EAST AYRSHIRE

Health & Social Care Partnership

Annual Performance Report 2016/17

CAPA Big Fit Walk

Contents

References

1. Scottish Government (2015) National Health and Wellbeing Outcomes A framework for improving the planning and delivery of integrated health and social care services.
http://www.gov.scot/Resource/0047/00470219.pdf

2. Scottish Government (2014) The Public Bodies (Joint Working) (Content of Performance Reports) (Scotland) Regulations 2014, Scottish Statutory Instrument, No 326.
http://www.legislation.gov.uk/ssi/2014/326/pdfs/ssi_20140326_en.pdf

3. Scottish Government (2016) Guidance for Health and Social Care Integration Partnership Performance Reports.
http://www.gov.scot/Resource/0049/00498038.pdf

4. Scottish Government (2015) Core Suite of Integration Indicators.
http://www.gov.scot/Resource/0047/00473516.pdf

1 Executive Summary

East Ayrshire Health and Social Care Partnership ("the Partnership") formed in April 2015, bringing together health and care services in East Ayrshire.

The Partnership includes the full range of community health and care services and is also the 'Lead Partnership' across Ayrshire and Arran for services commonly known as 'Primary Care'. Primary Care covers General Medical Services, community pharmacy, optometry practices, dental practices, the Public Dental Service, Pan-Ayrshire Out of Hours nursing service, Ayrshire Doctors on Call ("ADOC"), and Pan-Ayrshire Out of Hours Social Work Response Service.

The Partnership is a complex organisation bringing together partners, services and substantial financial resources. It is important to publicly report on how we are performing on the agreed outcomes that we work towards.

This is the Partnership's Annual Performance Report 2016/17. It describes how we have done against our outcomes for health, wellbeing, children and young people and justice in 2016/17, our second year of operation. It also builds on the information we published in our Annual Performance Report 2015/16, providing a year-on-year narrative of our progress.

This section gives an Executive Summary of the Annual Performance Report for 2016/17.

The work that the HSCP does fits with East Ayrshire's Community Plan for 2015-30. In taking forward our plans, the Health and Social Care Partnership works to a vision of:

"Working together with all of our communities to improve and sustain wellbeing, care and promote equity."

Progress is measured through tracking work plans and key measures. This report sets out a number of important measures of progress. It also describes some of the main areas we have been working on and the difference this has made.

The Annual Performance Report is a chance to reflect on the year and to celebrate the achievements delivered by employees and partners. It is also a chance to think about and appreciate the challenges that face us in terms of our performance now and in the months and years to come.

Performance Summary

Across the outcomes of wellbeing, children and young people and community justice the Annual Performance Report shows some significant progress:

- Alcohol-related hospital admission rates have continued to reduce, falling from 744 to 666 per 100,000 people. Referral to treatment for people needing support for alcohol and drug problems within three weeks was around 98 per cent in the year.
- The percentage of the last six months of life spent at home or in the community increased from just under 87 per cent to over 88 per cent.
- There has been substantial further progress in bed days occupied by people remaining in hospital where they could be more appropriately cared for in another setting with the number of days falling from 6,043 to 5,901. Bed days occupied for people with common long-term conditions fell further from 8,831 to 8,435.

- In the reporting period the number of people using 'technology enabled care' or Smart Supports has risen to almost 4,000.
- Care services graded as 'good' or above in Care Inspectorate inspection reports, during 2016/17, are almost 93 per cent.
- Premature mortality rates among those under 75 improved from 485 to 458 between the most recent and previous reporting periods.
- Over the same period the rate per head of 1,000 population aged 65 and over admitted to hospital for falls reduced from 22.8 to 21.7.
- Reports submitted to the Scottish Children's Reporters Administration (SCRA) within target timescales continued to outperform targets at 82 per cent for the years.
- Social Enquiry Reports submitted to Court by due date remained at 98 per cent – above the target of 95 per cent.
- Community Payback Orders with a requirement of unpaid work commencing within one week is at 90 per cent.

Where we have more challenging areas of performance, these relate to:

- Hospital admissions for drug-related diagnoses have not reduced further in the most recent period and stand at 259 per 100,000 compared with 256 in the previous report.
- Emergency admissions to hospital and emergency bed day rates have not reduced – with bed days rising from 121,232 to 125,883 over the last two reporting years.
- Premature deaths from CHD among people aged 75 and under have been stable and early mortality from cancer, while continuing to reduce, has not fallen to the level aspired to.
- Looked after children securing positive destinations in relation to education, employment and training is an area for continued focus on improving skills and life chances.
- Workforce challenges can be seen in terms of absence rates which are higher than target levels and in the lower than expected share of the workforce completing personal development and review plans.

Integration Joint Board – Governance and Decision-Making

Last year's Annual Performance Report detailed the Integration Joint Board's ("IJB") key decisions for 2015/16 and highlighted that these largely related to the establishment of the Partnership, delegation of functions and developing necessary governance arrangements. The nature of these decisions reflected the early stages of the Partnership during that reporting period.

In the course of 2016/17, the IJB's key decisions relate to a wide variety of service improvements across the functions delegated to the Partnership by East Ayrshire Council and NHS Ayrshire and Arran. These include directing the development of an action plan to implement the Pan- Ayrshire Telecare Strategy locally, investing the Integrated Care Fund in 48 distinct projects, implementing recommendations relating to the Scottish Living Wage and directing the production of a Financial Recovery Plan. Where appropriate, relevant performance narrative is provided for these key decisions. A detailed list of these can also be found in Section 14 of this report.

Financial Performance

The IJB must comply with financial regulations, codes of practice and guidance. A detailed auditing process is in place to ensure that proper practice is adhered to. The net cost of the provision of services commissioned through the IJB for 2016/17 was £210.765 million. Identified risks for 2016/17 related to the delivery of cash-releasing efficiency savings in the context of increasing demand and cost pressures (e.g., the Scottish Living Wage) were mitigated through close monitoring and the implementation of a recovery plan from November 2016 onwards.

Best Value

East Ayrshire Council's 'Transformation Strategy 2012-17' covers the reporting period and the range of best value activity undertaken as part of the transformation programme has been reported through appropriate governance structures throughout the course of the strategy. Work on the second transformation strategy for East Ayrshire Council is underway using detailed forecasting to shape change over the forthcoming five year period.

NHS Ayrshire and Arran has in place a 'Strategic Service Change Programme' covering mental health, unscheduled care (including older people and people with complex needs), acute services – whole system patient flow, primary care, planned care, children's services and technology enabled care. This programme has been taken forward over the course of 2016/17 and experiences are informing the development of a Transformational Change and Improvement Plan to 2020.

Community Health and Care Services continue to implement the recommendations of the 2015/16 Best Value Review of Adaptations in relation to influencing national policy and testing approaches to delivering adaptations which are not determined by housing tenure. Redesigned approaches to some adaptations are being taken forward on a pilot basis as tests of change. Implementing the next phase of the work programme will continue in the coming months.

Inspection Findings

Scheduled and unscheduled inspections by the Care Inspectorate continued in 2016/17. Quality of care was assessed as 'good' or better in 93% per cent of services.

Audit and Performance Committee

In 2016/17 the Audit and Performance Committee considered the Integration Joint Board audit reports from both parent bodies; East Ayrshire Council, Audit Scotland and PwC on behalf of NHS Ayrshire and Arran. The Committee considered the reports and provided a view on the governance and assurance arrangements and performance reporting arrangements to the IJB. The Committee receives regular reports on Performance Management and Financial arrangements including the IJB's Risk Register. From March 2017, the Strategic Commissioning for Sustainable Outcomes Board will report to the Audit and Performance Committee to oversee delivery of the Financial Recovery Plan.

