Integration Joint Board Meeting

NORTH AYRSHIRE
Health and Social Care Partnership

Thursday, 13 December 2018 at 10:00

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

1 Apologies

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

3 Minutes / Action Note
The accuracy of the Minutes of the meeting held on 15 November 2018 will be confirmed and the Minutes signed in accordance with Paragraph 7 (1) of Schedule 7 of the Local Government (Scotland) Act 1973 (copy enclosed).

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

Quality and Performance

4 Director's Report
Submit report by Stephen Brown, Director (NAHSCP) on developments within the North Ayrshire Health and Social Care Partnership (copy enclosed).

5 Audit Scotland Report: Health and Social Care Integration: Update on Progress
Submit report by Caroline Whyte, Chief Finance and Transformation Officer, on the Audit Scotland report on Health and Social Care Integration in Scotland (copy enclosed).

Strategy and Policy

6 Budget Monitoring – Month 7 (October 2018)

Submit report by Caroline Whyte, Chief Finance and Transformation Officer providing an update on the projected financial outturn for the financial year (copy enclosed).

7 Implementation on the Charter for Involvement

Submit report by Thelma Bowers, Head of Service (Mental Health) on actions to take forward the 12 statements within the Charter (copy enclosed).

8 Primary Care Services Update

Submit report by East Ayrshire, being presented to each Ayrshire IJB, providing a Primary Care Services update (copy enclosed).

Minutes

9 Strategic Planning Group Minutes

Submit the minutes of the Strategic Planning Group meeting held on 10 October 2018 (copy enclosed).

10 Urgent Items

Any other items which the Chair considers to be urgent.

Integration Joint Board

Sederunt

Voting Members

Bob Martin (Chair)	NHS Ayrshire & Arran
Councillor Robert Foster (Vice Chair)	North Ayrshire Council
Councillor Timothy Billings	North Ayrshire Council
Alistair McKie	NHS Ayrshire and Arran
Councillor Christina Larsen	North Ayrshire Council
John Rainey	NHS Ayrshire and Arran
Dr. Janet McKay	NHS Ayrshire and Arran
Councillor John Sweeney	North Ayrshire Council

Professional Advisors

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

Stakeholder Representatives

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

North Ayrshire Health and Social Care Partnership
Minute of Integration Joint Board meeting held on
Thursday 15 November 2018
at 2.00 p.m., Council Chambers, Cunninghame House, Irvine

Present
Bob Martin, NHS Ayrshire and Arran (Chair)
Councillor Robert Foster, North Ayrshire Council (Vice Chair)
Councillor Timothy Billings, North Ayrshire Council
Alistair McKie, NHS Ayrshire and Arran
John Rainey, NHS Ayrshire and Arran
Councillor Christina Larsen, North Ayrshire Council
Dr Janet McKay, NHS Ayrshire and Arran

Stephen Brown, Director of Health and Social Care Partnership
Caroline Whyte, Chief Finance and Transformation Officer
Dr Paul Kerr, Clinical Director
David MacRitchie, Chief Social Work Officer
Alistair Reid, Lead Allied Health Professional Adviser
Dr. Louise Wilson, GP Representative

David Donaghey, Staff Representative (NHS Ayrshire and Arran)
Marie McWaters, Carers Representative
Graham Searle, Carers Representative (Depute for Marie McWaters)
Fiona Thomson, Service User Representative
Nigel Wanless, Independent Sector Representative
Vicki Yuill, Third Sector Representative

Also Present
Councillor Anthea Dickson, North Ayrshire Council

In Attendance
Thelma Bowers, Head of Service, Mental Health
Michelle Sutherland, Strategic Planning Lead
Judith Reid (NHS Ayrshire and Arran)
Ruth Campbell (NHS Ayrshire and Arran)
Karen Andrews, Team Manager (Governance)
Diane McCaw, Committee Services Officer

Apologies for Absence
Councillor John Sweeney, North Ayrshire Council
Dr. Calum Morrison, Acute Services Representative
David Thomson, Associate Nurse Director/IJB Lead Nurse
Louise McDaid, Staff Representative (North Ayrshire Council)
Heather Malloy, Independent Sector Representative (Depute for Nigel Wanless)

1. Chair's Remarks

The Chair welcome Judith Reid and Ruth Campbell to the meeting.

2. Apologies

Apologies were noted.

3. Declarations of Interest

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

4. Minutes/Action Note

The accuracy of the Minute of the meeting held on 11 October 2018 was confirmed and the Minute signed in accordance with Paragraph 7 (1) of Schedule 7 of the Local Government (Scotland) Act 1973.

4.1 Matters Arising

Children's Services Update - The Board to receive an update to a future meeting. Ongoing Action.

Action - D. McKee

Budget Monitoring – Month 5 (August 2018)
The Board to receive (a) an update on the allied health professional resource, and how those budgets and staffing are devolved, at a future meeting; (b) an in-depth breakdown around carers funding at a future meeting; and (c) clarification on the Health Minister's announcement around NHS debts at the next meeting. Points picked up in report to Committee today. Remove action.

Action – C. Whyte

Adult Support and Protection – Thematic Inspection Improvement Work Plan Update – Strategic Advocacy Plan – The Strategic Advocacy Plan will be provided to the meeting of the IJB in December. Ongoing action.

Action – B. Walker

5. Presentation: MSK Physio in Primary Care

The Board received a presentation from Judith Reid, Consultant Physiotherapist, on MSK Physio in Primary Care and highlighting the following:-

- the current performance position;
- sustainability challenges in relation to staffing resource;
- where the service is now and steps for moving forward through testing different models of care;
- demand patterns in relation to physiotherapists within GP practices;
- the MATS service process;
- measures to improve efficiency within the service; and
- other developments in relation to social media.

Members asked questions and were provided with information on the following:-

- the positive response to the physiotherapy service within GP practices;
- sickness absence averages; and
- marketing around self-help advice and the app.

Noted.

6. Director's Report

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

Councillor Larsen joined the meeting at this point.

The report highlighted the following:-

- the Health and Social Care Scotland (HSCS) Conference taking place on 7 December 2018;
- the appointment of Julie Barrett as Senior Manager (Mental Health);
- the "Super Social Work" Programme for 5th and 6th year pupils across North Ayrshire;
- that nominations are now being accepted for the HSCP Staff Partnership Awards taking place in February 2019;
- the hosting of the first Global Care Family Gathering;
- participation in the Breakfast Blether at Pennyburn Primary School and the Mental Health Discussion Dinner at Kilwinning Academy;
- that the survey on views on Advocacy in North Ayrshire closes at midnight on 16 November;
- the visit by Maree Todd, Minister for Children and Early Years to Castlepark Early Years Centre;
- the hosting of a Pan Ayrshire Children's Visual Impairment Forum at Greenwood Conference Centre; and
- the North Ayrshire Achieves 2018 Award Ceremony.

The Board noted the ongoing developments within the North Ayrshire Health and Social Care Partnership.

7. North Ayrshire Alcohol and Drug Partnership (NAADP) Annual Report 2017-18

Submitted report by Thelma Bowers, Head of Mental Health, providing a summary on the Alcohol and Drug Partnership's Annual Report 2017-18 submitted to the Scottish Government. The full report was detailed within the Appendix to the report outlining the NAADP contribution to achieving the key outcomes and ministerial priorities.

Members asked questions and were provided with information on the following:-

- that future reports could provide more quantitative information in relation to drug deaths and suicides; and
- that the Partnership is working hard to address all elements in relation to deaths and provide more holistic evidence to shape future responses to Government.

The Board agreed to note the terms of the Annual Report detailed in Appendix 1 to the report.

8. Chief Social Work Officer Annual Report

Submitted report by David MacRitchie, Chief Social Work Officer on the annual report of the Chief Social Work Officer to the local authority covering the period April 2017 to March 2018. The full report on all statutory, governance and leadership functions of the role was detailed at Appendix 1, and highlighted information in relation to:-

- the most recent SIMD figures (2016) which show a worsening position in North Ayrshire in the domains of Income, Employment, Education and Housing;
- the conclusion of the Audit Scotland Report of 2016 on 'Social Work in Scotland' which states that current approached to delivering Social Work Services will not be sustainable in the long term;
- the new Health and Social Care Partnership structures and examples of innovative service delivery approaches; and
- the 9 key themes and challenges detailed within the report.

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

9. Budget Monitoring – Month 6 (September 2018)

Submitted joint finance report by the Chief Finance and Transformation Officer, Principal Manager (Finance) and the Strategic Planning Lead on the projected financial outturn for the financial year 2018/19 as at September 2018. Appendix A provided a detailed financial overview of the Partnership budgetary position while Appendix B gave a detailed variance analysis. Appendix C presented full detail on savings, with Appendix D detailing progress against the approved recovery plan and Appendix E highlighting the movement in the overall budget position.

Information was also provided on matters arising from the meeting held on 11 October in relation to (a) the allied health professional resource, and how those budgets and staffing are devolved; (b) an in-depth breakdown around carers funding; and (c) clarification on the Health Minister's announcement around NHS debts.

Members asked questions and were provided with information on the following:-

- the more positive emerging budget position, while taking account of significant risks which are still present;
- further clarification around the NHS write off position and implications for the future;
- the position with regard to unfunded beds and when the financial effect of this will be determined;
- further work in relation to set aside proposals and on how this issue is being addressed nationally; and
- underspends which are based around vacancies and on how this is impacting on service provision.

The Board agreed (a) to approve the alternative saving as detailed in Section 2.10 of the report; (b) to approve the changes in funding as detailed in Section 2.12 and Appendix E; and (c) to note (i) the projected year-end overspend of £0.458m; (ii) the favourable movement in the projected outturn position and the future financial risk of further movement; and (iii) the impact of the financial recovery plan and the progress being made in delivering financial balance.

10. Programme for Government Funding for Breastfeeding

Submitted report by Dr. Ruth Campbell, Consultant Dietician in Public Health Nutrition, on work to improve local breastfeeding rates and highlighting the following:-

- evidence on the benefits of breastfeeding on the short term and long term health of mothers and their babies;
- that mothers within deprived areas are less likely to breast feed;
- comparison rates in relation to breastfeeding across Scotland and the 3 Ayrshire Council areas; and
- additional funding being used to create a more integrated team.

Members asked questions and were provided with information on the following:-

- the requirement for the difference between natural breastfeeding and feeding by artificial methods to be made more widely known;
- the social stigma in relation to breastfeeding in public and the lack of emotional support for mothers;
- the need for age appropriate education on the normality of breastfeeding;
- that part of peer supporters funding will focus on education and that St. Matthew's Academy is endorsed as a breastfeeding friendly school;
- the usefulness of a detailed breakdown of the rates within deprived areas across North Ayrshire;
- the lack of public awareness that it is an offence to stop mothers breastfeeding in public places; and
- whether data regarding mothers who tried and failed to breastfeed is available.

The Board agreed to note (i) the additional funding NHS Ayrshire and Arran will receive over a three year period and (ii) the proposals for this funding.

11. What Matters to You? 2018

Submitted report by Michelle Sutherland, Strategic Planning Lead, on the outcomes from What Matters to You? Day in North Ayrshire. A full breakdown of the Teams and Services together with challenges and benefits was provided in the Appendices to the report.

The Board agreed to note the progress made to date.

12. Augmentative and Alternative Communication (AAC) – Part 4 of the Health (Scotland) Act 2016: Communication Equipment and Support

Submitted report by Alistair Reid, Lead AHP on the commencement of Part 4 of the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 – the Provision of Communication Equipment, and on the potential impact on the current AAC service delivery in Ayrshire and Arran.

Members asked questions and were provided with information on the following:-

- whether resource has reduced due to less demand;
- that there is no dedicated resource for this equipment at present, currently provided by the Speech and Language Therapy (SLT) Service;
- that this will be flagged up as a budget pressure for next year; and

- that the cost to North Ayrshire is higher than the other 2 Ayrshire's due to population numbers.

The Board agreed to note (i) the update provided within the report and (ii) the potential financial risks associated with this legislation.

13. Urgent Items

The Chair agreed that the following item be considered as a matter of urgency.

14. Urgent Items

The Chair of the Irvine Locality Partnership Forum (Fiona Thomson) has stepped aside from the role and Barbara Connor will now act as Interim Chair on a temporary basis.

Arrangements for the role of Chair will be looked at over the next few weeks in conjunction with the outgoing and interim Chairs.

The Chair of the IJB thanked Fiona Thomson for the work she has carried out over the last 2 years.

The Meeting ended at 11.35 a.m.

North Ayrshire Integration Joint Board – Action Note

Updated following the meeting on 15 November 2018

No.	Agenda Item	Date of Meeting	Action	Status	Officer
1.	Adult Support and Protection – Thematic Inspection Improvement Work Plan Update – Strategic Advocacy Plan	10/11/18	That the Strategic Advocacy Plan will be provided to the meeting of the IJB in December – post meeting update provided advising consultation in January and the Plan will come to the IJB in February/March.	Ongoing	Brenda Walker

Integration Joint Board
13 December 2018

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

Glossary of Terms	
NHS AA	NHS Ayrshire and Arran
HSCP	Health and Social Care Partnership
BSL	British Sign Language

1.	**EXECUTIVE SUMMARY**
1.1	This report informs members of the Integration Joint Board (IJB) of the work undertaken within the North Ayrshire Health and Social Care Partnership (NAHSCP) nationally, locally and Ayrshire wide.
2.	**CURRENT POSITION**
	National Developments
2.1	West of Scotland Health and Social Care Delivery Plan Engagement Event
	The next Regional engagement event on the West of Scotland Health & Social Care Delivery Plan will be held on: **Date :Thursday 20th December 2018** **Time: 1.30-4.30pm with lunch and registration taking place between 12.45pm and 1.30pm** **Venue: Arcoona Room, Golden Jubilee Conference Hotel, Clydebank** A programme for the day will follow in the near future. IJB and Board members have been invited to attend any IJB members wishing to attend the event, **should register via the link below:** https://link.webropolsurveys.com/EP/76EE2D7563568992 Any enquiries regarding the event arrangements should be directed to myself via: michelle.connelly1@nhs.net or 0141 278 2501.

2.2	Audit Scotland Report on Health and Social Care Integration
	This report was published on 15th November 2018 and a separate summary report will be provided to the IJB covering the key messages.
2.3	Public Audit and Post-Legislative Scrutiny Committee
	On 22nd November I gave evidence to the Public Audit and Post-Legislative Scrutiny Committee at Scottish Parliament in relation to children and young people's mental health. I had been asked to do as the recent Auditor General's report on the subject specifically highlighted some of the emerging best practice in Ayrshire and Arran. It is clear from the report itself however, that across Scotland, much has yet to be done to improve the mental and emotional well-being of our young people.
	Ayrshire Developments
2.4	Ayrshire Mental Health Conversation – Tuesday 4th December 2018
	The Ayrshire Mental Health Conversation Event took place on 4th December 2018, attended by staff, carers and people who access mental health services across Ayrshire. The event heard feedback from across Ayrshire from The Ayrshire Mental Health Conversation and continued those discussions, which included : • Input from mental health services regarding what is happening at the moment. • Stories from individuals who have accessed services, or who have cared for someone who has accessed services in Ayrshire. • An update on what people have been saying about mental health in Ayrshire. • Small discussions on the next steps. The event followed up on what people have said during the recent Ayrshire Mental Health Conversation, with a view to developing a new Ayrshire Mental Health Strategy. Attendees include people from across Ayrshire such as staff, carers and people who access our mental health services.
2.5	Launch of British Sign Language Plan
	Following the introduction of the British Sign Language (Scotland) Act 2015, public sector agencies are required to produce and publish a local Business Sign Language (BSL) Plan by October 2018.
	In Ayrshire it was agreed that we would take forward an Ayrshire Shared BSL which was published by all partners on Friday 26th October 2018. A copy of the plan is available through the link below :- https://www.north-ayrshire.gov.uk/council/strategies-plans-and-policies/british-sign-language.aspx
	The plan was officially launched on 27th November 2018 at Irvine Townhouse.

	North Ayrshire Developments
2.6	Getting Together, Working Together
	Over 200 staff from children, families and justice services went along to the whole-service day of celebration of achievements and networking at Fullarton Connexions. Information stalls from all the service teams were on display. The winner of the best stall was awarded to Residential Services for their display of the photos and quotes from the young people who live in our children's houses.
	The afternoon workshops proved really popular – *Nurture Approaches* with Xanthe Wylie and *The Place of Kindness* with Zoe Ferguson.
	Thanks to everyone who came along and to all those involved in the organising and to Fullarton Connexions for hosting a really friendly, useful and uplifting day!
2.7	What Mattered to You? Lunch – 15th November 2018
	The HSCP hosted a lunchtime event on the importance of having 'What matters to you?' style conversations with people on a daily basis. Feedback from the What Matters to You? Days has been great, including changes which have taken place across various services. However the partnership would like to promote that these conversations should be happening every day, across all services. Many services already do this without branding it as a 'What matters to you?' conversation, and having these simple, asset based conversations can lead to significant improvements in both people's wellbeing and our services.
	The audience was a mix of NAHSCP staff (from a variety of services and designations), Third and Independent Sector representatives and service users and carers.
2.8	Thinking Different, Doing Better
	NAHSCP management team want to promote the good practice of asset based/strength based working in the Partnership. A key part of this will be sessions with staff (NAC and NHS) during 2019. To start this work, two preparatory half day sessions for all managers took place on 30th November and 4th December. The purpose of these "Charter for Change" sessions was to communicate a consistent message to managers about what is planned and to get their valuable input into how to maximize the benefits of the staff sessions.
	The manager sessions precede and inform a series of Partnership-wide staff workshops that will take place from February to August 2019. The staff workshops will help progress our strategic intent through our commitment to asset based working. Managers are key to making asset-based working a signature strength of North Ayrshire Health and Social Care Partnership.
	Team members operate in an asset-based way and we also recognize that asset based working means different things in different roles. Managers and staff can share their experience and expertise in the workshops in 2019 to enhance our practice across the Partnership.

3.	**PROPOSALS**
3.1	**Anticipated Outcomes**
	Not applicable.
3.2	**Measuring Impact**
	Not applicable.
4.	**IMPLICATIONS**

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

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

4.	**CONSULTATION**
4.1	No specific consultation was required for this report. User and public involvement is key for the partnership and all significant proposals will be subject to an appropriate level of consultation.
5.	**CONCLUSION**
5.1	Members of IJB are asked to note the ongoing developments within the North Ayrshire Health and Social Care Partnership.

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

NORTH AYRSHIRE
Health and Social Care Partnership

Agenda Item 5

Integration Joint Board
13 December 2018

Subject:	**Audit Scotland Report: Health and Social Care Integration – Update on Progress**
Purpose:	To highlight a report produced by Audit Scotland on Health and Social Care Integration in Scotland and to note that an action plan will come to a future meeting outlining the actions for North Ayrshire IJB in response to the report's recommendations.
Recommendation:	It is recommended that the IJB: a) Note the Audit Scotland report and the findings therein; b) Note that an action plan outlining the actions for the North Ayrshire IJB will be presented at a future meeting.

Glossary of Terms	
NHS AA	NHS Ayrshire and Arran
COSLA	Convention of Scottish Local Authorities

1.	**EXECUTIVE SUMMARY**
1.1	On 15 November 2018 Audit Scotland published the second of three planned national performance audits of health and social care integration in Scotland following the introduction of the Public Bodies (Joint Working)(Scotland) Act 2014, a copy of the report on progress with integration is included as Appendix 1.
1.2	The Audit Scotland report highlights six areas that need to be addressed to ensure that integration can make a meaningful difference, under these areas there are 16 specific recommendations to be taken forward by Integration Authorities, Councils, NHS Boards, the Scottish Government and COSLA. This report provides a summary of the key messages from the Audit Scotland report and highlights that an action plan aligned to the recommendations will be presented at a future IJB meeting. The action plan will be developed in collaboration with NHS AA and North Ayrshire Council as the report clearly demonstrates that it is not possible for the IJB to address the issues alone.
2.	**DETAIL**
2.1	The Audit Scotland report is the second of three national performance audits on health and social care integration in Scotland. The audits are planned to focus on three main points in Integration:

	1. Report published in 2015 focussed on progress during the transitional year to review progress at an early stage to provide a picture of emerging arrangements for setting up and managing Integration Authorities as they became formally established; 2. The current report provides an update on progress and aims to examine the impact public bodies are having as they integrate health and social care services in the early years of integration; 3. The final planned future audit will look at the longer term impact of shifting resources to preventative services and community based care and improving outcomes for the people who use the services.
2.2	In late 2015, Audit Scotland carried out the first of the three planned audits, findings were published on 3 December 2015, the full report is available on Audit Scotland's website: https://bit.ly/2Qlh9q0. The first report included 16 recommendations directed to the Scottish Government, Integration Authorities, Councils and Health Boards. The recommendations for IJBs were directed towards ensuring the arrangements were in place relating to strategic planning, governance, transparency and accountability, locality planning and financial planning.
2.3	The second report published on 15 November 2018 is included in Appendix 1. The audit provides an update on progress with Health and Social Care Integration at a national level. This doesn't focus in detail on local processes or arrangements in individual Integration Authorities and instead aims to complement the programme of strategic inspections by the Care Inspectorate and Health Improvement Scotland.
2.4	The key messages from the report are: • Health and Social Care Integration is starting to make a difference and improvements demonstrate that integration can work within the current legislative framework, whilst acknowledging that the environment is challenging and there is more to be done to increase the scale and pace of improvements; • Financial planning is not integrated, long term or focussed on providing the best outcomes, financial pressures across health and social care services make it difficult for IJBs to achieve meaningful change; • Improvements are needed to strategic planning and local barriers must be overcome to speed up change, including leadership, capacity, governance and data; • Leadership capacity must be in place and all partners need to be signed up to the reforms, improvement needs to be made to how learning is shared across Scotland and change should be supported by meaningful engagement with staff, communities and politicians.
2.5	The report identifies six areas that must be addressed if integration is to be successful: 1. Collaborative leadership and building relationships; 2. Integrated finances and financial planning; 3. Effective strategic planning for improvement; 4. Agreed governance and accountability arrangements; 5. Ability and willingness to share information; 6. Meaningful and sustained engagement. Audit Scotland acknowledge that it is not possible for one organisation to address all of the issues raised and outline recommendations in line with the areas above for IJBs, Councils, NHS Boards, the Scottish Government and COSLA.

	There are 16 recommendations in the report, most of which require to be jointly addressed. The recommendations for the Scottish Government and COSLA are focussed around the leadership, funding and commitment to integration. The recommendations for Councils, Health Boards and IJBs are around working together to align operational plans to those of the IJB and to support an integrated approach to systems, data and finance. There are no recommendations in the report for IJBs to progress alone and a partnership approach to improvements requires to be taken.
2.6	This is a national report and there are a number of recommendations that align with the position for North Ayrshire IJB, there are also some which are not as challenging locally. The IJB should note that for some recommendations directed to the Board or in association with the Council and Health Board some actions are already underway, as a number of the areas highlighted are known challenges which are planned to be addressed.
2.7	The Audit Scotland recommendations will be reviewed supported by a self-assessment for North Ayrshire IJB and an action plan will be brought to a future IJB meeting for approval. This will require to be developed together with NHS Ayrshire & Arran and North Ayrshire Council to agree a collaborative approach to addressing the areas identified by Audit Scotland.
3.	**PROPOSALS**
3.1	**Anticipated Outcomes**
	The IJB should be aware of the national issues highlighted in the most recent Audit Scotland report reviewing the progress with Health and Social Care Integration in Scotland. This highlights a number of areas where improvements require to be made and these will need to be actioned appropriately locally.
3.2	**Measuring Impact**
	An action plan will be presented to the IJB for approval and thereafter monitored through the IJB Performance and Audit Committee.
4.	**IMPLICATIONS**

Financial:	Audit Scotland make a number of recommendations is relation to financial planning.
Human Resources:	None
Legal:	None
Equality:	None
Children and Young People	None
Environmental & Sustainability:	None
Key Priorities:	The Audit Scotland report outlines key areas for improvement to support the delivery of integration priorities.
Risk Implications:	There is a risk if areas in the report are not progressed that the success of integration both nationally and locally may be compromised.

Community Benefits:	None

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

4.	**CONSULTATION**
	The action plan to address the Audit Scotland recommendations will be developed in consultation with North Ayrshire Council and NHS Ayrshire & Arran.
5.	**CONCLUSION**
	It is recommended that the IJB: a) Note the Audit Scotland report and the findings therein; b) Note that an action plan outlining the actions for the North Ayrshire IJB will be presented at a future meeting.

For more information please contact Caroline Whyte, Chief Finance & Transformation Officer on 01294 324954 or carolinewhyte@north-ayrshire.gcsx.gov.uk

Health and social care series

Health and social care integration

Update on progress

ACCOUNTS COMMISSION

AUDITOR GENERAL

Prepared by Audit Scotland
November 2018

The Accounts Commission

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Audit Scotland is a statutory body set up in April 2000 under the Public Finance and Accountability (Scotland) Act 2000. We help the Auditor General for Scotland and the Accounts Commission check that organisations spending public money use it properly, efficiently and effectively.

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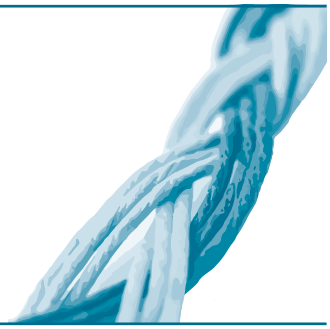

Links

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Exhibit data

When viewing this report online, you can access background data by clicking on the graph icon. The data file will open in a new window.

Audit team

The core audit team consisted of Leigh Johnston, Neil Cartlidge, Christopher Lewis and Lucy Jones, under the direction of Claire Sweeney.

Key facts

£222.5 million
Savings Integration Authorities needed to achieve in 2017/18

Almost £9 billion
Health and social care resources directed by Integration Authorities

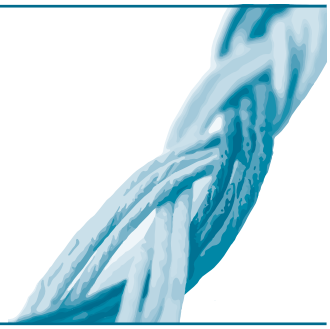
8.4 per cent
Increase in required savings from 2016/17

<70%
Integration Authority funding comes from the NHS

>30%
Funding comes from local authorities

31
Integration Authorities established through partnerships between the 14 NHS boards and 32 councils in Scotland

Summary



Key messages

1 Integration Authorities (IAs) have started to introduce more collaborative ways of delivering services and have made improvements in several areas, including reducing unplanned hospital activity and delays in discharging people from hospital. People at the end of their lives are also spending more time at home or in a homely setting, rather than in hospital. These improvements are welcome and show that integration can work within the current legislative framework, but IAs are operating in an extremely challenging environment and there is much more to be done.

2 Financial planning is not integrated, long term or focused on providing the best outcomes for people who need support. This is a fundamental issue which will limit the ability of IAs to improve the health and social care system. Financial pressures across health and care services make it difficult for IAs to achieve meaningful change. IAs were designed to control some services provided by acute hospitals and their related budgets. This key part of the legislation has not been enacted in most areas.

3 Strategic planning needs to improve and several significant barriers must be overcome to speed up change. These include: a lack of collaborative leadership and strategic capacity; a high turnover in IA leadership teams; disagreement over governance arrangements; and an inability or unwillingness to safely share data with staff and the public. Local areas that are effectively tackling these issues are making better progress.

4 Significant changes are required in the way that health and care services are delivered. Appropriate leadership capacity must be in place and all partners need to be signed up to, and engaged with, the reforms. Partners also need to improve how they share learning from successful integration approaches across Scotland. Change cannot happen without meaningful engagement with staff, communities and politicians. At both a national and local level, all partners need to work together to be more honest and open about the changes that are needed to sustain health and care services in Scotland.

several significant barriers must be overcome to speed up change

Recommendations

It is not possible for one organisation to address all the issues raised in this report. If integration is to make a meaningful difference to the people of Scotland, IAs, councils, NHS boards, the Scottish Government and COSLA need to work together to address six areas outlined below.

Commitment to collaborative leadership and building relationships

The Scottish Government and COSLA should:

- ensure that there is appropriate leadership capacity in place to support integration
- increase opportunities for joint leadership development across the health and care system to help leaders to work more collaboratively.

Effective strategic planning for improvement

Integration Authorities, councils and NHS boards should work together to:

- ensure operational plans, including workforce, IT and organisational change plans across the system, are clearly aligned to the strategic priorities of the IA
- monitor and report on Best Value in line with the requirements of the Public Bodies (Joint Working) (Scotland) Act 2014.

The Scottish Government should:

- ensure that there is a consistent commitment to integration across government departments and in policy affecting health and social care integration.

Integrated finances and financial planning

The Scottish Government should:

- commit to continued additional pump-priming funds to facilitate local priorities and new ways of working which progress integration.

The Scottish Government and COSLA should:

- urgently resolve difficulties with the 'set-aside' aspect of the Act.

The Scottish Government, COSLA, councils, NHS boards and Integration Authorities should work together to:

- support integrated financial management by developing a longer-term and more integrated approach to financial planning at both a national and local level. All partners should have greater flexibility in planning and investing over the medium to longer term to achieve the aim of delivering more community-based care.

Integration Authorities, councils and NHS boards should work together to:

- view their finances as a collective resource for health and social care to provide the best possible outcomes for people who need support.

Agreed governance and accountability arrangements

The Scottish Government and COSLA should:

- support councillors and NHS board members who are also Integration Joint Board members to understand, manage and reduce potential conflicts with other roles.

The Scottish Government, COSLA, councils, NHS boards and Integration Authorities should work together to:

- agree local responsibility and accountability arrangements where there is disagreement over interpretation of the Public Bodies (Joint Working) (Scotland) Act 2014 and its underpinning principles. Scenarios or examples of how the Act should be implemented should be used which are specific to local concerns. There is sufficient scope within existing legislation to allow this to happen.

Ability and willingness to share information

The Scottish Government and COSLA should:

- monitor how effectively resources provided are being used and share data and performance information widely to promote new ways of working across Scotland.

The Scottish Government, COSLA, councils, NHS boards and Integration Authorities should work together to:

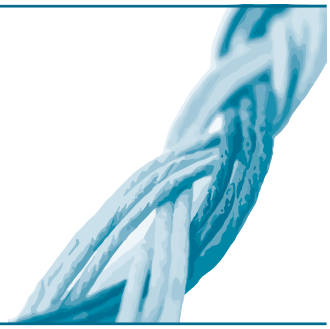
- share learning from successful integration approaches across Scotland
- address data and information sharing issues, recognising that in some cases national solutions may be needed
- review and improve the data and intelligence needed to inform integration and to demonstrate improved outcomes in the future. They should also ensure mechanisms are in place to collect and report on this data publicly.

Meaningful and sustained engagement

Integration Authorities, councils and NHS boards should work together to:

- continue to improve the way that local communities are involved in planning and implementing any changes to how health and care services are accessed and delivered.

Introduction



Policy background

1. The Public Bodies (Joint Working) (Scotland) Act, 2014 (the Act) is intended to ensure that health and social care services are well integrated, so that people receive the care they need at the right time and in the right setting, with a focus on community-based, preventative care. The reforms affect everyone who receives, delivers and plans health and care services in Scotland. The Act requires councils and NHS boards to work together to form new partnerships, known as Integration Authorities (IAs). There are 31 IAs, established through partnerships between the 14 NHS boards and 32 councils in Scotland.

2. As part of the Act, new bodies were created – Integration Joint Boards (IJBs) (Exhibit 1, page 9). The IJB is a separate legal entity, responsible for the strategic planning and commissioning of the wide range of health and social care services across a partnership area. Of the 31 IAs in Scotland, 30 are IJBs and one area, Highland, continues with a Lead Agency model which has operated for several years. In Highland, the NHS board and council each lead integrated services. Clackmannanshire and Stirling councils have created a single IA with NHS Forth Valley. You can find more information about integration arrangements in our short guide.

3. Each IA differs in terms of the services they are responsible for and local needs and pressures. At a minimum, IAs need to include governance, planning and resourcing of social care, primary and community healthcare and unscheduled hospital care for adults. In some areas, partners have also integrated children's services and social work criminal justice services. Highland Lead Agency, Dumfries and Galloway IJB, and Argyll and Bute IJB have also integrated planned acute health services. IAs became operational at different times but were all established by April 2016. The policy context for IAs is continually changing, and many policies have an impact on IAs, such as the new GP contract and changes to payments for social care services.

