Integration Joint Board Meeting

NORTH AYRSHIRE
Health and Social Care Partnership

Thursday, 21 June 2018 at 14:00

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
The accuracy of the Minutes of the meeting held on 24 May 2018 will be confirmed and the Minutes signed in accordance with Paragraph 7 (1) of Schedule 7 of the Local Government (Scotland) Act 1972 (copy enclosed).

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

Quality and Performance

4 Annual Governance Statement 2017/18
Submit report by Eleanor Currie, Principal Manager (Finance) on the Health and Social Care Partnership (HSCP) Annual Governance Statement for 2017/18 which will be included within the Annual Accounts.

5 2017/18 Financial Performance Update
Submit report by Eleanor Currie, Principal Manager (Finance) on the IJB's unaudited Annual Accounts for the year to 31 March 2018 and the IJB's financial performance for the year (copy enclosed).

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

7 IJB Set Aside Arrangements

Submit report by Shahid Hanif, Interim Chief Finance and Transformation Officer on progress made to date in implementing the statutory guidance on establishing set aside arrangements with NHS Ayrshire and Arran (copy enclosed).

Strategy and Policy

8 Preventing Drug Related Deaths: A Framework for Ayrshire and Arran

Submit report by Joy Tomlinson, Interim Director of Public Health, on the increase in drug related deaths across Ayrshire and Arran (copy enclosed).

9 Strategic Planning, Commissioning and Delivery of Health and Social Care Services within Ayrshire and Arran

Submit report by Stephen Brown, Director (NAHSCP) on the 2017 review of arrangements for planning, commissioning and delivery of health and social care services in Ayrshire and Arran (copy enclosed).

10 Arran Services Integrated Hub

Submit report by Ruth Betley, Senior Manager (Arran Services) on the development of an Arran Services Integrated Hub (copy enclosed).

11 Carer (Scotland) Act 2016: Eligibility, Assessment and Waiving of Charges

Submit report by Kimberley Mroz, Team Manager (Self Directed Support/Unpaid Carers) on proposed eligibility criteria to meet duties under the Carer (Scotland) Act 2016 (copy enclosed).

12 Mental Health Commission for Scotland: Report on the Right to Advocacy

Submit report by Thelma Bowers, Head of Service, Mental Health, on the proposed local response to the recommendations made within the Mental Welfare Commission for Scotland's report on the Right to Advocacy (copy enclosed).

13 Primary Care Improvement Plan - Implementation of new 2108 GMS Contract

Submit report by Vicky Campbell, Programme Manager for Primary Care Transformation on the draft Primary Care Improvement Plan (copy enclosed).

Tenders

14 Award of Framework Contracts for the Provision of Care at Home Services

Submit report by Helen McArthur, Senior Manager, Community Care Services, on the outcome of the procurement exercise for the Framework Contracts for the Provision of Care at Home Services (copy enclosed).

Appointments

15 Chair of Kilwinning Locality Forum

Submit report by Stephen Brown, Director (NAHSCP) on the interim process to appoint an interim Locality Planning Forum Chair for Kilwinning (copy enclosed).

16 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
Dr. Martin Cheyne	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
Shahid Hanif	Head of Finance
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)
Vacancy	(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 24 May 2018
at 10.00am, 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
Councillor Christina Larsen, North Ayrshire Council
Dr Janet McKay, NHS Ayrshire and Arran
Alistair McKie, NHS Ayrshire and Arran
Councillor John Sweeney, North Ayrshire Council

Stephen Brown, Director of Health and Social Care Partnership
Shahid Hanif, Interim Head of Finance
Dr Paul Kerr, Clinical Director
Alistair Reid, Lead Allied Health Professional Adviser
David Thomson, Associate Nurse Director/IJB Lead Nurse
Dr. Louise Wilson, GP Representative

David Donaghey, Staff Representative – NHS Ayrshire and Arran
Louise McDaid, Staff Representative – North Ayrshire Council
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 Representatives

In Attendance
Andrew Fraser, Head of Democratic Services
David Rowland, Head of Service (Health and Community Care)
Eleanor Currie, Principal Manager (Finance)
Thelma Bowers, Head of Service (Mental Health)
Michelle Sutherland, Strategic Planning Lead
Brenda Walker, Senior Officer - ASP
Mark Inglis, Senior Manager
Karen Andrews, Team Manager (Governance)
Diane McCaw, Committee Services Officer

Also In Attendance
Councillor Anthea Dickson, North Ayrshire Council

Apologies for Absence
Dr Martin Cheyne, NHS Ayrshire and Arran
Dr Calum Morrison, Acute Services Representative
David MacRitchie, Chief Social Work Officer - North Ayrshire

1. Apologies and Chair's Remarks

Apologies were noted.

The Chair welcomed new representatives Dr. Louise Wilson (GP representative), Graham Searle (Carer representative) and Clive Shephard (Service User representative) to the IJB. The Chair also thanked Robert Steel, who had recently resigned from the IJB, for his work with the IJB and his service to the community.

2. Declarations of Interest

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

3. Minutes/Action Note

The accuracy of the Minute of the meeting held on 19 April 2018 was confirmed and the Minute signed in accordance with Paragraph 7 (1) of Schedule 7 of the Local Government (Scotland) Act 1973.

3.1 Matters Arising

Volunteering Strategy - Publication of the Draft Volunteering Strategy has been slightly delayed due to a minor branding issue with partners and also in terms of the engagement process. Further discussion will take place to resolve this soon. Ongoing action.

Action - V. Yuill

Public Partnership Forum - Officers met with Fiona Thomson and an update on actions identified for going forward was provided including an outline of work ongoing with CPPs on joint arrangements, how to work together more effectively and on mapping across existing groups across the HSCP. Once all the ongoing work has been carried out a paper will be brought to the IJB. Ongoing action.

Action - F. Thomson

Veterans First Point Service - The service is located in North Ayrshire and accessed by South and East. Full agreement has now been reached across the 3 Ayrshires and Ayrshire and Arran and agreement regarding funding. Veterans First Point Service will continue and so far uptake has been greater than any Veterans Service elsewhere. Action complete and to be removed.

Action - T. Bowers

North Ayrshire Citizen's Advice Service - David Rowland advised that the Scheme of Delegation for additional posts within Money Matters is now complete. The posts will be filled to allow this service to be sustained. Ongoing action.

Action - D. Rowland

HSCP Challenge Fund Update - To receive a presentation to a future meeting on the effective savings model undertaken at Elderbank and Greenwood in relation to

reducing the number of accommodated children. Presentation to today's meeting. Action complete and to be removed.

4. Health and Social Care Partnership: Challenge Fund Projects

The Board received a presentation from Mark Inglis, Senior Manager, Intervention Services on the Challenge Fund, including information on:-

- build capacity within the universal early years service and new roles to enable access to appropriate interventions for children and families;
- the expansion of the Multi Agency Assessment and Screening Hub through the creation of an additional social worker post;
- the work of the Children and Families Challenge Team within Greenwood Academy and Elderbank Primary;
- efforts to reduce the number of children placed in external placements from 23-18;
- work with children within our own residential units to prevent escalation into external placements;
- outcomes to date; and
- highlights over the past 6 months.

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

- specific training provided to family nurturers;
- the positive outcome of a 50% increase in pupil attendance at Elderbank;
- how the Children and Families Team is utilising the wellbeing web programme to track changes in relation to young people involved in the project;
- that all children are identified through the Children and Families Team;
- that the presence of the Team within the schools gives a huge boost to young people in terms of the support they receive and also to staff; and
- the development of the process to assist with the identification and mapping of any young carers.

The Board congratulated the Team for the ongoing work and the positive outcomes in relation to the Challenge Fund projects.

Noted.

5. Appointment of an Interim Section 95 Officer of the Integration Joint Board (IJB)

The Board resolved, in terms of Standing Order 13, to suspend Standing Order 12.1 to allow consideration of this item as the report involved changing a decision taken by the IJB on 15 February 2018 where proposals are no longer possible. An apology was made to the Board in this regard.

Submitted report by Andrew Fraser, IJB Monitoring Officer, on the appointment of an interim Section 95 Officer of the IJB and detailing the position with regard to professional insurance and indemnity and timescales in relation to the appointment of a Chief Finance and Transformation Officer and sign off of annual accounts for 2017/18.

The Board indicated that they hoped the appointment of a permanent Chief Finance and Transformation Officer would be treated as a matter of urgency.

The Board agreed that, pending the appointment of the permanent post of Chief Finance and Transformation Officer, North Ayrshire Council's Executive Director (Finance and Corporate Support) be appointed as Interim Section 95 Officer of the Integration Joint Board.

6. Appointment of Vice-Chair of the IJB Performance and Audit Committee (PAC)

Submitted report by Stephen Brown, Director (NAHSCP) on the appointment of a Vice-Chair for the IJB PAC.

The Board was advised of a change within the report in that Councillor Robert Foster was indicated as the Chair of the PAC when this should have detailed Councillor Timothy Billings as Chair.

In April 2018, Robert Martin was appointed as Chair of the IJB which created a vacancy for the Vice-Chair of the Performance and Audit Committee. Councillor Timothy Billings currently Chairs the PAC and the Vice-Chair appointment should therefore be held by an NHS voting member. Alistair McKie was nominated for the position.

The Board agreed to appoint Alistair McKie to the position of Vice-Chair of the IJB Performance and Audit Committee.

7. Director's Report

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

The report highlighted works underway in the following areas:-

- That a final report on the review of the Integration Scheme will be provided to the next meeting of the IJB on 21 June 2018;
- The visit by the Cabinet Secretary, Shona Robison, to the Largs School Campus on 18 May 2018 had to be cancelled at short notice and did not take place;
- Recent unannounced inspections by the Care Inspectorate which awarded grades of 5s (very good in all aspects and no recommendations or requirements) across our care at home services;
- The position in relation to the NAHSCP 2017/18 financial outturn and that the full financial outturn report will be provided to the meeting of the IJB on 21 June 2018;
- The pan-Ayrshire working group created to progress work in connection with a pan-Ayrshire British Sign Language Plan which will be issued for consultation in May 2018;
- Publication by the Scottish Government of the Digital Health and Care Strategy;
- That North Ayrshire has been chosen as a case study site to explore the ways self-directed support approaches are being implemented across user groups and on the potential for scaling up and fuller implementation;
- A successful visit to Wigan Council which took place on 25 April 2018; and
- Engagement with Carer Positive to gain Level 1 status as a Carer Positive Employer.

Members were further advised that the Scottish Government have requested all IJBs to provide an up-to-date position on plans for sums set aside. It was suggested that the August meeting of the IJB be converted to a private briefing on set aside in order to provide more clarity for Members.

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

8. Adult Support and Protection (ASP) - Thematic Inspection Feedback

Submitted report by Brenda Walker, Senior Officer – ASP on the findings of the first Joint Thematic Inspection of Adult Support and Protection which took place at the end of October 2017 and consisted of three days of detailed file reading and two days of 'scrutiny sessions'. The North Ayrshire report was general highly complimentary in terms of outcomes, processes and leadership.

The Board was advised that a report will be provided to a future meeting giving detail on an action plan to deliver against ratings.

Noted.

9. Accounting Policies 2017/18

Submit report by Eleanor Currie, Principal Manager – Finance on accounting policies to be adopted in preparation of the Council's annual accounts for the year to 31 March 2018. Appendix 1 to the report detailed the accounting policies and there has been no change to policies since last year.

The Board agreed to approve the accounting policies as detailed in Appendix 1 to the report.

10. Strategic Risk Register

Submitted report by Eleanor Currie, Principal Manager – Finance outlining the Partnership Strategic Risk Register. Appendices A and B detailed the risks in full and the risk scoring respectively.

Members highlighted that it would be useful for the risk register to identify previous numerical risks and any changes in order to follow what has been successful or not.

The Board agreed to approve the Partnership Strategic Risk Register, including actions required to amend and control those risks.

11. Support Service for Adults with Enduring Mental Health Problems

Submitted report by Norma Bell, Independent Living Manager seeking approval to tender for a service provider to deliver a support service for adults with enduring mental health problems. Due to the urgency involved, this matter has already been progressed but required to be retrospectively approved by the Board.

Members asked for clarification in terms of human resource implications and the process in terms of recruitment of a provider for the service.

The Board agreed to retrospectively direct North Ayrshire Council, on behalf of the North Ayrshire Health and Social Care Partnership, to tender for a Service Provider to deliver support services for adults with enduring mental health problems, meeting

their assessed need and outcomes, initially at the property located at 2a Nethermains Road, Kilwinning and then potentially developing the service to cover the property at 2b Nethermains Road, Kilwinning.

12. Strategic Planning Group Minutes

Submitted the minutes of the Strategic Planning Group meeting held on 25 April 2018.

Noted.

13. Urgent Items

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

14. Exclusion of the Public

The Board resolved in terms of Section 50(A)4 of the Local Government (Scotland) Act 1973, to exclude from the Meeting the press and the public for the following item of business on the grounds indicated in terms of Paragraph 3 of Part 1 of Schedule 7A of the Act.

15. Private Briefing

The Board received a private briefing to make them aware of a matter of concern which may require a decision to a future meeting of the Board.

The Meeting ended at 11.15 a.m.

North Ayrshire Integration Joint Board – Action Note

Updated following the meeting on 24 May 2018

No.	Agenda Item	Date of Meeting	Action	Status	Officer
1.	Volunteering Strategy	15/2/18	Publication has been slightly delayed. Further discussion will take place to resolve this.	Ongoing.	V. Yuill
2.	Public Partnership Forum	15/2/18	Officers will meet with Fiona Thomson and bring forward a paper to a future meeting.	Ongoing.	Officers and F. Thomson
3.	North Ayrshire Citizen's Advice Service	15/2/18	Scheme of Delegation for additional posts within Money Matters now complete. Posts to be filled to allow service to be sustained.	Ongoing.	D. Rowland
4.	Director's Report: Review of Integration Scheme	24/5/18	Final report on the Review to be provided to the IJB on 21 June 2018.	Ongoing	S. Brown
5.	Director's Report: NAHSCP 2017/18 Financial Outturn	24/5/18	Full financial outturn report to be provided to meeting of IJB on 21 June 2018.	Ongoing	S. Brown/ E. Currie
6.	Adult Support and Protection	24/5/18	Report to future meeting giving detail on an action plan to deliver against ratings following the Joint Thematic Inspection.	Ongoing	B. Walker

Integrated Joint Board
21 June 2018
Agenda Item No.

Subject:	**Annual Governance Statement 2017/18**
Purpose:	To seek IJB approval of the Health and Social Care Partnership (HSCP) Annual Governance Statement for 2017/18 which will be included within the Annual Accounts.
Recommendation:	That the IJB approves the Annual Governance Statement which is attached at Appendix 1 to this report.

Glossary of Terms	
NHS AA	NHS Ayrshire and Arran
HSCP	Health and Social Care Partnership
IJB	Integrated Joint Board
PSMT	Partnership Senior Management Team
CIPFA	Chartered Institute of Public Finance & Accountancy
SOLACE	Society of Local Authority Chief Executives

1.	**EXECUTIVE SUMMARY**
1.1	The Partnership's Annual Governance Statement outlines the governance framework which is in place.
1.2	Approval of the Statement by the IJB will ensure that the Partnership complies with the requirements of the Local Authority Accounts (Scotland) Regulations 2014.
2.	**BACKGROUND**
2.1	North Ayrshire Health and Social Care Partnership is responsible for ensuring that its business is conducted in accordance with the law and proper standards, and that public money is safeguarded and properly accounted for and used economically, efficiently and effectively.
2.2	The Partnership is also responsible for putting in place proper arrangements for the governance of its affairs and facilitating the effective exercise of its functions, which includes arrangements for the management of risk.
2.3	The Partnership has approved and adopted a Code of Corporate Governance, which is consistent with the principles of the CIPFA/SOLACE Framework 'Delivering Good Governance in Local Government'.

2.4	The Local Authority Accounts (Scotland) Regulations 2014, which came into force on 10th October 2014, require preparation of an Annual Governance Statement, in accordance with proper practices in relation to internal control, and that this Annual Governance Statement should be approved by the appropriate committee of the body.
2.5	Following approval of the Annual Governance Statement by the IJB it requires to be signed by the Chief Officer and the IJB chair prior to its inclusion within the Partnership's draft annual accounts.
2.6	The Annual Governance Statement, which is attached in full at Appendix 1 to this report, explains how the Partnership complies with the Code of Corporate Governance. It identifies the main components of the Corporate Governance framework which is in place, including the system of internal control. The Annual Governance Statement complies with the requirements of recent guidance published by the Scottish Government in relation to the Annual Accounts for 2017/18.
2.7	The Statement also identifies a number of actions which the Partnership intends to implement during 2018/19 to further strengthen the governance framework and concludes with an assurance statement by the Chief Officer and the IJB Chair.
3.	**PROPOSALS**
3.1	It is proposed that the Integrated Joint Board approves the Annual Governance Statement for 2017/18 which is attached in full at Appendix 1 to this report.
3.2	**Anticipated Outcomes**
	The 2017/18 annual accounts will be prepared in accordance with the relevant governance framework.
3.3	**Measuring Impact**
	The 2017/18 annual accounts will be externally audited.
4.	**IMPLICATIONS**

Financial :	None
Human Resources :	None
Legal :	None
Equality :	None
Environmental & Sustainability :	None
Key Priorities :	Good governance arrangement help to underpin the delivery of the Partnership's key priorities.
Risk Implications :	Failure to comply with governance requirements could lead to a breach of specific regulations resulting in enforcement action from governing bodies, adverse public reaction and/or prosecution.
Community Benefits :	None

Direction Required to Council, Health Board or Both	Direction to :-	
	1. No Direction Required	x
	2. North Ayrshire Council	

	3. NHS Ayrshire & Arran	
	4. North Ayrshire Council and NHS Ayrshire & Arran	

5.	**CONSULTATION**
5.1	None
6.	**CONCLUSION**
6.1	Approval of the Statement by the IJB will ensure that the Partnership complies with the requirements of the Local Authority Accounts (Scotland) Regulations 2014.

For more information please contact Eleanor Currie on 01294 317814 or EleanorCurrie@north-ayrshire.gcsx.gov.uk

Annual Governance Statement 2017/18

The Annual Governance Statement explains how North Ayrshire IJB complies with the Code of Corporate Governance and meets the requirements of the CIPFA / SOLACE Framework 'Delivering Good Governance in Local Government 2016' and the 'Code of Practice for Local Authority Accounting in the UK: A Statement of Recommended Practice', in relation to the Statement on the System of Internal Financial Control.

Scope of Responsibility

North Ayrshire IJB is responsible for ensuring that its business is conducted in accordance with the law and proper standards, and that public money is safeguarded and properly accounted for and used economically, efficiently and effectively.

The IJB is also responsible for putting in place proper arrangements for the governance of its affairs and facilitating the effective exercise of its functions, which includes arrangements for the management of risk.

In discharging this responsibility, the Chief Officer has put in place arrangements for governance which includes the system of internal control. Reliance is placed on these controls which are designed to manage risk to a reasonable level, but cannot eliminate the risk of failure to achieve policies, aims and objectives. It can therefore only provide reasonable but not absolute assurance of effectiveness.

The Purpose of the Governance Framework

The governance framework comprises the systems and processes, and culture and values by which the IJB is directed and controlled and the activities through which it accounts to and engages with the community. It enables the IJB to monitor the achievement of its strategic priorities and to consider whether those priorities have led to the delivery of appropriate, cost-effective services.

The system of internal control is a significant part of that framework and is designed to manage risk to a reasonable level. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of North Ayrshire IJB's policies, aims and objectives, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The Governance Framework

The main features of the governance framework that was in place during 2017/18 are summarised below:

- The IJB, comprising all IJB Board members, was the key decision making body. The Performance and Audit Committee considered all matters in relation to Internal and External Audit, Risk Management and Performance;

- Strategic decision-making is governed by the IJB's key constitutional documents including the Integration Scheme, standing orders, scheme of administration, scheme of delegation to officers and financial regulations;

- The Integration Scheme sets out financial contributions by partners to Integration Joint Boards. This includes the Health Board and Council each considering funding their pay cost pressures and contracted inflation with shared responsibility for demographic cost pressures.

- The IJB's purpose and vision are outlined in the IJB Strategic Plan which links closely to the vision of the North Ayrshire Community Planning Partnership and the Local Outcome Improvement Plan (LOIP) and is underpinned by an annual action plan and performance indicators. Regular progress reports on the delivery of the Strategic Plan were provided to the Performance and Audit Committee and the IJB;

- The Performance Management Strategy focuses very firmly on embedding a performance management culture throughout the IJB. Regular reporting to Board Members takes place.

- A risk management strategy and strategic risk register is in place for the IJB

- A Health and Care Governance Framework was agreed by the IJB on 9 March 2017. This covers governance arrangements in relation to complaints and customer feedback, risk management, health and safety, Internal Audit, workforce planning and public protection.

- The IJB has adopted a 'Code of Conduct' for all of its Board Members and employees, a register of interests is in place for all Board members and senior officers;

- The IJB has in place a development programme for all Board Members, the Senior Management Team and senior managers across the Partnership. Performance and Personal Development (PPD) schemes are in place for all staff, the aim of which is to focus all staff on their performance and development that contributes towards achieving service objectives;

- The IJB has established six locality planning forums, reflecting the previously agreed local planning areas. These provide Board Members, health and social care staff and local community representatives with the opportunity to be involved in considering the priorities for each area; and

- A Change programme is in place, covering four main themes of building teams around children, developing a wider range of primary care services, supporting older people and people with complex care needs and creating mental health and learning disability services to better support people to stay well. A Change Programme Board, chaired by the Chief Officer and with senior representation from all IJB services as well as third and independent sector partners, has oversight of all the IJB's significant transformation projects.

The governance framework was in place during the year ended 31 March 2018.

The System of Internal Financial Control

The system of internal financial control is based on a framework of regular management information, financial regulations, administrative procedures (including segregation of duties), management supervision, and a system of delegation and accountability. Development and maintenance of these systems is undertaken by NHS Ayrshire & Arran and North Ayrshire Council as part of the operational delivery of the Health and Social Care Partnership.

In particular, these systems include:

- Financial regulations and codes of financial practice;
- Comprehensive budgeting systems;

- Regular reviews of periodic and annual financial reports that indicate financial performance against the forecasts;
- Setting targets to measure financial and other performance;
- Formal project management disciplines.

The IJB's financial management arrangements conform to the governance requirements of the CIPFA statement: 'The Role of the Chief Financial Officer in Local Government (2010)'.

Review of Effectiveness
North Ayrshire IJB has responsibility for conducting, at least annually, a review of the effectiveness of its governance framework including the system of internal control. The review of the effectiveness of the framework is informed by the work of the Senior Management Team who have responsibility for development and maintenance of the governance environment, the annual report by the Chief Internal Auditor and reports from Audit Scotland and other review agencies.

The Chief Internal Auditor reports directly to the IJB Performance and Audit Committee on all audit matters, with the right of access to the Chief Officer, Chief Financial Officer and Chair of the Performance and Audit Committee on any matter. In accordance with the principles of the code of corporate governance, regular reports were made to the IJB's Performance and Audit Committee during 2017/18.

The internal audit function has independent responsibility for examining, evaluating and reporting on the adequacy of internal control. During 2017/18, the service operated in accordance with relevant professional audit standards and the Public Sector Internal Audit Standards.

The Chief Internal Auditor is responsible for forming an annual opinion on the adequacy and effectiveness of the systems of internal control.

It is the opinion of the Chief Internal Auditor that the systems of internal control relied upon by the IJB continue to provide reasonable assurance against loss.

Governance Developments during 2017/18

Membership - the membership of the Integration Joint Board changed following the Local Government Elections in May 2017, and due to the resignation of key members.

New appointments were made to the undernoted positions:-
Chair and Vice Chair, IJB
Chair and Vice Chair, Performance and Audit Committee
Chair, Strategic Planning Group
Chair, Health & Care Governance Group
Service User and Carer Representative
Third & Independent Sector Representative
NHS Board Voting Member

New reporting responsibilities were placed on Integration Joint Boards by the Public Bodies (Joint Working) (Scotland) Act 2017, during 2017.

These were:-

- Complaints Handling Procedure
  The Scottish Public Services Ombudsman Complaints Standard Authority required all IJBs in Scotland to adopt their own model Complaints Handling Procedure.

- Model Publication Scheme
  The Freedom of Information (Scotland) Act 2002 (FOISA) requires Scottish public authorities to produce and maintain a publication scheme. North Ayrshire IJB adopted the Model Publication Scheme produced by the Scottish Information Commissioner.

- Climate Change Reporting
  Scottish Government issued guidance to Integration Joint Boards in May 2017 setting out the duty to produce an annual Climate Change report. This report will be submitted on the Sustainable Scotland Network (SSN) online portal by 30th November each year. North Ayrshire IJB submitted their report by the deadline of 30th November 2017. The North Ayrshire IJB report was published on the Sustainable Scotland Network on 31st January 2018.

North Ayrshire Integration Joint Board has no responsibility for employees, buildings or fleet vehicles and therefore the IJB Climate Change report does not include detail of these but instead reference is made to the two respective parent bodies plans as they have retained responsibility for these.

Health and Care Governance - the IJB agreed proposals submitted by the Chair of the Health & Care Governance Group to provide regular updates on clinical and care governance activity for North Ayrshire HSCP.

Annual Performance Report - the IJB endorsed the Annual Performance Report at the meeting in July 2017. This report, highlighted IJB's operations in 2016/17, outlined the good performance of the Health and Social Care Partnership and how it delivered against the strategic priorities and the national outcomes.

Review of Integration Scheme

A report was presented to the NHS Board, East Ayrshire and North Ayrshire Councils in June 2017 seeking approval to consult on and review the Ayrshire Health and Social Care Integration Schemes to explore whether there was a need for change to further improve the delivery of health and social care locally.

The consultation indicated that there is no clear case for changing the Integration Scheme at present. Indeed, there are elements within the existing scheme that have not been fully implemented and there are a number of issues which could be improved upon.

Carer's (Scotland) Act 2016

The Integration Schemes have been amended to reflect the requirements of the Carers (Scotland) Act 2016. The revised Integration Schemes for East Ayrshire, North Ayrshire and South Ayrshire IJBs were submitted to Scottish Government in March 2018 and approved by the Cabinet Secretary on 3rd April 2018.

Finance

The 2016/17 and 2017/18 overspend will require to be recovered by the IJB and this will be reflected in the updated Medium Term Financial Plan.

The IJB agreed to appoint a full-time Chief Finance and Transformation Officer to assist with the monitoring of financial performance and to drive transformational change in support of the future financial challenge.

Strategic Plan
Work was carried out to refresh the Strategic Plan for the period 2018-2021 and this was approved by the IJB in April 2018.

Clinical and Care Governance
Arrangements in relation to the Health and Care Governance Group were strengthened during 2017/18.

Further Actions
The IJB has identified the following actions for 2018/19 that will assist with the further strengthening of corporate governance arrangements:

- Records Management Plan

The Public Records (Scotland) Act 2011 came into force in 2013 and states that named authorities are required to prepare a Records Management Plan (RMP) for the management of the authority's records, and to submit the plan to the Keeper of the Records of Scotland for agreement. North Ayrshire Integration Joint Board is a named authority under the Act. The Keeper of Records of Scotland will invite IJBs to submit their RMPs in November 2018, for plans to be in place by March 2019. Arrangements are in place to meet this deadline.

- Financial Management

A new financial framework involving enhanced financial reporting and service performance is being implemented to ensure effective financial planning and management alongside robust governance and control measures to deliver services within the financial envelope.

- Change and Transformation

The Change Programme Board will establish more robust arrangements to secure delivery of change and transformation at scale and pace.

Assurance
Subject to the above, and on the basis of the assurances provided, we consider the governance and internal control environment operating during 2017/18 to provide reasonable and objective assurance that any significant risks impacting on the achievement of our actions will be identified and actions taken to avoid or mitigate their impact.
Systems are in place to continually review and improve the governance and internal control environment and action plans are in place to address identified areas for improvement.

NORTH AYRSHIRE
Health and Social Care Partnership

Integration Joint Board
21 June 2018

Subject:	**2017/18 Financial Performance Update as at 31 March 2018**
Purpose:	To (i) provide an overview of the IJB's unaudited Annual Accounts for the year to 31 March 2018; (ii) provide an overview of the IJB's financial performance for the year; and (iii) outline how the 2017/18 out-turn impacts on the IJB's overall financial position.
Recommendation:	It is recommended that the IJB: (a) approves, subject to audit, the IJB's Annual Accounts for 2017/18; (b) notes that Deloitte plan to complete their audit of the Accounts by early September 2018 and will present their annual audit report to the IJB on 13 September 2018; (c) notes the unaudited position of £2.562m overspent; and (d) notes that the cumulative deficit of £5.807m will be carried forward and will require the IJB to agree a recovery plan

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

1.	**EXECUTIVE SUMMARY**
1.1	The IJB prepares its Accounts on an annual basis to 31 March and is required, by the Local Authority Accounts (Scotland) Regulations 2014, to submit these Accounts to the appointed auditor by 30 June of each year. Deloitte plan to complete their audit of the Accounts by early September 2018 and will present their annual audit report to the IJB on 13 September 2018.
1.2	The Financial Statements are prepared in compliance with the Code of Practice on Local Authority Accounting in the United Kingdom 2017/18, supported by International Financial Reporting Standards (IFRS), unless legislation or statutory guidance requires different treatment.

1.3	The Annual Accounts provide an overview of the financial performance of the IJB. The Management Commentary provides a summary of the financial performance of the IJB and the financial outlook moving forward. At 31st March 2018 the IJB closed with a £2.562m overspend which is a favourable movement of £1.071m from period 10. This deficit will be added to the £3.245m deficit carried forward from 2016/17 and requires to be recovered in future years.
1.4	The main areas of pressure continue to be looked after and accommodated children, LD care packages, elderly and adult in-patients within the lead partnership and the unachieved NHS CRES savings. A combination of the 18/19 budget settlement, Challenge Fund projects and continued management action will address the looked after and accommodated children and LD care packages in 2018/19. There is ongoing work around the elderly and adult in-patients which will reduce the overspend. The recurring non achieved NHS CRES of £2.557m is being taken forward by the NHS board on a corporate basis but at this stage there are no agreed plans to address this. It is imperative that the IJB has clarity on its savings targets for 2018/19 to allow plans to be put in place at the earliest opportunity.
1.5	It is essential that the IJB operates within the budgets delegated and does not commission services which are higher than their delegated budgets. The IJB recognises that this is not being achieved and work is in progress to realign 2018/19 budgets and also bring a transformation and change agenda to the forefront. The IJB must agree a recovery plan which reassures partners of future financial sustainability.
2.	**BACKGROUND**
2.1	The financial position of the IJB is outlined in the annual accounts (Appendix A) and presented in the following statements: • Comprehensive Income and Expenditure Statements for the IJB (page 24); • Movement in Reserves Statement (page 24); • Balance Sheets for the IJB (page 25).
2.2	The Local Authority Accounts (Scotland) Regulations 2014 require various disclosures about the remuneration and pension benefits of voting board members and senior employees. The remuneration report can be found on pages 20 and 21 of the annual accounts.
2.3	The IJB is legally required to make its draft accounts available for public inspection for a 3-week period during the audit. An advert was placed in the local papers week commencing the 4th June, advising that the accounts will be available for inspection at Cunninghame House, Irvine between 2nd and 20th July 2018.
3.	**FINANCIAL PERFORMANCE**
3.1	Against the full-year budget of £227.581m there is an overspend of £2.562m (1.1%).

	The overspend has reduced by £1.071m since period 10 mainly due to securing additional funding of £0.971m from the NHS to bring the NHS element of the budget online. The following sections (section 4 – 10) outline the significant variances in service expenditure compared to the approved budgets. The variances are based on the position prior to allocating the £0.971m from the NHS to ensure it is reflective of the actual outturn. Appendix B provides the detailed year-end financial position.
4.	**Health and Community Care Services**
	Against the full-year budget of £65.543m there was an underspend of £0.829m (1.3%). The underspend has reduced by £0.215m since period 10 mainly due to the care home placement outturn (see below). The main reasons for the final overspend are: • **Locality Services –** year end underspend of £0.398m (adverse movement of £0.237m). This consists of: a) Additional income of £0.378m which has been mainly secured from charging order income. b) The planned underspend of £0.200m in equipment agreed as part of the mitigation plan has been achieved. c) Independent Living Services Care Packages underspent by £0.093m. d) Care home placements including respite placements – overspent by £0.300m (adverse movement of £0.200m) which was due to additional pressure on the respite beds as some people on the waiting list for a permanent placement were admitted on an emergency respite basis. The projection was understated at period 10 as it was based on a four weekly billing cycle up to 25th March rather than up to 31st March. This was a one-off isolated event. • **Community Care Service Delivery –** year end underspend of £0.504m (adverse movement of £0.091m). This consists of: a) Care at home (purchased and in house) underspent by £0.927m partly due to the agreed mitigation to delay the recruitment of posts. The underspend also includes £0.177m of funds previously held in contingency to cover the projected increased costs of homecare if more services are brought in house. This is a one off underspend for 2017/18 and will be required in 2018/19. b) Employee costs overspent by £0.228m (adverse movement of £0.061m) of which £0.075m related to Montrose House for cover costs. Day care overspent by £0.060m as it did not achieve the agreed £0.100m saving in 2017/18 but the full saving will be achieved in 2018/19. The business unit also overspent by £0.182m. c) Supplies, transport and admin overspent by £0.339m (adverse movement £0.088m) due to increased spend on mileage, phones, ferry charges, telecare and CM200 costs. These budgets are being reviewed and realigned to ensure increased staffing within care at home is matched by an increase in the staff related costs like mileage and phones. d) Income from charges to service users over-recovered by £0.077m.

	• **Rehab and Reablement –** year-end overspend of £0.331m (adverse movement of £0.018m) which was due to an overspend in employee costs in Ward 1 to ensure staffing levels were at a safe level to maintain a 30 bedded ward. This level of staff and overspend will continue into 2018/19 unless additional funding is made available or the number of beds is reduced to be in line with the funded establishment.
3.3	**Mental Health Services**
	Against the full-year budget of £71.761m there was an overspend of £1.011m (1.4%). The overspend has reduced by £0.512m since period 10 due to a reduction in the Learning Disability care package outturn and an improved outturn position for the Lead Partnership as outlined below. The main reasons for the final overspend are: • **Learning Disability –** year end overspend of £1.003m (favourable movement of £0.118m). This is mainly due to care packages (inc Direct Payments) which overspent by £0.847m which included a backdated charge of £0.392m. The packages continue to be reviewed and progress is monitored through the bi-weekly ARG funding panel chaired by head of service. Care package requests/reductions are made against a risk criteria to ensure all risks are mitigated and vulnerable people can access services in accordance with statutory requirements - the application of a 'discharge' for an 'admission' is not always possible given the high cost of packages currently attributed to young people in transition hence the adverse movement this month. Further work is taking place to address planning for young people in transition from children's services. There was also an overspend of £0.092m on respite provision due to contract rate increases and an under recovery of £0.092m in income from other local authorities using Taigh Mor respite home. The contract rate increase has been addressed as part of the 2018/19 budget. • **Lead Partnership – year end overspend of £0.191m (favourable movement of £0.277m).** a) Adult inpatients – overspent by £0.829m of which £0.610m relates to longer than anticipated ability to income generate from other health board areas in respect of forensic beds and additional supplementary staff in relation to an increase in enhanced observations in December. The level of observations had increased in this period due to the complexity of some individuals and their significant risk to others. The mitigation plan for mental health included improving the sickness rate and at the year-end was 7.4% which is slightly above the quarter 4 target of 7%. The average was 8.1% for 2017/18. The other contributor to the overspend is the Lochranza ward on the Ailsa site which is projected to overspend by £0.212m due to a combination of operating with Band 3 staff when there is only budget for Band 2 posts and staff above budgeted establishment to support a person on 1:1 support, staffed by staff who were unable to redeploy to Woodland View. This will continue into 2018/19 as there has been a delay in implementing discharge plans and identification of alternative supported accommodation solutions by East/South Ayrshire within the required time frame which will impact on the closure date in 2018. This will cause an overspend in the 2018/19 budget, however, staff are being moved to alternative posts within organisation as bed numbers reduce, making some improvement to overspend situation.

b) UNPACS – is underspent by £0.163m due a reduction in the three year service level agreement for Rowanbank.

c) Psychology – is underspent by £0.166m which is due to vacant posts.

d) Elderly Inpatients – is overspent by £0.449m due to the high level of constant observations. The increased observations are mainly in the EMH wards at Ailsa where ward environments are challenging and not in alignment with the Woodland view model. The mitigation plan for mental health included improving the sickness rate and at the year-end was 7.3% which is just below the quarter 4 target of 7.5%. The average for 2017/18 was 8%. Targeted sickness absence work is ongoing, particularly in Iona/Lewis and Jura where sickness absence at the year-end was 14.46% and 12.76% respectively.

e) CAMHS – is underspent by £0.122m due to unanticipated income and Place 2 B funding no longer being required.

f) Psychiatry – is overspent by £0.114m due to an increased use of locum staff in the absence of being able to recruit permanent posts.

g) There were underspends in LD services £0.065m, MH admin £0.061m and within the Associate Nurse Director budget £0.130m. There was also slippage in additional funding from resource transfer £0.186m and mental health funding allocations £0.307m.

3.4 **Children's Services and Justice Services**

Against the full-year budget of £33.504m there was an overspend of £2.461m (7.3%). The overspend has increased by £0.488m since period 10 mainly due to an increased outturn within Looked After and Accommodated Children as outlined below. The main reasons for the final overspend are:

- **Looked After and Accommodated Children – year end overspend of £2.950m (adverse movement of £0.673m).**

  Residential Schools and Community Placements – overspend of £1.669m (adverse movement of £0.446m from P10). This is the net result of rate changes for two providers, 2016/17 invoices that were not accrued and additional supports for children that were not included in the projection. Controls and processes have been put in place to ensure early identification of these things going forward.

  *Looked After Children Placements – o*verspend of £0.596m due to the current mix of fostering, adoption and kinship payments.

  Supplies and services – overspend of £0.092m due to increased spend on food within residential homes and clients clothing as the homes have had to operate above normal capacity, however, this has prevented more costly external placements.

	Employee costs – overspent by £0.420m (adverse movement of £0.153m) due to the impact of the closure of the Nethermains facility for refugees sooner than anticipated. This combined with the preparation to close Mount View, high sickness levels and the homes running above capacity resulted in supernumerary staff in the children's homes for a short period.
3.5	**Primary Care - Prescribing** Against a full year budget of £49.637m primary care prescribing underspent by £0.119m. This is due to the NHS funding the overspend which arose from the non-achievement of savings and an increase in drug costs. The Clinical Directors are continuing to work with the prescribing team to roll out projects relating to pain relief across the GP practices. This is part of a system-wide approach to delivery of prescribing CRES recognising cost drivers within Acute, Primary and Secondary Care, as well as external factors including price increases due to short supply of drugs.
3.6	**Management and Support Costs** Against the full-year budget of £4.266m there is an overspend of £1.532m (adverse movement of £0.204m). This mainly relates to the NHS savings target of £1.165m which has still to be agreed. There is also an unfunded post and a shortfall in the payroll turnover achieved within this section. The movement from period 10 relates to a year end charge in relation to the Apprenticeship Levy which was not factored into projections as it was presumed that this was already being charged throughout the year. A process is now in place to ensure the Levy is clearly identified.
3.7	**Change Programme** There was an underspend of £0.655m which is a favourable movement of £0.204m. The Integrated Care Fund element underspend of £0.485m is shown in Appendix D and the balance relates to the delayed discharge funding.
3.8	**Lead Partnerships**
	North Ayrshire HSCP Services managed under Lead Partnership arrangements by North Ayrshire Health and Social Care Partnership overspent by £0.191m prior to additional funding being awarded by the NHS. Mitigating action taken during the year and moving forward included payroll management via the vacancy scrutiny group, a freeze on non-essential spend e.g. supplies and admin budgets and minimising the use of overtime as well as agency staff. As NHS Ayrshire & Arran agreed to fund the overspend there will be no requirement to request additional funding from the other partnerships.
	South Ayrshire HSCP The partnership underspent by £0.969m in the year to March 2018. It has requested that South Ayrshire Council carry this forward for use in the next financial year.

	The was as a result of a difficulties in recruiting Allied Health Professionals, one off funding for the Community Loan Store and the Health Board funding prescribing overspends in line with the Integration Scheme.
	East Ayrshire HSCP Services managed under Lead Partnership arrangements by East Ayrshire Health and Social Care Partnership are underspent by £0.181m in total. This variance includes savings in Dental services due to vacant posts, as well as non-recurring slippage on the Primary Care Transformation Fund (PCTF) and anticipated savings on other lead services. Savings are partially offset by additional payments within Primary Medical Services to GP practices currently experiencing difficulty (mainly practices that the NHS Board is administering due to previous GPs handing back contracts), as well as delayed identification of recurring options to meet the approved Primary Care cash releasing efficiency target. The GP practices in difficulty issue is extremely fluid and there is the potential for additional financial pressures from 1 April 2018 and going forward. Any such pressures will be notified to the three Ayrshire IJBs at the earliest opportunity.
3.9	**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. In the year to March 2018 there was an overspend on Acute Services of £11.5m. A large proportion of this relates to the Set Aside Budget. 129 additional and unfunded beds were open at the 31st March. Significant numbers were open throughout the year. These were to meet operational demand and directly affect expenditure levels, particularly in Nursing. 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 level of spend against the set aside budget in North Ayrshire is in the context of the increased utilisation of acute inpatient capacity despite a reduction in attendances at the Emergency Department and improved discharge levels through increases in the number of individuals supported into step-down care, as well as by our Care at Home and Intermediate Care Teams.
3.10	**Savings Update** The 2017/18 budget included £6.226m of savings.

BRAG Status	**2017/18 Actual Position**
Red	2.743
Amber	0.052
Green	0.000
Blue	3.431
TOTAL	**6.226**

	Some savings have not been delivered and this is reflected in the update provided within Appendix C. This includes the £1.165m of NHS savings shortfall still to be agreed, £1.016m prescribing, £0.309m for the closure of the residential home for children, LD sleepovers £0.129m and SDS £0.100m .
4.	**<u>Anticipated Outcomes</u>**
4.1	The outturn will be reviewed alongside agreed pressures and savings for 2018/19 to inform any areas where virement or remedial action is required in 2018/19. It is essential that the IJB agrees a recovery plan which reassures partners of future financial sustainability.
5.	**<u>Measuring Impact</u>**
5.1	The year-end report outlines the variances from budget and provides an explanation for these.
6.	**IMPLICATIONS**

Financial :	The financial implications are as outlined in the report. Against the full-year budget of £227.581m there is an overspend of £2.562m (1.1%). The overspend has reduced by £1.079m since period 10 mainly due to securing additional funding of £0.971m from the NHS to bring the NHS element of the budget online. It is essential that the IJB operates within the budgets delegated and does not commission services which are higher than their delegated budgets. The IJB recognises that this is not being achieved and work is in progress to realign 2018/19 budgets and also bring a transformation and change agenda to the forefront. The position across Scotland is challenging for IJB's with many of Partnerships overspending in 2017/18 prior to any agreed additional contributions from partners. It is essential that the partnership develops plans which are financially sustainable. This will be achieved by: • maximising the savings achievable from the Challenge Fund with phase 2 being submitted for approval early in 2018/19. • the medium term financial strategy will be finalised and presented to the IJB in July. • the action plan from the budget management audit has been rolled out to ensure operational budget management arrangements are tightened to improve financial performance.
Human Resources :	There are no Human Resource implications for staff employed by Partner bodies.

Legal :	There are no Legal implications
Equality :	There are no Equality implications
Environmental & Sustainability :	There are no Environmental & Sustainability implications
Key Priorities :	There are no Key Priorities implications.
Risk Implications :	The Impact of Budgetary Pressures on Service Users and associated control measures are recognised in the Strategic Risk Register. The approved mitigation plan detailed the risk associated with each proposal.
Community Benefits :	There are no Community Benefits

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	

7.	**CONSULTATION**
7.1	This report has been produced in consultation with relevant budget holders, the Partnership Senior Management Team and the Director of Finance for NHS Ayrshire and Arran and the Executive Director Finance and Corporate Support for North Ayrshire Council.
8.	**CONCLUSION**
8.1	It is recommended that the IJB: (a) approves, subject to audit, the IJB's Annual Accounts for 2017/18; (b) notes that Deloitte plan to complete their audit of the Accounts by early September 2018 and will present their annual audit report to the IJB on 13 September 2018; (c) notes the unaudited position of £2.562m overspent; and (d) notes that the cumulative deficit of £5.807m will be carried forward and will require the IJB to agree a recovery plan

For more information please contact Eleanor Currie, Principal Manager – Finance on (01294) 317814

Annual Accounts 2017–18

North Ayrshire
Integration Joint Board

Delivering care together

CONTENTS

Management commentary

This publication contains the financial statements of North Ayrshire Integration Joint Board (IJB) for the year ended 31 March 2018.

The Management Commentary outlines the key messages in relation to the IJB's financial planning and performance for the year 2017/18 and how this has supported delivery of the IJB's strategic priorities. This commentary also looks forward, outlining the future financial plans for the IJB and the challenges and risks that we will face as we strive to meet the needs of the people of North Ayrshire.

North Ayrshire IJB

Each of the three Ayrshire health and social care partnerships established their Integration Joint Boards on 1 April 2015. The IJB's purpose is to improve the health and wellbeing of local people, create support within our communities and deliver joined-up care pathways for people who use health and social care services, particularly those who have complex care needs.

North Ayrshire Health and Social Care Partnership (NAHSCP/the Partnership) is the name given to the service delivery organisation for functions which have been delegated to the IJB.

NAHSCP is facing significant challenges.

In 2016, NAHSCP launched a refreshed strategic plan, *The way ahead*, outlining our ambitions for 2016–2018. The plan sets the key strategic priorities that will ensure that we deliver our vision. It seeks to address the increasing health inequalities in North Ayrshire and focuses on improving the efficiency and quality of the services being provided, putting individuals, families and communities at the heart of the plan.

North Ayrshire Health and Social Care Partnership vision is:

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

This vision is supported by five strategic priorities:

NAHSCP priorities

North Ayrshire Council and NHS Ayrshire & Arran delegate responsibility for the planning of services to the IJB. The IJB commissions services from North Ayrshire Council and NHS Ayrshire & Arran and is responsible for the operational oversight of integrated services. NAHSCP Chief Officer is responsible for the operational management of integrated services.

The Chief Officer is supported by heads of service for each service area and the senior management team. A dedicated Chief Finance and Transformation Officer for NAHSCP was introduced during 2017–18, with the post filled on an interim basis until a permanent appointment is made.

NAHSCP structure

The IJB Strategic Plan is supported by day to day management plans and individual service strategies. These plans and strategies provide greater detail on how the IJB will deliver on its key priorities and identifies the resources required for implementation. Further, implementation of the strategic plan is key for the Partnership to achieve the nine National Health and Wellbeing Outcomes set by the Scottish Government.

The strategic plan also complements North Ayrshire Community Planning Partnership's Local Outcome Improvement Plan (LOIP) and the NHS Ayrshire & Arran Local Delivery Plan. This is vital to ensure that our limited resources are targeted in a way that makes a significant contribution to our priorities.

North Ayrshire today

North Ayrshire is home to 136,000 people and covers an area of 340 square miles and includes the islands of Arran, Great Cumbrae and Little Cumbrae.

The area provides a number of opportunities for those who live and work here. However we also face a number of significant challenges as North Ayrshire is one of the most deprived areas of Scotland. We have high levels of unemployment, significant number of people on low income and almost a third of our children live in poverty.

We know that the population of North Ayrshire is expected to fall over the next 10 years, and we expect that there will be fewer people aged 65 and under, reducing the number of working age adults. We also expect that the number of people aged 65+ will increase by 20%, with the highest increase (38%) in those aged 75 or over.

According to Scottish Index of Multiple Deprivation (SIMD) 2016, **39%** of North Ayrshire's residents live in areas identified as amongst the **most deprived in Scotland**;

39% equates to almost **53,000** people.

Levels of multi-morbidity

(people with more than one chronic medical condition) are higher in the most deprived areas. For example North Coast locality has lower levels of deprivation compared with other areas in North Ayrshire and as such, have lower levels of people with multi-morbidities (**11% for those 65 and over**) compared with areas with higher levels of deprivation, such as Three Towns, where multi-morbidity levels are much higher (**36% for those 65 or older**).

The number of **children living in poverty** is increasing each year: In 2016 the Child Poverty Action Group (CPAG) reported that **7,051 (30.4%)** children in North Ayrshire lived in poverty, the second highest level of child poverty in Scotland (Glasgow City has the highest).

A snapshot of achievements

cafe solace

now in Ardrossan, Garnock Valley, Irvine

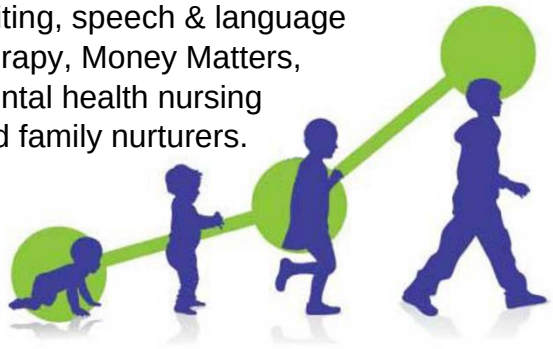
Developing an integrated on-island service on Arran including, GP, Social Work and Care at Home

Carers Appreciation Card, entitles local carers to receive, discounts, offers and concessions with a range of local businesses

Distributed **£50,000 to 42 local projects** via the Partnership's first participatory budgeting event

Collaborated with the **National Galleries of Scotland** to provide learning experiences to young people.

Enhanced our **Universal Early Years Team** to include, social work, health visiting, speech & language therapy, Money Matters, mental health nursing and family nurturers.



Rolled out **Partnership Community Link Workers** to 17 GP practices across North Ayrshire

Launched the Partnership's integrated drug and alcohol service, **NADARS**

Supported more people to stay at home, following 999 calls, thanks to joint working with our **Community Alert Team** and **Scottish Ambulance Service**

Since 2015, the Change Team has **enabled 36 projects** across the Partnership. This work has **generated an additional £3.378million investment**, **saved an estimated £1.192million** and generated costs avoidance (of an estimated £1.299million) through work to better manage demand

We engaged with 2500 people in North Ayrshire on 6 June 2017 #WMTY17

ask what matters • listen to what matters • do what matters
what matters to you?
www.whatmatterstoyou.scot

The financial plan

Strong financial planning and management is paramount to ensure that our limited resources are targeted to maximise the contribution to our objectives. Delivery of services in the same way is not financially sustainable. The updated strategic plan approved for 2018–21 is underpinned by the need to transform care models to find new solutions as the partnership might not always be the first source of support.

The ability to plan based on the totality of resources across the health and care system to meet the needs of local people is one of the hallmarks of integrated care. Medium term financial planning is key to supporting this process and identifying the transformation which is required to provide sustainable services to the local community over the medium term.

The Medium Term Financial Plan (MTFP) is currently being refreshed and will be key to supporting the delivery of the strategic plan. It sets out our plans to start to deliver a shift in care from a hospital setting to a community setting within the resources available.

Organisational performance

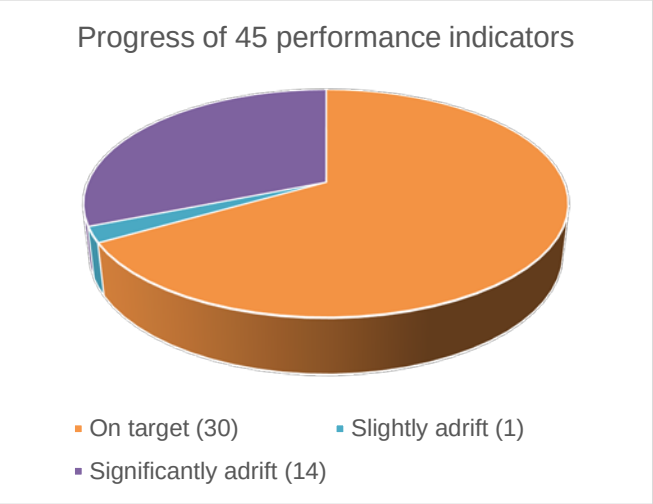
Changes to services have to make a difference to people's lives and North Ayrshire Health and Social Care Partnership continually monitor our services, report and review them in various ways.

It is important that we report the right level of performance information at the right level of the organisation. In all of our performance monitoring and reporting, we show trends over time, where we are against target and how we compare with other geographical areas, where available. We monitor against all the agreed national indicators, including Local Government Benchmark Framework (LGBF), Ministerial Steering Group Indictors, the NHS' Local Delivery Plan HEAT targets, HSCP national indicators, as well as a range of local defined measures.

All reports comprise of a series of key performance indicators and key actions, which link directly back to our strategic plan. Where an indicator or action is off-track, a commentary is provided on steps being taken to improve performance.

Performance is reported at a number of levels within the organisation including Performance and Audit Committee, the IJB, the Joint Review with North Ayrshire Council and NHS Ayrshire & Arran Chief Executives, and ASPIRE (All Service Performance, Information, Review and Evaluation) reviews within each service area.

The latest Joint Review Report (October 2017 – March 2018) showed the progress of the 45 measurable performance indicators as follows:



As part of our commitment to continuous improvement we recognise this as an area where we could do more and the indicators which are significantly adrift will be the focus of attention.

We will produce our third annual performance report in August 2018, and this will capture the main achievements in 2017–18, our performance against national outcomes and outline what we need to do to improve.

Annual accounts 2017–18

The annual accounts report the financial performance of the IJB. The main purpose is to demonstrate the stewardship of the public funds that have been entrusted to the IJB for the delivery of its vision and strategic priorities. The requirements governing the format and content of IJB annual accounts are contained in The Code of Practice on Local Authority Accounting in the United Kingdom (the Code). The annual accounts 2017–18 have been prepared in accordance with this Code.

Financial performance

Financial information is part of this performance management framework with regular reporting of financial performance to the IJB. This section summarises the main elements of our financial performance for 2017–18.

Partnership revenue expenditure 2017–18

The year-end position was a £3.533m overspend (£2.562m Council and £0.971m NHS) which was after one off funding from the Challenge Fund of £1.4m to alleviate in year demand pressures and £1.130m investment from the NHS for prescribing. The NHS have agreed to increase the funding to the IJB by £0.971m to bring their element on-line resulting in a final overspend of £2.562m.

2016/17 Budget £000	2016/17 Actual £000	Variance (Fav) / Adv £000		2017/18 Budget £000	2017/18 Actual £000	Variance (Fav) / Adv £000
59,664	60,982	1,318	Health & Community Care	65,543	64,714	(829)
69,752	70,544	792	Mental Health	71,761	72,772	1,011
31,027	32,289	1,262	Children, Families & Justice	33,504	35,965	2,461
48,095	47,929	(166)	Primary Care	49,637	49,518	(119)
4,825	5,038	213	Management & Support Costs	4,266	5,798	1,532
3,458	3,284	(174)	Change Programme	2,870	2,215	(655)
200	200	0	Lead Partnership & Set Aside	0	132	132
217,021	**220,266**	**3,245**	**TOTAL EXPENDITURE**	**227,581**	**231,114**	**3,533**
(217,021)	**(217,021)**	**0**	**TOTAL INCOME**	**(227,581)**	**(228,552)**	**(971)**
0	**3,245**	**3,245**	**NET EXPENDITURE**	**0**	**2,562**	**2,562**

NAHSCP financial performance 2017–18

During the year mitigating action was taken to reduce the projected overspend by £1.1m:

- Savings delivered from Challenge Fund projects
- Review of learning disability care packages
- Review of mental health care packages
- Spending freeze on non-essential non payroll spend not linked to care
- Reduction in overtime
- Review of management and support functions
- Equipment budget – waitlist new clients based on need
- Care at home – delay in the recruitment of staff

The main areas of variance during 2017/18 are given below:

Health and Community Care – underspend of £0.829m mainly relates to mitigating action in relation to equipment spend, additional charging order income and care at home. Care homes (including respite provision) overspent after using £0.977m of Challenge Fund monies to alleviate mitigating action and rehab and reablement also overspent.