Strategic Plan Review

The second Annual Review of the Strategic Plan 2015-18 has been completed, led by the Strategic Planning Group. The Review was undertaken, in line with the Partnership's Participation and Engagement Strategy, via a programme of stakeholder engagement including; four locality planning events, The BIG Plan Day and local conversation events. The Review found that the vision, values and priorities of the Partnership remain relevant and these were endorsed. It noted that there has been significant progress in delivery of integrated services while recognising an increasingly challenging operational context. The Review therefore makes specific reference to further necessary development of the Strategic Plan in 2017/18, strongly focused on strategic commissioning for sustainable outcomes within constrained resources and working in partnership in Localities.

Carers Centre

Locality Arrangements

Localities are based on Multi Member Wards with multidisciplinary working being further developed in communities during the year. Significant progress has been made in understanding local needs, assets and priorities by engaging with our communities as part of the Community Planning Partnership's commitment to locality planning. The initial Strategic Plan needs assessment has been built on with more detailed data being used to inform the Partnership's priorities. Three localities have been established; Kilmarnock, Northern (Annick & Irvine Valley) and Southern (Ballochmyle, Cumnock & Doon Valley) and locality profiles have been produced to provide "at a glance" understanding of these areas. Work is underway to embed multidisciplinary working in localities with Locality Planning groups operating to deliver locality-based approaches to practice and budgeting. Locality Profiles can be found in Section 20 of this report.

Lead Partnership Arrangements

Lead Partnership arrangements continue to be in place across Ayrshire & Arran. The North Ayrshire Partnership leads on Mental Health, South Ayrshire leads on Allied Health Professionals and East Ayrshire leads on the management and development of Primary Care services and Out of Hours Community Response services. The services provided outside normal working hours to the communities of Ayrshire include Ayrshire Doctors on Call, Out of Hours Nursing Services and Out of Hours Social Work Services.

In its lead Partnership role, East Ayrshire is responsible for the development and implementation of an ambitious programme of transformational change for Primary Care services. Excellent progress has been made in advancing the key priorities outlined in the 2016-17 programme, which included developing cluster-based working within localities, supporting effective pathways for people, tackling inequalities, maximising community capacity, workforce development, strengthening IT and infrastructure, and integrating out of hours/urgent care services.

Looking forward, the decision to revise the programme priorities for 2017/18 has meant a consolidation in the number of core work-streams to six key areas of activity. The focus of these six include the development of services around GP clusters and supporting the development of multidisciplinary team working in the GP environment, increasing capacity to provide community-based services, improving workforce sustainability, improving primary care infrastructure, establishing an integrated and sustainable Out Of Hours service and addressing health inequalities.

This work will be delivered in partnership between communities, Primary Care, Health and Social Care Partnerships, Acute and Third Sector. The Ambitious for Ayrshire Programme Board provides strategic oversight and co-ordination with most of the work being undertaken in clusters and localities

Service Improvement Plans

Service Improvement Plans were established in 2016/17 for the Partnership's three main portfolios; Children's Health Care & Justice, Community Health & Care and Primary Care & Out of Hours and these have been actioned and monitored throughout the year. The plans detail how each pillar of the Partnership will contribute to transformation programmes through workforce and infrastructure development and service review and redesign.

Looking Ahead

The focus in 2017/18 will continue to be on delivering safe and effective integrated services in the context of transformational change and challenging resource constraints. Strategic commissioning at Partnership, service and locality level will be the main method by which we achieve sustainable outcomes for our communities, families and individuals. Service Improvement Plans will again be the vehicle for each of the Partnership's service areas to demonstrate working towards these goals.

2 Introduction

This is the Annual Performance Report for East Ayrshire Health and Social Care Partnership for 2016/17 ("the/ this Report").

Section 42 of the Public Bodies (Joint Working) (Scotland) Act 2014 ("the 2014 Act") obliges Partnerships to produce annual performance reports setting out an assessment of performance in planning and carrying out their functions. In addition the Public Bodies (Joint Working) (Content of Performance Reports) (Scotland) Regulations 2014 ("the Performance Regulations") sets out the content that annual performance reports must contain.

This Report is produced to meet the Partnership's obligations relating to performance reporting and is for the benefit of our local communities. It focuses on our performance against the National Health and Wellbeing Outcomes, Outcomes for Children and Young People and Justice and takes account of national guidance.

The Report is delivered in the context of the national and local policy framework: the East Ayrshire Community Plan 2015-30, the Health and Social Care Partnership Strategic Plan 2015-18 and the National Outcomes for health, wellbeing, children and young people and justice.

Community Plan 2015-30

The East Ayrshire Community Plan 2015-30 is the sovereign and overarching planning document for the East Ayrshire area, providing the local strategic policy framework for the delivery of public services by all partners.

The vision set out in the Community Plan is that:

"East Ayrshire is a place with strong, safe and vibrant communities where everyone has a good quality of life and access to opportunities, choices and high quality services which are sustainable, accessible and meet people's needs."

Implementation of the Community Plan is through three thematic Delivery Plans, namely;

Economy and Skills **Safer Communities** **Wellbeing**

The Health and Social Care Partnership has a lead role in taking forward the Wellbeing theme as well a key contributory role in the delivery of the Economy and Skills and Safer Communities themes.

Strategic Priorities under the Wellbeing theme of the Community Plan are:

- Children and young people, including those in early years and their carers, are supported to be active, healthy and to reach their potential at all life stages.
- All residents are given the opportunity to improve their wellbeing, to lead an active, healthy life and to make positive lifestyle choices.
- Older people and adults who require support and their carers are included and empowered to live the healthiest life possible.
- Communities are supported to address the impact that inequalities have on the health and wellbeing of our residents.

2020 Vision for Health and Social Care

The national 2020 vision for health and social care overarches the Partnership's work:

2020 Vision
'By 2020 everyone is able to live longer healthier lives at home, or in a homely setting'.

We will have a healthcare system where we have integrated health and social care, a focus on prevention, anticipation and supported self management. When hospital treatment is required, and cannot be provided in a community setting, day case treatment will be the norm. Whatever the setting, care will be provided to the highest standards of quality and safety, with the person at the centre of all decisions. There will be a focus on ensuring that people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission.