About this audit

4. This is the second of three national performance audits of health and social care integration following the introduction of the Act. The aim of this audit is to examine the impact public bodies are having as they integrate health and social care services. The report sets out six areas which need to be addressed if integration is to make a meaningful difference to the people of Scotland. This audit does not focus in detail on local processes or arrangements and it complements the programme of strategic inspections by the Care Inspectorate and Healthcare Improvement Scotland.[1] Appendix 1 (page 41) has more details about our audit approach and Appendix 2 (page 42) lists the members of our advisory group who provided help and advice throughout the audit.

What is integration? A short guide to the integration of health and social care services in Scotland

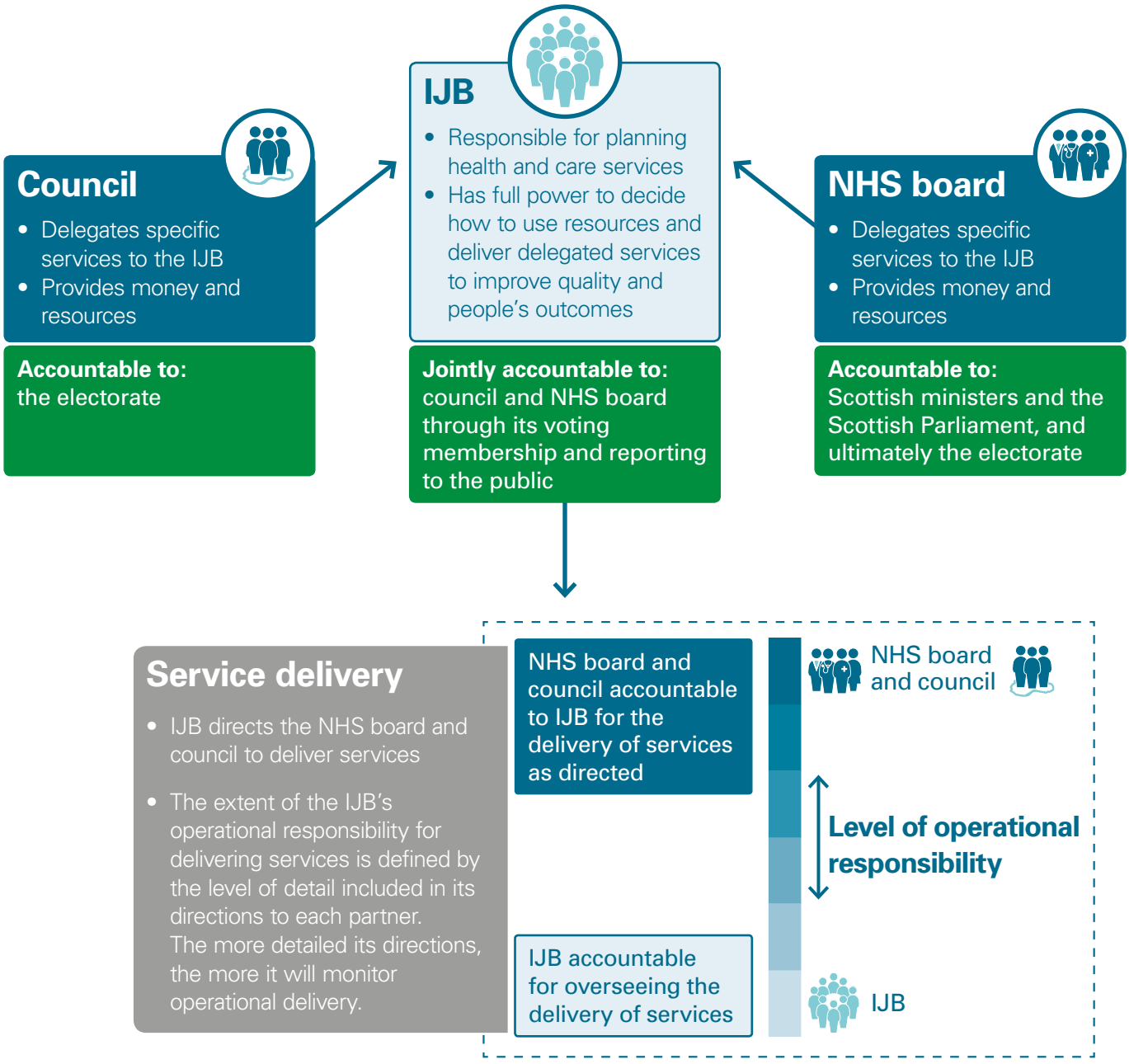
the reforms affect everyone who receives, delivers and plans health and social care services in Scotland

5. Appendix 3 (page 43) summarises progress against the recommendations in our first audit, which looked at transitional arrangements and highlighted several risks that needed to be addressed.[2] We will carry out a third audit in this series later in our work programme, which will report on the impact that integration has had and how health and social care resources are used.

Exhibit 1

Integration Joint Boards

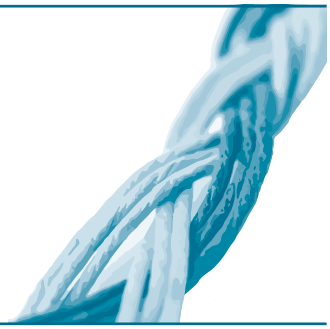
There are 30 Integration Joint Boards across Scotland.



Source: Audit Scotland

Part 1

The current position



Integration Authorities oversee almost £9 billion of health and social care resources

6. Our findings show that integration can work and that the Act can be used to advance change. Although some initiatives to integrate services pre-date the Act, there is evidence that integration is enabling joined up and collaborative working. This is leading to improvements in performance, such as a reduction in unplanned hospital activity and delays in hospital discharges. But there is much more to be done.

7. IAs are responsible for directing almost £9 billion of health and social care resources, money which was previously separately managed by NHS boards and councils (Exhibit 2, page 11). Over 70 per cent of this comes from the NHS, with the remainder coming from councils. As with councils and NHS boards, IAs are required to find efficiency savings from their annual budgets to maintain financial balance. Demands on services combined with financial pressures have led to many IJBs struggling to achieve this balance, with many needing additional financial contributions from partner organisations.

8. Each IA is underpinned by an integration scheme. This is the agreement between the council and the NHS board which shows how the IA will operate. For example, the scheme sets out arrangements for dealing with any budget overspends, which usually involves implementing a recovery plan. As local government bodies, IJBs can hold reserves if permitted by their integration schemes, although not all schemes allow this. Reserves are amounts of money that are built up from unspent budgets for use in future years. Generally, reserves are used for one of three purposes:

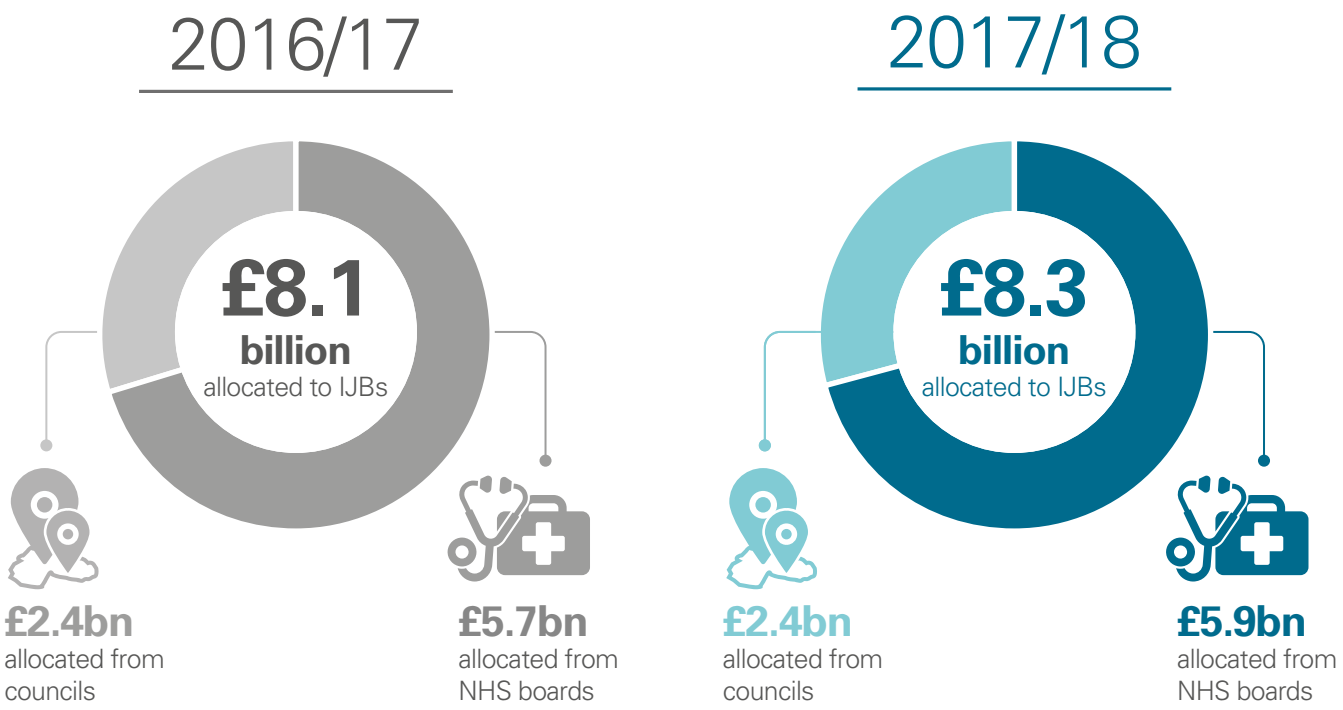
- as a working balance to help prevent the impact of uneven cash flows
- as a contingency to cushion the impact of unexpected events or emergencies
- held to fund known or predicted future requirements – often referred to as 'earmarked reserves'.[3]

there is evidence that integration is enabling joined up and collaborative working

Exhibit 2

Resources for integration

IAs are responsible for directing significant health and social care resources.



Lead Agency – the allocation for Highland Health and Social Care Services was:
£595 million in 2016/17 | £619 million in 2017/18

Note: Council allocations in 2016/17 and 2017/18 include criminal justice social work contribution.

Source: Audit Scotland, 2018

Financial pressures make it difficult for IAs to make sustainable changes to the way services are delivered

9. The Act was intended to help shift resources away from the acute hospital system towards preventative and community-based services. However, there is still a lack of agreement about whether this is achievable in practice – or whether rising demand for hospital care means that more resource is needed across the system. We have seen some examples of small-scale changes in the balance of care, which are explored further in Part 2 (page 23). These examples show that change can be achieved, but IAs now need to take the next steps to achieve wider-scale impact on outcomes over the coming years.

10. IAs needed to achieve savings of £222.5 million in 2017/18. This is an increase of 8.4 per cent on the previous year and is 2.5 per cent of the total allocation to IAs from NHS boards and councils. The level of savings, as a percentage of IA income, varied from 0.5 per cent in Moray, Orkney, Renfrewshire and South Lanarkshire, to 5.3 per cent in Shetland and 6.4 per cent in Highland Lead Agency. In several instances, budgets were agreed at the start of the financial year based on achieving savings which had yet to be identified.

Financial position

11. It is not easy to set out the overall financial position of IAs. This is due to several factors, including the use of additional money from partner organisations, planned and unplanned use of reserves, late allocations of money and delays in planned expenditure. This makes it difficult for the public and those working in the system to understand the underlying financial position.

12. In 2017/18, IJBs reported an overall underspend of £39.3 million. This represented 0.4 per cent of their total income allocation for the year.[4] However, this masks a much more complex picture of IJB finances. Appendix 4 (page 47) sets out more details about the financial position of IJBs in 2017/18. Many IAs have struggled to achieve financial balance at the year-end. The reasons for this vary but include rising demand for services, financial pressures and the quality of financial planning. In 2017/18, this resulted in several IJBs needing additional, unplanned allocations from their partners and adding to, or drawing on, reserves as follows:

- 17 needed additional money from NHS boards amounting to £33.3 million
- 11 needed additional money from councils amounting to £19.1 million
- eight drew on reserves amounting to £9.1 million
- 14 put money into reserves, amounting to £41.9 million.

13. Twenty-two IJBs are required by their integration schemes to produce a recovery plan if they forecast an overspend on their annual budget. Several IAs have had to produce recovery plans and are finding it harder to achieve the actions contained within them:

- In 2016/17, 11 IJBs needed to draw up a recovery plan. Of these, four IJBs achieved the actions set out in their recovery plans, but the remaining seven needed additional allocations from either their council or NHS board.
- In 2017/18, 12 IJBs needed to produce a recovery plan but only two achieved their recovery plans in full. In some cases, where additional allocations are required, the integration scheme allowed the NHS board or council to reduce the following year's allocation to the IJB by the same amount. In these circumstances there is a risk that IJBs will not have sufficient resources to deliver the services needed in future years.

14. An IA's integration scheme states how the IA will manage any year-end overspend and the responsibilities of the NHS board and council. For example, Fife IJB's integration scheme states that any overspend will be funded by partner bodies based on the proportion of their current year contributions to the IJB. In 2017/18, this meant that NHS Fife and Fife Council agreed to make additional contributions of 72 per cent and 28 per cent respectively.

15. The Highland Lead Agency model is also facing financial pressures. In 2017/18, NHS Highland overspent on adult social care services by £6 million. This was largely due to pressures on Highland Lead Agency adult social care services. This contributed to NHS Highland needing a loan of £15 million from the Scottish Government in 2017/18. Due to the way the Lead Agency model was established and the underlying agency agreement, the risks all rest with NHS Highland. Any increases in costs must be met by the NHS board.

16. Fourteen IJBs reported underspends in 2017/18 and these have arisen for a variety of reasons, for example: achieving savings earlier than expected; contingencies not being required; slippages in spending plans and projects; and staff vacancies.

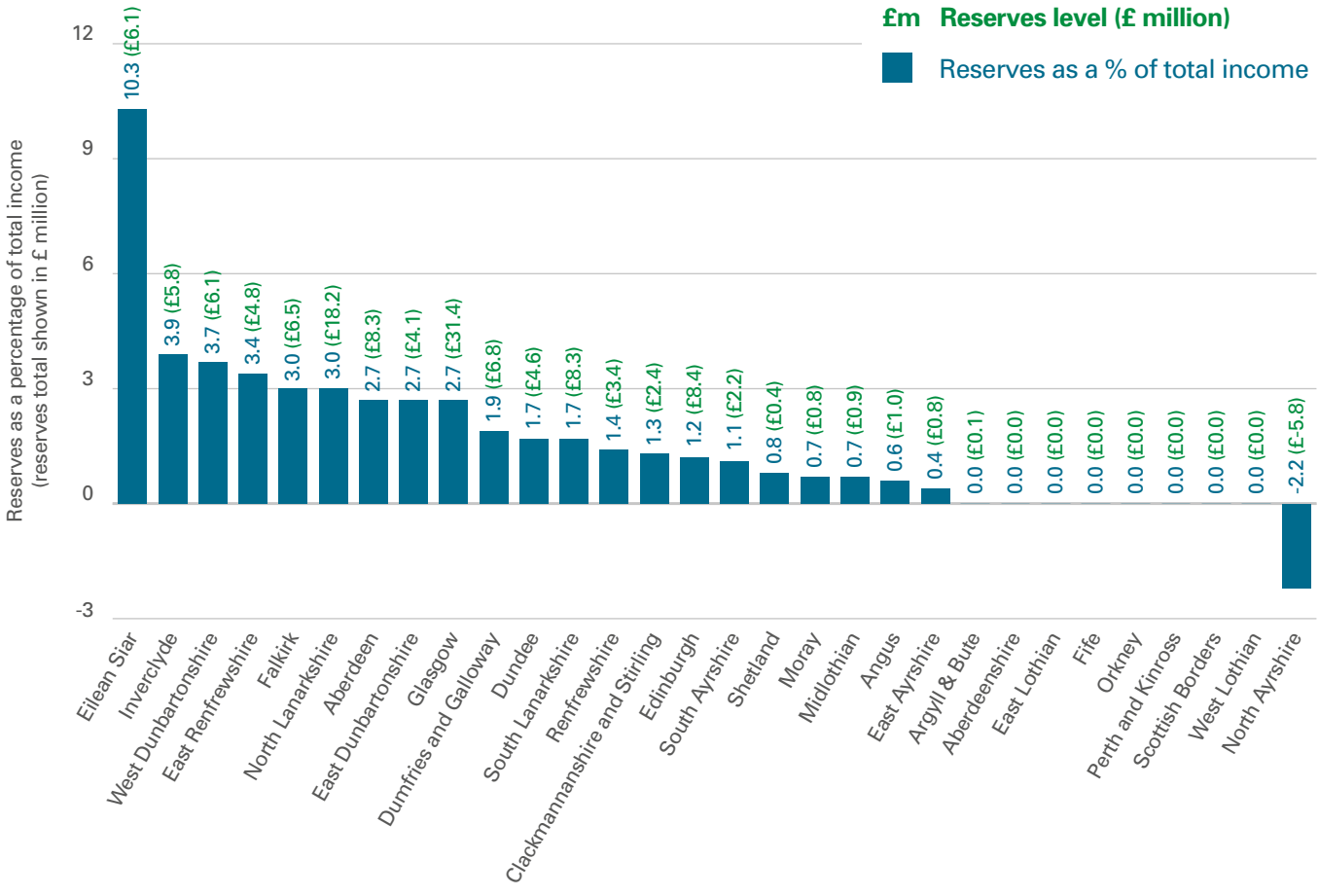
Reserves

17. The level of reserves held varies across IJBs, and not all integration schemes allow IJBs to hold reserves (Exhibit 3). In 2017/18, IJBs had built up reserves of £125.5 million, 1.5 per cent of their total income. This is not always a planned approach, and in some areas, reserves have arisen for several reasons including: the IJB receiving a late allocation of money; unspent strategic funding; staff vacancies; or year-end timing differences where money is received and allocated but unspent. Eilean Siar held the highest level of reserves as a percentage of its income at 10.3 per cent. The pressures on IJB budgets and the savings they need to achieve are significant, therefore the level of reserves in 2017/18 is not forecast to continue in future.

Exhibit 3

Reserves held by IJBs in 2017/18

There are significant differences in the levels of reserves held by IJBs.



Source: Integration Authority annual accounts, 2017/18

Hospital services have not been delegated to IAs in most areas

18. A key part of the reforms is that IJBs would direct some services provided directly within acute hospitals, to move care closer to people's homes and provide more joined-up care. Integration schemes, as approved by ministers, state that hospital services will be delegated to the IJB, as required under the Act. However, in practice, in most areas, the services have not been delegated. This has been a major source of debate and disagreement at a national and local level and is a fundamental issue which will hinder IJBs' ability to change the system.

19. The money for functions that are provided by large hospitals but are delegated to IJBs, such as unplanned care, is referred to as a 'set-aside' budget. Instead of paying this money to the IJBs along with payment for other delegated services, it is identified as a budget which should be directed by the IJB. The complexities around accurately preparing set-aside budgets has presented challenges to fulfilling this element of the Act. To date, the set-aside aspect of the Act is not being implemented. In line with Scottish Government guidance, NHS boards continue to manage the set-aside as part of their own resources.

20. In 2017/18, £809.3 million was included within IJBs' budgets for set-aside (where they were able to include a set-aside figure). This is 9.0 per cent of IJBs' income and is therefore a significant element of the health and social care budget that is not being directed by the IJBs. If IJBs are to use resources more strategically to prioritise prevention and care in a community setting, this issue needs to be resolved.

21. There are several reasons why all partners have struggled with this aspect of the Act, including fundamental issues in the data available to analyse set-aside-related activities. However, these technical issues do not appear to be the main issue. The main problem is a lack of common understanding and agreement on how to identify the set-aside budget and shared agreement on how to implement this aspect of the legislation.

Monitoring and public reporting on the impact of integration needs to improve

22. The context for integration is challenging, with many public bodies trying to work in partnership to achieve major changes while at the same time managing rising demand for services, financial pressures and continuing to deliver services and treat people. As we reported in *NHS in Scotland 2018*, the number of patients on waiting lists for treatment continues to rise while performance against targets is declining and an increasing number of NHS boards are struggling to deliver with the resources they have.[5] We have also reported that local government operates in an increasingly complex and changing environment with increasing levels of uncertainty.[6]

23. A significant number of measures are being used to monitor national and local progress which means IAs are reporting against a range of different measures to demonstrate progress (Exhibit 4, page 16). For the public to understand how the changes are working at a Scotland-wide level, these indicators need to be presented in a clear and transparent way.

24. It is important that the Scottish Government can demonstrate that resources provided have led to improvements in outcomes, in line with its national health and wellbeing outcomes. These outcomes are the Scottish Government's high-level statements of what health and social care partners are attempting to achieve through integration. These national outcomes are not being routinely reported at a national level, although IAs refer to them as part of their annual performance reports.

25. The Scottish Government introduced the National Performance Framework (NPF) in 2007 and launched a new framework in 2018. The NPF is made up of 11 national outcomes, each with indicators and aligned to the United Nations' sustainable development goals. There is a clear alignment between the aims of integration and several of the outcomes and indicators.[7]

26. The Ministerial Strategic Group for Health and Community Care brings together representatives from the Scottish Government, NHS, local government and IAs to monitor a set of six national indicators. These are used as indicators of the impact of IAs (Exhibit 5, page 18). These measures focus on the aim of integration helping to care for more people in the community or their own homes and reducing unnecessary stays in hospital. While these measures focus on health, performance can only improve with input from health and social care services. One of the six national indicators is supported by two measures: A&E attendances and achievement of the four-hour A&E waiting time target (3a and 3b at Exhibit 5, page 18).

27. Four of the indicators show improved performance, but there is significant local variation in performance between IAs. The performance measures do not themselves provide a direct indication of whether people's outcomes have improved, although they do represent key aspects of care which should ultimately improve people's lives.

Exhibit 4

Health and wellbeing outcomes and indicators

A significant number of measures are being used to monitor local and national progress.

National Performance Framework

Purpose

To focus on creating a more successful country, with opportunities for all of Scotland to flourish, through sustainable and inclusive economic growth

Values

We are a society which treats all our people with kindness, dignity and compassion, respects the rule of law, and acts in an open and transparent way

11 outcomes and 81 national indicators, for example:

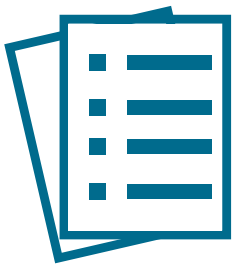
- **Outcome:** We are healthy and active
- **Indicators:** Healthy life expectancy, mental wellbeing, healthy weight, health risk behaviours, physical activity, journeys by active travel, quality of care experience, work-related ill health, premature mortality
- **Sustainable development goals:** gender equality, reduced inequalities, responsible consumption and production, good health and wellbeing

9 national health and wellbeing outcomes

- People are able to look after and improve their own health and wellbeing and live in good health for longer
- People, including those with disabilities or long-term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community
- People who use health and social care services have positive experiences of those services, and have their dignity respected
- Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services
- Health and social care services contribute to reducing health inequalities
- People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing
- People using health and social care services are safe from harm
- People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide
- Resources are used effectively and efficiently in the provision of health and social care services

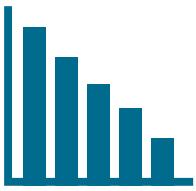
Cont.

Exhibit 4 (continued)



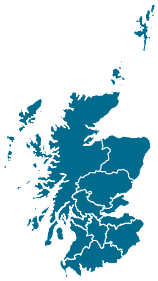
12 principles within the Act

- Be integrated from the point of view of the people who use services
- Take account of the particular needs of service users in different parts of the area in which the service is being provided
- Respect rights of service users
- Protect and improve the safety of service users
- Improve the quality of the service
- Best anticipate needs and prevent them arising
- Take account of the particular needs of different service users
- Take account of the particular characteristics and circumstances of different service users
- Take account of the dignity of service users
- Take account of the participation by service users in the community in which service users live
- Is planned and led locally in a way which is engaged with the community
- Make best use of the available facilities, people and other resources



6 national indicators

- Acute unplanned bed days
- Emergency admissions
- A&E performance (including four-hour A&E waiting time and A&E attendances)
- Delayed discharge bed days
- End of life spent at home or in the community
- Proportion of over-75s who are living in a community setting



Various local priorities, performance indicators and outcomes

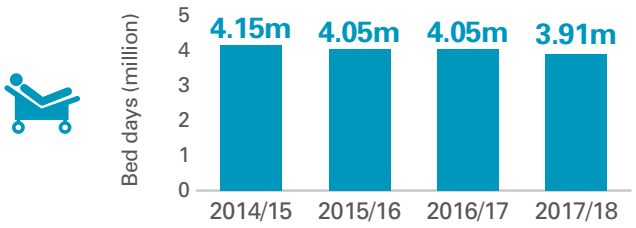
Source: Audit Scotland

Exhibit 5

National performance against six priority areas

National performance shows signs of improvement in some of the six key national indicators.

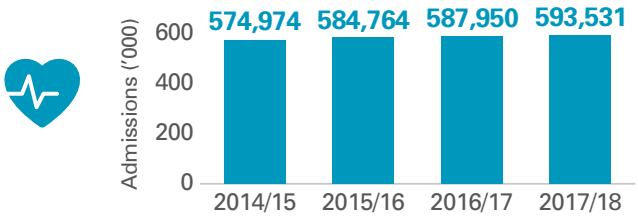
1. Acute unplanned bed days



Integration aims to reduce unplanned hospital activity

The number of acute unplanned bed days has reduced since 2014/15

2. Emergency admissions

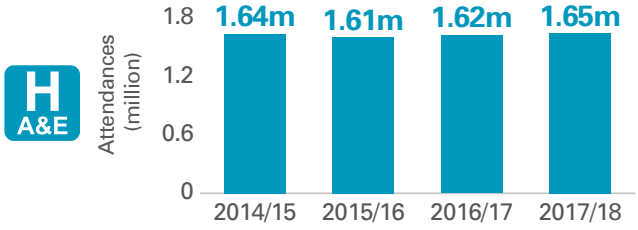


Integration aims to ensure that people's health and care needs are anticipated and planned appropriately, reducing unplanned hospital activity

The number of emergency admissions has risen each year since 2014/15

In 2017/18, local performance varied from 0.08 emergency admissions per head of population in NHS Orkney to 0.15 in NHS Ayrshire and Arran

3a. A&E attendances

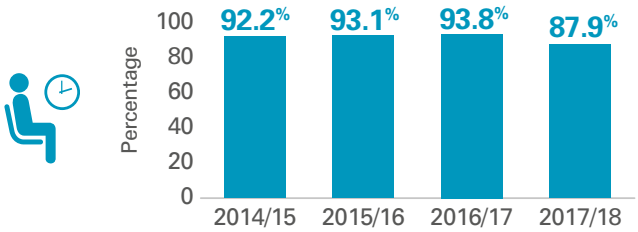


A&E attendances can be an indication of the degree to which community services are helping people receive care in the right place at the right time.

The number of A&E attendances has marginally increased since 2014/15

In 2017/18, local performance varied from 0.2 A&E attendances per head of population in NHS Grampian to 0.4 in NHS Greater Glasgow and Clyde

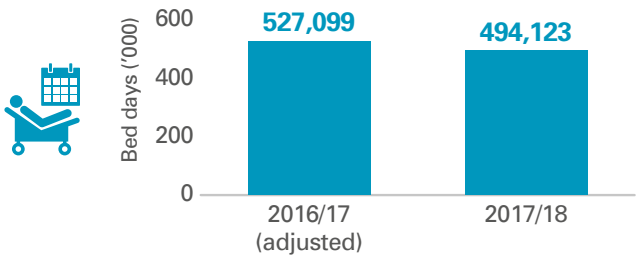
3b. Achievement of the four-hour A&E waiting time target



The achievement of the four-hour waiting time target has declined since 2014/15

Local performance varied in 2017/18 from 98.0% NHS Tayside to 75.4% NHS Lothian

4. Delayed discharge bed days (for population aged 18+)



Reducing delays in discharging people from hospital has been a long-standing aim for health and care services. With rising demand, some areas have struggled with this. Due to changes in data collection, comparable data is only available for two years.

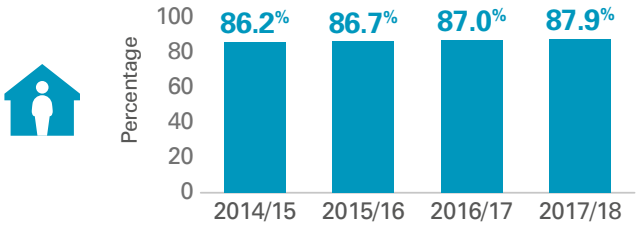
Delayed discharge rates have fallen since 2016/17

In 2017/18, local performance varied from 2.5% in Inverclyde to 26.5% in Eilean Siar delayed discharge bed days as a percentage of their population (18+)

Cont.

Exhibit 5 (continued)

5. End of life spent at home or in the community

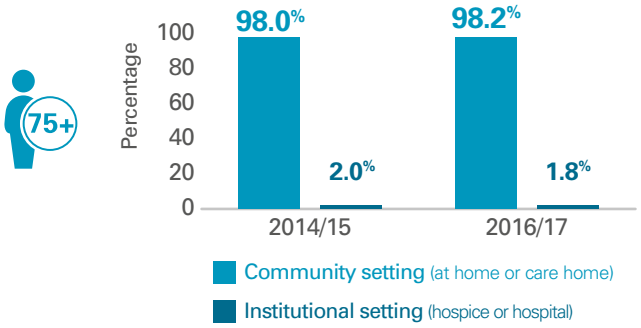


Integration aims to support people with health and care needs in their own home or in a community setting, especially at the end of life.

A gradual increase in the percentage of people's time spent at home or in a homely setting at the end of their life

In 2017/18, local performance varied from 95.1% of people's time spent at home or in a homely setting at the end of their life in Shetland to 85.2% in East Renfrewshire

6. Percentage of 75+ population in a community or institutional setting



Integration aims to shift the balance of care from an institutional setting to a community setting.

There has been a slight increase in the percentage of individuals aged over 75 who are living in a community setting. This is in line with the intentions of the Act.

Notes:

Indicator 1
1. These statistics are derived from data collected on discharges from non-obstetric and non-psychiatric hospitals in Scotland. Only patients treated as inpatients or day cases are included. The specialty of geriatric long stay is excluded.
2. Bed days for each year have been calculated based on the year in which the bed days were occupied. This differs from other analysis where length of stay or occupied bed days are reported by the year of discharge.
3. Unscheduled bed days relate to all occupied bed days within a continuous hospital stay following an emergency or urgent admission.
4. The Scotland total presented is the sum of all those resident in IA areas and excludes non-Scottish residents.
5. Approximately a quarter of IAs returned figures for people aged over 18 only. Where this is the case, bed days from 2016/17 for people aged under 18 in those partnerships have been applied to 2017/18 figures.
6. Based on data submitted to ISD in August 2018.

Indicator 2
1. ISD published data as at September 2018.

Indicator 3a
1. ISD published data as at August 2018.

Indicator 3b
1. ISD published data as at June 2018.
2. Performance for the month ending March for each year.

Indicator 4
1. ISD published data as at September 2018.
2. 2016/17 figures adjusted to reflect revised definitions across the whole year.

Indicator 5
1. ISD published data as at October 2018.

Indicator 6
1. Percentage of 75+ population in a community or institutional setting:
   - Community includes the following:
     - Home (unsupported) – refers to the percentage of the population not thought to be in any other setting, or receiving any homecare, on average throughout the year.
     - Home (supported) – refers to the percentage of the population estimated as receiving any level of homecare. Estimated from social care census carried out at the end of the reporting year (eg, Census carried out in March 2014 used to estimate home (supported) population during 2013/14).
     - Resident in a care home – based on care home census at the end of the reporting year (eg, Census at 31 March 2014 used to estimate 2013/14 care home population). The care home data is based on long-stay residents only. The proportion of incomplete long-stay residents aged 75+ cannot be calculated. Therefore, a scaling factor, based on the 65+ proportions, has been employed for the 75+ data. This assumes that there is the same degree of incompleteness in the census data returned for adults in each of the age bands.
   - Institutional includes the following:
     - Average population in hospital/hospice/palliative care unit throughout the year.
     - Hospital includes both community and large/acute hospitals.
     - Hospice activity is based on SMR records and will be incomplete as not all hospices submit this information.
2. Figures provided by ISD.

General
1. Population figures used taken from the National Records of Scotland mid-2017 estimates published in 2018.
2. Figures relate to all ages unless otherwise stated.

Source: Information Services Division (ISD) and Scottish Government

Integration Authorities' performance reports show local improvement

28. IAs are required to publish annual performance reports which contain information on local priorities and a range of local initiatives (Exhibit 6). These reports are an important way for IAs to inform the public about how well they have been performing against their stated priorities. The improvements that are set out in the performance reports are welcome and current pressures across the system have made them difficult to achieve. However, core indicators of performance are not improving in all areas of Scotland and nationally it is clear that there is much more to be done.