Mental Health– overspend of £1.011m is mainly within Learning Disability Community Packages. The Lead Partnership for Mental Health did not achieve the projected bed sale income but this was offset by underspend in other areas like psychology, CAMHS, UnPACs and funds not required in 2017–18.

Children, Families and Justice – overspend of £2.461m is mainly within Children's Services and reflects an increased requirement to place children within fostering, adoption and kinship placements as well as residential school placements. There was also a delay in closure of a children's home, which resulted in less savings than had been anticipated.

Management & Support Costs – overspend of £1.517m mainly relates to the unachieved NHS CRES (cash releasing efficiency saving) of £1.165m.

Lead Partnership

Each of the three Ayrshire IJBs reported a balanced position on their lead/ hosted service. This position was achieved by a range of actions including vacancy management; additional funding from NHS Ayrshire & Arran, application of non-recurring funding and delivery of cost reductions. The specific approach in each partnership was agreed by the relevant IJB.

The table (*NAHSCP financial performance, page 6*) reflects the budget managed by the IJB during the year, and excludes the net impact of Lead Partnership services of £1.935m. This is the difference between what NAHSCP charges to South and East Ayrshire for the Lead Partnership services it provides on their behalf and what South and East Ayrshire charge us for the Lead Partership services they provide on our behalf. This is reflected within the accounts (see page 24).

Challenge Fund

North Ayrshire Council, during the 2017–18 budget setting process, approved the development of an innovative approach for the establishment of a 'Challenge Fund'. This is an 'invest to change' programme which is an innovative approach in Scotland and has attracted attention of Scottish Government.

The Challenge Fund created an opportunity for services, using a change approach, to realise both the required North Ayrshire Council savings and additional savings which could be re-invested in their newly designed service to support future sustainability.

However, during 2017–18 the IJB approved use of £1.4m of the Challenge Fund to alleviate in year cost pressures. £0.977m was allocated to care home placements and £0.423m to learning dsability care packages leaving £2.6m for Challenge Fund projects.

Whilst a number of the projects in phase 1 are on track and delivering the transformation and savings anticipated, a number of them have not happened in the timelines planned or realised the amounts envisaged. This will be an area of focus during 2018–19 to ensure phase 1 projects are delivered and phase 2 is developed.

Set Aside Budget

The table (*NAHSCP financial performance, page 6*) reflects the budget managed by the IJB during the year. It excludes the large hospital Set Aside Budget of £28.055m which was allocated at the end of the year to the IJB. The set aside budget is reflected within the accounts (see page 24).

The deficit of £2.562m relates solely to social care and will be carried forward. Added to the £3.245m deficit brought forward from 2016–17 results in a cumulative deficit of £5.807m.

The Integration Scheme outlines the roles and responsibilities of the partners and the IJB in respect of overspends. In the case of a forecast overspend a recovery plan should be developed. If it is not successful the partners can consider making interim funds available with potential repayment in future years.

North Ayrshire Council has confirmed that there will be no further funding made available in respect of 2017–18 and the cumulative deficit will require to be repaid.

The financial challenges facing the partnership outlining a high level plan to start to bridge the financial gaps including the deficit which have been identified.

Strong financial leadership will be required to ensure that future spend is contained within the budget resources available. Moving forward the plan for 2018–19 is to ensure the following actions are implemented:

- Transformation and change will figure at the forefront of the IJB and NAHSCP agenda throughout 2018–19 and beyond
- Financial governance will be enhanced across those authorised to approve budgets to ensure robust control of expenditure
- Financial performance monitoring will be enhanced via a detailed financial framework allowing early detection and corrective action of adverse spend
- All savings, including the Challenge fund projects will be delivered per the agreed timetable to realise appropriate savings for 2018–19 and beyond
- Refresh of the Medium Term Financial Plan (MTFP) in 2018–19
- Phase 2 of the Challenge Fund will be implemented

Financial outlook, risks and plans for the future

In December 2016, the Scottish Government published the Health and Social Care Delivery Plan which sets out the programme for further enhancing health and social care services. Critical to this is shifting the balance of where care and support is delivered from hospital to community care settings, and to individual homes when that is the best thing to do. This provides a clear impetus to the wider goal of 50% of the health budget being spent in the community by 2021. During 2017–18 the Pan Ayrshire Intermediate Care and Rehab Model was approved by the NHS scrutiny board and will be implemented during 2018–19. This will see a shift from acute to community care.

In March 2017 the IJB approved the first Medium Term Financial Plan. This is being refreshed and presented to the IJB in July 2018 and will update The Partnership will continue to face high levels of demand for services, however, it is fundamental that services are commissioned within the resources made available and this will be the highest priority during 2018–19.

Availability of funding for public services correlates with economic growth which continues to be weak with continuing uncertainty on the impact of Brexit.

Other factors impacting on funding for local government services include the protection of other public sector portfolios, implementation of new policy initiatives and the lifting of the public sector pay cap.

The most significant risks faced by the IJB over the medium to longer term, alongside mitigation, are summarised below.

These risks emphasise the importance of effective planning and management of resources. It is therefore crucial that we focus on early intervention, prevention and recovery if we are to work within the total annual partnership budget of just over £225m.

Impact of budgetary pressures	Delivery of the Change Programme	Culture and practice
•**Mitigation** •Medium Term Financial Plan •Strategic Plan •Change Programme •Challenge Fund •Active Demand Management	•**Mitigation** •Change Programme Steering Group •Programme Leads •Strategic Planning Officers Group (SPOG) •Change Programme Risk Register.	•**Mitigation** •Challenge Fund Phase 2 •Multi Disciplinary Teams •Families First •Organisation Development Plan •Engagement Surveys

NAHSCP risks

Moving into 2018–19, the Partnership is proactively working to provide safe and effective services for the residents of North Ayrshire within the financial envelope.

To achieve its vision, the Partnership recognises it cannot work in isolation. The Partnership will continue to strengthen relationships with colleagues within the Community Planning Partnership to ensure a joint approach to improving the lives of local people.

Most importantly, the Partnership must work closer with local people and maximise the use of existing assets within communities to improve the overall health and wellbeing of people in North Ayrshire.

Conclusion

The third year as an integrated Health and Social Care Partnership has been both challenging and rewarding.

Our significant transformation programme will continue into 2018–19 with delivery of the Challenge Fund Projects and service redesign.

The IJB has a deficit of £5.807m as it moves into 2018–19. This presents us with a number of challenges, however we are clear that the deficit will need to be recovered over the medium term to deliver financial sustainability for the Partnership. The IJB recognises it must deliver services within its financial envelope for 2018–19.

The scale and pace of change requires to be accelerated. This will be challenging so, while the potential for improvement over the next year is significant, we will need to ensure plans are staged to ensure sustainability and deliverability.

Where to find more information

If you would like more information on IJB strategies, plans and policies and our performance and spending, please refer to the Partnership's website www.nahscp.org

Stephen Brown
Chief Officer

21 June 2018

Bob Martin
IJB Chair

21 June 2018

Laura Friel
Section 95 Officer

21 June 2018

Statement of responsibilities

Responsibilities of the IJB

The IJB is required to:

- Make arrangements for the proper administration of its financial affairs and to secure that the proper officer of the board has responsibility for the administration of those affairs (section 95 of the Local Government (Scotland) Act 1973). In this authority, that officer is the chief financial officer
- Manage its affairs to secure economic, efficient and effective use of resources and safeguard its assets
- Ensure the annual accounts are prepared in accordance with legislation (The Local Authority Accounts (Scotland) Regulations 2014), and so far as is compatible with that legislation, in accordance with proper accounting practices (section 12 of the Local Government in Scotland act 2003)
- Approve the annual accounts

I confirm that the unaudited annual accounts were approved for signature at a meeting of the IJB on 21 June 2018.

Bob Martin
IJB Chair

21 June 2018

Responsibilities of the Chief Financial Officer

The chief financial officer is responsible for the preparation of the IJB's annual accounts in accordance with proper practices as required by legislation and as set out in the CIPFA/LASAAC Code of Practice on Local Authority Accounting in the United Kingdom (the Accounting Code).

In preparing the annual accounts, the chief financial officer has:

- Selected suitable accounting policies and then applied them consistently
- Made judgements and estimates that were reasonable and prudent
- Complied with legislation
- Complied with the local authority Code (in so far as it is compatible with legislation)

The chief financial officer has also:

- Kept proper accounting records which were up to date
- Taken reasonable steps for the prevention and detection of fraud and other irregularities

I certify that the financial statements give a true and fair view of the financial position of the North Ayrshire IJB as at 31 March 2018 and the transactions for the year then ended.

Laura Friel
Section 95 Officer

21 June 2018

Annual governance statement

The Annual Governance Statement explains how North Ayrshire IJB complies with the Code of Corporate Governance and meets the requirements of the CIPFA / SOLACE Framework 'Delivering Good Governance in Local Government 2016' and the 'Code of Practice for Local Authority Accounting in the UK: A Statement of Recommended Practice', in relation to the Statement on the System of Internal Financial Control.

Scope of responsibility

North Ayrshire IJB is responsible for ensuring that its business is conducted in accordance with the law and proper standards, and that public money is safeguarded and properly accounted for and used economically, efficiently and effectively.

The IJB is also responsible for putting in place proper arrangements for the governance of its affairs and facilitating the effective exercise of its functions, which includes arrangements for the management of risk.

In discharging this responsibility, the Chief Officer has put in place arrangements for governance which includes the system of internal control. Reliance is placed on these controls which are designed to manage risk to a reasonable level, but cannot eliminate the risk of failure to achieve policies, aims and objectives. It can therefore only provide reasonable but not absolute assurance of effectiveness.

Purpose of the governance framework

The governance framework comprises the systems and processes, and culture and values by which the IJB is directed and controlled and the activities through which it accounts to and engages with the community. It enables the IJB to monitor the achievement of its strategic priorities and to consider whether those priorities have led to the delivery of appropriate, cost-effective services.

The system of internal control is a significant part of that framework and is designed to manage risk to a reasonable level. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of North Ayrshire IJB's policies, aims and objectives, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

Governance framework

The main features of the governance framework that was in place during 2017/18 are summarised below:

- The IJB, comprising all IJB Board members, was the key decision making body. The Performance and Audit Committee considered all matters in relation to Internal and External Audit, Risk Management and Performance
- Strategic decision-making is governed by the IJB's key constitutional documents including the Integration Scheme, standing orders, scheme of administration, scheme of delegation to officers and financial regulations
- The Integration Scheme sets out financial contributions by partners to Integration Joint Boards. This includes the Health Board and Council each considering funding their pay cost pressures and contracted inflation with shared responsibility for demographic cost pressures
- The IJB's purpose and vision are outlined in the IJB Strategic Plan which links closely to the vision of the North Ayrshire Community Planning Partnership and the Local Outcome Improvement Plan (LOIP) and is underpinned by an annual action plan and performance indicators. Regular progress reports on the delivery of the Strategic Plan were provided to the Performance and Audit Committee and the IJB
- The Performance Management Strategy focuses very firmly on embedding a performance management culture throughout the IJB. Regular reporting to Board Members takes place
- A risk management strategy and strategic risk register is in place for the IJB
- A Health and Care Governance Framework was agreed by the IJB on 9 March 2017. This covers governance arrangements in relation to complaints and customer feedback, risk management, health and safety, Internal Audit, workforce planning and public protection
- The IJB has adopted a 'Code of Conduct' for all of its Board Members and employees, a register of interests is in place for all Board members and senior officers
- The IJB has in place a development programme for all Board Members, the Senior Management Team and senior managers across the Partnership. Performance and Personal Development (PPD) schemes are in place for all staff, the aim of which is to focus all staff on their performance and development that contributes towards achieving service objectives
- The IJB has established six locality planning forums, reflecting the previously agreed local planning areas. These provide Board Members, health and social care staff and local community representatives with the opportunity to be involved in considering the priorities for each area
- A Change programme is in place, covering four main themes of building teams around children, developing a wider range of primary care services, supporting older people and people with complex care needs and creating mental health and learning disability services to better support people to stay well. A Change Programme Board, chaired by the Chief Officer and with senior representation from all IJB services as well as third and independent sector partners, has oversight of all the IJB's significant transformation projects

The governance framework was in place during the year ended 31 March 2018.

System of internal financial control

The system of internal financial control is based on a framework of regular management information, financial regulations, administrative procedures (including segregation of duties), management supervision, and a system of delegation and accountability. Development and maintenance of these systems is undertaken by NHS Ayrshire & Arran and North Ayrshire Council as part of the operational delivery of the Health and Social Care Partnership. In particular, these systems include:

- Financial regulations and codes of financial practice
- Comprehensive budgeting systems
- Regular reviews of periodic and annual financial reports that indicate financial performance against the forecasts
- Setting targets to measure financial and other performance
- Formal project management disciplines

The IJB's financial management arrangements conform to the governance requirements of the CIPFA statement: 'The Role of the Chief Financial Officer in Local Government (2010)'.

Review of effectiveness

North Ayrshire IJB has responsibility for conducting, at least annually, a review of the effectiveness of its governance framework including the system of internal control. The review of the effectiveness of the framework is informed by the work of the Senior Management Team who have responsibility for development and maintenance of the governance environment, the annual report by the Chief Internal Auditor and reports from Audit Scotland and other review agencies.

The Chief Internal Auditor reports directly to the IJB Performance and Audit Committee on all audit matters, with the right of access to the Chief Officer, Chief Financial Officer and Chair of the Performance and Audit Committee on any matter. In accordance with the principles of the code of corporate governance, regular reports were made to the IJB's Performance and Audit Committee during 2017–18.

The internal audit function has independent responsibility for examining, evaluating and reporting on the adequacy of internal control. During 2017–18, the service operated in accordance with relevant professional audit standards and the Public Sector Internal Audit Standards.

The Chief Internal Auditor is responsible for forming an annual opinion on the adequacy and effectiveness of the systems of internal control.

It is the opinion of the Chief Internal Auditor that the systems of internal control relied upon by the IJB continue to provide reasonable assurance against loss.

Governance developments during 2017–18

Membership of the Integration Joint Board changed following Local Government Elections in May 2017, and due to the resignation of key members.

New appointments were made as follows:

Chair and Vice Chair, IJB

Chair and Vice Chair, Performance and Audit Committee

Chair, Strategic Planning Group

Chair, Health & Care Governance Group

Service User and Carer Representative

Third & Independent Sector Representative

NHS Board Voting Member

New reporting responsibilities were placed on Integration Joint Boards by the Public Bodies (Joint Working) (Scotland) Act 2017, during 2017, including:

- **Complaints handling procedure**
  Scottish Public Services Ombudsman Complaints Standard Authority required all IJBs in Scotland to adopt their own model Complaints Handling Procedure.
- **Model publication scheme**
  The Freedom of Information (Scotland) Act 2002 (FOISA) requires Scottish public authorities to produce and maintain a publication scheme. North Ayrshire IJB adopted the Model Publication Scheme produced by the Scottish Information Commissioner.
- **Climate change reporting**
  Scottish Government issued guidance to Integration Joint Boards in May 2017 setting out the duty to produce an annual Climate Change report. This report will be submitted on the Sustainable Scotland Network (SSN) online portal by 30 November each year. North Ayrshire IJB submitted their report by the deadline of 30 November 2017. North Ayrshire IJB report was published on the Sustainable Scotland Network on 31 January 2018.North Ayrshire Integration Joint Board has no responsibility for employees, buildings or fleet vehicles and therefore the IJB Climate Change report does not include detail of these but instead reference is made to the two respective parent bodies plans as they have retained responsibility for these.

Health and Care Governance
The IJB agreed proposals submitted by the Chair of the Health & Care Governance Group to provide regular updates on clinical and care governance activity for North Ayrshire HSCP.

Annual Performance Report
The IJB endorsed the Annual Performance Report at the meeting in July 2017. This report, highlighted IJB's operations in 2016/17, outlined the good performance of the Health and Social Care Partnership and how it delivered against the strategic priorities and the national outcomes.

Review of Integration Scheme
A report was presented to the NHS Board, East Ayrshire and North Ayrshire Councils in June 2017 seeking approval to consult on and review the Ayrshire Health and Social Care Integration Schemes to explore whether there was a need for change to further improve the delivery of health and social care locally.

The consultation indicated that there is no clear case for changing the Integration Scheme at present. Indeed, there are elements within the existing scheme that have not been fully implemented and there are a number of issues which could be improved upon.

Carer's (Scotland) Act 2016
The Integration Schemes have been amended to reflect the requirements of the Carers (Scotland) Act 2016. The revised Integration Schemes for East Ayrshire, North Ayrshire and South Ayrshire IJBs were submitted to Scottish Government in March 2018 and approved by the Cabinet Secretary on 3 April 2018.

Finance

The 2016–17 and 2017–18 overspend will require to be recovered by the IJB and this will be reflected in the updated Medium Term Financial Plan.

The IJB agreed to appoint a full-time Chief Finance and Transformation Officer to assist with the monitoring of financial performance and to drive transformational change in support of the future financial challenge.

Strategic Plan

Work was carried out to refresh the Strategic Plan for the period 2018–2021 and this was approved by the IJB in April 2018.

Clinical and Care Governance

Arrangements in relation to the Health and Care Governance Group were strengthened during 2017–18.

Further actions

The IJB has identified the following actions for 2018–19 that will assist with the further strengthening of corporate governance arrangements:

Records Management Plan

The Public Records (Scotland) Act 2011 came into force in 2013 and states that named authorities are required to prepare a Records Management Plan (RMP) for the management of the authority's records, and to submit the plan to the Keeper of the Records of Scotland for agreement. North Ayrshire Integration Joint Board is a named authority under the Act. The Keeper of Records of Scotland will invite IJBs to submit their RMPs in November 2018, for plans to be in place by March 2019. Arrangements are in place to meet this deadline.

Financial Management

A new financial framework involving enhanced financial reporting and service performance is being implemented to ensure effective financial planning and management alongside robust governance and control measures to deliver services within the financial envelope.

Change and Transformation

The Change Programme Board will establish more robust arrangements to secure delivery of change and transformation at scale and pace.

Assurance

Subject to the above, and on the basis of the assurances provided, we consider the governance and internal control environment operating during 2017–18 to provide reasonable and objective assurance that any significant risks impacting on the achievement of our actions will be identified and actions taken to avoid or mitigate their impact.

Systems are in place to continually review and improve the governance and internal control environment and action plans are in place to address identified areas for improvement.

Stephen Brown
Chief Officer

21 June 2018

Bob Martin
IJB Chair

21 June 2018

Remuneration report

This Remuneration Report is provided in accordance with the Local Authority Accounts (Scotland) Regulations 2014. It discloses information relating to the remuneration and pension benefits of specified IJB members and staff.

The information in the tables below is subject to external audit. The explanatory text in the Remuneration Report is reviewed by the external auditor to ensure it is consistent with the financial statements.

Remuneration: IJB Chair and Vice Chair

The voting members of the IJB are appointed through nomination by North Ayrshire Council and NHS Ayrshire & Arran. Nomination of the IJB Chair and Vice Chair post holders alternates between a Councillor and a Health Board representative.

The IJB does not provide any additional remuneration to the Chair, Vice Chair or any other board members relating to their role on the IJB. The IJB does not reimburse the relevant partner organisations for any voting board member costs borne by the partner. The details of the Chair and Vice Chair appointments and any taxable expenses paid by the IJB are shown below.

Taxable expenses 2016/17 £	Name	Post(s) held	Nominated by	Taxable expenses 2017/18 £
0	Cllr Peter McNamara	Chair 1 April 2017 to 4 May 2017	North Ayrshire Council	0
0	Stephen McKenzie	Chair 5 May 2017 to 30 March 2018 Vice Chair 1 April 2017 to 4 May 2017	NHS Ayrshire & Arran	0
0	Robert Foster	Vice Chair 17 May 2017 to 31 March 2018	North Ayrshire Council	0
0	**Total**			**0**

The IJB does not have responsibilities, either in the current year or in future years, for funding any pension entitlements of voting IJB members. Therefore no pension rights disclosures are provided for the Chair or Vice Chair.

Remuneration: Officers of the IJB

The IJB does not directly employ any staff in its own right, however specific post-holding officers are non-voting members of the Board.

Chief Officer

Under section 10 of the Public Bodies (Joint Working) (Scotland) Act 2014 a Chief Officer for the IJB has to be appointed and the employing partner has to formally second the officer to the IJB. The employment contract for the Chief Officer adheres to the legislative and regulatory framework of the employing partner organisation. The remuneration terms of the Chief Officer's employment are approved by the IJB.

Other Officers

No other staff are appointed by the IJB under a similar legal regime. Other non-voting board members who meet the criteria for disclosure are included in the disclosures below.

Total remuneration 2016/17 £	Name and post title	Salary, fees and allowances £	Taxable expenses £	Total remuneration 2017/18 £
105,848	**Iona Colvin, Chief Officer**	0	0	0
0	**Stephen Brown, Chief Officer**	106,906	0	106,906
4,863	**Margaret Hogg, Chief Finance Officer**	3,479	0	3,479*

** This relates solely to the post of Chief Finance Officer. Margaret Hogg was remunerated separately by North Ayrshire Council for the post of Head of Finance.*

In respect of officers' pension benefits the statutory liability for any future contributions to be made rests with the relevant employing partner organisation. On this basis there is no pensions liability reflected on the IJB balance sheet for the Chief Officer or any other officers.

The IJB however has responsibility for funding the employer contributions for the current year in respect of the officer time spent on fulfilling the responsibilities of their role on the IJB. The following table shows the IJB's funding during the year to support officers' pension benefits. The table also shows the total value of accrued pension benefits which may include benefits earned in other employment positions and from each officer's own contributions.

	In Year pension contributions			Accrued pension benefits	
	Year to 31/3/17 £	Year to 31/3/18 £		Difference from 31/3/17	as at 31/318
Iona Colvin, Chief Officer from April 2016 to March 2017	20,429	0	Pension Lump Sum	n/a n/a	0 0
Stephen Brown, Interim Chief Officer from April 2017 to March 2018	0	0	Pension Lump Sum	0 0	0 0
Margaret Hogg, Chief Finance Officer from April 2016 to December 2017	16,405	11,556	Pension Lump Sum	n/a n/a	n/a n/a

n/a – both the Chief Officer and Chief Finance Officer were not in post at 31/3/18

Disclosure by pay bands

As required by the regulations, the following table shows the number of persons whose remuneration for the year was £50,000 or above, in bands of £5,000.

Number of employees in band 2016/17	Remuneration band	Number of employees in band 2017/18
1	**£105,000-£109,999**	1

Exit packages

There were no exit packages during 2017/18.

Stephen Brown
Chief Officer

21 June 2018

Bob Martin
IJB Chair

21 June 2018

Independent auditor’s report

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Financial statements

The **Comprehensive Income and Expenditure Statement** shows the cost of providing services for the year according to accepted accounting practices.

2016/17				2017/18		
Gross Expenditure £000	Gross Income £000	Net Expenditure £000		Gross Expenditure £000	Gross Income £000	Net Expenditure £000
60,960	0	60,960	Community Care & Health	63,268	0	63,268
25,070	0	25,070	Mental Health	26,730	0	26,730
30,213	0	30,213	Children's Services & Criminal Justice	35,535	0	35,535
47,929	0	47,929	Primary Care	49,518	0	49,518
5,040	0	5,040	Management & Support Costs	5,566	0	5,566
3,284	0	3,284	Change Programme	3,430	0	3,430
70,565	0	70,565	Lead Partnership & Set Aside	76,665	0	76,665
243,061	**0**	**243,061**	**TOTAL NET EXPENDITURE**	**260,712**	**0**	**260,712**
0	(82,382)	(82,382)	North Ayrshire Council Funding	0	(89,346)	(89,346)
0	(157,434)	(157,434)	NHS Ayrshire & Arran Funding	0	(168,804)	(168,804)
0	**(239,816)**	**(239,816)**	**TOTAL INCOME**	**0**	**(258,150)**	**(258,150)**
243,061	**(239,816)**	**(3,245)**	**SURPLUS/(DEFICIT)**	**260,712**	**(258,150)**	**(2,562)**

There are no statutory or presentation adjustments which affect the IJB's application of the funding received from partners. The movement in the General Fund balance is therefore solely due to the transactions shown in the Comprehensive Income and Expenditure Statement. Consequently an Expenditure and Funding Analysis is not provided in these annual accounts.

The **Movement in Reserves Statement** shows the movement in the year on the reserves held by the IJB. The movements which arise due to statutory adjustments which affect the General Fund balance are separately identified from the movements due to accounting practices. In 2017/18 there were no statutory adjustments.

Movement in reserves during 2017/18	General Fund Balance	Unusable Reserves	Total Reserves
Opening balance at 31 March 2017	(3,245)	0	(3,245)
Total Comprehensive Income and Expenditure			
Adjustments between accounting basis and funding basis under regulations	0	0	0
Increase or decrease in 2017/18	(2,562)	0	(2,562)
Closing Balance as 31 March 2018	**(5,807)**	**0**	**(5,807)**

The **Balance Sheet** shows the value of the IJB's assets and liabilities as at the balance sheet date. The net assets of the IJB (assets less liabilities) are matched by the reserves held by the IJB.

31 March 201 £000		Notes	31 March 20 £000	
(3,245)	**Short term creditors – due to North Ayrshire Council**	6	0	(5,807)
(3,245)	Net Assets		**0**	**(5,807)**
(3,245)	**Reserves –** IJB General Fund		0	(5,807)
(3,245)	Total Reserves		**0**	**(5,807)**

The Statement of Accounts present a true and fair view of the financial position of the Integration Joint Board as at 31 March 2018 and its income and expenditure for the year then ended.

The unaudited financial statements were authorised for issue on 21 June 2018 and the audited financial statements will be authorised for issue on 13 September 2018.

Laura Friel
Section 95 Officer

21 June 2018

Notes to the financial statements

Note 1 – Significant Accounting Policies

General principles

The Financial Statements summarise the authority's transactions for the 2017/18 financial year and its position at the year-end of 31 March 2018.

The North Ayrshire IJB was established under the requirements of the Public Bodies (Joint Working) (Scotland) Act 2014 and is a Section 106 body as defined in the Local Government (Scotland) Act 1973.

The Financial Statements are therefore prepared in compliance with the Code of Practice on Local Authority Accounting in the United Kingdom 2017/18, supported by International Financial Reporting Standards (IFRS), unless legislation or statutory guidance requires different treatment.

The accounts are prepared on a going concern basis, which assumes that the IJB will continue in operational existence for the foreseeable future. The 2017/18 annual accounts reflect a deficit position for the IJB. A medium term financial plan has been developed for the IJB. Plans are in place to recover this deficit in the medium term from 2019/20.

The historical cost convention has been adopted.

Accruals of expenditure and income

Activity is accounted for in the year that it takes place, not simply when cash payments are made or received. In particular:

- Expenditure is recognised when goods or services are received and their benefits are used by the IJB.
- Income is recognised when the IJB has a right to the income, for instance by meeting any terms and conditions required to earn the income, and receipt of the income is probable.
- Where income and expenditure have been recognised but settlement in cash has not taken place, a debtor or creditor is recorded in the Balance Sheet.
- Where debts may not be received, the balance of debtors is written down.

Funding

The IJB is primarily funded through contributions from the statutory funding partners, North Ayrshire Council and NHS Ayrshire & Arran. Expenditure is incurred as the IJB commissions specified health and social care services from the funding partners for the benefit of service recipients in North Ayrshire.

Cash and Cash Equivalents

The IJB does not operate a bank account or hold cash. Transactions are settled on behalf of the IJB by the funding partners. Consequently the IJB does not present a 'Cash and Cash Equivalent' figure on the balance sheet. The funding balance due to or from each funding partner as at 31 March is represented as a debtor or creditor on the IJB's Balance Sheet.

Employee Benefits

The IJB does not directly employ staff. Staff are employed by the funding partners who retain the liability for pension benefits payable in the future. The IJB therefore does not present a Pensions Liability on its Balance Sheet.

The IJB has a legal responsibility to appoint a Chief Officer. More details on the arrangements are provided in the Remuneration Report. The charges from the employing partner are treated as employee costs.

Provisions, Contingent Liabilities and Contingent Assets

Provisions are liabilities of uncertain timing or amount. A provision is recognised as a liability on the balance sheet when there is an obligation as at 31 March due to a past event; settlement of the obligation is probable; and a reliable estimate of the amount can be made. Recognition of a provision will result in expenditure being charged to the Comprehensive Income and Expenditure Statement and will normally be a charge to the General Fund.

A contingent liability is a possible liability arising from events on or before 31 March, whose existence will only be confirmed by later events. A provision that cannot be reasonably estimated, or where settlement is not probable, is treated as a contingent liability. A contingent liability is not recognised in the IJB's Balance Sheet, but is disclosed in a note where it is material.

A contingent asset is a possible asset arising from events on or before 31 March, whose existence will only be confirmed by later events. A contingent asset is not recognised in the IJB's Balance Sheet, but is disclosed in a note only if it is probable to arise and can be reliably measured.

Reserves

The IJB's reserves are Usable and there are no Unusable Reserves.

The IJB's only Usable Reserve is the General Fund. The balance of the General Fund as at 31 March shows the extent of resources which the IJB can either use or owe in later years to support service provision.

Indemnity Insurance

The IJB has indemnity insurance for costs relating primarily to potential claim liabilities regarding Board member and officer responsibilities. NHS Ayrshire & Arran and North Ayrshire Council have responsibility for claims in respect of the services that they are statutorily responsible for and that they provide.

Unlike NHS Boards, the IJB does not have any 'shared risk' exposure from participation in CNORIS (Clinical Negligence and Other Risks Indemnity Scheme). The IJB participation in the CNORIS scheme is therefore equivalent to normal insurance arrangements.

Known claims are assessed as to the value and probability of settlement. Where it is material the overall expected value of known claims taking probability of settlement into consideration, is provided for in the IJB's Balance Sheet.

The likelihood of receipt of an insurance settlement to cover any claims is separately assessed and, where material, presented as either a debtor or disclosed as a contingent asset.

Note 2 – Critical Judgements and Estimation Uncertainty

The critical judgements made in the Financial Statements relating to complex transactions are:

- The IJB has considered its exposure to possible losses and made adequate provision where it is probable that an outflow of resources will be required and the amount of the obligation can be measured reliably. Where it has not been possible to measure the obligation, or it is not probable in the IJB's opinion that a transfer of economic benefits will be required, material contingent liabilities would have been disclosed in a note, however, there are no material contingent liabilities.

Note 3 – Events after the Reporting Period

The audited Annual Accounts will be authorised for issue by the Chief Financial Officer on 13 September 2018. Events taking place after this date are not reflected in the financial statements or notes. Where events taking place before this date provided information about conditions existing at 31 March 2018, the figures in the financial statements and notes have been adjusted in all material respects to reflect the impact of this information.

Note 4 – Expenditure and Income Analysis by Nature

2016/17 £000's		2017/18 £000's
105,033	Services commissioned from North Ayrshire Council	**114,099**
138,001	Services commissioned from NHS Ayrshire & Arran	**146,589**
27	Auditor Fee: External Audit Work	**24**
(239,816)	Partners Funding Contributions and Non-Specific Grant Income	**(258,150)**
(3,245)	**Surplus or (Deficit) on the Provision of Services**	**(2,562)**

Note 5 - Taxation and Non-Specific Grant Income

2016/17 £000's		2017/18 £000's
82,382	Funding Contribution from North Ayrshire Council	89,346
157,434	Funding Contribution from NHS Ayrshire & Arran	168,804
239,816	**Taxation and Non-specific Grant Income**	**(258,150)**

The funding contribution from the NHS Board shown above includes £28.055m (2016/17 £22.406m) in respect of 'set aside' resources relating to acute hospital and other resources. These are provided by the NHS which retains responsibility for managing the costs of providing the services. The IJB however has responsibility for the consumption of, and level of demand placed on, these resources.

There were no other non-ring-fenced grants or contributions.

The funding contributions from the partners shown above exclude any funding which is ring-fenced for the provision of specific services. Such ring-fenced funding is presented as income in the Cost of Services in the Comprehensive Income and Expenditure Statement. In 2017/18 there was no ring-fenced funding.

Note 6 – Creditors

31 March 2017 £000's		31 March 2018 £000's
(3,245)	Funding: due to North Ayrshire Council	(5,807)
(3,245)	**Creditors**	**(5,807)**

Note 7 – Usable Reserve: General Fund

The IJB holds a balance on the General Fund for two main purposes:

- To earmark, or build up, funds which are to be used for specific purposes in the future, such as known or predicted future expenditure needs. This supports strategic financial management.
- To provide a contingency fund to cushion the impact of unexpected events or emergencies. This is regarded as a key part of the IJB's risk management framework.

There are no usable reserves as at 31 March 2018 and the table below shows the movements on the General Fund balance which results in a deficit position.

2016/17		2017/18		
Balance at 31 March 2017		Transfers Out 2017/18	Transfers In 2017/18	Balance at 31 March 2018
(3,245)	General Fund	0	(2,562)	(5,807)

Note 8 – Agency Income and Expenditure

On behalf of all IJBs within the NHS Ayrshire & Arran area, the IJB acts as the lead manager for Mental Health Services and Children's Services. It commissions services on behalf of the other IJBs and reclaims the costs involved. The payments that are made on behalf of the other IJBs, and the consequential reimbursement, are not included in the Comprehensive Income and Expenditure Statement (CIES) since the IJB is not acting as principal in these transactions.

The amount of expenditure and income relating to the agency arrangement is shown below.

2016/17 £000		2017/18 £000
30,574	Expenditure on Agency Service	29,685
(30,574)	Reimbursement for Agency Services	(29,685)
0	**Net Agency Expenditure Excluded from the CIES**	**0**

Note 9 – Related party transactions

The IJB has related party relationships with NHS Ayrshire & Arran and North Ayrshire Council. In particular the nature of the partnership means that the IJB may influence, and be influenced by, its partners. The following transactions and balances included in the IJB's accounts are presented to provide additional information on the relationships.

2016–17 £000	Transactions with NHS Ayrshire & Arran	2017–18 £000
(157,434)	Funding Contributions received from NHS Board	(168,804)
0	Service Income received from NHS Board	0
137,961	Expenditure on Services Provided by NHS Board	146,548
53	Key Management Personnel: Non Voting Board Members	53
0	Support Services	0
(19,420)	**Net Transactions with NHS Board**	**(22,203)**

31 March 2017 £000	Balances with NHS Ayrshire & Arran	31 March 2018 £000
0	Debtor Balances: Amounts due from NHS Board	0
0	Creditor Balances: Amounts due to NHS Board	0
0	**Net Balances with NHS Board**	**0**

2016–17 £000	Transactions with North Ayrshire Council	2017–18 £000
(82,382)	Funding Contributions received from the Council	(89,346)
0	Service Income received from the Council	0
104,994	Expenditure on Services Provided by the Council	114,058
53	Key Management Personnel: Non Voting Board Members	53
0	Support Services	0
22,665	**Net Transactions with the Council**	**24,765**

31 March 2017 £000	Balances with North Ayrshire Council	31 March 2018 £000
0	Debtor Balances: Amounts due from the Council	0
(3,245)	Creditor Balances: Amounts due to the Council	(5,807)
0	**Net Balances with the Council**	**0**

Key Management Personnel: The non-voting Board members employed by the Council and recharged to the IJB include the Chief Officer; representatives of primary care, nursing and non-primary services; and a staff representative. Details of the remuneration for some specific post-holders is provided in the Remuneration Report.

Support services were not delegated to the Integration Joint Board through the Integration Scheme and are instead provided by NHS Ayrshire & Arran and Council free of charge as a 'service in kind'. The support services provided is mainly comprised of: provision of the Chief Financial Officer, financial management, human resources, legal, committee services, ICT, payroll, internal audit and the provision of the Chief Internal Auditor.

Note 10 – VAT

VAT payable is included as an expense only to the extent that it is not recoverable from Her Majesty's Revenue and Customs. VAT receivable is excluded from income.

The VAT treatment of expenditure in the IJB's accounts depends on which of the partner agencies is providing the service as these agencies are treated differently for VAT purposes.

Where the Council is the provider, income and expenditure excludes any amounts related to VAT, as all VAT collected is payable to H.M. Revenue & Customs and all VAT paid is recoverable from it. The Council is not entitled to fully recover VAT paid on a very limited number of items of expenditure and for these items the cost of VAT paid is included within service expenditure to the extent that it is irrecoverable from H.M. Revenue and Customs.

Where the NHS is the provider, expenditure incurred will include irrecoverable VAT as generally the NHS cannot recover VAT paid as input tax and will seek to recover its full cost as Income from the Commissioning IJB.

Note 11 – Accounting standards issued not adopted

The Code requires the disclosure of information about accounting changes that will be required by new accounting standards that are not yet due to be adopted. There are none which are relevant to the IJB accounts.

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Cunninghame House, Friars Croft, Irvine KA12 8EE

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Delivering care together

2017/18 Budget Monitoring Report – Objective Summary

Appendix B

Partnership Budget - Objective Summary	2017/18 Budget									2017/18	
	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 10	Movement in projected budget variance from Period 10
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
COMMUNITY CARE AND HEALTH	**54,633**	**53,603**	**(1,030)**	**10,910**	**11,111**	**201**	**65,543**	**64,714**	**(829)**	**(1,044)**	**215**
: Locality Services	26,145	25,764	(381)	3,494	3,477	(17)	29,639	29,241	(398)	(635)	237
: Community Care Service Delivery	26,065	25,561	(504)	0	0	0	26,065	25,561	(504)	(595)	91
: Rehabilitation and Reablement	756	798	42	1,969	2,258	289	2,725	3,056	331	313	18
: Long Term Conditions	1,216	1,103	(113)	3,160	3,091	(69)	4,376	4,194	(182)	(7)	(175)
: Integrated Island Services	451	377	(74)	2,287	2,285	(2)	2,738	2,662	(76)	(120)	44
MENTAL HEALTH SERVICES	**22,399**	**23,311**	**912**	**49,362**	**49,461**	**99**	**71,761**	**72,772**	**1,011**	**1,538**	**(527)**
: Learning Disabilities	17,209	18,231	1,022	478	459	(19)	17,687	18,690	1,003	1,121	(118)
: Commmunity Mental Health	3,854	3,809	(45)	1,844	1,786	(58)	5,698	5,595	(103)	31	(134)
: Addictions	1,336	1,271	(65)	1,191	1,176	(15)	2,527	2,447	(80)	(82)	2
: Lead Partnership Mental Health NHS Area Wide	0	0	0	45,849	46,040	191	45,849	46,040	191	468	(277)
CHIDREN'S SERVICES AND CRIMINAL JUSTICE	**30,108**	**32,714**	**2,606**	**3,396**	**3,251**	**(145)**	**33,504**	**35,965**	**2,461**	**1,973**	**488**
: Intervention Services	3,835	3,616	(219)	295	324	29	4,130	3,940	(190)	(91)	(99)
: Looked After & Accomodated Children	15,426	18,376	2,950	0	0	0	15,426	18,376	2,950	2,277	673
: Fieldwork	6,527	6,549	22	0	0	0	6,527	6,549	22	124	(102)
: CCSF	395	385	(10)	0	0	0	395	385	(10)	(29)	19
: Criminal Justice	2,812	2,815	3	0	0	0	2,812	2,815	3	0	3
: Early Years	311	233	(78)	2,658	2,542	(116)	2,969	2,775	(194)	(196)	2
: Policy & Practice	802	740	(62)	0	0	0	802	740	(62)	(52)	(10)
: Lead Partnership NHS Children's Services Area Wide	0	0	0	443	385	(58)	443	385	(58)	(60)	2
PRIMARY CARE	0	0	0	49,637	49,518	(119)	49,637	49,518	(119)	0	(119)
MANAGEMENT AND SUPPORT COSTS	4,090	4,519	429	176	1,279	1,103	4,266	5,798	1,532	1,296	236
CHANGE PROGRAMME	708	353	(355)	2,162	1,862	(300)	2,870	2,215	(655)	(463)	(192)
LEAD PARTNERSHIP AND SET ASIDE	0	0	0	0	132	132	0	132	132	133	(1)
TOTAL	**111,938**	**114,500**	**2,562**	**115,643**	**116,614**	**971**	**227,581**	**231,114**	**3,533**	**3,433**	**100**
Additional Funding from NHS	0	0	0	0	(971)	(971)	0	(971)	(971)	0	971
Final 2017/18 Position	**111,938**	**114,500**	**2,562**	**115,643**	**115,643**	**0**	**227,581**	**230,143**	**2,562**	**3,433**	**1,071**

2017/18 Savings Tracker

Appendix C

Service	Description	B / R / A / G 2017/18	Budget Savings 2017/18	Actual Savings	Update on progress to date and proposed action moving forward
Teams Around the Child	Children's home - Service Redesign	Red	(327,000)	(18,000)	Mount View closed at the end of March 2018 which means this saving will be dully delivered in 2018/19
	Full Year Impact of Contract Savings	Blue	(76,000)	(76,000)	Complete
	Roll out of SDS in children Services	Red	(17,000)	0	Not yet commenced but planned for 2018/19
Care for Older People & those with complex needs	Whole system review of NHS provided beds in care of elderly/elderly Mental Health and purchased nursing care beds. This will be predicated on the development of a tiered model of care that offers the opportunity to continue living for longer within a community setting, with support appropriate to individual needs. This represents a 7.9% saving	Blue	(496,000)	(496,000)	Complete
	Review and redesign day care for older people with a view to securing a more flexible, person centred approach that is aligned with other services to deliver greater efficiency in service provision.	Blue	(50,000)	(52,000)	Complete
Delivery of the Mental Health Strategy	Mental Health Care Packages baseline budget adjustment based on historic underspends	Blue	(60,000)	(91,000)	Complete
	Integration of Teams Management and Support	Blue	(50,000)	(50,000)	Complete
Delivery of the Learning Disabilities Strategy	Learning disabilities - develop employability skills with a wide group of service users	Amber	(60,000)	(8,000)	Review of workforce and employability schemes underway. Posts all identified £8k achieved this year, with the balance of savings identified next year
	Review of sleepover provision in LD	Red	(151,000)	(22,000)	Sleep over pilots implemented and Canary assessment tool purchased. Current mapping of LD sleepovers, costings and areas and have identified 9 people who could transition to non sleepover provision but will require a bespoke response service and another 7 who with preparation over next year could transition from sleepover support with responder service in place. The responder service business case will be completed in 2018/19.

Service	Description	B / R / A / G 2017/18	Budget Savings 2017/18	Actual Savings	Update on progress to date and proposed action moving forward
Delivery of the Learning Disabilities Strategy	Introduction to SDS in LD	Red	(100,000)	0	LD strategy launched on 28.06.17 . Leadership capacity to accelerate change programme agreed with challenge fund for implementation in 2018/19.
	Savings in LD Community Packages	Blue	(50,000)	(83,000)	Review of packages continues within the ARG framework. CM2000 will be implemented during 2018/19.
Management and Support Services	Review of Partnership business support functions	Blue	(75,000)	(75,000)	A full review of business support has commenced and will be completed in 2018/19 with a view to achieving these savings. The 2017/18 saving has been made by using contingency funding.
	Review of Charging Policy	Blue	(100,000)	(100,000)	Complete but continue to monitor
	Review of Management and Support Across the Partnership	Blue	(80,000)	(80,000)	Complate - funded by contingency
	New ways of Working Across the Partnership	Blue	(50,000)	(50,000)	Complate - funded by contingency
	Review of Fleet Management and Catering Budgets across the Partnership	Blue	(22,000)	(22,000)	Complete but continue to monitor
	Workforce Modelling	Blue	(100,000)	(100,000)	Complate - funded by contingency
Teams Around the Child	Transfer of 12 external foster care placements to in-house carer provision, and a reduction of a further 4 external long term foster placements.	Blue	(91,520)	(91,520)	Complete
	Alignment and Rationalisation of Learning Development functions in Children Services	Blue	(50,000)	(50,000)	Complete
	A Review of Management and Support in Children Services	Blue	(65,000)	(65,000)	Complete
		GRAND TOTAL	**(2,070,520)**	**(1,529,520)**	

NHS Savings

Service	Description	B / R / A / G 2017/18	Budget Savings 2017/18	Actual Savings	Update on progress to date and proposed action moving forward
Mental Health	**Review of Psychology Services**	Blue	(200,000)	(200,000)	Psychology service review complete. Recommendations being progressed.
Primary Care - Prescribing	**Prescribing Annual Review**	Amber	(1,346,000)	(1,100,000)	Pregablin tariff not reduced to the level anticipated. Additional budget requested in 2018/19.
Primary Care - Prescribing	**Prescribing Incentive Scheme**	Red	(770,000)	0	Continue to engage with GPs including raising this at meetings that have with arranged with GPs.
Mental Health	**Phased Closure of House 4 at Arrol Park**	Blue	(125,000)	(118,000)	Refurb of unit to enable segregation of unit and transfer of workforce across the unit underway/reduction of beds. This will also enable the transition of an out of area patient pending a tier 4 supported accommodation solution being identified via capital bid. Business case developed.
Mental Health	**Substitute Prescribing** This proposal will result in a 1% reduction in substitute prescribing.	Blue	(30,000)	(30,000)	Complete 2017/18 only
Mental Health	CAMHS	Blue	(80,000)	(80,000)	Complete 2017/18 only
Mental Health	MH Admin	Blue	(100,000)	(100,000)	Complete 2017/18 only
Change Programme	Integrated Care Fund	Blue	(339,000)	(339,000)	Complete 2017/18 only
STILL TO BE IDENTIFIED		Red	(1,165,000)	0	Non achieved CRES
Total			**(4,155,000)**	**(1,967,000)**	

Change Programme

Appendix D

Integrated Care Fund Area of Spend	2017/18 Budget	2017/18 Actual	Variance	Comment
	£000's	£000's	£000's	
Funding Previously Agreed to 31/3/18	207	186	(21)	
Partnership Enablers	129	129	0	
Social Enterprise Development Opportunity	15	15	0	
Ideas and Innovation Fund	566	456	(110)	The Community Connectors will be funded by the Scottish Government for the second half of the year.
Reshaping Care for Older People Legacy	132	228	96	LOTS workers
Engagement and Locality Planning	123	74	(49)	
Teams around GPs	740	325	(415)	See and Treat Centre slippage
Change Team	870	565	(305)	Vacancies
Low Level Mental Health	108	88	(20)	
TOTAL	**2,890**	**2,066**	**(824)**	
Less amount taken as a non recurring saving in previous periods	**(339)**	**0**	**339**	
FINAL POSITION	**2,551**	**2,066**	**485**	

Appendix E

BUDGET RECONCILATION

	Partner	Period	Permanent or Temporary	£	£
Initial Approved Budget	NAC	4		86,907	
Resource Transfer		4	P	22,591	
Transfer from Housing - Aids and Equipment		6	P	199	
Increase to OP Care Homes		6	T	977	
Increase to LD Community Packages		6	T	423	
Removal of Depreciation		6	P	(70)	
Transfer from Housing to LD		8	P	4	
Reduction in Holiday Pay		8	P	(38)	
Intervention Services		8	T	25	
Budget for Redundancy Costs		12	T	222	
Challenge Fund spend 1718		12	T	708	
Commercial Refuse Collection		12	T	20	
Insurance Allocation		12	T	60	
Reduction in App Levy Budget		12	T	(7)	
CJ Underspend - reduction in income recd SG		12	T	(90)	
Public Wifi - Corporate Change Prog at Meadows		12	T	7	
Period 12 reported budget – Council					**111,938**
Initial Approved Budget	NHS			136,230	
Resource Transfer		2	P	(22,137)	
Dean Funding for Junior Doctors		2	P	9	
ANP Post to East (from ORT funding)		3	P	(49)	
AHP post funded by ADP		3	T	(31)	
NES Junior Doctor reduction in funding		3	P	(13)	
Veterans/Carers Funding		4	T	210	
ANP Funding from North to South		4	P	(49)	
Arrol Park GP medical service transfer to PC		4	P	(13)	
FNP Budget adjustment to match allocation		4	T	(3)	
Dementia Specialist Nurse		6	P	29	
West of Scotland CAMHs (anticipated)		6	T	24	
Veterans/Carers Funding to NAC		6	T	(210)	
Reduction in ADP funding for NAC		6	T	(30)	
Health Visitor Trainees		8	P	278	
Family Nurse Partnership expansion		8	T	16	
Transfer of Admin hours to East HSCP		8	P	(3)	
Veterans First allocation from SG		8	T	23	
Return of Police funding to ADP		8	P	(8)	
MH Clinical Services Secondment to SG		9	T	16	
MH Nursing Forum		9	T	2	
Dean Funding for Junior Doctors		9	P	12	
Health Visitor Trainees		10	P	5	

West of Scotland CAMHs		11	T	11	
FNP transfer to South		11	T	(528)	
CEL 13 HV trainees to East and South		11	P	(765)	
Transfer to PC for ORT and ABIs		11	T	(22)	
Funding to NAC		11	T	(36)	
GP Service for Arrol Park to PC		12	T	(9)	
Dean Funding for Junior Doctors		12	P	18	
GMS Uplift		12	P	238	
Oxenward nurse transfer		12	P	1	
Kirklandside staffing budget from East		12	T	186	
Balance of Phase 2 ORT funding		12	P	20	
Reduce Funding to NAC (ICF)		12	T	16	
Funding from NAC		12	T	389	
ABI funding from ADP to East		12	T	- 2	
PC Prescribing		12	T	1,818	
Period 12 reported budget – NHS					**115,643**
Total Partnership Budget					**227,581**

Agenda Item 6

Integration Joint Board
21st June 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
IJB	Integration Joint Board
V1P	Veterans 1st Point
ASN	Additional Support Needs

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	NHS Scotland Event – 18th/19th June
	The North Ayrshire HSCP was well represented at this year's annual NHS Scotland Conference. The following services all have posters featuring at the event :- • Creating a wellness service for children and young people in Ayrshire and Arran: Cluster modelling in schools and communities – Kilwinning; • NAHSCP Telecare and Scottish Ambulance Service Test of Change Pilot • Developing North Ayrshire Children's Services Plan in partnership with local children; • The use of telecare in the redesign of overnight supports for people with learning disabilities : implementing a cluster based approach in North Ayrshire.
	Our Children and Adolescent Mental Health Services (CAMHS) team delivered a spotlight session entitled "Creating a Wellness Service for Children and Young People in Ayrshire & Arran".
	On the second day, I delivered the morning plenary session on the topic of "Building Stronger Children".

	Ayrshire Wide Developments
2.2	Veterans 1st Point
	Veterans from across Ayrshire came together recently to celebrate the first birthday of Veterans First Point on 9th May 2018.
	Veterans First Point was first launched in Ayrshire in March last year to support service veterans and their families with the move from military to civilian life.
	Since its opening, Veterans First Point has managed to support over 300 veterans to seek help with things like housing, support with gaining employment, and accessing psychological treatment for mental health difficulties.
	North Ayrshire Developments
2.3	Appointments
	Following a successful round of interviews in early June, the undernoted appointments have been made to the Partnership :- Dalene Sinclair, Senior Manager (Universal Early Years) Caroline Whyte, Chief Finance and Transformation Officer
2.4	What Matters to You? Day – 6th June 2018
	Last year we spent the 6th of June talking to people across North Ayrshire about what mattered to them in relation to health and social care. We managed to speak to two and a half thousand people on the day, from patients and service users through to members of the public at train stations, in supermarkets and on the streets. It was a huge success and provided us with a real insight into what the people of North Ayrshire want when it comes to their health and social care.
	This year, we took a slightly different approach and asked as many of our staff to ask the question and have the conversation with as many of their service users and patients as possible on the day. Over 50 staff volunteered to be What Matters to You? Champions and we developed the postcards to make capturing the feedback as easy as possible. It is a simple question that allows practitioners to engage in a meaningful conversation that not only enhances the relationship with the individual they are working with but allows us to seek invaluable feedback.
	The results from the day will be presented to the IJB in October 2018.
2.5	National Secure Adolescent In-Patient Service
	Development of the new National Secure Adolescent In-patient Service is progressing well. This will be a brand new 12-bedded national resource for young people, being built on the Ayrshire Central site in Irvine, close to our Woodland View hospital. Despite the significant work involved in this development, we are still on track to open in 2020.

2.6	Additional Support Needs Resource
	Another development, agreed by Council in February this year and also scheduled to open in 2020, is a brand new 8-bedded residential resource for young people with Additional Support Needs (ASN) as well as a new 8-bedded respite resource. Both are being built alongside the new ASN school on the Auchenharvie site and will form part of a campus. This is a unique development in Scotland and one that provides a real opportunity to improve the support available locally for young people with complex needs and their families.
2.7	Change Programme Priorities 2018/19
	The Partnership Senior Management Team (PSMT) are in the process of agreeing the priorities for the Change Programme for 2018/19. As Director and Chief Officer, my priorities for 2018/19 have been agreed with both Chief Executives and these will inform the priorities for the Change Programme, as well as those agreed by the PSMT. Details of all priorities and proposed savings will be tabled at the IJB meeting in July 2018.
2.8	Carers Week – 11 – 17th June 2018
	Carers Week is an annual campaign to raise awareness of caring by highlighting the challenges that carers face and recognise the contribution they make to families and communities throughout the UK. The campaign encourages others to organise activities and events throughout the UK.
	In North Ayrshire the focus during Carers Week (11th - 17th June) was ways we can support carers to stay Healthy and Connected. Building communities which support carers to look after their loved ones well, while recognising that they are individuals with health and wellbeing needs of their own. A number of individuals and groups across North Ayrshire hosted events to raise awareness for Carers Week 2018, including :-
	• Nail Bar and Afternoon Tea at Stevenston Day Care, Largs • Young and Older Carers Get Together, Gowanlea Care Home, Kilbirnie • Carers Day Trip to Riverside Museum, Glasgow • Young Carers Street Dance Workshop • Hatters Tea Party, Stronach Day Centre, Arran
	Further to my last Director's Report, I can confirm that North Ayrshire Council have met the criteria to be recognised as a Carer Positive Employer. The Council provided evidence that there were wide ranging and comprehensive supports in place for staff with caring responsibilities, and that this is well communicated throughout the organisation. Carer Positive were encouraged by the wider approaches to support carers in the local community, underpinned by the partnership working with the NAHSCP and the local Carers Centre.

