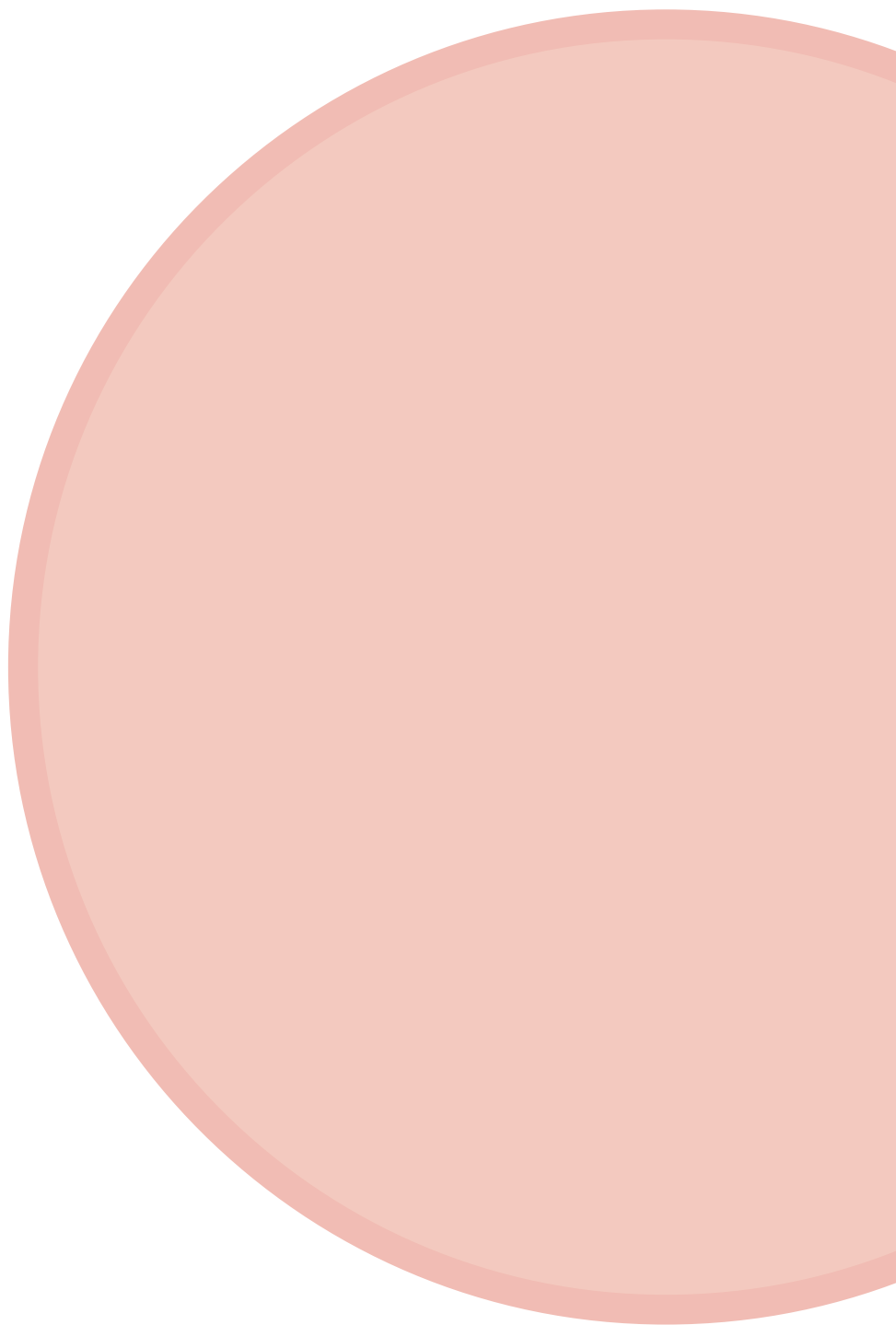


North Ayrshire Health and Social Care Partnership

# Annual Performance Report 2017–18





## Reflections from Stephen Brown

It is difficult to believe that this report is the third annual performance report to be published by North Ayrshire Health and Social Care Partnership. Contained within this document are some significant highlights from 2017–18. These highlights include continued progress with many of our registered services receiving further improved grades via the Care Inspectorate. Perhaps the most significant of these has been our directly provided Care at Home and Community Alert services, both now graded as 'Very Good' across all quality themes. These are the highest ever grades attained by the service and this is particularly pleasing given the growth of the Care at Home and Community Alert workforce and the significant role these services play, and will continue to play, in ensuring we support people to live as independently as possible for as long as possible. Our justice service and welfare rights advice team, Money Matters, continue to be exemplars in the support they give to vulnerable people.

We also continue to see forward progress in many areas of service delivery, including domestic abuse, referral to treatment times and recovery for people who access our drug and alcohol services.

We know, however, that the delivery of health and social care services in North Ayrshire continues to face significant demand pressures particularly in areas such as mental health, learning disability and children's services. Whilst we are working hard with our Community Planning Partners to address inequalities, the links between poverty and deprivation and poorer health outcomes remains one of our greatest challenges.

Our greatest challenge is, however, managing the current levels of demand for health and social care services within our allocated budget. We have a significant change and transformation agenda underway and we remain optimistic that this can not only help us manage our finite resources more effectively but also (and most importantly) continue to improve health and wellbeing outcomes for people who use our services, carers and communities.

I want to thank all of our partners and all of the staff working within North Ayrshire Health and Social Care Partnership for their continued hard work and dedication to improving the lives of people living in North Ayrshire. We have achieved much in our first three years but have much still to do.



**Stephen Brown**

Director, North Ayrshire Health and Social Care Partnership



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# Vision, values and priorities

**North Ayrshire Health and Social Care Partnership** (NAHSCP/the Partnership) is working to progress the **vision** that:

*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 third 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.

To enable the Partnership to fulfil our vision, and after asking people who use our services, North Ayrshire residents and staff, we will 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 our performance in relation to:

- Scottish Government National Health and Wellbeing Outcomes (see pages 8–21)
- Children’s and Justice Services Outcomes (see page 22–29)
- Local measures (see page 56)

Our Partnership has lead partnership responsibilities for Mental Health and Learning Disability Services as well as Child Health Services, (including immunisation and infant feeding). We have included some of the highlights and challenges of leading services across Ayrshire’s three health and social care partnerships (see pages 38–46).

We will show that all of 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 (see pages 47–49).

Finally, 2017–18 has been another financially challenging year. We have detailed our financial position (see pages 50–55). and shown how we have continued to provide best value for North Ayrshire health and social care services.

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

As we completed our third 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 priorities 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.

1.1 **Community Link Workers**, formerly Community Connectors, are available for consultation in 19 GP practices. Plans are in place to extend the service across all GP practices in North Ayrshire.

Community Link Workers provide a social prescribing service to local people, referring them to alternative opportunities within their own communities that can help address symptoms of illness. While attending GP practices, people can now access additional local information, including [www.carena.org.uk](http://www.carena.org.uk), via touch-screen kiosks installed in 17 GP practices and Bridgegate House.

During 2017–18, 1,586 people were referred to Community Link Workers. Of the 3,090 recorded contacts, 84% were successful and resulted in people attending an appointment. Community Link Workers are also trained to signpost people to one of six cancer support services. A total of 62 links were established from 1 October 2017, and one worker will provide this service in three GP practices until the end of September 2018.

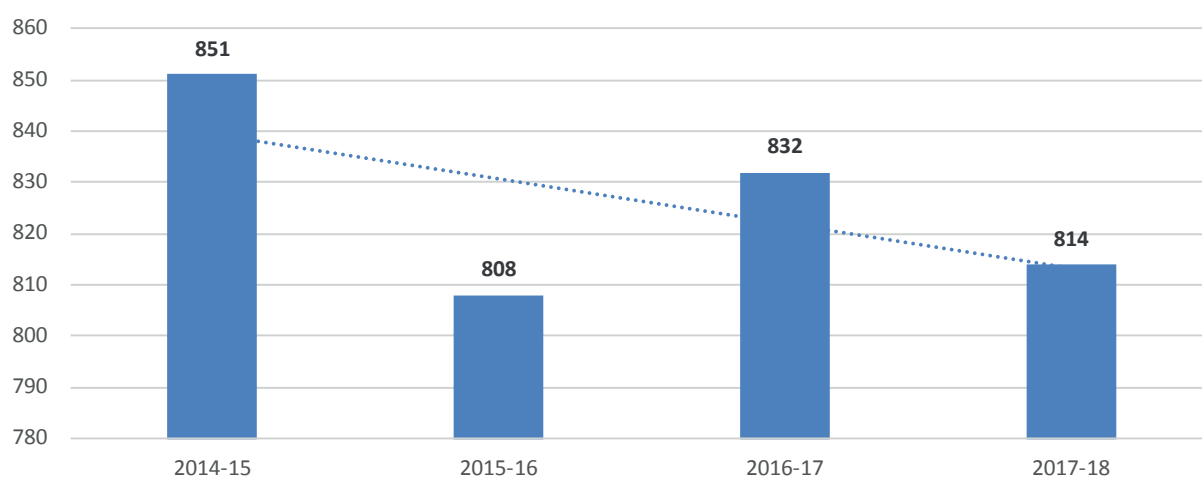
1.2 Our first integrated team, **North Ayrshire Drug and Alcohol Recovery Service (NADARS)**, has continued to demonstrate high levels of performance. NADARS is meeting all national and local standards and targets, such as, access to treatment waiting times, provision of alcohol brief interventions (ABIs),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

People being supported by NADARS, during 2017–18, evidenced:

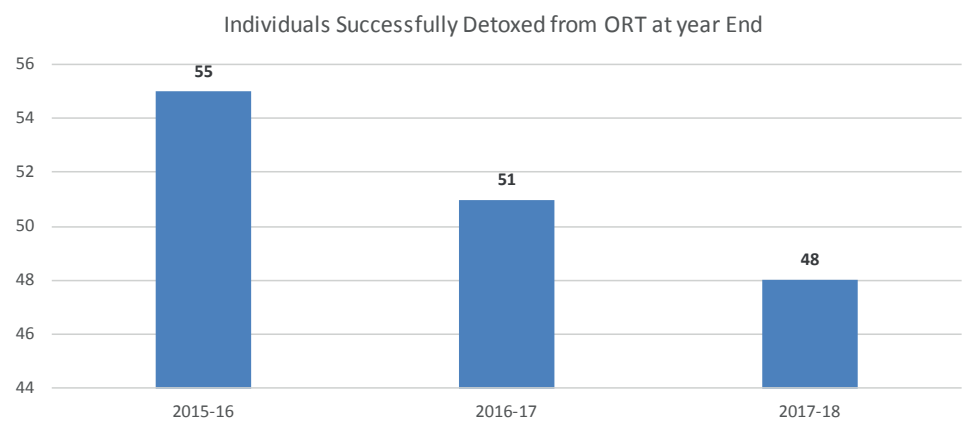
- 82% reduction in alcohol intake
- 67% reduction in non-prescribed drug use
- 61% improvement in physical health
- 60% improvement in physiological health

The positive impact being made can be seen with the downward trend at year end of individuals being prescribed methadone (see graph below) as well as a 14% reduction in the total quantity of methadone being prescribed.

