south ayrshire
health & social care
partnership

Annual Performance Report 2016/17

July 2017

NHS Ayrshire & Arran

South Ayrshire Council

Contents

DIRECTOR'S INTRODUCTION

South Ayrshire Health and Social Care Partnership brings together a wide range of health and social care services into a single operational delivery unit – all with a shared vision to, 'work together for the best possible health and wellbeing for our communities'.

This is the second Annual Performance Report for the South Ayrshire Health and Social Care Partnership. It allows us to reflect on the previous year – celebrate significant progress made and consider our agenda for the year ahead.

Over the past 12 months we have worked hard on our priority areas and details of achievements and progress are provided in this report.

Our Locality Planning arrangements have continued to develop and mature. Each of the six Locality Planning Groups has identified local priorities that they are addressing through bespoke local arrangements.

Our Transformational Change Programme, instigated in 2015/16 has developed further with a range of improvement areas identified such as:

- Anticipatory Care Planning;
- the forming of an Intermediate Care Team;
- developing Community Rehabilitation Services;
- the redesign of services within Biggart Hospital;
- supporting service re-design work at University Hospital Ayr;
- Care at Home service re design; and
- the implementation of the new Care First Social Work Information System.

In Children's Services – a Joint Children's Services Improvement Plan has been developed, reflecting the recommendations of the Joint Children's Services Inspection which took place during the year.

The Partnership is still working towards the co-location of teams within communities alongside the alignment of HSCP staff with GP Practices. One major movement in this regard has been the establishment of a HSCP Headquarters based at Elgin House in Ailsa Hospital. The co-location of senior managers, planning, performance and other staff has allowed more efficient arrangements and increased the momentum for change.

The Partnership has been established in a challenging environment of increasing demand and on-going austerity, but this has not deflected us from maintaining the provision of high quality front line services which have been delivered within the budget available from the Integration Joint Board. Whilst I am assured by the range of developments that have taken place and which have begun to produce a palpable impact over the last year, this process needs to be further strengthened to allow material improvements to be made to people's lives in the years ahead.

Tim Eltringham
Director, South Ayrshire Health and Social Care Partnership

STRATEGIC CONTEXT

The South Ayrshire Health and Social Care Partnership was formally established in April 2015 and brings together a wide range of health and social work services into a single operational delivery unit. The Integration Joint Board which is the principal governance group of the Partnership is responsible for planning, resource allocation and for overseeing the delivery of a full range of community health and social care services. These include; those for older people, adults, children and families and people in the Criminal Justice system in South Ayrshire. It is also responsible for a number of Pan-Ayrshire health services relating to Allied Health Professionals, Continence, Joint Equipment, Technology Enabled Care and Sensory Impairment.

The Integration Joint Board approved its first Strategic Plan at its inaugural meeting on 2 April, 2015 paragraph 13.1 of the approved Strategic Plan states that it will be reviewed and rolled-on each year. The process followed in this regard has been in accordance with that laid out by Scottish Ministers in Regulation. The Integration Joint Board held a workshop on 18th February 2016, with the Strategic Planning Advisory Group to discuss and agree the text of the updated Strategic Plan. The updated and rolled on Strategic Plan was subsequently approved by the IJB on 17 June 2016.

South Ayrshire Health and Social Care Partnership has responsibility for the delivery of the Community Planning Partnership priorities, as outlined in the Single Outcome Agreement, associated with Health and Wellbeing.

The HSCP vision is:

Working together for the best possible health and wellbeing of our communities

To deliver on this vision the Integration Joint Board has agreed the following strategic objectives:

- We will work together to reduce the inequality gradient and, in particular, address health inequality.
- We will protect children and vulnerable adults from harm.
- We will ensure children have the best possible start in life.
- We will support people to live independently and healthily in local communities.
- We will prioritise preventative, anticipatory and early intervention approaches.
- We will proactively integrate health and social care services and resources for adults and children.
- We will develop local responses to local needs.
- We will ensure robust and comprehensive partnership arrangements are in place.
- We will support and develop our staff and local people.
- We will operate sound strategic and operational management systems and processes.
- We will communicate in a clear, open and transparent way.

These strategic objectives are underpinned by our shared values:

- Safety
- Engaged
- Individually focused
- Integrity
- Caring
- Respectful

NATIONAL HEALTH AND WELLBEING OUTCOMES

The Scottish Government has set 15 National Health and Wellbeing Outcomes which detail what health and social care partners are working towards through integration. These Outcomes guide the activity of the South Ayrshire Health and Social Care Partnership. They are supported by a core suite of 23 National Performance Indicators. This report sets out our progress against these outcomes.

Health and Wellbeing Outcomes	
1.	People are able to look after and improve their own health and wellbeing and live in good health for longer.
2.	People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.
3.	People who use health and social care services have positive experiences of those services, and have their dignity respected.
4.	Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.
5.	Health and social care services contribute to reducing health inequalities.
6.	People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being.
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.
National Outcomes for Children	
10.	Our children have the best possible start in life.
11.	Our young people are successful learners, confident individuals, effective contributors and responsible citizens.
12.	We have improved the life chances for children, young people and families at risk.
National Outcomes for Justice	
13.	Community safety and public protection.
14.	The reduction of reoffending.
15.	Social inclusion to support desistance from offending.

Performance against the National Health and Wellbeing Outcomes

Performance against each of the National Health and Wellbeing Outcomes and associated National Performance Indicators is detailed below. Where relevant, performance against associated Local Performance Indicators is also provided. Further information for each action can be found in the Monitoring Report on Health and Social Care Implementation Plan.

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

National Performance Indicator		SAHSCP Baseline	Latest Value	Scotland Latest Value	RAG
1.1	% of adults able to look after their health very well or quite well (NI-1)	94% (2013/14)	94% (2015/16)	94% (2015/16)	

Local Performance Indicator		SAHSCP Baseline	Latest Value	Scotland Latest Value	RAG
1.2	% of adults who smoke (SOA)	22%	22%	21%	

		(2013)	(2014)	(2014)	
1.3	Rate of alcohol related hospital stays per 100,000 population (HSCP PF)	722.9 (2014/15)	702.9 (2015/16)	664.5 (2015/16)	
1.4	Rate of drug related hospital stays per 100,000 (HSCP PF)	176.5 (2014/15)	170.5 (2015/16)	142.5 (2015/16)	

Performance Analysis

- The percentage of adults able to look after their health very or quite well has been maintained at 94% which is in line with the national average.
- The percentage of adults who smoke has remained fairly static at 22% over the past two years and is just slightly higher than the national average.
- Performance has improved around the rate of alcohol related hospital stays with a reduction from 723 in 2014/15 to 703 in 2015/16 per 100,000 population. Drug related hospital stays have also reduced over the past year from 176.5 to 170.5 in 2015/16. Both alcohol and drug related hospital stay rates are higher in South Ayrshire than across Scotland.

Partnership Activity to Deliver Against National Outcomes

Within the resources available, universal services are delivered in proportion to need and combined with targeted and intensive support for those experiencing the greatest need or at highest risk, and this includes treatment and recovery support for those experiencing addictions.

Following a review of the previous Alcohol and Drug Strategy, South Ayrshire's Alcohol and Drug Partnership has developed a new Strategic Delivery & Commissioning Plan for 2015-18 which builds on the previous strategy and is aimed at working with individuals and local communities to identify their strengths and assets to reduce the impact of alcohol and drug misuse on individuals, families and communities. It identifies four priority work streams; Prevention, education and early intervention; Healthier and safer communities; Children and families affected by others' substance misuse; Implementing a Recovery Orientated System of Care, which will contribute to achieving the overarching vision.

A Tobacco Control Action Plan (2015-2018) has also been developed, based on 3 key themes:

- Cessation - which focuses on early years; children and young people; young adults aged 16-25; and adults aged 25- 64.
- Prevention - which focuses on young adults aged 16-24.
- Protection - which focuses on early years (pre-conception to 9 years).

Health and Social Care Partnerships offer an opportunity for both health and social care staff to raise the issue of smoking and signpost people to appropriate services; Public Health are working with Partnerships to ensure that they have the correct training and resources to allow them to take this forward.

Implementation of both the Alcohol and Drug Strategy and the Tobacco Control Action Plan is being monitored to determine impact on local performance indicators. Two South Ayrshire Alcohol and Drug Partnership initiatives: ADP Volunteer Peer Worker Project, and Children and families social work (addictions), were highlighted as good practice in a Care Inspectorate report; Care Inspectorate - Alcohol and Drug Partnerships - A report on the use and impact of the Quality Principles through validated self-assessment .

CASE STUDY

Recovery in Action – Our Journey, Your Journey

4th November 2016

Over the past four years the Alcohol and Drug Partnership (ADP) has taken a phased-approach to implementing a *Recovery Orientated System of Care* (ROSC) in South Ayrshire. The ROSC helps people to take charge of their own recovery and is well suited to the asset-based community development approach.

At its heart, the ROSC believes that recovery is possible and is at the centre of all services; that people will own their recovery journey; that people in recovery will support others on their recovery journey; that communities will support their members through recovery; and that people in recovery will support their communities.

The ADP has supported service users, peers and staff to develop a range of innovate projects to support individuals in recovery and their family and friends to move towards sustained recovery, training, employment and to become more involved in their local community.

On 4th November 2016 over 100 people attended the local Recovery in Action – Our Journey, Your Journey event, which aimed to showcase the journey over the last four years of moving towards a ROSC model.

The interactive event included a range of presentations from service users, peers, families and local services. Attendees were provided with information on the development of the ADP vision and the early activities including developing service user involvement, a recovery walk and Café Hope, a local recovery café.

Individuals described their experiences of being involved in the ADP Volunteer Peer Worker Project, including their work-based placements in local services and SVQ qualifications. Volunteers shared their experiences of being involved in recovery communities, the impact this has had on their lives and the lives of their families and friends. Presentations also included the importance of developing recovery projects in rural areas and the benefits and challenges this can bring.

The afternoon session included presentations on the importance of whole family recovery and developing new projects which are focussing on family support. A young person spoke about their experience of being supported by an ADP Volunteer Peer Worker, and the service provider described the positive impact of having a peer within the staff team.

Occupational Therapy staff provided entertaining presentations on the Work, Alcohol, Tobacco, Obesity and Mental Health (WATOM) and Physical Activity Group. The afternoon concluded with presentations from the Department of Work and Pensions on the innovative joint work with the ADP and the new Steps for Change Project. This project focusses on providing more intensive support for individuals in recovery to access training and move towards employment.

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.

National Performance Indicator		SAHSCP Baseline	Latest Value	Scotland Latest Value	RAG Status
2.1	% of adults supported at home who agree that they are supported to live as	83% (2013/14)	83% (2015/16)	84% (2015/16)	

	independently as possible (NI-2)				
2.2	% of adults with intensive needs receiving care at home (NI-18)	63% (2014/15)	65% (2015/16)	62% (2015/16)	✅
2.3	Emergency admission rate per 100,000 population for adults (NI-12)	16,339 (2015/16)	16,486 (2016/17) (p)	12,037 (2016/17) (p)	🛑
2.4	Emergency bed day rate per 100,000 population for adults (NI-13)	172,701 (2015/16)	171,638 (2016/17) (p)	119,649 (2016/17) (p)	🛑
2.5	Readmission to hospital within 28 days of discharge per 1,000 population (NI-14)	102 (2015/16)	109 (2016/17) (p)	95 (2016/17) (p)	🛑
2.6	Proportion of last 6 months of life spent at home or in a community setting (NI-15)	87% (2015/16)	85% (2016/17)	88% (2016/17)	✅
2.7	No. of days people aged 75+ spend in hospital when they are ready to be discharged per 1,000 population (NI-19)	838 (2015/16)	1273 (2016/17) (p)	842 (2016/17) (p)	🛑
2.8	% of people admitted to hospital from home during the year who are discharged to a care home (NI-21)	Data under development			
2.9	% of people discharged from hospital within 72 hours of being ready (NI-22)	Data under development			

Local Performance Indicator		SAHSCP Baseline	Latest Value	Scotland Latest Value	RAG Status
2.10	No. of service users in receipt of Enhanced Telecare (HSCP PF)	1390 (2015/16)	1698 (2016/17) (p)	Not Available	✅

Note: (p) = provisional

Performance Analysis

- 83% of adults report that they are supported to live as independently as possible, which is largely in line with the national average of 84%.
- A higher percentage of adults with intensive needs receive personal care at home at 65% in South Ayrshire compared to 62% nationally. A rise in this figure is expected due to the focus on supporting more people with complex needs in the community.
- Emergency admission rates have shown a very slight increase between 2015/16 and 2016/17. However, the bed day rate has decreased by a larger proportion which highlights the effectiveness of the focussed work around unscheduled care to ensure people are discharged as timeously as possible. The emergency bed days figure includes admissions to Community Hospitals for step down days, this equates to 25% of the total reported above.
  The graphs below demonstrate that although there has been an increase in admission rates over the past year the length of time people spend in hospital has decreased with around 1000 less bed days being utilised in the past year.