2.9	Parent/Baby Café, Kilwinning
	A brand new Parent and Baby Café opened in Kilwinning on 31st May 2018. This is in addition to the existing cafes in Saltcoats and Kilbirnie. The cafes offer an opportunity for parents to meet up on a weekly basis to chat about all things relating to parenting and family life, as well as an opportunity for peer support for infant feeding. More information on the Parent and Baby Cafes can be found on Twitter @Parent_BabyCafe so please retweet and spread the word!
2.10	Effectiveness of Peer Mentoring
	A recent production by Funky Films (https://www.youtube.com/watch?v=Z_7Nj8wpCo0&app=desktop) highlights the impact of peer mentoring. The piece clearly demonstrates the value in reaching and supporting those people within marginalised groups, and how this enhances their quality of life.
	The feedback from those being supported, along with the support workers own experiences is powerful. The recovery support workers have achieved great things, both on an individual basis including completion of a SVQ Level 3 award, as well as their contribution to North Ayrshire.
	The ADP has increased the number of hours offered to the recovery support workers, with a view to developing the model further.
2.11	Men's Shed in Garnock Valley
	Anam Cara has teamed up NAC libraries and Garnock Men's Shed in an exciting new partnership. Some of Anam Cara's male guests regularly pop up to the Garnock Men's Shed, where they are building memory boxes. The team (including modern apprentice and work experience student) behind this partnership working hopes to stimulate and revive skills and support the male guests to possibly learn a few new ones. Photographs are taken throughout the building process and the photos are then included in the contents of the finished box – this gives the participants a visual memory of their experience at the Men's Shed. The decoration and art work is carried out in Kilbirnie library. 
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, Interim Director/Chief Officer on 01294 317723 or sbrown@north-ayrshire.gcsx.gov.uk

NORTH AYRSHIRE
Health and Social Care Partnership

Agenda Item 7

Integration Joint Board
21 June 2018

Subject:	**IJB SET ASIDE ARRANGEMENTS**
Purpose:	To seek approval from the Integration Joint Board (IJB) for the response to the Finance Development Group request regards progress made to date in implementing the statutory guidance on establishing set aside arrangements with NHS Ayrshire and Arran.
Recommendation:	That the IJB approves the response sent to the Finance Development Group's request to outline progress in implementing the statutory guidance on establishing set aside arrangements with NHS Ayrshire and Arran.

Glossary of Terms	
NHS AA	NHS Ayrshire and Arran
HSCP	Health and Social Care Partnership
IJB	Integration Joint Board
FDG	Finance Development Group
CIPFA	Chartered Institute for Public Finance & Accountancy
COSLA	Convention of Scottish Local Authorities

1.	**EXECUTIVE SUMMARY**
1.1	A request was received on 12 April 2018 from Christine McLaughlin (Director, Health Finance, Scottish Government) on behalf of the Finance Development Group (FDG) which has been established to support implementation of the financial aspects of the health and social care integration legislation and associated guidance.
1.2	The FDG includes representation from NHS Boards, Integration Authorities, Local Authorities, Audit Scotland, CIPFA, COSLA and Scottish Government.
1.3	The FDG asked for a response agreed by both the IJB and NHS Ayrshire and Arran on what progress has been made to date versus the six steps laid out in statutory guidance for implementing set aside budget arrangements in relation to the full pathway of care, including the acute hospital component. A copy of the request from FDG is attached as Appendix A.
1.4	A single Pan Ayrshire collegiate response was submitted to the FDG on 18 May 2018 representing North Ayrshire HSCP, East Ayrshire HSCP, South Ayrshire HSCP and NHS Ayrshire and Arran. All the respective parties provided appropriate input to the response that was submitted. A copy of the response to the FDG is attached at Appendix B.

1.5	In summary the response reflected the fact that substantial work has been done in implementing the six steps outlined in the statutory guidance. However there still remains much work to be done, including development of a model that will help inform wider system changes.
2.	**BACKGROUND**
2.1	The Executive Summary highlights the background to this report.
2.2	The Statutory guidance on the use of delegated hospital budgets outlines six key steps for implementing the Set Aside arrangements, which are summarised as follows: 1. A group should be established comprising the hospital director and finance leads, and the Chief Officers and Chief Finance Officers of the IJB's whose populations use the hospital services. 2. The base line bed days used by the IJB residents in the ten speciality areas should be quantified and the relevant budgets mapped to the bed capacity. 3. A method should be agreed for quantifying how the sum set aside will change with projected changes in bed capacity. 4. A plan should be developed and agreed that sets out the capacity levels required by each IJB. 5. Regular information should be provided to the group to monitor performance against the plan. 6. As the plan for hospital capacity is a joint risk held by the IJB and the Health Board an accountability framework should be agreed that clarifies relevant risk sharing arrangements.
3.	**PROPOSALS**
3.1	Key highlights from the collective response **(see Appendix B)** to the FDG regards the six steps for implementing set aside arrangements are: 1. A Strategic Planning and Operational Group meet on a weekly basis and has been established for over three years. 2. Baseline data was set in 2015/16 in respect of the ten specialities and resulting set aside budget. 3. In the first three years the sum set aside has been updated to reflect actual usage. In future the intention is to take a 'commissioning' type approach, with Mental Health Inpatient beds being chosen to develop a model which shall inform wider system changes. 4. Ministerial Steering Group (MSG) performance indicators have been utilised to set trajectories. This in turn through our Unscheduled Care plans is being utilised to transfer into bed capacity. 5. The level of acute activity and the impact on hospital capacity is reported to each Health and Social Care Partnership quarterly by the Health Board alongside bi-monthly updates on the set aside budget via the Budget Monitoring Report to the IJB. 6. The 2015 Integration Schemes provide a framework for Risk Management, specific arrangements for the variation in activity in Unscheduled Care and therefore the set aside budget are detailed in the finance section of the Integration Scheme. The need for and development of an accountability framework is also being reviewed across the three IJB's and Health Board.

3.2	It is proposed that the IJB approve the collective response sent to the Finance Development Group regards progress made versus the statutory guidance via implementing the six steps for set aside arrangements.
	Anticipated Outcomes
3.3	The response to the request, coupled with the responses across Scotland will allow the FDG to assess and compare progress across all IJB's and Health Boards. Locally Pan Ayrshire it will provide focus across all four organisations to maintain the momentum around further developing our set aside arrangements to achieve the effective outcomes needed.
	Measuring Impact
3.4	The Set Aside arrangements are getting an ever increasing profile and as a result progress is being continually assessed and monitored by the three IJB's and the Health Board concerned, to ensure we are progressing towards key shared objectives.
4.	**IMPLICATIONS**

Financial:	No direct implications
Human Resources:	No direct implications
Legal:	No direct implications
Equality:	No direct implications
Children and Young People	No direct implications
Environmental & Sustainability:	No direct implications
Key Priorities:	The set aside arrangements being implemented per the six steps laid out in statutory guidance support delivery of the HSCP Strategic Plan Priorities.
Risk Implications:	Failure to make progress in implementing effective set aside arrangements with NHS Ayrshire and Arran could result in ineffective allocation of resources to meet strategic priorities of both the IJB and the Health Board.
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	

5.	**CONSULTATION**
5.1	This report has been produced in consultation with the Director of NAHSCP and members of the senior management team.
6.	**CONCLUSION**
6.1	That the IJB approves the response sent to the Finance Development Group's request to outline progress in implementing the statutory guidance on establishing set aside arrangements with NHS Ayrshire and Arran.

For more information please contact Shahid Hanif, Interim Chief Finance & Transformation Officer on 01294 324954 or shahidhanif@north-ayrshire.gcsx.gov.uk

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Integration Authority Chief Officers
Health Board Chief Executives

Cc Local Authority Chief Executives
Integration Authority Chief Finance Officers
Health Board Directors of Finance

12 April 2018

Dear Colleagues

Progress establishing set aside arrangements – integrated budgets

As you will be aware, a Finance Development Group (FDG) has been established to support implementation of the financial aspects of the health and social care integration legislation and associated guidance. The FDG includes representation from NHS Boards, Integration Authorities, local authorities, Audit Scotland, CIPFA, COSLA and Scottish Government. At the most recent meeting, the group agreed that there was a need to understand the progress that is being made towards planning across the full pathway of care, including the acute hospital component and the way in which the statutory guidance on the use of delegated hospital budgets is being applied in practice.

The statutory guidance sets out six key steps for implementing the arrangements, as follows:

1. A group should be established comprising the hospital sector director and finance leads, and the Chief Officers and Chief Finance Officers of the Integration Authorities, whose populations use the hospital services, including those with a material level of cross boundary flow. The purpose of the group is to develop an understanding of the baseline bed capacity used by Integration Authority residents in the delegated specialties and the resource affected; to develop projections and agree a plan for the capacity that will be needed in future; and to monitor implementation of the plan.

2. The baseline bed days used by Integration Authority residents in the ten specialties should be quantified and the relevant budgets mapped to the bed capacity. The resulting amounts would then be the baseline sum set aside.

3. A method should be agreed for quantifying how the sum set aside will change with projected changes in bed capacity. This should be at two levels of detail: one allowing for the development of outline plans, giving an initial indication of the potential resource implications; and a more comprehensive analysis of agreed changes in capacity, that takes into account cost behaviour and timing of resource changes. Although ultimately left to local decision, the guidance recommends that a similar process to the one successfully used for Learning Disability Same As You (LDSAY) should be used for the more detailed modelling.

4. A plan should be developed and agreed that sets out the capacity levels required by each Integration Authority (taking into account both the impact of redesign and of demographic change) and the resource changes entailed by the capacity changes.

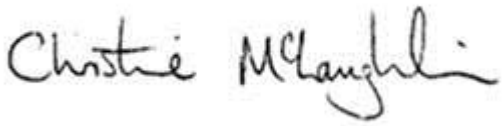
5. Regular information should be provided to the group to monitor performance against the plan.

6. As the plan for hospital capacity is a joint risk held by the Integration Authorities and the Health Board an accountability framework should be agreed that clarifies relevant risk sharing arrangements.

I am writing to you in my role as Chair of the FDG to request information on the development of your local arrangements for this key part of the legislation. I would be grateful if you could provide a response, agreed by both the Integration Authority and NHS Board. which sets out your assessment of your partnership's progress in implementing these six recommendations and plans for this financial year 2018/19. It would be helpful if you could identify any areas that would support further progress when responding.

Responses should be sent to Eilidh.love@gov.scot on completion, by close on 18th May. Please let me know if this timescale presents any practical difficulties.

Yours sincerely



CHRISTINE MCLAUGHLIN

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Private and Confidential

Christine McLaughlin
Health Finance Directorate
Scottish Government

Via Email:
Eilidh.Love@gov.scot

Date 18 May 2018
Your Ref
Our Ref JGB/lp
Enquiries to Laura Parker
Extension 13628
Direct line 01292 513628

E-mail l.parker4@nhs.net

Dear Christine

Progress Establishing Set Aside Arrangements – Integrated Budgets – NHS Ayrshire & Arran / East, North & South Ayrshire IJB

Thank you for your letter dated 12 April 2018.

I have set out below our progress in relation to each of the six steps.

1. In Ayrshire and Arran a Strategic Planning and Operational Group meet on a weekly basis. This comprises the three IJB Chief Officers, the Director of Acute Services, the Director of Transformational & Sustainability, NHSAA. The group has been established for over three years and is supported by pan Ayrshire meetings of Chief Finance Officers and Planning and Performance Leads. This provides oversight of planning and decision making that directly impacts on investment or disinvestment plans from an operational perspective.

   The group has continued to develop and hone regular reports to the NHS Board and IJB governance arrangements around Unscheduled Care and is making good use of the Ministerial Steering Group (MSG) performance indicators. The MSG trajectories are being viewed as a significant enabler with all three Ayrshire Partnerships collaborating on setting trajectories to reduce, for example, the use of unscheduled bed days and make progress on delayed discharge.

   The setting of the MSG trajectories has also helped bring more deliberation to our Unscheduled Care planning, with assumptions around impact being more robustly tested than ever before.

2. Baseline data was set in 2015/16 in respect of the ten specialties and resulting set aside budget. Further analysis of bed use by speciality and by Partnership area is currently being developed. This is taking into account historical data to ensure accuracy at Partnership level.

High level information is currently available to each Partnership relating to the value of the sum set aside and we are currently working with our data analysts to break this down further by specialty.

3. In the first three years of operation, the set aside value has been updated to reflect actual usage. This has therefore reflected the impact of service changes. The set aside has altered with 'actual' rather than 'projected' changes in bed capacity.

   In future we are intending to take a 'commissioning' type approach, recognising future planning is not solely about the value of the set aside changing with bed numbers, it is also about how this value is released to support care closer to home when the bed numbers go down, or indeed, how the value should increase if the balance between planned and unscheduled care changes in the acute setting.

   In order to develop a model that will help inform wider system changes, we have agreed to begin with the use of Mental Health Inpatient beds. Some significant work has already been done to quantify usage across the three Partnership areas and we are now working on the sum set aside values relating to that usage. The trajectories set by each Partnership to reduce the use of Mental Health Inpatient bed days can then be assigned a monetary cash-releasing value, depending on the extent of the impact of those trajectories being met and where savings can be safely made from the inpatient service.

   This approach will allow us to test the community mental health and inpatient plans to jointly deliver the reduction in bed days used. It will also allow us to work through the principles relating to planning and shifting financial resource which will inform the wider sum set aside relating to unscheduled general medical and geriatric bed days.

   In relation to that wider unscheduled care work the three Ayrshire Partnerships are working with acute colleagues in NHS Ayrshire & Arran to deliver the agreed Pan-Ayrshire Model for Enhanced Intermediate Care and Rehabilitation over 2018/2019. This model focuses on providing high quality care and support through pro-active early intervention and preventative action to stop older people and people with complex needs becoming unwell in the first place and supporting them to manage their conditions more effectively.

   This business case for the Pan-Ayrshire Model for Enhanced Intermediate Care and Rehabilitation proposed enhancements to the existing Intermediate Care services to offer 7 day working. This plan will reshape existing service provision through Partnership based Intermediate Care and Rehabilitation Hubs whilst working with Acute Care of Elderly (ACE) Practitioners and specialists based in the Acute Hospitals in order to get people home as soon as possible.

   Together, these changes will improve care quality and people's experience of care and begin to bring about the whole-system change in the use of local services required as part of the wider New Models of Care for Older People and People with Complex Needs.

   The assumptions that underpinned the business case were approved by the NHS Ayrshire & Arran Scrutiny Panel resulting in cost avoidance of £4,052,014 for an

investment of £2,516,175 to employ an additional 51.4 WTE staff. This equates to the closure of 22 unfunded UHA beds and unfunded 46 UHC beds.

In addition, a joint unscheduled care plan for each of the general hospital sites in Ayrshire has been developed to further reduce the bed usage.

4. As outlined in Section 1, the MSG Indicators have been utilised to set Partnership trajectories. This, in turn through our Unscheduled Care plans is being utilised to transfer into bed capacity. Any resource change, entailed by the capacity changes needs impacted on to be in a context of a £7m overspend on additional bed capacity to meet unplanned demand in Unscheduled Care. We recognise this is an area that requires improvement.

   We are collectively committed to agreeing the principles that will underpin what is required to improve this position. This includes progression of the workstreams highlighted in section 3.

5. Monitoring information is provided in line with 1 and 3 above. The level of acute activity and the impact on hospital capacity is reported to Partnerships quarterly.

   The Budget Management Report to the IJB has a section on the Set Aside budget and reports the unfunded bed position / demand levels for acute care.

6. The 2015 Integration Schemes provide a framework for Risk Management, specific arrangements for the variation in activity in Unscheduled Care and therefore the Set Aside budget are detailed in the finance section of the Integration Scheme. The three Ayrshire Partnerships, in conjunction with NHS Ayrshire & Arran, are further committed to developing an accountability framework. Following a review of East and North's Integration Schemes in 2017, it became increasingly clear that such a framework will be required as we further develop our plans around unscheduled care, the sum set aside and our aspirations to shift the balance towards more health and social care being provided via the community.

Please note that the information noted above has yet to be shared formally with the Integration Joint Board and the NHS Board. Unfortunately, the timing of meetings has prevented us sharing our self-assessment with our respective Boards. Nevertheless, the operational Directors are in agreement as to our progress to date and the approach being taken, and the response will be shared with the three IJBs and the NHS Board for approval in June. Clearly if there are any significant changes as a result of this, we will alert you immediately.

Kind regards

Yours sincerely

Mr John G Burns
Chief Executive

NORTH AYRSHIRE
Health and Social Care Partnership

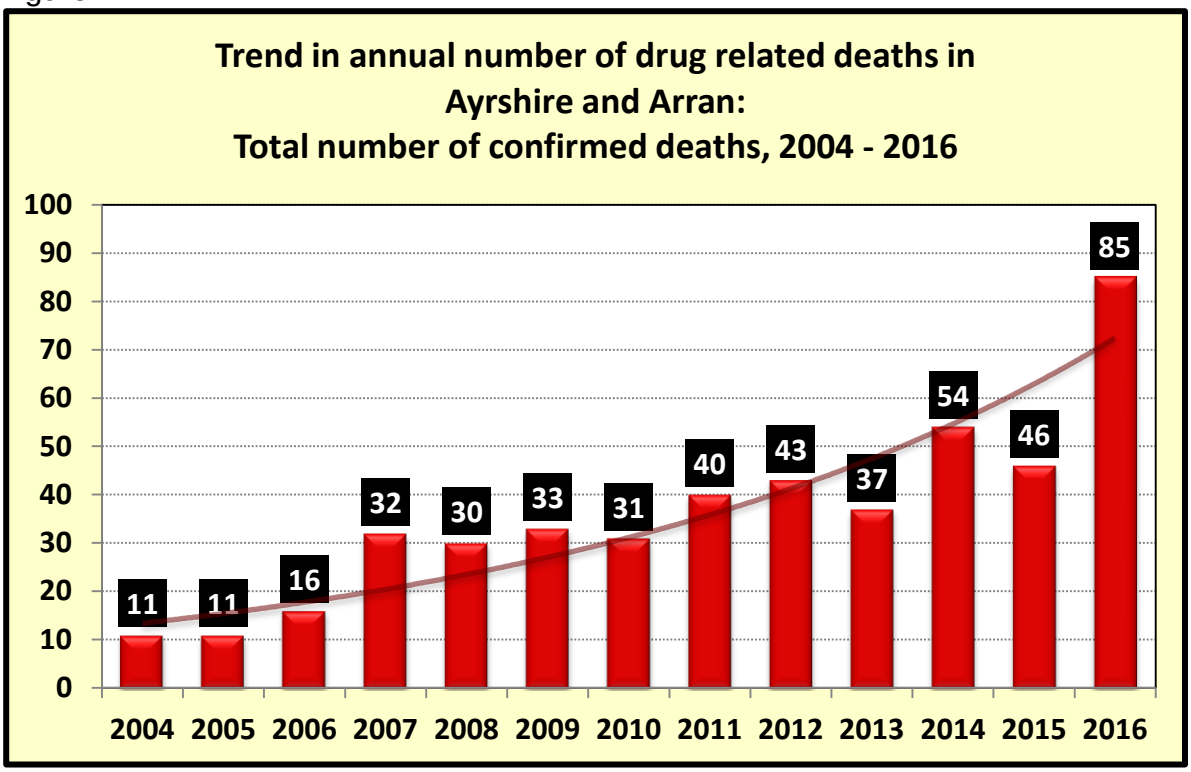
Agenda Item 8

Integration Joint Board
21 June 2018

Subject:	**Preventing Drug Related Deaths: A Framework for Ayrshire and Arran**
Purpose:	The purpose of this report is to highlight concerns about the number of deaths amongst problem drug users in North Ayrshire in 2016. This paper describes the trend seen and outlines actions taken to address this issue.
Recommendation:	It is recommended that the Integration Joint Board: • notes the increase in drug related deaths across Ayrshire and Arran in 2016 and the underlying reasons contributing to this • endorses the new Strategic Framework: Preventing Drug Related Deaths, which sets out the overarching response of the three Alcohol and Drug Partnerships in Ayrshire • receives further annual updates on progress within the action plans from the Alcohol and Drug Partnership given the deteriorating picture locally and • notes that the Chairs of the Alcohol and Drug Partnerships have agreed the Strategic Framework and is being presented to North, South and East Integration Joint Boards.

Glossary of Terms	
NHS A&A	NHS Ayrshire & Arran
HSCP	Health & Social Care Partnership
DRD	Drug Related Death
ADP	Alcohol and Drug Partnerships
DDRG	Drug Death Review Group
NRS	National Records of Scotland
ACEs	Adverse Childhood Experiences
DDPG	Drug Death Prevention Group

1.	**EXECUTIVE SUMMARY**
1.1	The purpose of this report is to highlight concerns about the number of deaths amongst problem drug users across Ayrshire and Arran in 2016. Although absolute numbers of deaths are relatively small, the increasing trend in deaths is of great concern. Drug related deaths are often indicative of other factors affecting the most vulnerable in society. Those affected are relatively young adults aged 35-44yrs and early intervention can make a significant difference to survival.

2.	**BACKGROUND**
2.1	In 2016 there were 85 confirmed drug related deaths (DRDs) recorded across Ayrshire and Arran. The final number of deaths was confirmed late in 2017, following confirmatory investigations. A similar increase in the number of deaths was seen across Scotland as a whole, raising significant concerns across agencies nationally and locally. As can be seen from **Figure 1,** drug deaths have risen systematically from 11 in 2004 to a marked peak of 85 in 2016. The 2016 figures showed a substantial increase from the confirmed total of 46 deaths in 2015. North Ayrshire experienced the highest number of drug related deaths at 35. It is of note that the majority of Intermediate Zone geographies in all three local HSCP areas also experienced increases in drug hospital stays in the three year period 2014/15-16/17. A summary slide showing the patterns of hospital stays in North Ayrshire is included in **Appendix 2**. Figure 1  Following the increase in the number of drug related deaths seen in 2016, the Alcohol and Drug Partnerships (ADP's) in Ayrshire jointly hosted a conference in November 2017. This set out to explore what more could be done to strengthen local responses to prevent drug related deaths. The key themes identified during the conference and subsequent discussion between the local Alcohol and Drug Partnerships led to the development of the strategic framework attached in **Appendix 1**. This strategic framework covers East, North and South Ayrshire and describes the principles the Alcohol and Drug Partnerships will use to work together over the next three years to reduce drug related deaths.
2.2	The strategic framework, which has been endorsed by each of the ADP's in Ayrshire, is a high-level document which agrees vision and direction for all local partners. Local action plans with agreed metrics will be developed to sit beneath this. The overarching vision set out in the framework document is to protect everyone who is at risk of a drug related death. Partners are agreed that central to this vision is the need to build strong relationships between and with people who are using drugs, their families and the wider community. Everybody matters.

2.3	The Scottish Government estimate that approximately 52,000 people in Scotland are problem drug users. Although this is a relatively small number of people, the risks associated with problem drug use are high and mortality is 12 times that of the general population. Since 2012, the number of deaths involving illicit drug use has steadily increased across the UK.
2.4	In Scotland in 2016 there were 867 drug-related deaths based on the definitions used by the National Records of Scotland (NRS).[1] This was the highest number ever recorded in Scotland with an increase of 161 on the total for 2015. The majority of deaths involved one or more opiates or opioids (including heroin/morphine and methadone). These drugs were implicated in, or potentially contributed to, 765 deaths across Scotland (88% of the total).
2.5	It is anticipated that a new national strategy will be published in coming months. The existing national strategy, 'The Road to Recovery' has been in place since 2008.[2]
2.6	Analysis of routinely available data has helped build understanding of the key issues involved in drug related deaths. The Public Health department completed an epidemiological Needs Assessment investigation into Drug and Alcohol Related harms in 2017. In addition, each year all Drug Related Deaths are collated and reviewed by the Ayrshire and Arran Drug Death Review Group.
2.7	Understanding the individual circumstances provides opportunity to learn about possible points of intervention. Almost all of those who died in 2016 were known to be a drug user by either a family member, service provider, police or general practitioner (75 of 85 deaths).
2.8	In Ayrshire and Arran in recent years, most deaths have occurred among men aged 35-44 years of age. Although the age of individuals has risen over time, these are still relatively young people who may have families of their own. In 2016 we know that 42 children were affected by a death and that 25 of these children were aged 16 or under. It is of note that these deaths contribute directly to adverse childhood experiences (ACEs). Breaking the cycle of harm is essential to the wellbeing of both current and future generations.
2.9	Heroin/morphine was the highest substance implicated in the cause of death in 2016, in keeping with the pattern of recent years. Polydrug use was common among those who died, with over half of all cases having more than one substance attributed to the cause of death.
2.10	National literature and investigation from the Ayrshire and Arran Drug Death Review Group show that the age profile of people who experience drug related deaths is increasing across Scotland among both men and women. With age, the risk of death from overdose increases. In addition, people are more likely to be living with long-term conditions and engaged in multiple risk-taking behaviours. Part of the explanation for the increase in drug related deaths in 2016 appears to be because people with problem drug use are getting older and accumulating risk.
2.11	Socio-economic pressures also contribute to problem drug use and drug related deaths. Risk factors include long-term poverty, unemployment and homelessness. More recent changes in welfare provision pose an additional pressure on individuals and communities.

[1] https://www.nrscotland.gov.uk/files//statistics/drug-related-deaths/drd2016/drug-related-deaths-16-pub.pdf
[2] http://www.gov.scot/Resource/Doc/224480/0060586.pdf

2.12	The purity of heroin may make a moderate contribution to the risk of fatal overdose, it is likely that the availability and price of heroin affects whether or not users take it, how much they take, and how often they take it.
2.13	The process of confirming whether a drug-related death has occurred takes several months and final figures for 2017 are as yet unconfirmed. The provisional figures for 2017 show a slight reduction in the number of deaths compared to 2016. The final total is likely to lie between 70-76. Final statistics will not be available till summer 2018 at the earliest.
2.14	Community Addiction Services are now delivered within East, North and South Health and Social Care Partnership areas. There is also a hospital based facility within Ward 5, Woodland View at Ayrshire Central Hospital and an Ayrshire-wide Prevention and Service Support Team.
2.15	Ward 5 provides a flexible service based on the needs of each individual person. The main treatment is through 1 to 1 support and group work, with each workshop designed to support each person on their road to recovery.
2.16	All these services offer an 'open' referral process e.g. anyone can refer direct to the service including self referrals, referrals on behalf of an individual or referrals from any service. 90% of all individuals referred will commence treatment within 3 weeks of referral and 100% of all individuals referred will commence treatment within 6 weeks of referral.
2.17	The North Ayrshire Alcohol and Drug Partnership recognise the importance of working together with South and East colleagues to address this complex and challenging issue. Using the themes identified in the conference, the ADPs agreed to work together to develop a strategic framework for the whole of Ayrshire and Arran. The ADPs are seeking support from Community Planning Partnerships and Integrated Joint Boards in each area for the approach set out in the framework.
3.	**PROPOSALS**
3.1	The Integrated Joint Board is asked to endorse the new Strategic Framework: Preventing Drug Related Deaths, which sets out the overarching response of the three Alcohol and Drug Partnerships in Ayrshire (**Appendix 1**).
3.2	The Framework includes a commitment to create local multi-agency prevention groups. These new groups will identify and deliver actions for the priority areas described in the framework. The groups will report to each local ADP, which will monitor progress over the lifetime of the framework.
3.3	The Pan-Ayrshire Drug Death Review Group has been responsible for collating and reporting the circumstances of individual deaths until now. Responsibility for investigating deaths will now move to the local multi-agency prevention groups. The focus of the pan-Ayrshire group will change to that of prevention and the group will develop responses which require a 'once for Ayrshire' solution. This will include agreeing information sharing protocols, public messaging, analysis and oversight of trends and pressures across agencies.
3.4	The North Ayrshire ADP Communities and Prevention Group will coordinate activities identified within the action plan. Updates will be provided on a quarterly basis to the ADP Strategic Management Team. The group will liaise with the pan Ayrshire Adverse Events Review Group to identify ongoing learning and approaches to reduce risk. Links with Adult Support and Protection will be improved to consider

	those near misses and reporting of concerns to address our coordinated responses of support.
3.5	There will be engagement from a diverse range of services to reflect the requirement of a whole population approach in reducing drug related deaths. The North Ayrshire ADP will lead on identified actions with clear accountability routes to the Integration Joint Board and Community Planning Partnership structures.
3.6	The ADP will continue to challenge stigma and perceptions of addiction through engagement and education within a diverse range of settings; whilst offering hope and inspiration to individuals through promoting the value of lived experience and enhancing engagement with marginalised groups, providing alternatives to traditional approaches. Arrangements and pathways will be developed to enhance engagement with individuals at risk. Services will promote and signpost individuals to recovery activities, and opportunities to engage in mainstream community provision.
3.7	**Anticipated Outcomes**
	• Creation of local drug death prevention group, ensuring local learning and rapid assessment of preventive actions • Creation of local action plan using the Strategic Framework as coordinating link • Strengthen pan-Ayrshire working arrangements with a focus on preventive activities
3.8	**Measuring Impact**
	The national 'Staying Alive in Scotland' will be used as a starting point to measure progress and the local action plan which is developed will agree additional key metrics for North Ayrshire.
4.	**IMPLICATIONS**

Financial:	No implications as the Strategic Framework sets out a shared commitment to focus on key areas requiring action. There are no resource implications.
Human Resources:	The framework itself will not result in changes to roles and responsibilities. There may be training implications once the action plan is developed (eg. Trauma informed practice).
Legal:	There are no legal issues.
Equality:	The strategic framework sets out the overarching vision of strengthening working to improve access and support for people in the most challenging circumstances. It does not specify actions at this point, any service changes which may develop as a result of the local action plans will be impact assessed.
Children and Young People	The Strategic Framework should have a positive impact on children as it requires local areas to consider their needs.
Environmental & Sustainability:	No sustainability or environmental issues.
Key Priorities:	Will link to the new National Strategy when this is released later in the year.
Risk Implications:	May raise expectations among the population that increased support will become available.
Community Benefits:	Only applies to reports dealing with the outcome of tendering or procurement exercises.

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	North Ayrshire Alcohol and Drug Partnership coordinated consultation through their network. East and South Alcohol and Drug Partnership consulted through their local mechanisms.
6.	**CONCLUSION**
6.1	There has been a significant increase in drug related deaths across Ayrshire and Arran with particularly high numbers in 2016. The underlying reasons for this are likely to be related to ageing of the problem drug using population combined with socioeconomic pressures and availability of opiates.
6.2	The Integrated Joint Board is asked to endorse the new Strategic Framework; Preventing Drug related Deaths, which sets out the overarching response of the North Ayrshire Alcohol and Drug Partnership. The framework sets out their commitment to create local drug death prevention groups in North, South and East Ayrshire as well as refreshing the coordinating role of the pan-Ayrshire Drug Death Review Group.

For more information, please contact Joy Tomlinson on 01292 885943 or joy.tomlinson@aapct.scot.nhs.uk

Appendix 1

Everybody Matters

Preventing Drug Related Deaths: A Framework for Ayrshire and Arran 2018-2021

Table of Contents

Introduction

This strategic framework is a call to action. In 2016 we saw the highest number of drug related deaths recorded across Ayrshire and Arran, following a longer term more gradual upward trend. Sadly, the increase in the number of drug related deaths across Ayrshire and Arran mirrored the picture seen across the rest of Scotland. This has raised widespread concern, among people seeking help, their families, supportive agencies, local communities and specialist services.

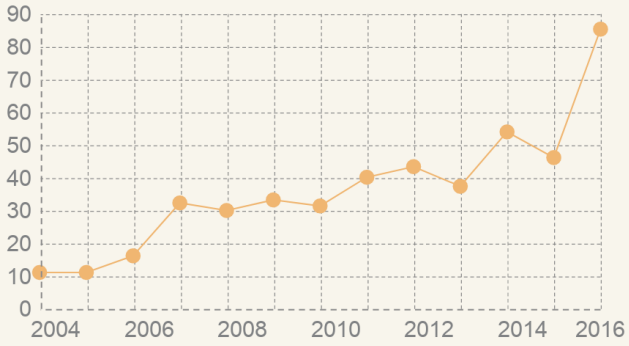
Following the dramatic increase in the number of drug related deaths seen in 2016, a conference was held in Ayrshire and Arran in November 2017. This set out to explore what more could be done to strengthen our local responses. The key themes raised during the conference and subsequent discussion between local Alcohol and Drug Partnerships led to the development of this strategic framework. This strategic framework covers East, North and South Ayrshire and describes the principles the Alcohol and Drug Partnerships will use to work together over the next three years to reduce drug related deaths. Action required to meet the strategic aims in this framework will be developed in East, North and South Ayrshire through local Prevention groups. These groups will report on progress through the Alcohol and Drug Partnerships and the actions will be supported through the pan-Ayrshire Drug Death Prevention group. We also commit to working with the Integrated Joint Boards and Community Planning Partnerships in each area to ensure that the strategic aims within this document are embedded within other local plans.

Our vision is to protect everyone who is at risk of a drug related death. We will do this by building strong relationships between and with people who are using drugs, their families and the wider community. Everybody matters.

Background

The pattern of drug related deaths over recent years has been carefully monitored both locally and nationally. The patterns seen require careful interpretation as there is significant year to year variability because relatively small numbers of individuals are affected. The trends and recent findings are shown below in summary form.

The Ayrshire Picture



Drug Related Deaths - Ayrshire 2004-2016

Drug Related Deaths have risen systematically from 11 in 2004 to their highest level - 85 - in 2016.

Source - Local Stats 2016

Drug Related Hospital stays

Large increases in the rate* of drug related hospital stays in reporting period 2014/15-2016/17 are displayed in the table below

	3 year rolling average no. of drug related hospital stays		Directly age-sex standardised rate per 100,000 popn	
	2011/12 -2013/14	2014/15 -2016/17	2011/12 -2013/14	2014/15 -2016/17
East Ayrshire	296	312	256.0	277.2
North Ayrshire	303	396	248.9	342.3
South Ayrshire	129	181	134.0	192.2
Ayrshire & Arran	728	889	218.6	276.1
Scotland			134.3	146.9

"Hospital stays" are defined here as general acute inpatient and day case stays with a diagnosis of drug misuse in any diagnostic position

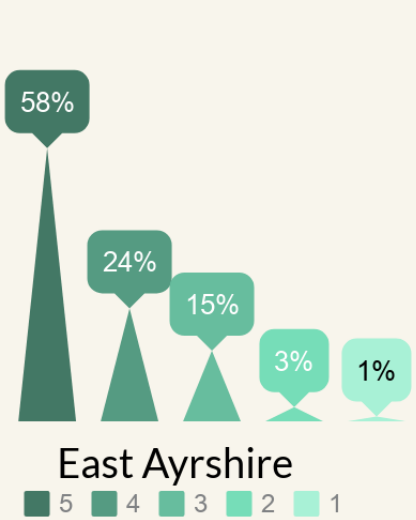
Source - Analysis of local HSCP areas Local Stats 2016 * Directly age - sex standardised rates per 100,000 popn/ Scotpho Locality Profiles (IZs)

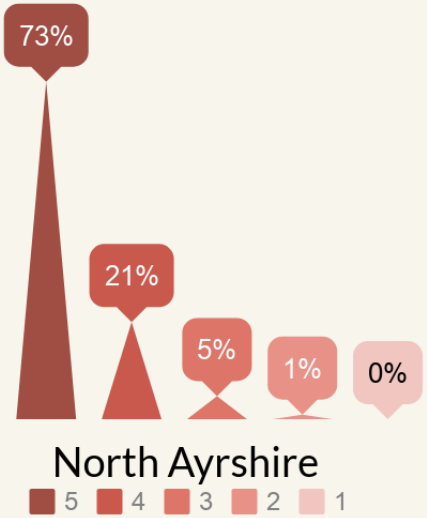
Drug Related Deaths & Deprivation

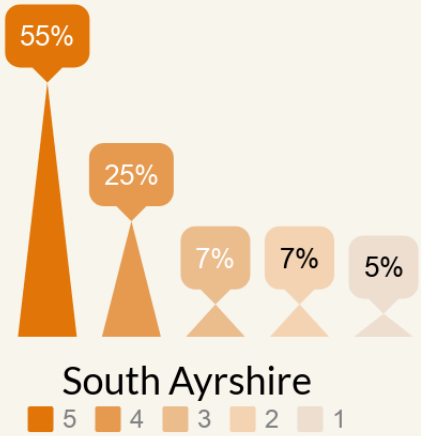
The charts below show the percentage of 2016 DRDs in each Ayrshire area by SIMD quintile.

5 represents Quintile 5 - the most deprived fifth of the population.

1 represents Quintile 1 - the least deprived fifth of the population.







The vast majority of DRDS affect the MOST deprived in Ayrshire

Source - Local Stats 2016

There is a substantial evidence base about problematic drug use and the actions which can be taken to help reduce drug related deaths and other harms. Scotland's national strategy 'The Road to Recovery' has been in place since 2008 and it recognised key areas for action. The national strategy is expected to be refreshed later in Spring 2018. It is anticipated that this new strategy will build on 'The Road to Recovery' and identify areas where greater efforts are needed to reduce the risks associated with drug related deaths. It will recognise the importance of working collaboratively across housing, employment, mental health services, with those who have lived experience and families. The infographic which follows captures the key points from the 2008 strategy.

The Scottish Government Strategy to tackle problem drug use

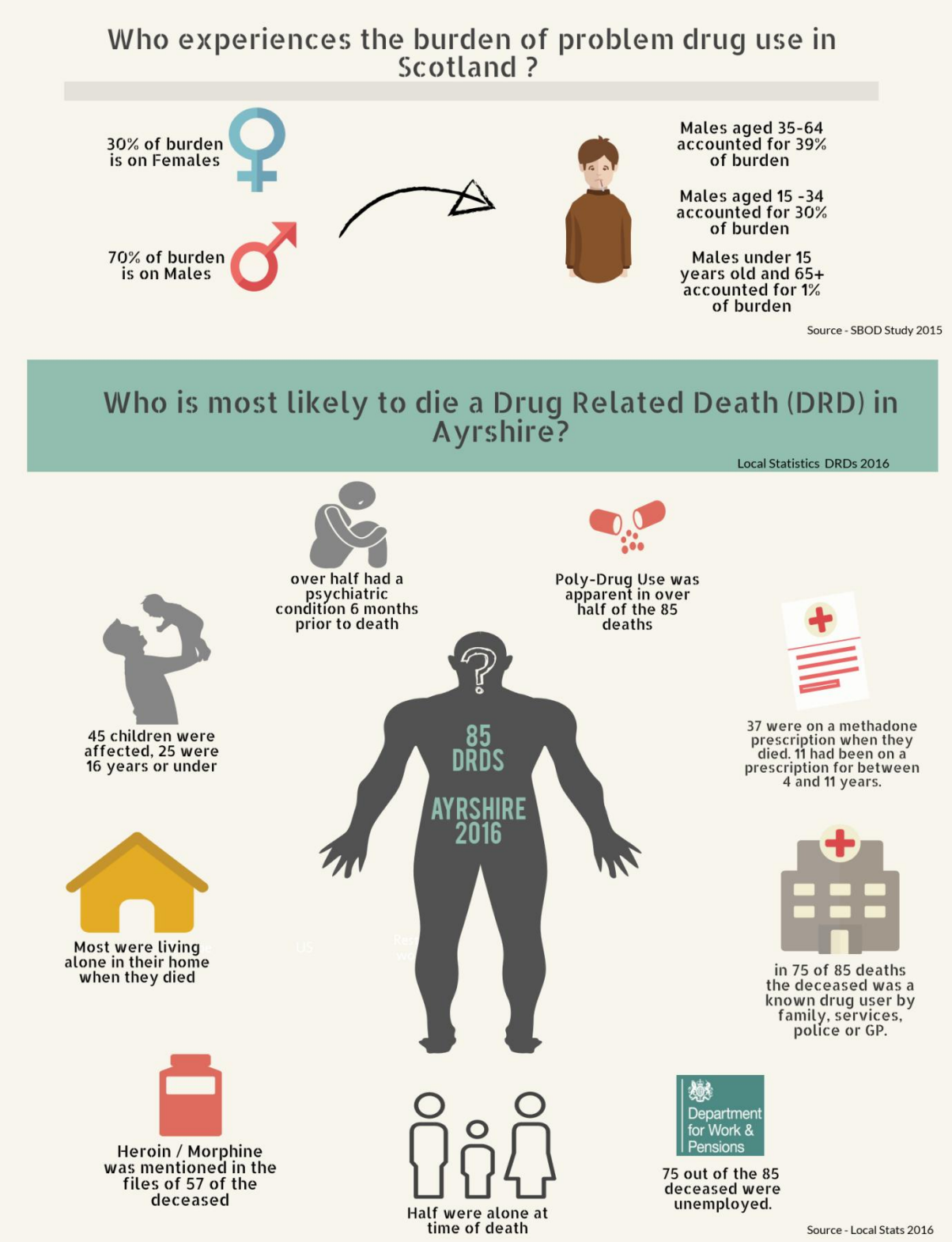
Preventing Drug Use

Reducing supply of illegal drugs

Getting it right for children affected by parental substance misuse

Promoting Recovery

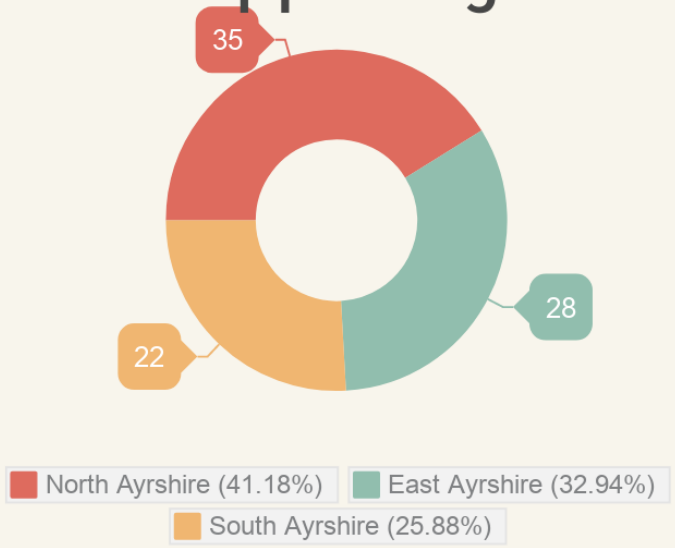
Although only small numbers of people living in Ayrshire and Arran have problematic drug use sadly this carries significant risks of health harms. The circumstances surrounding every death are already carefully scrutinised and collated. The central messages we have learned are shown below.



Across Ayrshire and Arran as a whole, from 2009-2014, 54% of people who died had an underlying medical condition recorded in the six months prior to death. This is broadly similar to the picture seen in Scotland. Deaths among people with

problematic drug use in Ayrshire and Arran are occurring in a slightly older age group than in the past and they commonly have underlying medical problems. The most common age group affected is 35-44yrs of age for both men and women.

Where are Drug Related Deaths happening?



In 2016, North Ayrshire had the highest number of Drug Related Deaths, South had the lowest and East fell between the two.

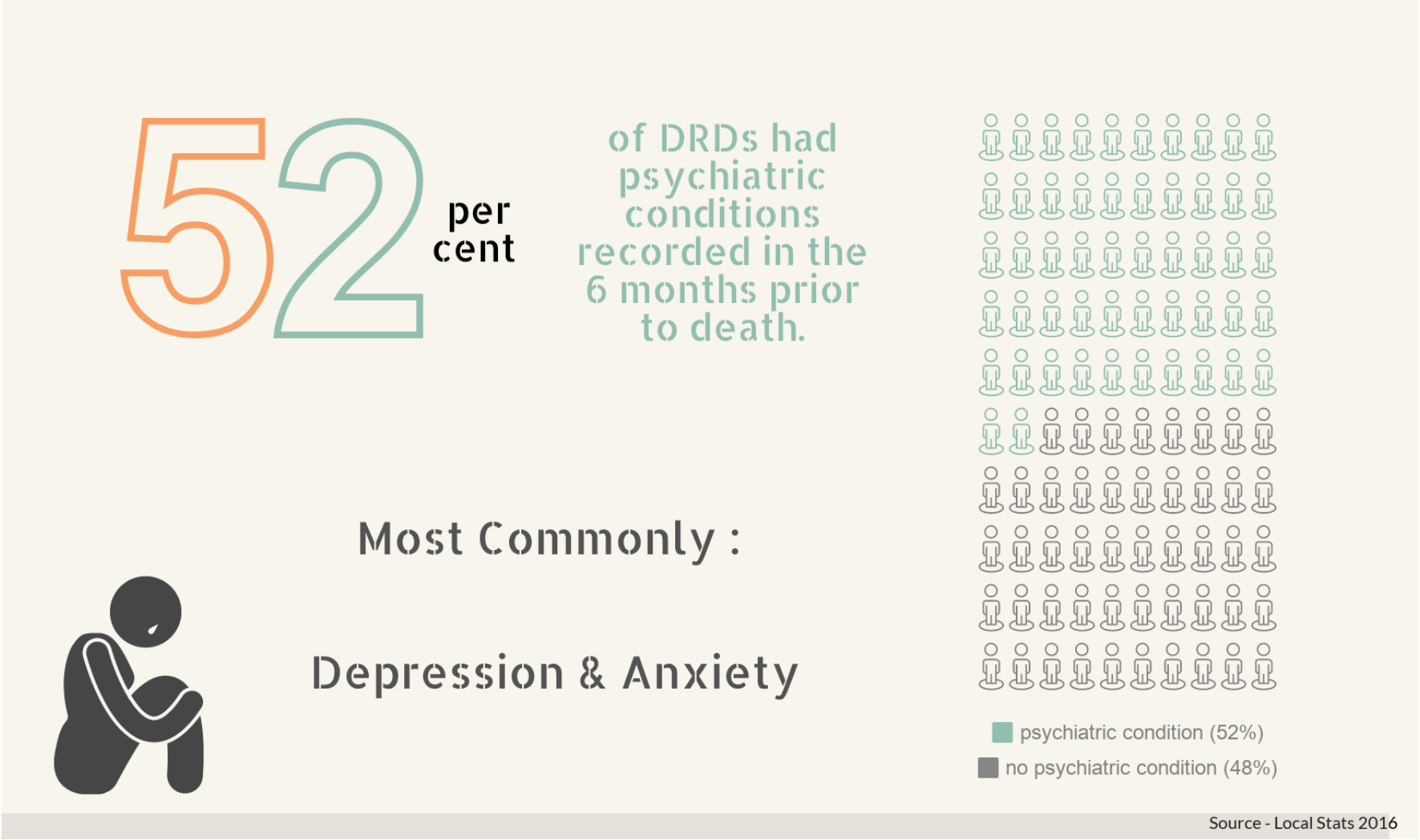
Drug Related Deaths & Gender

Male DRDs have been consistently highest in North Ayrshire and lowest in South over the last decade however East and South have seen the greatest relative increase - rates doubled over the last decade.

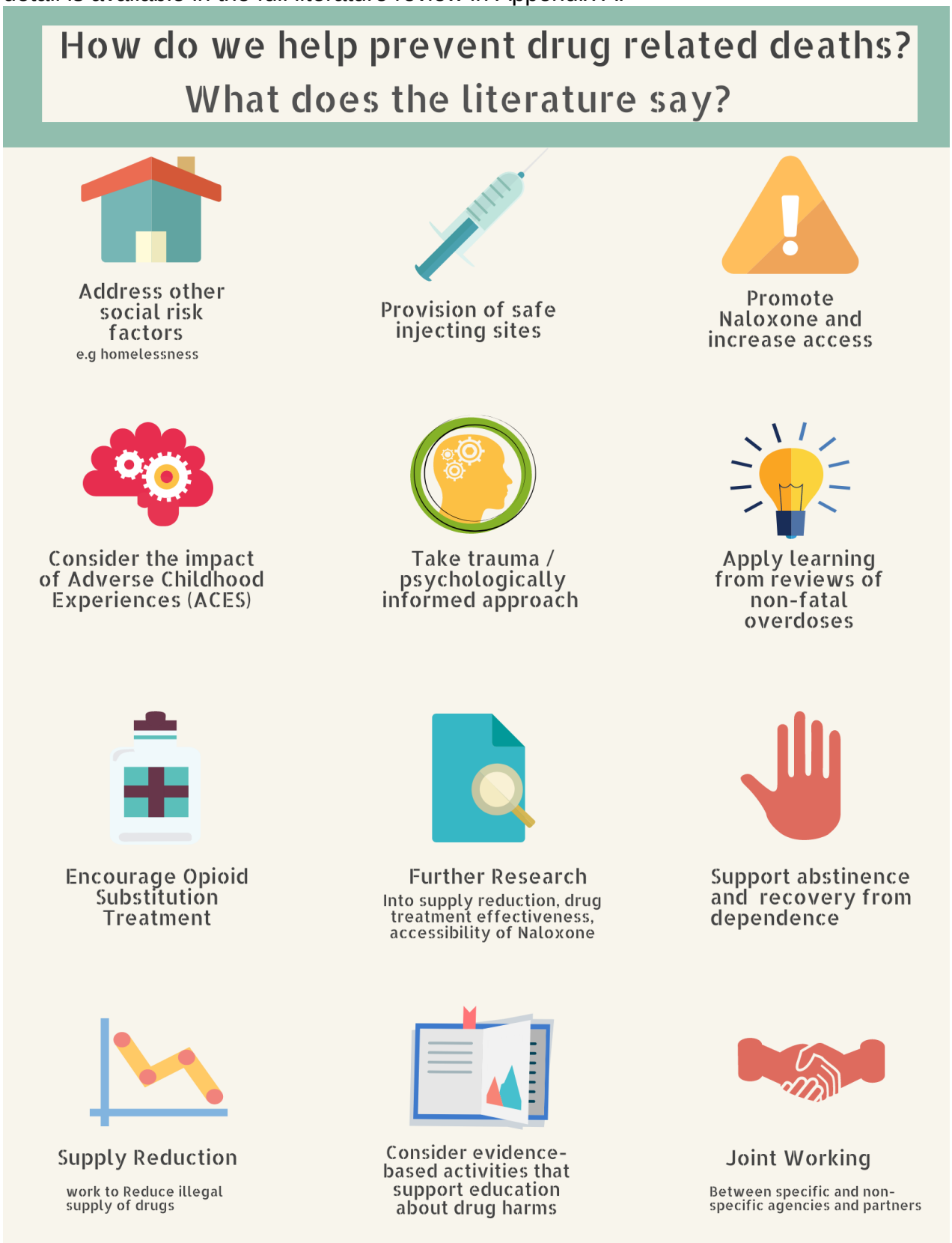
The rate of Female DRDs in Ayrshire has risen over the past decade, steadying over the most recent time periods

Source - Local Stats 2016

Across Ayrshire and Arran as a whole, from 2009-2014, 52% of people who died had a psychiatric condition recorded in the six months prior to death, with the most commonly recorded being depression and anxiety.



The central messages from our review of the literature describing the interventions that are likely to prove most effective are captured in the infographic below, further detail is available in the full literature review in Appendix A.



We know that in Ayrshire and Arran there are still a substantial number of people who die who are not in contact with specialist services at the time of their death. This

is slightly higher than the national findings. For Scotland as a whole, 36% of people who died had no contact with specialist services compared to between 39 and 44% for East, North and South Ayrshire.

Our local findings broadly agree with the wider literature. Further detail can be found at Appendix A, at the end of this framework document.

A Framework for Ayrshire

Strategic Aims

Through discussion at our joint conference we identified four key areas for action which together will strengthen protection of people at risk of drug related deaths. Running through each of these areas is our overarching vision of developing strong, trusting relationships between people with problematic drug use, their families, the wider community and all statutory services. We recognise the central importance of breaking the cycle of harm from problematic drug use that damages current and future generations. Evidence from the literature describes the importance of ensuring our services are 'trauma-informed', recognising the impact of earlier adverse events on the lives of people with problematic drug use and this theme was also identified during our conference.

<u>Caring for people in contact with services</u>

Everyone who has problematic drug use should have the same opportunities to access support from specialist services as a matter of fairness. The Quality Principles of care and support[3] set out the approach expected across all services. In addition, each local Prevention group will consider the local actions necessary to meet the priorities listed below.

- People with problematic drug use will access specialist, barrier free support as quickly as possible
- Services should be delivered as locally and flexibly as possible, taking care to use inclusive language especially for people seeking to re-engage with services (who may be described as 'closed' cases).
- Services will prioritise those at greatest risk, making contact with those at highest risk quickly. This approach will be take whether people have previously been known to services or not
- Services will maximise the strengths and assets of individuals, their families and the wider community to enhance recovery through the use of trauma informed approaches and recovery communities
- Families will be appropriately involved in care and recovery plans
- Communication between different services, those who access services and families will be strengthened using information protocols where appropriate
- We will work to support recovery in the community through meaningful activity
- We will work to reduce stigma and isolation of people in recovery
- People with Lived Experience (peer workers) will have a central role strengthening links between services, communities and people with problematic drug use

[3]The Quality Principles: Standard Expectations of Care and Support in Drug and Alcohol services http://www.gov.scot/Publications/2014/08/1726

Reaching people not in contact with services

We will maximise the opportunities to link people with problematic drug use to specialist services. Contact with specialist services is known to protect people with problematic drug use from dying. A significant proportion of people who die in Ayrshire and Arran are not in contact with specialist services. The need for strong, trusting relationships between services and people with problematic drug use was highlighted during our conference. These relationships are essential before we can reach everyone with problematic drug use. Local Prevention groups will work to ensure:

- Links will be strengthened between specialist services, wider services and families, so people with problematic drug use are identified and supported to gain rapid access to specialist support

- A range of interventions, including peer support or befriending, will be available. We will reach out to those not yet ready to make changes, testing assertive outreach approaches

- Flexible outreach approaches will be tested to ensure basic needs such as food, housing and non-judgemental support are met. This might include community cafe models and ‘Housing First’ for those with complex needs who are also at risk of homelessness

- We will develop local awareness among non-specialist services such as housing, fire, DWP and general health services (for example General Practices), exploring the use of routine enquiry

- There will be clear and rapid referral pathways across services for people seeking specialist support. Transitions between services will be strengthened ensuring no gaps in communication

- We will work to reduce stigma across agencies and communities.

<u>Reducing risk</u>

People who have experienced overdose are at increased risk of a drug related death and this is a key moment when rapid intervention can provide protection. Once again during our conference discussions the central theme of trusting, strong

relationships between people affected by problematic drug use and the services which support them was highlighted. Peers can play a pivotal role. Local prevention groups will work to ensure:

- People who have experienced overdose are identified (by all services) and prioritised for support, engagement and intervention
- There are clear referral pathways to specialist services for people who have overdosed. These will be developed using data from A&E and first responder agencies. Referral pathways from A&E into the concerns hub will be strengthened
- Information sharing protocols between services should be developed using learning from other parts of Scotland as a template. We will analyse the patterns in near-miss overdoses to identify opportunities to intervene
- People who have experienced overdose and their families should be offered training and support in how best to protect themselves using naloxone
- We will work to expand the role of peers to link and work with those at highest risk of drug related death.

Working with Families and Communities

Families and communities have an important role to play, and should be part of the local network of strong, trusting relationships wherever possible. Families can provide essential support for individuals with problematic drug use, depending on individual

circumstances. Families and children can feel overwhelmed and are not always aware of the support that is available to them through individual agencies. Our communities can provide a supportive environment but stigma and isolation remain challenges which we will continue to address.

- Families should have the opportunity of inclusion in all aspects of support where agreed with the person receiving treatment
- Links will be strengthened between services and families appropriate to individual circumstances
- Families and children should receive support for their own resilience through education, peer support, awareness of their own health and services that are available
- Bereaved children and families should receive tailored, sensitive support
- Work should continue to tackle stigma and isolation of children and families in the community

The Ayrshire Strategy

Caring for people in contact with services

Trauma informed services

Right treatment Right time

include families, peers and communities

Reaching those not in contact with services

Range of options from befriending to service involvement

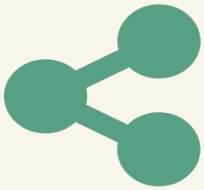
Outreach policy for those not yet ready to engage with services

Consider those at risk of homelessness

Reducing Risk

Those who have previously overdosed and may be at higher risk of DRD should have flexible, accessible support

Clear referral pathways for those who have overdosed



Develop and implement Information sharing protocols

Working with Families

Involvement in recovery

Support resilience and care for families

relationships and support

Next Steps:

We will seek endorsement of this strategic framework from the NHS Board, CPPs and IJBs in each area as quickly as possible.
We will task local multi-agency prevention groups to identify actions for the priority areas described in this framework. This will include detailed agreement on future service requirements.

We will monitor the progress of each local prevention group through the area ADP.

