Integration Joint Board
29 August 2019

Subject:	**Annual Performance Report**
Purpose:	To approve the North Ayrshire Health and Social Care Partnership (NAHSCP) Annual Performance Report 2018-2019.
Recommendation:	Integration Joint Board (IJB) to retrospectively approve the draft NAHSCP Annual Performance Report 2018-19 published on 31st July 2019.

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

1.	**EXECUTIVE SUMMARY**
1.1	Section 42 of the Public Bodies (Joint Working)(Scotland) Act 2014 requires partnerships to publish an annual performance report setting out an assessment of performance in planning and carrying out the integration functions for which they are responsible.
1.2	*Guidance for Health and Social Care Integration Partnership Performance Reports* (published by the Scottish Government, March 2016) was followed to ensure the content of our performance report met the requirements set out in the guidance.
1.3	As with previous years the timescale for publication is 31st July, which was once again met.
2.	**BACKGROUND**
2.1	This annual performance report and is part of a suite of partnership public-facing documents. These documents can be found on the NAHSCP website www.nahscp.org
3.	**PROPOSALS**
3.1	The IJB are asked to approve the NAHSCP Annual Performance Report 2018-19.
3.2	**Anticipated Outcomes**
	Informing the people of North Ayrshire and wider stakeholders about health and social care integration, specifically : • Outcomes for local people; • Locality health and social care needs;

	• Service provision (including lead partnership responsibilities and commissioned services); • Transformational Change; • Budget and financial information.
3.3	**Measuring Impact**
	With the publication of the Annual Performance Report 2018-19 the partnership will have met its obligations under the Public Bodies (Joint Working)(Scotland) Act 2014.
4.	**IMPLICATIONS**

Financial:	There are no additional financial implications
Human Resources:	There are no implications for staff
Legal:	There are no legal issues.
Equality:	No issues
Children and Young People	No issues
Environmental & Sustainability:	No issues
Key Priorities:	This would ensure we fulfil our obligations in the Integration Scheme.
Risk Implications:	None identified.
Community Benefits:	Community is aware and informed about community-based health and social care services, plans and outcomes.

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	Staff and partnership stakeholders of the Partnership Senior Management Team (PSMT) and IJB Performance and Audit Committee (PAC) were consulted on the Annual Performance Report.
6.	**CONCLUSION**
6.1	IJB are asked to consider and retrospectively approve the NAHSCP 2018-19 Annual Performance Report.

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North Ayrshire Health and Social Care Partnership

Annual Performance Report 2018-19

Reflections from Stephen Brown

This annual performance report reflects on the main highlights of the Partnership during 2018–19. We have faced significant challenges in continuing to deliver safe, sustainable and improving health and social care services against the backdrop of continued operational and financial constraints. We have increasing demands for social care services, in the main linked to our population changes, and whilst we have seen some improvement during the year, we continue to have unacceptable delays in hospital.

The HSCP has faced financial challenges since inception, with the impact of funding constraints and increased demand for services. During the year significant progress was made and for the first time we delivered financial balance and commenced repayment of the £5.8m debt due to North Ayrshire Council. The HSCP move into the new financial year in a financially sustainable position, with a transformational change plan in place aligned to our Strategic Plan priorities.

Our transformation plans are aligned with improving health and social care outcomes for the people of North Ayrshire, these plans are starting to gather pace and there has been significant progress during the year with a programme which not only ensures we can use our resources effectively but also ensures we work towards providing the right care at the right time and in the right place.

The services we deliver continue to be high quality, as evidenced by many of our registered services receiving and maintaining high grades via the Care Inspectorate. Many of our services continue to be exemplars in the support they provide to vulnerable people.

There is a focus on the integration of services to deliver real change to the way services are being delivered, with a realism that continuing to deliver services in the same way is no longer sustainable. The HSCP recognise more needs to be done to up the scale and pace of change, and to get partnership staff, partners and communities on board to deliver on our shared vision.

I have personally committed that during the next year I will engage with all of our staff and our communities to challenge us all to *Think Different* and *Do Better* to deliver the best health and social care services we can to the people of North Ayrshire.

Stephen Brown
Director, North Ayrshire Health and Social Care Partnership

Contents

Vision, values and priorities 5

Structure of this report 6

1. Performance in relation to National Health and Wellbeing Outcomes 7

2. Performance in relation to the three Children's Outcomes and three Justice Services Outcomes 30

3. Reporting on localities 43

4. Transformation Programme 48

5. Reporting on lead partnership responsibility 53

6. Inspection of Service 60

7. Financial performance and best value 64

Appendices 73

Vision, values and priorities

North Ayrshire Health and Social Care Partnership (NAHSCP/the Partnership) is working towards a **vision** where:

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

Our Partnership includes health and social care services within **Health and Community Care Services**, **Mental Health and Learning Disability Services** and **Children, Families and Justice Services.**

In this, our fourth annual performance report, we look back on the progress we have made, share some of our successes and reflect on some areas that have proved challenging.

The partnership refreshed the three-year Strategic Plan, this report aligns with the first year of our second Strategic Plan. The new Strategic Plan allowed us to confirm with the people who use our services and North Ayrshire residents and staff that we should continue to focus on these five **priorities**:

- Tackling Inequalities
- Engaging Communities
- Bringing Services Together
- Prevention and Early Intervention
- Improving Mental Health and Wellbeing

People who use our services and North Ayrshire residents will experience our Partnership **values** in the way our staff and volunteers engage with you and how we behave. We will:

- Put you at the centre
- Treat you with respect
- Demonstrate efficiency
- Care
- Be inclusive
- Embody honesty
- Encourage innovation

Structure of this report

We have measured and evaluated our performance in relation to:

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

The North Ayrshire Health and Social Care Partnership continues to have lead partnership responsibilities across Ayrshire and Arran for Mental Health and Learning Disability Services as well as Child Health Services (including immunisation and infant feeding). We have reflected on some of the highlights and challenges of leading these services across Ayrshire.

We will show that all our services (those provided by our Partnership staff and those provided by other organisations on our behalf) are providing high quality care and support to the people of North Ayrshire.

Finally, the partnership continues to face financial challenges in delivering and improving services from within the available budget, during the year we have made significant progress towards achieving financial balance and overall service sustainability. We have detailed our financial position and reflected on how we continue to provide assurance that we are delivering Best Value in North Ayrshire for Health and Social Care services.

1. Performance in relation to National Health and Wellbeing Outcomes

As we completed our fourth year, the Partnership continued to focus our efforts on providing services that improve the lives of all the people living in North Ayrshire.

Our five strategic objectives link directly to the nine national Health and Wellbeing Outcomes these outcomes provide a roadmap for us and we can demonstrate progress against each.

Outcome 1:

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

Our Highlights

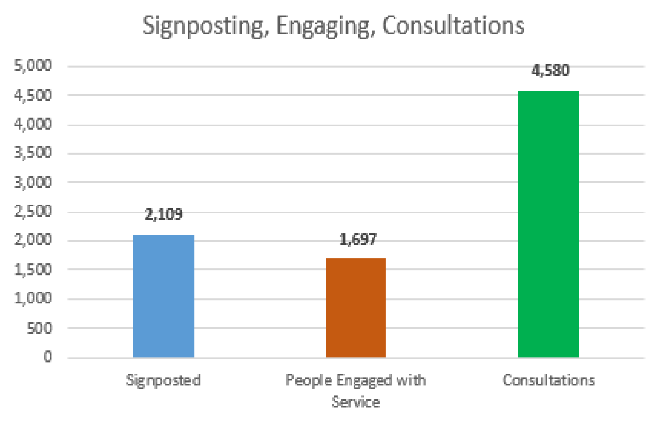
33% increase in referrals/ signposting to the Community Link Workers

48% increase in Community Link Worker consultations

Number of individuals prescribed methadone has **decreased by 7%**

1.1 Community Link Workers have continued to support mental and physical health by providing care and information on a wide range of issues, including managing stress, local activities and support groups, employment, a healthy lifestyle, alcohol and drugs and living with health conditions. The North Ayrshire Health and Social Care Partnership now employs 12 Community Link Workers, an increase of 5 since the last year. All **20 General Practices** now have a Community Link Worker.

1.2 We have seen a 33% increase in the number of people signposted to the service from 1,586 in 2017-18 to 2,109, with 1,697 people actively engaging with the service.



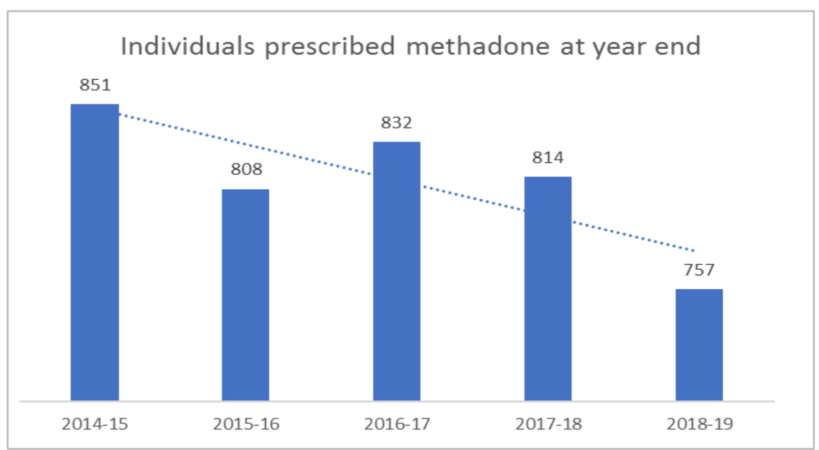
This led to a 48% increase in the number of consultations undertaken to 4,580 from 3,090 in 2017-18. Of the consultations undertaken, 80% were via the GP surgery and by telephone. The remaining were taken up via secondary telephone calls, home visits and other non-consultation recorded conversations.

1.3 Our first integrated team, North Ayrshire Drug and Alcohol Recovery Service (NADARS), has continued to demonstrate high levels of performance. NADARS is meeting all national and local standards and targets, such as, access to treatment waiting times, provision of alcohol brief interventions (ABIs), and the roll out of Naloxone supplies.

People being supported by NADARS, during 2018-19, evidenced:

- 76% reduction in alcohol intake
- 61% reduction in non – prescribed drug use
- 54% improvement in physical health
- 54% improvement in physiological health
- 52% improvement in social functioning

There also continues to be a downward trend towards the end of the year of individuals being prescribed methadone (see graph below).



1.3 The NADARS team continue to identify new ways of working to provide more agile and streamlined service delivery and further improve performance.

A further positive example of early intervention is in the delivery of Alcohol Brief Interventions (ABI).

Scottish Government in priority settings target for Ayrshire and Arran – **Priority Settings**	3,419
Delivered across all ABI settings	3,788

Scottish Government in priority settings target for Ayrshire and Arran – **Wider Settings**	856
Delivered across all ABI settings	3,489

1.5 NADARS have listened to the very positive feedback from the women who previously participated in the Women in North Ayrshire Group (WINA's) and have used that information and experience to develop a Men in North Ayrshire (MINA's) addiction recovery support group.

NADARS also recognised that men aged 35 years and over are highlighted in the national "**Staying Alive**" report as most at risk of drug related death and viewed this as an opportunity to increase practical and supportive interventions for males in service. This group is a 10-week programme aimed at men and topics include Health & Wellbeing (Mental, Physical Health, Exercise & relaxation), personal finance, basic fire safety & first aid, sexual health & blood borne viruses, naloxone awareness & medication management and concordance, confidence building, effective communication and strategies for moving on.

Outcome 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.

Our Highlights

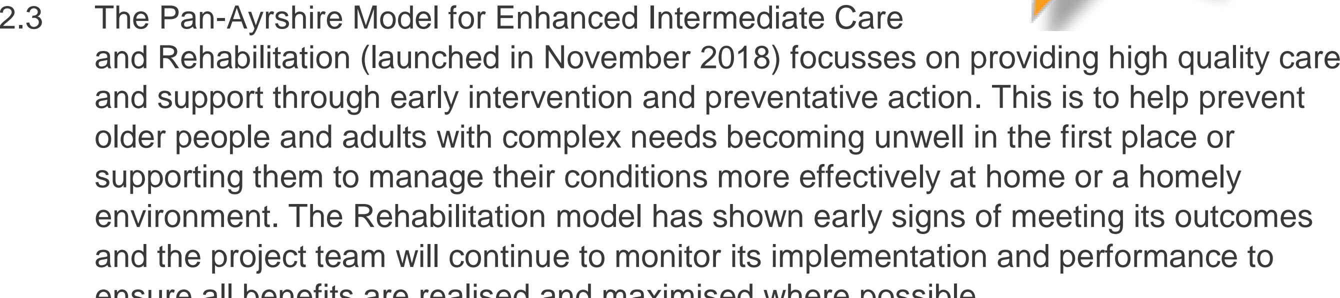
2,230 people receiving Care at Home Services

The number of people with a Community Alarm has **increased to 4,912**

84% of adults supported at home who agreed that they are supported to live independently (Scottish average; 81%)

2.1 With the number of Service users being provided with **Care at Home** support increasing by 10% to 2,230 from 2,021 in 2017-18 and the number of people receiving a **Community Alert** increasing by 9% to 4,912 in 2018-19 from 4,500, we have continued to work to ensure the high quality of service provision expected.

2.2 Our internal **Care at Home** service was inspected during 2018-19 with Quality of Care and Quality of Staffing being the focus. The outcome was a grading of ***'Very Good'*** for both inspected elements.



2.3 The Pan-Ayrshire Model for Enhanced Intermediate Care and Rehabilitation (launched in November 2018) focusses on providing high quality care and support through early intervention and preventative action. This is to help prevent older people and adults with complex needs becoming unwell in the first place or supporting them to manage their conditions more effectively at home or a homely environment. The Rehabilitation model has shown early signs of meeting its outcomes and the project team will continue to monitor its implementation and performance to ensure all benefits are realised and maximised where possible.

