Integration Joint Board Meeting

NORTH AYRSHIRE
Health and Social Care Partnership

Thursday, 14 February 2019 at 10:00

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

1 Apologies
Invite intimation of apologies for absence.

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

3 Minutes / Action Note
The accuracy of the Minutes of the meeting held on 18 December 2018 will be confirmed and the Minutes signed in accordance with Paragraph 7 (1) of Schedule 7 of the Local Government (Scotland) Act 1973 (copy enclosed).

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

Quality and Performance

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

Strategy and Policy

5 Budget Monitoring – Period 9
Submit report by Caroline Whyte, Chief Finance and Transformation Officer providing an update on the projected financial outturn for the financial year (copy enclosed).

6 Allied Health Professionals (AHP) Highlight Report 2018

Submit report by Alistair Reid, Lead Allied Health Professional providing detail on the activity of AHPs in North Ayrshire Health and Social Care Partnership (HSCP) during 2018 and on collective objectives for the next 12 months (copy enclosed).

7 Veterans First Point (V1P) Service

Submit report by Lindsay Kirkwood, Clinical Lead V1P, in consultation with Thelma Bowers, Head of Service (Mental Health), providing information on the Veterans First Point Ayrshire and Arran service (copy enclosed).

8 Joint Locality Planning Partnership – Arran Pilot

Submit report by Michelle Sutherland, Strategic Planning Lead on the development and pilot of an integrated HSCP Locality Planning Forum and CPP Locality Partnership arrangement on the Island of Arran (copy enclosed).

9 North Ayrshire Integration Joint Board Records Management Plan

Submit report by Julie Davis, Principal Manager Business Administration on the North Ayrshire Integration Joint Board Records Management Plan (copy enclosed).

10 Ministerial Strategic Group for Health and Community Care - Review of progress with integration of Health and Social Care

Submit report by Caroline Whyte, Chief Finance and Transformation Officer (copy enclosed).

11 Urgent Items

Any other items which the Chair considers to be urgent.

12 Exclusion of the Public

Resolve in terms of Section 50(A)4 of the Local Government (Scotland) Act 1973, to exclude from the Meeting the press and the public for the following item of business on the grounds indicated in terms of Paragraphs 1, 3 and 9 of Part 1 of Schedule 7A of the Act.

Non Disclosure of Information

In terms of Standing Order 19 (Disclosure of Information), the information contained within the following report is confidential information within the meaning of Section 50A of the 1973 Act and shall not be disclosed to any person by any Member or Officer.

13 Seabank Care Home

Submitted report by Helen McArthur, Senior Manager, Community Care Services (copy enclosed).

Integration Joint Board

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Voting Members

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

Professional Advisors

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

Stakeholder Representatives

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

North Ayrshire Health and Social Care Partnership
Minute of Integration Joint Board meeting held on
Thursday 13 December 2018
at 10.00 a.m., Council Chambers, Cunninghame House, Irvine

Present

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

Caroline Whyte, Chief Finance and Transformation Officer
David MacRitchie, Chief Social Work Officer
Dr. Calum Morrison, Acute Services Representative
Alistair Reid, Lead Allied Health Professional Adviser
Dr. Louise Wilson, GP Representative

David Donaghey, Staff Representative (NHS Ayrshire and Arran)
Louise McDaid, Staff Representative (North Ayrshire Council)
Graham Searle, Carers Representative (Depute for Marie McWaters)
Nigel Wanless, Independent Sector Representative

In Attendance

Thelma Bowers, Head of Service, Mental Health
Michelle Sutherland, Strategic Planning Lead
Pam Milliken (East Ayrshire Council)
Peter Omer (East Ayrshire Council)
Karen Andrews, Team Manager (Governance)
Hayley Clancy, Committee Services Officer

Apologies for Absence

Stephen Brown, Director of Health and Social Care Partners
Alistair McKie, NHS Ayrshire and Arran
Dr Paul Kerr, Clinical Director
Vicki Yuill, Third Sector Representative
Fiona Thomson, Service User Representative
Sam Falconer, (Chair) IJB Kilwinning Locality Forum

1. Apologies

Apologies were noted.

2. Declarations of Interest

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

3. Minutes/Action Note

The accuracy of the Minute of the meeting held on 15 November 2018 was confirmed and the Minute signed in accordance with Paragraph 7 (1) of Schedule 7 of the Local Government (Scotland) Act 1973.

4. Director's Report

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

The report, presented by Caroline Whyte, highlighted the "Charter for Change" sessions that communicate a consistent message to managers about what is planned and to get their valuable input into how to maximize the benefits of staff sessions.

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

5. Audit Scotland Report: Health and Social Care Integration: Update on Progress

Submitted report by Caroline Whyte, Chief Finance and Transformation Officer, on the Audit Scotland report on Health and Social Care Integration in Scotland with the report on progress with integration provided at Appendix 1 to the report.

Members asked a question and were provided with clarification on North Ayrshire Council's position in the financial performance 2017/2018 table at Appendix 4.

The Board agreed to note (i) the Audit Scotland report and the findings therein and (ii) an action plan outlining the actions for the North Ayrshire IJB would be presented at a future meeting.

6. Budget Monitoring – Month 7 (October 2018)

Submitted report by Caroline Whyte, Chief Finance and Transformation Officer on the projected financial outturn for the financial year. Appendix A provided a detailed financial overview of the Partnership budgetary position while Appendix B gave a detailed variance analysis. Appendix C presented full detail on savings, with Appendix D detailing progress against the approved recovery plan and Appendix E highlighting the movement in the overall budget position.

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

- primary care prescribing and general medical services projected to be underspent due to the reduction in drug costs; and
- the projected underspend due to part year vacancies.

The Board agreed to (a) note the projected year-end overspend of £0.481m; (b) approve the changes in funding as detailed in section 2.12 and Appendix E to the report; and (c) note the impact of the financial recovery plan and the progress being made in delivering financial balance.

7. Implementation on the Charter for Involvement

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

Members asked a question and were provided with clarification that review work to be undertaken in the Garnock Valley would be reported back to the IJB.

The Board agreed to support the existing actions outlined and undertake to promote the relevance of the Charter across all aspects of the North Ayrshire Health and Social Care Partnership.

8. Primary Care Services Update

Submitted report by East Ayrshire providing a Primary Care Services update with an appendix for each workstream provided.

The report highlighted the following:-

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

Members asked a question and were provided with information on primary dental care fees.

The Board also commended all involved in achieving significant progress with primary care services.

Noted.

9. Strategic Planning Group Minutes

Submitted Minutes of the Strategic Planning Group meeting held on 10 October 2018.

Noted.

The Meeting ended at 10.55 a.m.

North Ayrshire Integration Joint Board – Action Note

Updated following the meeting on 18 December 2018

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

Agenda Item 4

Integration Joint Board
14th February 2019

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

Glossary of Terms	
NHS AA	NHS Ayrshire and Arran
HSCP	Health and Social Care Partnership
IJB	Integration Joint Board
SVQ	Scottish Vocational Qualification
SCQF	Scottish Credit and Qualification Framework
MWC	Mental Welfare Commission
MHA	Mental Health (Scotland) Act

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**
	<u>Ayrshire Wide Developments</u>
2.1	<u>NAHSCP SVQ Centre</u>
	NAHSCP SVQ Centre, in conjunction with North Ayrshire Council Education colleagues, have received funding from Skills Development Scotland to deliver Foundation Apprenticeships in Care. This qualification comprises :- • 15 places across North/South/East Ayrshire for 5th or 6th year pupils • Classroom delivery of a National Progression Award (this prepares pupils for a HSCP placement) at Educational Hub which has been identified as Irvine Royal Academy • Each Authority provides 5 placements • Pupils will complete SVQ 2 (SCQF Level 6) The funding from Skills Development Scotland has been awarded to meet the costs which includes a full-time SVQ assessor post, travelling, IT equipment and PVG checks etc.

	This project will allow the HSCP to work closely with Education and give pupils more opportunities to progress either into Modern Apprenticeships at SVQ 3 Level or College and University.
	North Ayrshire Developments
2.2	Partnership Staff Awards
	The nominations are now closed for the HSCP Partnership Awards judging has commenced in preparation for the Awards Ceremony on 28th February. The finalists will be announced in due course.
2.3	Taster Sessions – Age Simulation Suit
	An age simulation suit offers the opportunity to experience the impairments of older people. It works by impacting upon your cognitive abilities and enabling you to experience some of the difficulties and challenges that people we support face on a daily basis. A number of taster sessions for staff have taken place over the last few weeks and another 30 minute taster slots is planned for **Friday 15 February 2019** (1-1.30pm and 2-2.30pm). Please contact Kerryanne Owens (01294 317784) if you'd like to book a session or for more information. Sessions for teams can be organised upon request.
2.4	Young Carers Awareness Day 2019
	The focus of Young Carers Awareness Day will be on mental health. On **Thursday 31 January**, Unity (North Ayrshire Carers Centre) hosted an event to explore examples of self-care, including a silent disco, beauty treatments, gardening activities etc.
	During 2018, North Ayrshire Carers Centre delivered Young Carer Awareness Assemblies in every school in North Ayrshire, reaching over 6,500 pupils from P5–S6. The centre now offers support to over 140 registered North Ayrshire young carers. Outreach services have recently expanded to include young carer groups in Irvine, Three Towns, Garnock Community Campus and Largs Academy.
	The Council and HSCP are in the process of applying for the Carer Positive Employer Level 2 (Established) and are focusing on peer support within the workplace for council and HSCP employees who also perform a caring role. The Carers Team within the partnership have hosted a series of drop in sessions within Cunninghame House, Irvine to offer advice and information on what support is available to employees who are unpaid carers.
2.4	Thinking Different, Doing Better
	As I reported in the last Director's Report, arrangements are underway for the staff workshops for all NAHSCP to go through an "experience session" to help progress the partnership's strategic intent through asset/value based working. These sessions are planned to run from March to September 2019 and I have committed to attend every one of those sessions.
	A "mop up" session for managers was held on Tuesday 5th February 2019.

2.5	Celebrating Success!
	Dementia Services
	At a national level, the fantastic work taking place in Ayrshire has not gone unnoticed and continues to be recognised. Claire Haughey, Minister for Mental Health, visited Ward 3 at Woodland View on Thursday 3 January in recognition of some of the ground breaking work taking place there in the field of dementia.
	Care at Home
	In early January, our Care at Home service received feedback from the annual unannounced inspection which took place late November/early December 2018. The inspections reviewed the themes of Care and Support and Staffing and I am pleased to report that the service has remained at a Grade 5 for Care and Support and an increase from a Grade 4 to Grade 5 for Staffing. This is in addition to the Grade 5 already received for Management and Leadership. The inspectorate were particularly impressed with the flexibility of the service in meeting the constant demands and pressures placed on it by the hospitals and the way in which the team is creative and driven in ensuring people are enabled to return home at the earliest opportunity. Well done to all involved!
2.6	Beings Exhibition
	Rosemount Kinship Group are part of an interactive exhibition at the Scottish National Portrait Gallery, addressing well-being, where young people explore their feelings by creating new art in direct response to powerful works of art from the national art collection. This experimental display presents these artworks alongside each other to form a collective mind-map. The aim is to create a visual environment where all responses are valued, including those of the visitors. *Beings* is a National Galleries of Scotland Learning project and exhibition co-produced by young people. The exhibition will run from 2nd February to 28th April 2019.
2.7	Mental Welfare Commission Visit
	The Mental Welfare Commission (MWC) End of Year Meeting with NHS Ayrshire and Arran and partnership authorities took place on Monday 14th January 2019 at Greenwood Centre, Dreghorn.
	This annual visit provides an opportunity for feedback from the Mental Welfare Commission, the partnerships and NHS Ayrshire and Arran. Topics on the day included an overview of MWC visits, investigations, publications, Adults with Incapacity (AWI) findings and Mental Health (Scotland) Act (MHA) findings.
	The MWC provided positive feedback on our response to the visits held throughout 2018, and recommendations arising from report findings.
	Discussions took place around the challenges of Mental Health Officer (MHO) recruitment, particularly in relation to Out of Hours Service; and delayed discharges.

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

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

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

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

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

NORTH AYRSHIRE
Health and Social Care Partnership

Agenda Item 5

Integration Joint Board
14 February 2019

Subject:	**Budget Monitoring – Month 9 (December 2018)**
Purpose:	To provide an update on the projected financial outturn for the financial year as at December 2018.
Recommendation:	It is recommended that the IJB: a) Note the projected year-end overspend of £0.227m; b) Approve the changes in funding as detailed in section 2.11 and Appendix E; c) Note the impact of the financial recovery plan and the progress being made in delivering financial balance; and d) Note the potential impact of the Lead Partnerships.

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

1.	**EXECUTIVE SUMMARY**
1.1	The report provides an overview of the financial position for the partnership and outlines the projected year-end outturn position informed by the projected expenditure and income commitments, these have been prepared in conjunction with relevant budget holders and services. It should be noted that although this report refers to the position at the December period end that further work is undertaken following the month end to finalise projections, therefore the projected outturn position is as current and up to date as can practicably be reported.
1.2	The projected outturn is a year-end overspend of £0.227m for 2018-19, taking account a number of mitigating actions outlined in the report and the improvement from implementation of the financial recovery plan. There is scope for this position to fluctuate due to in-year cost and demand pressures and assumptions in relation to funding and the achievement of savings. This risk reduces as we approach the end of the financial year. The projection has been adjusted to reflect the potential impact of Lead Partnership services. The projected underspend of £0.335m in relation to North Lead Partnership services will not be fully attributed to the North HSCP as a share will need to be allocated to East and South HSCPs. North will also be liable for

	a share of the projected overspend on East Lead Partnership services. Further clarity is required on the impact of this, for the purpose of reporting at period 9 an NRAC share of the projected position has been assumed as this would be in line with the allocation in previous years.
1.3	The position as at October (month 7) was a projected overspend of £0.481m therefore an improvement in the position is now reported. The projected outturn provides confidence that the scale of the projected overspend is reducing to a level whereby financial balance is possible by the year-end. There are further actions on the financial recovery plan which will potentially further improve the position and services will continue to deploy tight financial management controls.
1.4	Overall the main areas of pressure continue to be care homes, looked after children, learning disability care packages, elderly and adult in-patients within the lead partnership and the unallocated NHS CRES savings. The main adverse movements from period 7 are in relation to purchased homecare, LD care packages and residential placements for children. The main favourable movement was in relation to the lead partnership for mental health, care home placements and the change programme.
1.5	It is essential that the IJB operates within the delegated budget and commissions services from the Council and Health Board on this basis as financial balance has not been delivered in previous years. More is being done to ensure the financial sustainability of the partnership and to deliver financial balance for the current year and significant progress is being made to work towards this. The service transformation programme and the delivery of the those service changes will be at the forefront as this will have the greatest impact on the delivery of financial balance and the ongoing sustainability and safety of services.
2.	**CURRENT POSITION**
2.1	The report includes an overview of the financial position including commitments against the available resource, explanations for the main budget variances, an update on progress in terms of savings delivery, actions required to work towards financial balance and progress with delivery of the recovery plan.
	FINANCIAL PERFORMANCE
2.2	Against the full-year budget of £235.368m there is a projected overspend of £0.227m (0.1%). An integrated view of the financial position should be taken, however it is useful to note that this overall position consists of a projected overspend of £0.514m in social care services offset by a projected underspend of £0.287m in health services. The Integration Scheme outlines that there is an expectation that the IJB takes account of the totality of resources available to balance the budget in year. Appendix A provides the financial overview of the partnership position. The sections that follow outline the significant variances in service expenditure compared to the approved budgets with detailed analysis provided in Appendix B.
2.3	**Health and Community Care Services**
	Against the full-year budget of £65.629m there is a projected overspend of £0.308m (0.5%). The main reasons for the projected overspend are:

a) Care home placements including respite placements – projected to overspend by £0.718m. This is a favourable movement of £0.167m from period 7 mainly due to reduced number of permanent placements.

b) Independent Living Services are projected to overspend by £0.390m which is an adverse movement of £0.008m. This is mainly due to an overspend on physical disability care packages.

c) Over-recovery of Charging Order income of £0.100m which is an adverse movement of £0.100m based on income received to date.

d) Equipment and Adaptations are projected to underspend by £0.200m in line with the mitigation approved in period 4.

e) Packages of care are projected to overspend by £0.218m due to the use of supplementary staffing and one additional package planned from early 2019 onwards.

f) Care at home (purchased and in house) projected underspend of £0.400m. The projected underspend has reduced by £0.212m due to increased demand for purchased care.

g) Long Term Conditions (Ward 1), projected overspend of £0.395m which is mainly due to an overspend in employee costs to ensure staffing levels are at a safe level. This is a recurring pressure for which funding requires to be identified, this will be addressed as part of the 2019-20 budget process.

h) District Nursing is projected to underspend by £0.212m due to vacant posts.

2.4 **Mental Health Services**

Against the full-year budget of £72.982m there is a projected underspend of £0.207m (0.3%). The main reasons for the projected underspend are:

a) Learning Disabilities – projected overspend of £0.893m (adverse movement of £0.208m) of which £0.723m is in relation to care packages and £0.270m for direct payments. These overspends are partially offset by vacant posts.

b) Community Mental Health – is projected to underspend by £0.676m mainly due to vacancy savings and an underspend in care packages. The projected underspend for care packages has increased by £0.345m due to funding that was set aside for patients being discharged from hospital into the community not being required in 2018/19. These patients will be discharged in 2019/20.

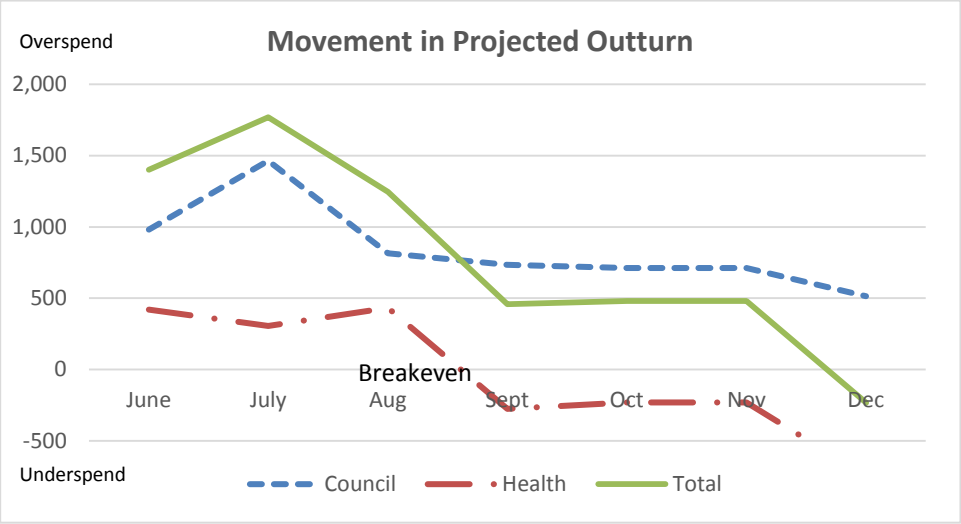
c) Lead Partnership – overall projected underspend of £0.341m which consists of:

Overspends:

- Adult inpatients £0.588m - mainly due to the delay in generating income from other areas in respect of forensic beds. All of the beds are expected to be sold and in use by the end of February 2019. The recovery plan assumes a fifth bed will be sold prior to the end of the financial year. This is dependent

	on ensuring delayed discharges in ward 6 are discharged to the community. This is a risk as some of the delayed discharges are South partnership patients and would require SAHSCP to provide funding to facilitate the discharge. • Psychiatry £0.129m - primarily due to locum costs, an unfunded EMH liaison post and a reduction in funding for trainee psychiatrists. There is an increased use of locum staff in the absence of being able to recruit permanent posts. • Elderly Inpatients £0.256m – due to the use of supplementary staffing which has reduced substantially since month 7. • CRES £0.986m - lead partnership share of the unachieved CRES carried forward, this element of the historic CRES will remain aligned to the Mental Health lead partnership and will be addressed as part of the budget planning for 2019-20. *Underspends:* • UNPACS £0.309m – due to the delay in the two new care packages assumed in year. The underspend is partially attributable to the availability and use of beds in ward 6 which have prevented more costly external placements. • Learning Disabilities £0.231m - due to a delay in the transfer of an UnPACs patient, this transfer has now taken place. • CAMHS £0.382m – due to vacancies and delays with recruitment. • Psychology £0.528m – due to vacancies. • Adult Community Mental Health £0.280m due to vacancies and the allocation of the Crisis Response Team to Action 15 funding.
2.5	**Children Services & Criminal Justice**
	Against the full-year budget of £35.260m there is a projected underspend of £0.151m (0.4%). The main reasons for the projected underspend are: a) Residential Schools and Community Placements – projected overspend of £0.967m. The projection is based on the current number of placements and estimated discharge dates for each placement based on the support from the Challenge Fund investment. The overspend has increased by £0.155m due to a delay in the planned discharge dates, the delivery of further planned discharges continues to be a risk to the projected outturn position. b) Looked After Children Placements – projected underspend of £0.429m due to the current demand for fostering, adoption and kinship payments. c) Early Years – are projected to underspend by £0.462m mainly due to the level of vacancies in heath visiting.
2.6	**Projected Outturn Movement**

The movement in the projected outturn position is illustrated in the chart below:



The position has fluctuated over the year to date which is reflective of the demand driven nature and high cost of some services. The position has significantly improved and become more stable period 5 mainly because the adverse movements caused by demand increases have been offset by favourable variances across the service. The position will continue to be closely monitored.

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

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

In addition there is a comprehensive review of the projections for month 10 planned by the NHS finance team, this review may result in a more significant movement in the projected outturn for health delivered services, this will be reflected in the next monitoring report.

2.7 **Primary Care and Prescribing**

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

2.8 **CRES update**

	Permanent or Temporary	**£ 000's**
CRES Saving brought forward		2.557
Additional Workforce savings	P	0.055
TOTAL		**2.612**
Arrol Park employee costs	T	(0.250)
Payroll turnover target increase	T	(0.215)
Addictions	P	(0.364)

Children's services employee costs	P	(0.060)
Balance still to be achieved in 2018-19		**1.723**

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

Given that overall there is a projected underspend in the Health element of the budget the unidentified CRES savings are being offset on a non-recurring basis for 2018-19. There is a requirement to formally identify these savings as part of the 2019-20 budget process.

The £0.986m aligned to the Lead Partnership against Mental Health services should remain aligned to those services. The service are developing plans to re-design Elderly Mental Health beds, this will deliver significant savings to contribute to this target.

2.9 **Savings Progress**

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

BRAG Status	Position at Budget Approval £m	Position at Period 9 £m
Red	3.148	2.424
Amber	0.519	0.649
Green	2.893	0.226
Blue	0.000	3.316
TOTAL	**6.560**	**6.615**

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

i. Reduction in care home places £0.391m
ii. Challenge Fund – physical disability care packages £0.200m
iii. Capping of respite £0.070m
iv. NHS CRES savings £1.723m
v. Reduction in mileage - £0.040m

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

The focus in the final quarter will be to focus on ensuring that the 18/19 savings are achieved in 19/20 to minimise the impact on the projections for next year.

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

	The Transformation Board is in place to provide oversight and governance to the programme of service change. A focus of the Board is to ensure plans are in place to deliver savings and service change, with a solutions focussed approach to bringing programmes back on track.
2.10	**Financial Recovery Plan**
	The IJB approved the recovery plan in August and progress against this is provided in appendix D. The impact of the plan so far has been to improve the financial position by £0.765m. There are a number of additional actions noted on the plan for which the financial impact cannot be quantified at this stage but these actions are expected to contribute positively to the financial position in 2018/19 and moving forward into 2019/20.
2.11	**Budget Changes**
	The Integration Scheme states that "*either party may increase it's in year payment to the Integration Joint Board. Neither party may reduce the payment in-year to the Integration Joint Board nor Services managed on a Lead Partnership basis…..without the express consent of the Integration Joint Board".* Appendix E highlights the movement in the overall budget position for the partnership following the initial approved budget. ***Reductions Requiring Approval:*** The specific reductions that the IJB are required to approve are: • AHP Workforce Saving £0.033m – reallocation of the target from South HSCP. It is recommended that the IJB approve the budget reductions outlined above. ***Increases For Noting:*** The part year North Ayrshire share of the Intermediate Care and Rehab (ICR) investment £0.303m is now included in the budget. ***Future Planned Changes:*** Further areas which are outstanding and will be included in future reports include: • The disaggregation of some mental health wards from the lead partnership arrangement.
2.12	**Lead Partnerships**
	North Ayrshire HSCP Services managed under Lead Partnership arrangements by North Ayrshire Health and Social Care Partnership are projected to be £0.335m underspent, this includes the allocation of the unachieved CRES target carried forward. Full detail on the underspend is given in section 2.4 above.
	South Ayrshire HSCP Services hosted and/or led by the South Partnership are forecast to be online as there was further investment in the Community Equipment Store.

The month 9 position for service led or hosted by South HSCP is given below:

Cost Centre Name	Annual Budget	YTD Budget	YTD Actuals	YTD Variance
Community Equip Store	£201,919	£151,440	£151,440	£0
Continence Team	£313,242	£234,932	£198,265	£36,667
Family Nurse Partnership	£828,765	£468,890	£460,953	£7,938
Incontinence Advisors	£117,378	£88,034	£107,293	(£19,260)
Mpower	£0	£27,779	£27,779	(£0)
Tec	£156,791	£113,696	£111,415	£2,281
Tec – Diabetes	£0	£0	£2,281	(£2,281)
South Hosted Services	**£1,618,096**	**£1,084,771**	**£1,059,426**	**£25,345**

East Ayrshire HSCP

Services managed under Lead Partnership arrangements by East Ayrshire Health and Social Care Partnership are projected to overspend by £0.697m. This represents adverse movement of £0.402m from month 7.

The overall Primary Care Lead Partnership projected overspend is £0.758m and this variance mainly relates to additional payments (£1m to date, £1.2m projected to year end) within Primary Medical Services to GP practices currently experiencing difficulty.

It is worthwhile noting that the highest proportion of costs in the current year have been incurred on GP practices located in North Ayrshire however costs have been incurred on practices across all three Partnership areas.

This pressure was offset in the previous financial year by non-recurring slippage on the Primary Care Transformation Fund, as well as non-recurring Dental Services savings. A non-recurring allocation of funding for Out of Hours services £0.305m which has been applied to Ayrshire Urgent Care Services (AUCS) has assisted in reducing the projected overspend. The overspend for AUCS is £0.165m which has improved due to a redesign of appointment allocation and better control of rates through positive management action.
Dental Services is projected to underspend by £0.451m however it should be noted that recruitment is ongoing for specialist posts which may impact in the final quarter of the current financial year.

Prison and Police Healthcare is projected to underspend by £0.053m predominately as a result of staffing savings which have resulted from vacancies within the service.

The following table provides a summary of services managed by East Ayrshire Health and Social Care Partnership under Lead Partnership arrangements:

	East Annual Budget £m
Community Prescribing	1.790
Dental	4.447
Family Health Services	45.279
PMS	12.065

Primary Care Development Director	12.551
Sub total: Primary Care	**76.132**
Guardianship patients - AWI	0.200
Standby Services	0.238
Prison and Police Healthcare	3.069
Marie Curie Cancer Care	0.088
War Pensioner	1.424
Sub total: East hosted	**5.019**
Total	**81.151**

Further work is being taken forward to develop a framework to report the financial position and impact of risk sharing arrangements across the 3 partnerships in relation to hosted or lead service arrangements. This is to ensure the IJB are fully sighted on the impact for the North Ayrshire partnership. The IJB will be kept informed of progress with this work which is being progressed by the Ayrshire Partnership Finance Leads.

At month 9 the impact of the Lead Partnerships has been calculated based on the average NRAC share which is the method that was used in previous years.

The NRAC shares are: North 36.8%, South 30.6% and East 32.6%

2.13 Set Aside

The Integration Scheme makes provision for the Set Aside Budget to be managed in-year by the Health Board with any recurring over or under spend being considered as part of the annual budget setting process.

The 2018-19 set aside budget for North HSCP is £28.055m, based on expenditure in 2017-18. The acute directorate, which includes the areas covered by the set aside budget, is projected to overspend of circa £9.3m.

129 additional and unfunded beds were open at the 31st March 2018. This had reduced to 58 by the 31st December 2018. There are clear plans in place to reduce these in a phased manner ensuring continuation of service and patient safety.

During 2017-18 the North Partnerships use of the set aside resources was £28.055m against the NRAC 'fair share' of £26.563m which is £1.492m above the 'fair share'. There is an expectation that the North Partnership will move towards its 'fair share'. The Models of Care programmes including the Intermediate Care and Rehab investment and the Palliative End of Life proposals being developed represent agreed or potential investment by NHS A&A to invest in community services with a view to reducing acute beds. This is in effect a mechanism to reduce the set aside resources.

3. PROPOSALS

3.1 **Anticipated Outcomes**

Continuing to closely monitor the financial position will allow the IJB to take corrective action where required to ensure the partnership can deliver services in 2018-19 from within the available resource, thereby limiting the financial risk the funding partners, i.e. NAC and NHS AA.

	The transformational change programme will have the greatest impact on the financial sustainability of the partnership, the IJB require to have a clear understanding of progress with plans and any actions that can be taken to bring the change programme into line.
3.2	**Measuring Impact**
	Updates to the financial position will be reported to the IJB throughout 2018-19.
4.	**IMPLICATIONS**

Financial:	The financial implications are as outlined in the report. Against the full-year budget of £235.368m there is a projected overspend of £0.227m (0.1%). The report outlines the action being taken and proposed action to reduce the projected overspend. The recovery plan totals £1.255m with £0.765m delivered to date. There are a number of other actions are being progressed to reduce the overspend further. The main areas of financial risk which may impact on this position are highlighted in the report.
Human Resources:	None
Legal:	None
Equality:	None
Children and Young People	None
Environmental & Sustainability:	None
Key Priorities:	None
Risk Implications:	If the financial recovery plan does not deliver the required improvement to the financial position there is a risk that further actions will require to be identified and service quality and performance may be compromised to achieve financial balance.
Community Benefits:	None

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

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

	The report is shared with the Director of Finance for NHS Ayrshire and Arran and the Executive Director Finance and Corporate Support for North Ayrshire Council.
5.	**CONCLUSION**
5.1	It is recommended that the IJB: a) Note the projected year-end overspend of £0.227m; b) Approve the changes in funding as detailed in section 2.11 and Appendix E; c) Note the impact of the financial recovery plan and the progress being made in delivering financial balance; and d) Note the potential impact of the Lead Partnerships

For more information please contact:

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2018-19 Budget Monitoring Report–Objective Summary as at 31 December 2018 — Appendix A

Partnership Budget - Objective Summary	2018/19 Budget									2018/19	
	Council			Health			TOTAL				
	Budget	Projected Outturn	Projected Over/ (Under) Spend Variance	Budget	Projected Outturn	Projected Over/ (Under) Spend Variance	Budget	Projected Outturn	Projected Over/ (Under) Spend Variance	Over/ (Under) Spend Variance at Period 7	Movement in projected budget variance from Period 7
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
COMMUNITY CARE AND HEALTH	**53,628**	**53,844**	**216**	**12,001**	**12,093**	**92**	**65,629**	**65,937**	**308**	**137**	**171**
: Locality Services	24,679	25,416	737	4,178	4,221	43	28,857	29,637	780	862	(82)
: Community Care Service Delivery	25,828	25,473	(355)	0	0	0	25,828	25,473	(355)	(562)	207
: Rehabilitation and Reablement	1,046	948	(98)	1,750	1,569	(181)	2,796	2,517	(279)	(265)	(14)
: Long Term Conditions	1,737	1,658	(79)	4,315	4,630	315	6,052	6,288	236	149	87
: Integrated Island Services	338	349	11	1,758	1,673	(85)	2,096	2,022	(74)	(47)	(27)
MENTAL HEALTH SERVICES	**23,549**	**24,118**	**569**	**49,433**	**48,657**	**(776)**	**72,982**	**72,775**	**(207)**	**133**	**(340)**
: Learning Disabilities	18,037	19,063	1,026	477	344	(133)	18,514	19,407	893	685	208
: Commmunity Mental Health	4,131	3,708	(423)	1,631	1,378	(253)	5,762	5,086	(676)	(524)	(152)
: Addictions	1,381	1,347	(34)	1,226	1,177	(49)	2,607	2,524	(83)	(84)	1
: Lead Partnership Mental Health NHS Area Wide	0	0	0	46,099	45,758	(341)	46,099	45,758	(341)	56	(397)
CHIDREN'S AND JUSTICE SERVICES	**31,737**	**31,931**	**194**	**3,523**	**3,178**	**(345)**	**35,260**	**35,109**	**(151)**	**(275)**	**124**
: Intervention Services	3,803	3,685	(118)	303	319	16	4,106	4,004	(102)	(62)	(40)
: Looked After & Accomodated Children	16,236	16,806	570	0	0	0	16,236	16,806	570	451	119
: Fieldwork	4,588	4,597	9	0	0	0	4,588	4,597	9	(16)	25
: CCSF	302	254	(48)	0	0	0	302	254	(48)	(53)	5
: Justice Services	2,661	2,661	0	0	0	0	2,661	2,661	0	0	0
: Early Years	321	226	(95)	2,847	2,480	(367)	3,168	2,706	(462)	(472)	10
: Policy & Practice	3,826	3,702	(124)	0	0	0	3,826	3,702	(124)	(110)	(14)
: Lead Partnership NHS Children's Services Area Wide	0	0	0	373	379	6	373	379	6	(13)	19
PRIMARY CARE	0	0	0	49,308	49,222	(86)	49,308	49,222	(86)	(86)	0
ALLIED HEALTH PROFESSIONALS				4,637	4,511	(126)	4,637	4,511	(126)	(153)	27
MANAGEMENT AND SUPPORT COSTS	5,150	4,769	(381)	460	1,069	609	5,610	5,838	228	737	(509)
CHANGE PROGRAMME	658	574	(84)	1,284	1,169	(115)	1,942	1,743	(199)	(12)	(187)
TOTAL	**114,722**	**115,236**	**514**	**120,646**	**119,899**	**(747)**	**235,368**	**235,135**	**(233)**	**481**	**(714)**
Remove the East (32.6%) and South (30.6%) Element of the North Lead Partnership Services	0	0	0			204			204		
Add the North (36.8%) element of the East Lead Partnership Services	0	0	0			256			256		
REVISED POSITION	**114,722**	**115,236**	**514**	**120,646**	**119,899**	**(287)**	**235,368**	**235,135**	**227**		

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

	Budget £000's	Projected Outturn £000's	Projected Over/ (Under) Spend Variance £000's	
COMMUNITY CARE AND HEALTH	**65,629**	**65,937**	**308**	
Locality Services	28,857	29,637	780	**Older People permanent care homes** - permanent placements are projected overspend of £0.712m based on 806 placements (557 Nursing and 249 Residential) and an assumption that placements are on a one in one basis to the end of the year. This is a reduction of 35 places from month 7. Respite care projected overspend of £0.006m, favourable movement of £0.039m based on the spend to date. This also reflects the £0.300m of agreed funding from the Carers allocation which was agreed as part of the recovery plan in period 4. **Independent Living Services :** * Direct Payment packages projected underspend of £0.103m on 59 current packages. * Indirect Payment packages no charges to date, projected underspend £0.045m based on prior year spend. * Adult respite care projected overspend £0.050m based on current spend to date. * Residential Packages projected overspend of £0.073m which is an adverse movement of £0.031m based on 40 current packages and an expected net decrease in packages of 1. * Community Packages (physical disability) overspend of £0.415m based on 62 current packages, and an expected decrease of 1 package. **Equipment Budget** - £0.318m budget for equipment- projected £0.100m underspend in line with approved mitigation. **Employee costs** - projected £0.212m underspend: Money Matters structure approved resulting in part year vacancies. **NHS Packages of Care** - projected overspend of £0.218m due to high use of supplementary staffing. **District Nursing** - projected underspend of £0.212m assuming Band 6 vacancies are filled. **Income from Charging Orders** - over recovery of £0.100m expected per income received to date and projected income receivable (adverse movement £0.100m).
Community Care Service Delivery	25,828	25,473	(355)	**Care at home** - in house service - projected underspend of £0.335m based on current costs. The cost of recruiting 30 staff in October and November is funded by a reduction in casual and overtime costs. - Purchased Care at home - projected underspend of £0.065m based on current level of spend continuing to end of year. This is an adverse movement of £0.205m. This follows a review of the projection and use of more accurate data from the business unit. **Direct Payments** - projected underspend of £0.068m based on 31 current package less 10% expected recovery from underspent balances. **Transport costs** - projected overspend of £0.076m due to increase in staff mileage within care at home and ferry charges. **Admin costs** - projected overspend of £0.102m mainly due to mobile phone equipment. **Voluntary Organisations** - projected overspend £0.080m (CLASP HOPE £0.020m and Alzheimer £0.060m). **Income** - projected over recovery £0.102m base+F7d on current receipts and an increase in Community Alarm income.

	Budget £000's	Projected Outturn £000's	Projected Over/ (Under) Spend Variance £000's	
Rehabilitation and Reablement	2,796	2,517	(279)	**Employee costs -** projected underspend £0.178m due to vacancies. Adaptations Budget - £0.487m - projected £0.100m underspend in line with approved mitigation.
Long Term Conditions	6,052	6,288	236	**Carers Centres** - projected £0.100m underspend based on additional funding for the Carers Strategy. **Ward 1 -** projected overspend of £0.395m assuming current staffing levels continue. **Ward 2 -** projected underspend of £0.035m, assuming funding from East HSCP for Kirklandside Ward. **Elderly CMHT -** projected underspend of £0.073m assuming current staffing levels continue.
Integrated Island Services	2,096	2,022	(74)	**Patient Transport** - is projected to underspend as the project commenced later than budgeted.
MENTAL HEALTH SERVICES	**72,982**	**72,775**	**(207)**	
Learning Disabilities	18,514	19,407	893	**Residential Packages-** projected underspend of £0.008m based on current 38 packages £2.434m less 2% invoice variances. Adverse movement as 3 projected discharges did not take place **Community Packages -** projected overspend of £0.723m based on current 337 packages less 9.75% invoice variances and a net movement in year of 1 new package. Challenge Fund savings of £0.256m expected to be achieved. **Direct Payments -** projected overspend of £0.270m based on 41 current packages less 10% underspent balances and an expected increase of 1 package in year. **Employee costs -** projected underspend £0.198m mainly due to vacant posts **Income -** projected under recovery of £0.080m based on current receipts and no income from other local authorities for use of Taigh Mor respite service as this is being fully utilised to meet the respite needs of North service users.
Community Mental Health	5,762	5,086	(676)	**Community Packages -** projected underspend of £0.272m based on 98 packages less assumed invoice differences between planned and actual service delivered plus a net increased of 4 packages. This underspend includes £0.150m in relation to additional funding projected for hospital discharges. **Employee costs** - projected underspend £0.247m mainly due to vacant posts
Addictions	2,607	2,524	(83)	**Addictions Team -** projected underspend of £0.083m due to in year vacancies. Assumes that any ADP underspend will require to be carried forward for use in future years.

	Budget £000's	Projected Outturn £000's	Projected Over/ (Under) Spend Variance £000's	
Lead Partnership (MHS)	46,099	45,758	(341)	**Adult Community** - projected underspend of £0.280m due to vacancies and the cost of the crisis team being met by Action 15 funding. **Adult Inpatients**- projected overspend of £0.558m due to a delay in bed sale income and use of supplementary staff. The projection assumes all of the beds will be sold by the end of February. **UNPACs** - projected to underspend by £0.309m. Assumption that there will be no change to NHS GG&C charge and there will be 2 new care packages in-year. **LDS -** projected to underspend by £0.231m due to delay in UNPACs transfer. **Elderly Inpatients** - projected to overspend by £0.256m due to use of supplementary staff. **CAMHS** - projected underspend is £0.382m based on projected staffing levels. **MH Admin** - projected underspend of £0.105m. This is after the transfer of services to East and South. **Psychiatry** - projected to overspend by £0.129m, primarily due to locums and a reduction in Dean funding. EMH Liaison post remains unfunded. **MH Pharmacy** - projected to underspend by £0.155m mainly within substitute prescribing due to the benefit on over-accrual in 2017-18. **Psychology**- projected to underspend by £0.528m based on projected staffing levels. **CRES target** - projected overspend of £0.986m in relation to savings still to be identified. **Projected underspends in other areas -** include Associate Nurse Director budgets £0.068m, slippage on mental health allocations of £0.070m and resource transfer reserve £0.023m.
CHIDREN'S SERVICES AND CRIMINAL JUSTICE	**35,260**	**35,109**	**(151)**	
Intervention Services	4,106	4,004	(102)	**Employee costs -** projected underspend £0.185m mainly due to vacant posts. **Care Leavers -** projected overspend 0f £0.054m based on current number of service users.

