It is our view that this has been achieved more by building positive working relationships and a shared vision among partners and stakeholders rather than by implementing a particular structure.

1.4 Criminal Justice Social Work Services across Ayrshire have demonstrated a commitment to partnership working in terms of vision, governance and the planning and development of shared services. We would be concerned that a structural reform may threaten the progress that we have made due to the uncertainty that this may create in terms of local planning, leadership and accountability. In particular, there are concerns about the role and powers of the proposed Community Justice Scotland and how this will impact on local leadership. In Ayrshire, it could be argued that we we have been guided by the principal of "form follows function" in that we have shaped our structures, governance, planning and services according to the specific needs and aspirations of our stakeholders across Ayrshire.

2. Are you content that the definition "community justice" in the Bill is appropriate?

2.1 No. The definition of "community justice" in the Bill focuses on agencies, services and the management of offenders. This is contrary to the focus in Ayrshire which is on the outcomes for people. The definition also does not appear to cover key areas such as early intervention and prevention.

3. Will the proposals for a new national body (Community Justice Scotland) lead to improvements in such areas as leadership, oversight, identification of best practice and the commissioning of services?

3.1 As has already been suggested, the creation of new structures does not guarantee improvements. We have concerns about the role of Community Justice Scotland and about the cost of establishing and running this agency, of around £2.2 million per year. It is our view that the Scottish Government could carry out the national functions envisaged for Community Justice Scotland, with additional support in order to provide oversight and assurance for the Cabinet Secretary. This would be a preferable approach to creating Community Justice Scotland at significant cost but with no guarantee of delivering improvements.

4. Taking into account the reforms set out in the Community Empowerment (Scotland) Bill relating to Community Planning Partnerships, will Community Justice Partners have the powers, duty and structures required to effectively perform their proposed role in relation to community justice?

4.1 The Bill draws a distinction between the "Community Justice Partners" and "Community Planning Partnerships (CPP)". The Scottish Government has suggested that CPP's cannot be mentioned specifically in the Bill as they cannot be legally accountable for delivering outcomes. However CPP's are mentioned in other legislation such as the recently passed Community Empowerment (Scotland) Bill. The failure to specifically name CPP's in the Bill will not help provide a mandate to bring partners together in a new way to tackle community justice issues.

4.2 CPP's are at the centre of local strategic planning from the Single Outcome Agreement to economic development and health improvement. It would appear that the Bill dilutes the role of the CPP's whereby the named Community Justice Partners can do as they wish so long as they are seen to consult the CPP as a stakeholder.

4.3 This proposed arrangement between the CPP's and the Community Justice Partners will result in the CPP's not having clear accountability or responsibility for delivering community justice outcomes. The Bill should make it clear that the CPP's are the lead in terms of leadership, governance and accountability for planning and delivery of shared outcomes in their areas.

4.4 There is concern that there has been a serious omission in that there is no explicit mention of the Crown Office and Procurator Fiscal Service in the Bill. They are essential partners and this omission should be rectified.

5. Does the Bill achieve the right balance between national and local responsibility.

5.1 No. The proposals are not clear enough about national and local responsibility. There is potential for the new national body, Community Justice Scotland, to create performance and reporting requirements which cut across the existing Single Outcome Agreement resulting in duplication of effort and creating a diversion from the focus of developing and delivering improvements in community justice. The Single Outcome Agreement is designed to be the single reporting system for community planning partnerships to communicate with communities and the Scottish Government. There is concern that with the creation of Community Justice Scotland community planning partnerships will be asked for a range of additional information and reports despite the national body having no governance role over local arrangements.

6. Will the proposed reforms support improvement in terms of:
(a) leadership, strategic direction and planning?
(b) consultation and accountability?
(c) partnership and collaboration?
(d) commissioning of services and achieving best value for money?

6.1 There is concern about the absence in the proposed reforms of a role for Elected Members. In the SWSCJA, Elected Members have provided strong community leadership, good governance and clear accountability. Elected Members also sit on the Criminal Justice Joint Committee which is the overview body for criminal justice social work services across the three Ayrshire local authority areas. As stated above, structural reform does not guarantee improvements and we would be concerned that the proposed reforms create an unwelcome diversion from our focus on developing and delivering improvements in community justice.

7. Are the resources, as set out in the Financial Memorandum, sufficient to transform the community justice system in the way envisaged by the Commission of Women Offenders in its 2012 report?

7.1 No. There have been long standing concerns about the under resourcing of the community justice system when compared to the Scottish Prison Service. Currently the Scottish Prison Service is receiving three and a half times more funding than community justice.

7.2 We need to establish a fair and transparent process to move funding from the Scottish Prison Service to community justice that takes into account the fact that currently there are 29% more community than custodial sentences being made by the courts. The establishment of a joint board for community justice and prisons, as proposed by the Commission on Women Offenders, could take on this function.

7.3 There are three staff in the SWSCJA who are currently funded with a role to support our partnership working around reducing reoffending. We would argue that with the proposed introduction of Community Justice Scotland, which will be funded at a higher level than all the CJA's put together, that additional funding should be made available to retain these staff. They would play a key role in supporting the three CPP's across Ayrshire and in liaising and helping the CPP's respond to the requirements of Community Justice Scotland. Although interim

funding has been made available to prepare for the new arrangements, it is our view that this funding should be made permanent.

8. Is the timetable for moving to the new arrangements by 1st April 2017 achievable?

8.1 We consider that the timescale is realistic. All stakeholders have been aware of the changes and the transitional arrangements for a significant time.

9. Could the proposals in the Bill be improved and, if so, how?

9.1 Improvements are noted throughout this response.

Integration Joint Board
13th August 2015
Agenda Item No. 16

Subject:	**Health (Tobacco, Nicotine etc. and Care) (Scotland) Bill / (Duty of Candour- Wilful Neglect)**
Purpose:	Inform the IJB of the progress of the legislation and our response to the proposals in the Bill
Recommendation:	The IJB to note the information submitted to Scottish Government (Health and Sport Committee) on behalf of the IJB.

1.	**INTRODUCTION**
1.1	In late 2014 the Scottish Government introduce two consultation documents - Duty of Candour and Wilful Neglect.
1.2	The Shadow Integration Board discussed both these consultations and responded to them. These were submitted to the Scottish Government in December 2014 and January 2015.
1.3	Following from the consultation on whether to introduce legislation covering both topics the Scottish Government has proposed the Health (Tobacco, Nicotine etc. and Care) (Scotland) Bill, which we are now invited to submit comment on, by 12th August 2015.
2.	**CURRENT POSITION**
2.1	The Bill was introduced in the Parliament on 4 June 2015 and the Health and Sport Committee has been designated by the Parliament as the lead Committee.
2.2	The Health and Sport Committee issued a call for written views on the Health (Tobacco, Nicotine etc. and Care)(Scotland) Bill on 3 July 2015.
2.3	The stated policy objective of the Bill is to make provision about tobacco, nicotine and related products, in particular to make provision about retailing, to amend the prohibition on smoking in certain areas and to control advertising and promotion; to make provision about a duty of candour following serious incidents in the course of providing care; to make provision about offences applying to ill-treatment or neglect where care is provided, and for connected purposes.
2.4	The draft legislation is contained in Appendix 2 of this briefing paper – commencing at page 16 (Part 2 of the draft legislation).

3.	**PROPOSALS**
3.1	**NVPs and Smoking in Hospital Grounds –** The Bill proposes to introduce restrictions on the sale of nicotine vapour products (NVPs). These restrictions include a minimum purchase age of 18, prohibiting the sale of NVPs via vending machines, restrict domestic advertising as well as make it an offence to smoke in parts of hospital grounds. NHSCP and NHSAA are fully supportive of these measures and have banned smoking on hospital grounds other than in the mental health in-patient setting where other arrangements have been put in place.
3.2	**Duty of Candour** – The Bill proposes to place a duty of candour on health and social care organisations. This would create a legal requirement for health and social care organisations to inform people (or their carers/families) when they have been harmed as a result of the care or treatment they have received.
3.3	**Ill-treatment and wilful neglect** – The Bill would establish a new criminal offence of ill-treatment or wilful neglect which would apply to individual health and social care workers, managers and supervisors. The offence would also apply to organisations.
3.4	Appendix 1 contains the feedback submitted to the Health and Sports Committee.
3.5	The feedback (Appendix 1), has also been submitted to North Ayrshire Council to form part of their formal response. It has also been submitted to NHS Ayrshire & Arran to where it will form part of a composite response.
4.	**IMPLICATIONS**
4.1	There are no direct implications of the IJB responding to the call for written submission on the draft legislation.
5.	**CONSULTATIONS**
5.1	There is no requirement for the IJB to consult on the draft legislation – that responsibility falls to the Scottish Government, in particular the Health and Sports Committee.
6.	**CONCLUSION**
6.1	The IJB is asked to note the written submission which, to meet parliamentary timescales has already been sent.

