south ayrshire
health & social care
partnership

Annual Performance Report 2015/16

September 2016

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 work 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'. In South Ayrshire, the Partnership includes adult community health and social care services, children's health and social care services and criminal justice services. It is also lead for the following services on behalf of the three Ayrshire Health and Social Care Partnerships (and in the case of Allied Health Professions this responsibility also extends to the Acute Sector):

- Allied Health Professions (AHP's)
- Continence
- Technology Enabled Care (TEC)
- Joint Equipment Store
- Falls Prevention

This is the first Annual Performance Report for South Ayrshire Health and Social Care Partnership for 2015-16. It provides the Partnership with a chance to celebrate our strengths and achievements; and to consider the challenges that face us in the coming months and years.

In line with the Guidance for Health and Social Care Integration Partnership Performance Reports, produced by the Scottish Government, this Annual Report sets out to show how, through effective leadership from the Partnership's Integration Joint Board, the Partnership has:

- worked towards delivering against our strategic priorities;
- performed in relation to the National Health and Wellbeing Outcomes and the Children's and Criminal Justice outcomes, as set out by Scottish Government;
- performed in relation to local measures;
- performed financially within the current reporting year; and achieved best value;
- progressed locality planning arrangements; and
- performed in inspections carried out by scrutiny bodies.

Over the last 12 months, we have worked hard to meet our priorities and the details of our achievements are covered in the pages that follow. Some of our key achievements include the development of our Locality Planning arrangements, which over time will support us to be more responsive to local priorities; our participation in a Pan Ayrshire Service Review Programme with a focus on areas including older people's services; a significant re-design of care pathways which, once implemented, will enable a focus on prevention, reablement and care package reviews; and the development of change programme focussed on a four key priority approach to managing care for those people most at risk of admission to hospital.

The Change Programme was developed in 2015/16, following successful and productive engagement with key stakeholders within our communities, partners and staff, which set out to ensure our understanding of the key areas for improvement was accurate. A number of key themes and priorities have emerged from this engagement and has informed the identification of 4 key priorities for change which we believe are most likely to make the biggest contribution to improving outcomes for the people who use our services:

1. Implementation of Anticipatory Care Planning: those who need an anticipatory care plan, have one.
2. Redesign of Community Rehabilitation and Enablement Team: those in crisis have alternatives to going to University Hospital Ayr.
3. Redesign of Biggart Community Hospital: those requiring intensive support and rehabilitation have appropriate access to the service.

4. Establishment of a Community Interface with Combined Assessment Unit at Ayr Hospital: those arriving at the Combined Assessment Unit receive a multi-disciplinary team assessment; with community management the default method of support.

We have already made some progress in these areas. A multi-disciplinary approach to anticipatory care planning has been established within one GP practice and feedback to date has been positive. A number of other practices have indicated their interest in implementing the approach and a plan to implement this approach across South Ayrshire in the coming year is being progressed.

Scoping work for the redesign of community rehabilitation and enablement teams is almost concluded and a high level model has been agreed. Further refinement work will be undertaken in 2016/17 before full implementation of the model is progressed.

A test of change with 8 rehabilitation beds within the Biggart Community Hospital has evidenced that a non-medical, multi-disciplinary decision making, personal goal-centred approach improves outcomes for individuals and reduces their length of stay in a hospital setting. Work will be progressed over the coming year, to include all 30 beds within the Hospital, while a broader redesign of the Hospital is planned.

The new Combined Assessment Unit at Ayr Hospital is due to open in 2017 and planning has already begun to understand the relationship with the emerging models of community care in South Ayrshire. This work will continue throughout 2016-17 to ensure that there is a shared approach to supporting the delivery of good outcomes for those living in South Ayrshire.

In order to maximise the benefits of integration; and to support on-going delivery of this ambitious programme of change we are working to co-locate teams within the same buildings wherever possible; and ensure teams have both the time and resource to develop new ways of joint working. We also recognise the need to establish good sharing of information, and integrate our IT systems where possible and work on procuring a new information system for social work is already being progressed in support of this.

It is clear from our successes to date, that by working together, we can successfully address both the opportunities provided by integration, and the challenges ahead. This year, and in the coming years, we face many challenges; not least the significant reduction in resources as a result of the reduction in public spending across Scotland. A key focus for the Partnership going forward, will be delivering on our programme of change to ensure that we can successfully address these challenges and opportunities.

We have already demonstrated competence and resilience in dealing with the challenging pace of change brought about through integration. I am confident that we will continue to deliver responsive services built around the needs of service users and communities by striving for improvement; in the decisions we make and in the services we deliver.

We will continue to publish an Annual Report on our performance each year – detailing our achievements and the impact that the Partnership is having through 'working together for the best possible health and wellbeing for our communities' in South Ayrshire.

Tim Eltringham
Director South Ayrshire Health and Social Care Partnership

STRATEGIC CONTEXT

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 in to a single operational delivery unit. The Partnership's Integration Joint Board is responsible for planning and overseeing the delivery of a full range of community health and social work/ social care services, including 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 and Technology Enabled Care. The Integration Joint Board approved its first Strategic Plan for 2015-18 in April 2015. Throughout the course of 2015/16, the Integration Joint Board has taken key decisions in relation to the establishment of the Partnership including the appointment of Officers, the delegation of functions and operating and governance arrangements. It has also agreed the Partnership's Strategic Plan 2015-18; and the establishment of a committee structure responsible for overseeing health and care governance, performance and audit, risk management, health and safety and other matters. Other significant reports considered by the Integration Joint Board include approval of the Ayrshire and Arran Winter Plan; a strategy to deliver improved outcomes for Looked After Children; and the Partnership's Change Programme.

This Annual Report is produced in the context of the national 2020 vision for health and social care; the South Ayrshire Single Outcome Agreement 2013-23; the South Ayrshire Health and Social Care Partnership Strategic Plan 2015-18; and the National Outcomes for Health and Wellbeing, Children and Young People and Criminal Justice that inform and frame our work.

The national 2020 Vision for health and social care is that, '*by 2020 everyone is able to live longer, healthier lives at home or in a homely setting*'.

The South Ayrshire Community Planning Partnership's Single Outcome Agreement 2013-2023 is the overarching planning document for South Ayrshire, which provides the strategic policy framework for the delivery of public services in South Ayrshire by all partners. The Community Planning Partnership's vision is, '*to establish South Ayrshire as the most dynamic, inclusive and sustainable community in Scotland'*.

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. This has informed the HSCP's vision, '*working together for the best possible health and wellbeing of our communities'*. To deliver on this vision, the Partnership's Strategic Plan for 2015-18 outlines 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.

In pursuit of these, the following are the key values to which the HSCP and its stakeholders are expected to adhere to:

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

NATIONAL OUTCOMES – HEALTH AND WELLBEING, CHILDREN AND CRIMINAL JUSTICE

Fifteen National Outcomes guide the activity of South Ayrshire Health and Social Care Partnership:

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.

These outcomes provide a strategic framework for the planning and delivery of health and social care services. They focus on the experiences and quality of services for people using these services, carers and their families.

The following pages provide an assessment of the Partnership's performance against these outcomes; and against agreed core national integration indicators linked to these outcomes. The core integration indicators provide an indication of progress towards the outcomes that can be compared across Partnerships and described at a national level over the longer term.

NATIONAL HEALTH AND WELLBEING OUTCOMES

The National Health and Wellbeing Outcomes, as detailed on page 6 are the Scottish Government's high-level statements of what health and social care partners are attempting to achieve through integration and ultimately through the pursuit of quality improvement across health and social care.

National Health and Wellbeing Indicators

An associated core suite of 23 National Performance Indicators has been developed, drawing together measures that were felt to evidence the nine National Health and Wellbeing Outcomes. Of the 23 indicators, 14 evidence the operational performance of South Ayrshire Health and Social Care Partnership - with the data provided by the NHS Information Services Division (ISD). The data for the remaining 9 indicators is taken from responses from the Scottish Government's biennial Scottish Health and Care Experience Survey. Our performance against the National Health and Wellbeing Indicators is detailed in Appendix 1.

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. The extent to which implementation of the Strategic Plan 2015-18 is contributing towards meeting the National Health and Wellbeing Outcomes is noted below with each associated action cross referenced within the foot-notes.

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

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

Local Performance Indicator		Baseline	Latest Value
1.2	% of adults who smoke (SOA)	22% (2013)	22% (2014)
1.3	Rate of alcohol related hospital stays (HSCP PF)	777 (2013/14)	723 (2014/15)
1.4	Rate of drug related hospital stays (HSCP PF)	153 (2013/14)	170 (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.
- Performance has improved around the rate of alcohol related hospital stays with a reduction from 777 in 2013/14 to 723 in 2014/15 per 100,000 population. Challenges remain around drug related hospital admissions which have increased with the rate rising from 154 to 177 over the same time period.

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[2].

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 which will contribute to achieving the overarching vision: Prevention, education and early intervention; Healthier and safer communities; Children and families affected by others' substance misuse; Implementing a Recovery Orientated System of Care.

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)[3].

Implementation of both the Alcohol and Drug Strategy and the Tobacco Control Action Plan is being monitored to determine impact on local performance indicators.

[1] Key: NI – National Indicator from Core Suite of Integration Measures; SOA (Single Outcome Agreement Local Indicator); HSCP PF- Health and Social Care Partnership Performance Framework Measure; MPF- Managers Performance Framework; SPIP-Strategic Plan Implementation -Plan Action Reference.
[2] South Ayrshire Health and Social Care Partnership Strategic Plan Implementation Plan A06
[3] South Ayrshire Health and Social Care Partnership Strategic Plan Implementation Plan E08

CASE STUDY

Stephen used to drink before work every day; and then go to the pub on his way home. He describes himself then as a 'functioning alcoholic', who didn't believe he had a problem and that thought he could stop drinking whenever he wanted.

After being made redundant, Stephen's drinking increased and friends and family raised concerns. Stephen still didn't think he had a problem and admits that the escape that alcohol gave him from his problems made it impossible for him to quit.

Eventually Stephen's drinking led to him becoming homeless and he turned to the Council's Homeless Service. After a few nights in homeless accommodation, Stephen was moved to a supported accommodation project and allocated his own Support Worker. Despite this support, time spent with people on the project with similar alcohol problems, did not help Stephen's drinking. After 18 months in supported accommodation, Stephen secured his own flat on the other side of town but things went downhill rapidly - he had no support, was struggling to manage his bills and his drinking started to have a major impact on his health.