Figure 1; Annual Rate of emergency admissions per 100,000 population for adults between 2010-2017

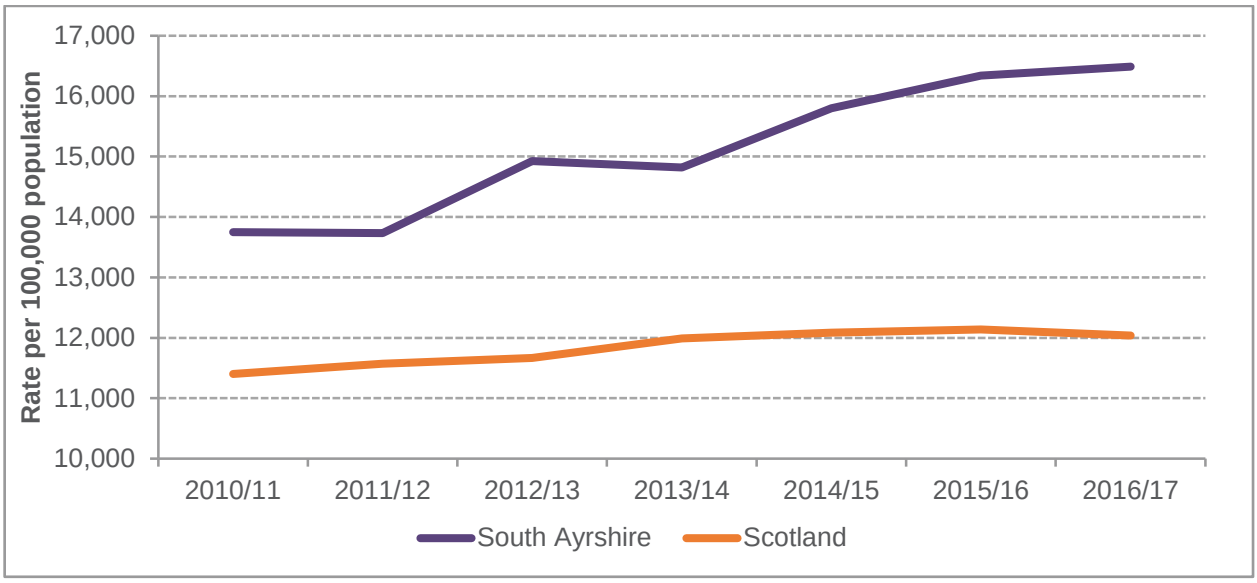
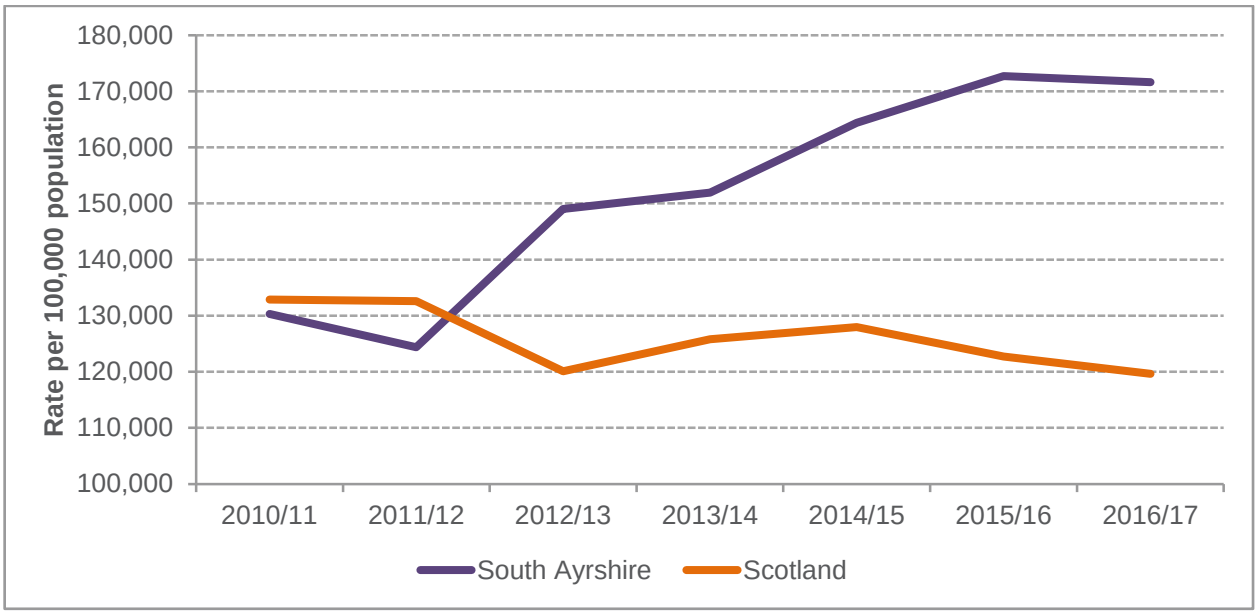


Figure 2: Annual rate of emergency bed days per 100,000 population for adults between 2010-2017



- Readmissions to hospital within 28 days of discharge have shown an increase from 102 to 109 over the past year and remain higher than the national average.
- The proportion of people who spend the last 6 months of life at home or in a community setting has decreased slightly from 87% to 85% and is below the national average of 88%.
- Our performance around the number of days people spend in hospital decreased over the past year due to the increased number of delayed discharges during for the first 6 months of 2016/17. The number of days people aged 75+ are delayed in hospital when they are ready to be discharged increased from 838 in 2015/16 to 1273 in 2016/17 which is higher than the national rate across Scotland of 842. The last quarter of 2016/17 has shown a marked decrease in the number of delayed discharges and associated bed days as shown in the graphs below. This is an improving trend which has continued into the early part of 2017-18. Since December 2016 we have been monitoring Delayed Discharges on a weekly basis, allowing for greater analysis on the reasons for the delay and for early management action to be taken on the up to date information available.

Figure 3: Total number of monthly Delayed Discharges between April 2016 and March 2017

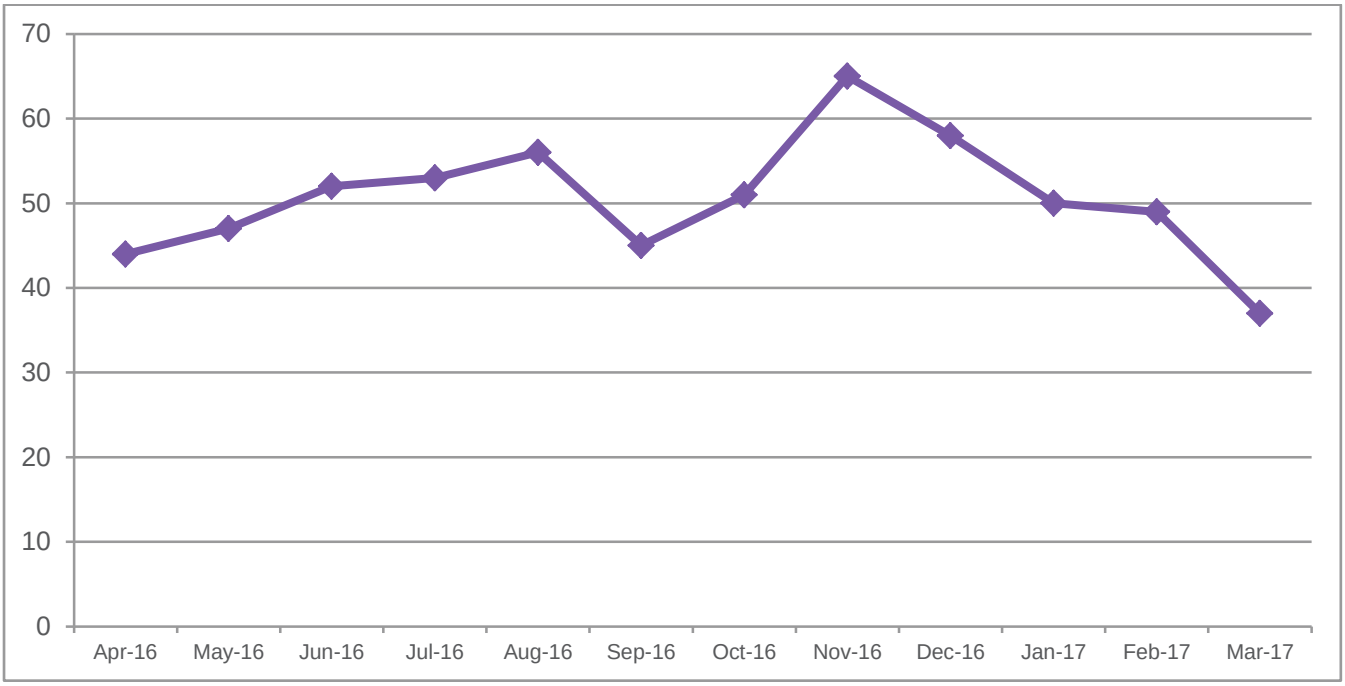
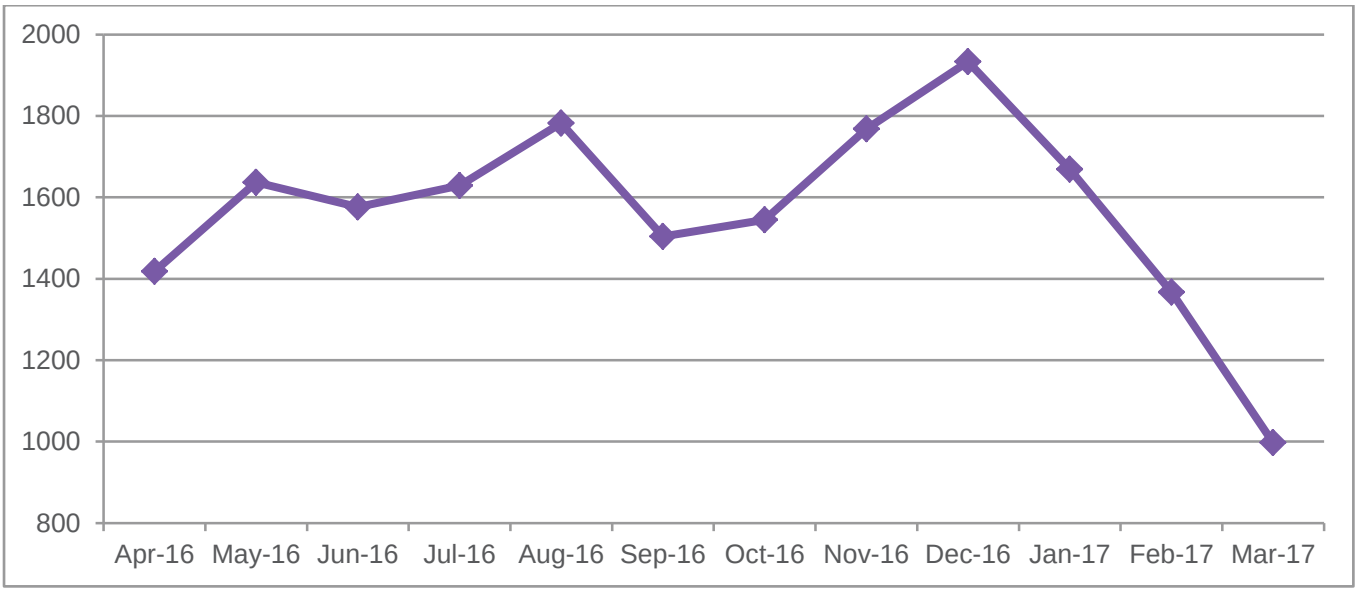


Figure 4: Number of Occupied Bed Days due to Delayed Discharges between April 2016 and March 2017



- The number of service users in receipt of Enhanced Telecare has risen markedly over the past 2 years from 610 in 2014/15 to around 1700 in 2016/17.

Intermediate Care Team

The service provided by the Integrated Care Team (ICT) resulted in

530 avoided hospital admissions and 259 early supported discharges during 2016/17. It is estimated locally that each avoided hospital admission saves 5 hospital bed days and each supported discharge saves 3 hospital bed days. The graphs below show the breakdown of the number of referrals to the Integrated Care Team and the associated estimated bed days saved each month during 2016/17.