Individuals prescribed methadone at year end



There is also a downward trend in individuals successfully being detoxed from opiate replacement therapies (ORT). NADARS is continuing to identify new ways of working to provide more agile and streamlined service



delivery and further improve performance. A positive example of this work is in the delivery of alcohol brief interventions (ABI):

Scottish Government in priority settings target for Ayrshire and Arran – priority settings	3,419
Delivered by across all ABI settings	3,827
Scottish Government in priority settings target for Ayrshire and Arran – wider settings	856
Delivered by across all ABI settings	3,823

- 1.3 Our Integrated Care funded programme, **Healthy Active Rehabilitation Programme (HARP)**, continues to provide health and wellbeing programmes for people with multiple conditions. Falling or being at risk of falling is identified as a key reason for participants to be referred to HARP. Participants must be identified as having coronary heart disease, history of stroke, COPD, cancer or have had a fall or be at risk of falling. People attending HARP classes benefit from, weight reduction, blood pressure reduction and increase in their general physical activity.

Mr K was recently discharged from NADARS, due to significant recovery progress.

Mr K had previously attended A&E numerous times, with a number of hospital admissions, including at our new addiction facility in Ward 5, Woodland View. Following discharge from Ward 5, Mr K's personal recovery journey has included applying for a place on a peer worker course and volunteering in Glasgow. Mr K talks positively about the benefit of services in helping him to access a wide range of physical and mental health support.

## Case study



**The services and support Mr K received has helped to reduce inappropriate out of hours emergency contact as well as discontinuing antipsychotics and improving his overall recovery capital.**

## 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.

- 2.1 With 2,021 people being provided with **Care at Home** service and 4,500 people receiving a **Community Alert** service, we have worked hard at continuing to provide a high quality service.

Our annual inspection, by Care Inspectorate, graded our care and support as '*very good*'. This is an extremely positive outcome, especially when demand for Care at Home services has increased by 18% from 2016–17.



- 2.2 Our **Care at Home Reablement** service provided people with intensive support from occupational therapists and reablement care at home assistants for up to 12 weeks. This intensive support helps people to regain their skills and independence after an illness or a spell in hospital. Reablement is not suitable for everyone but for those who receive this service, 50% either needed no further care support or had a greatly reduced care package (an improvement from 45.5% from 2016–17).

In 2017–18, 84% of people who received the reablement service rated it as '*excellent*' or '*very good*'.

- 2.3 **Ward 1 and Ward 2, Woodland View** were subject to unannounced HAI (Healthcare Associated Infection) inspections and were complemented on the knowledge of staff and quality of the environment.

## Outcome 3:

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

- 3.1 **Café Solace**, a community café run by volunteers as part of their recovery journey from drug and alcohol misuse, increased attendances to 6,826 during 2017–18, up from 4,745 in the previous year. This increase allowed even more people to make connections in their local communities.



- 3.2 Our **Dirrans Centre**, supporting those who have long-term health conditions, was inspected during 2017–18. The centre was awarded 'excellent' grades across the graded quality themes of, Care and Support, Environment, Staffing and Management/Leadership.

### Case study

Mr T was 44 years old when he suffered a CVA (cerebrovascular accident) in December 2017. He had received rehabilitation at Douglas Grant Rehab and was referred to the Dirrans Centre by occupational therapy. He has right sided hemiparesis (weakness in one side of the body), has difficulty with walking and has cognitive difficulties.

Mr T was in employment in the banking sector prior to his CVA and was keen to return to some form of employment in the future.

At the Dirrans Centre, Mr T identified long term and short term goals including, improving his health and wellbeing, improving his mobility, developing coping strategies to deal with stress and improve his confidence.

He started to participate in the literacy support group to assist with writing with his left hand as well as formulating numbers and initiating words. He is receiving one to one support to improve his walking ability, with the longer term aim of joining the walking group and the walking football group. He is also receiving support with independent travel.

In the wellbeing group, Mr T is learning coping techniques to deal with stress and gets advice about living a healthier lifestyle.

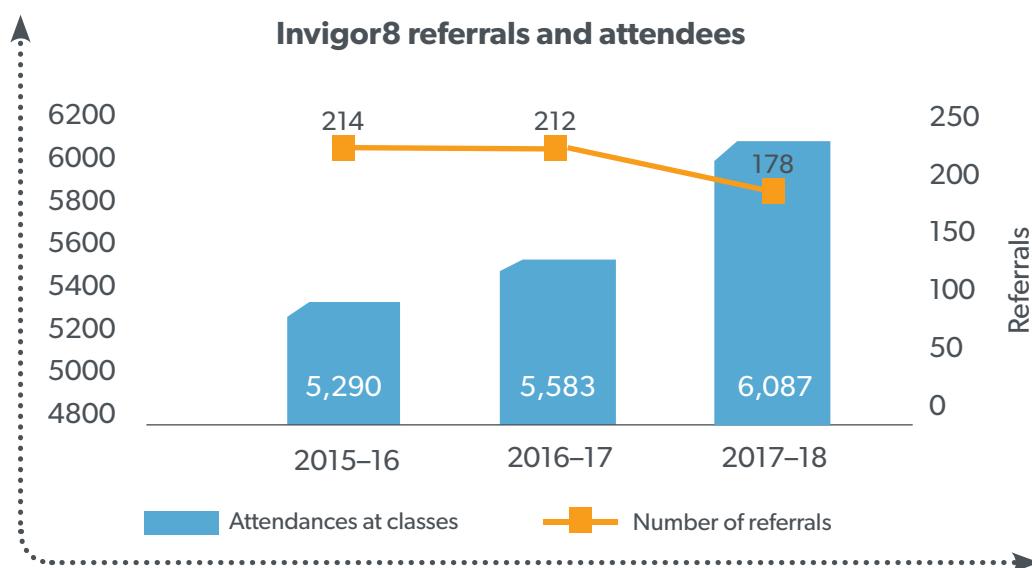
Mr T's situation is an example of good joint working and the benefits of slower rehabilitation.



## 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.

- 4.1 KA Leisure continues to provide the **Invigor8 Falls Prevention Programme**. During 2017–18, 178 people were referred, this is a slight reduction from the previous year (212 people), however, the number of attendances at classes increased to 6,087.



KA Leisure provided eight specific postural stability Invigor8 (PSI) falls prevention classes per week across North Ayrshire, including strength and balance circuit-based classes and chair based exercise classes. The classes take place within the Portal, Irvine and Auchenharvie Leisure Centre, Stevenston.

- 4.2 During 2017–18, capital funding was agreed for the creation of an **additional support needs eight-bedded respite unit and eight-bedded residential unit** for children. These will sit alongside the additional support needs school on the site of Auchenharvie Academy, Stevenson.
- 4.3 We piloted a new initiative for people affected by mental health problems. **North Ayrshire Wellbeing and Recovery College** offers participatory courses that focus on wellbeing and recovery. These courses are open to anyone over 16 years, who lives or works within North Ayrshire. Initially, two courses are offered within each locality. These courses include:
- Living Life to the Full – 8-week course based on cognitive behavioural therapy
  - Crafty Corner – peer-delivered series of six craft workshops
  - It's not what's wrong with me it's what happened to me that matters – trauma informed practice and the science of adverse childhood experiences (ACEs)
  - Stress less! – 4-week course providing tools and exercises to manage stressful circumstances

- Write to Recovery – 4-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 prevention and wellness process that anyone can use to get well and stay well

4.4 We successfully introduced a **befriending service** on Arran (during 2016) to support self-identified socially isolated people within the Arran community.

Building on this work, Arran Community and Voluntary Service (ACVS) secured a small amount of social isolation funding to run two projects.

- Brodick Early Years Centre, worked together with Brodick sheltered housing and Stronach Day Care, allowing four year olds to engage in activities and interact with the older residents and people who use our services. This had a positive impact for the older people, who engaged in the activities and looked forward to the sessions.
- Young people from Arran High School went along to the local sheltered housing in Lamlash. This project was a co-produced by S6 pupils and older residents. ACVS worked with the Partnership to deliver dementia awareness training to the young people and befrienders, with the use of an ageing suit. This gave the young people a significantly improved understanding of the challenges older people face and the realities of ageing.

Both projects have been well received and the intention is to keep both projects running.



## Outcome 5:

### Health and social care services contribute to reducing health inequalities.

5.1 In 2017–18, 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 is once again in excess of £8 million, as it was in 2016–17. Following the promise in our 2015–18 strategic plan that we would work to help people deal with their financial difficulties, we have managed to support people to the value of over £24.5 million (2015–18).



5.2 The Partnership continues to be a key partner in developing and delivering North Ayrshire's **Inequalities Strategy, 'Fair for All'**. We continue as members on the Fair for All Steering Group. In the past year, North Ayrshire Community Planning Partners, including the Partnership, have been developing a robust inequalities measuring tool to identify local areas that are greatly impacted by poverty, deprivation and inequality that could benefit from reallocated investment.

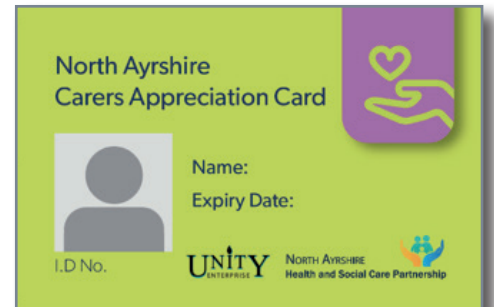
The Partnership is also supporting the 'Fairer Food' agenda. The aim is to improve access to food for families and to reduce the high levels of food insecurity in North Ayrshire. While work in this area is at an early stage, a local food forum has been created – involving local food related businesses; farmers, charities, restaurants – to help identify key priorities for action at the community level. Further, a North Ayrshire food map is under development to help identify areas of high food insecurity and food 'deserts'.

5.3 Our **Sensory Impairment** team experienced a reduction in referrals during 2017–18, receiving 416 referrals compared to 522 in the previous year. The team continues to provide essential assistive supports to residents of North Ayrshire.

## 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.

- 6.1 The uptake of our **Carer Appreciation Card** has resulted in 381 carers registered for a card. There are now 43 local businesses offering discounts and concessions to local carers who present a Carers Appreciation Card.
- 6.2 In preparation for the new Carers (Scotland) Act 2016, we have been working with young carers to develop and pilot a **Young Carers Statement**.



We also listened to feedback from adult carers and invited them to design a **Carers Assessment Tool**. This has been piloted and is now being rolled out to all North Ayrshire carers (from April 2018). North Ayrshire Health and Social Care Partnership will have the only Carers Assessment Tool in Scotland that has been designed by carers for carers.



## Outcome 7:

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

7.1 In 2017–18, the number of **domestic abuse incidents** has reduced after many years of continued increase. The Partnership, working within our Multi Agency Domestic Abuse Response Team (MADART), a significant element of our Multi Agency Assessment Screening Hub (MAASH), that consists of the combined support of Police Scotland, Housing, social workers and third sector organisations Women's Aid and Assist, has helped to better support victims of domestic abuse.

**39%**  
reduction in  
domestic  
abuse  
incidents

7.2 In comparison with last year, the number of individuals referred to **MADART**, who are under 16 years, has decreased by 29% during 2017–18. The number of victim referrals reduced by 39%. Additionally, the number of re-referrals has also reduced by 58% during the year.