Pictured:
Stephen receives his 'Ayrshire Achieves Volunteer of the Year' Award from John Burns, Chief Executive of NHS Ayrshire and Arran

After a few months, Stephen began to attend some community initiatives to access food and support and heard about an abstinence based initiative called Café Hope. With the support from a volunteer, he found the courage to attend and discovered that most of the people were in recovery from alcohol or drug misuse and he felt a connection to the group, which really helped him to relax and be himself.

Following a hospital based detox, Stephen stopped drinking and was looking for a way to use his experiences to help others. Stephen learned of the Alcohol and Drug Partnership (ADP) Volunteer Peer Worker Project and was offered a place on the project. Stephen admits he initially felt way out of his depth however with the group's support he gained 18 months' work experience with NHS Addictions Services working with some of the most chaotic service users they had, while working towards an SVQ Level 3 Health and Social Care qualification. He completed a full NHS training programme and helped develop a dental pilot project with the Oral Health Promotion Team, supporting people in addiction who would otherwise miss out on dental treatment. The pilot has been running since May 2015 and has been such a success that the NHS plan to roll it out across Ayrshire later this year.

Using his own experiences and the extensive training he has received on the Project, Stephen is now helping others to enter into their own recovery journey through various support groups, 1-to-1 supports and activities currently on offer in Ayr. Stephen volunteered with RecoveryAyr, a project he passionately feels is key to recovery in Ayr and is now Chairperson. This has opened up further opportunities for Stephen to engage in many other projects. He has subsequently graduated from the Volunteer Peer Worker programme. He has also won the 'Ayrshire Achieves Volunteer of the Year Award' for his work with NHS Addiction Services. In November last year, Stephen was appointed as a Peer Worker with the ADP which has given him the opportunity to work with others and show them that recovery is possible. He is clear that Café Hope, RecoveryAyr, and the ADP Volunteer Peer Worker project have been key to his recovery for the last 3 and a half years.

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		Baseline	Latest Value
2.1	% of adults supported at home who agree that they are supported to live as independently as possible (NI-2)	83% (2013/14)	83% (2015/16)
2.2	% of adults at with intensive needs receiving care at home (NI-18)	63% (2014/15)	65% (2015/16)
2.3	Emergency admission rate per 100,000 population for adults (NI-12)	15,576 (2014/15)	16,316 (2015/16) (p)
2.4	Emergency bed day rate per 100,000 population for adults (NI-13)	140,564 (2014/15)	160,197 (2015/16) (p)
2.5	Readmission to hospital within 28 days of discharge per 1,000 population (NI-14)	99 (2014/15)	94 (2015/16) (p)
2.6	Proportion of last 6 months of life spent at home or in a community setting (NI-15)	86% (2014/15)	86% (2015/16) (p)
2.7	No. of days people aged 75+ spend in hospital when they are ready to be discharged per 1,000 population (NI-19)	900 (2014/15)	838 (2015/16) (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	Data under development
2.9	% of people discharged from hospital within 72 hours of being ready (NI-22)	Data under development	Data under development

Local Performance Indicator		Baseline	Latest Value
2.10	No. of service users in receipt of Enhanced Telecare (HSCP PF)	610 (2014/15)	1400 (p) (2015/16)
2.11	% of older people living in the community rather than a care home or long stay hospital	-	96% (2015/16)

Performance Analysis

- 83% of adults report that they are supported to live as independently as possible, which is approximately 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. The rise in this figure is expected due to the focus in relation to supporting more people with complex needs within the community.
- Emergency admission rates have increased over the past year resulting in an increased bed day rate. Addressing the issue of unscheduled care was a key driver of the Integrated Care Fund programme for 2015/16.
- Readmissions to hospital within 28 days of discharge have improved over the past year with a slight decrease from 99 per 1,000 population in 2014/15to 94 in 2015/16.
- The proportion of people who spend the last 6 months of life at home or in a community setting has remained level over the past year and remains in line with the national average at 86%.
- Our performance around the number of days people spend in hospital has improved over the past year. The number of days people aged 75+ are delayed in hospital when they are ready to be discharged has decreased from 900 in 2013/14 to 838 in 2015/16 which is lower than the national rate across Scotland of 915.
- 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 1400 in 2015/16.
- Around 96% of older people live in housing in the community rather than a care home or long stay hospital.

Partnership Activity to Deliver Against National Outcomes

A Care at Home Review was completed in March 2016 and, following the Integration Joint Board's approval, recommendations from the service review are now being implemented. The review will result in a significant re-designed care pathway which will enable a focus on prevention, reablement and care package reviews.[4]

The Partnership has developed a 4 key priority approach to managing care for those people most at risk of admission to hospital. This includes the following priority areas: Anticipatory Care Planning, Community Rehabilitation and Enablement, Redesign of Services at Biggart Hospital and the Interface with Combined Assessment Unit at Ayr Hospital. These align with the Older People and Unscheduled Care Workstreams being taken forward on a pan-Ayrshire basis. Progress is being monitored through fortnightly meetings to determine impact.[5]

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. In 2015/16, a member of staff from the Scottish Fire and Rescue Service also took up post and has worked jointly with South Ayrshire staff to identify residents at risk, carry out joint fire safety visits and fit linked smoke detectors.[6]

[4] South Ayrshire Health and Social Care Partnership Strategic Plan Implementation Plan D08
[5] South Ayrshire Health and Social Care Partnership Strategic Plan Implementation Plan D01
[6] South Ayrshire Health and Social Care Partnership Strategic Plan Implementation Plan D09

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

National Performance Indicator		Baseline	Latest Value
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)
3.2	% of adults receiving any care or support who rate it as excellent or good (NI-5)	83% (2013/14)	82% (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)

Performance Analysis

- The Partnership performs 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 in line with 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 is being developed for further consultation.[7]

Engagement and participation is also being developed through progressing the implementation of locality planning arrangements. Six Locality groups in South Ayrshire have now been established and are working towards developing local agendas and priorities to respond to local needs.[8]

A designated Self-Directed Support (SDS) Officer is in place and a work plan has been developed which is in line with the national SDS strategy. The increase in uptake of SDS options demonstrates the extent to which service users are having a say in how their help, care or support was provided. Staff continue to be supported to promote SDS options through an ongoing training programme and an active SDS Practitioners Forum.[9]

Community Link Practitioners are now active in 9 GP Practices to assist people to access services and the support they require across sectors, thereby improving the experience provided by participating GP Practices.[10]

[7] South Ayrshire Health and Social Care Partnership Strategic Plan Implementation Plan K01
[8] South Ayrshire Health and Social Care Partnership Strategic Plan Implementation Plan G01
[9] South Ayrshire Health and Social Care Partnership Strategic Plan Implementation Plan D02
[10] South Ayrshire Health and Social Care Partnership Strategic Plan Implementation Plan G07

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		Baseline	Latest Value
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)
4.2	Proportion of care services graded "good" (4) or better in Care Inspectorate inspections (NI-17)	86% (2014/15)	89% (2015/16)

Local Performance Indicator		Baseline	Latest Value
4.3	% of people fully enabled at the end of an Enablement Service (MPF)	40% (2014/15)	40% (2015/16)
4.4	% of people who received an Enablement service who report that their quality of life had improved or had been maintained (MPF)	95% (2014/15)	98% (2015/16)

Performance Analysis

- 84% of adults supported at home agreed that services have improved or maintained their quality of life, which is slightly below the national average of 85%.
- Services provided by the Partnership continue to receive high grades by the Care Inspectorate. In 2015/16 as at 31st March 2016, 89% 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.
- Our Enablement service supported around 720 service users during 2015/16. 40% of people were fully enabled meaning that they no longer required any formal support at the end of their enablement service. 86% of service users stated that their quality of life had improved as a result of receiving a service and 12 % stated that it was about the same.

Partnership Activity to Deliver Against National Outcomes

A review of Care at Home is underway which will result in a revised operating model with a focus explicitly on delivery of reablement of service users and investment in a new reablement hub.[11]

Care Inspectorate Grades are continuously 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.[12]

[11] South Ayrshire Health and Social Care Partnership Strategic Plan Implementation Plan D08
[12] South Ayrshire Health and Social Care Partnership Strategic Plan Implementation Plan J02

CASE STUDY

Kirstin is a 73 year old lady living in Ayr with severe osteoporosis in her lumbar spine, hips and femur. She was in extreme pain which was eventually moderately relieved with painkillers however she found it difficult to function with everyday tasks and her quality of life was reduced due to pain. She also had a fear of injury after a fall which resulted in soft tissue damage.*

Through talking to a friend Kirstin heard about Invigor8, Falls Prevention Classes and had a discussion with her GP who referred her along to the programme. Kirstin subsequently had an Invigor8 assessment where her anxiety about falling over and injuring herself was discussed. The assessment showed that her lower limb strength was low, her balance was limited and that she had a 'high risk of fracture' score.

Pictured: An enthusiastic participant in an Invigor8 class

Subsequent assessments were carried out at weeks 1, 12, 33 and 48. The 48 week assessment showed an improvement in strength, balance and fear of falling. "My mobility has improved and the physiotherapist commented on this and was pleasantly surprised. The pain is not as much as it was at the beginning. I think this is because of a combination of the exercises, my physiotherapist and pain relief through medication. I feel I have built up my confidence. I'm not as anxious about hurting myself or having a fall. Invigor8 helps as you meet people who are in the same boat – we all help each other and swap stories and information."

**Name Changed*

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

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

Local Performance Indicator		Baseline	Latest Value
5.2	Life Expectancy in males (SOA)	77.7 (2012-14)	78.2 (2013-15)
5.3	Life expectancy in females (SOA)	80.9 (2012-14)	81 (2013-15)
5.4	Deaths per 100,000 from Coronary Heart Disease under 75 ((HSCP PF)	55.6 (2013)	58.2 (2014)

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 increased from 77.7 in males to 78.2, and 80.9 in females to 81.0 in females.
- Premature deaths from Coronary Heart Disease have increased slightly in the past year, although the previous two years had shown a decrease from 66.3 in 2011 to 55.6 in 2013. Scotland wide figures which have shown a decrease from 58.1 in 2013 to 53.7 in 2014.

