

# Let's deliver care together

**Strategic Plan  
2018–21**



**Delivering care  
together**



**North Ayrshire  
Health and Social Care**



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# Foreword

It is with great pleasure that I share our new North Ayrshire health and social care strategic plan 2018–21. It is designed to build upon the progress that has been made to date and lays out our key strategic priorities for the next three years.

The plan has been created in partnership with third and independent sector colleagues, public health, community planning partners, local communities and, most importantly, people who use our services.

The joining-up (integration) of community based health and social care services is still in its infancy and we have much to do in order to create services that will best support the people of North Ayrshire. The last three years have, nevertheless, seen significant advances in many areas of health and social care:

- We developed truly integrated Universal Early Years teams to better support parents of children under the age of five
- We opened our new hospital, Woodland View, in Irvine, which – as well as providing two community wards for older people – is primarily a state-of-the-art mental health hospital
- We have continued to develop our care at home workforce, ensuring that we can recruit and retain staff and ultimately support people to live at home
- To help support local carers, we have introduced a Carers Card that offers carers discounts at local businesses
- Partnership working with community planning partners has resulted in reduction in the levels of domestic violence, and more general crime, across North Ayrshire

All our achievements to date are far too lengthy to mention here, you can find out more about the progress being made in our **annual performance reports** at [www.nahscp.org](http://www.nahscp.org).

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*Delivering care together*

**TSI** North  
Ayrshire

**scottishcare**  
The voice of the independent care sector in Scotland

  
North Ayrshire Council  
Comhairle Siorrachd Àir a Tuath

  
NHS  
Ayrshire  
& Arran





Looking forward to the next three years, we remain aspirational in our desire to create health and social care services that are the very best they can be. We will continue being creative and innovative in our approach, particularly given the financial challenge we face and the increasing demand for our services.

I am consistently humbled by the motivation, dedication and compassion of our staff. We have a vast amount of skill and experience within the Health and Social Care Partnership, this enables our staff to provide the right advice, care and support to people when they need it. We work with individuals and families most often at times when they are at their most vulnerable and our staff continue, every day, to make a difference.

I am proud of the partnerships we have fostered to help improve people's lives; from Police Scotland and the Fire and Rescue Service, to the third and independent sectors and with housing, education and economies and communities, to name but a few. I look forward to these relationships growing stronger over the next few years; no one organisation can make the difference on their own.

I am excited about the ever-evolving relationships we have with those people who use our services, who provide care for family and friends and with our local communities. Whilst our staff have the skill and knowledge necessary to ensure the highest quality services are delivered, we want to continue to draw upon the expertise of those with lived-experience to help us design and provide services and new models of care and support over the next few years.

All three of these strands, our people, our partnerships and our relationship with those who use our services and their communities, give me great optimism that we will deliver on the priorities contained within this plan over the next three years.

### **Stephen Brown**

*Director, North Ayrshire Health and Social Care Partnership  
Chief Officer, North Ayrshire Integration Joint Board*

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# Partnership Pledge – working together for the future



We are all facing a period of significant challenge. More people than ever need health and social care services. Changes in population age and health, combined with significant levels of deprivation experienced in North Ayrshire, mean that demands are likely to increase year on year. We have smaller budgets available to meet this ever growing demand for services.

**We, North Ayrshire Health and Social Care Partnership (the Partnership)** will work differently; we will be more innovative. We will provide safe and effective services in an increasingly challenging financial environment.

**You, as a North Ayrshire resident, or as a user of health and social care services,** can help:

- By taking care of your own health and wellbeing
- By being more informed about how to best address your health concerns
- By being mindful of the wellbeing of others in your community

By working together, we can improve health and wellbeing in North Ayrshire and help to lessen the demand on local services. We hope that by working together with you, we can help build communities that are vibrant, resourceful and are places where people feel supported by family, neighbours and local services.

We hope that you will consider these pledges and join us so that our combined commitment ensures that **all people who live in North Ayrshire are able to have a safe, healthy and active life.**

# Let's deliver care together

you

Can support vulnerable children and adults to live independently as part of your community

we

Will support vulnerable children and adults to ensure they are able to live as well and independently as possible

Can recognise the factors that cause inequalities and work with us to reduce these in your local community

Will work with other organisations to reduce inequalities in North Ayrshire

Can continue to support your family, friends, neighbours and wider community for as long as you are able

Will work with you when your needs can no longer be supported by your family, friends or community

Will access services when you need them

Will provide services that support you and keep you well, when you need them

Can share your views and those of family, friends and neighbours about health and social care support in North Ayrshire.

Will tell you about proposed changes to local health and social care services



Being healthy is more than the absence of illness or disease. Good health and wellbeing is a resource that supports and sustains everyday life. It enables us to reach our potential and deal with changes and challenges in our lives.

Our health and wellbeing is influenced, positively and negatively, by factors such as:

- Experience in early years
- Level of support from friends and family
- Opportunities for learning
- Employment and income
- Feeling part of a community
- Environment
- Safety
- Lifestyle
- Access to appropriate resources
- Access to services

These social, emotional, environmental and relationship factors can shape how effectively we are able to prevent ill health, promote good health and sustain wellbeing.

Improvements in health and wellbeing can only be achieved when people, services and communities work together to make changes that will help to enable better health and wellbeing for local people.

# North Ayrshire Health and Social Care Partnership – who we are and what we do



**North Ayrshire Health and Social Care Partnership (the Partnership) brings together all community-based health and social care services in North Ayrshire, providing a range of services for children, adults and older people.**

**Some services are provided across Ayrshire.**

**Services are provided by the Partnership or are commissioned by us from another provider of community-based health and social care services.**

Working together, the Partnership, is made up of community-based health and social care services:

- NHS Ayrshire & Arran
- North Ayrshire Council
- Third sector organisations (represented by Third Sector Interface (TSI) North Ayrshire)
- Independent care organisations (represented by Scottish Care)

A list of services provided within the Partnership is at Appendix 1 (see page 61).

North Ayrshire Integration Joint Board (IJB) is the constituted legal governing body of the Partnership. It is responsible for the strategic direction, effectiveness, and efficiency of the Partnership.

The IJB has members from NHS Ayrshire & Arran, North Ayrshire Council, representatives of the third sector, independent sector, staff representatives and others representing the interests of patients, service users and carers.

Go to **[www.nahscp.org](http://www.nahscp.org)** for more information.

## Vision, values and priorities

Our vision is that **all people who live in North Ayrshire are able to have a safe, healthy and active life.**

To help us to reach our vision, we will continue to focus on these priorities:

- Tackling inequalities
- Engaging communities
- Prevention and early intervention
- Improving mental health and wellbeing
- Bringing services together

We hope you experience our values in the way we engage with you and how we behave. We will:

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

If you don't experience these values in your interactions with us, please tell us.

We will achieve our vision by working together in partnership with you!

- Communities are at the heart of our decision making – we want your involvement
- We want to build new and stronger relationships to take a fresh approach to health and wellbeing
- We want to work with you to tackle some of the inequalities experienced in North Ayrshire
- We want to improve your health as a local person

We will ensure that each service we provide:

- Is as smooth and straightforward as possible
- Takes account of people's needs
- Takes account of people's individuality and circumstances
- Respects people's rights and dignity
- Takes account of people's participation in the community they live
- Protects and improves people's safety
- Always seeks to improve
- Is planned and led in a way that engages with the community
- Best anticipates need
- Helps to prevent need arising
- Makes best use of available facilities, people's abilities and resources

## Our equality outcomes

All public bodies in Scotland must comply with the public sector equality duty (as set out in the Equality Act 2010). We must publish equality outcomes that do one or more of the following for those with a protected characteristic:

- Eliminate discrimination
- Advance equality of opportunity
- Foster good relations

The protected characteristics are:

- Age
- Disability
- Gender reassignment
- Marriage and Civil Partnership
- Race
- Religion or belief
- Sex
- Sexual orientation

To create a more consistent approach to improving the lives of those with a protected characteristic, a number of public sector organisations across Ayrshire worked together to develop a shared set of equality outcomes. Sharing outcomes in this way means we can work better together to improve the lives of those whose unique characteristics may make them vulnerable to victimisation or discrimination.

Our shared equality outcomes for 2017–21 are that, in Ayrshire:

- People experience safe and inclusive communities
- People have equal opportunity to access and shape our public services
- People have opportunities to fulfil their potential throughout life
- Public bodies will be inclusive and diverse employers

An action plan has been developed to support these equality outcomes. The action plan outlines work that will be progressed at a pan-Ayrshire level and by us in the Partnership.

More information on our **shared equality outcomes** can be found on our website **[www.nahscp.org](http://www.nahscp.org)**



# Preparing the plan

This document has been prepared in accordance with section 29 of the Public Bodies (Joint Working) (Scotland) Act 2014 which sets each integration authority's requirement to prepare a strategic plan.



**In order to prepare this plan, we took into account information from the following sources:**

- What Matters to You? *(see page 13)*
- Stakeholder engagement and consultation *(see page 15)*
- North Ayrshire today *(see page 16)*
- Our Partnership journey *(see page 19)*
- Our change programme *(see page 24)*
- Our consultation on the review of the scheme of integration *(see page 25)*
- Our review of stepping stones to change *(see page 26)*
- Our financial plan *(see page 28)*

## **What Matters to You? 2017**

On 6 June 2017, the Partnership took part in an international day of meaningful conversations 'What Matters to You?'. Partnership people took to the streets of North Ayrshire to engage with local people, in their own communities, to ask, 'What matters to you about health and social care services in North Ayrshire?'

As well as face to face conversations with local people, views were also gathered via a variety of different methods, including:

- Twitter (using #WMTY17 #NAHSCP)
- Online survey
- Dedicated text messaging service
- Peer researchers
- Engaging with youth groups
- Postcards

Around 2,500 responses were gathered on the day. This provided the Partnership with valuable insight into local people's thoughts about local health and social care services. You told us what was important, including:

- The competency and values of our staff
- The ability to easily access services
- Reduced waiting times for GP or hospital appointments

We have used the findings from What Matters to You? to help inform this strategic planning document.  
All of the feedback received is available to read online at [www.nahscp.org](http://www.nahscp.org)

Here are a few of the main findings:



## Stakeholder engagement

Throughout the process of developing this new strategic plan, we have engaged with a series of stakeholders through a variety of forums and events:



Independent sector event	1 June 2017
What Matters to You?	6 June 2017
Integration Joint Board	12 October 2017
Strategic Planning Group	2 November 2017
Integration Joint Board	16 November 2017
Extended Partnership Senior Management Team	7 December 2017
Strategic Planning Group	27 February 2018
Providers Forum	16 March 2018

We shared the draft strategic plan with the NHS Ayrshire & Arran and North Ayrshire Council for their consideration and to ensure that our approach aligns with their strategic direction.

## Public consultation

The public consultation of the draft strategic plan was from **8 January – 16 February 2018**. This included an online survey and a series of public events.

We held drop-in sessions in libraries across Ayrshire, including:

• Kilbirnie Library	16 January 2018
• Saltcoats Library	18 January 2018
• Stevenston Library	18 January 2018

• Largs Library	22 January 2018
• Millport Library	22 January 2018
• Kilwinning Library	24 January 2018
• Dalry Library	25 January 2018
• Arran Library	26 January 2018
• Irvine Library	6 February 2018
• West Kilbride Library	15 February 2018

We held two health and wellbeing events, showcasing a number of Partnership services and partner agencies:

• Irvine health and wellbeing session	1 February 2018
• Ardrossan health and wellbeing session	3 February 2018

We also met local people in their own communities at the social enterprise Café Solace:

• Café Solace Irvine	6 February 2018
• Café Solace Ardrossan	8 February 2018
• Café Solace Kilbirnie	9 February 2018

In total, we received 207 responses to the survey and engaged face-to-face with over 174 people during the consultation period.

## Going forward

We will develop an Participation and Engagement Strategy to help guide and inform consultation activity in the future. This will improve how we engage with those who do not traditionally respond to engagement activity.

# North Ayrshire today

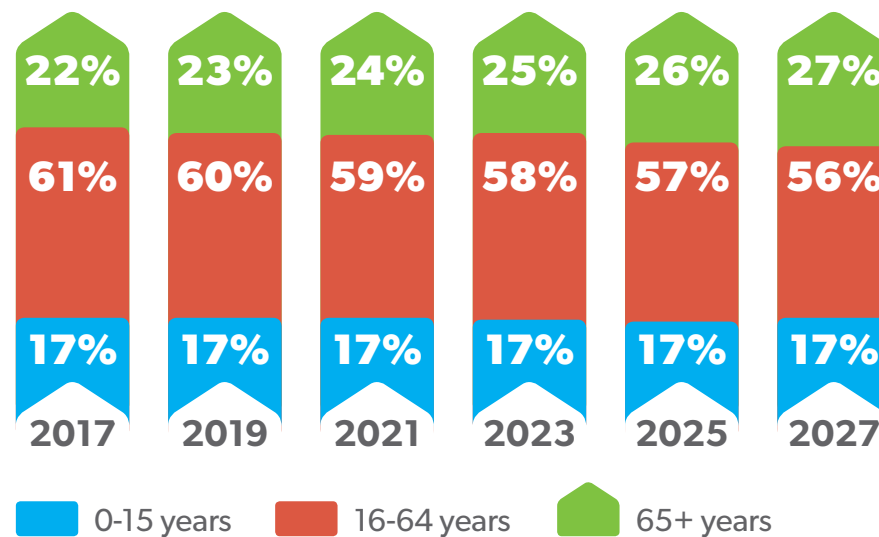


## Changing population

The number of people who live in North Ayrshire is falling. Current projections predict that there will be 3,800 fewer people in North Ayrshire by 2027.