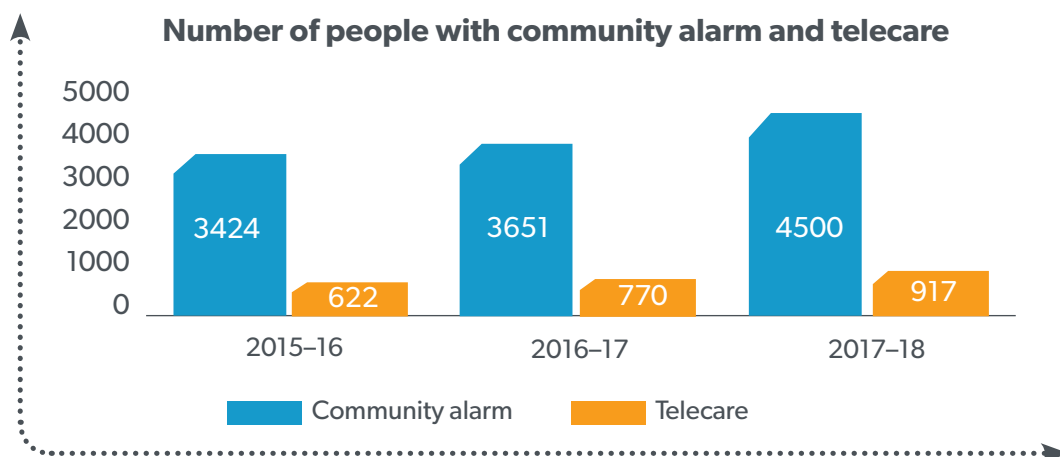
7.3 In 2017–18, the Partnership was subject to a joint inspection of **Adult Support and Protection** services. The Partnership received positive scoring for :

- Outcomes for adults at risk of harm – Good
- Key processes for adult support and protection – Very good
- Leadership for adult support and protection – Very good

During 2017–18, there was a slight reduction in the number of adults at risk of harm referrals to 516 (663 during 2016–17). We held 27 adult support and protection case conferences, putting in place and updating robust and creative, multi-agency protection plans to ensure all adults who require support and protection, have appropriate plans in place.

7.4 In 2017–18, we continued to expand our **Community Alarm** service. Community alarm and telecare equipment enables people to connect, via their telephone, to an emergency call centre. When the call centre is alerted, help can be sent out quickly to ensure people are safe and well.

More people have the equipment and this is making them feel safer and helping them to stay in their own homes for longer.



## 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.

- 8.1 Our second **Partnership Staff Awards** commended the collaborative efforts of our third sector, independent sector, North Ayrshire Council and NHS Ayrshire & Arran staff, including volunteers, all part of North Ayrshire Health and Social Care Partnership.



A judging panel of peers, including previous winners, had the difficult yet rewarding job of reading around 70 inspiring nominations to identify individual and team winners. Around 80 people attended *Breakfast for Champions* awards event to hear about, and celebrate, our everyday heroes, partnership champions, volunteers, innovative teams and trail blazers.

- 8.2 Once again **Partnership staff sickness absence** continues to be a cause for concern. Our three highest causes of absence remain as musculoskeletal issues, stress/anxiety and surgery. We continue to offer supports as early as possible and work with people to find solutions to help them get back to fitness and work as quickly as possible. We will continue to investigate new and innovative means to reduce staff sickness.

# Outcome 9:

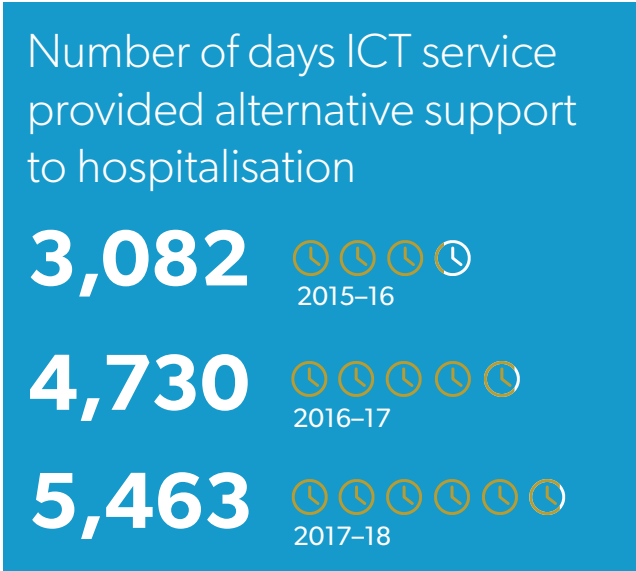
Resources are used effectively and efficiently in the provision of health and social care services.

9.1 We have seen a reduction in **care at home hours lost** during 2017–18, in comparison to the previous year. We have continued to work with our colleagues in acute hospitals to try to reduce the number of cancelled discharges. Together, we still have a great deal of work to do, however, the hours lost due to discharges being cancelled was almost 1,000 hours less than the previous year.

**6,305hrs** lost due to hospital discharges being cancelled

9.2 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 5,463 days of ICT service (during 2017–18) as an alternative to hospitalisation, a further improvement from 2016–17.

Additionally, at the end of March 2018, the team surpassed the target of 90% of newly referred people seen within 1 day of receiving the referral, by achieving 95.6%.



# National Health and Wellbeing Indicators

Scottish Government identified 23 indicators (4 remain in development) that were felt to evidence the nine National Health and Wellbeing Outcomes. Nine indicators come from the biennial Health and Care Experience Survey (*see below*) and the additional 14 indicators (*see page 21*), which evidence the operation of the Partnership, come from NHS Information Services Division (ISD).

The data reported below is based on the information circulated in June 2018.

Health and Social Care Experience Indicators	North Ayrshire 2013–14	North Ayrshire 2014–15	North Ayrshire 2015–16	North Ayrshire 2016–17	North Ayrshire 2017–18	Scottish average	Rank against family group*
Adults able to look after their health very well or quite well	93%		93%		91%	93%	4
Adults supported at home who agreed that they are supported to live as independently as possible	80%		82%		84%	81%	1
Adults supported at home who agreed that they had a say in how their help, care, or support was provided	80%		77%		70%	76%	7
Adults supported at home who agreed that their health and social care services seemed to be well co-ordinated	79%		78%		74%	74%	5
Adults receiving any care or support who rated it as excellent or good	79%		79%		78%	80%	7
People with positive experience of the care provided by their GP practice	85%		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	80%		82%		82%	80%	2
Carers who feel supported to continue in their caring role	39%		43%		39%	37%	4
Adults supported at home who agreed they felt safe	79%		79%		80%	83%	6

\*To support service improvement, 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. We can compare our performance information with other similar areas to enable learning. Rankings are on a scale of 1–8, where 1= best performing, 8=worst performing

North Ayrshire is partnered in its family group with:

- Dundee
- Glasgow
- North Lanarkshire
- Western Isles
- East Ayrshire
- Inverclyde
- West Dunbartonshire

Indicators based on administrative data	North Ayrshire 2013–14	North Ayrshire 2014–15	North Ayrshire 2015–16	North Ayrshire 2016–17	North Ayrshire 2017–18	Scottish average	Rank against family group*
Premature mortality rate (under 75s age-standardised death rates for all causes per 100,000 population)	448	459	484	490		440	2
Rate of Emergency Hospital Admissions for adults (per 100,000 population)	15,089	15,851	15,866	16,249	16,481	11,959	8
Rate of emergency bed days for adults	139,451	141,260	141,398	139,750	149,902	115,518	8
Readmissions to hospital within 28 days of discharge	100	105	107	105	106	97	6
Proportion of last 6 months of life spent at home or in community setting	87%	87%	88%	87%	87%	88%	7
Falls rate per 1,000 population aged 65+	24	21	23	20	24	22	5
Proportion of care services graded 'good' (4) or better in Care Inspectorate Inspections	73.3%	73%	79%	81%	87%	85%	5
Percentage of adults with intensive needs receiving care at home. (all levels of CAH)	64%	67%	67%	49%		61%	5
Number of days people aged 75+ spend in hospital when they are ready to be discharged per 1000 population)	576	663	443	624	1,033	772	7
Percentage of total health and care spend on hospital stays where the patient was admitted in an emergency	26%	26%	26%	26%	29%	23%	8

As well as the National Health and Wellbeing Indicators, we regularly report on local indicators to help us to evidence the nine National Health and Wellbeing Outcomes and also our strategic priorities. The list of indicators can be found in Appendix 1 (see page 56).

From January 2017, the Ministerial Strategy 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. The full list of indicators can be found in Appendix 2 (see page 57).

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



# Children's Outcome 1:

Our children have the best start in life and are ready to succeed.

- 1.1 Our **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 96.6% of all children having their review carried out when it should be, this is an increase of 1.9% from the previously published data. This is a positive achievement for the Partnership and was once again ranked highest in Scotland.

**96.6%**  
of children  
successfully  
reviewed at  
27–30 months

- 1.2 **Breastfeeding** uptake in North Ayrshire is amongst the lowest in Scotland, however, we are progressing in the right direction. This has been demonstrated during 2017–18, with NHS ISD published figures of 16.8% of all mums recorded as breastfeeding at 6–8 weeks, up from 15.8% in 2016.

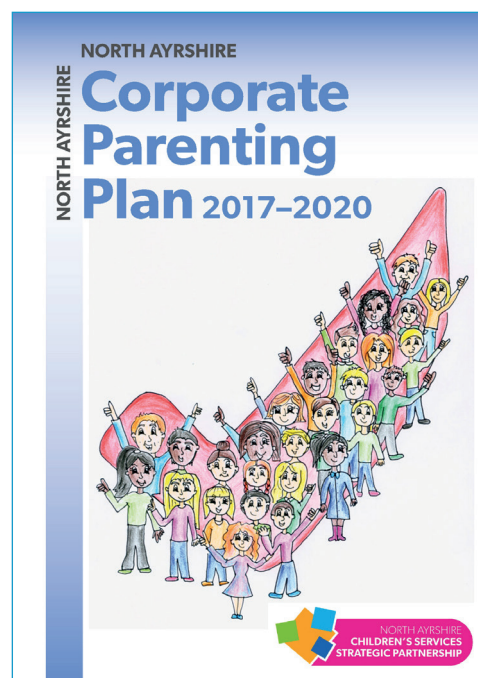


Following a recent assessment, we have been reaccredited as 'Baby Friendly' by UNICEF UK. This award recognises that we are providing high quality breastfeeding support to mothers and babies. We were commended for promoting close and loving relationships between babies and their parents. The assessment recognised that 97% of mothers were 'very happy' with the service and 100% reported that health visitors and family nurses were 'kind and considerate'.

- 1.3 In 2016, the Children's Services Plan, *Getting it right for you*, recognised that **looked after children and young people** need extra support because to their circumstances.

In 2017, more promises have been made in the *Corporate Parenting Plan*, to provide children and young people with the right help at the right time. This will help to ensure that looked after children and young people:

- Receive the right support when they need it
- Have their interests promoted
- Are provided with opportunities to take part in activities designed to promote their wellbeing
- Receive support to access these opportunities
- Receive help to make use of the services and support available to them



- 1.4 Included in our review of **residential accommodation** for looked after and accommodated children, we are focussing on engagement and participation of the children and young people to ensure that they are fully involved and their voices are heard. This work is being carried out in conjunction with the Corporate Parenting Officer and seeks to build young people's confidence and enable them to feel able to participate and contribute and meet their desired outcomes.
- 1.5 We are implementing evidence based models of care to **standardise care practice** across all residential children's houses. One model of care being introduced is the 'Nurture Approach'. This approach is being utilised in all schools across North Ayrshire and is being rolled out within our foster care service: using the same model ensures a unified approach.
- 1.6 **Foster carers** care for children and young people who cannot stay in their family home because it is not safe or they are not thriving. Children and young people can stay with foster carers for a short time or for years, depending on circumstances.

By the end of 2017–18, we had increased our number of foster carers to 103. We welcome new foster carers who can provide a homely, safe place for young people in North Ayrshire.



**103**  
foster carers in  
North Ayrshire



## Children's Outcome 2:

Our young people are successful learners, confident individuals, effective contributors and responsible citizens.

- 2.1 **Throughcare / Aftercare** services support young people who were looked after or accommodated by North Ayrshire Council, in areas of employment, training opportunities, work experience opportunities and education, to enable them to achieve what they want to in life.