The Pan-Ayrshire group will coordinate responses which require a 'once for Ayrshire' approach. This will include agreeing information sharing protocols, public messaging, analysis and oversight of trends and pressures across agencies.

This framework will be revisited by a small working group to ensure key actions from the future national strategy once published & any new recommendations are considered.

Appendices

Appendix A: Literature review

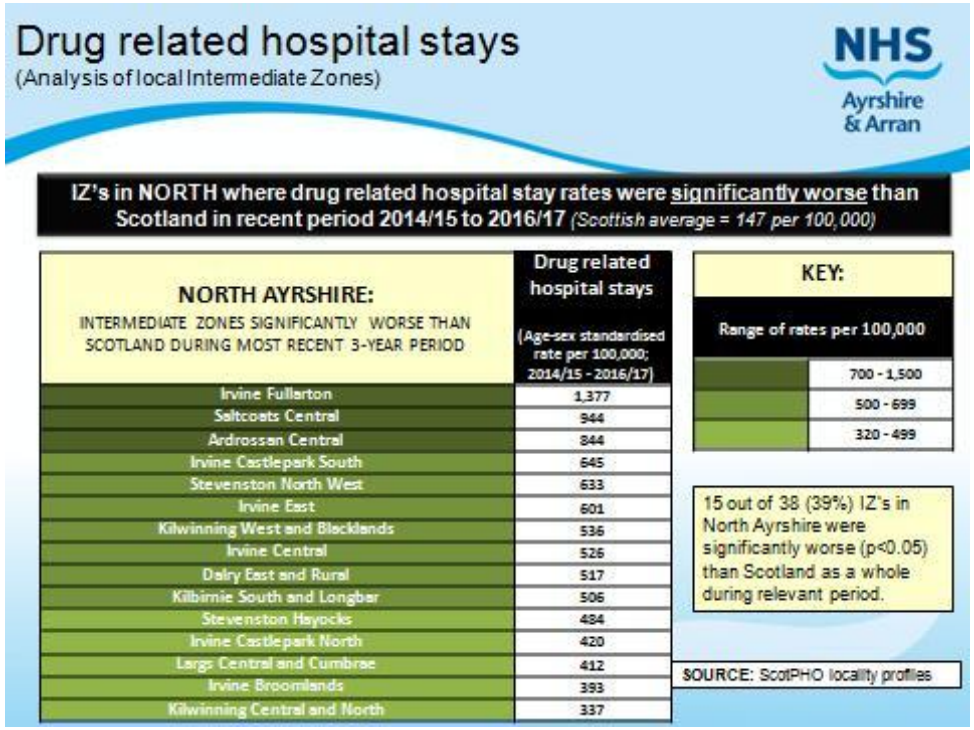

DRD literature review.docx

Appendix B: Emergent themes from conference


Emerging Themes.docx

Appendix 2

Drug related hospital stays – North



NORTH AYRSHIRE
Health and Social Care Partnership

Agenda Item 9

Integration Joint Board
21 June 2018

Subject:	**Strategic Planning, Commissioning and Delivery of Health and Social Care Services within Ayrshire & Arran**
Purpose:	(i) To provide a conclusion on the 2017 review of arrangements for planning, commissioning and delivery of health and social care services in Ayrshire and Arran; (ii) to present proposals to address the findings from the Review of the Integration Scheme between North Ayrshire Council and NHS Ayrshire & Arran in respect of lead partnership arrangements; (iii) to seek agreement for the next steps in respect of Fair Share commissioning within the Ayrshire and Arran Health and Care system, and ; (iv) to outline future development in respect of "Directions" as the Model provided by the Public Bodies (Joint Working)(Scotland) Act for Integration Joint Boards to commission services from the Council and NHS Board.
Recommendation:	(i) To note summary of findings from the first stage of the review of the North Ayrshire Integration Scheme; (ii) To agree the proposals for the transfer of management arrangements for community AHP services as detailed in paragraph 25; (iii) To agree the proposals for the implementation of the model to align financial and usage in Pan Ayrshire Mental Health Services as detailed in paragraphs 27 to 30; (iv) To agree the proposal to align the management of the Pan Ayrshire Family Nurse Practitioner Services with lead professional partnership with South Ayrshire HSCP in paragraph 31; (v) To note the report was considered and agreed by NHS Ayrshire & Arran Board meeting on 25th June 2018; (vi) To note a similar report will be presented to East and South Ayrshire Councils on 28th June 2018; (vii) To note reports were considered and approved by East Ayrshire Integration Joint Board on 13 June 2018.

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

1.	**EXECUTIVE SUMMARY**

1.1	On 28 June 2017 North Ayrshire Council considered and approved a report with proposals to review the arrangements for Planning, Commissioning and Delivery of Health and Social Care Services through a review of the Integration Scheme between North Ayrshire Council and NHS Ayrshire & Arran.
1.2	NHS Ayrshire & Arran and East Ayrshire Council respectively, considered similar reports approving a simultaneous review to be carried out of the East Ayrshire Integration Scheme. South Ayrshire Council confirmed at the NHS Ayrshire & Arran Board meeting on 26 June 2017 that they did not wish to participate in the review at that time.
1.3	A further report was presented to North Ayrshire Council on 4 October 2017 to consider the findings from the review of the Integration Scheme between North Ayrshire Council and NHS Ayrshire & Arran and to consider the next steps.
1.4	The overall conclusion in relation to the North Ayrshire Integration Scheme is although stakeholders identified issues that require to be addressed and changes that would be desirable, it is not evidenced that it is necessary to change the Scheme at this time. It was proposed that any further consideration of change to the Integration Scheme be held in abeyance until further work is undertaken.
1.5	Council at the time agreed to receive a future report on the outcome of this work and this report fulfils that commitment.
2.	**INTEGRATION SCHEME**
2.1	The Public Bodies (Joint Working) (Scotland) Act 2014 is the legislation that provides the framework for the integration of local authority social care services with community health services. An Integration Scheme is the Partnership agreement between the Council and NHS Board to establish an Integration Joint Board (IJB) for their local area.
2.2	During 2014/15 NHS Ayrshire & Arran and the three Ayrshire Councils took a partnership and pragmatic approach in developing the management arrangements to support delivery of the Integration Schemes. The default position in line with the intention of the legislation was when services could be delivered locally they were delegated to individual IJBs. It was recognised that for some services, predominantly but not exclusively in the NHS, there was good professional and clinical / financial governance reasons for services to remain on a pan Ayrshire basis. “Lead Partnership” arrangements were established for this function where one HSCP provides management and leadership on a pan Ayrshire basis.

2.3	The IJBs are required to develop and publish a Strategic Plan. This requires to express the ambitions for Health and Social Care Services over the period of the plan and the commissioning arrangements to deliver within the available resources. All three Partnerships developed initial Strategic Plans to cover the first three years of operation, 2015/18. As all three partnerships were developing the second three year Strategic Plans for 2018/21, an opportunity was also taken to review the Integration Scheme and associated management arrangements. It was also agreed that opportunities to consolidate to a single pan Ayrshire IJB should be explored.
3.	**INTEGRATION SCHEME REVIEW – CONCLUSIONS FROM STAGE ONE AND FINDINGS**
3.1	Through the legislation a three stage process was required before a single pan-Ayrshire IJB could be created: • Firstly, separate but simultaneous reviews of each Integration Scheme; • Following consideration of the consultation findings, a new Integration Scheme would be prepared for further consultation. This would be subject to the same extensive consultation process; • If the intention was still to move to a single IJB, Scottish Ministers would hold a final consultation.
3.2	A stage one process considered whether any changes to the scheme are "necessary or desirable". Agreement was reached by the two parties to the Integration Scheme; North Ayrshire Council and NHS Ayrshire & Arran in June 2017 with confirmation with Scottish Government that a programme of consultation would commence between July and August 2017.
3.3	The consultation questionnaire focused on considering whether there was a case for change to the Integration Scheme and in particular addressed all sections of the Scheme detailed below. In addition, a specific question was included to assess whether respondents felt that the review was 'necessary or desirable' as detailed in section 44 of the Public Bodies (Joint Working) (Scotland) Act 24. • Governance • Scope of Services- Lead Partnership • Strategic Commissioning Plans and Locality planning • Performance reporting and National Health and Wellbeing Outcomes • Health and Care Governance • Workforce • Finance • Participation and Engagement • Data Sharing
3.4	Following the consultation period and consideration of the findings in discussion with the Scottish Government Integration Team, it was concluded by the parties the review had not evidenced the necessity to change the Scheme at this time. It was agreed that any further consideration of change to the Integration Scheme is held in abeyance until further work on the issues below are addressed.

3.5	The first stage review process confirmed a number of areas that required to be addressed in order to improve planning, governance and delivery of Health and Social Care Services in Ayrshire. These include; • **Collaboration across Ayrshire** has demonstrated strong alignment across all three Ayrshire Partnerships in developing the Integration Schemes and Lead partnership arrangements. The arrangements are however complex, human resource intensive and can be slow in decision making; • **Decision making** being made by one IJB which impact on the other two IJB's without due regard or consultation with the other areas. This is particularly exacerbated in relation to lead partnerships;
	• **Financial Governance -** The arrangements for financial accountability between IJB's in relation to Lead Partnership arrangements requires review, there is potential for conflict over budget setting, detrimental impact of decision by IJBs and overspends; • **Performance Governance -** Legislation requires that decisions made by an IJB that have an impact on neighbouring IJBs require to be consulted upon. In the Ayrshire Lead Partnership model this is even more evident as decisions made by a Lead Partnership IJB have direct impact on services in other Ayrshire IJB areas and on Acute. These issues are not limited to lead partnership arrangements and can include strategic service and finance decisions of an IJB that impact adversely on residents of another area; • **Financial Context -** On an annual basis the IJB's are required to agree that the finance available from NHS/Councils is sufficient to deliver on the Strategic Plan. With increasing demand and restrictions on public sector funding, this is increasingly difficult. This presents a risk to early intervention and preventative services.
3.6	In terms of addressing these issues the review has identified that the full powers of the current Integration Scheme have not been utilised and there is further scope to take action within the current arrangements. In terms of evidencing the necessity for change, Scottish Government would anticipate the full powers being exhausted in respect of the requirements of the Act in relation to Directions.
3.7	The overall conclusion in relation to the North Ayrshire Integration Scheme is although issues were identified by stakeholders that require to be addressed and changes that would be desirable, further work was required to address the issues raised from the Review utilising the full powers within the Integration Scheme.
4.	**PROGRESS IN THE PLANNING, GOVERNANCE AND DELIVERY OF HEALTH AND SOCIAL CARE SERVICES IN AYRSHIRE**
4.1	**Financial Governance** In December 2016 Finance Officers met to consider and develop proposals for future funding of Ayrshire Health and Social Care Partnerships and to do so within the context of the provisions in the Integration Scheme. The focus included :- • process for reaching agreement on the funding,

	• the process of dealing with an in-year variation with Lead Partnership funding arrangements, and • the transition to the HSCP budgets reflecting "fair shares" for the resourcing of lead partnerships.
4.2	In considering the proposals from the Finance Officers report and the findings from the consultation on the Integration Scheme review it was agreed this would be an advantageous time to consider this aligned with the Partnerships developing second three year Strategic Plans for 2018/21.
4.3	The findings from the consultation identified that arrangements have been working well between Integration Scheme parties with strong alignment established across Ayrshire. The review also identified issues in relation to differentials across lead partnerships in level of activity and financial contributions across IJBs, i.e. one partnership may be contributing more or less financially than the activity it consumed in a particular area. It is proposed to address this anomaly.
4.4	It is proposed commissioning arrangements in respect of Lead Partnership arrangements over a three year period will be determined on an NRAC basis. Funding delegated to each IJB will be the NRAC allocation for that service. Remuneration to the Lead Partner will be based on level of activity stepped over the three year period. This same methodology can be applied to the commissioning of the "Set Aside" budget in Acute Services.
4.5	The NRAC formula determines funding due to NHS Boards and IJBs reflecting age, sex, morbidity and life circumstance demographics for services including Mental Health and other Lead Partnership Services.
4.6	Actual costed activity across each Partnership for the current year and previous three financial years would be established where possible. The format of any proxy activity data for Lead Partnership or Set Aside Budget Service will be agreed between all parties.
4.7	An illustrative example is set out below. From this both the East and North are currently using more of the service than the per the "Fair Share" calculations, South is using less than it would be entitled to.

	2015/16	**2016/17**	**2017/18**	**Average**		**Fair Share**		**Average vs Fair Share**
East	£11.0m	£12.0m	£11.0m	£11.3m	33.2%	£11.2m	33%	£0.1m
North	£11.0m	£13.0m	£15.0m	£13.0m	38.2%	£12.6m	37%	£0.4m
South	£12.0m	£9.0m	£8.0m	£9.7m	28.6%	£10.2m	30%	-£0.5M
TOTAL	£34.0m	£34.0m	£34.0m	£34.0m	100%	£34.0m	100%	£0.0m

4.8	Based on the example above it would be proposed to agree a mechanism and timescale to bring East and North activity and costs back down to "Fair Share" levels. This plan would be detailed in Strategic Plans. Individual partnership contributions

	would continue to be based on a 3 year rolling average of service use with a budget managed by the Lead Partnership.
5.	**LEAD PARTNERSHIP ARRANGEMENTS**
5.1	In considering the review finding of Lead Partnership an opportunity has been taken to reflect on experience of the past three years and proposals developed for changes in management arrangements that, whilst maintaining collaboration and professional governance, seek to clarify decision making and performance/financial governance.
5.2	**Mental Health Services** It is recognised over the past three years there are differentials across Partnerships in respect of the level of use within pan Ayrshire mental health services and at present there is no mechanism in place to bring alignment between financial commitments with usage.
5.3	Work has already started to identify historic and current activity for Mental Health services. A model to align financial investment and usage over a three year rolling review, looking at marginal and variable costs recognising all three Partnerships will still be required to contribute to fixed cost elements, is proposed.
5.4	It is proposed mental health is utilised as the initial example of this commissioning model, Unscheduled Care/Set Aside also requires similar consideration but is more complex, and will benefit from the learning in mental health. Other areas will be looked at in future including community equipment services and urgent care services.
5.5	**Allied Health Professionals (AHP)** In considering the review finding of Lead Partnership an opportunity has been taken to reflect on experience of the past three years and proposals developed for changes in management arrangements that, whilst maintaining collaboration and professional governance, seek to clarify decision making and performance / financial governance.
5.6	The initial arrangements for AHPs were developed at a time when the service had undergone a period of change. It was agreed that, although Community AHP services were delegated functions to IJBs, that they would remain not only with leadership in South Ayrshire but also management accountability. This was in contrast to other delegated services of this scale such as Community Nursing, Community Mental Health services, where core services are managed within each partnership.
5.7	Over the past three years, management arrangements have been developed that see AHP services for each partnership managed under a dedicated senior manager for the partnership.
5.8	As part of the implementation of the findings from the consultation it is proposed to devolve current Pan Ayrshire arrangements for both budget and management of Senior Managers AHP to Partnerships for services delivery within Partnerships. Professional accountability will remain to the Associate Director of Allied Health Professionals and ultimately the Executive Nurse Director.

5.9	As with all Lead Partnership arrangements there are a few smaller specialist services that will remain within Pan Ayrshire arrangements. In addition to align the new arrangements with patient activity, it is proposed that Acute AHP services in Crosshouse Hospital are managed through East Ayrshire, Ayr Hospital through South Ayrshire and Woodland View through North Ayrshire. Professional leadership will remain with Pan Ayrshire AHP Lead.
5.10	This is in line with the Public Bodies legislation which defined a number of services in categories of 'must', 'may' and 'must not' delegate, from Councils / NHS Boards to IJBs. Community AHP services are one of the services defined by legislation as a 'must' to delegate to IJB's. Acute AHPs are a "may" delegate. The proposals outlined above are therefore a change in management arrangements directed through IJBs and the NHS Board rather than a change to the Integration Schemes.
5.11	**Children's Services** Each Partnership have an Associate Nurse Director aligned with a designated pan Ayrshire Professional Lead for Children's Services (South), Primary Care and Community Nursing (East) and Mental Health (North). It is proposed to align the management of the pan Ayrshire Family Nurse Practitioner Services currently managed in North Ayrshire to South Ayrshire professional lead arrangements.
5.12	**Telehealth and United for Health and Smartcare European Programme**
	South Ayrshire HSCP was designated as the Lead Partnership for Telehealth and United for Health and Smartcare European Programme (TEC) services as HSCPs were established. In the intervening period the service has been successful in developing a wide range of innovative solutions to support people's care. However, given the size of the team it has been difficult to develop large scale models of care which can be applied across the wider system. In April 2018 the Scottish Government published the Digital Health and Care Strategy which describes an ambitious agenda for the development of digital health and care services over the coming years. In order to achieve the full potential of digital approaches within the context of the strategy it is now proposed to combine the TEC team within the NHS eHealth Service. It is anticipated that this larger service will be more able to effectively harness TEC innovation and bring it to scale. The new service will be renamed Digital Services and will be managed as a Lead Partnership within the NHS Corporate Support Services Directorate.
5.13	**Primary Care Services** Lead Partnership arrangements for Primary Care services are coordinated and managed through East Ayrshire IJB. The national contract for GP services was approved in January 2018 and work is underway to develop the Primary care Improvement Plan by 1st July 2018. The level of joint working to develop the Primary Care Improvement Plan is evident and supports the balance between lead partnership and local aspirations.
5.14	Primary Care contracting arrangements within legislation are a 'must not' delegate and remains the duty of Health Boards to oversee the contractual arrangements. Revenue associated with funding General Medical Services are detailed by Scottish

	Government to G.P. practice level and similarly Primary Care Prescribing and Family Health Services budgets are detailed to Partnership level for reporting and planning.
6.	**FINANCIAL AND PERFORMANCE GOVERNANCE – DIRECTIONS**
6.1	Financial and Performance Governance arrangements in Lead Partnerships were identified as requiring improvement. Within Ayrshire arrangements in respect of Chief Executive and Director level meetings are in place to assist with this process with a number of Pan Ayrshire Programme Boards established to coordinate implementation.
6.2	On consultation with the Scottish Government reference to the powers within the Public Bodies Act which sets out the mechanism for Integration Joint Boards to action their strategic commissioning plans, and this is laid out in sections 26 to 28 of the Act. This mechanism takes the form of binding directions from the Integration Authority to one or both of the Health Board and Local Authority and should be fully utilised.
6.3	The Scottish Government Good Practice Note on Directions, issued in April 2018, clearly sets out that in the case of an Integration Joint Board (IJB), a direction must be given in respect of every function that has been delegated to the IJB. Where the lead agency model is used, the Integration Authority *may* issue directions or may carry out functions itself. In either case, a direction must set out how each integrated health and social care function is to be exercised, and the budget associated with that.
6.4	All three Ayrshire Partnerships use directions however there is no consistency on how directions are implemented within pan Ayrshire arrangements and the current use does not reflect the detail in the Act or the recently issued Good Practice Note.
6.5	In order to comply with the requirements of the Act directions must be in writing and should set out a clear framework for operational delivery of the functions that have been delegated to the Integration Authority. A new form of directions will be required to be developed within Ayrshire in support of the Act.
7.	**IMPLICATIONS**

Financial:	Strategic Planning for Health and Social Care requires to be delivered within the resources available and take cognisance of public sector funding limitations. The proposals seek to support arrangements that match local and national aspirations for positive health and wellbeing within the delegated resource. Transformation Plans and Medium Term Financial Plans have been developed to address the projected financial shortfall in public funds. Working together across Health Boards, Councils and Integration Joint Boards are the only real way of delivering positive wellbeing including health and social care for local communities.

Human Resources:	Human resource implications arising from this report will be consulted on as part of established staff partnership and trade union arrangements. The alterations to the management arrangements seek to ensure integration of local services and opportunities to further develop multi-disciplinary working at a partnership level.
Legal:	The review of the Integration Scheme is in compliance with the Public Bodies (Joint Working) (Scotland) Act 2014 and associated Regulations and Guidance.
Equality:	A core purpose of the Integration of Health and Social Care is to mitigate the impact of inequalities for individuals and communities. The proposals within the report seeks to align financial resourcing of Lead Partnership services with the recognised national benchmark of NRAC that includes consideration of proportionality in relation to deprivation and need and provide opportunities to develop local services in line with Strategic Planning.
Children and Young People	N/A
Environmental & Sustainability:	N/A
Key Priorities:	ADD KEY PRIORITIES.
Risk Implications:	There is a risk that the arrangements within the current Integration Scheme to address the issues outlined in the review do not deliver improvements in outcomes for communities in North Ayrshire. Progress will be monitored and reported to IJB, Council and NHS Board.
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	

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

NORTH AYRSHIRE
Health and Social Care Partnership

Agenda Item 10

Integration Joint Board
21 June 2018

Subject:	**Arran Services Integrated Hub**
Purpose:	To provide an update to the Integration Joint Board on the Arran Services Integrated Hub.
Recommendation:	The Integration Joint Board is asked approve the Strategic Assessment for an Arran Integrated Hub and to begin work on the Initial Assessment.

Glossary of Terms	
NHS AA	NHS Ayrshire and Arran
HSCP	Health and Social Care Partnership
IJB	Integration Joint Board

1.	**EXECUTIVE SUMMARY**
1.1	The defined geographical area, advanced local integration blueprint and engagement of frontline teams on Arran presents an excellent opportunity to rapidly advance HSCP integration and new ways of working.
1.2	The development of a Health and Social Care Hub on Arran has been identified as a central requirement in the transformational change of care delivery that is necessary to meet future challenges.
1.3	Arran has a mix of estate with some modern facilities and some outdated buildings that are no longer fit for purpose. These have significant maintenance and refurbishment costs and include Arran War Memorial Hospital, Brodick Health Centre, Lamlash Medical Centre and Social Services offices.
2.	**BACKGROUND**
2.1	A NEW MODEL OF CARE IS NEEDED Reflecting national issues and an elderly population with high multimorbidity, there is already significant difficulty in meeting the need for health and social care on the island.
2.2	The high dependency ratio, shrinking workforce and the certainty of the demographic changes in coming years will have a profound impact on the demand for health, social and long-term care services. The current model of care is ill adapted to cope with this.
2.3	The Arran Review of Services 2015-16 led to a clear consensus on a future model of care. The review provided an overview of current services, need, challenges and opportunities. Detailed recommendations on delivering integration on the island were

	endorsed by the IJB in May 2016.
2.4	The aim is a genuine transformation with service user centred care delivered by a single, truly integrated team. This encompasses a very wide range of services and staff groups. It includes all primary care, community hospital, community health and social care teams, social work, residential care and administration teams. These services will be accessed through a single point of contact.
2.5	Several recurring themes arose in the examination of services on the island. There are a large number of small teams delivering care, these are often a small fragment of a larger Ayrshire service and are vulnerable to recruitment & retention issues and illness. There are multiple lines of management and little coordination of care between teams. The teams are geographically isolated with bases in different sites and significant time is lost to travel. There is much duplication of work and multiple records with repetition and little ability to share information between teams.
2.6	The Review identified key elements of a more efficient and sustainable service on Arran, including: • Single Management Structure • Single Team • Single Point of Contact • Single Care Record • Hub A Hub site is seen as crucial in two particular aspects.
2.7	Firstly, to meet predicted demand care must be efficient and cost effective. Crucial aspects to this on Arran include being able to reduce the costs of running and staffing multiple sites. Several significant opportunities exist here.
2.8	Secondly, developing a single integrated team is a core requirement of the plans. It will be a significant challenge to combine a disparate group of teams of varying sizes and differing cultures into an effective single unit. This is highly constrained by the current estates footprint and the associated geographical isolation, travel times, and communication limitations.
3.	**PROPOSALS**
3.1	<u>Initial steps</u> A draft accommodation schedule for an integrated hub on Arran is attached in Appendix 1. This proposes the rationalisation of the estate. Following the preparation of this it was agreed to follow SCIMP guidelines and produce a Strategic Assessment (Appendix 2). <u>Governance</u> A Project Steering Group has been established. Appendix 3 provides members of the Steering Group. The Group will meet on a monthly basis to progress the Initial Agreement and will report to the Joint Property Board which will act as the Project Board for the Steering Group. See Appendix 4 for outline of Governance arrangements.

	Workstreams The Project Steering Group will oversee the following workstreams • New model of care • Workforce • Design • Communication and engagement These will be key components of the Initial Assessment and detailed work in these areas has already started following the Arran Review of services. These plans are already at early implementation stage on Arran and will form the basis of the Initial Assessment. Timescales The Steering Group have already mapped the various processes that each organization – NAC and NHS need to have sight of the proposal for Arran. Once approved at these forums, the Strategic Assessment will need to formally approved at the NAC cabinet and NHS Board. Once approved the Strategic Assessment will be sent to Scottish Government. This approval process will be completed by August 2018. Following this process the following is an indication of timescales for next stages: • Initial Assessment – 8 months • Outline business case – 8 months • Full business case – 6 months • Construction Subject to agreement of the Strategic Assessment in August 218, the team will report back to IJB with a copy of the full Initial Assessment in February 2019.
3.2	**Anticipated Outcomes**
	It is anticipated that at the end of the process outlined above the Scottish Government will approve the Full Business case for an Integrated Hub on Arran. This will enable the outcomes identified in the Strategic Assessment – Appendix 2 to be delivered.
3.3	**Measuring Impact**
	The impact of such a facility on Arran will enable the outcome of the Arran Review to be fully implemented and delivered. This transformation of services on Arran will mean • The increasing elderly and complex care needs for residents on Arran will be met by a single fully integrated team, co located in the Hub • The team will be coordinated and managed via a single point of contact located in the Hub • People on Arran will be cared for in their own home or as close to home as possible • Care will be provided seamlessly and third and independent sector providers will be an integral part of how care is provided • Self care and independence will be a key component of the model

4.	IMPLICATIONS

Financial:	To facilitate this, and in line with the support offered to other such capital projects, it is proposed that the Steering Group should be awarded £50K to create the capacity required to deliver this work without further delay.
Human Resources:	There are no immediate implications for NASCP staff of this project.
Legal:	There are no immediate legal implications of this project.
Equality:	None
Children and Young People	None
Environmental & Sustainability:	Sustainability of health and social care services on Arran and the development of a suitable environment to provide services from are a key driver for the integrated Hub on Arran.
Key Priorities:	Providing integrated services is a key priority of the H&SCP.
Risk Implications:	There are major risks to the future sustainability of health and social care provision on Arran without a Hub.
Community Benefits:	Only applies to reports dealing with the outcome of tendering or procurement exercises.

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

5.	CONSULTATION
5.1	There has already been considerable work to engage with staff, public, key partners and community on Arran about service change. • Public /Community – there has already been significant engagement on Arran and further early engagement events are planned to take place on Arran starting in May and will be running until November. • Other partners - Ambulance and Dental- – have either been included in the membership of the Steering Group or early discussions have taken place on the intention to develop plans for an integrated hub. There has been a positive response to inclusion in the plan and further discussion and dialogue is taking place. This will include Police and Fire service on Arran.
6.	**CONCLUSION**
6.1	To approve the Strategic Assessment for an Arran Integrated Hub and to begin work on the Initial Assessment, the steering group also recommends: • To continue to progress the Strategic Assessment through the respective NHS and NAC governance structures. • Establish the workstreams set out above and begin development of the Initial Assessment. • To facilitate this, and in line with the support offered to other such capital

	projects, it is proposed that the case be made for the Steering Group to be awarded £50k to create the capacity required to deliver this work without further delay and that the CPMG will feedback on this in due course. • At the same time, agreement is sought to commission specialist expertise and support from South West Hub on no-commitment, speculative basis to support the design and delivery of further more detailed proposals. • Finally, it is recommended that NHS Ayrshire and Arran and North Ayrshire Council jointly conduct a site search to identify potential locations for the Hub.

For more information please contact: Ruth Betley, Senior Manager, Arran Services on 01770 601030 or Ruth.Betley@aapct.scot.nhs.uk

Arran Integrated Hub					
Proposed Draft Accommodation Schedule					
Generic Use/Cluster	**Room Name**	**No of rooms**	**Area (sqm)**	**Total (sqm)**	**Comments**
Public/General	Waiting Area (30 seats)	1	45	45	Combined for GP/Outpatients/In-patients/Hub
Public/General	Toilet Male	1	3	3	Main public toliets for Hub
Public/General	Toilet Female	1	3	3	Main public toliets for Hub
Public/General	Accessible Toilet	1	5	5	Main public toliets for Hub
				0	
Office	Reception (3 person)	1	13.5	13.5	Combined for GP/Outpatients/In-patients/Exisiting Montrose House Residentail Care/Hub
Office	Records	1	24.5	24.5	Small to Medium Size - hospital requires space for 2 years of records, minimal GP info (main GP records held off site at Shiskine) Guidance states 3.5m per GP (assumed 7)
				0	
Patient/Clinical	Consulting Rooms	7	14	98	Flexible use : for GP consulting/hospital outpatients/CPN
Patient/Clinical	Treatment Rooms	2	18	36	Flexible use : for GP consulting (minor surgical procedures GP / ANP's covering wide range of procedures)
Patient/Clinical	Lab Room	1	8.5	8.5	adjacent to Consulting and Treatment Rooms : to spin bloods/hold fridge/sluice
Patient/Clinical	Unscheduled Care 4 bay area	1	64	64	adjacent to Consulting and Treatment rooms - aim to have flexible use space where could also use for reablement. Base on BfBC 16.0m
Patient/Clinical	Inpatient beds individual rooms with en-suite	10	20	200	In-patient beds - aim to have flexible use of beds to be able to use as day case beds in addition to in-patient area. All bedrooms are sized the same i.e. No larger bedrooms?
Patient	Accessible Toilet	1	5	5	in unscheduled care area for day patients
Office/Clinical	Nurses Station	1	10	10	next to in-patient area
Office/Clinical	Duty room	1	10	10	next to in-patient area
Office/Clinical	GP doctor of the day Office	1	12	12	next to in-patient area
Patient/Clinical	Accident & Emergency/Resus Room (2 bays)	1	60	60	consider requires ambulance access / and vicinity to reception
Patient/Clinical	X-Ray	1	80	80	adjacent to A&E. This may seem large, but includes X-ray room, Waiting area,viewing room & reception
Patient/Clinical	Physio Treatment Area/Gym/Reablement Area	1	60	60	Based on a 15 place area - approx 6.5 per place
Clinical	Preparation Room	1	15	15	to accommodate drugs storage and bloods fridge. I have assumed that this is the same as a clean utility room, as it has the same function.
Clinical	Sluice	1	12	12	
Clinical	Clinical Waste	1	12	12	uplift from mainland only every fortnight
Clinical	Ward food prep area	1	15	15	Ward Kitchen Food Prep Area for patients/food supplements etc
Patient	Day Room	1	30	30	for inpatients . Depnds on use and how may this has to accommodate, for the npurposes and to be consistent I have assumed 15
Patient	Linen/Laundry Store	1	5	5	piece of work being undertaken by Clinical Support Services and Ken Campbell, NAC to scope capacity of current set-up at Montrose House.

Patient/Clinical	Mortuary	1	40	40	occupancy for 6, Includes Mortuary, Viewing Area and Relatives Room
Patient/Clinical	Chapel/viewing Area/multipurpose	1	20	20	adjoining mortuary to provide viewing area
Patient/Staff/Visitors	Kitchen	1	25	25	piece of work being undertaken by Clinical Support Services and Ken Campbell, NAC to scope capacity of current set-up at Montrose House - hope to be able to utilise for all. Roughly 1.5m per staff member
Office/Staff	Porter/Handyman room	1	12	12	query what is existing at montrose house
Office	Multipurpose Open Plan Office	1	180	180	32 workstations : staff groupings who would utilise office are Senior Nursing and Management, Admin Team, GP team, Community Nursing Team & AHP's, Social Work and Care at Home Team. Equates to headcount of 52 with WTE of 42.24. 32 workstations calculated on basis of 7.5 desks to 10 WTE as per Smarter Offices space plan ratio detailed in PAMs. NB Also need space within open plan office to site photocopier/shredder.
Office	Single Point Of Contact Office	1	12	12	to house 4 workstations
Meeting Space	Large Meeting Room	1	60	60	to accommodate 30 people, to have ability of being partitioned into 2 or 3 smaller areas
Meeting Space	Breakout rooms	2	12	24	sited off of multipurpose open plan office each to have capacity to seat 4 people
Staff amenties	Dining Room and soft seated rest area	1	80	80	Staffing numbers for hub calculated as 111. Rough guide 44 of whom would be classed as Community based workers who would by nautre of work be out in Community majority of time. NB Figure of 111 does not include the existing 35 Montrose House staff who already have a staff room area - which woudl remain for them. Query what should reasonable and practical provision be?
Staff amenties	Female Changing area (predominately for hospital staff) with showers and toilets also to comprise lockers	1	40	40	? Alternative would be provide separate Female and Male showers with communal shared locker area. Predominately female workforce - exact split unknown. Depends on how many staff. Guidance for 20 states 58 m
Staff amenties	Male Changing area (predominately for hospital staff) with showers and toilets also to comprise lockers	1	40	40	? Alternative would be provide separate Female and Male showers with communal shared locker area
Bedroom accommodation	Relatives bedroom with en-suite	1	20	20	
Bedroom accommodation	For use by on-call personnel with en-suite	1	20	20	
Bedroom accommodation	Staff accommodation with en-suite	2	20	40	
Utility	DSR	1	12	12	
Utility	Comms Room	1	15	15	
Utility	Plant Room	1		0	Engineering space is calculated on 12% of total accommodation
Storage	See below for rationale			0	Currently considerable number of storage rooms/areas varying in size in hospital (see Note 1)

	Equipment Store (housing electrical re-charging equipment and nursing equipment - see note 1 below for detail	1	12	12	in vicinity of nurses station and in-patient bedded area
	PPE + Major Incident Store - see note 1 below for detail	1	12	12	in vicinity of nurses station and in-patient bedded area
	Nursing Store (A&E, In-patients and Out-patients) - 18 linear metres	1	36	36	
	Stationery and General Supplies	1	8	8	sited off of multi-purpose office area
	Oxygen Store	1	14	14	external access required
	Sub Total			1548.5	
	Circulation - 33%			511.0	
	Engineering - 12%			185.8	
	Partitions - 5%			77.4	
	Total			2322.75	

Note 1

Electrical equipment recharging room - floor space plus 6 linear metres of shelving

Nursing Equipment Store - large equipment such as portable hoists, syringe drivers on stands, sit on weighing scales plus 6 linear metres of shelving

Look to combine these 2

PPE store - 8 linear metres + COSHH flammable liquids large 2 door metal cupboard

MAJAX store - 18 linear metres + hanging rail

Look to combine these 2

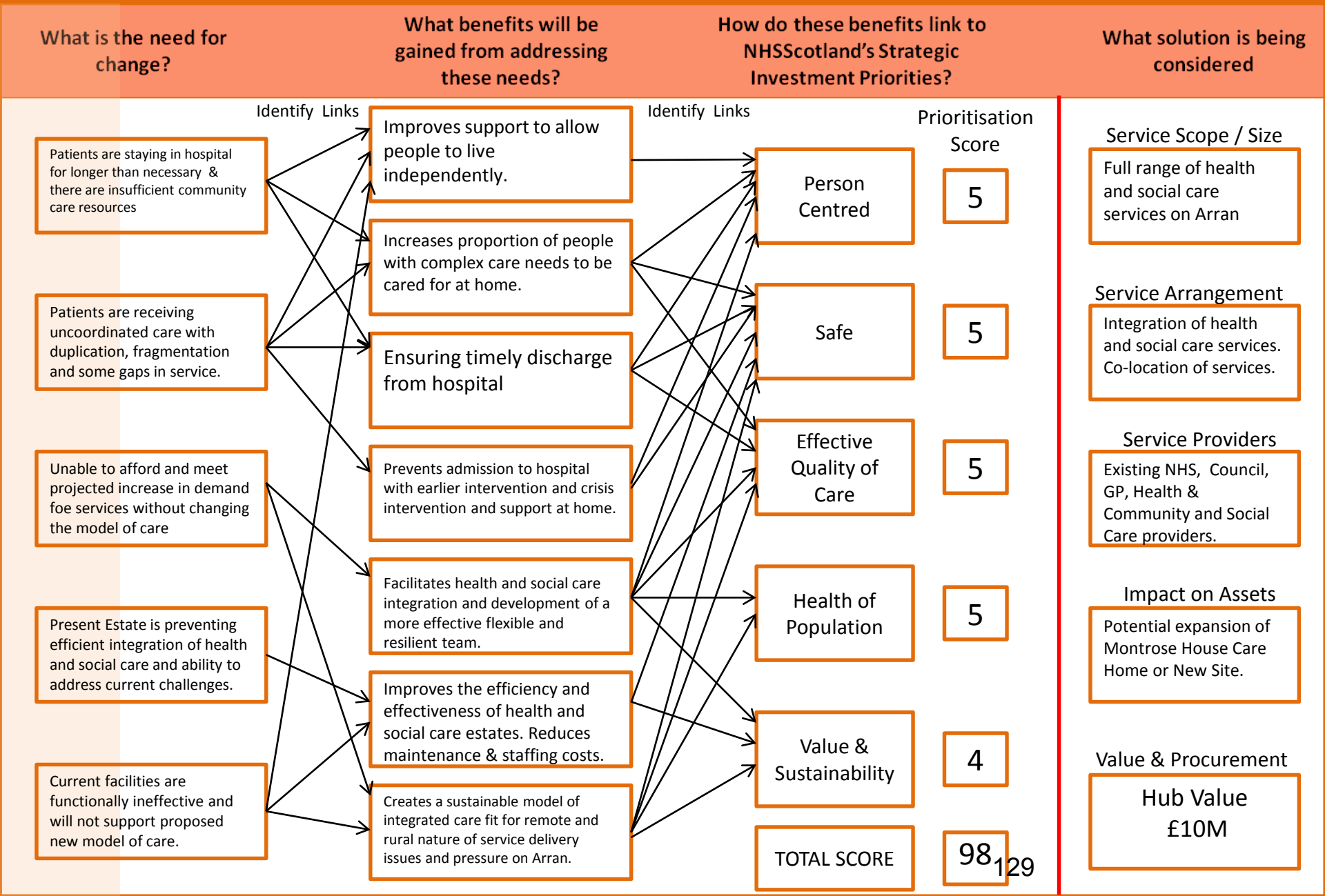
Nursing Store - (A&E, in-patients and outpatients) - 18 linear metres

Stationery and General Supplies

Oxygen Store - external

0

PROJECT: Arran Integrated Hub



Project Directory **as at 28 March 2018**

NHS Ayrshire & Arran **Review of Arran Clinical & Partnership Services** **Version 1**

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NHS Capital Project Governance

Scottish Government Capital Investment Group (CIG)

NHS A&A Board

Performance Governance Committee

Corporate Management Team (CMT)

NHS Board Chief Executive Group (BCE)

Capital Programme Management Group CPMG

NHS Transformation Project Governance

(TLG) Transformation Leadership Group

Strategic Planning and Operational Group (SPOG)

Joint Property Group NAHSCP

Directorate Project Boards (including joint accommodation board)

Project Steering Group

Operational Working Groups (as appropriate to project)

NAC Capital Project Governance

CPAG
(Capital Programme & Planning Asset Group)
Developing and delivering NAC's capital investment programme.

NAC Cabinet
Approval of strategic AM decisions

Executive Leadership Team
Corporate Decision-making body.

Strategic Property Asset Group
Coordinates asset management strategically and recommends to Executive Leadership Team

Finance & Corporate Support

Economy & Communities

Education & Youth Employment

Place

Health & Social Care Partnership

NORTH AYRSHIRE
Health and Social Care Partnership

Agenda Item 11

Integrated Joint Board
21st June 2018

Subject:	**Carer (Scotland) Act 2016 – Eligibility, Assessment & Waiving of Charges**
Purpose:	To seek ratification on the proposed Eligibility Criteria, Assessment paperwork and Waiving of Charges Statement in order that NAHSCP meet our duties under the Act.
Recommendation:	The Integration Joint Board are invited to note and agree the proposals in this paper which will change NAHSCP practice and promote more positive arrangements for supporting all carers.

Glossary of Terms	
NAHSCP	North Ayrshire Health and Social Care Partnership
GIRFEC	Getting it Right for Every Child
NCO	National Carer Organisations
Unity	Provider – Carers Centre in North Ayrshire
ACSP	Adult Carer Support Plan (Assessment for adult carer)
YCS	Young Carer Statement (Assessment for young carer)
E&EY	Education & Early Years Service
AYRshare	Multi agency client based system for children & families
RAS	Resource Allocation System
SSAQ	Supported Self Assessment Questionnaire (Adult Assessment for service users)

1.	**Introduction**
1.1	The Carers (Scotland) Act 2016 fully commenced on April 1st, 2018. Sections 21 & 22 outline the duties on each local authority to :- • set local eligibility criteria (allowing local authorities to prioritise support and target resources as effectively and efficiently as possible). • publish its local eligibility criteria and review of said local eligibility criteria.
1.2	This function is exercisable in relation to both adult and young carers requiring joint approval by the local authority and integration authority due to the functions agreed under the Integration Scheme.

2.	**Current Position**	
2.1	North Ayrshire Health & Social Care Partnership (NAHSCP) currently have eligibility criteria for young and adult service users based on (COSLA 2009) national guidance and GIRFEC performance indicators. The current position is to target support to service users who fall under substantial or critical categories of risk/impact.	
2.2	All local authorities must now set and publish a local eligibility criteria for carers. The Carers (Scotland) Act 2016 guidance proposes that all local authorities use the same suite of indicators but hold local discretion in establishing the thresholds for carers. It is suggested we adopt the National Eligibility Framework created by National Carer Organisations (NCO) and developed in response to the clear expressed views of carers (See Appendix 1). The table below shows the basic principles of the NCO Framework and what it will achieve.	
2.3	<u>Principles</u> • Focuses on 3 aspects; criteria + thresholds + services • Embraces prevention • Consistency in the way carers are treated & the support they receive • Rights based approach • Transparency & clarity • Outcomes focused • Applies to all carers with a few tweaks locally	<u>Will Achieve</u> • Portability of assessment through transition with only services varying according to locality • Consistent & equitable implementation of the Act • Comparable data to measure the impact of the Act • Strong framework for measuring need for, level of and uptake of services • Increased clarity on who is eligible for support • Better planning & budgeting for services • Better definition of universal and preventative supports – Carers Services
3.	**Proposals**	
3.1	This paper proposes to adopt the NCO Framework for National Eligibility Thresholds for adult and young carers. We have applied minor changes as directed by our staff and carers (See Appendix 2).	
3.2	NAHSCP must agree and publish our criteria in order to meet our duties under the Act 2016.	
3.3	NAHSCP resources are finite and variable and should be targeted fairly at those with the greatest need. This could be achieved by using the same criteria prioritising the needs of all carers who request or require support. It is fair and appropriate to mirror our approach to service users and propose that NAHSCP support carers who fall under substantial or critical categories of risk/impact.	

3.4	Many carers in North Ayrshire might not call for health or social care intervention. Support from universal services, local community supports or preventative measures may be the most appropriate way of addressing identified need.
3.5	NAHSCP have extended our Carer Support Service contract with Unity for 1 year. This will commence July 2018 with a revised specification, to act as an anticipatory measure, in each locality, to help low/moderate requirements and potentially reduce the need for increased service. No carer should have to wait until the caring situation is broken or in crisis to receive advice/guidance/support.
3.6	All professional staff across NAHSCP have a duty to offer an Adult Carer Support Plan (ACSP) or Young Carer Statement (YCS) upon identification of a person carrying out a caring role. Adult carers can complete their ACSP with or without support. Social Workers however must apply eligibility criteria, agree and record outcomes and offer the four options of Self-directed Support to determine the manner in which the carer would like their support to be delivered.
3.7	It has been agreed with Education colleagues that the Named Person (Head Teacher/Pastoral Staff) is the responsible lead for supporting young carers under 18, or having reached 18 and remaining in school, to complete their Statement. The Named Person can identify, refer for and provide support up to moderate levels of impact/risk to the young person.
3.8	A process for support on identifying critical or substantial levels of impact/risk to the young person has been established. The Named Person will securely email the Named Person Service Admin for logging/tracking and forwarding to the Team Manager (Children & Families Area Team) to allocate a Lead Professional to take forward any critical or substantial needs. The Lead Professional will open an AYRshare record adding the Named Person and both leads will maintain an integrated chronology and appropriate levels of support for the young carer.
3.9	Access to budgets for Low and Moderate or one-off support for young and adult carers would be referred to a Carer Resource Group led by Isabel Marr – Senior Manager Long Term Conditions (LTC) as lead for carers and responsible budget holder. The Resource Allocation System (RAS) therefore requires some focused attention and it is suggested that a small group develop this with Finance colleagues with a view to planning, developing, testing and implementation for April 1st, 2019.
4.	**Implications**
4.1	These changes will extend our opportunities to identify, recognise and support carers within their localities.

4.2	Financial
	In light of current budget difficulties there is general unease that funding allocation is still very vague and the implementation of the Act 2016 might be underfunded as we are dealing with unknown demand. Further concern surrounds the cost of waiving charges for carers. A proposed statement of intent is part of this paper for agreement (See Appendix 2).
4.3	The proposed eligibility criteria and thresholds need to be consistent with the NAHSCP current financial framework and resource allocation system. This requires some focused attention from a small working group.
4.4	Legislative
	The Carer (Scotland) Act 2016 is a key piece of legislation that promotes, defends and extends the rights of adult and young carers. The duties and powers under the Act are actionable from 1st April 2018 for NAHSCP. Eligibility Criteria must be published by NAHSCP and reviewed within 3 years from that date.
4.5	The Scottish Government Business and Regulatory Impact Assessment (BRIA) concluded that the Act will not have an adverse impact on the operational business of local authorities or other delivery partners.
4.6	Human Resources
	There are no HR implications at this time. There will be a requirement for staff knowledge and practice to be developed. It was noted that our Learning & Development Team are not resourced to support the development and delivery. With Senior Management agreement, the Carers Team will visit each Social Work Team across Children & Adults to advise of the agreed delivery and practice. Senior Managers will then ensure adoption and adherence to the new practice in supporting carers.
4.7	Systems and Reporting
	RAS - The proposed eligibility criteria and thresholds need to be consistent with the NAHSCP current financial framework and resource allocation system. We will continue with the current resource allocation systems in place until the new one is developed, agreed and implemented.
4.8	Carefirst/Proforma for North Ayrshire Carers Centre – For the purpose of meeting our reporting requirements of the new Carers Census to the Scottish Government. There will be minimal tweaks required to the SSAQ for the Cared-for person to ensure we are meeting our duty to offer Carers Plans/Statements
4.9	We will also make minor amendments to the reporting proforma completed by the North Ayrshire Carers Centre in order that we are capturing the full complement of data required.

4.10	*Main Key Strategic Plan Priorities* *<u>Tackling Inequalities</u>* - *Deliver our requirements to meet the new Carers Act* - *Consider the allocation of resources across NA, redirecting funds and services to where they are most needed and will deliver best value of agreed outcomes.* - *Engaging our Communities* - *Improving mental health & wellbeing* - *Early intervention and prevention*
5.	**Consultations**
5.1	Consultation and tests of change were carried out and included NAHSCP Heads of Service, Education & Early Years, NAHSCP Lead Professionals, Carers Advisory Group membership and local carer groups. The Assessment paperwork and eligibility were tested with 5 adults and 5 young carers.
6.	**Conclusion**
6.1	In order for NAHSCP to meet our duties under the Act 2016, this paper proposes a new eligibility criteria and thresholds for adult and young carers. This works in conjunction with the new Adult Carer Support Plan and Young Carer Statement.
6.2	It is further proposed that an agreement is reached on Waiving of Charges for all carers in order that all relevant stakeholders are aware of NAHSCP position.
6.3	This will mean changes to practice, but with the continued emphasis that eligibility criteria are a way of managing demand equally and consistently across all carer groups.
6.4	A progress update of the application of the carer's assessment, eligibility criteria and guidance will be presented quarterly to SWGB for the first year – in order that Clinical and Care Governance Board and IJB are sighted on practice.

For further information please contact Kimberley Mroz, Team Manager (Self Directed Support/Unpaid Carers) on 01294 317709 or
kmroz@north-ayrshire.gcsx.gov.uk

Carers FIRST

North Ayrshire Carer's Eligibility Criteria

Implementation Date: 1st April 2018

Carers Act: Statement of Intent

The Carers (Scotland) Act 2016 (fully implemented 1st April 2018) is intended to better support Scotland's adult and young carers on a more consistent basis so that they can continue to care, if they so wish, in good health, allowing them to have a life alongside caring. *(See appendix one for meaning of carer)*

Specifically for young carers, they should have a childhood similar to their non-carer peers and should be enabled to be children first and foremost, relieved of any inappropriate caring roles, allowing them to have a quality of life.

Carers Act: Provisions

The Act introduces the right to a new Adult Carer Support Plan (ACSP) or Young Carer Statement (YCS) *(See appendices two and three for examples)* encouraging meaningful conversations with people to understand their personal needs and outcomes. It will improve the access to support at all levels without any requirement for carers to provide care on a substantial or regular basis. Unity (North Ayrshire Carers Centre) are well placed to help the delivery of lower levels of support including accessible information, advice and guidance across the localities.

Engaging effectively with carers as equal partners will help empower them, providing carers and professionals with more useful information about the support that may be available in our communities. This is also reflected in the duty applied to health boards to involve carers in hospital discharge processes, ensuring support is relevant, appropriately timed and delivered in a cohesive way.

Effective delivery of support to carers will improve the physical and emotional health and wellbeing of carers in turn benefitting those being cared for and can help to sustain good caring relationships.

The North Ayrshire Carers Strategy, for carers written by carers, will be reviewed and a new plan for how we identify and support carers in their localities will be set. This will include a short break service statement again, for carers developed by carers.

An Eligibility Criteria Framework is required to be set locally to help the North Ayrshire Health & Social Care Partnership (NAHSCP) to determine levels of support based on assessed/identified need and impact/risk of the caring role.

Eligibility Criteria Framework: Why and what it achieves

Eligibility criteria ensures we have a fair and consistent system for determining how the NAHSCP targets finite public resources. It is the local authority's duty to set and apply the criteria alongside the ACSP or YCS to exchange information about caring. It means that carers with different needs will be treated equally in accessing the right level of information, advice, support and services.

The Framework covers two aspects:

I. Levels and types of need for support
II. The thresholds that must be met to be eligible for support

Eligibility Criteria Framework: Process

The process can be broken down into four phases:

Phase One – A carer who wishes to access support can request an ACSP/YCS from the NAHSCP. It is also the duty of NAHSCP staff to offer an ACSP/YCS on identification of someone carrying out a caring role. This leads to a joint conversation to consider their caring situation and needs, their health and general wellbeing and how they can best achieve their own outcomes. The ACSP/YCS is completed to identify and record fully each carer's individual needs, outcomes and support. Not all carers assessed will have eligible needs. However, all carers have access to information, advice, guidance, and universal preventative services.

Phase Two – The support plan or statement will identify what matters to the carer as well as the impact of caring on their life. As the conversation continues the carer and professional will consider how to achieve the things that matter to the carer.

Phase Three – The eligibility criteria framework is applied here to identify the level of support from the impact or risk of them caring. If there are outcomes that meet the eligibility threshold, it is our duty to offer and explain the four options of Self-directed Support to consider how the carer may have their support delivered along with all options of available resources.

Phase Four – When the level of support has been agreed, and the carer fully informed of all options and resources, the carer will decide how they wish their support to be arranged from the four options of Self-directed Support. The carer will be involved in each stage of the process and in all decision making. A review date will be set and recorded at this point.

Adult Carer Support Plan: Purpose & Preparation

The ACSP will identify and record each adult carer's individual needs, personal outcomes and support to be considered to meet those needs. The plan helps to find out what impact caring responsibilities are having on an adult's life. Adult carers can request a plan to be carried out. The Local Authority must offer and prepare the ACSP on identification of an adult carer, if accepted. Consideration should be given to who is best placed to support the adult carer to prepare their plan. The carer can start to complete their ACSP on their own or with the help of a person or organisation of their choice. However, it is the duty of the Local Authority to accurately capture the carers identified needs and come to a view on the carer's eligibility for support.

In all cases, the local authority must inform the carer of their eligibility and why it has reached that decision. When a carer is identified as having eligible needs for support, the local authority must discuss what these eligible needs are and outline how these might be met via the four options of Self-directed Support. The responsible authority is North Ayrshire Council with the exception of (section 28) the duty for each Health Board to involve the carer before the cared-for person is discharged. This duty applies in situations where:

- The identified carer is an adult carer or a young carer
- An individual is identified who intends to provide care to a patient post discharge
- An individual is providing or intends to provide care but does not self-identify as a carer
- Professionals consider it likely that the patient will require care from a carer following discharge
- A formal discharge process takes place

Young Carer Statement: Purpose & Preparation

The YCS will identify and record each young carer's individual needs, personal outcomes and support to be considered to meet those needs. The statement helps to ensure young carers do not take on inappropriate caring tasks or caring that is inconsistent with their age and maturity. The statement further ensures there is effective planning in place to support young carers in transition to adulthood.

The responsible authority is NHS Ayrshire & Arran for pre-school age, and the NAHSCP via the Named Person Service for school age up to the age of 18 years, or having reached 18 and still in school. Young carers can request a statement to be carried out and we must offer the YCS on identification of a young carer. The YCS should link to the Child's Plan if there is one in place. Consideration has been given to who is best placed to support the young carer to prepare their statement. The NAHSCP and Education & Early Years have agreed it will be Head Teacher/Pastoral staff until the young carer meets the eligibility thresholds of substantial or critical for one or more of their outcomes. The YCS will then be

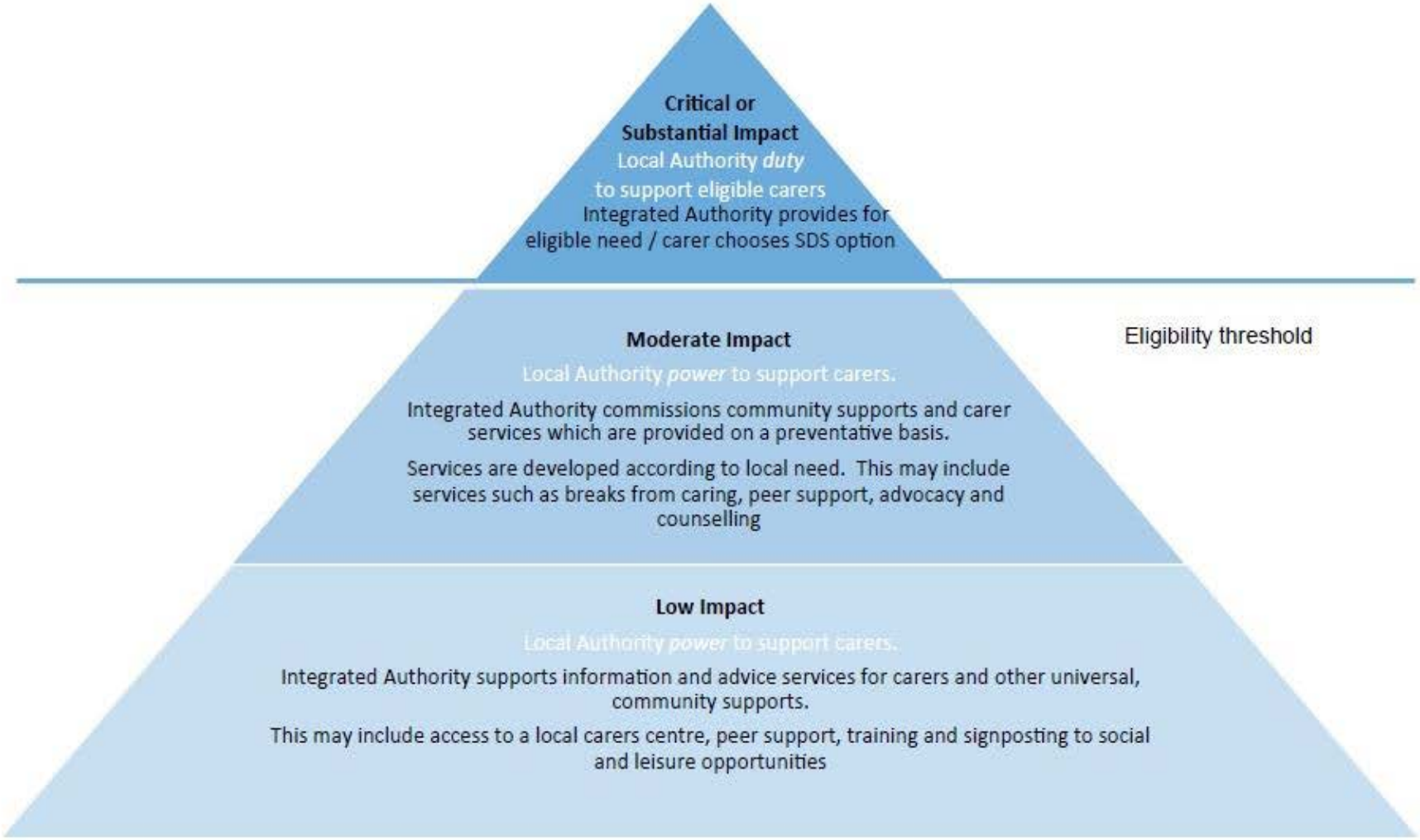
referred to the Named Person Service for tracking and passed to the appropriate Children & Families Social Work Team for action. The outcomes cover the SHANARRI indicators of wellbeing: Safe/Health/Achieving/Nurtured/Active/Respected/Responsible/Included.