The area has experienced a steady increase in the number of people aged over 65 years. A ten year projection indicates the number of older people in North Ayrshire will increase from 22.3% to 27.5%

## North Ayrshire % population change by age group



Overall, the working population (those who are economically active) is decreasing, and the dependent population (those who are not economically active) is increasing. This population change will place greater demands on local health and social care services as well as unpaid carers, families, friends, neighbours and local communities.



## Inequalities

North Ayrshire is a place of sharp inequalities. Some residents experience high levels of deprivation, poor health and child poverty.

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

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



### Levels of multi-morbidity

(people with more than one chronic medical condition) are higher in the most deprived areas. For example

North Coast locality has lower levels of deprivation compared with other areas in North Ayrshire and as such, have lower levels of people with multi-morbidities (**11% for those 65 and over**) compared with areas with higher levels of deprivation, such as Three Towns, where multi-morbidity levels are much higher (**36% for those 65 or older**).



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

If you live in a deprived area you are much more likely to experience poorer health over the long term than someone in a more affluent area. By reducing inequalities, deprivation and the impact of poverty, we can make a long term improvement to the health of local people.

## North Ayrshire's carers

We recognise that local carers are a uniquely valuable asset. Their contribution cannot be underestimated.

In 2015, North Ayrshire had more than 14,000 carers. In other words, about 10% of the local population provided care to family and friends, with the estimated value of care they provided (in 2015) being approximately £321 million.

Without our carers and the support they give, there would be an additional demand on local health and social care services.

We understand the commitment and valuable contribution our carers show every day to their families, friends, neighbours and loved ones.

We will support local carers to continue in their caring role.

We will work with them to ensure that their caring responsibilities are manageable. We will encourage carers to look after their own physical and mental health.

## Working with you in communities

By working together, with a focus on prevention and early intervention, we can help improve and maintain your long term health and wellbeing. We know that:

- Having strong relationships and good habits as a child and young person will enable better health and wellbeing into adulthood
- Many of the causes of ill health in our communities are because of lack of opportunities in early life or poor lifestyle decisions
- Addressing a health concern at an early stage can prevent it from growing into a serious long-term condition

When you need to access services, we will ensure they are centred on your needs and focussed on your wider health and wellbeing.

- We need to work with you, listening closely, to provide you with the best care possible
- We know that ill health, including mental ill-health, can be caused by other social and environmental factors, such as unemployment and poor housing. We will work closely with money advice, employability and housing services, ensuring you have the best advice and support when you need it
- Your local GP is one of a number of professionals who are able to advise and help with health and social care needs. We are developing alternative community based support to help people with a wide range of wellbeing concerns

## Local and national context

We reviewed relevant documents to gain additional insight into local and national policy that is important in health and social care. A list of these documents is available at Appendix 2 (*see page 62*).

Through our review we found that:

- A strong sense of purpose and community contributes to social and health benefits for you
- Strong, resourceful communities are better equipped to support you at times of need
- Vibrant communities are best placed to challenge the effects of social isolation
- Increased community-based support can change how you approach your health concerns, encourage self-management and ensure you know how to get the most appropriate support when the need arises
- A range of factors can impact on your mental health (some of the factors are listed at Appendix 3 (*see page 63*)).

# Our Partnership journey

North Ayrshire Health and Social Care Partnership was established in April 2015

Our reflections on some Partnership achievements.

We published our first strategic plan in April 2015 and a more focussed follow-up plan in August 2016.

Our annual performance reports (2015–16 and 2016–17) highlight ongoing exemplary health and social care within North Ayrshire as well as outlining the challenges we experience.

Here is a snapshot of some of our progress so far.



priority

## **Tackling inequalities**

we said...

**We would help people deal with their financial difficulties**

some examples of what we did...

Our Money Matters team increased combined household incomes across North Ayrshire by nearly £16 million (2015–17). This money, for the most vulnerable people in our local communities, makes a significant improvement to their quality of life. It also helps tackle some of the inequalities in our society.

**We would provide support to keep people safe**

Our Multi Agency Domestic Abuse Response Team (MADART) worked in a new way with people at risk of abuse at home. This led to more than 21% fewer incidences of domestic violence in North Ayrshire (2015–17).

**We would maximise the potential for people to work, with a particular focus on young people**

- We collaborated with partners and other organisations, including National Galleries of Scotland, to provide learning experiences for young people who had lived in care. 75% of the young people are now undertaking education or training.
- North Ayrshire Council agreed to provide five modern apprenticeships for young people who had lived in care.

**Justice and Youth Justice would work together to reduce re-offending in our communities**

Recorded crime in North Ayrshire reduced during 2015–2017, with a 12.9% reduction recorded in 2016–17.

priority

## Engaging communities

we said...

**We would improve how we involve and engage with local communities**

some examples of what we did...

- We held our first participatory budgeting event in February 2017. Over 250 people attended to vote for the projects they thought most worthy of receiving funding. £50,000 was distributed to 42 local organisations for projects that tackle mental ill-health and promote wellbeing.

- On 6 June 2017, we participated in 'What Matters to You?'. We used a variety of methods to record people's views, including:

- focussed events
- an online survey
- dedicated phone number

Partnership people actively engaged with around 2,500 local residents and people who use services and asked what was important to them about health and social care services in North Ayrshire.

- Locality planning forums have identified a clear set of priorities for each locality (*see page 38*)



priority

**Bringing  
services  
together**

we said...

We would work  
together to  
provide better  
services

some examples of what we did...

- We brought together our Universal Early Years team to include, social worker, health visiting, speech and language therapy, Money Matters, mental health nursing, support workers and family nurturers
- We began the process of bringing together community based teams from North Ayrshire Council and NHS Ayrshire & Arran. This will mean more seamless care for local people:
  - ◀ In May 2016, we launched our integrated North Ayrshire Drug and Alcohol Recovery Service (NADARS).
  - ◀ Arran has developed an integrated service model, including GP, social work, care at home and care home services.



priority

**Prevention  
and early  
intervention**

we said...

We would  
provide access  
to information  
about health and  
wellbeing

We would review  
our Care at  
Home service to  
ensure they meet  
individual needs

We will increase  
access to services  
that promote  
early intervention,  
prevention and  
recovery

We would  
support those  
who care for  
others

some examples of what we did...

We employed Community Connectors in six GP practices to signpost people to a range of alternative community and non-medical resources. By March 2017 Community Link Workers were in 17 GP practices and had engaged with almost 800 people.

We invested in care at home services to increase the number of people supported to live as independently and safely as possible in their own homes. As demand increased, we provided an average of 4,148 visits every day.

- We developed new rehabilitation models of care to reduce people's average length of stay in hospital from 41 days to 28.8 days (2015–16).
- Our community alert team alongside Scottish Ambulance Service responded to 999 calls. They supported 74.5% of people who requested an ambulance via their community alarm to remain in their own home and not be transferred to hospital.
- Over three years (2015 to 2018), with various projects, we have enabled people in North Ayrshire to avoid over 35,000 bed days in hospital.

- We developed a Carers Strategy.
- We began using carers assessment paperwork that was designed by carers for carers.
- We developed a Carers Appreciation Card. The card entitles carers to receive discounts, offers and concessions with a range of local businesses. Almost 381 carers have registered for a card and 43 businesses have come on board.

priority

**Improving  
mental health  
and wellbeing**

we said...

**We would build  
a new Mental  
Health and  
Community  
Hospital in  
Irvine, which will  
provide modern,  
purpose-built  
facilities to meet  
local needs**

some examples of what we did...

The new hospital, Woodland View, was opened in May 2016.

This is now an award winning facility providing older people's rehabilitation as well as dementia, mental health and addiction services for people across Ayrshire and Arran.

**36 projects  
generated**

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



### **Our change programme**

The Partnership took an innovative approach to its first strategic plan by creating a Change Team to support Partnership teams to identify, enable and deliver system wide change to local services.

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

## Challenges

While our performance against our first strategic plan has been good, it has not all been easy. We continue to have issues, such as:

- Maintaining high quality services for people while completing high level change
- Continuing growth in demand for services
- The financial challenge of delivering services within the Partnership's approved funding
- Managing information (policies and processes) and sharing of people's information
- Finding suitable shared accommodation for integrated teams
- IT systems incompatible and unable to talk to each other

For more information on what we have achieved to date please see our latest **performance report** at **[www.nahscp.org](http://www.nahscp.org)**

## Review of Integration Scheme

In June 2017, the Partnership's parent bodies – NHS Ayrshire & Arran and North Ayrshire Council, reviewed the existing scheme of integration. This review considered how the Partnership had operated since inception in April 2015 and if any changes should be made to improve service delivery. An identical review was carried out in East Ayrshire.

Partnership people and stakeholders gave their opinions about the existing scheme of integration and were asked about barriers they faced or how things in the Partnership could be improved.

Through consultation sessions, 190 stakeholders provided face-to-face feedback and 94 responses were received from an online survey. In total, this generated 616 comments for analysis.

The issues raised included:

- NAC and NHS having separate budget setting timescales
- Information sharing between the partner organisations
- The length of time taken for IJBs to provide approval to proposals
- Difficulties arising from IJBs not being a single employing body
- Lead Partnership arrangements
- Partnerships are in their infancy and should not be subject to large structural change at this time

However, it was identified that improvements could be made by enacting measures already contained within the existing scheme of integration.

# Stepping stones to change – Our journey to the future

In our first strategic plan, we set out our 'stepping stones to change', to show how we would move through the stages of transforming health and social care services.

We want to move from a historic state of delivering services for you, to a desired future state where you are the drivers of your own care, with full support from community resources.

The stepping stones to change model can be found at Appendix 4 (see page 64).



We asked our staff and our partner agencies to gauge our progress in transforming services. We asked, 'Are we in the same place as we started (historic), in the future state we aimed for three years ago (future) or are we still on the journey to the future (transitional)?'

This is what they told us.

## 1. Specialist service delivery

Good, positive progress has been made. Some community services are recognised as offering specialist services of high quality, safe and effective care.

We continue to work towards the future where specialist support is provided in communities with access to hospital when people need it.



## 2. Service integration

Some progress has been made in bringing community health and social care services together. Many people believe that care provision is still disjointed with disruptive hand-over between services.

Much more work is needed to bring services together and ensure seamless movement between services for local people.





### 3. Preventative

This remains our biggest area of challenge with many people believing we are still only delivering reactive care when people need it.

However, people also said we are beginning to take positive steps towards more preventative approaches.

### 4. Partners in delivery

We are still developing better relationships with partners. People feel that we could be better at working with our partner organizations to deliver better services to local people. Together we are all working towards co-design and co-production of services with communities.

### 5. Self-care maturity

Many people believe that self-care approaches are now being encouraged and supported by us. More positively, there are some small pockets of self-care being facilitated by local communities (this is our aim in the future).



### 6. Individual decision making

Many people feel that we actively engage with people in decisions about their care, and a small proportion of us feel that care is being actively driven by those who need the care themselves.

### 7. Valuing carers

Most of the people we asked felt that carers are valued and involved in decisions relating to their cared-for person. Some also feel that the value of carers is now being recognised by communities and is widely supported.

### 8. Managing risk and being innovative

A number of people feel that we are trying to be creative and find innovative solutions to people's care needs.

However, many believe we are still risk averse: we are using traditional models of care and not effectively embracing positive change.



# Our financial plan



Health and social care partnerships are operating in an increasingly challenging environment. The Partnership's budget is delegated to it by the Council and NHS. As financial settlements to the Council and NHS reduce, the financial challenges the Partnership faces become more difficult. Future funding will not keep pace with increasing demand and increasing costs.

We have experienced exceptional demand for services over the last three years – the cost of demand is higher than the funding the Partnership receives. Projections show that this imbalance between money-out and money-in is likely to continue. However, we know this imbalance is unsustainable, so we have developed a robust financial plan to ensure we remain financially sustainable, while targeting our resources to support our key priorities.

Analysis and projections of cost pressures have been undertaken and North Ayrshire IJB approved a medium term financial plan (MTFP) in March 2017, for 2017–20. The plan is being refreshed to reflect the period up to 2020–21. This will be presented to the IJB in spring 2018.

The **medium term financial plan** 2017–2020 is on the Partnership's website at [www.nahscp.org](http://www.nahscp.org)

The medium term financial plan is key to supporting the delivery of the strategic plan and setting out our plans to start to deliver a shift in the balance of care from hospital care to more care for people in their own homes. The ability to plan, based on the totality of resources across the health and care system to meet the needs of local people, is one of the hallmarks of integrated care. Medium term financial planning supports this process and identifies the transformation that is required to provide sustainable services to the local community over the medium term.

A number of areas have been explored to understand the scale of the financial challenge:

- A detailed analysis of costs and demands
- An assessment of increases and reduction in funding
- A review of non-recurring savings and implications for the future

The Partnership has a budget of £248.6 million for 2017–18. This is funded contributions from North Ayrshire Council of £88.4 million and NHS £160.2 million. (This includes £23.4 million of the unscheduled care set aside acute services budget – this is any

unplanned contact by a person requiring or seeking help or care, including emergency care.

The set aside budget is a pot of money allocated to all partnerships to meet the costs of unscheduled care or emergency admissions to hospital. While the budget is managed by the Partnership, the acute hospital sector delivers the care and spends the money. If we reduce the demand of unscheduled care, then savings can be re-invested into community based services.