National Outcomes- Health, Wellbeing, Children & Justice

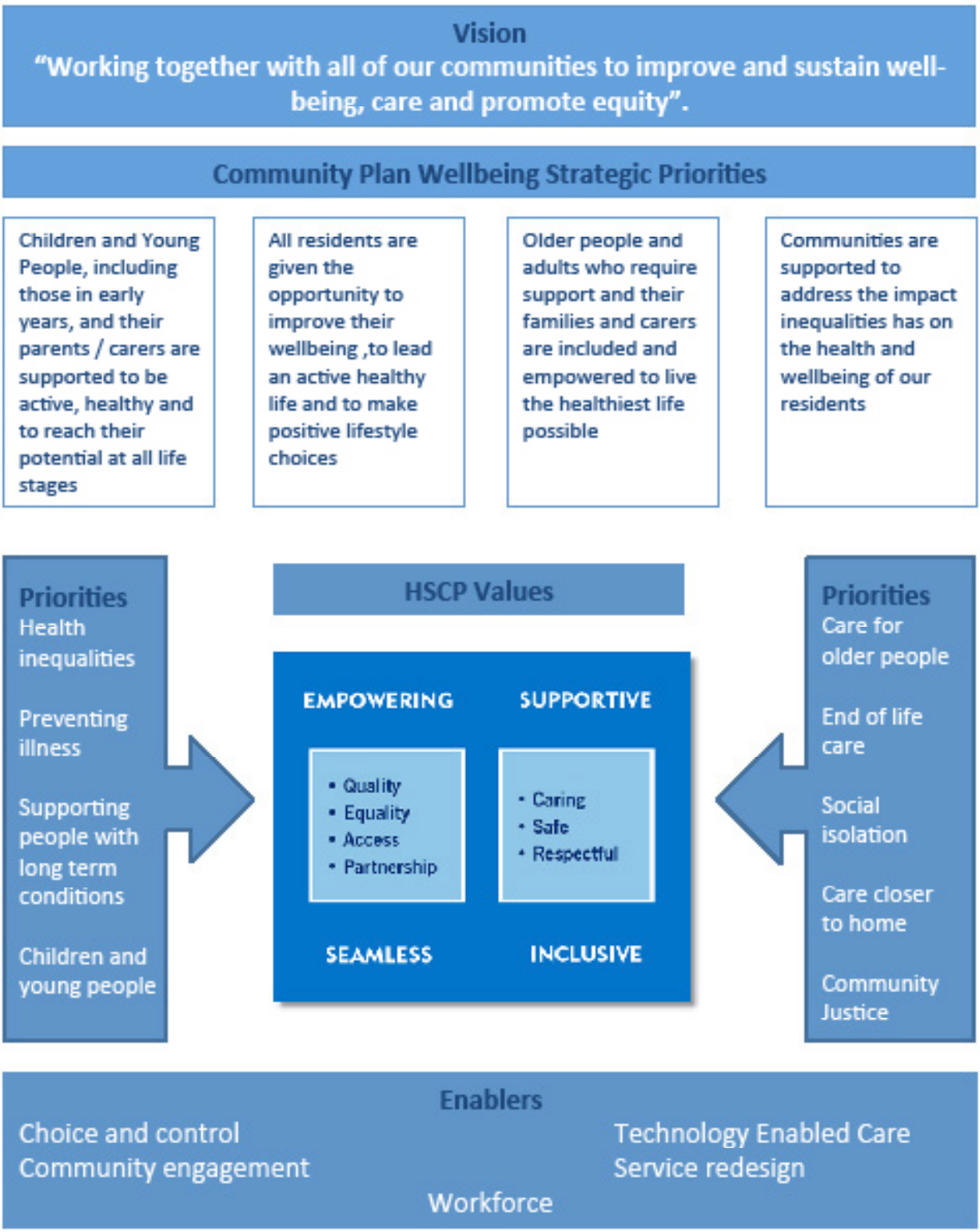
The suite of 15 national outcomes then frames the Partnerships' activities:

National Outcomes for Children	
Outcome 1	Our children have the best start in life.
Outcome 2	Our young people are successful learners, confident individuals, effective contributors and responsible citizens.
Outcome 3	We have improved the life chances for children, young people and families at risk.
Health and Wellbeing Outcomes	
Outcome 4	People are able to look after and improve their own health and wellbeing and live in good health for longer.
Outcome 5	People, including those with disabilities, 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.
Outcome 6	People who use health and social care services have positive experiences of those services, and have their dignity respected.
Outcome 7	Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.
Outcome 8	Health and social care services contribute to reducing health inequalities.
Outcome 9	People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing.
Outcome 10	People who use health and social care services are safe from harm.
Outcome 11	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.
Outcome 12	Resources are used effectively and efficiently in the provision of health and social care services.
National Outcomes Justice	
Outcome 13	Community safety and public protection.
Outcome 14	The reduction of reoffending.
Outcome 15	Social inclusion to support desistance from offending.

Health and Social Care Partnership Strategic Plan 2015-18

The Partnership developed its Strategic Plan for 2015-18 prior to being formally established in April 2015. Annual reviews of the Strategic Plan have been carried out in 2016 and 2017. The Strategic Plan aligns with the Community Planning Partnership vision and strategic objectives. A strategic framework of enablers and local priority areas, combined with the Partnership's values, is in place to deliver our strategic priorities and work towards the vision.

Strategic Framework



Performance Framework

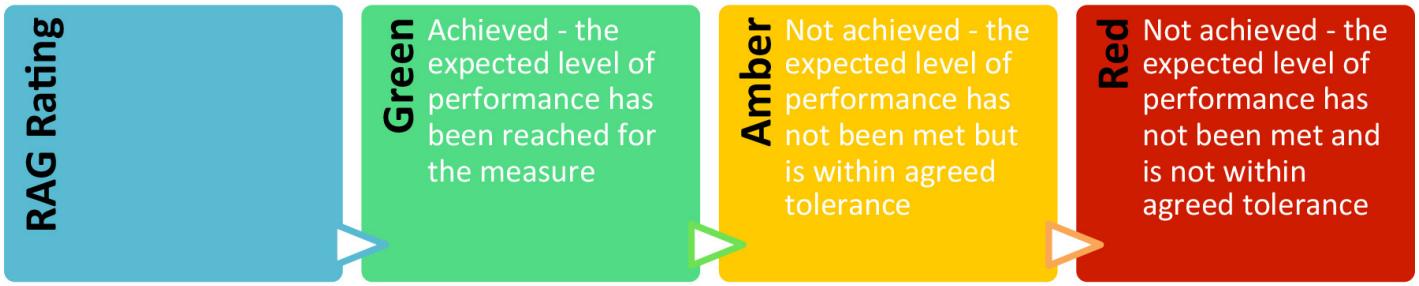
The framework around the Partnership's performance and the content of this report logically follow from the strategic policy arrangements set out in the preceding sections. This begins with the suite of measures supporting the National Health and Wellbeing Outcomes and the performance reporting requirements of the Public Bodies (Joint Working) (Scotland) Act 2014. The report takes into account the performance reporting guidance issued under this legislation by the Scottish Government.

In line with guidance, the report presents an assessment of performance against the outcomes, integration delivery principles, the core suite of measures, the extent to which the Strategic Plan 2015-18 is contributing to these , performance against key measures of those outcomes over this and the preceding year, financial performance and the significant decision-making of the Integration Joint Board.

Each performance measure has been cross-referenced to the core suite integration indicators under the national health and wellbeing outcomes, the Wellbeing Delivery Plan local outcome indicators, Statutory Performance Indicators, and measures from the Quality Assurance and Improvement Dashboards contained in Service Improvement Plans. Measures reported therefore align to delivery of the Strategic Plan 2015-18, Community Plan and National Outcomes, as illustrated below:

'Around The Town' Alzheimer Board Game

Where status against target is available, performance measures have been rated on a traffic light basis using Red, Amber or Green categories to reflect this. The key below shows how status has been determined. Traffic light status is based on performance thresholds, i.e., exceeding or within 3 percent of target for Green, between 3 and 5 percent of target from Amber and over 5 percent outwith target for Red. 'Progress' is reported using the most recent data while 'baseline' is illustrated by the data for the previous reporting period. Where targets have not been set these are marked in white with a 'n/a' status.



The report also presents narrative related to the performance journey over the 2016/17 period within East Ayrshire – highlighting areas of activity and personal experiences linked to shared outcomes.

For each indicator the key below is used to summarise the source(s):

[Key: CSII = Core Suite of Integration Measures; SOA Wellbeing LO = Single Outcome Agreement/ Wellbeing Delivery Plan Local Outcome Indicator; SPI = Statutory Performance Indicator; HSCP Scorecard = Health and Social Care Partnership Director's Scorecard; CHCS SIP = Service Improvement Plan for Community Health and Care Services; CHCJ SIP = Service Improvement Plan Children's Health, Care and Justice; PCOHCR SIP = Service Improvement Plan Primary Care and Out of Hours Community Response]

Ministerial Strategy Group – Measuring Performance Under Integration

The Ministerial Strategy Group ("MSG") – a joint leadership group for health and social care in Scotland – issued data under the banner 'Measuring Performance Under Integration' in 2016/17. The data focused on the six key areas of: emergency admission; unscheduled hospital bed days; emergency department (ED) attendances; delayed discharge bed days; the percentage of the last six months of life spent at home or in community settings, and; the balance of care between community and institutional settings.