Figure 5: Number of Early Supported Discharges and Avoided Admissions

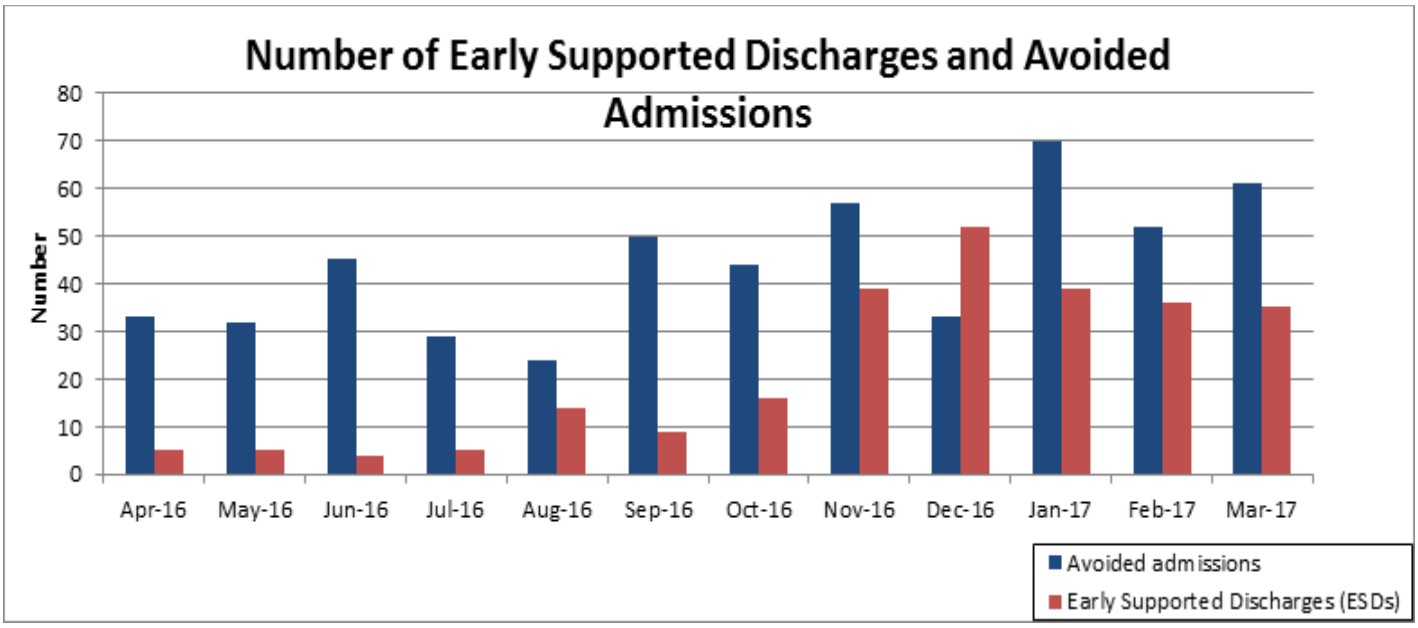
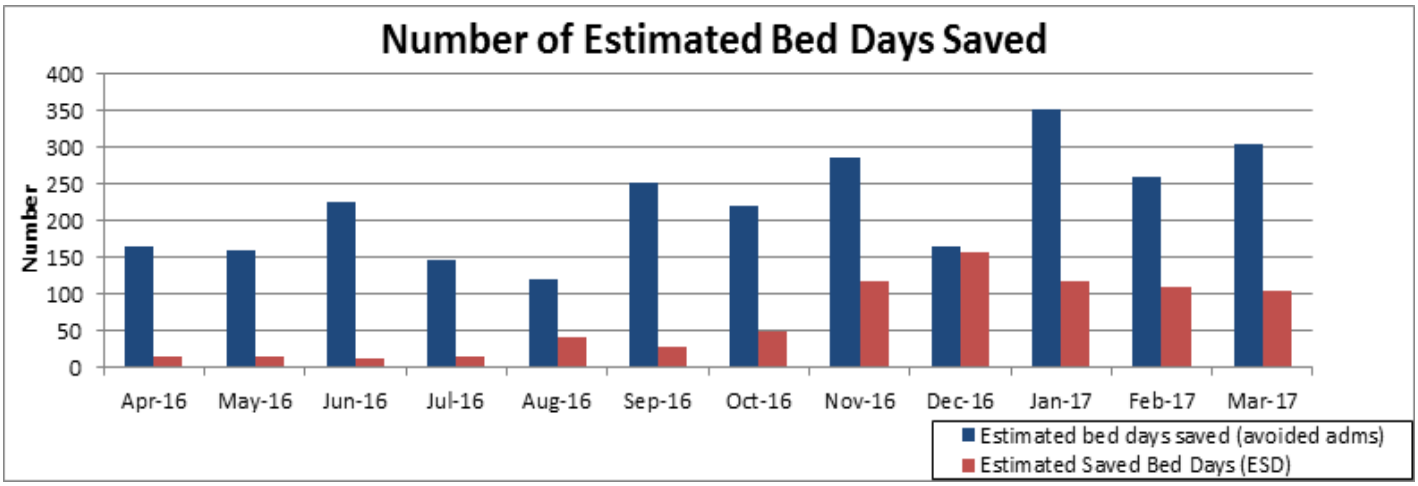


Figure 6: Number of Estimated Bed Days Saved



Housing Adaptations

Housing adaptations are installed in homes if there is an assessed medical and critical need for the adaptation. Medical adaptations is a term that refers to a range of products that enable someone to live as independently as possible within their home, and allow the person to carry out daily activities where their ability to do so may have been affected by age, impairment, ill health or a traumatic injury.

The process differs depending on whether a home is one that belongs to the Council or is a private property. Homeowners and private tenants are supported by the Scheme of Assistance which was introduced in the Housing (Scotland) Act 2006. Local authorities must provide assistance in the form of grants for disabled adaptations, the level of grant will be either 80% or 100%. The maximum award is provided where the household is in receipt of qualifying benefits.

Local Authority owned properties are required to report to the Scottish Housing Regulator through the Scottish Social Housing Charter. For Council owned properties the Charter sets out standards and outcomes and explains what tenants can expect from social landlords.

Below are tables looking at local performance for both Local Authority and private housing.

Council Houses

Measure	Result
The number of approved applications on the list for medical adaptations at the start of the reporting year plus any new, approved applications made during the reporting year	294
The number of approved applications completed between start and end of the reporting year*	265
The total number of days taken to complete approved applications	18,945
The number of medical adaptations completed in the reporting year*	304

Note:* The number of medical adaptations completed in the reporting year takes into account applications that were approved in 2015-16.

Indicator 22
Percentage of approved applications for medical adaptations completed during the reporting year - 90.14%

Indicator 23
Average time to complete approved applications for medical adaptations in the reporting year - 71.49 days

Private Sector Housing
Disabled Adaptation of Dwelling

Total Grants and Loans	Amount
Total Number of cases approved	206
Total amount spent (£)	628,325

Total Grants	Amount
Number of grants approved	206
Amount spent (£)	628,325

Partnership Activity to Deliver Against National Outcomes

The focus of the redesigned Re-ablement service is on the needs of those people requiring discharge from hospital. As a result very few delayed discharges were the results of a lack of care at home.

The Partnership has developed an approach comprising of four key priorities to manage care for those people most at risk of admission to hospital. These include the following priority areas: Anticipatory Care Planning, Community Rehabilitation and Enablement, Redesign of Services at Biggart Hospital and in 2017-18 the Interface with Combined Assessment Unit at Ayr Hospital which opened in June 2017. These align with the Older People and Unscheduled Care work streams being taken forward on a pan-Ayrshire basis. Progress is being monitored through fortnightly meetings to determine its impact.

Anticipatory Care Planning has been adopted in the majority of GP Practices in South Ayrshire. The initiative involves regular multi-disciplinary meetings within GP Practices focusing on the development of robust care plans for individual patients. The aim is to develop plans which will help maintain people within their own homes and enable a coordinated response to any deterioration to a person's health and care. One element of the planning is the production of the Key Information Summary (KIS) which can be used by

a range of professionals at times of crisis to better understand the care plan and contingency arrangements. The use of KIS should a person present at an emergency department is important to support a decision to avoid hospital admission.

An increase in enhanced Telecare has been achieved through the recruitment of a dedicated Telecare Officer who has promoted the use of Telecare solutions in delivering safe, effective and personalised support for individuals.

Patient experience of using District Nursing services

The patient was diagnosed with breast cancer and secondary lung cancer, and had articulated how the assessment of her care needs, and resulting service provided by the District Nursing Team has impacted positively on both her physical and emotional wellbeing. This included the invasive procedure of draining fluid from her lungs which would normally involve hospital admissions for 2-3 days. The District Nursing Team were able to provide this treatment in her own home, allowing her to carry on her day to day life as normal, looking after her grandchildren and going out for a coffee. The patient was keen that her story be told- shared with staff and other patients, to provide them with some hope that their needs can be met in a manner that supports them to maintain as much normality as possible. She describes the Team as being confident, competent and compassionate; describing the service she received as being so good that she doesn't know how it could be improved.

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

National Performance Indicator		SAHSCP Baseline	Latest Value	Scotland Latest Value	RAG Status
3.1	% of adults supported who agree that they had a say in how their help, care or support was provided (NI-3)	82% (2013/14)	79% (2015/16)	79% (2015/16)	
3.2	% of adults receiving any care or support who rate it as excellent or good (NI-5)	83% (2013/14)	82% (2015/16)	81% (2015/16)	
3.3	% of people with positive experiences of the care provided by their GP Practice (NI-6)	90% (2013/14)	91% (2015/16)	87% (2015/16)	

Performance Analysis

- The Partnership performs at or above average for all of the core integration measures in relation to positive experiences, quality services and personal outcomes.
- 79% of adults supported at home agreed that they had a say in how their help, care or support, which is in line with the national average.
- 82% of adults receiving any care or support rated it as excellent or good, which is slightly above the national average.
- People reporting positive experiences of care within GP practices is 91% for 2015/16 which is slightly higher than the previous survey results for South Ayrshire (90%) and higher than the national average of 87%.

Partnership Activity to Deliver Against National Outcomes

To ensure that the Partnership is able to effectively secure qualitative feedback from the people who use our services a Participation and Engagement Strategy was developed, consulted upon and approved by the IJB in December 2016. An updated version is now available on the HSCP website.

Self-Directed Support (SDS) continues to be embedded in South Ayrshire with a local work plan in place that reflects the Scottish Government National Work Plan for the period 2016-18. As well as being a key driver in the Partnership Strategic Plan, SDS has also been incorporated as a key strategic objective in the development of both the learning disability and mental health strategies. A key action in both strategies has been to take a proactive approach and invite people in receipt of services to information events within localities to focus on SDS and choice and control. The aim of the locality events will be to improve the opportunities for individuals to have more choice and control over the services they receive and to improve the uptake of all the SDS options. A key aspect of SDS development over the upcoming year will be the development of strategic commissioning plans that incorporate the values and principles of SDS and ensure that choice and control is available for individuals and carers.

Community Link Practitioners are now active in 13 GP Practices to assist people to access services and the support they require across sectors, thereby improving the experience provided by participating GP Practices. Where applicable, the aim is to create an alternative to national prescribing by signposting people to alternative community based supports, for example if someone is depressed, as a result of social isolation.

"Thank You from the bottom of my heart for everything"

This was submitted to Care Opinions by a 93 year old man who broke his leg and received rehab at the Lindsay Ward, Biggart Hospital. His wife of 69 years was a resident at a local nursing home with end stage dementia; he was unable to visit due to mobility issues, and the fact that the lift at the home was broken. Staff at Biggart spoke to the nursing home to provide him with regular updates. He was awoken one night to be told that his wife was very poorly, he was taken by one of the auxiliaries to be with his wife, the auxiliary sat with him all night ensuring that he was ok. The following day the Senior Charge Nurse from the Lindsay Ward came to see him at Ayr Hospital, informing him that his care was being transferred back to Ayr, so that he could be with his wife. They were put in a side room, and transferred eventually back to the Biggart where staff created a double room for them – and in his words were "welcomed back as part of the family." " Most comforting to me was the fact that at night they pushed our beds together to create a double and I was able every night to lay holding her in my arms and reassure her I was there, something I had not been able to do for some time since she entered the nursing home "

"Most of all I am grateful for the opportunity to have spent the last nights of her life with her in my arms as we had done for oh so many years prior to her leaving for the nursing home."

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

National Performance Indicator		SAHSCP Baseline	Latest Value	Scotland Latest Value	RAG Status
4.1	% of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life (NI-7)	82% (2013/14)	84% (2015/16)	84% (2015/16)	
4.2	Proportion of care services graded "good" (4) or better in Care Inspectorate inspections (NI-17)	86% (2014/15)	89% (2015/16)	83% (2015/16)	

Local Performance Indicator		SAHSCP Baseline	Latest Value	Scotland Latest Value	RAG Status
4.3	% of people fully re-abled at the end of a Re-ablement Service (MPF)	40% (2015/16)	38% (2016/17)	Not available	
4.4	% of people who received a Re-ablement service who report that their quality of life had improved or had been maintained (MPF)	83%	80%	Not available	

Performance Analysis

- 84% of adults supported at home agreed that services have improved or maintained their quality of life, which is in line with the national average of 84% across Scotland.
- Services provided by the Partnership continue to receive high grades by the Care Inspectorate. In 2016/17 as at 31st March 2017, 83% of South Ayrshire Health and Social Care Partnership inspected services were graded 'good' (4) or above. This is an improvement on the previous year and is higher than the national average. Further details on Inspections for Internal Services provided by the Partnership during 2016/17 are provided on page 39.
- The success of the Re-ablement service in improving the quality of life for service users is evidenced by the high level of satisfaction reported at the end of service. The Re-ablement approach is person centred and the practice in this area will be enhanced further during 2017/18 by introducing Occupational Therapy staff to the service, as well as increasing access to this area of service.

Partnership Activity to Deliver Against National Outcomes

The South Ayrshire Care at Home service is set to be redesigned in 2017/18 in order to introduce a new care pathway and a redesign of the current management structure. The new structure will offer a single point of access to the service through the Re-ablement Hub. The aim of the Hub will be to provide re-ablement and prevention first. To support this, re-ablement will be aligned with the mobile responder service and the telecare provision. This alignment will provide increased support across all of these areas of provision and offers a degree of flexibility with the aim of offering a more responsive service. This approach will allow a shorter intensive support to people using a rehabilitative model which encourages independence and self-care. Using learning from the successful implementation of this approach elsewhere in the UK, the Hub will be professionally led by two Occupational Therapists (OT's).