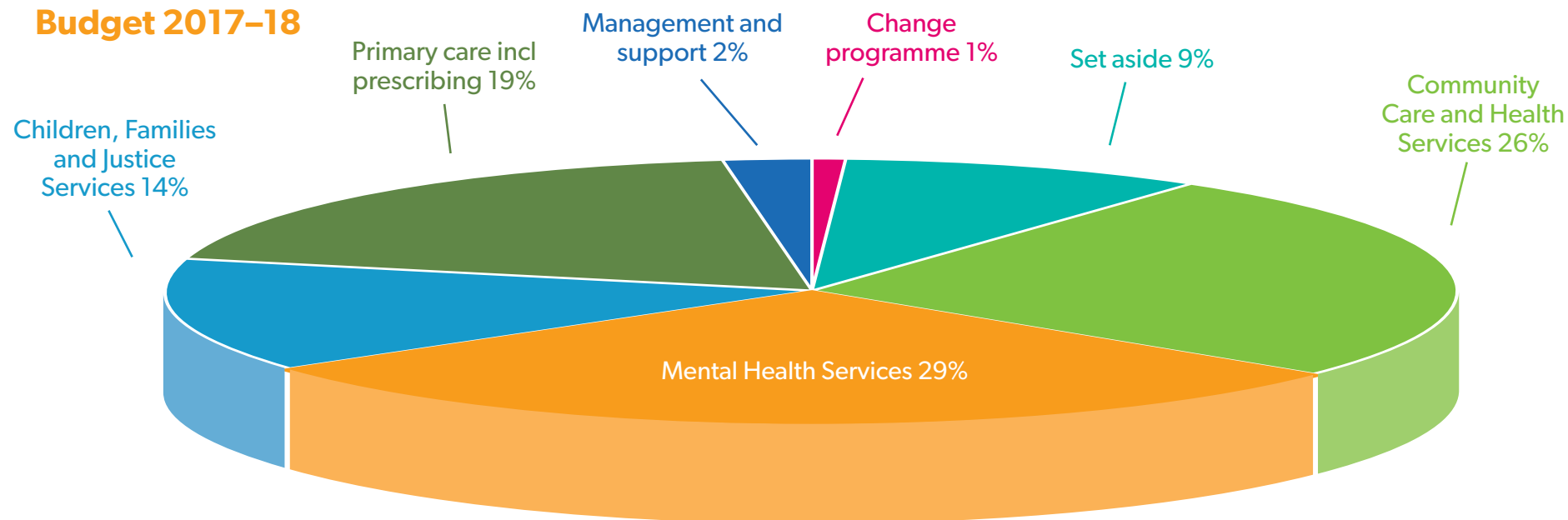
The illustration overleaf shows how the Partnership's budget was allocated in each service area in 2017–18.

Taking into account the issues identified and assuming nothing else changes, the MTFP estimates a £39.2 million indicative funding gap for the Partnership for the period to 2019–20.

The Integration Scheme states that the IJB will refine its strategic plan to take account of the totality of resources available. Accordingly, the IJB will align its strategic plan to available funding and take steps to ensure no further overspend occurs.

With growing demand for support and less money available we want to work with you to find ways to better support people in our communities.

## Budget 2017–18



- We will need to find new solutions – we will not always be your first source of support
- We want you to have better health and wellbeing
- We want you to live as independently as possible
- We will prioritise our services and we will involve you in this process
- All of us must think and do things differently – us, local communities and you

The way we provide services and how we pay for these services are directly linked. We cannot continue to provide services in the way we have before – we don't have enough money to do so.

The financial plan has four main parts:

- Better ways of working
- Shifting the balance of care (from hospital to home, homely settings and the community)
- Prioritisation of services
- Demand management

What we will do against each of these headings is explained on the next page, along with some examples.

These key areas are explored in more detail in our medium term financial plan.

### Better ways of working

Develop 'Teams around the Child' to respond more effectively to the needs of children

Implement our Participation and Engagement Strategy

Develop a See and Treat service in Three Towns

Continue to develop an online resource directory

Promote discussions around anticipatory care\*

Address barriers to accessing services

Review day services for people with learning disabilities

Develop a CAMHS intensive support service

Continue to implement a 24/7 police triage pathway with the mental health crisis resolution team

### Shifting the balance of care

Develop Locality Resource Forums to identify needs of local children and families

Further develop locally integrated health and social care services with all our partners

Develop multi-disciplinary teams in primary care services

Ensure access to rapid community based care to maximise independence and recovery

Identify and support those at greatest risk due to frailty, multiple conditions or complex circumstances

Develop facilities to ensure they are fit for re-designed learning disability services

### Prioritisation of services

Community link workers are placed in the areas of greatest need

Promote healthy lifestyles and self-management

Provide peer support for those with mental ill-health

Promote local pharmacies as the first point of call for medical queries

Work with local people to develop a range of clubs and activities that will help people support themselves, keep well, active and independent

Build the National Secure Adolescent Inpatient Service for young people aged 12-18 years

### Demand management

Encourage people to adopt healthy behaviours

Expand the level of advocacy support available

Continue to work with colleagues in the third and independent sectors to safely support those with complex needs

Bring together four teams in one integrated adult community mental health service with a single point of access

Develop a recovery college for people with lived experience of poor mental health

Promote wider delivery of alcohol brief interventions (ABI)

Extend Computerised Cognitive Behavioural Therapy (CCBT)

\* Thinking ahead about current and potential future health and social care needs. Designed to put people in control of decision making about their health and wellbeing. Many people with long term conditions or chronic health issues would benefit from having an anticipatory care plan, to ensure their wishes and needs for their future care are in place.

## Strategic commissioning of services

Strategic commissioning is how we consider local people's current and future needs, and how we plan investment and allocate funding to our health and social care services to improve people's health and wellbeing. Commissioning is closely linked to, and informs the process of procurement; a specific function that undertakes the purchasing of services. In 2016–17, 36% of the Partnership's total budget was used to commission 80 providers to provide community supports for people with complex needs.

To prepare for our commissioning responsibilities, we have:

- Undertaken a health and care needs assessment of the local population
- Set five strategic goals to work towards
- Identified a number of key areas for development
- Worked with partners throughout Ayrshire to commission specialist services

These responsibilities inform how we will procure and develop services to meet the health and social care needs of local people. Some Ayrshire wide commissioning that will be delivered during this planning cycle, with East and South Partnerships includes:

- Development of a CAMHS intensive support service to provide a timely response to young people when it is most needed, preventing and responding to crisis and preventing hospital admission.
- Warrix Avenue element of the Tarryholme Drive development will offer a Pan-Ayrshire community mental health rehabilitation resource as an alternative to in-patient rehabilitation at Woodland View.
- Expanding the role of the Crisis Resolution Team (CRT) to support those experiencing mental health crisis. By offering prompt and timely response when most needed, CRT aims to support those in crisis to remain in the community and prevent admissions to acute hospitals.

Feedback from Scottish Government, NHS and other health and social care partnerships in Ayrshire and across Scotland has shown that health and social care IJBs are not exercising their full responsibility in planning of acute hospital services (using the 'set aside' budget). This approach will be developed during this planning cycle.

We will work closely with colleagues at University Hospital Crosshouse and University Hospital Ayr to better understand the costs associated with unscheduled care. We will ensure that more people can be cared for at home or in a homely setting, and go into hospital only when necessary. Examples of this joint work, which will be delivered during this planning cycle, includes:



- Beginning delivery of some of the new models of care for older people and people with complex needs across Ayrshire. We estimate, by commissioning services differently across Ayrshire we can see a 30% increase in the number of people seen in Intermediate Care and Rehabilitation Services to more effectively support people at risk of hospital admission to be cared for – if not at home – in a more homely, community based environment.
- We anticipate, across Ayrshire than an additional investment of £2.5 million per year is expected to release up to 22 unfunded beds within University Hospital Ayr and 46 unfunded beds within University Hospital Crosshouse. This could lead to an acute hospital cost avoidance of approximately £4 million per year.

### Regional delivery of specialist care

There may be times when treatment from a specialist hospital is your best care option. At these times you may be required to attend a specialist hospital or treatment centre out-with Ayrshire and Arran Health Board area.

In the West of Scotland, work has been ongoing across Health Boards and IJBs to establish a common purpose for the planning of specialist services on a regional basis.

Through the West of Scotland regional planning arrangements, the North Ayrshire IJB will seek to effectively commission services on a regional basis, where appropriate, to ensure the right care is available for local people at the right time.

### Lead Partnership arrangements

Each Ayrshire Partnership (East, North and South) leads on a different Ayrshire-wide area of health and social care work. The Partnerships are continually reviewing and discussing these arrangements to make sure we are all providing effective and efficient services for everyone in Ayrshire and Arran.

- East Partnership leads on Ayrshire-wide primary care services (dentist, GP, pharmacy, optometrist)
- North Partnership leads on Ayrshire-wide mental health services and child immunisation programmes, child health administration and community infant feeding service
- South Partnership leads on provision of allied health professional (AHP) services, technology enabled care (TEC), joint equipment store, falls prevention and sensory impairment

More information on lead Partnership services across Ayrshire and Arran is at Appendix 5 (*see page 65*).

# Partnership people and the future

We realise that many of the challenges that face you cannot be addressed solely by any one organisation. We want to work with communities, groups and other organisations to improve the lives of people in our local communities. We make a bigger impact together.



## Working with you

We know that meaningful consultation and engagement is an important element in enabling healthier and more empowered communities.

Since the Partnership began (2015), we have worked hard to review how we engage (talking, listening and working) with you and our local communities.

We have used a variety of methods to engage with you – face to face, Locality Planning Forums, focus groups, surveys, and public events to do this.

Your ideas and opinions have helped us to define, plan, design and deliver services and supports in our communities. Your input into designing health and social care services has been and will continue to be of great value.

We plan to build on our existing approaches and things that are working well. Over the next three years we will deliver our Participation and Engagement Strategy working with you, our staff and our key partners.

Our Participation and Engagement Strategy seeks to:

- Work with the assets and strengths within our communities to empower them to identify and address local priorities
- Involve individual and community stakeholders in defining, planning, design and delivery of services and supports in our local communities
- Support consultation, engagement and participation in localities, contributing effectively to other consultation activity and local plans across the Community Planning Partnership (CPP)
- Facilitate a tailored and inclusive approach to consultation, participation and engagement by using a variety of methods
- Direct consultation, engagement and participation activity to address identified areas of inequalities, deprivation and/or communities of interest
- Recognise that all health, social care and partner staff have a key role in promoting, supporting and taking part in stakeholder involvement as part of their work
- Support the cultural change required to achieve co-production, by developing and improving relationships with local communities

## Partnership working

We have shared goals with organisations that we work with, such as Housing Services, Education and Youth Employment Service, Police Scotland, Scottish Fire and Rescue, Ayrshire College and the acute hospital sector. We will continue to focus on our shared goals over the next three years.



## Partnership people and volunteers

Our ability to deliver the aspirations described in this strategic plan depends on the talent, commitment and values of staff and volunteers. We must invest in Partnership people to ensure they can provide the care that you need, now and in the future. We have a workforce that is skilled and highly experienced; about 40% of our staff over the age of 50. Our aim is to develop an effective plan to transfer skills, experience and confidence on to newer members of staff.

We also value our volunteers and recognise that we need to develop our volunteering capacity to meet the growing demand for health and social care services.

We have immediate pressures. We must make sure that we have enough members of staff and volunteers to meet current demand for health and social care services.

A longer-term consideration is to ensure that the current workforce can achieve the ambitions of future care models and meet the ever growing demand for services.

Our workforce plan will focus on developing the future characteristics of our staff, ensuring that they are able to meet your needs in the future.

We will work to ensure the workforce of the future is:

- **Caring and competent** – with a focus on service users
- **Integrated** – a culture that values and trusts the skills and roles of others, not just in their immediate job family or organisation but across the Partnership
- **Flexible and resilient** – able to adapt to changing circumstances
- **Confident, well-informed** and **value-driven** – in ability to make decisions and act in their role, and addressing inequalities where possible
- **Creative and innovative** – in service design and delivering for service users
- Able to have a clear picture of **career progression**, **succession planning**, and **development**, taking mutual accountability for that development, with clear access as and when required



## Working in localities

We know our local communities are a vitally important asset in improving the health and wellbeing of local people.

In North Ayrshire, we have six localities. These are:

- Arran
- Garnock Valley
- Irvine
- Kilwinning
- North Coast
- Three Towns

Each locality has its own unique strengths and assets, as well as its own challenges. We are working within each of our localities to ensure the services provided in each locality are meeting the specific needs of the people who live there.

We have established Locality Planning Forums (LPF) in each locality. Their role is to identify the health and social care needs and priorities of their locality, by building on their existing local contacts and local knowledge. The LPF then tells us what needs to be done and we work together to find solutions.

Locality Planning Forums are the voice of local communities within the Partnership. They have real influence to effect changes at a local level. The forums work within our Strategic Planning Group (SPG), which has oversight of this strategic plan.

During the early development of the forums, local priorities for action were identified. Some common key issues emerged for most of the locality areas:

- Mental health issues that affect people of all ages
- The impact of social isolation
- The impact of musculoskeletal disorders

We are now working to address these issues. Individual locality priorities can be viewed on page 38.

Over the past year, the LPFs have been meeting with representatives of our services as well as locality based health and social care community groups. This increased the profile of the forums and helped to educate everyone involved about the scope of resources available in each locality. LPFs also discussed their identified priorities – these were unanimously supported.