For more information please contact Derek T Barron on 01294 8137800 or Derek.barron@aapct.scot.nhs.uk

Appendix 1

HEALTH (TOBACCO, NICOTINE ETC. AND CARE)(SCOTLAND) BILL
CALL FOR WRITTEN VIEWS
NORTH AYRSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

NVPs AND SMOKING IN HOSPITAL GROUNDS

1. Do you support the Bill's provisions in relation to NVPs?

NAHSCP and NHSAA are fully supportive of this measure – cigarettes and NVPs are not sold on NHS Ayrshire & Arran premises regardless of age of staff or in vending machines. North Ayrshire Council's Policy on smoking expresses concerns that e-cigarettes will potentially undermine the ban on smoking in public places, therefore, the council has decided that e-cigarettes and NVPs will be subject to the same restrictions as tobacco based products.

2. Do you support the proposal to ban smoking in hospital grounds?

NHS Ayrshire and Arran have banned smoking on hospital grounds other than in the mental health in-patient setting where there are gazebo type smoking shelters for in-patient's use in designated areas. Under current legislation such areas are currently exempt although there is an aspiration in NHS Ayrshire and Arran for mental health in-patient hospitals to move to being smoke free as of 2016 and there is a specific working group already in place supporting this.

In Arrol Park, one outside gazebo is available but it is only used in exceptional circumstances, e.g., someone under constant observation or at risk of absconding. Also if there was a safety risk e.g., too dark to go outside the grounds. Every individual who smokes is risk assessed and if the risk is minimal, they would smoke outside the grounds as everyone else on site is required to do.

Support measures to assist people to stop smoking are available and staff should be encouraged to utilise these if felt appropriate. These are referenced in the council's policy on smoking and the council is prepared to be flexible in supporting staff to access these.

Members of the public are aware there is currently no legislation that allows for any charges/prosecution of individuals who continue to smoke in hospital grounds and the measure in this Bill would be welcomed.

Support via nicotine replacement therapy and smoking cessation advice is crucial in supporting individuals who smoke who are admitted to hospital and there must be pro-active and immediate support available 24/7 365 days a year to minimise discomfort/distress.

3. Is there anything you would add/remove/change in the Bill with regards to NVPs or smoking in hospital grounds?

It has been suggested a 'distance from the building' measure may be re-introduced for no smoking purposes, this would be viewed as a backwards step as it risks the focus on any measures to address smoking on NHS premises to become a matter of perspective of distance; it would be a more effective public health action to enforce a total ban on NHS premises.

DUTY OF CANDOUR AND WILFUL NEGLECT

In our written response to the consultation, which ended in December, we expressed a view that we were unconvinced that introducing a legislative duty was required. It was, and remains our view, that our professions, within joint services, fully embrace the duty of candour which is embedded in their current Codes of Conduct.

In addition, for nurses, midwives and medical staff the clear duty of candour has been re-emphasised by the publication of 'Guidance on the Professional Duty of Candour', earlier this month (July 2015). The guidance was a joint MNC/GMC publication with the support of the other professional regulators.

With regard to the explicit provisions, as laid out in the Bill, we have concerns over a number of the requirements.

Part 2: Section 21(4)

There is no clarity around 'A responsible person' – additionally, if 'a responsible person' was the clinician involved in an adverse event they must seek another registered health professional to provide an opinion on harm (as laid out in Section 3). This seems to be at odds with the desired outcome that all professions exercise a duty of candour, in that the decision on harm is being taken outwith their sphere of influence/control. This is further complicated by the definition contained in section 25(a) to (f), where 'a responsible person' appears to mean an organisation.

We are unclear on the dichotomies in Section 21(1) a, b, c. The false subdivisions 'health', 'care' and 'social services' do not appear to take any cognisance of integrated services, delivered within the Health and Social Care Partnerships. The failure to place the legislation into a contemporary integrated services approach is a recurrent theme.

Section 21 (2)(b) is of concern – effectively this puts a 'registered health professional' as the arbiter of harm, no matter where or by whom care is being delivered. Additionally this appears to consider the opinion of a registered health profession to be of more value than that of a registered social care professional, effectively healthcare professionals undertake the 'policing' role of all services, including 'care' services.

Section 21(4) (d). The section does not appear to take due regard to contemporary healthcare provision. In many areas across Scotland urgent and/or life saving care, as laid out in (i) and (ii), is provided by healthcare professionals other than medical practitioners e.g. Advanced Nurse Practitioners, Emergency Nurse Practitioners, Paramedics etc. The requirement for intervention to be by a medical practitioner is unnecessarily restrictive in its application, additionally if interpreted as written this would mean, in the absence of a medical practitioner taking action then any harm would be outwith the scope of the legislation.

Section 22 appears to be contrary to the requirements set out by the NMC/GMC in their guidance document or duty of candour, that the individual practitioner should have the duty of candour placed 'personally' upon them rather than on a separate 'responsible person'. The introduction of a third person (the responsible person) appears to distance the individual from exercising the professional duty of candour.

Section 24(1) lacks synergy with the emerging integration of health and social care. The requirement to produce 'end of financial year' reports fails to take cognisance of the different financial reporting periods of health and local authority parent organisations. This will be additionally complicated for some organisations where all social work services are

not included in their health and social care partnerships (e.g. where children's services remain separate)..

Section 24(5) and the additional requirements of 24 (6) and 24 (7) will create a 'dis-integrated' approach to reporting and service delivery. The outlined approach is directly contrary to the principles and ethos of the Public Bodies (Joint Working) (Scotland) Act 2014, which seeks to ensure joint seamless service provision rather than disjointed separation of both provision and reporting. These sections represent an unnecessary, non value added bureaucracy.

Section 25(a) to (f) specifically excludes an 'individual' as being a 'responsible person'; this seems contrary to the requirements early in the Bill (Section 22) which necessitates the actions of an individual.

Part 3

In general we are in agreement with the provisions set out in this section of the Bill however there may be unintended consequences of some aspects that would require clarification before fully endorsing the Bill provisions.

Section 27(1) (6), (3) (6) and 29(3) (6). The interpretation of these provisions has the potential to include staffing levels for wards and/or community teams, potentially nursing, care and/or residential homes.

An example might be where a mandated workforce tool notes the requirement for 30 nurses; however the ward has only been funded for 28 nurses on a continuous basis – assuming the workload tool is designed to ensure safe staffing levels, anything below this level would be considered unsafe and therefore 'neglectful'.. Would an organisation be in breach of "a relevant duty of care" given that the shortage of staff is of a chronic nature and therefore care is not being provided to the required standard (as determined by the workforce tool), or would there need to be evidence of a specific failure in care?

In addition, if there is found to be wilful neglect by reason of insufficient staff numbers who is to be held accountable for the neglect – in the case of the NHS is it the Chief Executive, the responsible Director or a.n.other e.g the Senior Charge Nurse or Clinical Nurse Manager? The same question of responsibility is equally applicable in a nursing, care or residential home.

Part 3, Section 26(5) introduces the definition of adult services to mean services provided to a person aged 18 or over. As this is the only reference to age, we assume that the preceding section, under Part 3, apply to children and adults. It is our view that it is inconceivable to provide a lesser degree of protection to children than we afford to adults.

Health (Tobacco, Nicotine etc. and Care) (Scotland) Bill

[AS INTRODUCED]

CONTENTS

ACCOMPANYING DOCUMENTS
Explanatory Notes, together with other accompanying documents, are printed separately as SP Bill 73-EN. A Policy Memorandum is printed separately as SP Bill 73-PM.

Health (Tobacco, Nicotine etc. and Care) (Scotland) Bill
[AS INTRODUCED]

An Act of the Scottish Parliament to make provision about tobacco, nicotine and related products, in particular to make provision about retailing, to amend the prohibition on smoking in certain areas and to control advertising and promotion; to make provision about a duty of candour following serious incidents in the course of providing care; to make provision about offences applying to ill-treatment or neglect where care is provided; and for connected purposes.