We have a dedicated employability co-ordinator who supports young people with opportunities through activity agreements and with external employers offering modern apprenticeships and mainstream employment. Last year, seven care experienced young people were offered modern apprenticeships within North Ayrshire Council.

- 2.2 'Art of the FUTURE', is an art installation project that engages young people to create art from scratch, including young people from the Partnership's **Rosemount project**.

National Galleries of Scotland engaged with 27 groups across Scotland (including Rosemount) and posted each group a mail order art toolkit of disparate materials and equipment. The young people were then encouraged to create an artistic response that revealed their lives and how they see the future. 'Art of the FUTURE' was exhibited at the Scottish National Gallery, Edinburgh from 10 February–29 April 2018.

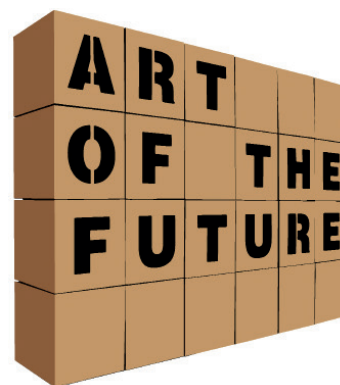
The exhibition will open at the Harbour Arts Centre, Irvine from 3 August –2 September 2018.

The Rosemount team supports young people who are furthest away from employment or further education and, through creative programmes, gives them hope and a purpose that enables the development of skills and confidence to progress towards a positive destination.

- 2.3 Our **Young Person Support** Team (YPST) continues to deliver a range of opportunities to develop young people who are at risk and socially isolated, including Duke of Edinburgh's Award programme. At this year's awards ceremony, six young people received awards; four received bronze awards and two received silver awards. Two more young people are working towards their gold awards. A bronze award recipients also received the Alex Pettigrew Outstanding Achievement Award.

- 2.4 **The CHARLIE programme** (within YPST), continues to achieve local and national recognition for their work with children (aged 8–12 years) affected by parental substance misuse. This unique project works with them to reflect on their life experiences and on how to manage their emotions, share their experiences and cope better with their family situations.

The annual CHARLIE show presents children's experiences and is a celebration of the CHARLIE programme. Stakeholders and parents attended 'Silent Voices' at the Harbour Arts Centre, Irvine to gain an insight into how 15 youngsters had benefitted and are now able to emotionally regulate more appropriately and manage stress more effectively.



## Children's Outcome 3:

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

- 3.1 **Family nurses** continue to work with young mums (19 and under) and their families from early pregnancy until their children are two years old, building on the strengths of their families.

Family Nurse Partnership began, in Ayrshire and Arran, in 2013. From 2013 to the end of 2017–18, we enrolled 145 young mums in North Ayrshire. To date, 115 (79.7%) of the first cohort have graduated and moved on from family nurse support.

- 3.2 Young people who have been looked after and reach a certain age are offered the supports of **Throughcare / Aftercare** services. This team offers both practical and emotional supports enabling those young people to live independently.

### Case study

M, a young person who was in residential accommodation, was referred to the challenge team and throughcare / aftercare services at a time when contact with his family was disjointed and fragmented. M told the workers that he was keen to move back home.

Partnership workers, in both teams, worked to support the young person to ensure that his needs in the family home were met. This included financial support with travel and subsistence when M was residing for extended periods in the parental home.

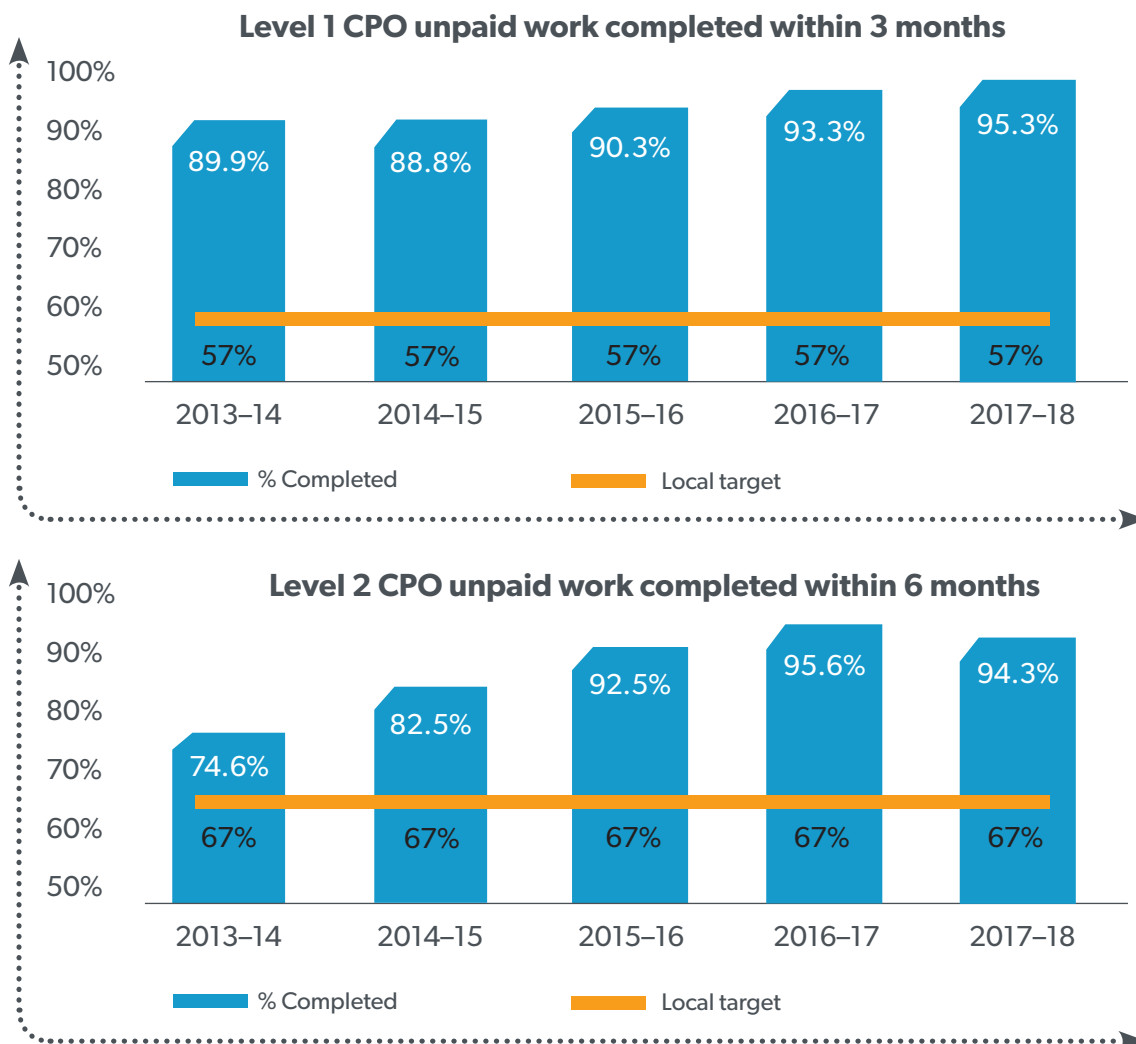


**The challenge team worker engaged with M, including relationship building, support with family issues and working with other services to ensure the smoothest transition possible to enable him to achieve positive outcomes.**

# Justice Service Outcome 1:

## Community safety and public protection.

- 1.1 Our Justice Service continues to have a positive impact on the local community through the **Community Payback Order** (CPO) unpaid work scheme. For the fifth year we have continuously achieved beyond our set targets with CPO level 1 and level 2, with North Ayrshire having 82 CPOs per 10,000 in Scotland.



- 1.2 People completing unpaid work are paying their debt to society by completing a wide variety of tasks that are needed in our local communities. We currently have almost 250 people of all ages and abilities completing unpaid work by doing gardening for the vulnerable and the elderly, house painting and heavy lifting when people are moving house.

The biggest role for the people on unpaid work is supporting North Ayrshire Foodbank. They pick-up the donations from supermarkets and Council buildings and take them to the foodbank centre in Ardrossan. They then carry out deliveries of the allocated food across North Ayrshire.

The sale days held at Smithstone House in Kilwinning are successful with the sale of hanging baskets, garden accessories and furniture. This resulted in a donations of £500 each to Warrior Mums, Kilwinning and Alzheimer's Scotland.

## Justice Service Outcome 2: The reduction of re-offending.

In our Strategic Plan we gave a commitment that our Justice and Youth Justice Services would work closer together to reduce reoffending. Our prevention and early intervention approach is seeing continued positive results being achieved by our continued improvement in our community payback service. Both level 1 and level 2 Community Payback Orders performed well above our regional targets.

## Justice Service Outcome 3:

### Social inclusion to support desistance from offending.

The **Caledonian System** works with men convicted of domestic abuse. The programme, of at least two years, helps them move away from abusive behaviour.

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 2017–18, the team worked with 62 women across Ayrshire and Arran, offering a variety of services and support, from safety planning sessions only, to longer term interventions and support. The team currently have ongoing work with 34 women from North Ayrshire.

#### Voices

[Your worker] went way above and beyond the call of duty. She showed compassion, kindness and practical help that she wasn't required to do. She did it of her own volition. She helped me transition from hospital into my first ever flat and not only helped me herself but put me in contact with others who could help me progress in my life.

[Your worker] made (and continues to make) a huge difference in my life. When I first met her I was at a very low ebb in my life. I was residing in Woodland View due to various suicidal and psychiatric issues. I had been abandoned by literally everyone in my life. I was faced with the prospect of dealing with this world alone, which was scary. But she was always there to lend support which meant a lot.

[Your worker's] only mandate was to ensure I met with her once a week for the term of my CPO. That was literally all she had to do. But she did more, way more, she provided me with both practical and emotional support. She didn't have to do these things but she did out of the goodness of her heart and kindness for others.

The ultimate difference, to be honest, I'm not sure if I would be here if it wasn't for [your worker's] help. I certainly wouldn't have my own flat and be moving forward with my life. She was the one constant rock of support I had during a very trying time in my life.

# 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-fits-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 treatment at the right time.

The six localities are:

- Arran
- Garnock Valley (including Beith, Dalry and Kilbirnie)
- Irvine
- Kilwinning
- North Coast (including Cumbrae, Fairlie, Largs, Skelmorlie and West Kilbride)
- Three Towns (including Ardrossan, Saltcoats and Stevenston)

We have established six locality planning forums (LPFs), whose role is to provide locality based strategic direction to our operational leads. As part of this role, LPFs make best use of local knowledge and information to identify key priorities and needs in their respective localities.