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) and corresponding locality plan to ensure that health and social care services are able to contribute to reducing health inequalities.[13]

Developing deployment of Anticipatory Care Planning is part of the Ayrshire New Models of Care Work Stream. The Anticipatory Care Planning (ACP) pilot phase has been completed and activity is now underway to progress the ACP roll out process involving around 12 GP Practices in South Ayrshire over the next 12 months.[14]

[13] South Ayrshire Health and Social Care Partnership Strategic Plan Implementation Plan A01
[14] South Ayrshire Health and Social Care Partnership Strategic Plan Implementation Plan D06, E04

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		Baseline	Latest Value
6.1	% of carers who feel supported to continue in their caring role (NI-8)	46% (2013/14)	42% (2015/16)

Local Performance Indicator		Baseline	Latest Value
6.2	No. of carers assessments completed (HSCP PF)	21 (2012/13)	102 (2015/16)

Performance Analysis

- The percentage of carers who feel supported to continue in their caring role was 42% in South Ayrshire which is slightly lower than the national average of 43%.
- There has been a significant increase in the number of carers who have had a carer's assessment completed over the past three years with an increase from 21 to 102.

Partnership Activity to Deliver Against National Outcomes

The Carers Strategic Planning Group has initiated the development of a new Carers and Young Carers Strategy. This will be partially determined by the Scottish Government's (as yet unpublished), 'Regulations and Guidance for the new Carers Act', notwithstanding this however it is anticipated that a substantial amount of the Strategy will be in place by March 2017. Carer's stakeholder sessions have been planned and will take place in November 2016.

New arrangements for carer's assessments and support planning have been developed with South Ayrshire Carers Centre and these will be in line with the demands of the new Carers Act. The Community Led Support programme will also address the lower level needs of carers.[15]

[15] South Ayrshire Health and Social Care Partnership Strategic Plan Implementation Plan D03

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

National Performance Indicator		Baseline	Latest Value
7.1	% of adults at home who agree they felt safe (NI-9)	84% (2013/14)	86% (2015/16)
7.2	Falls rate per 1,000 population aged 65+ (NI-16)	25% (2014/15)	24% (2015/16)

Local Performance Indicator		Baseline	Latest Value
7.3	No. of adult protection referrals (HSCP PF)	736 (2014/15)	845 (2015/16)

Performance Analysis

- People supported at home reporting feeling safe stands at 86% which is an increase of 2% on the last reporting period and 1 percentage point 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 25 to 24.
- The Adult Protection service received 845 referrals in 2015/16 which was an increase of 15% on referrals made in 2014/15. Response rates to protection concerns have improved over the past year with 66% of referrals being completed within 5 working days in the last quarter of 2015/16. Benchmarking information shows South Ayrshire to have a slightly higher rate of referrals than the National average, with South Ayrshire having 777 referrals per 100,000 adults in 2014/15 and, Scotland having 672 referrals per 100,000 adults.

Partnership Activity to Deliver Against National Outcomes

A local action plan for the prevention and management of falls has been published and implementation of the plan is being progressed. Work is underway with home care and mobile attendants to raise awareness of falls prevention and management, and improve early identification of those at risk of falls. A new post has been created within the Community Rehabilitation Team to support nursing homes with falls management. Staff are also involved in work that is being progressed nationally to develop pathway development with the Scottish Ambulance Service, for responding to people who have fallen.[16]

Work is being progressed to review the role and function of the Chief Officers Group for Public Protection who have responsibility for the strategic leadership and oversight of delivery of services and for improved outcomes for Child Protection, Adult Protection and Offender Management (MAPPA) issues affecting South Ayrshire and is responsible to Elected Members and Scottish Ministers.[17]

[16] South Ayrshire Health and Social Care Partnership Strategic Plan Implementation Plan D07
[17] South Ayrshire Health and Social Care Partnership Strategic Plan Implementation Plan B01

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.

National Performance Indicator		Baseline	Latest Value
8.1	% of staff who say they would recommend their workplace as a good place to work. (NHS Ayrshire and Arran figure reported) (NI-10)	66% (2014)	62% (2015)

Local Performance Indicator		Baseline	Latest Value
8.2	% of staff employed by the Partnership who believes it provides a positive workplace environment for employees (SAC)	Figures to follow	66% (2015)

Performance Analysis

- The NHS National Staff survey shows that 62% of employees would recommend NHS Ayrshire and Arran as a good place to work.
- The Local Authority Staff survey for 2015 shows that 66% of staff employed by the South Ayrshire Health and Social Care Partnership report that it provides a positive workplace environment.

Partnership Activity to Deliver Against National Outcomes

Work is being progressed to improve engagement with staff and a Joint Partnership Forum to engage with employees on the development and improvement of the Partnership has been developed.[18]

A Workforce Strategy remains a priority area for the Partnership and some initial work has been undertaken with the Scottish Social Services Council (SSSC) to develop a workforce planning tool. Integrated Funding has been used to employ a Workforce Planning Officer who will be employed through the Council.[19]

A revised Organisational Development Plan was prepared and included in the Partnership Strategic Plan. This is currently being implemented in areas such as Partnership identity and in equalities impact assessments.[20]

[18] South Ayrshire Health and Social Care Partnership Strategic Plan Implementation Plan I01
[19] South Ayrshire Health and Social Care Partnership Strategic Plan Implementation Plan I02
[20] South Ayrshire Health and Social Care Partnership Strategic Plan Implementation Plan I03

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

National Performance Indicator		Baseline	Latest Value
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)
9.2	% of health and care resource spent on hospital stays where the patient was admitted in an emergency (NI-20)	23% (2014/15)	27% (2015/16)
9.3	Expenditure on end of life care (NI-23)	Data under development	Data under development

Performance Analysis

- 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 27% than the national average of 22%. The current strategic focus on redesign work around unscheduled care will 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.[21] Good engagement with local stakeholders is also evident, particularly in relation to partnership working with GP's.

[21] South Ayrshire Health and Social Care Partnership Strategic Plan Implementation Plan G05

CHILDREN'S OUTCOMES

The National Outcomes for Children, as detailed on page 6, are the Scottish Government's high-level statements highlighting the importance that early years, and even pre-birth, plays in setting the pattern for future adult life.

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 2015-18 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		Baseline	Latest Value
10.1	% of babies with a healthy birth weight	91.2% (2012/13)	89.6% (2014/15)
10.2	% of children with a healthy weight in primary one	75.0% (2013/14)	78.2% (2014/15)

Performance Analysis

- There has been an improvement in terms of the % of children of primary one age that are a healthy weight with an increase from 75.0% to 78.2%, this is also higher than the national rate of 77.1%.

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.[22] The impact of the action plan's implementation is being monitored on a regular basis to identify emerging strengths and areas for further improvement.

[22] South Ayrshire Health and Social Care Partnership Strategic Plan Implementation Plan E07

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
11.1	Looked after children educational attainment (1 or more qualification ad SCQF Level 3 on leaving school)	SCQF Level 3 80% (2013/14)	SCQF Level 3 92% (2014/15)
11.2	Looked after children educational attainment (1 or more qualification at SCQF Level 4 on leaving school)	SCQF Level 4 60% (2013/14)	SCQF Level 4 58% (2014/15)

*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 increased over the past year and is above the national average rate of 86%. Those obtaining at least one SCQF at Level 4 have decreased and are below the national average of 73%.

Data which is collated and reported locally for Looked After Children's educational attainment includes all Looked After children (Looked After at Annual Pupil 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	Latest Value
11.3	Looked after children educational attainment (attainment during year session)	SCQF Level 3 or better 86% (2013/14)	SCQF Level 3 or better 80% (2014/15)
11.4	Looked after children educational attainment (attainment during year session)	SCQF Level 4 or better 55% (2013/14)	SCQF Level 4 or better 55% (2014/15)
11.5	Looked after children educational attainment (attainment during year session)	SCQF Level 5 or better 45% (2013/14)	SCQF Level 5 or better 20% (2014/15)

*SCQF - Scottish Credit and Qualifications Framework

Performance Analysis

- Although there is a decline in educational attainment for Looked After Children at SCQF Level 5 or better in 2014/15, it should be noted that the 45% achieved in 2013/14 represented a large increase from attainment in 2012-13 which was 15%

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.[23]

[23] South Ayrshire Health and Social Care Partnership Strategic Plan Implementation Plan C02

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

National Performance Indicator		Baseline	Latest Value
12.1	% of reports submitted to the Scottish Children's Reporter by due date		64% (p) (2015/16)
12.2	No. of foster carers recruited	55 (2014/15)	60 (2015/16)

Performance Analysis

- 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 55 to 60 foster carers reflects activity in this area.

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.[24]

[24] South Ayrshire Health and Social Care Partnership Strategic Plan Implementation Plan C01

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. The extent to which implementation of the Strategic Plan 2015-18 is contributing towards meeting Criminal Justice Outcomes is noted below with each associated action cross referenced within the foot-notes.

13. Community safety and public protection.

National Performance Indicator		Baseline	Latest Value
13.1	% of Criminal Justice Social Work Reports submitted to court by due date.	99% (2014/15)	99% (2015/16)

Performance Analysis

- There continues to be a very high rate of Criminal Justice Social Work reports submitted to court by 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.[25]

14. The reduction of reoffending.

National Performance Indicator		Baseline	Latest Value
14.1	% of those placed on Community Payback Orders with a requirement of unpaid work starting within one week.	82% (2014/15)	86% (2015/16)
14.2	% of individuals placed on Community Payback Orders with Offender Supervision seen within 5 days of court appearance	95% (2014/15)	96% (2015/16)

Performance Analysis

- Performance in terms of reducing reoffending has improved in both areas of Community Payback Orders noted above.
- 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.

[25] South Ayrshire Health and Social Care Partnership Strategic Plan Implementation Plan D13

FINANCIAL PERFORMANCE AND BEST VALUE

Financial information is part of our performance management governance with regular reporting throughout 2015/16 to the HSCP Integration Joint Board (IJB). This section summarises the main elements of our financial performance for 2015/16.

Revenue Summary 2015/16

Throughout the year there were emerging pressures on various aspects of service delivery particularly for the number of children who required to be cared for outwith the authority's services. In addition, there was an increased demand for care packages for older people and for those with physical and learning disabilities. The budget for residential places for people with learning disabilities was overspent as there was an increased demand for services for adults. There was an overspend at the Biggart Hospital due to the higher number of patients requiring care.