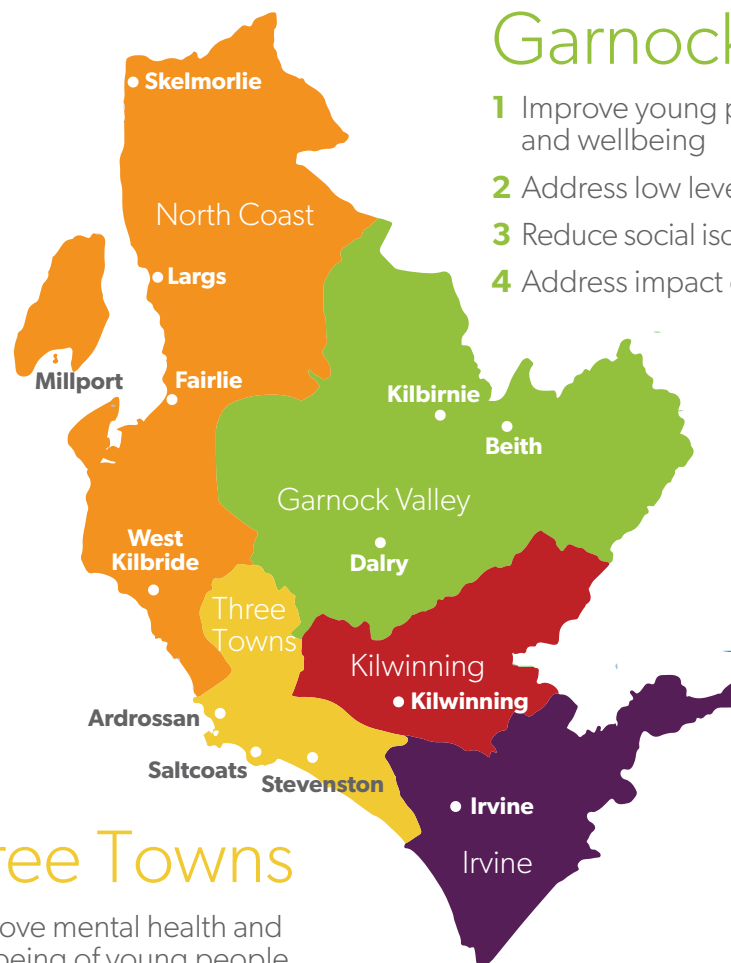
## Arran

- 1 Develop transport solutions
- 2 Reduce social isolation
- 3 Improve support to those with complex needs



## North Coast

- 1 Reduce social isolation for older people
- 2 Improve support for stress/anxiety
- 3 Address impact of musculoskeletal issues
- 4 Promote financial inclusion



## Garnock Valley

- 1 Improve young people's mental health and wellbeing
- 2 Address low level mental health (all ages)
- 3 Reduce social isolation across all age groups
- 4 Address impact of musculoskeletal issues

## Kilwinning

- 1 Engage with Early Years Centres
- 2 Provide GP visiting sessions to nursing homes
- 3 Provide occupational therapy in local pharmacy

## Three Towns

- 1 Improve mental health and wellbeing of young people
- 2 Reduce social isolation
- 3 Improve support to those with complex needs
- 4 Promote financial inclusion

## Irvine

- 1 Reduce social isolation
- 2 Improve low level mental health issues
- 3 Provide access to physiotherapy

## Going forward

The next phase for the Locality Planning Forums will be more relationship-building with local people and local community groups. We want to:

- Help LPFs to identify and better understand the issues facing local people
- Inform you and the people in your locality that you can influence the planning of local health and social care services
- Raise the profile of the LPF, the Partnership and partnership working
- Work with the Community Planning Partnership (CPP) Locality Partnerships on common goals

We want to work towards a truly co-productive relationship, where you have a greater say in the design of the services you receive.

Locality Planning Forums and CPP Locality Partnerships, share many priorities and work together where possible.

More information about the CPP and their Locality Partnerships in North Ayrshire can be found on the CPP website at [www.northayrshire.community](http://www.northayrshire.community)

North Ayrshire Council's Community Investment Fund has been developed as a way to empower you and return responsibility to local communities. Throughout 2018 and beyond, health and social care LPFs will continue to work closely with CPP Locality Partnerships to identify how best to allocate funds and resources so that they have a meaningful impact on local communities. Talking and listening – having conversations – with you and your local community will be key to successful community empowerment and effectively allocated services.

More information, including key demographics, supporting statistics and the locality planning forum priorities for each locality can be found at Appendix 6 (*see page 72*).



## Working with the third sector

Third Sector Interface (TSI) North Ayrshire is the single point of reference for all third sector organisations and community groups. Working on behalf of voluntary groups in North Ayrshire, TSI aims to:

1. Support voluntary organisations, local and national, who deliver services at a local level
2. Support volunteers and promote volunteering
3. Support and help develop social enterprise
4. Be the connection between the local Community Planning Partnership (CPP) and the third sector – facilitate communication and understanding between them

The TSI is another key partner for us. On our behalf, TSI North Ayrshire is best placed to support the development and growth of local voluntary services that can provide invaluable health, care and wellbeing support for you. Third sector and voluntary agencies can provide meaningful support, acting in a preventative manner to reduce the need to access services such as the Emergency Department (ED) or GP practice. Examples include:

- Peer support groups
- Activity and social clubs
- Information and support services
- Direct delivery of some care services

Encouraging and enabling you to make greater use of the opportunities within your own locality will help to create more sustainable, long term benefits for people and communities.

The TSI will:



- Continue to support and develop new and existing support networks, with a focus on connecting with groups and organisations that may be working in isolation
- Inform the planning and implementation of health and social care services by capturing activity and views at a local level
- Promote a third sector that continues to focus on addressing inequalities, realising the benefits we are looking for, community empowerment, and all at the community level
- Continue to work jointly with North Ayrshire's independent sector, to ensure benefits to local people are realised
- Explore new ways of offering volunteering opportunities while harnessing the potential of volunteering to support health and wellbeing
- Continue to strengthen the opportunities available for people to volunteer in their communities, supporting local organisations to become more sustainable
- Continue to support and develop new opportunities for growth within the social enterprise sector

More information on Third Sector Interface North Ayrshire can be found at [www.tsinorthayrshire.org.uk](http://www.tsinorthayrshire.org.uk)

The third sector comprises of non-governmental and non-profit making organisations, such as charities, voluntary organisations and community groups.

## Working with the independent sector

The independent sector in Scotland provides a wide range of care services for older people, those with long term conditions, learning disabilities, physical disabilities, dementia or mental health problems.

We work closely with the independent sector to provide care home and care at home services. Together, we endeavour to meet the increasing local demand for community based care services.

In North Ayrshire, the sector provides more than 900 residential care and nursing care home places, as well as approximately 11,000hrs of care each week to support people in their own home.

The sector employs over 1,800 people. Those staff work closely with medical, nursing and care professionals to support people to stay in their own home or homely setting. Where possible, independent sector staff will provide support to prevent people being admitted to hospital.

Care Homes are well placed as community assets to facilitate the required shift in the balance of care, to the benefit of local people and communities.

The independent sector also deliver services that:

- Provide local step up/step down services
- Create dementia friendly environments

The sector has a breadth of knowledge and experience of working with local people and will continue to review services to ensure they are ready to meet future demands and challenges.

Going forward, the sector will explore options for community based rehabilitation services to be in care homes.

We will continue to work closely with our independent sector colleagues to ensure the services they deliver in partnership with us provide the best possible community based care for local people.



## Working with housing services

Successful integration of health and social care services should enable more people to be cared for and supported at home, or in a homely setting. Housing services continues to work to contribute positively to improve health and wellbeing of local communities. Scottish Government directs local housing providers to support health and social care partnerships to prevent hospital admissions, alleviate delayed hospital discharges and tackle health inequalities.

The housing contribution statement highlights the significant contribution made by the housing sector to the national outcomes for health and social wellbeing, such as:

- Preventing and responding to issues relating to homelessness
- Referring and sign-posting people to relevant support services
- Providing preventative services to support people to remain living independently in their own homes
- Building neighbourhoods and communities

Housing services will continue to work closely with us to identify good practice, innovation and will support you by:

- Implementing dementia friendly designs in all new sheltered housing complexes and refurbishments, where possible
- Ensuring 25% of all new build homes are classified as 'specialist' housing
- Installing generic adaptations as part of the capital investment process
- Ensuring staff are able to anticipate the need for an adaptation before crisis point

More information on the Housing Contribution Statement can be found in the Local Housing Strategy at [www.north-ayrshire.gov.uk](http://www.north-ayrshire.gov.uk)



# Addressing our strategic priorities – the future



**In our original plan we identified key priorities for action, these were:**

Tackling inequalities

Engaging communities

Prevention and early intervention

Improving mental health and wellbeing

Bringing services together

We still believe these priorities are the right ones to improve services and, most importantly, to improve health and wellbeing for you and everyone in our local communities.

**Working together in these areas will help us to achieve our vision:**

That all people who live in North Ayrshire are able to have a safe, healthy and active life.

Through our public consultation, we asked if you agree with the Partnership's vision and the five identified priorities. Overall 207 online responses were received.

**We discovered that:**

- ✓ **96%** of respondents agreed with the **vision**.
- ✓ **76%** agreed or strongly agreed with the priority of **tackling inequalities**
- ✓ **86%** agreed or strongly agreed with the priority of **engaging communities**
- ✓ **87%** agreed or strongly agreed with the priority of **prevention and early intervention**
- ✓ **85%** agreed or strongly agreed with the priority of **improving mental health and wellbeing**
- ✓ **78%** agreed or strongly agreed with the priority of **bringing services together**

The five strategic priorities are all connected: progress made in one priority area can help in one or more of the other areas. For example, we would expect that work to prevent ill health by promoting healthy behaviours (prevention and early intervention) would have a positive impact on your overall health as well as reducing local health inequalities (tackling inequalities).

The work that we do is tackling multiple areas of health and social care need for you and your communities.



# Tackling inequalities

Inequalities, resulting from the high levels of deprivation and poverty, are the main cause of the high levels of ill health and poor mental wellbeing experienced by people in our communities.

We know that high levels of poverty and deprivation have a negative impact.



Deprivation is particularly high across North Ayrshire: around 40% of people live in areas that are considered to be among the most deprived in Scotland. Where deprivation is high, there are also higher levels of poor health.

Poverty comes in many forms; financial, food, fuel, transport, social and we are beginning to see digital poverty, where people face additional barriers to advice and support because they have no access to the internet or are unable to use it to best effect.

This is why, we – along with our partners – are committed to tackling the inequalities in our communities and improving the quality of life for everyone.

You can help by

You can help us to tackle inequalities.

Developing a firm understanding of inequalities and their potential impact on your long term health and wellbeing.



Encouraging those around you to think positively about changes they can make to improve their own long-term health and wellbeing.



## We will undertake the following to tackle inequalities:

Service area	To tackle inequalities, we expect to:
Communities	Continue to work with communities to co-produce the highest possible quality of health and social care, supporting you to stay well and self-manage your condition as effectively as possible
	Support you to gain confidence by developing social, educational and job support skills, particularly if you have complex needs
	Provide advocacy support to those who are not always able to speak for themselves
Partnership wide	Raise the profile of the impact of inequalities with our communities, staff, service users and volunteers, ensuring they have a firm understanding of inequalities and its impact on health and wellbeing
	Enhance the range of options and opportunities available (particularly for the most vulnerable people in our communities) to ensure everyone can achieve positive benefits and outcomes
	Work with partners to improve translation and interpretation services, including contributing to the development of a North Ayrshire British Sign Language Plan and exploring options for joint procurement of translation and interpretation services with Ayrshire equality outcome partners
	Deliver our requirements to meet Carers (Scotland) Act 2016
Children and families	Implement the Children's Services Plan and Corporate Parenting Plan to support vulnerable young people to access the same opportunities as their peers
	Develop teams around the family to help us respond more efficiently to the needs of children at the earliest possible stage
	Continue to deliver Family Nurse Partnership to support young mothers (19 years and under)
	Ensure health visitors carry out routine assessments (including financial checks and gender-based violence enquiries) to ensure families receive the support they need
Health and community care	Expand Community Link Worker service to assist people to understand the full range of formal and informal community based services available to them
	Work with Housing Services to ensure a range of future housing options that enable people to remain in their own home for as long as they wish
Mental health and learning disability	Develop commissioning plans to ensure people with complex needs can access community supports that are right for them
Justice	Support employability mentors to challenge stigma around people who have offended, enabling them to access employment and employment opportunities

# Engaging communities

We believe that our communities have strengths and assets. By working together, we can improve the health and wellbeing of the people of North Ayrshire.

At the heart of the Community Empowerment (Scotland) Act 2015, communities and individuals must have greater involvement in decision-making. The act seeks to empower communities by strengthening their voice.



We aim to go further with our community engagement than before. We are looking for you to play an active part, so that together we can design and change health and social care services for the future.

Vibrant communities can increase social connectedness and create supportive spaces and places for local people. We hope to help you to develop your supportive communities, where people are able to take care of their own health and wellbeing, as well as those around them.

You can help by

You can help us to engage in local communities.

Thinking about what you can do to make your local community a better place, for example, by joining or starting a social group or hobby club.



Actively engaging with the Partnership and your locality planning forum to help inform decisions that are right for your area.