Exhibit 6

Examples of impact from integration

IAs have set out a number of local improvements in their performance reports.

Prevention and early intervention

Dumfries and Galloway

The D&G Handyvan provides information, advice and practical assistance with adaptations to people's homes. This is available to disabled people of any age and older people aged 60 and over. People are also supported to access financial assistance for major adaptations. This service helps people to feel more confident about continuing to live independently in their own home and to feel safe and secure in their home. People are less likely to have a fall, have improved health and wellbeing, and have a better quality of life. Often adaptations support people to be better connected with their friends and family and their wider community. 1,626 referrals were received during 2017/18. These resulted in 2,149 tasks being carried out by the service. 808 people were referred to prevent a fall, 577 people for home security, 16 people for minor adaptations and 225 people for small repairs.

Dundee

Social prescribing 'Sources of Support' (SOS) is one means of supporting people to better manage their health conditions. Link workers, working within designated GP practices, take referrals for people with poor mental health and wellbeing affected by their social circumstances and support them to access a wide range of non-medical services and activities that can help. In 2017/18, 256 patients were referred to three link workers and 220 people were supported. An external evaluation demonstrated that the service had a positive impact on both clients and on GPs themselves. 65 per cent of patient goals were met and 84 per cent had some positive outcome, including decreased social isolation, improved or new housing, financial and benefits issues being addressed, and increased confidence, awareness and self-esteem.

Outcomes from a GP perspective include reduced patient contact with medical services, providing more options for patients, raising awareness of non-clinical services, and increased GP productivity. 2017/18 saw a major scale-up of the SOS scheme through the Scottish Government Community Link Worker programme, extending the service from four GP practices to 16.

Delays in people leaving hospital

East Ayrshire

The Red Cross Home from Hospital Service supported about 1,700 people in 2017/18. The service is delivered across Ayrshire and Arran from University Hospitals Crosshouse and Ayr and supports people to be discharged as early as possible, reducing their length of stay and re-settling them in their home. Once home, the service helps to prevent falls and reduce social isolation, supporting people to regain their confidence, skills for living independently and organises telecare to support families to continue to care. A total of 1,730 bed days have been saved, equivalent to £302,750. 73 admissions to hospital have been avoided, and 625 bed days saved, equivalent to £109,375.

Perth and Kinross

There have been increases in staffing within social care discharge teams, Perth Royal Infirmary liaison services, and care home nursing. This, alongside improved funding procedures for care home placements, has supported speedier discharge to a care home setting or repatriation to such. There has been a reduction of 2,391 (12.5 per cent) delayed discharge bed days between 2016/17 and 2017/18 to 16,785.

Cont.

Exhibit 6 (continued)

Preventing admission to hospital

East Dunbartonshire

Rapid Response Service has established a different referral route for patients between A&E and the Community Rehabilitation Team to provide next-day response. During 2017/18, the service prevented approximately 33 per cent of people referred being admitted to hospital.

South Ayrshire

The Intermediate Care Team provide rapid multidisciplinary team support to people to support them to return home from acute hospital and to remain at home through GP referral. In particular, they have worked closely to establish pathways with the Combined Assessment Unit to prevent admission. The service provided by the Intermediate Care Team resulted in 674 hospital admissions being avoided and 301 early supported discharges during 2017/18. It is estimated locally that each avoided hospital admission saves five hospital bed days and each supported discharge saves three hospital bed days. Overall, it is estimated that the intervention provided by the Intermediate Care Team saved 3,370 bed days due to avoided admissions and 903 bed days due to early supported discharges.

Aberdeenshire

Set up in 2016, Aberdeenshire's Virtual Community Ward (VCW) aims to avoid unnecessary hospital admissions through bringing together multidisciplinary health and social care teams who provide care for patients who need regular or urgent attention. This GP-led approach involves the teams working closely together, generally meeting daily under a huddle structure. They identify and discuss vulnerable/at risk patients and clients, and coordinate, organise and deliver services required to support them. The VCW identifies individuals who need health and social care services at an earlier stage, which can improve patient outcomes and experience. Based on an evaluation carried out by the VCW team, 1,219 hospital admissions have been avoided because of the VCWs .

Referral/ care pathways

Aberdeenshire

During 2017/18 a test of change was carried out in one GP practice to trial people's first appointment with a physiotherapist rather than a GP. Ongoing evaluation suggests that this has been successful and has proved popular with patients who now have immediate access to a physiotherapist for assessment and advice. If follow up is required, this can be booked at the time. 221 people have been directed to the physiotherapist first; only 58 per cent required a face-to-face appointment and 26 per cent were discharged following telephone advice.

Renfrewshire

Over the past three years, the Primary Care Mental Health Team (Doing Well) has introduced a self-referral route to the service. This has led to a decrease in clients attending a GP to be referred to the mental health team. The number of self-referrals to the service has increased from 207 in 2013/14 to 1,237 in 2017/18. This self-referral route has successfully redirected work away from GP surgeries.

Midlothian

An advanced practitioner physiotherapist for Chronic Obstructive Pulmonary Disease (COPD) was appointed to support people attending hospital frequently because of their COPD to help them manage their symptoms at home and avoid admission to hospital. In the first year the service has worked with 65 patients and successfully avoided 30 hospital admissions. This delivered a potential reduction of 520 days spent in hospital by Midlothian residents and a much better patient experience. It was also a more cost-effective approach to delivering services for the partnership.

Cont.

Exhibit 6 (continued)

Reablement

Falkirk

A Reablement Project Team (RPT) was developed in Social Work Adult Services Assessment and Planning service in January 2017 to test out various reablement approaches and processes. The team consists of occupational therapists (with community care worker background) and social care officers. The reablement team support service users for up to six weeks. Individuals are reviewed on a weekly basis and care packages are adjusted as the person becomes more independent. Fewer people required intensive packages at the end of six weeks, which has freed up staff time and has reduced the use of external providers. Early indications suggest this work has led to a £200,000 reduction in purchasing care from external homecare providers.

Scottish Borders

The Transitional Care Facility based within Waverley Care Home is a 16-bed unit which allows older people to regain their confidence and independence so that they can return to their own homes following a stay in hospital. The facility is run by a multidisciplinary team of support workers, allied health professionals and social workers. 81 per cent of individuals discharged from Transitional Care return to their own homes and the hospital readmission rate for these individuals is six per cent.

Pharmacy

South Lanarkshire

The pharmacy plus homecare initiative has created an opportunity to amend consultant and GP prescribing practices. A reduction in prescribing can lead to less homecare visits. The IA estimates that savings could be in the region of £1,800 per patient (within the trial).

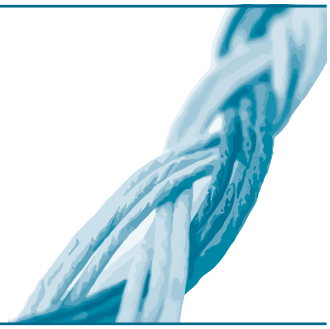
Angus

The Angus IA has improved how care homes manage medication. A new process developed by a Locality Care Home Improvement Group with GPs and pharmacy has led to zero medication waste in care homes.

Source: Audit Scotland review of Integration Authorities' Performance Reports, 2018

Part 2

Making integration a success

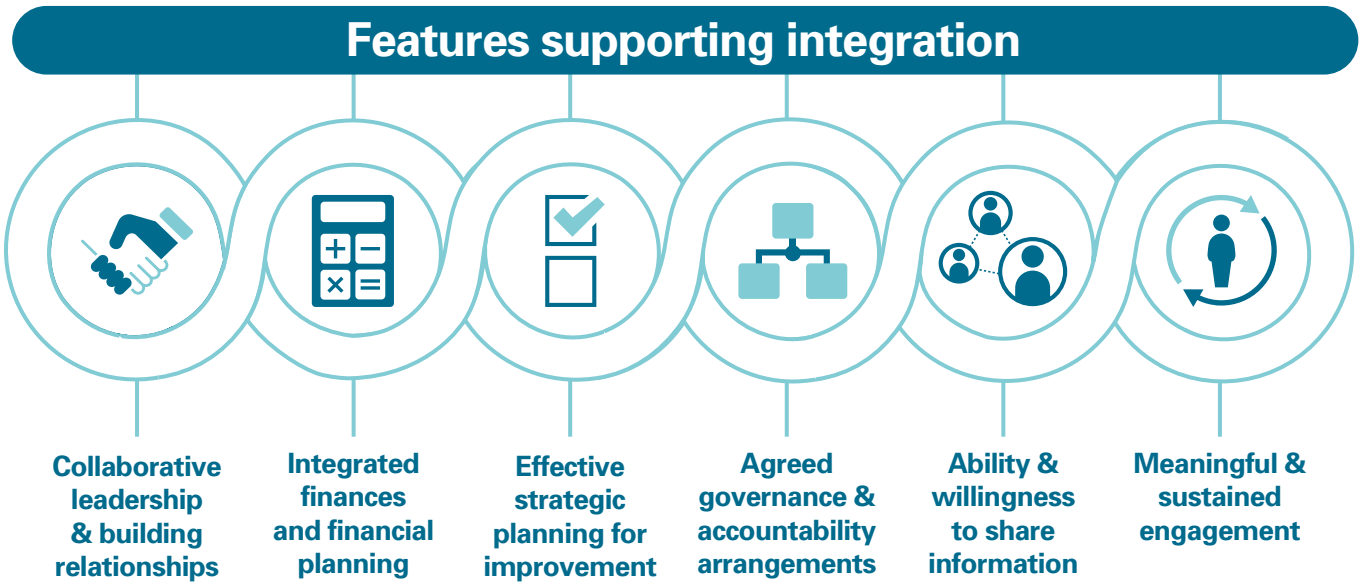


29. IAs are addressing some significant, long-standing, complex and inter-connected issues in health and social care. Our work has identified six key areas that, if addressed, should lead to broader improvements and help IAs to take positive steps toward making a systematic impact on health and care outcomes across their communities (Exhibit 7).

Exhibit 7

Features central to the success of integration

Six areas must be addressed if integration is to make a meaningful difference to the people of Scotland.



Source: Audit Scotland

A lack of collaborative leadership and cultural differences are affecting the pace of change

30. High-quality leadership is a critical part of the success of an organisation or programme of reform. Given the complexity of health and social care integration, it is important that leaders are highly competent, have capacity to deliver and are well supported. For transformation to succeed, the right leadership and strategic capacity need to be in place. Without this, the reforms will not succeed. We identified several risks in this area which need to be addressed:

- A significant number of IAs have had leadership changes with 57 per cent having had changes in their senior management team. As at October 2017, seven IJBs have a different Chief Officer (CO) in post than two years previously.

- There is significant variation in the role and remuneration of COs and Chief Financial Officers (CFO). Many have dual roles with positions held in partner organisations and there is a mix of full and part-time CFOs. This is a significant challenge, given the scale of the task facing IAs and the strategic role COs and CFOs have in directing change. In 2017/18, £3 million was spent on IJBs' CO remuneration and there are differences in salary levels, in part reflecting differences in roles and responsibilities.

- There is evidence of a lack of support services for IAs, in relation to HR, finances, legal advice, improvement, and strategic commissioning. This will limit the progress that they are able to make. It is important that the partner bodies support the IJB, including support services.

31. Top-down leadership which focuses on the goals of a single organisation does not work in the context of integration. NHS Education Scotland has described 'systems leaders' as having an ability to 'have a perspective from the wider system. They recognise that it is necessary to distribute leadership responsibilities to bring about change in a complex interdependent environment…They change the mind-set from competition to cooperation. They foster dialogue… which can result in new thinking… When leadership involves such a collective endeavour, the way people see their accountability matters.'[8] A lack of collaborative systems leadership and difficulties in overcoming cultural differences are proving to be significant barriers to change.

32. Leaders from all partners are operating in a complex and continually changing landscape and, without appropriate support in place, cannot fulfil their role effectively. Leaders need support if they are to deliver public services to improve wider outcomes and work collaboratively across organisational boundaries. This is hard to achieve, especially where there have been changes in key staff and local politicians, and in the context of the current financial and performance pressures. Accountability arrangements are important to encourage and incentivise the right kinds of leadership characteristics.

33. Cultural differences between partner organisations are proving to be a barrier to achieving collaborative working. Partner organisations work in very different ways and this can result in a lack of trust and lack of understanding of each other's working practices and business pressures. In better performing areas, partners can identify and manage differences and work constructively towards achieving the objectives of the IA. Overcoming cultural differences and improving understanding of each other's businesses will help partner organisations progress towards integration, particularly regarding integrated finances. Joint leadership development for people working in NHS boards, councils and IJBs can help with this. Exhibit 8 (page 25) provides an overview of the common leadership traits which are important in integrating health and social care services.

Exhibit 8

Traits of effective collaborative leaders

There are a number of leadership traits which are important in integrating health and social care services.

Influential leadership

- Clear and consistent message
- Presents a positive public image
- Ability to contribute towards local and national policy
- Shows an understanding of the value of services

Ability to empower others

- Encourages innovation from staff at all levels
- Non-hierarchical and open to working alongside others
- Respectful of other people's views and opinions
- Inspiring to others
- Creates trust
- Willing to work with others to overcome risks and challenges

Promotes awareness of IA's goals

- Confidence and belief in new technology to facilitate progress
- Facilitates planning of sustainable services
- Recruitment of staff to fit and contribute to a new culture
- Sets clear objectives and priorities for all
- Develops widespread belief in the aim of the integrated approach to health and social care

Engagement of service users

- People who use services feel able to contribute to change
- Ability to facilitate wide and meaningful engagement
- Open to and appreciative of ideas and innovation
- Ensures voices are heard at every level
- Transparent and inclusive

Continual development

- Encourage learning and development, including learning from mistakes
- Belief in training and understanding of who could benefit from it
- Encourage innovation, debate and discussion
- Driven to push for the highest quality possible

Source: Audit Scotland, 2018; from various publications by The Kings Fund; Our Voice; Scottish Government; Health and Sport Committee and the Scottish Social Services Council.

34. We have seen examples of good collaborative and whole-system leadership, including in Aberdeen City, where relationships have been built across the partnership. Although differences of opinion still exist and there is healthy debate, Aberdeen City is now better placed to implement widespread changes to improve outcomes. We saw:

- the promotion of a clear and consistent message across the partnership
- a willingness to work with others to overcome differences
- recruitment of staff to fit and contribute to a new culture
- development of openness and appreciation of ideas
- encouragement of innovation, learning and development, including learning from mistakes.

35. The Scottish Government and COSLA are co-chairing a group involving leaders from across councils and NHS boards. The aim of the group is to identify and overcome barriers to integration. The group has produced a joint statement on integration, confirming the shared responsibility of the Scottish Government, NHS Scotland and COSLA for ensuring the successful integration of Scotland's health and social care services. The statement acknowledges that the pace of integration needs to improve, and that the group needs to work together to achieve integration and to overcome challenges to better meet people's health and social care needs. The group is developing further support and training to support leadership for integration. The Scottish Government and COSLA are also co-chairing an Integration Review Reference Group. This group is reviewing progress on integration and will report its findings to the Ministerial Strategic Group for Health and Community Care. The group will conclude its work in January 2019. We will continue to monitor any actions resulting from the work of the group.

Integration Authorities have limited capacity to make change happen in some areas

36. IJBs are very small organisations, all of which have a CO and a CFO. Not all IJBs have the support they need, for example only half of IJBs have a full-time CFO and there have been difficulties in filling those posts in some areas. Each IJB has a chair and vice chair, but we have been told that many IJBs rely on its members working much more than contracted hours, and chairs and vice chairs have told us that they struggle to attend to IJB business during contracted time. Each IJB is made up of voting and non-voting members.

37. Typically, an IJB meets about six times a year. The IJB also has one or more Strategic Planning Group, which are consulted and give feedback on strategic plans and significant changes to integrated functions. For this structure to work, the IJB needs to draw on, and be supported by, skills and capacity from its partner NHS board and council. This can lead to a reliance on information and advice being provided by the statutory partner organisations which influences the decisions made by the IJB. In areas where information is being shared across the partnership, we can see that more progress is being made with integration. We saw this happening in Aberdeen City IJB, where senior officer and finance officer groups bring together staff from across partner organisations to share information and skills which are essential for joint decision-making. If this does not happen, the IJB has less capacity to make change and address challenges.

What is integration?
A short guide to the integration of health and social care services in Scotland

IJB membership
(page 10)

38. We saw several barriers affecting the way that IJBs are operating, and more action is needed to increase knowledge and understanding of those involved in the decision-making process:

- Topics for discussion at IJB and committee meetings are affected by problems with both the lack of time available and with people's knowledge.
- IJB papers are often lengthy and issued to members within timescales that do not allow for proper consideration.
- Papers are often technical and contain complicated financial information that lay representatives and representatives from voluntary sector bodies may struggle to understand.
- Officers are limited in the time available to provide IJBs with information. Many officers of the IJB fulfil their role alongside roles held within statutory partner bodies.
- High turnover of people in key positions in IJBs has affected the skills available and has led to a lack of continuity and extra time being spent in building trust and relationships.

Good strategic planning is key to integrating and improving health and social care services

39. In the past, health and social care services have not linked the resources they have to their strategic priorities or longer-term plans. IAs still have work to do to ensure that priorities are linked to available resources, and to demonstrate that new ways of working will be sustainable over the longer term. IAs can only achieve this change with the support and commitment of NHS boards and councils.

40. IJBs, with the support of council and NHS board partner bodies, should be clear about **how** and **when** they intend to achieve their priorities and outcomes, in line with their available resources; and ultimately how they intend to progress to sustainable, preventative and community-based services. This includes working with NHS boards and councils to: agree which services will be stopped or decommissioned to prioritise spend; plan effective exit strategies from current ways of delivering services; and being clear how they will measure improvements in outcomes. Exit strategies are an important element in the ability to move from one service provision to another.

41. Scenario planning will help IAs build a picture of what they will need in the future. This involves looking at current trends, such as the effects of an ageing population, current lifestyles and future advances in health and social care. IAs should then use this analysis to anticipate potential changes in future demand for services and any related shortfalls in available finances. Strategic planning groups of the IJB have a role to play in ensuring the needs of the community are central to service decisions (Case study 1, page 28).

Case study 1

Shetland Scenario Planning

As part of its Strategic Commissioning Plan, the Shetland IA identified a growing gap between service demand and resources. To support strategic planning, NHS Shetland hosted a session with health and social care staff, IJB representatives, NHS board representatives, councillors, community planning partners, third-sector organisations and representatives of people using services. It considered several high-level scenarios:

1. the lowest level of local healthcare provision that it could ever safely and realistically imagine being delivered on Shetland 5-10 years from now
2. a lower level of local healthcare provision in 5-10 years than it has now on Shetland – a 'step down' from where it is now in terms of local service delivery
3. a higher level of local healthcare provision in 5-10 years than it has now on Shetland – a 'step up' from where it is now in terms of local service delivery
4. a future that describes the highest level of local healthcare provision that it could ever realistically imagine being delivered on Shetland 5-10 years from now.

The group then concentrated on scenarios 2 and 3 and explored them in more detail.

This systematic approach towards strategic planning, involving a wide variety of stakeholders, allowed them to build consensus on the main priorities of the IJB. The key outputs from the scenario planning exercise involved clear actions that were linked to a wide range of plans and policies. The key messages from the scenario planning formed discussion points within the IJB meetings. Actions identified were then incorporated into the business programme and an action tracker is a standing agenda item.

Source: Shetland IJB, 2018

42. Although strategic planning is the statutory responsibility of the IAs, councils and NHS boards should fully support the IJB and provide the resources needed to allow capacity for strategic thinking. In addition, the Scottish Government has an important role to play in leading and enabling change to take place. There must be a consistent message and understanding of integration, but this is not always the case. For example, the current move towards some aspects of health planning taking place at a regional level is causing uncertainty for IAs. Many IAs are unclear as to how this fits with the need for local strategic planning and decision-making. For IAs to think long term, they must have confidence that Scottish Government policy will support integrated thinking.

43. Strategic planning also helps to encourage and promote joined-up working and a commitment to scaling up new ways of working. Angus IJB has shown a strong long-term commitment to its enhanced community support model. This has now been implemented in three of its four locality areas and therefore has the potential for long-term impact on people's outcomes (Case study 2, page 29).

Case study 2

Angus – Enhanced community support model

Angus IJB's Enhanced Community Support (ECS) workstream involves several multi-professional teams working together, including the third-sector. The teams provide care and support in people's own homes so that, where possible, hospital admission is avoided. As a result, staff can be more proactive, coordinate care and make referrals for additional support more quickly. The teams also hold weekly meetings to review the care that is being provided in a more coordinated way.

ECS has increased community and primary care capacity leading to an average of 37 empty hospital beds across Angus per day in 2017. This helped the IJB to close 21 of its 126 community hospital inpatient beds which are no longer needed. ECS has improved hospital readmission rates. It has also improved prevention and early intervention activity through an increase in the number of anticipatory care plans.

ECS has led to a more joined-up approach between the professional disciplines which has improved referral times and access to support. This has allowed people to be more independent, access local services and be supported to stay in their homes or a homely setting for longer.

The success of this approach has allowed the IJB to roll ECS out to three of its four localities, with plans to roll out to the final locality during 2018/19. The localities that have adopted this approach for the longest have seen improvements in the average length of stay and a reduction in the number of hospital admissions for people aged over 75.

Source: Angus IJB, 2018

44. A small number of IAs do not have detailed implementation/commissioning plans to inform their strategic plan. Of those which do, about half of these provide a link to resources. More needs to be done to show how the shift from the current ways of working to new models of care will happen and when positive changes to people's lives will be achieved.

45. Workforce pressures are a clear barrier to the implementation of integration plans and workforce planning is a particularly important element of strategic planning. Workforce planning remains the formal responsibly of councils and NHS boards. However, IJBs need to work closely with their partners to ensure that their plans for service redesign and improvement link with and influence workforce plans. IAs must be able to demonstrate what skills are required to ensure they can deliver services in the right place at the right time. IAs identify not being able to recruit and retain the workforce they need as a risk. The contribution of the third and independent sector should be part of workforce planning.

46. All three parts of the Health and Social Care National Workforce Plan have now been published, with the final part on the primary care workforce published in April 2018.[9] In our 2017 report, *NHS workforce planning*, we recommended that there is a need to better understand future demand and to provide a breakdown of the cost of meeting this demand.[10] We will publish a further report on workforce planning and primary care in 2019.

Housing needs to have a more central role in integration

47. Not enough links are being made between housing and health and social care which will improve outcomes and wellbeing. Housing services are an integral part of person-centred approaches and the wider delivery of health and social care integration. All IAs are required to include a housing contribution statement in their strategic plans and housing representation is mandatory on Strategic Planning Groups. Case study 3 illustrates strategic thinking within Glasgow City IJB which has used housing as a central aspect of health and social care. Three-quarters of IJBs reported some involvement of housing services in the planning of integrated health and social care services, although we found that the extent of this involvement varied greatly between partnerships.

Case study 3

The Glasgow Housing Options for Older People (HOOP) approach

The HOOP approach involves a small team working closely with social work, health and Registered Social Landlords (RSLs). The approach aims to: ensure a smooth transition for people from hospital to a homely setting; work closely with RSLs to prioritise people who are experiencing a delay in being discharged from hospital; develop knowledge of housing stock availability; and provide reciprocal information about RSLs tenants in hospital.

The team has worked on about 1,200 cases with surgeries in 19 sites across seven hospitals, six social work offices and six intermediate care units. The outcomes of the approach include helping:

- older people make informed choices along with their families, irrespective of tenure issues
- older people to return home or to community settings supported by a care package
- to reduce delayed discharge where there are housing issues
- prevent hospital admission and readmission, supporting older people with housing issues remain in the community
- secure appropriate accommodation for older people across the city suitable for their medical needs
- to increase knowledge of Glasgow's complex housing landscape among social workers and health professionals
- housing colleagues increase their knowledge about social work and health assistance to support older people returning home from hospital
- to future proof the city's new build investment by sharing information on customer needs and demand.

Source: Glasgow City IJB, 2018

Longer-term, integrated financial planning is needed to deliver sustainable service reform

48. Partners are finding it very difficult to balance the need for medium- to long-term planning, typically three to five years and five years plus, alongside annual settlements, current commitments and service pressures. We have called for longer-term financial planning in the health sector and local government for many years. While all IAs have short-term financial plans, only a third have medium-term plans and there were no longer-term plans in place at the time of our fieldwork. This is a critical gap as the changes under integration are only likely to be achieved in the longer term.

49. The Accounts Commission has previously reported that the 'Evidence from councils' annual audit reports generally demonstrates good medium-term (three to five years) financial planning, with some councils using scenario planning to provide a range of options'.[11] IAs should draw on the experience from councils to inform development of longer-term financial plans.

50. There is little evidence that councils and NHS boards are treating IJBs' finances as a shared resource for health and social care. This is despite the requirement to do this in the legislation, and budget processes set out in integration schemes describing budget-setting based on need. Partners must work with the IJBs to establish an approach to financial planning that considers the priorities of health and social care in the local community. Councils and NHS boards can be unwilling to give up financial control of budgets and IJBs can struggle to exert their own influence on the budget-setting process.

51. National data on the balance of spending between institutional care and care in the community is only available up to 2015/16. While this does not reflect any impact from IAs, it shows that the balance of spending changed little between 2012/13 to 2015/16 (Exhibit 9, page 32). Although this data is still collated, it is no longer published. This data should be publicly available and is a helpful indicator of whether IAs are influencing the shift of resources.

52. In October 2018, the Scottish Government published its *Medium Term Health and Social Care Financial Framework*.[12] The Framework is intended to help partners to improve strategic planning. It covers the period 2016/17 to 2023/24, and sets out trends in expenditure and activity, future demand and the future shape of health and social care expenditure.

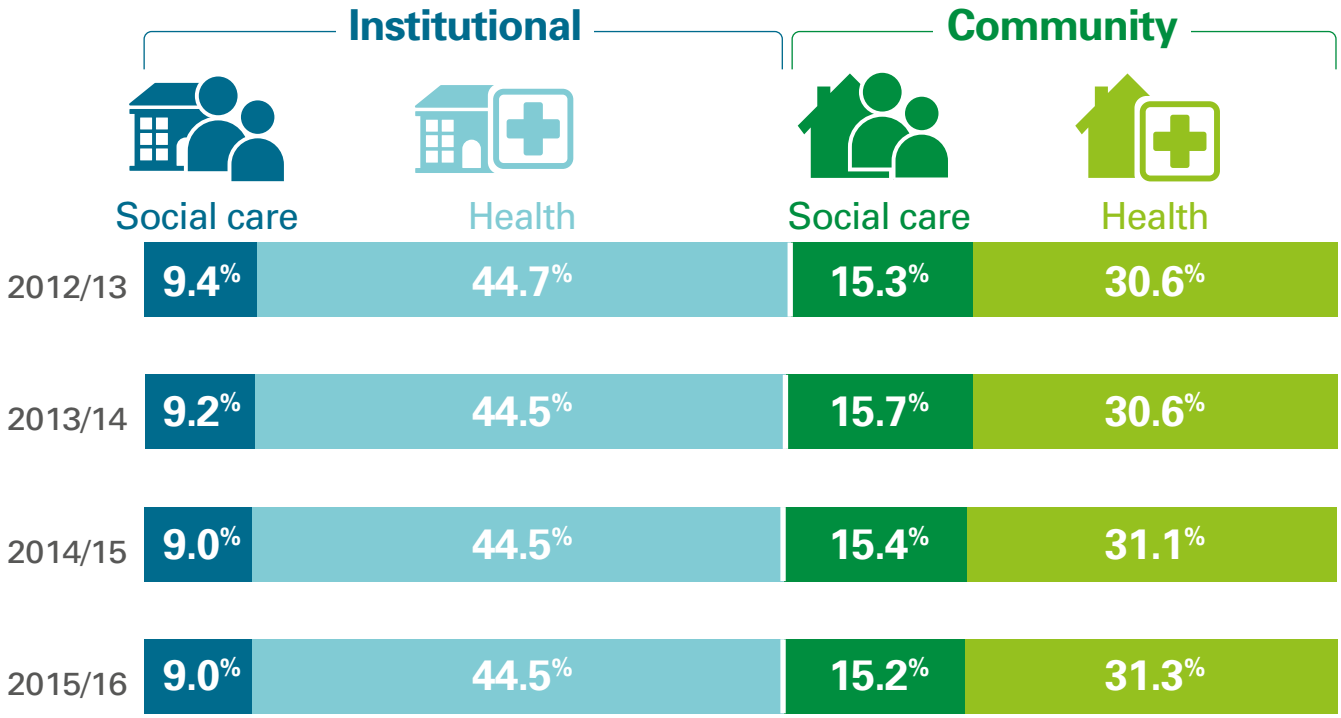
53. Attempts at integrating health and social care go back several years and it is not possible to identify the full cost of the reforms. This, in part, is due to the scale of the reforms and the interconnectedness with the rest of the health and social care system.

54. Due to ongoing financial pressures, most new service initiatives have been funded using additional financial support from the Scottish Government, rather than through the re-distribution of health and social care resources. Therefore, there should be an ongoing commitment from the Scottish Government to provide continued additional funding over coming years. This will provide financial stability to IAs while they implement new ways of working and plan how to redirect funding from current services.

Exhibit 9

The percentage of expenditure on institutional and community-based care

The percentage of expenditure on institutional and community-based care remained static between 2012/13 – 2015/16.



Source: Information Services Division, 2018

55. Major reforms have benefited from a degree of 'pump priming' money to help with change. In 2017/18, IAs total income included national funding which has been directed through NHS budgets, of:

- £100 million from the Integrated Care Fund to help shift the balance of care
- £30 million to help tackle delayed discharges
- £250 million to support payment of the living wage and help establish integration in its first year. This increased by £107 million in 2017/18.

56. The ring-fencing of funding intended to support delegated functions has not helped IAs' efforts to redirect resources, reducing their ability to use their resources flexibly. There are examples of small-scale transfers of resources and we appreciate that more time is needed for IAs to achieve this change (Case study 4, page 33). IAs need to demonstrate how they will sustain any improvements if specific dedicated funding is no longer available.

Case study 4

South Lanarkshire redirecting resources to provide more community-based care

In 2017, South Lanarkshire IJB decided to close 30 care of the elderly beds within Udston Hospital and invest in alternative community-based models of care. An assessment of need found that two-thirds of individuals on the ward could have been better cared for within a community setting. Recurring funding of about £1 million per annum was released as a result. The IJB planned for £702,000 of this to be redirected to community-based services, such as homecare and district nursing to build the area's capacity to support more people at home. To achieve this:

- engagement plans were developed to ensure people using care and their families, staff and elected members of the Udston area were involved in the changes
- financial modelling was undertaken to understand the profile of people on the ward and reallocate resources to more appropriate, alternative health and social services
- the IA worked in partnership with NHS Lanarkshire to ensure good governance.

The £702,000 provided a degree of financial flexibility to further develop intermediate care services and increase community-based rehabilitation services. The IJB plans to redesignate the Udston beds for use by step-down intermediate care patients to support a reduced reliance on the hospital and residential care.

Source: Bed Modelling in South Lanarkshire, IJB board paper, 30 October 2017

Agreeing budgets is still problematic

57. Fifteen IAs failed to agree a budget for the start of the 2017/18 financial year with their partners. This is partly down to differences in the timing of budget settlements between councils and NHS boards. It can also be due to a lack of understanding between councils and NHS boards of each other's financial reporting, accounting arrangements and the financial pressures faced by each. This lack of understanding can cause a lack of trust and reluctance to commit funds to an integrated health and social care budget.

58. There are difficulties with short-term and late budget settlements, but this should not preclude longer-term financial planning. IAs will only be able to plan and implement sustainable services if they are able to identify longer-term costs and funding shortfalls. This will also help to plan effective exit strategies from current services and larger-scale transfers of resources to community-based and preventative services.

It is critical that governance and accountability arrangements are made to work locally

59. Integrating services is a significant challenge, particularly when partners are dealing with current demand and constrained resources, while trying to better understand how services need to change. The Act should be a basis for all local partners to come together to implement changes. A perceived lack of clarity in the Act is adding to local disagreements and is delaying integration. This lack of clarity and misunderstanding is evident even among people working at senior levels and can impede good relationships.

60. Having a clear governance structure where all partners agree responsibility and accountability is vital. Disagreements can be particularly apparent when it is perceived that accountability for a decision rests with individuals who no longer have responsibility for taking them. Chief executives of councils and NHS boards are concerned that they will be held accountable for failures in how services are delivered when they are no longer responsible for directing those services. In practice, partners need to set out how local accountability arrangements will work. Integration was introduced to shift from a focus on what worked for organisations to what works for the person who needs a health and social care service. Applying this approach should help partners to implement the Act. In some areas partners are working through governance challenges as they implement the Act, and more should be done to share this experience.