To manage the anticipated overspend against budget, a recovery plan was agreed in October 2015. The final position was an underspend of £634,000 against budget as the recovery plan was successful in reducing costs and there were some unexpected benefits realised at the year end. The financial performance for the Partnership in 2015/16 was:

	Budget £'000	Actual £'000	Variance Fav / (Adv) £'000
Older People	34,924	35,054	(130)
Learning Disabilities	16,085	16,185	(100)
Physical Disabilities	3,356	3,387	(31)
Mental Health Community Teams	5,692	5,369	323
Addiction	1,715	1,517	198
Cross Client Services	190	230	(40)
Community Nursing	3,476	3,323	153
Prescribing	23,060	23,060	0
General Medical Services	14,302	14,302	0
Integrated Care Fund	2,351	1,802	549
Criminal Justice	223	95	128
Aids and Adaptations	588	702	(114)
Scheme of Assistance	574	462	112
Biggart Hospital	4,456	4,802	(346)
Girvan Hospital	1,123	1,215	(92)
Continence Team/Community Store	1,195	1,215	(20)
AHPs	20,389	20,550	(161)
C&F Social Work Services	18,851	19,761	(910)
Health Visiting	1,769	1,731	38
Support Services	4,403	3,326	1,077
Total Net Expenditure	**158,722**	**158,088**	**634**
South Ayrshire Council Funding	70,652	70,071	(581)
NHS Ayrshire & Arran Funding	88,070	88,017	(53)
Total Income	**158,722**	**158,088**	**(634)**
Surplus/ (deficit)	0	0	0

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.

While expenditure was below budget by £634,000, this was not a planned underspend. Under the provisions of the Integration Scheme, this underspend was returned to the 'Party' which provided the resource. South Ayrshire Council has made provision within their accounts to earmark £0.4 million of the underspend for use by the IJB in 2016/17.

In agreeing a budget for 2016/17 the service demands have been considered and, where possible, additional investment targeted at the areas with service pressures.

Integrated Care Fund

The additional funding received from the Scottish Government for the Integrated Care Fund (ICF) for 2015/16 was £2,340,000.

The ICF is used 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 can be found on page 39 of this report.

Financial Outlook

The IJB requires to live within the resources available. The Scottish Government has announced additional funding of £250 million for Health and Social Care Partnerships for 2016/17 to help address social care pressures. This is a very welcome investment but there will continue 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 generated. There is an on-going commitment to provide care to those in the greatest need while providing those services within the resource available.

Best Value

NHS Ayrshire & Arran and South Ayrshire Council delegated functions and budgets to the IJB. The IJB decides how to use these resources to achieve the objectives of 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 HSCP 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.

To strengthen governance arrangements and oversee the IJB's significant change programme, the Health and Social Care Change Programme was established during 2015/16. It is chaired by Tim Eltringham, IJB Chief Officer, with senior representation from all of the services within the Partnership.

Evidence of transformational change taking place at strategic and operational levels includes:

- Care at Home review;
- Learning Disabilities review;
- Business Case for central community stores covering all of Ayrshire and Arran area.

Financial Reporting on Localities

The 2015/16 financial information is not split into localities at this level of financial reporting. This will be developed during 2016/17.

REPORTING ON LOCALITIES

The delivery of health, social and community care is changing. From April 2015 the Integration of Health and Social Care brings services together in a way that will deliver coordinated care that is easy to access and is focused on the best outcome for the individual person.

In practice this will mean NHS and Council staff and those from the third and independent sectors working with service users, carers and community-based groups to plan and deliver care and support that is designed for the individual.

This is known as 'locality planning' and it is a key part of health and social care integration. It is also a legal requirement under the Public Bodies (Joint Working) (Scotland) Act, 2014

The Partnership's Integration Joint Board approved the development of locality arrangements in June 2015. Significant progress was made in 2015/16 on the development and approval of a locality planning framework for South Ayrshire which will be at the centre of efforts towards changes in the balance of care by growing capacity in local communities, developing local assets, and through locality planning groups providing local forums where local people and professionals from across the sectors can meet to discuss local needs and priorities and seek to have these inform and be reflected in the Partnership's Strategic Plan.

In South Ayrshire, six localities have been created following extensive consultation and engagement:

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

The six locality planning groups, comprising professionals and local people, along with others from across the sectors, first met in the autumn of 2015 and, through regular meetings and the effective use of profiling information and input from their members, have identified their initial priorities:

<u>Troon and Villages</u>

- Social isolation
- Mental health
- Locality directory – mapping groups, activities and assets
- Transport and accessibility
- Prevention/ promotion of healthy lifestyles
- Involvement of schools and young people
- Communication – collecting, collating and sharing information

<u>Prestwick and Villages</u>

- Social isolation
- Locality directory – mapping groups, activities and assets
- Support for carers and young people
- Promote and improve wellbeing
- Involvement of young people
- Communication – collecting, collating and sharing information

<u>Ayr South and Coylton</u>

- Social isolation
- Locality directory – mapping groups, activities and assets

- Ageing population
- Social care support for delayed discharges
- Health issues and healthy living advice
- Involvement of young people
- Communication – collecting, collating and sharing information

Ayr North and Former Coalfield Communities

- Social isolation
- Mental health, alcohol and drugs
- Poverty and elderly poverty
- Preventative care
- Locality directory – mapping groups, activities and assets
- Person centred services
- Misuse of A&E/ equity of access to services

Maybole and North Carrick Villages

- Social isolation and the development of day services in North Carrick
- Transport and access to services
- Self Directed Support
- Welfare Reform
- Dementia and the development of a safe and accessible place for all vulnerable groups
- Communication – collecting, collating and sharing information
- Opportunities for young people – deprivation and child poverty

Girvan and South Carrick Villages

- Rural isolation – transport and access to services
- Locality directory – mapping groups, activities and assets
- Communication – collecting, collating and sharing information
- Economic wellbeing
- Promotion of wellbeing – dementia friendly, keep safe and social isolation – valuing volunteers

Grants from a Small Grants Fund have been provided through the Integrated Care Fund to support the work of the forums.

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 this responsibility also extends to the Acute Sector:

- Allied Health Professions (AHP's)
- Continence
- Technology Enabled Care (TEC)
- Joint Equipment Store
- Falls Prevention

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

Allied Health Professions (AHPs)

Specialist AHP services are provided to the whole population of Ayrshire and Arran. They 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 provides professional and strategic leadership and operationally manages the six professions (Dietetics, Orthotics, Occupational Therapy, Physiotherapy, Podiatry, Speech and Language Therapy) 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 Ayrshire and Arran AHP Local Delivery Plan was launched in March 2013 in response to the AHP National Delivery Plan. The programme of work has been delivered in two phases:

- Phase 1 commenced in March 2013 and comprised of 16 workstreams. Via these workstreams, considerable progress has been made towards meeting the 25 actions from the AHP National Delivery Plan and the additional five local actions.

- Phase 2 commenced in August 2014 and enabled AHP services to refocus and accelerate progress in 2 key areas:
    1. Integration: Reviewing and development AHP services at the interface of Emergency Care and Community Rehabilitation including the integration of health and social care;
    2. Access: maintaining a quality, person centred and efficient service whilst aiming to meet the required referral to treatment waiting times targets.

In 2015/16, signification progress was made in achieving goals and delivering meaningful outcomes across Phase 1 and Phase 2 of the AHP Local Delivery Plan. As the current plan draws to a close, teams have worked to embed, sustain and spread these improvements across Health, Social Care and the Third Sector locally and nationally where appropriate.

As Allied health professionals (AHPs) within Ayrshire and Arran we have already shown that we can make a significant contribution to the shift towards people living longer, happier and healthier lives closer to home. However continuing to contribute to this amidst the backdrop of increasing demand for our services alongside shrinking resources will be a challenge.

Work is ongoing to develop the next National Plan (Active and Independent Living Improvement Programme) and finalise and implement our own local Allied Health Improvement Plan 2015-18. The aim

of the plan is to align the improvement and leadership activity with NHS Ayrshire and Arran's corporate objectives and with the Partnership's strategic priorities, where Allied Health Professionals can add most value.

Continence

The Community Continence Service was established in 2001, and provides the people of Ayrshire and Arran with easy access to Integrated Continence Care.
With an ageing population a well-educated, knowledgeable staff group is essential in assessing and treating bladder and bowel dysfunction. The impact of competent staff reduces the need for containment, admissions to hospitals and falls associated with overactive bladder symptoms.

The continence service delivers an annual educational programme to support staff from all areas of health and social care and throughout 2015/16, the service has been developing an e-learning module for Care Assistants which is due to be completed in 2017.

Work has also progressed to update catheter guidelines and initiate a catheter audit focussed on identifying ways to reduce symptomatic urinary tract infections associated with an indwelling catheter. This is due to be collated and reported in early 2017.

In 2015, performance data in relation to the Out of Hours call out rate for catheter related problems over a 3 month period was 30%. Through working with the Out Of Hours nursing service, the call out rate to problematic catheterised patients is now showing a reduction in 2016. This included the introduction of a patient held catheter diary, and updates to Continence Service leaflets.

A Catheter Care Formulary (list of products to manage a range of urology and continence care needs) was developed in collaboration with the West of Scotland Catheter Group and compliance is being reviewed regularly with community pharmacy.

The Continence Service continues to develop their bowel service to try and address increasing demands from secondary care. The improvements in this service have reduced emergency surgical readmissions in vulnerable groups, recurrent urinary tract infection admission rates and the need for stoma formation.

The National Procurement Contract for containment products has been ongoing since 2015 and NHS Ayrshire and Arran will change to a new national supplier in 2016. Collaborative planning for this contract implementation was initiated in 2015/16. Containment products are supplied to patients only after a comprehensive assessment and treatment plan has been completed. Cost effective use of containment products as well as their environmental impact remains a high priority for community nursing and the Continence Service continues to support clinicians with these challenges.

Work within the 3 Health and Social care partnerships will continue to develop over 2016/2017 and the service will continue to be proactive and mindful in keeping the individual at the centre of care.

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 health monitoring and telecare. South Ayrshire HSCP has been asked to lead 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.

It is well established that health and social care organisations are facing extraordinary challenges in meeting the needs of a rapidly growing older population who have increasingly complex needs and inequality. Significant economic pressures are driving changes to the way that resources are used to achieve the greatest benefits to health. Workforce sustainability and recruitment challenges mean that it is critical that our services change in order to meet this ever increasing demand.

In 2015/16, the strategic approach to the utilisation and expansion of sustainable TEC in Ayrshire and Arran was produced for 2016-19. The '*Technology Enabled Care and Innovation – Strategic Intent 2016-19'* aims to ensure that outcomes for individuals at home or community settings are improved through the application of technological solutions that will enable and support transformation in service delivery, as an integral part of quality cost effective care and support. The proposals within the strategy were developed based on the experience of the existing TEC Programme and are intended to dovetail with new models of care being developed on a Pan-Ayrshire basis. It also seeks to bring in learning and ideas from the forthcoming National TEC Strategy for Scotland. It is therefore acknowledged that this strategy will evolve in response to these national and local strategic priorities.