## We will undertake the following when engaging with communities:

Service area	To engage with communities, we expect to:
<b>Communities</b>	See you and your communities taking greater responsibility of your own health and wellbeing and consider how best to take forward specific local issues to develop a range of activities that will help you to keep well, be sociable, stay active and remain independent
	Involve you, people who use services and carers in the design and development of changes to services ensuring they are more visible, familiar and accessible to you and your community
<b>Partnership wide</b>	Ensure locality planning forums are more active in listening to communities by holding public events and using websites and social media to share information
	Implement our Participation and Engagement Strategy so that we are active and visible in local communities and engage with you in conversation about health and social care services and make every effort to engage with those who are 'seldom heard' in our communities
	Provide a range of peer support options to you, providing support from other local people with lived experience of specific issues.
<b>Children and families</b>	Develop locality based Early Years Leadership teams involving early years managers, education and local nurseries to identify local early years priorities, feed into locality planning forums and progress activity for improvement
	Create greater opportunity, through the Participation and Engagement Strategy for children, young people with care experience – and their families – to have their voices heard
	Help build strong circles of support around children and families, including developing mechanisms to identify and support young carers at the earliest stage
<b>Health and community care</b>	Encourage you to seek the correct professional (dentist, GP, pharmacist, optometrist) for your health concern advice
	Engage with our locality planning forums to better understand local needs to help develop multidisciplinary teams that targets resources at the earliest stage
<b>Mental health and learning disability</b>	Work with you and your communities, and our partners in the third and independent sectors, to identify and develop locally based activities to encourage independence, activity and social inclusion
	Work closely with communities and the third and independent sectors to develop community based addiction support services, including new anonymous drop-in sessions in localities for those who are concerned about their own, or another's alcohol and drugs
	Inform you of any changes we make to mental health services and regularly check with you that the service changes are working well and are beneficial
<b>Justice</b>	Appoint a dedicated Desistance Officer to support people in the justice system to integrate meaningfully within local communities

## Prevention and early intervention

Receiving support and care at an early stage can help to improve your long term quality of life. The impact of many health conditions, or events that lead to care interventions, may be reduced or even prevented if the right support is provided at the right time.

By promoting healthy living within supportive communities and by supporting you when concerns arise, we can work together to make significant improvements to your health, care and wellbeing.



Being able to get support, quickly and close to home, helps you to manage your concerns with more confidence. Immediate access to services can be challenging if you live in remote or rural North Ayrshire where transport and services are more limited. To improve your access and to help you get the support you need, we will work to provide services as close to where you live as possible.

We can help you to avoid developing severe health conditions by working with you to address your concerns at an early stage. This better enables you to live the life you want, including your personal safety and wellbeing.

When we act quickly we can protect the most vulnerable people in our communities and build protective networks around them to enable them to live happy and healthy lives.

You can help us with prevention and early intervention.

You can help by

Continuing and expanding on the healthy activities you already do, like walking regularly, exercising and cooking healthy meals.

## To shift our approach to prevention and early intervention, we will undertake the following:

Service area	To embed prevention and early intervention, we expect to:
Communities	Actively support you and your community so you can make informed decisions to help you keep active and well. Focussed support will include, self-management, the importance of a healthy diet, the benefits of physical activity and the risks associated with alcohol and substance misuse
	Develop services within localities that will provide you with the right health and social care support when you need it
	Help identify opportunities to prevent you from re-offending if you have been involved in the justice system
Partnership wide	Proactively identify concerns at the earliest stage to ensure multi-disciplinary team (MDT) support is available to people who are at greatest risk in our communities, due to frailty, multiple conditions or complex life circumstances
	Deliver training programmes to promote prevention, self-help and early intervention for the wider workforce and those who use services
	Create the opportunity and environment to support you adopt healthy lifestyle choices, including providing you with advice building a resource directory of health, social care and community services that are available to you
Children and families	Ensure health visitors offer 11 visits to all families from pre-birth to 5 years, helping families of young children, with breastfeeding support, infant nutrition, attachment, parenting issues, maternal mental health
	Work with partners in the Children's Services Strategic Partnership (CSSP) to raise awareness of 'No alcohol, No risk' in pregnancy message to help address the prevalence of foetal alcohol spectrum disorder.
	Continue to progress the Positive Family Partnership Strategy, through the Young Persons Support Team, delivering evidence based programmes that support young people affected by adverse circumstances.
	Continue to deliver the Multi Agency Assessment and Screening Hub (MAASH) to ensure fast response to domestic abuse and child welfare concerns.
Health and community care	Implement a primary care implementation plan to help you access a wider range of primary care services to ensure you continue to benefit from locally accessible MDT services that work with you, so that you have access to the best support and advice as early as possible including; GP, pharmacy, dentist and optometrist
	Implement early intervention and prevention approaches using an integrated approach on the islands of Arran and Cumbrae
	Provide more Community Link Workers in GP practices to enable you to access a wider range of local support options
Mental health and learning disability	Develop a range of low level community based supports for those with lived experience of mental health problems or addictions, including, further development of Veterans 1st Point, wider deliver of alcohol brief interventions (ABI), further roll out of computerised cognitive behavioural therapy (CBT), and development of a community based recovery college
	Develop a new model of primary care mental health, including a low intensity psychological therapy service to support those with mental health concerns
	Continue to develop child and adolescent mental health services (CAMHS) in further alignment with children's health and social work services and education
	Provide greater choice and flexibility around short breaks and day services to support you and those who care for you
Justice	Provide bail supervision as a mean of addressing needs related to risk



# Improving mental health and wellbeing

It is now estimated that more than 1 in 4 people will be affected by some form of mental ill-health at some point in their lives. We also know that 1 in 3 GP appointments relate to patients with mental ill-health.

Poor mental health influences many aspects of someone's potential.

Those with poor mental health are at risk of poor physical health.



People may become socially isolated and this can impact their social relationships and/or work opportunities. Very occasionally, mental health concerns may mean an individual's parental role is more challenging and, as a result, children may be vulnerable. Evidence shows that many people who become involved with the justice system as a result of adverse behaviour, also have underlying mental health problems.

We will continue to fully support you if you have existing mental ill-health. Furthermore, we will fully develop our early intervention and preventative approaches to stop you developing long term mental health conditions and support you in your recovery if you do.

You can help us improve mental health and wellbeing in North Ayrshire.

You can help by

Being understanding and empathetic towards those affected by poor mental health or addictions. Removing stigma and discrimination around these issues can help people in their recovery



Being more sociable in your community; getting to know your neighbours and helping to combat social isolation and loneliness

**To make a positive impact on the mental health and wellbeing of local people, we will undertake the following:**

<b>Service area</b>	<b>To improve mental health and wellbeing, we expect to:</b>
<b>Communities</b>	Work with communities to develop alternatives to statutory services that are more locality focussed, person centred, flexible and adaptable
	Support you to choose a community based support option, encouraging alternatives to prescribed medication, which will support you better to maintain improved mental health (e.g. physical activity)
	Ensure that if you misuse alcohol and drugs, you will be offered support and appointments close to where you live. To do this we will support a range of addiction related prescribers to offer locally available treatment and review opportunities
	Help you to remove barriers to achieving your personal and social aims (improving access to services, transport, stigma) and use assistive technology to provide less intrusive care that will ensure your safety as well as your independence, especially overnight
<b>Partnership wide</b>	Deliver the Mental Health Strategy 2017–2027 and Scotland’s National Dementia Strategy 2017–2020
	Work with partners to reduce the occurrence of social isolation
	Help individuals to have better choice and personal control of their support at an early stage by reinvigorating self-directed support (SDS) and the Partnership Charging Policy
<b>Children and families</b>	Bring together a single team of multi-skilled professionals in one primary school and one secondary school with the highest need to develop rapid intensive supports to young people and their families when needed
	Ensure vulnerable and emotionally affected children and young people have clear and immediate pathways to access appropriate CAMHS
<b>Health and community care</b>	Continue to develop dignified person-centred care and support for you if you are diagnosed and living with dementia
	Provide high-quality co-ordinated end of life care and support, by a range of specially trained and specialist staff, who will support you and your family
	Enact carer’s assessments/young carer’s statements to ensure we understand your goals, aspirations and preferences as well as how we can support you in your caring role.
<b>Justice</b>	Engage with service users in order to develop local Health Events to inform practice and service delivery



continued:

Service area	To improve mental health and wellbeing, we expect to:
<b>Mental health and learning disability Partnership wide</b>	Complete refurbishment and extension work at Tarryholme Drive and Warrix Avenue development, providing community based mental health services, including rehabilitation support
	Build the National Secure Adolescent Inpatient Service, as a Scotland-wide resource for young people. This will be based beside Woodland View, Irvine and construction will begin late in 2019–20 (subject to current business case and construction timescales being met)
	Review and maximise the community hospital estate to ensure services are coherent and designed to meet local need.
	Provide learning disability day services in a different, more targeted way, using a range of options to help you meet your personal goals
	Pilot Mental Health Practitioners in Three Towns and Kilwinning GP practices
	<b>As lead partner for mental health services across Ayrshire, we will:</b>
	Develop the mental health workforce in line with multi-disciplinary team working, including, expanding the prescribing capacity of advance nurse practitioners, pharmacists and GPs
	Continue to develop cluster modelling in schools and communities for children and young people
	Develop and deliver an intensive support services in CAMHS to provide a timely response to young people most in need
	Develop and implement the Ayrshire Mental Health Strategy
	Implement the findings of the psychological service review to continue to improve access to services
	Review the Psychiatric Emergency Plan with partners
	Deliver pan-Ayrshire Crisis Resolution Team (CRT) review with acute hospital and police partners
	Provide mental health services that will respond quickly to your needs and ensure people who are identified with mental health concerns by Police Scotland are referred onto CRT, who will provide community based support when possible
	Deliver North Ayrshire Learning Disability Strategy actions, including, review of respite services, day service review, supported accommodation, integrated teams, review of treatment and care models

## Bringing services together

Learning from the Healthier Scotland Conversation highlighted that services should be easily accessible and flexible to meet your needs. We need to be better at providing joined-up care and improve partnership working.



We are bringing together services, where appropriate, so that your care pathway is straightforward. We aim to develop seamless services so you can receive the care and support you need in an efficient and timely manner. We will improve how information is shared. If different services are involved in your care, we will ensure they work together to provide you with the best support possible.

We will continue bringing services together and will remove duplication where possible.

You can help us when we bring services together.

You can help by

Sharing your views and influencing the design and development of services, to ensure they are right for you and your community

.....

Telling us when things could be done better

.....

Accessing services, only when you really need to

## We will enhance our shared staff commitment to our vision and values. We will do this by:

Service area	To bring services together, we expect to:
<b>Communities</b>	Bring teams together and co-locate services, where possible, creating a single point of access to provide person centred care, treatment and support in localities
<b>Partnership wide</b>	Support our Integration Joint Board (IJB) to enact its full responsibility in terms of strategic planning, commissioning and the use of the unscheduled care pathway and set aside budget by developing commissioning plans to ensure that a range of community supports and new models of care are put in place that deliver best value and financial sustainability
	Support our Integration Joint Board (IJB) to effectively commission specialist hospital care services on a regional basis through the West of Scotland regional planning arrangements
	Strengthen communication and working relationships with staff groups, acute colleagues, third and independent sectors and East and South Partnership's to better achieve the goals of the Partnership
	Implement requirements set out by General Data Protection Regulation (GDPR) and develop a supporting Digital Strategy
	Implement the review of Business Support Services
<b>Children and families</b>	Develop 'Teams around the Family' in localities to ensure children, young people and their families have access to the right support when they need it.
	Ensure Universal Early Years teams consisting of social workers, health visitors, speech and language therapists, welfare rights advisors, mental health nurses and employability workers, are based within localities and aligned to GP practices
<b>Health and community care</b>	Ensure care is co-ordinated – and your family is involved as appropriate – so that you can go home from hospital as soon as you are well
	Ensure you have access to rapid community-based care, including short-term hospital care and reablement, to maximise your independence or to provide opportunity for further recovery when you need it. This includes the development of a See and Treat Service within Three Towns
	Implement the Review of Island Services for Arran and Cumbrae
<b>Mental health and learning disability</b>	Bring together mental health services to provide you with a local seamless mental health service
	Make the case to further roll out the 24 hour, 7 days per week, Police Triage Pathway within the Crisis Resolution Team to help prevent hospital admission and timely access to the right person at the right time.
	Develop a commissioning plan with the third and independent sectors to meet need, making best use of available resources to ensure delivery of best value and outcomes
<b>Justice</b>	Develop the desistance officer post and employability mentors to promote involvement and create/improve pathways for people to be meaningfully linked with existing services and maximise opportunities for training, volunteering experience, skills development and employment

# Measuring our performance

We measure our performance (actions and results) so that we can focus on how far our actual performance levels are from our targets. Sometimes targets are met or exceeded, sometimes they are not. We can then analyse our performance results and improve the way we work.

We work to continuously monitor and improve our services to ensure they are efficient and do what people need them to do. Managing and measuring our performance is all about ensuring we provide safe, efficient, person-centred care to those that use our health and social care services.



## Reporting our performance

The Scottish Government identified nine national health and wellbeing outcomes (for adults) that all health and social care partnerships work towards improving.

North Ayrshire Health and Social Care Partnership also works to improve three children's outcomes and three justice outcomes.

Health and social care partnerships are legally required by the Scottish Government to produce an annual performance report at the end of each financial year. Our annual report must show how we are working to improve outcomes for local people. We have produced two annual performance reports so far.

Here are the 15 outcomes that we work towards improving for people in North Ayrshire:

## National health and wellbeing outcomes for adults

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

## Outcomes for children

- 1 Our young people are successful learners, confident individuals, effective contributors and responsible citizens
- 2 We have improved the life chances for children, young people and families at risk
- 3 Our children have the best start in life and are ready to succeed

## Outcomes for people in the justice system

- 1 Public protection and community safety
- 2 Reduction of re-offending
- 3 Social inclusion to support desistance from offending



The Scottish Government also outlined a suite of 23 indicators that measure progress towards the nine national health and wellbeing outcomes for adults (see Appendix 7, page 79).

In addition, the Ministerial Strategic Group (MSG) for Health and Community Care developed a suite of six indicators (see Appendix 7, page 80) to monitor the effectiveness of health and social care integration.