	Budget £000's	Projected Outturn £000's	Projected Over/ (Under) Spend Variance £000's	
Looked After & Accom Children	16,236	16,806	570	**Looked After Children placements - projected underspend of £0.429m based on the following:-** **Kinship - p**rojected overspend of £0.193m. Budget for 302 placements, currently 320 placements and projecting 325 by the year end. **Adoption -** projected underspend of £0.041m. Budget for 78 placements, currently 67 placements and projecting 70 by the year end. **Fostering** - projected underspend of £0.334m. Budget for 140 placements, currently 120 placements and projecting 130 placements by the year end. **Fostering Xtra** - projected underspend of £0.144m. Budget for 32 placements, currently 26 placements and projecting 26 by the year end. **Private fostering - p**rojected underspend of £0.102m. Budget for 16 placements, currently 11 placements and projecting 12 by the year end. **Fostering respite-** projected overspend of £0.010m. **IMPACCT carers** - projected underspend of £0.010m based on 3 carers providing support for full year. **Adoption Fees** - projected overspend of £0.070m due to external agency fees and 2 placements from other Councils. **Residential School placements including community packages -** projecting an overspend of £0.967m. Projection based 1 current secure placement projected to March. 20 residential and community placements projected to leave as 1 in January and 1 from February with 18 placements remaining at March 2019. Remand budget of £100k, at present projection assumes this will be spent **Employee Costs - p**rojected underspend of £0.099m due to vacancies.
Fieldwork	4,588	4,597	9	**Outwith the threshold for reporting**
CCSF	302	254	(48)	**Outwith the threshold for reporting**
Criminal Justice	2,661	2,661	0	**Assumed to come in line with budget**
Early Years	3,168	2,706	(462)	**Employee costs -** projected underspend of £0.406m due to vacancies. **CAMHS budget** - projected underspend of £0.056m
Policy & Practice	3,826	3,702	(124)	**Children with a disability care packages** - projected underspend of £0.150m based on current placements.
Lead Partnership (CS & CJ)	373	379	6	**Outwith the threshold for reporting**

	Budget £000's	Projected Outturn £000's	Projected Over/ (Under) Spend Variance £000's	
PRIMARY CARE	49,308	49,222	(86)	**Prescribing -** projected underspend of £0.086m based on activity to date.
ALLIED HEALTH PROFESSIONALS	4,637	4,511	(126)	**Employee costs -** projected underspend due to vacancies.
Management & Support Services	5,610	5,838	228	**CRES savings -** projected overspend of £0.682m relating to CRES savings still to be identified and £0.055m in relation to workforce savings. This is partially offset by an underspend in contract inflation of £0.150m.
CHANGE PROGRAMME and challenge Fund	1,942	1,743	(199)	**ICF -** slippage on some projects.
TOTAL	**235,368**	**235,135**	**(233)**	

Threshold for reporting is + or - £50,000

North Ayrshire Health and Social Care Partnership
2018/19 Savings

Appendix C

Council Commissioned Services

Service	Description	RAG Status at budget setting	Updated Rag Status	Gross Saving 2018/19 £000's	Net Saving 2018/19 £000's	Net Saving Projected to be Achieved at Period 9 £000's	Projected Shortfall
Children & Criminal Justice	Children & Criminal Justice Challenge Fund Projects - Investment in Universal Early Years	Green	Amber	100	47	47	-
Children & Criminal Justice	Children & Criminal Justice Challenge Fund Projects - School-based Approach to Reducing Looked After (LAC)/Looked After and Accommodated Numbers(LAAC)	Green	Amber	200	106	106	-
Children & Criminal Justice	Children & Criminal Justice Challenge Fund Projects - Reduction in Needs for Residential School placements enhancing our community supports with a new team.	Green	Amber	536	340	340	-
Children & Criminal Justice	Children & Criminal Justice Challenge Fund Projects - Expansion of the Multi Agency Assessment and Screening Hub (MAASH)	Green	Amber	37	26	26	-
Children & Criminal Justice	Reallocation of Partnership Forum budget with associated savings	Green	Blue	40	40	40	-
Children & Criminal Justice	To reduce the Learning and Development team	Amber	Blue	75	75	75	-
Children & Criminal Justice	Reduction in Staffing	Green	Blue	25	25	25	-
Children & Criminal Justice	To discontinue the mentoring project for young people	Green	Blue	25	25	25	-
Community Care & Health	Community Care & Health Challenge Fund Projects - Physical Disabiliites	Green	Red	200	200	-	200
Community Care & Health	Community Care & Health Challenge Fund Projects - Reablement	Green	Blue	228	181	181	-
Community Care & Health	Reduction in staff from the Arran social work team	Amber	Blue	13	13	13	-
Community Care & Health	Withdrawl of funding to Crossroads, Largs	Green	Blue	14	14	14	-
Community Care & Health	Additional projected income	Green	Blue	155	155	155	-
Community Care & Health	WRVS saving	Green	Blue	8	8	8	-
Community Care & Health	Reduction in Care Home Placements - proposal to reduce 25 placements.	Red	Red	391	391	-	391
Community Care & Health	Reduction in Care at Home	Red	Blue	200	200	200	-

Service	Description	RAG Status at budget setting	Updated Rag Status	Gross Saving 2018/19 £000's	Net Saving 2018/19 £000's	Net Saving Projected to be Achieved at Period 9 £000's	Projected Shortfall
Mental Health	Mental Health - Challenge Fund Projects	Green	Green	226	226	226	-
Mental Health	Redesign and recommission a mental health support service at a reduced cost.	Amber	Blue	30	30	30	-
Mental Health	Reduction in Caley Court Learning Disability Team.	Amber	Blue	48	48	48	-
Mental Health	Reduction in staff at Hazeldene Day service	Amber	Blue	35	35	35	-
Management & Support	Review all support secondments/posts which could be provided by parent organisations to the HSCP.	Amber	Blue	50	50	50	-
Management & Support	Operational savings generated by the business support review.	Amber	Blue	150	150	150	-
Management & Support	Planning and Performance Team - reduction in staffing	Green	Blue	37	37	37	-
Cross Service	Pilot Sickness Absence Taskforce within the HSCP	Green	Blue	100	75	75	-
Cross Service	Staff Mileage - 10% reduction across the partnership	Green	Red	40	40	-	40
Cross Service	Bring forward phase 2 Challenge Fund savings from 2019/20 to 2018/19	Green	Blue	250	250	250	-
Cross Service	Cap respite across all services to 35 days	Green	Amber	200	200	130	70
Change and Improvement	Change Team Restructure	Green	Blue	108	108	108	-
Change and Improvement	Integrated Care Fund - reduction in spend and discontinued projects	Green	Blue	218	218	218	-
		TOTAL		**3,739**	**3,313**	**2,612**	**701**

NHS Commissioned Services **Appendix C**

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

Financial Recovery Plan (IJB approved Sept 2018)

Appendix D

Ref	Service Area	Recovery Action Proposed	Status: Complete In Progress Delayed	Estimated Benefit £ 000's	Achieved (included in the projected outturn) £ 000's	Remaining Balance £ 000's	Responsible Officer
1	Care Homes	Phased reduction in care home numbers as more people will be supported at home. This would focus on a reduction in residential care placements by utilising the capacity in community services (eg care at home, district nursing) to support people to remain supported in their own homes.	Complete	200	200	-	Stephen Brown
2	Learning Disability	From September there will be a full time care manager seconded to a dedicated learning disability review team. This will assist in achieving the planned Challenge Fund savings and contribute to the financial recovery plan.	In Progress	100	-	100	Thelma Bowers
3	Learning Disability	Sleepovers - the current sleepovers are being reviewed to assess which could be provided using the existing out of hours responder service. There is not currently a savings target aligned to sleepover services.	In Progress	100	-	100	Thelma Bowers
4	Learning Disability	Review of all 2:1 supports for clients, from reviews already undertaken a reduction has been delivered, plan to review remaining supports.	In Progress	75	25	50	Thelma Bowers
5	Cross Service	Review of all transition cases (e.g. LD adults aged 65+) to ensure the appropriate care is provided (saving is estimate net of alternative care provision).	In Progress	150	-	150	Thelma Bowers
6	Cross Service	Audit of compliance with the charging policy to ensure consistency of application across services.	In Progress	50	-	50	Caroline Whyte
7	Carers	Increased demand for Respite services, contributing to overall overspend, use element of Carers Act funding for support for respite. Non recurring basis for 2018-19, reviewed as part of 2019-20 budget in line with plan for Carer's Act funding and implementation.	Complete	300	300	-	Stephen Brown
8	Equipment	Temporary reduction (2018-19 only) in the equipment budget due to the Challenge Fund investment being used to clear the waiting list. This will be kept under review together with any waiting lists and impact on delivery of community based services.	Complete	100	100	-	Stephen Brown
9	Adaptations	Temporary reduction (2018-19 only) in the adaptations budget. This will be kept under review together with any waiting lists and impact on delivery of community based services.	Complete	100	100	-	Stephen Brown
10	MH Inpatients	Current plans assume 4 bed sales to support service costs, actively market a 5th bed.	In Progress	40	-	40	Thelma Bowers
11	Learning Disability	Cease payment of Resource Transfer for a historic arrangement in relation to one patient moving outwith NHS A&A.	Complete	40	40	-	Thelma Bowers
		TOTAL		**1,255**	**765**	**490**	

Other actions being taken:

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

2018/19 Budget Reconciliation

Appendix E

COUNCIL	Period	Permanent or Temporary	£
Initial Approved Budget	2		92,353
Resource Transfer	2	P	22,317
ICF Procurement Posts - Transfer to Procurement	2	T	(89)
Additional Pension Costs	4	P	(9)
Reduction in CJ Settlement for 1819	4	P	(243)
Budget from Education - Activity Agreements (Rosemount)	6	T	29
Transfer of Finance staff from Corporate to HSCP (part year budget)	9	P	308
Increase in Commercial Refuse Collection	9	T	56
Period 9 reported budget			**114,722**

HEALTH	Period	Permanent or Temporary	£
Initial Approved Budget (includes estimated pay award)	2		137,142
Resource Transfer	2	P	(22,317)
Girfec-HV S-Bar	3	P	47
Specialist Pharmacist Upgrade	4	T	11
Pay Award	4	P	1,462
MH Admin – transfer to East and South	5	P	(1,198)
NES junior doctor funding	5	P	(80)
HD424 - NMAHP Clinical Lead	5	P	16
Allocation of the AHP budget	6	P	4,570
Mental Health Strategy - Action 15	6	P	571
ADP	6	P	462
Medical Pay Award	6	P	204
Medical Training Grade Adjustment	6	P	49

Band 3 Admin funding transferred from East	6	P	14
Breast Feeding Programme - Health Visitor	6	P	9
Mental Health Admin Split to South/East(Supplies)	6	P	(72)
Prescribing Reduction	6	P	(567)
Biggart Ward Closure 2017 - North Split	7	P	10
Medical Pay Award Correction	7	P	(64)
Ailsa Hairdressing transferred to South	7	P	(11)
Medical Training Grade Adjustment	7	P	(9)
Workforce saving allocation	7	P	(55)
Models of Care Funding	8	P	316
Split out of AHP Vacancies and Salaries	8	P	99
Health & Wellbeing Post and Veterans First to North	8	P	29
V1P Allocation Split East	8	P	27
Redistribution of AHP workforce saving allocation	8	P	(33)
Medical Training Grade Adjustment	9	P	15
Models of Care - Turnover Adj	9	T	(13)
Integrated Care Fund	9	P	12
Period 9 reported budget			**120,646**

GRAND TOTAL	**235,368**

DIRECTION

From North Ayrshire Integration Joint Board

1.	**Reference Number**	14022019-01		
2.	**Date Direction Issued by IJB**	14th February 2019		
3.	**Date Direction takes effect**	15th February 2019		
4.	**Direction to**	**North Ayrshire Council**		
		NHS Ayrshire & Arran		*X*
		Both		
5.	**Does this direction supercede, amend or cancel a previous direction – if yes, include the reference numbers(s)**	**Yes**	*X* 15112018-01	
		No		
6.	**Functions covered by the direction**	All NAHSCP delegated functions		
7.	**Full text of direction**	NHS Ayrshire & Arran are directed to: a) Action the budget changes outlined in para 2.11 and Appendix E.		
8.	**Budget allocated by Integration Joint Board to carry out direction**	North Ayrshire Council £114.722m NHS Ayrshire & Arran £120.646m TOTAL £235.368m		
9.	**Performance Monitoring Arrangements**	Regular financial updates will be reported to the IJB during 2018/19, the financial recovery plan may require to be reviewed depending on progress and impact.		
10.	**Date of Review of Direction (if applicable)**	n/a		

NORTH AYRSHIRE
Health and Social Care Partnership

Agenda Item 6

Integration Joint Board
14th February 2019

Subject:	**Allied Health Professions Highlight Report 2018**
Purpose:	The purpose of this paper is to introduce the attached Allied Health Professions Highlight report for 2018 and, (i) Clarify the range of AHP Services now provided within North Ayrshire Health and Social Care Partnership; (ii) provide a highlight of the contribution of AHP services for the people of North Ayrshire in 2018; (iii) Provide a precis of the challenges faced in 2018; (iv) provide a summary of the objectives for AHP services in North Ayrshire for the next 12 months.
Recommendation:	It is recommended that the IJB : Note the content of the attached AHP Highlight report and, endorse the AHP Service objectives outlined within the attached report.

Glossary of Terms	
NHS AA	NHS Ayrshire and Arran
HSCP	Health and Social Care Partnership
AHP	Allied Health Professional
HCPC	Health and Care Professions Council

1.	**EXECUTIVE SUMMARY**
1.1	The attached report provides detail on the activity of Allied Health Professions (AHPs) in North Ayrshire Health and Social Care Partnership (HSCP) during the calendar year of 2018.
1.2	With the integration of Health and Social care almost 4 years on, and with the recent devolution of AHP services to each HSCP in Ayrshire, the attached report clarifies the range of AHP services now delivered within North Ayrshire HSCP, the range of roles this encompasses, and highlights the contribution AHPs are making for the people of North Ayrshire.
1.3	The attached report further sets out collective objectives for AHP services in North Ayrshire for the next twelve months as follows, to : o Maximise the AHP contribution to multi disciplinary working o Continue workforce planning, to maximise the AHP workforce available within North Ayrshire, within the resources available

	o Continue work that promotes early access to AHPs and preventative approaches o Continue to prioritise the wellbeing of AHP Staff o Continue to build on progress around digital agendas o Ensure progress that supports consistent and robust performance data
2.	**BACKGROUND**
2.1	The Scottish Government defines AHPs as being a diverse group of professionals who support people of all ages, with a focus on personal outcomes. AHPs provide support and interventions in areas such as self-management, diagnostic, therapeutic, rehabilitation and enablement services; to support people to live healthy, active and independent lives. AHPs in the UK are registered with and regulated by the Health and Care Professions Council (HCPC).
2.2	In North Ayrshire, AHPs encompass several different professional groups – Physiotherapy, Podiatry, Occupational Therapy, Dietetics and Speech and Language Therapy - working as part of multi disciplinary teams across health and social care, hospital and community settings, and across all stages of the life curve. As such, AHPs provide support across North Ayrshire, including Arran and Cumbrae within Ayrshire Central Hospital Site (providing inpatient and outpatient services), Douglas Grant Rehab Centre, Woodland View, and within community settings including day centres, care homes, people's own homes, social services premises, community clinics, health centres, education premises and community facilities.
2.3	The attached Highlight Report provides introduction to each of the professional groups led under the umbrella term of AHP in North Ayrshire Health and Social Care Partnership. It highlights the achievements of these professional groups in 2018, as well as some of the key challenges, and service objectives moving forwards.
2.4	The attached Highlight Report underlines the strong contribution that AHPs make to the people of North Ayrshire, the improvement culture that has been embraced among team members, and the ways in which AHPs work alongside a wide range of partners – carers, families, statutory, independent and voluntary sectors - as critical components of multi disciplinary teams; to support wellbeing, self management and promote independence.
3.	**PROPOSALS**
3.1	**Anticipated Outcomes**
	The attached Highlight report seeks to raise the profile of AHPs in North Ayrshire and to assist the IJB in understanding the contribution that this group makes for the people of North Ayrshire, as part of multi disciplinary teams
3.2	**Measuring Impact**
	Systems to record AHP performance and impact will continue to be refined, with regular reports to the Director of North Ayrshire HSCP, and the North Ayrshire Health and Care Governance group.

4.	IMPLICATIONS

Financial:	Nil
Human Resources:	Nil
Legal:	Nil .
Equality:	Nil
Children and Young People	The attached report highlights the contribution of AHPs for the people North Ayrshire, including children and young people.
Environmental & Sustainability:	Nil
Key Priorities:	The attached report outlines the contribution of AHPs in North Ayrshire to the priorities articulated in the HSCP's Strategic Plan
Risk Implications:	Nil
Community Benefits:	Nil

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	The attached report has been developed in consultation with the AHP Leadership team in North Ayrshire.
6.	**CONCLUSION**
6.1	The attached AHP Highlight Report • Clarifies the range of AHP Services now provided within North Ayrshire Health and Social Care Partnership • Provides highlight of the contribution of AHP services for the people of North Ayrshire in 2018 • Provides a precis of the challenges faced in 2018 • Provides a summary of the objectives for AHP services in North Ayrshire for the next 12 months The IJB are asked to : • Note the content of the attached AHP Highlight report • Endorse the AHP Service objectives as outlined within the attached report

For more information please contact Alistair Reid, Lead Allied Health Professional on 07825227834 or Alistair.Reid@aapct.scot.nhs.uk

ALLIED HEALTH PROFESSIONS

HIGHLIGHT REPORT 2018

NORTH AYRSHIRE
Health and Social Care
Partnership

Submitted for IJB approval 14 February 2019

Contents

1 Introduction 4

2 AHPs in North Ayrshire 5

3 AHP leadership team in North Ayrshire 6

4 AHP Professions 8
- *Dietetics* 8
- *Speech and language therapy* 10
- *Occupational therapy* 14
- *Physiotherapy* 17
- *Podiatry* 20

5 Governance 24
- *Clinical and care governance* 24
- *Finance* 24
- *Staff governance* 25

6 AHP Service Performance 26

7 Quality Improvement 27

8 AHP contribution to Partnership priorities 28
- *Tackling inequalities* 28
- *Engaging communities* 29
- *Bringing services together* 30
- *Prevention and early intervention* 31
- *Improving mental health and wellbeing* 33

9 AHP priorities for 2019 36

10 Conclusion 37

1 Introduction

This report highlights the activity of Allied Health Professions (AHPs) in North Ayrshire Health and Social Care Partnership (NAHSCP). The report content covers January to December 2018.

The Scottish Government defines Allied Health Professionals (AHPs) as being, 'a diverse group of professionals supporting people of all ages focusing on personal outcomes. They provide 'preventative interventions in such areas as supported self-management, diagnostic, therapeutic, rehabilitation and enablement services to support people to live healthy, active and independent lives' . AHPs in the UK are registered with, and regulated by the Health and Care Professions Council (HCPC).

There is no statutory requirement for an annual AHP report. However, as NAHSCP is about to enter year four of the integration of health and social care , and with the recent devolution of AHP services to each health and social care partnership area in Ayrshire, it is anticipated that this report will be useful for the Integration Joint Board. The report will clarify the range of AHP services and roles within North Ayrshire Health and Social Care Partnership, and highlight the contribution of AHPs to the Partnership's strategic ambitions.

In North Ayrshire, AHPs encompass several different professional groups – Physiotherapy, Podiatry, Occupational Therapy, Dietetics and Speech and Language Therapy. They work as an integral part of multi-disciplinary teams across health and social care, hospital and community settings, and across all stages of life. AHPs provide service across North Ayrshire, including Arran and Cumbrae, within Ayrshire Central Hospital Site (inpatient and outpatient services), Douglas Grant Rehabilitation Centre, Woodland View and within communities including day centres, care homes, people's own homes, social service premises, community clinics, health centres, education premises and community facilities.

This report provides an introduction to each of the professional groups under the umbrella term of AHP in North Ayrshire Health and Social Care Partnership. It highlights the achievements of these professional groups in 2018, as well as some of the key challenges, and service aims moving forwards, and underlines the valuable contribution that AHPs make to the people of North Ayrshire.

AHPs in North Ayrshire

2

The majority of AHPs in North Ayrshire are led within an AHP professional structure.

In addition, AHPs within North Ayrshire also sit as part of established multi-disciplinary teams across all services, including,

- Dirrans Centre
- Enhanced Intermediate Care Team
- Assessment and Reablement Teams
- CAMHS
- Universal Early Years Team
- Locality based community care teams, including learning disabilities teams and community mental health teams

Where AHPs are managed out with their own profession, lines of professional leadership and support are also in place.

Additionally there are also a number of small, specialist, pan Ayrshire AHP services, delivered across the three Ayrshire health and social care partnerships, that are led by North Ayrshire, including,

- The Alternative and Augmentative Communication Service
- Speech and Language Therapy Learning Disabilities Service
- Community physiotherapy for children and young people
- Occupational therapy, physiotherapy and dietetic input to forensic services
- Dietetic mental health teams
- Physiotherapy for the community mental health teams
- Physiotherapy for people with learning disabilities
- AHP input to pan Ayrshire neurological rehabilitation services based at Douglas Grant Rehabilitation Centre, Irvine

Similarly, there are a number of small, specialist, pan Ayrshire AHP services delivered to people in North Ayrshire, but led through AHP structures in neighbouring health and social care partnerships, including,

- Musculoskeletal (MSK) Services – Led via AHP structures in East Ayrshire Health and Social Care Partnership, currently under review
- Podiatry services – Led via AHP professional structures in East Ayrshire Health and Social Care Partnership, currently under review
- Pulmonary rehabilitation – Led via AHP professional structures in South Ayrshire Health and Social Care Partnership

3 AHP leadership team in North Ayrshire

The AHP leadership team in North Ayrshire works closely with a range of partners to provide leadership, management and professional governance for all AHPs in North Ayrshire Health and Social Care Partnership.

The AHP Senior Manager/ Lead Allied Health Professional has overall professional accountability for AHPs in North Ayrshire. This is supported by a team of service managers who lead and manage the profession for which they are responsible, and act as professional lead for that profession within North Ayrshire Health and Social Care Partnership.

In addition to those services which the AHP Senior team directly manage, they also provide professional leadership to those AHPs managed out with AHP structures.

The AHP senior team in North Ayrshire Health and Social Care Partnership currently comprises of:

- Alistair Reid – AHP Senior Manager/ Lead AHP
- Louise Gibson – Dietetics Service Manager / Professional Lead for Dietetics
- Elspeth Mair – Speech and Language Therapy Service Manager / Professional Lead for Speech and Language Therapy
- Linsey Stobo – Occupational Therapy Service Manager/ Professional Lead for Occupational Therapy
- Madelaine Halkett – Physiotherapy Service Manager / Professional Lead for Physiotherapy
- Rhona Allardice – Podiatry Service Manager / Professional Lead for Podiatry

The AHP senior leadership team provides AHP representation and participation in a range of strategic groups within North Ayrshire Health and Social Care Partnership:

- Integration Joint Board
- Strategic Planning Group
- Partnership Senior Management Team
- Health and Care Governance
- Social Work Governance

- Mental Health Governance Groups
- Staff Partnership Forum
- Transformation Board
- National Secure Adolescent Inpatient Service development
- Trindlemoss and Warrix Avenue development
- Additional Support Needs School Campus development

In 2017, the AHP leadership team participated in the Blue Wave leadership programme with Fiona MacNeill Associates. The strategic workforce intentions developed by the team through this programme remain relevant now:

1. AHPs will support early intervention and prevention by connecting with people within locality planning, education, the third sector and the private sector
2. AHPs will work to the top of their professional licence and empower support workers, volunteers and other colleagues to make a positive difference
3. AHPs will provide a targeted approach by working as part of multi-disciplinary teams using a generalist approach to meet needs of people with complex conditions whilst providing specialist advice and intervention as necessary
4. AHPs as a workforce will support the shifting balance of care by coordinating and advocating for people across traditional boundaries
5. AHPs will embrace alternative models of care and explore the development of new roles, skills and approaches

North Ayrshire AHP leadership team meets on a weekly basis. In addition, bi-monthly extended leadership sessions (including team leads) take place to support operational matters and professional/ leadership development.

In 2018, the full North Ayrshire AHP senior leadership team participated in NHS Education for Scotland (NES) Leading for the Future programme focusing on adaptive leadership and managing wicked problems.

The following pages introduce the role of each individual profession in North Ayrshire, articulate the workforce available, and highlight achievements and contributions during 2018.

4 AHP Professions

Dietetics

Dietetics is concerned with the assessment, diagnosis and treatment of nutritional and dietary problems at individual and population level.

Dietitians use public health and scientific research on food, health and disease, which they translate into practical guidance to enable people to make appropriate lifestyle and food choices.

In North Ayrshire, the dietetic service consists of 12.8 Whole Time Equivalent (WTE) with a headcount of 22 people.

Key achievements in 2018

- Continuing to provide regular, quality practice education opportunities to undergraduate dietetic students
- Working to reduce waiting times for community dietetic teams
- Input to the National Dietetic Prescribing Network taking forward pieces of work around data; care bundles and best practice guidance and will report progress through Scottish Dietetic Leadership Network
- Involvement in National Dietetic Supplies contract negotiations, commence November 2018
- Developing engagement resources and facilitators notes to promote discussion with local groups about the undernutrition strategy. Stakeholder events will be held in spring 2019
- Funding gained to carry out test of change with regard to oral nutritional supplements (ONS) in all Ayrshire partnership areas. This will involve direct requests to community pharmacy for ONS initiation; changes and cessation as part of a tightly monitored pathway to reduce the number of long-term users and subsequently prescribing costs. This work is in partnership with GP practice staff; community pharmacy; pharmacy prescribing advisors and care homes where aligned to GP practices/aligned dietitian. It is envisaged that a whole systems pathway will result in access to ONS via dietetic assessment only, for the majority of people in Ayrshire and Arran.

- Representation on acute and primary care prescribing groups. As a result, prescribing costs associated with ONS already reducing in all areas
- Integrating as part of the AHP team within the Beehive at Woodland View
- Supporting new mental health developments in Woodland View
- Providing support to people across Ayrshire who need neuro rehab
- Providing support to people across Ayrshire with mental health problems, learning disabilities, eating disorders, including children and young people

Challenges in 2018

- Waiting times for some community based services
- Managing workforce – including key staffing changes throughout 2018
- Timescales associated with recruitment
- Impact of Cash Releasing Efficiency Savings (CRES)
- Leading the local approach to international thickener descriptor changes
- Providing full support to care homes
- Supporting student colleagues

Aims for 2019

- Continue work with catering colleagues, linked to International Dysphagia Diet Standardisation Initiative (IDDSI), to include new descriptors on acute hospital menus by March 2019.
- Progress initiatives outlined above, including dietetic input to diabetes prevention work in North Ayrshire
- Build on existing positive dietetic contribution to the new intermediate care and rehabilitation model, and locality based multi-disciplinary working
- Contribute to and support new developments, including Trindlemoss and the National Secure Adolescent Inpatient Service (NSAIS).
- Work with primary care colleagues to review, streamline and optimise the dietetic service provided to GP practices and care homes via multi-agency work

Speech and language therapy

The service uses Care Aims as its main clinical decision-making methodology to support quality, effective and equitable speech and language therapy care. The service works with multi-disciplinary and multi-agency teams but increasingly is also developing strong links with the third sector to support early intervention and health promotion practices.

The main client groups supported by speech and language therapy are:

- Adults with acquired and progressive neurological difficulties (including MND, stroke, dementia, mulitple sclerosis, Parkinsons, traumatic brain injury)
- Adults with voice disorders
- Adults with head and neck cancer
- People who stammer
- Children and young people with speech, language, fluency or communication difficulties, some of whom may have associated other diagnoses (cerebral palsy, syndromes, autistic spectrum conditions, complex needs) and their families/carers
- Adults with learning disability
- People who have eating, drinking and swallowing difficulties

In North Ayrshire, the speech and language service consists of 13.02 WTE with a headcount of 21 people. Of this, 5.20 WTE deliver services to children and young people, and 7.82 WTE provide input to adults

The team work across a number of specialist areas (see below). There are staff members who work across teams and also have a responsibility to deliver service on an area-wide basis, dependent upon need.

Children's services

We offer an open requests for assistance system and accept requests from parents, carers, education, GPs, consultants, other AHPs, transfers from specialist services in Glasgow and individuals themselves. Speech and language therapists respond to requests, triage, deliver therapy information sessions, provide specialist assessment (where appropriate) and offer time-ended packages of intervention based on agreed outcomes.

Adult services

The adult service receives referrals from multiple sources including GPs, AHPs, specialist teams include Huntington's disease, motor neurone disease (MND), multiple sclerosis, neuro rehab, Woodland View, mental

health teams, learning disability service, enhanced intermediate care teams, care homes, health and therapy teams, ENT consultants. Referrals are triaged, assessed where appropriate and intervention offered.

Staff across both paediatric and adult services work with a range of multi-agency and multi-disciplinary teams to ensure the best care possible is provided. At every opportunity those most proximal to the individual are offered interventions that are enabling and support self-management and therefore engagement with local communities and 3rd sector organisations is beneficial.

Additionality

In addition to the core posts detailed above, additional fixed term funding has been achieved in partnership with education via various sources (Scottish Attainment Challenge, Early Years and Change Fund). This has enabled projects that specifically target capacity building, whole school approaches, parental engagement and promoting public awareness.

In 2018 the resource funded equates to:

Additionally funded resource	WTE	Headcount	Funded until
Within professional learning academy			
Band 6	1 WTE	1	March 2020
Band 7	1 WTE	1	March 2020
SPIN			
Band 6	2 WTE	5	March 2019
Raising Attainment Arran			
Band 5	0.5 WTE	1	January 2020
Band 6	1 WTE	1	March 2019
Change Fund (in universal health visitor team)			
Band 6	1 WTE	1	2019

Key achievements in 2018

- Reducing waiting times for children / young people accessing service
- Staff utilising improvement methodology to support change
- Staff accessing and engaging in training to ensure evidence based interventions and support succession planning
- Key staff being supported to develop dysphagia competencies, staff training at postgraduate level, which will ensure longer term sustainability and support capacity building across the speech and language service
- In partnership with IT, staff have developed a Learn Pro module, 'Supporting CYP Language and Communication' and will be tested with health visitors

- Success and continuing development of therapy information sessions and service access
- Maximising skill mix within teams
- Positivity and resilience of team
- Achieving continued funding from education partners
- Successful use of social media in engaging with parents and communities
- Extensive spread of Makaton training engaging parents, carers, families, local authority staff and third sector and building capacity and self-management approaches
- Introduction of remuneration for training, therefore allowing the department to backfill, support development of training strategy for Makaton, role development for speech and language assistant and building capacity across communities and organisations
- Increase in parents, carers and educators accessing training opportunities
- Update of AHP content on NHS Ayrshire & Arran public facing website
- Speech and language therapist engagement in national research projects
- Staff supporting and engaging in national initiatives
- Development of new pathways within voice service and discharge from acute hospitals to North Ayrshire to reduce waiting times, maximise self management and ensure the right service is delivered

Challenges in 2018

- Capacity of core service
- Unable to respond to the unmet need identified within our communities:
    - » Current staffing does not allow delivery of sufficient evidence based intervention at specialist level
    - » Inability to deliver sufficient universal and targeted approaches within core provision
- Inability to deliver approaches to reduce the barriers to access for most vulnerable individuals
- Impact of Cash Releasing Efficiency Savings (CRES)
- Sustainability of approaches undertaken via additional funding
- Increasing inequity of service delivery across Ayrshire due to variance of available funding
- Managing waiting times
- Patient / community dissatisfaction
- Recruitment and retention of staff

Aims for 2019

- Continue to build staff knowledge and capacity across early years and primary to support children in their speech and language communication development
- Develop skill mix across teams when the opportunity arises
- Deliver quality professional development experiences
- Maintain communication champion professional network
- Provide targeted speech and language services to support parents/ carers as part of the universal early years service
- Raise awareness of appropriate speech, language and communication resources by maximising use of technology and social media

- Engage in further joint working with education, third sector and communities to support speech language and communication development
- Establish joint CPD with universal early years and health visiting teams
- Establish language and communication policy with specialist educational environments, pathway and competency framework for other stakeholders.
- Build capacity by developing competencies and training for band 3, 4 support staff and other AHP staff to ensure every contact counts
- Build on progress and opportunities around digital agendas

Occupational therapy

Occupational therapy is a client centred profession concerned with promoting health and wellbeing through occupation. The primary goal of occupational therapy is to participate in the activities of everyday life. Occupational therapists achieve this outcome by working with people and communities to enhance their ability to engage in the occupations they want to, need to or are expected to, or by modifying the occupation or environment to better support occupational engagement .

The occupational therapy service works with people of all ages. It offers options and choices in respect of appointment locations that support their goals; at home, in clinics or in community resources, and utilises positive partnerships; peer support, volunteers, community resources, education.

Occupational therapy staff are based across North Ayrshire Health and Social Care Partnership, at Arran Social Work Dept, Rainbow House, Douglas Grant Rehabilitation Centre, Woodland View, The Horseshoe, Brooksby Resource Centre, Caley Court, Bridgegate House and Three Towns Resource Centre.

In North Ayrshire, the occupational therapy service consists of 31.38 Whole Time Equivalent (WTE) with a headcount of 37 people.

Occupational therapy team members are managed within community care teams, Dirrans Centre, Enhanced intermediate care and rehabilitation teams, Assessment and Reablement Team, Service Access Team.

Key achievements in 2018

- OT Attend Anywhere work initiated for people with MS experiencing fatigue
- Constraint based therapy – measureable outcomes on ability to improve function in arm after a stroke
- Supervision and support to Individual Placement Support (IPS) practitioner working for the Scottish Association of Mental Health based in the Three Towns Resource Centre. Occupational therapy staff supported the development of this service that assists people to directly access employment opportunities
- Greater diversity of work being undertaken with schools and desire expressed by schools to have greater occupational therapy involvement, for example, mindfulness work on Arran.
- Occupational therapist working within North Ayrshire Alcohol and Drug Partnership (ADP) supporting capacity building via Cafe Solace and wider partnership working

- Recovery focussed work within addictions – group programme, self-management. Occupational therapist facilitating 'Moving on Together' groups with peer practitioners. This includes support to training of peers.
- 'Health and Social Care Occupational Therapy – best use of resource and skills' – poster displayed at NHSScotland Event (June 2018)
- Shared staff training opportunities across Health and Social Care Partnership.
- Occupational therapist in Woodland View in-patient mental health working with voluntary partners across Ayrshire.
- Engagement with Ayrshire College to support in-patient learning. An example is recognition of the need to increase knowledge of local mental health services for occupational therapists working in community care. An event was organised where MDT colleagues (OT, nursing, SW) across mental health provision spoke to the services available and answered questions.
- Test of locality based specialist services with occupational therapist based within Brooksby's Health and Therapy Team offering therapy for people post stroke, to bring service closer to person's home.
- Test of closer working between occupational therapy colleagues across the system; health occupational therapist and social care colleagues undertaking joint visits to support grant process for some adaptations to reduce delays.
- Work on-going related to early diagnosis and intervention for people diagnosed with dementia
- Universal and targeted work within Child Health and Education
- New occupational therapist (Band 6 fixed term) confirmed for Low secure unit and IPCU in Woodland View
- Involved in triage testing with Adult Community Mental Health Team, skills development: CBT qualification, Behavioural Activation
- Carers – pilot work with Chest Heart & Stroke Scotland
- Improving Observation Practice Scottish Patient Safety Programme – Pilot work with an Acute ward team. This works aims to support occupational therapy intervention for people requiring ' continuous intervention' through direct engagement and supervision of nursing assistants.
- Engagement with adult literacy – North, South, East Ayrshire – to support people in Woodland View
- New carers support group for those under 65 diagnosed with dementia
- Key member of leadership teams associated with NSAIS, Trindlemoss/ Warrix Avenue, Forensic Review, Mental Health Review, Models of Care and ADP Quality work stream

Challenges in 2018

- Waiting times have increased in children's services and adult community mental health due to staff changes including retirement/left the service/ maternity leave. Demand, capacity and scrutiny processes are being reviewed in terms of impact.
- Inclusive and integrated workforce – occupational therapists and support staff are paid different salaries dependent on employer (NHS Ayrshire & Arran or North Ayrshire Council). This has challenged our ability to rotate staff and flexibly cross cover.

Aims for 2019

- Improve access and decrease waits – particularly CMHTA, young people and those referred to community occupational therapists
- Progress locality and cluster approaches for schools and communities
- Inclusive workforce planning – service not silo
- Demand and capacity modelling
- Focussed work with carers
- Benefits realisation of models of care investment and low secure investment.
- Progress group assessment models with children
- Progress work with interested partners associated with trauma informed care
- Opportunities to improve integrated approach Children's Services / CAMHS across North Ayrshire, including Arran
- Involvement in work around "Dementia Friendly Arran"
- Involvement in further developing Mental Health Service delivery on Arran
- Sustain goal setting, criteria led and early supported discharge within in-patients
- Progress use of technology for communication and treatment
- Ongoing work in obesity and multiple sclerosis pathways
- One records system – patient and staff risks highlighted by use of multiple systems
- Involvement in supporting and promoting activity for older adults with a functional mental health problem to improve wellbeing

Physiotherapy

Physiotherapy supports people affected by injury, illness or disability through movement and exercise, advanced manual therapy, education and advice. Using highly specialised assessment and treatment planning, physiotherapy maintains health for people of all ages, helping people to manage pain and prevent disease. Physiotherapy works across both physical and mental health, promoting self-management and preventing long term disability.

The Physiotherapy service in North Ayrshire has a headcount of 59, and a whole time equivalent of 47.24.

Physiotherapy services available in North Ayrshire:

- North Ayrshire Community Physiotherapy Team provides slower stream rehabilitation to patients including Arran (1.93 WTE), and Cumbrae and as part of Brooksby and Beechview Health and Therapy Team. The team was enhanced through investment in the Enhanced Intermediate Care and Rehabilitation Service. People are seen in their own homes, nursing home or can be brought in to hospital sites if more specialised equipment is required.
- The physiotherapy team based at Douglas Grant Rehabilitation Centre provides physiotherapy input to neuro outpatient services to people from North Ayrshire and they host pan Ayrshire physiotherapy services for people with muscular sclerosis, motor neurone disease and people with spasticity. The team also provides specialist inpatient rehabilitation for people following a stroke, for older adults, and for people with neurological conditions.
- The child health pan Ayrshire paediatric physiotherapy team provides highly specialist treatment to children who have additional needs, including children with cystic fibrosis and complex respiratory disorders, neurodevelopmental delay, neuromuscular conditions, cerebral palsy and MSK issues. They assess, treat and provide plans of care at home, in clinics in special schools, and in main stream schools.
- The combined, pan Ayrshire, mental health and learning disability physiotherapy team (formed in summer 2018) provides physiotherapy input to inpatient areas and community teams for people with learning disabilities, and the community mental health teams for adults and older people.
- In addition, there are physiotherapists working in North Ayrshire, managed through different structures – within the Integrated Care Teams, cardiac rehabilitation, pulmonary rehabilitation and MSK.

Key achievements in 2018

- Completion of physiotherapy restructure to bring closer alignment to the health and social care partnerships
- Integration of community rehabilitation team with wider partners as part of Enhanced Intermediate Care and Rehabilitation Service
- Training of band 3 interdisciplinary workers
- Successful recruitment to fill posts and stabilise teams including some hard to fill posts – e.g. Arran band 7, mental health band 7
- All teams progressing service improvement projects and have clear goals for 2019
- Increased focus on multi-disciplinary working and towards AHP collaborative work
- Skill mix review commenced in all areas – work ongoing to ensure workforce fit for the future.

Challenges in 2018

- Instability created by several key staff members retiring and gaps in filling post due to scrutiny process timescales
- Physiotherapy restructure and associated budget challenges
- Impact of Cash Releasing Efficiency Savings (CRES)
- Scrutiny process for recruitment
- Review of skill mix to include more support workers
- Unprecedented sick leave in key areas
- Challenging silo working and traditional models of practice

Aims for 2019

- Reduce wait list in all areas
- Evidence impact of models of care
- Continue clinical supervision pilot and embed into practice
- Focus on wellbeing of staff and maintenance of staff attendance levels
- Improve use of capacity and demand data to improve service provision
- Run postural stability course with paediatric and learning disability team
- Ensure LD and MH teams are integrated into one team, strengthen governance
- Review mental health team service provision
- Use data to demonstrate value of teams
- Closer team working with AHP colleagues and other partners
- Seek further opportunities to work with third sector and communities
- Inpatient teams to support earlier discharge from wards and out reach
- Embed self-management within all teams
- Embed quality improvement and leadership values in all staff

Podiatry

Podiatry focuses on the diagnosis, treatment, prevention and management of diseases, defects and injuries of the foot, ankle and lower limb. This includes ankle and foot injuries, problems with gait or walking, complications related to medical conditions such as diabetes and arthritis and diseases of the skin or nail. Interventions range from support in self-care through to specialist work in areas such as nail surgery, arthritis, diabetes, vascular, renal wound management, sports injuries and specialist footwear clinics.

The Podiatry Service is provided by a team of clinicians that include advanced practitioners, specialist podiatrists, podiatry assistants and healthcare assistants.

Podiatry is a pan Ayrshire, whole system service, currently led through East Ayrshire Health and Social Care Partnership. It provides open access/ self-referral. Assessment is undertaken to determine clinical need and provided to people on the basis of medical risk and/ or podiatric need.

The Podiatry Service continues to work with multi-disciplinary and multi-agency teams and has strong links with the third sector agencies following redesign of the service in 2015 with the introduction of nail cutting by trained volunteers.

Care is provided through three main Podiatry Care Pathways:

1. Podiatry High Risk and Diabetes Pathway

This pathway involves the provision of wound care and foot protection for those patients with high-risk and limb threatening conditions found in people with peripheral arterial disease, diabetes, PAD, chronic kidney disease and patients with compromised immune systems.

North podiatry community workforce associated with this work is 3.5 WTE.

Seamless care is provided with direct referral with the podiatric/ multidisciplinary team across acute and community settings

Podiatry diabetes annual screening – this is provided to people with diabetes who are 'low risk' and have no other foot problems. Patients are recalled annually for screening in community clinics or at consultant led hospital outpatient clinics, This service is provided by healthcare assistants.

North podiatry workforce associated with this work is 0.66 WTE

2. Podiatry Musculoskeletal (MSK) Foot and Ankle Pathway

This pathway provides assessment, diagnosis, treatment and rehabilitation of MSK foot and ankle conditions and combines gait analysis, assessment and treatment for other related lower limb conditions. Specialities within this pathway include MSK management of paediatric and rheumatology patients. North podiatry MSK workforce associated with this work is 3.3 WTE.

3. Podiatry Enablement Pathway

This pathway involves the provision of care to patients with long-term medical conditions such as COPD, stroke, dementia, Parkinson's disease, multiple sclerosis, learning disabilities, etc. This pathway also includes provision of minor surgery (nail surgery, electrosurgery) and falls prevention. Input into the Prison Service is also provided.

This pathway team also provides support to Enhanced Intermediate Care and Rehabilitation Service across three health and social care partnerships

North podiatry workforce associated with this work is 5 WTE

Within each pathway of care, podiatrists use specialist and advanced skills to manage a caseload of patients with high complex needs, using evidence-based/patient-centred principles to assess, plan, implement and evaluate interventions in both hospital and community settings as required.

Key achievements in 2018

- Podiatry workforce redesign - improved skill mix achieved with introduction of one Band 2, five Band 5s and one Band 8A advanced podiatrist in foot and ankle
- Minor surgery: significant improvements in patient waiting times as a result of ring fencing 2wte resource to this area of the service. Performance target for 'urgent' within 3weeks, 'routine' 8 weeks.
- E-Health Enablement Pathway transferred from Trak to EMIS for domiciliary visits, care homes and minor surgery. All clinics will move to EMIS during 2019. This transition is supported with the roll-out of 4G laptops to support agile working. In addition, for the first time, the service has access to electronic patient records (EPRs)
- Strategic planning and development – Podiatry senior management team agreed measures to demonstrate performance against the four pillars of management performance and governance; 1) people, 2) service, 3) quality and 4) finance.
- Podiatry Senior Management Team also considered how the service

will contribute to the transformation of services relating to the four transformation priorities: 1) prevention, 2) primary, community and social care, 3) digital and 4) models of care.

- Foot and ankle proposal – Submitted to Scottish Government to support the orthopaedic drive around service improvement. The primary ambitions are to abolish the orthopaedic backlog, establish MDT working and improve patient flow. The anticipated results are removal of unnecessary review appointments in orthopaedics, which will address the New:Return ratio, and to remove guided injections from theatre to podiatry out-patients, therefore releasing capacity in this area also.
- Approved bid – 12 month funding for 1wte Band 8A advanced podiatrist
- Introduction of 'Virtual Clinic' - joint working initiative with orthopaedic consultant at Ayrshire Central Hospital. By increasing knowledge and skills improves the decision making outcome of patients with complex foot needs
- MSK service user feedback: Local officer from the Scottish Health Council provided feedback on the recent information gathering exercise from 78 service users. No major issues around service design were identified and the majority of those surveyed were happy with the treatment and care they received
- 'CPR for Feet' - In-patient foot screening initiative linked to identify patients admitted to hospital who may be at risk of tissue breakdown
- Vascular Pathway - direct referral from vascular ward at Ayr Hospital to High Risk/ Diabetes Pathway for patients discharged from hospital with foot wounds/ulceration – post surgery
- Minor surgery – 'No Delays' (in partnership with NHS Grampian) is an online platform that health professionals can use to share video clips with patients following a consultation and treatment. A link to the video clip is sent by the clinician to the patient via email. No Delays is is a nail surgery package to 'prescribe' information to patients who are recovering from nail surgery
- Podiatry finance objectives and aims achieved:
    - » Podiatry Service Managers jointly working with Finance Team with a number of key action points to address areas of overspend within certain budget lines.
    - » Improved Pecos ordering aligned to pathway/budget lines
    - » MSK consignment company undertake 6 monthly pan Ayrshire audit to identify potential over stocking in hubs

Challenges in 2018

- Staff vacancy delays caused by introduction of scrutiny panel
- Maintaining and prioritising areas of service due to diminished resources caused by long term absences and filling vacancies
- Continued minimal admin support for service. Some support is provided by MSK and non-MSK hub, however since moving to EMIS, admin support has again decreased with staff undertaking admin tasks/ appointing patients and dealing with enquiries and phone calls.
- Workforce stressors – mainly as a result of lack of admin support.