It is anticipated that TEC will support the workforce and the infrastructure across the following areas of redesign, long term conditions pathways and groups:

- Community Care
- Intermediate Care and Rehabilitation
- Mental Health Services
- Acute Hospitals Interface
- Out Patients
- Primary Care
- Pharmaceutical Care
- Respiratory
- Coronary Heart Disease and Hypertension
- Diabetes
- Falls
- Dementia
- Learning Disabilities
- Adults and Older People

Initially funding sources to support the procurement of technology will be required and these are being sought through the National TEC Programme, various European sources and respective Health and Social Care Partnerships. Ultimately it is expected that this strategy will support the shift of resources necessary to enable more people to live at home for longer.

The implementation of the Strategy will be overseen by the Ayrshire and Arran TEC Programme Board.

Joint Equipment Store

For a number of years, officers from across the three 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 to the development of a joint store.

The programme of activity is being led by South Ayrshire HSCP with project management support from East Ayrshire HSCP and from National Procurement. Over the last 18 months a Board with wide representation from a number of stakeholders has been working collaboratively to develop a business case

for a joint solution. The work has required detailed analysis of the current arrangements for equipment provision. A wide range of risks for current service models and potential benefits for a joint store have been identified. It should be noted that the business case is primarily focussed on the assets used to manage the storage, distribution and retrieval of equipment; these are referred to as the "fixed costs". The funding available for the purchase of equipment is a separate issue and will depend on demand, budgets etc. The Summary Business Case was presented to a Pan-Ayrshire Strategic Planning Operational Group in March 2016.

Throughout the last year efforts have also been made to identify suitable premises for the store. An option appraisal paper was considered and approved by the Joint Equipment Board in March 2016 which recommended progressing with a potential lease of premises in Prestwick. As part of their ongoing support for the project, Scotland Excel has visited the premises and confirms that in their view they are suitable. They are currently working to develop a more detailed proposal and costing for the fit out of the premises.

In parallel with the development of proposals for a joint store base, work has progressed to develop proposals for the more effective use of resources to purchase and maintain equipment.

A detailed project plan is in development which will outline the range of actions necessary to conclude the move to the new store, including recruitment of a project manager.

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. Health and Social Care Partnerships within Ayrshire and Arran are expected to deliver against the actions in this framework.

In Ayrshire and Arran the strategic approach to falls is led by AHP Services and given the hosting 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.

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.

The Statement also outlines the current good practice locally at each stage of the falls pathway and promotes the need to spread and embed opportunistic falls questioning, onward referral, and Smart Care across service areas to maximise opportunities to prevent recurrent falls and fractures. Work is ongoing locally to develop safe and effective community alternatives to hospital admission for people who have fallen and gain further clarity re existing pathways for services responding to people who have fallen and are uninjured are required to ensure consistency and spread. Evidenced based interventions underpin the falls pathway locally and the Statement identifies that further work is required to spread availability of evidenced based interventions through training and a targeted approach to needs of local population.

It is clear that a focus on falls will continue to be critical as we seek to develop anticipatory and community-based service responses designed to reduce demand on hospital services. The work completed to date provides an opportunity for the three HSCPs in Ayrshire and Arran to review their approaches both locally and as part of pan-Ayrshire planning arrangements.

Further refinement of the local priorities identified within the Statement and the associated implementation plan requires to be undertaken with key stakeholders; and processes for monitoring and evaluating impact require agreement locally. Arrangements for a pan-Ayrshire workshop will be progressed in 2016/17 to enable the sharing of information and the development of evidence-based approaches. The aim will be to identify key areas for future action by partners to both reduce the numbers and manage the impact for those people who experience a fall.

Strategic Leadership for Pan-Ayrshire Activity – Sensory Impairment

In addition to the lead partnership responsibilities outlined above, South Ayrshire Health and Social Care Partnership is also the strategic lead for Pan-Ayrshire activity to deliver against an agreed Ayrshire Action Plan for Sensory Impairment.

In 2015/16, work was progressed to establish a Programme Board with strategic oversight for Sensory Impairment, with responsibility for overseeing the implementation of the agreed Ayrshire Sensory Impairment Action Plan and to provide advice and guidance on areas of work and priorities.

An operational group of sensory impairment staff from South, East and North Ayrshire Health and Social Care Partnership's, voluntary and third sector organisations who deliver services on behalf of people with learning, vision and dual sensory impairments has also been established to progress implementation of the Ayrshire Action Plan for Sensory Impairment.

OTHER LEAD PARTNERSHIP ARRANGEMENTS

North Ayrshire Health and Social Care Partnership is the lead partnership for 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 Doctors on Call (ADOC), 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. In 2015, 8 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. Appendix 2 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
Children and Families				
Cunningham Place, Ayr/ CS2013316915	12.02.16	Care and Support	4	1
		Environment	5	0
		Staffing	4	1
		Management/ Leadership	4	0
Woodhead Road, Ayr/ CS2003045401	12.02.16	Care and Support	4	1
		Environment	4	0
		Staffing	4	1
		Management/ Leadership	4	0
Adult's Services				
Nursery Court Day Service, Girvan/ CS2003045422	11.03.16	Care and Support	5	0
		Environment	5	0
		Staffing	5	0
		Management/ Leadership	5	0
Kyle Support Service, Ayr/ CS2010272231	23.02.16	Care and Support	5	1
		Environment	3	2
		Staffing	5	0
		Management/ Leadership	4	0
Arran View Support Service, Ayr/ CS2011289559	23.03.16	Care and Support	5	0
		Environment	5	0
		Staffing	5	0
		Management/ Leadership	5	0
Girvan Opportunities, Girvan/ CS2004079828	07.03.16	Care and Support	5	0
		Environment	N/A	0
		Staffing	5	1
		Management/ Leadership	5	1
Older People's Services				
South Ayrshire Home Care, Ayr/ CS2004059670	08.07.15	Care and Support	5	0
		Environment	N/A	0
		Staffing	5	0
		Management/ Leadership	5	0
South Lodge, Ayr/ CS2003001315	09.03.16	Care and Support	3	3
		Environment	3	0
		Staffing	3	2
		Management/ Leadership	3	0

One of 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 2016, 90% of South Ayrshire Health and Social Care Partnership inspected services were graded 'good' (4) or above.

External Services

Contract and Commissioning Officers within the Partnership's Planning and Performance service are responsible for managing the relationship between external providers and our service users.

Any concerns raised about the quality of care provided by an external provider are recorded and considered against other known information about the provider, such as previous concerns raised; and reports produced by the Care Inspectorate. Action taken by the Partnership in response to concerns raised is in accordance with the Partnership's contract management framework, 'Engaging with the Independent Sector'. Where there is an indication of systemic failure, action is taken in line with this framework, to determine whether breaches of contract have occurred.

Where a concern has been raised, providers are responsible for developing and delivering an action plan identifying planned improvement activity which satisfies the Partnership (and Care Inspectorate if they are involved). This action plan will be monitored by Contract and Commissioning Officers to ensure it is being progressed and that improvements are being delivered within agreed timescales. This level of contract monitoring activity will continue until such times as the Partnership is satisfied that the provider has made the necessary improvements to ensure the care, safety and wellbeing of residents.

Where no improvement is evidenced, the Head of Community Health and Care and the Head of Children's Health, Care and Criminal Justice will take decisions in relation to any further action required by the Partnership to address on-going concerns, such as reductions in rates paid, increased monitoring activity such as on-site visits, and imposing conditions on the service until issues are resolved or contracts are terminated. Any action taken to address concerns raised about provider's service provision will attempt to do so in ways that put the best outcomes for service users first and which promote safety and wellbeing.

REPORTING ON THE INTEGRATED CARE FUND

South Ayrshire Health and Social Care Partnership received a total of £2,340,000 from the Scottish Government's Integrated Care Fund (ICF) in 2015/16 to support delivery of improved outcomes from health and social care integration, help drive the shift towards prevention and early intervention and further strengthen our approach to tackling inequalities. The proposed investment programme for 2015/16 was built from components being progressed from the previous 'Change Fund' programme work but extended the target reach and development areas in line with national ICF Guidance, and the national Multi-Morbidity Action Plan priorities. The Programme was approved by the Partnership's Integration Joint Board in May 2015. In line with the overarching strategic policy drivers outlined in the Partnership's Strategic Plan 2015-18, the ICF Programme for 2015/16 has focussed on delivering the following key activities:

- Strategic Policy Driver: Reduce the number of avoidable emergency admissions to hospital
  - Extended Pharmacy/ Medicine Management: Development of Care Home service and domiciliary service;
  - Community Ward: Intensive community based support for patients who are at high risk of admission;
  - Telecare and Telehealth: Including Telecare dementia pathways and Telehealth home monitoring for Chronic Obstructive Pulmonary Disease and Coronary Heart Disease;
  - Invigor8 Falls Exercise Classes;
  - Rehabilitation: Development of new tier 4 community rehabilitation model;
  - Anticipatory Care Planning (ACP): Piloting ACP within GP Practices;
  - Girvan Community Health Hub: Locally based Multi-Disciplinary Team (MDT) and ACP work.

- Strategic Policy Driver: Minimise the time that people are delayed in hospital
  - Red Cross Home from Hospital Service
  - Community Equipment: development of Ayrshire service.

- Strategic Policy Driver: Institute a 'new ways of working' change programme across the functions delegated to the Partnership
  - Integrated Community Respiratory Services: Developing new respiratory based work in community settings;
  - Community Capacity Programme: Developing a large programme of community based services and projects;
  - Locality Planning: Establishing 6 Locality Planning Groups and framework of support;
  - Technology Enabled Care: Innovative use of home health monitoring, development of Smartcare including Falls Assistant;
  - Community Based Rehabilitation.

- Strategic Policy Driver: Integrated services and staff supported by the development of integrated strategy, systems and procedures
  - Occupational Therapy (OT) Integration: Further development of integrated OT services including community based drop-in services.

- Strategic Policy Driver: Efficiently and effectively manage all resources to deliver Best Value
  - Service Reviews: A service review of Care at Home services.