The measures aim to provide a whole system overview of performance and contribute to the Health and Social Care Delivery Plan and partnership's Annual Performance Reports. This Report incorporates the MSG indicators across the health and wellbeing outcome dimensions and assessment of performance is included in these sections throughout the report. In addition, detailed analysis of the East Ayrshire MSG data has been undertaken with the involvement of Ayrshire Local Intelligence Support Team (LIST) analysts:

- While emergency admissions have increased between 2015/16 and 2016/17, admissions from EDs have reduced by 13 per cent from 15,598 to 13,594 and attendances at ED have reduced by 3 per cent from 40,423 to 39,269;
- The ED 'conversion rate' from emergency presentation to hospital admission fell from 39 per cent at year end 2015/16 to 34 per cent at year end 2016/17;
- The unscheduled bed day rate in acute services for East Ayrshire fell from 67.2 at year end 2015/16 to 65.8 per 1,000 population in 2016/17 and benchmarked positively across NHS Ayrshire and Arran;
- The unscheduled bed day rate for mental health services for East Ayrshire was 31 per 1,000 population during 2016/17 and benchmarked strongly across NHS Ayrshire and Arran;

- Unscheduled bed day rates in geriatric long-stay per 1,000 population reduced from around 22 in 2015/16 to 10 during 2016/17;
- The average length of stay for East Ayrshire residents admitted to hospital on a non-elective basis tends to be lower than Scotland and NHS Ayrshire and Arran during the last two years and across age groups;
- Respiratory, COPD and Asthma are the main diagnostic groups related to unscheduled admission and taken together with Chest Pain and Gastric conditions account for 37 per cent of all admissions and around 30 per cent of bed days;
- Performance on the ED 'four hour standard' improved over the reporting people for East Ayrshire residents rising from 91.3 per cent at year end 2015/16 to 93.5 per cent at year end 2016/17;
- Delayed discharge bed rates for East Ayrshire are consistently low and stood at 4.6 per 1,000 for all reasons as at year end 2016/17 – though 'Code 9' complex discharge reasons make up a large proportion of bed days and are an improvement focus
- The percentage of the last six months of life spent in large hospital rather than community setting has reduced and 88.1 per cent of people are supported at home or in community settings and this compares favourably with 'family group' and national average (86.8 and 87.4 per cent respectively);
- In terms of the balance of care, East Ayrshire has over 97 per cent of the population living independently at home, 1.5 per cent with care at home support, 0.7 per cent with supported in care homes, 0.3 per cent in large hospitals and the remainder supported in community hospitals. This is similar to the national picture, though East Ayrshire supports a slightly higher proportion of the population through care at home services.

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

Performance Measures

Indicator/s	Baseline	Progress	Status
Percentage of adults able to look after their health very well or quite well (CSII-01)	92% (2013/14)	94% (2015/16)	n/a
Smoking prevalence (SOA Wellbeing LO2.1-1)	32.3% (2012/13)	22.6% (2014/15)	27%
Rate for alcohol-related hospital stays per 100,000 population (SOA Wellbeing LO2.1-3)	744 (2015/15)	666.5 (2015/16)	790
Rate for general acute and day case stays with a diagnosis of drug misuse per 100,000 population (SOA Wellbeing LO2.1-4)	256.1 (2014/15)	259.2 (2015/16)	230
Percentage of people who need help with their drug or alcohol problem will wait no longer than three weeks for treatment that supports their recovery (SOA Wellbeing LO2.2-1)	96.4% (2014/15)	97.8% (2016/17)	90%

NB: There is no 2016/17 update on indicators 1 and 2 above.

Performance Assessment

These measures indicate the extent to which we support people to care for themselves, manage their own health and our wider work to improve health locally. They are particularly related to our strategic priorities around long-term conditions, alcohol and drugs and wellbeing.

We are seeing good progress in relation to alcohol-related hospital stays and we are doing better than expected performance levels, with the rate continuing to reduce from 744 to 666.

An area where performance is more challenging is in hospital admissions for drug-related diagnoses. The rate for this measure has continued to increase to 259 against a target of 230.

However, our performance in relation to people seeking help for either drug or alcohol problems continues to improve in that almost 98% of people access treatment within three weeks.

Practice Examples

The Healthy Active Rehabilitation Programme (HARP) has developed a pathway to support people with more than one condition (known as multi-morbidity) to manage their health and wellbeing within a tiered model and made substantial progress during the reporting period to implement this complex model. In 2016/17, this menu-based self-management programme has had around 150 referrals and evaluation has shown improvement with participants reporting benefits relating to both physical and emotional wellbeing:

Smoking cessation and prevention activities are delivered by the FreshAirshire service and local pharmacies and include a range of support options including an intensive cut-down-to-quit programme. Specific services operate locally to target support at particular groups for example, pregnant women and the population of HMP Kilmarnock.

In response to the national trend of increasing drug related deaths, East Ayrshire Alcohol and Drug Partnership (ADP) together with local emergency services, has developed a low threshold approach in relation to preventing accidental overdose. This partnership work proactively connects vulnerable individuals with specialist support services at the earliest opportunity unless the person chooses to "opt out". The impact of this approach will be fully evaluated over the coming months and it is hoped will see a reduction in the number of preventable deaths.

A local 'festival of recovery' in November brought together around 80 participants that highlighted the assets that those in recovery possess as well as emphasising their individuality. This event is to be repeated annually in September as part of local activities around the national recovery week.

The ADP in partnership with the Department of Work and Pensions has developed additional work experience opportunities for those in recovery. As a pilot, two trainees secured work experience placements within East Ayrshire Council, one of whom recently secured paid full time employment with East Ayrshire Council.

4 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

Indicator/s	Baseline	Progress	Status
Percentage of adults supported at home who agree that they are supported to live as independently as possible (CSII-02)	87% (2013/14)	88% (2015/16)	n/a
Emergency admission rate per 100,000 (CSII-12)	14,859 (2015/16)	15,611 (2016/17)	n/a
Emergency bed day rate per 100,000 (CSII-13)	121,232 (2015/16)	125,883 (2014/15)	n/a
Readmission to hospital within 7 days (CHCS SIP)	4.7% (2015/16)	4.9% (2016/17)	4.3%
Readmission to hospital within 28 days (CSII-14)	10.2% (2015/16)	10.8% (2016/17)	9.2%
Proportion of last 6 months of life spent at home or in a community setting [revised method for calculating introduced nationally in the reporting period, local baseline and trajectories recalculated] (CSII-15; SOA Wellbeing LO2.2-2)	86.6% (2013/14)	88.1% (2016/17)	88.2%
Percentage of adults with intensive care needs receiving care at home – personal care at home aged 18+ (CSII-18)	67.9% (2015/16)	69% (2016/17)	n/a
Percentage of people discharged within 7 days of fit for discharge date (CHCS SIP)	39.6% (2015/16)	27% (2016/17)	33%
Bed days lost as a result of delayed discharge (CHCS SIP)	6,043 (2015/16)	5,901 (2016/17)	6,298 (2016) 5,865 (2018)
Number of days people spend in hospital when they are ready to be discharged, per 1,000 population (CSII-19)	616 (2015/16)	600 (2016/17)	664
Percentage of people admitted to hospital from home during the year, who are discharged to a care home (CSII-21)	n/a	n/a	n/a
Percentage of people who are discharged from hospital within 72 hours of being ready (CSII-22)	77.5% (2014/15)	66.8% (2015/16)	n/a
Percentage of older people aged 65 or older, who live in housing rather than a care home or hospital (SPI28)	96.7% (2015/16)	96.8% (2016/17)	96.5%
Number of bed days per 10,000 population for long-term conditions (asthma, COPD, heart failure, diabetes) (SOA Wellbeing LO3.1-2)	8,831 (2014/15)	8,435 (2015/16)	8,877
Number of people using telecare/ telehealth support packages (SOA Wellbeing LO3.1-4)	3,880 (2014/15)	3,980 (2016/17)	3,600

NB: There is no 2016/17 update on indicators 1, 11 and 12 above.