Eligibility Risk Indicators

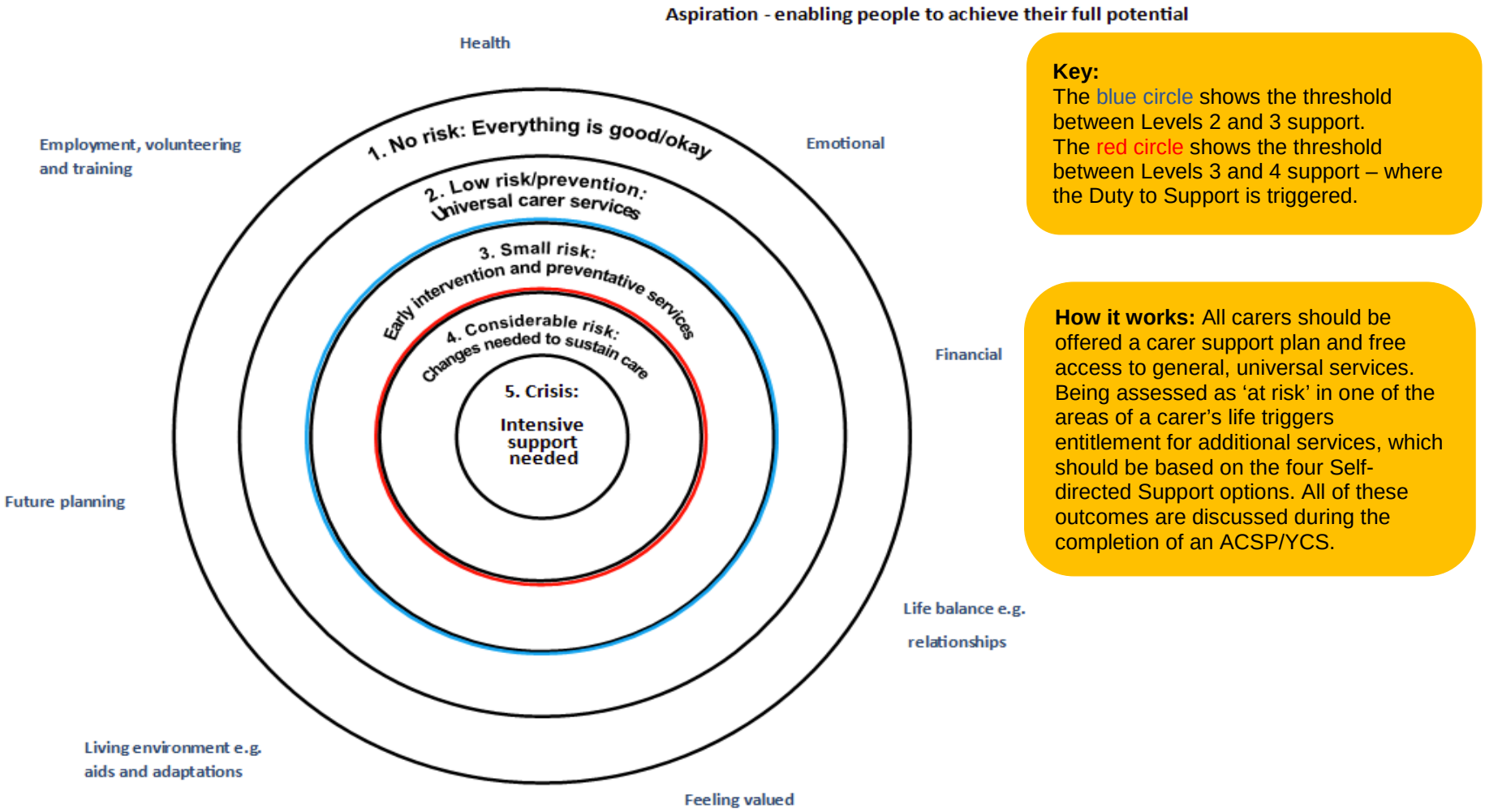
Eligibility for services is decided in terms of risk to an individual. There are five categories:

No Impact	Indicates no quality of life issues as a result of their caring role. There is no risk to the carer's health & wellbeing and they are able to experience a good life balance. There is no current need for information, guidance or support.
Low Impact	Indicates there may be some quality of life issues but they are low in risk to the carer's health and wellbeing and opportunities for independence. Some need for universal and/or preventative information, guidance or support.
Moderate Impact	Indicates there is some quality of life issues and they are causing enough risk to impact on the carer's health, wellbeing and potential for independent living. Some provision of health & social care services may be appropriate.
Substantial Impact	Indicates there is major risk to a carer's health, wellbeing and capacity for independent living. Urgent provision of health & social care services is likely.
Critical Impact	Indicates there is a significant risk to a carer's health, wellbeing and capacity for independent living. Immediate provision of health and social care services is likely.

Eligibility Thresholds: This shows where eligibility sits in relation to carer support in practice and how NAHSCP can support carers. This includes examples of services, which are not intended to be exhaustive or prescriptive (individual and local circumstances will determine services).



Eligibility Criteria Framework: This shows how criteria for reaching thresholds could be used to assess levels of need against the Carer outcomes



Key:
The blue circle shows the threshold between Levels 2 and 3 support.
The red circle shows the threshold between Levels 3 and 4 support – where the Duty to Support is triggered.

How it works: All carers should be offered a carer support plan and free access to general, universal services. Being assessed as 'at risk' in one of the areas of a carer's life triggers entitlement for additional services, which should be based on the four Self-directed Support options. All of these outcomes are discussed during the completion of an ACSP/YCS.

Table of Indicators – Adult Carer Support Plan

	Universal support moving to commissioned services & support (local authority 'power to support')			*More targeted commissioned services & support (local authority 'duty to support')*	
	Caring has no impact/no risk	**Caring has low Impact/risk prevention**	**Caring has clear impact/small, moderate risk. Response needed**	**Caring has considerable impact/high risk**	**Evidence of critical impact/crisis**
Health	Carer in good health	Carer's health beginning to be affected	Carer's health at risk without intervention	Carer's health requires attention	Carer's health is breaking/broken down
Emotional	Carer has good emotional wellbeing --- Good relationship with cared-for-person	Caring role beginning to have an impact on emotional wellbeing --- Risk of detrimental impact on relationship with cared-for person	Some impact on carer's emotional wellbeing is evident --- Some detrimental impact on relationship with cared-for person	Significant impact on carer's emotional wellbeing --- Relationship with cared-for person is significantly affected	Carer's emotional wellbeing is breaking/broken down --- Relationship with cared-for person is breaking/broken down
Finance	Caring is not causing financial hardship - carer can afford housing cost/utilities/food/clothing	Caring is causing a risk of financial hardship - some difficulty meeting housing cost/utilities/ food/ clothing	Caring is causing some detrimental impact on finances - difficulty meeting housing cost/ utilities/food/ clothing	Caring is having a significant impact on finances e.g. difficulty meeting housing cost/ utilities/food/ clothing	Caring is causing severe financial hardship e.g. carer cannot afford housing cost/utilities/ food/ clothing
Life balance	Carer has regular opportunities to achieve the life balance they want They have a broad choice of breaks/activities promoting physical, mental and emotional wellbeing	Carer has some opportunities to achieve the life balance they want They have access to a choice of breaks/ activities promoting physical, mental and emotional wellbeing	Carer has limited opportunities to achieve the life balance they want due to caring They have access to few breaks/activities promoting physical, mental and emotional wellbeing	Carer has few, irregular opportunities to achieve the life balance they want due to caring They have little access to breaks/activities promoting physical, mental and emotional wellbeing	Carer has no opportunity to achieve the life balance they want due to caring They have no access to breaks/activities promoting physical, mental and emotional wellbeing

Feeling valued	Carer feels their knowledge and expertise is always valued by health, social care and other professionals. Consequently they feel included and empowered	Carer feels their knowledge and expertise is sometimes valued and consequently they generally feel included and empowered	Carer increasingly feels their knowledge and expertise is not valued by health, social care and other professionals. Consequently they sometimes feel excluded and disempowered	Carer often feels their knowledge and expertise is not valued by health, social care and other professionals. Consequently they often feel excluded and disempowered	Carer feels their knowledge and expertise is never valued by health, social care and other professionals. Consequently they always feel excluded and disempowered
Future planning	Carer is confident about the future and has no concerns	Carer is largely confident about the future but has minor concerns	Carer is not confident about the future and has some concerns	Carer is anxious about the future and has significant concerns	Carer is very anxious about the future and has severe concerns
Employment	Carer has no difficulty managing caring and employment/education Carer does not want to be in paid work or education	Carer has some difficulty managing caring and employment/education. There is a risk to sustaining this in the long term. Carer is not in paid work or education - long term	Carer has difficulty managing caring and employment/education. There is a risk to sustaining this in the short term Carer is not in paid work or education but would like to be - medium term	Carer has significant difficulty managing caring and employment/education. There is a risk to sustaining this in the short term. Carer is not in paid work or education but would like to be soon	Carer has significant difficulty managing caring and employment /education. There is an imminent risk of giving up work or education. Carer is not in paid work or education but would like to be now
Living environment	Carer's living environment is suitable, posing no risk to the physical health and safety of the carer and cared-for person	Carer's living environment is mostly suitable but could pose a risk to the health and safety of the carer and cared-for person in the longer term	Carer's living environment is unsuitable but poses no immediate risk	Carer's living environment is unsuitable and poses an immediate risk to the health and safety of the carer and cared-for person	Carer's living environment is unsuitable. There are immediate and critical risks to the health and safety of the carer and cared for person

Table of Indicators – Young Carers Statement (Based on NCO Thresholds and SHANARRI Indicators)

	Universal support moving to commissioned services and support (local authority, power to support)			More targeted, commissioned services & support services & support (Local Authority 'Duty to support')	
	No Impact	**Low Impact**	**Moderate impact**	**Substantial Impact**	**Critical Impact**
Safe/Living Environment	Young Carer free from abuse, neglect or harm at home, at school and in their community.	Young carers situation at home, at school and in their community is currently stable and manageable.	Young carers situation at home, school or in their community is not ideal and potential risk to young carer and cared for person is evident.	Young carers situation at home, school or in their community is not ideal and there are safety risks which cannot be remedied in the short term.	Young carers situation at home, school or in their community is unsuitable and there are safety risks for the young carer and the cared for person.
Health	Young carer is in good physical and mental health with no identified medical needs.	Young carer is able to manage some aspects of their caring/family/social roles and responsibilities. There is a possibility of the young carer's health being affected.	Young carer is able to manage some aspects of their caring/family/social roles and responsibilities. It is evident the young carers health is being affected.	Young carer is having difficulty in managing aspects of the caring/family/ social roles and responsibilities. Young carer's mental and physical health is affected as a result.	Young carer has significant physical/mental difficulties due to the impact of their role as a carer which may cause life threatening or long term harm.
Achieving/ education	Young carer continues to access education/training and as no difficulty in managing caring role alongside.	Young carer has some difficulty managing caring alongside education/training There is a small risk to sustaining education/training in the long term.	Young carer has difficulty managing caring alongside education/training. There is a risk to sustaining education/training in the medium term.	The young carer is missing out on education/training and there is a risk of this ending in the near future due to their caring role.	The young carer is at significant risk or has had to give up education/training due to their caring role.
Nurtured/ relationships	Young carer displays positive emotional wellbeing. They have a	Young carer role beginning to have an impact on emotional	Some impact on the young carers emotional wellbeing and on their relationship	Major impact on a daily basis to the young carer's emotional wellbeing and	Relationship between the young carer and the cared-for person is

	nurturing place to live and a positive relationship with the cared for person. Young carer feels acknowledged by professionals and does not require additional help.	wellbeing and may require additional help when needed. Risk of detrimental impact on relationship with cared for person.	with the cared for person resulting in a strained relationship. Additional help needed where possible, in a suitable care setting.	therefore impacts on the cared-for person. Young carer is unable to sustain many aspects of their caring role.	broken. The young carer is unable to continue caring or has difficulty sustaining vital or most aspects of their caring role. Input is needed immediately for the young carer. The young carer never feels acknowledged and therefore feels excluded.
Active/life balance	Young carer has opportunities to take part in activities such as play, recreation and sport at home, in school and in their community.	Young carer has some opportunity to take part in activities such as play, recreation and sport at home, in school and in their community.	Young carer has limited opportunity to take part in activities such as play, recreation and sport at home, in school and in their community.	Young carer has few and irregular opportunities to take part in activities such as play, recreation and sport at home, in school and in their community. May have a negative effect on healthy growth/development.	Young carer has no opportunity to take part in activities such as play, recreation and sport at home in school and in their community. This has a negative effect on their healthy growth/development.
Respect/ Responsible	Young carer has regular opportunities to be heard and involved in decisions. They have an active and responsible role to be involved in decisions that affect them.	Young carer has some opportunities to be heard and involved in decisions and has an active and responsible role to be involved in decisions that affect them.	Young carer has limited opportunity to be heard and involved in decisions that affect them due to their caring role.	Young carer has few and irregular opportunities to be heard and involved in decisions that affect them due to their caring role.	Young carer has no opportunities to be heard and involved in decisions that affect them due to their caring role.
Included/ Finance	Young carer feels accepted in the	Young carer feels some acceptance in the	Young carer has limited acceptance in the	Young carer feels isolated and not confident in the	Young carer does not feel accepted in the

	community where they live and learn. Young carer has time to take part in community activities. Free from financial stress.	community where they live and learn but is unsure how to take part in community activities. There is a small risk of financial stress.	community where they live and learn, due to their caring role. There is a risk of financial pressure.	community where they live and learn. Need for financial support.	community where they live and learn. Young carer's financial position is severe and there is financial hardship.

Eligibility Criteria Review

This policy and associated procedures will be reviewed within three years subject to any further changes in legislation.

Documents and Policies Related to Eligibility Criteria

Carers (Scotland) Act 2016
Getting it right for every child - GIRFEC
Fair Access to Community Care Services
Self-Directed Support Policy
Local Carers Strategy

Appendix One

Meaning of Carer

1) In this Act 'carer' means an individual who provides or intends to provide care for another individual (the 'cared-for person)
2) But 1) does not apply –
    a) In the case of a cared-for person under 18 years old, to the extent that the care is or would be provided because of the person's age, or
    b) In any case to the extent that care is or would be provided, under or by virtue of a contract or as voluntary work.
3) The Scottish Ministers may by regulations –
    a) Provide that 'contract' in 2) b) does or, as the case may be, does not include agreements of a kind specified in the regulations,
    b) Permit a relevant authority to disregard 2) where the authority considers the relationship between the carer and cared-for person is such that it would be appropriate to do so.
4) In this part relevant authority means a responsible local authority or responsible authority (See section 41 (1) of the Act).

Meaning of Young Carer

1) In this Act 'young carer' means a carer who –
    a) Is under 18 years old, or
    b) Has attained the age of 18 years while a pupil at a school, and has since attaining that age remained a pupil at that or another school.

Meaning of Adult Carer

1) In this Act 'adult carer' means a carer who is at least 18 years old but is not a young carer.

Do you look after or care for someone at home?

The following questions are designed to help you think about your caring role and what support you might need to make your life a little easier or help you make more time for you and the things you enjoy.

Please feel free to make notes, draw pictures or use the form in the way that is best for you.

Primary School V 0.5 April 2018

What will happen to your statement?

This is your statement and it is your way to tell an adult who you trust about how you care at home. This will help you and the adult find ways to make your life and your caring role a bit easier.

Our Agreement

Adult helping to complete:

- I will make sure you get a copy of your statement.
- If you agree I will share your statement with people your family or with individuals you have requested.
- I will let you know who I share this with, unless I am worried about your safety
- I will make sure your statement is stored securely.
- Some details from your statement might be used for monitoring purposes. This is how we check that we are working with everyone we should and in the way we should.

Signed: _____

Young person:

- I will get a copy of my statement to keep.
- I know that if I agree my statement might get shared with other people who can help me and my family so that I don't have to explain it all over again.
- I understand what the adult supporting me might do with my statement and the information in it.

I am happy for you to share information with:

☐ ☐ ☐ ☐ ☐

School Nurse NAHSCP X Class Teacher X Young Carers Service X Family

Other (Please specify who) ……..

Signed: _____

Basic information about me:

My Name: **Gemima Puddleduck**…….....

My Date of Birth: **10/02/2007**……..

My Gender: …**Female**……..

My Ethnicity: **Scottish White**……..

My Address: ……**Puddle Lane Avenue, Irvine**,……..

……..

My Telephone number: …**01234 556 779**……..

My School: **Heartlake Primary**……

My GP: **Dr Drake**……

The best way to get in touch with me is: By **Telephone**……...

……

Please tell us if you need any help with communicating

(e.g. do you need an interpreter, braille, sign language, larger print)

……

About my role as a carer:

The person I care for is my….

☒ (Parents)

☐ (Grandparents)

☐ (Other family members)

☐ (Friends/neighbours)

I help them with….

☒ Medication

☐ Personal Care

☒ Shopping, cleaning, domestic tasks

☐ Transport

☒ Supervision/emotional support

☐ Financial Support

☒ Other (Please specify) Help look after my brother……

I help them because…

☒

☐ Drug & Alcohol Abuse

☐ Physical Disability

☐ Learning Disability

☐

Older People

Care Duration

Less than one year ☒ 1-4 years ☐ 5-9 years ☐ 10-19 years ☐ 20 years or more ☐ Not known ☐

Care hours per week

Up to 4 hours ☐ 5-19 hours ☒ 20-34 hours ☐ 35-49 hours ☐ 50+ hours ☐ Not known ☐

Do you live with the person you care for?

Yes No

If yes, who else lives at home? ……

Caring …

Draw or write on me …

What are the physical things I do?

What emotional support do I give?

Think about the things that you like helping with

Tell us what you do before school, after school and on your evenings and weekends to help in your caring role. What kind of things do you usually do to help? (e.g. cooking, cleaning, help with medicine, shopping, helping younger brothers or sisters, keeping an eye on the person you help, helping them to relax, cheering them up)

Physical	Emotional
Before school I make sure my little brother is up, dressed and got his breakfast and remind mum to take her medication. After school I walk my brother home and make sure he gets changed and has a snack. I help my mum to prepare the dinner, and get my brother to help set the table and clear away the dishes. I help to tidy the house, hoover and put away everyone's clothes.	I try to cheer up my mum when she is feeling down and reassure her. I also listen when she is worried or upset.
Like ☺	Do not like ☹

Think about the things you don't like or are difficult	• I like spending time with my mum when she is well, it nice to do things together. • I enjoy reading my brother a story at night before bed. • I like doing the hoovering and polishing.	• I don't like when things are cancelled because my mum is unwell, like days out or going to stay with friends. • I don't like having to go shopping it takes too long, and is difficult with my little brother. • I don't like doing the cooking, we always have the same dinners.

Time for me …

Draw or write on me ...	With my friends or family I enjoy …	The things I enjoy for myself are …
 What do you like to do for fun?	• Spending time with my mum when she is well. • I enjoy staying overnight with my friends but worry about my mum and brother.	• Reading my book in my bed. • Playing and learning my keyboard in my room.

How often do you do these things? Is there anything you would like to do more of? Why can you not do these things?	Things I would like to do but can't because of my caring role… • I would like to stay over with my friends more at the weekend, it is fun having sleepovers. • I would like to have someone teach me to play the keyboard, but there is not much money with mum being ill. • Play outside with my friends when it is nice, and not having to always have my little brother there.

School/Home

Draw or write on me ... 	Does your caring role affect school/home life in any way?  Yes  No *If yes, please tell us what things are positive or negative and what things might help you?* • I don't always have time to do my homework and the teacher gives me in to trouble. • Helping my mum makes me feel close to her.	Does your caring role affect you?  Yes  No *If yes, please tell us what things are positive or negative and what things might help you?* • Sometimes I am sad and don't have anyone to talk to about my mum. • I get tired sometimes and day dream in class.

	• I don't get a lot of time to myself, because I am looking after mum and my little brother. • Sometimes I am sad and don't have anyone to talk to about my mum. • I worry about my mum when I'm at school, it makes it difficult to concentrate	

Does your teacher(s)/other staff know about your caring role? Yes No

Are you happy for your teacher(s)/other staff to know you are a carer? Yes No

How I feel about my life …

Tick the one that suits me ... 	Do you feel confident in and outside of school/home?			
	very confident	quite confident	quite unconfident	very unconfident
	Overall in your life just now, how happy do you feel?			
	very happy	quite happy	quite unhappy	very unhappy

	Overall in your life just now, how safe do you feel?			
	very safe	quite safe	quite unsafe	very unsafe
	How healthy do you feel at the moment?			
	very healthy	quite healthy	quite unhealthy	very unhealthy
	How is your relationship with the person you care for?			
	very positive	quite positive	quite negative	very negative

My voice …

Tick the one that suits me ... 	Do people listen to what you are saying about your caring role?
	 Yes  No If no, can you tell us who you think is not listening (e.g. parents, teachers, friends, professionals, other) …… I don't have anyone to talk to, I don't think any of my friends are carers ……
	Are you included in important decisions about you and your life

	Yes No If no, can you tell us what you think would help to get your opinion heard or feel included? ……
	Are you included in decisions about your caring role?
	Yes No If no, can you tell us what you think would help to included you? …… I just do what I do to make sure everyone is okay, don't really think about it. ……
	Who do you talk to about your caring role?
	No one, it can be lonely sometimes and make me sad ……

My support …

Draw or write on me ... 	Below are some things that would make a difference to my life, help with my caring and make me feel better	
	• Not having things cancelled • Not having to always cook • Someone to look after my mum and brother to let me do things with my friends	
	Do you have time away from your caring role?	

	Yes  No If no, what would a time-out look like, and what would you do? Sometimes I get to stay over with my friends which can be lots of fun, this doesn't happen often though.			
	If you need to see a health professional (i.e Doctor/Dentist) how easy is it to do this?			
	very easy	easy	difficult	impossible

My support … how are we going to do this?

What do you need help with?	Who might be able to help?	How could they help?	Level of support No Support/Low/Moderate /Substantial/Critical	Timescales
Talking about my caring role	Local Carers Centre	Through 1 to 1 with young carer staff and fortnightly group with other young carers.	M	ASAP

Getting time with my friends	Health & Social Care Partnership	Look at putting support in for mum and brother to allow young carer time with her friends.	M	ASAP
Time to do homework in quiet space	School	Suitable time and place to do homework, with support if needed.	M	ASAP
Checking on Mum during school time	School	Telephone call allowed home at lunchtime	M	ASAP
Keyboard Lessons	School	Possible music lessons provided	L	ASAP

Statement completed on …… By……..

My statement will be reviewed on …… By ……..

Always remember …

Important things to do if I can no longer care or help …

(Think of the things that someone else would need to know, need to do, who they would contact to help and any useful contact details)

EMERGENCY & FUTURE PLANS

If an emergency unexpectedly arose what would your plan look like to meet your daily caring role. What are the practical arrangements for short-term, unplanned circumstances that would need to be put in place?

Emergency Plan:

Who to contact _____
How to contact _____
What to do and how _____

Future planning refers to the longer term plans for the person you care for when you are no longer able to care. Future plans are more in-depth than emergency plans and the carer, cared for person and all other relevant family members or friends should be involved in this plan. The wishes and preferences of the carer and the cared-for person should be taken into account. Some things to consider include, but are not limited to, current care and future care, living arrangements, practical, legal and financial provision including Power of Attorney, guardianship, wills and trusts (if relevant).

Future Plan:

Who to contact _____
How to contact _____
What to do and how _____

Where I can ask for help, advice or support …

- North Ayrshire Carers Centre on 01294 311333 or at northayrshire.carers@unity-enterprise.com
- North Ayrshire Health & Social Care Partnership on (local offices)
- NHS Direct on 111

Only in the event of an Emergency please contact

- Emergency – Police, Fire or Ambulance on 999

Office Use Only

Source of referral ……

Date YCS requested/offered ……

Statement completed ☐ **Statement declined** ☐

Young carers Carefirst number (if known) ……

Young carers CHI number (if known) ……

Cared for person

Name ……

Address (if not same as above) ……

……

Gender ……

Age ……

Ethnic Group ……

Carefirst number (if known) ……

Do you look after or care for someone at home?

The following questions are designed to help
you think about your caring role and what support
you might need to make your life a little easier or
help you make more time for you and the things you enjoy.

Please feel free to make notes or use the form in the way
that is best for you.

Secondary 1st May 2018 v.02

What will happen to your statement?

This is your statement and it is your way to tell an adult who you trust about how you care at home. This will help you and the adult find ways to make your life and your caring role a bit easier.

Our Agreement

Adult helping to complete:

- I will make sure you get a copy of your statement.
- If you agree I will share your statement with people your family or with individuals you have requested.
- I will let you know who I share this with, unless I am worried about your safety
- I will make sure your statement is stored securely.
- Some details from your statement might be used for monitoring purposes. This is how we check that we are working with everyone we should and in the way we should.

Signed: _____

Young person:

- I will get a copy of my statement to keep.
- I know that if I agree my statement might get shared with other people who can help me and my family so that I don't have to explain it all over again.
- I understand what the adult supporting me might do with my statement and the information in it.

I am happy for you to share information with:

School Nurse NAHSCP Class Teacher ☑ Young Carers Service Family ☑

Other (Please specify who) ……..

Signed: _____

Basic information about me:

My Name: Victoria Walker……

My Date of Birth: ……21/01/2004…….

My Gender: ……Female…….

My Ethnicity: …White Scottish……

My Address: …24 Greenwood Lane, Irvine

My Telephone number: …12345 573836

My School: ……Fleeting Academy, Irvine

My GP: ……Dr Jones

The best way to get in touch with me is: on my mobile/text message

Do you need any help with communicating (Like an interpreter, braille, sign language, larger print)

……No I don't.

About my role as a carer:

The person I care for is my... Parents ☑ Grandparents other family members Friends/neighbours

I help them with … Medication ☑ Personal Care ☑ Shopping, cleaning & domestic tasks ☑ Transport

Supervision/emotional support ☑ Financial Support Other (Please specify)……

I have been caring for … Less than one year 1-4 years ☑ 5-9 years 10-19 years 20 years or more not known

Hours per week that I care for … Up to 4 hours 5-19 hours 20-34 hours 35-49 ☑

Why I have to care … (Please tell us why the person you care for needs your help. Do they have an illness, disability or condition?)

My mum has MS

Do you live with the person you care for?

Yes ☑ No

Do you have any questions about what's wrong with the person you care for? If yes, what would you like to find out?

Yes ☑ No Will my mum's condition get worse as she gets older, I really worry about this?

Caring …

Write on me ...

What are the physical things I do?

What emotional support do I give?

Think about the things that you like helping with

Think about the things you don't like or are difficult

Tell us what you do before school/after school and on your evenings and weekends to help in your caring role. What kind of things do you usually do to help? (e.g. cooking, cleaning, help with medicine, shopping, paying bills, picking up medication, helping younger brothers or sisters, keeping an eye on the person you help, helping them to relax, cheering them up)

Physical	Emotional
I get my mum up, washed and dressed and give her breakfast and medication before I go to school. When I get home I prepare and cook the dinner, wash the dishes and do some housework then get my mum ready for her bed and make sure she takes her tablets again.	When I get home from school I spend time with my mum, talking to her and telling her about my day. When she is having a bad day I try to cheer her up.
Like	**Do not like**
I like spending time with my mum and enjoy cooking	I get embarrassed sometimes when I have to get my mum washed and dressed. I don't like doing the hoovering because the hoover is too heavy.

Time for me …

Write on me ...

What do I like to do for fun?

How often do I do these things?

With my friends or family I enjoy …

I enjoy spending time with my mum when she is feeling well.

I love catching up with my friends on Snapchat.

The things I enjoy for myself are …

I am learning the cello in school it is really relaxing.
I really love to watch Youtube videos about makeup and hair and practising so I can get better at it.

Things I would like to do …

I would like to play in the school orchestra but practise is after school and I have to get home to help my mum.

I would like to go out with my friends to the ice skating disco on a Friday night, then they go to McDonalds. I miss out on this quite a lot.

School/College/University/Work/Home

Write on me ...	Does your caring role affect school/home life in any way? If yes, please tell us what things are positive or negative and what things might help you Yes ☑ No Sometimes I get in to trouble from my year head for being late to school. Some teachers give me into trouble for not getting my homework done, especially because I have my exams this year.	Does your caring role affect you? If yes, please tell us what things are positive or negative and what things might help you Yes ☑ No I am really tired most of the time because I am up during the night with my mum and then I have to get up at 6am to make sure she takes her medication.

Does your teacher(s)/other staff/supervisor know about your caring role? Yes ☑ No

Are you happy for your teacher(s)/other staff/supervisor to know you are a carer? Yes ☑ No

How I feel about my life …

Tick the one that suits me best ...				
	Do you feel confident in and outside of School/College/University/Work/Home?			
	very confident	quite confident	quite unconfident ☑	very unconfident
	Overall in your life just now, how happy do you feel?			
	very happy	quite happy	quite unhappy ☑	very unhappy
	Overall in your life just now, how safe do you feel?			
	very safe	quite safe ☑	quite unsafe	very unsafe
	How healthy do you feel at the moment?			
	very healthy	quite healthy	quite unhealthy ☑	very unhealthy
	How is your relationship with the person you care for?			
	very positive	quite positive ☑	quite negative	very negative

My voice …

Tick the one that suits me …	Do people listen to what you are saying about your caring role?
	Yes No ☑ If no, can you tell us who you think is not listening (e.g. parents, teachers, friends, professionals, other) My Year Head and also some of my teachers. Also my doctor doesn't listen to me when I go to speak to him about how I am feeling.
	Are you included in important decisions about you and your life?
	Yes No ☑ If no, can you tell us what you think would help to get your opinion heard or feel included? I think if my teachers and my doctor saw what I have to do every day then they might understand me more. I would like to go to appointments with my mum but I already get into trouble from school because my attendance isn't very good.
	Are you included in decisions about your caring role?
	Yes No ☑ If no, can you tell us what you think would help to included you? I would like someone to speak to about where I could extra help to look after mum, especially when she has a bad turn.
	Who do you talk to about your caring role?
	I talk to my friends but they don't really understand.

My support …

Write on me ...

Below are some things that would make a difference to my life, help with my caring role and make me feel better.

Having someone to stay with my mum on a Friday night so I can go out with my friends.

Having some help to get mum washed and dressed.

Having someone to talk to who really understands what I have to do every day and how tired I am.

Not getting into trouble at school for things that are not really my fault or that I can't help.

Do you have time away from your caring role?

Yes No ☑ If no, what would a time away look like, and what would you do?

I don't have anyone else to look after my mum. I would like to stay at my friend's house one night and have some fun and get a whole night's sleep.

If you need to see a Doctor/Dentist or other Health Professional, how easy is it to do this?

very easy	easy	Difficult ☑	impossible

My support … how are we going to do this?

What do you need help with?	Who might be able to help?	How could they help?	Level of support No Support/Low/Moderate /Substantial/Critical	Timescales

Statement completed on …… By……..

My statement will be reviewed on …….. By ……..

Important things to do if I can no longer care or help …

(Think of the things that someone else would need to know, need to do, who they would contact to help and any useful contact details)

EMERGENCY & FUTURE PLANS

If an emergency unexpectedly arose what would your plan look like to meet your daily caring role. What are the practical arrangements for short-term, unplanned circumstances that would need to be put in place?

Emergency Plan:

Who to contact _____
How to contact _____
What to do and how _____

Future planning refers to the longer term plans for the person you care for when you are no longer able to care. Future plans are more in-depth than emergency plans and the carer, cared for person and all other relevant family members or friends should be involved in this plan. The wishes and preferences of the carer and the cared-for person should be taken into account. Some things to consider include, but are not limited to, current care and future care, living arrangements, practical, legal and financial provision including Power of Attorney, guardianship, wills and trusts (if relevant).

Future Plan:

Who to contact _____
How to contact _____
What to do and how _____

Where I can ask for help, advice or support …

- North Ayrshire Carers Centre on 01294 311333 or at northayrshire.carers@unity-enterprise.com
- North Ayrshire Health & Social Care Partnership on (local offices)
- NHS Direct on 111
- Police, Fire, Ambulance on 999 – only in the event of an emergency

Office Use Only

Source of referral ……..

Date YCS requested/offered ……..

Statement completed **Copy given to young carer**

Cared for person

Name ……

Address (if not same as above) ……..

……

Gender ……

Age (If known) ……

Ethnic Group ……

Carefirst number ……..

Carers FIRST

Are you a Carer?

If yes … your support starts here.

North Ayrshire Carer Support Plan

For carers by carers

UNITY
Equality Inclusion Opportunity

North Ayrshire
Health and Social Care Partnership

Are you caring for someone?

Do you look after a family member, friend or neighbour who could not manage without the day to day support you give them? If yes, completing your Carers FIRST Plan is a way to find out if you are getting the help and support that you need to continue in your caring role.

As a carer you have the right to have your needs considered even if;

- ✓ You do not live with the person you care for
- ✓ The person you care for is already being assessed or is currently open to support services
- ✓ The person you care for is not open to services and/or
- ✓ Circumstances have changed, meaning you may want to complete a new Carers FIRST Plan

Where do I get my Carers FIRST Plan?

You can contact your local Health and Social Care Partnership Office (details are on page) or the North Ayrshire Carers Centre in Irvine and a member of staff will be happy to assist you to access your plan.

How do I complete my Carers FIRST plan?

Before you complete your plan, sit down and take a moment to think about your role as a carer and the things you do on a daily basis. Be honest about the effects that caring has on your life. The plan will look at the impact that caring has on your physical and emotional needs, daily life and relationships. You can then;

- ✓ Complete your plan by yourself and send it back to your local Health and Social Care Partnership Office
- ✓ Contact the North Ayrshire Carers Centre and a member of staff will be happy to assist you to complete your plan
- ✓ Contact your local health & social care partnership office and we will allocate a worker to provide information, advice and assistance to complete your plan.

What support will I get?

On identifying your needs we need to apply our local eligibility criteria for carer support to confirm the level you need. This looks at your support as a whole and has three levels;

- ✓ Low may not require a full assessment and would either have little or no impact upon your caring role. We would look at supports such as registering with the Carers Centre, finding information and advice either online or from the Carers Centre, community groups or health centres. It could also be signposting from your local health and social care partnership or community connector.

- ✓ Medium requires a fuller conversation and Carers FIRST Plan completed. Your caring role would have a clear impact on aspects of your life with possible minor

risk if some support was not available. We would look at supports such as those mentioned above with the addition of other carer services like a break from caring, carer respite, advocacy or counselling.

- ✓ High will always require a full conversation and Carers FIRST Plan completed. Your caring role has a huge impact on aspects of your life with definite risk if support was not available. We would look at supports such as those mentioned above under the low and medium levels with the addition of applying self-directed support allowing you to choose how you prefer your support to be arranged, managed and delivered.

ABOUT YOU

Mr/Mrs/Miss/Ms _____

First Name _____ Surname _____

Address _____

_____

Postcode _____Telephone Number_____

Date of Birth _____ Gender _____

Are you the only carer in your family?

Yes ☐ No ☐

(Are the other carers in your family aware of their rights as a carer and the support that is available to them from the North Ayrshire Carers Centre?)

WHO DO YOU CARE FOR?

Do you live in the same household as the person/s you care for?

Yes ☐ No ☐

Please provide information below

Name	**Address**	**Relationship to You**
_____	_____	_____
_____	_____	_____
_____	_____	_____

Can you tell us a bit more about the illness or disability that affects the person(s) you care for?

_____

_____

_____

_____

Is the person you can for known to the Health and Social Care Partnership

Yes ☐ No ☐ (If yes please complete below)

Has the person you care for had an assessment or review of their needs in the past 12 months?

Yes ☐ No ☐ *(if no, would they like more advice on how to access this?)* Yes ☐

If yes, can you tell us a bit more about the support or services the person you care for currently receives?

YOUR CARING ACTIVITIES

Type of Care Provided

Help with Medication ☐ Help with Personal Care ☐ Helping with shopping, cleaning, domestic tasks ☐

Help with transport ☐ Supervison/emotional support ☐ Financial support ☐ Other (Please Specify)

_____

Complete the table below and identify the days/times that you may need support with your caring role and which task you may need help with:

	Morning	Afternoon	Evening	Night Time
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				
Sunday				

Care Duration Less than one year ☐ 1-4 years ☐ 5-9 years ☐ 10-19 years ☐ 20 years or more ☐ Not known ☐

Care Hours per week Upto 4 hours ☐ 5-19 hours ☐ 20-34 hours ☐ 35-49 hours ☐ 50+ hours ☐ Not known ☐

Are there caring tasks or activities you find easier to help with?

Are there caring tasks or activities you would prefer not to help with?

Are there caring tasks or activities you would like to change?

Do you have any legal powers in place for the person you care for?

Yes ☐ No ☐ *(if no, would you like more advice on how to access this?)*

If yes, can you tell us which responsibilities?

Welfare Guardianship ☐ Financial Guardianship ☐ both ☐

YOUR HEALTH

Does your caring role affect your health?

Yes ☐ No ☐

If yes, can you tell us a bit more and what could help you to improve your health?

Do you worry that your health may affect your ability to continue in your caring role?

Yes ☐ No ☐

If yes, could you tell us how your caring role would be affected and what would help you to be able to continue caring?

Have you contacted your GP or other health worker about your health?

Yes ☐ No ☐ If yes, what advice or guidance were you offered?

YOUR EMOTIONAL WELLBEING

Does your caring role affect your emotional wellbeing?

Yes ☐ No ☐

If yes, can you tell us a bit more and what could help you to improve your emotional wellbeing?

_____

_____

Do you worry that your emotional wellbeing may affect your ability to continue in your caring role?

Yes ☐ No ☐

If yes, could you tell us how your caring role would be affected and what would help you to be able to continue caring?

_____

Have you contacted your GP or other health worker about your emotional wellbeing?

Yes ☐ No ☒

If yes, can you tell us a bit more and what could help you to improve your emotional wellbeing?

_____

_____

Does your caring role have an impact on your relationship with the person you care for?

Yes ☐ No ☐

If yes, can you tell us a bit more and what could help you to improve your relationship?

_____

_____

LIFE BALANCE

Does your caring role affect your life balance?

Yes ☐ No ☐

If yes, can you tell us a bit more and what could help you to improve your relationship?

_____

_____

Are you able to keep up good relationships with other family members or friends?

Yes ☐ No ☐

If no, could you tell us how these relationships are affected?

_____

_____

Are you able to take time out or have a break to enjoy other interests?

Yes ☐ No ☐

If no, what would help you to get some time away from your caring role?

_____

_____

YOUR EMPLOYMENT AND EDUCATION

Does your caring role affect your ability to work?

Yes ☐ No ☐

If yes, what would help to support you in employment?

_____

_____

Does your caring role affect your ability to continue in education?

Yes ☐ No ☐

If yes, what would help to support you in education?

_____

_____

_____

YOUR FINANCES

Does your caring role impact on your finances?

Yes ☐ No ☐

If yes, would you like information on maximising your income or any of the following supports?

Disability Living Allowance	☐	Carers Allowance	☐
Income Support	☐	Job Seekers Allowance	☐
Housing Benefit	☐	Council Tax Benefit	☐
Personal Independence Payment	☐	Other	☐

EMERGENCY & FUTURE PLANS

If an emergency unexpectedly arose what would your plan look like to meet your daily caring role. What are the practical arrangements for short-term, unplanned circumstances that would need to be put in place?

Emergency Plan:

Who to contact _____
How to contact _____
What to do and how _____

Future planning refers to the longer term plans for the person you care for when you are no longer able to care. Future plans are more in-depth than emergency plans and the carer, cared for person and all other relevant family members or friends should be involved in this plan. The wishes and preferences of the carer and the cared-for person should be taken into account. Some things to consider include, but are not limited to, current care and future care, living arrangements, practical, legal and financial provision including Power of Attorney, guardianship, wills and trusts (if relevant).

Future Plan:

Who to contact _____
How to contact _____
What to do and how _____

SUMMARY OF THE CARER CONVERSATION

This should be a shared joint summary agreed with all parties involved in the conversation as well as the person helping to complete your plan.

YOUR Carers FIRST PLAN

From your conversation identify and agree actions to address your support needs. Think about what will help you, who will help and when your support would be of most benefit to help you to continue in your caring role.

Your Support	***Who will help/ When will it help me most***	***Low/Medium/High***
		
		
		
		

AGREEING YOUR Carers FIRST PLAN

- ✓ I have been actively involved in the conversation and completion of my Carers FIRST Plan. I have seen my completed plan and agree with the contents and support identified for me.
- ✓ I know who to contact if circumstances change and my support needs change.
- ✓ I understand you may need to share my information with other relevant professionals or services in order to support me in my caring role.

Carers signature _____

Date _____

Worker's signature _____

Date _____

REVIEWING YOUR Carers FIRST PLAN

We need to review your plan to check that the support in place is helping to meet the needs of your caring role. The review will be 6-weeks from completion of your Carers FIRST Plan and no less than annually thereafter.

Date support agreed (as above) _____

Date of review _____

Type of review 6 weeks ☐ Annual ☐ Other ☐

Location of review _____

I will contact _____ if circumstances change.

Office Use only

Is this a new support plan or review of an existing plan?

New plan ☐ Review ☐

Source of referral

Carer ☐ social work ☐ GP ☐ other health/NHS ☐

Carers Centre ☐ Other ☐

Date Support plan requested:_____

Date Support plan offered:_____

NORTH AYRSHIRE HEALTH & SOCIAL CARE PARTNERSHIP LOCAL OFFICES

Opening hours

Mainland offices are open: Monday to Thursday 9am to 4.45pm and Friday 9am to 4.30pm

Three Towns

Telephone: 01294 310005
Address: The Town Hall, Countess Street, Saltcoats, KA21 5HW

Irvine & Kilwinning

Telephone: 01294 310300
Address: Bridgegate House, Irvine, KA12 8BD

North Coast

Telephone: 01475 687592
Address: Brooksby Medical and Resource Centre, 31 Brisbane Road, Largs, KA30 8LH

Garnock Valley

Telephone: 01505 684551
Address: Craigton Road, Kilbirnie, KA25 6LJ

Arran

Telephone: 01770 600742
Address: Council Offices, Lamlash, Isle of Arran, KA27 8JY

Cumbrae

Telephone: 01475 530742
Address: Garrison House, The Garrison, Millport, Isle of Cumbrae, KA28 ODG

Cumbrae office opening hours

Monday 1pm to 5pm
Tuesday 1pm to 7.30pm
Wednesday and Thursday CLOSED
Friday 10am to 1pm & 2pm to 5pm

North Ayrshire Health & Social Care Partnership
Guidance on Waiving of Charges & Replacement Care - Unpaid Carers

Background

1.1 The National Carers Strategy for Scotland recognises that carers, whatever their circumstances, should be able to enjoy the same opportunities in life as other people without caring responsibilities and be able to achieve their full potential as citizens.
1.2 Carers should be considered as equal partners in care, where they are supported to manage their caring responsibilities with confidence and in good health and to have a life of their own outside of caring.
1.3 Carers should be fully engaged in the planning and development of their own support and of the services for the people they care for.
1.4 Carers should not be disadvantaged, or discriminated against, by virtue of their caring role.
1.5 All of these principles should be considered in the production, implementation and delivery of charging policy.

Legislative Framework

2.1 Section 3 of the Self-directed Support (Scotland) Act 2013, section 22 of the Children (Scotland) Act 1995, and the Carers (Waiving of Charges for Support) (Scotland) Regulations 2014, gave North Ayrshire Health & Social Care Partnership (NAHSCP) the **power to provide all carers** with support to help them continue in their caring role. Where we identified a need, applied eligibility criteria and agreed to provide support, this **discharged our duty to offer all self-directed support options**.
2.2 Similarly, the Self-directed Support (Direct Payments) (Scotland) Regulations 2014 prevent NAHSCP from means testing or requiring a contribution from a carer where carer support is being delivered by way of a Direct Payment.
2.3 The Carers (Scotland) Act 2016 introduces replacement Regulations encompassing all previous powers and duties to support carers under section 24(4) of the Act 2016. The requirement to waive charges for carers remains the same.

> *KEY MESSAGE: Charges will not be made for support provided to carers either directly by local authorities or commissioned by the local authority through other statutory, independent and third sector bodies. However, if a carer wishes to supplement and pay for support above the agreed assessed level they will receive through self-directed support, then this is a matter entirely between the individual carer and provider.*

Carer Support

3.1 There are challenges in deciding how and when certain forms of support meet the needs of the carer or the person they care for, or both. It is particularly difficult when the carer lives with the person they care for. The difference is subtle but vital to the waiving of charges.

3.2 The Adult Carer Support Plan (ACSP) / Young Carer Statement (YCS) are the tools that give carers the opportunity to talk about the impact of caring and how able and willing they are to continue to care for someone, alongside maintaining their quality of life. These conversations along with professional judgement are fundamental to the waiving of charges.

3.3 Carers may also be in receipt of support or services from the Health & Social Care Partnership because of their own assessed needs. These are not considered under section 24 of the Act and normal financial assessment(s) and charging policies apply.

3.4 Where a carer's identified needs are met as a result of support delivered to the person they care for, this is also not support under section 24 of the Act, normal local charging policy applies.

Breaks from Caring

4.1 Section 25 of the Act requires NAHSCP to consider a break from caring as an option of support for the carer to enable them to continue in their caring role, if willing and able to do so.

4.2 A break from caring can be any form of support that helps a carer to have time away, from their normal caring responsibilities. This can be within or out with the carers home. Breaks can be taken together with the person they care for, with extra help, or they can be taken apart.

Short breaks can include time to:

- maintain friendships
- rest and recharge your batteries
- enjoy personal interests, leisure or cultural activities

A break can be:

- a regular hour to yourself
- a one-off occasion
- daytime or overnight stay(s)

4.3 Where a break from caring is an agreed form of support, NAHSCP must waive the charges to support the carer to take a break as detailed in their ACSP/YCS. All components of the break will be considered but there are some elements that will not be subsidised.

4.4 The above bulleted suggestions for type and length of break are not exhaustive. The conversation between the carer and lead professional provides an opportunity to explore different ways to meet their outcomes. The focus of the good conversation (Talking Points) approach should be to maintain the health, wellbeing and quality of life of the carer.

4.5 There is no set resource allocation to support carers so it needs professional judgement linked to application of eligibility criteria to inform the allocation of any formal resources, as agreed by the Service budget holder.

Replacement Care

5.1 When a carer's needs for support are agreed as eligible and a break from caring is an appropriate form of support, there will need to be consideration of appropriate care for the person they care for during their absence. In some cases, this will be provided by family, friends or other community supports, but there may be a need for formal replacement care.

5.2 Replacement care according to the Act is;

"Care provided to the cared-for person, which replaces care previously given by the carer and which is provided as a form of support to the carer so the carer can have a break from caring."

5.3 Challenges may arise in determining who will benefit from the replacement care. There are key questions to consider –:
Is the care being provided to the cared-for person primarily in order to provide the carer with a break from caring? In this regard the following points need to be considered;

5.3.1 Is the care being provided to the cared-for person? If the answer is no, it is not replacement care.

5.3.2 Is the care replacing care routinely given by the carer? This will be answered in the ACSP or YCS when discussing the nature and extent of the caring role and tasks. There will be circumstances where the unpaid care usually provided by the carer cannot be exactly replicated by paid care.

5.3.3 Is the purpose of the care primarily for the carer to have a break? Time out for the carer can be achieved as a welcome consequence of the support. This would not constitute replacement care.

5.3.4 Aside from the need for a break, is the carer able and willing to resume their caring role after their break? This will be answered in the ACSP or YCS when discussing the nature and extent of the caring role and if the carer is willing and/or able to provide care. Where the carer is unable or unwilling to provide care then this is not replacement care to allow the carer to take a break. It could be if the carer is ill, in hospital or in recovery. If the carer wishes to pursue full or part-time work and will stop or reduce the care they provide. Employment is not a form of break and care provided would be to meet the cared-for persons identified needs. If some other reason results in the carer being unwilling or unable to provide the same level of care, then this would result in unmet need for the cared-for person.

5.3.5 For young carers, aside from the break, is it appropriate for them to continue in their caring role? This will be answered in the YCS when discussing the nature and extent of the caring role and tasks. Replacement care would not be provided in order to relieve a young carer from inappropriate caring responsibilities. This is unmet need for the cared-for person. Again it is not allowing the carer to have a break to help sustain their caring situation, instead it is to relieve them of responsibilities on a more permanent basis.

KEY MESSAGE: NAHSCP might decide to arrange replacement care for a cared-for person as part of the support which they provide to a carer under section 3 of the 2013 Act in order to give a break from caring. Where replacement care is provided as support under section 3 in order to meet the carer's needs, the local authority must waive charges for the cost of the replacement care.

Breaks with the Cared-For Person

6.1 This type of break would potentially meet both their outcomes. In these circumstances it is expected that the costs for any additional support could be included in the cared-for person's assessed needs and subsequent support package.

Links to relevant Legislation/Statutory Guidance

Self-directed Support - http://www.legislation.gov.uk/asp/2013/1/contents/enacted
Direct Payment - http://www.legislation.gov.uk/ssi/2014/25/contents/made
Carers - https://www.legislation.gov.uk/asp/2016/9/contents
NAC Charging Policy - https://www.north-ayrshire.gov.uk/health-and-social-care/accessing-health-social-care-services/social-services-charging-policy.aspx
Talking Points - http://www.jitscotland.org.uk/wp-content/uploads/2014/01/Talking-Points-Practical-Guide-21-June-2012.pdf

Integration Joint Board
21 June 2018

Subject:	**Mental Welfare Commission For Scotland: Report On The Right To Advocacy**
Purpose:	The purpose of this report is to submit to the IJB a report published by the Mental Welfare Commission for Scotland in March, 2018, on the Right to Advocacy (Appendix 1). It also outlines the response proposed locally to the recommendations made within the Commission's report.
Recommendation:	That the Integration Joint Board notes the findings detailed in the report by the Mental Welfare Commission and approves the proposed actions including the preparation of a Strategic Advocacy Plan in collaboration with partner organisations.

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

1.	**EXECUTIVE SUMMARY**
1.1	Local authorities and health boards have a legal duty to provide independent advocacy for people who have a mental disorder (this includes people who have a mental illness, learning disability or personality disorder, and covers people with dementia and acquired brain injury) under the Mental Health (Care and Treatment)(Scotland) Act 2003. This is not restricted to people subject to compulsory measures; "everyone with a mental disorder is entitled to access independent advocacy, regardless of which piece of legislation is being considered, and indeed, when no legislative intervention is being considered at all" (Patrick & Smith 2009).
1.2	Under the Adult Support and Protection (Scotland) Act (2007) local authorities are required to "have regard to the importance of the provision of appropriate services (including, in particular, independent advocacy services) to the adult concerned". Therefore it must be considered whether advocacy is required for any adult subject to ASP procedures, however, as identified above advocacy must be offered to any adult subject to ASP who has a mental disorder.
1.3	There is a range of legislation in Scotland that requires the local authority to give regard to the views of children, including the Children (Scotland) Act 1995, Children's Hearings (Scotland) Act 2011 and the Children and Young People (Scotland) Act 2014. This may involve the provision of advocacy to ensure children are able to express their views. Under the Mental Health (Care and Treatment)(Scotland) Act 2003, all children with a mental disorder are entitled to independent advocacy.