2.4 8 people who attend Hazeldene day services centre have completed, passed and received REHIS (Royal Environmental Health Institute of Scotland) awards.

Situation

W. had fallen from his bed after severe back pain and was unable to get back up. His wife was unable to help him due to her own disabilities, so she had called ambulance.

An ambulance attended, and the paramedic helped W. to sit up on a chair and assessed him, noting no obvious injuries. The paramedic phoned ICT and discussed W.'s needs. ICT agreed W. would benefit from an urgent ICT visit.

The Support

The team visited W. and his wife within two hours. Prior to the incident W. had been independent and actively involved in his local community. He also helped to support his wife and they both worried that W. would lose his independence and they would both need on-going support.

During the initial ICT visit W.s GP called and recommended a change to medication in case it was responsible for causing the pain. The ICT supported William for 10 days and he was also closely monitored by his GP.

The ICT provided support to enable W. to become more independent in his home by providing advice and equipment. They gave information on pain relief management and transferring techniques to help reduce the amount of pain W. was in and continued reassurance to W. and his wife over the period.

Outcome

At the end of the 10 days W.s pain was much more manageable, and he was able to go out and about in the community again and take this wife to the shops.

The Difference

- No Conveyance to hospital
- No initial GP visit
- No hospital admission
- Regained independence

2.5 With the devolution of Allied Health Professional (AHP) services to each health and social care partnership area an annual report was presented to the North Ayrshire HSCP Integrated Joint Board encompassing the range of services provided by the AHPs. The full report can be found here - **NAHSCP Allied Professional Report 2018**.

2.6 The following information summarises some of the key achievements during 2018-19.

The Professional Learning Academy delivers extensive training and targeted speech and language interventions in schools across North Ayrshire with the highest SIMD (Scottish Index of Multiple Deprivation) index. Outcomes have proved positive with interventions evaluating well.

Talk Boost is a targeted intervention, building capacity to ensure sustainability. Evaluated example, Story Telling and Narrative Skills:

- Children achieving appropriate level of skill pre-intervention was 9%, post-intervention is 76%
- Children have improved social interaction skills – pre-intervention score 50%, post-intervention score 91%

2.7 While emergency admissions to hospital have increased year on year from 2015-16 to 2017-18, in 2018-19 emergency admissions reduced by 3% to 18,959 (as at February 2019), from 19,475 in 2015-16. During the same period the number of Emergency Department admissions has decreased by 32% from 17,899 in 2015-16 to 12,087 (as at February 2019) in 2018-19.

Outcome 3:

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

Our Highlights

Internal Care at Home Service Inspection graded at **Level 5, 'Very Good'**

116 compliments received during 2018-19

3.1 Our internal partnership Care at Home service was inspected during 2018-19 with Quality of Care and Quality of Staffing being the focus. The outcome was a grading of **'*Very Good'*** for both inspected elements during a period of increased demand for the service.

3.2 A key element of the inspection of our Care at Home Service was the Care Inspectorate seeking comments and views about the quality of the service provided by supplying questionnaires to people who use the services and their relatives/carers. It demonstrates the success, engagement and commitment of the Care at Home staff when comments as those below are independently received.

Service User Comments

"The service is excellent. The staff who attend are lovely, friendly and professional, discrete and always jolly. They are wonderful."

"The staff are very good at the work that they do and I compliment them on the job they do"

"Regular carers always nice and treat with respect. Also when someone fills in there is no problem at all they are always nice to both of us"

"Your service is out of this world, don't change it"

"My carers are excellent and really make me independent in my own home"

"Staff are excellent courteous and kind"

3.3 During 2018-19 116 compliments were received relating to the service provided and the professionalism demonstrated by partnership staff. A sample of the compliments received include:

A thank you to Community Payback Team, Justice Services for excellent service and attitude

Home Care - Carers were all very nice, they were all helpful. They went above and beyond their role.

Advice provided by E. helpful and supportive

Home Care - Can't complain about service I've had from the team. All the CAHA are Excellent.

Family wished to commend social worker L. for being model of professionalism and care throughout dealings with family member

Thanks to Community Payback, Justice Services for the excellent work they carried out on behalf of the charity, COAST

Outcome 4:

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

Our Highlights

Continued investment in the **North Ayrshire Wellbeing and Recovery College**

Collaboration and further support to **children with additional support needs**

91% of Adults can look after their health very well or quite well

(Scottish average 93%)

4.1 We continued our pilot **North Ayrshire Wellbeing and Recovery College** for people affected by mental health problems by delivering further participatory courses that focus on wellbeing and recovery. These courses are open to anyone over 16 years old who lives, works or studies in North Ayrshire. Some of the more successful courses have been repeated as well as new courses being trialled. An example of the courses include:

- Living life to the full – 8-week course based on cognitive behavioural therapy
- Write to Recovery – 5-week course that focusses on self – management for people experiencing emotional difficulties or mental ill health
- WRAP (Wellness Recovery Action Plan) - 2-day course to support the development of a prevention and wellness process that anyone can use to get well and stay well.

We are developing the approach by supporting people with lived experience of mental health problems to access training to enable them to work towards co-facilitation of courses and other peer roles within the Wellbeing and Recovery College. We are also in the process of developing a website to increase access to the courses and share information more widely.

4.2 Following the successful business case to secure funding to develop an additional support needs residential and respite unit, a new Additional Support Needs School will be developed on the same site presenting a very necessary and unique opportunity for the North Ayrshire HSCP, as well as colleagues in Education and Youth Employability.

The ASN School will enable professionals to work together within the one campus which will highlight the advantages of an integrated approach to further benefit some of our most disadvantaged children and young people. This opportunity presents an investment in our children and young people with complex needs who require to have access to the best facilities we can provide to ensure that they are able and supported to make life choices and to realise their potential.

4.3 During 2018-19 we received a Joint Inspection of Adult Services relating to the effectiveness of strategic planning. Although the report was generally positive, we have acknowledged areas for improvement to further support the planning and provision of services.

Joint Inspection of Adult Services Evaluation

- Quality indicator 1: Key performance outcomes; ***Adequate***
- Quality indicator 6: Policy development and plans to support improvement in service; ***Good***
- Quality indicator 9: Leadership and direction that promotes partnership; ***Good***

Outcome 5:

Health and social care services contribute to reducing health inequalities

Our Highlights

Access to **over £9.5 Million** was achieved by our Money Matters Team

Money Matters **Income Advisors** now based within Service Access

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5.1 In 2018–19, our **Money Matters** team advised and supported the most vulnerable people in our communities to access more of the benefits they are entitled to. The value of this financial support was just over of **£9.5 million**, greater again than the £8.6 million achieved in 2017-18. From our promise in the 2015–18 strategic plan to help people deal with their financial difficulties, we have managed to support people to the value of over £34 million (2015–19).

5.2 Additional resources were allocated to the Money Matters Team and following consultation with our initial receiving service, Service Access, it was agreed that Money Matters Income Advisers would be based in Service Access and work in partnership addressing cases of destitution.

The priority was to tackle inequality and prevention and early intervention. Service users who require assistance with Foodbank vouchers or are facing Eviction will be immediately directed to Money Matters Income Advisers.

The initial on-site assessment prevents a wait or referring on process, meaning action is quicker and on most occasions the person will meet with the right person at the point of the referral being received.

Case Study

Notification received from Housing for Eviction of client due to rent arrears – through partnership working Money Matters assisted client to claim a DHP, arrears of £508.80 awarded which halted eviction. During initial appointment with client it transpired he had been sanctioned from Universal Credit (UC) and had not received any payment from UC since July 2018 – current month March 19. Advisers assisted to challenge the Sanction decision which was successful, awarding client £2,542.56 of benefit he had been due from July 2018

5.3 The North Ayrshire Health and Social Care Partnership contributes to the **Fair for All** strategy; a single vision to reduce inequalities across North Ayrshire. By 2030, the aim is to create a North Ayrshire that is Fair for All. To do that, we pledge to tackle the root causes of all inequalities in North Ayrshire. Which is why, at its very core, Fair for All North Ayrshire focusses on five key areas – Health, Environment, Fairer Food, Economic Growth and Children. We may be early in the delivery of Fair for All but there has already been some significant work undertaken.

5.4 During 2018-19 the Partnership's Equality Mainstreaming report 2018 was approved by the Integration Joint Board and builds on the 2017 Ayrshire Shared Equality Outcomes. This ensures that equalities are integrated into the day-to-day working of the Partnership by considering the impact of our actions on all our service users.

The pan Ayrshire group have a supporting action plan that outlines proposed achievements. An update on progress against these Ayrshire shared actions can be found at the North Ayrshire Health and Social Care Partnership web site (**http://www.nahscp.org/**) in the 'Ayrshire Shared Equality Outcomes Report – 2018', which accompanies the mainstreaming report.

Examples of the works undertaken, and further considered actions include:

- Progressing the development of Community Mental Health rehabilitation, Warrix Avenue, and Learning Disability Day Services and Supported Accommodation, Trindlemoss.

- NADARS (North Ayrshire Drug and Alcohol Recovery Service) will continue to work with the Scottish Transgender Alliance to help improve the experience of the trans community who access addiction services.

- In our Learning Disability Service, we undertook review of the Job Coaching programme and established an Employability Group to look at improving employability across the HSCP. To help mainstream employability support to service users, a measurement model and proposals to embed employability in assessment processes are under development.

Outcome 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

Our Highlights

39% of Carers feel supported to continue in their caring role

(Scottish average 37%)

Achieved **Level 2 Carer Positive Employer** status

48 service users now working with the Community Brokerage Network (CBN)

537 carers are now registered for a Carer Appreciation Card

6.1 The percentage of carers responding to the national Health and Care Experience Survey as feeling supported is 39%, although this is higher than the Scottish average the partnership would want to improve performance, this may include looking to other measures to assess the adequacy of carers supports.

carersUK
making life better for carers

6.2 The Carers Act came into force on 01 April 2018, the partnership provides significant supports for carers, some of which were in place in advance of the requirements of the Act. The implementation of the Act has allowed the partnership to build on these supports and allowed for additional targeted investment. The IJB approved the eligibility criteria for carers in June 2018, carers needs are identified and assessed either through an Adult Carer Support Plan or Young Carers Statement. The additional demand for services has been slower than anticipated with 100 carer's assessments completed in the first year, this is expected to increase as services actively encourage carers to request an assessment and services for support.

6.3 We purchased a Digital Resource for Carers, which is available to all unpaid carers across North Ayrshire. The North Ayrshire Health and Social Care Partnership was the first Local Authority or Partnership to sign up to such a resource.

The online resource helps carers support their own physical and emotional health and wellbeing alongside managing their caring responsibilities as well as information about supporting the health and wellbeing of the person they look after. Additionally, it offers a range of resources to support the carer including e-learning resources, essential reading guides and factsheets, advice around supportive technology, financial planning and advice on dealing with working and caring.

6.4 A relatively new collaboration for the Partnership has been with Community Brokerage Network (CBN). The CBN has secured funding to make this support service completely free to service users and the Partnership. In the past calendar year CBN have supported **48 service users and their families** in North Ayrshire with the majority being Children with Disabilities and Adult Services.

CBN employ brokers to work with people with social care needs to plan and organise their support whether they are eligible needs/individual budget or not. They help connect people back into their communities, in some cases have experience in directing their own support and use that to encourage people to be more creative in how they are supported.

6.5 The uptake of our **Carer Appreciation Card** has resulted in **537** carers registered for a card. There are now 45 local businesses offering discounts and concessions to local carers who present a Carers Appreciation Card. In addition, during 2018-19 we achieved Level 2 Carer Positive Employer status .

Outcome 7:

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

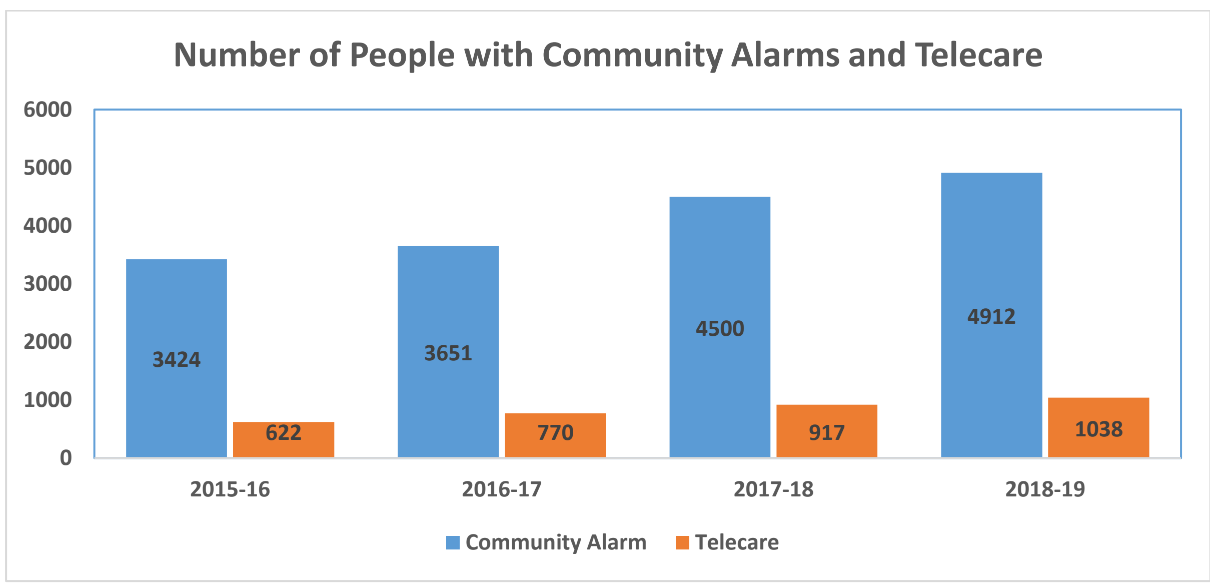
Our Highlights

Community Alarm use **increased to 4,912**

Increased Telecare to 1,038 in 2018-19

Reduced Child Protection Registrations to 117 at the end of March 2019

1.1 In 2018-19 we continued to expand the use of **Community Alarms** and **Telecare** enabling service users to remain safe in their homes with the peace of mind that there is contact with an emergency contact centre available if required.