Care Inspectorate Grades are monitored and reported to the Performance and Audit Committee on an annual basis as part of the ongoing utilisation of performance information to drive continuous improvement. In 2017-18 reporting to the Committee will be increase to twice per annum.

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

National Performance Indicator		SAHSCP Baseline	Latest Value	Scotland Latest Value	RAG Status
5.1	Premature mortality rate per 100,000 per population aged under 75. (NI-11)	391 (2014)	422 (2015)	441 (2015)	

Local Performance Indicator	SAHSCP Baseline	Latest Value	Scotland Latest Value	RAG Status

5.2	Life Expectancy in males (SOA)	78.2 (2012-14)	77.1 (2013-15)	77.1 (2013-15)	
5.3	Life expectancy in females (SOA)	80.9 (2012-14)	81.0 (2013-15)	81.1 (2013-15)	
5.4	Deaths per 100,000 from Coronary Heart Disease under 75 ((HSCP PF)	58.2 (2014)	52.9 (2015)	55.3 (2015)	

Performance Analysis

- The mortality rate in those under 75 has increased over the past year from 391 to 422 per 100,000. However this continues to be lower than the national rate across Scotland of 441.
- Life expectancy at birth has decreased from 78.2 in males to 77.1, which is the same as the national average of 77.1. For females life expectancy has increased from 80.9 to 81.0 which is around the national average (81.1).
- Premature deaths from Coronary Heart Disease have decreased over the past year from 58.2 to 52.9, which is now lower than the national average of 55.3. Scotland wide figures have increased to 55.3 in 2015.

Partnership Activity to Deliver Against National Outcomes

The Health and Wellbeing Strategic Delivery Partnership (SDP) within South Ayrshire's Community Planning Partnership is establishing a baseline position of the work that is already in place within South Ayrshire to tackle aspects of Health Inequality. The SDP is committed to developing an action plan of further measures in North Ayr in conjunction with the Locality Planning Group. This work will inform development of a Local Outcome Improvement Plan (LOIP) to ensure that health and social care services are able to contribute to reducing health inequalities.

6. People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being.

National Performance Indicator		SAHSCP Baseline	Latest Value	Scotland Latest Value	RAG Status
6.1	% of carers who feel supported to continue in their caring role (NI-8)	46% (2013/14)	42% (2015/16)	41% (2015/16)	

Local Performance Indicator		SAHSCP Baseline	Latest Value	Scotland Latest Value	RAG Status
6.2	No. of carers assessments completed (HSCP PF)	102 (2015/16)	69 (2016/17)	Not Available	

Performance Analysis

- The percentage of carers who feel supported to continue in their caring role was 42% in South Ayrshire which is slightly higher than the national average of 41%.
- The number of Carers Assessments being completed rose significantly from 21 in 2013/14 to 102 in 2015/16, however the past year has seen a decrease to 69.

Partnership Activity to Deliver Against National Outcomes

As part of the national implementation process for the Carers Scotland (2016) Act South Ayrshire HSCP is one of 9 pilot sites to develop the National Guidance to inform the implementation of the Act

by April 1st 2018. South Ayrshire HSCP will pilot work on the development of Adult Carer Support Planning.

7. People using health and social care services are safe from harm.

National Performance Indicator		SAHSCP Baseline	Latest Value	Scotland Latest Value	RAG Status
7.1	% of adults at home who agree they felt safe (NI-9)	84% (2013/14)	86% (2015/16)	84% (2015/16)	
7.2	Falls rate per 1,000 population aged 65+ (NI-16)	24%	22%	21%	

Local Performance Indicator		SAHSCP Baseline	Latest Value	Scotland Latest Value	RAG Status
7.3	No. of adult protection referrals (HSCP PF)	845 (2015/16)	882 (2016/17)	Not available	

Performance Analysis

- People supported at home report feeling safe stands at 86% which is an increase of 2% on the last reporting period and 2 percentage points higher than the national average.
- The rate per 1000 population of falls that occur in the population (aged 65+) who were admitted to hospital as an emergency has reduced over the past year from 24 to 22.
- The Adult Protection service received 882 referrals in 2016/17 which was an increase compared with 845 referrals in 2015/16. Response rates to protection concerns have improved over the past year with 70% of referrals being completed within 5 working days in the last quarter of 2016/17.

Partnership Activity to Deliver Against National Outcomes

Falls

A local stakeholder engagement event took place in February 2017 and a local falls group is to be set up to update and deliver on priority actions. The web based "Falls Assistant" tool is being actively promoted which allows users to complete their own multifactorial falls risk assessment, and formulate an action plan to aid self-management. This now has around 600+ views per month. A two way referral pathway has been developed and established between Scottish Fire and Rescue service and falls screening service with collaborative working to raise public community safety awareness of fire prevention and falls prevention.

Adult Support and Protection

More than half of Adult Support and Protection referrals continue to come from Police Scotland. In early 2016/17, specific training was developed and delivered for Police Scotland Sergeants across Ayrshire and was directly aimed at developing their understanding of social work's role, duty and function in relation to ASP and consequently result in more appropriate referrals, and fewer referrals overall.

In January 2017, the Adult Concerns Initial Response Team (ACIRT) was developed to work alongside Police Scotland, receiving and screening referrals. ACIRT receive all Police Scotland referrals, carries out any initial protective work that may be required and liaises with social work teams where the person at risk is "open" or known to that Team. Initial evaluations suggest that this is a much more effective way to deal with the increased demands of ASP.

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.

Local Performance Indicator		Latest Value	Scotland Latest Value	RAG Status
8.1	% of SAHSCP Staff who would recommend their organisation as a good place to work.	72% (2016/17)	Not available	

Performance Analysis

- The results from the SAHSCP iMatter questionnaire show that 72% of employees would recommend the organisation as a good place to work. This is higher than the results of previous surveys in 2015/16 of staff who work within the partnership. The latest NHS Ayrshire and Arran Employee survey for 2015/16 showed that 62% of staff would recommend their workplace as a good place to work, and the Local Authority staff survey for 2015/16 showed that 66% of staff employed by the South Ayrshire Health and Social Care Partnership reported it as providing a positive workplace environment.

Partnership Activity to Deliver Against National Outcomes

A Workforce Planning Lead has been employed by the Partnership as part of the Planning & Performance Team. A draft workforce strategy and implementation plan will be produced by the HSCP before the end of 2017.

In February 2017 it was agreed by all three Local Authorities to roll out iMatter, an Employee Engagement Questionnaire developed and used by the NHS, to Social Care staff within the Partnerships. This provided one staff engagement mechanism and staff experience metrics across the South Ayrshire Health and Social Care Partnership which incorporated 155 teams.

In June 2017 the iMatter questionnaire was sent to 1926 Health and Social Care Partnership staff and there was a return rate of 69%; 1325 respondents. The completed questionnaires were analysed independently by Webropol (questionnaire administrators) to be analysed. The return rate was above NHS Scotland.

A temperature chart displayed the overall experience of staff within the Partnership of 6.62, slightly below the NHS at 6.74. The ratings are:
0 = Very Poor Experience and 10 = Very Good Experience.

The Employee Engagement Index was 76%, above the NHS Scotland Index. The Partnership also had six teams with an index of 90% and above. The following chart shows the comparison with NHS Scotland results:

	Response Rate %	EEI	Temperature
NHS Scotland	63	76	6.74
SAH&SCP	69	75	6.62

Managers are now considering the best options for open discussions with their teams on the outcomes of the questionnaire and their Employee Engagement Index report (EEI). At the team meetings we will capture the highlights and areas that the teams agree to take forward over the next year. Identifying positives and suggestions and what the team believe they are good at. We recognise that whilst we have made some progress, and that as a Partnership we are still in transition, there is still more to do to improve Employee Engagement across our integrated workforce.

Going forward an I-Matters survey will be carried out annually, which will allow progress and areas to be improved to be monitored in a robust manner.

The number of CPD courses run in 2016/17 was 102 and the training days provided is 147. The following table shows the number of SVQ courses:

Qualification	Level	No of Staff	Cohort
SVQ	1	3	Care at Home
SVQ	2	21	Care at Home
SVQ	3	2	Care at Home
SVQ	4	1	Care at Home
Social Care	HNC	1	Children and Family
Social Care	MHO	2	Children and Family

The significant reduction in the number of courses and training days is due to all staff now having completed the two day Moving and Handling course. We use the new Passport scheme that includes a one hour observation when required; only if the two day course has been undertaken.

South Ayrshire Health and Social Care Partnership continues to offer Practice Learning opportunities for social work students to undertake work experience in a social work setting, enabling them to convert the theory they have learned into practice. This is delivered in partnership with the Learning Network West, who co-ordinate placement requests from the Universities.

In 2016/17 16 placements were provided; as part of the process students and educational providers are asked to evaluate their experience. Feedback included:

"The placement was excellent for the student's learning. The link worker was extremely helpful at all times to the student … the Team gave excellent feedback re the student and Link worker. I couldn't have asked for a better placement."
"The placement was well organised and ran like clockwork with no issues"
"The organisation and the support during the placement from the council's point of view was very good"

A group has been established to produce the Workforce Plan for the HSCP, by the end of 2017. This plan will support the delivery of the SAH&SCP Strategic Plan 2018 – 2021. It will continue with arrangements already in place and action required to attract, recruit, engage, support, develop and retain the workforce required to deliver the strategic outcomes and retain staff for our future workforce

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

National Performance Indicator		SAHSCP Baseline	Latest Value	Scotland Latest Value	RAG Status
9.1	% of adults supported at home who agree that their health and care services seemed to be well coordinated (NI-4)	81% (2013/14)	76% (2015/16)	75% (2015/16)	
9.2	% of health and care resource spent on hospital stays where the patient was admitted in an emergency (NI-20)	29% (2015/16)	29% (2016/17)	23% (2016/17)	
9.3	Expenditure on end of life care (NI-23)	Data under development			

<u>Performance Analysis</u>

- 76% of adults supported at home agreed that their health and care services seemed to be well coordinated. Performance in relation to this measure has decreased by 5% over survey period. This is a trend which has been seen nationally with the Scotland wide figures showing a similar 4-5% decrease. The results for this measure ranged nationally from 60% to 85%.
- Expenditure on unscheduled care has increased over the past year and is higher at 29% than the national average of 23%. The current strategic focus on redesign work around unscheduled care is designed to have an impact on this area.

Partnership Activity to Deliver Against National Outcomes

Service Hubs are now in place with supporting management structures. Monthly meetings have been established which form a strong link to regular locality meetings and a single point of contact for social work is now in place within each service hub area. Good engagement with local stakeholders is also evident, particularly in relation to partnership working with GP's.

MINISTERIAL STRATEGIC GROUP FOR HEALTH AND COMMUNITY CARE CORE INDICATORS

In addition to the Core Indicators noted against the National Outcomes in the previous section and in Appendix 1, The Ministerial Group for Health and Community Care (MSG) has proposed the following measures to track performance of Integration Authorities:

(1) Unplanned Admissions;

(2) Occupied bed days for unscheduled care;

(3) A & E Performance;

(4) Delayed Discharges;

(5) End of life care; and

(6) The balance of spend across institutional and community services.

We are currently developing targets for these in partnership with Information Services Division, and will be reporting performance against them going forward.

CHILDREN'S OUTCOMES

Performance against the National Outcomes for Children
Performance against each of the National Outcomes for Children and associated National Performance Indicators is detailed below. Where relevant, performance against associated Local Performance Indicators is also provided. The extent to which implementation of the Strategic Plan 2016-19 is contributing towards meeting Children's Outcomes is noted below with each associated action cross referenced within the foot-notes.

10. Our children have the best possible start in life.

National Performance Indicator		SAHSCP Baseline	Latest Value	Scotland Latest Value	RAG Status
10.1	% of babies with a healthy birth weight	89.6% (2014/15)	88.5% (2015/16)	90.1% (2015/16)	
10.2	% of children with a healthy weight in primary one	78.2% (2014/15)	76.1% (2015/16)	76.8% (2015/16)	

Performance Analysis

- There has been a slight decrease in both the percentage of babies with a healthy birth weight and the percentage of children with a healthy weight in primary one.

Partnership Activity to Deliver Against National Outcomes
Work is underway to implement the Healthy Weight Strategy action plan (2014-24). The action plan focuses on seven key themes: Awareness, knowledge, skills and empowerment; maternal and infant nutrition; availability and affordability of healthier food and drinks; active travel and active workplaces; built/ natural environment and infrastructure for active travel; physical activity; and weight management. The impact of the action plan's implementation is being monitored on a regular basis to identify emerging strengths and areas for further improvement.

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

Data which is collated and reported nationally for Looked After Children's educational attainment includes children who have been Looked After for a full year (1st August to 31st July):

National Performance Indicator		Baseline	Latest Value	Scotland Latest Value	RAG Status
11.1	Looked after children educational attainment (1 or more qualification at SCQF Level 3 on leaving school)	SCQF Level 3 92% (2014/15)	SCQF Level 3 85% (2015/16)	SCQF Level 3 87% (2015/16)	
11.2	Looked after children educational attainment (1 or more qualification at SCQF Level 4 on leaving school) Looked after children educational attainment (attainment during year session)	SCQF Level 4 58% (2014/15)	SCQF Level 4 77% (2015/16)	SCQF Level 4 77% (2015/16)	

*SCQF - Scottish Credit and Qualifications Framework

Performance Analysis

- The percentage of children who are Looked After obtaining at least 1 SCQF qualification at Level 3 has decreased over the past year and is slightly below the national average rate of 87%. Those who obtain at least one SCQF at Level 4 has increased from 58% to 77% which is in line with the national average.