The ICF has been used to initiate and support the development of Locality Planning in South Ayrshire (and the beginning of Neighbourhood Planning). The Partnership has initiated the development of 6 Locality Planning Groups in South Ayrshire in 2015/16. This process involved local profiling; identification and definition of local priorities; support for local grants (and now participatory budgeting) and linking to other locality work such as Charrettes and Dementia Friendly Communities. The Groups include a mixture of representatives from NHS, Local Authority, Independent Health Contractors, Third and Independent Sector,

and a range of community representatives. South Ayrshire's Community Planning Partnership has now agreed to utilise the Partnership's Locality Planning Groups for wider community planning purposes. Integrated Care Fund funding has also been used to support a wide range of community based activities and carers support services.

The Integrated Care Fund 2015/16 resource was allocated in the following ways:

Programme	Project	2015/16 Allocation £000	Total Year Spend £000	Over/ Underspend £000
Community Linking and Capacity Building	Voluntary Action South Ayrshire Community Capacity Programme	232	232	-
	Community Links Practitioners	73	0	73
	Carers Supports	81	80	1
	Good Morning Service	20	11	9
	Fire Safety Equipment	10	10	-
	Alcohol and Drug Partnership Peer Support	50	50	-
	Supporting Libraries	5	5	-
	Royal Voluntary Service Good Neighbours	30	18	12
Care Planning	General Practice Leadership/ Multi-Disciplinary Teams	40	2	38
	Anticipatory Care Planning	57	4	52
	House of Care	21	3	18
	Extended Pharmacy/ Medicine Management	102*	48	54
	Falls Prevention	31	25	6
	Community Ward	206	208	-2
	Biggart Hospital (Revised Models of Care)	0	286	-286
	Girvan Community Health Hub	60	61	-1
	Red Cross Home from Hospital**	50	85	-35
	Community Equipment	0	98	-98
Self-Management and Links to Managed Clinical Networks	Self-Management Network	3	0	3
	Integrated Community Respiratory Services	66	19	47
	Talking Mats	13	13	-
	Talking about Diabetes	10	1	9
Community Based Rehabilitation	Invigor8 Falls Exercise Classes	75	65	10
	Tier 1+2 Rehabilitation	59	59	-
	Tier 3+4 Rehabilitation	98	76	22
	Allied Health Professionals Food, Fluids and Nutritional Care	43	16	27
	Weigh to Go	17	8	9
Workforce Planning	Talking Points Training	10	0	10
	Occupational Therapy Integration	135	122	13
	Service Reviews	75	29	46
	Workforce Development	15	0	15
Technology Enabled Care	Telecare	222	50	172
	Telehealth	126	53	73
Locality Planning	Community Engagement Officers	193	168	25
	Housing Adaptations	23	23	-
Programme	Independent Sector Leadership	-	-	-

Management and Enablers	Programme Management	101	160	-59
Total ICF Spend - 2015/16		**2351**	**2088**	**263**

*It was agreed to utilise Resource Transfer monies for elements of this project reducing the ICF requirement during year.
**The Ayrshire-wide contract with Red Cross was extended to include more hours and weekend cover during the year resulting in additional costs.

Further information on the outcomes achieved as a result of Integrated Care Fund resource can be found in Appendix 3. Voluntary Action South Ayrshire has provided training for all funded Integrated Care Funding projects linked to developing outcome modelling and improved measurement of the success and reach of each project. This will help ensure that future reporting on the outcomes achieved as a result of Integrated Care Fund resource will based on activities and outputs linked to outcome (logic) models.

A programme for the proposed use of the Integrated Care Fund for 2016/17 was approved by the Integration Joint Board in April 2016.

THE YEAR AHEAD

Annual Review of the Partnership's Strategic Plan

The Integration Joint Board approved an updated version of the HSCP Strategic Plan in June 2016. This new plan seeks to build on the learning gained during the first year of the HSCP's operation and includes initial locality planning priorities; updated performance indicators; an updated Strategic Risk Register and an updated Implementation Plan. The Organisational Development Plan has also been updated and a link to the approved Integrated Care Fund Plan for 2016-17 has also been included. The process to refresh the Strategic Plan included a workshop with the Integration Joint Board and the Strategic Planning Advisory Group; and public consultation through the Partnership's public website.

The revised Plan has been published at a time of very significant pressure on the public purse and the activity we intend to undertake in 2016/17 to meet the objectives outlined above, needs to be considered in line with this financial context.

The Plan will be further refreshed and rolled on in 2017. In 2018, following the initial 3 year period covered by the original document, the Plan will be completely re-written and a new Strategic Plan produced.

Key Areas for Improvement and Development in 2016/17

For the Partnership, key areas of focus for improvement and development in 2016/17 include:

- Continuing work with neighbouring Ayrshire health and social care partnerships to ensure appropriate levels of consistency in the provision of pan-Ayrshire strategies and services.
- Progressing the work of the Community Planning Partnership's Strategic Delivery Partnership on Health and Wellbeing to address aspects of inequalities in South Ayrshire.
- Continuing work to sustain and develop the six Locality Planning Groups; reviewing their success and ensuring anticipated outcomes are being delivered.
- Continuing work to develop and implement organisational and workforce planning.

For Children's Health, Care and Criminal Justice, key areas of focus for improvement and development in 2016/17 include:

- Progressing the work to meet the health and social care responsibilities within the Children and Young People Act 2014.
- Supporting work to develop and implement the health and social care responsibilities within the Integrated Children's Services Plan for South Ayrshire.
- Refining and implementing a strategy for preventative and localised service provision for Looked After Children in South Ayrshire.
- Progressing work on a joint Concern Hub with Police Scotland, designed to ensure a prompt, informed and proportionate response to concerns referred to Police in South Ayrshire.
- Contributing to the development of a new model for Community Justice.

For Community Health and care, key areas of focus for improvement and development in 2016/17 include:

- Progressing work on the Partnership's Change Programme in relation to the following improvement activities:
  - Anticipatory Care Planning: ensuring that those who require an Anticipatory Care Plan have one in place.
  - Community Rehabilitation and Enablement Teams: ensuring that those in crisis have alternatives to going to University Hospital Ayr.
  - Redesign of Biggart Community Hospital: ensuring those requiring intensive support and rehabilitation have access to an appropriate bed space.

  - Community Interface with the Combined Assessment Unit at Ayr Hospital: ensuring those arriving at the Combined Assessment Unit receive a Multi-Disciplinary Team assessment, where community management is the default plan.
- Developing a new local Mental Health Strategy and commissioning arrangements with associated implementation plan.
- Developing a new local Learning Disability Strategy and commissioning arrangements with associated implementation plan.
- Progressing the review of the Care at Home Service and implementing the agreed actions arising from the review.
- Implementing the Ayrshire-wide Sensory Impairment Strategy 2014-2024 and local implementation plan.

For those areas that South Ayrshire has Lead Partnership responsibilities, key areas of focus for improvement and development in 2016/17 include:

Allied Health Professions (AHP's)
- Leading on Ayrshire and Arran's contribution to the new National Active and Independent Living Improvement Programme (AILIP) and developing a local programme for Ayrshire and Arran.

Technology Enabled Care
- Further refinement of the priorities identified within the TEC Strategic Intent 2016-19, and the associated implementation plan including:
  - Expansion of home health monitoring;
  - Expanding the use of video conferencing;
  - Building on emerging National digital platforms;
  - Expanding the take-up of Telecare; and
  - Exploring the scope and benefits of switching current provision of telecare from analogue to digital healthcare.

Continence:
- Progressing collaborative planning to implement the contractual arrangements with the new national supplier for containment products;
- Progressing work completed to date on training programme for Care Assistants;
- Progressing work to reduce symptomatic urinary tract infections.

Falls Prevention
- Further refinement of the priorities identified within the Falls Strategy Position Statement, and the associated implementation plan;
- Develop processes for monitoring and evaluating impact of work undertaken to address identified local priorities.

Joint Equipment Store
- Finalising a proposal and costings, and secure approval, for the fit out of new premises.
- Developing and implementing a detailed project plan outlining the range of actions necessary to conclude the move to the new store.
- Developing proposals for the more effective use of resources to purchase and maintain equipment.

APPENDIX 1: NATIONAL HEALTH AND WELLBEING INDICATORS DATA

NATIONAL INDICATORS		2013/14	2014/15	2015/16
NI-1	Percentage of adults able to look after their health very well or quite well	94%	N/A	94%
NI-2	Percentage of adults supported at home who agreed that they are supported to live as independently as possible	83%	N/A	83%
NI-3	Percentage of adults supported at home who agreed that they had a say in how their help, care or support was provided	82%	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	81%	N/A	76%
NI-5	Total percentage of adults receiving any care or support who rated it as excellent or good	83%	N/A	82%
NI-6	Percentage of people with positive experience of the care provided by their GP practice	90%	N/A	91%
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	82%	N/A	84%
NI-8	Total combined percentage of carers who feel supported to continue in their caring role	46%	N/A	42%
NI-9	Percentage of adults supported at home who agreed they felt safe	84%	N/A	86%
NI-10	Percentage of staff who say they would recommend their workplace as a good place to work	N/A	N/A	N/A
NI-11	Premature mortality rate per 100,000 persons	425 (2013) (m)	391 (2014) (m)	422 (2015) (m)
NI-12	Emergency admission rate (per 100,000 population)	14,808 (m)	15,576 (m)	16,316 (m) (p)
NI-13	Emergency bed day rate (per 100,000 population)	141,917 (m)	140,564 (m)	160,197 (m) (p)
NI-14	Readmission to hospital within 28 days (per 1,000 population)	101 (m)	99 (m)	94 (m) (p)
NI-15	Proportion of last 6 months of life spent at home or in a community setting	85% (m)	86% (m)	86% (m) (p)

NI-16	Falls rate per 1,000 population aged 65+	22% (m)	25% (m)	24% (m) (p)
NI-17	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	N/A	86% (m)	89% (m)
NI-18	Percentage of adults with intensive care needs receiving care at home	67% (m)	63% (m)	65% (m)
NI-19	Number of days people spend in hospital when they are ready to be discharged (per 1,000 population)	629 (m)	900 (m)	838 (m) (p)
NI-20	Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	26% (m)	23% (m)	27% (m) (p)
NI-21	Percentage of people admitted to hospital from home during the year, who are discharged to a care home			
NI-22	Percentage of people who are discharged from hospital within 72 hours of being ready			
NI-23	Expenditure on end of life care, cost in last 6 months per death			

(p) Notes provisional figures. (m) Management Information. The above figures were provided by ISD Scotland to all Partnerships for inclusion in Annual Performance Reports. Please note the following arrangements for the release of future data:

- Quarterly data for 2016/17 will be available from January 2017 - this will present the first quarter only, for hospital based data

APPENDIX 2 – INSPECTION OF SERVICES

Actions Being Taken to Address Care Inspectorate Recommendations 2015/16

The tables below highlight the areas identified by the Care Inspectorate as requiring improvement for the two services which received grades lower than good for quality themes, namely South Lodge and Kyle Resource.