1.2 We began the year with a high number of Children registered on our Child Protection Register and of the 143 family groups registered throughout the year 7 (4.9%) of those families had been registered previously within the last 12 months.

Throughout the year we have continued to monitor registrations via regular dedicated case audits undertaken by the Chief Social Worker Officer and Senior Children and Families Managers. These audits review current case status, placements where a child resides and their current support arrangements for making a professional risk-based assessment on each case and family situation.

The resulting decisions and supportive approach has seen the number of children registered at 31 March 2019 reduce to **113** from 141 at the beginning of the year.

1.3 The Care Inspectorate has published the report of a joint inspection of adult support and protection across six partnerships in Scotland (North Ayrshire, Midlothian, Dundee City, Highland, Aberdeenshire, East Dunbartonshire), the first such inspection since the Adult Support and Protection (Scotland) Act was implemented in 2008.

The published report provides an overview of key themes identified by inspectors and includes detail of the findings, gradings and recommendations for improvement for each area. North Ayrshire received the most positive gradings of all the partnership areas inspected, with gradings of Very Good for our processes and leadership, and Good for outcomes for adults at risk of harm. This is a testament to the hard work and commitment of people across the many agencies involved in adult protection across North Ayrshire.

There are some areas where we can continue to improve, and we will be incorporating further actions into our work plan for the next two years.

The full report can be found at this link -> **Joint Inspection Report 2018**

Outcome 8:

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

Our Highlights

120 attendees at the Staff Partnership Awards

MAD (Making a Difference) Team received NAHSCP Innovative Team Award

Cumbrae Asset Mapping Exercise liaising with the local island community

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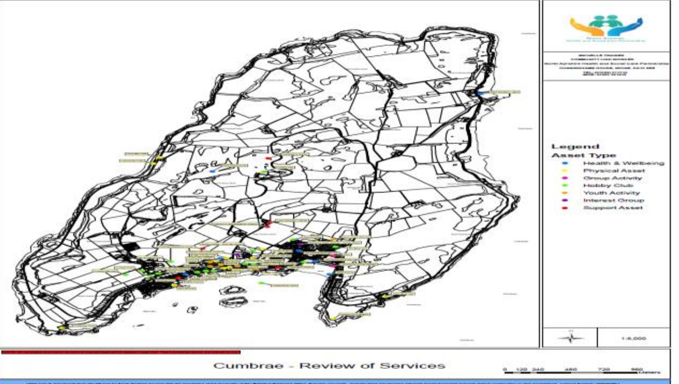
8.1 Our third Partnership Staff Awards commended the collaborative efforts of our workforce. There were 60 nominations and 120 attendees at the event which included North Ayrshire Council and NHS Ayrshire and Arran staff and the third and independent sector staff and volunteers.

8.2 The Partnership is committed to a holistic approach designed to support good health and positive wellbeing for all staff. We do this in various ways including offering supports such as Occupational Health checks, additional physiotherapy, counselling, 'healthy you' events, provision of flu Vaccination to all staff, Work – life Balance initiatives as well as intensive training in moving and handling and CALM (Crisis and Aggression, Limitation and Management). This approach has resulted in a reduction in the social care average working days lost from **15.4 days** per individual in 2017-18 to **13.8 days** in 2018-19, and, NHS staffing percentage of working days lost meeting the set target of **5.05%** per person**.**

8.3 In recognition of the MAD (**Making a Difference)** team work, and other developments in Social Work Justice Services, our Justice Fieldwork Team received the NAHSCP Innovative Team Award in March 2018.

8.4 As part of the ongoing review of island services on Cumbrae, an asset mapping exercise was undertaken to gain a better understanding of the community supports available. This exercise was not only for the public but also the professionals that operate on the island, ensuring that both groups have an awareness of the alternatives to statuary services that exist, and the wellbeing benefits that community-based supports can offer.



8.5 Our NADARS service has recognised the invaluable opportunity of lived experience and created **Recovery Development Worker** (RDW) posts for individuals with lived experience of alcohol and drug recovery.

This new development was an opportunity identified as part of a service review and redesign prompted by vacant posts within NADARS. A 'Thinking differently' approach to service delivery coupled with the appreciation of the value of individuals with lived experience could bring to statutory addiction services led to a review of the funding enabling a staff complement reconfiguration to recruit four permanents contracted RDW's.

This initiative increases the service capacity to provide a range of interventions in ways that enable the RDW's to connect and resonate with our drug and alcohol client group through their own life experience. This decision was based on the positive feedback from clients and staff and the recognition of the invaluable skills and experience they bring to the team.

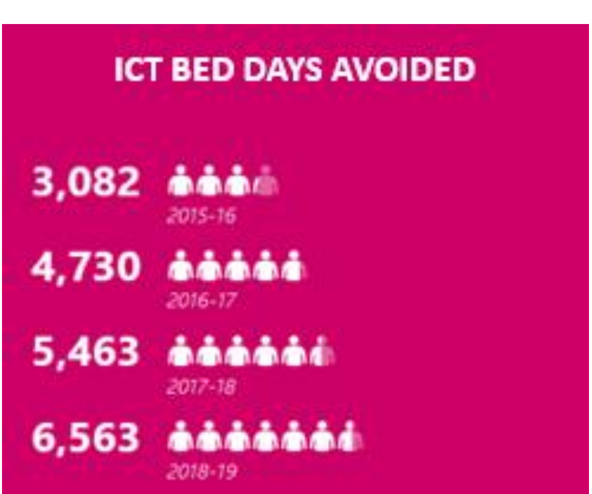
Outcome 9:

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

Our Highlights

6,563 bed days avoided during 2018-19

9.1 Our Intermediate Care Team (ICT) supports people to regain their independence by supporting them when they are either discharged from hospital, or in their own homes, to prevent admission to hospital. This early intervention and prevention approach provided **6,563 days** of ICT service (during 2018-19) as an alternative to hospitalisation, a continued improvement from 2017/18.



9.2 Compared to 2017-18 we have seen an increase (602 hrs or 9.5%) in care at home hours lost due to the cancellation of hospital discharges. We have set up a dedicated team within Crosshouse hospital to continue to work with our hospital colleagues to reduce the number of discharge cancellations.

6,907 hrs lost due to hospital discharges being cancelled

National Health and Wellbeing Indicators

Scottish Government identified 23 (4 remain in development) indicators that were felt evidenced the 9 National Health and Wellbeing Outcomes. Nine indicators come from the biennial Health and Care Experience Survey (see below) and the additional 14 indicators (also below), which evidence the operation of NAHSCP, come from the NHS Information Services Division (ISD) survey. This survey represents a sample of the community and asks about the collective services received whether it be from Social Services, NHS, the collective HSCP, Private or Voluntary organisations. The survey responses do not separate each organisations service provision.

The data reported in the tables below is based on the information circulated in May 2019.

Health and Social Care Experience Indicators	North Ayrshire 2014–15	North Ayrshire 2015–16	North Ayrshire 2016–17	North Ayrshire 2017–18	North Ayrshire 2018–19	Scottish Av % Diff	Rank against Family Group
Adults able to look after their health very well or quite well		93%		91%		93%	**4**
Adults supported at home who agreed that they are supported to live as independently as possible		82%		84%		81%	**1**
Adults supported at home who agreed that they had a say in how their help, care, or support was provided		77%		70%		76%	**7**
Adults supported at home who agreed that their health and social care services seemed to be well co-ordinated		78%		74%		74%	**6**
Adults receiving any care or support who rated it as excellent or good		79%		78%		80%	**7**
People with positive experience of the care provided by their GP practice		84%		80%		83%	**6**
Adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life		82%		82%		80%	**2**

Carers who feel supported to continue in their caring role		43%		39%		37%	**4**
Adults supported at home who agreed they felt safe		79%		80%		83%	**6**

To support service improvement, the Scottish Government has identified local authority / Partnership benchmarking families. These family groups are made up of eight local authorities that share similar social, demographic and economic characteristics. Comparing our performance information with our family group should provide a more meaningful comparison with similar areas and allow for greater opportunities for shared learning and best practice. Rankings are on a scale of 1–8, where 1= best performing, 8=worst performing.

North Ayrshire is partnered in its family group with: East Ayrshire, Dundee, Western Isles, Glasgow, Inverclyde, North Lanarkshire and West Dunbartonshire.

Indicators based on Administrative data	North Ayrshire 2014–15	North Ayrshire 2015–16	North Ayrshire 2016–17	North Ayrshire 2017–18	North Ayrshire 2018–19	Scottish Av % Diff	Rank against Family Group
Premature mortality rate. (Under 75s age-standardised death rates for all causes per 100,000 population).	459	484	490		446	425	**3**
Rate of Emergency Hospital Admissions for adults (per 100,000 population)	15,851	15,866	16,249	16,481	16,513	12,183	**8**
Rate of emergency bed days for adults.*	141,260	141,398	139,750	149,902	142,441	123,035	**8**
Readmissions to hospital within 28 days of discharge.	105	107	105	106	107	102	**6**
Proportion of last 6 months of life spent at home or in community setting.	87%	88%	87%	87%	88%	88%	**2**
Falls rate per 1,000 population aged 65+	21	23	20	24	22	22	**3**
Proportion of care services graded 'good' (4) or better in Care Inspectorate Inspections.	73%	79%	81%	87%	88%	85%	**6**
Percentage of adults with intensive needs receiving care at home. (all levels of CAH)	67%	67%	49%		49%	61%	**1**
Number of days people aged 75+ spend in hospital when	663	443	624	1,033	1,144	762	**7**

they are ready to be discharged per 1000 population)							
Percentage of total health and care spend on hospital stays where the patient was admitted in an emergency.	26%	26%	26%	29%	30%	25%	**8**

As well as the National Health and Wellbeing indicators, we regularly report on local measures to help us to evidence performance against the nine National Health and Wellbeing Outcomes and also our Strategic Priorities. The list of local indicators can be found in Appendix 1 (see page 73).

From January 2017, The Ministerial Strategic Group for Health and Community Care (MSG) advised that in order to measure the impact of integration they would be monitoring a suite of indicators. These are indicators which the government view as being appropriate to measure progress with integration and for which data is available to enable a comparison across partnership areas and to report on progress at a national level. The full list of indicators can be found in Appendix 2 (see page 75).

2. Performance in relation to the three Children's Outcomes and three Justice Services Outcomes

Children

Outcome 1: Our Children have the best start in life and are ready to succeed

Our Highlights

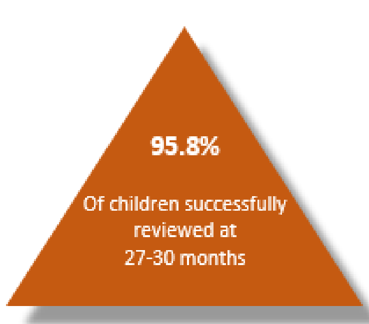
17.3% of all mums recorded as breastfeeding

95.8% of all children receiving a 27-30-month review in time by a Health Visitor

Percentage of children at 27 months with a BMI greater than 91 **reduced to 10.2%**

1.1 **Breastfeeding** uptake in North Ayrshire is amongst the lowest in Scotland, however, we are continuing to progress in the right direction. This has been demonstrated during 2018–19 with figures of 17.3% of all mums recorded as breastfeeding at 6-8 weeks, up from 16.8%.

1.2 **Health Visitors** carry out reviews at of all children in North Ayrshire at 27–30 months, to make sure they are healthy and thriving. From the most recently published data, we achieved 95.8% of all children having their review carried out when it should be, this is decrease of 0.8% from last year but remains 5% above the national percentage.



1.3 During 2018-19 our **Universal Early Years** team has continued to provide supports ensuring the health of young children. This support has seen the percentage of young children at 27 months with a BMI greater than 91 reduce to 10.2%, a 2.6% reduction from the previous year.

1.4 Within Greenwood Academy an early identification process has been established for those young people who require additional support as a **Young Carer**. This model has more recently been established within Elderbank, Kilwinning Academy and the Three Towns Localities and will support those young people and children for whom there are vulnerabilities as well as those who are young carers.

Outcome 2: Our young people are successful learning, confident individuals, effective contributors and responsible citizens

Our Highlights

100% of children supported through SNAP been sustained in their school

'The Syrian Swans' initiative enabling refugee local community integration

94% of children and young people seen by the Rosemount Project remained within their family homes

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2.1 Since its inception, the **SNAP** (STOP NOW AND PLAN) initiative has supported children ages 8-11 engaging in aggressive and anti –social behaviour at school or in the community. Experienced and highly trained staff work with each family to assess challenges and problems and develop an action plan aimed to reduce the potential of antisocial behaviour and chances of conflict with family, peers and authority figures.

For the period 2018-19 **100%** the children who have been involved through SNAP have been sustained within their local school.

2.2 The Rosemount Project is a crisis Intervention support service. It aims to support vulnerable children and young people assessed as high level of risk to remain within their family homes and local communities. This is done using a holistic multi-faceted approach with the delivery of customised service interventions to meet the need of complex families.

In 2018-19 the **Rosemount Project** worked with approximately 359 families with **94%** of children and young people remaining within their family homes on a long-term basis.

2.3 The Health and Social Care Partnership has continued to support the successful resettlement and integration of Syrian Refugees via the Syrian Refugee Coordinator to coordinate services delivered by the partnership to refugee families.