Data which is collected and reported locally for Locked After Children's Educational attainment includes all Looked After Children (Looked After Children at Annual Report Census) who are in attendance at schools in South Ayrshire; some of whom may be looked after by other Local Authorities.

Local Performance Indicator		Baseline 2013-14	2014/15	2015/16	RAG Status
11.3	Looked after children educational attainment: 1 or more qualifications at SCQF Level 3	SCQF Level 3 or better 86%	SCQF Level 3 or better 80%	SCQF Level 3 or better 87%	
11.4	Looked after children educational attainment: 1 or more qualifications at SCQF Level 4	SCQF Level 4 or better 55%	SCQF Level 4 or better 55%	SCQF Level 4 or better 83%	
11.5	Looked after children educational attainment: 1 or more qualifications at SCQF Level 5	SCQF Level 5 or better 45%	SCQF Level 5 or better 20%	SCQF Level 5 or better 35%	

*SCQF - Scottish Credit and Qualifications Framework

Performance Analysis

It is encouraging that most looked after school leavers (83%) have achieved one of more qualification at Level 4 in 2015-16, an increase from just over half on previous years. Attainment at Level 5 in 2015-16 (35%) improved compared to the previous year, with attainment being greatest in 2013-14.The fluctuation in attainment at Level 5 is due to small numbers of young people.

Partnership Activity to Deliver Against National Outcomes

Work to develop a strategy for Looked After Children is progressing. Work is being undertaken in partnership with the Centre of Excellence for Looked After Children in Scotland (CELCIS) focussing specifically on residential accommodation requirements and improving timescales in respect of permanency planning. Planned audit activity, being undertaken in partnership with CELCIS, to evaluate and analyse care provision, will inform the Looked After Children strategy for the next 5 years.

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

National Performance Indicator		Baseline	Latest Value	RAG Status
12.1	% of reports submitted to the Scottish Children's Reporter by due date	64% (2015/16)	Q1-71% Q2-48% Q3-70% (2016/17)	
12.2	No. of foster carers as at 31st March	60 (2015/16)	63 (2016/17)	Not Applicable

Performance Analysis

- Early indicators for Q1-3 evidence improved performance in relation to the percentage of reports submitted to the Scottish Children's Reporter by the due date.
- Investing in Fostering Services has been a key strategic priority to ensure additional local placement availability for the young people in South Ayrshire and the increase from 60 to 63 over the past year reflects this. The additional new carers has allowed for 7 new placements during 2016/17. There were no resignations of foster carers during this period.

Partnership Activity to Deliver Against National Outcomes

Work is being progressed in partnership with the Centre of Excellence for Looked After Children in Scotland (CELCIS) to further develop our Looked After Children strategy with a view to improving outcomes for the most vulnerable children, particularly in relation to Permanency Planning.

CRIMINAL JUSTICE OUTCOMES

The National Outcomes for Criminal Justice, as detailed on page 6, are the Scottish Government's high-level statements which aim to gain and sustain the public's confidence in the work of Criminal Justice related services through promoting the values of safety, justice, and social inclusion.

Performance against the National Outcomes for Criminal Justice
Performance against each of the National Outcomes for Criminal Justice and associated National Performance Indicators is detailed below. Where relevant, performance against associated Local Performance Indicators is also provided.

13. Community safety and public protection.

National Performance Indicator		Baseline	Latest Value	RAG Status
13.1	% of Criminal Justice Social Work Reports submitted to court by due date.	99% (2015/16)	99% (2016/17)	

Performance Analysis
- There continues to be a very high rate of Criminal Justice Social Work reports submitted to court by the due date.

Partnership Activity to Deliver Against National Outcomes
Criminal Justice services are in a transition process in relation to establishing a Pan-Ayrshire approach to Community Justice which will enable a more comprehensive community planning approach to service delivery.

14. The reduction of reoffending.

National Performance Indicator		Baseline	Latest Value	RAG Status
14.1	% of those placed on Community Payback Orders with a requirement of unpaid work starting within one week.	86% (2015/16)	88% (2016/17)	
14.2	% of individuals placed on Community Payback Orders with Offender Supervision seen within 5 days of court appearance	96% (2015/16)	92% (2016/17)	

Performance Analysis
- Performance in terms of reducing reoffending has improved in terms of those placed on Community Payback Orders with a requirement of unpaid work starting within one week. However performance has declined slightly in terms of those with Offender Supervision seen within 5 days of court appearance.
- A suite of national performance measures in relation to the new Community Justice arrangements is being produced which will shape how measures are reported against this in the future.

Partnership Activity to Deliver Against National Outcomes
As indicated in (13) above, Criminal Justice services are in a transition process in relation to establishing a Pan-Ayrshire approach to Community Justice which will enable a more comprehensive community planning approach to service delivery.

FINANCIAL PERFORMANCE AND BEST VALUE

Financial information is part of our performance management governance with regular reporting throughout 2016/17 to the Integration Joint Board (IJB). This section summarises the main elements of our financial performance for 2016/17.
The full analysis of the Financial Performance is detailed in the Finance Monitoring Report 31 March 2017 which details key budget pressures, and underspends , as well as details as to how these will be addressed going forward. A summary is presented in the table below.

	Budget £'000	Actual £'000	Variance Fav / (Adv) £'000
Older People	35,944	35,589	355
Learning Disabilities	17,814	17,897	(83)
Physical Disabilities	3,217	3,033	184
Mental Health Community Teams	5,928	5,842	86
Addiction	1,756	1,691	65
TEC	406	131	275
Community Nursing	4,058	3,848	210
Prescribing	24,766	24,766	0
General Medical Services	14,468	14,211	257
Integrated Care Fund	3,042	2,343	699
Criminal Justice	148	59	89
Aids and Adaptations	861	903	(42)
Biggart Hospital	4,612	5,127	(515)
Girvan Hospital	1,162	1,160	2
Continence Team/Community Store	946	1,079	(133)
AHPs	21,143	19,828	1,315
C&F Social Work Services	20,072	19,561	511
Health Visiting	1,925	1.815	70
Criminal Justice	148	59	89
Support Services	2,697	4,805	(2,108)
Total Net Expenditure	**164,104**	**162,825**	**1,279**
South Ayrshire Council Funding	68,401	67,671	730
NHS Ayrshire & Arran Funding	95,703	95,154	549
Total Income	**164,104**	**162,825**	**1,279**

It should be noted that the budget above reflects the budget managed by the IJB during the year and excludes the Large Hospital Set Aside Budget.

Integrated Care Fund

The additional funding received from the Scottish Government for the Integrated Care Fund (ICF) for 2016/17 was £2,340,000. The expenditure was slightly under budget at £2,235,501, and is summarised below:

Programme Theme	ICF investment	Actual Spend
Supporting Service Improvement, Redesign and Change	£238,625	£135,626
Developing Community and Locality based preventative programmes	£634,009	£593,419
Developing comprehensive clinical and care pathways	£559,000	£426,339
Developing Self-management and rehabilitation programmes	£401,945	£245,690
Developing Technology Enabled Care	£212,539	£214,096
Programme and Performance Support + Enablers	£193,400	£120,474
Additional Spend	£156,893*	£499,857*
Grand Total	**£2,396,411**	**£2,235,501**

Note:* The Additional Spend takes into account any underspend or funding discrepancy and is used to fund other projects in the financial year, see appendix 2 for further details

The ICF is used as a catalyst to deliver change in the way services are delivered with the overall aim of shifting the balance of care from a hospital based setting to the community. Further information on the ICF and how this funding was utilised in 2016/17 can be found in Appendix 2 of this report.

Financial Outlook

The IJB is required to live within the resources available. The Scottish Government announced additional funding of £250 million for Health and Social Care Partnerships in 2016/17 to help address social care pressures. This was a very welcome investment but there continues to be significant challenges. The ageing population and increasing numbers of people with long term conditions and complex needs will generate demands which cannot be met unless alternative service delivery models are created. The IJB has an on-going commitment to provide care to those in the greatest need while providing services within the resource available.

Best Value

NHS Ayrshire & Arran and South Ayrshire Council delegated functions and budgets to the IJB in accordance with the provision of the Integration Scheme. The IJB decides how to use these resources to achieve the objectives set out in the Strategic Plan. The IJB then directs NHS Ayrshire & Arran and South Ayrshire Council to deliver services in line with this Plan.

The governance framework is the rules and practices by which the IJB ensures that decision making is accountable, transparent and carried out with integrity. The IJB has legal responsibilities and obligations to its stakeholders and residents of South Ayrshire.

The IJB ensures proper administration of its financial affairs by having a Chief Finance Officer, in line with Section 95 of the Local Government (Scotland) Act 1973.

A number of service reviews have been progressed in 2016/17, as part of the HSCP agenda to modernise services, and the ways in which it provides support across the sectors:

- Older People With Complex Needs
- Community Mental Health Services
- Learning Disability Services
- Care at Home
- South Lodge and Hillcrest Care Homes

An update on service reviews was reported to the IJB on 9 December 2016.

Financial Reporting on Localities

The 2016/17 financial information has not been broken down and presented by localities as information has not been kept on this basis, given the recent creation of localities in 2015/16. Historically this information has been recorded at an Ayrshire and Arran and South Ayrshire level. Going forward the development of locality based financial information will be a development agenda item for the IJB and the Partnership.

REPORTING ON LOCALITIES

In 2016/17 there has been significant progress in developing the Locality Planning Framework which was approved in June 2015. Locality Planning Groups are established in each of the localities, with most of them being chaired by members of the community. A representative from each locality sits on the Strategic Planning Advisory Group (SPAG). The Locality Planning groups established are:

- Troon and Villages;
- Prestwick and Villages;
- Ayr South and Coylton;
- Ayr North and Former Coalfield Communities;
- Maybole and North Carrick Villages; and
- Girvan and South Carrick Villages.

Community Engagement Officers have been employed to support Locality Planning Group and to carry out a range of work at locality level. A key element of their role is to build and maintain relationships with community stakeholders to ensure that they are actively involved and engaged in different aspects of locality planning, and make it meaningful to them. Each locality has developed its own priorities, which were reflected in the updated 2016-19 Strategic Plan along with local arrangements to take these forward. A report reviewing progress in each locality was prepared by 31 March and is being considered by Locality Planning Groups. It will then be submitted to the SPAG and IJB in 2017-18 for further consideration and comment.

Some common themes have been identified across all localities:

- Social Isolation
- Transport
- Service access (particularly in villages)
- Mental Health
- Engaging with Young People
- Establishing accurate and appropriate profiling
- Effective signposting and enabling access to key information

Participatory Budgeting events have been held in each locality, where over £85k has been distributed to around 120 groups. In a number of localities participants were asked to evaluate participatory budget sessions, with the following recorded:-

- 80% happy to vote
- 85% thought the event was well organised
- 79% inspired by what they heard.

Feedback from participatory budgeting included:

"I thought the day was well thought out and organised. It opened my eyes to the unseen work going on in the area."

"The speeches "pitches" were really interesting –with many really worthwhile causes to vote for."

"I found it very interesting and informative to learn about the many different groups which are out there."

"We had no idea what to expect, but we enjoyed it so much and left with a big smile on our faces."

"I was delighted to be present at the recent Maybole decides event and seeing local community members reach collective decisions about the projects that they want to see supported."

An initial award of £5,000 was made to each Locality Planning Group by the IJB from the Integrated Care Fund to support local initiatives. This was matched by the Scottish Government and the BIG Lottery Fund and grew into a balance of £85,000 which was awarded locally for local priorities.

A number of challenges have been identified going forward which will be addressed through each Group:

- In some groups there are gaps within group membership which have been identified. As a result, further links with identified services and key stakeholders will be a priority over the next year to make sure the Groups are as representative as possible.
- Continue engagement with members of the community to ensure a wide range of people are supported to participate.
- All localities have actions plans, with some having developed sub-groups to focus on taking identified pieces of work forward. A requirement for support to do this has been identified which will be addressed in 2017/18.

COMMUNITY LED SUPPORT

South Ayrshire Health and Social Care Partnership is one of three Scottish HSCP's embarking on a Community Led Support (CLS) programme. This is being facilitated by the National Development Team for Inclusion (NDTi).

Community Led Support builds on what already is working, joining up good practice and strengthening common sense, empowerment and trust based on the following fundamental principles:

- co-production brings people and organisations together around a shared vision;
- there has to be a culture based on trust and empowerment;
- there is a focus on communities and each will be different;
- people are treated as equals, their strengths and gifts are built up;
- bureaucracy is the absolute minimum it has to be;
- people get good advice and information that helps avoids crises; and
- the system is responsive, proportionate and delivers good outcomes.

The programme in South Ayrshire has an initial focus on:

- Ensuring a personal outcomes approach rooted in effective conversations is at the heart of adult health and care.
- Providing better access and support through more local "front doors" (service access points).
- Utilising people's own capacities and resources together with those of their family, friends and the wider community.