Performance Assessment

These measures indicate how well we work together and plan to support people in their own homes or as close to home as is possible. They show the extent of proactive partnership working to anticipate need and coordinate care and support in the community. These measures are central to the 2020 Vision for health and social care set out in the introduction above.

Emergency admissions and bed day rates continue to be higher among our population and are above where we would expect them to be. The Unscheduled Care Programme continues to drive the work across Ayrshire and Arran to improve performance against these indicators. Correspondingly, readmission rates also continue to be higher; readmission within 28 days is outside tolerance at 10.8% while performance for readmission within 7 days continues to be inside tolerance levels at 4.9%.

The end of life key measure of last six months spent in a community setting is within agreed tolerance at 88%.

Our strong and consistent performance continues in relation to discharging people to the right setting when they no longer require hospital based treatment and we will continue to focus on this as a key indicator of good outcomes. This has further improved in 2016/17, reducing from 6,043 in 2015/16 to 5,901 in 2016/17. Performance has been especially positive in relation to 'standard' discharges where bed days have reduced from 5,114 in 2014/15 to 2,442 in 2015/15 and to 1,744 in 2016/17. At present, 75% of delays are in cases relating to Adults With Incapacity, where there may routinely be issues outside the Partnership's control.

Last year we reported a 10% reduction in the number of bed days lost as a result of delayed discharge and we continued to improve in this reporting period, showing a further 2% reduction.

Our commitment to telecare and telehealth also continues to be evident as the number of people using Smart Supports continues to improve. Now, almost 4,000 people use some form of technology enabled care as part of their support arrangements, promoting self-management of many health conditions and living as independently and safely as possible.

IJB Decisions

In June 2016, the IJB heard that £2.470m Integrated Care Fund ("ICF") monies have been fully utilised in 2015/16 and in March 2017 the IJB approved plans for investment of the ICF funding for 2017/18.

In August, the IJB approved arrangements for providing equipment and adaptations to support independent living within the local area, including providing directions to the Chief Officer to; extend the current service and repair contract until a pan-Ayrshire framework is implemented, test the provision of adaptations via Self-directed Support and progress further discussions regarding an adaptations framework alongside Registered Social Landlords.

In September, the IJB proposed a development session on Telecare and E-Health strategy and directed the Chief Officer to develop a local action plan to implement the strategy.

Practice Examples

Since July, Technology Enabled Care (TEC) Peer Mentors, in line with the East Ayrshire TEC Local Delivery Plan (2016-18) have attended the new health and social care Front Door Service's weekly 'hub' meetings to embed smart supports in local assessment and support planning processes. This activity has increased staff confidence in TEC and resulted in improved, cost-effective outcomes for people who use services. For example, where Care at Home services would previously have been relied upon to provide medication prompts, people can now self-manage their medication using an automated voice announcer function on their dispersed alarm.

Unscheduled Care refers to a range of activities that support people to stay in their own homes, return to their own

homes as quickly as possible when hospital treatment is needed and prevention related re-admission to hospital. People who present at local acute hospital Emergency Departments are now triaged via the Manchester Triage System which ensures they are treated according to priority needs and if treatment or other services would better meet their needs, they are redirected accordingly.

Since the opening of the Combined Assessment Unit at University Hospital Crosshouse, there has been a reduction in admissions overall and with the Combined Assessment Unit opening in Ayr in June 2017 a further reduction in is anticipated. When a hospital stay is required, East Ayrshire residents who may benefit from supports to facilitate their discharge are now identified within twenty-four hours of admission, enabling the earliest possible planning of supports to get the person home as soon as they are medically fit.

A whole system indicator is how long people wait in the Emergency Department for admission to a ward. Both sites have been improving against the national target of 95%.

A Care and Repair Services is funded from the ICF and carries out preventative work within people's homes related to safety, electrical upgrade work and minor adaptations. Around 450 people's cases have been progressed during 2016/17.

A programme of activity to develop and implement a pan-Ayrshire Joint Equipment Store and Minor Adaptations service has been agreed by the three local Partnerships and will be undertaken during 2017/18. The South Ayrshire Partnership will lead these activities with programme management support from East Ayrshire and national procurement. It is intended that this single service will enable seamless provision of equipment and minor adaptations across the local area, enabling people to live as independently and safely as possible.

The ICF funded Zone- Home Buddies deliver practical and household support for older people who are potentially isolated. The service has expanded in 2016/17 to support 150 people, with plans to further increase capacity and introduce a weekly membership fee, which will contribute to achieving sustainability.

The Red Cross- Home from Hospital Service supported around 1,800 people in 2016/17, funded by the ICF. This service is delivered across Ayrshire and Arran from University Hospitals Crosshouse and Ayr and supports people to be discharged from hospital as early as possible, reducing their length of stay. The service provides people with supported transport to their home and re-settling, such as helping to prevent falls and reduce social isolation, which enables people to regain their confidence at home and it organises telecare, which supports families and carers to continue to care. In addition to the reduction in length of hospital stay, 125 hospital admissions have been avoided, saving hospital services costs equivalent to 2,020 bed days.

Social Work

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

Performance Measures

Indicator/s	Baseline	Progress	Status
Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided (CSII-03)	88% (2013/14)	79% (2015/16)	n/a
Percentage of adults receiving any care or support who rate it as excellent or good (CSII-05)	87% (2013/14)	86% (2015/16)	n/a
Percentage of people with positive experience of the care provided by their GP practice (CSII-06)	85% (2013/14)	83.4% (2015/16)	n/a

NB: There is no 2016/17 update in relation to performance against these indicators.

Performance Assessment

The measures above relate to our strategic enablers of maximising choice and control, quality and continuous improvement via service redesign.

Our performance for care and support being rated as good or excellent is at 86% (2015/16 position), 5 percentage points over the national level.

79% of people (2015/16 position) agree that they have a say in how their care and support was provided.

Across HSCP services we strive to deliver high quality services for our residents. In so doing, the partnership promotes choice and control for individuals, families and carers so that they can direct their support and realise their personal outcomes. It is the case that the complex nature of circumstances means that we don't get things right all the time. Our complaints handling arrangements and processes aim to identify and address any issues which do arise. We received 57 complaints during the course of 2016/17. Analysis of complaints presents an opportunity to reflect on learning and improvement themes across the partnership.

Thematically, complaints responded to during 2016/17 often involved challenging family and individual circumstances with complex relationships, statutory requirements and decision-making in relation to support and protection as well as capacity issues. Communication related to access to services can also be a source of complaint.

Learning from complaints assist in improvement, in communication, in our flexibility and in consistency of response. Further regular analysis of complaints under the new Complaints Handling Procedure will influence improvement, corrective action and organisational learning.