A new initiative known as '**The Syrian Swans'** supports young girls to integrate with the local community. This runs from the Church hall on a fortnightly basis and includes various activities including; pamper nights, visits to a show home, talks from Royal Bank of Scotland community representatives regarding various aspects of banking, session rights and responsibilities of young people in North Ayrshire and visits to the Police and fire stations.

The idea is to expose the girls in a planned way to various aspects of Scottish life to encourage and foster ideas of aspirations for the future and to provide a relaxed and informal place to discuss different topics.

Of the girls supported to date, one is now a modern apprentice, one is at college planning to become an engineer, one is learning to drive, and another four girls will be attending High school from August and are looking to join the group.

Case Study 1

The young person presented as angry, losing control physically at times with peers, he is on the fringes of society and has been through a Syrian war, and subsequent fleeing to a Refugee camp and then to the UK.

His father has died and his mum is not always great with routines, boundaries and general parenting. She has also had her own health issues. There have been significant concerns about him being excluded from school and also some concerns about being placed into alternative care arrangement.

He is currently being supported by the Rosemount Project, Social Work, School and the Refugee Support Team. These teams are working in partnership together and have also accessed some Culturally Sensitive Counselling for him in Glasgow. The Counsellor has been using play therapy with him and looking at a variety of issues including anger management.

To date he has received approximately 8 sessions of counselling and is appearing a lot calmer

He seems to be happier, his personality is coming out a bit more e.g. his caring attitude towards his brother regularly, his is a bit cheekier – but in a positive manner and that he is beginning to get the message that it is ok to lose at games and that name calling is just that

He is currently being given positive opportunities to socialise within his local community.

Outcome 3:

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

Our Highlights

51% of Perinatal Nurse requests received from the most deprived areas

Family Nurse Partnership has supported 2 cohorts with **79.7% and 71.6% to graduate** from the service

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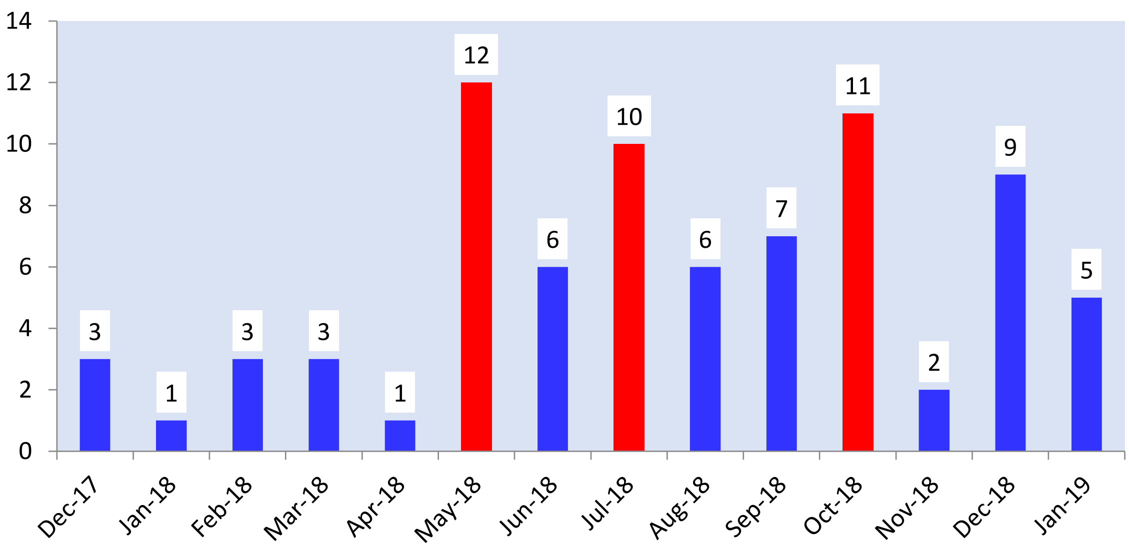
3.1 Since December 2017, the **Perinatal Nurse** has received 79 requests for assistance for 74 individuals. This equates to an average of 6 per month with an average waiting time from request for assistance to first contact was 10 days.

Requests for Assistance received per month



The post, specific to North Ayrshire where deprivation is high, received 40 requests (of known and recorded post codes) from the 20% most deprived areas. This equates to 51% of the total request for assistance.

The primary reasons for assistance were due to: Low Mood, General Anxiety and Stress. In 17 cases, the presentations were specific to the pregnancy with no underlying mental health concerns.

The service is person-centred with varying treatment and intervention types delivered throughout contact from guided self-help to stress symptoms management and CBT (Cognitive Behavioural Therapy). On average 5 home visits and 4 telephone contacts are scheduled per person. This equates to 2-3 contacts being made per working day.

The service has proven to be very successful in engaging with a unique cohort and to date:

- 15 have shown a significant improvement
- 16 have shown a general improvement
- 2 have shown a slight improvement
  Only 7 referrals were discharged with no clinical contact. A further 2 referrals were escalated for a higher intensive intervention.

3.2 The **Family Nurses** continue to work with young mums with 170 being enrolled to December 2018. Since the Family Nurse Partnership was established in 2013, 79.7% have graduated from cohort 1 and 71.6% from cohort 2. The purpose of the partnership is to support young mums (19 and under) and their families through early pregnancy until the children are two years old, building on the strengths of the available family support.

Justice Service

Outcome 1: Community Safety and Public Protection

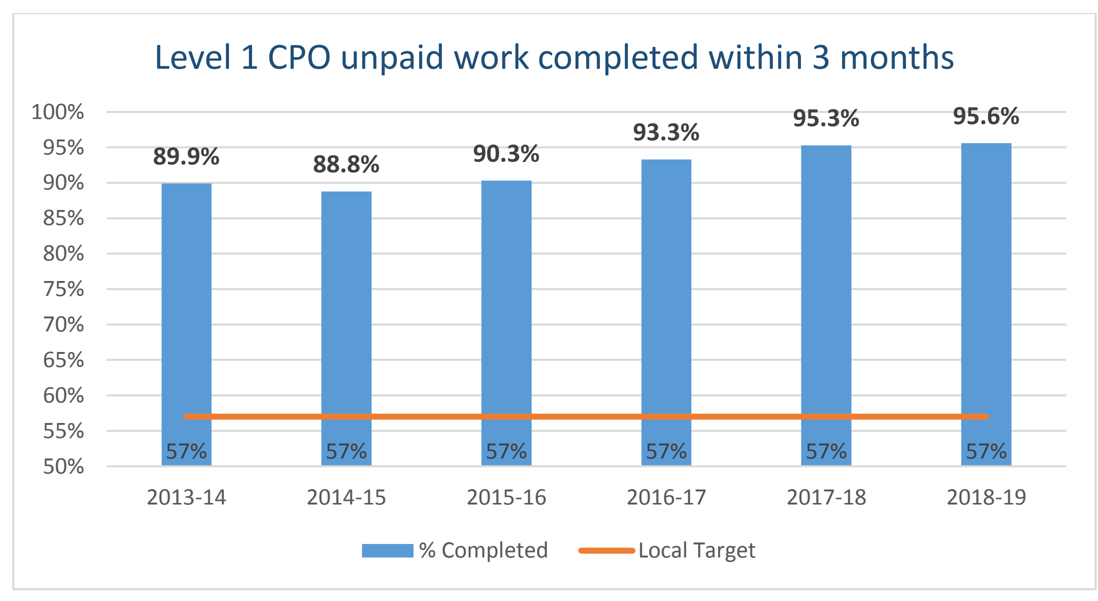
Our Highlights

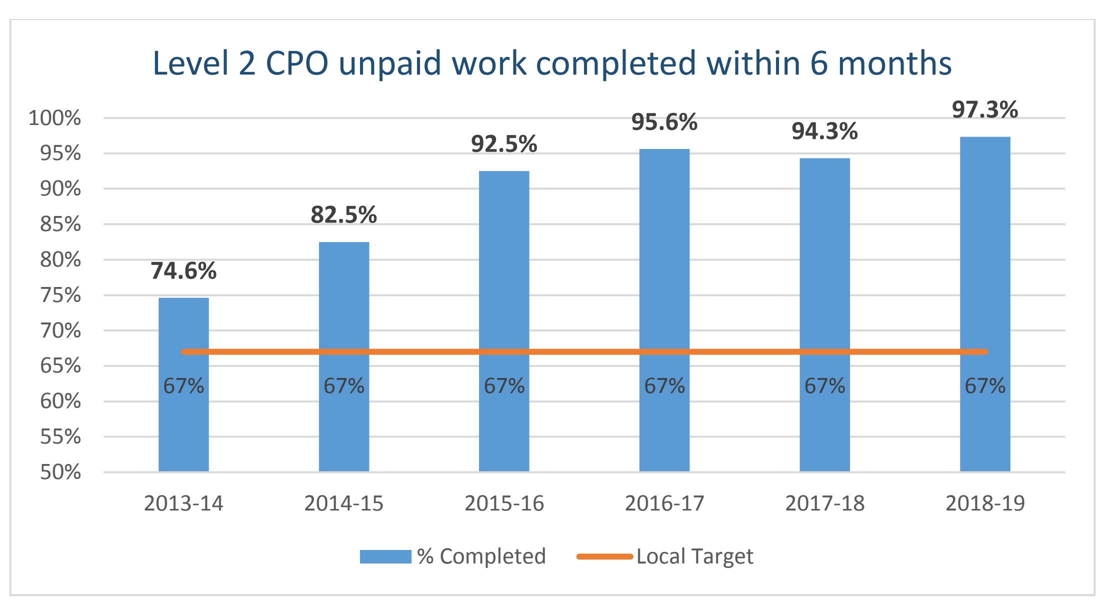
Further improvement in Level 1 CPO Unpaid Work to 95.6%

Further improvement in Level 2 CPO Unpaid Work to 97.3%

1.1 The targets set for unpaid work are pan-Ayrshire targets. The latest Government statistics on Community Payback Orders (CPO) for 2017/18 show that North Ayrshire has the second highest number of CPO's imposed per 10,000 population in Scotland at 71.9 per 10,000 population. In comparison, East Ayrshire has the highest at 73.7 and Glasgow sit at 66. The Scottish average is 46.1 per 10,000 population".

1.2 Our Justice Services continue to have a positive impact on the local community through the Community Payback Order (CPO) unpaid work scheme. For the sixth year we have continuously over-achieved against targets for CPO level 1 and level 2:





1.3 We currently have 230 people of all ages and abilities undertaking unpaid work. The unpaid work teams undertake a variety of tasks for the benefit of local communities, including;

Foodbank - undertaking collections for a local Foodbank at Church of Nazarene in Ardrossan. They then carry out distribution of the allocated food across North Ayrshire.

Schools – creation of furniture, planters and recently brightly coloured seats and wooden wigwams. The creative arts team have also painted a mural in the music corridor at Kilwinning Academy.

Community Councils – requests to undertake work in their areas such as; renovating pathways, clearing overgrown areas and litter picking. Last year seating was restored along the Ardrossan shore and railings painted at the sea front in Irvine.

Removals – support is provided to local Charity shops by collecting donated furniture and delivering purchased items. This is a valuable resource for those who might find it difficult to pay for uplift and delivery of large items.

Workshops - our three workshops are equipped to undertake training in woodworking skills and arts and crafts. Service users who have disabilities or health issues may be unable to undertake heavier work and have an opportunity to make items which are sold with the funds going to the Income Generation Fund.

Art work has been submitted to the Koestler Trust for the 2019 competition, following a number of Gold and Silver awards in 2017.

The funds raised from the sale of items enabled donations of £1,150 to Sense Scotland Ardrossan and Touched by Suicide in Irvine.

Sales Days - at Smithstone House, our horticultural base, we are fortunate to have a large garden where we are able to produce a range of vegetables and herbs for making hanging baskets to sell alongside a range of plants and garden furniture.

Painting and Decorating - our team on Arran have been very productive in painting community public toilets and a number of village halls. Further requests have been made that the team renovate some of the public seating around the island.

Employability - working with all justice service users to provide support in working towards employment; a significant factor in reducing re-offending.

1.4 Reintegration into communities is very much the ethos of Community Payback Orders and with that aim in mind Employability Mentors are now based within the Community Payback, Unpaid Work Team.

Outcome 2: The Reduction of re-offending

Our Highlights

CPO Level 1 and 2 surpassed targets

Continued support from the **Employability Mentors**

2.1 As stated in the **Justice Service Outcome 1**, we have surpassed the targets for Community Payback Orders (CPO).

2.2 Since September 2017, 2 **Employability Mentors** have been employed who are based in the unpaid work team and have the remit to focus on working with all justice service users to provide support in working towards employment; a significant factor in reducing re-offending. The Mentors work with service users over a period and the process begins with an in-depth assessment of the service user's learning/skills needs and includes assistance in preparing CVs for service users and identifying training relevant to the area of employment in which they have an interest. Since coming into post late in 2017 the mentors have been successful in supporting 18 service users into full time employment. In addition, the team have sourced and placed a significant number of service users into training likely to increase future employment opportunities.

2.3 A significant number of service users have undertaken training in Construction Health and Safety (CSCS), forklift driving, Health and Safety, Safety at Sea and Hospitality. Several service users have undertaken voluntary work which builds on their skills and experience in addition to adding to their CV. Some of the hours spent addressing employability count towards 'other activity' as part of the Unpaid Work Requirement.

2.4 The Mentors, alongside Economies and Communities, CEIS (Community Enterprise in Scotland) and DWP (Department for Work and Pensions) are organising a 'Recruit with Conviction Event' at the Ardrossan Hub in May 2019. Employers from a variety of sectors will be in attendance and advice for applicants will be available from Disclosure Scotland.