61. Our first report on the integration of health and social care recommended that integration partners 'need to set out clearly how governance arrangements will work in practice…This is because there are potentially confusing lines of accountability...People may also be unclear who is ultimately responsible for the quality of care.' Clarity is still needed for local areas over who is ultimately responsible for service performance and the quality of care. In some instances, this uncertainty is hampering decision-making and redesign of services provision. Not enough has been done locally to address this.

62. IJBs have a commissioning role but most IJB COs also have delegated operational responsibility for those functions and services that are delegated to the IJB, with the exception of acute care. There are difficulties in understanding how the 'operational responsibility' aspect works in practice. Auditors report that members of IA leadership teams have differing views about governance, especially clinical governance, and roles and responsibilities. In some areas, councils and NHS boards are putting in place additional layers of reporting as if each were accountable for the actions of the IJB. The IJB approach was introduced in part to simplify arrangements, not to add complexity. There are also significant concerns about the impact of integration on the rest of the acute hospital system.

63. It is the IJB's role, through the CO, to issue directions to its partner council and NHS board about service delivery and allocation of resources. This can be made more difficult by disagreements about governance arrangements. It is complicated further by the reporting lines of the CO, who directly reports to both chief executives of the council and NHS board. COs have reported that it can be difficult to direct those who are effectively their line managers. This reinforces the need for strong relationship building and the establishment of a collective agreement over policy direction, funding arrangements and vision for integration.

Decision-making is not localised or transparent in some areas

64. The Act envisaged that decision-making would be devolved as locally as possible. In some areas, IAs, councils and NHS boards have not yet devolved decision-making in the spirit of the Act and locality plans and management structures are still in development. Officers, staff and local service providers have reported that this is because of a risk-averse response to integration that sees NHS boards and councils retain central control over decision-making. Decision-making by IAs is often influenced by statutory partners' priorities. Often, IJB members rely on their statutory partners for information, advice and policy formulation rather than taking the lead on planning and implementing new ways of providing services.

65. There are examples of IAs working hard to establish decision-making arrangements in their partnership. Aberdeen City has put in place governance systems to encourage and enable innovation, community engagement and participation, and joint working. This should leave it well placed for progressing integration and implementing new services in its community (Case study 5). We have also seen how IAs such as South Lanarkshire and Dundee City are beginning to develop locality-based approaches to service delivery (Case study 6, page 36).

Case study 5

Governance arrangements in Aberdeen City IA

Aberdeen City IJB worked with the Good Governance Institute to develop its risk appetite statement and risk appetite approach. The IJB wanted to consider which decisions and risks should, and importantly those which should not, be considered by the IJB. The idea was to ensure there was capacity for decisions to be made locally, so that staff could influence the outcomes of individuals by ensuring that care was tailored to individual needs. Staff and managers say they now feel trusted to make decisions and implement new ideas to benefit individuals in their communities.

The IJB considers that it has demonstrated an aspiration to develop and encourage innovation in local service provision, and local managers and staff understand that decision-making within localities and input of ideas is welcomed and encouraged within agreed risk parameters. Aberdeen City has worked hard to build relationships and trust throughout the partnership. It accepts that achieving its priorities will involve balancing different types of risk and that there will be a need to balance the relationship between different risks and opportunities. There is also an acceptance and tolerance that new ideas will not always be successful.

Source: Aberdeen City IJB, 2018

Case study 6

Locality approach in South Lanarkshire

In 2017, South Lanarkshire IJB realigned its management structure around its four localities. Each locality has a manager responsible for a range of multidisciplinary teams and a health and social care budget. Moving the management of services to a locality level has empowered local teams to review the models of care in their area to see what fits best for the local community. A public forum in each locality gives the local community a voice in shaping local services. Each locality has produced a local strategic needs assessment setting out local needs and priorities and directing attention towards more locally specific outcomes. A 'community first' model of care places the emphasis on developing more community capacity and support.

Staff report that multidisciplinary working and, where possible, co-location, has improved communication and learning across disciplines. They have better knowledge of skills within the wider integrated team, allowing the most appropriate professional to see people at the right time. Working with separate IT systems is a source of frustration and requires less efficient work arounds. Another challenge is balancing trying to change at pace with a need to maintain day-to-day workload. Teams have taken an incremental approach to change, starting with a small number of staff and people using the health and social care services, and, if the new model goes well, gradually increasing this until the change becomes normal practice.

Source: North Lanarkshire IJB, 2018

Best value arrangements are not well developed

66. As IJBs are local authority bodies, the statutory duty of Best Value applies to them. This means that IJBs, from the outset, must clearly demonstrate their approaches to delivering continuous improvement. In July 2017, IJBs submitted their first annual performance reports in accordance with statutory requirements. One of the reporting requirements is that they demonstrate Best Value in the delivery of services.

67. We found that some aspects of Best Value are widely covered within IJBs' annual performance reports and annual accounts, including financial planning, governance and use of resources. About half of all IJBs had a section in their annual performance reports setting out how they intended to demonstrate the delivery of Best Value. Overall the coverage varies between IJBs and is often not in enough detail to allow the public to judge the IJB's activity on continuous improvement.

IAs are using data to varying degrees to help plan and implement changes to services but there are still gaps in key areas

68. Information Services Division (ISD) is part of NHS National Services Scotland, a special NHS board. ISD provides Local Intelligence Support Team (LIST) analysts to each IA area, along with social care information known as SOURCE. Using a LIST analyst to tailor and interpret local data helps IAs to better understand local need and demand and to plan and target services. LIST also works with Community Planning Partnerships in several areas including care for prison leavers presenting to the Homeless Service and children affected by parental imprisonment.

69. Part of the work IAs are doing, supported by the LIST, is to better understand how to support the top two per cent of people using services who account for 50 per cent of hospital and GP prescribing expenditure. By doing this, they can better direct resources and take preventative steps to ensure these users receive more targeted care. This prevents unnecessary hospital admissions and improves personal outcomes through providing more appropriate care in a homely setting.

An inability or unwillingness to share information is slowing the pace of integration

70. There are several areas which need to further improve to help IAs and their council and NHS board partners make better use of data. These include:

- GP practices agreeing data-sharing arrangements with their IA
- IAs being proactive about sharing performance information, ideas and new practice with other IAs
- IAs and ISD agreeing data-sharing protocols for using data in national databases
- IAs identifying gaps in data about community, primary care and social care services and establishing how this information will be collected. This is something we have highlighted in several of our previous reports
- improving consistency in IAs' data, making comparisons easier.

71. Sharing of information, including both health and performance information, is a vital part of providing effective care that is integrated from the point of view of the people who use services. It is also vital in helping to anticipate or prevent need. Throughout our work we were told of examples where this was not happening in practice, because of local systems or behaviours. Examples include: GP practices being unwilling to share information from new service pilots with other IAs; IAs themselves being unwilling to share performance and good practice information with others; and difficulties in setting up data-sharing agreements between IAs and ISD. Different interpretations of data protection legislation are not helping with the ease with which information is being shared.

72. NHS and social care services are made up of many different specialties and localities, often with different IT systems, for example, systems to record X-ray results or record GP data. Many of these systems have been built up over years and commissioned separately for different purposes. Some services still rely on paper records.

73. This disjointedness has an impact on people who need care and on the ability of health and care professionals to provide the best support that they can. For example, people with multiple and complex health and care conditions can have to explain their circumstances to many different professionals within a short space of time. This can delay people getting the help they need, waste resources and gets in the way of care provision being more responsive to people's needs. Local data-sharing arrangements need to be in place so that professionals can appropriately share and protect the data they hold.

74. Time and money are being spent on fixing local IT problems when national solutions should be found. Local fixes are being put in place to help overcome data-sharing barriers. This includes bringing teams of staff together under one roof, so

they can discuss individual cases, rather than relying on electronic systems such as internal emails to communicate. Local areas are spending time and money implementing solutions which may continue to be incompatible in the future. There is a need for a coordinated approach to the solution, which includes the need to consider a national, single solution for Scotland.

75. New IT systems and technology are crucial to implementing new ways of working. For example, many areas are beginning to introduce virtual means of contacting people using care services, such as video links to people's homes so they do not have to visit a health or care centre. To do this successfully, a reliable communication infrastructure is needed, particularly in rural areas.

76. In April 2018, the Scottish Government published *Scotland's Digital Health & Care Strategy: Enabling, Connecting & Empowering*. As part of this, a new national digital platform is to be developed to enable the sharing of real-time data and information from health and care records as required, across the whole care system. We will monitor developments as part of our work programme.

Meaningful and sustained engagement will inform service planning and ensure impact can be measured

77. IAs were set up to have active public involvement, for example through the make-up of their boards and requirements that they publish and engage with communities about their plans. We found some good local examples of engagement. From our analysis of IA strategic plans, we saw evidence of community engagement that influenced the IA's priorities (Case study 7, page 39). Levels of ongoing engagement, and how much it shapes service redesign, are more difficult to judge, but several IAs explicitly mention the importance of engagement and see it as a priority.

78. Several third and independent sector organisations reported that they do not feel that IAs seek or value their input, although they have innovative ways to improve local services that will positively affect the lives of local people. Providers believe that service decisions are based on the funding available over the short term, rather than the needs of the community. Third-sector providers also report that there is often not time to attend engagement meetings, gather information for consultations or research lengthy committee papers. Therefore, IAs have a responsibility to help them become involved and to work with them earlier. IAs must discuss potential changes to services and funding with providers as early as possible.

79. Early engagement with staff, as with the public, has reduced since IAs published strategic plans. Staff want to know how they are contributing to the progress of integration. More communication and involvement will both help increase knowledge of the services available across partnerships and help overcome cultural differences and reluctance to accept change in ways of working.

80. Throughout this report we have recognised the challenging context IAs are operating in. This is inevitably having an impact on the extent to which they can meaningfully engage communities in discussions about improvements to services. IAs need to have in place wide-ranging and comprehensive arrangements for participation and engagement, including with local communities. Where local arrangements for engagement have been shown to work, these should continue. Engagement does not have to be managed and directed solely by the IA. If a local department or service has established relationships and means of engaging with third and independent sector providers which have proved successful, these should continue as before.

Case study 7

Edinburgh IJB: public engagement

The enhanced and proactive engagement approach adopted by Edinburgh IJB facilitated the involvement of the voluntary sector organisations in the co-production of strategic planning. Via the Edinburgh Voluntary Organisation Council, which sits on the IJB board as a non-voting member, the IJB invited the Lothian Community Health Initiatives' Forum (LCHIF) onto its Strategic Planning Groups (SPG). This allowed the LCHIF to get involved in developing the IJB's five strategic Commissioning Plans: Older People, Mental Health, Physical Disabilities, Learning Disabilities, and Primary Care.

LCHIF was subsequently invited to be part of the Older People's and Primary Care Reference Groups. Through involvement on the two reference groups, LCHIF and its members were able to contribute to the work that most reflected the services being delivered by them. The initial involvement of LCHIF on the SPG led to further engagement with other key influencing groups and networks which they felt ultimately benefited the sector, the forum and its members.

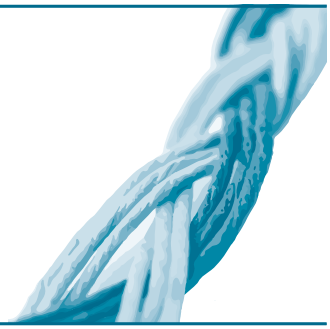
In addition to this involvement, the IJB has also embarked upon a review of its grants to the third-sector. This has been done in full collaboration and partnership with the third-sector. Through the SPG, a steering group was appointed, again with the involvement of LCHIF. This involvement contributed to a commitment being made to establish a grants forum in recognition of the ongoing dialogue that is required to ensure that prevention, early intervention and inequalities remains a priority for the IJB.

Source: Edinburgh IJB, 2018.

81. In September 2017, the Scottish Parliament's Health and Sport Committee published *Are they involving us? Integration Authorities' engagement with stakeholders*, an inquiry report on IAs' engagement with stakeholders.[13] The Committee also found a lack of consistency in stakeholder engagement across IAs. While some areas of good practice were cited, the Committee heard concerns over engagement being 'tokenistic', 'overly top down' and 'just communicating decisions that had already been made'. The Committee argued that a piecemeal approach to engagement with stakeholders cannot continue and that meaningful engagement is fundamental to the successful integration of health and social care services.

82. There is also a role for the Scottish Government in continuing to develop how learning from successful approaches to integration is shared across Scotland. IAs are not being proactive about sharing success stories and the principles behind the planning and implementation of new ways of working which have worked well. Much could be learnt from the work done to date in local areas and IAs should be encouraged to engage with each other and share knowledge and performance information.

Endnotes



1 More details about the joint inspections are available at the Care Inspectorate website.

2 *Health and social care integration*, Auditor General and Accounts Commission, December 2015.

3 *English local authority reserves,* Chartered Institute of Public Finance and Accountancy, June 2015.

4 This takes account of North Ayrshire IJB, which was the only IJB to have an accumulated negative reserve balance. This amounted to £5.8 million and was because of overspends in social care services that were not funded by additional allocations from the NHS board or council.

5 *NHS in Scotland 2018*, Auditor General, October 2018.

6 *Local government in Scotland: Challenges and performance 2018*, Accounts Commission, April 2018.

7 National Performance Framework, Scottish Government, June 2018.

8 *Systems thinking and systems leadership*, NHS Education for Scotland, 2016.

9 *National Health and Social Care Workforce Plan Part 3 – improving workforce planning for primary care in Scotland*, Scottish Government, April 2018.

10 *NHS workforce planning*, Auditor General, July 2017.

11 *Local government in Scotland: Challenges and performance 2018*, Accounts Commission, April 2018.

12 *Medium Term Health and Social Care Financial Framework*, Scottish Government, October 2018.

13 *Are they involving us? Integration Authorities' engagement with stakeholders*, Health and Sport Committee, Scottish Parliament, September 2017.

Appendix 1

Audit methodology

Our objective: To examine the impact public bodies are having as they work together to integrate health and social care services in line with the Public Bodies (Joint Working) (Scotland) Act 2014.

Our audit questions:

- What impact is integration having and what are the barriers and enablers to this change?
- How effectively are IAs planning sustainable, preventative and community-based services to improve outcomes for local people?
- How effectively are IAs, NHS boards and councils implementing the reform of health and social care integration?
- How effectively is the Scottish Government supporting the integration of health and social care and evaluating its impact?

Our methodology:

- Reviewed documents, such as integration schemes, IAs' strategic plans, IJBs' annual audit reports, annual performance reports, national performance data and other key documents including the Scottish Government's National Health and Social Care Financial Framework.
- Interviews, meetings and focus groups with a range of stakeholders including third-sector and independent sector providers. Our engagement involved hearing about experiences of engaging with IAs and how services had changed through integration.
- Interviews at four case study sites – Aberdeen City IJB, Dundee City IJB, Shetland Islands IJB and South Lanarkshire IJB. We met with:
  - Chief Officers and Chief Finance Officers
  - Chairs and vice-chairs of IJBs
  - NHS and council IJB members
  - Chief social work officers
  - IJB clinical representatives (GP, public health, acute, nursing)
  - IJB public representatives (public, carer and voluntary sector)
  - Heads of health and social care, nursing, housing and locality managers and staff
  - NHS and council chief executives and finance officers
  - IT, communications and organisational development officers.

Appendix 2

Advisory group members

Audit Scotland would like to thank members of the advisory group for their input and advice throughout the audit.

Member	Organisation
Alison Taylor	Scottish Government
Alistair Delaney	Healthcare Improvement Scotland
Allison Duncan	IJB Vice Chair
Eddie Fraser	IJB Chief Officer
Fidelma Eggo	Care Inspectorate
Gerry Power	Health and Social Care Alliance
Jeff Ace	NHS Chief Executive
John Wood	Convention of Scottish Local Authorities (COSLA)
Julie Murray	Society of Local Authority Chief Executives
Robin Creelman	IJB Vice Chair
Tracey Abdy	IJB Chief Finance Officer

Note: Members sat in an advisory capacity only. The content and conclusions of this report are the sole responsibility of Audit Scotland.

Appendix 3

Progress against previous recommendations

Recommendations	Progress
Scottish Government should:	
• work with IAs to help them develop performance monitoring to ensure that they can clearly demonstrate the impact they make as they develop integrated services. As part of this: – work with IAs to resolve tensions between the need for national and local reporting on outcomes so that it is clear what impact the new integration arrangements are having on outcomes and on the wider health and social care system.	IAs are reporting locally on outcomes but this is not being drawn together to give a national picture of outcomes for health and social care.
• monitor and publicly report on national progress on the impact of integration. This includes: – measuring progress in moving care from institutional to community settings, reducing local variation in costs and using anticipatory care plans – reporting on how resources are being used to improve outcomes and how this has changed over time – reporting on expected costs and savings resulting from integration.	We found there are a significant number of indicators and measures being used nationally and locally to understand whether integration is making a difference and to monitor changes. But, for the public to understand how the changes are working at a Scotland-wide level, these indicators need to be presented in a clear and transparent way. The Scottish Government has introduced a series of national outcomes for health and social care. The outcomes are not being routinely reported at a national level. The savings estimated to be made from integration were expected to derive from a reduction in unplanned bed days, fewer delayed discharges, improved anticipatory care and less variation in bed day rates across partnerships. The savings from these have not been specifically monitored by the Scottish Government, although actual and projected performance across these measures is reported to the Scottish Government's Ministerial Steering Group.
• continue to provide support to IAs as they become fully operational, including leadership development and sharing good practice, including sharing the lessons learned from the pilots of GP clusters.	Some leadership development has been commissioned from the Kings Fund by the Integration Division at Scottish Government but there is a lack of joint leadership development across the health and social care system to help to embed and prioritise collaborative leadership approaches. There is an appetite for examples of good practice from local partnerships but still a lack of good learning resources.

Cont.

Recommendations	Progress
Integration Authorities should:	
• provide clear and strategic leadership to take forward the integration agenda; this includes: – developing and communicating the purpose and vision of the IJB and its intended impact on local people – having high standards of conduct and effective governance, and establishing a culture of openness, support and respect.	We found that a lack of collaborative leadership and cultural differences are proving to be significant barriers to change in some areas.
• set out clearly how governance arrangements will work in practice, particularly when disagreements arise, to minimise the risk of confusing lines of accountability, potential conflicts of interests and any lack of clarity about who is ultimately responsible for the quality of care and scrutiny. This includes: – setting out a clear statement of the respective roles and responsibilities of the IJB (including individual members), NHS board and council, and the IJB's approach towards putting this into practice – ensuring that IJB members receive training and development to prepare them for their role, including managing conflicts of interest, understanding the organisational cultures of the NHS and councils and the roles of non-voting members of the IJB.	There is a lack of agreement over governance and a lack of understanding about integration which is acting as a significant barrier to progress in some areas. There are still circumstances where clarity is needed over who is ultimately responsible for service performance and the quality of care. In some instances, this uncertainty is hampering decision-making and redesigning how services are provided. Not enough has been done locally to address this.
• ensure that a constructive working relationship exists between IJB members and the chief officer and finance officer and the public. This includes: – setting out a schedule of matters reserved for collective decision-making by the IJB, taking account of relevant legislation and ensuring that this is monitored and updated when required – ensuring relationships between the IJB, its partners and the public are clear, so each knows what to expect of the other.	IAs have helped to improve engagement with the public and providers in the local area in some instances but there is more to do.
• be rigorous and transparent about how decisions are taken and listening and acting on the outcome of constructive scrutiny, including: – developing and maintaining open and effective mechanisms for documenting evidence for decisions – putting in place arrangements to safeguard members and employees against conflict of interest and put in place processes to ensure that they continue to operate in practice – developing and maintaining an effective audit committee – ensuring that effective, transparent and accessible arrangements are in place for dealing with complaints. – ensuring that an effective risk management system is in place.	We found that decision-making is not localised or transparent in some areas and risk management arrangements are not well developed.

Cont.

Recommendations	Progress
• develop strategic plans that do more than set out the local context for the reforms; this includes: – how the IA will contribute to delivering high-quality care in different ways that better meets people's needs and improves outcomes – setting out clearly what resources are required, what impact the IA wants to achieve, and how the IA will monitor and publicly report their progress – developing strategies covering the workforce, risk management, engagement with service users and data sharing, based on overall strategic priorities to allow the IA to operate successfully in line with the principles set out in the Act and ensure these strategies fit with those in the NHS and councils – making clear links between the work of the IA and the Community Empowerment (Scotland) Act and Children and Young People (Scotland) Act.	IAs are beginning to link their resources to strategic priorities but more needs to be done to show when their planned outcomes will be achieved. They also need to show how the shift from the current ways of working to new models of care will happen.
• develop financial plans that clearly show how IAs will use resources such as money and staff to provide more community-based and preventative services. This includes: – developing financial plans for each locality, showing how resources will be matched to local priorities – ensuring that the IJB makes the best use of resources, agreeing how Best Value will be measured and making sure that the IJB has the information needed to review value for money and performance effectively.	There is some evidence of small-scale transfers of resources, but most IAs have funded changes to services using ring-fenced funding, such as specific additional integrated care funding provided by the Scottish Government. This is instead of shifting resources from an acute setting, such as hospitals, to community settings such as local clinics and GP surgeries. While this may have achieved performance improvement in things such as delayed discharges, ring-fenced funding may not be available long term. Therefore, IAs need to ensure the financial sustainability of ongoing support for changes made. Financial planning is not integrated, or long term and financial pressures make meaningful change hard to achieve. Arrangements for understanding and measuring Best Value arrangements are not well developed.
• shift resources, including the workforce, towards a more preventative and community-based approach; it is important that the IA also has plans that set out how, in practical terms, they will achieve this shift over time.	We found there has been limited change in how resources are being used across the system at this stage – see above.

Cont.

Recommendations	Progress
Integration Authorities should work with councils and NHS boards to:	
• recognise and address the practical risks associated with the complex accountability arrangements by developing protocols to ensure that the chair of the IJB, the chief officer and the chief executives of the NHS board and council negotiate their roles in relation to the IJB early in the relationship and that a shared understanding of the roles and objectives is maintained.	We found a lack of agreement over governance and a lack of understanding about integration remain significant barriers in some areas. There are still circumstances where clarity is needed over who is ultimately responsible for service performance and the quality of care. In some instances, this uncertainty was hampering decision-making and redesigning how services are provided. In our opinion, not enough has been done locally to address this.
• review clinical and care governance arrangements to ensure a consistent approach for each integrated service and that they are aligned to existing clinical and care governance arrangements in the NHS and councils.	Auditors report that members of IA leadership have differing views about governance, especially clinical governance, and roles and responsibilities.
• urgently agree budgets for the IA; this is important both for their first year and for the next few years to provide IAs with the continuity and certainty they need to develop strategic plans; this includes aligning budget-setting arrangements between partners.	We found that at present, not all councils and NHS boards view their finances as a collective resource for health and social care. Some councils and NHS boards are still planning budgets around their own organisations rather than taking account of their IJBs local strategic priorities. The ambition for integration is that the health and social care resources in the local area would be brought together and used to deliver integrated services with improved outcomes for people. While this is happening in some areas, councils and NHS boards in other areas can be unwilling to give up financial control of budgets and IJBs can struggle to exert influence over their budgets. Some IAs have little or no involvement in the budget-setting process. At a very basic level IJBs struggle in some areas to agree budgets. Fourteen IJBs failed to agree a budget for the start of the 2017/18 financial year.
• establish effective scrutiny arrangements to ensure that councillors and NHS non-executives, who are not members of the IJB board, are kept fully informed of the impact of integration for people who use local health and social care services.	We have seen that IJB board papers are shared with council and NHS board partner organisations. In some areas though, rather than streamlining governance and scrutiny arrangements, councils and NHS boards are putting in place additional layers of reporting as if each were accountable for the actions of the IJB.
• put in place data-sharing agreements to allow them to access the new data provided by ISD Scotland.	IAs and ISD are have difficulties in agreeing data-sharing protocols for using national databases.

Appendix 4

Financial performance 2017/18

IJB	Position (pre-additional allocations) Overspend/ (underspend)	Additional allocation/ (reduction) Council	Additional allocation/ (reduction) NHS board	Use of reserves	Year-end position Deficit/ (Surplus)
	(£million)	(£million)	(£million)	(£million)	(£million)
Aberdeen City	2.1	0	0	2.1	0
Aberdeenshire	3.5	1.5	2.0	0	0
Angus	(0.4)	0	0	0	(0.4)
Argyll and Bute	2.5	1.2	1.4	0	0
Clackmannanshire and Stirling	2.2	0.6	0.6	1.1	0
Dumfries and Galloway	(2.5)	0	0	0	(2.5)
Dundee City	2.5	0	2.1	0.4	0
East Ayrshire	3	2.2	1.3	0	(0.5)
East Dunbartonshire	1.1	0	0	1.1	0
East Lothian	0.7	0.6	0.1	0	0
East Renfrewshire	(0.4)	0	0	0	(0.4)
Edinburgh	7.4	7.2	4.9	0	(4.7)
Eilean Siar	(3.0)	0	0	0	(3.0)
Falkirk	1.3	0	1.4	0.2	(0.3)
Fife	8.8	2.5	6.4	0	0
Glasgow City	(12.0)	0	0	0	(12.0)
Inverclyde	(1.8)	0	0	0	(1.8)
Midlothian	(0.7)	0.2	0	0	(0.9)
Moray	1.9	0	0	1.9	0
North Ayrshire	3.5	0	1.0	0	2.6
North Lanarkshire	(11.7)	0	0.6	0	(12.3)
Orkney	0.7	0.2	0.5	0	0
Perth and Kinross	(1.4)	(2.6)	1.3	0	0
Renfrewshire	4.8	2.7	0	2.1	0
Scottish Borders	4.5	0.3	4.2	0	0
Shetland	2.4	(0.3)	2.9	0	(0.2)
South Ayrshire	0.3	0	0	0.3	0
South Lanarkshire	(1.2)	0	1.0	0	(2.2)
West Dunbartonshire	(0.6)	0	0	0	(0.6)
West Lothian	1.8	0	1.8	0	0

Note: Arithmetic differences arising from roundings.
Source: Audited Integration Authority annual accounts, 2017/18

Health and social care integration

Update on progress

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NORTH AYRSHIRE
Health and Social Care Partnership

Agenda Item 6

Integration Joint Board
13 December 2018

Subject:	**Budget Monitoring – Month 7 (October 2018)**
Purpose:	To provide an update on the projected financial outturn for the financial year as at October 2018.
Recommendation:	It is recommended that the IJB: a) Note the projected year-end overspend of £0.481m; b) Approve the changes in funding as detailed in section 2.12 and Appendix E; and c) Note the impact of the financial recovery plan and the progress being made in delivering financial balance.

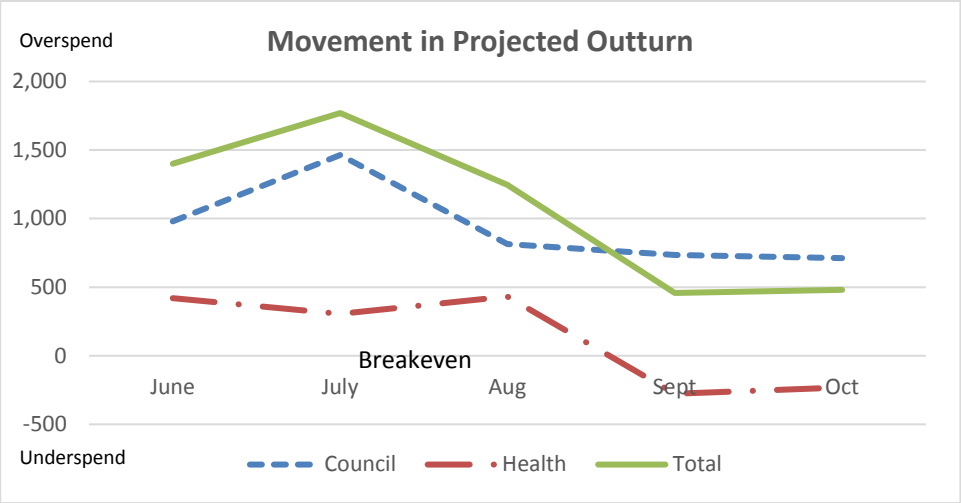
Glossary of Terms	
NHS AA	NHS Ayrshire and Arran
HSCP	Health and Social Care Partnership
MH	Mental Health
CAMHS	Child & Adolescent Mental Health Services
BRAG	Blue, Red, Amber, Green
UNPACS	UNPACS, (UNPlanned Activities) – Extra Contractual Referrals
ARG	Allocation of Resources Group
CRES	Cash Releasing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

1.	**EXECUTIVE SUMMARY**
1.1	The report provides an overview of the financial position for the partnership and outlines the projected year-end outturn position informed by the projected expenditure and income commitments, these have been prepared in conjunction with relevant budget holders and services. It should be noted that although this report refers to the position at the October period end that further work is undertaken following the month end to finalise projections, therefore the projected outturn position is as current and up to date as can practicably be reported.
1.2	The projected outturn is a year-end overspend of £0.481m for 2018-19, taking account a number of mitigating actions outlined in the report and the improvement from implementation of the financial recovery plan. There is scope for this positon to fluctuate due to in-year cost and demand pressures and assumptions in relation to funding and the achievement of savings.
1.3	The position as at September was a projected overspend of £0.458m, this excluded the impact of the workforce savings target therefore a deterioration in the position is now reported. The projected outturn position has not changed materially which provides assurance over the reliability of projections and further confidence that the

	scale of the projected overspend is reducing to a level whereby financial balance is possible by the year-end. There are further actions on the financial recovery plan which will potentially further improve the position and services will continue to deploy tight financial management controls. If the financial recovery plan does not deliver the required improvement to the financial position or there is a significant deterioration to the projected position there is a risk that further actions will require to be identified and service quality and performance may be compromised to achieve financial balance.
1.4	Overall the main areas of pressure continue to be care homes, looked after children, learning disability care packages, elderly and adult in-patients within the lead partnership and the unallocated NHS CRES savings. The main adverse movements from period 6 are in relation to independent living services, charging order income and residential placements for children. The main favourable movement was in relation to community mental health reflecting resource following patients from hospital to community.
1.5	It is essential that the IJB operates within the delegated budget and commissions services from the Council and Health Board on this basis. Financial balance has not been delivered in previous years and in the current financial year there is a projected overspend position. More is being done to ensure the financial sustainability of the partnership and to deliver financial balance for the current year and significant progress is being made to work towards this. The service transformation programme and the delivery of the those service changes will be at the forefront as this will have the greatest impact on the delivery of financial balance and the ongoing sustainability and safety of services.
2.	**CURRENT POSITION**
2.1	The report includes an overview of the financial position including commitments against the available resource, explanations for the main budget variances, an update on progress in terms of savings delivery, actions required to work towards financial balance and progress with delivery of the recovery plan.
	FINANCIAL PERFORMANCE
2.2	Against the full-year budget of £234.552m there is a projected overspend of £0.481m (0.2%). An integrated view of the financial position should be taken, however it is useful to note that this overall position consists of a projected overspend of £0.712m in social care services partly offset by a projected underspend of £0.231m in health services. Appendix A provides the financial overview of the partnership position. The sections that follow outline the significant variances in service expenditure compared to the approved budgets with detailed analysis provided in Appendix B.
2.3	**Health and Community Care Services**
	Against the full-year budget of £65.279m there is a projected overspend of £0.137m (0.2%). The main reasons for the projected overspend are: a) Care home placements including respite placements – projected to overspend by £0.885m. This is a favourable movement of £0.035m from period 6 mainly due to reduced use of respite placements.

	b) Independent Living Services are projected to overspend by £0.382m which is an adverse movement of £0.088m mainly due to two new residential care packages. c) Over-recovery of Charging Order income of £0.200m which is an adverse movement of £0.090m based on a review of projected income. d) Equipment and Adaptations are projected to underspend by £0.200m in line with the mitigation approved in period 4. e) Packages of care are projected to overspend by £0.230m due to the use of supplementary staffing and one additional package assumed from early 2019 onwards. f) Care at home (purchased and in house) projected underspend of £0.612m. The projected underspend has reduced by £0.048m due to increased demand.. g) Long Term Conditions (Ward 1), projected overspend of £0.411m which is mainly due to an overspend in employee costs to ensure staffing levels are at a safe level. This is a recurring pressure for which funding requires to be identified, this will be addressed as part of the 2019-20 budget process. h) District Nursing is projected to underspend by £0.165m due to vacant posts.
2.4	**Mental Health Services**
	Against the full-year budget of £72.875m there is a projected overspend of £0.133m (0.2%). The main reasons for the projected overspend are: a) Learning Disabilities – projected overspend of £0.685m of which £0.635m is in relation to care packages and £0.223m for direct payments. These overspends are partially offset by vacant posts. b) Community Mental Health – is projected to underspend by £0.524m mainly due to vacancy savings and an underspend in care packages. The underspend in care packages has increased by £0.195m due to funding being released for patients being discharged from hospital into the community. c) Lead Partnership – overall projected overspend of £0.056m which consists of: *Overspends:* • Adult inpatients £0.466m - mainly due to the delay in generating income from other areas in respect of forensic beds. All of the beds are expected to be sold and in use by the end of January 2019. The recovery plan assumes a fifth bed will be sold prior to the end of the financial year. This is dependent on ensuring delayed discharges in ward 6 are discharged to the community. This is a risk as some of the delayed discharges are South partnership patients and would require SAHSCP to provide funding to facilitate the discharge. • Psychiatry £0.131m - primarily due to locum costs, an unfunded EMH liaison post and a reduction in funding for trainee psychiatrists. There is an

	increased use of locum staff in the absence of being able to recruit permanent posts. • Elderly Inpatients £0.399m – due to the use of supplementary staffing. • CRES £0.986m - lead partnership share of the unachieved CRES carried forward, this element of the historic CRES will remain aligned to the Mental Health lead partnership and will be addressed as part of the budget planning for 2019-20. *Underspends:* • UNPACS £0.334m – due to the delay in the two new care packages assumed in year. The underspend is partially attributable to the availability and use of beds in ward 6 which have prevented more costly external placements. • Learning Disabilities £0.261m - due to a delay in the transfer of an UnPACs patient, this transfer has now taken place. • CAMHS £0.370m – due to vacancies and delays with recruitment. • Psychology £0.430m – due to vacancies.
2.5	**Children Services & Criminal Justice**
	Against the full-year budget of £35.235m there is a projected underspend of £0.275m (0.8%). The main reasons for the projected underspend are: a) Residential Schools and Community Placements – projected overspend of £0.812m. The projection is based on the current number of placements and estimated discharge dates for each placement based on the support from the Challenge Fund investment. The overspend has increased by £0.069m due to a delay in the planned discharge dates, the delivery of further planned discharges continues to be a risk to the projected outturn position. b) Looked After Children Placements – projected underspend of £0.408m due to the current demand for fostering, adoption and kinship payments. The underspend has decreased by £0.026m mainly due changes in the assumptions on future demand. c) Early Years – are projected to underspend by £0.472m mainly due to the level of vacancies in heath visiting.
2.6	**Projected Outturn Movement**
	The movement in the projected outturn position is illustrated in the chart below:



The position has fluctuated significantly in the five months of reporting this financial year. This is reflective of the demand driven nature and high cost of some services. The position has significantly improved and become more stable period 5 mainly because the adverse movements have been offset by favourable variances, the position will continue to be closely monitored.