Progress to date:

- A steering group for the Programme has been established, with representation from the HSCP, Third Sector, Independent Sector, Locality Planning, Housing, Libraries and Customer Services.
- In late autumn 2016, six local engagement events took place involving around 140 participants from across South Ayrshire. These events generated significant ideas and suggestions.

INTEGRATION JOINT BOARD – GOVERNANCE AND DECISION MAKING

The table below highlights the key decisions taken by the Integration Joint Board in 2016/17. Copies of the relevant reports can be found on in the committee reports and agendas section of the website.

Key Decision	Date of Integration Joint Board
Interim Kinship Care Policy approved	20 April 2016
Utilisation of ICF Budget	20 April 2016
Technology Enabled Care Strategy approved	18 May 2016
Care at Home Review – including approval of £400k for short-term investment of care pathway , and additional ICF funding of £35k	18 May 2016
Approval of 2016/17 Integrated Budget	17 June 2016
Approval of updated and rolled on Strategic Plan	17 June 2016
Review of residential care facilities owned by South Ayrshire Council-authorised to proceed	17 June 2016
Approval of proposals to further the development of a Pan Ayrshire Joint Equipment Store	18 June 2016
Appointment of Head of Legal and Democratic Services to IJB as Standards Officer	15 Sept 2016
£25K to support implementation of alignment of nursing homes to GP practices within the areas of Ayr and Prestwick	15 Sept 2016
Equality Outcomes for Health and Social Care Partnership agreed	15 September 2016
Participation and Engagement Strategy agreed	7 December 2016
Approval of a range of actions being taken to improve the position around Delayed Discharges within available resourcing	2 February 2017
Approval of activity relating to South Ayrshire Health and Social Care Partnership Models of Care Change Programme 2016-17	2 February 2017
Clinical Care Governance Framework approved	1 March 2017

LEAD PARTNERSHIP RESPONSIBILITIES

South Ayrshire Health and Social Care Partnership is the Lead Partnership for the following services on behalf of the three Ayrshire Health and Social Care Partnerships, and in the case of Allied Health Professions and Joint Equipment Store this responsibility also extends to the Acute Sector:

- Allied Health Professions (AHP's)

- Continence
- Technology Enabled Care (TEC)
- Joint Equipment Store
- Falls Prevention
- Sensory Impairment

This means that South Ayrshire Health and Social Care Partnership is responsible for the strategic planning, funding and operational oversight of these services.

Allied Health Professions (AHPs)

Specialist AHP services are provided to the whole population of Ayrshire and Arran. 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 both 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. AHPs are the only professions expert in rehabilitation and enablement at the point of registration. The Associate Director for AHPs as part of the management team of the South Ayrshire HSCP provides professional and strategic leadership and operationally manages the six professions (Dietetics, Orthotics, Occupational Therapy, Physiotherapy, Podiatry, Speech and Language Therapy.) This is achieved through three AHP Senior Managers (one in each partnership) and provides professional leadership for the other AHP services (Radiography, Orthoptics, Arts Therapy, Music Therapy).

The National Active and Independent Living Programme (AILIP) was published by Scottish government in June 2017. A local improvement plan is in development with the ambition of aligning AHP improvement and leadership activity with the pan-Ayrshire Transformation and Delivery Plan. From this, four key work streams (listed below) have been identified to ensure that teams have the necessary support and infrastructure to contribute to the development of services:

1. Workforce for the Future

2. Staff Support and Resilience

3. Quality Improvement

4. Data for Improvement

In addition, ten 'bottom up' projects aligned to local transformation priorities have been identified and supported; and delivery groups and a governance infrastructure have been established. There have been significant challenges in the continuity of quality improvement support due to staffing changes. Project management, impact measurement and quality improvement training for project leads and partners have all been delivered during 2016.

The case study below illustrates the improvements that are being made in how in-patient Occupational Therapy Services are being delivered.

Biggart Hospital: BRIDGING THE GAP

A service user’s journey from hospital to home

Over the past 2 years, a change in the inpatient occupational therapy service delivered at Biggart Hospital has been implemented. The intention of this new way of working is to provide a continuity of care to service users. Previously the OT service consisted of inpatient rehabilitation for older adults over three wards. Treatment plans would traditionally conclude on discharge, whereas further identified occupational therapy need would be transferred to community services, for equipment, adaptations and rehabilitation.

Our aim has been to look at how we could minimise duplication, allow for continuity in the duty of care, continuation of the therapeutic relationship and provide maximum opportunity for regain of function. This was in response to people highlighting a benefit in continuing interventions with a familiar clinician rather than starting with a new clinician on discharge.

In response to this, a single point of referral process within OT has been established to encourage appropriate allocation rather than limiting therapists to a specific ward. All service users discharged home are offered follow-up visits from their initial therapist to re-evaluate their client centred goals and continue with their occupational therapy treatment plan. Once the intervention has come to an end with the service user meeting their desired goals, service users and their families are made aware that they can self-refer to the service via telephone in the future. Prior to this change, service users would have been directed to their GP for them to refer onto community occupational therapy. It is hoped that we have enhanced the occupational therapy journey for service users, decreased waiting times for service users, and improved satisfaction particularly on discharge.

Initial qualitative findings suggest that there is value in providing a follow up service, with continuity of therapist. This was established through collating information from phone calls to the service users and their family/carer. It appears that individuals and families appreciate the current service provided by occupational therapy, stating that their views and opinions are highly valued and they felt supported during admission and transition from hospital to home. They stated that they appreciated knowing that their occupational therapist was readily accessible via telephone during working hours to respond to any of their concerns.

From this research we are continuing to evaluate the changes made to the service and intend to promote our findings within NHS Ayrshire and Arran and across the Health and Social Care Partnerships.

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 - The Continence team deliver clinics in 12 locations throughout Ayrshire including a monthly Arran clinic. The number has increased over the last four years and the service aims to develop clinics where and when the need arises thus allowing patients to access services locally.The aim is to allocate patients a clinic slot within eight weeks.
- To offer an advisory and educational service to NHS clinicians thus enhancing the quality of evidence based continence care being delivered to patients and carers.The service delivers an annual programme of education.
- To offer an advisory service to patients, carers and voluntary organisation
- Provide a 9am-5pm Monday to Friday helpline.
- To improve motivation and self mangement so reducing reliance on continence products.

Technology Enabled Care (TEC)

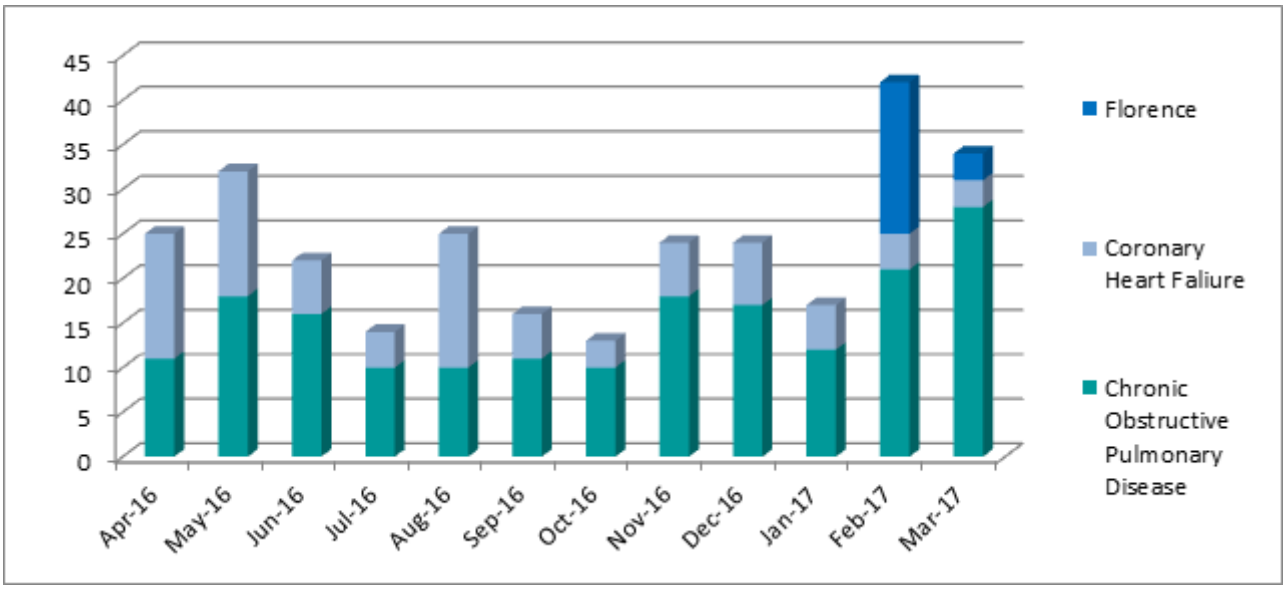
Technology Enabled Care includes Telehealth and Telecare which are part of a current National Delivery Plan launched by the Scottish Government in 2014. Activity currently includes home and mobile health monitoring and telecare. South Ayrshire HSCP leads on the development of a strategic approach to the use of TEC across the three Partnerships in Ayrshire. The TEC Programme Team is managed through the South Ayrshire Partnership.

The Scottish Government's 2020 Vision for health and social care, provides the strategic context for TEC in Scotland. The intention is that by 2020 *everyone is able to live longer, healthier lives at home or in a homely setting*. TEC is viewed nationally as being vital to the successful delivery of this vision, in supporting these changes across the whole system of health and social care.

The Ayrshire and Arran strategy for TEC and Innovation was presented to the IJB in May 2016. The ambition outlined in the strategy document is to harness the advances in technology and to develop the use of TEC across Ayrshire and Arran over the next three years. North, South and East Health and Social Care Partnerships and Acute Services are currently redesigning models of care and TEC will support and further enable services, the workforce and infrastructure transformational redesign.

The implementation of the Strategy is being overseen by the Ayrshire and Arran TEC Programme Board on behalf of the South Ayrshire IJB.

Figure 5: Recruitment for TEC Home and Mobile Health Monitoring



Florence is named after Florence Nightingale and is the simple text messaging service used for Home and Mobile Health Monitoring. Coronary Heart Failure and Chronic Obstructive Pulmonary Disease (COPD) are Long Term conditions which are monitored using the Home pods enhanced Home and Mobile Health Monitoring service.

Analysis of Emergency Admissions to hospital for patients with COPD who have used the Home and Mobile Health Monitoring service shows a reduction in both the number of admissions (29% reduction) and the total hospital bed days (40% reduction) over a 12 month period following intervention. This is in line with results from other studies nationally.

Patient's Story

Mr Hunter was diagnosed with Chronic Obstructive Pulmonary Disease (COPD) and before using Telehealth, had to go to hospital two to three times a month due to his condition. He was referred for the Telehealth Service within South Ayrshire Health and Social Care Partnership at Girvan Community Hospital to help, monitor and manage his condition. Mr Hunter said "The home pod has been absolutely brilliant. There is a feel good factor with it – when I can see that my blood pressure is good every day that makes me feel better. If I am feeling bad or the questions on the pod are not correct I

know that I will get a phone call which cuts down on visits to hospital. I only go into hospital now for my yearly check-up. I would recommend this to anybody. It is so easy to use and it gives you peace of mind knowing that the nurses are only ever a phone call away"

Joint Equipment Store

Officers from across the three Ayrshire Council's and NHS Ayrshire & Arran have been in discussion about the feasibility of establishing 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. The establishment of the 3 Health and Social Care Partnerships in Ayrshire has provided further impetus to the drive to develop a joint solution and development of a joint store.

The programme of activity is being led by the South Ayrshire HSCP with project management support from East Ayrshire HSCP and National Procurement. In 2016/17 the following progress has been made on this project:

- A business case has been agreed by all Partners to progress with the implementation of a Joint Community Equipment and Minor Adaptations Service for all four Partners in Ayrshire and Arran, including NHS Ayrshire and Arran Acute.
- A suitable building in Prestwick, South Ayrshire has been identified to house the operational base for the new service and a feasibility study on the suitability of the premises has been conducted.
- A Feasibility Study Cost Report has identified additional one-off costs in terms of the modifications not identified in the original business case, and funding for this has been agreed by all three IJB's.

Falls Prevention

The *'Prevention and Management of Falls in the Community - A Framework for Action for Scotland 2014/2016'* was published in October 2014 by the Scottish Government as part of the National Falls Programme.

In Ayrshire and Arran the strategic approach to falls is led by AHP Services and given the Lead Partnership arrangements, South Ayrshire HSCP is providing oversight and leadership in this area.

A Falls Strategy Position Statement was developed in 2015/16 which outlines the local response to the National Framework for Action and details the associated Improvement Action Plan that has emerged from the formal self-assessments undertaken by each Health and Social Care Partnership on behalf of the Scottish Government. This was presented to the IJB in May 2016.

The Statement provides an overview of service demand resulting from individuals falling within the community. Its aim is to identify key areas for future action by partnerships to both reduce the numbers and manage the impact for those people who experience a fall.

A local stakeholder engagement group event took place in February, and a local falls group is being set up to update and deliver on local priority actions. The web based "Falls Assistant" tool which allows users to complete their own multifactorial fall risk assessment and formulate an action plan to aid self-management is being actively promoted, with over 600 users per month. The tool has been evaluated through focus groups and discussions, the outcomes include having a positive impact on motivation and ability to perform daily activity and anxiety around falling.