Outcome 3: Social inclusion to support desistance from offending

Our Highlights

Appointment of a Desistance Officer to the MAD (Making a Difference) Group

Justice Fieldwork Team received the NAHSCP Innovative Team Award

The Caledonian Women's Service worked with **59 women in the North and 123 women across Ayrshire**

3.1 The **Early Intervention from Custody (Women)** project seeks to offer support to women to access and attend existing health and other services to improve their health outcomes. The project also seeks to develop improved integrated pathways between Health and Social Care Services in North Ayrshire, leading to sustainable improvements in how services work together and deliver services more effectively.

3.2 The project intervenes with women at an early stage to support them accessing health services, particularly Addictions and Mental Health services. Ultimately to support them to improve their health and avoid custody whilst promoting social inclusion and decreasing marginalisation.

Case Study 1

Ms S appeared as a first offender in September and was referred to the Early Intervention Service for extra support. The allocated staff member completed a home visit and explained the court process. It was agreed that phone contact would be maintained through the court process to support Ms S emotionally and to help reduce her anxiety and this worked best for her as she was in full-time employment. The staff member supported Ms S to court when she appeared for her trial.

Case Study 2

Ms G was referred to the Early Intervention Service for breaching her curfew. She was granted supervised bail to attend a check-in twice weekly with a staff member. During these check-ins, it was identified that Ms G required a referral to addiction services for alcohol detox. In addition, Ms G also discussed that she would like the staff member to support her with an application to move house.

Case Study 3

Ms B appeared through court as a first offender. A home visit was undertaken and the staff member was able to reduce Ms B's anxiety by explaining the court process and what her bail conditions meant. The staff member kept in regular contact with Ms B and she continued to engage with Women's Aid and Ayrshire Cancer Support. Ms B has ongoing alcohol issues which impact on areas of her life. Ms B was supported to attend a medical assessment regarding her state benefits and continues to be supported by the Early Intervention Service.

3.3 The **Making a Difference (M.A.D)** group, the first of its kind in Scotland, is an innovative and collaborative initiative to ensure that those directly affected can inform and shape the design, development and delivery of Community Justice Services across North Ayrshire. Towards the end of 2018, while meeting our strategic objective, we appointed a **Desistance Officer** to support our service user engagement and social reintegration. Again, this is the first post of its type in Justice Services in Scotland. In recognition of the MAD work, and other developments in Social Work Justice Services, our Justice Fieldwork Team received the NAHSCP Innovative Team Award in March 2018.

3.4 While the work of the MAD group is having a demonstrable positive impact on services, the focus is on creating spaces for service users to participate in services in different ways, to be decided by those service users. The core aims of the MAD group include:

- Establishing and enhancing effective partnerships
- Encouraging and enhancing exit processes and opportunities for participation

- Establishing and embedding a variety of opportunities for user involvement and participation in the design, development and delivery of community justice services
- Building community facing and community engaging services
- Supporting recovery, desistance and social integration

3.5 The **Caledonian Women's Service** offers emotional and practical support to women, advice on safety planning, risk assessment and advocacy. Working in partnership with the women, we aim to reduce their vulnerability and work with other services, including; education, housing, Police Scotland and the voluntary sector, so that women and their families are better supported.

In 2018-19 the team worked with 123 individuals across Ayrshire and Arran (an increase from 62 the previous year). Offering a variety of services and support, from safety planning sessions, to longer term interventions and support. The team currently continue to support 59 women across North Ayrshire (an increase from 34 the previous year).

Within the Caledonian Woman's Service, the **Children's Worker** role is to ensure the rights of the child and that the child's needs are met. Although through a specific role, the approach involves team and multi-agency working. It is everyone's job to support and protect children involved. Since re-accreditation of the Caledonian System, the Children's worker role involves not only direct work with children, but also fathers in terms of the impact of domestic abuse on their children. The Children's service worker is also trained to co-facilitate the children and fathering module on the group work programme.

3. Reporting on localities

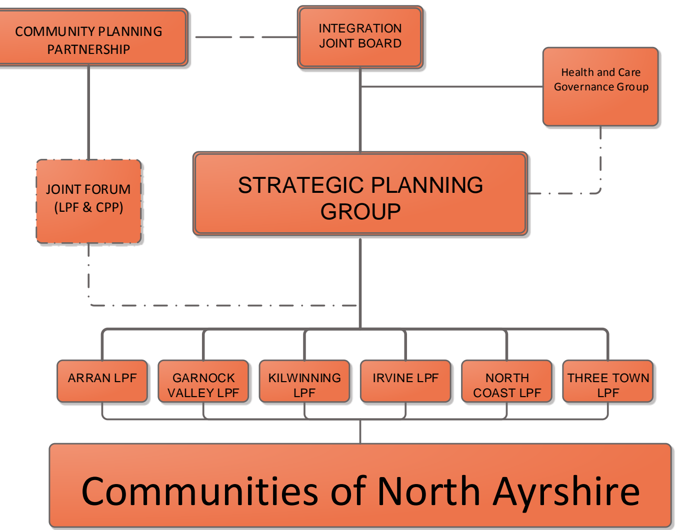
North Ayrshire is home to over 136,000 people, all living in its many towns, villages and islands. These places are home to many different communities, each with their own characteristics and needs.

We recognise that a one - size- all approach to service delivery is not appropriate. A blanket service may be of great benefit to one community and of little value to another. That is why we are now designing local services based on local need, identifying the health and social care priorities in communities and developing services that help people access the right service at the right time.

Localities

2018-19 has been a period of review and reflection for the locality planning forums (LPFs). Following the publication of the partnership's new strategic plan, "Let's Deliver Care Together", the decision was taken to review the governance structure and terms of reference for the forums. In partnership with forum members and the HSCP Strategic Planning Group, the revised terms of reference were approved by our Integration Joint Board in (October) 2018.

A key part of the revision was the recognition that Locality Planning Forums are sub-groups of the Strategic Planning Group. This confirmed LPFs as key partners in the development of the strategic direction of the North Ayrshire Health and Social Care Partnership.



Over the past year, the forums have been working to establish the foundations for an engagement pilot in each locality. These pilots will seek to identify the best methods for LPFs to actively engage and communicate with local communities.

Through more effective conversations with local people, it is expected that each forum can better identify local need and further shape health and care priorities for action. Each engagement pilot is expected to run for six months and be completed during 2019-20.

Arran

The Arran locality is taking part in the first "pilot" for a combined LPF with the Community Planning Partnership. The pilot will start in 2019. As part of the preparation for this we have developed and enhanced our existing Patient and Service User group to include our LPF members as Community Champions. We are excited about this new development and think this will give even more opportunity for us to engage with our community on our plans for the locality.

This year we also completed our Complex Care pilot, and this has tested both new ways of working and a new role. We have worked with 12 individuals on the pilot and developed a new multi-disciplinary care planning tool that puts the goals and outcome of the person at its heart. We were lucky to have the support of a Community Navigator from the MPower programme and the role has helped support people with one of our other key priorities, social isolation.

The LPF Chair is part of a new group looking at innovative ways to address our other key priority Transport.

The group has also been involved in supporting the Participatory Budgeting exercise on Arran and this has also supported new ways to tackle social isolation, one great example is the horticultural therapy group.

Garnock Valley

A positive inspection of the Care at Home service within the Garnock Valley saw grades 5, 'Very Good', for Care and Support and Staffing.

Irvine

Following a change of Chair, the Irvine Locality Planning Forum has continued to work towards progressing its identified priorities.

During the year, the Irvine LPF received an input in relation to the Fairer Food work being developed by North Ayrshire Council. This presentation highlighted the extent of food poverty in the area and possible strategies for better food provision. The group has agreed to help support this work and has begun initial enquiries on how to engage local groups who can produce 'Canny Cookers': insulated cooking utilities that can slow cook food with no power required. These Canny Cookers can help address people impacted by both food and fuel poverty. The Irvine LPF will work with colleagues to receive instruction on how to make the Canny Cookers and gain information on a menu of healthy meals.

The Irvine LPF has begun planning its approach to its own engagement pilot. Building on opportunities already available, members of the Irvine LPF will join in the local 'Chit Chats' that have taken place around the many communities in Irvine. Chit Chats are locally based conversations, where members of the community can discuss issues and possible solutions. By engaging in this activity, the Irvine LPF aims to identify local health and wellbeing concerns and work more with communities to identify joint solutions. Further, in recognising the challenges to engaging with those hardest to reach, forum members will take a focussed approach to meeting with front line health professionals and social workers, to gather their views on the issues facing socially isolated local people.

Kilwinning

In 2018-19, the Kilwinning LPF appointed a new Chair of the group, who will now steer the forum in its work to improve the health and wellbeing of the locality and continue to deliver against its established priorities.

The Kilwinning pilot of additional GP support into the Buckreddan Care Home continued to achieve positive outcomes, including improved wellbeing of care home residents, less demand at local GP practices and fewer hospital admissions.

The forum had undertaken a scoping exercise to consider the implementation of Occupational Therapy support in local pharmacies. However, following evaluation it was agreed the approach would not be practical for delivery.

The forum has developed close links with education services and early years through the Kilwinning Wellbeing Project set up by CAMHS. This engagement has allowed the LPF to consider more carefully the mental health concerns impacting the young people of Kilwinning. As a result, both Kilwinning medical practices have now been actively involved with the project for around 18 months.

Going forward, Kilwinning is the first Locality Planning Forum to undertake the locality engagement pilot. Over the coming months, members from the LPF and other key community members will develop an engagement process that aims to establish a clear line of communication with the people of Kilwinning. They will be seeking to gather the views of Health and Care services in Kilwinning, and what other opportunities could be employed to help improve the health and wellbeing of local people. To date, the forum has established a robust engagement steering group and are finalising the preferred engagement model to deliver during 2019.

It is intended that the Forum will use the findings from the engagement work to help refresh their locality priorities.

North Coast

In 2018-19 the North Coast locality re-established the LPF with new membership and has been working on reviewing priorities and seeking to identify future actions.

Since the revision of the LPF terms of reference, the North Coast Locality Planning Forum has been refreshed and now hosts a wide-ranging membership of health and social care representatives and community members.

A first task for the refreshed forum was to consider the forums priorities, following group agreement the priorities have been revised as such:

Old priorities

- Reduce social isolation for older people
- Improve support for stress and anxiety
- Address impact of musculoskeletal issues
- Promote financial inclusion

New Priorities

- Reduce social isolation across all age groups
- Improve support for stress and anxiety
- Promote physical activity across the locality
- Promote financial inclusion

In relation to the priority of addressing the impact of Musculoskeletal Issues, the forum's GP representative reported the MSK services were performing much better in the North Coast with demand being more manageable. It is for this reason, the LPF revised their priority to promoting physical activity to local people.

Three Towns

During 2018-19, the Three Towns forum gained a new Chair as well as a new lead officer. Following the review of the terms of reference for Locality Planning Forums, this new core group has focussed on identifying the direction for the forum going forward.

The group has undertaken an initial review of the original priorities for the forum and have made some minor amendments.

Old priorities	New Priorities
• Improve mental health and wellbeing of young men.	• Improve mental health and wellbeing of young people
• Addressing issues of social isolation	• Reduce social isolation
• Ensure appropriate care at home options for older people.	• Improve support to those with complex needs
	• Promote financial inclusion

In progressing the priorities, forum members have met with the Parent Council at Auchenharvie Academy to highlight the role of the forum and present on their priorities. Feedback was positive, with the Parent Council voicing their support for the priorities. Further meetings are planned at both St Matthews Academy and Ardrossan Academy.

In addition, the Chair of the Three Towns LPF has also actively engaged with local community groups, presenting on the forum's priorities. To date, the chair has met with Saltcoats Community Council, Stevenston Community Council and Hayocks Tenants and Residents Association.

4. Transformation Programme

North Ayrshire's Transformation Team support Partnership teams to identify, develop and deliver system wide change to local services and improve outcomes for the people of North Ayrshire.

Some of our key achievements and initiatives supported during 2018-19 include:

Communities

- **Arran Engagement** - 138 attendees plus a further 37 patient and service user group members and staff from the Arran Health and Social Care teams attended engagement events on the island between May and November. This ensured both staff and the community on Arran were engaged and involved in the ongoing developments for service improvement.

- **Implementation of the Island Review of Services on Arran** - Autumn 2018 saw the launch of the Arran complex care pilot. This is a "test of change" pilot encompassing Multi-disciplinary Team working, comprehensive assessment and outcome-based care planning, utilising a new "generic role". This will inform the future island model.

- **What Matters to You? Day 2018 -** A total of 1612 conversations were recorded across the Partnership on the 6th of June 2018

Health and Community Care

- **End of life/Palliative care (Pan Ayrshire)** - The three Ayrshire Partnerships and Acute Services have been working together through the New Models of Care for Older People and People with Complex Needs Programme to ensure an individual's dignity and respect at end of life is preserved. The design of an overarching framework is to ensure that a consistent approach during this time can be applied reflecting the differing needs, ambitions and operational arrangements of each partnership while providing a person-centred service. During 2018-19 early scoping of a business case was undertaken.

- **Implementation of the Primary Care Improvement Plan** – The introduction of Multi-Disciplinary Teams (MDTs) within General Practices provides a unique opportunity to progress longer term transformational change to deliver the vision for Primary Care. The ambition of MDTs is to deliver care to the patient in a seamless way, reducing the number of visits and number of professionals working with a person and their family, as well as reducing the amount of times a person needs to repeat the same story to a range of professionals.

- **Reforming General Practice** – aims to improve infrastructure and reduce risk in areas such as ownership of premises, ICT and information sharing. These

areas are being taken forward and explored on a national basis with a view to transitioning new arrangements by 2020.

- **Delayed Discharges** – a team has been established within Crosshouse Hospital for the purposes of reducing hospital discharge timescales and ensuring service packages are in place as soon as possible

- **Intermediate Care and Rehabilitation –** The new services are developed around Intermediate Care and Rehabilitation Hubs which provide a single point of access, with screening and clinical triage, ensuring the person is seen by the right service, first time and includes 7-day support. The model supports people at different stages of their recovery journey and builds on existing intermediate care and rehabilitation services, reducing duplication and fragmentation of services across Ayrshire.