Practice Examples

We continue to recognise the importance of hearing directly from people who use services as key to improving the quality of local services. The Quality Checkers' Group is made up of individuals who use services, family carers and people who work in Partnership community health and care services.

In 2016/17, Quality Checkers completed their evaluation of Adult Support Services within the Partnership. They consulted with individuals that use services; family members of individuals that use service; 'Big Cheeses' and frontline staff. They presented their findings to Elected Members; service users and family members; staff and

Managers and Senior Management earlier in 2017. The Quality Checkers are in the process of finalising a report for this work and also developing a newspaper easy read version.

Throughout the reporting period, we have used a number of public events as opportunities to have meaningful conversations with people who use health and social care services, their families and carers, using a range of "What Matters to You" questions and methods. What people told us has been fed into the Partnership's operational and strategic decision making processes via the Strategic Planning Group:

"To truly, honestly work in communities accross disciplines and services in order to provide a robust response to communities in terms of direct service delivery and enabling communities and individuals to support themselves."

"Connecting young people and older people together and improve social inclusion and loneliness, improve sense of community and involvement of all members"

"Pop up health services!
Based on the principle of pop-up shops and restaurants.
Services go to where the need is."

As a test of change, Advanced Practitioner Physiotherapists were introduced in three GP Practices in each of the Ayrshire Partnership areas to work as the 1st point of contact for patients presenting with a musculoskeletal ("MSK") condition and manage a caseload previously seen by GPs. These Advanced Practitioner Physiotherapists, who previously worked in acute services, are now delivering clinics in a Primary Care setting highlighting a successful shift in the balance of care and helping to avoid over-medicalisation and promote a culture of self-management and enablement.

An experience survey was carried out in East Ayrshire Community Hospital ("EACH"), focussing on the frail elderly mental health patients. 100% of the patients strongly agreed that; staff make me feel welcome; staff take the time to get to know me as a person; staff treat me with dignity and respect and overall, the quality of care I receive is very good. Similarly, 100% of the relatives interviewed strongly agreed that overall, the quality of care is very good.


LDAW Showcase

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

Performance Measures

Indicator/s	Baseline	Progress	Status
Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life (CSII-07)	88% (2013/14)	85% (2015/16)	n/a
Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections (CSII-17)	87.8% (2014)	92.9% (2016/17)	n/a

NB: There is no 2016/17 update in relation to performance against these indicators. The figure provided is provisional local data.

Performance Assessment

The measures above relate to person-centred and outcome-focussed work with people in relation to improving quality of life.

85% of people (2015/16 position) agree that their services and supports contribute to improving or maintaining their quality of life.

The Care Inspectorate assesses quality for our local care and support providers against four categories: care and support, environment, staffing and management and leadership. Local data indicates that 92.9% of providers of care at home, care homes, housing support and services for children and young people are assessed as "good" or better.

Practice Examples

Building on the success of Lily Hill Gardens in Kilmarnock, which was reported last year, three further builds in Hurlford, New Cumnock and Mauchline have been secured and form part of the Council's Strategic Housing Investment Plan 2017-2022. This future model of supported living for adults with complex needs, based on the principles of the "Keys to Life" strategy has been developed in collaboration with local communities.

A new framework of service providers for adults with mental health problems or learning disabilities was developed during 2016/17, together with the Quality Checkers, who arranged a user's panel and interviewed all potential providers. Quality Checkers will also continue to be part of the ongoing monitoring of the services provided. The new arrangements have introduced more choice for people who use services with a total of nine service providers offering support across all of East Ayrshire. Providers are able to work together to offer shared support, such as overnight responses.

The "My Home Life" leadership development programme has been delivered across sectors including care are home services and in care homes, in partnership with the independent sector. The programme drives a shift from 'fixing it' to working together to change things for the better and improving practice such as: exploring what matters to care home residents to enable meaningful activities and building relationships, improving shared decision making and exploring real feelings and anxieties. The improvements made are captured in this quote from a Care Inspector:

> "You can see the different approach in the care homes that have done MHL, from the front door in. There's a change of attitude and you can see it cascading down and can see a difference in the staff."

We are one of several areas participating in the Care Inspectorate's "Care…about physical activity" ("CAPA") improvement programme, aimed at increasing levels of physical activity of older people in Scotland's care sector, through collaborative working. Learning sessions will take place over 2017/18 to bring people together to find out how to use CAPA, to consider strategies for increasing levels of physical activity and in turn enable people to be more active.

7 Health and social care services contribute to reducing health inequalities

Performance Measures

Indicator/s	Baseline	Progress	Status
Premature mortality rate per 100,000 aged under 75 (CSII-11; SOA Wellbeing LO4.1-2)	484.6 (2014)	458.2 (2015)	506
Life expectancy at birth – males (SOA Wellbeing LO4.1-1)	75.9 (2012-14)	76.1 (2013-15)	76
Life expectancy at birth – females (SOA Wellbeing LO4.1-1)	79.7 (2012-14)	79.4 (2013-15)	80
Deaths per 100,000 from coronary heart disease (CHD) under 75 years (SOA Wellbeing LO4.1-3)	66.6 (2012-14)	66.9 (2013-15)	58.4
Deaths per 100,000 from all cancers under 75 years (SOA Wellbeing LO4.1-4)	175.5 (2011-14)	173.8 (2013-15)	154

Performance Assessment

Tackling health inequalities is a cross-cutting priority for the Community Planning Partnership in East Ayrshire and is fundamental to the Wellbeing Delivery Plan, which the Health and Social Care Partnership leads. The measures for this outcome align to this local priority and inform progress and action on tackling poverty, deprivation and inequality. The Strategic Plan 2015-18 sets out our approach to preventing, mitigating and undoing the causes and effects of inequality.

The core integration measure of premature mortality among people aged 75 and under continues to show positive progress with a reduction from 484 to 458 deaths per 100,000 population. This represents an improved performance against the expected peer group benchmark of 506 per 100,000.

Life expectancy among males has increased slightly to 76.1 years, which is in line with the expected increase of 76 years. For females, life expectancy has seen a marginal decrease from 79.7 years to 79.4 years, which continues to be below the expected 80 years.

Premature death from all cancers has improved to 173.8 per 100,000 population with performance continuing to be below the expected level of 154. Premature death arising from coronary heart disease has not continued to improve to the extent expected and is currently 66.9 deaths per 100,000 population.

IJB Decisions

In June 2016, the IJB heard that £2.470m Integrated Care Fund ("ICF") monies have been fully utilised in 2015/16 and in March 2017 the IJB approved plans for investment of the ICF funding for 2017/18.

In March 2017, IJB approved recommendations in relation to the Scottish Living Wage in respect of service users who commission services through Self Directed Services options 1 and 2 and directed the Director to implement the recommendations.

Practice Examples

Initiatives to support people with long term conditions, funded by the ICF, were reviewed and more closely aligned in 2016/17. Dietetics and weight management is now a single programme delivering the Lifestyle Exercise and Nutrition (LEAN), Weigh to Go and the Weight Management Referral Pathway. Seven new Weigh to Go facilitators from four different organisations have been trained. The first and second LEAN programmes started August-October 2016 working with Primary Care to identity participants. Outcomes shown are an average of 5 per cent weight loss, with all participants improving physical exercise abilities such as grip strength, walk test and sitting-to-standing.

Improving our use of data to better understand population needs has continued during 2016/17. Much of this has linked to engagement in Locality Planning and the development of profiles to help inform Local Outcome Improvement Plans ("LOIPs"). We have built on initial needs assessment completed for the Strategic Plan, collating more detailed data and carrying out engagement with our communities on our needs, assets and priorities. Our findings show we need to continue to prioritise action on deprivation, inequalities and the consequences of these for the whole community. As part of its commitment to locality planning, the Community Planning Partnership's focus is on continuing to strengthen working between partners and building networks to enable multi-disciplinary, cross sector working within localities.