### Improving our performance

We use a robust framework (a structure that enables us to categorise the outcomes of the people who use our services) to manage and analyse our performance. Everything we do is to improve people's health and wellbeing outcomes and falls within our five strategic priorities of tackling inequalities, engaging communities, prevention and early intervention, improving mental health and wellbeing, and bringing services together.

We have a regular reporting cycle to staff and stakeholders, including North Ayrshire Council, NHS Ayrshire & Arran, the Scottish Government and others. Areas of excellence are highlighted, underperformance is discussed and mitigating actions are put in place.

In addition to our local operational management information, our reporting includes:

- Six-monthly joint performance report for chief executives of North Ayrshire Council and NHS Ayrshire & Arran
- Three-monthly review by North Ayrshire IJB Performance and Audit Committee
- Six-monthly review of each Partnership directorate (Health and Community Care, Children, Families and Justice Services and Mental Health and Learning Disability Services) using the ASPIRE approach (All Services Performance Information Review and Evaluation)

Measuring our performance and managing our improvements means that we are working to serve the people of North Ayrshire in the best way by delivering high quality health and social care services that meet people's needs.

### Financial performance

Complementing the operational framework outlined above, we also use robust financial performance monitoring procedures. Financial sustainability and delivering services within available funding is essential. Our reporting and monitoring includes;

- Monthly financial reports viewed by IJB
- Continual financial monitoring versus the medium term financial plan (MTFP)
- Regular financial review of progress and delivery of projects designed to enhance financial sustainability

# Appendices





# Appendix 1 – Services included in North Ayrshire Integration Joint Board

## Children, Families and Justice Services

Child Protection Committee  
Children and Families Fieldwork  
Children's Homes  
Children with Disabilities Service  
Community Children's Services  
Fostering & Adoption  
Health Visiting  
Justice Social Work Services  
MAASH (Multi Agency Assessment Screening Hub)  
MADART (Multi Agency Domestic Abuse Response Team)  
Mentoring  
Practice & Policy  
Programmes Approach (Youth Justice)  
Rosemount Project Crisis Intervention and Intensive Support Service  
School Nursing  
Snap  
Social Work Access Services  
Social Work Fieldwork (Child Protection)  
Strategic Liaison with Education/ Early Years/Police  
Throughcare and Aftercare  
Universal Early Years  
YPSTIS (Young Persons Support Team Intervention Services)

## Health and Community Care Services

Acute Strategic Liaison  
Adult Support & Protection  
Aids and Adaptations  
Arran War Memorial Hospital  
Care at Home  
Care Homes  
Carer Support Services  
Community Alarms  
Day Care Centres  
Dementia Support Service including Anam Cara  
District Nursing  
Elderly Mental Health Community Liaison  
Frail Elderly Services  
Hospital-based Complex Care  
Housing Support Services  
Intermediate Hospital Services  
Lady Margaret Hospital (Cumbrae)  
Locality Social Work Teams  
Local Older People's Teams  
Meals at Home  
Money Matters  
Primary Care Services Liaison  
Reablement  
Rehabilitation and Intermediate Care (including Ward 1, Woodland View, Dirrans Centre, Health and Therapy Teams)  
Self-Directed Support  
Telecare

## Mental Health and Learning Disability Services

Acute Inpatient and Intensive Psychiatric Care  
Child Adolescent Mental Health Services (CAMHS)  
Community Eating Disorder Service  
Community Mental Health Team (including Social Work Team)  
Community Learning Disability Services (including Social Work Team)  
Community Learning Disability Day Services (Fergushill and Hazeldene)  
Elderly Mental Health Services  
In-Patient forensic and rehabilitation services at Woodland View Community Hospital  
North Ayrshire Drug and Alcohol Recovery Service (NADARS)  
Pan-Ayrshire Crisis Resolution Team  
Pan-Ayrshire Addiction and Prevention and Service Support Team  
Primary Care Mental Health Team  
Prison Services  
Psychiatric Liaison Team  
Psychological Services  
Student Mental Health and Wellbeing Officer (Ayrshire College)

## Appendix 2 – Documents and references

	Published	Published by	Web link
<b>Creating a Healthier Scotland</b> (Summary Report)	Mar 2017	Scottish Government	<a href="http://www.gov.scot/Resource/0049/00497965.pdf">www.gov.scot/Resource/0049/00497965.pdf</a>
<b>Everyone Matters</b> 2020 Workforce Vision	Jun 2013	Scottish Government	<a href="http://www.gov.scot/Resource/0042/00424225.pdf">www.gov.scot/Resource/0042/00424225.pdf</a>
<b>Fair for All</b> A strategy to reduce inequalities in North Ayrshire	Mar 2016	North Ayrshire Community Planning Partnership	<a href="http://www.northayrshire.community/about-us/fair-for-all/">www.northayrshire.community/about-us/fair-for-all/</a>
<b>Gaun Yersel!</b> The Self-Management Strategy for Long Term Conditions in Scotland	Aug 2008	Scottish Government	<a href="http://www.gov.scot/Resource/0042/00422988.pdf">www.gov.scot/Resource/0042/00422988.pdf</a>
<b>Getting it Right for You</b> North Ayrshire Children's Services Plan 2016–20	Mar 2016	North Ayrshire Children's Services Strategic Partnership	<a href="http://www.north-ayrshire.gov.uk/Documents/SocialServices/childrens-services-plan.pdf">www.north-ayrshire.gov.uk/Documents/SocialServices/childrens-services-plan.pdf</a>
<b>Health and Social Care Standards</b> My support, my life	Jun 2017	Scottish Government	<a href="http://www.gov.scot/Resource/0052/00520693.pdf">www.gov.scot/Resource/0052/00520693.pdf</a>
<b>Learning Disabilities Strategic Plan 2017–19</b>	2017	North Ayrshire Health and Social Care Partnership	<a href="http://www.north-ayrshire.gov.uk/Documents/SocialServices/learning-disability-strategy.pdf">www.north-ayrshire.gov.uk/Documents/SocialServices/learning-disability-strategy.pdf</a>
<b>Mental Health Strategy: 2017–27</b>	Mar 2017	Scottish Government	<a href="http://www.gov.scot/Resource/0051/00516047.pdf">www.gov.scot/Resource/0051/00516047.pdf</a>
<b>NHS Ayrshire &amp; Arran Mental Health and Wellbeing Strategy (2015–27)</b>		NHS Ayrshire & Arran (Public Health)	<a href="http://www20.south-ayrshire.gov.uk/ext/committee/CommitteePapers2015/Community%20Planning%20Board/24th%20February/AG11%20Appendix.pdf">ww20.south-ayrshire.gov.uk/ext/committee/CommitteePapers2015/Community%20Planning%20Board/24th%20February/AG11%20Appendix.pdf</a>
<b>North Ayrshire Corporate Parenting Plan 2017–20</b>	Oct 2017	North Ayrshire Children's Services Strategic Partnership	<a href="http://www.north-ayrshire.gov.uk/Documents/SocialServices/corporate-parenting-plan.pdf">www.north-ayrshire.gov.uk/Documents/SocialServices/corporate-parenting-plan.pdf</a>
<b>North Ayrshire Local Housing Strategy 2018–22</b>	Dec 2017	North Ayrshire Housing Services	<a href="http://www.north-ayrshire.gov.uk/Documents/PropertyServices/HousingBuilding/local-housing-strategy.pdf">www.north-ayrshire.gov.uk/Documents/PropertyServices/HousingBuilding/local-housing-strategy.pdf</a>
<b>Trees that bend in the wind:</b> Exploring the experiences of front line support workers delivering palliative and end of life care	Feb 2017	Scottish Care	<a href="http://www.scottishcare.org/wp-content/uploads/2017/02/PEOLC-Report-final-.pdf">www.scottishcare.org/wp-content/uploads/2017/02/PEOLC-Report-final-.pdf</a>

## Appendix 3 – Factors impacting mental health

	Protective factors	Risk factors
<b>Environmental</b>	Social protection and active labour market programmes against economic downturn	High unemployment rates
	Equality of access to services	Economic recession
	Safe, secure employment	Socio-economic deprivation and inequality
	Positive physical environment including housing, neighbourhoods and green space	Population alcohol consumption
		Exposure to trauma
<b>Social circumstances</b>	Social capital and community cohesion	Social fragmentation and poor social connections
	Physical safety and security	Social exclusion
	Good, nurturing parental/care relationships	Isolation
	Close and supportive partnership/family interaction	Childhood adversity (neglect, abuse, bullying)
	Educational achievement	(Gender-based) violence and abuse
		Family conflict
		Low income/poverty
<b>Individual factors</b>	Problem-solving skills	Low self-esteem
	Ability to manage stress or adversity	Loneliness
	Communication skills	Difficulty in communicating
	Good physical health and healthy living	Substance misuse
	Spirituality	Physical ill health and impairment
		Work stress
		Unemployment
		Debt

## Appendix 4 – Stepping stones to change

		Historical	Transitional	Future
1	<b>Specialist service delivery</b>	Specialist health care needs are dealt with by hospitals only	Community services are recognised as offering high quality, safe and effective care	Specialist support is provided in communities with access to hospital when people need it
2	<b>Service integration</b>	Care provided is disjointed, with handover of individuals between services	Bringing community health and social care services together to offer seamless service	Health and social care services are brought together
3	<b>Preventative</b>	The care delivered to meet acute needs is reactive	There is a strategy of proactive care and early intervention to meet ongoing needs	The emphasis is on a preventative approach, with ease of access to availability of information
4	<b>Partners in delivery</b>	Statutory agencies are responsible for planning and delivery of services and prioritisation of resources	Health and social care and the third sector and independent sectors operate as partners in the planning and delivery of services and prioritisation of resources	Communities plan, drive and deliver change and prioritise resources
5	<b>Self-care maturity</b>	Self-care is infrequent	Self-care is encouraged, supported and facilitated by health and social care and the third and independent sector	Self-care is encouraged, supported and facilitated by local communities
6	<b>Individual decision making</b>	Individuals are passive recipients care	Individual is engaged in decisions about their care	Individuals determines how their needs can be best met with professional support and advice.
7	<b>Valuing carers</b>	Carers are largely undervalued	Carers are valued and involved	The value of carers is recognised by local communities, and proactive help is given to support their role
8	<b>Managing risk and innovation</b>	Care and support is risk averse	Personalised care and support packages are developed with the goals of the individual in mind	Development of a new approach to managing risk, which ensures the delivery of safe, effective and innovative services

## Appendix 5 – Lead Partnership services

### East Ayrshire Health and Social Care Partnership

will lead the following services on behalf of the North and South Ayrshire Health and Social Care Partnerships:

East Ayrshire HSCP will continue to manage and deliver the following services on behalf of the North and South Partnerships.

- Primary Care (General Medical Services, General Dental Services, General Ophthalmic Services, Community Pharmacy)
- Public Dental Services
- Ayrshire Urgent Care Services
- Contracting for GP services for settings such as Prison Service and Police Custody Services

The agreed vision for primary care services across Ayrshire and Arran is to achieve:

***A strong local primary care service, supporting people in their day-to-day lives to get the best from their health, with the right care available in the right place when they need it. The overall theme is of partnership between individuals, communities, the health and social care and with partners.***

The Ayrshire and Arran vision aligns to the Scottish Government's vision for the future of primary care services, which is for multi-disciplinary teams, made up of a variety of health professionals, to work together to support people in the community.

In its Lead Partnership role, East Ayrshire is responsible for the development and implementation of the 'Ambitious for Ayrshire' programme of transformational change for Primary Care services. Good progress has been made in advancing the key priorities outlined in this programme, which includes the development of GP clusters and supporting the development of multidisciplinary team working in and with GP Practices, increasing capacity to provide

community-based services, improving workforce sustainability, improving primary care infrastructure and establishing an integrated Out Of Hours service.

Going forward our work will be informed by key Scottish Government policies including the new GP Contract 2018, 'Achieving Excellence in Pharmaceutical Care – A Strategy for Scotland', 'Community Eyecare Review', 'Oral Health Improvement Plan' and 'Realising Realistic Medicine' as well as addressing health inequalities.

This work is being delivered in partnership between communities, GP Practices, the three Ayrshire Health and Social Care Partnerships, Acute and third sector. These partners are committed to working collaboratively and positively to deliver real change in local health and care systems that support people to receive the right care at the right time.

### General medical services

General practice provides continuing, comprehensive, coordinated and person-centred healthcare to the communities of Ayrshire and Arran. A strong and thriving general practice is critical to sustaining high quality healthcare, which is available to all and which can realise Scotland's ambition to improve our population's health and reduce health inequalities.

A new General Medical Services (GMS) contract has been agreed with GPs and will be implemented across Ayrshire and Arran from April 2018. The way in which General Practice will work in the future will change in line with the new contract, the guiding principles of which are to support:

- accessible contact for individuals and communities
- comprehensive care of people – physical and mental health
- long term continuity of care enabling an effective therapeutic relationship
- co-ordinating care from a range of service providers

The benefits of the proposals is to develop partnerships between patients, their families and those delivering healthcare services to provide care which is appropriate and based on an assessment of individual needs and values and improves wellbeing, demonstrates continuity of care, clear communication and shared decision-making.

What this will mean for local residents is that other professionals such as Advanced Nurse Practitioners, Pharmacists and Community Link Workers or Connectors, Physiotherapists and Mental Health workers will work alongside GPs to assess and treat individuals in line with their own expertise. GPs will focus more on seeing patients who present with undifferentiated, chronic and complex illness where a GP's skills are required for diagnosis and development of a treatment plan. People often know what care they need and in future more people will be able to seek this directly, so that for example a person with shoulder pain may choose to see a Physiotherapist as a first point of contact, while individuals with minor ailments will increasingly find that Community Pharmacists can provide a range of treatment.