PART 1

TOBACCO, NICOTINE VAPOUR PRODUCTS AND SMOKING

CHAPTER 1

SALE AND PURCHASE OF TOBACCO AND NICOTINE VAPOUR PRODUCTS

Nicotine vapour products

1 Nicotine vapour products

After section 35 of the 2010 Act insert—

"**35A Meaning of "nicotine vapour product"**

(1) In this Part, a "nicotine vapour product" is—

(a) a device which is intended to enable the inhalation of nicotine-containing vapour by an individual,

(b) a device which is intended to enable the inhalation of other vapour by an individual but is intended to resemble and be operated in a similar way to a device within paragraph (a),

(c) an item which is intended to form part of a device within paragraph (a) or (b),

(d) a substance which is intended to be vaporised by a device within paragraph (a) or (b) (and any item containing such a substance).

(2) But the following are not nicotine vapour products—

(a) a tobacco product,

(b) a smoking related product,

(c) a medicinal product (within the meaning of the Human Medicines Regulations 2012 (S.I. 2012/1916)),

(d) a medical device (within the meaning of the Medical Devices Regulations 2002 (S.I. 2002/618)).".

Sale and purchase of tobacco and nicotine vapour products

2 Sale of nicotine vapour products to persons under 18

(1) After section 4 of the 2010 Act insert—

"**4A Sale of nicotine vapour products to persons under 18**

(1) A person who sells a nicotine vapour product to a person under the age of 18 commits an offence.

(2) It is a defence to a charge in proceedings against a person ("the accused") under subsection (1) that—

(a) the accused believed the person under the age of 18 ("the customer") to be aged 18 or over, and

(b) the accused had taken reasonable steps to establish the customer's age.

(3) For the purposes of subsection (2)(b), the accused is to be treated as having taken reasonable steps to establish the customer's age if and only if—

(a) the accused was shown any of the documents mentioned in subsection (4), and

(b) that document would have convinced a reasonable person as to the customer's age.

(4) The documents referred to in subsection (3)(a) are any document bearing to be—

(a) a passport,

(b) a European Union photocard driving licence, or

(c) such other document, or a document of such description, as may be prescribed.

(5) A person guilty of an offence under subsection (1) is liable on summary conviction to a fine not exceeding level 4 on the standard scale.".

(2) The italic heading immediately preceding section 4 of the 2010 Act becomes "*Sale and purchase of tobacco and nicotine vapour products*".

3 Age verification policy

(1) After section 4A of the 2010 Act (inserted by section 2) insert—

"**4B Age verification policy**

(1) A person commits an offence if the person—

(a) carries on a tobacco or nicotine vapour product business, and

(b) fails to operate an age verification policy in respect of premises at which the person carries on the tobacco or nicotine vapour product business.

(2) Subsection (1) does not apply to premises ("the business premises") from which—

(a) tobacco products, cigarette papers or nicotine vapour products are, in pursuance of a sale, despatched for delivery to different premises, and

(b) no other tobacco or nicotine vapour product business is carried on from the business premises.

(3) An "age verification policy" is a policy that steps are to be taken to establish the age of a person attempting to buy a tobacco product, cigarette papers or a nicotine vapour product on the premises (the "customer") if it appears to the person selling the tobacco product, cigarette papers or nicotine vapour product that the customer may be under the age of 25 (or such older age as may be specified in the policy).

(4) The Scottish Ministers may by regulations amend the age specified in subsection (3).

(5) The Scottish Ministers may publish guidance on matters relating to age verification policies, including, in particular, guidance about—

(a) steps that should be taken to establish a customer's age,

(b) documents that may be shown to the person selling a tobacco product, cigarette papers or a nicotine vapour product as evidence of a customer's age,

(c) training that should be undertaken by the person selling the tobacco product, cigarette papers or nicotine vapour product,

(d) the form and content of notices that should be displayed in the premises,

(e) the form and content of records that should be maintained in relation to an age verification policy.

(6) A person who carries on a tobacco or nicotine vapour product business must have regard to guidance published under subsection (5) when operating an age verification policy.

(7) A person guilty of an offence under subsection (1) is liable on summary conviction to a fine not exceeding level 2 on the standard scale.".

(2) In section 40(4) of the 2010 Act (subordinate legislation subject to affirmative procedure) before "section 24" insert—

"section 4B(4)".

4 Sale by persons under 18

After section 4B of the 2010 Act (inserted by section 3) insert—

"4C Sale of tobacco or nicotine vapour products by persons under 18

(1) A responsible person who allows a tobacco product, cigarette papers or a nicotine vapour product to be sold by a person under the age of 18 commits an offence.

(2) For the purposes of subsection (1), "responsible person" means—

(a) where the sale is at premises which are noted in a registered person's entry in the Register, the registered person for those premises,

(b) where the sale is at premises which are not noted in a registered person's entry in the Register—

(i) any employer of the person who made the sale, and

(ii) any other person having management or control of those premises.

(3) Subsection (1) does not apply to a sale which—

(a) is made at premises which are noted in a registered person's entry in the Register, and

(b) is authorised by the registered person for those premises.

(4) Each authorisation mentioned in subsection (3)(b) must be recorded and kept at the premises at which a sale by a person under the age of 18 is made.

(5) The Scottish Ministers may prescribe—

(a) the form and content of authorisations made under subsection (3)(b),

(b) the method of recording authorisations for the purposes of subsection (4).

(6) An authorisation is, for the purposes of subsection (3)(b), deemed not to have been made, if—

(a) it is not recorded and kept in accordance with subsection (4), or

(b) it is not made in accordance with any provision made under subsection (5).

(7) A person guilty of an offence under subsection (1) is liable on summary conviction to a fine not exceeding level 1 on the standard scale.".

5 Defence of due diligence for certain offences

After section 4C of the 2010 Act (inserted by section 4) insert—

"**4D Defence of due diligence for certain offences**

(1) It is a defence for a person charged with an offence to which this section applies to prove that the person (or any employee or agent of the person) took all reasonable precautions and exercised all due diligence to prevent the offence being committed.

(2) This section applies to an offence under any of the following provisions of this Act—

(a) section 4(1),

(b) section 4A(1),

(c) section 4C(1).".

6 Purchase of nicotine vapour products on behalf of persons under 18

After section 6 of the 2010 Act insert—

"**6A Purchase of nicotine vapour products on behalf of persons under 18**

(1) A person aged 18 or over who knowingly buys or attempts to buy a nicotine vapour product on behalf of a person under the age of 18 commits an offence.

(2) A person guilty of an offence under subsection (1) is liable on summary conviction to a fine not exceeding level 5 on the standard scale.".

7 Extension of vending machine prohibition

(1) The Scottish Ministers may by regulations amend the definition of "vending machine" in section 9(3) of the 2010 Act (prohibition of vending machines) so as to include automatic machines for the sale of nicotine vapour products.

(2) In subsection (1), "nicotine vapour products" has the meaning given in section 35A of the 2010 Act.

Register of tobacco and nicotine vapour product retailers

8 Register of tobacco and nicotine vapour product retailers

(1) In section 10(1) of the 2010 Act (duty to keep Register), after "tobacco" insert "or nicotine vapour product".

(2) In section 35(1) of the 2010 Act (interpretation)—

(a) after the definition of "fixed penalty notice" insert—

""nicotine vapour product business" means a business involving the sale of nicotine vapour products by retail,", and

(b) after the definition of "tobacco business" insert—

""tobacco or nicotine vapour product business" means a business which involves (either or both) a tobacco business or a nicotine vapour product business,".

9 Registration and changes to the Register

(1) In section 11 of the 2010 Act (application for registration and addition of premises etc.)—

(a) in subsection (2), after "tobacco", in both places where it occurs, insert "or nicotine vapour product",

(b) after subsection (2) insert—

"(2A) An application under subsection (1) must state, in relation to each of the premises included in it, whether the applicant proposes to carry on—

(a) a tobacco business at the premises,

(b) a nicotine vapour product business at the premises, or

(c) both a tobacco business and a nicotine vapour product business at the premises.",

(c) in subsection (3)(b), for "retailing banning order, from carrying on a tobacco" substitute "and nicotine vapour product banning order from carrying on a tobacco or nicotine vapour product",

(d) in subsection (4)(b), for "business" substitute "or nicotine vapour product business, noting, in relation to each of the premises, whether the applicant proposes to carry on—

(i) a tobacco business at the premises,

(ii) a nicotine vapour product business at the premises, or

(iii) both a tobacco business and a nicotine vapour product business at the premises", and

(e) in subsection (5), for "business" substitute "or nicotine vapour product business, noting, in relation to each of the premises, whether the applicant proposes to carry on—

(a) a tobacco business at the premises,

(b) a nicotine vapour product business at the premises, or

(c) both a tobacco business and a nicotine vapour product business at the premises".