Aims for 2019

- Progress digital agendas including agile working and use of Electronic Patient Records.
- Continue skill mix review and workforce planning
- Podiatry high risk/diabetes – NHS Ayrshire & Arran Vascular Service transfer to NHS Lanarkshire will require joint MDT planning to ensure seamless provision of care continues for patients residing in Ayrshire
- Podiatry enablement to complete domiciliary re-design/re-assessment of all caseloads including podiatry assistant caseloads. Podiatry assistant time released will be reinvested into foot health prevention/ promotion activities which includes delivery of focus on WATOM factors (Work, Alcohol, Tobacco, Obesity, Mental health).
- Continue to progress self-management approaches across all three pathways
- Extend the enhanced intermediate care and rehabilitation model and its continuing development with podiatry contributing to multi-disciplinary locality working.

5 Governance

Clinical and care governance

Clinical and care governance for AHPs in North Ayrshire is assured through a variety of mechanisms.

A pan Ayrshire, uni-professional governance group exists for each of the individual AHP professions in Ayrshire and Arran, chaired by one of the service managers. These groups comprise of clinical and management leads from the relevant profession who meet on a monthly basis to provide update and build assurance on service activity, following the strands of the quality strategy – safe, person centred and effective. As such, these forums report and assure on service activity – waiting times, learning from adverse events or complaints, celebrate success in terms of positive feedback and compliments received, provide updates on service improvement, and manage or escalate risk.

These uni-professional groups report into a pan Ayrshire AHP governance group which meets on a monthly basis and is chaired on a rotational basis by one of the AHP senior managers.

The AHP governance group reports to provide assurance on the activity of AHPs to the relevant HSCP health and care governance group. As such, the AHP lead has a standing agenda item on North Ayrshire Health and Social Care Partnership governance meeting agenda; to provide update and assurance on any North Ayrshire AHP matters.

Finance

The information detailed within this section relates to AHPs managed within the AHP professional structure in North Ayrshire – physiotherapy, occupational therapy, dietetics and speech and language therapy.

AHP staff budget for 2018–19 is £4,636,534 with an establishment of 114.24 WTE.

- Within 2018–19, £161,532 CRES was applied to the North AHP budget – predominantly a combination of application of the previous year's share of CRES, CRES applied while still part of the South Lead Partnership arrangement in 2018–19, and a share of additional savings attributed by the Workforce Scrutiny Group (2019).

- At month 9 there was a year to date variance of £90,425 with a projected underspend of £126,000 by year end. The underspend is due predominantly to natural delays experienced within the recruitment system, challenges in recruiting to some vacant posts, and also linked to levels of maternity leave across AHP services.

Staff governance

Staff governance of AHPs in North Ayrshire is assured through a variety of mechanisms. All teams participate in iMatter, with associated action plans developed at team level to further improve staff experience at work.

There has been significant progress made in 2018 to ensure robust arrangements are in place to support quality supervision for all AHPs working in NAHSCP. Based on the recently published national position statement on supervision for AHPs, this work has been tested with teams in 2018 with a view to rolling the approach out in 2019.

In addition, AHP senior manager input to the AHP professional committee, North Ayrshire staff partnership forum, and AHP partnership rep forum provide additional opportunity for partnership input and support during periods of change.

AHP staff wellbeing remains a priority area. The AHP leadership team remain committed to regular engagement with teams and individuals, and are currently in dialogue with Partnership colleagues as to how best to further develop this approach.

6 AHP Service performance

MAST (%complete)

Fire	86%
Management of aggression	8%
Moving and handling	93%
Infection control	86%
Safe information handling	83%
Adult protection	93%
Child protection	93%

All North AHP services as at 31st December 2018

Absence %

Service	Short term	Long term
AHP North Management	0.31%	0.00%
Dietetics	1.15%	0.25%
Occupational Therapy	1.03%	2.64%
Physiotherapy	1.49%	3.87%
Podiatry	1.32%	3.26%
Speech and Language Therapy	0.87%	2.55%

Accumulative - All North AHP services as at 31st December 2018

Activity data

With AHP services working across a variety of referral mechanisms and recording systems, it has proved problematic to achieve a consistent method of recording and reporting on service activity and demand. In anticipation of the roll out of a national dataset for AHPs, the focus this year has been on achieving such data; to evidence the AHP contribution and be better placed to monitor and manage demand. While progress has been made around this, the collection of robust, consistent data will remain a focus in 2019.

Quality improvement

7

Across all AHP services, there is a continued focus on quality improvement, with the development of a culture of improvement, through training and mentorship to promote the ethos that improvement is everyone's business. A number of AHPs have now completed the Scottish Improvement Leader (ScIL) or local practitioner level Improvement Science Fundamentals (ISF) programmes, with corresponding quality improvement activity progressed locally.

At a national level, the Active and Independent Living Programme (AILP) supports AHPs, working in partnership with multi-disciplinary teams and agencies to improve the health and wellbeing of the population throughout the life-course. (SG 2018).

In response to this national AHP programme, four local workstreams were developed and have been progressed during 2018:

1. Workforce

This workstream seeks to determine the future vision of the AHP workforce - to ensure the right AHP staff, in the right place, at the right time with the right skills and competences to provide quality services – through analysis and consideration of the existing workforce using agreed tools and techniques.

2. Wellbeing

This group seeks to enable AHP staff to be healthy and happy at work through supporting and developing an understanding of individual and team resilience and its role in maintaining healthy working lives and our ability to adapt to change.

3. Data for improvement

This group has progressed testing and implementation of a framework to provide the information necessary to inform improvement.

4. Research, development and evaluation

This workstream seeks to build on the previously published improvement framework for AHPs; to enable AHP teams and individuals to use information in a meaningful way, to demonstrate impact and improvement.

8 AHP contribution to Partnership priorities

The contribution of AHPs to NAHSCP vision 'all people who live in north Ayrshire are able to have a safe, healthy and active life'

Tackling inequalities

- Improved workforce planning associated with specific services – thinking better outcomes for people, thinking service and not silo. Use of digital technology, Attend Anywhere, to reduce impact of inequalities.
    - » Project plan developed with digital services to enable video link between Arran War Memorial Hospital and mainland hospitals. The use of Attend Anywhere will enable a range of consultations with Arran residents, reducing their need to travel to the mainland. This will also support the discharge of patients from Redburn, following stroke, who would not be able to receive weekly speech and language therapy on Arran, but will be able to have a consultation via Attend Anywhere.
    - » Occupational therapy Attend Anywhere work initiated for people with MS experiencing fatigue, again to facilitate access to therapy from within people's own homes, reducing the need to travel.
- Constraint based therapy – measureable outcomes on ability to improve function in arm after a stroke.
- Opportunities realised to access grants from non-statutory organisations that improve people's quality of life in line with 'Living not enduring' programme from the Royal College of Occupational Therapy (RCOT).
- Extensive involvement with Scottish Government Assisted Communications Team on work streams to underpin development of guidance and procurement to support legislation on provision of communication equipment and support to use that equipment.
- Supervision and support to the Individual Placement Support (IPS)

practitioner working for the Scottish Association of Mental Health based in Three Towns Resource Centre. Occupational therapy staff have supported the development of this service that assists people to directly access employment opportunities.

- AHP input to the service redesign work on the Isle of Cumbrae on-going.
- Attainment project on Arran providing on-island access to universal/ targeted and additional specialist speech and language therapy support. This project focuses on building staff capacity and ensuring that approaches are sustainable – provision of Ican Training, Talk Boost, Learning Language and Loving It for early years and primary staff, supporting promotion of language and communication skills across communities via drop in sessions, BookBug and community activities.
- Speech and language therapy in the Professional Learning Academy delivering extensive training and targeted interventions in North Ayrshire schools with highest SIMD index. Outcomes have proved positive with interventions evaluating well, for example, Talk Boost is targeted intervention, which builds capacity to ensure sustainability. Evaluated example, storytelling and narrative skills:

	pre-intervention	post intervention
Children achieving appropriate level of skill	9%	76%
Social interaction	50%	91%

Engaging communities

- A greater diversity of work being undertaken with schools and desire expressed by schools to have greater occupational therapy involvement, leading to mindfulness work on Arran. Sessions provided at annual health and wellbeing week on Arran leading to established links within the school. This has also begun to raise the profile of mindfulness. A number of education staff are booked to attend the next 8-week course in January 2019. This programme aims to support a longer term vision of having education staff who can take forward the mindfulness agenda within the school.
- In February 2018 the musculoskeletal project team (MSK) identified that waiting times in Ayrshire and Arran were above the national average. The project team had support from the Scottish Health Council (SHC), including independent patient engagement within the MSK sites leading to themed feedback and identified areas for further improvement – mainly around waiting times, and parking/signage.

- Occupational therapist working within ADP supporting capacity building via Cafe Solace and wider partnership working.
- Recovery focussed work within addictions – group programme, self management. Occupational therapist facilitating 'Moving on Together' groups with peer practitioners. This includes support to training of peer workers.
- Self-management work with Chest Heart & Stroke Scotland
- Falls prevention drop in event held at Brooksby in November, linking with seasonal flu clinic
- Active Kilwinning – multi agency, multi professional group developed collated infographic to support access to physical activity opportunities within Kilwinning locality.

Bringing services together

- Since the opening of Woodland View, AHP services are co-located in the Beehive hub, including dietetics, occupational therapy and physiotherapy. Staff work in a supportive and multi disciplinary manner to provide care and support in a co-ordinated way to people who access services in Woodland View.
- A major focus in 2018 was the development of the new model of enhanced intermediate care and rehabilitation. North Ayrshire component of this included bringing together referral management and professional triage of several, previously separate, community rehabilitation services. As well as reducing duplication, and supporting a 'right person, right place' approach, the progression of this takes community rehabilitation closer to NAHSCP ambition around locality based multi disciplinary working and is demonstrating impact by avoiding unnecessary hospital admission and keeping people at home.
- Health and social care occupational therapy – continued focus on the integration of approaches with a poster on best use of resource and skills displayed at NHS Conference June 2018.
- Arran locality complex care pilot
- Shared post OT main service and ICT for North Coast locality with one occupational therapy post working across traditional service boundaries in the locality
- Shared staff training opportunities across health and social care partnership.
- Occupational therapist in Woodland View in-patient mental health working with voluntary partners across Ayrshire.
- Additional speech and language therapy post focussed on adults

in North Ayrshire has focussed on delivering increased speech and language therapy input for families to support early discharge from wards in Ayrshire Central Hospital and north residents in University Hospital Crosshouse. Team are now able to respond to acute dysphagia community requests, therefore minimising the risk of hospital admission. A new pathway has also been developed for patients who have communication difficulties following a stroke.

- Engagement with Ayrshire College to support in-patient learning.
- Falls pathway test of change at Brooksby, linking with wide range of stakeholders, on-going.
- Test of closer working between occupational therapy colleagues across the system; health occupational therapist and social care colleagues undertaking joint visits to support grant process for some adaptations to reduce delays.

Prevention and early intervention

- Dietetics are working with pharmacists and GPs to review the prescribing of nutritional supplements to ensure the patients who need these most receive them and efficient spend. A test of change is underway in Irvine – testing dietitians prescribing supplements directly to free up GPs and ensuring appropriate patients receive what they need. This also involves training nursing staff at GP practices to help identify patients at risk of malnutrition to enable them to be seen early and prevent hospital admission.
- Buckreddan Project enables senior support staff in Buckreddan Care Home, Kilwinning to have increased skills and knowledge, to optimise use of walking aids, increase activity and exercise for residents, and to understand the importance of care to prevent respiratory complications. It is hoped to link up some of this work with the Care inspectorate's Care About Physical Activity (CAPA) programme. This work seeks to reduce unnecessary referrals to physiotherapy and to maximise activity and wellbeing for residents of Buckreddan, and to increase the skills and confidence of the care staff.
- Occupational therapists working within the Assessment and Reablement Teams (ART) have continued to deliver positive outcomes for the people of North Ayrshire and North Ayrshire Health and Social Care Partnership. Following investment through the Challenge Fund, there are now eight occupational therapists working as key

components of the Care at Home Service, alongside service users, their families and carers; to promote independence and reduce long term requirements for care at home. This approach has the dual benefit of supporting capacity within our Care at Home Service, whilst also supporting people's recovery and independence.

- Tests have continued, utilising advanced practice physiotherapists as first point of contact within GP practices to support early intervention for people with MSK issues. In North Ayrshire, the pilot sites have been South Beach, Ardrossan, and Largs Medical Practice. Across Ayrshire, this approach has continued to prove a success.
    - » 66% of people are seen by the physiotherapist as first point of contact, saving GP time and appointments.
    - » Only 1.3% of those who saw the physiotherapist have required to see a GP linked to the same complaint.
    - » 72% of those seen have been able to self manage their condition after brief physiotherapy advice and intervention, with a 20% reduction in referral to core MSK Services.

  Following a successful recruitment campaign, plans are progressing to spread this approach across Ayrshire, with 4 WTE posts in place by May 2019.
- Anticipatory care planning – increased completion of plans collaboratively.
- Work on-going related to early diagnosis and intervention for people diagnosed with dementia.
- Dietetics thickener usage change implemented across organisation, further work will continue as new international descriptors to be in place April 2019.
- Universal and targeted work within child health and education services.
- Set up and evaluate circuits class for learning disability population – promoting physical activity and wellbeing
- Podiatry high risk/diabetes joint initiative and development of "CPR for Feet" training for Home Care staff
- Podiatry enablement to provide diabetes annual foot screening training to prison healthcare staff
- Podiatry MSK continue to develop and promote self-management phone apps/tools
- Successful collaboration with Centrestage, 'AHPs on the bus', six week programme where AHPs attended Centrestage sessions to provide informal advice, signposting and guidance to promote health and wellbeing. Over 60 individuals benefitted from this approach to early intervention, which evaluated positively by all stakeholders. Further collaboration planned for 2019.

- A number of initiatives have been introduced, focussed upon and scaled up during 2018 to reduce waiting times. This example sought to improve access to speech and language therapy for children and young people in North Ayrshire:
    - » Telephone helpline established to support open access
    - » All staff trained in 'initial conversations' to support personal outcomes for families/practitioners
    - » Increase in universal and targeted approaches offered from the core team
    - » Increased capacity building opportunities for parents, (Makaton workshops delivered flexibly in evenings and at weekends to maximise attendance and access for families and practitioners, therefore supporting self-management)
    - » Supporting a colleague from Education through Makaton tutor training to ensure increased responsibility /self management within Education
    - » Developed social media presence to improve engagement, share information and signpost families to community and national assets
    - » Maximised clinical time available by introducing opt in appointments and implementing a new system of triage/ assessment and intervention to maximize parental understanding and engagement with the service.

Improving mental health and wellbeing

- Ayrshire College has long standing links with in-patient mental health services through the delivery of group work; an in-patient art group has been running for over 10 years with tutors from Ayrshire College. Ayrshire College began collaborating NHS Ayrshire & Arran to initiate a group in November 2018 that supported in-patients to recognise their learning in health and wellbeing while in hospital and evidence this with the support of occupational therapy staff and Ayrshire College tutor. All participants are registered as students of Ayrshire College and are completing personal learning journeys. The first cohort will finish end of January 2019 with an award ceremony February 2019. The aim is to repeat this work and grow the joint working opportunities.
- Support to local response around Action 15 Mental Health strategy monies with funding for speech and language therapist and

occupational therapist posts at HMP Kilmarnock. These posts are new opportunities and work is ongoing to develop links locally and nationally to support a planned model of intervention with benchmarking and joined up working that supports people coming to HMP Kilmarnock and returning to their home locality in Scotland.

- KA Leisure project is a collaborative project between staff in Ward 5, Woodland View, physiotherapy and KA Leisure. The project seeks to ensure that people who engage with activity within Woodland View are supported to carry on with activity in the community, once discharged from hospital. Currently people who attend Ward 5 as an inpatient, have a program of exercise offered by the physiotherapy TI. Exercise often stops when people are discharged from Ward 5, before they are able to engage with community services.
  This project enables staff from KA Leisure to meet and get to know people while still in Ward 5, discuss the range of exercise available in their local community, and ensure people continue to exercise once discharged, maximising both physical and mental health.
- New occupational therapist (Band 6) fixed term post confirmed for low secure and IPCU in Woodland View.
- Podiatry Service clinical development – Neurology presented by advanced practitioners. In addition includes dementia level 1 training for all staff.
- CMHTA – Involved in triage testing, skills development: CBT qualification, Behavioural Activation.
- Carers – pilot work with Chest Heart & Stroke Scotland.
- Support to local response around Action 15 Mental Health strategy monies with funding for speech and language therapist and occupational therapist posts at HMP Kilmarnock.
- Engagement with adult literacy – North, South, East Ayrshire to support in-patients in Woodland View.
- Commenced carers support group for those under 65 diagnosed with dementia.
- Collaborative working with AHP and nursing staff in Woodland View implementing an observation pilot – Scottish Patient Safety Programme.
- Mental Welfare Commission reports for visits to Woodland View in spring 2018, positive feedback on collaborative work with occupational therapy and interdisciplinary teams re activity, structure and person centred care planning.

- Speech and language and occupational therapy assistants at Ayrshire Central have been running a weekly music and communication group since early September. The aim of the group is to enhance mood, promote movement and stimulate speech and activity through interactive music group. Evaluations from participants and staff have been positive with plans to spread approach. Similarly, a relative / carer group was established with family members of those patients who have recently had a stroke and were on Redburn Ward invited to attend weekly information sessions on stroke and its effects on communication delivered by speech and language therapists. Feedback has been excellent with plans to provide these sessions on a rolling basis.

9 AHP priorities for 2019

- Maximise the AHP contribution to multi-disciplinary working
- Continue workforce planning to maximise AHP workforce available in North Ayrshire, within resources available
- Continue work that promotes early access to AHPs and preventative approaches
- Continue to prioritise the wellbeing of AHP staff
- Continue to build on progress around digital agendas
- Ensure progress supports consistent and robust performance data

Conclusion

10

This report underlines the valuable contribution that AHPs make to the people of North Ayrshire, the improvement culture embraced by team members, and the ways AHPs work alongside a wide range of partners, as critical components of multi-disciplinary teams to support wellbeing, self-management and promote independence.

NORTH AYRSHIRE Health and Social Care Partnership

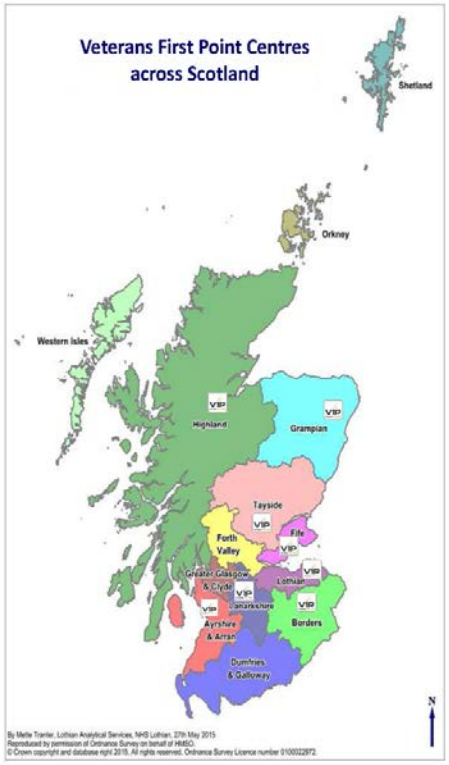
North Ayrshire Integration Joint Board
14th February 2019
Agenda Item No.

Subject:	**VETERANS FIRST POINT SERVICE**
Purpose:	To provide North Ayrshire Integration Joint Board with information about the Veterans First Point Ayrshire & Arran (V1P A&A) service, which has been delivering welfare and specialist mental health services to veterans and their family members since March 2017.
Recommendation:	It is recommended that the Integration Joint Board (IJB): Acknowledges the very positive work of V1P A&A in operationalizing the Armed Forces Covenant (as referred to in paragraph 2.1.1 of this report) across North, East and South Ayrshire, ensuring better access to NHS services, including pathways for ensuring priority treatment for those veterans who should receive early treatment for health problems that have resulted from military service. Acknowledges the steps that are being taken as outlined in paragraphs 3.4.1 – 3.4.3 of this report to determine the future model and financial framework for the service. Notes the content of the Scottish Veterans Commissioner's report; Veterans' Health & Wellbeing (attached as Appendix 1).

Glossary of Terms	
V1P	Veterans First Point
NHS AA	NHS Ayrshire and Arran
HSCP	Health and Social Care Partnership

1.	**EXECUTIVE SUMMARY**
1.1	The purpose of this report is to provide Ayrshire & Arran Integration Joint Board with information about the Veterans First Point Ayrshire & Arran (V1P) service, which has been delivering welfare and specialist mental health services to veterans and their family members since March 2017.

1.2	**Key Messages**: • The paper outlines existing veteran services within Ayrshire see 3.18. However, V1P A&A service acts as a single point of entry for veterans to access other services both in the third sector and statutory services. Veterans are able to access the one stop shop, where their needs are reviewed and the specific services required are identified and accessed with the support of the veteran peer support worker/ Clinical staff. This service-model is unique within Ayrshire. • This service is successfully providing a service to a large proportion of clients who are male and come from SIMD 1 and SIMD 2 areas, factors which have historically been shown to have a negative impact on client engagement with services. • Each Health and Social Care Partnership and Boards are expected to play a key role in delivering the commitments set out in the Community Covenant. • Elected members are Armed Services and veterans Champions are be delivering on Government Commitment to Veterans through their support of this service.
2.	**BACKGROUND**
2.1	**Developing V1P Services in Scotland**
2.1.1	The Armed Forces Covenant is about fair treatment and sets out the relationship between the nation, the government and the Armed Forces. It recognises that the whole nation has a moral obligation to members of the Armed Forces and their families and it establishes how they should expect to be treated. The Covenant's two principles are that: • the Armed Forces community should not be disadvantaged compared to other citizens in the provision of public and commercial services in the area where they live; • special consideration is appropriate in some cases, especially for those who have given most such as the injured and the bereaved. All local authorities have pledged to uphold the Armed Forces Covenant.
2.1.2	The initial V1P Centre was set up in 2009 by NHS Lothian. The model aims to provide: • Information and Signposting • Understanding and Listening • Support and Social Networking • Health and Wellbeing - including a comprehensive mental health service delivered by a multi –professional team on site.
2.1.3	Funding was secured from the Mental Health and Protection of Rights Division of the Scottish Government (£200,000) and NHS Lothian Strategic Programme Budget for Mental Health and Wellbeing (£60,000). The success of V1P Lothian was recognised by the UK Military and Civilian Health Partnership Awards as a double award winner in 2011 and single award winner in 2013. A strength and key component of the V1P model has been the employment of veterans as peer workers. V1P psychological therapists deliver a range of quality evidence based care, treatment and support to veterans and their families. This includes the delivery of evidence based therapies.

2.2	**The UK Government Funding (LIBOR Fund)**
2.2.1	Building on the success of V1P Lothian, a comprehensive proposal was submitted to the LIBOR fund in October 2012. The stated objective was to "*work in partnership to deliver high quality evidence based care, treatment and support for veterans and their families across Scotland".* The proposal set out how a hub and spoke model – supported by a small development team, would establish a further three centres in Tayside, Highland and Grampian. The proposal was successful and £2,560,586 was awarded to NHS Lothian to develop and deliver this model.
2.3	**What has been achieved?**
2.3.1	The V1P Scotland development surpassed the original intent to develop an additional three centres. Instead, due to the commitment to partnership working and relationship building, a total of eight centres were established (including V1P A&A) with the support of the V1P Scotland team (see Figure 1). Six of the eight centres were sustained beyond the initial LIBOR fund period (March 2017). Highland and Grampian services were disbanded in 2017 when 100% external funding was discontinued.
	Figure 1:V1P Centres across Scotland 
3.	**A BRIEF OVERVIEW OF V1P SCOTLAND CENTRES AND NETWORK**
3.1	**An Overview Of V1P Ayrshire & Arran**
3.1.1	The remaining six V1P Centres reflect the local needs, priorities, service landscape and partnerships and are therefore quite different in their staff composition, premises and partnership arrangements. However, the three core principles of the V1P model are: Creditability, Accessibility and Coordination.
3.1.2	In 2009 the NHS in Scotland were issued with guidance (CEL 3 2009 – UK VETERANS) which detailed the rights of veterans and their families to have priority treatment.

3.1.3	Extensive consultation with local stakeholders confirmed the need for the development of health services for veterans, and emphasised the importance of joint working and co-ordination with other services (statutory and voluntary). The Stakeholders supported a model combining integration into generic care for most Veterans and specialist intervention for those unable or unwilling to engage.
3.1.4	In 2017, under the corporate leadership of the NHS Ayrshire & Arran Head of Adult Mental Health – Thelma Bowers, the V1P Ayrshire & Arran service was created. NHS Ayrshire & Arran entered into a Memorandum of Understanding (MoU) with V1P Scotland and the local veterans' charity – Poppy Scotland.
3.1.5	It was agreed for the V1P Ayrshire & Arran Service to sit within the existing Psychological Therapies Service. It was thought that the advantages of being a Psychology led service would support assertive communication between V1P Ayrshire & Arran and other psychiatric and psychological therapy services and enhance access to a range of psychotherapies or other main stream NHS services. Being a Psychology led service also ensures the required Clinical Governance necessary to run a safe and effective service.
	The team is comprised of:- Clinical Service Lead (Band 8B) – 0.9 whole time equivalent (WTE) Psychological Therapist (Band 7) – 1.0 WTE Veteran Peer Support Workers (Band 3) – 1x1.0 WTE + 2x0.5WTE Service Administrator (Band 3) - 0.6 WTE.
3.1.6	The location of the service was carefully chosen and is in a shop front in the centre of Irvine, to attract footfall and facilitate accessibility.
3.1.7	The service acts as a single point of entry for veterans to access the 'one stop shop', where their needs are reviewed and the specific services required for each veteran are identified and accessed, with the support of the veteran peer support worker. This may include welfare, mental health, physical health or a combination of a range of needs. Initial mental health assessments are the responsibility of the Psychological Therapist (who is a qualified Cognitive Behavioural Therapist). They are also able to devote time to the delivery of evidence based psychological treatment. The clinical service lead is a HCPC Registered Psychologist and is also able to offer a small clinical service to those who present with complex mental health needs as well as offering leadership support to the team. (See Appendix 1 for the veteran pathway).
3.1.8	Historically within Ayrshire & Arran, veterans were able to access assessment, treatment and support for mental health issues from a range of services including general adult psychiatry, psychology and substance misuse services. Veterans also accessed inpatient treatment from *Combat Stress* - a nationally funded Veterans' charity. Welfare support was available from a range of resources such as SAFFA, Armed Services Advice Project (ASAP), Veterans UK and the local Veterans charity based in South Ayrshire – the Veterans First Point – South Ayrshire (not to be confused with V1P A&A and is now disbanded).

	Existing Services currently available for Veterans within Ayrshire Mainstream NHS services Many of the veterans who have self referred to V1P have already had contact with mainstream NHS services in Ayrshire but have not engaged. This seems to be due to : • Accessibility of mainstream services • Stigma often associated with mainstream services (such as mental health services) • Waiting times (despite prioritisation given to Veterans) • Credibility of the service – veterans being solely treated by civilians with no knowledge, understanding or experience of combat/military life. Often, the reluctance of veterans to access mainstream services leads to conditions going untreated. This in turn, can cause issues to become more chronic in nature, meaning that even if a veteran does present to mainstream services, it is often when in crisis or only after the condition has become more chronic in nature, taking longer and being more expensive to treat.
	Third Sector Organisations/Charities There are several third sector veteran support organisations operating within Ayrshire. Such organisations offer a range of specialities from providing emergency funding support for veteran families to support for veterans to access/apply for welfare. However, such organisations cannot cater for physical or mental health needs of the veterans, nor do they have strong links with the current mainstream NHS services. These organisations are wholly dependent on charitable donations and have therefore no long term security. As charities, these organisations do not employ any healthcare professionals or indeed carry the same level of clinical governance and accountability as that within the NHS. For full list of third sector organisations see Appendix 2 attached.
	Soldiers Off The Street Soldiers off the Street are a veteran's charity who have recently opened 2 houses in Dundonald, North Ayrshire. They offer temporary accommodation to veterans who find themselves homeless for up to 12 weeks. Soldiers off the street work very closely with Veterans First Point and take their main referrals for V1P A&A.
	SACRO SACRO are another veteran's charity who are based in Glasgow, but who cover Ayrshire the area. They have support workers who offer general support to veterans within the criminal justice system. Again SACRO work in close partnership with V1P A&A. Referrals to V1P A&A are received from SACRO on behalf of their clients who require ongoing support, support for welfare issues or mental health assessment.
	Combat Stress This organisation currently offers intensive mental health treatment from professionally trained staff, on an inpatient basis. V1P A&A work in close partnership with Combat Stress and often work with veterans to prepare them for the inpatient programme and then provide follow up after they have undergone the 6 week programme. However, there are many veterans who are unable to commit to a 6 week stay due to work/family commitments and therefore require to be treated within V1P on an outpatient basis.

	Poppy Scotland Welfare Centre – Kilmarnock The Poppy Scotland Welfare centre opened in Kings street Kilmarnock last year. Poppy Scotland acts as a host to a variety of veteran charity organisations such as SSAFFA, VETS UK, ASAP. This is an excellent provision for Veterans living within Ayrshire, although Poppy Scotland itself, does not provide veteran peer support, nor are they able to offer any clinical provision. Poppy Scotland have been very clear to state that their service has been developed to host and facilitate other Veteran services only. It is important to note that no other veteran organisation operating within Poppy Scotland welfare centre can offer the clinical expertise within the community along with the clinical governance which is offered from V1P as an NHS HSCP service. Due to this, V1P A&A receives regular referrals from Poppy Scotland on behalf of clients seeking mental health support.
	Defence Medical Welfare Service DMWS provide support for veterans across Ayrshire who are over the age of 65 and in hospital. Support workers within DMWS aim at providing practical support often required at point of discharge. Often this support can be welfare related such as helping with applications for practical aides. Again, referrals to V1P A&A are received from DMWS for clients seeking ongoing support, social opportunities with other veterans, welfare support or mental health support. For further information on DMWS, please see report submitted by DMWS.
3.2	**V1P Ayrshire & Arran: Who Have We Supported So Far?**
3.2.1	V1P Ayrshire & Arran became operational in March 2017. Since then we have supported over 480 veterans and their family members. 58%, the majority, have self-referred to V1P services. 70% of self-referring veterans are encouraged to do so by forces charities/regimental associations. 42% are aged 45 yrs to 59 yrs. 97% consider themselves White Scottish or White British. 90% are male and 91% have been in regular services. 80% were in the Army. 35% served for between six and 12 years, with 21% discharged on medical grounds. The most common deployments are Northern Ireland, Iraq and Afghanistan.
3.2.2	The social circumstances of veterans who access V1P Ayrshire & Arran indicate a large proportion live in areas which are defined as most deprived areas of multiple deprivation. Housing and homelessness is a significant issue with 41% having experienced homelessness and 27% considering their current living situation unstable.
3.2.3	In terms of relationships, 42% are married, in civil partnerships or co-habiting; the remaining 58% are single, divorced, separated or widowed. 79% have children. 44% live alone.
3.2.4	In terms of educational attainment and employability, 68% of veterans are educated to high school standard (10% did not complete school). Only 3% have attained degree level qualification (bachelor, masters or doctorate). 37% are in employment (full time and part time); while 34% are currently unemployed.
3.2.5	In terms of mental health and wellbeing, 91% of the veterans who access V1P Ayrshire & Arran report some degree of problem with anxiety or depression. 50% report severe or extreme problems, including those who report symptoms of post-traumatic stress disorder.

3.2.6	Physical health issues are also significant. Chronic pain is a reported difficulty for 44% of veterans accessing V1P Ayrshire & Arran. 79% report pain interfered with carrying out daily activities to some degree, with 33% of reporting pain extremely interfered with daily routines.
3.3	**How Do We Know We Are Making A Difference? - *V1P Scotland Evaluation***
3.3.1	Queen Margaret University were commissioned to conduct the evaluation of Veterans First Point Scotland. The V1P Centres began accepting referrals at different times and all have contributed to the evaluation. In reviewing activity to date, each Centre is building up substantial numbers of veterans who they are activity working with and the number of veteran contacts is steadily increasing as the Centres become established. The total number within the data set is **N=692**.
3.3.2	Three clinical measures used in the evaluation have all demonstrated improvements over time. In relation to depression, distress and functional impairment improvements are clinically significant and reliable. The V1P Scotland service is therefore a credible provider of psychological therapies to veterans. While these improvements are clear, it should be noted that Veterans presentations are complex. Initial assessment scores often meet the severe criteria for clinical assessments at engagement with services. However, the improvements veterans experience, while significant and reliable, continue to meet the criteria for moderate distress or depression. Veterans are therefore likely to need ongoing support and monitoring. Additionally, it is important to acknowledge that greater improvements are seen over time, increasing with duration of engagement with therapy. Mainstream services, in order to meet pressure of demand, often prescribe a time limited period of psychotherapy. Veterans seem to be one population group who appear to benefit from intervention of a longer duration.
3.4	**Next Steps**
3.4.1	Since V1P Ayrshire & Arran was developed in 2017, it has demonstrated the North Ayrshire IJB's commitment to the Armed Forces Covenant, ensuring that veterans – and particularly those with the most enduring health and welfare difficulties are able to access priority care and treatment from mainstream and specialist services.
3.4.2	Although a small service, V1P Ayrshire & Arran has delivered care and treatment to over 480 veterans and their family members living across Ayrshire and is the busiest of all the V1P centres across Scotland. The service has been independently evaluated and demonstrates clinically significant outcomes. The credibility, accessibility and coordination of care has resulted in high levels of service user satisfaction through a cost effective service structure.
3.4.3	Following the recent independent evaluation by Queen Margaret University, the V1P network of Centres are now focussed on a range of initiatives over the next 12 months to ensure V1P services are accessible across all tiers of service delivery, while maintaining a focus on those affected by the most severe, enduring and life changing difficulties. We aim to undertake Ayrshire wide service development in partnership with stakeholders across health, social care and third sector stakeholders.

4.	**ADDRESSING INEQUALITIES**
4.1	VIP Ayrshire & Arran is reaching those it needs to, demonstrated by high self-referral rates and the demographics of those using the service in the short time it has been open. This service is successfully providing a service to a large proportion of clients who are male and come from SIMD 1 and SIMD 2 areas, factors which have historically been shown to have a negative impact on client engagement with services.
4.2	There are increasing numbers of younger veterans who have completed two tours are coming forward. Armed Service changes will see an influx of new veterans to Scotland. (current number of Veterans living in Ayrshire make up 10% of the general population)
5.	**Measuring Impact**
	This is an internal paper and does not require to be impact assessed.
6.	**IMPLICATIONS**
	Policy Implications
6.1	The Scottish Government restated their commitment to recognising and valuing the Armed Forces community as a true asset and in 2016 renewed their commitments to support them and pledge to make Scotland the most attractive destination for the Armed Forces, Service leavers and their families.
6.2	This report highlights that Scotland has demonstrated great strengths in mental and physical healthcare provision, and states that this will continue to be a fundamental priority to support particularly in terms of improving awareness of long-term clinical needs and transfer of data.
6.3	The published Force in Mind report - Ca*ll to Mind: Scotland / Findings from the review of veterans' and their families' mental and related health needs in Scotland*. (2016) states that Scotland has one of the most robust mental health and related health provision for veterans in the UK, with a thriving specialist statutory and voluntary sector that has been supported and resourced by the Scottish Government.
6.4	Scotland's Veterans Commissioner recently published report (attached as Appendix 2) – *Veterans' Health and Wellbeing: A Distinctive Scottish Approach,* (April 2018) set out his ambition for veteran services in Scotland – "To see mainstream and specialist provision for veterans protected and enhanced, especially for those with the most severe and life-changing conditions; and to ensure veterans' healthcare is a properly planned and embedded feature of the new health and social care landscape in Scotland" (page 4).
6.5	In relation to V1P services, he added - "Veterans in Scotland have been able to access a number of key specialist services... including Veterans First Point teams. I have seen for myself during visits to these establishments, and heard first-hand just how vital and valued they are" (page 13). In terms of sustainability he suggests - "The recent experience of sustaining V1P has demonstrated that funding from time-limited, non-core sources can lead to uncertainty and insecurity, which will undoubtedly worry those who rely on such support" (page 15).

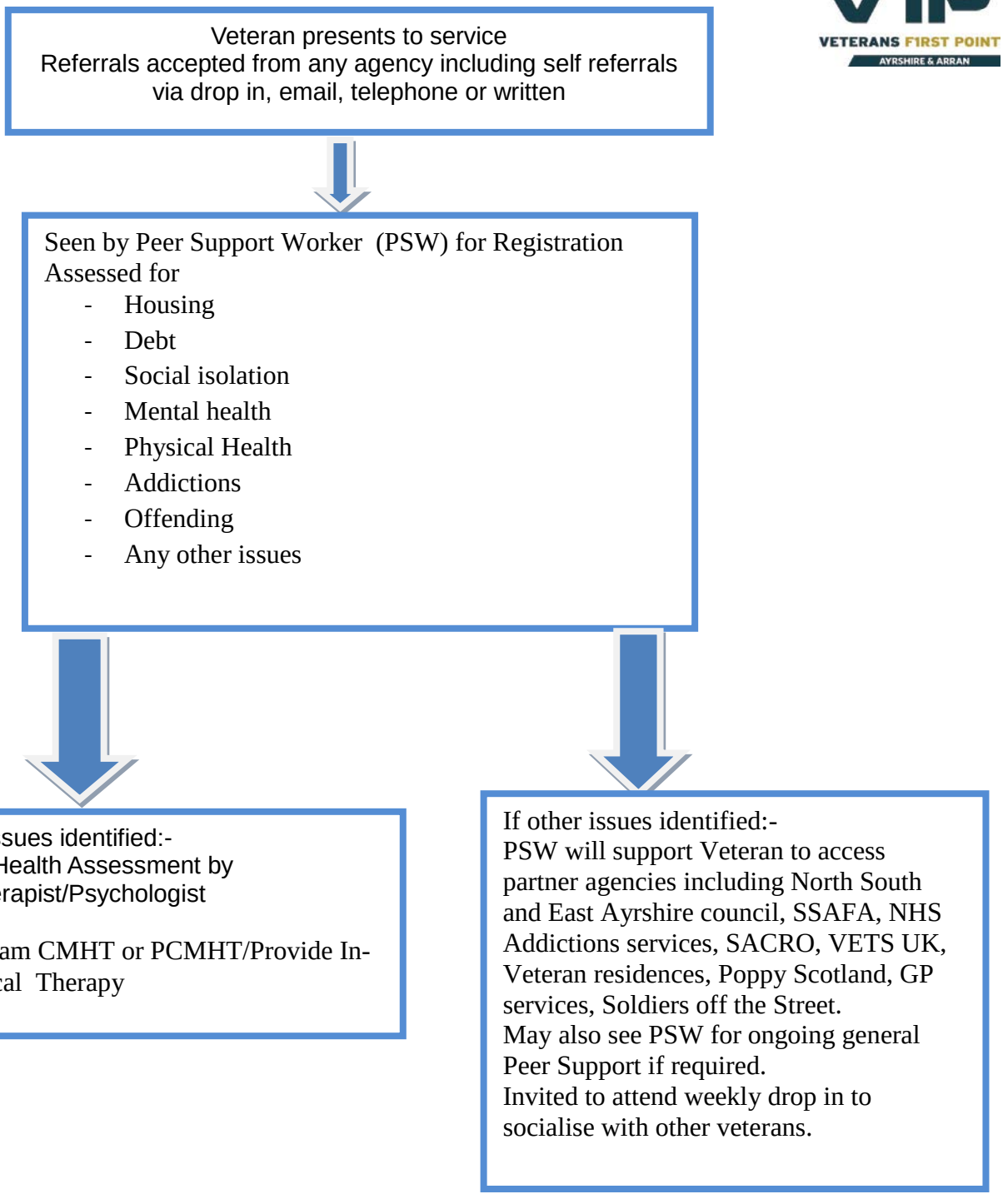
Financial :	The financial implications are outlined in the paper.
Human Resources :	Currently there is 1 members of the V1P team that is seconded from another service. (0.6 WTE Administrator) The other members of the V1P team (0.9 Clinical Lead, 1.0 Psychological Therapist, 1.0 Peer Support Worker and 2x 0.5 Peer Support Workers) are all on fixed term contracts until 31st of March 2020.
Legal :	No Legal issues
Equality :	This report has been screened for any policy implications in respect of Equality Impact Assessment. There are no major issues
Environmental & Sustainability :	N/A
Key Priorities :	V1P is set out as a key item within the Local Delivery plan.
Risk Implications :	An assessment has not been undertaken at this stage as there are no imminent risks to the delivery of the service
Community Benefits :	N/A

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

7.	**CONSULTATION**
7.1	Paper was prepared in consultation with Head of Adult Mental Health, Thelma Bowers.

For more information please contact Lindsay Kirkwood, Clinical Lead V1P on 01294 310 400 or Lindsay.kirkwood2@aapct.scot.nhs.uk

Appendix 1


Veteran presents to service
Referrals accepted from any agency including self referrals via drop in, email, telephone or written
Seen by Peer Support Worker (PSW) for Registration
Assessed for
- Housing
- Debt
- Social isolation
- Mental health
- Physical Health
- Addictions
- Offending
- Any other issues
If Mental Health Issues identified:-
Carry out Mental Health Assessment by Psychological Therapist/Psychologist
and/or
Refer to Main stream CMHT or PCMHT/Provide In-house Psychological Therapy
If other issues identified:-
PSW will support Veteran to access partner agencies including North South and East Ayrshire council, SSAFA, NHS Addictions services, SACRO, VETS UK, Veteran residences, Poppy Scotland, GP services, Soldiers off the Street.
May also see PSW for ongoing general Peer Support if required.
Invited to attend weekly drop in to socialise with other veterans.