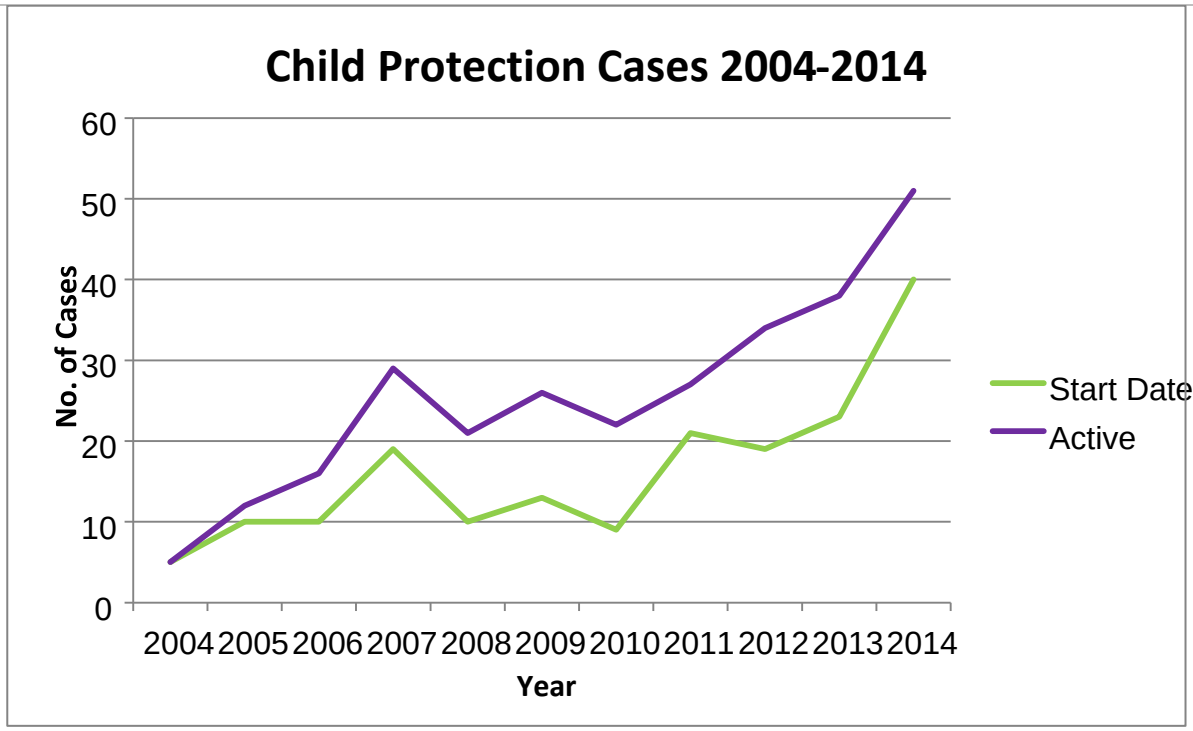
1.4	Under the Equality Act 2010, local authorities and health boards have a statutory duty to ensure services provided are equitable and accessible and that any barriers to this are addressed. For people who are marginalised or face discrimination it is particularly important that they have access to independent advocacy to ensure equitable access to services. People may face discrimination or exclusion of the basis of age, gender, ethnicity, disability, sexual orientation, mental health or substance dependency. This duty requires consideration of the provision of advocacy on a wider basis than that required for people with a mental disorder.
1.5	In addition to legal requirement, there is a range of policy and guidance that recommends access to advocacy for particular groups, such as Getting It Right for Every Child (2010) and Advocacy for Unpaid Carers, Guidance (2016).
	Mental Welfare Commission
1.6	The Mental Health (Scotland) Act 2015 built upon the right to independent advocacy in the 2003 Act by requiring health boards and local authorities to advise the Mental Welfare Commission about how they ensure access to services, both up until now and in the future.
1.7	The Mental Welfare Commission report on the Right to Advocacy is based on information the Commission collected from health boards and local authorities, and from the new health and social care partnerships (HSCPs). The Commission asked about the services available in local areas, and how these organisations are planning for the future provision of advocacy services and to improve access to advocacy. The Mental Welfare Commission also asked local authorities to tell them if their integrated children's services plans covered the provision of independent advocacy services for children and young people with mental illness, learning disability or related conditions.
1.8	The Scottish Government's expectation, set out in the document Independent Advocacy: Guide for Commissioners, published in December 2013, is that local strategic advocacy plans should be developed.
1.9	Independent advocacy, in all its forms, seeks to make sure people are able to have their voice heard on issues which are important to them, and have their views and wishes genuinely considered when decisions are being made about their lives. It is an important part of the process of safeguarding rights. It is a particularly important safeguard for people with a 'mental disorder', who may find that their views and wishes are not always taken seriously, or may not be fully involved in decisions about their care and treatment.
2.	**BACKGROUND**
2.1	North Ayrshire Health & Social Care Partnership submitted a response to the Mental Welfare Commission's questionnaire which was issued in July 2017. A link to this is provided within Appendix 1. In this the Health & Social Care Partnership confirmed that it commissions independent advocacy services for adults in South Ayrshire.
2.2	<u>Current Situation in North Ayrshire</u> North Ayrshire Health and Social Care Partnership carried out a scoping exercise during 2017 to identify the level of advocacy provision, the level of need and any gaps in service provision. This resulted in an increase in funding for adult provision of advocacy in the area.

2.3	The scoping exercise also identified a gap in service for children and young people who have a mental disorder (where they are not on the child protection register or looked after and accommodated. It should be noted that children in kinship care are not currently covered under the looked after and accommodated group). The provision of advocacy for children and young people in North Ayrshire requires further review to inform commissioning.
2.4	<u>Demand for Advocacy in North Ayrshire</u> The scoping exercise identified an increased numbers of referrals for advocacy within the area over a number of years. This includes the following data which informs a potential need for advocacy:
2.5	A steady and sustained rise in applications made under Adults with Incapacity legislation over a number of years. Table 1 provides figures for the number of applications within North Ayrshire over a 10 year period:

Table 1

2006 - 2007	16
2007 - 2008	22
2008 - 2009	32
2009 - 2010	41
2010 - 2011	44
2011 - 2012	52
2012 - 2013	48
2013 - 2014	62
2014 - 2015	82
2015 - 2016	66
Total	**465**

2.6	There has also been a significant increase in referrals for parents of children subject to child protection processes (as shown in Table 2 below). Between 2010 and 2014, the percentage of AIMS Advocacy cases related to Child Protection almost tripled, with an increase from 4.86% to 13.78%. Table 2 shows an increase in referrals over a 10 year period.

2.7	**Table 2**
	
2.8	In addition to this there appears to been some change in the nature of advocacy accessed, with an increase in the level of complexity within the advocacy role. One reason for this may be increasingly complex processes and systems that people are required to navigate to access support. This change results in an increased amount of advocacy hours being required once a piece of work has started.
2.9	There is also likely to be an increasing need for advocacy out with that required on a statutory basis, as indicated by factors such as an ageing population and levels of deprivation in North Ayrshire.
2.10	<u>Advocacy Provision in North Ayrshire</u> North Ayrshire Health and Social Care Partnership currently fund the following provision for advocacy: • AIMS Advocacy (adults and older people): £275.454 annual budget in 2018-19 rising incrementally to £308.950 in year 5 of the contract (funded via social services, mental health, and NHS) • Who Cares? Scotland (looked after and accommodated children and young people): £52,780 annual budget (funded via social services, children and families) • Children First (children and young people): £79,000 annual budget (funded via social services, children and families) • Community Housing Advocacy Project (CHAP): £55,000 annual budget (funded via housing)

3.	**PROPOSALS**
3.1	In its report the Mental Welfare Commission recognises the role and remit of Integration Joint Boards (IJBs) and their responsibility for planning integrated arrangements, for strategic planning and for the delivery of services. It has indicated, given this that it expects that responses to its recommendations will be discussed by each IJB. One of the major recommendations of the report is that each area should have a Strategic Advocacy Plan.
3.2	In addition, the Commission has made the following recommendations in its report: • Ensure that there is clarity about which organisation will be responsible for coordinating the preparation of a strategic advocacy plans for its area. • Ensure that strategic advocacy plans are in place by the end of December 2018. • Ensure that strategic plans are developed based on a local needs assessment and information about unmet need and gaps in local provision. • Ensure that advocacy planners carry out equalities impact assessments and develop approaches to monitoring and enabling access to advocacy which cover all the protected characteristics.
3.3	Specific recommendations relating to services for children and young people included in the report are: • Ensure there is clarity about where the responsibility lies for planning and commissioning independent advocacy services which are accessible for all children and young people under 18 with a mental disorder. • Ensure that arrangements for planning for the provision of independent advocacy services for children and young people include processes for assessing the projected need for these supports.
3.4	The Mental Welfare Commission has asked for a response to its report and the recommendations it has made by 30th June, 2018.
3.5	The Director of Health and Social Care is proposing that the HSCP work with its partners to produce a Strategic Advocacy Plan for all of those requiring access to services and that this be submitted for IJB approval prior to the due date of 31st December, 2018.
3.6	**Strategic Advocacy Plan** Ayrshire and Arran had an independent advocacy strategic plan in place between 2012 and 2014. This was developed by NHS Ayrshire and Arran in partnership with each of the local authorities in Ayrshire.
3.7	As the right to advocacy covers all service user groups, a meeting will be arranged involving staff from children's services, adult and older people's services, housing, and contracts and commissioning. This will provide a starting point for planning the development of a strategic advocacy plan, action plan and equalities impact assessment.
3.8	During the scoping exercise, it was identified that further consultation with people who use, or may require, advocacy is required to provide a fuller understanding of the need for advocacy and advocacy provision within North Ayrshire. This will be progressed within the process of developing a strategic advocacy plan and action plan.

3.9	**Anticipated Outcomes**
	The proposals set out in this report is in alignment with and will assist the Integration Joint Board to deliver against the following Strategic Objectives set out in the North Ayrshire Strategic Plan for 2018-21: • Tackling inequalities • Bringing services together • Prevention and early intervention • Engaging communities • Improving mental health and wellbeing
3.3	**Measuring Impact**
	Impact of current provision to be reviewed and engagement/consultation with stakeholders to be undertaken.
4.	**IMPLICATIONS**

Financial:	There are no additional financial implications arising directly from the consideration of this report.
Human Resources:	There are no human resource implications arising directly from the consideration of this report.
Legal:	There are no legal implications arising directly from the consideration of this report.
Equality:	There are no equalities implications arising directly from the consideration of this report. A full Equalities Impact Assessment will be prepared as part of the exercise to develop a Strategic Advocacy Plan.
Children and Young People	This report identifies a gap in service for children and young people who have a mental disorder (where they are not on the child protection register or looked after and accommodated. It should be noted that children in kinship care are not currently covered under the looked after and accommodated group). The provision of advocacy for children and young people in North Ayrshire requires further review to inform commissioning.
Environmental & Sustainability:	There are no environmental sustainability issues arising from any decisions made on this report.
Key Priorities:	Tackling inequalities, improving mental health and wellbeing, engaging communities.
Risk Implications:	There are no risk implications arising from the consideration of this report.
Community Benefits:	Strategic Advocacy Plan will ensure equitable access to services and ensure any barriers to equitable provision are addressed.

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	

5.	**CONSULTATION**
5.1	During the scoping exercise, it was identified that further consultation with people who use, or may require, advocacy is required to provide a fuller understanding of the need for advocacy and advocacy provision within North Ayrshire. This will be progressed within the process of developing a strategic advocacy plan and action plan. An initial consultation with East and South Health & Social Care Partnership has been undertaken to inform the development of this report and next actions required. A copy of South Health & Social Care Partnership IJB Report presented on 15 May 2018 and also East Health & Social Care Partnership response to the report on The Right to Advocacy is contained within the appendices.
5.2	A decision is required about whether strategic advocacy plans should be developed on a pan Ayrshire basis or by each HSCP within Ayrshire.
6.	**CONCLUSION**
6.1	A strategic Advocacy Plan will be developed with the following milestones and timescales: • Provide response to Mental Welfare Commission report and recommendations by 30 June 2018 with proposal for the Health & Social Care Partnership to work with it's partners and stakeholders to produce a strategic Advocacy Plan. • Consultation and Engagement events to be developed by September 2018 with ongoing consultation and participation • Final plan to be submitted to IJB for approval no later than November 2018 • Submission of plan to Mental Welfare Commission by 31 December 2018.

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ADVOCACY PLAN 2017 TO 2021 for EAST AYRSHIRE

Introduction

New Statutory duties are placed on Health Boards and Local Authorities under the Mental Health [Scotland] Act 2015. In East Ayrshire we are a Health and Social Care Partnership and wish to look at our previous plan and update this with current work and values.

The Mental Health [Care & Treatment] [Scotland] Act 2013 states that any person with a mental illness, learning disability, dementia and related conditions has a right to access Independent Advocacy. Partnerships, which are a mix of health and social care, should work together to ensure people have independent advocacy available in their area. That appropriate steps are taken to ensure people have the opportunity to make use of those services.

This plan continues to have the desire already well established in East Ayrshire to set the strategic and practical direction for Ayrshire based independent advocacy.

Definition and Scope of Independent Advocacy

The Scottish Independent Advocacy Alliance [SIAA, 2010] defined that advocacy:

- Safeguards people who are vulnerable and discriminated against or whom service find difficult to serve.
- Empowers people who needs a stronger voice by enabling them to express their own needs and make their own decisions.
- Enables people to gain access to information, explore and understand their options, and to make sure their views and wishes known.
- Speaks up on behalf of people who are unable to do so for themselves.

The role of the advocate is to ensure that the voice and opinions of the vulnerable person are heard particularly in circumstances where decisions are being made by the service systems that will directly affect or impact on that vulnerable person. Therefore the loyalty of the independent advocate lies solely with the person for whom they are advocating.

Roles and Responsibilities/Commissioning

Independent Advocacy is usually provided by the voluntary sector, community led, charitable advocacy organisations. Independent advocacy service provision can take a number of different formats dependent on the type of advocacy provision being offered by the advocacy organisation.

It is vital that the role of independent advocacy is not compromised in any way. As such, it is important to ensure that the advocacy services provided to an individual are separate from the interests of all other persons concerned with the individuals care or welfare. On that basis in East Ayrshire, advocacy is provided locally and

independent from the Statutory Partnership via a Service Level Agreement with East Ayrshire Advocacy Services Ltd (EAAS).

The service whilst jointly funded this is ring fenced and Grant Funded to ensure the independence is kept at all levels. Scrutiny is undertaken by the commissioner and then further scrutinised by the Grants Committee which has Elected Members on Board to ensure quality, best value and independence is maintained. It further allows the opportunity through Planning and Performance for the advocacy organisation to feedback directly out-with the commissioning role and reporting mechanisms.

Children's Advocacy

Independent advocacy for our children and young people in East Ayrshire is mostly undertaken by Who Cares? Scotland, and is provided for young people who are Looked After and Accommodated, or who have previously been so. Requests for advocacy are responded to by the Who Cares? Scotland youth support officer who supports the young person to complete or achieve their desired outcome.

Who Cares? Scotland also provides independent advocacy services for very young children (including babies) involved in the permanency planning process to help reduce delay in permanency planning.

East Ayrshire H&SCP was responsible for the care of 504 children and young people in the financial year 1 April 2017 – 31 March 2018. The children were supported in various accommodation settings including kinship care, internal and external fostering, external education/residential placements, external secure accommodation and residing within our East Ayrshire Children's Houses.

While recognising that all of these children and young people are vulnerable, we are faced with resource constraints which mean finding a balance between what we have, against identified need, with a model which only allows us access to one youth support worker for East Ayrshire. With this in mind we have to be ambitious about developing this service to represent the number of young people who request advocacy, in particular for those children and young people who are looked after at home and who would not necessarily know how to access advocacy and have their voices heard. Additionally, our current contract with Who Cares? Scotland includes North and South Ayrshire in an Ayrshire wide contract. This will only be the case during 2018/2019 financial year as North and South Ayrshire are preparing to tender for independent advocacy services at the end of this period.

Funding

The annual budget for Who Cares? Scotland is £158,340 split equally between the three Ayrshire Authorities. The annual funding paid by East Ayrshire Council is £52,780 and this will remain the case until the end of 2018/2019 when North and South Ayrshire go to tender for independent advocacy we shall review the funding terms for the Who Cares? Scotland. This is unlikely to result in savings and means our financial resource to expand independent advocacy services will be unchanged i.e. there is no current identified resource to expand the service.

The current contract agreed by East Ayrshire and Who Cares? Scotland is over a period of 2 + 1 + 1 years from April 2018 until March 2022.

East Ayrshire Advocacy Service

In addition to Who Cares? Scotland, East Ayrshire Advocacy Service (EAAS) provides independent advocacy which impacts on our children and young people through supporting their parents. Where a parent has mental health problems, a brain injury or learning disability, EAAS can provide them with support going through the Child Protection process, assisting in reading materials, writing reports and speaking on their behalf at meetings, Children's Hearings and other forums where required.

ADVOCACY FOR ADULTS AND OLDER PEOPLE

Currently independent advocacy provision (via EAAS Ltd) is prioritised for East Ayrshire residents aged 16-65 yrs who have:

- Mental Health issues
- Learning disability
- Acquired Brain Injury

All provided on a one to one basis and via group advocacy.

- *This service is also available to any East Ayrshire resident over the age of 65 yrs.*

o Prison Advocacy at HMP Kilmarnock [35 hours per week with cover for all annual leave]

❖ Psychiatric setting at Woodland Hospital [1 to 1 and a patients forum once a week]

✓ Parents who have a LD/MH/Addiction – 35 hours per week with cover for all annual leave]

- Young people under the age of 16yrs who are subject to Mental Health Legislation

Funding

The annual funding in respect of Advocacy is £348,676. This is grant funded and will be reviewed annually by the Elected Members, Council Planning and Performance Team.

Need for Independent Advocacy in East Ayrshire

During 2016/17 we saw a significant increase in referrals to the advocacy.
Older people's services = 1451
Children and Families = 757

People supported who were subject to Adult Support and Protection Procedures = 23
People supported who were subject to Adults with Incapacity Legislation = 77
People supported who were subject to Mental Health [Care and Treatment] [Scotland]… = 349

Demography shows that the amount of residents in East Ayrshire and future investment in housing will attract more people into the area. This proportionally we anticipate a rise in demand by around 40% over the next few years, potentially.

Raising Awareness

EAAS promotes its independence and service through leaflets, website and talks at schools, colleges, day centres etc.

There is a high level profile at management meetings where the service sits in partnership at the table. This allows the service to identify any potential areas they can offer support and for the management team to be able to establish if the service has the capacity or may leave a gap in the service.

The service places great importance on networking with other organisations both statutory and voluntary in order to create a better understanding of independent advocacy and its role. EAAS is also an active member of the Third Sector Forum and as a Community Planning Partner, promotes the protection of children and the safety of vulnerable adults, individuals and families.
Awareness raising sessions are regularly held for student nurses, social workers, nursing home staff and carers to highlight the service and referral pathway.
EAAS also sits on the Management Board of the Scottish Independent Alliance and is committed to promoting and defending independent advocacy throughout Scotland.

Monitoring and Governance

There are agreed activities and outputs with quarterly updates. Face to face support and discussion with the Commissioner.

Areas that are covered:
Pathways to access and use the advocacy service.
Communication Strategies and plans to reach vulnerable people.
Awareness raising both within statutory and voluntary sectors.
Appropriate, up to date and accessible information and systems so people can make informed choices.
Drop in offered in localities.
Oversight of needs being delivered/met.
Attendance and support with reviews, Care programme meetings, discharge planning, Tribunals.
Support network of advocacy groups.

Training.
Quick response timescales set and targets met.

Strategic Vision

The vision remains one of a desire to ensure that all vulnerable people within East Ayrshire have timeous access to independent advocacy as necessary.

That this service is the best and remains sustainable and in line with current legislation and guidance.

"All vulnerable people living in Ayrshire are pro-actively supported to access the independent advocacy services to which they are entitled, in order to have their voice and opinions heard, make informed choices and maintain control over their lives" **A Joint Strategic Plan for Ayrshire and Arran 2012 – 2014**

Consultation/stakeholder engagement

This plan will be subject to ongoing engagement and starts with events being held on the 28th September 2017 in Kilmarnock and 5th October 2017 in Cumnock. The focus for these events will be:

- ✓ Consultation on the plan for 2017 to 2021
- ✓ How we engage
- ✓ Agreeing priorities
- ✓ Consult on the final plan
- ✓ Ongoing consultation, participation – how we know the plan is working and where it may need changed or added to.

27th August 2017

Mental Welfare Commission: Right to Advocacy report and recommendations

1. **Ensure there is clarity about which organisations will be responsible for coordinating the preparation of strategic advocacy plans for their area.**

   Ayrshire and Arran had an independent advocacy strategic plan in place between 2012 and 2014. This was developed by NHS Ayrshire and Arran in partnership with each of the local authorities in Ayrshire. A decision is required about whether strategic advocacy plans should be developed on a pan Ayrshire basis or by each HSCP within Ayrshire.

   The MWC report includes reference to South Ayrshire advising that they do not plan to develop a strategic advocacy plan as advocacy provision and planning will be included in individual care group plans, such as their mental health and learning disability strategies. This may influence the decision about whether a pan Ayrshire approach is taken.

   Ayrshire and Arran have already advised the MWC that the HSCPs are responsible for planning and commissioning advocacy. This would indicate a joint approach between NHS and the local authorities for the development of any strategic plan.

   The Mental Welfare Commission has developed a template which will assist with the development of a strategic advocacy plan.

2. **Ensure that strategic advocacy plans are in place by the end of December 2018.**

   Further to the decision about whether strategic plans will be developed within each HSCP or on a pan Ayrshire basis, an action plan will be required setting out timescales for consultation with service users, carers, third sector organisations, advocacy providers as well as HSCP staff.

3. **Ensure that strategic plans are developed based on a local needs assessment, and information about unmet need and gaps in local provision. They should be developed in partnership with people who use or may use services, and with service providers. Barriers people may experiencing accessing advocacy support, including barriers created by prioritisation criteria and people being placed outwith their home areas, should be addressed in plans.**

   North Ayrshire HSCP carried out a scoping exercise regarding the need for advocacy in 2017. This informed the need for an increase in adult provision of advocacy. It also highlighted specific gaps, such as in relation to children and young people with a mental disorder. This can provide a foundation for the strategic plan.

   There remains a need to seek the views of service users, carers and service providers to add to this information. This requirement will form part of the action plan to develop a strategic advocacy plan.

4. **Ensure that advocacy planners carry out equalities impact assessments and develop approaches to monitoring and enabling access to advocacy which cover all the protected characteristics.**

   The main provider of advocacy for adults in North Ayrshire is currently required to gather monitoring data. This provides information about the groups that are accessing the service so that it can be identified if any particular groups are not using the service and lead to action to address this (similar for housing and children's advocacy services?).

An equalities impact assessment will be undertaken alongside the development of a strategic advocacy plan and will inform actions required to ensure services are accessible and that barriers to access are addressed.

5. **Ensure there is clarity about where the responsibility lies for planning and commissioning independent advocacy services which are accessible for all children and young people under 18 with a mental disorder. This includes children and young people receiving care and treatment on an informal basis, or in placements outwith their home area.**

   Information required from children's services.

6. **Ensure that arrangements for planning for the provision of independent advocacy services for children and young people include processes for assessing the projected need for these supports.**

   Information required from children's services.

South Ayrshire Health and Social Care Partnership

REPORT

Meeting of South Ayrshire Health and Social Care Partnership **Held on**	**Integration Joint Board** **15 May 2018**
Agenda Item	
Title	**MENTAL WELFARE COMMISSION FOR SCOTLAND: REPORT ON THE RIGHT TO ADVOCACY**

Summary:

The purpose of this report is to submit to the IJB a report published by the Mental Welfare Commission for Scotland in March, 2018, on the Right to Advocacy. It also outlines the response proposed locally to the recommendations made within the Commission's report.

Presented by	**Tim Eltringham, Director of Health and Social Care**

Action required:

That the Integration Joint Board (1) notes the findings detailed in the report by the Mental Welfare Commission; and (2) approves the action proposed by the Director of Health and Social Care to address these in South Ayrshire, including the preparation of a Strategic Advocacy Plan in conjunction with partner organisations.

Implications checklist – check box if applicable and include detail in report									
Financial	☐	HR	☐	Legal	☐	Equalities	☐	Sustainability	☐
Policy	☐	ICT	☐						

Directions required to NHS Ayrshire & Arran South Ayrshire Council, or both	1. No Direction Required	X☐
	2. Direction to NHS Ayrshire and Arran	☐
	3. Direction to South Ayrshire Council	☐
	4. Direction to NHS Ayrshire and Arran and South Ayrshire Council	☐

SOUTH AYRSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP
INTEGRATION JOINT BOARD
15 May 2018
Report by Director of Health & Social Care

MENTAL WELFARE COMMISSION FOR SCOTLAND: REPORT ON THE RIGHT TO ADVOCACY

1. PURPOSE OF REPORT

1.1 The purpose of this report is to submit to the IJB a report published by the Mental Welfare Commission for Scotland in March, 2018, on the Right to Advocacy (Appendix 1). It also outlines the response proposed locally to the recommendations made within the Commission's report.

2. RECOMMENDATION

2.1 That the Integration Joint Board (1) notes the findings detailed in the report by the Mental Welfare Commission; and (2) approves the action proposed by the Director of Health and Social Care to address these in South Ayrshire, including the preparation of a Strategic Advocacy Plan in conjunction with partner organisations.

3. BACKGROUND INFORMATION

3.1 The Mental Health (Care and Treatment) (Scotland) Act 2003 imposed a duty on local authorities and health boards to collaborate to ensure the availability of independent advocacy services in their area. The Act gave everyone with mental illness, learning disability, dementia and related conditions the right to access independent advocacy support. The Mental Health (Scotland) Act 2015 builds on the right in the 2003 Act to independent advocacy support, by requiring health boards and local authorities to tell the Mental Welfare Commission how they have ensured access to services up to now, and how they plan to do so in the future.

3.2 The report is based on information the Commission collected from health boards and local authorities, and from the new health and social care partnerships (HSCPs). The Commission asked about the services available in local areas, and how these organisations are planning for the future provision of advocacy services and to improve access to advocacy. The Mental Welfare Commission also asked local authorities to tell them if their integrated children's services plans covered the provision of independent advocacy services for children and young people with mental illness, learning disability or related conditions.

3.3 The Scottish Government's expectation, set out in the document Independent Advocacy: Guide for Commissioners, published in December 2013, is that local strategic advocacy plans should be developed.

3.4 Independent advocacy, in all its forms, seeks to make sure people are able to have their voice heard on issues which are important to them, and have their views and wishes genuinely considered when decisions are being made about their lives. It is an important part of the process of safeguarding rights. It is a particularly important safeguard for people with a 'mental disorder', who may find that their views and wishes are not always taken seriously, or may not be fully involved in decisions about their care and treatment.

4. REPORT

4.1 South Ayrshire HSCP submitted a response to the Mental Welfare Commission's questionnaire which was issued in July, 2017. A link to this is provided at the Background Papers Section at the end of this report. In this the HSCP confirmed that it commissions independent advocacy services for adults in South Ayrshire. Currently this is provided by Circles Network. In South Ayrshire advocacy services have been commissioned to support adults, aged 16 years old and over under the following categories:

- Adult Advocacy in terms of the Mental Health (Care and Treatment) (Scotland) Act 2003 i.e. the service is available to people aged 18 years up to 65 years who have a mental disorder, defined as any mental illness, personality disorder or learning disability;

- Adults aged 65 years and over;

- Adults who are in receipt of support services, or may be in need of such services and are vulnerable by reason of age, illness or mental or other disability;

- Residents of care homes where there is a concern that their needs are not being addressed;

- Adults with incapacity as defined by The Adults with Incapacity (Scotland) Act 2000;

- Adults covered by the provisions of the Adult Support and Protection (Scotland) Act 2007; and

- Those seeking to access services under the provisions of the Self-Directed Support (Scotland) Act 2013.

4.2 With regards to advocacy provision for children and young people information was sent to the Mental Welfare Commission regarding the advocacy services commissioned locally.

4.3 In South Ayrshire independent advocacy services for children and young people are commissioned from Who Cares? Scotland and Barnardos.

4.4 In its report the Mental Welfare Commission recognises the role and remit of Integration Joint Boards (IJBs) and their responsibility for planning integrated arrangements, for strategic planning and for the delivery of services. It has

indicated, given this that it expects that responses to its recommendations will be discussed by each IJB. One of the major recommendations of the report is that each area should have a Strategic Advocacy Plan.

4.5 In addition, the Commission has made the following recommendations in its report:

- Ensure that there is clarity about which organisation will be responsible for coordinating the preparation of a strategic advocacy plans for its area.
- Ensure that strategic advocacy plans are in place by the end of December 2018.
- Ensure that strategic plans are developed based on a local needs assessment and information about unmet need and gaps in local provision.
- Ensure that advocacy planners carry out equalities impact assessments and develop approaches to monitoring and enabling access to advocacy which cover all the protected characteristics.

4.6 Specific recommendations relating to services for children and young people included in the report are:

- Ensure there is clarity about where the responsibility lies for planning and commissioning independent advocacy services which are accessible for all children and young people under 18 with a mental disorder.
- Ensure that arrangements for planning for the provision of independent advocacy services for children and young people include processes for assessing the projected need for these supports.

4.7 The Mental Welfare Commission has asked for a response to its report and the recommendations it has made by 30th June, 2018.

4.8 The Director of Health and Social Care is proposing that the HSCP work with its partners to produce a Strategic Advocacy Plan for all of those requiring access to services and that this be submitted for IJB approval prior to the due date of 31st December, 2018.

5 STRATEGIC CONTEXT

5.1 The proposals set out in this report will assist the Integration Joint Board to deliver against the following Strategic Objectives set out in its draft Strategic Plan for 2018-21:

- We will improve outcomes for children who are looked after in South Ayrshire.
- We will protect vulnerable children and adults from harm.
- We will work to provide the best start in life for children in South Ayrshire.
- We will reduce health inequalities.

- We will support people to exercise choice and control in the achievement of their personal outcomes.
- We will give all of our stakeholders a voice.

6 RESOURCE IMPLICATIONS

6.1 **Financial Implications**

6.1.1 There are no additional financial implications arising directly from the consideration of this report.

6.2 Human Resource Implications

6.2.1 There are no human resource implications arising directly from the consideration of this report.

6.3 Legal Implications

6.3.1 There are no legal implications arising directly from the consideration of this report.

7 CONSULTATION AND PARTNERSHIP WORKING

7.1 There has been no public consultation on the contents of this report. Stakeholders will be part of the exercise going forward to develop a Strategic Advocacy Plan.

7.2 The Chair and Vice-Chair of the IJB have been consulted on the content of this report.

8 EQUALITIES IMPLICATIONS

8.1 There are no equalities implications arising directly from the consideration of this report. A full Equalities Impact Assessment will be prepared as part of the exercise to develop a Strategic Advocacy Plan.

9. SUSTAINABILITY IMPLICATIONS

9.1 There are no environmental sustainability issues arising from any decisions made on this report.

REPORT AUTHOR AND PERSON TO CONTACT

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BACKGROUND PAPERS

Appendix 1 to Mental Welfare Commission Report outlining questionnaire responses received from HSCPs in respect of Adult Services
https://www.mwcscot.org.uk/media/395521/the_right_to_advocacy_appendices_march_2018.pdf

08.05.18

NORTH AYRSHIRE Health and Social Care Partnership

Integration Joint Board
21st June 2018

Subject:	**PRIMARY CARE IMPROVEMENT PLAN IMPLEMENTATION OF NEW 2018 GMS CONTRACT**
Purpose:	The purpose of this report is to: • Seek approval from members on the requirements set out in the Memorandum of Understanding between Scottish Government, British Medical Association, Integration Authorities and NHS Board for implementing the new General Medical Services (GMS) Contract. • Present the draft Primary Care Improvement Plan and seek approval on the actions, timescales and investment that demonstrate how the new GMS contract will be implemented between 2018 and 2021.
Recommendation:	It is recommended that the Integration Joint Board: (i) Agree the requirements and responsibilities set out in the MoU. (ii) Approve the content, actions and financial spend set out in PCIP for implementing the new GMS contract before 2021.

GP	General Practitioner
GMS	General Medical Services
HSCP	Health and Social Care Partnership
IJB	Integrated Joint Board
LMC	Local Medical Committee
MoU	Memorandum of Understanding

1.	**EXECUTIVE SUMMARY**
1.1	Following the approval on 18 January 2018 to introduce a new GMS Contract in Scotland, Ayrshire and Arran has taken a three stage approach to advise the IJBs and the NHS Board of the requirements in the contract, as well as update on the development of the PCIP seeking approval from the Boards at each stage. This is the third of the three papers presenting the draft PCIP for approval.
1.2	The aim of the plan is to set out a clear direction of travel and act as a core framework for the HSCPs and NHS Board to reform primary care services. The PCIP describes the discussions and actions to date that have been approved through the previously agreed governance and programme arrangements.

1.3	Board areas were advised that the PCIPs should be developed jointly with the GP Sub Committee and signed off by the LMC. The PCIP was co-produced with the GP Sub Committee and approved by the LMC on 12 June 2018.
1.4	The PCIP will be presented to each of the IJBs between the 13 and 27 June 2018 for approval.

2. BACKGROUND

2.1 The first paper presented in February 2018 shared the content of the contract and the key actions set out within the MoU which included that each IJB was required to develop a three year PCIP by 1 July 2018.

2.2 The second paper was presented in March 2018 advising there had been agreement that there should be one coordinated PCIP produced for Ayrshire and Arran, with a focus on local priorities and delivery based on population need

2.3 The paper in March also described the governance arrangements (structures and reporting processes) that had been designed to provide a programme approach to the development of the PCIP. This approach ensured collaborative working across the three HSCPs and NHS Board to produce a joint PCIP in collaboration with the GP Sub Committee, aligned to the MoU priorities.

2.4 East Ayrshire Integration Joint Board is the lead partnership for Primary Care Services in Ayrshire and Arran. The Primary Care Transformation Programme – 'Ambitious for Ayrshire' which was previously co-produced with local Primary Care Professionals, the other HSCPs and the NHS Board.

2.5 The workstreams within the current programme have been aligned to the priorities set out in the MoU to be achieved by 2021. The national priorities include:

- Vaccination Services
- Pharmacotherapy Services
- Community Treatment and Care Services
- Urgent Care
- Additional Professionals for Multidisciplinary Team
- Community Link Workers

The PCIP sets out the remit of each of the Implementation Groups in detail along with the membership on each Group.

3. MEMORANDUM OF UNDERSTANDING

3.1 This MoU, attached as Annex 1, is an agreement between the Scottish Government, the Scottish General Practitioners Committee of the British Medical Association, Integration Authorities and NHS Boards, and represents a landmark statement of intent, recognising the statutory role (set out in the Public Bodies (Joint Working) (Scotland) Act 2014) ("the Act") of Integration Authorities in commissioning primary care services and service redesign to support the role of the GP as an expert medical generalist. The MoU also recognises the role of NHS Boards in service delivery and as NHS staff employers and parties to General Medical Services ("GMS") contracts.

3.2 The MoU provides the basis for HSCPs to develop the PCIP as part of their statutory Strategic Planning responsibilities, setting how additional funding will be used and the timescales for the reconfiguration of services currently delivered under GMS contracts. It is stated that PCIPs should have a specific focus on the key priority areas listed at paragraph 7 of the MoU, with the aim of transitioning their delivery by the wider MDT between 2018 and 2021.

3.3 The respective responsibilities of the Integration Authority (typically delivered through the Health and Social Care Partnership delivery organisations) are:

- Planning, design and commissioning of the primary care functions (including general medical services) delegated to them under the 2014 Act based on an assessment of local population needs, in line with the HSCP Strategic Plan.
- The development of a HSCP Primary Care Improvement Plan, in partnership with GPs and collaborating with other key stakeholders including NHS Boards that is supported by an appropriate and effective MDT model at both practice and Cluster level, and that reflects local population health care needs.
- Collaboration with NHS Boards on the local arrangements for delivery of the new Scottish GMS contract.
- Section 2c of the National Health Service (Scotland) Act 1978 places a duty on NHS Boards to secure primary medical services to meet the reasonable needs of their NHS Board area. To achieve this, NHS Boards can enter into GMS contracts. HSCPs will give clear direction to NHS Boards under sections 26 and 28 of the 2014 Act in relation to the NHS Board's function to secure primary medical services for their area and directions will have specific reference to both the available workforce and financial resources.
- Where there is one or more HSCP covering one NHS Board area, the HSCPs will collaborate under section 22 of the 2014 Act in relation to the effective and efficient use of resources (e.g. buildings, staff and equipment) to achieve coherence and equity across service planning, design and commissioning, ensuring that patient needs identified in care plans are met

4. THE PRIMARY CARE IMPROVEMENT PLAN

4.1 The PCIP, attached as Annex 2, sets out how Ayrshire and Arran plans to implement the new GMS Contract by 31 March 2021. This is an introductory plan that meets both the national and pan Ayrshire requirements as set out in the MoU.

4.2 The aim of the plan is to set out a clear direction of travel and act as a core framework for the HSCPs and NHS Board to reform primary care services. The plan describes the discussions and actions to date that have been approved through the previously agreed governance and programme arrangements. It is noted that further discussion with General Practice, service providers and the public is required as implementation arrangements evolve and mature, this will fall within the Strategic Planning function of the IJBs.

4.3 The new contract introduces greater responsibilities for GP Sub-committees to engage in the implementation of the new contract at a local level and to provide a leadership role in organising and collating the views of GP Quality clusters across their Health Board area, and working with Medical Directors and Cluster Quality Leads to promote a cohesive general practice view on how the IJBs

commission services. This approach has been encouraged throughout the development of the PCIP and as implementation progresses, it is expected that the plans will become more detailed with local ownership.

4.4 Each requirement within the MoU has been addressed through the implementation action plans along with associated workforce and funding plans. The implementation and recruitment plans have been developed on the basis that initial funding will be available across 2018/19 and 2019/20.

4.5 The PCIP is being presented to each of the IJBs, NHS Board and Local Medical Committee in June for approval before submission to Scottish Government no later than 1 July 2018.

5 PRIMARY CARE IMPROVEMENT FUND

5.1 The Integration Joint Boards and NHS Board have received confirmation from Scottish Government of the allocated Primary Care Improvement Fund (PCIF) for 2018/19 which will be used by IJBs to commission primary care services, and is allocated on an NRAC basis through Health Boards to IJBs.

5.2 To assist with preparation of the PCIP, Scottish Government has announced its commitment to increase the overall funding to £250 million by 2021-22. Strictly as a planning assumption, and subject to amendment by Ministers, the IJBs have been advised that it is expected that the Primary Care Improvement Fund (PCIF) will increase to approximately £55 million in 2019-20, £110 million in 2020-21, and £155 million in 2021-22. This will, as this year, be distributed on an NRAC basis. As described earlier in the paper, this has allowed early planning assumptions for investment to be made for 2018-2020.

5.3 Scottish Government have advised that all PCIF in-year allocations should be considered as earmarked recurring funding, therefore staff may be recruited on a permanent basis to meet the requirements set out in the MoU.

5.4 On 29 May 2018 the Cabinet Secretary for Health and Sport issued a letter to Chairs/Vice Chairs of IJBs and Chairs of NHS Boards emphasising a “commitment to seeing the full sums invested and spent on the priorities identified” and “a guarantee that any funds covered by these allocation letters retained centrally due to slippage in delivery in 2018/19 or any other reason will be made available in full to Integration Authorities in subsequent years”. This has given us the reassurance in this initial plan to budget over a two year period.

5.5 Through each of the Implementation Groups initial work has been carried out to understand the investment required from now until 2022. This has also taken into account previous projects and tests of change that were invested in via the Primary Care Transformation Fund 2016-2018.

5.6 For the purpose of the plan, the required investment detailed in the financial summary, plans has been divided into IJB area based on that IJB’s NRAC share of the funding. This summary is supported by detailed investment plan for each Implementation Group. It should be noted that investment has been requested as pan Ayrshire service model funding, with each IJB being able to track investment and spend against their share of the PCIF.

6. GOVERNANCE AND OVERSIGHT ARRANGEMENTS

6.1 The Primary Care Programme Board will be the accountable Committee for overseeing the delivery of the PCIP, which is co-chaired by the Director of Health and Social Care (East) and the Chair of the GP Sub Committee.

6.2 The Director of the East Health and Social Care Partnership is the lead Director for Primary Care and also the Senior Responsible Officer for the Primary Care Programme – Ambitious for Ayrshire.

6.3 The Primary Care Programme Board meets every eight weeks with full details of the governance and reporting structure outlined within the PCIP.

6.4 The Strategic Programme Manager will be responsible for the management and oversight of the PCIP implementation, with each Implementation Group being assigned a Project Manager.

6.5 The Implementation Groups will meet on a regular basis and work to detailed project plans, including the workforce/recruitment plan, and the associated budget attached to that particular Group

6.6 Regular progress will be reported through the NHS Programme Office and Transformational Leadership Group. Formal update reports will be submitted to the IJBs and NHS Board every six months on progress and spend.

6.7 A detailed update will also be submitted to the Local Medical Committee every eight weeks.

7. CARER/ PEOPLE WHO USE SERVICE IMPLICATIONS

7.1 The benefits of the proposals in the new contract for patients are to help people access the right person, at the right place, at the right time in line with the Scottish Government Primary Care Vision and Outcomes.

- Maintaining and improving access;
- Introducing a wider range of health and social care professionals to support the Expert Medical Generalist (GP);
- Enabling more time with the GP for patients when it is really needed, and
- Providing more information and support for patients.

8. STRATGIC CONTEXT

8.1 The strategy and programme outlined in this report will assist the IJB to deliver the following Strategic Objectives from its Strategic Plan to:

- Support people to live independently and healthily in local communities.
- Develop local responses to local needs.
- Operate sound strategic and operational management systems and processes.
- Communicate in a clear, open and transparent way.

The development and delivery of sustainable Primary Care and Community Health and Care Services supports the ambitions of the National Health and Care Delivery Plan.

9. Implications

Financial :	The implementation of the 2018 General Medical Services Contract for Scotland will see additional investment of £250m 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 Contract will support the development of new roles within multi-disciplinary teams working in and alongside GP Practices. The Contract also plans the transition of the GP role into an Expert Medical Generalist. These changes will require local and national workforce planning and development. 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 through reformed primary care services is not just to extend life, but also reduce the time spent in poor health. Implementing the new GMS contract is an opportunity to mitigate health inequalities where possible. In support of the national 'Every Child, Every Chance, particular consideration will be given to: • Lone Parents • Families with 3 or more children • Families where the youngest child is under 1 • Mothers aged under 25 • Children and families whose lives have been impacted by Adverse Event Childhood Experiences (ACEs)
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.
Community Benefits :	The Wellbeing of people and communities is core to the aims and successes of Community Planning. Primary Care Improvement Plan, 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	

5.	**CONSULTATION**
5.1	Consultation has taken place across Ayrshire and Arran with IJB Chief Officers, GP Sub Committee representatives, strategic planning partners, and colleagues involved in Primary Care services delivery across Ayrshire and Arran. The PCIP was endorsed through the LMC on 12 June 2018.
6.	**CONCLUSION**
6.1	It is recommended that the Integration Joint Board: (iii) Agree the requirements and responsibilities set out in the MoU. (iv) Approve the content, actions and financial spend set out in PCIP for implementing the new GMS contract before 2021.

For more information please contact Vicki Campbell, Programme Manager for Primary Care Transformation at vickicampbell1@nhs.net

Memorandum of Understanding between Scottish Government, British Medical Association, Integration Authorities and NHS Boards

GMS Contract Implementation in the context of Primary Care Service Redesign

Introduction and Context

The principles underpinning the approach to general practice in Scotland were set out in a document *General Practice: Contract and Context – Principles of the Scottish Approach* published by the Scottish General Practitioners Committee ("SGPC") of the British Medical Association (BMA) and the Scottish Government in October 2016, noting that the Scottish Government and the SGPC are the two negotiating parties on commercial general practitioner (GP) contractual matters in Scotland. This Memorandum of Understanding ("MOU") between **The Scottish Government**, **the Scottish General Practitioners Committee of the British Medical Association, Integration Authorities and NHS Boards** builds on these arrangements and represents a landmark statement of intent, recognising the statutory role (set out in the Public Bodies (Joint Working) (Scotland) Act 2014) ("the Act") of Integration Authorities in commissioning primary care services and service redesign to support the role of the GP as an expert medical generalist. The MOU also recognises the role of NHS Boards in service delivery and as NHS staff employers and parties to General Medical Services ("GMS") contracts.

For the purposes of this MOU, we refer to Health and Social Care Partnerships (HSCPs) responsible for the planning and commissioning of primary care services.

As an Expert Medical Generalist (as defined in the Scottish GMS contract offer document for 2018 the "Scottish Blue Book"), the GP will focus on:

- undifferentiated presentations,
- complex care,
- local and whole system quality improvement, and
- local clinical leadership for the delivery of general medical services under GMS contracts.

Expert Medical Generalists will strive to ensure robust interface arrangements, connection to and coherence with other parts of the wider primary care team (e.g. nurses physiotherapists), health and social care community based services and with acute services where required. The EMG will be supported by a multi-disciplinary team (MDT); maximising the contribution of both clinical and non-clinical staff in medicine, nursing, allied health professions, links workers, practice management, administration and others.

Delivering improved levels of local care in the community will have a clear benefit for patients and must rely on effective collaboration between GPs, HSCPs, NHS Boards and other partners, both in and out of hours, valuing the respective contributions of those who deliver these services. This will require clear articulation of the respective roles and responsibilities of GPs and other members of

the primary care team both generally and in respect of each of the services set out in a HSCP Primary Care Improvement Plan (see Sections F and G of this MOU).

The development of primary care service redesign in the context of delivery of the new GMS contract should accord with seven key principles:

Safe –Patient safety is the highest priority for service delivery regardless of the service design or delivery model.

Person-Centred - Partnerships between patients, their families and those commissioning and delivering healthcare services work to provide care which is appropriate and based on an assessment of individual needs and values and is outcome focussed, demonstrates continuity of care (in the context of both professionals and services), clear communication and shared decision-making. Having regard to the five principles underpinning the Health and Social Care Standards: dignity and respect, compassion, to be included, responsive care and support and wellbeing.

Equitable – fair and accessible to all.

Outcome focused – making the best decisions for safe and high quality patient care and wellbeing.

Effective - The most appropriate treatments, interventions, support and services will continue to be accessible, provided in the most appropriate place by the right person at the right time to everyone. Changes to service delivery should not result in any diminution of care or outcomes for patients.

Sustainable – delivers a viable long term model for general practice that is resilient in the context of the wider community care setting on a continuous basis; and promotes and supports the development of the skill mix within the practice setting.

Affordability and value for money – Making the best use of public funds; delivering the general practice model within the available resources; with appropriate quality assurance processes.

An important determinant of success will be how the planned changes are implemented, seek to influence and depend on wider services.

This change has already started with the move away from the Quality and Outcomes Framework introduced in the 2004 GMS contract. The new approach introduced by the GMS Statement of Financial Entitlements for 2016-17, sees GP practices working together in local Clusters with their HSCP and NHS Boards to identify priorities and improve the quality of services and outcomes for people.

<u>Further key enablers for change include:</u>

(1) Premises: The National Code of Practice for GP Premises sets out how the Scottish Government will support a shift, over 25 years, to a new model for GP premises in which GPs will no longer be expected to provide their own premises. The measures outlined in the Code represent a significant

transfer in the risk of owning premises away from individual GPs to the Scottish Government. Premises and location of the workforce will be a key consideration in delivering the multi-disciplinary arrangements envisaged in the HSCP Primary Care Improvement Plan. Details on the criteria for lease transfer and for accessing interest free loans will be set out in the premises Code of Practice and summarised in the GMS contract offer document which sets out the terms of the proposed new Scottish GMS contract.

*(2) Information Sharing Arrangements***:** The Information Commissioner's Office (ICO) has issued a statement that whilst they had previously considered GPs to be sole data controllers of their patient records; they now accept that GPs and their contracting Health Boards have joint data controller processing responsibilities towards the GP patient record.

The new GMS contractual provisions in Scotland will reduce the risk to GPs of being data controllers by clarifying respective responsibilities within this joint controller arrangement. These contractual changes will support ICO's position that GPs are not the sole data controllers of the GP patient records but are joint data controllers along with their contracting NHS Board. The contract will clarify the limits of GPs' responsibilities and GPs will not be exposed to liabilities relating to data outwith their meaningful control.

The new contractual provisions will lay the foundations for increased lawful, proactive and appropriate sharing of information amongst professionals working within the health and social care system for the purposes of patient care.

*(3) Workforce***:** The national health and social care workforce plan published on 28 June 2017 noted that Part 3 of the Plan, which would determine the Scottish Government's thinking on the primary care workforce, would be published in early 2018 following the conclusion of the Scottish GMS contract negotiations. The Plan will set out a range of options at national, regional and local level for the recruitment and retention of GPs and the expansion of the capacity and capability of the multi-disciplinary team. This will include plans for recruitment, training and development of specific professional groups and roles.

A. Purpose and aim of the MOU

This MOU will cover an initial 3 year period 1 April 2018 to 31 March 2021 and is structured to set out the key aspects relevant to facilitating the statement of intent the document represents:

Section A – Purpose and aim
Section B - Parties and their responsibilities
Section C - Key stakeholders
Section D - Resources
Section E - Oversight
Section F – Primary Care Improvement Plans
Section G – Key Priorities

It provides the basis for the development by HSCPs, as part of their statutory Strategic Planning responsibilities, of clear HSCP Primary Care Improvement Plans, setting how additional funding will be used and the timescales for the reconfiguration of services currently delivered under GMS contracts. Plans will have a specific focus on the key priority areas listed at Section G of this MOU with the aim of transitioning their delivery by the wider MDT between 2018 and 2021.

Taken together with the Scottish GMS contract offer document, the National Code of Practice for GP premises, and the National Health Service (General Medical Services Contracts) (Scotland) Regulations 2018, this MOU underpins the new Scottish GMS contract; and enables the move towards a new model for primary care that is consistent with the principles, aims and direction set by the Scottish Government's National Clinical Strategy (NCS) and the Health and Social Care Delivery Plan.

In addition, The *National Health and Social Care Workforce Plan: Part 3 Primary Care,* to be published following agreement on the new Scottish GMS contract, will set out the context and arrangements for increasing the Scottish GP and related primary care workforce and both the capacity and capability of the multi-disciplinary team.

This MOU will be reviewed and updated by the parties before 31 March 2021 through arrangements that will be agreed by March 2018.

B. Responsibilities (of parties to the MOU)

The respective responsibilities of the parties to this MOU are:

Integration Authority responsibilities (typically delivered through the Health and Social Care Partnership delivery organisations):

- Planning, design and commissioning of the primary care functions (including general medical services) delegated to them under the 2014 Act based on an assessment of local population needs, in line with the HSCP Strategic Plan.
- The development of a HSCP Primary Care Improvement Plan, in partnership with GPs and collaborating with other key stakeholders including NHS Boards that is supported by an appropriate and effective MDT model at both practice and Cluster level, and that reflects local population health care needs.
- Collaboration with NHS Boards on the local arrangements for delivery of the new Scottish GMS contract.
- Section 2c of the National Health Service (Scotland) Act 1978 places a duty on NHS Boards to secure primary medical services to meet the reasonable needs of their NHS Board area. To achieve this, NHS Boards can enter into GMS contracts. HSCPs will give clear direction to NHS Boards under sections 26 and 28 of the 2014 Act in relation to the NHS Board's function to secure primary medical services for their area and directions will have specific reference to both the available workforce and financial resources.

- Where there is one or more HSCP covering one NHS Board area, the HSCPs will collaborate under section 22 of the 2014 Act in relation to the effective and efficient use of resources (e.g. buildings, staff and equipment) to achieve coherence and equity across service planning, design and commissioning.
- Ensuring that patient needs identified in care plans are met

Scottish General Practice Committee responsibilities:

- Negotiating, with the Scottish Government, the terms of the GMS contract in Scotland as the negotiating committee of the BMA in Scotland.
- Conducting the poll (and any future poll) of its members on the terms of the GMS contract in Scotland.
- Representing the national view of the GP profession.
- Explaining the new Scottish GMS contract to the profession (including communication with Local Medical Committees (LMC) and GP practices).
- Ensuring that GP practices are supported encouraged and enabled to deliver any obligations placed on them as part of the GMS contract; and, through LMCs and clusters, to contribute effectively to the development of the HSCP Primary Care Improvement Plan.

NHS Territorial Boards responsibilities:

- Contracting for the provision of primary medical services for their respective NHS Board areas
- Ensure that primary medical services meet the reasonable needs of their Board area as required under Section 2C of the NHS (Scotland) Act 1978.
- Delivering primary medical services as directed by HSCP as service commissioners.
- Arrangements for local delivery of the new Scottish GMS contract via HSCPs
- As employers, NHS Boards will be responsible for the pay, benefits, terms and conditions for those employees engaged in the delivery of the priority areas set out in Section G.

Scottish Government responsibilities:

- Setting the legislative framework underpinning the commissioning of primary medical services by HSCPs and delivery by NHS Boards.
- In collaboration with NHS Boards and with HSCPs, shaping the strategic direction and the development of commissioning guidance in respect of primary care that is in line with the aims and objectives set out in National Clinical Strategy and the Health and Social Care Delivery Plan.
- Providing financial resources in support of the new Scottish GMS contract and primary care transformation (including the transfer of services) in line with the Scottish Government spending review process.

- Making arrangements with stakeholders to meet the future GP workforce requirements both in terms of numbers and education and training.
- Agreeing the metrics and milestones against which progress will be measured; with regular progress reporting as part of the existing statutory arrangements for reporting performance against Strategic Plans.

C. Key Stakeholders

HSCPs must collaborate with NHS Boards as partners in the development and delivery of their Strategic Plan (and the associated Primary Care Improvement Plan). Local and Regional Planning arrangements will need to recognise the statutory role of the HSCP as service commissioners; and the partnership role of NHS Boards as NHS employers and parties to the GMS contracts for the delivery of primary medical services in their Board area.

In addition to this, HSCPs have a statutory duty via the Public Bodies (Joint Working) (Prescribed Consultees) (Scotland) Regulations 2014 to consult a wide range of local stakeholders and professional groups on their Strategic Plans and take decisions on the size and shape of local health and social care services on a collective basis based on dialogue with the local communities and service users. In relation to the development of the Primary Care Improvement Plan that would include (but not be limited to):

- Patients, their families and carers
- Local communities
- SAS and NHS 24
- Primary care professionals (through, for example, GP subcommittees of the Area Medical Committee and Local Medical Committees)
- Primary care providers
- Primary care staff who are not healthcare professionals
- Third sector bodies carrying out activities related to the provision of primary care

In order to ensure that the provision of any new or reconfigured service has a patient-centred approach to care based on an understanding of patient's needs, life circumstances and experiences it is important that patients, carers and communities are engaged as key stakeholders in the planning and delivery of new services. HSCPs should ensure that patient engagement is a key part of their Primary Care Improvement Plans.

Good communications and understanding across the wider health and social care interfaces with both services and professional groups (e.g. primary/secondary, community health and social care services, district nursing, out of hours services, mental health services) will also be required to address direct patient care issues, such as prescribing, referrals, discharges, follow up of results and signposting. An important principle here is that each part of the system respects the time and resources of the other parts. There should not be an assumption that patient needs or work identified in one part of the service must be met by another without due discussion and agreement. This should ensure that patients do not fall through gaps in the health and care system.

D. Resources

General Practice funding – through the GMS contract funding allocated to NHS Boards, general practice funding represents a significant element of the public investment in community and primary care. The published draft Primary Medical Services budget was £821 million in 2017-18 – funding the remuneration of 4,460 General Practitioners; the c.3000 practice staff they employ, both nursing and non-clinical, and the non-staff expenses of running practices. This investment enables over 23 million healthcare interactions every year. The Primary Medical Services investment funds the part of the system that is the first port of call for most people's healthcare needs most of the time. In addition to the direct care enabled by this investment, the clinical decisions GPs make – whether to treat; how to treat; whether to refer to further specialist treatment – have a much wider impact on the health and social care system. The "GP footprint" is estimated to be as much as four times the direct investment in Primary Medical Services. This investment through the contract is, therefore, critical to the sustainability of the whole health and care system.

In March 2017 the Cabinet Secretary for Health and Sport announced that in addition to the funding for the provision of general medical services, funding in direct support of general practice will increase annually by £250 million by the end 2021-22. In 2017-18 £71.6 million was invested through the Primary Care Fund in direct support of general practice. Further investment will see this increase over the 3 financial years from 1 April 2018 to £250 million 2021-22.

<u>Process</u>

Specific levels of resource will be agreed as part of the Scottish Government's Spending Review and budget processes and allocated in line with the arrangements set out in this MOU.

Where appropriate these resources will be allocated to HSCPs through their NHS Board partners in line with the Scottish Government's National Resource Allocation formula (based on population need and taking account of geography and of life circumstances, including deprivation). Resources will be spent for the purposes set out in this Memorandum and in line with each HSCP Primary Care Improvement Plan to enable the transition to be managed and implemented effectively. The HSCP Plans must demonstrate how the funding will flow/be used to enable the redistribution of work from GPs to others and to optimise the role and functionality of the wider MDT. HSCPs will agree these Plans locally. These plans will be developed in collaboration with local GPs and others and should be developed with GP Subcommittee (or representatives of by agreement locally) as the formally agreed advisors on general medical service matters. However, the arrangements for delivering the new GMS contract will be agreed with the Local Medical Committee. Integration Authorities will hold their officers to account for delivery of the milestones set out in the Plan, in line with their responsibility to ensure delivery of Strategic Plans, and through regular reporting to the Authority. Key partners and stakeholders should be fully engaged in the preparation, publication and review of the plans.

The resources and any associated outcomes and deliverables (aligned to the Scottish Government's National Performance Framework and the six Primary Care Outcomes) will be set out in an annual funding letter as part of the Scottish Government's budget setting process.