The Financial Inclusion Team ("FIT") was created as part of the Council's Financial Inclusion Strategy to assist the most vulnerable people in society against the impact of the UK Government's Welfare Reform programme. In 2016-17, FIT achieved financial gains totalling over £4.5M on behalf of its service users, an increase of over £300,000 the previous year.

In September, the Council and Partnership signed up to the national campaign against homophobic bullying and abuse when they signed off Stonewall's No Bystanders pledge:

"I will never be a bystander to bullying and teasing language. If I hear it, I will call it out and if I can, I will stop it.

By adding my name, I promise to stand up for fairness, kindness and never be a bystander"

You can sign the pledge here:

www.nobystanders.org.uk


Skills Development Scotland
ourskillsforce.co.uk
0800 783 6000

Dice Launch

8 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

Performance Measures

Indicator/s	Baseline	Progress	Status
Percentage of carers who feel supported to continue in their caring role (CSII-08)	48% (2013/14)	51% (2015/16)	n/a

NB: there is no 2016/17 update in relation to performance against this indicator.

Performance Assessment

We recognise carers as equal partners in care and this is reflected in performance against this core integration measure. For 2015/16 carers reporting feeling supported to continue in their caring role stands at 51%. This is 9 percentage points higher than the national average.

We have also continued to work alongside carers, promoting the value of carer's support plans with over 2,100 now in place.

IJB Decisions

In June 2016, the IJB heard that £2.470m Integrated Care Fund ("ICF") monies have been fully utilised in 2015/16 and in March 2017 the IJB approved plans for investment of the ICF funding for 2017/18.

Practice Examples

The Older People Support Project continued in 2016/17, funded through the ICF, to assist carers either unknown to services or who have recently become carers. This is done on a one-to-one basis through individualised provision of information, advice, benefits checks, training and links to other sources of support. In the reporting period, around 340 new carers are expected to have registered and work in Primary Care has identified around 100 "hidden" carers.

In relation to addressing carer poverty, the project has lodged 195 benefit applications with an annual benefit of over £415,000. The project provides added value by accessing other resources such as local Trusts that gift monies to specified groups or individuals.

The project also works in partnership with Community Connectors, aligned to GP practices. Community Connectors aim to enable people to make better use of local assets, reducing the potential for isolation and building strong local networks. In 2016/17 over 1,000 referrals were received by the Community Connectors and they are increasingly becoming a core constituent of multidisciplinary working at locality level.

The Thinking Differently Team is leading local preparations for the implementation of the Carers (Scotland) Act 2016 because of the clear links between the principles, duties and powers of the carers legislation and the Social Care (Self-directed Support) (Scotland) Act 2013 and the opportunity to consider Technology Enabled Care as a core support for carers. A number of tests of change are being progressed including further development of the Peer Support Model to include carers and young carers, preparation of a local carer's strategy and the setting of local eligibility criteria.

9 People using health and social care services are safe from harm

Performance Measures

Indicator/s	Baseline	Progress	Status
Percentage of adults supported at home who agree they felt safe (CSII-09)	85% (2013/14)	88% (2015/16)	n/a
Falls rate per 1,000 population aged 65+ (CSII-16)	22.8 (2015)	21.7 (2016/17)	n/a

NB: there is no 2016/17 update in relation to performance against this indicator.

Performance Assessment

The measures associated with supporting people to be safe from harm are strongly linked to integrated work undertaken to protect adults at risk and prevent potentially avoidable harm, such as falls.

The falls rate continues to show incremental improvement against a background of local long term reduction, linked to proactive work to deliver a tiered falls pathway, with the rate improving from 26 per 1,000 people to 22 per 1,000 people over the last six years.

Our good performance in relation to adult protection continues with only 2.2% of all referrals being in respect of adult protection interventions.

IJB Decisions

In June 2016, the IJB heard that £2.470m Integrated Care Fund ("ICF") monies have been fully utilised in 2015/16 and in March the IJB approved plans for investment of the ICF funding for 2017/18.

Practice Examples

The local Keep Safe Scheme is modelled on the national I am Me Scheme and to date, operates 25 Safe Places in East Ayrshire. Safe Places are local shops/facilities that have received training from local people with disabilities to understand their needs and rights to feel safe when out and about.

The local Call Blocker initiative now provides call blocker systems to 155 people/homes. Installation of call blockers has led to the development of Connect Call service (a phone befriending service) which has been aimed at reducing isolation and loneliness for 71 people who access calls from befrienders. The service has also encouraged service users to become volunteers as well as recruiting 9 volunteers from the local community. Volunteers and people using the service meet up for social events, further supporting their sense of health and wellbeing and the community presence reduces factors that may make them more vulnerable to scams and fraudulent activity.

Over 100 delegates came together to consider self-neglect as the subject of this year's Annual Conference held by the three Ayrshire Adult Protection Committees, hosted by East Ayrshire. The conference focused on the fact that self-neglect can happen to an adult of any age when someone is unable, for a number of reasons, to take care of their physical and mental health or needs. It is a type of harm that is recognised within adult support and protection law, but is often misunderstood and therefore under reported.

A fall can be an indication of a new or worsening health problem and for some people it could represent a trigger that challenges their ability to live independently. Vibrant Communities, funded via the ICF, deliver the Invigor8 and Motiv8 element of the local falls prevention pathway. This is an exercise based programme designed to improve


Lean Health Programme

mobility, strength and balance helping to reduce the risk of falls. In January, 875 people were participating in these classes; 151 in the Southern locality, 577 in the Kilmarnock locality and 147 in the Northern locality.

Technology is recognised nationally as having a key role in supporting, identifying and responding to those at risk of falling. Locally, the Partnership's TEC Local Delivery Plan commits to utilising technology to minimise risk of falls, and we pro-actively explore falls data and target high-risk individuals with bespoke TEC solutions. An increasing number of people are being supported in community settings by basic community alarm packages, fall detectors, bed and chair occupancy sensors and other person-centred TEC while another group of people are also using online 'Smartcare' tools, aimed at falls prevention and information sharing.

10 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

Performance Measures

Indicator/s	Baseline	Progress	Status
Percentage of staff who say they would recommend their workplace as a good place to work (CSII-10) (NHS Ayrshire and Arran figure reported)	66% (2014)	62% (2015)	n/a
Percentage of personal carers who are qualified to SSSC (Scottish Social Services Council) standard (SPI30)	84.5% (2015/16)	82.4% (2015/16)	n/a
Average number of working days lost per WTE employees (local authority employees) (HSCP Scorecard; CHCS SIP; PCOHCR SIP; CHCJ SIP)	0.47 (March 2016)	0.77 (March 2017)	0.67
Percentage absence as at end of month (NHS employees) (HSCP Scorecard; CHCS SIP; PCOHCR SIP; CHCJ SIP)	5.5% (March 2016)	5.3 (March 2017)	4.0
Percentage of EAC staff completing EAGER (East Ayrshire General Employee Review) as at end of month (HSCP Scorecard; CHCS SIP; PCOHCR SIP; CHCJ SIP)	86% (March 2016)	66% (March 2017)	95%
Percentage of Personal Development Review (PDR) completed and signed-off by both parties at end of month for NHS employees (HSCP Scorecard; CHCS SIP; PCOHCR SIP; CHCJ SIP)	55% (March 2016)	50% (March 2017)	95%

NB: There is no 2016/17 update for performance against indicator 1.