(2) In section 12 of the 2010 Act (certificates of registration)—

(a) the existing text becomes subsection (1), and

(b) after that subsection, insert—

"(2) A certificate issued under subsection (1) must state whether the premises are noted in the applicant's entry in the Register as premises at which the person carries on—

(a) a tobacco business,

(b) a nicotine vapour product business, or

(c) both a tobacco business and a nicotine vapour product business.".

(3) In section 13(1) of the 2010 Act (duty to notify certain changes), after paragraph (b) insert—

"(c) the fact that the person is no longer carrying on a nicotine vapour product business at an address noted in the person's entry in the Register.".

(4) In section 14 of the 2010 Act (changes to and removal from Register)—

(a) in subsection (2), for "retailing" substitute "and nicotine vapour product",

(b) in subsection (3)(b), after "tobacco" insert "or nicotine vapour product", and

(c) in subsection (5)(b), after "tobacco" insert "or nicotine vapour product".

10 Tobacco and nicotine vapour product banning orders

(1) In section 15 of the 2010 Act (banning orders)—

(a) in subsection (1), after "tobacco" insert "or nicotine vapour product",

(b) in subsection (2), after "tobacco" insert "or nicotine vapour product",

(c) in subsection (3)—

(i) after "tobacco" insert "or nicotine vapour product", and

(ii) in paragraph (a), for "the person has been the subject of" substitute "there have been",

(d) in subsection (4), for "person is the subject of a relevant enforcement action if the person", substitute "relevant enforcement action occurs where a person mentioned in subsection (4A)",

(e) after subsection (4), insert—

"(4A) The persons are—

(a) the person who is the subject of the application,

(b) an employee or agent of that person.", and

(f) in subsection (6), for "retailing" substitute "and nicotine vapour product".

(2) In section 16 of the 2010 Act (ancillary orders)—

(a) in subsection (1), for "retailing", in both places where it occurs, substitute "and nicotine vapour product",

(b) in subsection (2), after "tobacco", in each place where it occurs, insert "or nicotine vapour product",

(c) in subsection (3)(b), for "retailing" substitute "and nicotine vapour product",

(d) in subsection (4), for "retailing" substitute "and nicotine vapour product", and

(e) in subsection (5), for "retailing" substitute "and nicotine vapour product".

(3) In section 17 of the 2010 Act (appeals), for "retailing", in both places where it occurs, substitute "and nicotine vapour product".

(4) In section 18(1) of the 2010 Act (notification to Scottish Ministers), for "retailing" substitute "and nicotine vapour product".

(5) In section 19 of the 2010 Act (display of notices)—

(a) in subsection (1)(a), for "retailing" substitute "and nicotine vapour product",

(b) in subsection (3), for "retailing", in both places where it occurs, substitute "and nicotine vapour product", and

(c) for subsection (4), for "or smoking related products" substitute ", smoking related products or nicotine vapour products".

11 Offences relating to the Register

In section 20 of the 2010 Act (offences relating to the Register)—

(a) in subsection (1), after "tobacco" insert "or nicotine vapour product",

(b) in subsection (2), after "Register" insert "as premises at which the person carries on a tobacco business (or both a tobacco business and a nicotine vapour product business)",

(c) after subsection (2) insert—

"(2A) A registered person who carries on a nicotine vapour product business at premises other than those noted in the person's entry in the Register as premises at which the person carries on a nicotine vapour product business (or both a tobacco business and a nicotine vapour product business) commits an offence.",

(d) in subsection (4), for "retailing" substitute "and nicotine vapour product", and

(e) in subsection (6)(a), after "(2)" substitute ", (2A)".

12 Public inspection of the Register

In section 21(1) of the 2010 Act (public inspection of the Register), for "at which tobacco businesses are carried on or proposed to be carried on" substitute ", specifying for each of those premises whether there is carried on, or there is proposed to be carried on—

(a) a tobacco business,

(b) a nicotine vapour product business, or

(c) both a tobacco business and a nicotine vapour product business".

The 2010 Act: miscellaneous

13 Power to exclude certain premises

In section 35(1) of the 2010 Act (interpretation), in the definition of "premises", for ", vessel, or moveable structure" substitute "or moveable structure (and, for this purpose, "vehicle" includes any aircraft or ship, boat or other water-going vessel, other than one of a prescribed description).".

14 Presumption as to contents of container

In section 33(1) of the 2010 Act (presumption as to contents of container), for "5 or 6" substitute "4A, 4B, 4C, 5, 6, 6A or 9".

15 Part 1 of the 2010 Act: miscellaneous

(1) The title of Chapter 1 of Part 1 of the 2010 Act becomes "DISPLAY, SALE AND PURCHASE".

(2) The title of section 10 of the 2010 Act becomes "Register of tobacco and nicotine vapour product retailers".

(3) The title of section 15 of the 2010 Act becomes "Tobacco and nicotine vapour product banning orders".

(4) The title of section 16 of the 2010 Act becomes "Tobacco and nicotine vapour product banning orders: ancillary orders".

(5) The title of section 17 of the 2010 Act becomes "Tobacco and nicotine vapour product banning orders etc.: appeals".

(6) The title of section 18 of the 2010 Act becomes "Tobacco and nicotine vapour product banning orders etc.: notification to Scottish Ministers".

(7) The title of section 19 of the 2010 Act becomes "Tobacco and nicotine vapour product banning orders: display of notices".

(8) The italic heading immediately preceding section 15 of the 2010 Act becomes "*Tobacco and nicotine vapour product banning orders*".

(9) The italic heading immediately preceding section 21 of the 2010 Act becomes "Register of tobacco and nicotine vapour product retailers: miscellaneous and supplementary".

(10) The title of Chapter 2 of Part 1 of the 2010 Act becomes "REGISTER OF TOBACCO AND NICOTINE VAPOUR PRODUCT RETAILERS".

(11) The title of Part 1 of the 2010 Act becomes "TOBACCO AND NICOTINE VAPOUR PRODUCTS ETC.".

Interpretation

16 Meaning of "the 2010 Act"

In this Part, "the 2010 Act" means the Tobacco and Primary Medical Services (Scotland) Act 2010.

CHAPTER 2

ADVERTISING AND PROMOTION OF NICOTINE VAPOUR PRODUCTS

17 Advertising and brandsharing

(1) The Scottish Ministers may by regulations make provision prohibiting or restricting an activity, in the course of a business, which relates to—

(a) a nicotine vapour product advert,

(b) nicotine vapour product brandsharing.

(2) Regulations under subsection (1) may in particular—

(a) make provision for offences and penalties for a person who contravenes a prohibition or restriction on an activity mentioned in subsection (1),

(b) provide for exceptions to the offences,

(c) provide for defences to the offences,

(d) impose on a person a duty to enforce the provisions in the regulations and, in relation to such a duty, apply with modifications, or make provision equivalent to, sections 25 and 26 of Chapter 3 of the 2010 Act,

(e) provide powers to a person whose duty it is to enforce the provisions and, in relation to such powers, apply with modifications, or make provision equivalent to, sections 28 to 32 of Chapter 3 of the 2010 Act.

(3) The maximum penalties that may be provided for in regulations under subsection (1) for a person who commits an offence under those regulations are—

(a) on summary conviction, imprisonment for a term not exceeding 12 months or a fine not exceeding the statutory maximum or both,

(b) on conviction on indictment, imprisonment for a term not exceeding 2 years or a fine or both.

(4) In this section—

"nicotine vapour product" has the meaning given in section 35A of the 2010 Act,

"nicotine vapour product advert" means a published advertisement or a display whose purpose or effect is to promote a nicotine vapour product,

"nicotine vapour product brandsharing" means the use of any name, emblem or other feature where—

(a) the name, emblem or other feature is used in connection with—

(i) any service or product (other than a nicotine vapour product) and the name, emblem or other feature used is the same as, or similar to, a name, emblem or other feature connected with a nicotine vapour product, or

(ii) any nicotine vapour product and the name, emblem or other feature used is the same as, or similar to, a name, emblem or other feature connected with any service or product other than a nicotine vapour product, and

(b) the purpose or effect of the use is to promote a nicotine vapour product,

"public" means the public at large, or any section of the public or individually selected members of the public,

"published" means published, distributed or otherwise made available to the public, in any form and by any means.