Appendix 2

Below is a list of veteran organisations within the West of Scotland. It is of note that there are only 7 organisations with offices within Ayrshire (highlighted in grey below)

Organisation	Type of Support	Mental Health Support	Nearest Offices
Houses for heroes	Housing	X	Glasgow
Scottish veterans residences	Housing	X	Glasgow
Haig housing trust	Housing	X	Surrey
Royal Air Force Association	Housing	X	Edinburgh
Housing Options Scotland – Military Matters	Housing	X	Edinburgh
Blind Veterans Uk	Welfare, Funding	X	London
Thistle Foundation	Support	X	Renfrew
Scottish War Blinded	Welfare, Funding	X	Livingston
Defence Medical Welfare Services	Support over 65	X	Ayrshire
Veterans Scotland	Funding	X	Edinburgh
Blesma	Prosthetics	X	Essex
Canine Partners	Assistance dogs	X	Stirling
SAMH	General support for Mental health	✓	South Ayrshire & Irvine (V1P)
Combat Stress	Inpatient Mental Health	✓	Hollybush & Kilmarnock
Erskine	Medical care	✓	Erskine
Lady Haig's Poppy Factory	employment	X	Edinburgh
Poppy Scotland	SignPosting	X	Kilmarnock
Remploy	Employment	X	Glasgow
ASAP	Welfare	X	Kilmarnovck & Irvine (V1P)
SSAFA	Funding	X	Kilmarnock & Irvine (V1P)
Civvy Street	Employment	X	Online
Royal Naval Benevolent Trust	Funding	X	Portsmouth
Sea Farers	Funding	X	Linlithgow
ABF – The Soldiers charity	Funding	X	Edinburgh
RAF Benevolent Fund	Funding	X	London
Royal Air Force Association	Funding & support	X	Edinburgh
Officers Association	Funding & Employment	X	London
National War Pensions	Pensions	X	England

Regular Forces Employment Association	Employment	X	Kilmarnock & Irvine (V1P)
Skillforce	Employment	X	England
Royal Caledonian Education Trust	Veterans Child Support	X	London
Royal Navy & Royal Marines Charity	Welfare, Funding	X	England
Royal Naval Association	Welfare, Funding	X	England
Glasgow's Helping Heroes	welfare	X	Glasgow
Royal British Legion	Funding general support	X	Irvine
Veterans UK	Military & War Pensions	X	Glasgow

SVC SCOTTISH VETERANS COMMISSIONER

Veterans' Health & Wellbeing

A Distinctive Scottish Approach

APRIL 2018

Contents

Foreword		3
Introduction		5
Chapter 1	A Distinctive Scottish Approach to Veterans' Health	7
Chapter 2	Making It Happen	12
Chapter 3	Mental Health	20
Chapter 4	Physical Health	31
Chapter 5	Improving Outcomes for All	42
Chapter 6	Conclusions	53
Annex 1	Recommendations and Findings	56
Annex 2	Case Studies	62

Foreword




Foreword

Last year I published a paper entitled *Veterans' Health & Wellbeing in Scotland – Are We Getting it Right?* This set the scene on veterans' health matters and offered my first impressions on the main issues that strike to the heart of whether Scotland is providing the best possible treatment and care for its ex-Service community.

Since then my team and I have looked in significant detail at the topics raised in that initial report and others, setting ourselves the task of finding answers to the four fundamental questions we posed at the very start of this study, namely:

- are health outcomes of our veterans population as good as they can be?
- do veterans face any disadvantages when accessing health and social care provision?
- does our health system properly fulfil our obligation to veterans with the most severe and enduring illnesses and injuries acquired as a result of their military service?
- are the needs of our veterans population properly understood and considered by those who work in health and social care?

Our assessment of where things currently stand and what the future might hold can be found throughout this report, alongside findings and recommendations aimed at the Scottish Government, NHS Scotland and their partners. My ambition is two-fold: firstly, to see the mainstream and specialist provision for veterans protected and enhanced, especially for those with the most severe and life-changing conditions; and, secondly, to ensure veterans' healthcare is a properly planned and embedded feature of the new health and social care landscape in Scotland.

When embarking on this project I quickly recognised that there is much we can be proud of in terms of the support provided to our veterans by statutory services and the many charities working in this field. However, I was also aware of concerns within the community – reinforced by several health professionals and officials – that veterans' health and wellbeing is no longer attracting the same levels of attention, innovation or ambition as had been seen previously. There appears to be less enthusiasm for new ideas, some hesitation in seizing fully those opportunities offered by recent transformations in healthcare, and a degree of stagnation within a sector which has typically enjoyed a well-earned reputation for the quality and accessibility of the care provided.

My hope in writing this report is to re-focus and re-energise Scotland's approach to looking after its ex-Service men and women and to faithfully represent the views of as many of them as possible. Most importantly, I want to offer both an ambitious and realistic vision of health and social care for Scotland's veterans. This should be one that the entire nation can support, champion and ultimately be proud of.

Eric Fraser CBE
Scottish Veterans Commissioner

Introduction

In my initial paper, the main focus was on the mercifully small group of ex-Service men and women with severe and enduring health conditions acquired as a result of military service. Some had been wounded in action while others either suffered serious injuries or had been affected by life changing illness while serving their country. In every case these are the people who have sacrificed the most and will live with permanent conditions for the rest of their lives.

This paper set out the compelling moral case for these men and women to receive the very best medical treatment and social care that Scotland has to offer. Anything less, I suggested, would be a betrayal of the promises made in the Armed Forces Covenant and by the Scottish Government in its *Renewing Our Commitments* strategy.

It has been reassuring that in every conversation and interaction since publishing that paper, there has not been a single person who has disagreed with or questioned that argument. Put simply, this group of veterans has earned the right to be considered a strategic priority for politicians and all who provide support within our health and social care sector. Ultimately, this is the central and recurring theme throughout most of this report.

In highlighting this cohort, however, it is also important that we don't overlook the wider veterans community and their health needs. Theirs will not necessarily fall into the most serious category of severe and enduring injuries or conditions but they still deserve as good treatment as possible with an appreciation that their condition might be attributed, in some way, to their military service. This group will be typically treated by mainstream services within the NHS but, even here, their unique background and common experiences need to be recognised if the best outcomes are to be achieved.

Structure of Report

My original intention when scoping this subject had been to produce separate papers that focussed, in turn, on veterans suffering from severe and enduring conditions, followed by a later one on the broader health needs of our wider ex-Service community. Since then my team and I have come to realise that so many of the issues across these groups are intertwined and have, therefore, decided that there is greater merit in publishing a single report that covers the full range.

Chapters 1 and 2 cover subjects that are relevant to the health of all veterans but with a particular emphasis on those who suffer from the most severe and enduring injuries and conditions. The first culminates in a proposal for a distinctive approach to veterans' health in Scotland, and the second considers the main challenges as to how that approach might be delivered.

Chapters 3 and 4 concentrate, in turn, on the mental and physical health of this same group who will need dedicated mainstream and specialist support over many years.

Chapter 5 is more wide-ranging and considers the general health of the veterans community and where there might be opportunities to improve health and wellbeing outcomes for all.

Chapter 6 comprises my conclusions having spent many months investigating the issues. I hope this provides a useful summary of a complex and challenging agenda.

The full list of my recommendations can be found at **Annex 1**. As in previous reports, extracts and quotes from case studies are included throughout. These offer a fascinating insight into the subject matter and I am extremely grateful to the contributors for providing such candid and meaningful material. **Annex 2** contains these case studies in full.

‘Severe and Enduring’ Explained

The term ‘severe and enduring’ is a phrase used throughout this report to describe the most serious and life-changing injuries and conditions faced by veterans. For some in the military community this equates to those who are ‘wounded, injured or sick’ (WIS), but for the wider population the term severe and enduring provides a more recognisable description. It may, though, leave the reader begging the question exactly which injuries and conditions fall into this category and which do not. This is never going to be an easy question to answer.

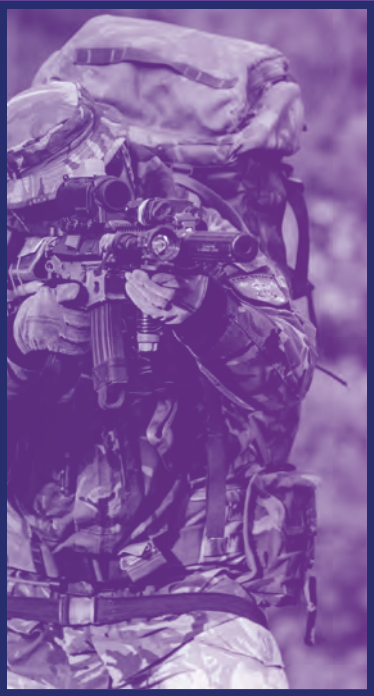
I want to be clear that it is not my place to define, prescribe or list what constitutes this type of injury or illness. It would also be wrong for me to direct the medical profession when trying to determine how contingent such conditions might be on previous military service. These are decisions that must be left to experts.

I do, though, recognise that making such decisions can sometimes be far from straightforward – a view that has been crystallised during discussions with a range of medical and allied health professionals. There will always be grey areas where the severity of the illness or injury, and its unequivocal link to military service, divide opinion or are difficult to establish.

It is, therefore, imperative that those professionals who are being asked to make such decisions have as good an understanding of veterans’ health issues as possible and are provided with advice and support where necessary. Ultimately, verdicts about whether a veteran who presents with particular injuries or illness falls into the category of severe and enduring – and therefore has access to ‘special’ care over and above that typically provided by mainstream services – will never be an exact science. I would, however, urge those involved to err on the side of the veteran in borderline cases. These individuals have already served their country and now struggle with conditions that may be wholly, or partly, the result of this service.

Chapter 1

A Distinctive Scottish Approach to Veterans' Health

A Distinctive Scottish Approach to Veterans' Health

Chapter 1

This chapter covers a range of issues that relate to the delivery of health and social care to veterans and considers how the current system might be strengthened or adapted to improve outcomes for all in this community. It includes discussion about the commitments made in the Armed Forces Covenant (the 'Covenant') and the Scottish Government's *Renewing Our Commitments* strategy, priority treatment, funding arrangements and the structure of current services.

The fact is that the provision of healthcare for veterans in Scotland has always contrasted with other parts of the UK, just as for the wider population. Different structures, funding arrangements, governance and, in some cases, delivery models have led to a national health service which varies from those found in England, Northern Ireland and Wales. For veterans this also extends to the specialist care that is provided for those with serious and life-changing injuries or illnesses that have resulted from their military service. These bespoke services, some of which were set up in response to a series of reports by Dr Andrew Murrison MP, provide a level of support which goes beyond that typically offered by NHS Scotland (NHS(S)) and local Councils. They are also recognised by Lord Ashcroft in his various reports about veterans and fulfil a significant part of the promises laid out in the Covenant and in *Renewing Our Commitments*.

The combination of mainstream and specialist services has established a robust package of support that meets the needs of most veterans. This has been particularly so for the thankfully small number of those whose military careers have left them with the most severe and debilitating conditions. The impressive work at the start of this decade in establishing 'specialist' physical and mental health services in Scotland has had a significant impact over subsequent years and has rightly attracted considerable attention and praise. We still see the benefits of this today.

However, despite there still being a significant number of men and women in our communities who struggle with Service-related injuries and conditions, it is obvious that the levels of ambition and innovation which characterised this work have waned in recent years. This may be understandable given the pressures on the health system, but it is also disappointing that the health of veterans no longer attracts the same level of attention it once did. Discussions with senior decision-makers indicate a strong desire to check this trend, rekindle the spark that set up the current structures and invest in future long-term planning. This is encouraging.

Having examined the provision of healthcare over many months, it has become apparent to me that there is merit in now adopting a distinct strategic approach that ensures veterans' health sits squarely at the heart of current and future models of service provision in Scotland. Furthermore, this approach should aim to present a realistic and practical means of embedding the specific needs of veterans within mainstream services, ensuring current specialist care is protected and improving planning for long-term support.

Of course, veterans' issues do not sit in isolation within Scotland's healthcare system. The fast-paced, transformational nature of this landscape can be expected to have a significant impact in the years ahead and it will be crucial that veterans are part of, and benefit from, recent Scottish Government and NHS(S) policies in this field. Of these, I recognise the importance of the integration of health and social care services, an increasing role for allied health professionals within Primary Care settings, the Chief Medical Officer's proposals for *Realistic Medicine* and national strategies covering healthcare quality and mental health. Each has had considerable influence on this report and informed many of my recommendations.

In order to maximise the opportunities presented by these initiatives the following sections set out my thinking on what a new approach should seek to achieve and go on to discuss some of the key factors relevant to making it a reality.

Rethinking Priority Treatment

Before exploring some of the ideas behind this approach, I believe it important to address the prominent subject of 'priority treatment' for veterans from the outset. This was first introduced in the 1950s, is currently a significant feature of the Covenant and continues to be the most controversial and contested issue in terms of providing healthcare for this community. Its central premise is that veterans should receive early treatment for health problems that have resulted from military service, unless there is an emergency or another case that demands clinical priority. This is laudable, but as stated in my previous paper, the concept is flawed, often misunderstood and occasionally ignored by a number of health professionals and veterans – whether unwittingly or, in some cases, quite deliberately.

These views have been emboldened in recent months by feedback received from many individuals and organisations. This has reinforced the fundamental point that care within the NHS is based on **clinical need** and not on the background, occupation or category of a patient. As a consequence, the promise of priority treatment for veterans is a largely meaningless concept that rarely has any direct impact on individuals. Like many, I also have a growing conviction that an emphasis on waiting time lists, while never irrelevant, is no longer as important as it used to be. Instead, I sense an increasing demand – certainly in NHS(S) – for greater focus on the principles of excellence, accessibility and sustainable treatment for all veterans.

Frankly, the current confusion about what priority treatment means and its impact serves nobody well, especially if it results in unrealistic expectations which cannot be matched. It is clear to me that the time is right for a fresh and bolder vision, which will be especially important for those with the most severe and enduring injuries and conditions.

But in suggesting any alternative, I recognise there is a great deal of political and public support for these veterans receiving 'special' treatment and I am determined there must be no hint of any reduction in the level of support that has been hard-won over many years. Notwithstanding, there is a definite need for greater clarity about what veterans can expect from the health and social care system.

Addressing this aspect of treatment and care is, however, only the start. I am convinced that those in charge of healthcare in Scotland should go even further by taking a refreshed approach to all aspects of veterans' health. Recent transformational changes in the sector – more on which later – and a growing appetite for adapting to changing needs, offer a unique opportunity to develop a more innovative, focused and relevant approach to veterans' healthcare. Within this, priority treatment will be just one aspect.

Principles of a Scottish Approach to Veterans' Health

It is with this in mind – together with the need to refocus efforts within the Scottish Government, NHS(S), Health Boards and local Councils – that I am proposing a distinct Scottish Approach to Veterans' Health. This needs to provide the impetus and framework that protects and enhances Scotland's reputation for supporting its veterans while ensuring we place particular emphasis on those coping with the most severe and enduring conditions. It should also seek to promote the wider ex-Service community as a unique cohort whose health and wellbeing can benefit from the changes currently being seen across the health and social care sector in Scotland.

In particular, the unambiguous focus and priority placed on the small group of veterans with the most serious and life-changing conditions will send the strongest possible message of compassion and appreciation from Scotland's citizens. These are, after all, the people who have made the greatest sacrifices, suffered the most challenging consequences and are, therefore, in need of specialist and sustained support. Even more important than the message it sends, the prioritisation and long-term commitment to this group will provide the clarity and reassurance that their medical and social care needs will be met properly, now and in the future.

As a first step to establishing this fresh approach, it will be important that the Scottish Government, NHS(S) and their partners can agree a set of principles to provide strategic direction and guidance for those individuals and organisations responsible for planning and delivering day-to-day support. Many ideas have emerged during the past few months since the publication of my initial paper. The following set of proposed principles reflect the key priorities of the many health professionals, veterans, charities and officials that I have engaged with over that time.

Guiding Principles

Generally…

> Veterans, like the rest of the Scottish population, have the right to the highest possible standards of health and live longer, healthier lives.

> Veterans never suffer disadvantage and instead benefit from efforts to reduce health inequalities caused or exacerbated by military service.

> Veterans' specific characteristics and needs are recognised and well understood, shaping the design and delivery of their health and social care.

Exceptionally…

> Individuals with severe and enduring conditions caused by military service are the most important and deserving group within the veterans community and are the focus of efforts and resources.

> The treatment and care for these veterans is based on the best possible mainstream and specialist services, both in the statutory and third sectors, that is available no matter their circumstances or where they live.

> These veterans can be confident that this support – across the health and social care sector – is available whenever required and for the rest of their lives.

These principles are not intended to be either prescriptive or exhaustive. The Scottish Government and NHS(S) may wish to adapt or add to them now and in the future but I believe that in their current form, they offer a coherent and ambitious framework that will help raise the profile of veterans while ensuring they get the support they need and deserve. They also offer the chance for those in positions of leadership to make a public commitment to support our ex-Service community and satisfy their health needs over the long term.

Recommendation 1 – A Distinctive Scottish Approach to Veterans' Health

The Scottish Government and NHS(S) should commit to establishing a distinctive Scottish Approach to Veterans' Health at a strategic level, accept or adapt the guiding principles of this approach and work with their partners to embed it at an operational level.

Chapter 2

‘Making It Happen’

Over the course of the many visits and discussions undertaken in preparing this report, I was struck by the evident dedication and determination of professionals and others to ensure veterans in Scotland are given the best possible treatment, care and support. It was equally impressive that so many in the sector, from those in positions of leadership and practitioners through to volunteers, expressed a desire to do even more to improve health outcomes. In these times of stretched public finances and constantly competing demands, this commitment is not one to be underestimated.

Allied to this powerful sense of goodwill and resolve is a strong track record of providing impressive specialist and mainstream health services to veterans. This is something which is important to acknowledge. That said, we cannot afford to allow complacency to compromise that record nor see veterans’ health take lower priority. To do so would put Scotland’s hard earned and deserved reputation for supporting and valuing its veterans community at a degree of risk. Now is, therefore, an opportune time to protect the best practice that already exists, build on it with improvements wherever possible – in terms of practice, policy and governance – and prepare for the future. It is intended that the distinctive Scottish Approach to Veterans’ Health should provide the strategic framework to drive that ambitious agenda.

The next sections set out the key issues that need to be addressed if this approach is to transition from a worthy set of high-level principles into day-to-day practical measures that will impact positively on the lives of our veterans now and for years to come.

Protecting Specialist Services

Over the past decade or so, veterans in Scotland have been able to access a number of key specialist services that include dedicated prosthetics clinics, a network of Veterans First Point (V1P) teams and Combat Stress’ Hollybush House. I have seen for myself during visits to these establishments, and heard first-hand just how vital and valued they are.

This specialist provision is an important and well-established feature of how healthcare is delivered for veterans in Scotland today, especially those with severe and enduring conditions. It complements mainstream services very well, provides additional support and is seen as a model of care that deserves to be protected for current and future generations. As part of the Scottish Approach to Veterans’ Health I believe the Scottish Government and NHS(S) should reaffirm their commitment to protecting this level of specialism.

That said, a responsible and responsive health system must adapt to changing needs and demands over time; just because a service has been provided or structured in a particular way does not mean it should always continue in the same form. In the case of the specialist services mentioned above, I anticipate these having to evolve and this should not be seen as a backward step or reduction in the levels of support. Indeed, in the case of Hollybush House, Combat Stress has recently proposed adjusting its delivery model from an exclusively residential course to one that includes community based modules that fit around a veteran’s work and family life. This reflects changes across the wider health sector and it will be important to monitor its impact given the organisation’s prominent role in supporting veterans with severe mental health issues.

In other words, we should never lose sight of making sure our veterans are cared for and supported in the best possible way – whatever that ‘way’ may be. The ultimate aim should be to ensure Scotland is a place where treatment – both in the mainstream and specialist sectors – is dynamic and responsive to the needs of the ex-Service community.

Finding 1:

Specialist physical and mental health services are a vital and valued part of supporting our veterans with the most severe and enduring injuries and conditions. While their exact make-up and models of delivery will inevitably change and adapt over time, it is imperative that the availability of specialist services – and the outcomes they support – are protected for current and future generations.

Improving Collaboration and Partnership

While the proposed Scottish Approach to Veterans' Health will see distinct planning, resourcing and delivery in Scotland, there remains much to be gained from engaging regularly with health and defence colleagues from other parts of the United Kingdom and beyond. By doing so there will be an opportunity to share our expertise and experience of supporting veterans while also improving our awareness of good practice, and increasing involvement in new health initiatives elsewhere.

Over the past few months, my team and I have had a number of informative meetings with colleagues in the MOD and NHS England, including the Director of Veterans Commissioning. These have alerted us to several projects that encompass new mental health services, a complex trauma service, and the Veterans Covenant Hospital Alliance scheme that accredits 'Veteran Aware' hospitals across the UK. The 'Step into Health' initiative is also interesting given its potential for seeing more veterans employed within the NHS.

I am aware there used to be active networks and dialogue linking health officials from across the United Kingdom but some of that has been lost in recent times. This is relatively easy to correct and should be done with some urgency. It has also been apparent that the Military Medical Liaison Officer (MMLO) to the Scottish Government has fewer opportunities to engage and influence the Government on its relationship with the MOD. This is largely because the role is now part-time and an additional responsibility for an already busy NHS(S) senior consultant and Reservist. As a result we are missing opportunities to benefit our veterans community and the health system in Scotland.

I would particularly advocate regular participation in the MOD's high-level Partnership Board, chaired by the Surgeon General and DG Health, and attendance at the relevant Clinical Reference Groups run by NHS England which tackle practical issues affecting Service personnel, veterans and their families.

Recommendation 2 – Improving Collaboration and Partnership

The Scottish Government should reinvigorate senior participation in cross-border networks with a view to improved information sharing and increased involvement in collaborative working and initiatives.

Finally in this section, it is important to highlight the key role that charities play in supporting veterans’ health. The expertise and variety of treatments and projects that they offer complement and, in many instances, enhance those provided by the statutory sector. The partnership between these sectors is a vital feature of veterans’ healthcare and must be nurtured and protected over the long-term.

Securing Funding

In my initial paper I state that, “*I do not anticipate that protecting the best of the current specialist services requires a large investment of new resource. I do, though, think it is crucial to ensure that this provision is protected in the medium to long-term and that the evolving needs of this group of veterans [with severe and enduring injuries and conditions] is part of a strategic plan*”. Key to this will be a review of the way parts of these specialist services are funded.

I have been careful to recognise the good levels of specialist health provision for veterans throughout this report. There is, though, a remaining concern about the consistency and longer-term sustainability in some instances.

Current funding arrangements, in part, lack cohesion and can appear *ad hoc*. For example, the prosthetics clinics are commissioned, performance managed and, crucially, funded by a specialist part of NHS(S) called the National Services Division (NSD). The NSD receives top-sliced, ring-fenced funding directly from the Scottish Government, which means that the services it funds enjoy a degree of security and certainty that doesn’t necessarily apply elsewhere.

The V1P services, on the other hand, were established and have been sustained using a combination of Scottish Government and Armed Forces Covenant (LIBOR) Fund money. The former directly funded the first V1P service in the Lothians in 2009 and thanks to on-going LIBOR money it was later expanded to eight locations across Scotland. However, last year when the Fund closed, V1P had to resort to a combination of funding directly from Government, individual NHS Boards and other partners. Matched funds from the Scottish Government will allow most of those services to continue to 2020, at which point Boards and partners will become fully liable. This process has caused an element of turmoil and posed serious questions about the long-term future of services in certain areas.

However, I do not believe that specialist services need to be delivered in exactly the same way forever without close review. For example, NHS Grampian and NHS Highland have decided to discontinue the V1P service in its current form and made alternative arrangements for providing mental health treatment and support to their veterans communities. I am aware that NHS Highland was awarded an additional LIBOR grant in 2017 to continue mental health support in partnership with Poppyscotland. Notwithstanding that welcome development, the recent experience of sustaining V1P has demonstrated that funding from time-limited, non-core sources can lead to uncertainty and insecurity, which will undoubtedly worry those who rely on such support.

Finding 2:

Funding for specialist mental and physical health services for veterans is disjointed and in some cases ad hoc. This results in a degree of uncertainty and raised questions about the sustainability of some of these services, which is a worry for those who rely on and value them. It is an issue that needs addressed as a priority.

Integrating health and social care

I have made much of a widely held desire to see the health and social care needs of veterans properly planned and co-ordinated over the longer-term. This is central to providing holistic and co-ordinated support as they age and their needs change, especially for those with severe and enduring conditions. In Scotland we are fortunate to already have an advanced and progressive approach to the integration of these services across the entire population; one which ought to lend itself to fulfilling this ambition for the ex-Service community.

Health and Social Care Partnerships (HSCP) were launched in 2016, bringing together local health and social care services. Partnerships are overseen by 31 Integrated Joint Boards (IJBs), also known as Integration Authorities, who are responsible – and carry the budget – for planning, innovating and working with professionals, communities and the third sector to deliver a range of services locally.

The creation of these partnerships and IJBs marks a fundamental shift in the way in which health and social care is delivered. It also changes the levers of control and accountability. As the budgets and responsibility for delivery are delegated to an increasingly more localised level then so must the focus of those interested in veterans’ health. The idea of a centralised system of command and control is now outdated and will have little impact in this new environment.

The HSCPs provide the vehicle for ensuring that long-term planning of veterans’ health and social care services is embedded in mainstream structures and budgets. Although they are still in their infancy and will no doubt evolve as they become a more established part of the system, it is still striking that only one IJB mentions veterans within their current strategic plans. I would anticipate this changing over time.

Their existence also offers an opportunity to plan and co-ordinate services across a wider range of areas, extending beyond the fields of health and social care. For example, I heard from Glasgow’s Chief Officer about how his HSCP also has responsibility for children and families, homelessness and criminal justice services. All of which can be relevant to the veterans community.

Finding 3:

The integration of health and social care services in Scotland provides a unique opportunity to ensure the longer-term needs of veterans are properly planned and met. The new structure of IJBs and HSCPs is the vehicle for delivering this ambition. They must play a central role in decision-making about veterans’ health and wellbeing and the delivery of both mainstream and specialist services.

Leadership, Planning & Governance

Strong and visible leadership will be critical in delivering the high standards envisaged throughout this report. It will also be required to make the most of the opportunities offered by a changing landscape and to maximise the evident desire to do the best by our veterans. Most will naturally look to the Scottish Government and NHS(S) but in order for veterans services to be consistently at their best over the long-term, leadership and ambition will be required from many others at different levels.

The obvious means for bringing together senior decision-makers and providing national leadership is via the Armed Forces and Veterans Health Joint Group. It was formed back in 2009 and includes representatives from, amongst others, NHS(S), Scottish Government, Armed Forces, veterans' organisations, charities and academia. It is chaired by Director-General Health and Social Care/Chief Executive NHS(S) and sits annually.

In the past this group has been responsible for overseeing the delivery of innovative support, that has included several successful pieces of work. For example, in 2012 a Sub-Working Group implemented recommendations from Dr Andrew Murrison's report *A Better Deal for Military Amputees in Scotland*, which led directly to the formation of the national prosthetics clinics. This was an impressive achievement but my strong sense is that the group has now become unwieldy in number, lost much of its original purpose and has, as a result, been far less impactful than it was in its earlier days.

In recent times, much of that loss of purpose can be attributed to the changing landscape across health and social care, which means that the group no longer sufficiently reflects current models of delivery. A new structure of oversight and governance of veterans' health that accords with the current system of greater local responsibility and accountability is, therefore, overdue.

That said, there is still a need for a national group that can provide high-level leadership across the health, social care and veterans sectors. The Joint Group should still fulfil that role but will undoubtedly require a refresh – both of membership and remit. It would need to 'own' the Scottish Approach to Veterans' Health at a national level and in doing so provide strategic direction and ideas to those tackling the issues set out in this report on a day-to-day basis. Its membership also needs to reflect the new environment of integrated environment and draw on a smaller senior cohort who can drive the veterans health and wellbeing agenda. It would also benefit from meeting more regularly.

Recommendation 3 – Leadership and Governance

The Armed Forces and Veterans Health Joint Group should refresh its membership and remit in order to provide the vital strategic leadership that will deliver the Scottish Approach to Veterans' Health

Alongside this, there is a need to introduce a mechanism at an operational level to develop further national thinking, tackle the issues highlighted in this report, and oversee the delivery of veterans' health. This is a challenging remit that demands a dynamic, innovative and effective body, under strong leadership that can influence and instigate change within a complex structure.

With this in mind, I heard recently from the CEO of the Mental Welfare Commission about a structure which provides an interesting example of how veterans' health issues could be considered. Its work on perinatal mental health of mothers and infants culminated in the establishment of a National Managed Clinical Network (NMCN).

There are a number of different National Managed Clinical Networks (NMCNs) in operation in Scotland. They are funded by the NHS(S) National Services Division and bring together those involved in providing specialist care for particular groups of patients with the most complex healthcare needs – health and other professionals, patients, carers, families and voluntary groups. Each network designs pathways of care that ensure patients and their families have equal access to the highest standards, regardless of where they live in Scotland. Networks focus on issues such as service planning and delivery, education, collating data to measure and improve quality of care, and engaging key stakeholders.

A new NMCN, or similar group, focussed on veterans' health would have responsibility for considering the issues highlighted in this report and others it regards as relevant. It would need to draw on a wide range of stakeholders with an interest in the health and wellbeing of veterans; including representatives from statutory services, charities, academia, carers organisations and, of course, veterans themselves. I would also anticipate the network drawing on the experience and knowledge of individuals like the MMLO and organisations like the Health and Social Care Alliance. The network's key responsibilities would be:

Network on Veterans' Health

> Advise, influence and monitor the planning and delivery of mainstream and specialist services for veterans based on the principles of the Scottish Approach to Veterans' Health.

> Lead on improving awareness, knowledge and understanding of veterans' needs and characteristics.

> Produce a Mental Health Action Plan and influence its delivery at a national and local level. (See Chapter 3)

> Identify and address health inequalities for veterans, using those set out in this report as a starting point. (See Chapter 5)

While issues of planning and governance may not seem particularly exciting, or directly relevant to the day-to-day lives of veterans, they are in fact crucial to ensuring that the Scottish Approach to Veterans’ Health underpins the delivery of services and support. Those in positions of leadership have an opportunity – perhaps even a duty – to ‘make it happen’ and play their part in improving the health and wellbeing of our veterans community.

Recommendation 4 – National Managed Clinical Network

The Scottish Government and NHS(S) should establish a network on veterans’ health. The network will have oversight of delivering the Scottish Approach to Veterans’ Health, and will consider the key issues raised in this report and others it deems relevant. It should reflect current structures in the health and social care sector in its membership and approach.

Chapter 3

Mental Health

Scotland's role in treating those suffering from the mental effects of combat dates back to WWI when Craiglockhart War Hospital cared for 'shell-shocked' men struggling with their experiences on the Western Front. Many, including famous war poets Wilfred Owen and Siegfried Sassoon, were given radical and sometimes controversial new treatments to address the devastating effects of extreme trauma and constant bombardment. The display at Edinburgh Napier University provides a fascinating record of this work and Scotland's contribution in an important field.

Over the following decades the military recognised high risk groups within their ranks and worked hard to return affected individuals to duty whenever possible. However, amongst the general public there largely remained a reluctance to discuss mental health issues and as a consequence there were veterans who never sought or received the treatment and care they needed. It was only during recent conflicts in Iraq and Afghanistan that the impact of combat on the mental health of those who served was fully recognised. Thankfully, we now see far more extensive and effective support, less associated stigma and a growing acceptance that these wounds of war are no less debilitating than the physical ones.

It is, therefore, only right that in this report I acknowledge the significantly improved support for those suffering mental ill health after time spent in the Armed Forces. In recent years, veterans have been able to access a number of specialist – as well as mainstream – projects and services introduced to address their specific needs. Scotland has been in the vanguard in many instances. That said, many of the experts in this field that I have spoken to say there is still work to be done. This has been one of the main factors that motivated me to produce this report.

This chapter details some of the vital work being done in this area by both the statutory and charitable sectors, and then focuses on the future needs of veterans with serious mental health issues. It covers some of the key topics relevant to ensuring that Scotland maintains – and enhances – its well-earned reputation for innovative and compassionate care of its Service men and women, stretching all the way back to Craiglockhart Hospital in 1916.

Background

As I highlighted in a previous report, the vast majority of those leaving the military do so without severe mental health problems and cope well with the transition to civilian life. When problems occur they are most likely to be the same ones that can affect anyone in the wider population, such as depression, general anxiety or stress related disorders. The majority will be treated by local mainstream NHS services – typically through their GP – and it has been reassuring to hear consistently positive stories about the support received and the good outcomes achieved. There are, though, a number of individuals with serious, life-changing and distressing mental health problems after a career in the Armed Forces. It is only right they are the focus of medical efforts and are given the best treatment and support available; but it is equally important to counter exaggeration of the numbers of those seriously affected and not to allow myths to subsume the facts.

As this chapter focuses on those with the most complex and serious mental health conditions, I am reassured to note that they are able to access a number of impressive specialist services in Scotland. These deliver the type of 'special' treatment promised as part of the Covenant and *Renewing Our Commitments*. Such services should be cherished and never taken for granted.

Current Provision

Based on what I've observed in nearly four years as Commissioner and specifically on what my team and I have taken from our months of research and engagement on this topic, I support the finding from the 2016 Forces in Mind Trust *Call to Mind: Scotland* report, which stated:

"Arguably, Scotland has one of the most robust mental health and related provision for veterans in the UK, with a thriving specialist statutory and voluntary sector that has been supported and resourced by the Scottish Government"

This is a heartening assessment of the set-up in Scotland and one that has been borne out in the many conversations I have had about veterans and their mental health. The authors of that report and I have separately identified areas where more could – and should – be done to maintain or enhance this level of provision. It is, after all, important that we never stand still and allow our reputation to slip. Notwithstanding those opportunities for improvement, we ought not to lose sight of the overall positive position. It is evident that we have much good practice to protect for current and future generations and I would argue that the Scottish Approach to Veterans' Health is intended to do exactly that.

The treatment and care for veterans with severe and enduring mental health conditions is delivered by a mixture of statutory sector providers, under the responsibility of Integration Authorities, and third sector providers. Some services sit within the mainstream and others are specialist.

Veterans in several parts of the country are able to access the network of NHS-led Veterans First Point (V1P) services. In addition, the Scottish Government currently funds, through an arrangement with NHS Ayrshire and Arran, nationally available specialist treatment at Combat Stress' Hollybush House. I also heard from NHS Greater Glasgow and Clyde's Head of Mental Health about how their veterans are treated within the range of mainstream services. Just one of these is the Anchor Centre in Govan which brings together specialist resources from different disciplines to treat those with complex mental traumas.

Alongside that key provision, there are a number of third sector organisations offering support. Legion Scotland and Poppyscotland are two of the most widely identifiable charities that work with veterans, complementing support provided by the statutory sector. Other smaller, but no less important examples, include the work of Horseback UK and Bravehound, both of which use animals to help veterans cope with their mental health problems. Beyond the traditional Service charities, organisations such as the Scottish Association for Mental Health (SAMH) and Support in Mind Scotland provide help for veterans and others suffering from the widest range of mental health conditions. There are others besides. The Mental Welfare Commission for Scotland acts as 'watchdog' and ensures quality standards for care provision.

This mixture of provision – for both those suffering the most severe and enduring conditions, and more widely – adds up to a highly valued network for the veterans community.

Looking Ahead

Lest we get complacent about the level of support available to those struggling with mental illnesses, it is vital that we never forget the devastating impact that such conditions can have on individuals and their families. *Both the Call to Mind: Scotland* report and my own findings suggest that while Scotland has a range of services that have served the veterans community well, there are concerns that this support can be piecemeal on occasions and often quite limited for those with the most complex and difficult conditions.

Aidan Stephen, an ex-Army Major who served in Northern Ireland, Bosnia, Kosovo and Iraq over a 17 year career provides a graphic reminder of this. His testimony starts in 2003 and highlights the personal nature of these illnesses, the depths to which they can drag an otherwise fit and healthy individual, and the risks of unsuitable treatment. His is a traumatic story that reinforces the need for that 'special' level of support for those affected. Thankfully, Aidan has gone on to make a remarkable recovery, a testament to his own resolve and resilience, and to the help and support he received from many individuals and organisations. His full account can be read on page 63.

Aidan Stephen – Former Army Major

"A few months after returning from Iraq, I attempted suicide and spent five days in a coma. When I woke up, I was admitted to a military psychiatric facility in Germany. Most patients were relatives of soldiers, and the support I received wasn't suitable to my needs.

"I returned to Scotland where my wife and I separated and I ended up living alone, isolated with little family support. I was still in the Army at this point and they were trying to figure out what to do with me. I was sent to the Priory in Glasgow, a civilian mental health unit which treats people with addictions and eating disorders. This was one of the worst decisions made. None of the staff were trained to deal with patients from a military background and none of my fellow clients shared my experiences, yet I had to participate in group therapy with them.

"One day, one of the patients said she was feeling low because she had eaten loads of chocolate cake. Whilst acknowledging that seemingly minor issues such as this can have a much deeper psychological root for some, I was suffering from night terrors and traumatic flashbacks to my time in the Army, and comments like this only increased the distance I felt between myself and everyone else at the facility, leaving me feeling even more isolated.

"In 2006 I was discharged and was in the care of civilian rather than military doctors. I returned to Edinburgh and continued to spiral, culminating in an incident where I threatened to kill myself and self-harmed in public. I was arrested and ended up on remand. A doctor I spoke with while there told me to get in touch when I was out and he made me aware of veteran-specific support services that he thought would help.

"This is where things finally started to turn around...."

Crucially, both the UK and Scottish Governments remain committed to the idea of 'special' consideration for veterans such as Aidan, who suffer mental ill health following military service. That commitment is one of the cornerstones of how healthcare is delivered in Scotland.

I also welcome the fact the Scottish Government acknowledges veterans as a distinct group, albeit briefly, in its 10-year Mental Health Strategy which was published in 2017. This states: *"Armed Forces veterans, including those who have experienced trauma, may benefit from particular models such as peer support, combined with mainstream treatment. The Scottish Government will support efforts to meet the needs of veterans and their families, and local partnerships will want to consider how best to provide services locally for them."*

The Scottish Approach to Veterans' Health is intended to take matters further still. Its guiding principles provide a framework for ensuring that the best of specialist and mainstream provision is protected and the long-term needs of those with severe mental health conditions are properly planned and met. Resolving issues such as security of funding, equality of access and long-term planning are critical to living up to the commitments made. Most importantly, doing so will offer reassurance to veterans who currently or will in the future rely on bespoke mental health services.

A Long-Term Action Plan

The Government's Mental Health Strategy and *Renewing Our Commitments* provide an important statement of intent. However, given the specific commitments to, and sometimes unique needs of, veterans with severe mental health conditions, I believe there is a strong case for the creation of a separate Action Plan for the delivery of services.

The network proposed in recommendation 4 can provide the necessary expertise and governance to deliver such a plan, either as part of its core work or separately by a sub-group dedicated to mental health. The Action Plan would need to complement the Scottish Government's national strategy and address the key topics set out in chapter 2 'Making it Happen' and the ones that follow here. Ultimately, it should provide an articulation of how excellent, dedicated and sustained treatment will be delivered over the long-term, at a national level and locally by Integration Authorities. Quick referrals and early interventions should remain a central feature of that provision.

The following considerations – both structural and clinical – are the ones that featured most regularly during conversations with veterans and health professionals. Neither set is exhaustive but I hope they provide a useful starting point for those who may be responsible for delivering a long-term Action Plan. It will also be important that it reflects new issues and changing needs as they emerge.

Recommendation 5 – Mental Health Action Plan

The Scottish Government and NHS(S), through the network on veterans health (see recommendation 4), should produce a Mental Health Action Plan for the long-term delivery of services and support. Systemic issues of funding, collaboration, leadership, planning, governance and training of staff will be key.

Structural Considerations

The topics covered in detail in chapter 2 'Making it Happen' will be central to any plan for mental health provision for veterans. They include, protecting and funding specialist services, collaborating with others, demonstrating leadership, embedding long-term planning, and providing governance. I don't intend repeating any of that material but aspects are worthy of additional mention in this section as they apply to mental health care.

Funding

I say earlier that funding for specialist services is "disjointed and in some cases ad hoc". This is particularly evident in the field of mental health, as demonstrated by the experience of V1P and Combat Stress which is indicative of the short-term and insecure nature of funding. This is in sharp contrast to arrangements for some physical health provision, particularly prosthetics clinics, and demonstrate a clear anomaly that demands an urgent review. I would expect the proposed network to consider this as a priority as failure to do so will only leave a worrying degree of anxiety amongst veterans and dedicated providers, while increasing uncertainty for a number of our most important services.

Geographical Inequalities

There is also a need for separate consideration of how specialist mental health services are delivered across different parts of Scotland. I have consistently argued that veterans and others should see no threat in the fact that services will vary across the country, depending on factors such as rurality and remoteness, population density and demand. This is a consequence of the system of local delivery and accountability that underpins health and social care provision in Scotland.

What I don't consider inevitable or acceptable, though, is if the needs of all veterans with severe and enduring mental health conditions are not properly met. Should that be due to a lack of availability or delays in access then there is a clear question of inequality or disadvantage, which needs to be addressed.

Understanding of Veterans

Finally in this section, I would like to mention a recurring theme from veterans which suggest that health practitioners within the mainstream NHS do not always understand their specific needs and experiences. The implication is that those providing treatment and care are not as well equipped as they could be. Sharon Fegan, a psychological therapist, and Lauren Anderson, an occupational therapist, both from V1P Lothian, expand on this and their words are illuminating:

Sharon Fegan – Psychological and Occupational Therapist

"We have occupational therapist trainees who come to V1P for placements, so at a very early stage in their career they are learning how those from an ex-Service background might differ from civilian clients, and the best ways to approach this. Considering ways in which this increased awareness could be replicated across all positions in the NHS would be a really positive step towards improving engagement with veterans".

Lauren Anderson – Occupational Therapist

"Language is a hugely important aspect of treating the ex-Service community. Since I began working at V1P, I've picked up a great deal of military terminology which I previously didn't know. Building a good relationship with veterans in a therapy context involves showing appreciation and respect for their background, and acknowledging that there are aspects of Service life you don't know about, but which you hope to learn from them."

While parts of the health system are clearly well attuned to veterans' specific mental health needs there remains much to be gained from raising awareness, and increasing understanding, amongst as wide a network as possible, including GPs, mental health and allied health professionals.

Clinical Considerations

There are also a number of clinical considerations that will need to be incorporated into the Action Plan. Once again, this list is neither comprehensive nor exclusive but the topics are of sufficient importance to merit separate consideration and, in some cases, specific recommendations.

Post Traumatic Stress Disorder (PTSD)

Discussions about PTSD often elicit strong responses amongst an Armed Forces and veterans community that can sometimes appear critical of the attitudes and support provided by the MOD and statutory services. Many believe the number of veterans suffering from PTSD is significantly under-estimated and there has been insufficient investment in their treatment and care over several years.

Academics at institutions like Kings College London and University of Glasgow have conducted numerous studies over the past 10 years or so to assess the incidence, impact and treatment of PTSD amongst serving personnel and veterans. These have provided an impressive statistical evidence base for policy-makers and have shown that rates of PTSD in military personnel are similar to the wider population, although there is a modest increase in risk amongst combat troops and deployed reservists. Their specific findings have sometimes been at odds with some of the anecdotal evidence provided by those who struggle daily with the condition or offer direct support to the veterans community. This has led to debate and understandably caused a degree of confusion amongst the general public.