Sensory Impairment

A Pan Ayrshire and Arran Sensory Locality Plan was developed and South Ayrshire Health and Social Care Partnership is the identified lead for the three Ayrshire Health and Social Care Partnerships. This Plan was

produced in response to new statutory requirements on local partners, and links directly to the recommendations of the “See Hear” Strategy. The Ayrshire and Arran Plan was the first plan of its type developed in Scotland and has been developed as a template plan which is being used in many other areas.

It contains a clear commitment to the creation of an integrated Pan Ayrshire and Arran delivery of service – maximising the effectiveness of a strongly rooted partnership approach between the statutory and third sector organisations.

In 2016/17, in order to advance the Pan Ayrshire Sensory Impairment Locality Plan a number of actions have been taken:

- A Pan Ayrshire Sensory Impairment Action Plan has been developed.
- A “Programme Board” to oversee and support the implementation of the strategy and action plan has been put in place.

It has been agreed to commission a new Community Support Service comprising of 10 (half day sessions) over two weeks between Monday and Friday, to members of the public across ten fixed locations in North, East and South Ayrshire (including Arran).The service will raise awareness of sensory loss and of services available to those with auditory loss.

OTHER LEAD PARTNERSHIP ARRANGEMENTS

North Ayrshire Health and Social Care Partnership is the lead partnership for specialist and in-patient Mental Health Services as well as some Early Years Services for North, East and South Ayrshire. They are responsible for the strategic planning and operational budget of all Mental Health in-patient services, Learning Disability Assessment and Treatment Service, Child and Adolescent Mental Health Services, Psychology Services, Child Health Service, Children's Immunisation Team, Infant Feeding Service and Family Nurse Partnership.

East Ayrshire Health and Social Care Partnership is the lead partnership for Primary Care and Out of Hours Community Response. This lead responsibility relates to Primary Care, Medical Practices, Community Practices, Optometry Practices, Dental Practices, Public Dental Service, Pan- Ayrshire Out of Hours (evening) nursing service; Ayrshire Unscheduled Care Service (AUCS), and; Pan Ayrshire Out of Hours Social Work Response Service.

INSPECTION OF SERVICES

Internal Services

The Partnership's internal care services, such as Home Care, Day Care, Respite, Fostering and Adoption Services, and Children's Care Homes, are regulated and inspected by the Care Inspectorate.

Care Inspectorate Grading's are based on an Evaluation Grade from 1-6 as noted below:

Evaluation Grade	
1	Unsatisfactory
2	Weak
3	Adequate
4	Good
5	Very Good
6	Excellent

In 2016/17, seven care services were inspected and the table below shows the evaluations awarded to each service. The table also indicates whether any recommendations were made by the Care Inspectorate. This summary of Care Inspectorate Reports The Care Inspectorate Reports as at 31st March 2017 report provides further detail on the actions taken by each service within the Partnership to address the recommendations.

Base/ Care Inspectorate No.	Inspection Date	Quality Theme	Evaluation Grade (Out of 6)	No. of Recommendations	No. of Requirements
Children and Families					
Cunningham Place, Ayr/ CS2013316915	22.03.17	Care and Support	5	0	0
		Environment	Not Assessed		
		Staffing	5		
		Management/ Leadership	Not Assessed		
Woodhead Road, Ayr/ CS2003045401	23.02.17	Care and Support	4	2	0
		Environment	Not Assessed		
		Staffing	Not Assessed		
		Management/ Leadership	4		
Older People's Services					
Overmills, Ayr/ CS2003044050	15.04.16	Care and Support	4	5	0
		Environment	5		
		Staffing	4		
		Management/ Leadership	Not Assessed		
Hillcrest, Girvan/ CS2003001298	22.04.16	Care and Support	6	1	0
		Environment	5		
		Staffing	5		
		Management/ Leadership	Not Assessed		
South Lodge, Ayr/	12.08.16	Care and Support	2	12	8
		Environment	2		

CS2003001315	Follow Up 10.03.17	Staffing	2		
		Management/ Leadership	2		
SAC Care at Home, Ayr/ CS20061336 77	08.12.16	Care and Support	4	3	3
		Environment	Not Assessed		
		Staffing	3		
		Management/ Leadership	3		
Adult Service's					
Chalmers Road, Ayr CS20030012 99	20.04.16	Care and Support	4	5	0
		Environment	Not Assessed		
		Staffing	Not Assessed		
		Management/ Leadership	4		

One of the Scottish Government's suite of National Indicators is the proportion of care services evaluated as 'good' (4) or above by the Care Inspectorate. As at 31st March 2017, 83% of South Ayrshire Health and Social Care Partnership internal inspected services were graded 'good' (4) or above.

Joint Inspection of Children's Services in South Ayrshire

The Care Inspectorate published the Joint Inspection of Services for Young People in South Ayrshire on 4th October 2016. The overall evaluation against the nine quality indicators used in the inspection is set out below:

How well are the lives of children and young people improving?	
Improving the well-being of children and young people	Adequate
Impact on children and young people	Good
Impact on families	Good
How well are partners working together to improve the lives of children, young people and families?	
Providing help and support at an early stage	Adequate
Assessing and responding to risks and needs	Good
Planning for individual children	Adequate
Planning and improving services	Weak
Participation of children, young people, families and other stakeholders	Adequate
How good is the leadership and direction of services for children and young people?	
Leadership of improvement and change	Weak

In response to the Inspection Report, the HSCP and its partners have prepared an Action Plan, which has been agreed with the Care Inspectorate to address the issues raised in its report. Lead responsibility for taking this forward rests with the Community Planning Partnership of which the HSCP is part. Progress on

the implementation of the Action Plan will be monitored within the HSCP by the IJB Performance and Audit Committee.

External Services

Contract and Commissioning Officers within the Partnership's Planning and Performance Service are responsible for managing the relationship between external providers and South Ayrshire Council as the Commissioner of Services.

A number of service areas are currently under review and these will see the development of new strategy documents, implementation, resource, commissioning plans and performance and risk frameworks. Service users, carers, staff and providers are engaged in these exercises. Providers will continue to be engaged collaboratively in service redesign on an on-going basis. Currently this includes Leaning Disability, Mental Health and services for Older People. The Provider Forums will be the main vehicle for the Contracts and Commissioning Team to engage with the Third and Independent sectors to develop and continually improve the SAH&SCP contract monitoring and reporting framework arrangements.

The Partnership recognises and appreciates the significant work undertaken by external providers from the Third and independent Sectors in the provision of care and support services in South Ayrshire.

In 2016-17 the Contracts and Commissioning Team faced resourcing issues which significantly impacted on the level of contract monitoring that took place. The issues were as a result of overall low staffing numbers brought about by maternity leave, sickness absence and vacancies. Steps have been taken in 2017-18 to address these issues.

CHANGE PROGRAMME

South Ayrshire Health and Social Care Partnership has in place an ambitious change programme , which is managed through the Change Programme Board, chaired by the Director of Health and Social Care. Programmes are detailed below:

- Services to Older People
- Care at Home
- Care Home Review
- District Nursing Service – Model of Care
- Adult Learning Disability Strategy and Implementation Plan
- Biggart – redesign of hospital based services
- Cluster Arrangements
- Community Adult Mental Health Strategy and Implementation Plan
- New Carer's Act and Strategy
- Alignment of Care Homes to GP practices
- Children's Strategy
- HQ Premises
- Care First Project
- Community Led Support
- Anticipatory Care Planning
- Review of sleepover service

Carefirst Implementation

The HSCP has secured funding from South Ayrshire Council to modernise the social work client database. The existing SWIS system is a legacy from the days of Strathclyde Regional Council. In December 2016 a contract was signed off with OLM the providers of the Carefirst System. Carefirst is used as the client database by a significant number of local authorities in Scotland, including North Ayrshire. We have been fortunate to agree a secondment arrangement with a key manager from North Ayrshire on a part time basis to support the implementation in South Ayrshire. The process of implementation is expected to take two years in total with the system going live within Criminal Justice Services in the first instance in the summer of 2017.

HSCP Headquarters

Since the establishment of the HSCP in April 2015 a key objective has been to achieve the co-location of the key members of the management team from both health and social care services. In the summer of 2016 the vacant Elgin Ward at Ailsa Hospital was identified as suitable space for the establishment of the headquarters for the HSCP. Funding from both the NHS and South Ayrshire Council allowed the modest refurbishment of the accommodation. The ward has been renamed Elgin House and accommodates approximately 50 management and support staff who were able to take up residence in the spring of 2017.

THE YEAR AHEAD

2017-18 will again be a busy year of transformational change for the Integration Joint Board, the Health and Social Care Partnership Management Team, our staff and our partners from across the sectors in South Ayrshire, as we secure front-line changes for patients, service users and carers in the way that support and services are delivered in South Ayrshire.

A number of the key developments that will take place throughout the year will include the following:

- Development of a new Strategic Plan for 2018-21 **-** the current South Ayrshire Integration Joint Board Strategic Plan is due for a full re-write in 2017-18 in preparation for its approval in April, 2018. This will be a key delegated piece of work in 2017/2018 as it will summarise the transformational and delivery agendas for health and social care functions in South Ayrshire and how the Integration Joint Board plans to resource key service areas and programmes and how it will oversee these. Development of updated Service Plans for each of the three principal service areas – Community Health and Care Services, Children's Health and Care Services & Criminal Justice, and Allied Health Professions - reflecting the requirements to deliver against strategic priorities.

- Delivering the service improvements identified in the Joint Children's Services Inspection.

- Develop and implement approaches and actions for early intervention and support for looked after children and their families.

- Develop a new Commissioning plan for externally sourced Children's Services from the Third and Independent Sectors as a precursor to market testing.

- Further development of a robust Performance Management Framework, supported by a culture of self-evaluation, as drivers for continuous improvement.

- Implementation of the new Adult Learning Disability Strategy and corresponding Delivery Plan following its approval by the Integration Joint Board.

- Implementation of the new Adult Community Mental Health Strategy and corresponding Delivery Plan following its approval by the Integration Joint Board.

- Development of short and medium-term outcomes and commissioning plans for Adult Learning Disability Services and Adult Community Mental Health Services as a precursor to market testing later in 2017 with new contracts coming into effect early in 2018.

- Develop with service users and carers, a new cluster based model of support for some people currently receiving night-time support to replace the current one to one arrangements.

- Put in place a short-term contract for day services for older people to facilitate a full review exercise which will include in-house services to be completed during 2017/19.

- Full implementation of the Care at Home Review started in 2016-17 and prepare for the recommissioning of Care at Home Services with the Third and Independent Sectors which will start in 2017-18.

- Development and implementation of an Older People's Strategy which will also include elements of the transformational change agenda started in 2016-17 and referred to in other parts of this report, including anticipatory care planning, Biggart Community Hospital redesign, community rehabilitation and enablement and a developing interface with the new Combined Assessment unit at Ayr Hospital. The strategy will also set out proposals for reducing hospital admissions, occupied bed

days, delayed discharges and promote proposals for shifting the balance of care from the acute sector to community settings.

- Development of a Plan for the South Ayrshire Health and Social Care Partnership to implement the Carers (Scotland) Act 2016.

- Develop a local Dementia Strategy.

- Implementation of the Technology Enabled Care Strategy and corresponding Delivery Plan.

- Review of prescribing arrangements within South Ayrshire and the achievement of Best Value in this regard.

- Continue to implement the Community Led Support programme started in 2016-17 which will see the creation of a single point of contact for Partnership services, service hubs and community contact points or “front doors” within each of the six localities, which will see professionals and local people working together to provide access to a range of services and supports provided across the sectors.

- Development of a Workforce Plan for the Partnership that will sustain the current and future delivery of integrated care services by the end of 2017.

- Develop a suite of Partnership specific training programmes, including Induction and Management and Leadership.

- Continue to improve access to information and information management across the Partnership with the focus in 2017-18 being the continuing implementation of the Care First Social Work system.