  The new Enhanced Intermediate Care and Rehabilitation Service went live on 19 November 2018. Initial outputs are showing positive trends which will continue to be monitored on an on-going basis. Across the Partnerships, referrals have increased by 16.3% since last year while prevented admissions have increased by 48%.

Children, Families and Justice Services

Service transformation in Children's Services has focussed on bringing accommodated Children back from expensive external residential placements, which not only reduces costs but provides better outcomes for the child, this has included avoiding carer breakdown with foster and kinship carers and wrapping children's intervention teams around school settings.

- **Children's Service Challenge Fund**

  Evaluation of the prevention work at Elderbank Primary School

  Further assessment on the impact of this locality-based approach on the children's services team structures.

- **Teams in Schools** – has seen the implementation of a Children's Services team being based in Kilwinning Academy. Results to date have led to a review of developing such an approach across Children's Services affecting the traditional area team construct.

- **Child Protection** – Implementation of new arrangements to take a professional risk-based review of children on our Child Protection Register for appropriately reducing the number of children registered.

Mental Health and Learning Disability Services

Warrix Avenue Development – The workforce for this initiative has been recruited and care model pathways completed with first patient admissions in the summer of 2019. This positive development moves an inpatient rehabilitation mental health ward into a step-down supported community setting.

- **Trindlemoss** – Work is well progressed to develop a new model of service delivery for Learning Disability Day Services in preparation of transfer of services from Fergushill and Hazeldene to Trindlemoss. In addition, the site includes a Complex Care Unit and Supported Housing which will allow patients and service users to be cared for in a service established to support independence and improve outcomes. The full site refurbishment is scheduled for completion during the final quarter of 2019.

  Nethermains Supported Living - The Nethermains project aims to give individuals greater independence and choice in their day to day life whist recognising the challenges they may face integrating into the community. The supported living project provides 24hr care for individuals living with some of the most debilitating symptoms of mental ill health. Each individual living within Nethermains had been previously cared for within long term/ continuing care rehabilitation. The care is commissioned and provided by The Richmond Fellowship whose staff integrated into clinical areas several weeks before the transition to Nethermains in order to develop trust and rapport with the people they would be caring for.

- **Learning Disability Strategy** - The service user planning group has been meeting since November and has recently been focussing on issues of transport and getting around within communities. Opportunities are being sought to link this with other activity addressing this theme, through the work of **Upstream**, an organisation exploring a range of transport issues in relation to marginalised populations (with a focus on dementia). Work is commencing on looking at the integrated team workforce; as part of which fresh links with primary care are being pursued (including closer collaboration with Community Link Workers). The work of the team in the Garnock Valley has provided a template for review which will continue to be developed, but which will also inform the undertaking of reviews as part of the broader programme of change within day services.

- **Elderly Mental Health Inpatient Services –** The majority of adult inpatient services have moved to Woodland View from Ailsa in order to ensure occupancy levels and better support the patient need. In addition, there is an expectation that the Ailsa site will no longer provide inpatient services by

relocating remaining wards to Ayrshire Central Hospital. As part of this change, elderly functional inpatient assessment was consolidated resulting in the Croy ward closing in November 2018. The Iona/ Lewis ward closure is progressing with alternative care provision being identified. As a result of these changes a reconfiguration of inpatient services was identified with the relocation to the best accommodation available. The completion of these changes will result in significant whole service savings.

- **Mental Health Action 15 Investment –** As part of the Mental Health Strategy 2017-2027, Scottish Government Ministers made a commitment to provide funding to support the employment of 800 additional mental health workers. In Ayrshire and Arran, the additional funding has been targeted in three main areas; supplementing the prison healthcare team, employing mental health practitioners (MHP) in GP practices and expanding the crisis resolution team to include direct access for Police. There are four MHPs already working within GP practices as part of the wider multidisciplinary teams in General Practice with another four going through induction. It is expected that this additional resource will free GP time as well as have a positive impact on demand for community mental health.

5. Reporting on lead partnership responsibility

Each Ayrshire health and social care partnership has lead responsibility for specific services across Ayrshire.

North Ayrshire Health and Social Care Partnership has lead responsibility for:

- **Mental health services** (including psychology, CAMHs, learning disability assessment and treatment)
- **Child health services** (including child immunisation and infant feeding)

East Ayrshire Health and Social Care Partnership has lead responsibility for primary care and out of hours community response

South Ayrshire Health and Social Care Partnership had lead responsibility for technology enable care (TEC) and falls prevention.

During 2018-19 Allied Health Professionals (AHPs) responsibility was devolved to each Partnership, in previous years this was led by South Ayrshire.

Details of North Ayrshire's performance in these services are available from:

East Ayrshire Health and Social Care Partnership

www.east-ayrshire.gov.uk/CouncilAndGovernment/About-the-Council/Information-and-statistics/CouncilPerformanceIndicators/Annualperformancereport.aspx

South Ayrshire Health and Social Care Partnership

www.south-ayrshire.gov.uk/health-social-care-partnership/partnershipperformance.aspx

Mental Health Services

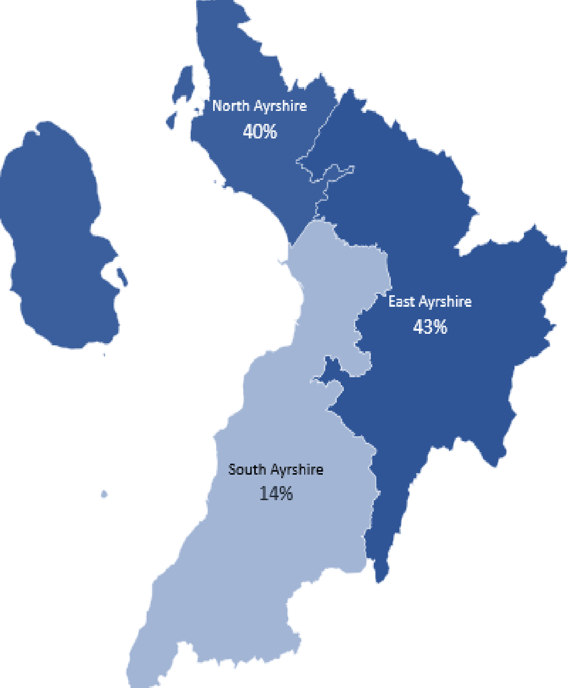
We want to see a nation where mental healthcare is person-centred and recognises the life-changing benefits of fast, effective treatment

– Mental Health Strategy, 2017–2027

The 3 Ayrshire Health and Social Care Partnerships have committed to the development of an Ayrshire and Arran Mental Health Strategy. Our aim was to ensure the Ayrshire Mental Health Strategy includes the views of people who use services, their family members, carers, the local workforce and people and communities across Ayrshire. This was accomplished via the Ayrshire Mental Health Conversation.

To capture as many responses as possible people had the opportunity to provide feedback via local conversation events, paper-based questionnaires (available in all local libraries and within other local services) and an online survey. The Conversation led to **777 responses**.

It was positive to see that the responders to the Conversation encompassed a diverse section of the population as demonstrated, with only 3% not providing a postcode.



Service Experience

42% responded as someone who had personal experience of accessing services,
32% as someone who has never accessed services
26% responded on behalf of someone they care for.

Mental Health Conversation Findings

Overall the top 5 things that challenge people's mental health in Ayrshire are:

1. Work Related – 430, 55%
2. Relationships – 401, 52%
3. Money/Debt – 337, 43%
4. Body issues/Self-image – 306, 39%
5. Isolation/loneliness – 272, 35%

Things to Improve Mental Health

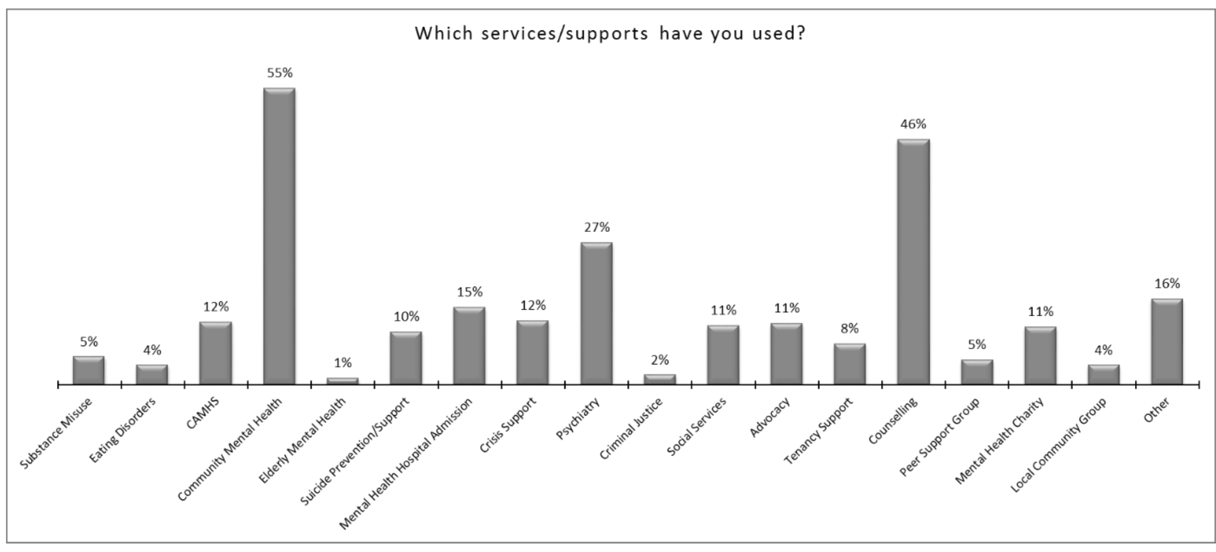
Overall the top 5 things that people do to improve their mental health and wellbeing are:

1. Spend time with family and friends – 393, 51%
2. Go for a walk – 378, 49%
3. Listen to music – 314, 40%
4. Physical Exercise – 306, 39%
5. Talking to family/friends about things that worry you – 306, 39%

Services and Supports

Overall the top 5 used services or supports by service users are:

1. Community Mental Health – 263, 50%
2. Counselling – 202, 38%
3. Psychiatry – 139, 26%
4. Mental Health Hospital Admission – 104, 20%
5. CAMHS – 91, 17%



Conversation Feedback and Comments

Longer long-term support – 8 weeks is not enough

Having longer sessions provided and not being passed from pillar to pillar

The staff are great but there simply are not enough of them

Strategic/planned support for schools from professionals – proactive support – before children need to be referred, don't show up and then get send back to school anyway

More counsellors or people to talk to. There is nobody to talk to at the moment unless you want to wait for years

Not losing patients in the system – still waiting for a follow up. Just so happens it has suited me

Having reception and nursing staff who don't make you feel like a nuisance when asking for help

Less Medication

Being able to get help instead of being told I'm not a priority

Let the family know what is happening

More knowledge of what's available

Mental Health problems having same importance as physical health problems to service planners & funders and primary care clinicians

At the end of 2018-19 the **partnership CAMHS (Children and Adolescent Mental Health Services)** service was supporting **over 3,000** children and young adults with Mental Health issues.

CAMHS work to a 7-day access to treatment model. The demand for this service has continued to increase for the 3rd consecutive year with the number of referrals reaching **1,937** and **346** of these being '**high risk**' presentations. Over the last 3 years there is been a 24% increase in these urgent referrals and during 2018-19 this equates to approximately one per day.

Woodland View, the facility providing older people's rehabilitation as well as dementia, mental health and addiction services for people across Ayrshire and Arran, saw a **10.5%** increase in unscheduled admissions during the year, 587 from 531 in 2017-18. During the same period there was a **22.6% reduction** in the re-admission rate within a 28-day period from discharge, 41 from 53 in 2017-18.

The Quality Improvement Top Team Award went to the **Ward 10, Woodland View Therapeutic Groups Project**. The team set out to improve the therapeutic environment and culture at Ward 10 and in turn reduce self-harm, violence and the need for restraint. The project had a hugely positive impact on the ward environment and patient safety.

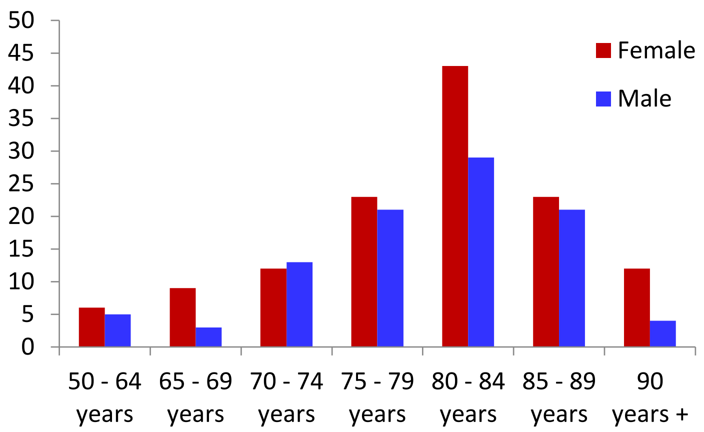
Although there were no announced or unannounced visits by the Mental Welfare Commission to mental health inpatient services during 2018-19, we hosted a number of high-profile visitors to our Woodland View facility.