Over the past few years there has been a growing recognition by politicians, officials and health professionals of the need for effective and more accessible treatment for any who have served in the military and subsequently present with PTSD. The result has been a much greater willingness to see them as deserving 'special' support and an increasing number of initiatives that provide relief to individuals and their families. In Scotland this treatment is provided by a combination of NHS(S) mainstream services, V1P and Combat Stress. These must be protected now and over the long-term.

Although the overall number of veterans who suffer from PTSD in Scotland is relatively small, it is still vital that a national Action Plan considers the needs of those most at risk. It should also take account of the current move away from residential programmes towards an increased emphasis on community-based treatment and support. This will shape future provision of care for a vulnerable and deserving group. The severe and long-lasting impact of the illness, its link with other physical and mental conditions, and the levels of public interest reinforce these points on many levels.

Suicide Risk

Without doubt, the most poignant and thought-provoking conversations I've had during my time as Commissioner were with June Black. Her words laid bare the challenges her son, Aaron, faced when he returned from Afghanistan in 2009 that ultimately led to him taking his life in 2011. Matthew Green, in his book *Aftershock*, tells Aaron's story in the most moving way, leaving the reader to reflect on the sad and tragic loss of a young man.

We owe it to Aaron's memory to redouble efforts to support current and former Service personnel struggling with their mental health to such a worrying degree that suicide feels like the only escape. It is also essential that family and friends who are affected by suicide receive appropriate bereavement support.

In that respect, it is heartening to note some of the MOD's recent work, including the establishment of a 24hr Military Mental Health Helpline, and the publication of the Defence Mental Health and Wellbeing Strategy 2017-22. I have also been interested in NHS England's Transition, Intervention and Liaison (TIL) pilot, which seeks to improve mental health care for veterans and Armed Forces personnel approaching discharge. I believe NHS(S) should consider this latter initiative and work closely with organisations who have already invested time and resources in identifying and supporting those at increased risk of suicide.

NHS England's Transition, Intervention and Liaison (TIL) Mental Health service was set up in 2017 for veterans and those Armed Forces personnel about to leave the military who might have mental health difficulties.

The three elements that make up TIL are:

- A **Transition** service that is targeted at those about to leave the Armed Forces who may need continuity of mental health care during the transition process.
- An **Intervention** service that provides an assessment within two weeks of a referral which determines whether an individual has complex needs and, if so, provides an appointment with a clinician who has an expert understanding of Armed Forces life and culture. Veterans may also be supported by a care coordinator who can liaise with other services and organisations to ensure a coherent approach to their care.
- A **Liaison** function that supports those who do not have complex presentations yet would benefit from NHS care. They will be referred into local mainstream NHS mental health services where they will receive treatment and support.

Also of note, the Scottish Government intends to publish a Suicide Prevention Action Plan later this year. I have submitted a response to the consultation, highlighting veterans and their particular circumstances. An important aspect of identifying veterans within this plan will be the opportunity to extend the knowledge and understanding of the medical community on the challenges faced by some of our most vulnerable ex-Service men and women.

Finding 4:

The publication of the Suicide Prevention Action Plan by the Scottish Government later this year is a welcome step in ensuring everything possible is done to help anyone struggling with mental ill health. Vulnerable veterans, and their particular circumstances, will be an important consideration as the plan is developed.

Substance Misuse

All three Services are historically associated with a culture of heavy drinking and, while much has been done within the military to shift behaviours, alcohol misuse is still significantly higher than amongst the general population. Inevitably that culture extends into the veterans community which also reflects a national trend that has seen alcohol consumption increase significantly over the past few decades. This is a problem which the Scottish Government and others within the veterans community have done much to tackle nationally in recent years.

Alcohol misuse is often linked to poor mental health, with Combat Stress suggesting that almost 70% of veterans with PTSD also have drink-related problems. This organisation is currently piloting a Veterans' Substance Misuse Case Management Service, which helps veterans access the most appropriate services to support their abstinence and prevent relapse. I will watch with interest as this scheme develops.

The misuse of powerful painkillers, including opioids and other synthetic drugs, amongst veterans has received significant attention in the USA. There is, however, a growing sense that self-medication using both prescription and non-prescription drugs amongst UK veterans is also on the rise. This parallels trends in the wider community.

To date, there is minimal research on the subject but my conversations with senior medical professionals and practitioners working for Help for Heroes have left me in no doubt that this could be a serious concern. Given the tendency in the UK to follow US trends, and the devastating effect of drugs misuse, I believe it is important that we quickly determine the scale and nature of the problem in Scotland. The Action Plan should include details about how this will be done and initiate measures to counter this worrying trend.

Recommendation 6 – Drugs Misuse

The Scottish Government and NHS(S) should assess the scale and nature of drugs misuse – especially prescription and non-prescription painkillers – amongst the veterans community in Scotland and introduce remedial measures. This should be taken forward by the Joint Group and network, and included as part of the Mental Health Action Plan.

Stigma, awareness and other barriers

Mental health problems can be hard for anyone to cope with but it is made worse by having to deal with stigma, ignorance and discrimination from others. There is a widely held perception that the stigma associated with admitting to struggles with mental health is a major factor in veterans being reluctant to seek treatment and support. However, it seems the reality is more complicated than this.

A 2017 report by King's Centre for Military Health Research, *Stigma and Barriers to Care in Service Leavers with Mental Health Problems*, proposes that stigma is not a singular influence that prevents ex-Service personnel from seeking help for mental health problems. Failure to recognise that they have a mental health problem in the first instance, making the decision to seek help, and difficulty accessing and then maintaining support are all also contributing factors. This can be compounded when veterans live alone or have no-one to push them into seeking treatment. A recent study by Dr Margaret Bowes also identifies that the inherent culture of the Armed Forces may protect personnel from mental ill health during combat but then impede good recovery amongst veterans; in other words, the coping strategies required for good mental health may be at odds with the sort of resilience required to cope in battlefield situations.

Work has been undertaken in recent years by the MOD to overcome the challenges identified above. As attitudes in the military, amongst the veterans community and wider society have shifted, it has become evident that serving members of the Armed Forces and veterans now feel far more able to raise and discuss issues about their mental health. The increasing use of peer support workers by organisations like V1P and Help for Heroes has undoubtedly encouraged this and is widely regarded as good practice.

Nevertheless, for some, particularly those who served in less enlightened times, there may still be feelings of stigma attached to being mentally ill. I would like to make particular mention of the national programme *See Me*, funded by Scottish Government and Comic Relief and managed by SAMH and the Mental Health Foundation, which is aimed at changing negative attitudes and ending discrimination against all those with mental health problems. This work is important and I would expect an Action Plan to reflect this approach. I would also encourage any veteran who may be reluctant to seek help, to find out more about this programme and how it might benefit them.

During the past few years there have also been a number of initiatives aimed at improving awareness and understanding of the specific mental health challenges faced by some veterans. These have included education and information material produced by the Royal College of General Practitioners, NHS(S) and several charities. This has had an impact but I sense there is now need to refresh some of the content and renew efforts to disseminate it amongst as wide an audience as possible, including GPs, mental health specialists and allied health professionals.

This will be of particular importance to the 800 additional mental health workers that the Scottish Government has committed to funding over the next four years.

Recommendation 7 – Barriers to Accessing Services

The Scottish Government and NHS(S) should build on existing work aimed at reducing barriers to veterans accessing mental health services. This will include measures to address issues of stigma, seeking help, and improving awareness and understanding within the medical profession. This should be taken forward by the Joint Group and network, and included as part of the Mental Health Action Plan.

Conclusion

Throughout this chapter I have sought to emphasise that there are, thankfully, relatively few veterans who will experience severe mental health problems following their time in the Armed Forces. Furthermore, these problems are not always attributable to military service, with a proportion having been affected by adverse life experiences such as abuse, financial or relationship problems or as a victim of crime. Unfortunately for some, their time in the Services may have compounded their situation.

For those veterans who do suffer, there is no doubt that their lives can be devastated, sometimes for many years. Prompt access to the best possible treatment and support is vital in helping them to recover, and lead happy and fulfilling lives. We can be proud of the specialist and mainstream mental health services in Scotland and the role this plays in helping these individuals – and their families – achieve that aim.

We must, though, never allow complacency or lack of interest to compromise that level of provision and instead work to protect it for current and future generations. In that respect, I have concerns about the long-term sustainability of some of these services and the ability of some veterans to access them.

That is why I have called on the Scottish Government, NHS(S), local delivery organisations and partners to develop an Action Plan for the protection and long-term delivery of mental health services for veterans, especially those with severe and enduring conditions. In this chapter I have highlighted just some of the topics which should be considered and addressed as part of the creation of such a plan. There may be others that are worthy of inclusion, now and into the future as both services and needs evolve.

Chapter 4

Physical Health




"After the guns have fallen silent, and the din of battle quietened, the real fight begins" – Prince Harry

The image of a wounded veteran is the most stark reminder possible that the men and women of the UK Armed Forces, both regulars and reserves, are often called on to put themselves in harm's way on our behalf. Some end up paying a heavy price and it is only right that our health and social care system provides the best possible treatment and support for these individuals for the rest of their lives. More widely, it should be recognised that a career in the Armed Forces is nearly always physically demanding, often dangerous and can put a severe strain on the human body.

Combat operations obviously expose individuals to a significant risk of death or being seriously wounded. There are, however, those who suffer life-changing injuries and chronic conditions due to the physical nature of their job or as the result of training or other accidents experienced in military service. All will have to live with severe and enduring conditions for many years, and may need – and deserve – specialist treatment and care over and above that typically provided by NHS(S) and local Councils.

In this chapter I explore some of the most challenging physical conditions that veterans may experience. Most injuries will be obvious and demand immediate treatment although some may not present for many years. Others will change over time as physical demands and age take their toll.

I should stress that what follows is by no means an exhaustive list. Rather, it reflects the priorities and concerns expressed by veterans, their families and members of the health and social care professions. My aim is to highlight some of the good practices already in place and to identify improvements that will help protect and enhance the care Scotland provides to its veterans community. Ultimately we want all veterans, especially the most seriously injured, to have the care that allows them to look forward to enjoyable and productive lives after time spent in the Armed Forces.

Protect and Prepare – The Challenges To Be Faced

Two of the principles of the Scottish Approach to Veterans' Health are, firstly, to protect vital specialist services currently required by veterans with severe and enduring conditions, and secondly, to plan for their long term care. In my time as Commissioner, I have consistently heard concerns expressed by veterans, charities and other organisations that the first-rate medical treatment provided will not always continue for the long-term. This is a fear of many coping with life-changing injuries who worry that their needs will not be properly met as they get older and struggle with a number of related conditions.

The good news is that Scotland's overall approach to looking after our veterans, the broad support provided across all sectors and recent changes in healthcare – especially the integration of health and social care services – provide a solid foundation on which to address many of these concerns.

However, in order to make a real difference and provide reassurance to veterans, effective planning and a sustained commitment of public resources will be critically important as their needs change over time. The entire health and social care system will require to be well informed, co-ordinated and responsive if these individuals are to be properly supported. I cannot stress too highly that as the impact of the injuries sustained will be with them for the rest of their lives, so must the care and support.

An example of needs changing over time comes from Andy McIntosh, who served as an Army Corporal for 15 years in Bosnia, Northern Ireland and the Falklands. Whilst at work in 2008, a persistent kidney pain worsened and he collapsed. He was taken to hospital and it was discovered that he had very serious vascular problems stemming from his time in uniform.

Andy McIntosh – SSAFA Lanarkshire Branch Secretary

"I had been in excruciating pain but had just put it down to a chronic kidney infection. It was difficult to believe that I'd been suffering such serious injury. The medics traced it back to the trauma of an explosion in Northern Ireland. Even though I had walked away relatively fine at the time, I was now experiencing the aftermath."

I am encouraged that the Scottish Government already recognises the need for this longer-term planning. Its 2016 strategy *Renewing Our Commitments* states, *"looking ahead, we want to ensure that long-term clinical needs of Service personnel and veterans are better understood and supported…"*. This is an important statement and an ambition that I hope this report can help deliver.

Recommendation 8 – Access to Life-long Services

The Scottish Government, NHS(S), Health Boards and local Councils should make a commitment to veterans with the most severe and enduring physical (and mental) conditions that they can access the highest quality health and social care services for life and as their needs change. Health and Social Care Partnerships and Integrated Joint Boards will be instrumental in planning the delivery of these services and the national network recommended in chapter 2 should assume responsibility for oversight of this work as an early priority.

Severe Physical Conditions

What now follows is a consideration of some of the most severe physical conditions and illnesses faced by our veterans, and suggestions for how we can continue to provide the best care and support in the future.

Multiple and complex injuries

It is a fact of modern warfare that survival rates of those who sustain multiple injuries on the battlefield have increased significantly over the past 20 years or so. Better personal protection, rapid transfer to advanced hospitals and enormous improvements in medical treatment now mean that many more men and women make remarkable recoveries from the most horrific wounds. The initial treatment, in theatre and later back home, is the start of a very long recovery pathway that involves Defence Medical Services, NHS and charities. This is often a painful, complex and difficult process for all – including the families of those affected. It is also one that demands the wholehearted and co-ordinated support of many different organisations.

The most common cause of these multiple, severe injuries – typically labeled polytrauma – are the blast effects from Improvised Explosive Devices or Rocket Propelled Grenades. The impact can be devastating on the human body and can result in Traumatic Brain Injury, amputations, burns, internal injuries, hearing/sight loss and spinal cord injuries. Some victims also subsequently suffer from PTSD and other mental illnesses.

Care for the most severely injured puts clinical and financial pressures on statutory services but it is reassuring that these veterans, probably fewer than 150 individuals in Scotland, are typically looked after extremely well. This starts with specialist support at Queen Elizabeth Hospital in Birmingham or the Defence Medical Rehabilitation Centre at Headley Court and eventually involves local Personnel Recovery Centres/Units, NHS specialists and GPs. I have little doubt that this system provides a level of care that is only right and proper.

Edinburgh House Personnel Recovery Centre

Personnel Recovery Centres (PRCs) are MOD-run facilities for injured Service personnel and veterans undergoing recovery. They provide a range of medical, rehabilitation, welfare and education services that support either a return to duty or a good transition to civilian life.

Edinburgh House is an Army led PRC which is funded by the Royal British Legion and hosted in Erskine's Edinburgh Home. It was the first PRC to open in 2009 and was originally funded by Help for Heroes before RBL took over in 2011. During a recent visit I saw first-hand the excellent support given to injured Service personnel and veterans.

That said, I am aware that issues over the funding for this support come to the fore fairly regularly. Treatment can be expensive and there have been public disagreements about where costs should fall – whether between NHS Boards in Scotland or with their counterparts in the rest of the UK. This is worrying, but I am hopeful that instructions soon to be issued by NHS(S) will clarify which organisations should pay in disputed cases.

I have already addressed the general topic of funding in chapter two, but I also have a specific concern about how we pay for the complex needs of those affected by polytrauma. It has been suggested that their long-term care could be funded centrally through NHS(S)'s National Services Division as is done for other discrete groups who need expensive, specialist treatment. By doing so it would reduce the financial risk to individual Boards by spreading the costs between them, and would also minimise inequalities for those in need of such support. I believe this idea warrants further investigation.

Recommendation 9 – Funding for Multiple Injuries

The Scottish Government and NHS(S) should give consideration to whether the costs of specialist care for veterans who have suffered polytrauma should be funded through the National Services Division (NSD).

Finally in this section, I want to highlight current Scottish Government plans to establish a national Trauma Network that aims to deliver "the highest quality of integrated, multi-speciality care" to all severely injured patients. This project is still in its infancy but discussions with several medical professionals and officials point to its potential role in improving the quality of support to our most seriously injured veterans. This will be especially beneficial as they progress through the rehabilitation process.

I should mention that this proposed network is different from the Veterans Trauma Network, recently launched by NHS England, which is intended as an additional layer of support for trauma-recovering veterans and those transitioning from the Services. It is built around 10 trauma centres that bring together veterans and NHS doctors with military experience to offer bespoke care. Given our number of seriously injured veterans, I do not believe there would be sufficient demand for a similarly dedicated network here.

I sense that the intention of a national network to operate across geographical boundaries and clinical specialities fits well with the needs of veterans. It could promote best practice and contribute towards improving outcomes for all who have suffered the most devastating injuries. By taking specific account of these veterans' needs in the trauma network, there would also be the opportunity to provide an effective means of tracking them along their recovery pathway and into later life.

Recommendation 10 – The National Trauma Network

NHS(S) should include the specific needs of veterans who have suffered polytrauma as part of its work in setting up a national Trauma Network.

Amputees

Loss of a limb, whether or not as part of polytrauma, has a devastating impact on anyone, including those men and women who have previously led very active lives in the Armed Forces. For those affected, and in response to the Murrison reports mentioned earlier, the Scottish Government set up a dedicated national prosthetic service which provides specialist treatment and care. It operates using a single multidisciplinary team across two centres in Glasgow and Edinburgh, runs alongside the wider NHS(S) prosthetics service and charities such as BLESMA, and is funded by the National Services Division. The establishment and sustainment of this service can rightly be regarded as a key and impressive part of Scotland's commitment to those veterans who have suffered the most obvious and life changing injuries.

Notwithstanding the excellent care offered by the specialist centres, military amputees and their families have particular concerns about the provision of long-term care, and whether this will continue to adapt to their emerging needs. I heard this directly from Jay Hare, a former Corporal in 45 Commando Royal Marines, who sustained life-changing injuries from an explosion in Helmand Province in 2008. He lost his left leg below the knee, several fingers and had injuries to his right arm, right leg and face which required multiple reconstructive surgeries over a number of years.

Now aged 36, Jay already feels twinges from his prosthetic leg, his other injured knee and back. He questions whether the excellent care and support he has received to date, from both the national and his local clinic in Aberdeen, will be available in the future. He worries about breaking his prosthetics and having access to replacements and updated models. Jay's concerns are best summed up in his own words…

Jay Hare – Former Royal Marine

"The Armed Forces Covenant made a promise to the veterans community that we would be treated fairly. Are enough future resources in place to really deliver this promise? As 'Operational', we were told that we were going to be looked after – that was the deal that was on the table and I hope this is still the case"

Providing answers to these concerns and reassurances to veterans like Jay, whose full story can be read on page 62, lie at the heart of my proposal for the Scottish Approach to Veterans' Health.

Mobility

During a recent visit to one of the specialist centres, Southeast Mobility and Rehabilitation Technology (SMART) in Edinburgh, I was impressed by the wide range of facilities and the quality of support. These services include prosthetics, orthotics and bioengineering (artificial limbs and special equipment); mobility and posture; a disabled living centre; gait analysis; and the national driving assessment centre. This prosthetic service is evidently well resourced, with clinicians and technical staff being confident of providing first-rate support to veterans.

However, these specialists expressed concern about being able to offer the most appropriate wheelchairs to veterans they treat. As with prosthetics, the provision of mobility aids should meet both clinical need, and current and future lifestyles. It was concerning to learn that this is not always the case.

Many veterans have had very specialised and generally light-weight wheelchairs from DMRC at Hedley Court. When these need replaced, SMART can only provide chairs through NHS(S) contracts, thereby leaving veterans with reduced functionality. Furthermore, when it comes to maintaining these specialised chairs, I was told that the parts can be very difficult and costly to source due to current contract and procurement procedures.

Those I spoke to felt it would be hugely beneficial if they were able to access more specialised wheelchairs, in much the same way they do for specialist prosthetics. I now understand just how important a wheelchair is to an amputee – as important as their prosthetic in many ways – and this will become increasingly so when they become more reliant on them as they age.

This issue puts the provision and funding of wheelchairs in sharp contrast to that of the excellent prosthetics service and seems illogical to me. It may require some additional resourcing or it may simply be that more flexibility around current arrangements is all that is required. In either case, this is a problem which ought to be rectified and one I would like to see addressed as a priority.

Recommendation 11 – Wheelchairs for Amputees

NHS(S) should adapt current arrangements to ensure an appropriate level of funding is available to guarantee that wheelchairs provided by the MOD for veterans with severe amputations can be serviced, maintained and replaced with the best possible equipment commensurate with that individual's needs.

Musculoskeletal Disorders and Injuries

Musculoskeletal disorders (MSDs) and injuries are consistently the main cause of medical discharge across all three Services. In basic terms they are described as damage to the muscles, bones or connective tissue that support someone's limbs, neck and back. They almost always cause an individual to suffer pain – meaning that MSDs and long-term chronic pain are intrinsically linked – and can be resistant to some treatments.

Given the often physical nature of many jobs within the military, and the prevalence of related medical discharge, it is apparent that a significant proportion of veterans are likely to be affected by MSDs of varying severity. As with the general population, they receive treatment and care predominantly within the NHS, with GPs likely to be the first point of contact. Where ex-Service men and women can differ from their civilian counterparts is that their MSDs are more likely to be just one aspect of a complex picture of acute post-combat and/or training injuries. In the case of such injuries, which are likely to involve high levels of pain, a range of treatments and support will be required.

In an ideal world, GPs will be aware if a patient presenting with MSDs is a veteran and will be able to assess if these are linked to other severe and enduring injuries. In such cases, the GP can refer onwards to a number of specialist services, including rehabilitation treatments provided by physio and occupational therapists. However, I am also aware that these are in high demand and veterans can sometimes face long delays in gaining access. Given the long term benefits of proper rehabilitation – both to the individual and wider society – this is an area that clearly needs attention. I suggest there may also be an opportunity here for charities to play an increased role.

Finding 5:

Rehabilitation services, such as those provided by physio and occupational therapists, can be of huge benefit to those suffering from MSDs. Given the high demand for such services, veterans suffering from severe MSDs as a result of their military service should be given early access as part of their special treatment.

Chronic Pain and Pain Management

Chronic pain is often defined as a condition that causes disabling and severely limiting pain which lasts for more than three months. It can become progressively worse and reoccur intermittently.

"Chronic pain is not simply a physical problem. It is often associated with severe and extensive psychological, social and economic factors…The impact of chronic pain on patients' lives varies from minor restrictions to complete loss of independence" – Dr Colin Tidy, GP and author on chronic pain.

The above quote also demonstrates starkly the complexity and often multiple issues faced by sufferers. Given the links to MSDs, polytrauma and other severe physical injuries, many ex-Service men and women are consequently living with pain. This has been highlighted in my conversations with health professionals in both the statutory and charity sectors.

Pain Concern is an Edinburgh based charity whose goals are to produce information, provide support and raise awareness for those with pain. They have a dedicated veterans section on their website and in collaboration with Forces in Mind Trust and the MacRobert Trust, they provide information and support to veterans in pain and to those who care for them. They have produced three interesting radio programmes featuring ex-Service men and women sharing their experiences of managing pain and interviews with the healthcare professionals who treat them.

Most veterans will be treated firstly by GPs, who may prescribe analgesics and other painkillers. For more serious cases they can refer patients to NHS(S) run clinics that deliver a variety of pain management programmes. It has also been interesting to hear about alternative approaches, such as self-management, mindfulness and regular exercise. These approaches would appear to suit many in the veterans community.

Of note was the recent establishment by the Scottish Government of the National Advisory Committee for Chronic Pain (NACCP). The group has a remit to guide improvement of chronic pain management at all levels of health and social care, and to inform national policy. Given the relatively high proportion of veterans who are likely to suffer chronic pain, the work of this group will be highly relevant. There is obvious merit in it considering veterans as a distinct cohort.

Recommendation 12 – Chronic Pain Management

The National Advisory Committee for Chronic Pain (NACCP) should consider veterans specifically as part of their work to improve chronic pain management in Scotland.

Severe Sensory Impairment

Serious instances of hearing and sight loss impact significantly on an individual's life, both physically and psychologically. Severe sensory impairment may occur as a result of combat injuries from gunfire or explosions, or from other major accidents, and may be every bit as traumatic as some of the other physical conditions discussed earlier.

During conversations with several veterans and organisations I have become increasingly aware of the extent of hearing loss amongst the ex-Service community. One of the starkest figures I have come across is that veterans under the age of 75 are approximately three and a half times more likely than the general population to suffer some sort of hearing impairment. This is a staggering statistic that indicates a serious problem amongst the veterans population. On a positive note, it is clear that the MOD is now investing heavily in training and protective equipment to prevent such high instances in the future. This will, of course, do nothing for those who have been previously exposed to the sounds of artillery, explosions or been in close proximity to jet engines and heavy machinery without proper hearing protection.

For a number of these individuals their disability will have a severe and enduring impact for the remainder of their lives. As well as profound hearing loss, some may also experience tinnitus – a constant ringing, buzzing or whistling sound which can be so overwhelming that around a third of sufferers say they are driven to despair.

The first point of contact for veterans with hearing difficulties is likely to be, yet again, their GP and many will find their needs largely met by the statutory sector. However, for those with severe or profound hearing loss acquired as a result of their military service, they may find NHS(S) is limited in the types of specialist hearing aids that can be provided. In accordance with the commitment to 'special' care for these veterans and the principles of the Scottish Approach, resources should be found to provide them with the best possible aids and support in keeping with their needs and lifestyle.

Medical professionals and veterans dealing with hearing loss of whatever severity, should be aware of the substantial additional support available from the charity sector. Some of this has been funded by Government via LIBOR and the Aged Veterans Fund, with those providing support including the Royal British Legion, Action on Hearing Loss, and UK Veterans. They can provide access to some of the best hearing aids available.

Recommendation 13 – Funding Hearing Aids

The Scottish Government and NHS(S) should make funding available so that veterans with the most severe hearing loss as a result of their military service can have access to the best possible hearing aids and support.

Sight impairment is fortunately not as widespread in the veterans community as hearing loss, but for those affected it is significant and life changing. Partial or complete loss of sight may be the result of a combat injury or occur in later life, not necessarily because of military service. The charity Scottish War Blinded runs two centres providing support with independent living, sport and other activities, social events, financial assistance, and rehabilitation for veterans with sight loss.

During a visit to its Linburn Centre in West Lothian, I heard that the majority of those who are supported have lost their sight due to old age and illnesses such as glaucoma and macular degeneration. There are, though, still a proportion of veterans who are blind or partially sighted as a direct result of their military service and clearly the support of charities like this is invaluable.

One such individual, Robert Reid, was a 25 year old Lance-Corporal in the Royal Regiment of Scotland on duty in Iraq when a roadside bomb exploded. He was gravely injured, losing the sight in his right eye. He spent time at DMRC Headley Court and Selly Oak Hospital receiving treatment for his injuries, and while there was put in touch with Scottish War Blinded who have since helped him to adjust to his new circumstances. Such support, over and above that provided by NHS(S), has been a key feature of care for wounded service personnel in Scotland for many years. You can read Roberts' full story on the Scottish War Blinded website.

The treatment and support available to all veterans with severe sensory loss, both from the statutory and charity sectors, is largely very good, but we must never take it for granted or allow complacency to compromise that situation. Only by properly protecting current services and effectively planning for the future can we ensure that those severely affected can continue to be well supported and cared for. These often 'hidden' injuries can be devastating and I strongly encourage Health and Social Care Partnerships, in particular, to take account of these when designing support for veterans.

The Invictus Games

Sports and fitness programmes and events are amongst the most recognisable and popular non-clinical pursuits for veterans with severe injuries. Perhaps the most iconic and high-profile in terms of competitive sport are the Invictus Games.

First held in London in 2014, they are now an established international, multi-sport fixture. Following the last gathering in Toronto in 2017, an evaluation was undertaken which concluded that it was 'a gift for competitors in their recovery' – something most of us instinctively knew and observed. Interestingly, the research also highlighted that Canadians' perceptions of, and support for, injured veterans shifted dramatically for the better in their aftermath. The next will be held in Sydney later this year.

It would be exciting to think of a future Games coming to Scotland. Both Edinburgh and Glasgow, of course, have a proud history of staging successful international sporting occasions and the idea of the Invictus Games being held here would be an enormous boon to our veterans community and fans of sport alike.

Recommendation 14 – The Invictus Games

The Scottish Government should work with partners, charities and others to scope a proposal to host a future Invictus Games in Scotland.

Conclusion

In this chapter I have highlighted some of the most severe physical conditions that can affect veterans following a career in the military. This is not an exhaustive list and I recognise that I haven't covered issues such as the impact of various cancers, Gulf War Illnesses, non-freezing cold injuries, or exposure to nuclear weapon testing. These often have very serious repercussions but I am confident that veterans have access to effective and compassionate care from NHS(S) in these and similar circumstances.

In concluding this chapter it is worth re-emphasising that the overall numbers of veterans struggling with severe and enduring physical conditions in Scotland is relatively small, and that the vast majority receive very good treatment and care. Mainstream and specialist NHS(S) services – complemented by the work done by a number of charities – are well-placed to provide this. At present, very few 'fall between the cracks' and fail to get the level of support they need.

That said, the concern amongst many veterans is that statutory services will struggle to provide this level of care in the long term, and that it will be unable to adapt to their needs as they age. This causes significant worry and I believe the Government can do much to allay such concerns by reinforcing its commitment to providing the best possible 'special' life-long care. Integrated Joint Boards, Health and Social Care Partnerships, NHS(S) and local Councils will be required to plan and deliver this. By doing so, I believe this vulnerable group will get the reassurance they seek and the care they deserve.

Chapter 5

Improving Outcomes for All

For much of this report the emphasis has been on veterans who face serious and life-changing injuries or conditions resulting from military service, our obligation to provide them with 'special' treatment and care and how this can be guaranteed for as long as it is required. This is only right given their previous sacrifice and the cost which they will bear over many years. As is evident from previous chapters, this has been the main thrust of the proposed Scottish Approach to Veterans' Health and I make no apology for giving these individuals, and their needs, such prominence.

However, it is also important to consider the wider population of veterans, their health and social care needs, and determine whether the support provided is as good as it could be.

Jane Duncan – Veterans Support Adviser

"When you leave the Armed Forces, you leave a community, and that is very difficult to step away from. Replicating that community sense via social groups and organisations can, for some, help military personnel feel part of a tight knit group and most importantly, valued. The appetite from the three councils [Renfrewshire, East Renfrewshire & Inverclyde] to help veterans integrate into the community has significantly increased since 2014 and they all want to play their part in ensuring that the region is viewed as a place to settle for veterans. They want ex-Service personnel to know that they, and their families, are welcomed to the area and that there is support and help in place at a local level."

Veterans in Society

The overall number of veterans who live in Scotland is still not known precisely, something that is a continued source of frustration for those who are responsible for planning and allocating resources for their treatment and care. A series of reports from MOD, Royal British Legion and Poppyscotland provide an estimate of the size and socio-demographic characteristics of the population and, although these have proved useful, they have their limitations. I have therefore strongly supported the campaign to include questions about previous military service in the next national census, given its potential to provide clarity and inform future policy and resource decisions.

Despite this lack of absolute certainty, the most recent studies suggest approximately a quarter of a million veterans currently live in Scotland, with the expectation that this figure will decrease over time as the older generation of National Servicemen pass away, and as a consequence of our Armed Forces having reduced in size. Of this community – which comprises about 4% of the nation's population and includes individuals who range in age from their late teens to over 90 – the majority will have served in the military for less than four years, in many cases up to 50 or 60 years ago, and at least half will be over the age of 75. They are found in every part of society, include increasing numbers of women and have very similar personal aspirations, worries and challenges to their peers who have not served. Many of their health and social care needs are no different to those in the wider population.

For everyone in Scotland, the Scottish Government makes clear they have a fundamental right to the *"highest possible standard of health"* and a *"fairer share of the opportunities, resources and confidence to live longer, healthier lives".* This is enshrined in policy documents such as *A Fairer, Healthier Scotland 2017-22* and dictates the approach taken by NHS(S), Integrated Joint Boards, Health and Social Care Partnerships, Health Boards and Councils as they strive to reduce inequalities and improve the overall health of the nation. One of the key aims of my report is to ensure all veterans benefit from this strategic framework.

However, throughout this report I have also attempted to address the fundamental question as to whether veterans face any disadvantage when accessing health and social care provision. The good news is that I have come across very few instances where this is the case and none that suggest it is an endemic problem across the statutory services. That said, the focus on addressing inequalities within the health system has opened my eyes to members of the ex-Service community who may be experiencing what NHS(S) describes as *"unjust and avoidable differences in [their] health…that are socially determined by circumstances largely beyond [their] control"*.

Health Inequalities

According to the same source, health inequalities are rooted in the unequal distribution of power, wealth and income, and the associated social determinants of health which include housing, employment, education, family income, social support, communities and childhood experiences.

It has long been recognised in the veterans community how vital many of these determinants are to ensuring ex-Service men and women and their families prosper after a career in the military. Much effort and resource is invested by both government and charities to support those leaving the Armed Forces and veterans on these and other fronts.

As Commissioner, I have previously published reports on aspects of the transition to civilian life, housing, employment, skills and learning. All have been seeking, firstly, to promote veterans as valuable assets to their local communities and Scotland's wider economy and, secondly, to increase opportunities for them to secure suitable housing, meaningful and sustainable jobs, and college, university and training places. As well as helping to ensure veterans are properly recognised and rewarded for the skills and attributes they have, it is heartening to think that improvements in all of these areas may, in part, also contribute to them living well and being in good health.

As with the wider population, the veterans community stands to benefit from the holistic approach to health which exists in Scotland. There are, though, certain characteristics that distinguish veterans from the general population that mean some may still face health inequalities and are worthy of separate consideration within the system. Research by different academic organisations and my own discussions over the past few years indicate that Early Service Leavers (ESLs), the elderly and those who served as reservist members of the Armed Forces may be at particular disadvantage.

Early Service Leavers

ESLs are those who leave the military voluntarily before completing the minimum term of four years, have been compulsorily discharged or who have not completed basic training.

There is a growing body of research that shows this group at particular risk of being adversely affected by a range of health conditions. We also know some experience difficulty in securing accommodation and work, and on occasion end up in the criminal justice system after their time in the military. I have examined some of these challenges in previous reports and recognise they all have an effect on the future health and wellbeing of this more vulnerable cohort.

The reasons for ESLs being at higher risk of poor health are varied and complex. It is a subject that is increasingly the focus of investigation and debate amongst the academic, Armed Forces and veterans communities. I won't, therefore, go into detail here other than to highlight the emerging understanding that their physical and mental health issues can often be a legacy of their lives prior to joining the military. Factors such as social deprivation, lower educational attainment, childhood traumas and poverty all play a part.

A report on mental health in the military by ForcesWatch highlights just some of the challenges faced by these individuals: *"The youngest personnel from the most disadvantaged backgrounds are: more vulnerable to trauma; more likely to be in a close-combat role and exposed to traumatic stress when deployed; and then less likely to be able to draw on the social support they need to manage a mental health problem after leaving the forces. This group is therefore disadvantaged before, during and after their military career in terms of the mental health risks they face"*

Regardless of the reasons and whether they are attributable to time in the military or beforehand, what is clear is that some ESLs are more likely to suffer adverse health conditions and consequently face inequalities.

Armed Forces Reserves

Whether an individual has served as a regular member of the Armed Forces or a reservist, they have the same status as a veteran afterwards and are rightly regarded no differently by the health system, charities and others. There is, though, evidence to suggest reservists face a number of health challenges which merit separate consideration.

For example, a number of academic reports found that reservists who had been deployed in a combat situation were at higher risk of developing PTSD compared to regular members of the military. The reasons for this are likely to be many, and will include issues such as the stresses of balancing other jobs and family commitments, less well established networks of support and comradeship within the military, and the disruption of transitioning between Service and civilian life.

There are already joint NHS and MOD programmes with a particular focus on mental health, run for reservists who have previously been deployed. This is an important part of addressing the needs of this group. Notwithstanding, it remains a cohort that still faces an increased health risk and about which there appears to be limited understanding. While the numbers affected are relatively small, I still believe there is a clear need to invest time and effort in recognising and addressing the specific health and wellbeing needs of this group in Scotland.

Older veterans

Laura Anderson – Occupational Therapist

"At V1P Lothian we have seen a rise in physical problems, most commonly loss of hearing, general wear and tear, frailty, and occasionally weight management, breathing difficulties and malnourishment…

As with the elderly in the wider population, one of the biggest challenges we face is social isolation and the team facilitates group activities and attendance at drop-in sessions to combat this. Some veterans are fit enough to get themselves to such activities, but for those that aren't we work with partners to assess carer needs and assist with putting any requirements in place."

Our population of veterans is aging and declining in number. As I mentioned earlier, almost half of veterans are aged 75 or older, with the majority having spent a relatively short time in the military during National Service. Most encounter similar health challenges to anyone as part of the natural consequences of aging, such as different forms of dementia. They increasingly face a range of illnesses and conditions that have a cumulative and often significant impact on their quality of life. Some of these later-life health conditions can, at least in part, be attributed to or exacerbated by military service.

Veterans charities have traditionally provided invaluable support to older members of the community. However, the challenges faced by this group have gained a higher profile and a greater priority amongst many more organisations in recent years. For example, last year I was pleased to launch a large UK Government funded programme of services to veterans over the age of 65. Called Unforgotten Forces it brings together 15 organisations in a consortium led by Poppyscotland. It includes a number of the traditional military charities but also several others such as Age Scotland and Music in Hospitals Scotland. One of the main concerns the programme is seeking to tackle is loneliness and isolation, something that is particularly acute amongst many in the older veterans community.

There are also veterans whose military career will leave various legacies which can impact their future health and wellbeing. This is especially evident amongst the large number of ex-Service men and women who struggle with pain and mobility issues resulting from musculo-skeletal conditions, the long-term effects of smoking and excessive alcohol consumption, and the consequences of frequent exposure to extreme noise. All are associated, to a greater or lesser extent, with service in the Armed Forces and can have a detrimental impact on an individual's quality of life, health, employability and, in the most serious circumstances, their life expectancy.

Mobility Concerns

Severe Musculoskeletal Disorders (MSDs) are highlighted earlier and comprise the most common medical reason and conditions for someone leaving the Armed Forces. However, it is apparent that for a large number of veterans, other MSDs and conditions like arthritis may develop in later life and lead to considerable mobility and other difficulties. This is not surprising when one considers the physical nature of the working life many will have led and the associated risk of injury, stresses and strains to the body.

The most recent Household Survey produced by Poppyscotland highlights mobility, both inside and outside the home, as the most common health problem cited by veterans themselves. This is backed up by a number of other reports and reflects the older and aging profile of the ex-Service community. Mobility problems can often lead to struggles with activities of daily living, such as washing, cooking and dressing. They can also result in isolation and loneliness if, for example, someone struggles to get out of the home, cannot drive or readily use public transport.

Smoking

Many older veterans completed their military service, including National Service, in an era when the dangers of smoking were not well understood and cigarettes were given out freely as a daily allowance. The consequences have been highlighted by Dr Beverly Bergman in a 2016 report which confirmed veterans in Scotland born before 1955 were at increased risk of smoking-related diseases.

Although overall smoking rates are decreasing in the Armed Forces, it is still the case that serving personnel are more likely to smoke, and more heavily, than their civilian counterparts. The potential future health implications are now well-known and spoken about. It is encouraging that the MOD is taking action to reverse this trend. For example, a Tri-Service Tobacco Control Working Group has been tasked with increasing smoking cessation, including identifying ways of discouraging recruits from taking it up in the first instance.

I am optimistic that smoking levels within the military will continue to fall, as across the wider population, with the consequent positive impacts on future veterans' health. However, the effects of a historical culture of heavy smoking will still leave some with related health problems that include certain cancers, cardiovascular and respiratory diseases, that will be seen for many years to come.

Alcohol Consumption

A previous chapter covered the serious effects of very heavy drinking when linked to mental ill health. However, it is still the case that veterans are more likely than their civilian peers to display problem levels of drinking. Some of this can be explained by aspects of the culture and attitudes within the Armed Forces. The following quote from a 2011 King's College London report, *Alcohol Use and Misuse Within the Military*, by Edgar Jones and Nicola Fear neatly encapsulates the nature of the problem and the difficulties the medical profession have in responding to it.

"Of necessity, the Armed Forces recruit risk-taking individuals. It may be that some of the characteristics that make a successful combat soldier also put them at risk of alcohol misuse. Sub-groups within the Armed Forces are particularly predisposed to heavy drinking. In particular those who are young, single and who have been involved in traumatic incidents. Because drinking has been used by UK Armed Forces as an agent to assist cohesion and informal operational debriefing, it requires a powerful cultural shift to modify ingrained habits and traditions….Alcohol has played such a significant part in service culture for so long that any intervention will take the form of a war of attrition."

Research by The Northern Hub for Veterans and Military Families' Research at Northumbria University also found barriers to veterans accessing appropriate treatment for alcohol problems. These include the inherent drinking culture within the military, a lack of understanding amongst the medical profession of their unique needs, and the stigma associated with asking for help. As with smoking, there are encouraging signs of problem drinking being tackled and reduced both within military and veterans circles. However, the effects of heavy drinking still leave some facing related health problems which can adversely impact on the individual, their family and the community.

Hearing Loss

Almost everyone who served in the Armed Forces will have been exposed to a significant amount of noise, which will almost inevitably take a toll on their auditory system. Severe hearing loss has already been covered earlier but it is also important to recognise that many, perhaps most, veterans will experience lesser degrees of impairment following their time in the military. This may entail noise-induced hearing loss from prolonged and repeated exposure to loud noise, or acoustic trauma usually as the result of an explosion or gunshot at close range.

The Royal British Legion report *Lost Voices* succinctly summarises some of the impacts of this hidden cost of military service when it states, *"hearing problems can have a profound effect on an individual's career prospects, family relationships, social life and mental health".*

Veterans – a distinct group?

All of the above leads me to the conclusion that there are a number of veterans who, despite the many improvements made in recent years, remain susceptible to health inequalities after a Service career. For many, it will have exposed them to combat, harsh physical conditions, stressful situations and a lifestyle that has had a detrimental effect on their long-term health and general wellbeing.

Given NHS(S)'s emphasis on reducing such occurrences of disadvantage, and an increasing body of academic evidence that highlights the long-term health implications of a military career, I believe there is a strong case for considering veterans as a group that deserves closer attention. In most cases, there will be an existing national strategy, framework or plan that dictates the approach and treatment required for specific conditions. However, these sometimes fail to consider the often unique requirements and characteristics of a sizeable veterans population. I am also concerned that they don't always address the multiple co-morbidities that frequently appear amongst this group.

I should stress at this point that I am not making a direct plea for significant resources to provide exceptional treatment for veterans as a whole. This is only relevant to those with the most severe and life-changing injuries, as I have argued in previous chapters. However, I firmly believe that the Scottish Government, NHS(S) and their partners should identify veterans as a distinct group whose health and wellbeing is influenced by their prior military service which leads, in certain circumstances, to inequalities that need to be addressed. I appreciate this is a complex ask that will involve many different organisations but the approach mirrors that taken for other groups in Scottish society. It has the potential to help build a better understanding of veterans' needs and characteristics, and develop practical measures that will improve health and wellbeing outcomes for all.

Recommendation 15 – Tackling Health Inequalities

The Scottish Government, NHS(S) and partners should identify veterans as a distinct group in their work to tackle health inequalities. In doing so they should produce proposals for preventing or mitigating inequalities as they apply to this group, with the ultimate aim of improving health outcomes for all.

Process and Administration

Given the size and complexity of the health and social care sector in Scotland it is unsurprising that issues of process and administration are important. This affects veterans just as much as the rest of the population but I have become aware of several factors which can complicate and hamper access to treatment and affect health outcomes for this group. These cover a range of subjects which may, on first inspection, be relatively minor and procedural in nature. However, each has a noticeable impact on how veterans are treated by the system and the quality of care provided.