APPENDIX 1: NATIONAL HEALTH AND WELLBEING INDICATORS DATA

NATIONAL INDICATORS		South Ayrshire Health and Social Care Partnership Data						Scotland Latest Data	RAG STATUS
		2011/12	2012/13	2013/14	2014/15	2015/16	2016/17		
NI-1	Percentage of adults able to look after their health very well or quite well	N/A	N/A	94%	N/A	94%	N/A	94%	
NI-2	Percentage of adults supported at home who agreed that they are supported to live as independently as possible	N/A	N/A	83%	N/A	83%	N/A	84%	
NI-3	Percentage of adults supported at home who agreed that they had a say in how their help, care or support was provided	N/A	N/A	82%	N/A	79%	N/A	79%	
NI-4	Percentage of adults supported at home who agreed that their health and social care services seemed to be well coordinated	N/A	N/A	81%	N/A	76%	N/A	75%	
NI-5	Total percentage of adults receiving any care or support who rated it as excellent or good	N/A	N/A	83%	N/A	82%	N/A	81%	
NI-6	Percentage of people with positive experience of the care provided by their GP practice	N/A	N/A	90%	N/A	91%	N/A	87%	
NI-7	Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life	N/A	N/A	82%	N/A	84%	N/A	84%	
NI-8	Total combined percentage of carers who feel supported to continue in their caring role	N/A	N/A	46%	N/A	42%	N/A	41%	
NI-9	Percentage of adults supported at home who agreed they felt safe	N/A	N/A	84%	N/A	86%	N/A	84%	
NI-10	Percentage of staff who say they would recommend their workplace as a good place to work	N/A	N/A	N/A	N/A	N/A	72%	N/A	N/A
NI-11	Premature mortality rate per 100,000 persons	417 (m)	387 (m)	425 (m)	391 (m)	422 (m)	2016 data available in July 2017	441 (m)	

NATIONAL INDICATORS		South Ayrshire Health and Social Care Partnership Data						Scotland Latest Data	RAG STATUS
		2011/12	2012/13	2013/14	2014/15	2015/16	2016/17		
NI-12	Emergency admission rate (per 100,000 population)	13,733 (m)	14,926 (m)	14,817 (m)	15,800 (m)	16,339 (m)	16,486 (m) (p)	12,037 (m) (p)	
NI-13	Emergency bed day rate (per 100,000 population)	124,364 (m)	149,036 (m)	151,926 (m)	164,354 (m)	172,701 (m)	171,638 (m) (p)	119,649 (m) (p)	
NI-14	Readmission to hospital within 28 days (per 1,000 population)	93 (m)	107 (m)	108 (m)	105 (m)	102 (m)	109 (m) (p)	95 (m) (p)	
NI-15	Proportion of last 6 months of life spent at home or in a community setting	87% (m)	86% (m)	85% (m)	86% (m)	87% (m)	85% (m)	88% (m)	
NI-16	Falls rate per 1,000 population aged 65+	20% (m)	24% (m)	22% (m)	25% (m)	24% (m)	22% (m)	21% (m)	
NI-17	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	N/A	N/A	N/A	86% (m)	89% (m)	Data not published	83% (2015/16)	
NI-18	Percentage of adults with intensive care needs receiving care at home	67% (m)	71% (m)	67% (m)	63% (m)	65% (m)	Data not published	62% (2015/16)	
NI-19	Number of days people spend in hospital when they are ready to be discharged (per 1,000 population)	N/A	414 (m)	629 (m)	900 (m)	838 (m)	1273 (m) (p)	842 (m) (p)	
NI-20	Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	23% (m)	25% (m)	28% (m)	27% (m)	29% (m)	29% (m)	23% (m)	
NI-21	Percentage of people admitted to hospital from home during the year, who are discharged to a care home	**Indicator under development**							
NI-22	Percentage of people who are discharged from hospital within 72 hours of being ready	**Indicator under development**							
NI-23	Expenditure on end of life care, cost in last 6 months per death	**Indicator under development**							

(p) Notes provisional figures. (m) Management Information. The above figures were provided by ISD Scotland to all Partnerships for inclusion in Annual Performance Reports.

	No concerns
	Some concerns
	Major concerns

APPENDIX 2 - INTEGRATED CARE FUND

Achievement of ICF Outcomes 2016/17

The report below details the achievement of the ICF Outcomes for each funding stream .

Integrated Care Fund

Programme Theme	Project Title	ICF investment	Actual Spend	Outcomes
Supporting Service Improvement, Redesign and Change	Workforce Planning + Redesign	£16,625	£16,012	Post-holder recruited and in post from November. I-Matter survey and focus groups successfully set up for Partnership employees to assess employee satisfaction and their thoughts on the Partnership.
	Service Improvement + Change + Reviews	£60,000	£15,331	Funding used input from The Scottish Commissioning for Learning Disability to develop and write the learning disability strategy with similar input form Health Improvement Scotland inot the new Community Adults Mental Health Strategy.
	Care @ Home Implementation	£53,000	£20,094	Consultant continues to develop and work on the Care @ Home framework with the senior manager. Also attends programme board meetings as a critical friend, and is a key link within the process.
	Community Led Conversations	£60,000	£57,425	The National Team for Development for Inclusion was commissioned to facilitate an 18 month process seeking to better manage demand for Social Work and related services through better triaging, signposting and use of community resources.

	Action on Hearing Loss	£9,000	£8,434	Develop a “Hear to Help” service across the three Ayrshire Partnership’s which primarily focussed on assisting people to make the most of their hearing aids and manage their hearing loss effectively through the provision of hearing aid batteries= 4462 distributed and replacement of earmould tubing= 2930.
	My Home Life	£25,000	£3,330	Recruitment of a full cohort 16 of participants. Participants in My Home Life Programme include; 12 Managers from 7 Care Home, 3 Managers from Home Care Services and 1 Community Nurse.
	Autism Strategy	£15,000	£15,000	One Stop Shop (Ayrshire) continue to be the main point of contact for parents/carers and professionals who are seeking information in relation to autism. Individuals are supported to access benefits such as personal independence payments, employment support allowance and disability living allowance. In South Ayrshire 51 individuals were supported to reduce health inequalities.
Total		**£238,625**	**£135,626**	
Developing Community and Locality based preventative programmes	VASA Core Community Capacity programme	£100,000	£100,000	This funding covers different aspects of VASAs work, some key outcomes include: • Ran 10+ classes per week to meet clients’ needs, 50% increase in demand from 2015-16. • 1100 one to one and 90 group befriending sessions took place. • Strictly Seniors event was organised which was attended by over 400 people. • Third Sector Lead **a**ttended 120 Partnership meetings.
	VASA Community Connector	£27,000	£27,000	Supported and encouraged socially isolated older people to become active members of their local community. There have been 94 referrals, 220 interactions such as accompanying clients to activities and 92 one to one visits.
	VASA-led 3rd sector programme	£93,221	£93,221	Four community groups are supported by this funding, some key outcomes for each are: • Worked with 51 service users to enable them to stay in

				their own homes for longer. • Over 50 individuals have attended the recovery service drop in since July 2015. • All three projects targeted at over 50s; 226 walking football session per year over 5 venues, with 65 men registered to play, 36 football memory sessions and 36 little art school sessions per year. • Multi sports club for individuals with physical disabilities at The Citadel has between 25 and 32 attendees weekly.
	Social Isolation	£15,000	£22,000	This money has help create South Ayrshire Life a directory available online and to call. An 0800 number has been set up, 200 data entry forms printed off 50 organisations contacted by phone and data collection forms sent out, 100 activities entered into the online directory. Directory will come online in 2017-18.
	Carers Support programme	£70,000	£76,105	Carers have indicated that they enjoy the service and it makes them feel safe and less isolated. We have supported 618 older carers aged between 60 years old and 100 years old. This is 159 more carers than last year.
	RVS Good Neighbours programme	£29,788	£29,778	Pilot programme seeking to develop community based responses aimed at older people. However, due to low levels of referrals and activity the service has been discontinued as of 31st March 2017.
	Community Engagement Officers	£120,000	£122,566	Each locality group has now elected a Chair, Vice Chair and Strategic Planning Advisory Group representative and have met at least ten times throughout the year. Local sub-groups have also become established for a range of subjects and key priorities have been identified for each locality with some common themes emerging such as social isolation.
	Small grants fund	£30,000	£30,000	Through an initial focus on a modest small grants budget of £5,000 per locality each group has made significant wider connections with the local community through small grants and participatory budgeting events. This activity has enabled some

				local priorities to begin to be tackled through small local project activity.
	Locality Planning admin	£9,000	£8,451	Administration monies used to support broad range of locality work including sourcing; venues, transport and hospitality.
	Community Links Practitioners (CLP)	£90,000	£84,298	CLPs have established a presence within GP practices. Developing case studies to demonstrate patients personal outcomes being met. Review Appointments over 6 months in All Sectors = 226. New Contact over 6 Months in All sectors = 164. Did not attend Appointments over 6 Months in All sectors = 29.
Total		**£634,009**	**£593,419**	
Developing comprehensive clinical and care pathways	Medicine Management	£78,000	£61,658	Four different projects are funded with this money, some key outcomes are: • Currently 500 patients are accessing help with their medications. • Patients able to access a clinical pharmacy service in the care home setting. • More intensive input to the pharmaceutical care needs of patients with more complex needs. • 856 patients are accessing clinical pharmacy service in Girvan community hospital. • Medication Policy and Guidelines have been developed for South Ayrshire including the agreed use of MAR charts.
	Integrated Care Team (ICT)- formally Community Ward	£208,000	£175,287	Three specialist posts that comprise of a Doctor, Advanced Nurse Practitioner and administrative support have been recruited and are in posts. They form a significant clinical aspect of the newly formed ICT.
	Falls Prevention	£31,000	£28,271	Contribution to two Ayrshire wide posts that have successfully been filled. The Strategic Falls Post co-ordinates a response to the national strategy. The Falls Trainer delivers training in care

				homes, and to care at home staff.
	Anticipatory Care Planning	£90,000	£54,967	12 sites have established routine Multi-Disciplinary Team (MDT) meetings, taking place either monthly or fortnightly. 300 patients have been identified and reviewed at MDTs over the first five- six months of the project.
	Girvan CH	£15,000	£21,220	Transition from previous arrangements to support clinical work in Girvan Community Hospital. This provided six GP locum sessions to take place within the hospital.
	Red Cross Home from Hospital	£94,000	£71,936	Have a positive impact on admissions and waiting time breaches as well as reduced length of waits for individuals. Help reduce delayed discharges and improve patient flow within hospitals. Total number of patients transported = 1769.
	Ayrshire Doctors on Call (ADOC)/ Single Point of Contact (SPOC)	£13,000	£13,000	South Ayrshire contribution to Ayrshire wide administrative support to provide a single point of contact. Posts filled to answer calls for out of hour's appointments.
Total		**£559,000**	**£426,339**	
Developing Self-Management and Rehabilitation Programmes	Talking about diabetes	£3,000	£347	This provides self-management training to small groups of diabetics in order to manage their symptoms.
	Self-Management network	£2,400	£1,067	Annual network event held to promote local schemes and amenities, allows networking between those attending. Turnout for the events was high, with positive feedback from attendees of the usefulness and variety of programmes.
	Invigor8	£54,000	£64,178	We have 16 successful Invigor8 classes across South Ayrshire Attendances at classes = 6,277 Falls Referrals= 222.
	Tier 1 and 2 Rehab	£30,000	£27,822	Three levels of evaluation covering: programme level evaluation, individual outcomes, and qualitative outcome, have been created. Total New Referrals = 256 Attendances at classes 2016 / 2017 = 4,728

				Referrals Include - Cardiac - 79 people referred which is 45% of all referrals, and the main reason for referrals.
	Tier 3 and 4 Rehab	£50,000	£49,190	99 individuals were referred, 43 male and 56 females. Of these, 93 individuals have been offered an appointment with 6 awaiting appointments. 15 staff received training on history taking and clinical assessment.
	Additional Community Rehab capacity	£262,545	£103,086	The project successfully recruited three staff members in the Intermediate Care Team (ICT) and five in the Community Rehabilitation Team. ICT avoided 273 admissions and facilitated 201 discharges in that period. Community Physiotherapy waiting times (Ayr) reduced from 17 weeks to 8 weeks with additional staff in post.
Total		**£401,945**	**£245,690**	
Developing Technology Enabled Care	Telecare	£122,000	£129,578	A new telecare officer has been recruited. The pathway for care services has been redesigned. Telecare is now embedded within a single point of access for care at home supports.
	Telehealth	£90,539	£84,518	Advanced nurse practitioner and administrative and clerical support both successfully recruited and in post. This has led to an increased uptake of telehealth through home visits and helping individuals with COPD and heart failure monitor their conditions at home.
Total		**£212,539**	**£214,096**	
Programme and Performance Support + Enablers	Programme Management and admin	£155,000	£84,675	To provide leadership and administrative resource to respond and monitor all Partnership change programmes including ICF.
	Independent Sector leadership	£26,400	£26,400	Established a vital link between the independent sector and the Partnership. Active participation in Care Homes Review Challenge Team. Actively supporting / identifying participants for 2nd cohort of My Home Life Leadership Programme.

	Communication + information	£12,000	£9,399	Partnership information event took place in University of the West of Scotland in June, which was well attended. Strictly Seniors 2016 was printed, and widely distributed.
Total		**£193,400**	**£120,474**	
Additional Spend	SPT Transport invoice	£8,000	£8,000	South Ayrshire's contribution, as SPT was commissioned to carry out an Ayrshire-wide transport review. This originated from the North Ayrshire Health and Social Care Partnership.
	Care homes contribution from Health	£100,000	£100,000	This allowed care home packages to continue to be funded as demand increased, creating increased capacity in hospitals as a result.
	Programme Management and Enablers	£0	£12,618	Post-holder recruited and in post from late November. Post provides monitoring support to Partnership programmes including ICF and to input inot strategic development.
	Care home fees funded from slippage	£0	£100,000	This allowed care home packages to continue to be funded as demand increased, creating increased capacity in hospitals as a result.
	Dementia	£0	£5,000	Contribution to support an Ayrshire-wide research post seeking to identify improved clinical response re people diagnosed with dementia.
	Senior Community Nurse	£0	£39,800	Post funded and successfully filled in mid-July to develop the district nursing service in South Ayrshire.
	Community Equipment	£0	£9,828	South Ayrshire contribution to manager post, plus supplies which include; a completed feasibility study and payment for VAT advice.
	Uncommitted Funds	£48,893	£224,611	To be carried forward to the 2017-18.
Total		**£156,893**	**£499,857**	
Grand Total		**£2,340,000**	**2,235,501**	

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