Over the past year, LPFs have made strong contributions to improving health and social care services to people in North Ayrshire. This has included facilitating new developments in localities to support local people, based on identified need, such as:

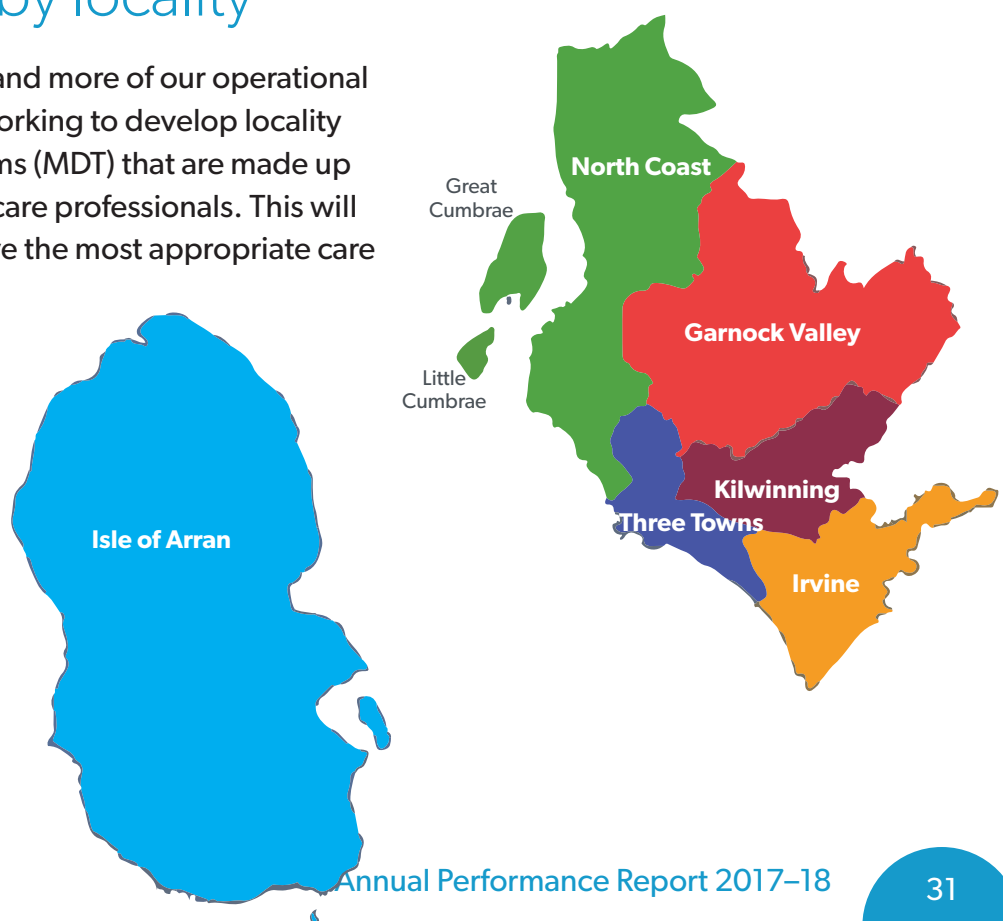
- Promotion of financial inclusion services in the North Coast
- Establishing Café Solace in the Garnock Valley
- Enhancing the befriender service on Arran to help address social isolation
- Providing regular GP presence in Buckreddan Care Home

Localities have also contributed to the development of our new strategic plan for 2018–21, *Let's deliver care together*, as well as working closely with Community Planning Partnership's (CPP) Locality Partnerships to provide a joined up approach to difficult-to-resolve issues in North Ayrshire.

## Achievements by locality

We continue to direct more and more of our operational focus on localities. We are working to develop locality based multi-disciplinary teams (MDT) that are made up of a range health and social care professionals. This will help to ensure people receive the most appropriate care as soon as possible.

Our community link workers continue to operate on a locality basis, working from local GP practices and supporting local people to access community based services to help improve long term health and wellbeing.



# Arran

## *Some key developments*

On the Island of Arran a great deal of work has been completed in bringing services together to ensure a more cohesive health and care service for people living on the island.

In the past year a **single management structure** has been established. This has created a single Arran Partnership team that is communicating well and working to better meet the health and social care needs of the people of Arran. This work has been supported by the Collaborative Leadership in Practice Programme over the past two years. Provided by NES (National Education Scotland) and RCGP (Royal College of General Physicians), the programme brings health and social care teams together to identify ways in which frontline teams can join up services.

Next steps include:

- Creating a clear **single point of contact** for the service that will ensure simpler access to services for local people
- Completing a **strategic assessment for an integrated Arran hub** to enable services to be located in one place.

# Garnock Valley

## *Some key developments*

Over the past year, Garnock Valley Locality Planning Forum (LPF) has enhanced its working relationship with the CPP Garnock Valley Locality Partnership (LP). A result of this closer working is that the LP has adopted the LPFs identified priorities to; reduce social isolation, address low level mental health concerns – particularly for young people, address impact of musculoskeletal issues, and financial inclusion. Sharing these priorities will mean working closer together to improve the lives of people in the Garnock Valley.

In March 2018, supported by the LPF, the Garnock Valley Locality Partnership hosted a **participatory budgeting (PB)** event in Dalry Primary School. At this event local people and community groups were invited to bid for funds up to £1,500 to support projects that would have significant local benefit. All applications had to demonstrate that it would help achieve one of the following:

- Encourage people to be healthy and active
- Bring people together in the community
- Support positive mental health and wellbeing

Over 350 people from the Garnock Valley attended on the day and voted for their favourite projects. There was a great buzz in the venue with people learning about the large range of work being carried out in their local area by volunteers, groups, and individuals. Overall 19 groups were successful in their bids for funding, with many being awarded the full amount of £1,500.



# Irvine

## *Some key developments*

The Challenge Fund initiative enabled the Partnership to think more creatively about ways to enhance services for **children and young people looked after**, or at risk of becoming so. As part of this initiative we have created a team of professionals to deliver focussed support to children and young people who attend Elderbank Primary School and Greenwood Academy, and their families.

Using a multi-disciplinary team approach, the team can draw on a range of specialist knowledge and expertise. This ensures the right support can be provided more quickly, at the right time and in the right place. For young people, this could mean support from mentors to address issues of low confidence and encourage them onto positive outcomes, both educationally and socially. For families, this could mean support with developing routines, implementing parenting structures and advice on housekeeping skills. It is anticipated that this approach will ensure:

- Fewer children will progress through the care system
- Greater educational outcomes for young people, including improved positive destinations
- Improved levels of confidence and resilience for our young people
- More empowered and resilient families

# Kilwinning

## *Some key developments*

As part of Kilwinning's approach to provide better and more responsive **mental health support to children and young people**, a locality wellness model has been set up in the Kilwinning campus. This joint initiative between Child and Adolescent Mental Health Services (CAMHS) and North Ayrshire Education Services will develop a whole system approach of mental health support within Kilwinning.

By the end of 2020, a fully integrated model will ensure children and young people are better supported to develop capacity, confidence and resilience in schools, local communities and built on the key principles of GIRFEC, placing the child, young person and family at the centre of care.

As a result of this work we expect that:

- Every young person with a mental health concern is supported in an environment that is suitable to their needs
- Young people with more complex mental health concerns will be able to access specialist support faster
- Staff will have the knowledge and confidence to support young people and signpost them to appropriate specialist services when required

We hope that every child and young person in Kilwinning will be supported to flourish emotionally.

# North Coast

## *Some key developments*

In the past year a **memory café** has been run, once a month, in Brooksby Medical Centre, Largs. Memory cafés are a great way for people with dementia and their families to meet and interact with others going through a similar experience. They can help maintain or improve the wellbeing of those living with dementia through valued social interaction and can help combat the risk of social isolation.

Initially started by two nursing assistants, the café is run by the Community Mental Health Team. Each month around 30 people attend, including those with dementia and close family members. At each café, community psychiatric nurses (CPNs) take the opportunity to engage with people in a more informal setting. This helps build stronger relationships between people living with dementia, their families and those who provide care. The café is supported by a number of local businesses – they provide free catering and refreshments – and is a great example of business supporting local communities.

To help provide **drug and alcohol recovery** support to people in the more rural areas in North Ayrshire, the Partnership has developed drop-in sessions in local communities. North Ayrshire Alcohol and Drug Recovery Service (NADARS) anonymous drop-in sessions are provided on Cumbrae (and other North Ayrshire localities). This service allows people to access advice and guidance on any drug or alcohol concerns they may have. It provides local people the opportunity to discuss concerns anonymously and receive useful advice and signposting to further supports.

# Three Towns

## *Some key developments*

We are piloting a new opportunity for people affected by **mental health problems to participate in a range of courses that focus on wellbeing and recovery**. The recovery college is part of an educational approach to mental health whereby participants become students and work collaboratively to learn self-management techniques. There is a strong emphasis on peer support.

The courses have been running in venues across North Ayrshire, with the aim of making the pilot accessible within each locality area. In the Three Towns, local people have benefitted from 'Crafty Corner'. This resource includes six sessions (lasting two hours each), each session is delivered by a peer mentor and focusses on a different craft, requiring different skill set, at each session.

South Beach Medical Practice has been a pilot site for a new model to support people with **musculoskeletal (MSK) complaints**. In many cases, people with an MSK concern can effectively self-manage their symptoms through appropriate physical exercise. In these cases, people are more effectively supported by a physiotherapist (as opposed to a GP). In South Beach, a model has been introduced that makes a physiotherapist the first point of contact for people turning up with an MSK complaint, meaning people are given the most appropriate support at the earliest stage.

This pilot is also being run in Largs with the plans to roll out this approach across North Ayrshire GP practices when the pilot is complete.

# 4. Change programme

North Ayrshire took an innovative approach to its first strategic plan by creating a dedicated change team to support Partnership teams to identify, enable and deliver system wide change to local services and improve outcomes for the people of North Ayrshire.

Since 2015, the change team and transformational change programme has enabled 36 projects across the Partnership. This work has (to date) generated an additional £3.378 million investment, saved an estimated £1.192 million and generated costs avoidance (of an estimated £1.299 million) via work to better manage demand.

# Some of our achievements in 2017–18:

## Communities

- Engaging with 2,500 local people through participation in the international 'What Matters to You?' day on 6 June 2017
- Expanding Café Solace into the Garnock Valley
- Rolling out additional Community Link Workers to 19 GP practices across North Ayrshire



## Health and Community Care Services

- Developing an integrated service model on the island of Arran, including GP, social work and care at home.
- Developing a pan-Ayrshire business case for intermediate care and rehabilitation supporting local people to stay at home, or homely environment, for as long as they choose
- Reviewing our process for adaptations – ensuring simpler, faster and more effective service, including partnership working with housing colleagues
- Engaging with residents and staff on Cumbrae, to review health and social care services on the island – first step to developing a fit-for-purpose on island hub
- Piloting a new way of providing intermediate care beds for people who are medically fit to leave hospital and would benefit from additional support before returning home

### INTERMEDIATE CARE REHABILITATION



## Children, Families and Justice Services

- Enhancing our Universal Early Years Team to include, social work, health visiting, speech & language therapy, Money Matters, mental health nursing, assistant nurse practitioners and family nurturers
- Creating a dedicated challenge team to consider creative ways to enhance the services we provide to young people who are looked after and accommodated, or at risk of being so
- Reviewing services for children who are accommodated outwith North Ayrshire, changing the model of care to enable those children to move back in area, to a safe and stable environment
- Expanding our MAASH service at Kilmarnock Police Station to include an additional social worker to support police with adult concerns referrals

# Mental Health and Learning Disability Services

- Establishing North Ayrshire Wellbeing and Recovery College for people affected by mental health problems to participate in a range of supportive courses
- Woodland View becoming an award winning (EHD 2017 awards, Mental Health Design winner) facility providing older people's rehabilitation as well as dementia, mental health and addiction services for people across Ayrshire and Arran
- Implementing computerised cognitive behavioural therapy (cCBT)
- Developing a business case for supporting secure adolescent inpatient services
- Beginning a complex process of redesigning overnight supports to people with a learning disability, including successful delivery of a pilot in partnership with a local provider
- Delivering on a redesign of respite provision in learning disability services
- Continuing to engage with staff and services on transition of learning disability day services to a new site at Tarryholme Drive, Irvine

## Our change programme

**36 projects generated**

**£3.378 million investment, generated £1.299 million cost avoidance, saved £1.192 million**



# 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**

has lead responsibility for allied health professions (AHPs), continence, technology enabled care (TEC) and falls prevention.