Identifying Veterans

One of the great frustrations expressed by many health professionals is their inability to identify consistently and accurately those who have served in the military. There is no doubt that the current practice that requires GP surgeries to ask new patients whether they have served is a good starting point but it is also evident that the process has several limitations.

One of the first hurdles to overcome is the reluctance by some veterans to identify themselves as such, typically citing security concerns or personal antipathy for their decision. This is an entirely legitimate and understandable response but the consequences can be far-reaching, both for the individual and his/her access to bespoke care, and the health professionals who may not have a full medical history on which to base decisions. Ultimately, it is a personal choice to declare prior military service but I sense more can be done by the MOD, veterans organisations and NHS(S) to reassure and encourage people along this path. My personal experience is that this is a fundamental building block to enabling health professionals to better understand and consequently treat veterans.

There is also an internal problem with this process in that it misses a large proportion of those who may have been with a practice for many years and have never had the opportunity to formally share information about their previous military careers. Some are 'caught' during consultations and when surgeries request an update of personal records but too many are never identified. In the most serious situations this can limit access to the 'special' treatment covered in previous chapters but it may also deny health professionals extra background information that can influence diagnoses and decisions about treatment. I am also aware that this lack of basic data and medical statistics makes it more difficult to measure outcomes, shape future policy and address the health inequalities that affect some in our communities.

Recommendation 16 – Identifying Veterans

The Armed Forces and Veterans Joint Health Group should oversee work to increase the number of veterans declaring their previous service to GPs and others in the system. This will likely involve NHS(S), MOD and veterans organisations.

Using the Information

Further shortcomings of the present process concern the consistency of recording a veteran's military service on primary healthcare IT systems, the low profile this is given on electronic medical records once logged, and the difficulty of sharing it with systems supporting other areas within the NHS. This is partly a technical issue but I am surprised that there is still no contractual requirement, or incentive, for GPs to formally encode data fields about military service. The result is that busy surgeries will often give this work a lower priority despite the requirement to record such information during initial consultations with new patients.

To my mind this is a fundamental breakdown in a process that was first intended to ensure veterans were properly recognised by the health system and it is disappointing that after several years there is still no reliable method of recording, displaying and sharing this vital information. I strongly urge that NHS(S) address this issue as a priority since failure to do so could have an adverse impact on health outcomes for veterans and easily act as a block on other initiatives that rely on good statistical data.

Recommendation 17 – Using Information

The Armed Forces and Veterans Joint Health Group should oversee efforts to improve methods of recording, displaying and sharing information about veterans within the health and social care sector. This will be with a view to providing health professionals with the information needed to better understand and support veterans.

Registering with a GP

The final paragraphs in this section examine the recurring challenge of getting Service personnel to register with civilian medical practices when they leave the military.

I should stress that for the majority, and certainly for those with on-going severe medical conditions, responsibility for providing care is transferred effectively and efficiently from the Defence Medical Services to a local GP and NHS(S). In most routine cases the onus will be on Service leavers to follow instructions provided by MOD during their overall transition process. This is straightforward and rarely presents problems for those who are well-organised and confident of their future plans.

Despite this, there remains a significant number of Service men and women – usually younger and single – who leave and delay enrolling with a local medical practice. In the past I considered this to be a serious problem and disadvantage but am now aware that these individuals join many others in our society who rely on Accident & Emergency units, drop-in clinics and ad hoc visits to surgeries whenever they need treatment. This is not the preferred approach and I would encourage the MOD and NHS(S) – including through its *Inform* website – to do more to help these Service leavers to organise their healthcare more responsibly.

Veterans Champions

During the past four years I have had the privilege of meeting many Health Board veterans champions and have seen, at first hand, the positive impact they have in their local areas. Each has the latitude to tackle the role in their own way but there is no doubt that they have raised the profile of veterans amongst their colleagues and provided a valuable point of contact for those with concerns or needing help to access NHS(S) services. I admire and strongly support the work they do.

Warwick Shaw – Veterans Champion at NHS Borders

"By signposting help and resources, such as SSAFA and Veterans Scotland, champions allow GPs to direct veterans towards the right support as soon as they are seeking advice."

Circumstances have changed since the role was created and there is now a significantly different landscape following the integration of health and social care services across Scotland. Traditionally, champions have been recruited from the senior management or local board levels within NHS(S) but the introduction of Integrated Joint Boards (IJBs) and Health and Social Care Partnerships (HSCPs) present a markedly different structure in which they must now operate. With responsibility for delivery of services shared between this partnership of Councils and NHS Boards, champions will need to extend their influence more widely, work closely with a broader range of interested parties and be prepared to assist veterans who may struggle to understand the new set-up. This is likely to be a more complex and time consuming task.

A recent aide memoire issued by the Scottish Government and Veterans Scotland provides a welcome reminder about the role, its purpose and the key characteristics of an effective champion. I am pleased to see this document and believe it offers a good starting point as the role adapts to changing structures. Future work will, I anticipate, need to focus on (1) coordinating the efforts of local Council and NHS champions in supporting the provision of health and social care, (2) harnessing the clear commitment and tenacity of champions so they can influence IJB and HSCP decisions that affect veterans, and (3) empower champions as they support ex-Service personnel in their communities. In many cases this is already being done on an informal basis but there is a role for the Scottish Government, Veterans Scotland and NHS(S) to provide further advice and support as this important resource adjusts to changing demands.

Recommendation 18 – Veterans Champions

The Scottish Government and Veterans Scotland should build on recent work to support the network of NHS and Council champions to develop the role so that it can continue to be effective in supporting the delivery of health and social care to veterans within the new health landscape of Scotland.

Chapter 6

Conclusions

Conclusions

Chapter 6

The topic of veterans health and wellbeing is, by far, the most wide-ranging and complex that I have tackled during my time as Commissioner. Preparing this report has been a fascinating and thought-provoking experience that has exposed my team and me to very many issues and concerns affecting the ex-Service community at a time of **significant change across Scotland's health and social care sector**. During the study we have turned, repeatedly, to the four fundamental questions I posed at the outset (and can be found in the Foreword) which were intended to determine whether we are 'getting it right' for some of the most deserving members of society. I sincerely hope that my conclusions, and the subsequent findings and recommendations, will assist those responsible for planning and delivering improved outcomes for these individuals.

The first – and probably key – conclusion I have come to is that there is both a need, and a timely opportunity, to **rekindle awareness and concern for veterans' healthcare** in Scotland today. I acknowledge that the vast majority of ex-military personnel, especially those with serious and life-changing conditions, have access to impressive standards of treatment and support but the levels of ambition and innovation which characterised Scotland's approach in previous years have sadly waned since peaking at the start of the decade. My proposal for a distinct Scottish Approach to Veterans' Health is intended to provide the motivation, agenda and governance structure that will raise the profile of veterans and reinvigorate efforts to provide them with the best possible treatment and care.

At the heart of this proposed approach is an unequivocal **emphasis on the small – but vitally important – group of veterans with the most severe and enduring injuries** and conditions caused or exacerbated by military service. It is my opinion that the provision of specialist services for these individuals, who have given the most in serving our country and suffered life-changing consequences, should be at the very centre of Scotland's health system. I should stress that this support, usually delivered by the statutory and third sectors, is very good and that one of the main purposes of any approach should be to protect and enhance this care for current and future generations.

Another area in which the commitment to providing the best possible treatment to veterans, and ensuring it is well planned and resourced, can be most usefully met is in the field of mental health. The Scottish Government, NHS(S) and charities have done much on this front in recent years but there are still concerns about sustainability and, in some instances, accessibility. This has led me to call for a **Mental Health Action Plan** that secures long-term delivery of dedicated services and support to veterans. I have concluded that this should be one of the responsibilities of a new **network focussed on all aspects of veterans' health**. It will be important that the network reflects, both in membership and approach, a significantly changed health and social care landscape and local models of service delivery in Scotland today.

A further factor for ex-military personnel with the most serious and debilitating conditions is ensuring that their **changing health and social care requirements are properly planned and met for the rest of their lives**. In studying this theme, it became apparent early on that the system in Scotland has undergone transformational change in recent years, most prominently through the integration of health and social care services. I have, therefore, offered suggestions and recommendations which I believe reflect that change and will ensure consideration of veterans' health issues, especially for this group, is embedded within this new landscape.

While my focus has rightly been on the needs of those with severe and enduring conditions, I also recognised that there are others in the community that merit attention. It is pleasing to report that most veterans are in good health and I have discovered no obvious examples of disadvantage in either the availability of, or access to, services and support. However, there are some who are at an increased risk of facing **health inequalities as a result of military service**, which in itself constitutes a disadvantage. I have, therefore, concluded that by identifying veterans as a distinct group within the health system, there is an opportunity which must be grasped to redress some of these inequalities and improve the outcomes for a broad number of our veterans.

In one sense this report provides a snapshot of veterans' health and associated issues in 2018. More than that and with an eye to the future, I hope that the proposals it contains also offer a vision, framework and ideas for ensuring a reinvigorated approach to veterans' health. Ultimately, I believe Scotland has an opportunity to build on its well-deserved reputation and the quality of care it provides to our veterans community.

Annex 1

Recommendations and Findings




Recommendation 1 – A Distinctive Scottish Approach to Veterans' Health

The Scottish Government and NHS(S) should commit to establishing a distinctive Scottish Approach to Veterans' Health at a strategic level, accept or adapt the guiding principles of this approach and work with their partners to embed it at an operational level.

Recommendation 2 – Improving Collaboration and Partnership

The Scottish Government should reinvigorate senior participation in cross-border networks with a view to improved information sharing and increased involvement in collaborative working and initiatives.

Recommendation 3 – Leadership and Governance

The Armed Forces and Veterans Health Joint Group should refresh its membership and remit in order to provide the vital strategic leadership that will deliver the Scottish Approach to Veterans' Health

Recommendation 4 – National Managed Clinical Network

The Scottish Government and NHS(S) should establish a network on veterans' health. The network will have oversight of delivering the Scottish Approach to Veterans' Health, and will consider the key issues raised in this report and others it deems relevant. It should reflect current structures in the health and social care sector in its membership and approach.

Recommendation 5 – Mental Health Action Plan

The Scottish Government and NHS(S), through the network on veterans health (see recommendation 4), should produce a Mental Health Action Plan for the long-term delivery of services and support. Systemic issues of funding, collaboration, leadership, planning, governance and training of staff will be key.

Recommendation 6 – Drugs Misuse

The Scottish Government and NHS(S) should assess the scale and nature of drugs misuse – especially prescription and non-prescription painkillers – amongst the veterans community in Scotland and introduce remedial measures. This should be taken forward by the Joint Group and network, and included as part of the Mental Health Action Plan.

Recommendation 7 – Barriers to Accessing Services

The Scottish Government and NHS(S) should build on existing work aimed at reducing barriers to veterans accessing mental health services. This will include measures to address issues of stigma, seeking help, and improving awareness and understanding within the medical profession. This should be taken forward by the Joint Group and network, and included as part of the Mental Health Action Plan.

Recommendation 8 – Access to Life-long Services

The Scottish Government, NHS(S), Health Boards and local Councils should make a commitment to veterans with the most severe and enduring physical (and mental) conditions that they can access the highest quality health and social care services for life and as their needs change. Health and Social Care Partnerships and Integrated Joint Boards will be instrumental in planning the delivery of these services and the national network recommended in chapter 2 should assume responsibility for oversight of this work as an early priority.

Recommendation 9 – Funding for Multiple Injuries

The Scottish Government and NHS(S) should give consideration to whether the costs of specialist care for veterans who have suffered polytrauma should be funded through the National Services Division (NSD).

Recommendation 10 – The National Trauma Network

NHS(S) should include the specific needs of veterans who have suffered polytrauma as part of its work in setting up a national Trauma Network.

Recommendation 11 – Wheelchairs for Amputees

NHS(S) should adapt current arrangements to ensure an appropriate level of funding is available to guarantee that wheelchairs provided by the MOD for veterans with severe amputations can be serviced, maintained and replaced with the best possible equipment commensurate with that individual's needs.

Recommendation 12 – Chronic Pain Management

The National Advisory Committee for Chronic Pain (NACCP) should consider veterans specifically as part of their work to improve chronic pain management in Scotland.

Recommendation 13 – Funding Hearing Aids

The Scottish Government and NHS(S) should make funding available so that veterans with the most severe hearing loss as a result of their military service can have access to the best possible hearing aids and support.

Recommendation 14 – The Invictus Games

The Scottish Government should work with partners, charities and others to scope a proposal to host a future Invictus Games in Scotland.

Recommendation 15 – Tackling Health Inequalities

The Scottish Government, NHS(S) and partners should identify veterans as a distinct group in their work to tackle health inequalities. In doing so they should produce proposals for preventing or mitigating inequalities as they apply to this group, with the ultimate aim of improving health outcomes for all.

Recommendation 16 – Identifying Veterans

The Armed Forces and Veterans Joint Health Group should oversee work to increase the number of veterans declaring their previous service to GPs and others in the system. This will likely involve NHS(S), MOD and veterans organisations.

Recommendation 17 – Using Information

The Armed Forces and Veterans Joint Health Group should oversee efforts to improve methods of recording, displaying and sharing information about veterans within the health and social care sector. This will be with a view to providing health professionals with the information needed to better understand and support veterans.

Recommendation 18 – Veterans Champions

The Scottish Government and Veterans Scotland should build on recent work to support the network of NHS and Council champions to develop the role so that it can continue to be effective in supporting the delivery of health and social care to veterans within the new health landscape of Scotland.

Finding 1:

Specialist physical and mental health services are a vital and valued part of supporting our veterans with the most severe and enduring injuries and conditions. While their exact make-up and models of delivery will inevitably change and adapt over time, it is imperative that the availability of specialist services – and the outcomes they support – are protected for current and future generations.

Finding 2:

Funding for specialist mental and physical health services for veterans is disjointed and in some cases ad hoc. This results in a degree of uncertainty and raised questions about the sustainability of some of these services, which is a worry for those who rely on and value them so much. It is an issue that needs addressed as a priority.

Finding 3:

The integration of health and social care services in Scotland provides a unique opportunity to ensure the longer-term needs of veterans are properly planned and met. The new structure of IJBs and HSCPs is the vehicle for delivering this ambition. They must play a central role in decision-making about veterans' health and wellbeing and the delivery of both mainstream and specialist services.

Finding 4:

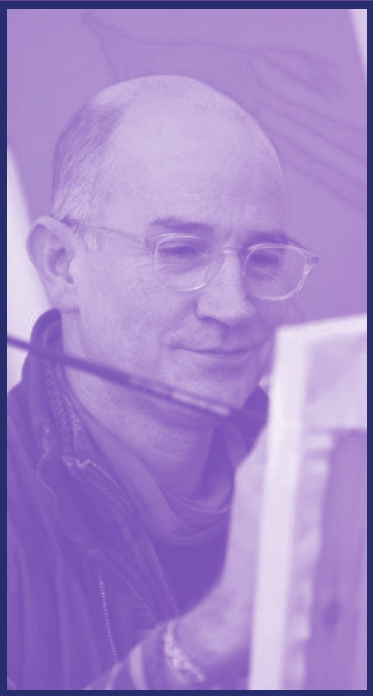
The publication of the Suicide Prevention Action Plan by the Scottish Government later this year is a welcome step in ensuring everything possible is done to help anyone struggling with mental ill health. Vulnerable veterans, and their particular circumstances, will be an important consideration as the plan is developed.

Finding 5:

Rehabilitation services, such as those provided by physio and occupational therapists, can be of huge benefit to those suffering from MSDs. Given the high demand for such services, veterans suffering from severe MSDs as a result of their military service should be given early access as part of their special treatment.

Annex 2

Case Studies

Case Study 1

Jason Hare – Veteran and Operations Manager - Horseback UK

Serving his Country

Jason (Jay) Hare was a Corporal in 45 Commando Royal Marines where he experienced some of the world's toughest and most hazardous environments, serving in Northern Ireland and Afghanistan. His case study provides an insight into the traumas he suffered and his hopes for the future.

Having previously been injured by an IED in Afghanistan in 2006, Jay then sustained severe injuries in 2008 after being blow up by another IED in Sangin, Helmand Province; frequently referred to as the 'valley of death'. Aged just 27, the incident left him with life-changing injuries including, the loss of his left leg below the knee, several fingers, injuries to his right arm and right leg and serious injury to his face which required multiple reconstructive surgeries over a number of years.

Jay received treatment at Selly Oak Hospital and then the Defence Medical Rehabilitation Centre Headley Court. Remarkably, Jay was only in hospital for five weeks before being discharged and back home for Christmas 2008 - something he attributes to the exceptional treatment he received at Selly Oak. Subsequently he received further treatment at the Recovery Centre near Epsom and returned to 45 Commando in April 2009. He notes that the Recovery Centre wasn't initially equipped to deal with such severe injuries, but quickly evolved due to the number of severely injured servicemen coming through its doors.

His welfare package extended to specialised support to his family, including the assignment of a welfare support officer. Part of this involved communication between families going through similar experiences, meaning they developed a close relationship adding an extra layer of support described by Jay as *"crucial"*.

Looking to the Future

Jay now works as Operations Manager at Horseback UK which uses horsemanship to inspire recovery, regain self-esteem and provide a sense of purpose and community to the wounded, injured and sick of the military community.

Aged 36, Jay already feels twinges in his prosthetic leg, other injured knee and back. He questions whether the same level of support he has received to date will be available in the next ten years. Now based in Aberdeen where he receives any treatment or assistance required, Jay worries that if he is to break his two prosthetics he would struggle to find funding for an equivalent replacement or new updated models. He questions what measures are in place to ensure that this is never a problem combat veterans will have to worry about.

Although Jay notes that it is highly promising and encouraging to see a variety of Scottish veteran charities allocated money, he is also concerned about enough funding being reserved for future resources to effectively deal with the delayed onset health conditions experienced by the ex-Forces community, such as PTSD and Adjustment Disorder.

He said: *"The Armed Forces Covenant made a promise to the veteran community that we would be treated fairly. It stated that 'British soldiers must always be able to expect fair treatment, to be valued and respected as individuals, and that they (and their families) will be sustained and rewarded by commensurate terms and conditions of service'. Are enough future resources in place to really deliver this promise? As Operational, we were told that we were going to be looked after if injured – that was the deal that was on the table and I hope that is still the case."*

Having said this, Jay is very positive of the current services and support that is available and believes that we need to

keep this momentum going.

"Although I think that we definitely need to readdress how we are preparing for veterans' future needs in terms of health and wellbeing, the current services available are the best that we have had access to for generations.

"Veterans also now have a louder public voice with a proactive Veterans Minister and the Scottish Veterans Commissioner working in parallel to improve outcomes for veterans in Scotland across a range of key areas - this is extremely encouraging."

Case Study 2

Aidan Stephen – Veteran and Full-time Art Student

47-year-old Aidan Stephen served in the Army (Royal Armoured Corps) for seventeen years, during which time he undertook operational tours in Northern Ireland, Bosnia, Kosovo and finally Iraq in 2003. When he returned from Iraq, his life spiralled badly, and he was medically discharged from the army due to serious mental health issues. After an extensive range of support over several years, he is back on track, and is now active on the veterans scene where he shares his story at events. For the past two years, he has sat as a member of the Scottish Veterans Fund panel, which makes recommendations to Scottish Ministers on the allocation of funding to veterans projects.

"I was diagnosed with depression in 2000 while still in the Army, however I was deployed to Iraq in 2003 regardless. At the time, if you were suffering from mental illness in the army, only your superior officer would be informed – you didn't want any of your juniors to know in case it lowered their respect for you and affected your leadership capabilities. There was a real stigma attached and I kept it very much to myself.

"A few months after returning from Iraq, I attempted suicide and spent five days in a coma. When I woke up, I was admitted to a military psychiatric facility in Germany for four months, where I spent many hours heavily medicated and receiving electroconvulsive therapy (ECT). Most patients were relatives of soldiers, and the support I received wasn't suitable for my needs.

"I returned to Scotland where my wife and I separated and I ended up living alone in a small basement flat in Edinburgh, isolated with little family support. I was still in the Army at this point and they were trying to figure out what to do with me. I was sent to the Priory in Glasgow, a civilian mental health unit which treats people with addictions and eating disorders. This was one of the worst decisions made in the duration of my treatment. None of the staff were trained to deal with patients from a military background and none of my fellow clients shared my experiences, yet I had to participate in group therapy with them.

"One day, one of the patients said she was feeling low because she had eaten loads of chocolate cake that morning. Whilst acknowledging that seemingly minor issues such as this can have a much deeper psychological root for some people, I was suffering from night terrors and traumatic flashbacks to my time in the Army, and comments like this only increased the distance I felt between myself and everyone else at the facility, leaving me feeling even more isolated.

"I was then sent to Bedlam in London, regarded as the best psychiatric hospital in the UK at the time, where I was given more medication and ECT. In 2006, I was given medical discharge from the Army, and with no progress in the previous three years, I was now in the care of civilian doctors rather than military doctors. Both had told me that it was up to me to make the changes I needed to start getting better.

"I returned to my flat in Edinburgh and continued to spiral, culminating in an incident where I threatened to kill myself and self-harmed in public. I was arrested for this and ended up on remand for eight days. A doctor I spoke with while there told me to get in touch when I was out and he made me aware of veteran-specific support services that he thought would help me. This is where things finally started to turn around.

"When Veterans F1rst Point launched in Edinburgh in 2009, for the first time I had the opportunity to access peer-to-peer talking therapy. It was the first time I had really spoken to anyone about my experiences – until that point, my treatment plan had mostly included medication and ECT. I was diagnosed with PTSD which I got support for from Combat Stress, and accessed a range of other services through veterans charities.

"I had a real breakthrough with Poppyscotland and SAMH in 2011. After identifying that I wasn't socialising enough and learning that art therapy had worked to a degree at Bedlam, they referred me to a project called Artlink. I really enjoyed it and Poppyscotland helped me explore art courses, taking me to visit Edinburgh College of Art. A woman at the Student Disability Service encouraged me to apply and I was accepted on my chosen course. I am now in my third year, and my mental health has improved massively.

"Looking back on my own experience, I would say that the value of recreational organisations and initiatives aimed at veterans, such as Horseback UK, should not be underestimated and the veterans support scene would benefit from more of these. For instance, I am not aware of any art organisation with a veteran-focus, despite art therapy being a common form of treatment for all people with mental health issues.

"Alongside reintegrating into the civilian community through art, actually talking to someone about my experience was key to making progress with my mental health. It seems obvious, yet it was six years after my suicide attempt before I was given the opportunity to do this with a fellow veteran, and I just didn't feel like I could open up to anyone else. I felt like they wouldn't understand and also that there were some things I could say which a civilian might consider reporting to the police. I think ensuring that peer-to-peer support is made available at the earliest stage possible would significantly improve the outcomes for Service leavers with mental health issues.

"All veterans have completely different experiences and needs, and have different ways of adjusting to the civilian world. However, being able to talk with someone openly and honestly provides the basis for developing a suitable treatment plan which can effectively address these.

"In addition to a one-to-one therapy setting, chatting on a social basis with other veterans is also extremely important, and I feel the support organisations which work best are ones which facilitate this through group settings. Building on the existing network of veteran cafes and respite break initiatives available in Scotland would be hugely beneficial in easing transition and combating isolation, which I know first-hand can be deadly.

"Although I have come a long way since my lowest point, I still have bad days which are unlikely to ever go away completely. Most veterans agree that continuity is essential - PTSD can't be cured, only controlled, and long-term support for this is vital. Many of the initiatives aimed at improving veterans' wellbeing can only provide certain types of support on a limited basis due to funding.

"Horseback UK runs a five-week course which many service users benefit from on a short term basis, however, for the impact to be maximised, their access to the service needs to be sustained. There needs to be more funding allocated to help veterans access specialised recreational programmes on a long-term basis, as recovery is a lifelong process."

Case Study 3

John Johnston – Veteran and Research Project Officer, Borders General Hospital

John Johnston of Galashiels left the Army in 1988 after six years of service, despite enduring a severe injury to his back in 1983. On returning to Civvy street, John went on to fulfil a successful career in the prison service for 23 years until 2011 when his injury prevented him from continuing work. After medical assessment, he was categorised as disabled. Forced into unemployment, John felt a great sense of worthlessness which led to suicidal thoughts until Veterans First Point Borders intervened.

Leaving a Community

Leaving the Armed Forces where there is a real sense of belonging and comradeship is difficult, John explained, as you feel as if you're going it alone in the civilian world. Employment within the prison service replicated this feeling of community for John, and it wasn't until he had to stop working due to his Service-sustained injury that a sense of worthlessness set in.

His mental health rapidly deteriorated which led to the breakdown of his long-term relationship and suicidal thoughts as he resorted to living in his car.

He said: *"I had hit rock bottom and felt as if I had literally been thrown on the scrap yard, I had lost a sense of belonging and felt as if I had no purpose with no job prospects."*

In September 2016 John initially approached Citizens Advice Bureau for housing advice, where a staff member recognised that he needed further support and directed him to Veterans First Point (V1P) Borders. Within just a few days, V1P assigned a peer support worker to John who was able to provide one to one support and that crucial feeling of military familiarity.

Within the subsequent days, John met with a psychologist who diagnosed him with clinical depression and high functioning autism. The lack of support in dealing with this was leading to his suicidal thoughts. Accessing the services through Veterans First Point Borders was the pinnacle moment of John transforming his future.

Why V1P Works

It can be extremely overwhelming for ex-Service personnel to even recognise that they are in need of help. The beauty of V1P, John explained, is that it can help you recognise that you do need support and that it is available.

John accessed the services at V1P from September 2016 to November 2017 where he was provided with weekly therapy sessions, open invites to group sessions and practical sessions such as CV writing to help him secure employment.

"The whole ethos of V1P is that they go the extra mile for everyone who accesses the service. They helped me get out of the house and meet with likeminded people which ultimately is the reason I am still here today.

"It gets people from all Forces backgrounds around the same table and creates that sense of belongingness that we have all been a part of. There is no medical jargon to cut through either which for many of us can be a deterrent from visiting health practitioners. Speaking with someone who 'gets you' from a Military perspective is fundamental."

Support at V1P extends to volunteers setting up mock job interviews, a technique which helped John secure his role as Research Project Officer at the Clinical Governance and Quality department at Borders General Hospital.

John continued: *"Even once you've finished treatment or completed a programme through V1P, it never closes its doors on you. 18 months ago I couldn't see a future, but through its continued support I now welcome the light at the end of the tunnel.*

"Now if I have an issue I can phone up and speak on the phone. That's probably the most important part – I feel like a person rather than just being a statistic."

Limitations and Looking to the Future

V1P is not an emergency service nor is it able to provide all levels of care, but what it does ensure is that when it can't provide a certain type of support directly, it will signpost veterans in the right direction.

John noted that whilst he thinks the promise set out in the Armed Forces Covenant is valuable, more needs to be done to ensure that those who make the pledge are taking steps to fulfil it.

He also voiced concerns about what would happen if the service was ever to permanently close its doors.

He said: *"I can confidently speak on behalf of almost all veterans who access V1P in saying that we would feel a great sense of loss if it wasn't for the support, comradeship and friendship the service has provided.*

"From personal experience I know how the mental health stability of veterans can go from one extreme to another rapidly, so having an instant support service in place is crucial and potentially life-saving. I don't believe that veterans should get support first just because they were a soldier, but we should get some sort of recognition for our Service to the country in reflection of what the Covenant sets out to achieve.

"Accessing treatment through GPs can sometimes be months and that length of time can hinder veterans seeking support, so it would be a fantastic step in the right direction if a service similar to V1P Borders was rolled out nationally."

After successfully completing his treatment, John now volunteers at V1P Borders.

Case Study 4

Andy McIntosh – Veteran and SSAFA Branch Secretary

Andy McIntosh, 44, from Strathaven near Glasgow, served as an Army Corporal with the Cheshire regiment for 15 years, serving in Bosnia, Iraq, Northern Ireland and the Falklands.

Andy decided to leave the military in 2003 with an exemplary record to pursue a different career path. After leaving the Forces, he found employment as a shift worker in a factory in Bellshill and later started to work as a depot manager in the East End of Glasgow. Whilst at work in 2008, a persistent kidney pain that Andy had been experiencing worsened and he collapsed. He was taken to hospital and treated for a kidney infection, but through further medical testing it was discovered that Andy had over 150 blood clots in his lower leg, afflicting the main vein that carries blood from the leg to the heart.

Andy explained: *"I had been in excruciating pain but had just put it down to a chronic kidney infection. It was difficult to believe that I'd been suffering such serious injury. The medics traced it back to the trauma of an explosion in Northern Ireland. Even though I had walked away relatively fine at the time, I was now experiencing the aftermath."*

Andy was referred to various vascular specialists across the UK and was told that he would never be able to work again. There was a glimmer of hope when he was referred to a specialist professor in London. Through consulting with a global vascular specialist based in Amsterdam, he proposed a procedure that would help Andy walk again if he could get physio to help his legs. With support from Poppyscotland and Erskine, he was given access to intense physiotherapy treatment to help him get to the required level of health. Unfortunately, despite his efforts, the specialist deemed the treatment too risky, and Andy's hopes were quashed.

He said: *"Being offered the chance of walking again and getting so far down the procedure line for it to then be, what felt like, snatched away, left me in a really dark place.*

"I didn't have an income and found myself in crippling debt, losing my house. Us in the Military are quite a proud lot and if I'm honest I didn't want to ask for help, nor did I know who to approach for help – I was at my wits end."

Whilst attending a talk by former British Army Officer and motivational speaker Chris Moon, Andy was advised to approach Poppyscotland and the Armed Services Advice Project (ASAP). This was a turning point.

He explained: *"An ASAP advisor visited me and helped me organise my finances. The beauty of the help that I received was that I didn't feel I was being judged by my situation. They didn't put any blame on me and told me to stop beating myself up. All they wanted to do was get me back on the right track. I also had the difficulty of dealing with my physical disability and had become a recluse, refusing to go out in my wheelchair. It just wasn't who I was and I was finding it difficult to adapt. That's when David McAllister, branch chairman for SSAFA Lanarkshire, visited me on behalf of Poppyscotland. He could see I was struggling with this new lifestyle and he helped me get a mobility scooter which has given me my life back."*

Looking to the Future

Through regaining confidence and use of his mobility scooter, Andy has now returned to work and is the SSAFA Lanarkshire's branch secretary and a case worker.

He said: *"It's great to give something back to SSAFA, and it's fulfilling to be able to speak with veterans who are referred to us who can relate to me and my experiences. For many veterans, speaking with someone on their level can be more effective than going to their GP or a psychologist.*

"Since starting the role, my eyes have been opened to the amount of veterans out there that are struggling and with so many charities, many ex-Service personnel don't know which one is right for their needs. As a company, Veterans First Point (V1P) has been one of the biggest benefits in the last 18 months – the work they provide is phenomenal and it would be good to see this or a similar project rolled out nationally.

"I think we also need to consider how we're going to ensure that we can sustain this level of support in the future. I'm an example of how health and wellbeing issues can arise way down the line after leaving Service, and I know that I'm not the only veteran in this situation. We need to ensure that we are equipped to meet the demand of veterans who require health and wellbeing services in the future, which is likely to increase if anything."

Case Study 5

Sharon Fegan & Lauren Anderson – V1P Therapists

Sharon Fegan, a psychological therapist and occupational therapist, and Lauren Anderson, an occupational therapist, both work at Veterans F1rst Point (V1P) Lothian, a service staffed by an alliance of clinicians and veterans with the aim of providing a one-stop-shop for the ex-Forces community. The service is delivered in partnership with the NHS, with a total of six V1P centres throughout Scotland.

Although they provide support and treatment for a wide range of issues, veterans experiencing mental health issues form the largest proportion of service users that Lauren and Sharon work with.

Meaningful occupation based on individual aspirations

On the subject of treatment, Lauren says: *"Our central aim is to ensure that our clients are engaged in diverse and meaningful occupation that will lead to regular social contact, routine, and improved self-esteem. Whether that is employment or leisure activities depends on the individual's situation, taking into account a range of factors including mental and physical health, their aims and their abilities.*

"The service users I see are seeking fulfilment through employment, and the key challenge I face with them is helping them identify a starting point. Collaboratively, we figure out what they are able to do, what they want to do and where they need to start to get there. Veterans sometimes require additional support and experience to navigate the employment "highway" of the civilian world.

"At Veterans First Point Lothian, a supported employment model known as Individual Placement and Support (IPS) is used. IPS is the most effective approach in helping people with mental health conditions gain employment and involves one-to-one support, rapid job searching, and ongoing support for an unlimited length of time once the individual is in work.

"Much of our day-to-day work involves providing practical employment support such as writing CVs and cover letters, liaising with employers, honing interview techniques, and learning how military skills can be transferred to the civilian workplace. In addition to this, I will provide ongoing emotional and practical support to veterans and their employers once they are in work. Although it is not essential for IPS to be delivered by an occupational therapist, our core skills help enhance this role with regards to mental health training, assessment skills, job retention and symptom management.

"At V1P Lothian we have seen a rise in physical problems, most commonly loss of hearing, general wear and tear, frailty, and occasionally weight management, breathing difficulties and malnourishment. As a team, we signpost and support veterans towards the most suitable services to assist with their physical issues, whilst looking at how we can manage the emotional aspects through meaningful activity.

"As with the elderly in the wider population, one of the biggest challenges we face is social isolation and the team facilitates group activities and attendance at drop-in sessions to combat this. Some veterans are fit enough to get themselves to such activities, but for those that aren't we would work with partners to assess carer needs and assist with putting any requirements in place.

"Our focus is not solely on a client's symptoms, but their aspirations. On the whole, age isn't a huge consideration; we work with the individual to identify their needs and goals, breaking down barriers to help them to engage in their desired occupations and activities."

Instilling a greater understanding of veteran-specific needs across the sector

Sharon continues: *"We are working in an environment that was developed by and for the ex-Forces community, therefore we are always aware of our client's Service background, with colleagues who are veterans themselves offering valuable insight on effective communication. We have access to a veteran's military records which also gives us greater understanding of their military experiences, and we work in partnership with veterans' statutory services and charities to best meet the needs of a veteran, which is difficult in mainstream services given the range of service charities in Scotland.*

"For veterans accessing services in a wider healthcare setting, their clinician may not even know they are a veteran, and their knowledge of veteran-specific issues and preferences may be limited.

"For instance, we've found that, across all healthcare settings, veterans frequently turn up 15 minutes early for their appointment, and when clinics are running late, this may result in a substantial wait which may lead to feelings of frustration around the support some veterans are accessing. Additionally, veterans, the majority of whom are male, are less likely to approach services for help and given they are mainly from the most deprived sections of society they are even less likely to access services. Due to the complexity of some veterans' experiences, many face multiple barriers to accessing the relevant care."

Lauren adds: *"Language is also a hugely important aspect of treating the ex-Service community. Since I began working at V1P, I've picked up a great deal of military terminology which I previously didn't know. Building a good relationship with veterans in a therapy context involves showing appreciation and respect for their background, and acknowledging that there are aspects of Service life you don't know about, but which you hope to learn from them."*

Sharon continues: *"Students and trainees come to V1P for placements as they would in any other health setting, and we have developed practice education placements for them. At a very early stage in their career they are learning how clients from a Service background might differ from civilian clients, and the best ways to approach this. Considering ways in which this increased awareness could be replicated across all positions in the NHS would be a really positive step towards improving engagement with veterans.*

"I was recently helping a client complete a PIP form and I noticed a question about having served in the Armed Forces was included. This is something which I think should be added to all forms when registering for health services. Through basic training, an affirmative answer would prompt a range of considerations for the clinician at the outset, such as whether or not there are any other physical or mental health issues, and how this client might require additional support to access public service systems.

"As standard, GPs in Scotland include the question on their registration forms, however, unfortunately, many still do not know what to do with that information. It would be beneficial to provide a short crib sheet on their system to give options for onward referral and analyse that information."

Occupational therapists as the specialist and influencers in engaging with veterans

Lauren says: *"Occupational Therapists are trained to promote physical and mental health and to work in both health and social care. These skills could potentially be utilised in V1P Teams to holistically address the needs of veterans and minimise onward referrals, or where appropriate, expedite the most appropriate supported onward referral."*

Sharon adds: *"Many of the current Scottish Government policies around health, wellbeing and justice are positioned within a rights-based approach. Our profession's resulting connection to occupational justice and people's right to engage in meaningful activities that influence health and well-being supports our unique understanding of the multiple factors that can limit or diminish engagement with occupation. A key message for the Scottish Government is that occupational therapists are the 'go-to' experts to influence and drive change towards the promotion of occupation for people and communities, including veterans, and increase their access and engagement.*

"It's important we instigate a sector-wide shift where we see staff develop a greater understanding of what support veterans actually need, as opposed to administering treatment programmes based on what they think veterans need."

Case Study 6

Jane Duncan – Veteran and Veterans Support Advisor

Jane Duncan is the Veterans Support Advisor for Renfrewshire Council, East Renfrewshire Council and Inverclyde Council. Having served 22 years in the British Army, Jane is a veteran herself and therefore has a wealth of understanding about the resources that are crucial to ensuring Military personnel are provided with the right services and tools when returning to Civvy street.

The idea of implementing a Veterans Support Advisor arose in 2012 when all three Councils signed the Armed Forces Covenant and it was decided that to maximise their commitment, a lead individual was necessary. Commencing the role in 2014, Jane underpinned what services were already in place and what needed to be implemented to improve services and opportunites for Military personnel within these regions. It was quickly apparent that whilst there was information and services available, these were not readily accessible for veterans due to poor communication.

After reviewing what initiatives, services and tools were already available within these Councils and NHS boards, Jane initiated a veterans' 'Mini Champions' programme. She built upon the information and tools already in existence and used this material to train individuals within Council teams such as employment, finance and housing so they were equipped to provide veteran specific advice.

Having the 'Mini Champions' programme ensures that someone within the local area is immediately aware of an issue faced by a veteran and in turn can guide them to the support available; whether it is locally or nationally. Many veterans voice that it can sometimes be overwhelming to know what support is available so having someone trained within their local area can remove this barrier.

Why 'Mini Champions' Works

The 'Mini Champion' programme extends to equipping veterans with the confidence to attend local social groups which is a valuable network for veterans.

Jane commented: *"There is no reason for any veteran to feel alone or isolated when leaving the Armed Forces and joining social clubs can often be a crucial element to help build confidence and give a sense of purpose.*

"When you leave the Armed Forces, you leave a community, and that is very difficult to step away from. Replicating that community sense via social groups and organisations can, for some, help Military personnel feel part of a tight knit group and most importantly, valued.

"My role extends to liaising with local clubs and initiatives within the area to ensure that they are equipped with the knowledge of how to help veterans in their community integrate. We need such clubs and groups to welcome veterans, and recognise the pool of talent and skills they withhold."

How have Attitudes Towards Veterans Changed

Through the implementation of Jane's role, she has noted that there has been a huge shift in attitudes towards veterans within the three Councils she works with.

She said: *"The appetite from Renfrewshire Council, East Renfrewshire Council and Inverclyde Council to help veterans integrate into the community has significantly increased since 2014 and they all want to play their part in ensuring that the region is viewed as a place to settle for veterans. They want ex-Service personnel to know that they, and their families, are welcomed to the area and that there is support and help in place at a local level."*

Looking to the Future

Jane fundamentally believes that there would be great benefit for each Council in Scotland to implement a Veterans Support Advisor role but if it were to do so, then it would need to be coordinated through a body such as Veterans Scotland.

"I would love it if every veteran in Scotland was able to contact their local authority directly and get the support they required. Whilst it's great to promote national level services, it can be difficult for veterans to know who to turn to for advice. The 'Mini Champions' programme acknowledges a veterans' query immediately and can help prevent it manifesting onto a larger scale."

Case Study 7

Warwick Shaw – Veteran and NHS Borders Veterans Champion

Warwick Shaw is the NHS Borders Armed Forces and Veterans Champion. He has worked within the NHS after a fulfilling career in The Royal Artillery, Regular Army, for 19 years. Throughout his career in the NHS, he has always been personally interested in the care and provision for Armed Forces veterans due to his Military background and had a watching brief for arising ex-Forces issues. Warwick was depute for five years before his appointment to the role of Armed Forces & Veterans Champion.

What is an Armed Forces And Veterans Champion?

The NHS Armed Forces and Veterans Champion has a responsibility to provide support to past and present Armed Forces personnel, as well as their families, within their local authority area, to ensure their needs are met. The Borders no longer has the capacity levels of a large number of serving personnel to set up specific veterans services as in other locations. Instead, Warwick has concentrated his efforts and resources on equipping GPs with information and the right tools that they could use to help veterans.

He explained: *"By signposting help and resources, such as SSAFA and Veterans Scotland, we can cut out the middle man and allow GPs to direct veterans towards the right support as soon as they are seeking advice."*

Services Implemented

In 2015, Warwick, in cooperation with other NHS Scotland Boards, saw an opportunity with available LIBOR funding and helped establish a Veterans First Point Borders service.

Warwick explained: *"V1P has been a great tool and we have had about 80 referrals since establishing the service, of which about half are still accessing the advice and services that are provided.*

"The fundamental element that makes V1P a success is that veterans are provided with a peer support worker who, through shared experiences, one to one dialogue and assistance, ensures that veterans feel like they are being listened to and someone is actually trying to help.

"As well as being more equipped to understand veterans, using peer support workers has the secondary benefit of overcoming funding challenges, being more cost-effective than exclusively hiring clinicians."

Does the Current System Work?

Warwick believes that the peer support work delivered through V1P is key to facilitating successful support for veterans; repositioning the support as chatting to someone at the same level, as opposed to them being a '*recipient*' of care. It also encourages ex-Military personnel to feel part of a network, heightening their self-esteem and preparing them to move on to new ventures.

He commented: *"I think what we're doing is good but what we need to really showcase this is more financial support and ultimately rolling the programme out across the whole of the UK. We aren't looking for all singing, all dancing services but veterans do deserve the right to dedicated support."*

He continued: *"As an ex member of the Forces with physical injuries, I don't think I should get any more service than someone who sustained injuries from say a car accident, but I should get at least the same level of care.*

"Veterans with severe and enduring conditions should have equal access to specialist treatment and care, regardless of their geographical location."

How Could the Role of NHS Veterans Champion Be Improved?

Warwick highlighted that whilst the current system does work for the veterans who access the service, there is a large pool of veterans who are unaware that his role and support exists.

He commented: *"NHS Armed Forces and Veterans Champions are a complete mystery to veterans. V1P is helping raise awareness but the people who do access V1P did not know that there was a Veterans/Armed Forces Champion within NHS Boards or local authorities. I have never been approached directly by an ex-Servicemen."*

This insight indicates that there is a need to highlight that such bodies are available to veterans, although Warwick noted that Armed Forces champions could not cope with the demand from every single veteran in Scotland, so that's why it's so important to have a strong relationship with the likes of SSAFA and V1P.

He noted: *"V1P is an excellent model that I think should be made exemplary across Britain. Equally I think what should be rolled out across Scotland and perhaps Britain is for veterans to have access to NHS services through a GP rather than going to a specialist who they may only see infrequently."*

Case Study 7

'Joe' – a veteran

'Joe's' story was shared with us by Charlie Allanson-Oddy, Consultant Psychological Therapist at Veterans First Point Lothian. It gives a glimpse into the struggles and challenges faced by someone with PTSD and, in this case, a successful adjustment to civilian life.