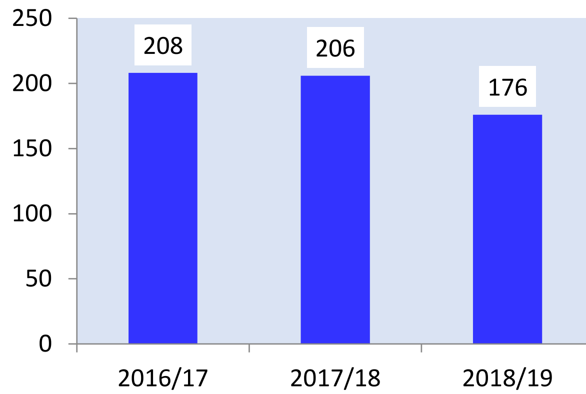
Since **Veterans 1st Point** (**V1P)** Ayrshire and Arran was developed in 2017, it has demonstrated the North Ayrshire IJB's commitment to the Armed Forces Covenant, ensuring that veterans – and particularly those with the most enduring health and welfare difficulties are able to access priority care and treatment from mainstream and specialist services.

Although a small service, V1P Ayrshire & Arran has delivered care and treatment to over **500 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's satisfaction through a cost-effective service structure.

Our **Crisis Support Team** supported over **1,000 residents** during short periods of crisis. The benefit of having such a team is that just **7%** of those being assessed by the team resulted in an inpatient admission.

2018-19 welcomed a **new Dementia Lead**. In support of the service this lead launched a **carer group** that has been well received providing networking sessions, advice opportunities covering all areas affecting dementia diagnosed individuals and their families. Throughout the year over 200 residents of North Ayrshire were diagnosed with dementia with **100% offered post-diagnostic supports**.





2018-19 saw the 3rd consecutive year in **decreasing admissions** to acute elderly mental health. The merger of the Ailsa site with Ward 4 saw the closure of Croy House with the continuing plan to bring all elderly mental health into a single site.

Child Health Services

Child Health Service is responsible for the comprehensive immunisation/screening/health review programmes and fail-safe aspects provided to the eligible population across Ayrshire and Arran. The Child Health Service is governed by Scottish Government legislation and protocols.

- **Children's Immunisation Service** provides the Ayrshire school-based immunisation programme, including human papilloma virus (HPV), diphtheria tetanus and polio, meningitis ACWY, and measles, mumps and rubella (MMR). In North Ayrshire this programme is offered to **7,670** pupils between the cohorts of S1 to S6. The annual influenza vaccine is offered to **10,229** pupils from Primary 1 to 7.

- Health visitors in the **Infant Feeding Service** continue to promote, protect and support breastfeeding, referring mums to the community infant feeding nurse for support with more complex issues. Audit shows that the care provided is of a high standard and well received. Work remains ongoing across Ayrshire to increase the number of premises signed up to the '**Breastfeed Happily Here**' scheme (***see* page 31** for more information).

6. Inspection of Service

The Partnership works closely with independent care providers to ensure that the care and support provided is being delivered in line with peoples' outcomes, offers best value, meets regulatory requirements and keeps people healthy, safe and well.

Care services provided by Partnership teams also undergo external inspections and are subject to rigorous review and inspection.

Working together, we ensure that all required standards of quality and safety are met.

Independent care providers who provide care services on our behalf

Independent care and 3rd sector providers, via the contract management framework, maintain and improve their standards of care and support on an on-going basis. We use a range of methods to monitor performance, including:

- Compliments, complaints and feedback from staff, carers and people who use services
- Information that we collect, before visits, from the provider or from our records
- Local and national information, for example, Care Inspectorate reports
- Visits to providers, including observing care and support and looking at records and documents

The information below represents how services are performing, monitored via the contract management framework and ensures services are safe, effective and most of all, that they meet people's needs.

Registered services: Minimum grades across all themes		Current lowest grade in any assessed quality theme						
Care Service	Subtype	1 - Unsatisfactory	2 - Weak	3 - Adequate	4 - Good	5 - Very Good	6 - Excellent	Total
Adoption						1		1
Adult Placement Service						2		2
Care Home Services	Older people		1	6	9	4		20
	Children and young people				4	3	2	9
	Learning Disabilities		1		3	1		5
	Mental Health				1			1
Fostering					1	1		2
Housing support Services				2	5	10	3	20
School care accommodation					2	5		7
Support services	Care at Home		1	2	7	11		21
	Other than Care at Home			1	7	3	1	12
Total		**0**	**3**	**11**	**39**	**41**	**6**	**100**

Care services provided by Partnership teams

The services that the Partnership provides undergo inspection from the Care Inspectorate. In 2018–19, 14 internal services were inspected, 1 scheduled and 13 unscheduled, and the table below shows the care grades awarded.

The **highlights of the inspections** over the last year have been:

- 'Excellent' grades awarded to Throughcare (Supported Carer's Scheme)
- 'Very Good' grades awarded to Canmore, Abbey Croft, The Meadows, Achnamara Children's Houses
- 'Very Good' grades awarded to Anam Cara and Montrose House
- 'Very Good' grades awarded Care at Home Services

Children and family services		
	Care Inspectorate Number/ Inspection Date	Quality Theme = Care Grade (Out of 6)
Canmore	CS2003001160 23-May-18	C&S = 5 Env = N/A Staffing = 4 M&L =N/A
Abbey Croft Children House	CS2003001163 23-Jul-18	C&S = 5 Env = 4 Staffing = 5 M&L = 4
Throughcare (Supported Carers Scheme)	CS2008168320 09-Aug-18	C&S = 5 Env = N/A Staffing = N/A M&L = 6
The Meadows Children's House	CS2007142325 14-Aug-18	C&S = 5 Env = N/A Staffing = N/A M&L=4
Achnamara Children's Unit	CS2007142322 23-Nov-18	C&S = 4 Env = 5 Staffing = 5 M& L= 5

Adult Services		
Thistle Day Services	CS2003045869 09-Apr-18	C&S = 4 Env = N/A Staffing = 4 M&L = N/A
Burns Day Services	CS2003034607 21-May-18	C&S = 4 Env = N/A Staffing = 4 M&L = N/A
Ananm Cara	CS2008177877 19-Jul-18	C&S = 5 Env = N/A Staffing = 4 M&L = N/A
Castleview Day Service	CS2003034610 23-May-18	C&S = 4 Env = N/A Staffing = 4 M&L = N/A
Dementia Support Service	CS2002306108 26-Jul-18	C&S = 4 Env = N/A Staffing = 4 M&L = 4
Fergushill Day Services	CS2003001155 21-Sep-18	C&S = 3 Env = 4 Staffing = 3 M&L = 3
Montrose House	CS2003001167 05-Oct-18	C&S = 4 Env = 5 Staffing = 4 M&L = 4
Care at Home – Three Towns, North Coast & Arran	CS2008192560 08-Jan-19	C&S = 5 Env = N/A Staffing = 5 M&L = N/A
Care at Home – Irvine, Garnock Valley and Community Alarm (U)	CS2008192553 08-Jan-19	C&S = 5 Env = N/A Staffing = 5 M&L = N/A

One of the Scottish Government's suite of National Indicators is the proportion of care services graded as 'good' (4) or above in Care Inspection grades.

As at 31 March 2019 all but one of North Ayrshire HSCP inspected services received a grade 4 or above.

7. Financial performance and best value

Financial information is part of our performance management framework with regular reporting of financial performance to the IJB.

This section summarises the main elements of our financial performance for 2018/19.

Partnership Revenue Expenditure 2018/19

The year-end position was an overall underspend of £0.945m (£0.389m in social care services and £0.556m in health services). This position includes the £1.486m budget being held on behalf of the IJB by the Council for debt repayment, as this is required to be transferred back to the IJB at the financial year-end. This position is also before earmarking £0.277m of resource for use in future years. The final adjusted year-end position was a £0.668m underspend after earmarking, this balance will be used to commence repayment of the historic debt carried forward from previous years.

The intention during 2018-19 was that prior to the £1.486m set aside for debt repayment being reallocated to the partnership that the IJB would work towards delivering financial balance in-year which would have allowed the full amount set-aside to be allocated towards the debt at the year-end. The full repayment was not possible due to significant financial challenges during the year in relation to the increasing demand for social care services, the delivery of the transformation programme and associated savings.

Throughout the year there was a projected overspend position, consequently a financial recovery plan was put in place to support the delivery of services from within the delegated budget. The financial recovery plan and progress was monitored throughout the financial year.

2017-18 Budget £000	2017-18 Actual £000	Variance (Fav) / Adv £000		2018-19 Budget £000	2018-19 Actual £000	Variance (Fav) / Adv £000
65,543	64,714	(829)	Health and Community Care	65,900	65,952	52
71,761	72,772	1,011	Mental Health	73,308	72,982	(326)
33,504	35,965	2,461	Children, Families and Justice	35,591	35,705	114
49,637	49,518	(119)	Primary Care	48,916	48,839	(77)
0	0	0	Allied Health Professionals	4,636	4,588	(48)
4,266	5,798	1,532	Management and Support Costs	6,821	5,970	(851)
2,870	2,347	(523)	Change Programme	2,623	2,290	(333)
227,581	**231,114**	**3,533**	**TOTAL EXPENDITURE**	**237,795**	**236,326**	**(1,469)**
(227,581)	**(228,552)**	**(971)**	**TOTAL INCOME**	**(237,795)**	**(237,795)**	**0**
0	**2,562**	**2,562**	**OUTTURN ON A MANAGED BASIS**	**0**	**(1,469)**	**(1,469)**
0	0	0	Lead Partnership Allocations	0	524	524
0	**2,562**	**2,562**	**OUTTURN ON AN IJB BASIS**	**0**	**(945)**	**(945)**
0	0	0	Earmarking	0	277	277
0	**2,562**	**2,562**	**FINAL OUTTURN POSITION**	**0**	**(668)**	**(668)**

Table 1: Financial Performance for 2018/19

The main areas of pressure continue to be looked after and accommodated children, LD care packages, elderly and adult in-patients within the lead partnership and the unachieved NHS Cash Releasing Efficiency Saving (CRES) savings. The main areas of variance during 2018–19 are noted below:

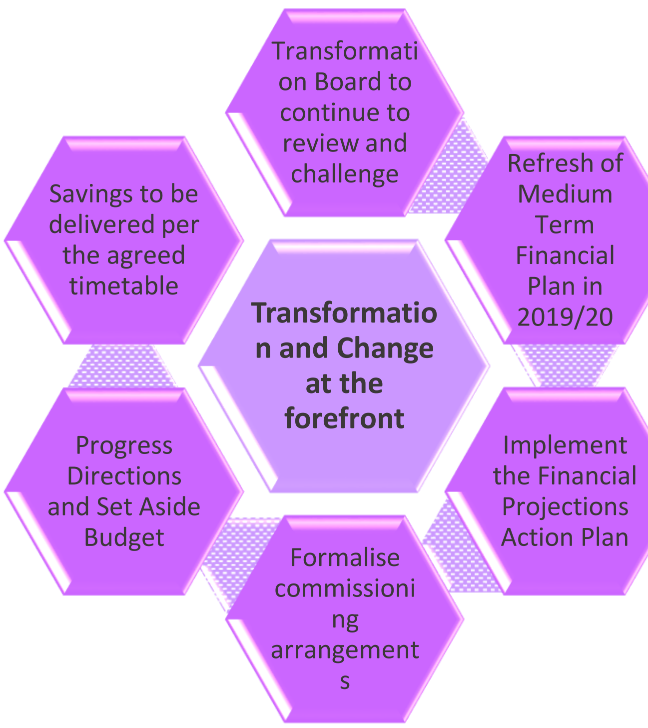
> ***Health and Community Care – overspend of £0.052m*** mainly relates to an overspend in care home placements and community packages, partially offset by underspends in care at home, adaptations and district nursing.

Mental Health – underspend of £0.326m which relates to an overspend in learning disability care packages which is offset by underspends in community mental health and the Lead Partnership for mental health (psychology, child and adolescent mental health services (CAMHS)) and unplanned activities (UnPACs).

Children, Families and Justice – overspend of £0.114m is mainly related to an overspend in residential and secure placements partially offset by an underspend within fostering.

Management and Support Costs – underspend of £0.851m mainly relates to the allocation of the £1.5m for the debt repayment offset by unachieved NHS CRES savings (cash releasing efficiency saving).

Moving into 2019-20, the Partnership is proactively working to provide safe and effective services for the residents of North Ayrshire within the financial envelope. Several areas have been implemented or are programmed as outlined below:



Financial Outlook, Risks and Plans for the Future

The Health and Social Care Delivery Plan (published December 2016) outlined the need to shift the balance of where care and support is delivered, to outwith a hospital setting when that is the best thing to do. This provides a clear impetus to the wider goal of 50% of the health budget being spent in the community by 2021. During 2018–19 the Pan Ayrshire Intermediate Care and Rehab Model was implemented which is predicated on a shift from acute to community care.

In October 2018, the Scottish Government published the Medium-Term Health and Social Care Financial Framework which sets out the future shape of Health and Social Care Demand and Expenditure. Within the report it outlined that the Institute of Fiscal Studies and

Health Foundation reported that UK spending on healthcare would require to increase in real terms by an average of 3.3% per year over the next 15 years to maintain NHS provision at current levels, and that social care funding would require to increase by 3.9% per year to meet the needs of a population living linger and an increasing number of younger adults living with disabilities. The report recognised that despite additional planned investment in health and social care the system still needs to adapt and change.

The focus of the financial framework is on the main health and social care expenditure commitments, as set out below.

- Over the course of this parliament, baseline allocations to frontline health boards will be maintained in real terms, with additional funding over and above inflation being allocated to support the shift in the balance of care.
- Over the next five years, hospital expenditure will account for less than 50% of frontline NHS expenditure. This relates to the policy commitment to 'shift the balance of care', with a greater proportion of care provided in a setting close to a person's home rather than in a hospital.
- Funding for primary care will increase to 11% of the frontline NHS budget by 2021–22. This will amount to increased spending of £500 million, and about half of this growth will be invested directly into GP services. The remainder will be invested in primary care services provided in the community.
- The share of the frontline NHS budget dedicated to mental health, and to primary, community, and social care will increase in every year of the parliament. For adults, and in some cases for children, these services, along with unscheduled hospital care, are now managed by Integration Authorities.