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](http://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](http://www.south-ayrshire.gov.uk/health-social-care-partnership/partnershipperformance.aspx))

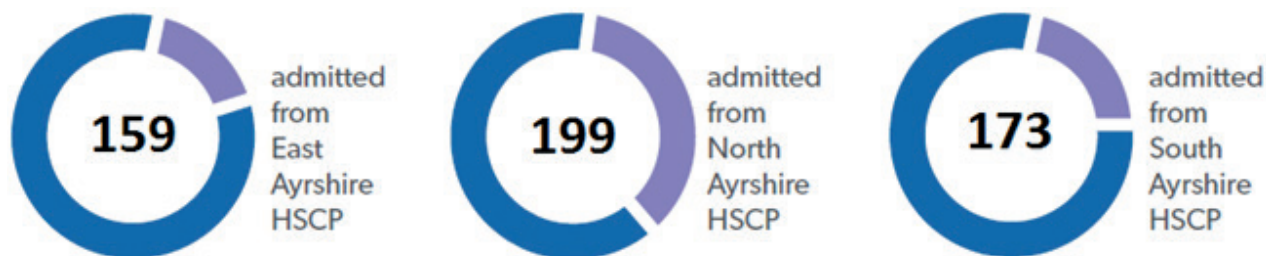
# Mental health services



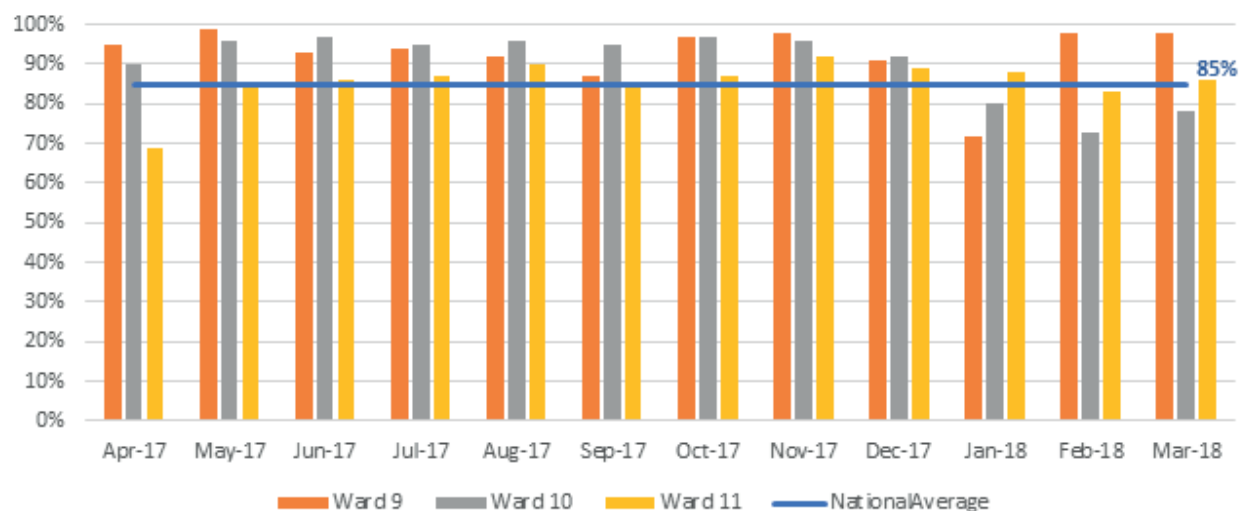
We want to see a nation where mental healthcare is person-centred and recognises the life-changing benefits of fast, effective treatment

– Mental Health Strategy, 2017–2027

- Since opening in May 2016, **Woodland View** has been recognised as an award winning community facility, in terms of design and positive impact on patient care. The Mental Welfare Commission provided positive feedback from their announced and unannounced visits. **Ward 6** (low secure) has been recognised nationally as an area of progressive and innovative practice. **Acute inpatient activity** saw 531 admissions to acute wards (159 from East Ayrshire, 199 from North Ayrshire, 173 from South Ayrshire). This is a further reduction from the previous year of 605 admissions.



Admissions to acute **Wards 9, 10 and 11** are for people who requiring specialist supports. Our performance is monitored against the national average, which is seen as the optimum level of performance. For 2017–18, this was 80% bed occupancy.



During 2017, additional funding was secured to appoint additional positions of liaison/mental health advanced nurse practitioners, a consultant for low secure and adult acute inpatient and ward 5 services. These appointments have resulted in the provision of urgent 24/7 psychiatric assessment, 365 days per year. A new simplified referral process is effective in avoiding unnecessary admissions to the psychiatric inpatient setting.



- Our **student mental health and wellbeing liaison officer** practices in all Ayrshire colleges. 140 mental health workshops have been held with over 1,500 students in attendance. The workshops have been supplemented with the development of an online resource, a mental health hub, which has had over 1,600 views since launch in September 2017. Early indications are positive with a improvement in the early withdrawal rates: In the first year of this role, 2017–18, the early withdrawal rate due to mental health issues has dropped over 4%.

## Mental health workshops evaluation:

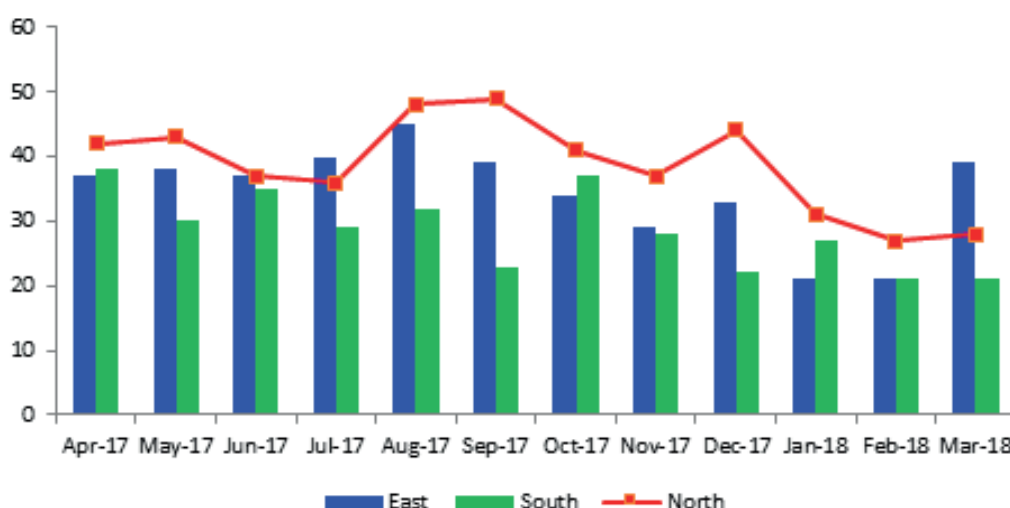
914 evaluations

781 students responded positively



It's good to know that there are things that I could try if I am feeling stressed, anxious and overwhelmed.

- Our **alcohol and drug liaison officer** also practices in all Ayrshire colleges. During academic year 2017–18, 136 workshops were delivered to 1,587 students. 78% of students returned feedback forms, 91% would recommend the workshop to others. Additionally, 50 alcohol/drug brief interventions were delivered to students.
- **Crisis Resolution Team (CRT)**, a service that provides a community based alternative to inpatient admissions, received 1,239 referrals. This is a 5% decrease from the previous year, however, this is due to a reduction of referrals from East and South Ayrshire. Of all the assessments carried out, only 6% required a person to be admitted to hospital, with the remaining 94% being provided with community based support. In 2017–18, CRT piloted a new pathway, with Police Scotland in the out of hours period (7pm–9am), looking to prevent the need for police to attend the Emergency Department (ED) when they have concerns regarding an individual's mental health. On average 31 unnecessary attendances per month have been prevented and individuals have been able to access the correct support in a more timely manner. CRT is now being maintained as an essential core service.





- Our **Child and Adolescent Mental Health Service** (CAMHS) continues to provide essential supports to children and young people including: psychiatry, psychology, nursing, speech and language therapy, occupational therapy and psychotherapy. As at March 2018, 96% of 1,379 children/ young people had commenced treatment within the 18 week requirement.



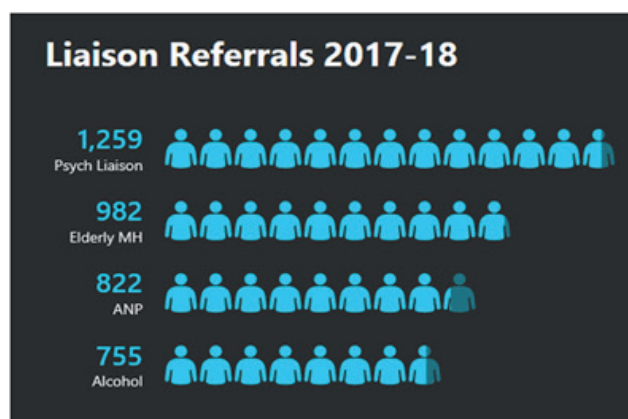
CAMHS in Ayrshire and Arran have embarked on a redesign to achieve a whole system model of mental health support.

In South Ayrshire, Dalmilling Primary has set up a Wellbeing Community with the help of CAMHS. As part of developing the whole system approach CAMHS and education colleagues in East Ayrshire are joint funding a post through the pupil equity fund (PEF) providing a unique opportunity to develop school based support and intervention.

In North Ayrshire, a joint proposal has been submitted to the Scottish Government by CAMHS and North Ayrshire Education in order to develop a fully integrated approach aligning specialist child and adolescent mental health teams with initiatives, in partnership with North Ayrshire schools and other parts of the community. By the end of 2020 it is anticipated there will be a fully integrated model of delivery to children and young people, developed capacity, confidence and resilience in schools, local communities and built on the key principals of GIRFEC, placing the child, young person and family at the centre of care. Scottish Government are keen to use the practice model, following evaluation, as a template for service redesign across Scotland.

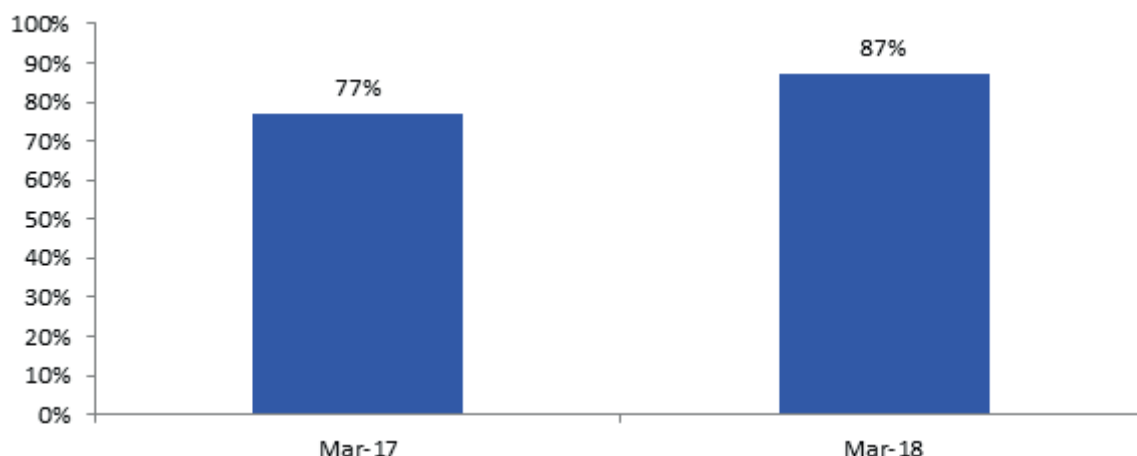
CAMHS, in Ayrshire and Arran, has been recognised locally, nationally and internationally for striving to redesign a whole systems approach that many others would like to achieve.