There are a number of high risk areas that may impact on the movement in the projected outturn position in future months:

- Children's Residential School Placements
- Remand Placements within Children's Services
- Learning Disability Care Packages
- Local Government pay award settlement
- Impact of any delays in discharge of South Ayrshire patients
- Impact of Lead Partnership services

2.7 **Primary Care - Prescribing**

Against a full year budget of £49.308m primary care prescribing and general medical services are projected to be underspend by £0.086m, this is in relation to an underspend in enhanced services.

2.8 **CRES update**

	Permanent or Temporary	**£ 000's**
CRES Saving brought forward		2.557
Additional Workforce savings	P	0.055
TOTAL		**2.612**
Arrol Park employee costs	T	(0.250)
Payroll turnover target increase	T	(0.215)
Addictions	P	(0.364)
Children's services employee costs	P	(0.060)
Balance still to be achieved in 2018-19		**1.723**

Of the £1.723m still to be achieved £0.986m is allocated to the Lead Partnership for Mental Health and the balance of £0.737m remains to be allocated across other services and is reported against Management and Support costs.

Given that overall there is a projected underspend in the Health element of the budget the unidentified CRES savings are being offset on a non-recurring basis for 2018-19.

There is a requirement to formally identify these savings as part of the 2019-20 budget process.

The £0.986m aligned to the Lead Partnership against Mental Health services should remain aligned to those services. The service are developing plans to re-design Elderly Mental Health beds, this will deliver significant savings to contribute to this target. The business case for the review will be brought to a future IJB meeting for approval.

2.9 **Savings Progress**

a) The 2018-19 budget included £4.003m of savings plus £2.557m of carried forward NHS CRES savings (total £6.560m). A further workforce saving of £0.055m was approved in period 6 taking the total to £6.615m.

BRAG Status	Position at Budget Approval £m	Position at Period 7 £m
Red	3.148	2.424
Amber	0.519	0.649
Green	2.893	0.676
Blue	0.000	2.866
TOTAL	**6.560**	**6.615**

b) The projected year-end outturn position assumes that the Red savings will not be delivered as planned and this is reflected in the overall projected outturn position, these are:

i. Reduction in care home places £0.391m
ii. Challenge Fund – physical disability care packages £0.200m
iii. Capping of respite £0.070m
iv. NHS CRES savings carried forward £1.668m
v. Reduction in mileage - £0.040m
vi. Additional Workforce saving - £0.055m

If progress is made to deliver the savings this would improve the overall outturn position. It is encouraging that the level of savings with red status has reduced since the budget was approved, recognising a greater level of confidence of delivery and the progress made so far with identifying savings against the CRES target.

The projected financial position assumes that all remaining savings on the plan will be delivered. Progress with savings delivery requires to be closely monitored to ensure the impact on the financial position can be assessed and corrective action taken where necessary. Appendix C provides full detail on the savings.

A Transformation Board is in place to provide oversight and governance to the programme of service change. A focus of the Board is to ensure plans are in place to deliver savings and service change, with a solutions focussed approach to bringing programmes back on track. This also includes ensuring we have the right resources in place to support the delivery of service change programmes.

2.10 **Financial Recovery Plan**

	The IJB approved the recovery plan in August and progress against this is provided in appendix D. The impact of the plan so far has been to improve the financial position by £0.740m. There are a number of additional actions noted on the plan for which the financial impact cannot be quantified at this stage but these actions are expected to contribute positively to the financial position. The plan will be an iterative document to remain under review. Progress with the financial recovery plan will continue to be monitored to ensure it has the required impact. There is a risk that if the planned impact is not achieved that further actions will require to be added to the plan and these may include actions that would impact on the quality and performance of front line services.
2.11	**Budget Changes**
	The Integration Scheme states that "*either party may increase it's in year payment to the Integration Joint Board. Neither party may reduce the payment in-year to the Integration Joint Board nor Services managed on a Lead Partnership basis…..without the express consent of the Integration Joint Board".* Appendix E highlights the movement in the overall budget position for the partnership following the initial approved budget. ***Reductions Requiring Approval:*** The specific reductions that the IJB are required to approve are: • Medical Pay Award £0.064m – correction to the pay award uplift which was wrongly allocated last month.. • Ailsa Hairdressing £0.011m – transferred to the South partnership. • Medical Training Grade adjustment £0.009m - NES have reduced the number of posts being funded by 0.4WTE. It is recommended that the IJB approve the budget reductions outlined above. ***Future Planned Changes:*** Further areas which are outstanding and will be included in future reports include: • The North Ayrshire share of the Intermediate Care and Rehab (ICR) investment; • The disaggregation of some mental health wards from the lead partnership arrangement.
2.12	**Lead Partnerships**
	North Ayrshire HSCP Services managed under Lead Partnership arrangements by North Ayrshire Health and Social Care Partnership are projected to be £0.043m overspent, this includes the allocation of the unachieved CRES target carried forward.
	South Ayrshire HSCP

	Services hosted and/or led by the South Partnership are forecast to overspend by £0.200m as at month 7. This primarily relates to a projected overspend of £0.212m over on the Community Equipment Store.
	East Ayrshire HSCP Services managed under Lead Partnership arrangements by East Ayrshire Health and Social Care Partnership are projected to overspend by £0.295m. This represents an improved position on the £1.211m month 4 projected overspend. The overall Primary Care Lead Partnership projected overspend is £0.398m and this variance mainly relates to additional payments within Primary Medical Services to GP practices currently experiencing difficulty (£0.785m). This pressure was offset in the previous financial year by non-recurring slippage on the Primary Care Transformation Fund, as well as non-recurring Dental Services savings. A non-recurring allocation of funding for Out of Hours services £0.305m which has been applied to Ayrshire Urgent Care Services (AUCS) has assisted in reducing the projected overspend. The overspend for AUCS is £0.165m which has improved due to a redesign of appointment allocation and better control of rates through positive management action. Dental Services is projected to underspend by £0.475m however it should be noted that recruitment is ongoing for specialist posts which may impact in the final quarter of the current financial year. Prison and Police Healthcare is projected to underspend by £0.095m predominately as a result of staffing savings which have resulted from vacancies within the service.
	Further work is being taken forward to develop a framework to report the financial position and impact of risk sharing arrangements across the 3 partnerships in relation to hosted or lead service arrangements. This is to ensure the IJB are fully sighted on the impact for the North Ayrshire partnership. The IJB will be kept informed of progress with this work which is being progressed by the Ayrshire Partnership Finance Leads.
2.13	**Set Aside** The Integration Scheme makes provision for the Set Aside Budget to be managed in-year by the Health Board with any recurring over or under spend being considered as part of the annual budget setting process. The 2018-19 set aside budget for North HSCP is £28.055m, based on expenditure in 2017-18. The acute directorate, which includes the areas covered by the set aside budget, is projected to overspend of circa £11.4m. 129 additional and unfunded beds were open at the 31st March 2018. This had reduced to 58 by the 31st October 2018. There are clear plans in place to reduce these in a phased manner ensuring continuation of service and patient safety. During 2017-18 the North Partnerships use of the set aside resources was £28.055m against the NRAC 'fair share' of £26.563m which is £1.492m above the 'fair share'. There is an expectation that the North Partnership will move towards its 'fair share'. The Models of Care programmes including the Intermediate Care and Rehab investment and the Palliative End of Life proposals being developed represent agreed or potential investment by NHS A&A to invest in community services with a view to reducing acute beds. This is in effect a mechanism to reduce the set aside resources.

3.	**PROPOSALS**
3.1	**Anticipated Outcomes**
	Continuing to closely monitor the financial position will allow the IJB to take corrective action where required to ensure the partnership can deliver services in 2018-19 from within the available resource, thereby limiting the financial risk the funding partners, i.e. NAC and NHS AA. The transformational change programme will have the greatest impact on the financial sustainability of the partnership, the IJB require to have a clear understanding of progress with plans and any actions that can be taken to bring the change programme into line.
3.2	**Measuring Impact**
	Updates to the financial position will be reported to the IJB throughout 2018-19.
4.	**IMPLICATIONS**

Financial:	The financial implications are as outlined in the report. Against the full-year budget of £234.552m there is a projected overspend of £0.481m (0.2%). The report outlines the action being taken and proposed action to reduce the projected overspend. The recovery plan totals £1.255m with £0.740m delivered to date. There are a number of other actions are being progressed to reduce the overspend further. The main areas of financial risk which may impact on this position are highlighted in the report.
Human Resources:	None
Legal:	None
Equality:	None
Children and Young People	None
Environmental & Sustainability:	None
Key Priorities:	None
Risk Implications:	If the financial recovery plan does not deliver the required improvement to the financial position there is a risk that further actions will require to be identified and service quality and performance may be compromised to achieve financial balance.
Community Benefits:	None

	Direction to :-	
	1. No Direction Required	√

Direction Required to Council, Health Board or Both	2. North Ayrshire Council	
	3. NHS Ayrshire & Arran	
	4. North Ayrshire Council and NHS Ayrshire & Arran	

4.	**CONSULTATION**
4.1	This report has been produced in consultation with relevant budget holders and the Partnership Senior Management Team. The report is shared with the Director of Finance for NHS Ayrshire and Arran and the Executive Director Finance and Corporate Support for North Ayrshire Council.
5.	**CONCLUSION**
5.1	It is recommended that the IJB: a) Note the projected year-end overspend of £0.481m; b) Approve the changes in funding as detailed in section 2.12 and Appendix E; and c) Note the impact of the financial recovery plan and the progress being made in delivering financial balance.

For more information please contact:

Caroline Whyte, Chief Finance & Transformation Officer on 01294 324954 or carolinewhyte@north-ayrshire.gcsx.gov.uk

Eleanor Currie, Principal Manager – Finance on 01294 317814 or eleanorcurrie@north-ayrshire.gcsx.gov.uk

2018-19 Budget Monitoring Report–Objective Summary as at 31 October 2018

Appendix A

Partnership Budget - Objective Summary	2018/19 Budget									2018/19	
	Council			Health			TOTAL				
	Budget	Projected Outturn	Projected Over/ (Under) Spend Variance	Budget	Projected Outturn	Projected Over/ (Under) Spend Variance	Budget	Projected Outturn	Projected Over/ (Under) Spend Variance	Over/ (Under) Spend Variance at Period 6	Movement in projected budget variance from Period 6
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
COMMUNITY CARE AND HEALTH	**53,591**	**53,589**	**(2)**	**11,688**	**11,827**	**139**	**65,279**	**65,416**	**137**	**(156)**	**293**
: Locality Services	24,708	25,488	780	4,178	4,260	82	28,886	29,748	862	691	171
: Community Care Service Delivery	25,793	25,231	(562)	0	0	0	25,793	25,231	(562)	(613)	51
: Rehabilitation and Reablement	1,017	903	(114)	1,437	1,286	(151)	2,454	2,189	(265)	(322)	57
: Long Term Conditions	1,735	1,624	(111)	4,315	4,575	260	6,050	6,199	149	114	35
: Integrated Island Services	338	343	5	1,758	1,706	(52)	2,096	2,049	(47)	(26)	(21)
MENTAL HEALTH SERVICES	**23,514**	**24,017**	**503**	**49,361**	**48,991**	**(370)**	**72,875**	**73,008**	**133**	**370**	**(237)**
: Learning Disabilities	18,000	18,813	813	477	349	(128)	18,477	19,162	685	757	(72)
: Commmunity Mental Health	4,131	3,856	(275)	1,628	1,379	(249)	5,759	5,235	(524)	(329)	(195)
: Addictions	1,383	1,348	(35)	1,226	1,177	(49)	2,609	2,525	(84)	(84)	0
: Lead Partnership Mental Health NHS Area Wide	0	0	0	46,030	46,086	56	46,030	46,086	56	26	30
CHIDREN'S AND JUSTICE SERVICES	**31,712**	**31,829**	**117**	**3,523**	**3,131**	**(392)**	**35,235**	**34,960**	**(275)**	**(247)**	**(28)**
: Intervention Services	3,772	3,696	(76)	303	317	14	4,075	4,013	(62)	(74)	12
: Looked After & Accomodated Children	16,229	16,680	451	0	0	0	16,229	16,680	451	356	95
: Fieldwork	4,588	4,572	(16)	0	0	0	4,588	4,572	(16)	21	(37)
: CCSF	319	266	(53)	0	0	0	319	266	(53)	(42)	(11)
: Justice Services	2,655	2,655	0	0	0	0	2,655	2,655	0	0	0
: Early Years	321	242	(79)	2,847	2,454	(393)	3,168	2,696	(472)	(469)	(3)
: Policy & Practice	3,828	3,718	(110)	0	0	0	3,828	3,718	(110)	(25)	(85)
: Lead Partnership NHS Children's Services Area Wide	0	0	0	373	360	(13)	373	360	(13)	(14)	1
PRIMARY CARE	0	0	0	49,308	49,222	(86)	49,308	49,222	(86)	(86)	0
ALLIED HEALTH PROFESSIONALS				4,570	4,417	(153)	4,570	4,417	(153)	(152)	(1)
MANAGEMENT AND SUPPORT COSTS	4,883	5,006	123	460	1,074	614	5,343	6,080	737	677	60
CHANGE PROGRAMME	658	629	(29)	1,284	1,301	17	1,942	1,930	(12)	52	(64)
TOTAL	**114,358**	**115,070**	**712**	**120,194**	**119,963**	**(231)**	**234,552**	**235,033**	**481**	**458**	**23**

2018-19 Budget Monitoring Report – Detailed Variance Analysis per service

Appendix B

	Budget £000's	Projected Outturn £000's	Projected Over/ (Under) Spend Variance £000's	
COMMUNITY CARE AND HEALTH	**65,279**	**65,416**	**137**	
Locality Services	28,886	29,748	862	**Older People permanent care homes** - permanent placements are projected overspend of £0.930m based on 841 placements (584 Nursing and 257 Residential) and an assumption that placements are on a one in one basis to the end of the year. This is an increase of 5 places from prior month. Respite care projected overspend of £0.045m, favourable movement of £0.042m based on the spend to date. This also reflects the £0.300m of agreed funding from the Carers allocation which was agreed as part of the recovery plan in period 4. **Independent Living Services :** * Direct Payment packages projected underspend of £0.093m on 59 current packages. * Indirect Payment packages no charges to date, projected underspend £0.045m based on prior year spend. * Adult respite care projected overspend £0.050m based on current spend to date. * Residential Packages projected overspend of £0.042m which is an adverse movement of £0.067m based on 39 current packages and an expected net decrease in packages of 2. * Community Packages (physical disability) overspend of £0.428m based on 64 current packages, and an expected decrease of 1 package. **Equipment Budget** - £0.318m budget for equipment- projected £0.100m underspend in line with approved mitigation. **Employee costs** - projected £0.188m underspend: Money Matters structure approved resulting in part year vacancies. **NHS Packages of Care** - projected overspend of £0.230m due to high use of supplementary staffing. **District Nursing** - projected underspend of £0.165m assuming Band 6 vacancies are filled. **Income from Charging Orders** - over recovery of £0.200m expected per income received to date and projected income receivable.
Community Care Service Delivery	25,793	25,231	(562)	**Care at home** **- in house service -** projected underspend of £0.342m based on current costs. The cost of recruiting 30 staff in October and November will be funded by a reduction in casual and overtime costs. - **Purchased Care at home** - projected underspend of £0.270m based on current level of spend continuing to end of year. **Direct Payments** - projected underspend of £0.056m based on 33 current package less 10% expected recovery from underspent balances. **Transport costs** - projected overspend of £0.079m due to increase in staff mileage within care at home and ferry charges. **Admin costs -** projected overspend of £0.099m mainly due to mobile phone equipment. **Voluntary Organisations** - projected overspend £0.080m (CLASP HOPE £0.020m and Alzheimer £0.060m). **Income** - projected over recovery £0.142m based on current receipts and an increase in Community Alarm income.

	Budget £000's	Projected Outturn £000's	Projected Over/ (Under) Spend Variance £000's	
Rehabilitation and Reablement	2,454	2,189	(265)	**Employee costs -** projected underspend £0.190m due to vacancies. Adaptations Budget - £0.487m - projected £0.100m underspend in line with approved mitigation.
Long Term Conditions	6,050	6,199	149	**Carers Centres** - projected £0.100m underspend based on additional funding for the Carers Strategy. **Ward 1 -** projected overspend of £0.411m assuming current staffing levels continue. **Ward 2 -** projected underspend of £0.045m, assuming funding from East HSCP for Kirklandside Ward. **Elderly CMHT -** projected underspend of £0.097m assuming current staffing levels continue.
Integrated Island Services	2,096	2,049	(47)	**Outwith the threshold for reporting**
MENTAL HEALTH SERVICES	**72,875**	**73,008**	**133**	
Learning Disabilities	18,477	19,162	685	**Residential Packages-** projected underspend of £0.038m based on current 38 packages £2.439m less 2% invoice variances. **Community Packages -** projected overspend of £0.635m based on current 338 packages less 9.75% invoice variances and a net movement in year of 3 new packages. Challenge Fund savings of £0.256m expected to be achieved. **Direct Payments -** projected overspend of £0.223m based on 40 current packages less 10% underspent balances and an expected increase of 3 packages in year. **Employee costs -** projected underspend £0.220m mainly due to vacant posts **Income -** projected under recovery of £0.100m based on current receipts and no income from other local authorities for use of Taigh Mor respite service as this is being fully utilised to meet the respite needs of North service users.
Community Mental Health	5,759	5,235	(524)	**Community Packages -** projected underspend of £0.276m based on 99 packages less assumed invoice differences between planned and actual service delivered plus a net increased of 4 packages. This underspend includes £0.150m in relation to additional funding projected for hospital discharges. **Employee costs** - projected underspend £0.249m mainly due to vacant posts
Addictions	2,609	2,525	(84)	**Addictions Team -** projected underspend of £0.084m due to in year vacancies. Assumes that any ADP underspend will require to be carried forward for use in future years.

	Budget £000's	Projected Outturn £000's	Projected Over/ (Under) Spend Variance £000's	
Lead Partnership (MHS)	46,030	46,086	56	**Adult Community** - projected underspend of £0.079m due to vacancies in the crisis team. **Adult Inpatients**- projected overspend of £0.466m due to a delay in bed sale income. The projection assumes three low secure beds from November and a further bed from January. **UNPACs** - projected to underspend by £0.334m. Assumption that there will be no change to NHS GG&C charge and there will be 2 new care packages in-year. **LDS -** projected to underspend by £0.261m due to delay in UNPACs transfer. **Elderly Inpatients** - projected to overspend by £0.399m due to use of supplementary staff. **CAMHS** - projected underspend is £0.370m based on projected staffing levels. **MH Admin** - projected underspend of £0.076m. This is after the transfer of services to East and South. **Psychiatry** - projected to overspend by £0.131m, primarily due to locums and a reduction in Dean funding. EMH Liaison post remains unfunded. **MH Pharmacy** - projected to underspend by £0.082m mainly within substitute prescribing due to the benefit on over-accrual in 2017-18. **Psychology**- projected to underspend by £0.430m based on projected staffing levels. **CRES target** - projected overspend of £0.986m in relation to savings still to be identified. **Projected underspends in other areas -** include Associate Nurse Director budgets £0.033m, slippage on mental health allocations of £0.070m and resource transfer reserve £0.098m.
CHIDREN'S SERVICES AND CRIMINAL JUSTICE	**35,235**	**34,960**	**(275)**	
Intervention Services	4,075	4,013	(62)	**Employee costs -** projected underspend £0.147m mainly due to vacant posts. **Care Leavers -** projected overspend 0f £0.057m based on current number of service users.

	Budget £000's	Projected Outturn £000's	Projected Over/ (Under) Spend Variance £000's	
Looked After & Accom Children	16,229	16,680	451	**Looked After Children placements - projected underspend of £0.408m based on the following:-** **Kinship - p**rojected overspend of £0.167m. Budget for 302 placements, currently 319 placements and projecting 320 by the year end. **Adoption -** projected underspend of £0.028m. Budget for 78 placements, currently 68 placements and projecting 71 by the year end. **Fostering** - projected underspend of £0.307m. Budget for 140 placements, currently 116 placements and projecting 130 placements by the year end. **Fostering Xtra** - projected underspend of £0.142m. Budget for 32 placements, currently 26 placements and projecting 26 by the year end. **Private fostering - p**rojected underspend of £0.080m. Budget for 16 placements, currently 11 placements and projecting 12 by the year end. **Fostering respite-** projected on-line. **IMPACCT carers** - projected underspend of £0.007m based on 3 carers providing support for full year. **Adoption Fees** - projected overspend of £0.070m due to external agency fees and 2 placements from other Councils. **Residential School placements including community packages -** projecting an overspend of £0.812m. Projection based 2 current secure placements, one projected to December, one projected to March. 22 residential and community placements projected to leave as 1 in November, 1 in December, 6 in January and 1 from February with 13 placements remaining at March 2019. Remand budget of £100k, at present projection assumes this will be spent **Employee Costs - p**rojected underspend of £0.088m due to vacancies.
Fieldwork	4,588	4,572	(16)	**Outwith the threshold for reporting**
CCSF	319	266	(53)	**Employee costs -** projected underspend £0.041m mainly due to vacant posts.
Criminal Justice	2,655	2,655	0	**Assumed to come in line with budget**
Early Years	3,168	2,696	(472)	**Employee costs -** projected underspend of £0.418m due to vacancies. **CAMHS budget** - projected underspend of £0.056m
Policy & Practice	3,828	3,718	(110)	**Children with a disability care packages** - projected underspend of £0.100m based on current placements.
Lead Partnership (CS & CJ)	373	360	(13)	**Outwith the threshold for reporting**

	Budget £000's	Projected Outturn £000's	Projected Over/ (Under) Spend Variance £000's	
PRIMARY CARE	49,308	49,222	(86)	**Prescribing -** projected underspend of £0.086m based on activity to date.
ALLIED HEALTH PROFESSIONALS	4,570	4,417	(153)	**Employee costs -** projected underspend due to vacancies.
Management & Support Services	5,343	6,080	737	**CRES savings -** projected overspend of £0.682m relating to CRES savings still to be identified and £0.055m in relation to workforce savings.
CHANGE PROGRAMME and challenge Fund	1,942	1,930	(12)	**Outwith the threshold for reporting**
TOTAL	**234,552**	**235,033**	**481**	

Threshold for reporting is + or - £50,000

North Ayrshire Health and Social Care Partnership

Appendix C

2018/19 Savings

Council Commissioned Services

Service	Description	RAG Status at budget setting	Updated Rag Status	Gross Saving 2018/19 £000's	Net Saving 2018/19 £000's	Net Saving Projected to be Achieved at Period 7 £000's	Projected Shortfall
Children & Criminal Justice	Children & Criminal Justice Challenge Fund Projects - Investment in Universal Early Years	Green	Amber	100	47	47	-
Children & Criminal Justice	Children & Criminal Justice Challenge Fund Projects - School-based Approach to Reducing Looked After (LAC)/Looked After and Accommodated Numbers(LAAC)	Green	Amber	200	106	106	-
Children & Criminal Justice	Children & Criminal Justice Challenge Fund Projects - Reduction in Needs for Residential School placements enhancing our community supports with a new team.	Green	Amber	536	340	340	-
Children & Criminal Justice	Children & Criminal Justice Challenge Fund Projects - Expansion of the Multi Agency Assessment and Screening Hub (MAASH)	Green	Amber	37	26	26	-
Children & Criminal Justice	Reallocation of Partnership Forum budget with associated savings	Green	Blue	40	40	40	-
Children & Criminal Justice	To reduce the Learning and Development team	Amber	Blue	75	75	75	-
Children & Criminal Justice	Reduction in Staffing	Green	Blue	25	25	25	-
Children & Criminal Justice	To discontinue the mentoring project for young people	Green	Green	25	25	25	-
Community Care & Health	Community Care & Health Challenge Fund Projects - Physical Disabiliites	Green	Red	200	200	-	200
Community Care & Health	Community Care & Health Challenge Fund Projects - Reablement	Green	Blue	228	181	181	-
Community Care & Health	Reduction in staff from the Arran social work team	Amber	Blue	13	13	13	-
Community Care & Health	Withdrawl of funding to Crossroads, Largs	Green	Blue	14	14	14	-
Community Care & Health	Additional projected income	Green	Green	155	155	155	-
Community Care & Health	WRVS saving	Green	Blue	8	8	8	-
Community Care & Health	Reduction in Care Home Placements - proposal to reduce 25 placements.	Red	Red	391	391	-	391
Community Care & Health	Reduction in Care at Home	Red	Blue	200	200	200	-

Service	Description	RAG Status at budget setting	Updated Rag Status	Gross Saving 2018/19 £000's	Net Saving 2018/19 £000's	Net Saving Projected to be Achieved at Period 7 £000's	Projected Shortfall
Mental Health	Mental Health - Challenge Fund Projects	Green	Green	226	226	226	-
Mental Health	Redesign and recommission a mental health support service at a reduced cost.	Amber	Blue	30	30	30	-
Mental Health	Reduction in Caley Court Learning Disability Team.	Amber	Green	48	48	48	-
Mental Health	Reduction in staff at Hazeldene Day service	Amber	Green	35	35	35	-
Management & Support	Review all support secondments/posts which could be provided by parent organisations to the HSCP.	Amber	Blue	50	50	50	-
Management & Support	Operational savings generated by the business support review.	Amber	Green	150	150	150	-
Management & Support	Planning and Performance Team - reduction in staffing	Green	Green	37	37	37	-
Cross Service	Pilot Sickness Absence Taskforce within the HSCP	Green	Blue	100	75	75	-
Cross Service	Staff Mileage - 10% reduction across the partnership	Green	Red	40	40	-	40
Cross Service	Bring forward phase 2 Challenge Fund savings from 2019/20 to 2018/19	Green	Blue	250	250	250	-
Cross Service	Cap respite across all services to 35 days	Green	Amber	200	200	130	70
Change and Improvement	Change Team Restructure	Green	Blue	108	108	108	-
Change and Improvement	Integrated Care Fund - reduction in spend and discontinued projects	Green	Blue	218	218	218	-
		TOTAL		**3,739**	**3,313**	**2,612**	**701**

NHS Commissioned Services **Appendix C**

Service	Description	RAG Status at budget setting	Updated Rag Status	Gross Saving 2018/19 £000's	Net Saving 2018/19 £000's	Net Saving Projected to be Achieved at Period 7 £000's	Projected Shortfall
Change and Improvement	Integrated Care Fund - reduction in spend and discontinued projects	Green	Blue	242	242	242	-
Planning and Performance	Change Team Restructure	Green	Blue	108	108	108	-
Mental Health	Review of Psychology Services - Phase 2	Green	Blue	47	47	47	-
Mental Health	Prescribing - Secondary 1%	Amber	Blue	7	7	7	-
Mental Health	Add UNPACS 1%	Amber	Blue	23	23	23	-
Mental Health	Psychiatry 1%	Amber	Blue	55	55	55	-
Mental Health	Addictions 1%	Amber	Blue	13	13	13	-
Community Care & Health	Arran	Amber	Blue	20	20	20	-
Community Care & Health	Delayed Discharge Funding	Green	Blue	53	53	53	-
Community Care & Health	District Nursing Supplies	Green	Blue	7	7	7	-
Community Care & Health	Reduction in staffing - Arran	Green	Blue	30	30	30	-
Cross Service	Supplies	Green	Blue	80	80	80	-
Cross Service	Transport	Green	Blue	5	5	5	-
Cross Service	Savings carried forward from 2017/18	Red	Red	2,557	2,557	889	1,668
Cross Service	Workforce saving allocation	Red	Red	55	55	-	55
		TOTAL		**3,302**	**3,302**	**1,579**	**1,723**
	GRAND TOTAL			**7,041**	**6,615**	**4,191**	**2,424**

Financial Recovery Plan (IJB approved Sept 2018)

Appendix D

Ref	Service Area	Recovery Action Proposed	Status: Complete In Progress Delayed	Estimated Benefit £ 000's	Achieved (included in the projected outturn) £ 000's	Remaining Balance £ 000's	Responsible Officer
1	Care Homes	Phased reduction in care home numbers as more people will be supported at home. This would focus on a reduction in residential care placements by utilising the capacity in community services (eg care at home, district nursing) to support people to remain supported in their own homes.	Complete	200	200	-	Stephen Brown (David Rowland)
2	Learning Disability	From September there will be a full time care manager seconded to a dedicated learning disability review team. This will assist in achieving the planned Challenge Fund savings and contribute to the financial recovery plan.	In Progress	100	-	100	Thelma Bowers
3	Learning Disability	Sleepovers - the current sleepovers are being reviewed to assess which could be provided using the existing out of hours responder service. There is not currently a savings target aligned to sleepover services.	In Progress	100	-	100	Thelma Bowers
4	Learning Disability	Review of all 2:1 supports for clients, from reviews already undertaken a reduction has been delivered, plan to review remaining supports.	In Progress	75	-	75	Thelma Bowers
5	Cross Service	Review of all transition cases (e.g. LD adults aged 65+) to ensure the appropriate care is provided (saving is estimate net of alternative care provision).	In Progress	150	-	150	Thelma Bowers
6	Cross Service	Audit of compliance with the charging policy to ensure consistency of application across services.	In Progress	50	-	50	Caroline Whyte
7	Carers	Increased demand for Respite services, contributing to overall overspend, use element of Carers Act funding for support for respite. Non recurring basis for 2018-19, reviewed as part of 2019-20 budget in line with plan for Carer's Act funding and implementation.	Complete	300	300	-	Stephen Brown (David Rowland)
8	Equipment	Temporary reduction (2018-19 only) in the equipment budget due to the Challenge Fund investment being used to clear the waiting list. This will be kept under review together with any waiting lists and impact on delivery of community based services.	Complete	100	100	-	Stephen Brown (David Rowland)
9	Adaptations	Temporary reduction (2018-19 only) in the adaptations budget. This will be kept under review together with any waiting lists and impact on delivery of community based services.	Complete	100	100	-	Stephen Brown (David Rowland)
10	MH Inpatients	Current plans assume 4 bed sales to support service costs, actively market a 5th bed.	In Progress	40	-	40	Thelma Bowers
11	Learning Disability	Cease payment of Resource Transfer for a historic arrangement in relation to one patient moving outwith NHS A&A.	Complete	40	40	-	Thelma Bowers
		TOTAL		**1,255**	**740**	**515**	

Other actions being taken:

Ref	Service Area	Action	Responsible Officer
1	Learning Disability	Extension of CM2000 to adult services which will enable payment to care providers based on actual service delivered. Greatest potential impact will be from 2019-20.	Thelma Bowers
2	Learning Disability	Developing alternative approaches to personal assistant provision to accompany service users to social events	Thelma Bowers
3	Learning Disability	Developing alternative approaches to transport for service users to social events.	Thelma Bowers
4	Cross Service	The partnership vacancy scrutiny group continues to review all vacant posts which leads to non-recurring savings. This has been added to by the NHS also undertaking a workforce management review group.	Stephen Brown
5	Cross Service	The absence pilot approved by the IJB in August may lead to reduced sickness rates and associated reduced absence related costs.	Julie Davis
6	Mental Health	A review and redesign of Elderly Mental Health wards is being undertaken. There will be no savings in 2018-19 but outcome may reduce the projected overspend.	Thelma Bowers
7	Commissioned services	Review all outstanding contractual uplifts	Caroline Whyte

2018/19 Budget Reconciliation

Appendix E

COUNCIL	**Period**	**Permanent / Temporary**	**Budget £000's**
Initial Approved Budget	2		92,353
Resource Transfer	2	P	22,317
ICF Procurement Posts - Transfer to Procurement	2	T	(89)
Additional Pension Costs	4	P	(9)
Reduction in Criminal Justice Settlement	5	P	(243)
Budget from Education - Activity Agreements at Rosemount	6	T	29
Period 7 reported budget			**114,358**

HEALTH	**Period**	**Permanent / Temporary**	**Budget £000's**
Initial Approved Budget (including estimated pay award funding)	2		138,638
Resource Transfer	2	P	(22,317)
GIRFEC – Health Visitors	3	P	47
Remove estimated pay award	4	P	(1,496)
Actual pay award	4	P	1,462
Specialist Pharmacist upgrade	4	P	11
MH Admin – transfer to East and South	5	P	(1,198)
NES junior doctor funding	5	P	(80)
HD424 - NMAHP Clinical Lead	5	P	16
Allocation of the AHP budget	6	P	4,570
Mental Health Strategy - Action 15	6	P	571
ADP CRES Reduction	6	P	462
Medical Pay Award	6	P	204
Medical Training Grade Adjustment	6	P	49
Band 3 Admin funding transferred from East	6	P	14
Breast Feeding Programme - Health Visitor	6	P	9
Mental Health Admin Split to South/East(Supplies)	6	P	(72)

Prescribing Reduction	6	P	(567)
Biggart Ward Closure 2017 - North Split	7	P	10
Medical Pay Award Correction	7	P	(64)
Ailsa Hairdressing transferred to South	7	P	(11)
Medical Training Grade Adjustment	7	P	(9)
Workforce saving allocation	7	P	(55)
Period 7 reported budget			**120,194**

GRAND TOTAL	**234,552**

Agenda Item 7

Integration Joint Board
13 December 2018

Subject:	**Implementation of the Charter for Involvement**
Purpose:	To provide an update on actions to take forward the 12 statements within the Charter
Recommendation:	That the IJB support the existing actions outlined and undertake to promote the relevance of the Charter across all aspects of the North Ayrshire Health & Social Care Partnership.