The extent and pace of change to deliver the changes to ways of working over the three years (2018-21) will be determined largely by workforce availability, training, competency and capability, the availability of resources through the Primary Care Fund, and will feature as a key element of the National Health and Social Care Workforce Plan: Part 3 Primary Care.

E. Oversight

New oversight arrangements for the implementation of the GMS contract in the context of wider primary care transformation in Scotland will be developed including:

A *National GMS Oversight Group* ("*the national oversight group*") with representatives from the Scottish Government, the SGPC, HSCPs and NHS Boards will be formed to oversee implementation by NHS Boards of the GMS contract in Scotland and the HSCP Primary Care Improvement Plans, including clear milestones for the redistribution of GP workload and the development of effective MDT working.

National issue specific groups – A range of national issue specific groups with members drawn from a range of stakeholders, including NHS Boards, HSCPs and SGPC where appropriate will support and provide policy and professional advice to the national oversight group on a range of national policy areas relevant to the delivery of primary care transformation. These may include: GP Contract Implementation Group; GP premises; GP IT, e-Health; Data and Information; Remote and Rural; Nursing; GPN Group; Vaccination Transformation Programme; Patient Groups.

As well as the requirements on the HSCP to develop a Primary Care Improvement Plan as set out in Section D, NHS Boards with HSCPs will develop clear arrangements to deliver the commitments in respect of the new Scottish GMS contract as set out in the Scottish GMS contract offer document. These arrangements will include the priority areas set out in Section G of this MOU and must be agreed with the LMCs.

HSCPs should establish local arrangements to provide them with advice and professional views on the development and delivery of the Primary Care Improvement Plan. Arrangements will be determined locally and will take account of the requirement to engage stakeholders as set out above. The HSCP Primary Care Improvement Plan should be agreed with the local GP subcommittee of the Area Medical Committee with the arrangements for delivering the new GMS contract being agreed with the Local Medical Committee as set out above. HSCPs and NHS Boards will discuss and agree locally the arrangements for providing appropriate levels of support to enable this advice to be provided.

Within HSCPs, GP clusters have a critical role in improving the quality of care in general practice and influencing HSCPs both regarding how services work and service quality. Improving Together: a new quality framework for GP Clusters in Scotland[i] provides a framework for how that learning, developing and improving may be achieved. As GP Clusters mature, they will be expected to have a key role in proactively engaging with HSCPs, advising on the development of HSCP Primary Care Improvement Plans and working with their MDT and wider professional networks to ensure highly

effective health and social care provision within and across the HSCP area and where relevant across HSCPs.

HSCPs will support and facilitate GP Clusters to ensure their involvement in quality improvement planning and quality improvement activity as part of whole system improvement. *Healthcare Improvement Scotland* will work in support of HSCPs where required to ensure that GP clusters have the support they need to engage effectively in quality improvement activity.

The *Local Intelligence Support Team* (LIST) already provides support to HSCPs and has been commissioned to provide support through HSCPs to GP clusters. This support involves on-site expert analytical advice to provide local decision-makers with meaningful and actionable intelligence, leading to improved outcomes for service users.

F. Primary Care Improvement Plan

The collaborative implementation of the new GMS contract in Scotland should be set in the context of the HSCP Primary Care Improvement Plan. Plans must determine the priorities based on population healthcare needs, taking account of existing service delivery, available workforce and available resources. To support that aim HSCPs will collaborate on the planning, recruitment and deployment of staff.

Some services which are currently provided under general medical services contracts will be reconfigured in the future. Services or functions which are key priorities for the first 3 years from 2018 - 2021 are listed in Section G below. The expectation should be that, where appropriate, reconfigured general medical services should continue to be delivered in or near GP practices.

Additional investment is intended to provide additional MDT staff, which should, where appropriate, be aligned to GP practices to provide direct support to these practices under the oversight of GPs as senior clinicians. It will be important that GPs continue to work to their responsibility to ensure that their premises remain fit for purpose, services remain accessible to patients, that they are responsive to local needs and can maintain continuity of care; all of which will allow GPs to deliver an effective, integrated service as part of the MDT.

The HSCP Primary Care Improvement Plans will be considered alongside the NHS Board arrangements for the delivery of the GMS contract in Scotland in line with the requirements of the Scottish contract offer document.

The Plan should also consider how the new MDT model will align and work with community based and where relevant acute services, subject to wider stakeholder engagement to be determined by the HSCP in line with their statutory duty to consult.

<u>Key Requirements of the Primary Care Improvement Plan:</u>

- To be developed collaboratively with HSCPs, GPs, NHS Boards and the stakeholders detailed in Section C;

- To detail and plan the implementation of services and functions listed as key priorities under Section G, with reference to agreed milestones over a 3 year time period;

- To give projected timescales and arrangements for delivering the commitments and outcomes in the priority areas under Section G and in particular to include intended timescales for the transfer of existing contractual responsibility for service delivery from GPs.

- To provide detail on available resources and spending plans (including workforce and infrastructure);

- To outline how the MDT will be developed at practice and cluster level to deliver primary care services in the context of the GMS contract.

- Initial agreement for the Primary Care Improvement Plan secured by 1 July 2018

G. Key Priorities

Existing work to develop and test new models of care has shown benefits from the effective deployment of other professional staff working within a wider MDT aligned to general practice. The priority between 2018 and 2021 will be on the wider development of the services detailed below. Changes to services will only take place when it is safe to do so. The service descriptions and delivery timescales given here are provided for the purposes of this MOU.

(1) The Vaccination Transformation Programme (VTP) was announced in March 2017 to review and transform vaccine delivery in light of the increasing complexity of vaccination programmes in recent years, and to reflect the changing roles of those, principally GPs, historically tasked with delivering vaccinations.

In the period to 2021, HSCPs will deliver phased service change based on a locally agreed plan as part of the HSCP Primary Care Improvement Plan to meet a number of nationally determined outcomes including shifting of work to other appropriate professionals and away from GPs. This has already happened in many parts of the NHS system across Scotland for Childhood Immunisations and Vaccinations. This change needs to be managed, ensuring a safe and sustainable model and delivering the highest levels of immunisation and vaccination take up. As indicated above, there may be geographical and other limitations to the extent of any service redesign.

(2) Pharmacotherapy services – These services are in three tiers divided into core and additional activities, to be implemented in a phased approach.

By 2021, phase one will include activities at a general level of pharmacy practice including acute and repeat prescribing and medication management activities and will be a priority for delivery in the first stages of the HSCP Primary Care Improvement Plan. This is to be followed by phases two (advanced) and three (specialist) which are additional services and describe a progressively advanced specialist clinical pharmacist role.

(3) Community Treatment and Care Services - These services include, but are not limited to, basic disease data collection and biometrics (such as blood pressure), chronic disease monitoring, the management of minor injuries and dressings, phlebotomy, ear syringing, suture removal, and some types of minor surgery as locally determined as being appropriate. Phlebotomy will be delivered as a priority in the first stage of the HSCP Primary Care Improvement Plan.

This change needs to be managed to ensure, by 2021 in collaboration with NHS Boards, a safe and sustainable service delivery model, based on appropriate local service design.

(4) Urgent care (advanced practitioners) - These services provide support for urgent unscheduled care within primary care, such as providing advance practitioner resource such as a nurse or paramedic for GP clusters and practices as first response for home visits, and responding to urgent call outs for patients, working with practices to provide appropriate care to patients, allowing GPs to better manage and free up their time.

By 2021, in collaboration with NHS Boards there will be a sustainable advance practitioner provision in all HSCP areas, based on appropriate local service design. These practitioners will be available to assess and treat urgent or unscheduled care presentations and home visits within an agreed local model or system of care.

(5) Additional Professional roles **-** Additional professional roles will provide services for groups of patients with specific needs that can be delivered by other professionals as first point of contact in the practice and/or community setting (as part of the wider MDT); this would be determined by local needs as part of the HSCP Primary Care Improvement Plan. For example, but not limited to:

- *Musculoskeletal focused physiotherapy services*
- *Community clinical mental health professionals (e.g. nurses, occupational therapists) based in general practice .*

By 2021 specialist professionals will work within the local MDT to see patients at the first point of contact, as well as assessing, diagnosing and delivering treatment, as agreed with GPs and within an agreed model or system of care. Service configuration may vary dependent upon local geography, demographics and demand.

(6) Community Links Worker (CLW) is a generalist practitioner based in or aligned to a GP practice or Cluster who works directly with patients to help them navigate and engage with wider services, often serving a socio-economically deprived community or assisting patients who need support because of (for example) the complexity of their conditions or rurality. As part of the Primary Care Improvement Plan HSCPs will develop CLW roles in line with the Scottish Government's manifesto commitment to deliver 250 CLWs over the life of the Parliament. The roles of the CLWs will be consistent with assessed local need and priorities and function as part of the local models/systems of care and support.

Workforce As part of their role as EMGs, GPs will act as senior clinical leaders within the extended MDT as described in this MOU. Many of the MDT staff deployed in the priority areas under (1) to (6) of Section G in the MOU will be employed by the NHS Board and work with local models and systems of care agreed between the HSCP, local GPs and others. Staff will work as an integral part of local MDTs. NHS Boards, as employers, will be responsible for the pay, benefits, terms and conditions for these staff. Some MDT members will be aligned exclusively to a single GP practice while others may be required to work across a group of practices (e.g. Clusters). Workforce arrangements will be determined locally and agreed as part of the HSCP Primary Care Improvement Plans.

Existing practice staff will continue to be employed directly by practices. Practice Managers, receptionists and other practice staff will continue to have important roles in supporting the development and delivery of local services. Practices Managers should be supported and enabled to contribute effectively to the development of practice teams and how they work across practices within Clusters and in enabling wider MDT working arrangements.

Signatories

Signed on behalf of the Scottish General Practice Committee

Name: Alan McDevitt, Chair, Scottish GP Committee of the British Medical Association
Date: 10 November 2017

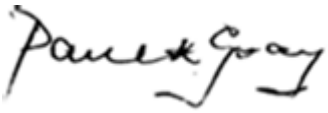
Signed on behalf of Health and Social Care Partnership Chief Officers

Name: David Williams, Chief Officer, Glasgow HSCP and Chair, Chief Officers, Health and Social Care Scotland
Date: 10 November 2017

Signed on behalf of NHS Boards

Name: Jeff Ace, Chief Executive, NHS Dumfries & Galloway and Chair, Chief Executives, NHS Scotland
Date: 10 November 2017

Signed on behalf of the Scottish Government



Name: Paul Gray, Chief Executive, NHS Scotland
Date: 10 November 2017

EAST AYRSHIRE
Health & Social Care
Partnership

North Ayrshire
Health and Social Care Partnership

south ayrshire
health & social care
partnership

NHS
Ayrshire
& Arran

AYRSHIRE ARRAN
GENERAL PRACTICE

Ambitious for Ayrshire

Implementation of 2018 General Medical Services Contract

2018-2021

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Contents

Foreword

Eddie Fraser
Director of East Health and Social Care Partnership
Lead Partnership for Primary Care
Ayrshire & Arran

Hugh Brown
Chair of the GP Sub Committee
Ayrshire & Arran

We are delighted to present Ayrshire & Arran's, once for Ayrshire, Primary Care Improvement Plan that sets out a new vision for General Practice and an overview of the considerations required to achieve it.

Following the agreement of the new General Medical Services contract, developing the Improvement Plan quickly gained momentum with the teams locally. It was seen as an opportunity to sustain general practice, whilst improving the coordination of care, access to services and taking a more proactive approach to supporting our population's health and wellbeing. Management and GP colleagues across the three Health and Social Care Partnerships have worked jointly throughout the development process and have established good working relationships to ensure a smooth transition to implementation over the next three years and beyond.

The plan represents the collaborative working between our clinicians, Integration Authorities, NHS Board, and other stakeholders to build on the work to date to find solutions to the current challenges within primary care, supporting the healthcare within our communities. As we work to build our devolved Health and Social Care System in Ayrshire and Arran, the critical role of primary care has been emphasised throughout the plan, and is viewed as a core component of an integrated community based care system.

Our joint vision focuses on the place and the people who live in it rather than the needs of an organisation or specific group. Throughout the implementation of our plan we are fully committed to working closely with our patients, communities, service users, and our staff across General Practice and wider services to achieve fully integrated services.

Mr Eddie Fraser
Director of East Health and Social Care Partnership

Dr Hugh Brown
Chair of the GP Sub Committee

Executive Summary

The Ayrshire & Arran Primary Care Improvement Plan is the initial plan setting out how we aim, as three Integration Joint Boards and NHS Board, to deliver the implementation of the new 2018 General Medical Services (GMS) Contract. It describes the discussions and actions agreed to date with the understanding that further discussion with General Practice, service providers and the public is required as implementation arrangements evolve and mature.

The new model for General Practice and primary care describes how clinical pathways, the role of the General Practitioner (GP), and other health and care professional roles and their workload will be redesigned to enable consultation and treatment by the right professional.

Primary care in Ayrshire and Arran has been under significant strain over the last few years due to the increase in demand and changing health needs of our population. The Primary Care Improvement Plan will function as a framework that sets out an ambitious and attractive vision for how services will be delivered in General Practice and primary care that operate in partnership with the wider health and care system.

The new 2018 GMS Contract includes clear underlying principles and requirements for each NHS Board area to introduce the new contract by 2021.

Each requirement has been addressed throughout the implementation actions plans, as well as the associated funding required from the fund committed to the implementation of the contract.

It is anticipated that alongside the core framework for delivery that has been developed, different areas across Ayrshire and Arran will deliver at different times, and at a different pace depending on their starting point, with local populations and professionals being involved in developing detailed plans based on what works best for that community.

The changes and pace required to reform Primary Care will not be possible without significant investment in workforce, estate, and infrastructure. Although the plans indicate initial funding required, further work is required in 2018/19 to assess the overall costs of new services.

The implementation plans have been developed on the basis that the full funds will be made available, including fully spending the allocation for financial year 2018-19. In this initial year of funding, the funding will issue in two tranches starting with allocation of 70% of the funding in June 2018. A high level report on how spending has been profiled must be submitted to SG by the start of September and, subject to confirmation via this report, that we will be able to spend the full 100% allocation in-year, the remaining 30% of funding will be allocated in November 2018.

Chapter 1: National Policy **The Scottish Government Strategic Primary Care Vision and Outcomes focuses on the modernisation of primary care to deliver a safe, effective and person-centred healthcare service in line with the 2020 vision, the National Clinical Strategy and Health and Social Care Delivery Plan 2016.**

The new 2018 Scottish GMS Contract came into effect from 1 April 2018. The contract facilitates a refocusing of the GP role as Expert Medical Generalist (EMG). This role builds on the core strengths and values of General Practice. The national aim is to enable GPs to use other skills and expertise to do the job they train to do.

This refocusing of the GP role will require some tasks currently carried out by GPs to be carried out by additional members of a wider primary care multi-disciplinary team – where it is safe, appropriate, and improves patient care. Integration Authorities, the Scottish GP Committee (SGPC) of the British Medical Association (BMA), NHS Boards and the Scottish Government have agreed priorities for transformative service redesign in primary care in Scotland over a three year planned transition period. These priorities include vaccination services, pharmacotherapy services, community treatment and care services, urgent care services and additional professional services including acute musculoskeletal physiotherapy services, community mental health services and community link worker services. GPs will retain a professional role in these services in their capacity as EMGs.

The funding of general practice in Scotland has been reformed and a phased approach has been agreed to implement the contract fully. In Phase one, from April 2018, a new funding formula that better reflects practice workload has been introduced. A new practice income guarantee is also in operation to ensure practice income stability. The new funding formula will be accompanied by an additional £23 million investment in GMS to improve services for patients where workload is highest.

In addition, the contract offer proposes to introduce a new minimum earnings expectation to ensure no GP partner earns less than £80,430 (including pension contributions) NHS income for a whole-time equivalent post from April 2019. Evidence indicates this will benefit approximately one fifth of GP partners in Scotland.

The Memorandum of Understanding (MoU) with the new contract requires NHS Boards and local Integration Joint Boards to develop a Primary Care Improvement Plan (PCIP) to set how they will deliver the priorities over a three year period (April 2018-March 2021).

Chapter 2: Introduction **Sets out the plan and direction of travel to implement the 2018 Scottish General Medical Services (GMS) Contract that has been developed to re-invigorate and re-energise the core values of General Practice**.

There was agreement that there should be one coordinated PCIP produced for Ayrshire and Arran, with a focus on local priorities and delivery where services are commissioned within the Health and Social Care Partnerships(HSCPs) based on population need. This is an introductory plan that meets both the national and pan Ayrshire requirements. The PCIP describes how Ayrshire and Arran plan to implement the new GMS contract by 31 March 2021.

The aim of the implementation plan is to set out a clear direction of travel, and outline the key characteristics of successful, high quality General Practice. As implementation progresses, it is expected that the plans will become more detailed with local ownership,

Throughout the plan collaborative working is demonstrated between General Practice, the three HSCPs, NHS Ayrshire and Arran, the wider Primary Care services, voluntary and third sector organisations, as well as other national Boards across Scotland.

Our plan details:

- Our vision of what General Practice will look like in Ayrshire and Arran
- How we will achieve the requirements set out in the MoU, ensuring that General Practice are empowered to own and drive the changes needed along with their HSCP.
- How we will invest the Primary Care Improvement Fund into General Practice

In delivering the implementation of the new GMS contract by 2021, we strive to drive continuous improvement in quality of access to health services across Ayrshire and Arran. By improving access in General Practice we aim to reduce health inequalities, improve access to practices, improving pathways, improve overall health, and support the reduction of inappropriate attendances at our Emergency Departments.

Chapter 3: Our Vision **Sets out a vision which sees GPs and GP-led multi-disciplinary teams manage a wide range of health problems, providing both systemic and opportunistic health promotion, diagnoses and risk assessments, dealing with multi-morbidity, coordinating long term care, and addressing the physical, social and psychological aspects of patients' well-being throughout their lives.**

Ambitious for Ayrshire – Our Aim
To deliver safe, effective, person centred, sustainable Primary Care Services at the heart of the healthcare system for the people of Ayrshire and Arran

General Practice is at the core of primary care and through the implementation of the new contract, General Practice in Ayrshire and Arran will be supported to deliver, in a sustained way, the 4C guiding principles outlined to ensure patients access the right person, at the right place, at the right time. These are described in the Scottish Government Primary Care Vision and Outcomes as:

- **Contact** – maintain and improve access
- **Comprehensiveness** – introducing a wider range of health professionals to support the expert medical generalist
- **Continuity** - enabling more time with the GP for patients when it is really needed
- **Co-ordination** – providing more information and support for patients

To achieve this to a high standard General Practice will require to be fully integrated within a network of health and social care providers in the local communities. This includes an expanded multidisciplinary team within or attached to Practices, as well as links to community health and social care teams, and voluntary sector organisations.

Over the next three years a combination of additional investment, service redesign and increased capacity will allow for workload to evolve, increasing the time available for GPs to focus on the most complex patients with sufficient time to meet their care needs, as well as increase the time for professional development.

Using the additional investment through that Primary Care Improvement Fund, the HSCPs will invest in and support General Practice to:

1. Transform how practices work to allow them to manage workload, improve access, and provide high quality services
2. Improve population health, particularly amongst those at greatest risk of illness or injury
3. Manage and coordinate the health and care of those with long-term conditions
4. Manage urgent episodes of illness or injury
5. Manage and coordinate care for those who are at the end of their lives
6. Support practices to work together in their clusters and share resource, developing more resilient services to their locality based population
7. Fully integrate with community and healthcare service providers in the communities, wrapping services around patients in the community

Chapter 4: The Case for Change **General Practice is the first and most commonly used point of access to health care in Scotland. A combination of pressures including demographic changes, increasing complex health care needs, workforce shortages, financial demands and public expectations has resulted in the continued delivery of primary and community services no longer being tenable.**

More people in Ayrshire and Arran are living longer and as we grow older we tend to accumulate more long term conditions which results in requiring access our health and social care services more frequently. We know that 90% of patient activity occurs within primary care. As stated by the King's Fund & Nuffield Trust, Primary care is the "bedrock of NHS care" which, through GPs and primary care teams, provides the population with access to general medical care and onward referral to specialist care.

Activity data demonstrates that demand has now reached a critical point where if General Practice is to continue to meet this demand, whilst not being able to recruit GPs, there is a requirement to significantly redesign the way in which primary care services are delivered.

Whilst we know that the patients with the most complex chronic conditions will consume over 50% of health resources, we do not routinely and systematically identify and support those patients with the most complex needs. This can often lead to avoidable admissions to Acute Services where patients can remain until their condition or multiple conditions stabilise due to the limited resource available in community services.

As well as the increasing demand on Acute Services, the pressure on primary care services increases each year and GP practices have been absorbing this growth. Recent local data shows that GP Consultation rates have gone up 7% since 2015 and telephone consultations have gone up 37%.

Many GP Practices are absorbing this growth whilst losing experienced GPs from their practice and there have been difficulties attracting replacement GP partners. Many other Boards in the West of Scotland are also having difficulties attracting GP replacements. It has also been noted that many GPs will now work on a part time basis have other professional interests, therefore one GP leaving could result in two vacancies requiring to be filled.

To deliver the vision of primary care and shift the balance of care from hospital to community there needs to be a move to more proactive care to be delivered in the community. Through the implementation of a core MDT within General Practice at the heart of health and social care, as well as linking with the wider teams built around GP Surgeries in each locality, this will adopt system wide clinical care pathways and protocols, enabling teams to interface effectively with wider health and social care teams. This will support access to advice and expertise in order to manage patient care within primary care as well as the ability to facilitate the escalation of care needs when required, enabling patients to be stepped up and stepped down as appropriate and also ensuring appropriate access to specialist services and hospital based care. Ayrshire and Arran is also progressing a programme of Technology Enabled Care (TEC) interventions such as self-management in patients with COPD and Asthma, Tele-monitoring in heart-failure and assertive case management in mental health, comprehensive geriatric reviews and multidisciplinary interventions

Chapter 5: The Population of Ayrshire and Arran **Understanding our population and current demand to plan the most efficient and effective services for the future**

There are 56 General Medical Practices in Ayrshire and Arran with approximately 386,000 patients registered. 147,000 of these patients have been diagnosed with at least one lifelong chronic disease. In total there are 298,000 incidences of chronic disease with many patients suffering from multi-morbidity who require multiple clinical inputs and are on multiple medications requiring regular monitoring.

The projected increase in the number of patients who will be diagnosed with a chronic disease will further increase demand for services, and if nothing else were to change, would outstrip current service capacity. This projected growth and demand emphasises the need to prioritise different approaches to the delivery of health care services in Ayrshire and Arran, as well as supporting patients with chronic conditions more in the community.

A number of practices agreed to share data relating to a number of common activities from 2011 to 2015 to help understand demand (prescribing, co-morbidity, consultations and laboratory tests). This has shown:

- Acute "new" prescription – across 5 years 2010-2015 a 31% increase
- Increase in the rate of consultations per 1000 patients between January 2011 to November 2015 (almost 5 years) of 22%
- Increase in average annual rate of laboratory test results processed (main test types) between 2013 to 2015 of 13%.
- Increase in one practice of contacts (surgery consultations, home visits, phone consultations) per patient per year from 7.46 in 2014 to 8.17 in 2015 (9.5% increase) and scripts generated from 20.58 per patient in 2014 to 21.65 in 2015 (5%).

In summary, this gives an average rise in activity across 5 years of between 22% and 48%, with a median of 25%, this equates to 5% per annum.

There are areas where enhanced expertise in practices would enable more patients to be managed entirely within primary care without referral to secondary care or specialist services, along with providing more proactive and early intervention care. There are successful models in Ayrshire and Arran currently for the management of care within Primary Care for people with musculoskeletal and primary care mental health conditions. Although these have been at small scale as test sites, they have provided better outcomes for patients and more effective use of resources, which in turn has increased GP capacity to allow them to focus on the more complex patients. Through the PCIP these services will be scaled up across the wider population of Ayrshire and Arran.

Initial research work has been carried out by Public Health and Business Intelligence to review our population demographics including high deprivation, affluence, urban communities and rural areas. It is recognised that implementation plans must be flexible to meet diverse needs in relation to both geography and population. To achieve consistent quality it will not be possible to take a 'one size' fits all approach and this will be reflected in the detailed roll out plans going forward

Reducing Inequalities: Closing the Gap

The Health and Wellbeing outcomes within the HSCP Strategic Plans include a key outcome to reduce health inequalities.

The health and wellbeing gap is preventable and there are a range of factors that significantly contribute to premature mortality and people living in poor health. These factors include individual behaviours, poverty and deprivation, and poor housing. Closing the health and wellbeing gap requires us to take action in prevention, early intervention and mitigation of variation of service delivery.
As well as national indicators, local indicators will also be used to address the inequalities across Ayrshire and Arran.

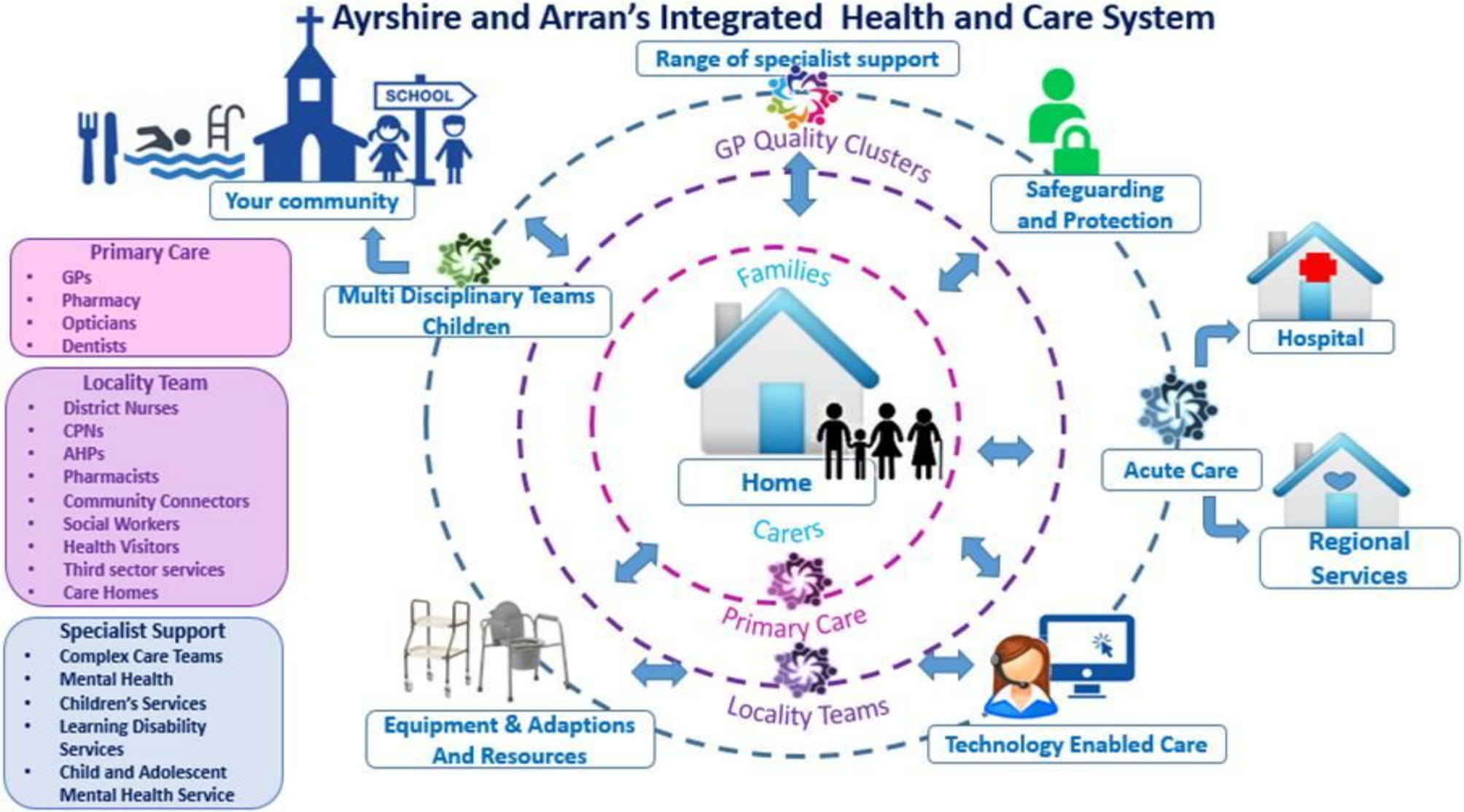
This will allow us to share good practice and address areas where there is significant variation affecting care and outcomes.

The publication 'The Role of the Health and Social Care Partnerships in Reducing Health Inequalities' was published in April 2018 to provide a framework to assist with preparing plans along with guidance and tools to be considered as plans are developed and implemented.

Ayrshire and Arran are committed to fully utilising the resources available within this publication to mitigate health inequalities where possible in the reform of primary care services.
To support the national 'Every Child, Every Chance, particular consideration will be given to:

- Lone Parents
- Families with 3 or more children
- Families where the youngest child is under 1
- Mothers aged under 25
- Children and families whose lives have been impacted by Adverse Event Childhood Experiences (ACEs)

Our aim through reformed Primary Care services is not just to extend life, but also reduce the time spent in poor health. Our integrated Health and Care System model to support all the population of Ayrshire and Arran is shown on Page 9.


Ayrshire and Arran's Integrated Health and Care System
Range of specialist support
GP Quality Clusters
Safeguarding and Protection
SCHOOL
Your community
Primary Care
GPs
Pharmacy
Opticians
Dentists
Multi Disciplinary Teams Children
Families
Hospital
Locality Team
District Nurses
CPNs
AHPs
Pharmacists
Community Connectors
Social Workers
Health Visitors
Third sector services
Care Homes
Home
Acute Care
Carers
Regional Services
Primary Care
Specialist Support
Complex Care Teams
Mental Health
Children's Services
Learning Disability Services
Child and Adolescent Mental Health Service
Locality Teams
Equipment & Adaptions And Resources
Technology Enabled Care

Chapter 6: Developing the Plan **Local Integration Authorities have been tasked by the Scottish Government to develop a Primary Care Improvement Plan in collaboration with the GP Sub Committee and the NHS Board.**

As the lead HSCP for Primary Care in Ayrshire and Arran, the development of the plan has been led by East Ayrshire HSCP. The Integration Authorities are responsible for the oversight and commissioning of services through the HSCPs with agreement from the Local Medical Committee (LMC). The NHS Board continues to hold and oversee the contract with GP Practices.

A programme approach with robust governance arrangements was designed to provide a structure to the process for development of the joint PCIP and overseeing the implementation. It was recognised locally that the GP Sub Committee had an integral advisory role in developing the plan and also all spend from the Primary Care Transformation Fund should be agreed with the LMC.

A core Writing Group was convened to develop the PCIP with four Implementation Groups were established to design and implement the required changes to meet the priorities set out in the MoU. These Implementation Groups are:

- Pharmacotherapy Service
- Primary Care Nursing Services (includes the delivery of Vaccinations and Community Treatment and Care services)
- Urgent Care
- Practice Based Multi-disciplinary Team (includes Community Link Workers)

The structures and reporting processes along with the membership details for each Implementation Group clearly articulate the roles and responsibilities of the Groups along with the pan Ayrshire membership of all key stakeholders. The programme governance structure is included in Appendix 1.

Remote and Rural Areas

In parallel to the Implementation Groups, discussions have taken place with GPs and service providers on the two Islands, Arran and Cumbrae, to align any new service developments with development work that is already taking place, and understanding the requirements and models will vary on the Islands.

It is recognised that alternative delivery models will also need to be considered on a population and practice basis for other remote and rural areas of Ayrshire.

Chapter 7: Key Benefits **Describes how the Primary Care Improvement Plan will improve the health needs of our population and support the implementation of the GMS Contract.**

The plan sets out a framework for integrating and expanding services in Primary Care and local communities that will deliver better outcomes for patients, ensuring services are delivered in the right place by the most appropriate person.

The implementation of the new contract provides an opportunity to develop a primary care workforce through additional recruitment and skill mix working towards changing the role of the GP by 2021. The plans set out how General Practice will operate within an integrated model with the focus on population outcomes.

A successful implementation will be achieved by creating the conditions for professionals to use their experience and judgement to maximum effect, improving the outcomes for all patients, empowering them to make effective evidence based decisions.

The Implementation Team will continue to engage with local GPs, Practice Managers and stakeholders, as well as work with the HSCPs and the public in the development of their local plans to ensure a joined up approach in designing the delivery of local services with a focus on specified populations.

The delivery of the new contract will see improved monitoring of demand in Primary Care and sharing of resource at scale. This will provide a greater level of sustainability to practices at a cluster and locality level providing more continuity of care to patient.

Key performance indicators will be developed through each of the detailed project plans to follow progress, share learning and evaluate if the aims within the plan are being achieved.

Implementing the new contract also provides opportunities to further engage with services and GPs across Ayrshire and Arran to deliver the most effective services for our population. As clinical leaders within Primary Care, GPs will actively contribute to the clinical governance and oversight of service design and delivery across health and social care as part of the GP cluster arrangements.

GP practices participate in cluster working and there will be a requirement for practices to provide agreed local and national data extractions to enable intelligence led quality planning, quality improvement and quality assurance.

Cluster working will contribute to the development of local population health needs assessments undertaken by public health and local information analysts. The Cluster and Practice Quality Leads will also provide professional clinical leadership on how those needs are best addressed. These arrangements will be enhanced by developing formal collaborative which will extend to practice and locality based GPs to ensure a bottom up approach to the development of service development.

Key principles

Regionally, the principles outlined in Regional Position and Discussion Document - Transforming Care Together for the West of Scotland, outlines the following principles to deliver the collective ambition of the West of Scotland Health and Care system:

1. Enable individuals and families to make informed decisions about their wellbeing and their care that are right for them within the context of their communities.
2. Encourage individuals, families and communities to enjoy healthy and independent lives.
3. Deliver high quality and safe care and support to people within or as close to their home as possible.
4. Emphasise prevention and early intervention across services.
5. Assure that staff and services work together and share information appropriately in a co-ordinated manner.
6. Promote equality of outcomes, experience and access to services across communities.
7. Recognise and support paid and unpaid carers
8. Engage, develop and motivate staff and teams.
9. Nurture a culture of continuous improvement and innovation.
10. Galvanise collective resources to ensure services are fair and sustainable.

Linking to the regional principles, locally within Ayrshire and Arran the key principles that underpin the transformation programme, and align to the IJB Strategic Plans, will ensure that through the implementation of the new contract and reform of primary care:

1. **We will encourage and empower our citizens and carers to take control of their own health and wellbeing by ensuring a 'do it with' and not 'do it to approach within our communities and services**
2. **We aim to deliver outcome-focused and responsive services for the population of Ayrshire and Arran**
3. **Service developments will aim to improve patient health and the patient journey aligned with the goal of supporting the continuous improvement and sustainability of Primary Care**
4. **Development of service delivery will, where practical, have clear alignment to the requirements stated within the Memorandum of Understanding and General Medical Services Contract (2018)**
5. **Service changes will, by default, be delivered to meet local needs and make best use of services available within localities and neighbourhoods recognising there will be times when, for good practical and clinical/financial governance sense, will remain pan Ayrshire.**
6. **Seek to ensure a balance between operating as a consistent, equitable service across Ayrshire and Arran alongside appropriate local flexibility to include the aspirations of local communities and professionals.**
7. **Within the context of a pan-Ayrshire improvement plan, we will support a reasonable, proportionate and consistent approach across each of the Health and Social Care Partnerships within Ayrshire and Arran**

Chapter 8: What will it look like and what will be the benefits? **Sets out the changes that will be visible to our patients, staff and communities.**

There are a number of key initiatives and design principles that the Implementation Groups have come up with to support our Primary and Community teams to work together.

For all patients

- Greater opportunity and support to self care
- More consistent care
- Signposting and triage to the most appropriate person to support/treat

For patients with less complexity/predominantly needing episodic care

- Quicker assessment to the right person
- More opportunity to self care with greater use of technology
- Better triage and assessment to specialist advice to reduce any unnecessary interventions

For patients with greater complexity/predominantly needing continuous care

- Wrap around care from an integrated multi-disciplinary team
- More time with and easier access to a GP
- A greater range of services provided through the GP Practice
- Pro-active support, empowering people to plan their own health

Local care delivered by local teams

- GP Practices providing clinical leadership within a wider multi-disciplinary team, offering integrated care for patients within increased capacity.
- Practices working together at a bigger scale
- Opportunities to link with other multi-disciplinary teams as the model progresses

Access and advice when needed

- Patients are assessed and streamlined in a consistent way
- The system is simplified with fewer and more accessible access points
- More triage, more self care, more skill mix

Grow our workforce

- Grow and keep our own workforce across all professions
- Offer attractive packages for portfolio careers
- Diversity skill mix
- Support practices on an individual basis, to improve their workload
- Manage and shape demand
- Establish opportunities for new roles such as mentoring and supervision

← ← ← ← ← ← ← ← **Infrastructure** → → → → → → → →

Integrated Care Records | **Digital solutions** | **Improved facilities**

Chapter 9: Interdependencies with other Plans **Ensuring joined up working across all transformation programmes within Ayrshire and Arran to maximise the benefits and outcomes for patients.**

In addition to implementing the new GP contract and transforming the role of the GP, there are a number of transformational programmes underway across the HSCPs and NHS Board that currently have an impact on GP workload and capacity, and will require to link closely with the implementation groups due to interdependencies and capabilities across all programmes. These programmes are currently linked and monitored via the NHS Programme Management Office and rely on close working between the identified Programme Managers. A high level summary of each Programme is detailed below.

Unscheduled Care
Unscheduled care demand continues to increase within the Ayrshire Health and Social Care system. This results in increased demand for community services and hospital care beyond current resources. Unscheduled care is a key element of the Health and Social Care system in Ayrshire and Arran. Services require to be responsive to need, whilst at the same time transforming in a way that, where appropriate, moves contact from reactive to planned engagement and from hospital based care to community. The aim of the Unscheduled Care Programme is to

- reduce emergency admissions by providing accessible community alternatives;
- reduce occupancy and length of stay by improving systems and processes within the Acute Hospital and reduce delays in discharge by providing appropriate community capacity.
- reducing delays in discharge by providing appropriate community capacity.

Intermediate Care and Rehabilitation Model
East, North and South Ayrshire Health and Social Care Partnerships are working with partners in NHS Ayrshire and Arran to deliver the agreed Pan-Ayrshire Model for Enhanced Intermediate Care and Rehabilitation over 2018/2019. This new investment over and above the fund provided for primary care focuses on providing high quality care and support through pro-active early intervention and preventative action to stop older people and people with complex needs becoming unwell in the first place or supporting them to manage their conditions more effectively. In addition, Technology Enabled Care (TEC) such as telehealth, telecare, video conferencing and self-care and digital apps and web based platforms have the potential to transform the way people engage in and control their own healthcare, empowering them to manage it in a way and a place that is right for them. When deterioration is unavoidable, the model aims to create integrated, multi-disciplinary services delivered in the home and in the community through health, social services, third and independent sectors to prevent unnecessary hospital admissions and get people home from hospital quickly.

This is the first steps towards achieving the New Model of Care for Older People and People with Complex Needs by focussing on providing an alternative to acute hospital admission or supporting early discharge from acute hospital through a four tier Pan-Ayrshire Model for Enhanced Intermediate Care and Rehabilitation that supports people at different stages of their journey.

End of Life Care

A considerable number of people within Ayrshire and Arran die in hospital when they prefer to be supported to die at home or in a homely setting. In order to support more people to die where they choose, we need to improve how we identify people with palliative and end of life support needs. We need to start these conversations much earlier in the course of their chronic conditions so that we discuss and plan for their future care through Advanced Care Planning conversations, share these plans with all professionals, and make it easy for professionals from all settings to access the Key Information Summary of the plan. Developing a new model for Palliative and End of Life Care will require effective co-ordination of care, excellent communication skills and up skilling of a range of community professionals including, district nurses, GPs, Ayr Hospice staff, care at home staff, care home staff, pharmacists, social workers and allied health professionals to ensure end of life care and support meets the needs of individuals, their families and carers. In addition, a small number of dedicated palliative and end of life care beds in each partnership to provide medical support, where necessary.

Transformation of Out-patients

The Modern Out-Patient (previously known as TOPS and then Delivering Outpatient Integration Together, or DOIT), is a national programme which supports NHS Boards and Health and Social Care Partnerships to deliver more integrated and accessible outpatient services to provide better outcomes for people who need to use these services. The Modern Out-Patient aims to ensure that all patients are seen at the right time, by the right person, and that the right information is available.

In Ayrshire we want to use our outpatient resources appropriately and improve the patient experience by reviewing and streamlining administrative procedures so that they support the patient pathway and make effective use of resources. This includes implementing initiatives such as; advice only referrals, implementing e-Internal referrals, develop the workforce to support the delivery of effective and efficient patient centred care, along with considering non-doctor staffing and skill mix in outpatient departments.

Infant, Children and Young People's Transformational Change Programme

Supporting children and young people's wellbeing is key to achieving the most positive outcomes for them. It develops their potential to grow up ready to succeed and play their part in society. GIRFEC is the national approach to how services aim to promote, support and safeguard the wellbeing of children and young people in Scotland. Promoting children's and young people's rights, it supports them and their parents to work in partnership with the services that can help them.

Most children get all the support and help they need from their parents, wider family and local community, in partnership with universal services like healthcare services. Where extra support is needed, the GIRFEC approach aims to ensure that support is easy to access, and seamless with the child always being at the centre. This approach has been tested and developed across Scotland over a period of more than ten years, during which time children's services have become more integrated and child-centred.

Developing a common understanding of the Getting It Right for Every Child (GIRFEC) is critical within primary care services in Ayrshire.

Key Messages

- Getting it right for every child (GIRFEC) is the Ayrshire approach to improving outcomes and supporting the wellbeing of our children and young people.
- It puts the rights and wellbeing of children and young people at the heart of all our services, and helps ensure that we all work together to get things right.
- It is built on the good practice already used by services across Ayrshire to improve outcomes for children and families.

Mental Health and Wellbeing

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.

In 2017 Ministers established the *Health & Justice Collaboration Improvement Board* (HJCIB). Ministers asked the Board to consider how our commitment to additional mental health workers might best be delivered. The Board has also adopted some broad principles (helpfully informed by a Short Life Working Group with membership from Integration Authorities, Health Boards, justice and local government) that it believes are likely to inform credible local improvements. These include recognition that:

- the application of additional resources should result in additional services commensurate with the commitment in the Mental Health Strategy to provide 800 additional mental health workers by 2021-22
- the nature of the additional capacity will be very broad ranging – including roles such as peer and support workers;
- prospective improvements may include the provision of services through digital platforms or telephone support;
- improvement may include development for staff who are not currently working in the field of mental health

The PCIF includes recurring funding for mental health services, building on the funding for primary care mental health previously provided.

Although it is separate to the primary care funding line, it is recognised there will cross-over between the services, particularly in general practice settings, and in some cases the staff may be the same individuals.

Scottish Government have written to all IJBs on 23 May asking them to each develop a plan by 31 July that sets out goals for improving capacity in the settings outlined in Action 15 of the Mental Health Strategy. To ensure IJBs are able to utilise the additional resources for 800 mental health workers and the PCIF flexibly to support sustainable mental health and primary care service redesign, the IJBs and NHS Board are being encouraged to align planning, governance and evaluation processes.

Each IJB is being asked to set out:

- How it contributes to the broad principles
- How it takes account of the views of local Justice and other Health partners in the area about what improvements should be introduced
- How it fits with other local plans currently in development.
- Initial scoping of potential staffing changes over the next four years as a result of this additional funding, towards the committed 800.

As set out in the letter, PCIPs should also demonstrate how this allocation of funding is being used to re-design primary care services through a multi-disciplinary approach, including mental health services.

Scottish Government have also advised that the PCIP should also show how wider services, including the mental health services which are the subject of this letter, integrate with the new primary care services. This section will be further developed in conjunction with the development of the plan to address Action 15 of the Mental Health Strategy.

Chapter 10: Workforce – what do we already know? **Describes our workforce and training needs within General Practice and the proposed wider multi-disciplinary team members to identify development opportunities and grow a sustainable workforce and service models.**

The PCIP is a step change in the level of investment and support to General Practice. The HSCPs and NHS Board are fully committed to supporting the development of our local workforce to reform Primary Care and develop multi-disciplinary capacity across Ayrshire and Arran.

The first step to ensuring we achieve the right staffing and service models is to scope and fully understand our current workforce and skill mix. Through the implementation groups, consistent data on the shape of the current workforce, including recent and predicted future trends in workforce numbers, will be collated to assist with the service model proposals, detailed implementation and roll out plans. Some of this data is already available pan Ayrshire or in each HSCP area, but having this collated across every service to form an overarching view will provide a more comprehensive and robust evidence base to inform workforce planning going forward.

The recruitment and retention project continues in Ayrshire and Arran to attract and retain GPs where possible. The GP with Special Interest (GPwSI) posts that were tested 2016-18 are now being developed in conjunction with Acute Services to provide support and sustainability to secondary care services that are experiencing workforce challenges. This approach sees the GP working a mix of sessions within a GP Practice and also sessions within an Acute speciality.

General Practice

Initial data returns from General Practices in Ayrshire and Arran from May 2017 demonstrates:

- The GP age profile is increasing and as doctors retire they are becoming increasingly difficult to replace. Currently 35% of local GP workforce is aged over 50 years (21% are 55 years and over) of which the majority will be eligible to retire over the next 5 years.
- There are 30 Advanced Nursing Practitioners (ANP) (27.60 wte) and 115 Nurses (80.09 wte), which includes all other nurses, are all female. 79% of these posts are part time. The age profile reflects that of NHS community nursing with 53% aged 50 years or more (8% are 60 years plus). Only 3% are under 30 years old.
- Other practice employees - staff 98% of these employees are female, over two thirds are part time and almost half (47%) are aged 50 years and over (9% are 60 years plus). The majority are administration roles (58%) although role breakdown varies greatly by practice.

Overall the workforce profile for Ayrshire and Arran GP Practices reflects national position of:

- an ageing GP workforce
- more GPs wishing to work more part time hours within practice
- an ageing nursing workforce, all female, majority part time
- a growing resource of ANPs

Community Nursing

The Chief Nursing Officer Transforming Roles to accommodate the need to look at the wide MDT/AHPS Group is responsible for directing and coordinating the future work in relation to role development within nursing and midwifery across Scotland.

The first practice areas being reviewed and transformed are:

1. Children and Young People
2. Community (adult) Nursing (including General Practice Nursing)
3. Advanced Practice

Planning for the future of the nursing workforce in Ayrshire and Arran is also set in context of both the national and local strategic imperatives as set out in The National Clinical Strategy for Scotland (2016), NHS Ayrshire & Arran's People Strategy – People Matter, NHS Ayrshire and Arran Transformational Change & Improvement Plan and East, North and South Ayrshire HSCP Strategic Plans.

NHS Ayrshire and Arran with the three HSCPs have established local Transforming Nursing Roles (TNR) Implementation arrangements for all three work streams in a manner which is integrated and connected to the wider board transformational change programmes.

Within the Community (adult) Nursing work stream and specifically related to primary care, there is national work underway to identify areas for developing a refreshed General Practice Nursing role which includes the need to

- Identify requirements for contemporary General Practice Nurse (GPN) educational provision with Chief Nursing Officer/ Primary Care provision to support proposed refreshed role.
- Utilise best available evidence to support decision making and current models of good practice within General Practice / NHS Boards/ HSCPs
- Have cognisance of the new Scottish General Medical Services Contract and the potential for the GPN role to evolve.
- Scope and agree the future interface with wider community nursing services

It is also recognised that within TNR programme the role of the District Nurse (DN) should be transformed to ensure successful implementation of both the Unscheduled Care and Intermediate Care and Rehabilitation Programmes. In order to deliver this the relationship between DN and GPN, and the professional opportunities need to be explored, understood and maximised.

With the demographic changes in our communities leading to significant increases in demand for community health and care services, there is evidence that a growing number of nursing interventions are required to be delivered across the primary care / community service interface. This is occurring at a time when the workforce itself is demographically changing with over two thirds of both GPN and DN staff over 40 years of age.

Advanced Practitioners

As the deployment of Advanced Practitioners is becoming an increasingly popular and preferred option in the provision of new models of frontline health care delivery within the NHS and HSCPs in Scotland. Through the leadership of the Associate Nurse Directors, these roles should be developed within a framework which promotes safe, effective and efficient delivery of clinical care.

Due to the ongoing recruitment difficulties to GP vacancies and review of reasons for GP appointments, it is anticipated that an Advanced Nurse Practitioners (ANPs) could see a large percentage of patients requesting an appointment with a GP with undifferentiated and urgent care needs, manage long terms conditions as well as support the Practice triage system.

An ANP is a highly educated and skilled registered nurse who can manage the complete clinical care for patients, not solely any specific condition. As a clinical leader they have the freedom and authority to act and accept responsibility for their actions. Their level of practice is characterised by high level autonomous decision making, including assessment, diagnosis and treatment, including prescribing for patients with complex health needs. An ANP will make decisions using high level expert knowledge and skills and this includes the authority to refer, admit and discharge, or refer to secondary care.

NHS Ayrshire & Arran, in collaboration with NHS Lanarkshire and Dumfries and Galloway, have developed a robust advanced practice training and development programme (ANP Academy) for Primary Care ANPs to meet the challenges of family medicine. Practitioners will be developed with generic primary care experience similar to that of a GP Trainee in order that they can provide clinical sessions, make referrals, do house calls, visit care homes, and undertake reviews of those with the long terms conditions.

There are 14 Ayrshire and Arran practice nurses included within ANP Academy Cohort 1 training places funded through the Primary Care Transformation Fund which commenced in September 2017 with a view to commencing Cohort 2 in September 2018. It is recognised that formal ANP training takes around 18 months to complete and can be a significant pressure on GP Practices whilst the training ANP is mentored and supervised until they feel confident acting in the role fully. In some cases this can take up to 36 months.

Following an educational needs assessment and audit of ANPs in Primary Care, it was projected in 2017 that Ayrshire and Arran required to be developing a minimum of 10-15 ANPs each year between 2017-2022 to address workforce challenges and meet the requirements of the GP contract. This has been projected through the ANP Academy costs until 2022 to meet this commitment.

Pharmacotherapy Service

From April 2018 there is a three year trajectory to establish a sustainable Pharmacotherapy Service where every GP Practice will receive pharmacy and prescribing support. This timeline has been established within the MoU to provide opportunity to test and refine the best way to deliver this service and to allow for new pharmacists and technicians to be recruited and trained.

The Pharmacotherapy Service will build on the investment over the last few years from the Primary Care Fund to allow more pharmacists and pharmacy technicians to work with GP practices, reducing GP workload and improving patient care through achieving better outcomes with medicines.. The Pharmacotherapy service vision will be to effectively manage the medicine-related issues and tasks that arise in GP practices on a day-to-day basis and to support people in the management of their long term conditions. As well as reducing GP workload the Pharmacotherapy Team will have responsibility for improving the cost effective use of medicines in primary care.

Combining the prescribing support team and the Primary Care Funding, NHS Ayrshire & Arran has a total of 37.9 pharmacy and prescribing support staff within Primary Care supporting General Practice and testing new ways of working. More detail is included within the Pharmacotherapy Service Implementation Plan on how this service will be expanded and rolled out across Ayrshire and Arran at scale.

Primary Care Mental Health and Wellbeing

There have been tests of change carried out throughout 2017/18 and early evidence suggests that many patients attending with low level mental health conditions are better supported through their GP Practice whilst linking with the Community Connectors/Community Link workers where patients present for non clinical support and advice on a wide range of issues that assist them with their health and wellbeing. The aim of the Primary Care Mental Health Practitioners attached to the GP Practices is to:

1. Reduce the number of GP clinical appointments for people seeking advice about their mental health
2. Reduce the number of referrals into specialist mental health services
3. Direct and support more people in their localities to access and use alternative self-management tools, community resources and other services.
4. Develop more comprehensive local networks of mental health support between GP practices, mental health services and community organisations

It is proposed Mental Health Practitioners are employed on a cluster basis to deliver sessions with GP Practices. The Practitioner would be able to assess patients, make a diagnosis, and triage patients for onward referral to the specialist Primary Care Mental Team where appropriate. The pathways and service models for Primary Care Mental Health will be scoped further in 2018/19 with three HSCP teams to address the requirements set out in the MoU and as part of the Mental Health Strategy to provide 800 additional mental health workers by 2021-22. Further detail on actions and timescales can be found within the MDT Implementation Plan in Appendix E

Community Link Workers

Initial scoping work has confirmed that all HSCPs have the correct number of community link worker posts to provide a basic level service to all GP Practices, with the exception of South Ayrshire who require an additional 1.5 wte workers to ensure full coverage. A more detailed scoping exercise on the tasks carried out, along with patient outcomes is underway through the sub group reviewing this element of the MDT.

Musculoskeletal (MSK) Physiotherapist

Due to the increasing number of GP appointments relating to an MSK complaint and the high number of onward referrals or self referrals to secondary care MSK service it was recognised that having and Advanced Practice Physiotherapists in post to deliver 1st point of contact roles in GP practices would impact significantly on GP workload and time, as well as ensure patients were seen in an appropriate timeframe by the most experienced clinician, providing the best outcome medium and longer term.

From December 2016 three Advanced Practice Physiotherapists were funded through the PCTF, one in each HSCP area working across identified GP Practices. Each WTE has 0.8 direct clinical time, currently delivering approximately 15 new patient appointments each day. Clinical leadership is provided by an identified lead GP for each practice and peer support provided by MSK/Orthopaedic Advanced Practice Physiotherapy Team. Day to day management continues to be delivered by Team Lead Physiotherapist for each partnership area.

Data collection commenced in February 2017.Over the first year the following activity was captured:

- **6013** patients presenting with an MSK condition in primary care have been assessed by the Advanced Practice Physiotherapist
- **66.19%** were seen as a first point of contact
- Only **1.32%** required GP involvement

Chapter 11: NHS Scotland Special Board Support **Describes the wider support available from other NHS Scotland Health Boards to achieve the aims set out within our action plans.**

The NHSScotland national boards provide services where improved quality, value and efficiency are best achieved through a national approach. They share a common purpose, enabling improvements in the health and wellbeing of the people of Scotland. Working more closely together and with our key partners in the Scottish Government, territorial boards, regions and Integration Joint Board will enable the transformational change required to improve services and strengthen leadership to protect and improve Scotland's health and reduce demand on services. These Boards include, NHS Scottish Ambulance Service, NHS 24, Health Improvement Scotland, and NHS Education for Scotland.

Collaborative Principles

To help key partners redesign services to meet technological, demographic and societal changes. Underpinning the National Boards overarching plan are the following principles, the special boards will:

- use existing capacity and capability
- focus on the potential benefits
- focus on where we can achieve most by working differently together
- be ambitious
- work in partnership across health and social care
- involve the public and staff in defining and implementing change

Primary and Unscheduled Care

The national boards will work with regions, health and social care partnerships and improvement, transformation and evaluation support to develop alternative routes into services which will help reduce the pressure on primary and unscheduled care. This will require new models of care and advanced clinical support which ensures the safe and seamless flow of people from one service to another.

In particular we will continue to work closely with the Scottish Ambulance Service in lead up to the roll out of the Advanced Paramedics in 2020, identifying opportunities to be involved in any test sites. The cluster support team in Ayrshire and Arran will also seek to learn from the Healthcare Improvement Scotland Collaborative Programme on Signposting as well as developing and testing improvements locally through establishing a collaborative with our cluster and quality lead GPs.

Healthcare Improvement Scotland and LIST analysts from National Services Scotland will work with HSCPs to provide support and learning in development of the new services.