The recommendations and associated actions which shall be implemented by the service provider are noted below.

Quality Theme	Recommendation/ Requirement:	Action Planned	Timescale	Responsible Person
Cunningham Place, Ayr				
Care and Support	Recommendation 1 The service should develop robust risk assessments and plans for young people.	Establish a short life working group to review and improve risk assessments and care plans; and further develop person centred safe plans to ensure that young people are kept safe. Implement a process to ensure that risk assessments are reviewed and updated regularly and are countersigned by Senior Residential Staff/ House Leads.	June 2016	Team Leader, Children's Houses
Staffing	Recommendation 1 The service should ensure that all staff receive supervision in line with policy and procedures.	Review staff supervision to ensure that the existing supervision and support policy is fully implemented; and that 'Nurture Coaching Sessions' form part of the supervision process. Implement revised responsibility framework for supervision. Implement a 2 day induction programme for new Senior Residential Staff. Ensure annual Professional Development Records for staff.	May 2016	Team Leader, Children's Houses

Quality Theme	Recommendation/ Requirement:	Action Planned	Timescale	Responsible Person
Woodhead Road, Ayr				
Care and Support	Recommendation 1 The service should develop robust risk assessments and plans for young people.	Establish a short life working group to review and improve risk assessments and care plans; and further develop person centred safe plans to ensure that young people are kept safe. Implement a process to ensure that risk assessments are reviewed and updated regularly and are countersigned by Senior Residential Staff/ House Leads.	June 2016	Team Leader, Children's Houses
Staffing	Recommendation 1 The service should ensure that all staff receive supervision in line with policy and procedures.	Review staff supervision to ensure that the existing supervision and support policy is fully implemented; and that 'Nurture Coaching Sessions' form part of the supervision process. Implement revised responsibility framework for supervision. Implement a 2 day induction programme for new Senior Residential Staff. Ensure annual Professional Development Records for staff.	May 2016	Team Leader, Children's Houses
Kyle Support Service, Ayr				
Care and Support	Recommendation 1 The provider should ensure that all staff members supporting service users have the necessary training and skills in order to meet that persons assessed needs.	Train the Day Centre transport escort to administer necessary medication; regrade the post to facilitate this.	March 2016	Manager, Kyle Resource Centre
Environment	Recommendation 2 The Provider should review how feedback received is	Health and Social Care Partnership to undertake a review of all Learning Disability	March 2017	Senior Manager, Learning Disabilities.

Quality Theme	Recommendation/ Requirement:	Action Planned	Timescale	Responsible Person
	used to improve the services for people supported.	facilities including all current internal and purchased services to consider a range of factors, one of which is suitability of buildings.		
	<u>Recommendation 3</u> The service provider should review the service environment, paying particular attention to those areas highlighted within this report. Where areas are identified as needing improvements appropriate action plans should be put in place and progress towards these actions recorded.	In conjunction with Property and Asset Management, discuss and, where possible, make improvements to the environmental issues highlighted within the report. Formulate a new action plan to record progress made in delivering improvements.	May 2016	Manager, Kyle Resource Centre
South Lodge, Ayr				
Care and Support	<u>Recommendation 1</u> The Provider should make improvements to the review system by: - Developing a clear system of tracking and scheduling; and - Ensure minutes of reviews are available timeously and that assessments and care plans are updated to reflect the most recent reviews.	Implement a tracking system for the Manager to access and monitor reviews. Ensure Care Managers provide review paperwork within timescales requested. Ensure staff members attend reviews and complete review paperwork.	On-going	Manager, South Lodge
	<u>Recommendation 2</u> The Provider should ensure that quality surveys are evaluated and action plans produced to show how issues raised or suggestions made will be addressed and how this information is communicated to all stakeholders concerned.	Design and implement a quality survey and ensure key stakeholders are included in feedback cycles.	On-going	Manager, South Lodge
	<u>Recommendation 3</u> The Provider should ensure that the accident audit system is maintained using up to date and accurate information. The accident audit should be able to identify patterns relating to overall numbers of accidents, time of day and location in order to inform staffing levels and deployment.	Ensure the accurate recording of accidents and identify trends and training issues.	On-going	Manager, South Lodge
	<u>Requirement 1</u> The Provider must improve the quality of risk	Ensure service users receive a home visit by Management prior to admission to the Care	On-going	Manager, South Lodge

Quality Theme	Recommendation/ Requirement:	Action Planned	Timescale	Responsible Person
	assessment and care planning for all service users including those on respite. Including: The Provider should introduce care plans specifically relating to individuals skin and pressure care where there is an identified risk and also introduce a specific risk assessment based on best practice such as Waterlow to assist with this process.	Home. Further develop the Care Plan to ensure skin care etc. is monitored and any changes can be evidenced.		
	<u>Requirement 2</u> The Provider must ensure that medication administered and recorded is in accordance with up to date best practice guidance The Provider must ensure that medication is securely and safely stored at all times and that keys to the medication storage area are also secured at all times.	Locate Medication PODS in service user's bedrooms. Improve Duty Room security to ensure medication can only be accessed by authorised staff members.	On-going	Manager, South Lodge
	<u>Requirement 3</u> Keep a record of the assessment that identifies the minimum staffing levels and deployment of staff on each shift over a four week period. This will take into account the aggregated information of the physical, social, psychological and recreational needs and choices in relation to the delivery of care for all individuals over any 24 hour period, also taking into consideration the physical layout of the building. Including: The Provider must review current staffing levels in the service over the 24 hour period to ensure that there is sufficient staffing in such numbers as to meet the care needs of service users.	Ensure full use is made of the IoRN for residential care to provide an overview of staffing levels based on resident's needs. Review current staffing structure and submit proposal for consideration by senior management.	On-going	Manager, South Lodge/ Head of Community Health and Care
	<u>Requirement 4</u> The provider must ensure that risk assessments are in place for service users located on the upper floors to identify the level of risk open stairways may present and	Ensure risk assessments are completed for all service users at risk and those who are not at risk who are located on upper floors.	On-going	Manager, South Lodge

Quality Theme	Recommendation/ Requirement:	Action Planned	Timescale	Responsible Person
	the risk reduction measures put in place.			
	Requirement 5 The provider must improve record keeping for accidents and incidents.	Implement an audit system to ensuring record keeping is in place.	On-going	Manager, South Lodge
Management and Leadership	Requirement 6 The provider must ensure that the quality of management and leadership for the service is improved. Managers and seniors must have a clear overview of the different elements of the service and ensure that staff are aware of their roles and responsibilities that systems are person centred, efficient and effective and there is strong leadership values promoted throughout the staff group.	Appoint a Depute Manager and Senior Social Care Worker to complete the Management Team. Implement staff training to take place to improve communication and ensure staff are clear on roles and responsibilities.	On-going	Manager, South Lodge
Staffing	Recommendation 4 Evidence must show that staff receive regular planned supervision. This supervision should evidence that staff practice is being monitored and how it links to individual training and development plans.	Implement a new structure to evidence all staff receiving regular supervision.	On-going	Manager, South Lodge
	Recommendation 5 The provider should use the Promoting Excellence Framework, Scottish Government 2011, to review staff training and development to ensure that staff have the necessary knowledge and skills to meet the needs of people with dementia. This should include training at skilled and enhanced level for all staff working directly with residents.	Implement training on dementia, linked to the Promoting Excellence Framework, for all staff.	On-going	Manager, South Lodge

APPENDIX 3 - INTEGRATED CARE FUND

Achievement of ICF Outcomes 2015/16

Workstream	Activity/ Project	Achievement of Outcomes for 2015/16

Community Linking and Capacity Building	Voluntary Action South Ayrshire (VASA) Community Capacity Programme	• Significant numbers of older people's activity programmes are now in place with high levels of user take up:
		  ○ Currently 10 classes per week, with an average of 15 per class.
		• Feedback indicates good user satisfaction levels.
		• Good quality 1:1 and group befriending programmes are now in place with high levels of user take up:
		  ○ One to one befriending: 35 relationships with 35 volunteers
		• Feedback indicates good user satisfaction levels.

	VASA-led Third Sector Integrated Care Fund Programme	• Six third sector organisations have been funded to support social isolation, physical activity and improve access to transport. These include: Aspire2gether, Ayr United Football Academy, Access to Sport/ Ayrshire Sport Ability, Care and Share, Ayr Action for Mental Health, BRICC.
		  ○ Aspire2gether provides the HOPE Service which enables adults who are 55 years and older to make informed choices about their housing, support and care needs. The service:
		  ▪ Links clients to other services and agencies that are able to assist them to retain their independence and allow clients to self-manage within their own home, personal life and finances.
		  ▪ Monitors the over 55's health and wellbeing and engages with health services where needed.
		  ▪ Helps reduce social isolation for over 55's in South Ayrshire towns and rural villages by signposting the over 55's to activity groups within their communities, day care centres, book clubs, dance and exercise classes etc.
		  ▪ Maximises benefits so the over 55's get all the benefits they are entitled to.
		  ▪ To date the service has ensured 26 service users have been kept out of hospital, saving 78 bed days; kept 12 service users out of care homes; and supported 27 service users to attend medical appointments, helping reduce further hospital admissions through addressing immediate health issues before they worsened.
		  ○ Ayr United Football Academy has 4 strands of work:
		  ▪ Walking Football which targets the 50 years plus age group
		  ▪ Light Exercise and Walking
		  ▪ Art Activity providing an introduction to art, meeting individual needs in a communal lesson (often working with people with dementia)
		  ▪ Football Reminiscence which provides an opportunity for participants to share footballing memories, led by a coordinator from Alzheimer South Ayrshire.
		  ○ Access to Sport/ Ayrshire Sport Ability provides sporting events for people with disabilities; help towards the costs of venue hire and trainers and helps to reduce social isolation.