Glossary of Terms	
NHS AA	NHS Ayrshire and Arran
HSCP	Health and Social Care Partnership
ARC Scotland	Association for Real Change Scotland
LD	Learning Disabilities

1.	**EXECUTIVE SUMMARY**
1.1	The Charter For Involvement is a set of 12 statements developed by the National Involvement Network which describes how members of the network wanted to be involved in services and communities. It arose out of a learning disabilities context, but has relevance across all care groups.
1.2	North Ayrshire Health and Social Care Partnership signed up to the Charter in 2017, and continues to deliver on its aspirations through the ongoing work in relation to the North Ayrshire Learning Disabilities Strategic Plan. ARC Scotland have also created new opportunities for the promotion of the Charter through the creation of an Ayrshire Policy and Development Worker post, tasked with working with the 3 Ayrshire Partnerships to implement the Charter.
1.3	While work is ongoing in relation to the Charter and people with learning disabilities, there is a need to ensure that the Charter impacts across the breadth of services within the Partnership.
2.	**BACKGROUND**
2.1	North Ayrshire Health and Social Care Partnership has signed up to the Charter for Involvement. With this commitment there comes an expectation of actions that will progress the realisation of the Charter's 12 statements within North Ayrshire. This commitment is reflected in the prioritisation of the adoption of the Charter within the North Ayrshire Learning Disabilities (LD) Strategic Plan. Discussion of the Charter

	was a key facet at the launch of the LD Strategic Plan, and it continues to be promoted in discussions with the integrated team, service users, and providers.
3.	**PROPOSALS**
3.1	The recent establishment of a Policy and Development Worker, working across Ayrshire for 3 years and supported by ARC Scotland, provides a strong additional mechanism for realising the Charter within North Ayrshire. Discussions with the ARC Development Worker have led to the identification of 3 priority areas for their involvement: • Involvement in the North Ayrshire Service User 'strategy group': Reflecting the Charter's focus on involvement in service development, it was agreed that the Development Worker would have an ongoing role in support of the new service user group established in order to take forward themes within the North Ayrshire LD Strategic Plan. The first meeting of this group took place on the 8th of November, with service users from Hazeldene and the George Steven Centre comprising the majority of the group. In addition there was representation from the Enable ACE group, based in Saltcoats. The group explored the themes of Keeping Safe, Getting Around, Making Connections, and Staying Well, with a view to identifying the topic they wanted to focus on at the next meeting. The topic chosen was Getting Around, reflecting a wide variety of issues and opportunities in relation to transport and travel. The next meeting of the group is scheduled for the 6th of December. • Involvement in the Review project: The review work to be undertaken (in the first instance) in the Garnock Valley represents an extremely valuable opportunity to explore current experiences of service users in relation to participating in reviews, with a view to informing the approach to be taken in this work. It was agreed that the Development Worker would support this process by facilitating discussions with service users as required, again reflecting the Charter's focus on involvement in decisions made by organisations. • Involvement in the establishment of a new Day Service at Trindlemoss: Building on discussions within the Tarryholme Drive Project Communication Group, it was agreed that the Development Worker would support engagement with service users at Fergushill and George Steven Centre, in the interests of keeping them informed and involved with regard to the move to the new Day Service. The Charter includes a focus on involvement in communities, which is a key aspect of the vision for Trindlemoss. In addition to the above, the existing Ayrshire National Involvement Network has been involved in the naming of a new pan-Ayrshire Newsletter covering learning disability issues (initiated by staff within the North Partnership). The newsletter reflects (and will continue to reflect) the aims of the Charter with regard to keeping people informed and involved, and will serve as a means of sharing good news stories across Ayrshire. Distribution of the first newsletter will take place before the end of November, with the intention that it is produced quarterly. As noted above, the Charter has relevance across all care groups, as such opportunity will also be sought to raise the profile of the Charter within the forthcoming Partnership-wide staff programme around asset based working.

3.2	**Anticipated Outcomes**
	Properly realising the Charter across the breadth of services within the Partnership will comprise a significant step towards the co-creation of services and communities along with the people of North Ayrshire, empower them to be active participants in the ongoing evolution of the Partnership, and (at an individual level) ensure that the supports they receive are relevant to their needs and hoped for outcomes.
3.3	**Measuring Impact**
	The National Involvement Network has already undertaken a review of the organisations who had, at that point, signed up to the Charter, with regard to how they had been implementing it. We would anticipate being part of any future such exercise, as well as working with the ARC Scotland Policy and Development Worker, and other partners to record and describe actions and outcomes in relation to the Charter on an ongoing basis.
4.	**IMPLICATIONS**
	The relevance of the Charter extends across all the priorities identified within the LD Strategic Plan. As such, progressing the implementation of the Charter will be fundamentally linked to all the work associated with the Strategy implementation. However it is essential to note that it has relevance beyond people with learning disabilities, and should impact across all care groups, reflecting the Partnership's strategic aims around delivering care together. Initial discussion with the ARC Policy and Development Worker involved CAMHS. While this represented a positive start to broadening the impact of the Charter, it is hoped that the IJB will take a key role in affirming the responsibility of all services to realise the 12 statements, to the benefit of the people of North Ayrshire.

Financial :	NA
Human Resources :	Promotion of the Charter and the realisation of the Partnership's responsibilities in relation to it will require staff and services to be aware of and support its implementation
Legal :	NA
Equality :	Implementing the Charter will support marginalised care groups to become more involved in shaping their supports, services and communities.
Environmental & Sustainability :	NA.
Key Priorities :	Implementation of the Charter aligns closely with the North Ayrshire LD Strategic Plan but also reflects the Noth Ayrshire Health & Social Care Partnership's STRATEGIC Plan (2018-2021) with regard to working in partnership with service users and communities.
Risk Implications :	NA
Community Benefits :	NA

Direction Required to Council, Health Board or Both *(where Directions are required please complete Directions Template)*	Direction to :-	
	1. No Direction Required	X
	2. North Ayrshire Council	
	3. NHS Ayrshire & Arran	
	4. North Ayrshire Council and NHS Ayrshire & Arran	

5.	**CONSULTATION**
5.1	The Charter for Involvement comprises a regular feature of local discussions with people with learning disabilities, and was used to frame part of the event at which the local LD Strategic Plan was launched. It will comprise an ongoing part of the discussions within the strategy service user group, and will inform discussions with service users in relation to the move to Trindlemoss and other service developments. Our experience has been that the Charter provides a relevant and accessible framework for people to frame and communicate their expectations of services.
6.	**CONCLUSION**
6.1	The Charter for Involvement provides a powerful supportive framework for realising the empowerment of individuals and communities, but delivering on its promise requires commitment from all levels within the organisation.

For more information please contact Thelma Bowers **on** 01294 317849 **or** thelmabowers@north-ayrshire.gcsx.gov.uk

Agenda Item 8

Integration Joint Board
13 December 2018

Subject: **Primary Care Services Update**

Purpose: The purpose of this report is to provide an update on progress on:

- the Primary Care and Out of Hours Services strategic direction and implementation of the Ambitious for Ayrshire Programme from 2016-2018
- the Primary Care Improvement Plan (PCIP) that was signed off on 28 June 2018 by the three Integration Joint Boards (IJBs), GP Sub Committee, and NHS Board in Ayrshire.
- the progress and future strategic direction of the Public Dental Service (PDS)

Recommendation: It is recommended that the Integration Joint Board:

(i) Consider the updates and receive assurance on progress

ANP	Advanced Nurse Practitioner
AUCS	Ayrshire Urgent Care Service
GDP	General Dental Practitioner
GP	General Practitioner
GPwSI	General Practitioner with Special Interest
GMS	General Medical Services
HSCP	Health and Social Care Partnership
IJB	Integrated Joint Board
LMC	Local Medical Committee
MDT	Multi Disciplinary Team
MoU	Memorandum of Understanding
MSK	Musculoskeletal
NDIP	National Dental Inspection Programme
OHIP	Oral Health Improvement Plan
OOH	Out Of Hours
PCIP	Primary Care Improvement Plan
PDS	Public Dental Service
VTP	Vaccination Transformation Programme

1. EXECUTIVE SUMMARY

	In May 2016 a paper setting out the strategic direction for Primary Care was presented to the IJBs and NHS Board. This strategic direction was developed after two pan Ayrshire, 'Ambitious for Ayrshire' events that took place in 2015 with all stakeholders to review and understand the priorities as well as the challenge ahead for Primary Care and Out of Hours Services. The Ambitious for Ayrshire Programme was established in 2016 to provide strategic oversight for the range of workstreams and projects that had been agreed to be taken forward within the Programme. Following the success of these projects in 2017/18, and with the introduction of the new GMS contract framework, the full spread and roll out of these services were included within the PCIP. The PCIP was signed off on 28 June 2018 by the three Integration Joint Boards, GP Sub Committee, and NHS Board in Ayrshire. It was agreed when the PCIP was presented at these groups, a six month update would be provided in December 2018 to share the progress against all the actions outlined, as well as receive an update on the Primary Care Improvement Fund. The PDS was formed in September 2013 by the merger of the Community Dental Service and Salaried Dental Service. The PDS ensures access to dentistry for all priority groups, with a specific focus on providing enhanced care to patients with complex physical, mental, medical and behavioural needs. The Scottish Government's new OHIP was published in January 2018. The document provides the strategic framework for improving the oral health of the next generation. Consideration is evolving of a future model of PDS services in Ayrshire and Arran which will support the delivery of the OHIP. This report provides an update on the range of work that has taken place 2016-2018 across Primary Care, including Dental Services, Out of Hours and the current progress of the PCIP that has been put in place to implement the new GMS contract in Ayrshire and Arran. On update on each area is included in Sections 1 to 3.

In May 2016 a paper setting out the strategic direction for Primary Care was presented to the Integration Joint Boards (IJBs) and NHS Board. This strategic direction was developed after two pan Ayrshire, 'Ambitious for Ayrshire' events that took place in 2015 with all stakeholders to review and understand the priorities as well as the challenge ahead for Primary Care and Out of Hours Services.

The Ambitious for Ayrshire Programme was established in 2016 to provide strategic oversight for the range of workstreams and projects that had been agreed to be taken forward within the Programme.

Following the approval of a new General Medical Service (GMS) Contract in January 2018, the Primary Care Improvement Plan (PCIP), which sets out how we plan to implement the new contract in Ayrshire and Arran, was presented and approved at the three IJBs and the NHS Board in June 2018, and was then submitted to Scottish Government on the 28 June 2018.

1. Ambitious for Ayrshire

Prior to the introduction of the new GMS Contract in January 2018, the Ambitious for Ayrshire Programme was structured around the identified high priority areas grouped into six workstreams, with a number of key projects within them. These were:

1) Placing Primary Care at the heart of health and social care
2) Increasing capacity in community
3) Workforce and contingency planning
4) Improved primary care infrastructure
5) Integrated and sustainable out-of-hours service
6) Address health Inequalities

The projects ranged across a number of services within Primary Care including General Practice, Community Pharmacy, Optometry and Dentistry. These were taken forward from 2016-2018. Many of them were funded as tests of change in 2016/17 through the Primary Care Transformational and Recruitment and Retention Funds. The aim of the tests of change were to enable patients to be seen at the right time, in the right place, by the most appropriate professional. Details of these tests are provided below and included: introducing Advanced Practitioner Physiotherapists, Independent Pharmacy Prescribers, Mental Health Practitioners, establishment of an Advanced Nurse Practitioner (ANP) Academy, Eyecare Ayrshire and Pharmacy First.

Following the success of these tests in 2017/18 and with the introduction of the new GMS contract framework, the full spread and roll out of these services were included within the PCIP and introducing a multi-disciplinary team in General Practice is now a standalone workstream within the implementation arrangements. A refined structure for the Programme was presented to the IJBs and NHS Board in March 2018. The sections below detail an update for each of the areas of work that were taken forward under the previous Ambitious for Ayrshire headings.

2. Placing Primary Care at the Heart of Health and Social Care

2.1 Establishment of GP Clusters

In 2016/17 eleven GP Clusters were established across the three Ayrshire and Arran H&SCPs, with each GP practice identifying a Practice Quality Lead and all GP clusters also nominating a Cluster Quality Lead.

In 2017/18 work continued to develop a bottom up approach to cluster improvement work and the Clusters, through localities, linked directly into locality planning arrangements. The Primary Care Team provided support to cluster improvement work as well as funding cluster administrative support. Currently Ayrshire and Arran is scoping with Healthcare Improvement Scotland establishing a local improvement collaborative and testing quality management system for Clusters.

2.2 Signposting and Redirection

A focussed piece of work to support the GP Practice, working with other Independent Contractors (Community Pharmacists, Dentists and Optometrists) in Stewarton commenced in August 2017. This was promoted to public through a number of platforms including, social media, local press and a young people's poster competition.

The campaign worked closely with the GP Practice supporting reception staff to be confident (via a suite of triage cards) in redirecting patients to the Optometrist, Pharmacy and Dentist. The campaign was evaluated after 12 months and this included speaking with patients and the local primary care contractors to determine its success as well as to take any learning for wider roll out. This approach is now being tested in Girvan.

Through the Centre of Excellence a training programme commenced in 2018 for front line reception/ administration staff in GP Practices to support triaging and redirecting patients who contact their surgery for an appointment. Three hundred staff have been trained (240 at level 1, 40 at level 2 and 3 at level 3 which is a train the trainer course so that Ayrshire and Arran can become self-sufficient at training) and the triage cards that were developed in Stewarton have now been circulated to a large number of practices. Feedback to date from the majority of practices has been that they are now encouraging signposting.

Redirection remains a key programme of work to support the implementation of the new GMS contract, ensuring patients are being seen by the right person, which can often be outside the GP Practice. Informing the public about the role and expertise of new practitioners working in GP Practices as well as that of other primary care contractors is essential and this will be progressed through the PCIP Engagement and Communication Plan.

2.3 Musculoskeletal Service in General Practice

In 2017 three Advanced Practitioner Physiotherapists were introduced across nine general practices to provide a first point of contact for individuals presenting with a musculoskeletal (MSK) conditions. These physiotherapists deliver assessments, diagnoses and brief interventions (e.g. exercise plans and corticosteroid injections).

NHS Ayrshire & Arran has the third highest rate of MSK demand per head of population in Scotland and MSK conditions relate to around 30% of patient of appointments within

General Practice. Over 12 months these practitioners have:Assessed 6013 patients presenting with an MSK conditions

- 66% were seen as a first point of contact with a direct saving of around 3900 GP appointments
- Following assessment by the physiotherapist only 1.3% were identified as requiring a GP intervention
- 72% of patients assessed were enabled to self-manage their condition**.**

Being based within a GP Practice also allows opportunities for the physiotherapists to work with other professionals within the Practice, as well as to signpost to community assets (e.g. weight management and local leisure facilities).

Following the early success of these new roles further recruitment has taken place. A further six physiotherapists have been appointed and will come into role December 2018/ January 2019 to provide Musculoskeletal care in more GP practices across Ayrshire.

2.4 Clinical Pharmacists in GP Practice

In line with the GMS contract there is a three year trajectory to establish a sustainable Pharmacotherapy Service where every GP practice in Ayrshire and Arran will receive pharmacist and technician support. The Pharmacotherapy service vision is to provide pharmacy support within general practice which will manage the medicine related tasks that arise in GP practices on a day-to-day basis whilst also developing specialist prescribing clinics to contribute to MDT working.

Following an existing workforce recruited with Primary Care Transformational Funding a three-year plan is in place to recruit a range of pharmacists and technicians which will maximise skill mix. Nine General Practice Clinical Pharmacists and eight Pharmacy Support Technicians have been appointed recently who will commence work following induction during December 2018 and January 2019. A further three General Practice Clinical Pharmacist posts are currently being advertised.

Focussed work will take place in four GP Practices to test the staffing levels and skill mix required for the new service model as well as to produce standard processes and procedures.

A training academy will be established to ensure comprehensive training is provided in primary care to enable pharmacy staff to develop the skills essential to provide a full pharmacotherapy service.

2.5 Mental Health Practitioners in GP Practice

In line with the GMS Contract the PCIP commits to develop Primary Care Mental Health Practitioners attached to the GP Practices. This proposal build on learning from tests of change involving Mental Health Practitioners in South Ayrshire.

A model has now been agreed to utilise around half of the new mental health Action 15 funds to develop Mental Health Practitioners who will be woven into General Practice multi-disciplinary teams, current mental health services and existing community assets to optimise their impact. Posts will provide the opportunity to test this developing model and produce evidence and data to support next stages.

2.6 Linkworkers / Community Connectors

Each H&SCP has developed Community Linkworker / Community Connector roles working in GP Practices. There has been a differing genesis of the role in each HSCP but they have significant common elements. Through the PCIP the roles developed are being reviewed with a view to evolve an approach for future pan-Ayrshire working. The number of Linkworkers / Connectors whole time equivalent in post and planned is 12 in North Ayrshire H&SCP, 8 in East Ayrshire HSCP and 6.5 in South Ayrshire HSCP.

These workers support individuals living with long term conditions, significant mental health challenges, socially challenging circumstances and social isolation. These roles have been received very positively by both the public and GPs.

2.7 Ayrshire Community Phlebotomy Service

The new Ayrshire Community Phlebotomy Service went live on 15 August 2018. The service supports taking blood for acute specialities for patients in the community. The introduction of this service means that GPs are not required to action the results of these tests. Initially the service was tested for renal patients with a cautious uptake, the first patient was seen by a Community Phlebotomist in North Ayrshire on 12 September. Urology has now commenced referring patients and the intention in October is to extend access across all Acute services.

The current thinking in the Primary Care Nursing Workstream is that the Ayrshire Community Phlebotomy Service may form a basis for the Care and Treatment Service planned in the PCIP.

3. Increasing Capacity in the Community

3.1 Eyecare Ayrshire

The Eyecare Ayrshire service was launched in February 2017. This service was developed to redirect patients from attending their GP Practice or an Emergency Department with any eye complaints or injury, recognising that the Community Optometrist is the most appropriate clinician to review and treat these conditions.

The service allows protected appointment slots to be held in high street Optometry practices and patients can access these normally within a 48 hour time frame depending on how their condition has been triaged. Where medication is required patients are provided with an order to take to a Community Pharmacy. Engagement with communities and GP Practices confirms that a very small number of patients are now attending their GP Practice with eye complaints and GP reception staff are able to redirect patients with a confidence that patients will be seen.

Since the introduction of the Eyecare Ayrshire initiative the number of people using the service has increased with typically 1,100 items being dispensed per month. This service continues to be invested in through the PCIP under the Urgent Care Workstream to ensure patients are being assessed by the most appropriate person at the first point of contact.

The Scottish Government *Community Eyecare Services Review* published April 2017 considered care currently provided within Community Optometry and identified examples of good practice across Scotland that could be replicated. NHS Ayrshire & Arran was commended in the report for the locally developed initiatives and examples of care already developed within Community Optometry.

3.2 Pharmacy First and expanded range of services in Community Pharmacies

As part of the national initiative, Ayrshire and Arran launched a Pharmacy First service in December 2017. The aim of the initiative is to make better use of Community Pharmacy skills and widen the range of services available in local pharmacies.

During 2018, 97 of 98 Community Pharmacy Practices in Ayrshire and Arran provided treatment for urinary tract infections and impetigo which are two of the most common conditions seen in primary care. Community Pharmacists are also open six days-a-week with some open in the evenings and on Sundays. On average 300 patients are treated per month through Pharmacy First. A national awareness campaign has promoted the service and a local campaign will be run as part of winter planning this year. Work is underway to sign up Community Pharmacies to extend the service to cover skin infections and shingles.

The publication of *Achieving Excellence in Pharmaceutical Care – A Strategy for Scotland'* in 2017 by the Chief Pharmaceutical Officer for Scotland, makes a commitment to increase access to Community Pharmacy as the first port of call for self-limiting illnesses and supporting self-management of stable long term conditions, in and out of hours. Through the Minor Ailment Service (MAS) Community Pharmacies are increasingly becoming the first port of call for eligible patients for a range of common clinical conditions. It has been announced that in 2019 the Minor Ailment Service will be available to all citizens free of charge.

A number of Community Pharmacists are qualified as Independent Pharmacist Prescribers (IPPs), providing clinics from their community pharmacy, in conjunction with local GP practices. These clinics include respiratory clinics, as well as hypertension and sexual health clinics. In 2018 a Community Pharmacy in Kilwinning began working in partnership with a GP Practice enabling patients to be appointed to a consultation with the Community Pharmacist in his pharmacy rather than the GP Practice, to do so he accesses the GP Practice system.

3.3 General Dental Services and Oral Health Plan

During the last two years NHS Ayrshire & Arran has implemented its *Oral Health Action Plan 2016-2019*. The next plan will be informed by the national *Oral Health Improvement Plan*, issued in January 2018.

The national plan sets the direction of travel for oral health improvement for the next generation and has a strong focus on reducing oral health inequalities, moving to a preventive based approach for NHS dentistry and meeting the needs of the ageing population. Dentists have also been involved in the redirection work outlined above.

A separate report is provided to the IJB in relation to dental services due to strategic change envisaged in this service.

4. Workforce and Contingency Planning

4.1 GP Recruitment

In 2016 a General Practice Workforce Plan was developed and then subsequently updated in early 2017. This was informed by a workforce survey conducted across all GP Practices which had a 98% return rate and identified a projected gap of around 80 General Practitioners in total from 2016 until 2022.

The GP Practice workforce survey also showed a high number of Practice Nurses, Practice Managers and Administrative Staff would be of retirement age before 2027. This workforce data is now collated on an annual basis, either from a national data collection or locally. The availability of this data will inform future workforce planning to assist with implementation of the new GMS contract.

The workforce paper helped inform where additional MDT support was required and the Primary Care Transformation Fund tests of change.

A main test of change was the creation of a GP with Special Interest (GPwSI) Development Programme commenced in 2017 with four GPs in post during 2017/18. In March 2018 additional posts were advertised in conjunction with Acute Services. There were nine post holders appointed, eight of which commenced in August and one is due to take up post early 2019.

This programme has been highly successful in attracting young GPs to the area, by allowing them to have the opportunity to work across a range of services and gather different experience

The Board developed a new website in conjunction with the Local Medical Committee to promote living, working and training in Ayrshire and Arran. Social media platforms have also been used to promote vacancies. Ayrshire and Arran is also part of the Scottish Rural Collaborative which seeks to improve recruitment in rural boards.

A number of focus groups were run to identify what would attract and retain GPs as well as a Networking and Educational Event on 4 November 2017 for GP in training and practices and a further event is planned for the New Year.

4.2 Support for Practices in Difficulty

Extensive work has taken place to support GP Practices experiencing difficulties. This is key to ensure that the population of Ayrshire and Arran have the required access to general medical services. Since 2016, ten Practices have had a range of support to ensure sustainability and continuity of patient care. This work has been progressed on a practice by practice basis.

Actions taken have included taking over the management of three practices, splitting one of these and returning half to independent contractor status and dispersing a practice. On-going GP Practices have been supported to consolidate the use of their workforce, provided administrative support, arranging locums and sourcing GPs, working with the H&SCPs to provide other professionals to support practice workload, managing patient lists and reducing practice risks including those relating to premises.

4.3 Advanced Nurse Practitioner (ANP) Academy

One of the proposals in the GP Workforce Plan was to develop a new workforce of Primary Care Advanced Nurse Practitioners. Following an initial test of change in EAH&SCP in 2015 a plan was made to train and develop existing General Practice Nurses to an advanced practice level. In order to achieve this an Advanced Nurse Practitioner Academy was established in conjunction with NHS Dumfries & Galloway. This Academy has now expanded across the West of Scotland.

There are 14 Ayrshire and Arran Practice Nurses included within ANP Academy Cohort 1 training places which commenced in September 2017. Cohort 2 commenced in September 2018, with six nurses. It is recognised that formal ANP training takes around 18 months to two years to complete and key to its success is mentoring and supervision from GPs in the host practice in order to develop new competencies and confidence.

5. Improve Primary Care Infrastructure

5.1 Premises

Primary Care Premises Group oversees the strategic direction of travel for Primary Care Premises within Ayrshire and Arran. The Group has representation from each of the H&SCPs who also feed into the Partnership Premises Group. The new GMS Contract seeks to reduce the risk relating to premises for general practice with a view to offer loans to practices and support for lease arrangements. Details of this national support are emerging.

Between November 2016–January 2017 a *Review of Primary Care Premises, IT infrastructure and Digital Technology in NHS Ayrshire & Arran* was completed with the findings included in NHS Ayrshire & Arran Property and Asset Management Strategy (PAMS). In addition, each H&SCP has reviewed their premises, risks and future plans for developments to contribute to PAMS and the Health Board's estate masterplan.

Premises will feature as a focussed piece of work within the PCIP to encompass the risk to GP Practices as well as to progress the space requirements for the additional MDT consultations.

5.2 Information Technology Infrastructure

Work is currently underway to improve network connectivity for General Practices including the implementation of a Community of Interest Network (CoIN) which is in effect a private Wide Area Network.

Support has been given to practices through a national digital fund including providing dual screens for more efficient working and remote access to allow GPs to complete documentation management at home.

Telehealth has been rolled out across some GP practices. There are currently forty-eight GP practices using, or trained to use, telehealth protocols for hypertension, Chronic Obstructive Pulmonary Disease (COPD) or Beating the Blues, computerised Cognitive Behavioural Therapy (cCBT). Across the HSCPs, this equates to nineteen in South, thirteen in East and sixteen in North. With regards to breakdown per protocol, 45 are using, or trained, for hypertension and 43 for cCBT. The COPD protocol is currently suspended. Not all practices currently trained to use telehealth are currently making referrals, as there is ongoing capacity issues within the TEC Hub.

The Attend Anywhere video consulting platform is currently in the development phase, with system tests ongoing. There currently no practices using Attend Anywhere for consultations.

6. Establish an Integrated and Sustainable Out of Hours Service

NHS Ayrshire & Arran and EAH&SCP launched, the "Ayrshire Urgent Care Service" (AUCS) in November 2017. This brings together Out of Hours (OOH) Primary Care, District Nursing, Social Work, Crisis Mental Health Resolution Team and Community Alarms for East Ayrshire services into an 'urgent care hub', operating from the Lister Centre at University Hospital Crosshouse.
This is supported by local urgent care centres and the home visiting service. In partnership with NHS24 there will be continued promotion of self-care and redirection to the most appropriate service, for example local pharmacies.

This redesign was in-line with national policy for urgent care services as set out in the report *Pulling Together: transforming urgent care for the people of Scotland, 2016*, which recognised the difficulty in sustaining GP involvement in out-of-hours services.

A key ambition of integration is to enable professional joint working and to empower the professionals working in the service to provide the best care for the population. Also to develop continuous improvement, innovation and a learning environment.

As part of the OOH Integration Programme, tests of change and improvements have been undertaken:

- Skill mixing of professionals providing care (testing community pharmacists and physiotherapists working in the OOH Hub)
- Testing the role of a clinical coordinator
- Undertaking improvements in efficiency and more flexible working
- Moving administration tasks away from district nurses freeing up clinical time
- Further ANPs have continued to be recruited and trained
- Use of technology to support individuals with **Chronic** Obstructive Pulmonary Disease who have a pattern of high use of OOH services
- Planned use of Attend Anywhere between the AUCS Hub and Centres and appointing patients to Community Pharmacists
- Opening the Crosshouse Centre overnight for appointments
- Supporting call handling for Social Work, freeing up professional time.

These tests of change were informed by extensive engagement events with GPs, staff and other stakeholders. An Action Group is in place, which is led by frontline staff, and GP user group is commencing. The lack of sustainability in the service has, however, made introducing any changes very difficult with GPs risk adverse about testing new ways of working.

Action to improve the sustainability of the service has continued and this included an option appraisal considering service configuration in 2017 and work is underway to identify if utilising an enhanced service to provide the clinical aspects of AUCS would be effective and efficient.

Ayrshire and Arran was also the test site for the successful launch of the new NHS24 platform and model office working in 2017.

7. Health Inequalities

A number of initiatives within Ambitious for Ayrshire sought to contribute to reducing health inequalities, in particular the introduction of Linkworkers / Community Connectors. In addition, the process for allocating additional staff will be carried out with General Practice and the H&SCP teams striving to ensure equitable services pan Ayrshire, targeting the areas in most need.

Key information for planning at a Cluster and Partnership level has been provided by the Public Health Department working with Primary Care to map the distribution of primary care resources against deprivation, multi-morbidity and age. The national GMS funding formula was updated in 2018 and this lead to a greater, but not exact, correlation between practice funding and assessed need.

Addressing health inequalities will be a key focus throughout the programme and will be considered as part of each workstream.

8. Primary Care Improvement Plan

The Primary Care Improvement Plan sets out a number of priorities to be delivered in year one (2018/19). The two main areas are the roll out of the Pharmacotherapy Service and enhancing the MSK Physiotherapist Service, with these professionals being based in GP Practices where possible.

Implementation is being driven through the following workstream groups:

- Pharmacotherapy Implementation Group
- Primary Care Nurse Service Implementation Group
- Urgent Care Implementation Group
- MDT in General Practice Implementation Group

Ayrshire and Arran undertook a wide recruitment exercise jointly with the Intermediate Care and Enablement Teams throughout July 2018 to attract as many applicants as possible to the area. This was successful and a high number of staff have been interview and appointed as preferred candidates.