18 Free distribution and nominal pricing

(1) The Scottish Ministers may by regulations make provision prohibiting or restricting, in the course of a business—

(a) giving away to the public any product or coupon (separately or with something else), where the purpose or effect is to promote a nicotine vapour product,

(b) making products or coupons available to the public (separately or with something else) for a nominal sum, where the purpose or effect is to promote a nicotine vapour product.

(2) Regulations under subsection (1) may in particular—

(a) make provision for offences and penalties for a person who contravenes a prohibition or restriction mentioned in subsection (1),

(b) make further provision about the circumstances in which a product or coupon is to be treated as being made available for a nominal sum,

(c) provide for exceptions to the offences mentioned in paragraph (a),

(d) provide for defences to the offences,

(e) impose on a person a duty to enforce the provisions in the regulations and, in relation to such a duty, apply with modifications, or make provision equivalent to, sections 25 and 26 of the 2010 Act,

(f) provide powers to a person whose duty it is to enforce the provisions and, in relation to such powers, apply with modifications, or make provision equivalent to, sections 28 to 32 of the 2010 Act.

(3) The maximum penalties that may be provided for in regulations under subsection (1) for a person who commits an offence under those regulations are—

(a) on summary conviction, imprisonment for a term not exceeding 12 months or a fine not exceeding the statutory maximum or both,

(b) on conviction on indictment, imprisonment for a term not exceeding 2 years or a fine or both.

(4) In this section—

"coupon" means a document or other thing which, by itself or not, can be redeemed for a product or service or for cash or for any other benefit,

"nicotine vapour product" has the meaning given in section 35A of the 2010 Act,

"public" means the public at large, or any section of the public or individually selected members of the public.

19 Sponsorship

(1) The Scottish Ministers may by regulations make provision prohibiting or restricting the entering into, in the course of a business, of a sponsorship agreement, where the purpose or effect of anything done as a result of the agreement is to promote a nicotine vapour product.

(2) Regulations under subsection (1) may in particular—

(a) make provision for offences and penalties for a person who contravenes a prohibition or restriction mentioned in subsection (1),

(b) provide for exceptions to the offences,

(c) provide for defences to the offences,

(d) impose on a person a duty to enforce the provisions in the regulations and, in relation to such a duty, apply with modifications, or make provision equivalent to, sections 25 and 26 of the 2010 Act,

(e) provide powers to a person whose duty it is to enforce the provisions and, in relation to such powers, apply with modifications, or make provision equivalent to, sections 28 to 32 of the 2010 Act.

(3) The maximum penalties that may be provided for in regulations under subsection (1) for a person who commits an offence under those regulations are—

(a) on summary conviction, imprisonment for a term not exceeding 12 months or a fine not exceeding the statutory maximum or both,

(b) on conviction on indictment, imprisonment for a term not exceeding 2 years or a fine or both.

(4) In this section—

"nicotine vapour product" has the meaning given in section 35A of the 2010 Act,

"sponsorship agreement" means an agreement under which a party to it makes a contribution towards something, whether the contribution is in money or takes any other form (for example, the provision of services or of contributions in kind).

CHAPTER 3

SMOKING OUTSIDE HOSPITALS

20 Smoking outside hospitals

(1) The Smoking, Health and Social Care (Scotland) Act 2005 is modified as follows.

(2) After section 4 insert—

"**4A Offence of permitting others to smoke outside hospital building**

(1) A person who, having the management and control of the no-smoking area outside a hospital building, knowingly permits another to smoke there commits an offence.

(2) A person accused of an offence under this section is to be regarded as having knowingly permitted another to smoke in the no-smoking area outside a hospital building if that person ought to have known that the other person was smoking there.

(3) It is a defence for an accused charged with an offence under this section to prove—

(a) that the accused (or any employee or agent of the accused) took all reasonable precautions and exercised all due diligence not to commit the offence, or

(b) that there were no lawful and reasonably practicable means by which the accused could prevent the other person from smoking in the no-smoking area outside a hospital building.

(4) A person who commits an offence under this section is liable, on summary conviction, to a fine not exceeding level 4 on the standard scale.

4B Offence of smoking outside hospital building

(1) A person who smokes within the no-smoking area outside a hospital building commits an offence.

(2) It is a defence for an accused charged with an offence under this section to prove that the accused did not know, and could not reasonably be expected to have known, that the place in which it is alleged the accused was smoking was within the no-smoking area outside a hospital building.

(3) A person who commits an offence under this section is liable, on summary conviction, to a fine not exceeding level 3 on the standard scale.

4C Display of warning notices in hospital buildings and on hospital grounds

(1) The Health Board for the area in which a hospital is situated must conspicuously display no-smoking notices at every entrance to the hospital grounds.

(2) The person having the management and control of a hospital building must conspicuously display no-smoking notices at every entrance to the building.

(3) A no-smoking notice is a notice stating that it is an offence to smoke in the no-smoking area outside a hospital building or knowingly to permit smoking there.

(4) The Scottish Ministers may by regulations make further provision as to the manner of display, form and content of no-smoking notices.

(5) A person who fails to display no-smoking notices in accordance with subsection (2) (and regulations made under subsection (4) insofar as they relate to the duty under subsection (2)) commits an offence.

(6) A person who commits an offence under subsection (5) is liable, on summary conviction, to a fine not exceeding level 3 on the standard scale.

4D Meaning of "no-smoking area outside a hospital building" and related expressions

(1) For the purposes of this Part, the "no-smoking area outside a hospital building" is the area—

(a) lying immediately outside the hospital building, and

(b) bounded by a perimeter the specified distance from the building,

but only insofar as the area forms part of hospital grounds.

(2) The Scottish Ministers may by regulations—

(a) specify the distance for the purposes of subsection (1)(b),

(b) make further provision about determining the perimeter around a building for the purposes of that subsection.

(3) In this Part—

"hospital" means a health service hospital (as defined in section 108(1) of the National Health Service (Scotland) Act 1978),

"hospital building" means a building situated on hospital grounds,

"hospital grounds", in relation to a hospital, means land in the vicinity of the hospital and associated with it.

(4) The Scottish Ministers may by regulations—

(a) provide that hospitals of a specified description are not hospitals for the purposes of this Part,

(b) provide that land of a specified description is or is not to be considered "hospital grounds" and otherwise make further provision to elaborate the meaning of "hospital grounds" for the purposes of this Part,

(c) provide that buildings of a specified description are not hospital buildings for the purposes of this Part,

(d) provide that land of a specified description does not form part of the no-smoking area outside a hospital building for the purposes of this Part.

(5) Regulations under subsection (4) may modify the application of section 4C as the Scottish Ministers consider appropriate.".

(3) In section 5(1) (proceedings for offences), for "or 3" substitute ", 3, 4A, 4B or 4C(5)".

(4) The section title of section 5 becomes "**Proceedings for offences under sections 1 to 3 and 4A to 4C**".

(5) In section 6(2) (fixed penalties), for "or 3" substitute ", 3, 4A, 4B or 4C(5)".

(6) In section 7 (powers to enter and require identification)—

(a) after subsection (1) insert—

"(1A) An authorised officer of the appropriate council may enter and search any hospital grounds to ascertain whether an offence under section 4A, 4B or 4C(5) has been or is being committed there.",

(b) in subsection (3)(a)(i), for "or 3" substitute ", 3, 4A, 4B or 4C(5)",

(c) in subsection (5), in the definition of "the appropriate council"—

(i) the words "in relation to no-smoking premises, the council of the area in which those premises are" become paragraph (a),

(ii) after that paragraph insert—

"(b) in relation to a no-smoking area outside a hospital building, the council of the area in which the hospital is.".

(7) In section 40(3)(a) (regulations or orders), for "or 4(2) or (8)" substitute ", 4(2) or (8) or 4D(2)(a) or (4)(a)".

(8) In schedule 1—

(a) in paragraph 1(1), after "premises" insert "or under section 4A within the no-smoking area outside a hospital",

(b) in paragraph 1(2), for "or 3" substitute ", 3, 4A, 4B or 4C(5)",

(c) in paragraph 1(3), for "or 3" substitute ", 3, 4A, 4B or 4C(5)",

(d) in paragraph 2, for "or 3" substitute ", 3, 4A, 4B or 4C(5)",

(e) in paragraph 4(1), for "or 3" substitute ", 3, 4A, 4B or 4C(5)",

(f) the title becomes "FIXED PENALTY FOR OFFENCES UNDER SECTIONS 1, 2, 3, 4A, 4B AND 4C(5)".