The Ministerial Strategic Group (MSG) for Health and Community Care published a report following the Review of Progress with Integration of Health and Social Care (February 2019). Within the integrated finance and financial planning area the proposals include:

- Health Boards, Local Authorities and IJBs should have a joint understanding of their respective financial positions as they relate to integration
- Delegated budgets for IJBs must be agreed timeously
- Delegated hospital budgets and set aside requirements must be fully implemented
- Each IJB must develop a transparent and prudent reserves policy
- Statutory partners must ensure appropriate support is provided to IJB Section 95 officers
- IJBs must be empowered to use the totality of resources at their disposal to better meet the needs of their local populations.

The Partnership has a responsibility, with our local hospital services at University Hospital Crosshouse and University Hospital Ayr, for planning services that are mostly used in an unscheduled way. The aim is to ensure that we work across the health and care system to deliver the best, most effective care and support. Service areas most commonly associated with unplanned use are included in the 'Set Aside' budget. Set Aside budgets relate to the strategic planning role of the Partnership. Key areas within this budget are:

- Accident and emergency
- Inpatient services for general medicine
- Geriatric medicine

- Rehabilitation
- Respiratory
- Learning disability, psychiatry and palliative care services provided in hospital

Acute Services within NHS Ayrshire and Arran continue to face particular budget pressures around the costs of covering a high level of medical vacancies and the increasing needs of patients requiring nursing support above funded levels. There have been a high number of unfunded beds in use to meet demands and this pressure has been managed in-year by NHS Ayrshire and Arran in line with the Integration Scheme. The ability to plan with the overall resource for defined populations and user groups and to use budgets flexibly is one of the hallmarks of integrated care.

A national Finance Development Group has been established to support implementation of the financial aspects of health and social care integration legislation and associated guidance. It is recognised that there is a need to understand the progress that is being made towards planning across the full pathway of care, including the acute hospital component and the way in which the statutory guidance on the use of delegated hospital budgets is being applied in practice.

Set Aside resources, as well as Lead Partnership / hosted services were recognised as areas requiring further development as part of the review of the Integration Scheme carried out in 2017 and in the Strategic Planning, Commissioning and Delivery of Health and Social Care Services within NHS Ayrshire and Arran report to the IJB on 13 June 2018. This report sets out arrangements for the next steps in respect of 'fair share' commissioning within the NHS Ayrshire and Arran health and social care system. The report also outlines future developments in respect of Directions as per the model provided by the Public Works (Joint Working) Scotland Act 2014 for IJBs to commission services from Councils and NHS Boards. Pan-Ayrshire workshops have been held with representatives from the Scottish Government to take forward a national pilot project on 'fair share' commissioning through the use of Directions. This national pilot will ensure that delegated hospital budgets and Set Aside budget requirements will be fully implemented. The Ministerial Strategic Group for Health and Community Care Review of Progress with Integration of Health and Social Care report published February 2019 set this out as a key proposal under integrated finances and financial planning requirements

The most significant risks faced by the IJB over the medium to longer term are summarised as follows:

Impact of budgetary pressures	Delivery of the Change Programme	Culture and practice
•Mitigation	**•Mitigation**	**•Mitigation**
•Medium Term Financial Plan	•Transformation Board	•Thinking Different, Doing Better HSCP experience
•Strategic Plan	•Programme Leads	•Multi Disciplinary Team Approach
•Change Programme	•Strategic Planning Officers Group (SPOG)	•Strategic Workforce Plan
•Active Demand Management	•Change Team Project Management Support	

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

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

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

The planned Thinking Different, Doing Better sessions will focus on thinking differently about how we support people more appropriately, moving away from a deficit-based approach to assessment and care provision. By supporting people to think about resources and support they have available and allowing statutory services to prioritise resources to support people who need it the most, ensuring our resources are used equitably across the population of North Ayrshire.

Best Value

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

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

Regular performance information is provided to the Performance and Audit Committee, IJB members and operational managers. Benchmarking is used to compare performance with other organisations to support change and improvement, with national outcomes being monitored through quarterly and annual reporting.

The budget also recognises the need to link expenditure to outcomes, but there is still a need to improve the links between budget and outcomes. There is evidence of transformation taking place at strategic and operational level within the partnership.

We have begun to see some of the benefits of integrated system working for example in supporting older people to remain at home or get home from hospital as soon as possible.

The partnership has well developed approaches to community engagement to ensure the community are informed of plans for services and also to gain feedback from communities on the strategic priorities of the partnership. This positive engagement and new ways of connecting with communities will continue in the future, an example being the Thinking Different, Doing Better experience which will be opened up to communities.

Some of our achievements in 2018/19 include:

- The **Money Matters** team assisted in putting more than £9.5m into the pockets of our most vulnerable residents, assisting with 629 appeals and dealing with 3,677 enquires to the Money Matters Advice Line.

- **Community Link Worker** team increased from 7 to 12 by September 2018. All 20 General Practices in North Ayrshire now have Community Link Worker in post. During the year the team engaged with 1,697 people which is a 25% increase on the previous year and provided 4,114 signposts/referrals to supports and services which is 30% more than the previous year.

- **North Ayrshire Achieves** winners included **Montrose House management team** (Promoting Wellbeing category) **Care at Home** for Building Community Capacity category.

- **Enhanced Intermediate Care and Community Rehabilitation Service** went live on 19 November 2018. The service has a common framework, ensuring a consistent approach across Ayrshire. This is applied locally to reflect the differing needs, ambitions and operational arrangements of the different partnerships in East, North and South Ayrshire.

- In consultation with people who use our **learning disability services**, we are re-developing the property, gardens and grounds at Trindlemoss (previously Red Cross House, Irvine) to provide person-centred, wraparound care focussing on each person's outcomes and people in the heart of their community.

- Our partners in the **independent care home sector** continued to provide care home services during a period of instability in the sector.

- **Partnership Care at Home Services** graded as 5 by the Care Inspectorate.

- The **Veterans 1st Point (V1P) Service** celebrated its 1st birthday

- **Carers Week** was celebrated with events taking place in all six localities.

The fourth year as an integrated Health and Social Care Partnership has seen significant progress towards achieving financial balance and overall service sustainability. The IJB has a deficit of £5.139m (reduced from £5.807m) as it moves into 2019–20. There is a repayment plan to allow the deficit to be recovered over the medium term to support the financial sustainability of the Partnership.

The IJB recognises it must deliver services within its financial envelope for 2019–20 and our transformation programme will continue with delivery of the savings plan and service redesign.

There is a focus on the integration of services to deliver real change to the way services are being delivered, with a realism that continuing to deliver services in the same way is no longer sustainable and changes need to be made in the way services are accessed and provided. The scale and pace of change requires to be accelerated, the financial challenges drive the pace of change, however the requirement to change and re-design services to improve outcomes for individuals would exist despite the financial pressures.

There is an expectation that within North Ayrshire the pattern of spend will change and there will be a shift in the balance of care from institutional to community settings. The integration of health and social care provides a unique opportunity to change the way services are delivered, it is an opportunity to put people at the heart of the process, focussing on the outcomes they want by operating as a single health and social care service.

The IJB through the Strategic Plan outlines the belief that together we can transform health and social care services to achieve the joint vision for the future "all people who live in North Ayrshire are able to have a safe, healthy and active life". Moving into 2019-20, we are working proactively to address the financial challenges, while at the same time, providing high-quality and sustainable health and social care services for the communities in North Ayrshire.

Spend in Localities

The Partnership has arrangements to consult and involve localities via their locality forums. The IJB has established six Locality Planning Forums, reflecting the previously agreed local planning areas. These provide Board Members with the opportunity to be involved in considering the priorities for each area and outline the role for each Community Planning Partner in meeting these priorities in conjunction with the local communities.

The expenditure has been split into localities by initially allocating spend which could be directly identified to a locality and the remainder which was not locality specific was allocated on a population basis. The table below shows the spend allocated based on population which means at this stage the spend per locality can only be used as a guide and will not fully reflect actual locality usage of services. This is an area which will continued to be developed with Children and Justice Services being the first to move to a locality-based approach in 2019/20.

The population information used is given below and was taken from the 2017 mid-year population statistics (sourced from ScotPHO)

Age Group	Irvine	Kilwinning	Three Towns	Garnock Valley	North Coast	Arran	TOTAL	% of spend allocated on this basis
Children age 0-15	30.8%	13.0%	25.6%	14.3%	13.8%	2.4%	**100.0%**	12.1%
Adults aged 16-64 years	29.9%	12.1%	24.7%	15.2%	15.2%	3.0%	**100.0%**	24.3%
Older People aged 65+	25.6%	10.2%	22.0%	13.8%	23.5%	4.9%	**100.0%**	12.6%
Share of total population	29.1%	11.8%	24.2%	14.7%	16.8%	3.3%	**100.0%**	5.9%
Total allocated on population basis								57%
By locality								43%
Total								**100%**

This resulted in the following spend per locality:

	Irvine £000's	Kilwinning £000's	Three Towns £000's	Garnock Valley £000's	North Coast £000's	Arran £000's	TOTAL £000's
2018/19 Expenditure	**62,712**	**22,545**	**69,009**	**30,185**	**38,505**	**13,368**	**236,324**
% share of spend	26.5%	9.5%	29.2%	12.8%	16.3%	5.7%	100.0%
% of total population	29.1%	11.8%	24.2%	14.7%	16.8%	3.3%	100.0%

Appendices

Appendix 1: Local indicators

Performance indicator	2016-17	2017-18	2018-19	Target	Status
People subject to level 1 Community Payback Order (CPO) Unpaid Work completed within three months	93.37%	95.33%	95.6%	57%	
Individuals subject to level 2 Community Payback Order (CPO) Unpaid Work completed within six months	95.63%	94.27%	97.3%	67%	
Number of Learning Disability service users in voluntary placements	71	67	58	43	
Number of bed days saved by ICT, Intermediate Care Team (formerly ICES), providing alternative to acute hospital admission	4,730	5463	6,563	3,060	
People seen within 1 day of referral to ICT	98.5%	95.66%	100%	90%	
Number of people receiving Care at Home	1,715	2021	1,793	1,703	
Number of secure remands for under 18s	1	0		5	
Addictions referrals to treatment within 3 weeks (Alcohol)	93.7% (at Q3)	95%	100%	90%	
Addictions referrals to treatment within 3 weeks (Drugs)	95.0% (at Q3)	98%	100%	90%	
Children who have been through Stop Now and Plan (SNAP) who have been sustained within their local school	100%	100%	100%	100%	
Preschool children protected from disease through % uptake of child immunisation programme (Rotavirus)	95.53%	96.10%	91%	92.2%	
Preschool children protected from disease through % uptake of child immunisation programme (MMR1)	96.21%	96%	95%	98.2%	
Care at Home capacity lost due to cancelled hospital discharges (shared target with acute hospital services) (number of hours)	7,153	6,305	9,907	4000	
Uptake of Child Flu Programme in schools	75.25%	74.70%		72.1%	
Number of unique individuals referred to MADART (under 16 years)	776	551	704	Data only	

Performance indicator	2016-17	2017-18	2018-19	Target	Status
Number of re-referrals to MADART	89	37	54	Data only	
Number of Victim Referral Incidents to MADART	601	365	393	Data only	

Appendix 2: Measuring performance under Integration

Please note: this table shows our performance using the most up to date published national data. Throughout this document, we have provided more recent performance data where this is available.

Performance indicator	2016-17	2017-18	2018-19	Target	Current Status
Emergency admissions to acute hospitals	1,840	1,763	1,622	1,836	✓
Emergency admissions to acute hospitals (rate per 1000)	13.6	13	12	13.6	✓
Admissions from emergency department	1,202	1,131	1,007	1,173	✓
Admissions from emergency department (rate per 1000)	8.9	8.4	7.5	8.7	✓
% people at emergency department who go onto ward stay (conversion rate)	36	34	33	33	✓
Unscheduled 'hospital bed days' in acute hospital	12,333	8,798	9,348	12,320	✓
Unscheduled 'hospital bed days' in acute hospital (rate per 1000)	91	65	69	91	✓
Unscheduled 'hospital bed days' in long stay mental health hospital	6,782	5,866 (Mar18)	8,128 (Dec 18)	6,782	●
Unscheduled 'hospital bed days' in long stay mental health hospital (rate per 1000)	50	43.3	60	50.1	✓
Unscheduled 'hospital bed days' in geriatric long stay	1,665	1,454	943	1,772	✓
Unscheduled 'hospital bed days' in geriatric long stay (rate per 1000)	12.3	10.7	7	13	✓
Emergency department attendances	3,385	3,292	3,039	3,292	✓
Emergency department attendances (rate per 1000)	25	24.3	22.5	24.4	✓
% people seen within 4 hrs at emergency department	91.4%	88.5%	87%	95%	●
Delayed Discharges bed days (all reasons)	781	1,889	1,916	1,515	●
Delayed Discharges bed days (all reasons) (rate per 1000)	7.1	17.3	17.5	13.9	●
Delayed Discharges bed days (code 9)	308	279	196	770	✓
Delayed Discharges bed days (Code 9) (rate per 1000)	2.8	2.5	1.8	7	✓

Where to find more information

If you would like more information on IJB strategies, plans and policies and our performance and spending, please refer to the following websites.

- www.nahscp.org/partnership-strategies-plans-reports/
- www.nhsaaa.net/about-us/how-we-perform/
- www.north-ayrshire.gov.uk/council/strategies-plans-and-policies
- www.north-ayrshire.gov.uk/council/performance-and-spending

Additional financial information for Ayrshire wide services can be found in:

www.east-ayrshire.gov.uk/SocialCareAndHealth/East-Ayrshire-Health-and-Social-Care-Partnership/Governance-Documents.aspx

www.south-ayrshire.gov.uk/health-social-care-partnership/strategy.aspx