- The **Liaison Service** responds to referrals and requests to assist in the management of patients who are presenting with psychological, psychiatric or alcohol problems. The service provides psychosocial assessment, advice on management and acts as the referring agent for psychiatric follow up as appropriate. Acute Care Quality standard 23 requires, 'single call access for mental health referrals to be available 24 hours a day, seven days a week with a maximum response time of 30 minutes'.



During 2017–18, the psych liaison average response time to the ED, at University Hospital Crosshouse, was 30 minutes.

- **Psychological Services** continue to work towards the 18-week minimum standard.



Several of the fourteen specialist teams in areas of mental and physical health are achieving and sustaining optimum access for residents of Ayrshire and Arran. NAHSCP undertook a full review of Ayrshire-wide psychological services to better understand the challenges and constraints to delivery and outcomes and improvement measures are being implemented throughout 2018.

## Voices

*I have been impressed with (clinician) unchanging positive belief in me. I find it remarkable that someone can have the same caring supportive attitude session after session, year after year.*

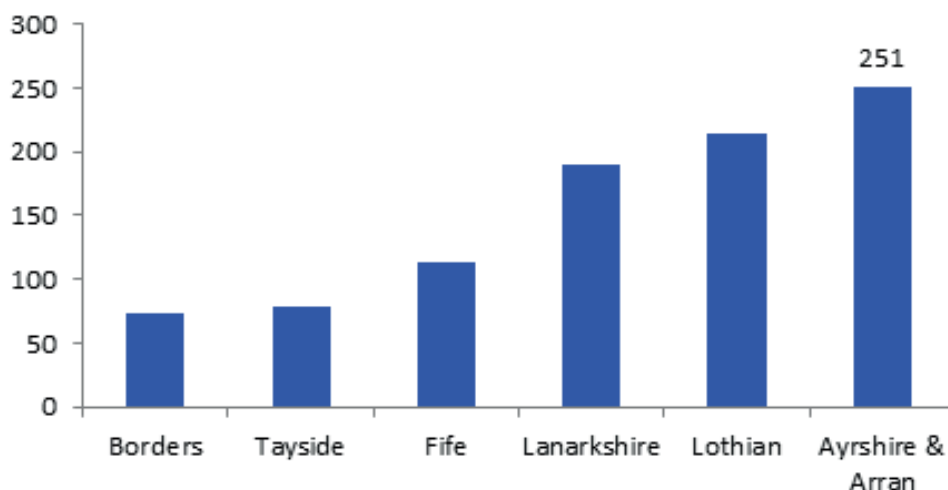
*Thank you so much for all your help and advice. You have given me the tools to make my life easier and to realise that I do count.*

*I want you to know that for the first time in such a long time, possibly ever, I now actually want to grab life with two hands and start living.*

*Thank you for your kindness and compassion, for giving my secrets a soft place to fall, for never showing disgust, disappointment or anger, for being supportive and hopeful.*

- **Veterans 1st Point**

(VIP) Ayrshire and Arran opened its doors in February 2017 and is one of six national centres. VIP acts as a signposting service to help veterans access appropriate mainstream services and/or to point them in the right direction of



specialist organisations. There is also a small in-house provision to see veterans for psychological assessment and evidence based psychological treatments.

During 2017–18, the service received the highest number of referrals within Scotland, despite only being open for 14 months.

## VIP voices

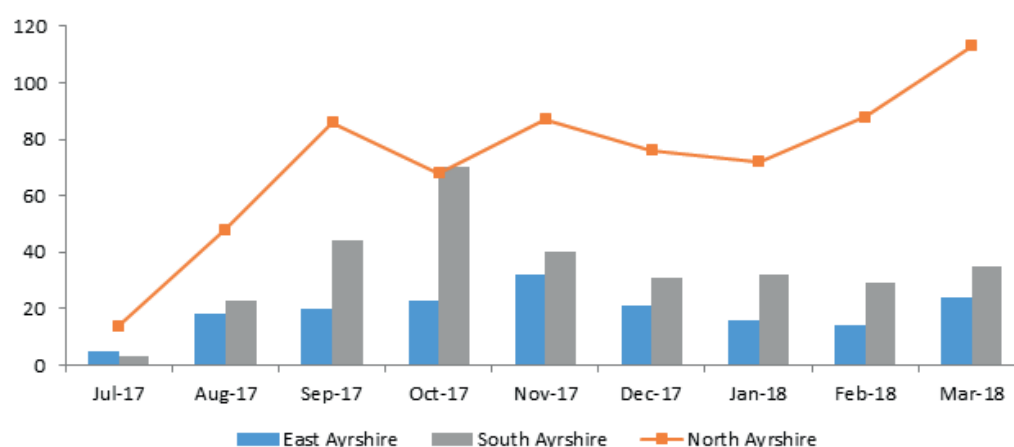
*Hi there*

*I'm writing to you with regards to the invaluable service that VIP provides.*

*I'm an ex serviceman and am currently getting help from the Irvine branch. I can't put into words how helpful and professional the staff are towards myself. The help they give me is amazing and I'd be in a very bad place had it not been with them helping me. I truly hope that this service will be a permanent thing as ex servicemen and women really need this and there would many of us living rough etc without it. Please thank all the staff involved for all there excellent help and assistance.*

*To [support worker] and all the team at VIP,  
Thanks very much for all your support and  
guidance in the last four months.*

- **Beating the Blues** has been proven to help people suffering with mild and moderate depression to get better and stay better. Beating the Blues is based on cognitive behavioural therapy (CBT) that helps people to learn to cope with anxiety and depression. Beating the Blues has been recommended by the National Institute for Health and Clinical Excellence (NICE). Independent research has shown that cCBT (computerised CBT) works by teaching practical, lifelong skills to help people feel better and stay better. Following the implementation of cCBT in June 2017, 1,015 referrals were received with 43 people completing the course, and 71 completed 5 of the 8 sessions to the end of 2017–18. During these sessions, 70 individuals were identified with suicide alerts.



- Following a three year pilot project, the **Foetal Alcohol Advisory and Support Team** (FAAST) are delighted to announce plans to continue their work in Ayrshire and at a national level, having secured three years grant funding. The learning gained from the Ayrshire pilot has led to eleven abstracts from FAAST being accepted to the European Foetal Alcohol Spectrum Disorders Conference. Presentations include three posters, six parallel talks and two plenary talks. The project recently featured on the STV news and was been mentioned during a recent parliamentary discussion as having, 'proven its worth, including cost effectiveness, and is offering this liaison service across Scotland'.
- **Learning Disability Service** continues to collaborate with a broad range of partners and is facilitated by strong joint working with a wide range of staff. The Assessment and Treatment Unit at Arrol Park has been undertaking an extensive process of examining its activity in the context of the Standards for Adult Inpatient Learning Disability Services, developed by the Royal College of Psychiatry. This work has been used to shape existing activity and support processes, as well as informing the future delivery of the service. Work has also been started around delayed discharges, which will ensure that these are addressed in a consistent and timely manner.

## Case study

Miss M was referred to the Learning Disability Team, as she moved into adult services, with a range of issues, including social isolation due to problem behaviours. The team as unaware of Miss M's abilities. Miss M's mum was her main source of support.

With the involvement of nursing and occupational therapy, the team looked at the needs of Miss M and her family. They supported Miss M to develop her social skills and confidence, she became involved in a range of groups, including exercise and wellbeing groups. Miss M's mum was supported to join a Wellness Recovery Action Planning Group®, which helped her to identify her personal goals and ways to manage her own wellbeing. This helped her, but also the family as a whole. With support from social work, the family looked retaining a personal assistant for Miss M, which led to another family member being employed in this role.



**Miss M continues to develop her skills and involvement in community groups. This has included lots of support around independent travel, which has enabled Miss M to reduce her reliance on her mum for getting around.**

**Miss M wants to get a job, and live in her own place; the team have helped her to submit an application for housing.**

**She enjoys time to herself, and has shown that she has the skills to live independently with support, and to help others. The occupational therapist, learning disability nurse, psychiatrist, dietitian, and social worker have all helped with this, through focusing on nurturing the strengths of M and her family, and empowering them to identify and work towards new goals.**

## Child health service

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, meningitisACWY, and measles, mumps and rubella (MMR).  
In North Ayrshire this programme is offered to 7,670 pupils between the cohorts of S1 to S6 and to 20,343 pupils throughout Ayrshire. The annual influenza vaccine is offered to 10,595 North Ayrshire pupils from Primary 1 to 7, and to 27,941 pupils throughout Ayrshire.
- 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 23 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 the highest quality of rigour.

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 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 we gather helps us to see how services are performing and ensures services are safe, effective and most of all, that they meet people's needs.

REGISTRATION TYPE	Number of services	Average grade: Quality of care and support	Average grade: Quality of environment	Average grade: Quality of environment	Average grade: Quality of management
ADULT PLACEMENT SERVICE	1	5	N/A	5	5
CARE HOME SERVICE					
• Children and young people	1	5	5	5	5
• Learning disability	2	5	4.5	4.5	4
• Mental health	2	4.5	3.5	4.5	4
• Older people	19	4	4	3.9	3.8
HOUSING SUPPORT SERVICE	10	4.4	N/A	4.3	4.4
SCHOOL CARE ACCOMODATION SERVICE					
• Residential Special School Support	7	4.1	4.4	4.3	4.3
CARE AT HOME	20	4.7	N/A	4.5	4.4
<b>Average grades (all services)</b>		<b>4.6</b>	<b>4.3</b>	<b>4.5</b>	<b>4.4</b>

# Care services provided by Partnership teams

The services that the Partnership provides undergo inspection from the Care Inspectorate. In 2017–18, 15 internal services were inspected, 1 scheduled and 14 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 Dirrans Centre
- ‘Excellent’ grades awarded to Supported Carers Scheme
- ‘Very Good’ grades awarded to Care at Home service
- ‘Very Good’ grades awarded to Community Alert service

## Children and family services

	CARE INSPECTORATE NUMBER/ INSPECTION DATE	QUALITY THEME = CARE GRADES (OUT OF 6)
Abbey Croft, Kilwinning	CS2003001163 26 June 2017	Support = 5 Environment = N/A Staffing = N/A Management = 5
Abbey Croft, Kilwinning	CS2003001163 12 March 2018	Support = 3 Environment = N/A Staffing = N/A Management = 3
Achnamara, Saltcoats	CS2007142322 10 November 2017	Support = 3 Environment = 4 Staffing = 4 Management = 3
Canmore, Kilwinning	CS2003001160 24 April 2017	Support = 4 Environment = 4 Staffing = 4 Management = 5
The Meadows, Irvine	CS2007142325 26 June 2017	Support = 4 Environment = N/A Staffing = 5 Management = N/A

## Adult services

Supported Carers Scheme	CS008168320 4 May 2017	Support = 6 Environment = N/A Staffing = 5 Management = N/A
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Older people services		
	CARE INSPECTORATE NUMBER/ INSPECTION DATE	QUALITY THEME = CARE GRADES (OUT OF 6)
Anam Cara, Kilbirnie	CS2008177877 16 October 2017	Support = 4 Environment = N/A Staffing = N/A Management = 4
Dementia Support Services	CS2012306108 24 October 2017	Support = 5 Environment = N/A Staffing = N/A Management = 3
Dirrans Centre	CS2003001135 6 October 2017	Support = 6 Environment = 6 Staffing = 6 Management = 6
Gowanlea Day Services	CS2003017637 13 April 2017	Support = 5 Environment = N/A Staffing = 4 Management = N/A
Irvine & Garnock Valley Care at Home	CS2008192553 28 March 2018	Support = 5 Environment = N/A Staffing = N/A Management = 5
Montrose House, Arran	CS2003001167 31 October 2017	Support = 4 Environment = 5 Staffing = 3 Management = 4
Montrose House, Arran	CS2003001167 5 March 2018	Follow-up inspection from 31 October 2017. Grades not reported.
Stronach Day Service, Arran	CS2003034609 5 May 2017	Support = 4 Environment = N/A Staffing = 4 Management = N/A
Three Towns & Arran Care at Home	CS2008192560 28 March 2018	Support = 5 Environment = N/A Staffing = N/A Management = 5

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 2018, 83.3% of North Ayrshire HSCP inspected services were graded 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 Integration Joint Board (IJB). This section summarises the main elements of our financial performance for 2017–18.