PART 2

DUTY OF CANDOUR

Duty of candour procedure

21 Incident which activates duty of candour procedure

(1) A responsible person must follow the duty of candour procedure set out in section 22 as soon as reasonably practicable after becoming aware that subsection (2) applies to a person who has received—

(a) a health service from the responsible person,

(b) a care service from the responsible person, or

(c) a social work service from the responsible person.

(2) This subsection applies to a person if—

(a) an unintended or unexpected incident occurred in the provision of a health service, a care service or a social work service to the person, and

(b) in the reasonable opinion of a registered health professional—

(i) that incident appears to have resulted in or could result in an outcome mentioned in subsection (4), and

(ii) that outcome relates directly to the incident rather than to the natural course of the person's illness or underlying condition.

(3) For the purposes of subsection (2)(b), a responsible person must ensure that the registered health professional who gives the opinion following an unintended or unexpected incident is not an individual who was involved in the incident.

(4) The outcomes are—

(a) the death of the person,

(b) a permanent lessening of bodily, sensory, motor, physiologic or intellectual functions (including removal of the wrong limb or organ or brain damage) ("severe harm"),

(c) harm which is not severe harm but which results in—

(i) an increase in the person's treatment,

(ii) changes to the structure of the person's body,

(iii) the shortening of the life expectancy of the person,

(iv) an impairment of the sensory, motor or intellectual functions of the person which has lasted, or is likely to last, for a continuous period of at least 28 days,

(v) the person experiencing pain or psychological harm which has been, or is likely to be, experienced by the person for a continuous period of at least 28 days,

(d) the person requiring treatment by a registered medical practitioner in order to prevent—

(i) the death of the person, or

(ii) any injury to the person which, if left untreated, would lead to one or more of the outcomes mentioned in paragraph (c).

(5) The Scottish Ministers may by regulations modify subsection (4).

22 Duty of candour procedure

(1) The "duty of candour procedure" means the actions to be taken by the responsible person in accordance with regulations made by the Scottish Ministers.

(2) Regulations under subsection (1) may in particular make provision about—

(a) the notification to be given by the responsible person,

(b) the apology to be provided by the responsible person to the relevant person,

(c) the actions to be taken by the responsible person to offer and arrange a meeting with the relevant person,

(d) the actions which must be taken at, and following, such a meeting,

(e) an account of the incident as mentioned in section 21(2), information about further steps taken and any other information to be provided by the responsible person,

(f) the form and manner in which information must be provided,

(g) the circumstances in which the responsible person is to make available, or provide information about, support to persons affected by the incident,

(h) the keeping of information by the responsible person,

(i) steps to be taken by the responsible person—

(i) to review the circumstances leading to the incident, and

(ii) following such a review,

(j) training to be undertaken by a responsible person,

(k) training, supervision and support to be provided by a responsible person to any person carrying out any part of the procedure on behalf of the responsible person.

(3) In this section "relevant person" means—

(a) the person who has received the health service, the care service or the social work service, or

(b) where that person—

(i) has died, or

(ii) is, in the opinion of the responsible person, lacking in capacity or otherwise unable to make decisions about the service provided,

a person acting on behalf of that person.

23 Apologies

(1) For the purposes of this Part, an "apology" means a statement of sorrow or regret in respect of the unintended or unexpected incident.

(2) An apology or other step taken in accordance with the duty of candour procedure under section 22 does not of itself amount to an admission of negligence or a breach of a statutory duty.

24 Reporting and monitoring

(1) A responsible person who provides a health service, a care service or a social work service during a financial year must prepare an annual report on the duty of candour as soon as reasonably practicable after the end of that financial year.

(2) The report must set out in relation to the financial year—

(a) information about the number and nature of incidents to which the duty under section 21(1) has applied in relation to a health service, a care service or a social work service provided by the responsible person,

(b) an assessment of the extent to which the responsible person carried out the duty under section 21(1),

(c) information about the responsible person's policies and procedures in relation to the duty under section 21(1), including information about—

(i) procedures for identifying and reporting incidents, and

(ii) support available to staff and to persons affected by incidents, and

(d) information about any changes to the responsible person's policies and procedures as a result of incidents to which the duty under section 21(1) has applied,

(e) such other information as the responsible person thinks fit.

(3) A report must not—

(a) mention the name of any individual, or

(b) contain any information which, in the responsible person's opinion, is likely to identify any individual.

(4) The responsible person must publish a report prepared under subsection (1) in such manner as the responsible person thinks appropriate.

(5) On publishing a report, the responsible person must notify—

(a) Healthcare Improvement Scotland, in the case of a report published by a responsible person which provides an independent health care service (within the meaning of section 10F(1) of the 1978 Act),

(b) the Scottish Ministers, in the case of a report published by any other responsible person which provides a health service,

(c) Social Care and Social Work Improvement Scotland, in the case of a report published by a responsible person which provides a care service or a social work service.

(6) A person mentioned in subsection (7) may, for the purpose of monitoring compliance with the provisions of this Part, serve a notice on a responsible person requiring—

(a) the responsible person to provide the person serving the notice with information about any matter mentioned in subsection (2) as specified in the notice, and

(b) that information to be provided within the time specified in the notice.

(7) The persons are—

(a) Healthcare Improvement Scotland, in relation to a responsible person which provides an independent health care service (within the meaning of section 10F(1) of the 1978 Act),

(b) the Scottish Ministers, in relation to any other responsible person which provides a health service,

(c) Social Care and Social Work Improvement Scotland, in relation to a responsible person which provides a care service or a social work service.

(8) The Scottish Ministers, Healthcare Improvement Scotland and Social Care and Social Work Improvement Scotland may publish a report on compliance with the provisions of this Part by responsible persons.

Interpretation

25 Interpretation of Part 2

In this Part—

"the 1978 Act" means the National Health Service (Scotland) Act 1978,

"care service" has the meaning given by section 47(1) of the Public Services Reform (Scotland) Act 2010, except that it does not include a service mentioned in paragraph (k) of that section (child minding),

"health service" means—

(a) services under the health service continued under section 1 of the 1978 Act, and

(b) an independent health care service mentioned in section 10F(1) of the 1978 Act,

"registered health professional" means a member of a profession to which section 60(2) of the Health Act 1999 applies,

"responsible person" means—

(a) a Health Board constituted under section 2(1) of the 1978 Act,

(b) a person (other than an individual) who has entered into a contract, agreement or arrangement with a Health Board to provide a health service,

(c) the Common Services Agency for the Scottish Health Service constituted under section 10(1) of the 1978 Act,

(d) a person (other than an individual) providing an independent health care service mentioned in section 10F(1) of the 1978 Act,

(e) a local authority,

(f) any other person (other than an individual) who provides a care service or a social work service,

"social work services" has the meaning given by section 48 of the Public Sector Reform (Scotland) Act 2010.

PART 3

ILL-TREATMENT AND WILFUL NEGLECT

Offences by care workers and care providers

26 Care worker offence

(1) An individual commits an offence if the individual—

(a) has the care of another individual by virtue of being a care worker, and

(b) ill-treats or wilfully neglects that individual.

(2) An individual who commits an offence under subsection (1) is liable—

(a) on summary conviction, to imprisonment for a term not exceeding 12 months or a fine not exceeding the statutory maximum (or both),

(b) on conviction on indictment, to imprisonment for a term not exceeding 5 years or a fine (or both).

27 Care provider offence

(1) A care provider commits an offence if—

(a) an individual who has the care of another individual by virtue of being part of the care provider's arrangements ill-treats or wilfully neglects that individual,

(b) the care provider's activities are managed or organised in a way which amounts to a gross breach of a relevant duty of care owed by the care provider to the individual who is ill-treated or neglected, and

(c) in the absence of the breach, the ill-treatment or wilful neglect would not have occurred or would have been less likely to occur.

(2) An individual is "part of a care provider's arrangements" where the individual—

(a) is not the care provider, but

(b) provides adult health care or adult social care as part of the adult health care or adult social care provided or arranged for by the care provider,

including where the individual is not the care provider but supervises or manages individuals providing adult health care or adult social care as described in paragraph (b) or is a director or similar officer of an organisation which provides adult health care or adult social care as described there.