These new changes will be brought in over the next 3 years as part of a Primary Care Improvement Plan. East Ayrshire Integration Joint Board will have the responsibility to ensure the Plan is in place and delivered across Ayrshire.

Some of the first areas for change will be the way local people receive services such as vaccinations, repeat prescribing and medication reviews, community treatment and care services (e.g. minor injuries and dressings, phlebotomy, ear syringing, suture removal, chronic disease monitoring), urgent care and out of hours being supported by advanced practitioners (nurses and paramedics) including for home visits; physiotherapy, mental health services and more use of Community Connectors and Link Workers attached to GP practices.

The Plan will outline how these changes will be delivered before the end of the transition period at March 2021.

## **Community pharmacy**

The publication of 'Achieving Excellence in Pharmaceutical Care – A Strategy for Scotland' in 2017 by the Chief Pharmaceutical Officer for Scotland, provides an opportunity to review and align community pharmacy services with the Ambitious for Ayrshire vision for multi-disciplinary team (MDT) working in Primary Care. The Strategy makes a commitment to increase access to community pharmacy as the first port of call for self-limiting illnesses and supporting self-management of stable long term conditions, in and out of hours.

Through the Minor Ailment Service (MAS) community pharmacies are increasingly becoming the first port of call for eligible patients for a range of common clinical conditions and NHS Ayrshire & Arran has added to the range of common clinical conditions treatable by community pharmacists under the Pharmacy First Ayrshire service. Women between 16 and 65 can now be treated for uncomplicated urinary tract infections and patients aged 2 years and over, can also be treated for impetigo. Both conditions previously required prescriptions through GP practices or OOH services.

We are also expanding the range of common clinical conditions that can be treated by community pharmacists for other skin infections and shingles, and intend to further expand the range of conditions that can be treated. Expanding the range of common clinical conditions treated will improve outcomes for patients and reduce the workload for GPs and other health and social care professionals.

A number of community pharmacists are qualified as Independent Pharmacist Prescribers (IPPs), providing clinics from their community pharmacy, in conjunction with local GP practices. These clinics include respiratory clinics, as well as hypertension and sexual health



clinics. Further training and development of this workforce will unlock a further resource that can play a role in the MDT. Supporting patient self-management of long term conditions will improve outcomes for patients whilst reducing the workload of GPs and other health and social care professionals.

The changes to the GP contract and development of the pharmacotherapy service over the next 3 years provides us with an opportunity to introduce a serial prescription service to reduce the time spent in GP practices dealing with repeat prescriptions and to streamline the process at community pharmacies. If more patients have serial prescriptions in place this will allow a greater range of activities identified within the pharmacotherapy service to be carried out by the practice based pharmacists.

The development of GP practice based pharmacists also provides an opportunity for better joint working between GP practices and local community pharmacists. Their mutual understanding of one other's issues will provide opportunities to provide better patient care and medicines management.

## Optometry

Community optometrists provide a comprehensive eye examination service model to care for an aging population. The eye examination is universally funded and therefore free of charge to all eligible patients. Geographical access to eye care at optometrist practices across all HSCP's in NHS Ayrshire and Arran is good.

The 'Modern Outpatient Programme' (2016) outlines the further need for a collaborative approach to health care. In Ayrshire and Arran accredited optometrists provide locally enhanced eye care services reducing the burden on secondary care. These include: Low Visual Aids (Visual Impairment); Bridge to Vision (Learning Disability); Post-Operative Cataract Surgery Assessment; Medical Contact Lenses and Diabetic Retinopathy Screening.

Launched in February 2017, the 'Eyecare Ayrshire' re-direction initiative aims to shift the balance of care for eye problems from GP practices and EDs to local optometry practices and promotes the use of the optometrist as first point of contact for eye problems, advising people that eye drops will be available free of charge dispensed from community pharmacists.

Where needed electronic referrals are made directly from optometrists to the hospital eye service. These referrals allow for images to be attached which further enhance the effectiveness of the triage/vetting process and patient care as a consequence. NHS Ayrshire and Arran attain approximately 80% referrals electronically which compares favourably to other Health Boards.

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

## General dental services

The Scottish Government published the Oral Health Improvement Plan (OHIP) in January 2018. The plan sets the direction of travel for oral health improvement for the next generation and has a strong focus on reducing oral health inequalities, moving to a preventive based approach for NHS dentistry and meeting the needs of the ageing population.

The aims of the new plan are to focus on prevention, encouraging a more preventive approach to oral health care for patients of all ages to ensure that everyone can have the best oral health possible and that education and information sharing is specifically targeted at individuals and groups most at risk such as those who do not attend

regularly for check-ups, communities in low income areas and particularly those people who either smoked or drink heavily. New approaches will also be introduced to make it easier for dentists to treat older people who live in a care home or are cared for in their own home and to enable those dentists with enhanced skills to provide services that would otherwise be provided in a Hospital Dental Service i.e. oral surgery, treatment under intravenous sedation and complex restorative services.

The aim of the NHS Ayrshire and Arran Oral Health Strategy 2013–2023, closely aligns with the new national Plan with the aim of ensuring the 'best oral health possible for the people of Ayrshire and Arran'. The strategy covers stages of life (children and adults) and targets oral health promotion work for priority groups, such as the homeless and prisoners, people in care homes and those with specific care needs. We are currently progressing the NHS Ayrshire and Arran Oral Health Action Plan 2016–2019 and have completed the second year of the 3 year Plan and will continue to deliver oral health improvement activity over the remaining year of the Plan.

### **Ayrshire urgent care services**

NHS Ayrshire & Arran and East Ayrshire Health and Social Care Partnership has launched a new out-of-hours service which will bring together the skills, expertise and capacity of existing out of hours services to enable the citizens of Ayrshire to access the right person, with the right skills at the right time.

Launched in November 2017, the 'Ayrshire Urgent Care Service' (AUCS) brings together Primary Care and Social Work services into an 'urgent care hub', operating from the Lister Centre at University Hospital Crosshouse. This will be supported by local urgent care centres and the home visiting service as required. In partnership with NHS24 there will be continued promotion of self-care and redirection to the most appropriate service, for example local

pharmacist. Ayrshire Urgent Care Service includes

- Doctors and Advanced Nurse Practitioners
- Out-of-hours district nursing service
- Crisis Resolution Team;
- Out-of-hours social work
- East Ayrshire overnight emergency response personal carers
- Service support staff

This redesign is in-line with national policy for urgent care services as set out in the report 'Pulling Together: transforming urgent care for the people of Scotland, 2016', which recognised the difficulty in sustaining GP involvement in out-of-hours services. The service will continue to test new ways of working to ensure a safe, high quality, effective and efficient out of hours service is delivered to the communities of Ayrshire

Ayrshire and Arran will continue to have an out-of-hours primary care service which will include Doctors and Advanced Nurse Practitioners working as part of a wider team to ensure that members of the public will see the most appropriate healthcare professional

## North Ayrshire Health and Social Care Partnership

manages and delivers the following Mental Health services on behalf of the HSCPs in East and South Ayrshire:

### Mental Health Inpatient Services

NA HSCP leads on wide range Mental Health Inpatient services across Ayrshire, including,

- Addictions services
- Psychiatric Medical Services
- Forensic Services
- Liaison Services

The service also delivers adult and older adult mental health services from the newly developed Woodland View Community Hospital in Irvine and manages elderly mental health wards at the Ailsa Hospital site in Ayr.

### Crisis Resolution Team

The Ayrshire Crisis Resolution Team offers a home based alternative to in-patient care for adults (aged 16–65) experiencing acute and severe mental health crisis. The service offers short term support up to 21 days, in line with the national standards for crisis services.

### Psychology Services

Psychological Services are provided across Ayrshire and Arran and are embedded within various specialist teams. Specialities covered are:

- Child Psychology
- Adult Mental Health
- Older Adults, physical health and neuropsychology
- Learning disability services



The service deploys a range of staff within these specialist roles to undertake focused work, such as primary care mental health, community mental health and eating disorders.

### Learning Disability Assessment and Treatment Service

The Learning Disability and Treatment Service based at Arrol Park Resource Centre, provides an inpatient facility for individuals who require a high level of support for a period of time. Care and support is provided by a range of specialist professionals.

### Child and Adolescent Mental Health Service (CAMHS)

CAMHS service is available to young people aged 5 to 18 years old and offers short term treatments for those with mild to moderate mental health problems; to more complex treatments for children and young people experiencing more severe and complex problems.

North Ayrshire shall deliver mental health services in line with the 10 year National Mental Health Strategy 2017–2027. This strategy aims to ensure that mental health problems are treated with the same commitment and passion as physical health problems. We will work to improve:

- Prevention and early intervention
- Access to treatment, and joined up accessible services
- The physical wellbeing of people with mental health problems
- Rights, information use, and planning

In developing a localised, pan-Ayrshire approach, the North Ayrshire Partnership will actively engage with local people and stakeholders via public consultation and a series of public events. Engagement activity is scheduled to take place from May to July 2018.

In addition North Ayrshire has lead responsibility for the following early year's services:

### Child Immunisation Team

In East and South Ayrshire, the HSCP Immunisation Team deliver all immunisation clinics, where in North clinics are delivered by both the Immunisation Team and many GP surgeries.

The team is also responsible for the pupil immunisation programme in all Ayrshire schools.

### Community Infant Feeding Service

The community infant feeding nurse works across Ayrshire to provide a specialist service to families experiencing complex challenges with infant feeding. The service supports health visiting staff with advice and provides direct support to families via telephone, face to face discussions or home visits.

### Child Health Administration

Child Health Administration team co-ordinates, manages and supports the delivery of Ayrshire's child immunisation programme and development screening programmes. The team maintains all records and information in relation to its remit and provides information to the Information Statistics Division (ISD) via nationally established data systems.

Over the next three years, the early years teams will support the implementation of the 3 year Vaccination Transformation Programme and will prepare for the replacement of the current Child Health & Community Health Index (CHI) system, expected by 2020.

In developing a localised, pan-Ayrshire approach, the **North Ayrshire Partnership will actively engage with local people and stakeholders via public consultation and a series of public events. Engagement activity is scheduled to take place from May to July 2018.**

### South Ayrshire Health and Social Care Partnership

manages and delivers the following services on behalf of the HSCPs in East and North Ayrshire:



### Allied Health Professionals

South Ayrshire HSCP leads on Allied Health Professional (AHP) services across Ayrshire. Within this remit are the following services: Dietetics, Orthotics, Occupational Therapy, Physiotherapy, Podiatry and Speech and Language Therapy. AHPs are a distinct group of specialist and sub-specialist practitioners who apply their expertise to diagnose, treat and rehabilitate people of all ages within mental and physical health, education and social care and across acute and community settings. They work with a range of technical and support staff to deliver direct care and provide rehabilitation, self-management, "enabling" and health improvement interventions. The Active and Independent Living Programme provides a National Strategic framework for the development of AHP services. Locally, four key work streams have been identified to ensure that teams have the necessary support and infrastructure to contribute to the development of services: Workforce; Staff Support and Development; Data for Improvement and Research and Development and Evaluation.

### Falls Prevention

A Falls Strategy Position Statement was developed in 2016 which outlined the local response to the national action framework for The Prevention and Management of Falls in the Community (Scottish Government, 2014). Key areas for future action by each of the Ayrshire Partnerships have been identified to both reduce the numbers of people who fall and improve the personal outcomes for those people who experience a fall. Further development of

the multi-agency, pan-Ayrshire falls pathways is required, as well as improved access to community services and local supports that will improve an individual's ability to perform daily activity and reduce anxiety around falling.

### **Sensory Impairment**

Key priority areas have been identified by the Sensory Impairment Service. A Pan-Ayrshire British Sign Language Plan is being developed and requires to be published by October 2018. Other key areas that will be prioritised include the development and provision of Sensory Impairment Awareness Training; the development of mechanisms to share service user's confidential information across council services; to improve access to service buildings; to provide a wider range of diagnostic procedures and specialist services in the community; and to develop a structure where those with sensory loss are involved to improve services.

### **Continence**

The Integrated Continence Service promotes continence by empowering patients to self-manage through behaviour and lifestyle interventions. The objectives of the service are to offer intermediate clinics across Ayrshire, to offer an advisory service to patients, carers and voluntary organisations and also an educational service to NHS clinicians.

### **Technology Enabled Care (TEC)**

The Ayrshire and Arran Strategy for TEC and Innovation outlines the need to harness advances in technology and to develop the use of TEC across Ayrshire and Arran over the next three years. North, South and East Ayrshire Health and Social Care Partnerships and Acute Services are currently redesigning models of care and TEC will support, and further enable, the transformational redesign of services, the workforce and infrastructure.

### **Joint Equipment Store**

South Ayrshire and East Ayrshire Health and Social Care Partnerships and NHS Ayrshire & Arran have developed a proposal to establish a joint store for the provision of equipment to people living in the community.

The equipment referred to is wide ranging and intended to enable people to live safely within their own homes.

4,589

Arran is the largest Island on the Firth of Clyde and has a population of approximately 4,589 people, however the population has a seasonal variance, with an increase in temporary residents between April and October.

83.8  
years  
life expectancy81.1  
years

The Arran locality has a higher life expectancy compared to the rest of North Ayrshire, and is also above the Scottish average, however Arran has a much higher frail elderly population (1 third), who have more than one health condition.

The working age population is set to fall to 4 in 10 of the local population by 2026.

0.0%  
Live in Deprivation

The island has relatively low levels of deprivation, and unemployment.

0.6%  
Unemployment Rate

Of the 7 datazones in Arran, none of them fall into the most deprived in Scotland, however it should be noted that pockets of deprivation on the island will still exist.