# Partnership revenue expenditure 2017–18

The **year-end position was a £3.533 million overspend** (£2.562 million Council plus £0.971 million NHS). This was after one-off funding of £1.4 million (via Council Challenge Fund – see page 52) to alleviate the impact of mitigating actions on service delivery and £1.130 million investment from NHS for prescribing. The NHS agreed to increase the funding to the IJB by £0.971 million to bring their element on-line resulting in a final overspend of £2.562 million.

During the year, mitigating action was taken to reduce the projected overspend by £1 million, including:

- Savings delivered from challenge fund projects
- Review of learning disability care packages
- Review of mental health care packages
- Spending freeze on non-essential non-payroll spend that was not linked to care
- Reduction in overtime
- Review of management and support functions
- Review of equipment budget – waitlist new clients based on need
- Delay in recruitment of care at home staff

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

**(Fav)** is an underspend against budget (favourable)

**Adv** is an overspend against budget (adverse)

The **main areas of pressure** continue to be looked after and accommodated children, learning disabilities care packages, elderly and adult in-patients within the lead partnership and the unachieved NHS Cash Releasing Efficiency Saving (CRES) savings.

Health and Community Care Services	Mental Health and Learning Disability Services	Children, Families and Justice Services
Care home and care home respite placements Woodland View, Ward 1 reablement 	Learning disability care packages Adult and elderly inpatients Non-achieved savings 	Residential schools Fostering and kinship Non-achieved savings 

A combination of the 2018–19 budget settlement, Challenge Fund projects and continued management action will address the looked after and accommodated children and learning disability care packages in 2018–19. There is ongoing work around the elderly and adult in-patients which will reduce the overspend.

The deficit of £2.562 million solely relates to social care and will be carried forward. Added to the £3.245 million deficit brought forward from 2016–17, results in a cumulative deficit of £5.807million, which requires to be repaid to North Ayrshire Council in future years.

## Partnership Challenge Fund

North Ayrshire Council, during the 2017–18 budget setting process, approved the development of a Challenge Fund. This innovative approach was an ‘invest to change’ programme, and has attracted attention of Scottish Government.

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

However, during 2017–18, the IJB approved use of £1.4 million of the Challenge Fund to alleviate the impact of mitigation action on frontline services:

- £0.977 million was allocated to care home placements
- £0.423 million to learning disability care packages

Therefore leaving £2.6 million for Challenge Fund projects.

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

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

A number of areas have been implemented or are programmed as outlined:



## Financial outlook, risks and plans for the future

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

In March 2017, the IJB approved the first **medium term financial plan**. The plan is being refreshed and will provide an update, to the IJB, of the financial challenges facing the Partnership. The plan needs to articulate clearly the service change and savings required to ensure financial balance can be achieved in a planned way, to enable the Partnership to achieve its objectives.

The Partnership will continue to face **high levels of demand for services**, however, it is fundamental that services are commissioned within the resources made available and this will be the highest priority during 2018–19. Looking ahead, most of the key indicators suggest little possibility of a strong bounce back in economic prospects in the near term. Despite this backdrop, employment and unemployment continue to perform better than expected and are low by historic standards.

NHS Ayrshire & Arran and North Ayrshire Council delegate funding to the IJB. The IJB then decides how to use resources to achieve the objectives in the strategic plan. There is continued pressure on public sector funding that impacts on the funding available for the Partnership, there are challenges from both the local government and health perspective in terms of overall funding and pressures. These include funding being allocated in line with the priorities of the Scottish Government with the relative protection of some services over others, the implementation of new policy initiatives, the alignment of additional funding against national priorities and the wider policy implications, including the lifting of the public sector pay cap.

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

Impact of budgetary pressures	Delivery of the change programme	Culture and practice
<b>Mitigation</b> <ul style="list-style-type: none"> <li>• Medium term financial plan</li> <li>• Strategic plan</li> <li>• Change programme</li> <li>• Challenge Fund</li> <li>• Active demand management</li> </ul>	<b>Mitigation</b> <ul style="list-style-type: none"> <li>• Change programme steering group</li> <li>• Programme leads</li> <li>• Strategic Planning Officers Group (SPOG)</li> <li>• Change programme risk register</li> </ul>	<b>Mitigation</b> <ul style="list-style-type: none"> <li>• Challenge Fund phase 2</li> <li>• Multi disciplinary teams</li> <li>• Families First</li> <li>• Organisational development plan</li> <li>• Engagement surveys</li> </ul>

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

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

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

Most importantly, the **Partnership must work more closely with local people** and maximise the use of existing assets within communities to improve the overall health and wellbeing of local people.

This is our **third year** as an integrated health and social care partnership. It has been both challenging and rewarding. Our significant transformation programme will continue into 2018–19 with delivery of the Challenge Fund projects and service redesign.

The IJB has a deficit of £5.807 million, as it moves into 2018–19. This presents us with a number of challenges, however we are clear that the deficit will need to be recovered over the medium term to deliver financial sustainability for the Partnership. **The IJB recognises it must deliver services within its financial envelope for 2018–19.** The scale and pace of change requires to be accelerated. This will be challenging, so, while the potential for improvement over the next year is significant, we will need to ensure plans are staged to ensure sustainability and deliverability.

## 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 accounts to, engages with and leads 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.

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.

## Spend in localities

The Partnership has arrangements to consult and involve localities via locality planning forums. They provide IJB board members with the opportunity to be involved in considering priorities for specific areas and outline the role of each community planning partner in meeting priorities with local communities.

This spend has been split into localities by initially allocating spend that 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 percentage of 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 of analysis will continued to be developed.

The population information used is given below and was taken from 2016 mid-year population statistics ([www.statistics.gov.scot](http://www.statistics.gov.scot))





















Age group	Irvine	Kilwinning	Three Towns	Garnock Valley	North Coast	Arran	TOTAL	% of spend allocated on this basis
Children (age 0–15)	30.3%	13.1%	25.5%	14.7%	13.8%	2.4%	100%	12.3%
Adults (age 16–64)	29.8%	12.2%	24.7%	15.2%	15.1%	3.0%	100%	20.4%
Older people (age 65+)	25.5%	10.1%	21.9%	13.9%	23.7%	5.0%	100%	12.4%
Share of total population	29.0%	11.9%	24.2%	14.8%	16.7%	3.3%	100%	11.9%
Total allocated on population basis								57%
By locality								43%
Total								100%

This resulted in the following spend per locality:

	Irvine £000s	Kilwinning £000s	Three Towns £000s	Garnock Valley £000s	North Coast £000s	Arran £000s	TOTAL £000s
2017–18 expenditure	61,155	23,282	63,393	31,626	38,912	12,746	231,114
% share of spend	26.5%	10.1%	27.4%	13.7%	16.8%	5.5%	100.0%
% of total population	29.0%	11.9%	24.2%	14.9%	16.7%	3.3%	100.0%



# Appendix 1: Local indicators

Performance indicator	2015–16	2016–17	2017–18	Target	Status
People subject to level 1 Community Payback Order (CPO) unpaid work completed within three months	90.32%	93.37%	95.33%	57%	
Individuals subject to level 2 Community Payback Order (CPO) unpaid work completed within six months	92.45%	95.63%	94.27%	67%	
Number of learning disability service users in voluntary placements	78	71	67	43	
Number of bed days saved by Intermediate Care Team (ICT) providing alternative to acute hospital admission	3,082	4,730	5463	3,060	
People seen within 1 day of referral to ICT	82.1%	98.5%	95.66%	90%	
Care at home hours lost due to cancelled hospital discharges (shared target with acute hospital services)	3,657	7,153	6,305	4000	
Number of people receiving care at home	1,839	1,715	2021	1,703	
Number of secure remands for under 18s	5	1	0	5	
Addictions referrals to treatment within 3 weeks (alcohol)	96.5%	94%	95%	90%	
Addictions referrals to treatment within 3 weeks (drugs)	96%	95%	98%	90%	
Children completing 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)	93%	95.53%	96.1%	92.2%	
Preschool children protected from disease through % uptake of child immunisation programme (MMR1)	97.8%	96.21%	96%	98.2%	
Uptake of Child Flu Programme in schools	75.4%	75.25%	74.7%	72.1%	
Number of people attending Café Solace	3,621	4,745	6,826	4,000	
Number of volunteers working with Café Solace	27	22	24	30	
Number of unique individuals (under 16 years) referred to MADART	708	776	551	Data only	
Number of re-referrals to MADART	91	89	37	Data only	
Number of victim referral incidents to MADART	597	601	365	Data only	
People indicating an improvement in their holistic strengths-based recovery	61.22%	50%	59%	Data only	



## Appendix 2: 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	2015–16	2016–17	2017–18	Target	Status
Emergency admissions to acute hospitals	1,702	1,840	1,763	1,836	✓
Emergency admissions to acute hospitals (rate per 1000)	12.5	13.6	13	13.6	✓
Admissions from emergency department	1,607	1,202	1,131	1,173	✓
Admissions from emergency department (rate per 1000)	11.8	8.9	8.4	8.7	✓
% people at emergency department who go onto ward stay (conversion rate)	40	36	34	33	✗
Unscheduled 'hospital bed days' in acute hospital	10,474	12,333	8,798	12,320	✓
Unscheduled 'hospital bed days' in acute hospital (rate per 1000)	76.5	91	65	91	✓
Unscheduled 'hospital bed days' in long stay mental health hospital	6,538	6,782	5,866	6,782	✓
Unscheduled 'hospital bed days' in long stay mental health hospital (rate per 1000)	48.1	50	43.3	50.1	✓
Unscheduled 'hospital bed days' in geriatric long stay	1,967	1,665	1,454	1,772	✓
Unscheduled 'hospital bed days' in geriatric long stay (rate per 1000)	14.5	12.3	10.7	13	✓
Emergency department attendances	3,988	3,385	3,292	3,292	✓
Emergency department attendances (rate per 1000)	29.3	25	24.3	24.4	✓
% people seen within 4 hrs at emergency department	91.9	91.4	88.5	95	✗
Delayed discharges bed days (all reasons)	604	781	1,889	1,515	✗
Delayed discharges bed days (all reasons) (rate per 1000)	5.5	7.1	17.3	13.9	✗
Delayed discharges bed days (code 9)	181	308	279	770	✓
Delayed discharges bed days (code 9) (rate per 1000)	1.6	2.8	2.5	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/](http://www.nahscp.org/partnership-strategies-plans-reports/)
- [www.nhsaaa.net/about-us/how-we-perform/](http://www.nhsaaa.net/about-us/how-we-perform/)
- [www.north-ayrshire.gov.uk/council/strategies-plans-and-policies](http://www.north-ayrshire.gov.uk/council/strategies-plans-and-policies)
- [www.north-ayrshire.gov.uk/council/performance-and-spending](http://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](http://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](http://www.south-ayrshire.gov.uk/health-social-care-partnership/strategy.aspx)

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