'Joe' was medically discharged due to PTSD following events in Afghanistan in 2012. Following discharge he had been allocated a veterans house but was isolated and finding it very difficult to communicate with his neighbours. Eventually Joe attended the V1P Lothian offices in June 2016.

A Clinical assessment was offered but not attended. After discussion with Veterans UK another assessment was offered which Joe attended. He continued to present with PTSD and aspects of Generalised Anxiety Disorder (GAD) – difficulty in eye contact and a reluctance to discuss anything relating to events on a tour of Afghanistan.

Joe was offered Acceptance and Commitment Therapy (ACT) one of the Cognitive and Behavioural Therapies particularly effective in reducing avoidances. In Joe's case these avoidances were maintaining his trauma symptoms and affecting his quality of life significantly. Eventually, Joe was able to discuss in detail the events from his tour of Afghanistan that had so greatly affected his confidence in himself and other people and to take part in a range of social activities that had become increasingly difficult for him over the last few years.

He was encouraged to increase his activity levels and he now attends the gym regularly. He was also referred to the Citizens Advice Bureau (CAB) for a benefits related appeal. CAB attended the tribunal with him and helped to win his appeal.

Internally referred by his clinician to Occupational Therapy (OT), Joe now attends sessions with both the psychological therapist and occupational therapist. The OT meets Joe to discuss work options and as part of the graded exposure to work, and supports him to apply for jobs.

Joe is now largely free of symptoms, applying for jobs and continuing his adjustment to civilian life.

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Veterans' Health & Wellbeing in Scotland
A Distinctive Scottish Approach

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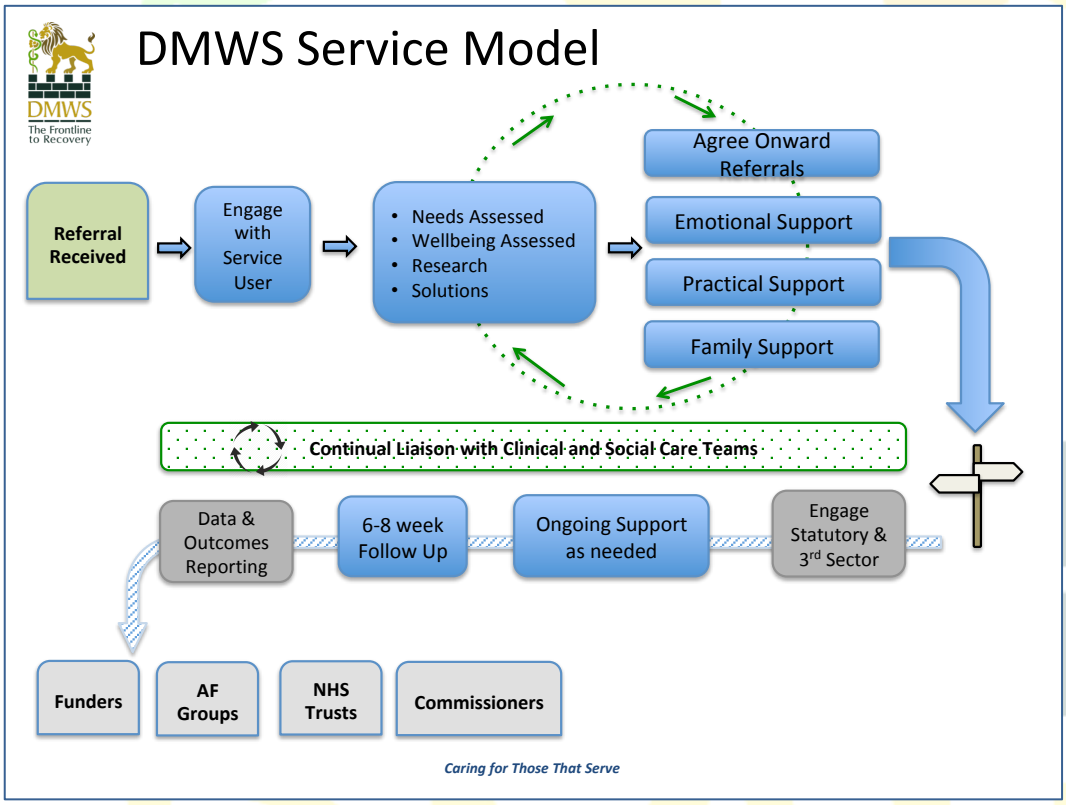
Summary of Proposal for DMWS Medical Welfare & Wellbeing Service Ayrshire

PROPOSAL: An Ayrshire medical welfare and wellbeing service, over 1 year, to deliver person centred, confidential, and independent support to the Armed Forces Community, when admitted to hospital (emergency or planned care) or on a physical or mental health care pathway, through the provision of welfare officers based in NHS hospital sites, and support to those receiving treatment in other community facilities or at home. Supporting Armed Forces Community, including those in or at risk of DToC, at risk of unnecessary readmission, with identified social, care or wellbeing issues, frequent attenders at A&E. The service will provide an holistic service to the individual and their family and carers. Armed Forces Community defined as serving, reservist, ex-forces, who have served at least one day, their family, dependents, and/or carers.

Service: Applying a Social Model of Health - acting as care navigators and social prescribers, providing emotional and practical support to assess need and address wider determinants of health, social care and wellbeing. Working predominately within secondary acute health care facilities alongside the clinical and medical teams, and responding to Community and Home Treatment within Ayrshire; utilising a network of contacts across the statutory, third, and specialist military and ex-forces sector, DMWS support the individual service user and their families to access appropriate services and support where and when they need it.

DMWS will respond to referrals from hospital staff (clinical and administrative), statutory, military and third sector organisations, or self-referrals, and provide immediate intervention, including liaison with family, health, and social care staff; advocacy; liaison with and timely supported referrals to statutory and third sector organisations; and emotional and practical support throughout the care pathway.



Episodic - Hospital Inpatient, Short term illness or injury, Short term outpatient treatments

Medium Term - Longer Hospital Stay, Ongoing outpatient treatment, Home based treatments

Longer Term - Complex health & wellbeing issues, Life-limiting or life-changing illness or injury

Continuation of Care - Telephone support as and when needed, additional face to face support if required.

DMWS levers access to Third Sector services, reducing the burden, and cost implications, on the NHS and statutory social care. Individuals are fully supported to access services who provide on-going support beyond the scope of DMWS, ensuring continuing care to service users, often with complex needs, to develop self-sufficiency and self-management of issues, improved health and wellbeing, and addressing wider determinants of health. The support provided: Reduces delayed transfer of care; Improves discharge plans and bed flow; Reduces DNA; Reduces hospital admissions where social care and wellbeing are a dominant factor; Reduces social isolation; Enables independent living. DMWS provide longer-term direct support and continuation of care for service users and families diagnosed with life-limiting or life-changing illness or injury, and those diagnosed with long-term health conditions and cancer. DMWS support and align with Major Incident, Multiple Casualty and RAMP incident plans.

Service Model - Ten Step Care Plan Encompasses:	
Assessment	Conversational approach 10 point assessment on current health and wellbeing position and the wider determinants of health. Measure of improvement in each assessed area.
Wellbeing Measure	WEMWBS Full 14 question measure identifying improvement in wellbeing

CONTACT: Bob Reid, Area Manager Scotland | email rreid@dmws.org.uk Tel: 07721 127780

Complexity Measure	Developed by DMWS to measure the complexities of wellbeing. Provides understanding of complexity, impact of, and outcomes achieved in relation to complexity factors.
Building Relationships	Identification of local community and specialised schemes and services to support the service user and their families within their local community, improving access and reducing social isolation
Supported Onward Referrals	Levering services, resources and funding through third sector & statutory organisations
Solution Focused Self reliance	Support service users to become confident in dealing with issues and solutions themselves
Recording Data & Outcomes	Bespoke comprehensive online case management, data and outcomes performance tool. Outcomes and Information, including availability, capacity and capability of local services, analysed and shared with stakeholders, relevant groups, commissioners, and government bodies

Outcomes and Impact:

Achieved through person centred emotional and practical support, addressing social care and wellbeing needs and accessing services from a range of predominately third sector organisations (Scotland Unforgotten Forces Project Outcomes Report for July 2017 – August 2018: 80% of referrals were made to third sector provision).

Person Centred Measured Outputs and Outcomes	Organisational Measured Outcomes
Number of Service Users	Reduction to delayed transfer of care
Number of Additional Beneficiaries	Reduction in Outpatient DNA
% of high, medium, low complexity	Reduced unnecessary readmission
Areas assessed as "of concern"	Improved Bed Flow
Onward Referrals Made – type and sector	Improved Discharge Plans
Analysis & Improvement in assessed areas of concern	Improved appropriate use of NHS service provision
Analysis & Improvement in Wellbeing Measure	Improved use of nursing, medical & clinical staff time
Needs addressed and support accessed	Cost analysis: reduction of costs associated with DToC
Impact of Military Service understood and Covenant delivered	Cost analysis: improvement in outpatient attendance
Positive impact on family	Cost analysis: reduction at A&E for previous frequent attenders
Improved confidence, resilience, and self-reliance	Cost analysis: Value of alternative 3rd sector services accessed

Person Centred Outcomes: Existing DMWS project outcomes have shown improved recovery and wellbeing; reduced isolation and loneliness; reduced length of hospital stay; improved discharge plans; improved access to services and support; reduction in stress and anxiety; increasing self-management of issues; and improved personal resilience.
Organisational Outcomes: By considering non-medical barriers to discharge, identifying solutions and addressing social care and wellbeing, existing DMWS projects have secured services and funding to enable discharge by accessing services eg. respite and permanent social care places; support for living independently, and funding for home adaptations; access to third sector health, social care, welfare, and wellbeing services and support; access to specialised support linked to previous employment or military service. By listening, understanding concerns, providing emotional support, and a focus on person centred solutions, DMWS impacts upon delayed transfers of car, including those recorded as patient choice.
Cost Benefit Analysis DMWS are developing a cost benefit analysis tool with support from Prof Ceri Phillips, Health Economist, Swansea University.

Achieved DToC Reduction Outcomes – 2017-18 Sample: 300 Cases *(Avg Cost of Bed day @ £400/day)*

- 37% cases High Complexity, 41% Medium Complexity
- Total days reduced 751
- 2 cases reduced 29 days, 1 by 30 days, 1 by 33 days
- Reduction in DToC in 59.2% of cases
- Majority of cases reduced by up to 7 days
- Average reduction in DToC 4.1 days

Reducing cost associated with DToC for those patients by approx £300,400 (average of £1,659 per patient)

Please refer to attached Scotland Unforgotten Forces Project Report for outcomes achieved for veterans in Scotland.

Contributing to the South, North & East Ayrshire Health & Social Care Partnerships' Strategic Priorities

Priority	How DMWS Contributes to the Priority
Manage resources effectively, making best use of integrated capacity Bringing Services Together New Models of Care	• Works across health and social care • Combination of support to meet individual's needs. • Coordinates access to statutory and third sector services and support.
Reduce Health Inequalities Tackling Inequalities Early Intervention & Prevention	• Assesses 10 areas of welfare & wellbeing including housing, finance, access to services, activity, employment, social isolation, and independent living. • MHFA qualified - identify early signs of poor mental health • Improves wellbeing, recovery, confidence, self-reliance, and self-management of health & wellbeing

	• Identifies accessible support and services to meet needs, working within local communities, 3rd sector, and statutory services, addressing rural isolation and inequalities • Holistic inclusive approach supports family and carers • Identifies & addresses concerns relating to service user's carer responsibilities • Carers of ex-forces - addressing health and wellbeing issues, and impact on the person they care for • DMWS is available 24/7. Core hours can be flexed to meet needs • Out of hours support utilises telewelfare support, with emergency call out
Giving stakeholders a voice **Engaging Communities** **Transformation & Sustainability**	• Data on needs and access to services & support will be fed back to the partnership to support outcomes and service developments • Service Users will be supported to participate in Partnership stakeholder events
Shift Balance of Care from Acute Hospital to Community Settings **Prevention and Early Intervention** **Early Intervention & Prevention** **New Models of Care**	• Care Navigation and Social Prescribing within DMWS model • Work across the health and social care landscape • Emotional and practical support to address barriers to discharge • Coordinating onward referrals and early involvement of other organisations, supporting service user to access, and maximising recovery and outcomes • Accessing services, and financial support (eg for adaptations) that enable independent living and reduces unnecessary readmission to hospital • Utilising military networks to access alternative respite or where necessary residential care, and financial support, reducing burden on statutory provision • Support for those receiving health treatment at home and in the community • Improves wellbeing, recovery, confidence, self-reliance, and self-management of health & wellbeing.
People to exercise choice and control in achievement of personal outcomes **Person Centred Support** **Effective, Safe, Quality & Timely** **New Models of Care**	• Care navigation and Coordination of services and support provided by the statutory and 3rd sector • Person centred solutions meeting the needs of the individual, the right support at the right time, in the right place • Information Sharing Protocols and Agreements to reduce barriers and improve transition between services • Feedback to referrers and update on services accessed to organisations involved (based on consent to inform) • Single point of contact for Armed Forces Community
Mental Health & Wellbeing **Improving Mental Health & Wellbeing** **Early Intervention & Prevention**	• Early identification of possible mental health issues • Appropriate referrals to formal or informal, NHS or 3rd sector support • Supporting service user to address stress/anxiety, preventing escalation to crisis • Proven improvement in wellbeing (utilising WEMWBS)

Cost Summary:

Welfare Officers: based at acute hospitals and responding to community health facilities, and home based treatment

Funding Required for one year (1st July 2019 to 31st June 2020)

1 WTE Welfare Officer (Individual H&SCP funding own locality Welfare Service) **£ 53,803**

2 WTE Welfare Officers (2 H&SCPs sharing costs for a joint Welfare Service) **£101,063**

3 WTE Welfare Officers (3 Ayrshire H&SCPs sharing costs for a Ayrshire wide Welfare Service) **£149,220**

Targets & Savings from DToC Reduction for each WTE Welfare Officer				**Year 1**
Case Capacity per WO per year	250		Total Cases per year	250
% of Cases DToC Saved	60		Numer of Cases with DToC Saved	150
Average Days Saved	4		Estimated Days Saved	600
Cost per day	£400		Estimated DToC Costs Reduced	**£240,000**
Number of Welfare Team	1		Cost of Service	£53,803
			Cost Benefit	**£186,197**

Additional Cost Savings eg: reduction in Readmission; Reduction in A&E Attendance: Reduced Finanical Burden on Social Care

Sustainability: The Ayrshire Medical Welfare & Wellbeing Service will form part of a bid made by Poppy Scotland to the Scottish Government for funding from July 2020. Poppy Scotland are leading the Forgotten Forces Consortium delivering a range of services and support to the Armed Forces Community across Scotland. DMWS current delivery in Ayrshire is one of 4 areas of DMWS delivery within the Unforgotten Forces Project (Grampian, Fife & Lanarkshire). This application therefore, is to support the services currently delivered during the one year funding gap between July 2019 and July 2020 to enable continuity whilst Poppy Scotland secure further longer term funding.

CONTACT: Bob Reid, Area Manager Scotland | email rreid@dmws.org.uk Tel: 07721 127780

Integration Joint Board
14 February 2019

Subject:	**Joint Locality Planning Partnership – Arran pilot**
Purpose:	To develop and pilot an integrated HSCP Locality Planning Forum and CPP Locality Partnership arrangement on the island of Arran.
Recommendation:	The IJB approves the integration of the HSCP Locality Planning Forum in to the CPP Locality Partnership for a pilot period of 12 months. The IJB agrees to accept a future report on the results of the Arran Joint Locality Planning Partnership pilot.

Glossary of Terms	
HSCP	Health and Social Care Partnership
LPF	Locality Planning Forum
LPP	Locality Planning Partnership

1.	**EXECUTIVE SUMMARY**
1.1	The HSCP Locality Planning Forum (LPF) arrangement underwent review during 2018, resulting in a new terms of reference, to reflect the ambitions laid out in the new strategic plan to 2020 and the development of the new Community Planning Partnership (CPP) Locality Partnerships (LP). A consistent theme throughout the development of this work has been the need to respond to local need effectively by creating greater synergy between HSCP LPFs and the CPP arrangements.
1.2	As a result of closer working, shared priorities to respond to challenges, have been identified for the locality of Arran. There was also recognition of both a duplication of membership at the LPF and LP Board and a concern that having two arrangements may make it difficult for the community to engage easily.
1.3	It is therefore proposed to create a Joint Locality Planning Partnership on Arran. This new approach will be piloted for 12 months. This will create the first such arrangement in Scotland.
2.	**BACKGROUND**
2.1	To meet the Scottish Government - Localities Guidance, North Ayrshire Health and Social Care Partnership (HSCP) developed Locality Planning Forums (LPFs) in 2015/16. The LPFs enabled the Partnership to meet the ambitions of its first Strategic plan 2015-2018. The HSCP LPF arrangement underwent review during 2018, resulting in a new terms of reference, to reflect the ambitions laid out in the new strategic plan to 2020 and the development of the new Community Planning Partnership (CPP) Locality Partnerships (LP).
2.2	The HSCP LPF is made up of 3 core members (HSCP LPF Chair who is also an IJB member, Senior Manager Coordinator who is also a Strategic Planning Group

	member and Lead GP). There can be up to an additional 10-15 stakeholder members and work is currently going on to develop 'community champion' engagement networks to support each LPF.
2.3	On Arran a patient representative group has been formed since 2012and over the last year the Senior Manager for the island the HSCP team have been undertaking engagement events to inform the community of the integration of health and social care provision on Arran and the new emerging model of care. Five events have been held between May and November at local village halls and the High school with a total of 150 people attending.
2.4	A consistent theme throughout the development of this work has been to create greater synergy between HSCP LPFs and the CPP arrangement. The HSCP LPF Chair is also a member of the CPP LP Board and the HSCP also provides a Strategic Planning support officer to work between the LPF and LP. As a result of closer working shared priorities and challenges have been identified for the locality.
2.5	On the 30 March 2016 North Ayrshire Council approved Terms of Reference for six Community Planning (CP) Locality Partnerships (LPs) in 2016. They meet quarterly, and with interim working groups/workshops as required. Their remit focuses on a partnership approach to tackling local issues and inequalities. They are the means by which we fulfil duties under the Community Empowerment Act (Scotland) 2015 to have locality arrangements. The overall aim of locality planning is to harness the power of Community Planning Partners and communities to work together towards shared, data led, priorities. Their membership comprises • Elected Members(including the chair); • community representatives, • Community Council Chairs and • Community Planning partners. The Senior Lead Officers for the LPs are members of the CPP's Strategic Management Team. The Chairs of the LPs are Elected Members and they all sit on the CPP Board. The CPP LPF core members (Elected Members, Community Council members and three senior support officers) and additional stakeholders' total 22-25 members.
3.	**PROPOSALS**
3.1	It is proposed to create a Joint Locality Planning Partnership on Arran. This new approach will be piloted for 12 months.
3.2	It is proposed that the HSCP LPF 3 core members and the HSCP Strategic Planning Lead will join the Arran LP: • HSCP LPF Chair, who is also an IJB member in her TSI Lead role and currently the Aran LP Senior Officer, • Senior Manager Coordinator, who is also a Strategic Planning Group member and • the island Lead GP
3.3	It is proposed that the Lead GP become a vice chair of the LP, in addition to the existing vice chair arrangement.

	It is proposed that HSCP business be tabled first, in the event that medical emergency, requires the HSCP vice chair to leave the meeting. In order to support this development there will be a short pre-meeting before each of the LP Boards with the following: • LP Chair • LP Vice Chairs (1 x HSCP or senior manager coordinator as deputy, 1x LP Vice Chair) • LP Senior Officer (Third Sector Interface) • LP Lead Officer (due to a recent retirement this role will be delivered by the Head of Service from North Ayrshire Council Economies & Communities) • HSCP Strategic Planning lead After each LP a short de-brief meeting will be held to support continuous improvement.
3.4	It is proposed to merge the other LPF members such as the third sector, community link worker, voluntary group and other community stakeholders currently on the HSCP LPF in to the patients representative group to enhance and create the Arran HSCP 'community champion' network.
3.5	Section 35 of the Public Bodies (Joint Working etc.)(Scotland) Act 2015 contains a duty which requires an Integration Joint Board to consult where it proposes to make a significant decision which might significantly affect the provision of a service. Such consultation would be through the HSCP LP. In the event that any consultation is required during the period of the pilot, the wider Arran HSCP community champion engagement network would be consulted.
3.6	A further range of community engagement events, will be coproduced by the Arran HSCP 'community champion' network, in 2019.
3.7	**Anticipated Outcomes**
	The Joint Locality Planning Partnership – Arran pilot, will enhance the delivery of the HSCP Strategic Plan priority 'Engaging Communities' and the CPP Local Outcome Improvement Plan (LOIP)
3.8	**Measuring Impact**
	The Joint Locality Planning Partnership – Arran pilot will measure the impact of the changes with LP Board members, stakeholders and the communities over the 12 month pilot period.
4.	**IMPLICATIONS**

Financial:	This approach allows for some staff time savings for both the HSCP and North Ayrshire Council Communities teams.
Human Resources:	None
Legal:	Consultation with the Head of Service (Democratic and Administration) has identified that as a result of implementing the pilot an amendment to the terms of reference would be required and this will be actioned after IJB approval.

Equality:	Piloting a single approach allows easier access for the public to engage in locality planning arrangements, by removing organisational barriers.
Children and Young People	There are robust engagement arrangements
Environmental & Sustainability:	Pilot will determine the sustainability of the approach on the island of Arran. At the current time there is no stakeholder support for a change to mainland locality arrangements.
Key Priorities:	Consider the impacts on key priorities and plans.
Risk Implications:	A risk assessment will be developed as the pilot develops and mitigation put in place.
Community Benefits:	N/A.

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

5.	**CONSULTATION**
5.1	There has been detailed on island discussions with the HSCP Director, Lead GP, Arran Senior Manager and Third Sector Interface lead. There have also been detailed discussions with North Ayrshire Council Communities Head of Service, Head of Service (Democratic and Administration), LP Lead Officer and the CPP Lead Officer. An engagement session with all of the HSCP LPF Lead Officer and Chair took place on the 24 January 2019. An engagement session took place with the CPP LP Chairs on the on closer working relationships between the two structures on 11 September 2018. Further discussions will follow with a supporting paper to North Ayrshire Council to cabinet. No significant issues were highlighted that will not be considered during the pilot phase on Arran.
6.	**CONCLUSION**
6.1	The development and pilot of an integrated Joint Locality Partnership arrangement on the island of Arran, will create the first such arrangement in Scotland, recognising the shared priorities and challenges the localities and people in North Ayrshire face.

For more information please contact Michelle Sutherland on 01294 317751 or msutherland@north-ayrshire.gcsx.gov.uk

Agenda Item 9

Integration Joint Board
14th February 2019

Subject:	**North Ayrshire Integration Joint Board - Records Management Plan**
Purpose:	North Ayrshire Integration Joint Board (NAIJB) approves the NAIJB Records Management Plan (RMP)
Recommendation:	The Integration Joint Board is asked to: 1. Note the report 2. Approve the North Ayrshire Integration Joint Board RMP

NAIJB	North Ayrshire Integration Joint Board
RMP	Records Management Plan

1.	**EXECUTIVE SUMMARY**
1.1	The Public Records (Scotland) Act requires North Ayrshire Integration Joint Board (NAIJB) to produce and follow a Records Management Plan (RMP).
1.2	The plan covers 14 elements which the Board will implement: 1. Senior Management responsibility 2. Records Manager responsibility 3. Records Management policy statement 4. Business Classification 5. Retention Schedules 6. Destruction arrangements 7. Archiving and transfer arrangements 8. Information Security 9. Data Protection 10. Business continuity and vital records 11. Audit trail 12. Competency framework for records management staff 13. Assessment and review 14. Shared Information Compliance statements and evidence are contained within the RMP.
1.3	Advice from the Keeper of Scotland indicates that where IJB records sit within one of the partner agencies (either NHS or Local Authority) then the RMP evidence and policies and procedures of that partner should be adopted for the IJB RMP. All NAIJB records sit within North Ayrshire Council systems and are managed in accordance with North Ayrshire Council policies and procedures. Ms Lauren Lewis, Information Management Officer is the designated Officer of the Council who has operational responsibility for North Ayrshire Council and NAIJB records management.

1.4	The Senior Officer of NAIJB and the Chief Executive of North Ayrshire Council have endorsed the NAIJB RMP.
3.	**PROPOSALS**
3.1	NAIJB to approve the RMP for the Integration Joint Board.
3.2	**Anticipated Outcomes**
	N/A
3.3	**Measuring Impact**
	N/A
4.	**IMPLICATIONS**

Financial:	None
Human Resources:	None
Legal:	The Public Records (Scotland) Act 2011 places a number of duties on the Integration Joint Board. Where authorities fail to meet their obligations under the Act, the Keeper has powers to undertake records management reviews and issue action notices for improvement.
Equality:	None
Children and Young People	None
Environmental & Sustainability:	None
Key Priorities:	Consider the impacts on key priorities and plans.
Risk Implications:	Failure to comply with the Public Records (Scotland) Act 2011 presents a legal and reputational risk to the Integration Joint 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	

5.	**CONSULTATION**
5.1	The Keeper has hosted 'surgeries' during 2018 for representatives of IJBs with a responsibility for developing RMPs. North Ayrshire IJB have been represented at these surgeries. In addition consultation has taken place with Information Governance representatives from both NHS Ayrshire & Arran and North Ayrshire Council.

For more information please contact Julie Davis, Principal Manager Business Administration on 01294 317766 or jdavis@north-ayrshire.gcsx.gov.uk

North Ayrshire Integration Joint Board
Records Management Plan

Information and Records Management
[January 2019]

Table of Contents

Records Management Plan **1**
Summary **1**
About the Public Records (Scotland) Act 2011 ..... **1**
About the North Ayrshire Integration Joint Board **1**
Review **2**
RMP Element Description **3**
Element 1: Senior management responsibility: **3**
Element 2: Records manager responsibility: **4**
Element 3: Records management policy statement: **5**
Element 4: Business classification **6**
Element 5: Retention schedules **7**
Element 6: Destruction arrangements **8**
Element 7: Archiving and transfer arrangements **9**
Element 8: Information Security **10**
Element 9: Data protection **11**
Element 10: Business continuity and vital records **12**
Element 11: Audit trail **13**
Element 12: Competency framework for records management staff **14**
Element 13: Assessment and review **15**
Element 14: Shared Information **16**

Records Management Plan

Summary

North Ayrshire Integration Joint Board is fully committed to compliance with the requirements of the Public Records (Scotland) Act, which came into force on the 1st January 2013. North Ayrshire Integration Joint Board will therefore follow procedures that aim to ensure that all of its officers, employees of constituent authorities supporting its work, contractors, agents, consultants and other trusted third parties who create public records on behalf of the authority, or manage public records held by the authority, are fully aware of and abide by this plan's arrangements.

About the Public Records (Scotland) Act 2011

The Public Records (Scotland) Act 2011 (the Act) came into force on the 1st January 2013, and requires named public authorities to submit a Records Management Plan (RMP) to be agreed by the Keeper of the Records of Scotland. Integration Joint Boards were added to the Act's schedule by the Public Bodies (Joint Working) (Scotland) Act 2014. This document is the Records Management Plan of North Ayrshire Integration Joint Board.

About Integration Joint Boards

The integration of health and social care is part of the Scottish Government's programme of reform to improve care and support for those who use health and social care services. It is one of the Scottish Government's top priorities.

The Public Bodies (Joint Working) (Scotland) Act provides the legislative framework for the integration of health and social care services in Scotland.

It will put in place:

- Nationally agreed outcomes, which will apply across health and social care, in service planning by Integration Joint Boards and service delivery by NHS Boards and Local Authorities.
- A requirement on NHS Boards and Local Authorities to integrate health and social care budgets.
- A requirement on Partnerships to strengthen the role of clinicians and care professionals, along with the third and independent sectors, in the planning and delivery of services.

About North Ayrshire Integration Joint Board

North Ayrshire Integration Joint Board (the Board) is responsible for the planning and oversight of delivery of health and social care integrated functions for North Ayrshire.

The Board's Integration Scheme sets out the functions which are delegated by NHS Ayrshire & Arran and North Ayrshire Council to the IJB.

The Board operates as a body corporate (a separate legal entity), acting independently of NHS Ayrshire & Arran and North Ayrshire Council. The Board consists of six voting members appointed in equal number by the NHS Ayrshire & Arran and North Ayrshire Council, with a number of representative members who are drawn from the third sector, independent sector, staff, carers and service users. The Board is advised by a number of professionals including the Chief Officer, Medical Director, Nurse Director and Chief Social Work Officer.

The key functions of the Board are to:

- Prepare a Plan for integrated functions that is in accordance with national and local outcomes and integration principles
- Allocate the integrated budget in accordance with the Plan
- Oversee the delivery of services that are within the scope of the Partnership.

Information underpins the Board's over-arching strategic objective and helps it meet its strategic outcomes. It's information supports it to:

- Demonstrate accountability.
- Provide evidence of actions and decisions.
- Assist with the smooth running of business.
- Help build organisational knowledge.

Good recordkeeping practices lead to greater productivity as less time is taken to locate information. Well managed records will help the Board make:

- Better decisions based on complete information.
- Smarter and smoother work practices.
- Consistent and collaborative workgroup practices.
- Better resource management.
- Support for research and development.
- Preservation of vital and historical records.

In addition we are more accountable to the public now than ever before through the increased awareness of openness and transparency within government. Knowledge and information management is now formally recognised as a function of government similar to finance, IT and communications. It is expected that the Board is fully committed to creating, managing, disclosing, protecting and disposing of information effectively and legally.

Review

Section 5 (1) of the Act requires authorities to keep their plans under review to ensure its arrangements remain fit for purpose.

RMP Element Description	North Ayrshire Integration Joint Board (IJB) Compliance Statement	Evidence	Further Development
Element 1: Senior management responsibility: Section 1(2)(a)(i) of the Act specifically requires a RMP to identify the individual responsible for the management of the authority's public records. An authority's RMP must name and provide the job title of the senior manager who accepts overall responsibility for the RMP that has been submitted. It is vital that the RMP submitted by an authority has the approval and support of that authority's senior management team. Where an authority has already appointed a Senior Information Risk Owner, or similar person, they should consider making that person responsible for the records management programme. It is essential that the authority identifies and seeks the agreement of a senior post-holder to take overall responsibility for records management. That person is unlikely to have a day-to-day role in implementing the RMP, although they are not prohibited from doing so. As evidence, the RMP could include, for example, a covering letter signed by the senior post-holder. In this letter the responsible person named should indicate that they endorse the authority's record management policy (See Element 3). Read further explanation and guidance about element 1 - http://www.nas.gov.uk/recordKeeping/PRSA/guidanceElement1.asp	**The Chief Officer, Stephen Brown has senior responsibility for all aspects of the Board's Records Management, and is the corporate owner of this document.** **The Chief Officer is also the Board's Senior Information Risk Owner (SIRO).** **All records relating to North Ayrshire IJB are held on North Ayrshire Council systems**	Evidence attached: Job profile and objectives of CO (Director Health & Social Care Partnership) Covering letter signed by CO endorsing the authority's Record Management Policy IJB Report approving appointment of IJB Chief Officer	What further development, if any, remains to be undertaken to bring this element into full compliance?

RMP Element Description	North Ayrshire Integration Joint Board (IJB) Compliance Statement	Evidence	Further Development
Element 2: Records manager responsibility: Section 1(2) (a)(ii) of the Act specifically requires a RMP to identify the individual responsible for ensuring the authority complies with its plan. An authority's RMP must name and provide the job title of the person responsible for the day-to-day operation of activities described in the elements in the authority's RMP. This person should be the Keeper's initial point of contact for records management issues. It is essential that an individual has overall day-to-day responsibility for the implementation of an authority's RMP. There may already be a designated person who carries out this role. If not, the authority will need to make an appointment. As with element 1 above, the RMP must name an individual rather than simply a job title. It should be noted that staff changes will not invalidate any submitted plan provided that the all records management responsibilities are transferred to the incoming post holder and relevant training is undertaken. This individual might not work directly for the scheduled authority. It is possible that an authority may contract out their records management service. If this is the case an authority may not be in a position to provide the name of those responsible for the day-to-day operation of this element. The authority must give details of the arrangements in place and name the body appointed to carry out the records management function on its behalf. It may be the case that an authority's records management programme has been developed by a third party. It is the person operating the programme on a day-to-day basis whose name should be submitted. Read further explanation and guidance about element 2 - http://www.nas.gov.uk/recordKeeping/PRSA/guidanceElement2.asp	**The records of North Ayrshire IJB sit within North Ayrshire Council systems and are subject to the Council's policies and procedures. The person with corporate responsibility for records management is :** **Lauren Lewis, Information Management Officer, North Ayrshire Council, Cunninghame House, Friarscroft, Irvine KA12 8EE** **Ms Lewis is able to access and manage IJB information**.	Evidence Previously submitted with North Ayrshire Council Records Management Plan: • Role Profile – Info Management Officer Evidence attached: • Letter of confirmation from IJB Chief Officer • Letter of confirmation from North Ayrshire Council	What further development, if any, remains to be undertaken to bring this element into full compliance?

RMP Element Description	North Ayrshire Integration Joint Board (IJB) Compliance Statement	Evidence	Further Development
Element 3: Records management policy statement: The Keeper expects each authority's plan to include a records management policy statement. The policy statement should describe how the authority creates and manages authentic, reliable and useable records, capable of supporting business functions and activities for as long as they are required. The policy statement should be made available to all staff, at all levels in the authority. The statement will properly reflect the business functions of the public authority. The Keeper will expect authorities with a wide range of functions operating in a complex legislative environment to develop a fuller statement than a smaller authority. The records management statement should define the legislative, regulatory and best practice framework, within which the authority operates and give an overview of the records management processes and systems within the authority and describe how these support the authority in carrying out its business effectively. For electronic records the statement should describe how metadata is created and maintained. It should be clear that the authority understands what is required to operate an effective records management system which embraces records in all formats. The records management statement should include a description of the mechanism for records management issues being disseminated through the authority and confirmation that regular reporting on these issues is made to the main governance bodies. The statement should have senior management approval and evidence, such as a minute of the management board recording its approval, submitted to the Keeper. The other elements in the RMP, listed below, will help provide the Keeper with evidence that the authority is fulfilling its policy. Read further explanation and guidance about element 3 – http://www.nas.gov.uk/recordKeeping/PRSA/guidanceElement3.asp	**The Board has adopted and is fully committed to the Records Management Policy of North Ayrshire Council.** **All Officers who have access to IJB records are governed by North Ayrshire Council's policies and procedures relating to records management**	Evidence Previously submitted with North Ayrshire Council Records Management Plan: • Information & Records Management Policy (v5.0 Feb 2018) • Records Management Manual (v3.0 June 2018) • Information Management Strategy (v2 Dec 2015) • Information Governance Procurement Framework Evidence attached • IJB Report for February 2019 Committee • Letter of confirmation from North Ayrshire Council	What further development, if any, remains to be undertaken to bring this element into full compliance?

RMP Element Description	North Ayrshire Integration Joint Board (IJB) Compliance Statement	Evidence	Further Development
Element 4: Business classification The Keeper expects an authority to have properly considered business classification mechanisms and its RMP should therefore reflect the functions of the authority by means of a business classification scheme or similar. A business classification scheme usually takes the form of a hierarchical model or structure diagram. It records, at a given point in time, the informational assets the business creates and maintains, and in which function or service area they are held. As authorities change the scheme should be regularly reviewed and updated. A business classification scheme allows an authority to map its functions and provides a structure for operating a disposal schedule effectively. Some authorities will have completed this exercise already, but others may not. Creating the first business classification scheme can be a time-consuming process, particularly if an authority is complex, as it involves an information audit to be undertaken. It will necessarily involve the cooperation and collaboration of several colleagues and management within the authority, but without it the authority cannot show that it has a full understanding or effective control of the information it keeps. Although each authority is managed uniquely there is an opportunity for colleagues, particularly within the same sector, to share knowledge and experience to prevent duplication of effort. All of the records an authority creates should be managed within a single business classification scheme, even if it is using more than one record system to manage its records. An authority will need to demonstrate that its business classification scheme can be applied to the record systems which it operates. Read further explanation and guidance about element 4 - http://www.nas.gov.uk/recordKeeping/PRSA/guidanceElement4.asp	**The Board's records will be wholly created and managed on North Ayrshire Council systems.** **The Council has a comprehensive and in-depth Information Asset Register (IAR) which is based on the Local Government Classification Scheme.** **The Council intends to use the existing IAR to inform the file plan structure when the authority begins the implementation of the Office 365 and SharePoint project. This project aims to deliver this new solution to all Council staff by end 2019.**	Letter of confirmation from North Ayrshire Council	What further development, if any, remains to be undertaken to bring this element into full compliance?

RMP Element Description	North Ayrshire Integration Joint Board (IJB) Compliance Statement	Evidence	Further Development
Element 5: Retention schedules Section 1(2) (b)(iii) of the Act specifically requires a RMP to include provision about the archiving and destruction or other disposal of the authority's public records. An authority's RMP must demonstrate the existence of and adherence to corporate records retention procedures. The procedures should incorporate retention schedules and should detail the procedures that the authority follows to ensure records are routinely assigned disposal dates, that they are subsequently destroyed by a secure mechanism (see element 6) at the appropriate time, or preserved permanently by transfer to an approved repository or digital preservation programme (See element 7). The principal reasons for creating retention schedules are: • to ensure records are kept for as long as they are needed and then disposed of appropriately • to ensure all legitimate considerations and future uses are considered in reaching the final decision. • to provide clarity as to which records are still held by an authority and which have been deliberately destroyed. "Disposal" in this context does not necessarily mean destruction. It includes any action taken at the agreed disposal or review date including migration to another format and transfer to a permanent archive. A retention schedule is an important tool for proper records management. Authorities who do not yet have a full retention schedule in place should show evidence that the importance of such a schedule is acknowledged by the senior person responsible for records management in an authority (see element 1). This might be done as part of the policy document (element 3). It should also be made clear that the authority has a retention schedule in development. An authority's RMP must demonstrate the principle that retention rules are consistently applied across all of an authority's record systems. Read further explanation and guidance about element 5 - http://www.nas.gov.uk/recordKeeping/PRSA/guidanceElement5.asp	**IJB records are maintained in line with North Ayrshire Council Retention and Disposal Schedules, which are based on the Retention and Disposal Schedules produced by the Scottish Council on Archives**.	Evidence Previously submitted with North Ayrshire Council Records Management Plan: • NAC Retention Schedule Evidence attached: • Letter of confirmation from North Ayrshire Council	What further development, if any, remains to be undertaken to bring this element into full compliance?