### Arran Locality Planning Forum have identified three priorities for the area

- Transport solutions for local people
- Social isolation
- Improved support to those with complex care needs

1 in 18  
hospital

patients from Arran that are **65+** and have been admitted to hospital as an emergency on multiple occasions

Based on patients **65+** with 2 or more emergency hospital admissions

44%  
of people

live in areas considered to be 'access deprived'

Based on % of population living within '20% most access deprived' areas in Scotland  
Access: Transport time to GP, petrol station, post office, schools, retail etc

29%  
of adults

in Arran live within a single adult dwelling

Number and percentage of dwelling subject to Council Tax Discount of 25%. This may include for example dwelling with a single adult dwellings with one adult living with one or more children, or with more adults who are 'disregarded' for Council Tax purposes

1 in 13  
patients

admitted to hospital from Arran are admitted in an emergency

Based on patients discharged from hospital following an emergency admission



20,329

Beith, Dalry and Kilbrinie make up the main towns within the Garnock Valley. The area has a combined population of approx. 20,329, which accounts for 15% of the total North Ayrshire Population.

**81.9 years**  
life expectancy



In recent years, Female Life Expectancy has increased with the Kilbirnie North area now hosting the highest Female Life Expectancy within North Ayrshire.

**75.6 years**



The area has a high percentage of the population of working age, and has an overall low dependency ratio (for every 100 people working, 59 people are dependent on them)

 **37.5%**  
Live in Deprivation

The Garnock Valley has high levels of deprivation and unemployment.

 **4.2%**  
Unemployment Rate

Of the 27 datazones in the Garnock Valley, 10 fall into the Most Deprived in Scotland. This equates to more than a third of the Garnock Valley population being considered to live in deprivation.

### Garnock Valley Locality Planning Forum have identified four priorities for the area

- Young people mental health and wellbeing
- Low level mental health, all ages
- Social isolation
- Impact of MSK




Population prescribed drugs for anxiety/depression/psychosis  
**Garnock Valley: 18%**  
**North Ayrshire: 20%**  
**Scotland: 18%**

more than **1 in 300**



people from the Garnock Valley will have an admission to a mental health hospital

Based on 3 year aggregate.

**41%**   
of adults in Garnock Valley live within a single adult dwelling

Number and percentage of dwelling subject to Council Tax Discount of 25%. This may include for example dwelling with a single adult dwellings with one adult living with one or more children, or with more adults who are 'disregarded' for Council Tax purposes

**1 in 10**   
patients admitted to hospital from the Garnock Valley are admitted in an emergency

Based on patients discharged from hospital following an emergency admission

**39,387**

Irvine has a population of approx. 39,387, which accounts for 29% of the total North Ayrshire Population and is the most highly populated areas within North Ayrshire.

**78.8 years**  
life expectancy



**74.7 years**



Both male and female Life Expectancy has increased in recent years. The area Irvine Perceton and Lawthorn has the highest male life expectancy in North Ayrshire however, the Irvine Locality also hosts the lowest male life expectancy (Irvine Fullarton) within North Ayrshire.

Irvine has an overall younger age profile, and this contributes to the area having a high number of people of working age.

**44.3%**  
Live in Deprivation



**4.1%**  
Unemployment Rate



The Irvine Locality has high levels of health deprivation as well as high levels of unemployment (2nd highest in North Ayrshire), which contributes to local people experiencing a wide range of health issues.

Of the 55 datazones within the locality, 24 fall into the most deprived in Scotland.

### Irvine Locality Planning Forum have identified four priorities for the area

- Young people mental health and wellbeing
- Low level mental health, all ages
- Social isolation
- Impact of MSK

Population Prescribed Drugs for anxiety/depression/psychosis  
**Irvine: 22%**  
**North Ayrshire: 20%**  
**Scotland: 18%**



more than **1 in 300** people from Irvine will have an admission to a mental health hospital



Based on 3 year aggregate

**41%** of adults in Irvine live within a single adult dwelling.



Number and percentage of dwelling subject to Council Tax Discount of 25%. This may include for example dwelling with a single adult dwellings with one adult living with one or more children, or with more adults who are 'disregarded' for Council Tax purposes

**1 in 9** patients admitted to hospital from Irvine are admitted in an emergency



Based on patients discharged from hospital following an emergency admission

16,203

Kilwinning has a population of approx. 16,203, which accounts for 12% of the total North Ayrshire Population and is one the smaller localities within North Ayrshire.

80.3  
years

life expectancy

76.3  
years

In recent years, overall there has been a slight decrease in life expectancy in the Kilwinning Locality. Kilwinning Whitehirst Park and Woodside previously hosted the highest male life expectancy in North Ayrshire, however this has decreased over the years and is now the second highest.

Kilwinning has an overall younger age profile, with a high percentage of people being of working age. The locality also has the lowest rate of over 65s of all the localities.


 46.3%  
Live in Deprivation

In recent years the Kilwinning locality has grown in affluence, with declining levels of multiple deprivation and income deprivation, however almost 50% of the population still live in deprivation.


 3.6%  
Unemployment Rate

Of the 22 datazone within the locality, 9 fall into the most deprived in Scotland.

### Kilwinning Locality Planning Forum have identified three priorities for the area

- Engage with early years centres
- Provide GP visiting sessions to nursing homes
- Provide OT in local pharmacy

Childhood obesity in Primary 1  
**Kilwinning: 12%**  
**North Ayrshire: 12%**  
**Scotland: 10%**

Children whose BMI is within the top 5% of the 1990 UK reference age for their age and sex – % of all children reviewed in 2015–16 school year

Breastfeeding at 6–8 weeks  
**Kilwinning: 18%**  
**North Ayrshire: 17%**  
**Scotland: 28%**

Based on 3 year rolling average of % of babies reported by parents to be breastfed at 6-8 week review.  
 2013–14 to 2015–16 financial years

 39%  
of adults


in Irvine live within a single adult dwelling.

Number and percentage of dwelling subject to Council Tax Discount of 25%. This may include for example dwelling with a single adult dwellings with one adult living with one or more children, or with more adults who are 'disregarded' for Council Tax purposes

1 in 13  
patients  
admitted to  
hospital from  
Irvine are admitted  
in an emergency



Based on patients discharged from hospital following an emergency admission

22,851

The North Coast and Cumbraes included the towns in West Kilbride, Fairlie, Largs, Cumbrae and Skelmorlie. It has a combined population of 22,851, which accounts for 17% of the total North Ayrshire population.

84.5  
years

life expectancy

79.7  
years

Female life expectancy is the highest in North Ayrshire, while Male life expectancy is also one of the highest in North Ayrshire.

There is a large elderly demographic within this locality, which bring significant health and social care challenges, as people are living longer with multiple co-morbidities and disabilities. The elderly population within the locality is set to increase by 16% in 2026.

9.6%  
Live in Deprivation

This locality is one of the most affluent in North Ayrshire and has one of the lowest rates of unemployment. Household income tends to be higher here although there are still some pockets of deprivation.

1.8%  
Unemployment Rate

Of the 31 datazones within the locality three fall into the Most Deprived in Scotland, including the isle of Cumbrae which is classed as a fragile economy.

### North Coast Locality Planning Forum have identified four priorities for the area

- Support to young people with stress and anxiety
- Social isolation
- Impact of MSK



Population Prescribed Drugs for anxiety/depression/psychosis  
**North Coast: 16%**  
**North Ayrshire: 20%**  
**Scotland: 18%**

more than  
1 in 600

people from the North Coast will have an admission to a mental health hospital

Based on 3 year aggregate

31%  
of people

live in areas considered to be 'access deprived'

Based on % of population living within '20% most access deprived' areas in Scotland.  
 Access: Transport time to GP, petrol station, post office, schools, retail etc

1 in 13  
patients  
admitted to

hospital from the North Coast are admitted in an emergency

Based on patients discharged from hospital following an emergency admission

32,981

The Three Towns consist of Ardrossan, Saltcoats and Stevenson and approximately has a combined population of 32,981. This accounts for 24% of the total North Ayrshire population.

**81.1 years**  
life expectancy



Female Life expectancy has increased slightly in recent years while Male Life Expectancy has decreased somewhat slightly. The area Saltcoats Central hosts the lowest Female Life Expectancy in North Ayrshire.

**74.8 years**



The area has seen a rise in the young adult population that is coupled with improving education performance and school attendance.

**56.3%**  
Live in Deprivation



The Three Towns locality has a high level of deprivation (highest in North Ayrshire) coupled with rising levels of health deprivation. Of the 44 intermediate zones within the locality, 24 fall within the most deprived in Scotland.

**4.7%**  
Unemployment Rate



The Three Towns also has the highest rate of unemployment in North Ayrshire.

### Three Towns Locality Planning Forum have identified three priorities for the area

- Mental health and wellbeing of young people
- Social isolation
- Improve support to those with complex care needs



Population Prescribed Drugs for anxiety/depression/psychosis  
**Three Towns: 22%**  
**North Ayrshire: 20%**  
**Scotland: 18%**

**around 1 in 300**  
people from the Three Towns will have an admission to a mental health hospital



Based on 3 year aggregate.  
Note: patients are counted only once per year

**44%**  
of adults in the Three Towns live within a single adult dwelling



Number and percentage of dwelling subject to Council Tax Discount of 25%. This may include for example dwelling with a single adult dwellings with one adult living with one or more children, or with more adults who are 'disregarded' for Council Tax purposes

**1 in 9**  
patients admitted to hospital from the three town are admitted in an emergency.



Based on patients discharged from Hospital following an emergency admission

## Locality profile data sources

Measurement	Source
Population	Scottish Index of Multiple Deprivation 2016
Life expectancy	Scotpho, 2011 (5 year average)
Live in deprivation	Scottish Index of Multiple Deprivation 2016
Unemployment claimant rate	September 2017 Claimant Rates
Prescribed drugs	Scotpho & ISD, 2015–16 financial year
Mental health hospital admission	Scotpho, 2013/14–2015/16, 3 year rolling average
Single adult dwelling	Scotpho & NRS, 2016
20% access deprived	Scottish Index of Multiple Deprivation 2016
Breastfeeding 6-8 weeks	Scotpho, 2013/14–2015/16, 3 year rolling average
Childhood obesity	Scotpho, In primary 1, 2015–16 academic year
Emergency admissions	Scotpho, 2013–2015, 3 year rolling average
Patients 65+ with multiple emergency admissions	Scotpho, 2013–2015, 3 year rolling average





## Appendix 7 – National indicators

- 1** Percentage of adults able to look after their health very well or quite well.
- 2** Percentage of adults supported at home who agree that they are supported to live as independently as possible.
- 3** Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided.
- 4** Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated.
- 5** Percentage of adults receiving any care or support who rate it as excellent or good
- 6** Percentage of people with positive experience of care at their GP practice.
- 7** Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life.
- 8** Percentage of carers who feel supported to continue in their caring role.
- 9** Percentage of adults supported at home who agree they felt safe.
- 10** Percentage of staff who say they would recommend their workplace as a good place to work.\*
- 11** Premature mortality rate.
- 12** Rate of emergency admissions for adults.
- 13** Rate of emergency bed days for adults.
- 14** Readmissions to hospital within 28 days of discharge.
- 15** Proportion of last 6 months of life spent at home or in community setting.

- 16** Falls rate per 1,000 population in over 65s.
- 17** Proportion of care services graded 'good' (4) or better in Care Inspectorate Inspections.
- 18** Percentage of adults with intensive needs receiving care at home.
- 19** Number of days people spend in hospital when they are ready to be discharged.
- 20** Percentage of total health and care spend on hospital stays where the patient was admitted in an emergency.
- 21** Percentage of people admitted from home to hospital during the year, who are discharged to a care home.
- 22** Percentage of people who are discharged from hospital within 72 hours of being ready.\*
- 23** Expenditure on end of life care.\*

\*Still under development by the Scottish Government

## MSG indicators

- 1** Unplanned admissions
- 2** Occupied bed days for unscheduled care
- 3** A&E performance
- 4** Delayed discharges
- 5** End of life care
- 6** The balance of spend across institutional and community services

## Abbreviations used in this document

ABI	Alcohol (and Drug) Brief Intervention
ADP	Alcohol and Drug Partnership
AHPs	Allied Health Professionals
ASP	Adult Support and Protection
CAMHS	Child and Adolescent Mental Health Service
CBT	Cognitive Behavioural Therapy
CPAG	Child Poverty Action Group
CPP	Community Planning Partnership
CRT	Crisis Resolution Team
CSSP	Children's Services Strategic Partnership
ED	Emergency Department (Previously Accident and Emergency (A&E))
GBV	Gender Based Violence
GP	General Practitioner/General Practice
HSCP	Health and Social Care Partnership
IJB	Integration Joint Board
IPS	Individual Placement Support
LPF	Locality Planning Forum
LRF	Locality Resource Forum (Early Years)

MAASH	Multi Agency Assessment and Screening Hub
MADART	Multi Agency Domestic Abuse Response Team
MDT	Multi-disciplinary Team
MSG	Ministerial Strategic Group
MSK	Musculoskeletal
MTFP	Medium Term Financial Plan
NA	North Ayrshire
NADARS	North Ayrshire Drug and Alcohol Recovery Service
NHS	National Health Service
NIN	National Involvement Network
NPS	New Psychoactive Substances (Legal Highs)
PB	Participatory Budgeting
ScotPHO	Scottish Public Health Observatory
SIMD	Scottish Index of Multiple Deprivation
TEC	Technology Enabled Care
TSI	Third Sector Interface
UEY	Universal Early Years
WMTY	What Matters To You?



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