8.1 Summary of Progress from each Workstream

Below is a high level summary outlining the progress within each workstream since the end of June 2018. There is an appendix for each workstream which shows the progress against each action set out in the PCIP for cross reference.

The Programme Implementation Support Team took up post on 3 September 2018, and have been working on detailed programme plans/tracker with each of the workstream implementation groups. This will be finalised over the coming weeks and monitored through the next Primary Care Programme Board meeting.

An evaluation framework is being developed for the PCIP. This will be informed by an external evaluation completed in September 2018 by the Scottish School of Primary Care of the new models of care developed in Ayrshire and Arran through the Primary Care Transformation Fund. This is now available and shows that good progress has been made. Ayrshire and Arran was also used as a “deep dive” area for their national Advanced Nurse Practitioner Case Study. This report will be published imminently.

It should be noted that throughout July – October, the main focus of the workstream implementation groups was to work with the high level actions that were set out in the PCIP, and work with the relevant teams and stakeholders to start identifying the ‘how’ and the actions/work required to deliver on the actions.

Work is also underway with the wider Primary Care Team and Health and Social Care Partnership (HSCP) teams to determine and highlight throughout the detailed programme plans what actions are planning actions, and what are implementation and delivery. To date many of the actions have been planning, with the programme now reaching implementation in some areas.

8.2 Pharmacotherapy Service

The lead role to develop the Pharmacotherapy Service came into post in October. Following the successful recruitment campaign throughout July and August 2018, 11 Band 7 GP Clinical Pharmacists were appointed along with 7.4 wte Band 5 Pharmacy Technicians. The total number of pharmacists now in post in Ayrshire and Arran to deliver the pharmacotherapy service is 32 wte Band 7 GP Clinical Pharmacists and 16.4 wte Band 5 Pharmacy Technicians.

Due to a large number of internal appointments and promotions, this left a gap of around 3.5 wte Band 7 GP Clinical Pharmacists against the aspired number for Phase 1 in 2018/19. These posts are currently out to recruitment. The resource that is in place now will allow pharmacy input to all GP Practices across Ayrshire and Arran to begin to develop the Pharmacotherapy Service and transfer the tasks outlined in the GMS Contract.

A pilot has commenced with four GP Practices whilst the new posts are being developed to test the staffing level and skill mix assumptions required to deliver level 1 and level 2 pharmacotherapy services with the inclusion of level 3 polypharmacy reviews only, and excluding level 1 authorising/action all repeat prescribing requests.

An engagement event with local community pharmacists took place which included a presentation on the benefits of the CMS serial prescribing from the national lead. A focus on roll out of serial prescribing will be built into the plans along with the employment of pharmacy rolls to ensure maximum benefit of both parts of the service working together.

9. Primary Care Nurse Service

9.1 Community Treatment and Care

The Implementation Group had a single item agenda on 22 August to discuss the requirements to scope the current workforce who deliver community treatment and caretasks, and understand the demand for these services. Outcomes from this exercise are still on track to be reported back by December 2018 with a view to proposing the workforce models by March 2019.

A formal sub group of the Primary Care Nurse Implementation Group has been created to oversee and deliver the required actions to develop the Community Treatment and Care Service.

An engagement event is scheduled for all practice nursing teams to attend on 6 December 2018 to discuss the requirements in the contract for community treatment and care and share the vision for this service.

Interviews took place in October for 9 new Primary Care Nurses that were recruited as part of the new graduate development programme, interviewing students from University West of Scotland.

9.2 Ayrshire Community Phlebotomy Service

The new Ayrshire Community Phlebotomy Service went live on 15 August 2018. The service supports taking blood for acute specialities for patients in the community. The introduction of this service means that GPs are not required to action the results of these tests. Initially the service was tested for renal patients with a cautious uptake, the first patient was seen by a Community Phlebotomist in North Ayrshire on 12 September. Urology has now commenced referring patients and the intention in October is to extend access across all acute services.

The current thinking in the Primary Care Nursing Workstream is that the Ayrshire Community Phlebotomy Service may form a basis for the Care and Treatment Service planned in the PCIP.

9.3 Vaccination Transformation Programme (VTP)

The VTP was split into 5 main areas (Pre-school, travel, influenza, school based and at risk groups).
Timescales for review of each delivery model are included within the PCIP, with the two areas identified to progress in 2018/19 being pre-school and pregnant ladies. The vaccinations required by pregnant ladies (at risk group) transferred to the Ayrshire Maternity Unit on 1 October 2018. All vaccinations are either carried out at the 20 week scan or by the community midwife.

10. Urgent Care

The list of high level actions had been agreed in this area were against what was outlined with the GMS contract document for this section. Through carrying out a range of actions focussing on practice triage, signposting, home visits and urgent presentation pathways, a lot of these actions will be addressed.

The Urgent Care Implementation Group considered the first priorities in 2018/19 based on feedback from practices on the main areas of demand for urgent care attention. These were:

1. To reduce demand for home visits
2. Focus on redirection and signposting, and
3. Develop and Ayrshire and Arran Collaborative to share best practice and learning from triaging and pathway development, as well as a range of other processes within the GP Practice.

An audit questionnaire has been created for each practice to undertake that will analyse their home visit demand and learn from best practice whilst trying to introduce a consistent approach. This week long audit will take place 5-9 November 2018 to understand the demand and need from each practice, as well as review how they triage home visits.

Within the PCIP it was outlined that a focussed piece of work was underway in Stewarton, working with the GP Practice, other independent contractors in the area, along with community resources to maximise the redirection processes and pathways. The focussed piece of work allowed close engagement the practice and contractors to identify efficient processes for triaging and signposting that could be captured into quick reference cards for practice reception staff to use.

Materials on the range of services available were also shared with the community, school children, and a local campaign to highlight the range of services that could be accessed as an alternative to the GP Practice when appropriate.

The pilot in Stewarton has now concluded and an evaluation available. The cards that were developed for use at triage by the reception staff have now been cascaded across GP Practices to be used. This approach is now being tested in Girvan.

Around 280 receptionist / administration staff have now attended triaging and signposting training that was hosted by the Centre of Excellence locally. This has equipped reception / administration staff to ask patients for brief information when they contact the practice for an appointment to ensure they are directing to the most appropriate place, whether this be in the practice or the community. Further work has been discussed and agreed through the Communication and Engagement Group targeted social media campaigns to the public to share with them the range of professionals they can see.

In conjunction with the Scottish Ambulance Service the input of a Specialist Paramedic is being tested in a GP Practice in Kilmarnock and working with AUCS.

The first meeting has taken place with Healthcare Improvement Scotland and NHS 24 to discuss the quality improvement initiative to support Clusters to test improvements in documentation management and prepare for triaging to the MDT and other community resources.

11. MDT in General Practice

11.1 Advanced MSK Physiotherapy Service

There was commitment in the PCIP to recruit to 6 wte Advanced MSK Physiotherapists. As four Advanced MSK Physiotherapists were already in post, this took the total number to 10 wte roles. There was also a commitment to recruit to a lead MSK Advanced Physiotherapist role.

The lead post was recruited to from the existing cohort of Advanced MSK Physiotherapists which created a gap of seven posts. Interviews took place in September 2018 and three posts were not filled. These are currently back out to advert through another recruitment campaign.

11.2 Mental Health Service in GP Practice

There are currently a range of models across General Practice in Ayrshire and Arran which includes low level support, and in some practices mental health practitioners. Part of the aim through the PCIP and the implementation of the actions, and funding associated with Mental Health Strategy Action 15, is to implement a fair and equitable mental health service available in all GP Practices.

As part of the Mental Health Strategy 2017-2027, Scottish Government Ministers made a commitment to provide funding to support the employment of 800 additional mental health workers to improve access in key settings such as Accident and Emergency departments, GP practices, police station custody suites and prisons.

There was agreement to spend £2.5 million between now and 2021/22 on Mental Health workers based within GP Practices. A core sub group with key representation from each HSCP has been established to plan the investment of the Mental Health Action 15 for primary care mental health workers, based within GP Practices. The first meeting took place on 5 October and this group will report to the MDT Implementation Group.

For 2018/19 this equates to 2x Band 6 MH workers for each HSCP area. Recruitment for these roles is being led by each HSCP with support from the Implementation Support Team.

11.3 ANP Academy

Cohort 1 of the ANP Academy will run in 2019/20 with students scheduled to finish their modules around July 2019. There were delays with students accessing the V300 non medical prescribing course due to the availability of courses being provided by UWS.

It was agreed that up to 10 students could sign up for Cohort 2 of the ANP Academy. Out of 10 places, eight students expressed an interest to attend from GP Practices across Ayrshire and Arran, with four students progressing with the application process with UWS in September 2018.

Arrangements for the ANP Academy are considered and discussed under the working group that is a formal group of the MDT Implementation Group, chaired by the Associate Nurse Director for Primary Care.

11.4 Allocation of new MDT Staff

Discussions to date with HSCP teams and GP colleagues have highlighted that the allocation of this resource should be done in an open and transparent way, involving all stakeholders, and considering all the data we have available to make the best informed decisions.

An engagement session took place with all GP Practices on 31 October 2018 as part of Protected Learning Time. This allowed an opportunity for practices to come together in their clusters with HSCP colleagues to discuss the resource available and how this could be prioritised in a cluster, aligned to the wider aims of the HSCPs.
Feedback and themes from discussions will be summarised and reported back no later than the end of November 2018.

11.5 Induction of new Staff

It is recognised that, for new individual staff members to be embedded into a GP Practice teams, there will be a requirement to invest time in supporting the individuals as well the wider practice team in the new ways of working.

Corporate Induction dates have been protected to try and ensure all new staff are on induction days together, and there will be a separate induction day for the new staff to meet with the key staff to understand how general practice works and what is required from their roles.

12. Memorandum of Understanding

Core to developing the new GP contract will be effective multidisciplinary team working and clinical leadership. To ensure everyone understands their team's roles and responsibilities, it is proposed that a local memorandum of understanding is developed to outline what these areas are and will include:

- HSCP role and responsibilities
- The service responsibilities
- The professional line management responsibility
- Day to day management responsibility within the GP Practice
- The individuals responsibilities
- Supervision needs
- Mentoring needs (professional and peer support)
- Absence management

13. Evaluation of Outcomes and Actions

The programme team have been working with East Ayrshire HSCP performance team, as the Lead Partnership for the Programme, and the NHS Programme Management Office performance team to review the actions and planned outcomes within the Primary Care Improvement Plan.

The teams are working jointly with the Workstream Implementation Groups to develop measures that can be captured on an ongoing basis against each of the areas outlined. National measures are also being considered that will demonstrate and evidence the transfer of tasks that are currently carried out by GPs move to being carried out by another professional or service.

14. Primary Care Improvement Fund

The Primary Care Improvement Fund of £2,820,385 was allocated to Ayrshire and Arran as a ring fenced allocation. For workforce and financial planning the PCIP was planned as an initial funding profile over 2 years 2018-2020 at a total cost of £7,407,473 as £4,074,685 is expected in 2019/20.

Due to timing of the allocation being received (month 4 of the financial year), Scottish Government wrote to all Health Boards and IJBs advising that they could draw down 70% of funding and leave 30% of the funding with Scottish Government for 2019/20. Ayrshire and Arran knew that due to recruitment of workforce being the main spend, it was likely only 70% of the allocation would be required for 2018/19, and this was in line with the funding profile within the PCIP. 2019/20 will see the remaining 130% of spend being required.

A large proportion of cost in the first two years was for a large workforce that in June hadn't been advertised yet so was best projection based on timescales for staff taking up post. Following approval of the PCIP on 28 June, we moved to recruitment on 6 July with posts being advertised until early August to gather interest through the social media campaigns.

This resulted in a large amount of interest for each posts and a successful round of interviews. Due to notice periods and following up of paperwork with new employees/referees, many of the start dates are 1 -2 months later than first anticipated.

This delay in recruitment will allow £272,720 to be reinvested into other developmental projects on a non-recurring basis in 2018/19 and bringing forward investment in additional support to GP practices. Options for this investment will be considered with the implementation groups, HSCPs and GP Sub Committee over the coming weeks.

Planning and discussions over the next six month period will be focussed on the investment and allocation due to be received in 2020/21.

All the projections and spend to date, against the funding profile is shown in Appendix 5.

15. Communication and Engagement

A Communication and Engagement Group has been established and is chaired by the Head of Primary Care and Out of Hours. The Group has met twice and includes representation from the Programme, HSCPs, and NHS Board to develop an effective Communication and Engagement Plan for key stakeholders and the public.

Key actions have already been taken forward to develop the Communication and Engagement Plan which is undergoing some final refinements before being published.

There have been a number of engagement events or opportunities to discuss the PCIP in more detail following the sign off in June. These include:

- Presenting at the Strategic Planning Groups for each of the HSCP
- Regular attendance or feedback to the GP Sub Committee on progress
- Monthly reporting to the NHS PMO which is shared with the Strategic Planning and Operational Group and NHS Corporate Management Team
- Presenting at the Practice Managers Conference on 6 September 2018
- PLT session with GPs and Practice Managers on 31 October 2018
- Attendance at team meetings across Ayrshire and Arran as requested

16. Interdependencies with other Programmes across Ayrshire and Arran

Primary Care has close links to a range of work across Ayrshire and Arran. For service improvement and change the main programmes are the Unscheduled Care Programme, Intermediate Care Programme and Transforming Outpatients.

The transformation work that is taking place through the implementation of the PCIP should be considered throughout these programmes and vice versa to ensure planning is interlinked and not duplicated.

17. Risk Register

There was previously a risk register in place for the Ambitious for Ayrshire Programme that is under review.

A session has taken place to review the previous risks, PCIP and risks that have been highlighted through the Implementation Groups to refine and present the revised Risk Register. This will be monitored through the Primary Care Programme Board and escalated where required to East IJB Risk Management Committee and if appropriate the NHS Board Strategic Risk Group. It has been agreed across the IJBs and NHS Board that an update will be provided every six months on the progress of the PCIP.

18. Public Dental Services

The Public Dental Service (PDS) was formed in September 2013 by the merger of the Community Dental Service and Salaried Dental Service. The PDS is a safety net service that ensures access to dentistry for all priority groups, with a specific focus on providing enhanced care to patients with complex physical, mental, medical and behavioural needs. These patients require a level of care that cannot appropriately be provided in General Dental Practices.

The PDS operates from three Hubs in Ayr Hospital, Ayrshire Central Hospital and Northwest Kilmarnock Area Centre. In addition there are currently clinics in Dalmellington, Patna, Cumnock, Lamlash, Crosshouse Hospital and HMP Kilmarnock.

18.1 Special Care Dental Service

The PDS provides a service to patients of all ages who require specialised dental care that is not available in a General Dental Practice. Patients in this category include those with a physical, sensory, intellectual, mental, medical, emotional or social impairment or disability. The service seek to meet the individual's needs through the provision of dental hubs and highly skilled staff. Through acclimatisation and desensitisation appointments trust can be developed between staff and patient to successfully treat patients and have a positive outcome. Staff have further developed their skills by attending training specific to this patient group. Staff have researched and purchased aids which have made a significant difference in engagement from children and adults with additional needs/learning disabilities. The PDS is in the process of recruiting a Specialist in Special Care Dentistry

18.2 Phobic and Anxious Patients

The PDS offers a referral based service for phobic and anxious patients. Using de-sensitising skills and techniques can sometimes allow a patient to receive dental treatment that previously the patient would not be able to tolerate. If these are unsuccessful then treatment with the use of a type of sedation would be tried, however it would be hoped that by using sedation and de-sensitising through time the patient would be able to have treatment normally.

18.3 Inhalation Sedation Service

This service is provided at all three hubs to both paediatric and adult patients who require a mild form of sedation in order for them to be able to tolerate dental treatment.

The PDS had two of its sedationists retire at the beginning of the year with replacement staff coming into post in April 2018. Unfortunately as the result of long term absence the waiting list has increased. A review of the appointing process and waiting list management has taken place and it is anticipate that in early 2019 the list will have notably reduced. The current waiting time for assessment is between 20 to 35 weeks depending on locality.

18.4 Intravenous Sedation Service

This service is provided at all three hubs to adult patients who require a stronger form of sedation in order for them to be able to tolerate dental treatment. This service is time intensive with treatment appointments lasting two hours to allow the patient to be sedated, have treatment and then recover enough to be able to go home. The PDS has been under increased demand with limited resources which makes providing this time consuming service challenging. The current waiting time from referral to assessment is between 38 to 46 weeks depending on the locality.

The Scottish Governments Oral Health Improvement Plan 2018 (OHIP) includes a commitment to introduce a system of accreditation for General Dental Practitioners (GDPs) with enhanced skills, for example sedation. It is anticipated that these GDPs would be able to provide a level of care in a Primary Care setting which is currently provided by the PDS or Secondary Care.

18.5 Paediatric General Anaesthetic Service

The service operates from Crosshouse Day Surgery Department on a Tuesday and Wednesday, providing treatment sessions in the morning and assessment clinics in the afternoon. The service is to treat children (aged approximately between 1 year and 14 years) who have pain and/or sepsis as a result of decay, abscessed teeth or trauma that require extraction. These children would not be able to tolerate treatment in a general practice setting.

At the assessment clinic a Dental Health Support Worker provides advice to the child and family to help ensure positive oral health messages are reinforced. Links between the dental department and Health Visitor or School Nurse are in place to ensure follow-up where required. The PDS is in the process of recruiting a Specialist in Paediatric Dentistry.

18.6 Adult General Anaesthetic Service

The service operates from Crosshouse Day Surgery Department. There are two sessions, the Wednesday session is in the main for phobic/anxious adults that require all their remaining teeth extracted.

The Friday session is for adults with additional needs; these patients can be challenged by general treatment and therefore require a general anaesthetic for examination and comprehensive dental treatment that ensues.

18.7 Chaotic Lifestyles

The PDS is a safety net services and is therefore able to offer treatment within the dental hubs in each locality, ensuring access to dental care for patients who are unable to maintain NHS registration with a GDP. This situation can be compounded by dental phobia, addiction or homelessness.

18.8 Daldorch House School

The health provision, including dental, for the residents of Daldorch is covered by a service level agreement with the Health Board. These residents are some of the most challenging patients the PDS treat.
There is regular intervention by a hygienist to support tooth brushing and provide de-sensitising to patients to try and increase engagement within the clinical environment. This has been hugely beneficial as it has improved client engagement when oral screening is carried out. The patients within Daldorch are screened bi-annually by one of the PDS dentists.

18.9 Undergraduate Outreach Service

Since 2007 the Teach and Treat Dental Centre in Northwest Kilmarnock has provided an Undergraduate outreach service in conjunction with the University of Glasgow, which allows final year dental students to gain experience in providing care in a dental clinic rather than in a teaching hospital environment.

The service operates during university term time with four students providing free dental care to their patients while gaining the valuable competencies they require to ensure they have the necessary skills to treat patients upon graduation as a dentist.

18.10 Prison Dental Service

The PDS currently provides six dental sessions within HMP Kilmarnock which is made up of dentists and hygienist time. This needs of these patients are high and demand for this care is significant.

18.11 Doon Valley & Arran General Dental Service

The PDS currently operates three salaried dental practices in Dalmellington, Patna and Lamlash, Isle of Arran. The future of these practices is to transition patient care to a general dental practice model and work is currently underway to progress this.

18.12 Millport

The PDS provides a twice yearly dental service to those patients who cannot travel to the mainland due to their physical or mental health wellbeing.

18.13 Inpatients and support to other Specialities

The PDS provides care as required to inpatients within any ward across all hospitals in Ayrshire and Arran. Currently a clinic operates at Crosshouse Hospital twice monthly treating medically compromised patients who require to be made dentally fit prior to surgery. Links are in place with Consultants in Haematology and Oncology providing training and support to staff on best oral health practice.

The PDS has also provided advice and support to the Intensive Care Unit at Crosshouse Hospital on how to provide effective oral healthcare to their patients as improving oral cleanliness during critical illness has been to shown to reduce the incidence of ventilator acquired pneumonia.

The PDS has further rolled this training out to the wider Intensive Care Unit team at Ayr Hospital and continue to support the teams to deliver effective oral healthcare. Each unit continues to be provided with oral care packs for each patient admitted.

The PDS attends the Cleft Lip Palate Clinic on a quarterly basis to provide dental support to the multi-disciplinary team, guidance to patients and their family, and discuss registering the patient with the PDS should this be the appropriate service for the patient to be cared for.

18.14 Comprehensive Medical Assessments

As dental health is a good indicator for overall health and wellbeing of a child, the PDS has liaised with a Paediatric Consultant to develop an understanding of what dental health information would be advantageous when completing a comprehensive medical assessment. A robust process is in place for gathering dental health information from multiple sources, these include, the registered GDP, Out of Hours Emergency Dental Service attendance, referral and treatment for General Anaesthetic and any Childsmile interventions. This information is collated and forwarded to the Paediatric Consultant who will review this in conjunction with all other relevant information on a child's health. The PDS is contributing to the development of an oral health pathway for care for children and young people with Public Health.

18.15 Additional Needs Schools

Within Additional Needs Schools the PDS provides several services, these include resources for the school to operate a daily tooth brushing programme, a monthly visit from our hygienists to undertake a hands on tooth brushing and de-sensitising session, bi-annual fluoride varnish programme and provide the staff with any training or development they require to help support the child's oral health.

18.16 Out of Hours Emergency Dental Service (OOHs EDS)

The service operates on Weekends and Public Holidays, in three areas;

- Crosshouse Hospital 9am – 12 noon
- Ayrshire Central Hospital 11am – 2pm
- Ayr Hospital 12noon – 3pm

The service is provided by GDPs who provide cover at weekends with a rota in place of a session once every 70 weeks. Ayrshire Central Hospital is staffed from weekday PDS Dentists who rota on once every four weeks, they provide clinical guidance and basic operational management. The service is supported by dental nurses. Patients are triaged and appointed to this service by NHS24.

Patients who are unable to attend the clinic (i.e. are in hospital or are unable to leave home), are care for by the staff at Ayrshire Central Hospital and are treated by the PDS Dentist. This service also provides clinical cover during the festive and Easter public holiday

19. Tests of Change

19.1 Domiciliary & Care Home Service

Domiciliary care is provided throughout Ayrshire and Arran covering 64 residential Care Homes. The PDS provides dental care to 57 out of the 64 residential care homes in Ayrshire. In addition domiciliary care is provided to those patients who are unable to travel to dental clinics.

The PDS works in collaboration with an independent GDP in Largs adopting the domiciliary care scheme which has been very successful. The executive summary is attached **(Appendix 1)** with the full evaluation report available on request.

19.2 Oral Surgery Pilot

A pilot oral surgery service (one day per week) based in Primary Dental Care was introduced in Kilmarnock in May 2016 with a view to reducing waiting times for patients requiring Minor Oral Surgery procedures and facilitating treatment closer to patients' homes. The service was supported by Integrated Care Fund to address the initial outlay for equipment and provide salaries on a time limited basis for staff providing the service until December 2017. It was hoped that this initial supported stage would pump-prime continued delivery of the service on an independent contractor model following the pilot phase.

Patients were seen and treated by the service from May 2016 to December 2017. Data collection for evaluation purposes began in November 2016 once the service had become established, during which time 537 referrals were accepted. Evaluation of the service was based on a database of referrals, R4 practice management system, interviews with stakeholders and patient evaluation questionnaires.

The pilot demonstrated that it was possible to provide an oral surgery service within Primary Care, with a significant reduction in waiting times for those attending the service. Treatment provided covered a range of procedures, with high patient attendance rates. The service received positive feedback from patients and referring GDPs who were happy with the service delivered and the clinic's location.

Some challenges were encountered during the course of the pilot but most were easily overcome. Direct referrals from GDPs were found to be appropriate and were the preferred pathway for all stakeholders.

"Virtual" fee per item claims generated through R4 demonstrated that the service was not financially viable in its current format. Unfortunately this eliminated the possibility of the service continuing beyond the pilot phase and the service ceased on 19th December 2017. There is a will for the service to be reinstated, however consideration will be required as to the most appropriate model and how this could become a more attractive business proposition. The executive summary is attached **(Appendix 7)** with the full evaluation available on request**.**

20. Quality

20.1 Clinical Governance

The PDS clinical governance structure is a reporting line from the Clinical Director of Dental Services to the Associate Medical Director for Primary Care.

20.2 Quality Improvement Initiative in Dentistry

The “Quality Improvement Initiative in Dentistry” was set-up in May 2018 to bring together colleagues from primary and secondary care to work collaboratively to improve dental care and prevent poor care. Each year, the initiative will focus on a different theme. In the first year, the focus is on Antimicrobial Stewardship.

Representatives from Public Health, Public Dental Service, General Dental Service and the acute sector with colleagues in Pharmacy have identified a number of activities where whole-systems change could drive reductions in antimicrobial prescribing for oral pathology and encourage more appropriate patient management. This includes:

- audit and peer review;
- circulation of evidence-based guidelines;
- programme of education for individuals and teams in dentistry and across primary and secondary care;
- developing care pathways for patients presenting out-of-hours and as in-patients with oral pathology;
- agreement on quality indicators.
- The group has also established contacts with National Education Scotland and the national Dental Stewardship Steering Group. The group’s activity will also mean that NHS A&A is prepared for the introduction of a national database of quality indicators in 2020 that includes antimicrobial prescribing patterns in dentistry.

20.3 National Dental Inspection Program

The PDS is required to support the National Dental Inspection Program (NDIP) requiring a clinician to inspect over 9000 children in their primary school annually. This epidemiological inspection is used to assess the dental health of children and to inform new ways to improve paediatric oral health

21. Future Strategic Direction

21.1 Service Demand

The numbers and proportion of patients with more complex needs are increasing. The treatment needs for children with medical or support needs, was recognised in 2017, by the Scottish Dental Needs Assessment Programme (SDNAP) Report, which stipulated the need for a Specialist in Paediatric Dentistry.

The number of adults with a long-term health condition or disability is increasing, too. As the population ages (33% in 2016) with the number of registered places in care homes increasing by 4% in East Ayrshire and by 22% in South Ayrshire between 2006 and 2016.

The PDS will need to maintain and increase the current level of care delivery, while also providing an enhanced level of service to meet the needs of these additional patients.

21.2 Scottish Government Oral Health Improvement Plan 2018

The Scottish Government's new Oral Health Improvement Plan (OHIP) was published in January 2018. The document provides the strategic framework for improving the oral health of the next generation. Ayrshire and Arran is represented on the national OHIP steering group. This gives an opportunity to share best practice, learn from local work and pilot small tests of change proposed.

In order to plan for the improvement in the oral health of the Scottish population, the OHIP has laid out ten workstreams:

- Challenge Fund Programme
- Domiciliary Care Implementation Programme
- Making the Connections with Health Boards and Health & Social Care Partnerships
- Preventive Care and Oral Health Risk Assessment
- Care Pathways and Flows
- Clinical Assurance and Governance
- Regulation of General Dental Services
- Allowances
- Remote and Rural Areas
- Communicating Better with Dentists

These workstreams are further broken down into 41 Actions. The national Chief Dental Officer has identified the first five prioritised Actions for the coming financial year. These are described briefly below;

- Action 7. Community Challenge Fund - This fund will initially be a three-year test of change programme to reduce oral health inequalities. Third sector organisations will be invited to help formulate the approach and agree appropriate outcomes. The national fund is for £2.5m (total over three years) which includes financing for central evaluation and administrative support. It will be available to community-led interventions with an emphasis on improving oral health outcomes for children.

- Action 11. Domiciliary Care – Scottish Government will introduce arrangements to enable accredited GDPs to provide dental care in care homes. These practitioners will also work with care home staff and the PDS to ensure the maintenance of good oral health and hygiene.

- Action 20. Director of Dentistry role in each NHS Board area – Further guidance is expected to be provided nationally with regard to this role. The Scottish Government will work with NHS Boards to introduce a Director of Dentistry in each Board area. The role is intended to provide a single professional source of dental advice and accountability, through the oversight of Board functions which include GDP listing, practice inspections, compliance with the NHS Terms of Service, Payment Verification, and overall Clinical Governance, including NHS Discipline or Tribunal.

  Through this, the role would ensure a more co-ordinated approach to local assurance and a strategic approach to primary and secondary care service planning, oral health improvement and public health across each of the Board functions.

- Action 25. Local disciplinary procedures - SG will publish a pathway to support dental practitioners locally; and, when appropriate, ensure that NHS Boards use local disciplinary procedures and NHS Tribunals.

- Action 34. Occupational Health – SG has introduced an occupational health service for GDPs, members of the dental team and other practice staff. Ayrshire and Arran currently has a ten-year Oral Health Strategy that was first developed in 2013. The OHIP will be taken into account when developing the final Action Plan for 2019-23.

Ayrshire and Arran has already made progress against these priority actions as described below:

- Action 7. Community Challenge Fund – The PDS has an award-winning Oral Health Improvement Team which is known for innovative work with communities and has expertise in community development. As more detail of the Fund becomes known, discussion with the three Health and Social Care Partnerships (HSCPs) and key Third Sector stakeholders will take place.

- Action 11. Domiciliary care – as above Ayrshire has piloted a shared care model on this.

- Action 25. Local disciplinary procedures – The Scottish Government will publish a pathway to support dental practitioners locally; and, when appropriate, ensure that NHS Boards use local disciplinary procedures and NHS Tribunals. Ayrshire and Arran has robust processes in place for performance support for independent contractors.

- Action 34. Occupational Health – Scottish Government has introduced an occupational health service for GDPs, members of the dental team and other practice staff, which is available locally.

21.3 Workforce Development

The implementation of the newly produced Oral Health Improvement Plan is dependent on an effective and skilled PDS workforce, with the Specialist post holders providing enhanced training to the PDS, as well as the envisaged 'enhanced GDP'.

Without an enhanced layer of care provided by the PDS patients would be inappropriately referred to secondary care for treatment resulting in:

- An increased reliance for dental treatment under General Anaesthetics
- Teeth extracted rather than filled
- Increased risk of chronic pain, infection and clinical complications
- Reduced quality of life
- This would mean that access to care would be become service driven, not person centred.

The appointment of the two Specialist posts:

1) Specialist in Special Care Dentistry
2) Specialist in Paediatric Dentistry

will enhance the care of the current patients in Ayrshire, and would allow even more complex patients to be treated locally rather than be referred to the Secondary Care or out of Ayrshire. These Specialist post would also afford the opportunity to provide training to enhance dental practitioners, both in the PDS and the General Dental Service.

21.4 Implementation of the Oral Health Improvement Plan

Consideration is evolving of a future model of PDS services in Ayrshire and Arran. This is shown diagrammatically in Appendix 8. Under this model at each level of dental services, specialist acute, local secondary care, PDS and general dental services expertise would be maximised. The model envisages shared care and development support between these levels which will maximise capacity and enable patients to be cared for as close to home as possible.

In order to explore this model and seek wider engagement, a wide engagement event is proposed with a range of stakeholders including the public and local dental professionals to raise awareness of the evolving PDS and engage stakeholders in the implementation of the Scottish Government Oral Health Improvement Plan which will impact on both the PDS and General Dental Practitioners.

The programme of work will be reported to and governed through the Primary Care Programme Board and Senior Dental Management Team. Implementation will be whole-system and pan-Ayrshire.

9. Implications

Financial :	The implementation of the 2018 General Medical Services contract for Scotland will see additional investment of £250million per annum in support of General Practice by the end of this Parliament. This is part of an overall commitment of £500million per annum investment in Primary and Community Health and Care services by the end of this parliament.
Human Resources :	The new GMS Contract, Oral Health Improvement Plan, Community Eyecare Review and Achieving Excellence in Pharmaceutical Care support the development of new roles and competencies within Primary Care. These changes will require local and national workforce planning and the development multi-disciplinary teams working. Additional capacity as outlined within the PCIP will be deployed over the period of the plan to ensure effective delivery.
Legal :	The central purpose of the 2018 GMS contract is to provide better service to patients by providing stability and sustainability to General Practice. In so doing it also provides an environment that supports the wider policy aim of delivering care and support close to home when possible.
Equality :	Our aim is to achieve a strong local primary care service, supporting people in their day-to-day lives to get the best from their health, with the right care available in the right place when they need it, in line with the Scottish Government Primary Care Vision and Outcomes. This will require a partnership between individuals, communities, the health and social care and with partners.
Environmental & Sustainability :	None.
Key Priorities :	None.
Risk Implications :	A key risk will be the availability of the identified additional professional staff to fill the new roles. By working in partnership within the professional groups we will seek to make the posts attractive and that Ayrshire and Arran becomes a workplace of choice. A second key risk is the continued sustainability of GP practices while the new GMS contract is being implemented.
Community Benefits:	The Wellbeing of people and communities is core to the aims and successes of Community Planning. Primary Care services are delivered as an integral part of the Wellbeing Delivery Plan, Integration Authorities Strategic Commissioning Plans and the Transformation Plan of both the NHS and Council, will contribute to support this wellbeing agenda.