RMP Element Description	[Name] Integration Joint Board (IJB) Compliance Statement	Evidence	Further Development
Element 6: Destruction arrangements Section 1(2) (b)(iii) of the Act specifically requires a RMP to include provision about the archiving and destruction, or other disposal, of an authority's public records. An authority's RMP must demonstrate that proper destruction arrangements are in place. A retention schedule, on its own, will not be considered adequate proof of disposal for the Keeper to agree a RMP. It must be linked with details of an authority's destruction arrangements. These should demonstrate security precautions appropriate to the sensitivity of the records. Disposal arrangements must also ensure that all copies of a record – wherever stored – are identified and destroyed. Read further explanation and guidance about element 6 - http://www.nas.gov.uk/recordKeeping/PRSA/guidanceElement6.asp	**Destruction of Board records, in all formats, will be undertaken in line with North Ayrshire Council policies and procedures.** **The Council, in partnership with East and South Ayrshire Councils, maintains a secure hardware destruction contract which conforms to the relevant legislative requirements**	Evidence Previously submitted with North Ayrshire Council Records Management Plan: • Records Management manual • Information Classification Guidelines • Confidential Waste Guidelines for Services • ICT Disposal Guidelines • Back up procedure for electronic records Evidence attached: Letter of confirmation from North Ayrshire Council	What further development, if any, remains to be undertaken to bring this element into full compliance

RMP Element Description	North Ayrshire Integration Joint Board (IJB) Compliance Statement	Evidence	Further Development
Element 7: Archiving and transfer arrangements Section 1(2)(b)(iii) of the Act specifically requires a RMP to make provision about the archiving and destruction, or other disposal, of an authority's public records. An authority's RMP must detail its archiving and transfer arrangements and ensure that records of enduring value are deposited in an appropriate archive repository. The RMP will detail how custody of the records will transfer from the operational side of the authority to either an in-house archive, if that facility exists, or another suitable repository, which must be named. The person responsible for the archive should also be cited. Some records continue to have value beyond their active business use and may be selected for permanent preservation. The authority's RMP must show that it has a mechanism in place for dealing with records identified as being suitable for permanent preservation. This mechanism will be informed by the authority's retention schedule which should identify records of enduring corporate and legal value. An authority should also consider how records of historical, cultural and research value will be identified if this has not already been done in the retention schedule. The format/media in which they are to be permanently maintained should be noted as this will determine the appropriate management regime. Read further explanation and guidance about element 7- http://www.nas.gov.uk/recordKeeping/PRSA/guidanceElement7.asp	**All IJB records of enduring value will be archived/transferred in line with North Ayrshire Council policy.**	Evidence attached: Letter of confirmation from North Ayrshire Council	What further development, if any, remains to be undertaken to bring this element into full compliance

RMP Element Description	North Ayrshire Integration Joint Board (IJB) Compliance Statement	Evidence	Further Development
Element 8: Information Security Section 1(2) (b)(ii) of the Act specifically requires a RMP to make provision about the archiving and destruction or other disposal of the authority's public records. An authority's RMP must make provision for the proper level of security for its public records. All public authorities produce records that are sensitive. An authority's RMP must therefore include evidence that the authority has procedures in place to adequately protect its records. Information security procedures would normally acknowledge data protection and freedom of information obligations as well as any specific legislation or regulatory framework that may apply to the retention and security of records. The security procedures must put in place adequate controls to prevent unauthorised access, destruction, alteration or removal of records. The procedures will allocate information security responsibilities within the authority to ensure organisational accountability and will also outline the mechanism by which appropriate security classifications are linked to its business classification scheme.	**All systems, devices, information sharing platforms, etc. that the IJB relies upon are owned and maintained by North Ayrshire Council.**	Evidence Previously submitted with North Ayrshire Council Records Management Plan: • Information Assurance Policy • IT & Cyber Security Policy • Third Party Access to Council Resources Guidelines • Guidelines for Handling Information and Data • Guidelines for Reporting IT and Cyber Security Incidents • Loss of IT Equipment Guidelines Evidence attached: Letter of confirmation from North Ayrshire Council	What further development, if any, remains to be undertaken to bring this element into full compliance

RMP Element Description	North Ayrshire Integration Joint Board (IJB) Compliance Statement	Evidence	Further Development
Element 9: Data protection The Keeper will expect an authority's RMP to indicate compliance with its data protection obligations. This might be a high level statement of public responsibility and fair processing. If an authority holds and process information about stakeholders, clients, employees or suppliers, it is legally obliged to protect that information. Under the Data Protection Act, an authority must only collect information needed for a specific business purpose, it must keep it secure and ensure it remains relevant and up to date. The authority must also only hold as much information as is needed for business purposes and only for as long as it is needed. The person who is the subject of the information must be afforded access to it on request. Read further explanation and guidance about element 9 - http://www.nas.gov.uk/recordKeeping/PRSA/guidanceElement9.asp	**The Council employs a full time Data Protection Officer. This role meets the requirements of the General Data Protection Regulation (GDPR). All Data Protection policy and guideline documents have been revised to reflect the introduction of the GDPR and the Data Protection Act 2018. These include: Data Protection Policy, Privacy and fair processing of personal data, Guidance on handling subject access requests, Data breach reporting and management procedures, Data protection impact assessment information and guidance. The Council's Privacy Notice has also been updated.** **The Board members of the IJB have undertaken specific induction training including Data Protection**	Evidence Previously submitted with North Ayrshire Council Records Management Plan: • Privacy and Fair Processing of Personal Data (v 1 March 2018) • Data Protection Policy (v2.2 May 2018) • Guidance on Handling Subject Access Requests (v.1.2 May 2018) • Data Breach Reporting and Management Procedures (v1 May 2018) • Data Protection Impact Assessment & Guidance (v2 April 2018)	What further development, if any, remains to be undertaken to bring this element into full compliance

RMP Element Description	North Ayrshire Integration Joint Board (IJB) Compliance Statement	Evidence	Further Development
Element 10: Business continuity and vital records The Keeper will expect an authority's RMP to indicate arrangements in support of records vital to business continuity. Certain records held by authorities are vital to their function. These might include insurance details, current contract information, master personnel files, case files, etc. The RMP will support reasonable procedures for these records to be accessible in the event of an emergency affecting their premises or systems. Authorities should therefore have appropriate business continuity plans ensuring that the critical business activities referred to in their vital records will be able to continue in the event of a disaster. How each authority does this is for them to determine in light of their business needs, but the plan should point to it. Read further explanation and guidance about element 10 - http://www.nas.gov.uk/recordKeeping/PRSA/guidanceElement10.asp	**NAIJB records are subject to the policies and procedures of North Ayrshire Council in relation to business continuity.**	Evidence attached: Letter of confirmation from North Ayrshire Council	What further development, if any, remains to be undertaken to bring this element into full compliance

RMP Element Description	North Ayrshire Integration Joint Board (IJB) Compliance Statement	Evidence	Further Development
Element 11: Audit trail The Keeper will expect an authority's RMP to provide evidence that the authority maintains a complete and accurate representation of all changes that occur in relation to a particular record. For the purpose of this plan 'changes' can be taken to include movement of a record even if the information content is unaffected. Audit trail information must be kept for at least as long as the record to which it relates. This audit trail can be held separately from or as an integral part of the record. It may be generated automatically, or it may be created manually. Read further explanation and guidance about element 11 - http://www.nas.gov.uk/recordKeeping/PRSA/guidanceElement11.asp	**The records of NAIJB will be wholly covered by the audit arrangements of North Ayrshire Council.**	Evidence Previously submitted with North Ayrshire Council Records Management Plan: • Document Control Guidelines (v2.0 May 2018) • File Naming Convention Guidelines (v10 May 2018) Evidence attached: Letter of confirmation from North Ayrshire Council	What further development, if any, remains to be undertaken to bring this element into full compliance

RMP Element Description	North Ayrshire Integration Joint Board (IJB) Compliance Statement	Evidence	Further Development
Element 12: Competency framework for records management staff The Keeper will expect an authority's RMP to detail a competency framework for person(s) designated as responsible for the day-to-day operation of activities described in the elements in the authority's RMP. It is important that authorities understand that records management is best implemented by a person or persons possessing the relevant skills. A competency framework outlining what the authority considers are the vital skills and experiences needed to carry out the task is an important part of any records management system. If the authority appoints an existing non-records professional member of staff to undertake this task, the framework will provide the beginnings of a training programme for that person. The individual carrying out day-to-day records management for an authority might not work for that authority directly. It is possible that the records management function is undertaken by a separate legal entity set up to provide functions on behalf of the authority, for example an arm's length body or a contractor. Under these circumstances the authority must satisfy itself that the supplier supports and continues to provide a robust records management service to the authority.	**As part of the GDPR project in North Ayrshire Council, a comprehensive training programme was rolled out across all staff and Elected Members.** **The information Management Officer has corporate responsibility for records management and is a current and active member of the Information and Records Management Society (IRMS). She will be undertaking relevant training courses and qualifications to further develop**	Evidence attached: Letter of confirmation from North Ayrshire Council	What further development, if any, remains to be undertaken to bring this element into full compliance

RMP Element Description	North Ayrshire Integration Joint Board (IJB) Compliance Statement	Evidence	Further Development
Element 13: Assessment and review Section 1(5) (i)(a) of the Act says that an authority must keep its RMP under review. An authority's RMP must describe the procedures in place to regularly review it in the future. It is important that an authority's RMP is regularly reviewed to ensure that it remains fit for purpose. It is therefore vital that a mechanism exists for this to happen automatically as part of an authority's internal records management processes. A statement to support the authority's commitment to keep its RMP under review must appear in the RMP detailing how it will accomplish this task. Read further explanation and guidance about element 13 – http://www.nas.gov.uk/recordKeeping/PRSA/guidanceElement13.asp	**NAIJB will participate in the annual Progress Update Review that is recommended by the National Records Scotland to ensure records management practices are regularly reviewed, and where necessary, require to be updated.** **NAIJB will also ensure ongoing assessment of those elements of the plan for which it holds direct and sole responsibility, i.e. elements 1 and 14.**	Evidence attached: Letter of confirmation from North Ayrshire Council	What further development, if any, remains to be undertaken to bring this element into full compliance

RMP Element Description	North Ayrshire Integration Joint Board (IJB) Compliance Statement	Evidence	Further Development
Element 14: Shared Information The Keeper will expect an authority's RMP to reflect its procedures for sharing information. Authorities who share, or are planning to share, information must provide evidence that they have considered the implications of information sharing on good records management. Information sharing protocols act as high level statements of principles on sharing and associated issues, and provide general guidance to staff on sharing information or disclosing it to another party. It may therefore be necessary for an authority's RMP to include reference to information sharing protocols that govern how the authority will exchange information with others and make provision for appropriate governance procedures. Specifically the Keeper will expect assurances that an authority's information sharing procedures are clear about the purpose of record sharing which will normally be based on professional obligations. The Keeper will also expect to see a statement regarding the security of transfer of information, or records, between authorities whatever the format.	**NAIJB have in place information sharing agreements to support the regular sharing of information between parties. The aim of the Information Sharing Agreement is to facilitate the sharing of information and put in place a framework which will allow information to be exchanged in ways which respect the rights of individuals and in compliance with the law**	Evidence attached: • IJB Report 02/04/15 re Information Sharing • Information Sharing Agreement: NHS Ayrshire & Arran/ North/South/East Ayrshire Councils & North/South/East Ayrshire Integration Joint Boards Information Sharing Agreement Common Services Agency	What further development, if any, remains to be undertaken to bring this element into full compliance

DIRECTOR (North Ayrshire Health & Social Care Partnership): Stephen Brown
5th Floor West Wing, Cunninghame House, Friarscroft, Irvine, KA12 8EE
Tel: 01294 317700

Your Ref: Our Ref:

If telephoning please call: 01294 317700

Registrar General and Keeper of the
Records of Scotland
National Records of Scotland
HM General Register House
2 Princes Street
EDINBURGH
EH1 3YY

Dear Sir

Public Records (Scotland) Act 2001 – North Ayrshire Integration Joint Board Records Management Plan

The Public Records (Scotland) Act requires North Ayrshire Integration Joint Board (NAIJB) to produce and follow a records management plan. The plan covers 14 elements which the Board will implement:

1. Senior Management responsibility
2. Records Manager responsibility
3. Records Management policy statement
4. Business Classification
5. Retention Schedules
6. Destruction arrangements
7. Archiving and transfer arrangements
8. Information Security
9. Data Protection
10. Business continuity and vital records
11. Audit trail
12. Competency framework for records management staff
13. Assessment and review
14. Shared Information

As the Chief Officer I confirm that I have overall responsibility for the North Ayrshire Integration Joint Board (NAIJB) Records Management Plan which has my full support and that of the Integration Joint Board members.

I also fully endorse the policy statement that NAIJB records will be managed in accordance with North Ayrshire Council policies and procedures and that Ms Lauren Lewis, Information

Management Officer is the designated Officer of the Council who has operational responsibility for records management.

In following good practice, North Ayrshire Integration Joint Board will ensure it has confidence of the public in our data and information management and that we comply with legislation including the Freedom of Information (Scotland) Act 2002, the Data Protection Act 2018 and other access to information legislation.

Yours faithfully

Stephen Brown
Director Health & Social Care Partnership
Chief Officer North Ayrshire Integration Joint Board

Integration Joint Board
14 February 2019

Subject:	**Ministerial Strategic Group for Health and Community Care – Review of Progress with Integration of Health and Social Care**
Purpose:	To inform the IJB of the publication of the final report relating to the review of progress with Integration of Health and Social Care
Recommendation:	The IJB notes the final report and the joint COSLA and Scottish Government proposals to ensure the success of integration. The HSCP will benchmark the North Ayrshire position against the findings of the review and the Audit Scotland report with an evaluation of our position together with an Action Plan to be presented to the IJB in April 2019.

Glossary of Terms	
HSCP	Health and Social Care Partnership
MSG	Ministerial Strategic Group
COSLA	Convention of Scottish Local Authorities

1.	**EXECUTIVE SUMMARY**
1.1	At a health debate in the Scottish Parliament on 2 May 2018, the then Cabinet Secretary for Health and Sport undertook that a review of progress by Integration Authorities would be taken forward with the Ministerial Strategic Group (MSG) for Health and Community Care, and that outputs arising from any further action stemming from such a review would be shared with the Health and Sport Committee of the Scottish Parliament. This review has been concluded with the final report published, the report is included as Appendix 1.
1.2	The Ministerial Strategic Group agreed that the review would be taken forward by a small "leadership" group of senior officers chaired by Paul Gray (Director of General Health and Social Care and Chief Executive of NHS Scotland) and Sally Loudon (Chief Executive of COSLA). The purpose of the review being to increase the pace and effectiveness of integration, building on addressing the key areas for further action identified in the Audit Scotland report.
1.3	In undertaking the review the Scottish Government and COSLA built upon Audit Scotland's observation that integration can work within the current legislative framework, but that Integration Authorities are operating in an extremely challenging environment and there is much more to be done. The focus being on tackling the challenges; rather than revisiting the statutory basis for integration or proposing any legislative changes.
1.4	A number of proposals to ensure the future success of integration have been included in the report. The North Ayrshire HSCP will benchmark and assess the partnership against the proposed areas for improvement from the review alongside the Audit

Scotland report and will bring forward an evaluation and Action Plan to the IJB in April 2019.

2. BACKGROUND

2.1 At a health debate in the Scottish Parliament on 2 May 2018, the then Cabinet Secretary for Health and Sport undertook that a review of progress by Integration Authorities would be taken forward with the Ministerial Strategic Group (MSG) for Health and Community Care, and that outputs arising from any further action stemming from such a review would be shared with the Health and Sport Committee of the Scottish Parliament. This review has been concluded with the final report published, the report is included as Appendix 1.

2.2 At its meeting on 20 June 2018, the Ministerial Strategic Group agreed that the review process would be taken forward via a small "leadership" group of senior officers chaired by Paul Gray (Director General Health and Social Care and Chief Executive of NHS Scotland) and Sally Loudon (Chief Executive of COSLA).

A group of stakeholders including Chief Executives, Chief Officers and third and independent sectors were also key members of the reference group.

2.3 The work of the review leadership group followed the timetable below:

Meeting Date	Topics for discussion
24/09/18	Finance: agreeing, delegating and using integrated budgets
23/10/18	Governance and commissioning arrangements, including clinical and care governance
27/11/18	Delivery and improving outcomes including consideration of the Audit Scotland report on integration (published 15/11/18)
19/12/18	Conclusions and agreement on recommendations, to be reported to the MSG on 23/01/19

2.4 Audit Scotland's report on integration, which was published on 15 November 2018, highlights that evidence is emerging of good progress in local systems. However a series of challenges also need to be addressed, particularly with regard to:

- financial planning,
- governance,
- strategic planning arrangements and
- Leadership capacity.

The MSG review group recognised that the Audit Scotland report on integration provides important evidence for changes that are needed to deliver integration well. The group noted their agreement with Audit Scotland's recommendations and these should be acted upon in full by the statutory health and social care partners in Scotland.

3. PROPOSALS

3.1 The report outlines a number of proposals and not recommendations, reflecting joint and mutual leadership responsibility to improve the pace and success of integration in improving outcomes for people using health and social care services in Scotland. There is only one proposal in the report which is stated as a

	recommendation, this is in relation to support provided to IJB S95 (Chief Financial) Officers.
3.2	The MSG group identified the following areas for improvement with proposals for implementation over the next 6 to 12 months: **1. Collaborative leadership and building relationships** i. All leadership development will be focused on shared and collaborative practice. ii. Relationships and collaborative working between partners must improve. iii. Relationships and partnership working with the third and independent sectors must improve. **2. Integrated finances and financial planning** i. Health Boards, Local Authorities and IJBs should have a joint understanding of their respective financial positions as they relate to integration. ii. Delegated budgets for IJBs must be agreed timeously. iii. Delegated hospital budgets and set aside requirements must be fully implemented. iv. Each IJB must develop a transparent and prudent reserves policy. v. Statutory partners must ensure appropriate support is provided to IJB S95 officers. vi. IJBs must be empowered to use the totality of resources at their disposal to better meet the needs of their local populations. **3. Effective strategic planning for improvement** i. Statutory partners must ensure that Chief Officers are effectively supported and empowered to act on behalf of the IJB. ii. Improved strategic inspection of health and social care is developed to better reflect integration. iii. National improvement bodies must work more collaboratively and deliver the improvement support partnerships require to make integration work. iv. Improved strategic planning and commissioning arrangements must be put in place. v. Improved capacity for strategic commissioning of delegated hospital services must be in place. **4. Governance and accountability arrangements** i. The understanding of accountabilities and responsibilities between statutory partners must improve. ii. Accountability processes across statutory partners will be streamlined. IJB chairs must be better supported to facilitate well run Boards capable of making effective decisions on a collective basis. iii. Clear directions must be provided by IJBs to Health Boards and Local Authorities. iv. Effective, coherent and joined up clinical and care governance arrangements must be in place. **5. Ability and willingness to share information** i. IJB annual performance reports will be benchmarked by Chief Officers to allow them to better understand their local performance data.

	ii. Identifying and implementing good practice will be systematically undertaken by all partnerships. iii. A framework for community based health and social care integrated services will be developed. **6. Meaningful and sustained engagement** i. Effective approaches for community engagement and participation must be put in place for integration. ii. Improved understanding of effective working relationships with carers, people using services and local communities is required. iii. We will support carers and representatives of people using services better to enable their full involvement in integration. In addition, the group noted that workforce issues were not considered in any detail in the audit, but recommends that those should be a key focus for statutory and non-statutory partners taking forward integration.
3.3	In support of these proposals the MSG leadership team will: • Provide support with implementation; • Prepare guidance and involve partners in the preparation of these; • Assist with the identification and implementation of good practice; • Monitor and evaluate progress in achieving proposals; • Make the necessary links to other parts of the system, such as workforce planning; • Continue to provide leadership to making progress with integration; • Report regularly on progress with implementation to the Ministerial Group for Health and Community care.
3.4	In support of these proposals the MSG expect that : • Every Health Board, Local Authority and IJB will evaluate their current position in relation to this report and the Audit Scotland report, and take action to make progress using the support on offer. • Partnerships to initiate or continue the necessary “tough conversations” to make integration work and to be clear about the risks being taken, and ensure mitigation of these is in place. • Partnerships to be innovative in progressing integration.
3.5	**<u>Anticipated Outcomes</u>**
	The review proposals aim to improve people’s outcomes by increasing the pace of delivery of the integration of health and social care.
3.6	**<u>Measuring Impact</u>**
	The HSCP will benchmark and evaluate its current position against the review proposals alongside the Audit Scotland recommendations producing an Action Plan to be presented to the IJB in April 2019, progress against the action plan will then be monitored and reported through the Performance and Audit Committee.

4.	IMPLICATIONS

Financial:	There are financial proposals as part of the review focus on developing an integrated partnership budget.
Human Resources:	There are no workforce proposals as part of the review. However this issue should be a key focus for statutory and non-statutory partners taking forward integration
Legal:	No legal amendments to the existing legislation will be made as a result of the review.
Equality:	The integration of health and social care seeks to improve the equalities outcomes of the people of North Ayrshire.
Children and Young People	There are planning proposals which will impact on all service areas as part of the review.
Environmental & Sustainability:	There are proposals to support HSCP sustainability, through increased pace of implementation.
Key Priorities:	The review proposals will aid the delivery of the HSCP strategic plan.
Risk Implications:	A risk assessment will be developed as part of the benchmarking report.
Community Benefits:	N/A.

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

5.	CONSULTATION
5.1	No prior consultation on this report has taken place due to the short timescale between the MSG report publication date and the IJB meeting. Consultation will also take place with NHS Ayrshire and Arran and North Ayrshire Council and our independent and third sector partners to inform a local partnership Action Plan.
6.	**CONCLUSION**
6.1	The proposals from the review on progress with integration of health and social care provides an opportunity to improve its pace and effectiveness. A follow up report in relation to the review and the Audit Scotland report will be presented to the IJB in April 2019.

For more information please contact Stephen Brown on 01294 317788 or sbrown@north-ayrshire.gcsx.gov.uk

Cabinet Secretary for Health and Sport
Jeane Freeman MSP

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Lewis Macdonald MSP
Convener
Health and Sport Committee

By Email.

1 February 2019

Dear Lewis,

Please find attached a copy of the final report on progress with integration prepared by the Integration Review Leadership Group, which was considered by the Ministerial Strategic Group for Health and Community Care (MSG) on 23 January. Following some minor redrafting the MSG has now agreed the final report.

I look forward to providing evidence on this report and its proposals at the Health and Sport Committee's meeting on 19 February 2019.

Kind Regards,

JEANE FREEMAN

St Andrew's House, Regent Road, Edinburgh EH1 3DG
www.gov.scot

Ministerial Strategic Group for Health and Community Care

Review of Progress with Integration of Health and Social Care

Final Report

February 2019

COSLA

Scottish Government
Riaghaltas na h-Alba
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REVIEW OF PROGRESS WITH INTEGRATION OF HEALTH AND SOCIAL CARE

Introduction

Since 2016, work has been underway across Scotland to integrate health and social care services in line with the requirements of the Public Bodies (Joint Working) (Scotland) Act 2014. By integrating the planning and provision of care, partners in the public, third and independent sectors are improving people's experience or care along with its quality and sustainability. Evidence is emerging of good progress in local systems. Audit Scotland's[1] report on integration that was published on 15 November 2018 highlights a series of challenges that nonetheless need to be addressed, in terms particularly of financial planning, governance and strategic planning arrangements and leadership capacity.

The pace and effectiveness of integration need to increase. At a health debate in the Scottish Parliament on 2 May 2018, the then Cabinet Secretary for Health and Sport undertook that a review of progress by Integration Authorities would be taken forward with the Ministerial Strategic Group for Health and Community Care, and that outputs arising from any further action stemming from such a review would be shared with the Health and Sport Committee of the Scottish Parliament.

Why has Scotland integrated health and social care?

We have integrated health and social care so that we can ensure people have access to the services and support they need, so that their care feels seamless to them, and so that they experience good outcomes and high standards of support. We are also looking to the future: integration requires services to be redesigned and improved, with a strong focus on prevention, quality and sustainability, so that we can continue to maintain our focus on reforming and improving people's experience of care. In undertaking this review we have built upon Audit Scotland's observation that integration can work within the current legislative framework, but that Integration Authorities are operating in an extremely challenging environment and there is much more to be done: our focus is on tackling the challenges rather than revisiting the statutory basis for integration.

As part of the review, it is important to acknowledge fully the key importance of staff working across the entirety of health and social care. People working in health and social care services are driving forward many improvements in the experience of care, every day and often in challenging and difficult circumstances. Without the insight, experience and dedication of the health and social care workforce we will simply not be able to deliver on out ambitions for integration. This review does not make recommendations about the health and social care workforce: that work is being undertaken through the National Workforce Plan for health and social care. We nonetheless felt it important to emphasise here the importance of our shared ambitions to develop and support the workforce for integration.

[1] Health and social care integration: update on progress

Reviewing progress with integration

As we have reviewed our progress to date, our approach has been to focus on the key questions that matter most to people who use services and the systems we have put in place in order to better support those priorities. We have asked ourselves where we are making progress and where the barriers are that may prevent professionals and staff across health and social care from using their considerable skills and resources to best effect. When the Scottish Government first consulted upon plans for integration[2], it focused on four key objectives, which remain central to our aims:

- Health and social care services should be firmly integrated around the needs of individuals, their carers and other family members
- Health and social care services should be characterised by strong and consistent clinical and care professional leadership
- The providers of services should be held to account jointly and effectively for improved delivery
- Services should be underpinned by flexible, sustainable financial mechanisms that give priority to the needs of the people they serve, rather than the organisations through which they are delivered

The legislation for integration, the Public Bodies (Joint Working) (Scotland) Act 2014, sets out principles and outcomes, which sit at the centre of our ambitions:

Principles of integration: services should[3]:

1. Be integrated from the point of view of service-users
2. take account of the particular needs of different service-users
3. Take account of the particular needs of service-users in different parts of the area in which the service is being provided
4. Take account of the particular characteristics and circumstances of different service-users
5. Respect the rights of service-users
6. Take account of the dignity of service-users
7. Take account of the participation by service-users in the community in which service-users live
8. Protect and improve the safety of service-users
9. Improve the quality of the service
10. Be planned and led locally in a way which is engaged with the community (including in particular service-users, those who look after service-users and those who are involved in the provision of health or social care)
11. Best anticipate needs and prevents them arising, and
12. Makes the best use of the available facilities, people and other resources.

[2] Integration of Adult Health and Social Care in Scotland: Consultation on Proposals (May 2012)
[3] http://www.legislation.gov.uk/asp/2014/9/pdfs/asp_20140009_en.pdf

National health and wellbeing outcomes[4]

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

The purpose of this review is to help ensure we increase our pace in delivering all of these objectives.

Review process

At its meeting on 20 June 2018, the Ministerial Strategic Group agreed that the review would be taken forward via a small "leadership" group of senior officers chaired by Paul Gray (Director General Health and Social Care and Chief Executive of NHS Scotland) and Sally Loudon (Chief Executive of COSLA). A larger group of senior stakeholders has acted as a "reference" group to the leadership group.

Membership of the review leadership group is as follows:

- Paul Gray (co-chair) (Director General for Health and Social Care and Chief Executive of NHSScotland)
- Sally Loudon (co-chair) (Chief Executive of COSLA)
- Paul Hawkins (Chief Executive of NHS Fife, representing NHS Chief Executives)
- Andrew Kerr (Chief Executive of Edinburgh City Council, representing SOLACE)
- David Williams (Chief Officer of Glasgow City IJB and Chair of the Chief Officers' network, representing IJB Chief Officers)
- Annie Gunner Logan (Chief Executive of CCPS, representing the third sector)
- Donald MacAskill (Chief Executive of Scottish Care, representing the independent sector)

[4] http://www.legislation.gov.uk/ssi/2014/343/pdfs/ssi_20140343_en.pdf

The work of the review leadership group followed this timetable:

Meeting date	Topics for discussion
24/09/18	Finance: agreeing, delegating and using integrated budgets
23/10/18	Governance and commissioning arrangements, including clinical and care governance
27/11/18	Delivery and improving outcomes including consideration of the Audit Scotland report on integration (published 15/11/18)
19/12/18	Conclusions and agreement on recommendations, to be reported to the MSG on 23/01/19

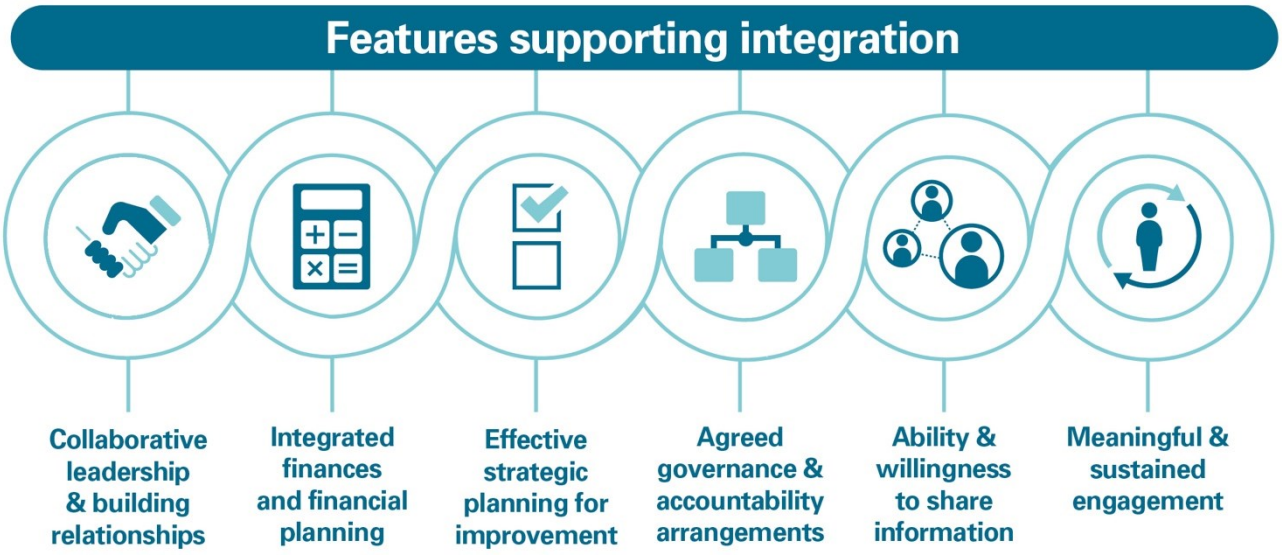
This report draws together the group's proposals for ensuring the success of integration. It builds upon the first output of our review, the joint statement issued on 26 September 2018, which is at Annex A of this report.

Integration Review Leadership Group
4 FEBRUARY 2019

Audit Scotland report

1. The group recognised that the Audit Scotland report on integration that was published in November 2018 provides important evidence for changes that are needed to deliver integration well. The group noted their agreement with Audit Scotland's recommendations. The group recommends that these recommendations should be acted upon in full by the statutory health and social care partners in Scotland. In addition, the group noted that workforce issues were not considered in any detail in the audit, but recommends that those should be a key focus for statutory and non-statutory partners taking forward integration.

2. Within a broad context of focussing on improving outcomes for people who use services and delivering sustainable, high quality services, the group noted specifically that exhibit 7 from the Audit Scotland report, reproduced below, provides a helpful framework within which to make progress. The group agreed to set out its proposals, in this report, under the headings identified in the exhibit, each of which was considered fully in turn.



3. As a group, we decided to set out "proposals" in this report rather than "recommendations" to underline that the commitments our proposals make are a shared endeavour, which we are each signed up to on a personal level as senior leaders and on behalf of our respective organisations. We have used "we" throughout the proposals set out in this document to further emphasise this.

4. In our review work, we recognised, as the Audit Scotland report does, that there is good practice developing, both in terms of how Integration Joint Boards (IJBs) are operating, and in how services are being planned and delivered to ensure better outcomes. However, this is not yet the case in all areas. We know there are challenges we must address and want to make use of good practice to drive forward change and reform to truly deliver integration for the people of Scotland.

Leadership Group Proposals

Our proposals focus on our joint and mutual responsibility to improve outcomes for people using health and social care services in Scotland. They are a reflection of our shared commitment to making integration work, set out in our joint statement from September 2018.

1. **Collaborative leadership and building relationships**

Shared and collaborative leadership must underpin and drive forward integration.

We propose that:

1. (i) **All leadership development will be focused on shared and collaborative practice.** An audit of existing national leadership programmes will be undertaken by the Scottish Government and COSLA to identify gaps and areas of synergy to support integration of health and social care. Further work will be delivered on cross-sectoral leadership development and support.
Timescale: 6 months

1. (ii) **Relationships and collaborative working between partners must improve**. Statutory partners in particular must seek to ensure an improved understanding of pressures, cultures and drivers in different parts of the system in order to promote opportunities for more open, collaborative and partnership working, as required by integration.
Timescale: 12 months

1. (iii) **Relationships and partnership working with the third and independent sectors must improve**. Each partnership will critically evaluate the effectiveness of their working arrangements and relationships with colleagues in the third and independent sectors, and take action to address any issues.
Timescale: 12 months

2. **Integrated finances and financial planning**

Money must be used to maximum benefit across health and social care. Our aim for integration has been to create a system of health and social care in Scotland in which the public pound is always used to best support the individual at the most appropriate point in the system, regardless of whether the support that is required is what we would traditionally have described as a "health" or "social care" service. Our proposals for integrated finances and financial planning focus on the practicalities of ensuring the arrangements for which we have legislated are used fully to achieve that aim, and to support the Scottish Government's Medium Term Framework for Health and Social Care[5].

We propose that:

2. (i) **Health Boards, Local Authorities and IJBs should have a joint understanding of their respective financial positions as they relate to integration.** In each partnership area the Chief Executive of the Health Board and the Local Authority, and the Chief Officer of the IJB, while considering the service impact of decisions, should together request consolidated advice on the financial position as it applies to their shared interests under integration from, respectively, the NHS Director of Finance, the Local Authority S95 Officer and the IJB S95 Officer.
Timescale: By 1st April 2019 and thereafter each year by end March.

2. (ii) **Delegated budgets for IJBs must be agreed timeously.** The recently published financial framework for health and social care sets out an expectation of moving away from annual budget planning processes towards more medium term arrangements. To support this requirement for planning ahead by Integration Authorities, a requirement should be placed upon statutory partners that all delegated budgets should be agreed by the Health Board, Local Authority and IJB by the end of March each year.
Timescale: By end of March 2019 and thereafter each year by end March

2. (iii) **Delegated hospital budgets and set aside requirements must be fully implemented**. Each Health Board, in partnership with the Local Authority and IJB, must fully implement the delegated hospital budget and set aside budget requirements of the legislation, in line with the statutory guidance published in June 2015. These arrangements must be in place in time for Integration Authorities to plan their use of their budgets in 2019/20. The Scottish Government Medium Term Financial Framework includes an assumption of efficiencies from reduced variation in hospital care coupled with 50% reinvestment in the community to sustain improvement. The set aside arrangements are key to delivering this commitment.
Timescale: 6 months

2. (iv) **Each IJB must develop a transparent and prudent reserves policy**. This policy will ensure that reserves are identified for a purpose and held against planned expenditure, with timescales identified for their use, or held as a general reserve as a

[5] Scottish Government Medium Term Health and Social Care Financial Framework

contingency to cushion the impact of unexpected events or emergencies. Reserves must not be built up unnecessarily.
Timescale: 3 months

2. (v) **Statutory partners must ensure appropriate support is provided to IJB S95 Officers.** This will include Health Boards and Local Authorities providing staff and resources to provide such support. Measures must be in place to ensure conflicts of interest for IJB S95 Officers are avoided – their role is to provide high quality financial support to the IJB. To ensure a consistent approach across the country, the existing statutory guidance should be amended by removing the last line in paragraph 4.3 recommendation 2, leaving the requirement for such support as follows:

> *It is recommended that the Health Board and Local Authority Directors of Finance and the Integration Joint Board financial officer establish a process of regular in-year reporting and forecasting to provide the Chief Officer with management accounts for both arms of the operational budget and for the Integration Joint Board as a whole. It is also recommended that each partnership area moves to a model where both the strategic and operational finance functions are undertaken by the IJB S95 officer: and that these functions are sufficiently resourced to provide effective financial support to the Chief Officer and the IJB.*

Timescale: 6 months

2. (vi) **IJBs must be empowered to use the totality of resources at their disposal to better meet the needs of their local populations**. Local audits of the Health Board and Local Authority must take account of the expectation that money will be spent differently. We should be focused on outcomes, not which public body put in which pound to the pot. It is key that the resources held by IJBs lose their original identity and become a single budget on an ongoing basis. This does not take away from the need for the IJB to be accountable for these resources and their use.
Timescale: from 31st March 2019 onwards.

3. Effective strategic planning for improvement

Maximising the benefit of health and social care services, and improving people's experience of care, depends on good planning across all the services that people access, in communities and hospitals, effective scrutiny, and appropriate support for both activities.

We propose that:

3. (i) **Statutory partners must ensure that Chief Officers are effectively supported and empowered to act on behalf of the IJB.** This will include Health Boards and Local Authorities providing staff and resources to provide such support. The dual role of the Chief Officer makes it both challenging and complex, with competing demands between statutory delivery partners and the business of the IJB. Chief Officers must be recognised as pivotal in providing the leadership needed to make a success of integration and should be recruited, valued and accorded due status by statutory partners in order that they are able to properly fulfil this "mission critical" role. Consideration must be made of the capacity and capability of Chief Officers and their senior teams to support the partnership's range of responsibilities.
Timescale: 12 months

3. (ii) **Improved strategic inspection of health and social care is developed to better reflect integration**. As part of this work, the Care Inspectorate and Healthcare Improvement Scotland will ensure that:

- As well as scrutinising strategic planning and commissioning processes, strategic inspections are fundamentally focused on what integrated arrangements are achieving in terms of outcomes for people.
- Joint strategic inspections examine the performance of the whole partnership – the Health Board, Local Authority and IJB, and the contribution of non-statutory partners – to integrated arrangements, individually and as a partnership.
- There is a more balanced focus across health and social care ensured in strategic inspections.

Timescale: 6 months

3. (iii) **National improvement bodies must work more collaboratively and deliver the improvement support partnerships require to make integration work**. These bodies include Healthcare Improvement Scotland, the Care Inspectorate, the Improvement Service and NHS National Services Scotland. Improvement support will be more streamlined, better targeted and focused on assisting partnerships to implement our proposals. This will include consideration of the models for delivery of improvement support at a national and local level and a requirement to better meet the needs of integration partners.
Timescale: 3 - 6 months

3. (iv) **Improved strategic planning and commissioning arrangements must be put in place.** Partnerships should critically analyse and evaluate the effectiveness of their strategic planning and commissioning arrangements, including establishing capacity and

capability for this. Local Authorities and Health Boards will ensure support is provided for strategic planning and commissioning, including staffing and resourcing for the partnership, recognising this as a key responsibility of Integration Authorities.
Timescale: 12 months

3. (v) **Improved capacity for strategic commissioning of delegated hospital services must be in place.** As implementation of proposal 2 (iii) takes place, a necessary step in achieving full delegation of the delegated hospital budget and set aside arrangements will be the development of strategic commissioning for this purpose. This will focus on planning delegated hospital capacity requirements and will require close working with the acute sector and other partnership areas using the same hospitals. This should evolve from existing capacity and plans for those services.
Timescale: 12 months

4. Governance and accountability arrangements

Governance and accountability must be clear and commonly understood for integrated services.

We propose that:

4. (i) **The understanding of accountabilities and responsibilities between statutory partners must improve**. The responsibility for decisions about the planning and strategic commissioning of all health and social care functions that have been delegated to the IJB sits wholly with the IJB as a statutory public body. Such decisions do not require ratification by the Health Board or the Local Authority, both of which are represented on the IJB. Statutory partners should ensure duplication is avoided and arrangements previously in place for making decisions are reviewed to ensure there is clarity about the decision making responsibilities of the IJB and that decisions are made where responsibility resides. Existing committees and groups should be refocused to share information and support the IJB.
Timescale: 6 months

4. (ii) **Accountability processes across statutory partners will be streamlined.** Current arrangements for each statutory partner should be scoped and opportunities identified for better alignment, with a focus on better supporting integration and transparent public reporting. This will also ensure that different rules are not being applied to different parts of the system particularly in circumstances of shared accountability.
Timescale: 12 months

4. (iii) **IJB chairs must be better supported to facilitate well run Boards capable of making effective decisions on a collective basis.** There are well-functioning IJBs that have adopted an open and inclusive approach to decision making and which have gone beyond statutory requirements in terms of memberships to include representatives of key partners in integration, including the independent and housing sectors. This will assist in improving the effectiveness and inclusivity of decision making and establish IJBs as discrete and distinctive statutory bodies acting decisively to improve outcomes for their populations.
Timescale: 12 months

4. (iv) **Clear directions must be provided by IJBs to Health Boards and Local Authorities.** Revised statutory guidance will be developed on the use of directions in relation to strategic commissioning, emphasising that directions are issued at the end of a process of decision making that has involved partners. Directions must be recognised as a key means of clarifying responsibilities and accountabilities between statutory partners, and for ensuring delivery in line with decisions.
Timescale: 6 months

4. (v) **Effective, coherent and joined up clinical and care governance arrangements must be in place.** Revised statutory guidance will be developed based on wide ranging consultations with local partnerships, identifying good practice and involving all sectors.

The key role of clinical and professional leadership in supporting the IJB to make decisions that are safe and in accordance with required standards and law must be understood, co-ordinated and utilised fully.
Timescale: 6 months

5. Ability and willingness to share information

Understanding where progress and problems are arising is key to implementing learning and delivering better care in different settings.

We propose that:

5. (i) **IJB annual performance reports will be benchmarked by Chief Officers to allow them to better understand their local performance data**. Chief Officers will work together to consider, individually and as a group, whether their IJBs' annual reports can be further developed to improve consistency in reporting, better reflect progress and challenges in local systems, and ensure that, as a minimum, all statutorily required information is reported upon.
Timescale: By publication of next round of annual reports in July 2019

5. (ii) **Identifying and implementing good practice will be systematically undertaken by all partnerships.** Chief Officers will develop IJBs' annual reports to enable partnerships to identify, share and use examples of good practice, and lessons learned from things that have not worked. Inspection findings and reports from strategic inspections and service inspections should also provide a clear means of identifying and sharing good practice, based on implementation of the framework outlined below at 5 (iii) and the national health and social care standards.
Timescale: 6 - 12 months

5. (iii) **A framework for community based health and social care integrated services will be developed**. The framework will be key in identifying and promoting best practice in local systems to clearly illustrate what good looks like in community settings, which is firmly focused on improving outcomes for people. This work will be led by Scottish Government and COSLA, involving Chief Officers and other key partnership staff to inform the framework.
Timescale: 6 months

6. Meaningful and sustained engagement

Integration is all about people: improving the experience of care for people using services, and the experience of people who provide care. Meaningful and sustained engagement has a central role to play in ensuring that the planning and delivery of services is centred on people.

We propose that:

6. (i) **Effective approaches for community engagement and participation must be put in place for integration.** This is critically important to our shared responsibility for ensuring services are fit for purpose, fit for the future, and support better outcomes for people using services, carers and local communities. Revised statutory guidance will be developed by the Scottish Government and COSLA on local community engagement and participation based on existing good practice, to apply across health and social care bodies. Meaningful engagement is central to achieving the scale of change and reform required, and is an ongoing process that is not undertaken only when service change is proposed.
Timescale: 6 months

6. (ii) **Improved understanding of effective working relationships with carers, people using services and local communities is required.** Each partnership should critically evaluate the effectiveness of their working arrangements and relationships with people using services, carers and local communities. A focus on continuously improving and learning from best practice will be adopted in order to maximise meaningful and sustained engagement.
Timescale: 12 months

6. (iii) **We will support carers and representatives of people using services better to enable their full involvement in integration**. Carers and representatives of people using health and social care services will be supported by partnerships to enable meaningful engagement with their constituencies. This will support their input to Integration Joint Boards, strategic planning groups and locality arrangements for integration. This would include, for example, receipt of IJB papers with enough time to engage other carers and people using services in responding to issues raised. It would also include paying reasonable expenses for attending meetings.
Timescale: 6 -12 months

In support of these proposals we will:

- Provide support with implementation;
- Prepare guidance and involve partners in the preparation of these;
- Assist with the identification and implementation of good practice;
- Monitor and evaluate progress in achieving proposals;
- Make the necessary links to other parts of the system, such as workforce planning;
- Continue to provide leadership to making progress with integration;
- Report regularly on progress with implementation to the Ministerial Group for Health and Community care.

In support of these proposals we expect:

- Every Health Board, Local Authority and IJB will evaluate their current position in relation to this report and the Audit Scotland report, and take action to make progress using the support on offer.

- Partnerships to initiate or continue the necessary “tough conversations” to make integration work and to be clear about the risks being taken, and ensure mitigation of these is in place.

- Partnerships to be innovative in progressing integration.

Annex A – Joint Statement

Cabinet Secretary for Health and Sport
Jeane Freeman MSP

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NHS Board Chairs
Local Authority Leaders
Integration Joint Board Chairs and Vice Chairs
NHS Board Chief Executives
Local Authority Chief Executives
Integration Joint Board Chief Officers
Chief Executive, SCVO
Chief Executive, Health and Social Care Alliance
Chief Executive, CCPS
Chief Executive, Scottish Care

26 September 2018

Dear colleagues

The Scottish Government, NHS Scotland and COSLA share responsibility for ensuring the successful integration of Scotland's health and social care services. We are therefore delighted to send to you today a joint statement, attached to this letter, setting out our shared commitment to integration as leaders in the public sector.

This statement is the first output from our review of integration, which is now underway via the Ministerial Strategic Group for Health and Community Care. It frames our joint ambitions for integration and sets the context for recommendations that will follow from the review.

We look forward to continuing to work with you all to deliver integration, and, through it, better care for people using health and social care services in Scotland.

JEANE FREEMAN
Cabinet Secretary for Health and Sport

COUNCILLOR ALISON EVISON
COSLA President

DELIVERING INTEGRATION

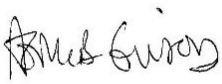
We need to step up the pace of integrating health and social care. Truly integrated services, focused on the needs of citizens – individuals, carers and families, and on the health and wellbeing of local communities – require our leadership and personal commitment. We need to act together and in our individual roles to accelerate progress.

There are challenges that we must address. We will work together, and with our local populations as well as partners in the third and independent sectors, to understand public expectations and better meet needs for health and social care, which go hand-in-hand with improvements in life expectancy and the availability of new medicines and technologies. We are already making progress. We recognise that we are jointly responsible for tackling these challenges and that we need to adapt, compromise and support one another to deliver integration for the people of Scotland.

The Public Bodies (Joint Working) Act 2014 puts in place governance and financial arrangements, and a set of outcomes, for us to work within to achieve integration. We share a duty to empower Integration Authorities, to hold ourselves and one another to account in order to make integration work. We will learn from one another and adopt good practice. We will also work collaboratively and in partnership beyond the statutory sector to deliver improvements.

We commit to delivering together because that is the right way to deliver better services for our citizens.

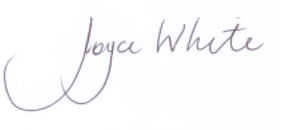
CABINET SECRETARY FOR HEALTH AND SPORT



COSLA PRESIDENT

DIRECTOR GENERAL, SCOTTISH GOVERNMENT HEALTH AND SOCIAL CARE DIRECTORATES AND CHIEF EXECUTIVE, NHSSCOTLAND

CHIEF EXECUTIVE, COSLA



CHAIR, SOLACE 26 SEPTEMBER 2018

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