(3) In this section—

(a) a "relevant duty of care" means a duty owed in connection with providing, or arranging for the provision of, adult health care or adult social care,

(b) a breach of a relevant duty of care is a "gross" breach if the conduct alleged to amount to the breach falls far below what can reasonably be expected of the care provider in the circumstances.

(4) A care provider who commits an offence under subsection (1) is liable—

(a) on summary conviction, to a fine not exceeding the statutory maximum,

(b) on conviction on indictment, to a fine.

28 Meaning of "care worker" and "care provider" etc.

(1) In this Part, "care worker" means—

(a) an employee who provides adult health care or adult social care,

(b) a volunteer who provides adult health care or adult social care,

(c) an individual who supervises or manages employees or volunteers providing adult health care or adult social care,

(d) a director or similar officer of an organisation whose employees or volunteers provide adult health care or adult social care.

(2) For the purposes of subsection (1)—

(a) "employee" means an individual in paid employment, whether under a contract of service or apprenticeship or under a contract for services,

(b) "volunteer" means a volunteer for a body, other than a public or local authority, the activities of which are not carried on for profit.

(3) In this Part, "care provider" means—

(a) a body corporate, a partnership or an unincorporated association which provides or arranges for the provision of—

(i) adult health care, or

(ii) adult social care, or

(b) an individual who provides that care and employs, or has otherwise made arrangements with, other persons to assist with the provision of that care.

(4) In this section—

(a) references to a person providing adult health care or adult social care do not include a person whose provision of that care is merely incidental to the carrying out of other activities by the person, and

(b) references to a person arranging for the provision of that care do not include a person who makes arrangements under which the provision of care is merely incidental to the carrying out of other activities.

(5) In this Part—

"adult health care" means a service for or in connection with the prevention, diagnosis or treatment of illness provided to an individual aged 18 or over—

(a) under the health service continued under section 1 of the National Health Service (Scotland) Act 1978, or

(b) by persons providing an independent health care service mentioned in section 10F(1) of that Act,

"adult social care" means a service—

(a) in section 47(1)(a), (b), (d) or (m) of the Public Services Reform (Scotland) Act 2010 to the extent that the service is provided to an individual aged 18 or over, or

(b) in section 47(1)(g) or (j) of that Act to the extent that the service is provided to an individual aged 16 or over.

Remedial orders and publicity orders

29 Power to order offence to be remedied or publicised

(1) This section applies where a care provider is convicted by a court of an offence under section 27(1).

(2) The court may, instead of or in addition to dealing with the care provider in any other way, make either or both of the following orders—

(a) a remedial order,

(b) a publicity order.

(3) A "remedial order" is an order requiring the care provider to take specified steps to remedy one or more of the following—

(a) the breach mentioned in section 27(1)(b) (the "relevant breach"),

(b) any matter that appears to the court to have resulted from the relevant breach and to be connected with the ill-treatment or neglect,

(c) any deficiency in the care provider's policies, systems or practices of which the relevant breach appears to the court to be an indication.

(4) A "publicity order" is an order requiring the care provider to publicise in a specified manner—

(a) the fact that the care provider has been convicted of the offence,

(b) specified particulars of the offence,

(c) the amount of any fine imposed,

(d) the terms of any remedial order made.

(5) An order made under subsection (2) is to be taken to be a sentence for the purposes of an appeal.

(6) The court may make an order under subsection (2)—

(a) at its own instance, or

(b) on the motion of the prosecutor.

(7) An order made under subsection (2) must specify a period (the "compliance period") within which the requirements specified in the order must be complied with.

(8) On an application by the care provider in respect of whom the order under subsection (2) was made, the court may—

(a) extend the compliance period,

(b) vary the steps specified in a remedial order.

(9) An application under subsection (8) must be made before the end of the compliance period.

(10) A care provider who fails to comply with an order made under subsection (2) commits an offence.

(11) A care provider who commits an offence under subsection (10) is liable—

(a) on summary conviction, to a fine not exceeding the statutory maximum,

(b) on conviction on indictment, to a fine.

30 Remedial and publicity orders: prosecutor's right of appeal

(1) The Criminal Procedure (Scotland) Act 1995 is amended in accordance with this section.

(2) In section 108 (Lord Advocate's right of appeal against disposal)—

(a) in subsection (1), after paragraph (cc) insert—

"(cd) a decision under section 29(2) of the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 not to make a remedial order,

(ce) a decision under section 29(2) of that Act not to make a publicity order,",

(b) in subsection (2)(b)(ii), for the words "or (cc)" substitute ", (cc), (cd) or (ce)".

(3) In section 175 (right of appeal from summary proceedings)—

(a) in subsection (4), after paragraph (cc) insert—

"(cd) a decision under section 29(2) of the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 not to make a remedial order,

(ce) a decision under section 29(2) of that Act not to make a publicity order,",

(b) in subsection (4A)(b)(ii), for "or (cc)" substitute ", (cc), (cd) or (ce)".

Ill-treatment and wilful neglect of mentally disordered person

31 Penalty for ill-treatment and wilful neglect of mentally disordered person

In section 315 of the Mental Health (Care and Treatment) (Scotland) Act 2003 (ill-treatment and wilful neglect of mentally disordered person)—

(a) in subsection (3)(b), for "2" substitute "5",

(b) for subsection (4), substitute—

"(4) In subsection 1(c), "provides care services" means anything done—

(a) by a care service,

(b) by an employee of a care service, or

(c) in the course of a service provided or supplied by a care service,

whether by virtue of a contract of employment or any other contract or in circumstances as may be prescribed by regulations.",

(c) after subsection (4), insert—

"(5) For the purposes of subsection (4), "care service" means a service mentioned in section 47(1)(a), (b), (d), (f), (g), (j) or (m) of the Public Services Reform (Scotland) Act 2010.".

PART 4

FINAL PROVISIONS

32 Regulations

(1) Any power of the Scottish Ministers to make regulations under this Act includes power to make—

(a) different provision for different purposes,

(b) incidental, supplementary, consequential, transitional, transitory or saving provision.

(2) Regulations—

(a) under section 17(1),

(b) under section 18(1),

(c) under section 19(1),

(d) under section 21(5),

(e) under section 33(1) which contain provisions that add to, replace or omit any part of the text of an Act,

are subject to the affirmative procedure.

(3) All other regulations under this Act are subject to the negative procedure.

(4) This section does not apply to regulations under section 34.

33 Ancillary provision

(1) The Scottish Ministers may by regulations make such incidental, supplementary, consequential, transitional, transitory or saving provision as they consider necessary or expedient for the purposes of, or in connection with, any provision made by or under this Act.

(2) Regulations under subsection (1) may modify any enactment (including this Act).

34 Commencement

(1) This section and sections 32, 33 and section 35 come into force on the day after Royal Assent.

(2) The other provisions of this Act come into force on such day as the Scottish Ministers may by regulations appoint.

(3) Different days may be appointed for different purposes.

(4) Regulations under subsection (2) may contain transitional, transitory or saving provision.

35 Short title

The short title of this Act is the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016.

Health (Tobacco, Nicotine etc. and Care) (Scotland) Bill

[AS INTRODUCED]

An Act of the Scottish Parliament to make provision about tobacco, nicotine and related products, in particular to make provision about retailing, to amend the prohibition on smoking in certain areas and to control advertising and promotion; to make provision about a duty of candour following serious incidents in the course of providing care; to make provision about offences applying to ill-treatment or neglect where care is provided; and for connected purposes.