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

Pharmacotherapy Service Implementation – Update at 4 November 2018

Appendix 1

Action set out in PCIP June 2018	Timescale set	Update on Progress as at November 2018	Status of action
Establish Arrangements to scope what the Pharmacotherapy Service will look like			
Create a Pharmacotherapy Planning and Innovation Team to focus on the design of the service	In 2018/19	The Planning and Innovation Team have had a series of workshops to explore the pharmacotherapy model and develop thinking to take into the 3 month pilot.	Complete
Undertake a 3 month pilot to test the staffing level assumptions and produce standard processes and procedures.	In 2018/19	A 3 month pilot in four practices has commenced to explore skill mix and time required to achieve all core tasks set out within the GMS contract. Work with practices as the service develops to further develop and refine the model that is required.	Live – on track
Roll out Serial Prescribing and Dispensing			
Fill vacancy within the Community Pharmacy Team to lead the enabling and rollout of serial prescribing	In 2018/19	Job description revised and have recruited to vacancy.	Complete
Establish a systematic and standard approach for initial identification and take up of patients. 1. Undertake pilot in three practices 2. Agree shared care agreement with practices and community pharmacies 3. Develop checklist and specific guidance for tasks that identifies accountabilities and responsibilities. 4. Agree roll out plan for achieving 60-70% for all practices by 31 March 2021 5. Adapt checklist and associated guidance during pilot period.	2018/19 – 2021	1. Have identified three practices 2.	Live – on track
Leadership and Training Academy to develop Pharmacotherapy Service			
Establish a Pharmacotherapy Education and Training Leadership Structure	2018/19	A Pharmacotherapy Lead role has been developed and recruited to with the leadership structure in place.	Complete
Establish a training academy to bring pharmacists and technicians through training based in Primary Care and develop them towards a role in the pharmacotherapy service.	2018-2020	Working with the current ANP Academy model in Ayrshire and reviewing the competency framework for developing pharmacy roles to develop business plan for training academy. Also reviewing possibilities for cross board collaboration.	Live – on track

Workforce Recruitment for Service			
Recruit to the Band 8b Lead post	2018/19	In post	Complete
Recruit Band 5 Project Support to assist with implementation	2018/19	Recruitment in progress	Live
Recruit Band 8a for leadership structure	2018/19	Start date in place	Complete
Recruit 4 Band 6 Pharmacists to test training and growing our own method	2018/19	Recruitment in progress	Live
Recruit up to 14 Band 7 Pharmacists to mix with current group already in post	2018/19	11 recruited in September 2018. Recruitment in progress for an additional 3 – 4 wte (vacancies created due to internal promotions)	Live
Recruit up to 8 Band 5 Pharmacy Technicians	2018/19	Recruited to 7.4 wte in September. Further recruitment will take place early 2019.	Complete
Phase 2 recruitment 2019/20 • 12.5 x Band 5 Pharmacy Technicians • 14.5 x Band 7 GP Clinical Pharmacists	2019/20		For 2019/20

Primary Care Nurse Service Implementation – Update at 4 November 2018

Appendix 2

Action set out in PCIP June 2018	Timescale set	Update on Progress as at November 2018	Status of action
Establish Community Treatment and Care Service			
Group to be established to carry out full scoping exercise to understand the workforce requirements	May – December 2018	• Group has been established to carry lead scoping and data collection before the end of December 2018. • Engagement event is scheduled for 6 December for all practice nursing staff to share the vision for Community Treatment and Care, and discuss the scoping work.	Live – on track
Test Primary Care Nurse model with new graduates providing training and development in community and primary care nursing	2018-2019	• 9 preferred candidates have been advised they were successful at interviews that took place in October 2018. • 3 x graduate nurses will be allocated to each HSCP area. Discussions are taking place with GP Practices and HSCP teams to identify development placements. • The Senior Primary Care Nurse is working with NES to finalise the framework and development programme.	Live – on track
Design proposed workforce models to share with services	March 2019	Will be developed between December and March	Live – on track
Community Phlebotomy – Secondary Care Requests			
Phase 1 – Test sites Renal and Urology	June – October 2018	Renal test site went live on 15 August 2018 Urology Test site went live. Standard operating procedures to be tested and amended during test period.	Complete
Phase 2 – Extend to other specialties	October – March 2019	Plans to be confirmed on evaluation of the test sites.	Live – on track
Phase 3 – Provide Phlebotomy Service for General Practice	2019-2020		For 2019/20
Vaccination Transformation Programme			
Pre-school Programme	March 2019	A pan Ayrshire model has been scoped and costed. Decision still to be reached for new model	Live – on track
Travel Vaccinations and Travel Advice	March 2019	Awaiting national guidance on options that can be considered for safe potential options.	Live – on track
Influenza Programme	January 2019	Programme to be scoped using Primary Care Nurses	Live – on track
At risk groups. Pregnant ladies agreed as first at risk group to be transferred from GP Practice. Other groups to be considered and proposed from the Vaccination Transformation Programme.	October 2018	Service to immunise pregnant ladies has transferred to the Ayrshire Maternity Unit from 1 October 2018.	Complete

Urgent Care Implementation – Update at 4 November 2018

Appendix 3

Action set out in PCIP June 2018	Timescale set	Update on Progress as at November 2018	Status of action
Advanced Practitioner Resource to Assess and Treat Unscheduled Care Presentation and Home Visits with an agreed Model			
Link to MDT workstream to establish standardised pathways for advanced practitioners to assess urgent care presentations and support home visits. Develop signposting algorithms/pathways linked to clinical decision making in line with MDT development	2018-2020	• An audit is taking place week of 5 Nov in all GP Practices to understand the demand for home visits as well as who carries these out, or could carry them out. • Link to the planning and development of the first point of contact roles in the MDT to ensure the advanced practitioners are assessing and treating wherever appropriate.	Live – on track
Develop policy on Joint Data Controller	2018-2019	A short life working group has been developed and chaired by the Head of Primary Care and Out of Hours. National guidance and requirements have still to be announced to allow the policy to be developed.	Live – on track
Review IT infrastructure to maximise redirection pathways	2018-2020	IT infrastructure system requirements continue to reviewed by practices and the services who will be based in them. This will be taken forward as a sub piece of work under the MDT workstream, linked to the eHealth Community and Primary Care Group.	Live – on track
Support Implementation of NHS 24 Practice Websites	2018-2020	Will work NHS 24 and practices as the implementation of this rolls out	Live – on track
Provide infrastructure and pathways to support consistent signposting and navigation across Ayrshire from practice triage, NHS 24/HSCP directories, and community link workers/connectors to maximise community assets and resource	2018 – 2019	• A specific piece of redirection work has been carried out on a pilot site and evaluated to develop triaging pathways/procedures and quick reference cards for staff and patients. The reference cards have now been shared across all GP Practices to assist with triaging. • Local directories continue to be utilised by GP Practices, HSCPS and Community Connectors to direct patients to the most appropriate services or groups to meet their needs. • There is a separate piece of work being taken forward under the MDT Workstream to review the role and evaluation of community link workers/connectors to ensure a consistent core service is provided to patients within GP Practices.	Live – on track
Continue to promote Eyecare Ayrshire	2018-2021	• A relaunch of the service is due scheduled to take place during Nov/Dec 2018.	Live – on track

Continue to promote Pharmacy First and maximise the uptake of community pharmacy as a first port of call for common clinical conditions by utilising the Minor Ailment Service	2018-2021	• A relaunch of the service is due scheduled to take place during Nov/Dec 2018. • Pharmacy First covers a range of conditions such as uncomplicated UTIs in women and skin conditions including impetigo and shingles. Patients who call the GP Practice for an appointment can be redirected straight the pharmacist using the triage cards that have been developed through the redirection work.	Live – on track
Undertake a social media campaign for right care, right person, right time linking to the national work as appropriate	2018-2021	• The Engagement and Communication Group has been established and chaired by the Head of Primary Care and Out of Hours, with a Communication and Engagement Plan in place. • This Group reports to the Urgent Care Implementation Group.	Live – on track
Reduce GP Delivered Home Visits (including care homes)			
Seek to become a test change site for NHS 24 Advanced Paramedics	2018/19	An Advanced Paramedic is based in a practice within East Ayrshire HSCP. The Scottish Ambulance Service are hosting the paramedic in the practice aligned to their Kilmarnock hub, linked also to AUCS, sharing a range of best practice from other site areas such as Inverclyde. The test is being overseen and evaluated by the Head of Primary Care and Out of Hours.	Live – on track
Create a local collaborative with clusters to undertake quality improvement including minimising home visits.	2018/19	Work is underway with Healthcare Improvement Scotland and NHS 24 to become a host Board area to develop a local collaborative and work with a range of representative from their Boards to…. A number of initiatives outlined in the urgent care implementation plan will be covered within the collaborative for GPs and Clusters to share learning and implement best practice.	Live – on track

MDT Team in General Practice Implementation Plan – Update at 4 November 2018

Appendix 4

Action set out in PCIP June 2018	Timescale set	Update on Progress as at November 2018	Status of action
Advanced MSK Physiotherapy Service in General Practice			
Recruit to 1 Band 8a Advanced Practice Physio lead post to develop and lead the service.	2018/19	• Recruitment took place July – October and the post has been appointed to.	Complete
Recruit to 6 Band 7 Advanced MSK Physiotherapists	2018/19	• Recruitment campaign July – September 2018. One of the current in post Band 7s was successful in being promoted to the Band 8a Lead post. This led to 7 posts being available. 5 of which were filled (one of which was part time). • Advert is currently out to fill the remaining roles. • Development work continues within the MSK service to ensure large gaps in workforce are not created through current roles applying for advanced posts. This will continue to be kept under review.	Live – on track
Primary Care Mental Health Services			
Further work required with operational community mental health teams to scope pathways and models before other investment could be agreed.	2018-2019	• Action 15 monies allocation letter has been received by all HSCPs. • Agreement to spend £2.5 million between now and 2021/22 on Mental Health workers based within GP Practices. This investment will be allocated on gradual basis each year. • For 2018/19 this equates to 2x Band 6 MH workers for each HSCP area. Recruitment for these roles is being led by each HSCP with support from the Implementation Team. • A sub group of the MDT Implementation Group has been formed with representation from the HSCP teams and GP Practices to plan for the additional investment in future years, and service models/pathways.	Live – on track
Community Link Workers			
Group established with HSCP Leads to review the number of link workers in post and scope current roles.	2018-2020	A report has been circulated and discussed with the MDT Implementation Group on early findings and evaluation. The evaluation will assist with developing core principles that the service will offer members of the public, recognising there will be additional services provided that will be HSCP specific to population need.	Live – on track

Development of ANPs			
Cohort 1 of 14 students commenced September 2017	July 2019	• It is predicted the students in cohort 1 will complete their modules by July 2019. • An evaluation has been carried out involving all GP Practices and students from cohort 1. This will be reviewed to continue to enhance the academy and take any learning into further cohorts.	Live – on track
Cohort 2 to commence in September 2018 – up to 10 students	September 2018	8 students have joined cohort 2.	Live – on track
Cohort 3 – 10 students September 2019	September 2019		For 2019
Cohort 4 – 15 students 2020	September 2020		For 2020
Training and Development Academy			
Develop and academy approach, following a similar model to the recognised ANP academy model and framework to grow our own required workforce from existing staff and trainees.	2018/19	Discussion to take place with all professions 12 November 2018 to scope possibility.	Live – on track
Allocation of Resource of Staff			
Discuss key principles for allocating resource with the Writing Group	September 2018	Key information on principles was discussed and developed into an SBAR for SPOG.	Complete
Discussion with SPOG on process for allocation and agree approach	14 Sept 2018	The SBAR was discussed with the three HSCP Directors on 14 September and it was agreed the protected learning time (PLT) scheduled for all GP Practices should be used as engagement event to discuss practices thoughts on the MDT structure and resource available.	Complete
Develop a draft local Memorandum of Understanding (MoU) that outlines the roles and responsibilities for the HSCPs, services, GP Practices, and NHS Board for discussion across all areas.	9 October 2018	• An early draft has been developed with Pharmacy and MSK Physio colleagues. • There are ongoing discussions nationally on potential content and this will be developed further in the coming weeks and shared with other stakeholders for comment and consideration of further content.	Live – on track
Meet with GP Practices and HSCPs to explore priorities	31 October 2018	• The session with GPs took place on 31 October 2018 • Most GP Practices had two representatives from their practice, and discussions took place as a cluster with HSCP reps also in attendance. • Feedback from each cluster is being collated into a summary report and will be shared with colleagues no later than 20 Nov 18	Live – on track
Ensure the appropriate supervision and mentoring arrangements are in place	December 2018	• Requirements are being progressed with each profession to be followed with allocated GP Practices. • Will be outlined with the MoU	Live – on track

Summary of Primary Care Improvement Fund as at 4 November 2018 (Project 2017/19 position)

Appendix 5

Priority in MoU	PROGRAMME COMITTMENT (£)	18/19 COMMITTMENT (£)	18/19 COMMITTMENT (WTE)	18-19 PROJECTED SPEND	18/19 POTENTIAL CARRY FORWARD (£)
Pharmcotherapy Service	**3,880,163**	**1,506,815**	**40.99**	**1,181,610**	**325,206**
GP Clinical Pharmacist - Band 8b				**31,508**	
GP Clinical Pharmacist - Band 7		429,531	12.50	134,952	
Pharmacy Technician - Band 5		131,658	8.00	70,245	
Pharmacy pre-reg trainees - Band 6		73,526	3.99	16,471	
Pre-existing PCTF pharmacists		872,100	16.50	928,433	
Primary Care Nurse Service	**575,996**	**185,730**	**11.49**	**104,072**	**81,659**
Urgent Care Service	**451,500**	**203,500**	**-**	**197,650**	**5,850**
MDT in General Practice	**2,202,939**	**917,266**	**19.49**	**696,021**	**221,245**
Programme Delivery	**296,875**	**98,958**	**3.50**	**91,498**	**7,460**
COMMITTED PROJECTS	**7,407,473**	**2,912,269**	**75.47**	**2,270,849**	**641,420**
FUNDING (100%)				**3,389,685**	
FUNDING (70%)				**2,543,570**	

Funding Profile	
Total Allocation	£3,389,685
Baseline Budget (from existing Pharmacy)	£569,300
Amount due from Scottish Government	£2,820,385
Allocation (70%)	£1,974,270
Budget received in total	£2,543,570
Available to draw down in 2019/20 (30%)	£846,116
Funding available to invest in non-recurring projects 2018/19	£272,720

Appendix 6

GDS/PDS Shared Care, Care Home Pilot – Evaluation

Executive Summary

Since early 2017, a “shared care” arrangement has been operating to ease the burden on the Public Dental Service, by supporting a General Dental Practitioner to treat patients in a Care Home environment. Of the 20 residents in Auchinlea Care Home in Largs, around half now receive routine dental treatment from a local GDP rather than the PDS team based in Ayrshire Central Hospital. Under the arrangement, a nominated GDP liaises with a named Senior PDS dentist who continues to care for patients with the most complex needs and who can provide advice and support to facilitate care by the GDP where appropriate.

This evaluation report is based on findings from the working group who met regularly during the course of the pilot and feedback from key stakeholders: the nominated GDP, the Senior PDS Dentist, the Care Home manager and a local Oral Health Improvement Lead.

The pilot demonstrated that a shared care arrangement between PDS and GDS is feasible and was successful in enabling more patients to receive dental treatment from a GDP. A number of learning points became apparent during the pilot which will be important to consider if this type of arrangement is to be introduced on a larger scale.

Training for the GDP in working in the Care Home environment was recognised by all as a key factor, with particular value placed on time spent shadowing the experienced PDS dentist. Close links were established between the GDP and PDS dentist and the value of having a named single point of contact within the PDS was highlighted. Links between general dental services and oral health improvement activities did not appear to have developed to the same degree, highlighting a need to raise awareness of Caring for Smiles among the wider dental profession.

Differences in working arrangements between PDS and GDPs were also highlighted which could present some challenges for GDPs wishing to provide dental care in Care Homes. The need for visits to fit around Care Home schedules, and possibility of late cancellations were mentioned as difficulties. Increasing awareness of the Adults with Incapacity (2000) Act among GDPs was fully supported, however the ability to sign a Section 47 certificate was not felt to be essential for the GDP as the certificate could be issued by another professional.

The most significant challenge encountered was that under current arrangements, it was not possible for patients to receive care from the PDS dental hygienist whilst remaining registered with the GDP. A solution to this will be required to ensure patients in Care Homes have access to the valuable services of DCPs.

The service will continue in its current format, with potential interest for a similar model in another area. This will provide an opportunity to explore how well these arrangements can be transferred to another Care Home.

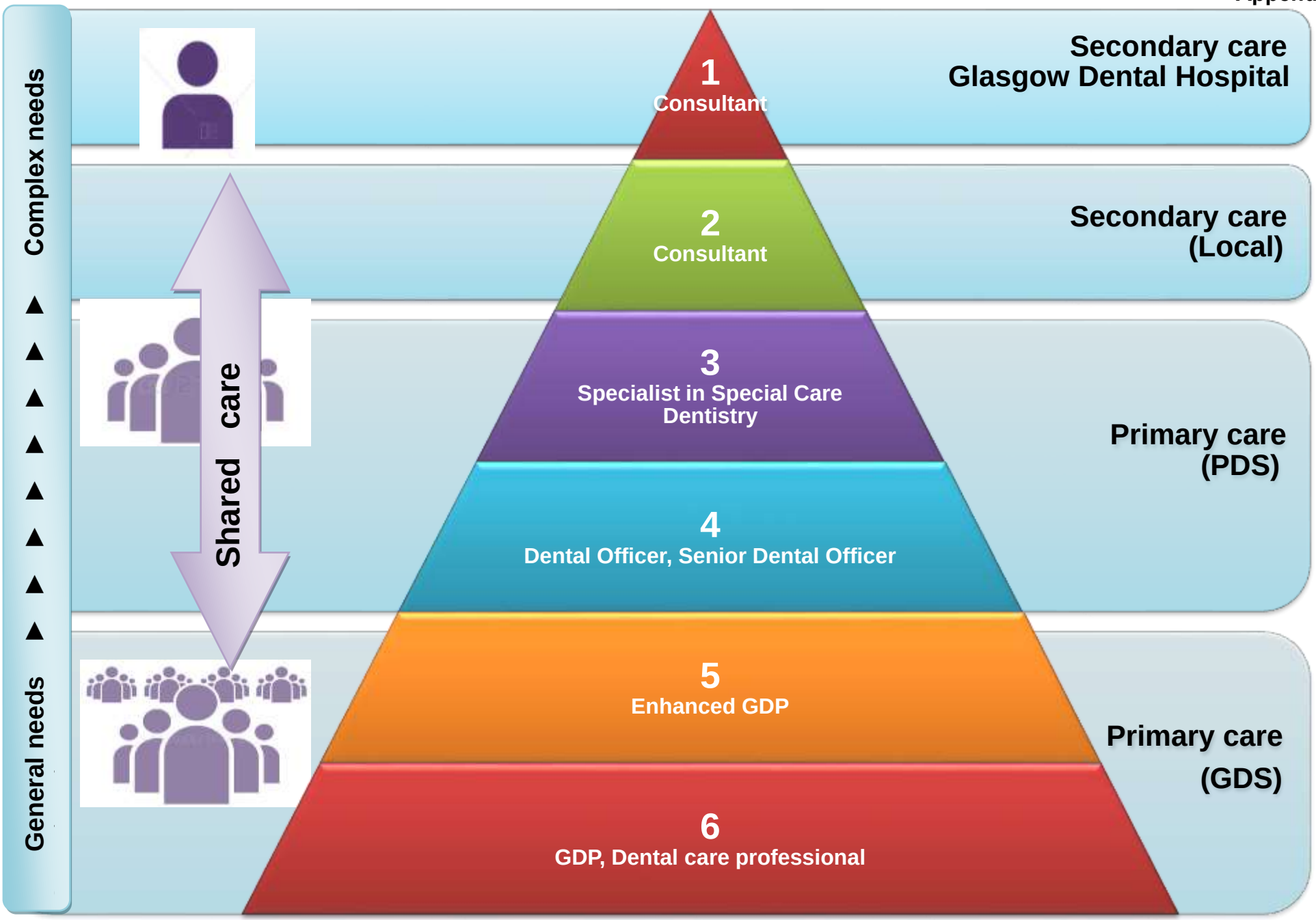
Oral Surgery Pilot – Evaluation

Executive Summary

A pilot oral surgery service (one day per week) based in Primary Dental Care was introduced in Kilmarnock in May 2016 with a view to reducing waiting times for patients requiring Minor Oral Surgery procedures and facilitating treatment closer to patients' homes. The service was supported by Integrated Care Funding to address the initial outlay for equipment and provide salaries on a time limited basis for staff providing the service until December 2017. It was hoped that this initial supported stage would pump-prime continued delivery of the service on an independent contractor model following the pilot phase.

Patients were seen and treated by the service from May 2016 to December 2018. Data collection for evaluation purposes began in November 2016 once the service had become established, during which time 537 referrals were accepted. Evaluation of the service was based on a database of referrals, R4 practice management system, interviews with stakeholders and patient evaluation questionnaires.
The pilot demonstrated that it was possible to provide an oral surgery service within Primary Care, with a significant reduction in waiting times for those attending the service. Treatment provided covered a range of procedures, with high patient attendance rates. The service received positive feedback from patients and referring GDPs who were happy with the service delivered and the clinic's location.
Some challenges were encountered during the course of the pilot but most were easily overcome. Direct referrals from GDPs were found to be appropriate and were the preferred pathway for all stakeholders. Shared oversight of the service by OMFS and DMT did not work particularly well, with consideration required to the most appropriate leadership structure for any future service.

"Virtual" fee per item claims generated through R4 demonstrated that the service was not financially viable in its current format. Unfortunately this eliminated the possibility of the service continuing beyond the pilot phase and the service ceased on 19th December 2017. There is a will for the service to be reinstated, however consideration will be required as to the most appropriate model and how this could become a more attractive business proposition.


Complex needs
General needs
Shared care
1
Consultant
2
Consultant
3
Specialist in Special Care Dentistry
4
Dental Officer, Senior Dental Officer
5
Enhanced GDP
6
GDP, Dental care professional
Secondary care
Glasgow Dental Hospital
Secondary care
(Local)
Primary care
(PDS)
Primary care
(GDS)

Minutes of North Ayrshire Strategic Planning Group Meeting

Held on Wednesday 10th October 2018 at 10.00am
Fullarton Connexions, Irvine

Present:
Councillor Robert Foster (Chair)
John Rainey (Vice Chair)
Michelle Sutherland, Strategic Planning & Transformational Change Lead, NAHSCP
Christine Speedwell, Care Centre Manager
Brenda Knox, Health Improvement Lead, NHS A&A
Louise McDaid, Staff Representative
David Bonellie, Optical Representative
Norma Bell, Manager, Planning & Performance, Mental Health, NAHSCP
Clive Shephard, NA Federation of Community Associations
Sam Falconer, Community Pharmacist NHS A&A
Louise Gibson, Dietetic lead, integrated services, NHS A&A
Gavin Paterson, Engagement Officer, NAHSCP
Marion Gilchrist, Interim Manager/Senior Nurse LD Services
Lynne McNiven, Consultant in Public Health, NHS
Jacqui Greenlees, Policy & Community Planning Officer
Fiona Comrie, KA Leisure
Dr Morag Henderson
Fiona Thomson, Service User Representative, IJB Stakeholder Rep/LPF Lead
Elaine Young, Assistant Director of Public Health, NHS
Sharon Bleakley, Scottish Health Council
Lorna McGoran, Primary Care Manager, NAHSCP
Scott Bryan, Team Manager, Planning, NAHSCP
Louise Harvie, Governance Assistant (Minutes) NAHSCP

In Attendance:
Stephen Rankin, Care Inspectorate Inspector
Sheena McIntosh, Care Inspectorate Inspector
Bruce McMaster, Food Development Officer
Kathleen Cooper, Senior Health Promotion Officer

Apologies Received:
Donna McKee, Head of Service, Children & Families and Justice Services, NAHSCP
David Donaghey, Partnership Representative, NAHSCP
Annie Robertson, Business Planning Manager, NAHSCP
Thelma Bowers, Head of Service, Mental Health, NAHSCP
Eleanor McCallum, Partnership Communication & Engagement Officer, NAHSCP
Laura Barrie, KA Leisure
Elaine Young, Assistant Director of Public Health, NHS
Simon Morrow, Dental Representative
Betty Saunders, Service Design & Procurement Manager
Caroline Whyte, Chief Transformation
Andrew Keir, Manager, Children & Families, GIRFEC, NAHSCP
Vicki Yuill, Operations Manager, Arran CVS
Dr Paul Kerr, Clinical Director, NAHSCP
David Thomson, Associate Nurse Director/Lead Nurse, NAHSCP
Isabel Marr, Senior Manager, Long Term Conditions, NAHSCP
Ruth Betley, Senior Manager, Island Services, NAHSCP

1.	**WELCOME & APOLOGIES**	
1.1	Councillor Foster welcomed all to the meeting and introduced John Rainey to his first Strategic Planning Group as the new Strategic Planning Group Vice Chair. As part of the Joint Inspection of Adult Health & Social Work, Councillor Foster also introduced to the meeting, Stephen Rankin and Sheena McIntosh who were in attendance to observe the SPG.	
2.	**MINUTES/ACTION NOTE OF PREVIOUS MEETING (15.10.18)**	
2.1	Minutes of the previous meeting were approved as accurate with no amendments required.	
3.	**MATTERS ARISING**	
3.1	Dates of forthcoming LPF Meetings Scott Bryan provided an update on future Locality Planning Forum dates. Scott also provided an update on the Partnerships newsletter; Your Health & Social Care in North Ayrshire. Produced by the Partnerships Communication team, the newsletter is aimed at informing local people of developments and services within the Partnership. It will be available in a number of Partnership buildings and public spaces. SPG members are invited to contribute articles to the newsletter and can do so by contacting Eleanor McCallum, Partnership Communications Officer.	
3.2	Planned timelines for the LPF engagement and communication champion pilot Gavin Paterson provided an update on the timeline of the phased roll-out of the Locality Engagement Pilot. The first locality will be Kilwinning commencing in November 2018. Localities will come online in two month periods and each Pilot will last for six months.	
Focus on: Working to alleviate inequalities across North Ayrshire		
4.	**Community Link Worker Development**	
4.1	Lorna McGoran, Primary Care Development Manager attended the meeting to deliver a presentation on the progress and emerging Locality Themes on the developments of the new Community Link Workers.	
4.2	Presentation slides included:- • Community Link Worker in General Practice • Patient Details • Activity (Consultations Recorded) • Signposting • Community Link Worker Case Studies • In the Community • Community Link Worker Feedback • The Future	

4.3	**Fairer Food**	
	Bruce McMaster, Food Development Officer attended the meeting to deliver a presentation on the progress of Fairer Food across North Ayrshire. Slides included: • National and Local Context • Fair for All Food Pledges and Associated Data • Performance Framework • Food Forum Evaluations • Next Steps - Continue to use baselines and evidence gathered to support delivery of pledges - Support groups to gather information against measures and impact relating to pledges - Weekend Food Support - Community Food Map and Plan - Explore Options for Enhances Summer Scheme for Schools/Communities.	
4.4	Following the presentations highlighted above, the following question was asked to the group: **How might your service or professional group link to or support these approaches?** Feedback received: <u>Fairer Food</u> • Suggested that Bruce McMaster be invited to future Locality Planning Meetings to progress Fairer Food work at Locality level. • Highlighted close possible links with HSCP Gardening/Allotment Projects including Hazeldene, Woodland View and potentially Tarryholme. • Discussions ongoing with AHP colleagues. <u>Community Link Workers</u> • It was suggested that the Fairer Food identified opportunities could be shared via the Community Link Worker Model and be listed on Carena. • Thelma commented on the need to ensure demand is identified appropriately to make best use of the Community Link Worker service.	
Focus on: Assessing Inequalities		
5.	**Health Inequalities Self-Assessment**	
5.1	Kathleen Cooper, Senior Health Promotion Officer provided a presentation on the Health Inequalities Self-Assessment.	
5.2	The presentation covered the following areas:- • An overview of Socioeconomic Inequalities in Health • Health Inequalities • Causes of Health Inequalities	

	• Proportionate Universalism • The Role of the HSCP's in reducing Health Inequalities - Working with Individuals - Workforce Learning & Development - Quality of Services Provided - Working in Partnership	
5.3	Following the presentation, the group was asked to address the following question: **How might your service of professional group roll out this approach across HSCP?** Feedback received: • Discussion on how the tool could be employed, highlighted that some teams have already used the tool and others are keen to do so. • The use of this tool will be actively encouraged going forward.	
Focus on: Locality Profile Information		
6.	**Enhancing our Locality Profiles**	
6.1	Scott Bryan provided a presentation on the Locality Planning Forums Profile Refresh.	
6.2	The presentation covered the following areas:- • Background on the Locality Profiles since being produced in January 2016 • Validated Data Used • Information on the Locality Priorities • Profile Refresh & how information has improved since 2016 • Demographic Updates • New Locality Level information • Data Visualisations • Poverty Alleviating Grants Index	
6.3	Following the presentation, Scott put forward the following question to the group: **Are there key issues you would want more detail on in the Locality Profile?** Feedback received: • Previous profile useful as it was broken down to sub locality level. It would be good if that could continue • The inclusion of more Social Work data would be useful • Crisis payment information (highlights inequalities) • Hospital discharge information • Advise of review of Source dataset, which is national linked Health and Social Care information. Need to ensure information that is shared is done so appropriately • Using relevant information is useful when engaging with public. • Would be good to include information on travelling communities. This may provide difficult as Equalities Monitoring Information is not always available.	

Focus on: Service Redesign		
7.	Reconfiguration of Mental Health Wards.	
7.1	William Lauder, General Manager, Mental Health Services, provided a presentation on the Changes in Elderly Mental Health Inpatient Services. The presentation covered areas such as: • Background on the current accommodation - Poor Standard - Isolated Services - Overspend on supplementary staff - ECT Issues - Low Percentage of Occupancy • Opportunities - Maximise use of Woodland View - Increase Staffing Complement/Skill Mix - Align Wards/Models for future provision - Shift Balance of Care - Release Resource for Reinvestment • Proposal - Merge Croy and Ward 4 = 'New' Ward 4, 17 bedded functional assessment ward, effectively closing Croy Ward. - Additional Staff - Reduce Bed Numbers to match average % Occupancy - Progress scoping of enabling works to enable • Consultations with staff • Benefits - Improve staffing & skill mix - Allow Occupancy of best Inpatient Accommodation (Ailsa & Woodland View) - Release Resource for Alternative Investment - Rationalise number of Wards and Beds making future Re-Provision readily achievable. William highlighted that consultations across all Stakeholder Groups has been high and this has helped ensure a smooth transition to the new site. Families have also been engaged with and been invited to join the group that will have an overview on the process for transparency. Individual meetings will also take place with families around the assessment of their loved one.	
8.	**Agenda Items for Future Meetings**	
8.1	The next meeting will focus on Prevention and Early Intervention. Any agenda items to be forwarded to Michelle Sutherland or Scott Bryan.	
9.	**AOCB**	
9.1	Future <u>Venues</u> Acknowledged that Fullarton Connexions was not suitable for future meetings, therefore changes will be made to 2019 dates. <u>Housing Representative</u> Acknowledged that David Hammond, Senior Manager from Housing has been invited to attend future meetings.	

	Inspectors The Inspectors in attendance held an Inspection Session following the SPG, therefore Members were encouraged to stay behind and attend.	
9.2	There was no other business to be discussed, therefore the meeting was brought to a close.	
10.	**Future Meetings**	

Date	**Time**	**Venue**
Wednesday 23rd January	10.00am - 12.00pm	Fullarton Community Hub, Irvine KA12 8DF
Wednesday 6th March	10.00am - 12.00pm	Fullarton Community Hub, Irvine KA12 8DF
Wednesday 17th April	10.00am - 12.00pm	Greenwood Conference Centre, Dreghorn
Wednesday 29th May	10.00am - 12.00pm	Greenwood Conference Centre, Dreghorn
Wednesday 10th July	10.00am - 12.00pm	Greenwood Conference Centre, Dreghorn
Wednesday 21st August	10.00am - 12.00pm	Fullarton Community Hub, Irvine KA12 8DF
Wednesday 2nd October	10.00am - 12.00pm	Fullarton Community Hub, Irvine KA12 8DF
Wednesday 13th November	10.00am - 12.00pm	Greenwood Conference Centre, Dreghorn
Wednesday 18th December	10.00am - 12.00pm	Greenwood Conference Centre, Dreghorn