At the national level, the Scottish Government plans to publish a 10-year Primary Care Monitoring and Evaluation Strategy in June 2018, setting out our overarching approach to evaluating primary care reform. A Primary Care Outcomes Framework will also be published which maps out planned actions and priorities against the changes we are working towards. The Framework was co-produced by the Primary Care Evidence Collaborative, which includes NHS Health Scotland, the Scottish School of Primary Care, Healthcare Improvement Scotland, NHS Education for Scotland, National Services Scotland, the Alliance, and the Scottish Government

Chapter 12: Engagement and Communication **Our approach to communicating with our public and staff, as well as engaging widely in the design of services and pathways.**

For our plans to succeed all providers and users of our Primary Care services need to be fully engaged as we work towards our aim of achieving a fully integrated health and care system.

There will be one Engagement and Communication Group, with wide representation from across the Implementation Groups and stakeholders that underpins the whole programme of implementation to ensure our communication messages to staff, patients and the public are consistent and clearly show the benefits of transforming our services. We will continue to develop meaningful dialogue with all our stakeholders as we develop our plans and services.

It is the aim to have one engagement and communication plan attached to the PCIP with sub sections to each Implementation Group.

Our communication and engagement plans will include:

Engagement:

- Continuous engagement, including mapping all our stakeholders
- Regular stakeholder engagement events with specific services as well as overall informative sessions

Communications

- internal and external communications
- an online and social media presence
- opportunities to share best practice, news and invite feedback

The engagement and communication plan will also link to each of the HSCP communication plans as well as the NHS Ayrshire & Arran communication plan.

Chapter 13: Delivering the Plan **Provides an overview of the actions and oversight arrangements that have agreed through the Implementation Groups and overarching Writing Group. Each area of the contract has been discussed and explored in detail with key stakeholders and representatives on each Group.**

Leadership

It is recognised that the changes set out in the implementation action plans will require significant leadership. The Director of the East Health and Social Care Partnership will be the lead Director and Senior Responsible Officer for the Programme and will co-Chair the Programme Board along with the Chair of the GP Sub Committee.

The Ayrshire wide model will have joint pan Ayrshire management clinical leads and GP Sub Committee representatives leading each Implementation Group for the duration of the programme. Through the Writing Group, these Groups will report to the IJBs, the LMC and NHS Board. There will also be formal reporting from and to the Cluster and Practice Quality Lead arrangements within localities to ensure wider engagement with the GPs in each locality. The full governance and reporting structures are included within Appendix 1.

The Implementation Groups and Writing Group have met on at least two occasions. The outcomes from these discussions to date are summarised below with more detailed actions and timescales captured in the Implementation Action Plans within the Appendices

Due to the pace and size of change, effective leadership is essential for the delivery of the programme of implementation, ensuring alignment to the wider objectives and initiatives across the four organisations. As stated within the the Kings Fund 'Centre for Creative Leadership' (2014), the key components to successful collective leadership are:

- a partnership approach between staff and management
- strong components of leadership through engagement
- communication of information on engagement levels and linked improvements in service delivery throughout the organisations
- quick action after listening to bring change
- timely feedback to staff and stakeholders on achievements using simple methods.

The approach in the development of the PCIP has focussed on collective leadership across the system, striving to ensure that all leaders have a responsibility to ensure delivery of the programme of implementation as a whole. It is the aim to embed this culture throughout delivery also.

Pharmacotherapy Service Implementation

The GP contract includes an agreement that every GP practice will have access to a pharmacotherapy service. The combined skill mix of these pharmacists and technicians are supporting over one third of GP practices across Scotland.

There is a requirement for the PCIP to set out a three year trajectory from April 2018 to April 2021, to establish a sustainable pharmacotherapy service which includes pharmacist and pharmacy technician support to the patients of every practice. Pharmacists and pharmacy technicians will become embedded members of core practice clinical teams and, while not employed directly by practices, the day-to-day work of pharmacists and pharmacy technicians, will be co-ordinated by practices and targeted at local clinical priorities. The implementation of the pharmacotherapy service is being led by Director of Pharmacy during the three year trajectory period through the Pharmacotherapy Service Implementation Group.

Pharmacists and pharmacy technicians will take on responsibility for:

a) Core elements of the service, including: acute and repeat prescribing, medicines reconciliation, monitoring high risk medicines
b) Additional elements of the service, including: medication and polypharmacy reviews and specialist clinics (e.g. chronic pain)

During the three year trajectory to establish a sustainable pharmacotherapy service, the service will be front loaded in terms of recruitment and training of the eventual required workforce. This will ensure that capacity is in place by year three, the final implementation stage. This approach allows a contingency for adjustment and refinement to the provision of level one, two and three pharmacotherapy services across all practices by the last half of 2020/2021. A three month pilot will test the staffing level assumptions and involve four practices in providing level 1 and level 2 pharmacotherapy services (excluding serial prescribing and dispensing). It is noted that National investment in additional training posts (up from 170 to 200) will support a sustainable pool of staff.

The list sizes and resource required that is detailed below has been made on best evidence available from the current test sites. It is recognised that individual conversations will take place with individual practices where this number requires to be explored further.

A critical success factor to the provision of pharmacotherapy services is the take up of serial prescribing and dispensing which is the subject of national enabling work as well as a local three month pilot and roll out plan to be at least in step with the pharmacotherapy pilot and implementation plan

List size	Number of Practices	Assumed Clinical Pharmacist resource	Assumed Technician resource
>5000	34	1.0WTE	0.4WTE
<5000	21	0.5WTE	0.2WTE

Primary Care Nurse Service Implementation

It was identified in the early planning of the PCIP that there were many synergies with scoping and developing the Community Treatment and Care services and Vaccination Transformation Programme, therefore these priorities within the MoU are included within this implementation group.

Community Treatment and Care

As stated within the MoU, these services include, but are not limited to, basic disease data collection and biometrics (such as blood pressure), chronic disease monitoring, the management of minor injuries and dressings, phlebotomy, ear syringing, suture removal, and some types of minor surgery as locally determined as being appropriate. IJBs have been advised that phlebotomy should be delivered as a priority in the first stage of the PCIP.

As with all the services, there will be a three year transition period to allow the responsibility for providing these services to pass from GP practices by April 2021. These services are currently delivered by NHS staff, practice staff and HSCP staff and the implementation plan details the timeframes attached to reviewing and understanding the current workforce and skill mix across Ayrshire and Arran to deliver the services listed within the MoU, and propose service models that span across General Practice to community. The Health and Social Care Delivery Plan (2016) states that District nurses, along with General Practice nurses and mental health nurses, play a pivotal role within our integrated community teams.

The contract states that community treatment and care services should be prioritised for use by primary care. They should also be available for secondary care referrals if they would otherwise have been workload for GPs (i.e. if such use means they are directly lifting workload from GPs). It is essential that the new funding in direct support of General Practice is only used to relieve workload from General Practice. Work from secondary care sources should be funded from other streams.

To develop and grow a sustainable primary care nursing workforce, and taking into consideration the age profile of the current nursing teams, it has been suggested that 2018/19 would be an ideal time to trial and test what the Primary Care Nurse role would like. This can be achieved through developing a training programme for newly qualified nurses who have trained in Ayrshire and Arran, offering them the opportunity to gain further skills and experience on a rotational learning programme within General Practice and Community. This would be with the aim to include this cohort of staff in the first roll out of the developed service in 2019/20. It is anticipated that 3 training posts in each HSCP would allow different models to be fully tested with the different teams, as well as provide immediate support to General Practices.

Vaccination Transformation Programme

Vaccination programmes in Ayrshire & Arran have been embedded within General Practice over many years and this model of delivery has proved highly successful, however changes have to be made in light of the increasing levels of complexity of vaccination programmes and pressures across Primary Care. The MoU states that by 2021, vaccinations will have moved away from a model based on GP delivery, to one based on NHS Board delivery through dedicated teams. We have been empowered to develop local solutions to meet local needs in a planned way, progressing at a pace that ensures safe and sustainable delivery continues.

The Vaccination Transformation Programme has been divided into different work streams:

1. pre-school programme
2. school based programme
3. travel vaccinations and travel health advice
4. influenza programme
5. at risk and age group programmes (shingles, pneumococcal,
6. hepatitis B and other groups associated with increased risk such as pregnant women)

It is expected that each Board area will have all five of these programmes in place by April 2021. The order and rate when the transition occurs may vary but progress is expected to be delivered against locally agreed milestones in each of the 3 years, including significant early developments in financial year 2018-19.As plans are developed the Primary Care Programme Board will have oversight of these plans.
The Public Health Department of NHS Ayrshire & Arran remains responsible for the effective co-ordination and monitoring of all immunisation programmes to the local population in line with national policy and guidance. The responsibility for this within the department resides with the named Immunisation Coordinator (IC) – this is a nationally recognised post, is normally at Consultant level and is found in all territorial Health Boards.
The IC Chairs and leads the Vaccination Implementation Group, reviewing each of the workstreams advising on the requirements and practicalities to ensure a safe transfer of each of the vaccine groups to a new service model.
To date it has been agreed in Ayrshire that scoping work is required to understand some of the more complex vaccination programmes, with a view to prioritise the following areas in 2018/19:

- Pre-school programme
- At risk group – pregnant women
- Travel vaccination is also an early priority and initial scoping has been completed. A national group has been convened which will provide specialist advice to all Health Boards in Scotland about a ‘national model/approach’ for Travel Vaccination.

Urgent Care Service Implementation

When people seek urgent care about their physical, mental health and wellbeing this can be a stressful and our vision is to enable the population of Ayrshire and Arran to get the right care they need in the right place, at the right time. This will be delivered, in partnership with the HSCPs, third sector and partners such as NHS24 and NHS Inform, by enabling informed self-care, self-management and supportive and connected communities.

As we implement our new multi-disciplinary teams in practices this will mean that professionals such as Advanced Practitioners (Nursing, Paramedics and AHPs), Pharmacists and Community Link Workers or Connectors, and Mental Health workers will often be the first point of care assessing and treating individuals presenting with urgent care needs. This will enable GPs to have the time to develop their role as Expert Medical Generalists, focusing on caring for individuals who present with undifferentiated, chronic and complex illness.

People often know what care they need and in future more people will be able to seek this directly, so that for example a person with shoulder pain may see a Physiotherapist as a first point of contact, while individuals with minor ailments will increasingly find that Community Pharmacists can provide a range of treatment. Key to achieving efficient joint working between professionals will be the implementation of Joint Data Controller agreements in 2018/19 and improved information technology infrastructure.

To achieve individuals receiving the right care quickly we will develop clear pathways between services as well as share good practice in relation to triage in 2018-2020. The role of administrative staff in GP practices will be key in directing patients and supporting them to navigate care and we have commenced extensive training on this for staff. We will work collaboratively across the three Ayrshire and Arran HSCPs, NHS Inform and the Alliance to communicate and inform the public about where they can access support for self-care, third sector and professional input from the range of primary and community services. We will work to support the roll out of NHS24 Practice Websites to practices, where desired, during 2019/20.

Home visits and on the day requests from patients were identified by the Urgent Care Implementation Group. The contract made particular reference to home vists within the contract as an area where other professionals and Advanced Practitioners, could provide input and release GP time to provide greater focus and continuity of care for individuals with complex health needs.

The Implementation Group agreed to review the existing pattern of home visit provision across Ayrshire and Arran, seeking to learn from good practice. We will test out new models of Advanced Practitioners undertaking home visits and this will include HSCP staff as well as working with the Scottish Ambulance Service. We will seek to be a test site for Advanced Paramedics undertaking home visits in 2019/20 and if this is not possible we will prepare for the national roll out from 2020 to 2023. The HSCPs are developing the use of Advanced Nurse Practitioners and other professionals supporting older people and those with complex at home and in care homes and primary care will work collaboratively with these initiatives.

We will scope our urgent care requirements for our island and rural populations in 2018/19 and will seek solutions including those involving technology. We will continue to test collaborative working with communities, partners and primary care independent contracts at a community level, with a test of change underway in Stewarton and other initiatives in development for 2018/19.

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Links to Other Urgent Care Services

The publication of 'Achieving *Excellence in Pharmaceutical Care – A Strategy for Scotland' in 2017* by the Chief Pharmaceutical Officer for Scotland, provides an opportunity to review and align community pharmacy services with the Ambitious for Ayrshire vision for multi-disciplinary team working in Primary Care. The Strategy 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 and Ayrshire and Arran has added to the range of common clinical conditions treatable by community pharmacists under the Pharmacy First Ayrshire service. Women between 16 and 65 can now be treated for uncomplicated urinary tract infections and patients aged two years and over, can also be treated for impetigo. Both conditions previously required prescriptions through GP practices or Out of Hours services.
We are also expanding in 2018/19 the range of common clinical conditions that can be treated by community pharmacists for other skin infections and shingles, and intend to further expand the range of conditions that can be treated. Expanding the range of common clinical conditions treated will improve outcomes for patients and reduce the workload for GPs and other health and social care professionals.

A number of community pharmacists are qualified as Independent Pharmacist Prescribers, providing clinics from their community pharmacy, in conjunction with local GP practices. These clinics include respiratory clinics, as well as hypertension and sexual health clinics. Further training and development of this workforce will unlock a further resource that can play a role in the multi-disciplinary team and promote patient self-management of long term conditions, improving outcomes for people.

Community optometrists provide a comprehensive eye examination service model to care for an aging population. The eye examination is universally funded and therefore free of charge to all eligible patients. Geographical access to eye care at optometrist practices across Ayrshire and Arran is good.

The 'Modern Outpatient Programme' (2016) outlines the further need for a collaborative approach to health care. In Ayrshire and Arran accredited optometrists provide locally enhanced eye care services reducing the burden on secondary care. These include: Low Visual Aids (Visual Impairment); Bridge to Vision (Learning Disability); Post-Operative Cataract Surgery Assessment; Medical Contact Lenses and Diabetic Retinopathy Screening.

We will continue to promote 'Eyecare Ayrshire' which offers community optometrists as a first point of contact for eye problems with the provision of eye drops available free of charge dispensed from community pharmacists. This was launched in February 2017 and is a re-direction initiative which provides effective, swift and accessible care for eye problems in local optometry practices meaning that individuals no longer need to seek a GP appointment or attend Emergency Departments.

We will promote dentists as a first point for contact for individuals with oral health concerns and dental pain. As well as working in line with the Scottish Government published Oral Health Improvement Plan, 2018. The 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.

The aims of the new plan are to focus on prevention, encouraging a more preventive approach to oral health care for patients of all ages to ensure that everyone can have the best oral health possible and that education and information sharing is specifically targeted at individuals and groups most at risk such as those who do not attend regularly for check-ups, communities in low income areas and particularly those people who either smoked or drink heavily. New approaches will also be introduced to make it easier for dentists to treat older people who live in a care home or are cared for in their own home and to enable those dentists with enhanced skills to provide services that would otherwise be provided in a Hospital Dental Service i.e. oral surgery, treatment under intravenous sedation and complex restorative services. NHS Ayrshire and Arran's *Oral Health Strategy 2013-2023,* closely aligns with the new national Plan with the aim of ensuring the 'best oral health possible for the people of Ayrshire and Arran'.

Out of Hours services are key to delivering urgent care for our residents. East Ayrshire Health and Social Care Partnership launched in November 2017 a new pan Ayrshire out-of-hours service, 'Ayrshire Urgent Care Service'. This brings together the competencies, expertise and capacity of health and social care out of hours services to enable the citizens of Ayrshire to access the right person, with the right skills at the right time.

Ayrshire Urgent Care Service delivers services through an 'urgent care hub', operating from the Lister Centre at University Hospital Crosshouse, 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 pharmacists. Ayrshire Urgent Care Service includes

- Doctors and Advanced Nurse Practitioners
- Out-of-hours district nursing service
- Out-of-hours social work
- East Ayrshire overnight emergency response personal carers
- Service support staff

North HSCP is currently developing a pan Ayrshire Mental Health Crisis Resolution Team to deliver a community based, single point of contact service to GPs, Ayrshire Urgent Care Service, the Emergency Departments, and Police Scotland to enhance service provision to GPs, Ayrshire Urgent Care Service, the Emergency Departments, and Police Scotland. This service will also provide enhanced communication with day time GP services and reduce urgent next day appointments where patients have attended the Emergency Department with a mental health condition out of hours.

This redesign is 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. The service will continue to test new ways of working to ensure a safe, high quality, effective and efficient out of hours service is delivered to the communities of Ayrshire.

We recognise that the above changes to in-hours and out of hours urgent primary care will require extensive engagement and communications with our residents to support them to access the right care, first time. We welcome working in conjunction with national or regional communication campaigns and will scope and plan local initiatives during 2018/19.

We will measure our improvements and performance through local patient and the national patient experience surveys; level of redirection and access to support for self-care; the level and appropriateness of home visits and the effective use of multi-disciplinary team professionals as first points of care, releasing GP capacity.

The detailed action plan for Urgent Care Services is included as Appendix D.

Multi-disciplinary Team in General Practice

The introduction of MDT working is complex and the scale of change required across professions is a unique opportunity to progress a longer-term strategy of transformational change to deliver the vision for Primary Care. The teams within General Practice will also link closely with the wider locality teams as shown in the Health and Social Care Diagram on Page 8. For the purposes of the implementation of the contract, the Implementation Group has focussed only on the GP Practice based team as outlined in the MoU.

The ambition of the MDT is to deliver care to the patient in a seamless way, reducing the number of visits and number of professionals working with a person and their family, as well as reducing the amount of times a person needs to repeat the same story to a range of professionals.

There is agreement that during the initial investment and recruitment, additional resource should be directed to the areas in most need, resource will be allocated using the local population data and intelligence from GP Practices, along with clusters, to ensure resource is fairly spread to the areas of need.

To ensure the most sustainable services are delivered to patients, arrangements should be developed between the GP Clinical Lead in the Practice and the service manager around the coordination of duties and roles and responsibilities.

Where there are already additional professionals within the GP Practice that form part of the MDT, discussions will take place regarding transfer of employment to the wider service where appropriate.

It is recognised within current core services that, as well as recruiting new staff members, there should be a skill mix of development and recruitment within the core team for succession planning. We are committed to working with teams to develop their skills and support development opportunities to grow and invest in our workforce during this transition towards more community based care models. In order to deliver the extended teams in the community, an increased level of training and development is required to attract, retain and support staff.

As the GP Clinical Pharmacist and MSK Physio roles have been tested, and the services models defined on evidenced based outcomes for patients and GP workload, there is agreement that these two services should be invested in within Year 1 of the programme. It is widely acknowledged that recruiting to large numbers of staff is going to be a challenge. Ayrshire and Arran are having ongoing discussions with the Universities across the country, along with NHS Education for Scotland to consider all options for training and developing staff from a basic competency level in their profession. Due to the success of the ANP Academy, this is an approach being considered for all professions within the MDT along with organising a pool of mentors and supervisors from current GPs to assist with ongoing trainee support.

Scoping work with the nursing services across our communities and mental health services team to understand current service models and staffing numbers/skill mix is required. This will be concluded within Year 1, also linked to the development plan and investment to address Action 15 of the Mental Health Strategy.

Full details of the roll out numbers within the MDT are included within Appendix E. It should be noted that the GP Clinical Pharmacist role is included as part of the Pharmacotherapy Service within Appendix B.

Chapter 14: Primary Care Infrastructure **Introduces a number of measures designed to manage the risks of GPs carrying the responsibility for premises and providing the infrastructure to support services to patients.**

One of the overarching aims of reforming General Practice is to improve infrastructure and reduce risk in areas such as ownership of premises, IT and information sharing. These areas are being taken forward and explored on a national basis with a view to transitioning new arrangements by 2020. A local Premises and Infrastructure Group will be established to oversee the national guidance and steps required locally to implement in line with the GMS Contract

The National Code of Practice for GP Premises was published on 13 November 2017. Following the acceptance of the GMS contract offer by SGPC, Scottish Government and Health Boards are working to implement the Code of Practice. The Code sets out plans to offer interest-free secured loans to GPs who own their premises. It sets out the steps that GP contractors who lease their premises privately must take if they wish their Health Board to take on the lease.

The Primary Care Premises and Infrastructure Workstream within the Programme Structure will oversee the local arrangements in relation to the sustainability loans, GP Premises Survey, GP Leased Premises and IT Systems.

This section includes an overview of the requirements set out in the contract for these areas with additional guidance expected from Scottish Government expected in the near future.

GP Owned Premises

New interest-free sustainability loans will be made available, supported by £30 million investment over the next three years. GP contractors have been informed of the priority categories for applications and requested to provide notes of interest by 25 May. The District Valuer has provided refreshed estimates of the existing-use value of GP owned premises and the intention is that these will be provided to GP contractors before the scheme opens.

The GP Premises Implementation Group have met and agreed broad principles for the loan documents. There will be discussions with BMA and NHS representatives on the detail of the loan documents with a view to all parties reaching agreement. The plan is to open the scheme once the detail of the loan documents has been agreed.

GP Premises Survey

Health Facilities Scotland has prepared the High Level Information Pack for bidders for the survey contract and an assessment panel is being identified. Health Boards have been asked to confirm that the list of properties to be surveyed is correct.

GP Leased Premises
The Scottish Government's long term strategy is that no GP contractor will need to enter a lease with a private landlord for GP practice premises. NHS Boards will gradually take on the responsibility from GP contractors for negotiating and entering into leases with private landlords and the subsequent obligations for maintaining the premises. NHS Boards will ensure that GP contractors are provided with fit-for-purpose accommodation which complies with the standards set by the Premises Directions. There are three ways in which NHS Boards can take on the responsibility of providing a GP contractor with practice premises. These are:

- negotiating a new lease for the GP contractor's current premises, with the NHS Board as the tenant
- accepting assignation of the GP contractor's current lease
- providing alternative accommodation for the GP contractor when its current lease expires

If a lease expires before 1 April 2023, the most likely course of action is for the NHS Board to negotiate a new lease or provide alternative accommodation.

If the lease expires after 1 April 2023, NHS Boards will take on the existing lease from GPs where:

- The practice has ensured that its premises are suitable for the delivery of primary care services and are sufficient to meet the reasonable needs of its patients
- The practice has met its statutory obligations regarding the premises
- The practice has provided all relevant information to its NHS Board
- The practice has given sufficient notice to its NHS Board of its need for assistance
- The practice has registered the lease with the NHS Board
- The practice has the agreement of the landlord to the assignation of the lease (and the other necessary conditions)
- The practice has complied with its obligations under its existing lease
- The rent represents value for money

IT Infrastructure
NHS Boards have commissioned a procurement competition to provide the next generation of GP clinical IT systems for GPs in Scotland. This is being undertaken by NHS National Services Scotland.

The new systems will be more intuitive and user friendly. They will be quicker and more efficient, with increased functionality. They will be underpinned by strong service levels and performance management, with clear lines of responsibility and accountability, providing, overall, a more professional GP IT Service.

All GP practices will transition to the new systems by 2020. GPs will continue to have the right to choose a clinical IT system from those which have been approved by the Scottish Government.

Information Sharing
The new contractual provisions will reduce the risk to GP contractors of being data controllers. The contract recognises that contractors are not the sole data controllers of the GP patient record but are joint data controllers along with their contracting NHS Board. The contract will clarify the limits of GP contractors' responsibilities. GP contractors will not be exposed to liabilities beyond their effective control.
Further guidance is expected imminently from Scottish Government on how this is implemented locally. The actions within the guidance will be introduced through a Short Life Working in conjunction with the Head of Information Governance for the Board, reporting progress through the Urgent Care Service Implementation Group.

Chapter 15: Primary Care Improvement Fund **Provides a financial summary of the overall investment from each IJB against the funding required against of the implementation programmes.**

Funding Allocation

The Integration Joint Boards and NHS Board have received confirmation from Scottish Government of the allocated Primary Care Improvement Fund for 2018/19 which will be used by IJBs to commission primary care services, and is allocated on an NRAC basis through Health Boards to IJBs.

To assist with preparation of the PCIP, Scottish Government has announced its commitment to increase the overall funding to £250 million by 2021-22. Strictly as a planning assumption, and subject to amendment by Ministers without notice, the IJBs have been advised that it is expected that the Primary Care Improvement Fund (PCIF) will increase to approximately £55 million in 2019-20, £110 million in 2020-21, and £155 million in 2021-22. This will, as this year, be distributed on an NRAC basis. This has allowed early planning assumptions for investment to be made within the PCIP.

All PCIF in-year allocations should be considered as *earmarked recurring* funding. It should be assumed therefore that staff may be recruited on a permanent basis to meet the requirements set out in the MoU. Scottish Government will engage with the IJBs and NHS Boards over the three years on any plans to baseline these funds.

Investment Required

Through each of the Implementation Groups initial work has been carried out to understand the investment required from now until 2022. This has also taken into account previous projects and tests of change that were invested in via the Primary Care Transformation Fund 2016-2018.

As detailed in the summary of outcomes from the Implementation Groups, there is recognition of what projects have added value to General Practice, and where further scoping work is required to understand how we meet the requirements set out in the MoU. This is outlined in detail within the implementation action plans.

For the purpose of the plan, the required investment detailed in the implementation action plans has been divided into IJB area for each year, along with WTE share, based on that IJB's NRAC share of the funding. It should be noted that investment has been requested as pan Ayrshire service model funding, as outlined in the actions plans, but this approach to financial planning will be helpful for each IJB to track investment and spend against their share of the PCIF. As noted earlier in this document, the aim is to deliver a core pan Ayrshire service delivery model where possible in General Practice, with the recognition that there may be slight variation in delivery models based on the HSCP local delivery plans and population need. Any changes or adjustments to the PCIP as it develops and matures will require to be signed off by the LMC.

Any discussions on variation of service delivery models should take place through the Implementation Groups in the first instance and then escalated to the Writing Group or Oversight Group where required.

Summary of Investment by IJB Allocation of Primary Care Improvement Fund

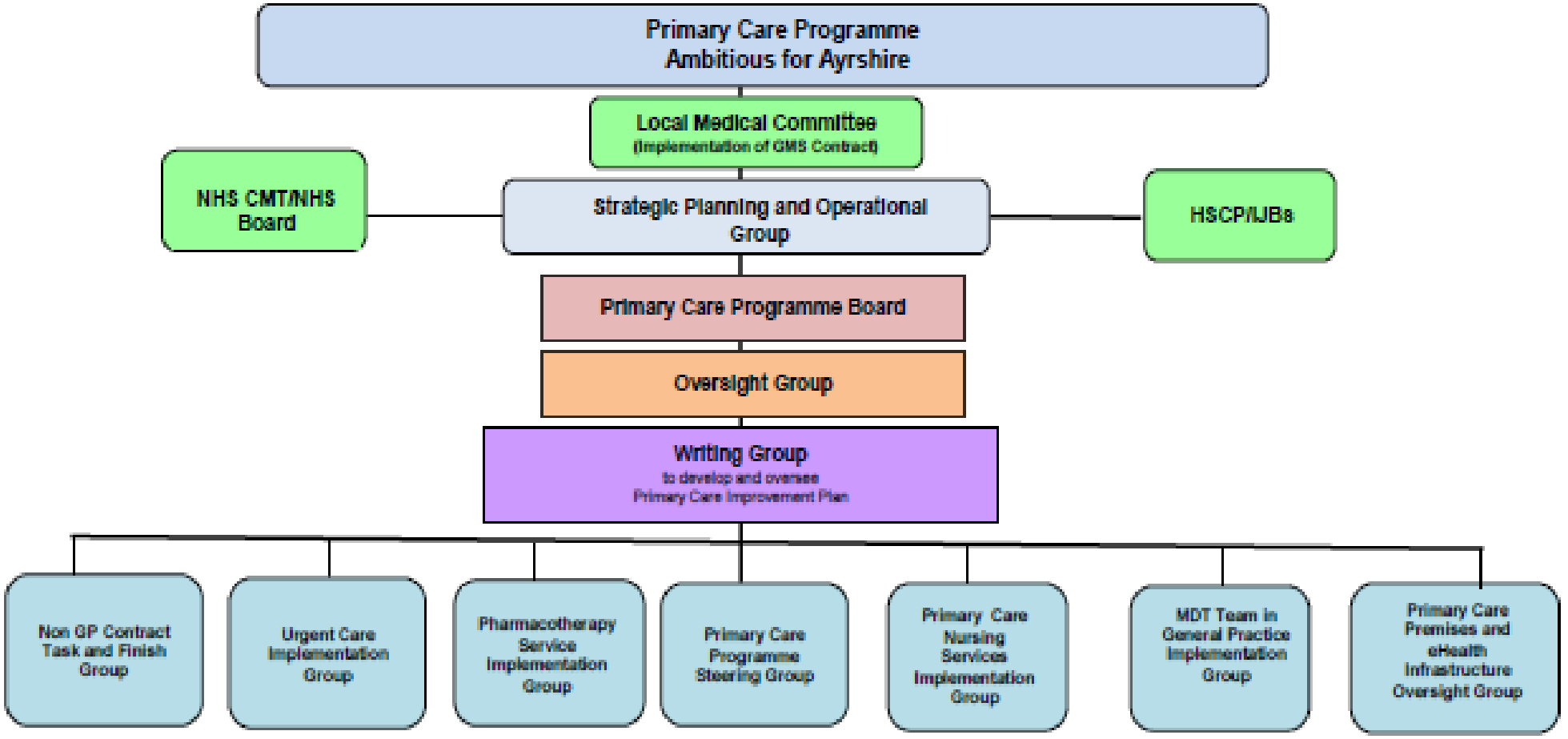
For the areas that have been identified as early priorities in 2018-2020, the tables below details the summary of investment required for the priority areas over a two year funding and recruitment period. This takes into account the £3,389,685 investment in 2018/19 and the £4,074,685 (£685,000 additional) in 2019/20. Resource for 2018/19 has been costed on part year costs in 2018/19 and recruitment will be phased accordingly through the workforce plans for each implementation group.

As stated within the funding allocation section, future additional allocations of a larger sum will be received in 2020/21 and 2021/22. The implementation plans detail the scoping and design work that will be carried out 2018-20 to understand how this resource will be invested. It is noted that some pan Ayrshire proposals will be an equal NRAC split across the IJBs, with other proposals specific to the relevant IJB.

Table 1 – Summary of Required Investment

Priority within MoU/ Implementation Group	Investment £	2018/19 to 2019/20 Total Allocation £7,464,370		
		32.80% EA £2,463,2421 £	36.70% NA £2,761,816 £	30.44% SA £2,239,311 £
Pharmacotherapy Service	3,880,163	1,347,802	1,327,763	1,204,598
Primary Care Nurse Service	575,996	195,929	204,004	176,033
Urgent Care Service	451,500	148,600	166,490	136,410
MDT in General Practice	2,202,939	660,589	936,346	666,004
Programme Delivery	296,875	97,385	109,110	90,380
TOTAL	**£7,407,473**	**£2,450,137**	**£2,743,713**	**£2,273,425**

Appendix A


Primary Care Programme
Ambitious for Ayrshire
Local Medical Committee
(Implementation of GMS Contract)
NHS CMT/NHS Board
Strategic Planning and Operational Group
HSCP/IJBs
Primary Care Programme Board
Oversight Group
Writing Group
to develop and oversee
Primary Care Improvement Plan
Non GP Contract Task and Finish Group
Urgent Care Implementation Group
Pharmacotherapy Service Implementation Group
Primary Care Programme Steering Group
Primary Care Nursing Services Implementation Group
MDT Team in General Practice Implementation Group
Primary Care Premises and eHealth Infrastructure Oversight Group

Membership Agreed for Implementation Structure to Date

Oversight Group	Writing Group
Director of East HSCP (Accountable Officer) Chair GP Sub Committee Secretary GP Sub Committee Associate Medical Director for Primary Care (Professional Lead)	The Head Primary Care and Out of Hours (co-chair) Secretary GP Sub Committee (co-chair) Associate Medical Director Primary Care Associate Nurse Director Primary Care Director of Pharmacy Director of Public Health (Children's Services Lead also) Three Representatives from GP Sub Committee North HSCP Representative – Clinical Director South HSCP Representative – Partnership Facilitator Programme Manager

Urgent Care Implementation Group	Pharmacotherapy Service Implementation Group	Primary Care Nurse Service Implementation Group	MDT Implementation Group
Associate Medical Director Primary Care – Co Chair GP Sub Exec Member – Co Chair The Head Primary Care and Out of Hours Clinical Director – Out of Hours SAHCP – Community Ward GP Practice Manager x 2 NAHSCP Senior Manager – Intermediate Care & Clinical Nurse Manager - Lead General Practice Nurse	Director of Pharmacy Co-Chair Chair GP Sub – Co-chair GP Stakeholder NAHSCP – Primary Care Mental Health Services Lead SAHSCP – Clinical Director Lead Pharmacists x 2 Lead Community Pharmacists Practice Manager x 2	Associate Nurse Director –Co-Chair Secretary GP Sub – Co-Chair Chair VTP Implementation Group Clinical Lead Phlebotomy Management Lead Phlebotomy Director of Public Health Lead General Practice Nurse – pan Ayrshire SAHSCP – Associate Nurse Director NAHSCP – Head of Service, Children and Families & Team Leader MHS Lead Community Pharmacist Practice Managers x 2	AHP Lead EAHSCP – Co-Chair GP Sub Exec Member – Co Chair NAHSCP Rep – Team Leader Mental Health & Senior Manager Locality Services SAHSCP – Partnership Facilitator Lead General Practice Nurse – pan Ayrshire Clinical Nurse Manager ANPs Clinical Lead MSK Physio Lead Pharmacist Practice Manager x 2

Priority:	**Pharmacotherapy Service**	**Appendix B**
Objective	**How do we get there**	**Timescale**
Establish a sustainable pharmacotherapy service by 2021	Establish project structure and governance arrangements	2018/19
	Create a Pharmacotherapy Planning and Innovation team to focus on meeting this objective in order that existing service provision and improvements continue and transition can be managed safely and efficiently	2018/19
	A three month pilot to test the staffing level assumptions and produce standard service processes and procedures	2018/19
Rollout serial prescribing and dispensing	Fill existing vacancy (existing funding, post re-focused on Pharmacotherapy roll out) within the Community Pharmacy Team – Band 8a – to lead enabling and rollout of serial prescribing and dispensing	2018/19
	Establish a systematic and standard approach for initial identification and take-up of suitable patients; documentation templates; phased implementation and roll out plan	2018/19
Leadership and Training Academy	Establish a Pharmacotherapy/Education and Training leadership structure	2018/19
	Establish a training academy to bring pharmacists and technicians through training based in primary care and develop towards providing full pharmacotherapy service role	2018-20
	Create a refreshed pharmacy management structure to reflect eventual model of pharmacotherapy services	2018-2020
Workforce Recruitment	Recruit one band 8b Pharmacist as Pharmacotherapy/Education & Training lead	2018/19
	Recruit one band 5 wte project support	2018/19
	Recruit one band 8a wte pharmacist (will become cluster lead in new structure)	2018/19
	Recruit one band 6 pharmacy technician (existing funding)	2018/19
	Recruit four band 6 pharmacists to test primary care training academy (plan to move to core establishment when primary care training academy tested and established)	2018/19
	Recruit up to 14 band 7 pharmacists	2018/19
	Recruit up to eight Band 5 pharmacy technicians	2019/20
	Recruit up to 14.4wte band 6/7 pharmacists (skill mix subject to pilot and year 1 experience, potentially reduce by 4 WTE if primary care training academy successful))	2019/20
	Recruit up to 4.5wte band 5 pharmacy technicians(subject to pilot and year 1 experience)	2019/20

Priority:	**Primary Care Nurse Service** **Community Treatment and Care Services & Vaccination Transformation Programme**	**Appendix C**
Key Action set out in Memorandum of Understanding	**How do we get there**	**Timescale**
• Management of minor injuries and dressings • Ear syringing • Suture removal • Chronic disease monitoring and related date collection	1. Group established to carry out full scoping exercise to understand the current workforce and requirements.	May -December 2018
	2. Test Primary Care Nurse model with new graduates – providing training and development in community and primary care nursing	2018/19
	3. Design proposed workforce models to share with services	March 2019
	4. Implementation and roll out of workforce	2019-21
Phlebotomy	Secondary Care Blood Requests	
	1. Phase 1 – test site renal and urology	June 2018– October 2018
	2. Phase 2 – Extend to other specialties	October 2018 – March 2019
	5. Phase 3 – Provide Phlebotomy Service for General Practice	2019/20
Vaccination Programme		
Pre-school Programme	1. Scope and cost a pan Ayrshire model	July 2018
	2. Implement new model (excluding flu)	March 2019
School based Programme	1. No changes	
Travel vaccinations and travel health advice	1. Scope current landscape	June 2018
	2. Criteria for assessment of the minimum requirements for the safe and effective delivery of potential options. Await national guidance.	March 2019
Influenza Programme	1. Scope planned programme approach to deliver via nurse bank/primary care nurse development roles	January 2019
At risk and age group programmes (pregnant women shingles, pneumococcal, hepatitis B	2. Pregnant Woman to be delivered by midwife at 20 week scan within Ayrshire Maternity Unit. A cost of 2.5 wte midwives to expand the service will be required.	October 2018

Priority:	**Urgent Care Service**	**Appendix D**
Key Action set out in Memorandum of Understanding	**How do we get there**	**Timescale**
Advanced Practitioner Resource to assess and treat urgent or unscheduled care presentations and home visits within an agreed local model or system of care	**Access Multi-Disciplinary Team (MDT) Practitioner Resource to assess and treat urgent care presentations by:**	
	1. Link to MDT workstream to establish standardised pathways for Advance Practitioner Resource to assess and treat urgent or unscheduled care presentations	2018-20
	2. Develop policy on Joint Data Controller	2018/19
	3. Review IT infrastructure to maximise re-direction pathways	2018/19
	4. Develop signposting algorithms / pathways linked to clinical decision making 2018-20 in line with MDT development	2018-20
	5. Provide infrastructure /pathways for consistent signposting / navigation across A&A in line with MDT development (signposting training, NHS24 / H&SCP directories, Linkworkers / Community connectors)	2018-19
	6. Scope Remote and Rural specific requirements and solutions	2018-19
	7. Support implementation for NHS24 Practice Websites where add value	2019/20
	8. Maintain Eyecare Ayrshire and continue to promote	2018-21
	9. Maintain existing Pharmacy First and promote	2018-21
	10. Maximise the uptake of community pharmacy as a first port of call for common clinical conditions by utilisation of the Minor Ailment Service (MAS)	2018-21
	11. Support the development of Independent Pharmacist Prescribers (IPPs) for common clinical conditions	2018-21
	12. Undertake social media / communication campaign for right care, right person, linking to national work as appropriate – scoping and planning	2018-21
	13. Support implementation for NHS24 Practice Websites where add value	2019/20
	14. Develop Mental Health pathways for PC MDT and CMHT	2019/20
	Reduce GP Delivered Home Visits (including care homes) by:	
	1. Seek to become a test of change site with NHS24 advanced paramedics	2018/19
	2. Create a local collaborative with clusters to undertake quality improvement activity including minimising home visits	2018/19
	3. Scope home visit activity, demography, ANP involvement and practice protocols across practices, learning from good practice	2018/19
	4. Link to MDT workstream to enable continuing development of Community Nursing team and engagement of ANP for nursing home visits	2018-21

Build capacity and resilience in local community to pre-empt and avoid individual seeking urgent care services	1. Maximise digitally enabled support to reduce GP attendance (continued rollout of A&A Tec 2018/19; seek to be a test site for NHS24 MH digital service in 2019/20 with national rollout 2020-23)	2018-23
	2. Learn from test of change in Tam's Brig Practice for electronic case management planning for housebound patients 2018/19	2018/19
	3. Continue and learn from Stewarton pilot 2018/19 and work with H&SCP on approaches to community capacity and resilience 2019-21	2018-21

Priority:	**Multidisciplinary Team in General Practice**	**Appendix E**
Key Action set out in Memorandum of Understanding	**How do we get there**	**Timescale**
MSK Physio	1. 4 MSK physios currently in post across Ayrshire	Already Committed
	2. 6 x Band 7 MSK Physios to scale across Ayrshire	2018/19
	3. 1 x Band 8a to develop and manage the MSK Physio Service aligned to General Practice as well as provide clinical leadership and support for decision making. This post will also be half time clinical providing	2018/19
Primary Care Mental Health Services	1. 2016-18 £85k was invested in Community Mental Health Services in each HSCP area. This included a mix of MH practitioners and community link workers.	Already committed
	2. Further work required with operational community mental health teams to scope pathways and models before further investment could be agreed	2018/19
Community Link Workers	1. Group established with HSCP Leads to review number of Link Workers in post and scope current roles.	
	2. North Ayrshire allocated additional link workers from national programme – now incorporated into programme	Already committed
	3. Initial scoping identified South Ayrshire required 1.5wte to ensure full coverage across all practices in line with other HSCPS	2018/19
Development of ANPs	1. Development of 15 ANPs through ANP Academy – includes academic study and mentoring/supervision in their place of work. Cohort 1 of 14 commenced September 2017	Committed
	2. Cohort 2 – 10 students and spread across additional GP Practices. Reduced number due to evaluation taking place and learning to take place on cohort 1	September 2018
	3. Cohort 3 – 10 students	September 2019
	4. Cohort 4 – 15 students	September 2020

Integration Joint Board
21 June 2018

Subject:	**Award of the Framework Contracts for the Provision of Care at Home Services**
Purpose:	To advise the Integrated Joint Board (IJB) and Cabinet of the outcome of the procurement exercise for the Framework Contracts for the Provision of Care at Home Services. .
Recommendation:	To acknowledge and note the award of contracts to: (i) Inverclyde & North Ayrshire Care Services trading as Carewatch; (ii) Mears Care; (iii)Rainbow Services (UK) Ltd; (iv) Ayrshire Quality Care and Support, Community Interest Company (CIC); and (v) First Homecare. The contracts are for a period of 2 years with the option to extend for up to a further 2, twelve month periods.

Glossary of Terms	
NHS AA	NHS Ayrshire and Arran
HSCP	Health and Social Care Partnership
IJB	Integrated Joint Board
LOTS	A defined geographical area which appointed Providers will operate within

1.	**EXECUTIVE SUMMARY**
1.1	This report summarises the outcome of the procurement process undertaken by North Ayrshire Council at the request of the North Ayrshire IJB in respect to Care at Home services. This report confirms the five contracts have been awarded to deliver Care at Home support to service users in North Ayrshire.
1.2	Care at Home Services are currently delivered through in-house provision across the six localities of North Ayrshire and partially outsourced across five of those localities. Given its remote and rural nature, resulting in difficulties in recruiting and retaining staff, service provision on Arran is completely in house and will remain as is. Cumbrae, however, is now part of the tender award.
1.3	Services are currently delivered through interim contract arrangements that will remain in place until 30 June 2018. Newly tendered contracts will commence on 1 July 2018 for a period of two (2) years with the option to extend for a further two (2) 12 month periods.

2.	**BACKGROUND**
2.1	The procurement followed an Open Procedure, conducted in 2 stages. Stage 1 examined minimum requirements and Stage 2 evaluated quality and price. Tender evaluation was undertaken using the Most Economically Advantageous Tender (MEAT) criteria with a ratio of 20% Price and 80% Quality. Only Tenderers that successfully passed both Stage 1 - Minimum Requirements and Stage 2 - Quality Evaluation had their tender price considered. The tender evaluation was carried out by a panel of appropriately experienced Council Officers against the published criteria.
2.3	The contract notice attracted 32 expressions of interest from a range of potential bidders and 10 bids were submitted for evaluation. 8 of the 10 bidders, who submitted a tender response, met the minimum requirements at Stage 1 of the evaluation process. 5 of the 8 bidders met the required standard at Stage 2 of the process and therefore qualified for the contract award.
3.	**PROPOSALS**
3.1	At the IJB of 9 March 2017 approval was given for the percentage split of inhouse and externally purchased care at home to change to be weighted more to inhouse provision. At March 2017 the split was 61% inhouse and 36.5% externally purchased (with the remaining 2.5% of the care at home outsourced budget allocated to Direct Payments). The IJB approved the split to move to 70 % inhouse with 27.5% externally purchased (with the remaining 2.5% of the care at home outsourced budget allocated to Direct Payments). IJB are asked to note the contracts within the various LOTS to the following 5 Providers, who are listed in ranked order, based on outcomes from evaluations. For the purposes of the procurement exercise and the tender award Irvine and Kilwinning were joined as one LOT area.

	LOT 1: Irvine & Kilwinning areas:	**LOT 2: Three Towns: Ardrossan, Saltcoats & Stevenston**	**LOT 3: North Coast: Largs, Fairlie, West Kilbride, Skelmorlie & Cumbrae**	**LOT 4: Garnock Valley: Kilbirnie, Beith & Dalry**
Provider no. 1	Inverclyde & North Ayrshire Care Services t/a Carewatch	Inverclyde & North Ayrshire Care Services t/a Carewatch	Inverclyde & North Ayrshire Care Services t/a Carewatch	Inverclyde & North Ayrshire Care Services t/a Carewatch
Provider no. 2	Mears Care	Mears Care	First Homecare	Ayrshire Quality Care & Support CIC
Provider no.3	Rainbow Services (UK) Limited	Rainbow Services (UK) Limited		First Homecare
Provider no. 4	Ayrshire Quality Care and Support	Ayrshire Quality Care and Support		
Provider no.5	First Homecare	First Homecare		

In summary of the table above: five providers will provide Care at Home services across the Irvine and Kilwinning localities; five providers will provide services across the 3Towns localities; two providers will provide services across the North Coast

	localities; and three providers will provide services across the Garnock Valley localities. The Framework will be a contractual agreement between North Ayrshire Council (NAC) and the aforementioned Service Providers. The island of Arran will continue to receive in-house provision only.
3.2	**Anticipated Outcomes**
	➢ To ensure North Ayrshire Council continues to deliver services in line with Procurement legislation and meets the Procurement Reform (Scotland) Act 2014 for sustainable public procurement that supports economic growth through improved procurement practice. Furthermore assurance for the IJB that the Partnership's Care at Home service is secured and will be delivered in accordance with the outcome of the IJB report in March 2017. ➢ To ensure that delivery of provision has positive outcomes for service users and that service users continue to have choice and control over their lives. In addition to ensure the service users receive provision that meets their assessed need and is delivered safely and is of a high qualitative standard. ➢ To consolidate current off framework spend into a newly tendered framework so that all outsourced care at home delivery is purchased from one framework agreement. However there may be a need to commission care at home services from alternative Providers under a call off arrangement should there be capacity issues with any of the Framework providers. To mitigate this risk, the ongoing capacity growth of the Framework providers will be subject to contract monitoring and forms part of the KPI's. ➢ To procure services that take account of providers approach to fair work practices including fair and equal pay, travel arrangements and the living wage as part of a package of positive fair work practices. ➢ To contribute to the Council's commitment to UNISON'S Ethical Care Charter with a requirement that providers take cognisance of and work towards achieving the key recommendations within the charter. ➢ To use technological solutions that assist in their management of services that includes CM2000. ➢ To provide value for money.
3.3	**Measuring Impact**
	The Council will ensure that effective services are delivered to support service users and Carers. Contracts will be managed through the Council's Contract Management Framework at all stages throughout the contract term in terms of performance and compliance, relationship management and continuous improvement. There will also be progress updates contained within the reports tabled at the Performance and Audit Committee.

4.	IMPLICATIONS

Financial :	The value of the framework is £4,823,697 per annum. The contract is for two years with an option to extend for a further 2 x 12 month period. Based on the budget identified for the two years the value of the contract is £9,647,394. However should the Partnership decide to extend for the further two years the whole life value of the framework is £19,294,788.
Human Resources :	TUPE applies within this procurement. The contract award has involved a transition period for involving the transfer of service users and business in the Irvine, Three Towns and North Coast localities. This has been carried out in the best interests of service users. There are transition and implementation plans in place to support the process which has involved consultation and communication with service users by members of the Community Care Services team. The dialogue between outgoing and incoming providers is ongoing regarding affected staff re TUPE.
Legal :	In order to comply with the Council's Standing Orders Relating to Contracts and Contract Procedure Rules, Public Contracts (Scotland) Regulations 2015 a formal tender exercise was advertised via the Public Contracts Scotland advertising portal.
Equality :	The Council has due regard to the need to eliminate discrimination, harassment and victimisation, and to advance equality of opportunity, and foster good relations, between those who share a relevant protected characteristic and those who do not share it (section 149 Equality Act 2010). The Council has a duty to have due regard to the need to remove or minimise disadvantages, take steps to meet needs, in particular steps to take account of disabled persons' disabilities, and encourage people to participate in public life. The Council must have due regard to the need to tackle prejudice and promote understanding. The contract includes a requirement to comply with the equality act.
Environmental & Sustainability :	Impact areas identified for these services are Moving and Handling, Lone Working and Infection Control. These areas are contractually required to be robustly risk assessed by providers throughout operational delivery.
Key Priorities :	The procurement supports the following NAHSCP priorities; Priority 4 – Prevention and Early Intervention Priority 5 – Improving Mental Health and Well-being.
Risk Implications :	The Council's Contract Management Framework provides a robust risk rating matrix.
Community Benefits :	See table; Appendix 1.

Direction Required to Council, Health Board or Both	Direction to :-	
	1. No Direction Required	X
	2. North Ayrshire Council	

	3. NHS Ayrshire & Arran	
	4. North Ayrshire Council and NHS Ayrshire & Arran	

5.	**CONSULTATION**
5.1	Formal consultation was not applicable in this procurement as there has been no change to the delivery of the service.
6.	**CONCLUSION**
6.1	Following a comprehensive procurement process, contracts were awarded to: Invercare and North Ayrshire Care Services t/a Carewatch, Mears Care, Rainbow Services (UK) Ltd, Ayrshire Quality Care CIC and First Homecare. There were no legal challenges during the Standstill period.
6.2	That the IJB are aware that implementation work is progressing with both outgoing and incoming providers and that the new Framework Contract will commence, as scheduled, on 1 July 2018.

For more information please contact Helen McArthur, Senior Manager, Community Care Services on 01294 317783.

Appendix 1

Provider	Community Benefits offered
The following Community Benefits offered were dependent on the amount of business awarded to providers through the framework. Therefore the undernoted cannot be guaranteed that they will be delivered	
Inverclyde & North Ayrshire Care Services t/a Carewatch	▪ 6 new jobs being created ▪ Work placement for a minimum of 5 days for an S4, S5 or S6 pupil from a North Ayrshire School ▪ Support for Community Groups by participating in NAC workshops to identify skills that could be shared with Community Organisations to build capacity and improve relationships
Mears Care	▪ Target 1 apprentice position throughout lifetime of contract ▪ 1 job created per additional 25 hours care/support delivered ▪ Target 1 graduate position throughout lifetime of contract ▪ Support for a school project agreed in conjunction with NAC Education & Skills department involving local school pupils. ▪ Support for a community project agreed in conjunction with NAC Economies and Communities department involving local people and reflecting local priorities.
Rainbow Services (UK) Limited	▪ 4 new jobs being created ▪ 1 Support Worker Modern Apprentice ▪ Work placement for a minimum of 5 days for an S4, S5 or S6 pupil from a North Ayrshire School ▪ Support for a school project agreed in conjunction with NAC ▪ Education & Skills department involving local school pupils Support for a community project agreed in conjunction with NAC Economies and Communities department involving local people and reflecting local priorities. ▪ Support for Community Groups by participating in NAC workshops to identify skills that could be shared with Community Organisations to build capacity and improve relationships.
Ayrshire Quality Care & Support CIC	▪ 20 new jobs being created ▪ 1 HR Manager post being created ▪ Work experience for a young person facing challenges or barriers completed over a 6 week period (1 day per week) ▪ Support for a community project agreed in conjunction with NAC Economies and Communities department involving local people and reflecting local priorities.
First Homecare	▪ 35 new jobs being created ▪ Support for a school project agreed in conjunction with NAC Education & Skills department involving local school pupils ▪ Support for a community project agreed in conjunction with NAC Economies and Communities department involving local people and reflecting local priorities.

Integration Joint Board
21 June 2018

Subject:	**Chair of Kilwinning Locality Forum**
Purpose:	To update IJB on the resignation of the current Locality Planning Forum (LPF) Chair of Kilwinning locality and agree an interim process going forward to appoint an interim LPF Chair.
Recommendation:	The IJB is asked to note the resignation of the current chair and to agree an interim process to nominate an interim LPF Chair.

Glossary of Terms	
NHS AA	NHS Ayrshire and Arran
HSCP	Health and Social Care Partnership
IJB	Integration Joint Board
LPF	Locality Partnership Forum

1.	**EXECUTIVE SUMMARY**
1.1	Following the resignation of Robert Steel as Chair of Kilwinning Locality Planning Forum (LPF), the IJB are asked to agree an interim process to appoint an interim LPF chair. The IJB will approve the outcomes of the LPF review in late Autumn 2018.
2.	**BACKGROUND**
2.1	On 20th July 2017, the IJB after considerable debate, agreed to revise the Terms of Reference for LPFs. Two approaches were highlighted for consideration: • An IJB member be identified to become the LPF chair. • The LPF to propose one of their members to act as the LPF Chair and that this individual then sits on the IJB. This individual would not have voting rights on the IJB. On the 20th July 2017, the IJB chose the second approach, reflecting the key strategic commissioning role that LPFs play in their localities, building on the knowledge of partnership staff and key stakeholders working in those areas. Unfortunately at that time no further updates of the Terms of Reference was undertaken, to include detailed guidance on how LPF Chairs should be appointed or be refresh, to ensure a fair, equitable and democratic process.

2.2	The Kilwinning LPF agreed to appoint Robert Steel as Chair at their meeting on 29th August 2017.
2.3	The current Chair, Robert Steel, tendered his resignation as Chair of the LPF, and IJB member, on 15th May 2018.
2.4	As agreed at the Strategic Planning Group on 24th April 2018, a review of the current Locality Partnership Forum arrangements is taking place with initial recommendations being presented to the Strategic Planning Group on Wednesday 20th June 2018. This review includes a detailed review of the LPF Terms of Reference covering the following areas: • Role of LPF and clarity around strategic commissioning • Core membership and temporary membership to take forward key pieces of work • Chair and membership arrangements, including the appointment process and length of office to ensure a fair, equitable and democratic process • Meeting frequency and HSCP support role • Feedback routes for the strategic commissioning health and social care services in each locality to the Strategic Planning Group • Links with the Community Planning Partnership (CPP) Partnership Forums to reduce duplication and increase the outcomes for people living in our localities.
2.5	The new Terms of Reference proposals, including the Chair arrangement, will be after considered by the LPF Chairs at a session on 2 August 2018. A finalised version will be brought forward to the IJB thereafter.
3.	**PROPOSALS**
3.1	It is proposed that in the interim the IJB ask the Kilwinning LPF to nominate a lead member, to act as the interim Chair, and for this individual to sit as a non-voting member on the IJB in that role.
3.2	**Anticipated Outcomes**
	Each community will have a mechanism for having a voice at the IJB.
3.3	**Measuring Impact**
	The priorities identified by the Locality Planning Forums, were considered by the Strategic Planning Group and the IJB. These priorities are now included in the Strategic Plan and their delivery will be measured through our performance monitoring.
4.	**IMPLICATIONS**

Financial:	None
Human Resources:	None
Legal:	It is important that any legal issues arising from the report are made clear.
Equality:	This will ensure equality, giving the communities of Kilwinning an equal voice at the IJB.

Children and Young People	Consider the impacts on children and young people in North Ayrshire.
Environmental & Sustainability:	None
Key Priorities:	This will fulfil the obligations of the Integration Scheme and fit with the strategic priority of Engaging Communities.
Risk Implications:	None
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	

5.	**CONCLUSION**
5.1	The IJB is asked to agree the interim proposal to request Kilwinning Locality Partnership Forum nominate a new Chair, who will attend future IJB meetings as a non-voting member. This is an interim position and will be subject to further review in Autumn 2018 on completion of the LPF review.

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