		○ Care and Share provides a one-to-one befriending services which: ▪ Reduces the level of isolation and loneliness in the community ▪ Maximises people's independence and self-support ▪ Encourages people to develop appropriate community support ▪ Provides small group community activities. ○ Ayr Action for Mental Health's Recovery Initiative (Drop in Café) is for people in recovery from alcohol and addiction issues. The service: ▪ Offers self-management and development courses ▪ Provides 'Wellness Recovery Action Planning' training for participants at the Drop In. ▪ Holds family events to support children affected by substance misuse. ▪ Provides a range of activities such as IT, creative writing, art, music tuition and outdoor activities. ▪ Provides opportunities for those in recovery to meet others and share experiences and where those keen to get into recovery can meet and get access to a safe, inclusive environment and professional services. ○ Ballantrae Rural Initiative Care in the Community provides day opportunities for vulnerable adults in Ballantrae. The inclusive support service is provided to people in a homely environment where they can meet and interact with their peers, participate in various activities including chair exercises, healthy eating, arts and crafts etc. • Reporting on each project evidences high levels of user take up and good user satisfaction levels. There is also some good self-reported evidence in relation to the impact of this work.
	VASA Community Connector	• The Community Connector post has had very high referral rates of more than 100+ each year and has demonstrated the effectiveness of low key, community referral. There is evidence of significant positive outcomes for users.
	Royal Voluntary Service Good Neighbours	• The Royal Voluntary Service has used 2015/16 to establish the service, base premises and team, volunteer pool and referral routes.
	Good Morning Service	• Whilst numbers using the service have not been high (up to 40 users), the impact on the individual users has been significant as evidenced in case studies received.
	Carers Supports	• There are now higher levels of carers receiving services and support from the Carers Centre. There is evidence of positive outcomes for individual service users. • There is also evidence of a higher take-up of carer's benefits.
	Community Links Practitioners	• It has taken time to design, approve and recruit Community Link Practitioners in line with NHS recruitment processes. Community Link Practitioners are expected to be in post early in 2016/17.
	Fire Safety Equipment	• Fire Safety Equipment has been purchased and is being utilised.
	Alcohol and Drug Partnership Peer Support	• 34 Volunteer Peer Workers (VPWs) were recruited across 2 intakes in 2015/16. • Each VPW has completed a 12 week induction on ICT, communication, care and skills in volunteering. Other training has also been delivered e.g. Adult/ Child Protection, Naxolene, etc. • 30 of the VPWs took part in placements in 2015/16.

		• 12 VPW's 'graduated' from the first two intakes. • A full evaluation of project will take place in 2016/17.
Care Planning	GP Leadership	• 10 GPs involved in 'Appreciative Inquiry' work in relation to Anticipatory Care Planning. • 1 GP trained to lead on diabetes work within their Practice.
	GP Multi-Disciplinary Teams/ Anticipatory Care Planning	• Following Appreciative Inquiry work on Anticipatory Care Planning, a steering group has been established and a pilot is being progressed within one GP Practice.
	House of Care	• House of Care is now being progressed at NHS Ayrshire and Aran level with some additional resource being provided by Scottish Government.
	Medicine Management 1	• This medicine management service continues to show value. The CAP Pharmacy Technician service is also now linking with this service allowing the potential available in both services to be maximised. In 2015/16, the service had 287 patients; 260 medical reviews; identified 165 medical issues; and had 174 interventions. Case studies illustrating the value of the service continue to be recorded.
	Medicine Management 2	• Training has been provided for the social work and carer teams prior to the roll-out of the service in the Troon, Dundonald, Symington and Prestwick areas. Engagement by private providers has been variable and so work is planned to link with the Private Providers Forum. There are approximately 30 patients currently assessed as requiring level 3 support and who are therefore in receipt of the Medicine Administration Record (MAR) Chart service. • Implementation in Ayr area will be progressed in 2016/17 following roll-out of training in this area. • Separate training has been devised for new-joins. "Top up" sessions focussing on management of MAR Charts; and social work training focussing on assessments of level of support around medication (Levels 1-4), is being implemented. The potential to adapt "Learn Pro" in order to have refresher training that could be taken annually by care staff is being considered.
	Medicine Management 3	• The service continues to develop with an increasing case-load. In 2015/16, the service had 69 referrals into the service; 57 issues; 150 pharmacy interventions; 36 domiciliary visits; reduction of 75 minutes of daily carer visits; 29 referrals to other health and social care professionals; 21 adaptive medication aids supplied. • There are on-going issues in relation to access to 2 different IT systems. • Going forward, the Pharmacy Technician will be sited with a number of social work and homecare teams to widen access to the service. Ongoing, awareness raising of the service is planned with GP practices; with a presentation on the service planned for the GP Medicines Management (MMS) LES. • Evaluation questionnaires provided to a sample of 28 patients over February and March, showed that 23 (82%) of people surveyed felt more confident managing their medicines independently.
	Falls Prevention	• <u>Falls Leadership</u>: As detailed elsewhere in this Annual Report, work has been undertaken in 2015/16 to develop an Ayrshire wide strategic approach to falls. Self-evaluation activity, carried out against the National Framework for Falls Prevention, has been used to inform this planning activity. • <u>Falls Prevention Training</u>: Training on Falls Prevention has been completed at an Ayrshire-wide level, supporting both Care Home and Care@Home sectors.

	Community Ward	• In 2015/16, 57 referrals were accepted on to the Community Ward; and 78 patients were discharged.
	Girvan Community Health Hub Extended Work	• There has been enhanced Multi-Disciplinary Team working on Girvan Community Health Hub involving 3 GP Practices and related teams. • Work is underway to develop a comprehensive write-up of the work taking place to support existing case studies which are emerging.
	Red Cross Home from Hospital	• This service has been evaluated at both University Hospital Crosshouse and University Hospital Ayr with the following outputs: - 475 South Ayrshire patients have been transported since the service started (approximately 20 per week from University Hospital Ayr) - 92 admissions have been avoided for University Hospital Ayr - The service is mainly used by 75+ age group - Qualitative evaluation suggests high patient and carer's satisfaction with service.
Self-Management and Links to Managed Clinical Networks	Self-Management Network	• Ayrshire-wide self-management events have successfully continued with high participation from all sectors.
	Integrated Community Respiratory Services	• Girvan Community Respiratory Clinic: This service is now established in Girvan and sees approximately 130 patients per year, avoiding University Hospital Ayr attendance. • Community, Person Centred Respiratory Care: This Ayrshire-wide project now includes 4 GP practices, with 2 participating from South Ayrshire. An initial patient survey of 500 patients has been completed; and a staff survey of 80 staff has also been completed. Analysis of survey responses is being used to inform future service developments. • Sleep Apnoea: A pilot of practice based work has been initiated to raise awareness of sleep apnoea issues.
	Talking Mats	• Mats have now been purchased and related training programmes are being implemented for different sectors/ disciplines across Ayrshire.
	Talking about Diabetes	• 12 carers have been recruited to take part in an e-training module. The results from this will be fed into a national evaluation.
Community Based Rehabilitation	Invigor8 Falls Exercise Classes	• There have been 1850 attendances at community based falls prevention activity sessions – this includes 255 people, including 51 new clients. • There are 15 classes in place: - 4 x Level 1 classes - 6 x Level 2 classes - 2 x Mixed Level 1/ Level 2 classes - 2 x Level 3 classes - 1 x care centre chair class • 42 people are attending level 3 maintenance classes.
	Tier 1+2 Community Rehabilitation	See below
	Tier 3+4 Community Rehabilitation	• Referral pathways have now been established at all levels for Pulmonary, Cardiac, Stroke, Cancer and Falls related concerns.

		• Training has been delivered for a broad range of key staff e.g. history taking and clinical assessment. • Referral rates to the service have been in line with the predicted level for 2015/16. • A three tier evaluation framework has been established including: - Level 1 programme goals - Level 2 individual clinical outcomes - Level 3 person centred review • The next phase of development will be a volunteer led programme.
	Food, Fluid and Nutritional Care	• Staff recruitment difficulties have limited the activity and impact of this programme although some training on under-nutrition has been delivered to carers.
	Weigh To Go	• 3 Weigh to Go programmes have been completed. - First programme: 12 clients started, 7 completed - Second programme: 5 clients started, 4 completed • An average weight loss of 5-7kg has been recorded for those completing the programmes.
Workforce Development, Service Integration and Change	Talking Points Training	• This work has now been subsumed within a much wider and comprehensive reform programme which will be delivered in 2016/17.
	Occupational Therapy Integration	• Early Intervention Stream: Three neighbourhood clinics have been tested: 1. Alloway Pharmacy 2. Templehill Practice, Troon 3. Carnegie Library, Ayr Due to a lack of uptake, Carnegie library has been discontinued. The preferred model will emerge following evaluation of data from the two remaining clinics. • Learning and Development Stream: A community of practice has been established online, with password secured access to content. A Training Calendar is also being developed, and a measurement plan and baseline data collection method has been established. • Co-production Stream: A baseline data collection method has been established and a survey has been written and distributed. • Reducing Duplication Stream: A Business Plan has been developed, and 2 tests of change have been identified. A single point of referral has been created. • Service User Involvement Work Stream: A business case has been established and baseline data collection is underway with group members.
	Workforce Development	• This was not required as part of the District Nurse review process.
	Service Reviews	• The Care@Home Review was completed and is now the subject of a full implementation plan which will be implemented during 2016/17.
Locality Planning	Community Engagement Officers	• Community Engagement Officers have supported the development of 6 Locality Planning Groups as outlined elsewhere in this report. Each Locality Planning Group has an agreed core membership, comprehensive profiling and needs assessments, and is progressing work to map services; develop sub-groups to take forward agreed pieces of work; provide small grants; develop local priorities etc.

	Small Grants	• Approximately £27k of Small Grants have been awarded from very local organisations supporting health and wellbeing outcomes including carer's projects, garden projects, disease specific projects, activity programmes, friendship and social isolation work, arts and cultural activity, dementia friendly work, etc.
Technology Enabled Care	Telecare	• Since the pathway for self-referral was established in September 2015, there has been a growth in referrals and the team are working to grow the customer base of this service each month in order to spread the use of telecare solutions. A review of the care at home service is being carried out which will review the mobile responder service as part of this. Telecare solutions are being used on the wards at Biggart Hospital and individuals are being discharged with telecare equipment.
	Telehealth	• Patients utilising Telehealth in 2015/16 for: - COPD: 116 - Coronary Heart Disease: 111 Total: 227 In addition, 13 renal patients are using telehealth monitoring; and a further 100 patients are using surgery pods to monitor hypertension.

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