Introduced by: Shona Robison
Supported by: Maureen Watt
On: 4 June 2015
Bill type: Government Bill

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Minutes of North Ayrshire Strategic Planning Group (NA SPG)

held on Thursday, 25th June 2015 at 9.30am, Greenwood Conference Centre, Dreghorn, KA11 4GZ

Present	Ms Jo Gibson, Planning and Performance, NAC (stand in Chair) Mr David Rowland, Head of Service Health & Community Care Mr Derek Barron, NHS Mental Health Representative Mr Stephen Brown, Children and Families, Criminal Justice, NAC Mr Martin Hunter, Public Partnership Forum Representative Mrs Marjorie Adams, Programme Manager Mrs Eunice Johnstone, Planning Manager; Policy, Planning & Performance Mr Jim Nichols, Third Sector Representative Mr Geoff Coleman, Mental Health Public Reference Group Representative Ms Loiuse McDaid, Staff Side Mr David Donaghey, Staff Side Ms Barbara Hastings, Third Sector Interface Representative Mr Paul Ryan, NHS Pharmacy Representative Ms Fiona Thomson, Public Partnership Forum Representative Mr Nigel Wanless, Independent Sector Representative Ms Thelma Bowers, Head of Service Mental Health Cllr Grace McLean
In Attendance	Ms Annie Weir, Programme Manager, Integration of Health and Social Care, NAC Ms Norma Bell, Manager (Planning & Performance) Mr John McCaig, Senior Manager Learning Disabilities Mr John Burns, Alcohol and Drugs Partnership Policy Officer Ms Lynne Murray, Clinical Nurse Manager, Adult Acute Inpatients Mr William Lauder, Senior Manager Inpatients Ms Helen Lynn, Clinical Director Learning Disabilities Services Mr Tommy Stevenson, Senior Manager, CAHMS Ms Jackie Blackwood, Charge Nurse, CAHMS Mr Craig Stewart, Senior Manager Mental Health, Addictions and Learning Disabilities for East Ayrshire Ms Anne Lee, Joint Service Manager, Addictions

Mr Alan Burt, Addictions Service Development Facilitator Specialist
Mr James Hill, Charge Nurse Addictions
Mr Ian Wilson, Charge Nurse, Ailsa
Mr Peter McArthur, Senior Manager Addictions
Mr John O'Dowd, Consultant Public Health Medicine
Ms Helen Lynn, Clinical Director of Learning Disabilities
Mr Freddie Crawford-Grundy, Member of the Mental Health Public Reference Group
Mr Brian Fitzpatrick, Service Manager, Community Based Services
Ms Lynsey Graham, Community Based Services
Mrs Karen Broadfoot, Clerical Assistant (minutes)

1. Coffee and Market Place on Mental Health and Wellbeing was open for everyone to look around prior to meeting commencing at 9.30am.

2. Welcome/Apologies

2.1 Jo Gibson welcomed everyone to the meeting and noted that the Strategic Planning Group (SPG) purpose is to advise the Integrated Joint Board (IJB) on the Strategic Plan and develop the plan for the year ahead. At the last meeting the group looked at ways to carry out their role and agreed to take the five strategic priorities and focus on one of these at each of the upcoming five meetings.

The group also agreed that Mental Health and Wellbeing was one of the most important priorities and should therefore be discussed at today's meeting. Introduction packs with background information on Learning Disabilities, Addictions and CAHMs were distributed to the group in advance of this meeting.

2.2 Apologies for absence were noted from Stephen McKenzie, Lesley Aird, Simon Morrow, Yvonne Baulk, David Bonellie, Lorne Campbell, Liz Moore, Gordon McKay, Morna Rae, Tim Ross, Clive Shepherd, Christine Speedwell, Sharon Bleakley, Elaine Hill, Dr Paul Kerr, Marion McKinner and Mark Gallagher.

3. Draft minutes of the meeting on 14th May 26 March 2015

The SPG approved the minutes of the meeting held on 14th May 2015 as an accurate record.

4. Matters Arising

4.1 All items on the action note from the 14th May 2015 to be brought back to the group when completed.

4.2 Action note Item 5.3, Strategic Pan Priorities in Action
Jim Nichols advised the outcome of this meeting with David Rowland will be brought back to the next SPG meeting. JN

5. Strategic Planning Group – Forward Planner

5.1
- Proposal for the year ahead

Jo Gibson advised that today is the first attempt to look at what we do well, receive feedback on the plan and agree what the group are expecting from these sessions.

6. Strategic Planning Group – Terms of Reference

6.1 Jo Gibson advised as time was short comments on the terms of reference would be welcomed and will be discussed at the next meeting. **JG**

7. Mental Health and Wellbeing Priorities

7.1 Thelma Bowers noted that there has been a huge amount of work done in Mental Health services and it is important to use all knowledge and skills from across the partnership to take the priorities forward. Service improvement has been achieved by implementing the Mental Health Strategy in line with the national strategy.

8. Learning Disabilities

8.1 John McCaig provided a presentation on Learning Disabilities highlighting the following areas:

- What we are currently doing
- What's in the Strategic Plan
- Key drivers and challenges

8.2 Freddie Crawford sought clarification on how we define learning disabilities. People with dyslexia are classed as having a learning disability as not able to cope with their dyslexia.

Thelma Bowers noted that this was an important point and looking at people being seen at first point of need so they do not get into specialised services. Looking at engaging schools, the wider community, peer support across services and service user engagement as part of the strategic plan.

Helen Lynn agreed to discuss dyslexia further with Freddie at the coffee break. **HL**

Louise McDade wished the good work at Hazeldene to be noted.

Barbara Hastings advised the group that she is the Social Enterprise lead for North Ayrshire and also sits on the Transition Economic Regeneration

Board. Barbara has offered to raise the issues of people with learning disabilities at these two groups.

9. CAHMS

9.1 Tommy Stevenston provided a presentation on CAHMS highlighting the following areas:

- Diversity in multiagency working
- Integrating children services
- Multiagency working
- Developing a common language
- Distributed leadership

9.2 Fiona Thomson raised the issue of coping with an ADHD child moving into adulthood as most have a learning disability. Martin Hunter enquired what the early intervention pathway was and at what stage would the doorway into CAHMS be looked at.

Tommy Stevenston advised that they try and keep children out of CAHMS. They want children to be seen quickly and work to commence as soon as possible. If a child is unwell then they should be seen and treated as work could be done whilst awaiting the diagnosis.

Jim Nichols stated that as the representative for the Third and Independent Sectors sitting on the Integrated Joint Board and the SPG he was not aware of this. Jim to raise profile of CAHMs with all providers as little interaction in this area at the moment. **JN**

Stephen Brown added that we need to bring providers together due to the pressure on CAHMS. This pressure could be helped by schools making diagnosis and young people in school environment to go to GPs to be referred to CHAMs. Look at emotional wellbeing being taught in schools with support for teachers leading to pressures being taken off CAHMS. Testament to the CAHMS team for their great work under pressures.

10. Coffee and Market Place

There was an opportunity for group to visit the mental health and wellbeing market place again.

11. Learning Disabilities/CAHMS World Café

11.1 Annie Weir invited all members to participate in the World café style of discussion. This involved discussing learning disabilities and CAHMS, each with a 15 minute time slot along with a table facilitator to gather

suggestions. The topics for discussion were:

- What work is currently going on in your area that aligns with this?
- How can we do this differently?
- How will we know when we have succeeded?

Jo Gibson thanked everyone for participating and advised feedback would be written up and sent out to the group as time was running short. **JG**

12. Mental Health

12.1 Thelma Bowers provided a presentation with an overview to Mental Health highlighting the following areas:

- Improve mental health and well being
- Improve services available to support mental health and wellbeing
- Implement and lead on mental health strategy for Scotland
- Develop new services to meet local needs

12.2 No questions were raised as time was running short.

13. Addictions

13.1 Peter McArthur provided a presentation with on addictions highlighting the following areas:

- What's in the Strategic Plan
- Key Drivers
- What we have planned
- Key challenges/opportunities

13.2 There were no questions raised on the presentation as time was running short.

14. Mental Health/Addictions World Café

14.1 Jo Gibson invited all members to participate in the World café style of discussion. This involved discussing mental health and addictions, each with a 15 minute time slot along with a table facilitator to gather suggestions. The topics for discussion were:

- What work is currently going on in your area that aligns with this?
- How can we do this differently?
- How will we know when we have succeeded?

Jo Gibson thanked everyone for participating and advised feedback would be sent out to all members including people in attendance. **JG**

14.2 A progress report on the Strategic Plan will be brought to the next SPG. **PMcA**
Peter McArthur to email an addictions questionnaire to everyone for completion and return. **PMcA**

14.3 Jo Gibson encouraged the group stay and revisit the mental health and wellbeing market place for further discussions and thanked Thelma Bowers, John McCaig, Tommy Stevenson and Peter McArthur for their presentations.

15. Date and Time of the Next Meeting

6 August 2015 at 9.30am, Greenwood Conference Centre, Dreghorn

16. Additional dates and venues for 2015:

17 September 2015 at 2pm, Volunteer Rooms, High Street, Irvine
29 October 2015 at 9.30am, Volunteer Rooms, High Street, Irvine
10 December 2015 at 2pm, Greenwood Conference Centre, Dreghorn

Signed (Chair) …… Date…….