Performance Assessment

Workforce engagement, participation, training and development continues to be at the centre of our plans. We have arrangements in place to address communication, engagement, wellbeing and health and safety as well as having policies in place to support maximum attendance.

Performance should be assessed on the totality of these activities.

Personal carers qualified to the Scottish Social Services Council (SSSC) standard stands at 82.4%.

The number of working days lost to the Partnership, relating to Council employees has increased to 0.77 days per WTE, which is outside expected performance levels. Similarly, absence performance for NHS employees continues to be above the levels we would wish to see. We are also seeing corresponding performance levels in relation to individual development activities in personal development plans linked to EAGER and to e-KSF PDPs.

IJB Decisions

In March 2017, IJB approved recommendations in relation to the Scottish Living Wage in respect of service users who commission services through Self Directed Services options 1 and 2 and directed the Director to implement the recommendations.

Practice Examples

We have developed our methods of communicating, creating a social media presence on Facebook and Twitter over the course of 2016/17, which has enabled the Partnership to reach and connect with employees, partners, community organisations and the public. A "Folk of East Ayrshire" feature has been developed together with care home providers, which has seen recordings being made with local residents sharing memories of growing up and living East Ayrshire. This increase in social media reach has also allowed our wider distribution network to share local campaigns such as, 'know where to turn to' and Eyecare Ayrshire and to circulate invitations and information about local events.

As Lead Partnership for Primary Care, we introduced a Development & Competency framework for Advanced Nurse Practitioners ("ANP") and launched the ANP Academy. These linked initiatives will significantly increase the number of nurses undergoing training in advanced practice and ensure they are an integral element of the GP based primary care team. A General Practice Workforce Plan has also been implemented to work towards GP workforce sustainability and provide support for practices where there are particular workforce challenges.

As part of the ongoing implementation of the Partnership's Workforce Development Plan, the programme of "Getting to Know You" events has evolved into ongoing engagement being carried out by Partnership senior managers ranging from topic-specific development sessions to regular contribution to team meetings.

The Partnership has adopted iMatter, an online survey tool that will help its people, teams, managers and governance groups understand the extent to which employees feel motivated, supported and cared for at work. The results will inform team and organisational development plans across the Partnership from 2017/18.

As part of the Chief Social Work Officer Wellbeing Programme, staff participated in two events during 2016/17 on the practice of mindfulness. The first introduced staff to the practice while the latter highlighted that there is a growing evidence base about its effectiveness.

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

Performance Measures

Indicator/s	Baseline	Progress	Status
Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated (CSII-04)	84% (2013/14)	81% (2015/16)	n/a
Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency (CSII-19)	24% (2015/16)	25% (2016/17)	n/a
Expenditure on end of life care (CSII-22)	n/a	n/a	n/a

NB: There is no 2016/17 update for performance against indicator 1 above. At present, the spend on end of life care is not available.

Performance Assessment

These measures inform understanding of the availability of alternative, community-based services to prevent unnecessary admission to hospital and the associated use of resources. There has been a 1 percentage point increase in the amount of resource spent on hospital stays that were the result of an emergency admission, with performance at 25 per cent.

They also cover the effective co-ordination of support for people in their own homes. 81 per cent of adults (2015/16 position) report that their health and care services seem well co-ordinated, demonstrating positive performance.

At present, the spend on end of life care is not available. National work continues to confirm the data on end of life expenditure and work also continues at Partnership level on the back of this programme. Some provisional and unconfirmed information exists, based on a historical pattern of spend, that suggests the local spend on the last twelve months of life may be around £15,000 per person.

IJB Decision

In November 2016, the IJB noted and agreed the Financial Recovery Plan and directed the Chief Officer to continue discussions with the Council around the risks arising from the mitigating actions contained.

Practice Examples

During 2016/17, we began the redesign of the "front door" to community health and care services. A single multidisciplinary team of social workers, occupational therapists and support assistants based across two locations is now in place to have the initial conversation with people accessing services. The Front Door's approach is one focused on reablement, personal strengths and assets and utilising available community resources to provide appropriate support. To date, the impact of the redesign has been to provide a co-ordinated response to a request for support, enabling people to access appropriate supports in a seamless way.

As Lead Partnership for Out of Hours Community Response we have established a single business unit to see that Out of Hours Primary Care, Community Nursing and Social Work services are managed collectively:

The model was developed by engaging with local communities to understand what out of hours services should be, using service redesign workshops, surveys and "What Matters to You" methods to understand local peoples' views.

12 Our children and young people have the best start in life, are successful learners, confident individuals, effective contributors and responsible citizens, improved the life chances for children, young people and families at risk

Performance Measures

Indicator/s	Baseline	Progress	Status
Percentage of babies with a healthy birth-weight (SOA Wellbeing LO1-8)	89.6% (2014/15)	89.3% (2015/16)	90%
Estimated percentage of children with a healthy weight in Primary 1 (SOA Wellbeing LO1-6)	72% (2013/14)	76.1% (2015/16)	Increase
Looked after children in positive and sustained destinations (employment, training and education)	92.3% (2013/14)	71.4% (2014/15)	80%
Proportion of Child Protection re-registrations in-year (SPI45)	20.4% (2015/16)	14.6% (2016/17)	n/a
Percentage of reports submitted to the Scottish Children's Reporters Administration (SCRA) by due date (SPI46)	82.7% (2015/16)	82.2% (2016/17)	80%
Percentage of child protection decision making within standard timescales (CP1s completed within 10 days) (CHCJ SIP)	84.6% (2015/16)	73% (2016/17)	90%
Number of foster carers recruited (HSCP Scorecard; CHCJ SIP)	55 (March 2016)	60 (March 2017)	64

Performance Assessment

Measures reported in this section reflect the high-level priorities in the Partnership's Strategic Plan. They also refer to the Wellbeing and Economy and Skills Delivery Plans under the Community Plan 2015-30 and the refreshed Children and Young People's Service Plan 2017-20.

Performance continues to be positive on the percentage of reports submitted to the Scottish Children's Reporters Administration with over 80 per cent submitted to timescale. Similarly, there is good performance in the number of foster carers recruited in the last financial year.

Child Protection Register re-registration is an indicator of the management of risk. It is inappropriate to set targets on this given the complexity of factors involved. This data is monitored routinely and trends are analysed in detail. Fluctuations in performance in recent years have been attributed to larger family groups being appropriately re-registered.

In East Ayrshire there has been a focus on ensuring that child protection investigations and the child protection report (CP1) are completed within 10 days, with oversight by the Senior Manager (Localities). There is recognition that this is one of the most stressful experiences for children, their parents and carers and quick decision making is therefore important in order to ensure that children are kept safe. In 2016-17, 73.5% of all children subject to a child protection investigation had this investigation and assessment report completed within 10 days and 88% within 14 days. Those that were not concluded within these timescales involved a high degree of complexity.

Practice Examples

In 2016/17, the Children and Young People's Strategic Partnership ("CYPSP") developed a refreshed Children and Young People's Service Plan for 2017-2020 to adhere to new statutory guidance. The new plan contains up to date supporting data, resource and performance information and an early review in 2017/18 will provide an opportunity for joint reflection along with a review of the stretch aims and underpinning action plans. The CYPSP conducts robust self-evaluation, which has ensured the new plan is informed by a range of data, evidence and self-evaluation activity including; our multi-agency data compendium and health profiling tool, the results of our annual Wellbeing Survey and practice based self-evaluation activity including multi-agency file audits.

As at 31st March 2017, 400 children and young people were Looked After with 232 Looked After at home or in the community, 131 Looked After and Accommodated away from home in Foster Care, and 37 Looked After away from home in Children's Houses or residential care.

The new Corporate Parenting Action Plan 2016-18 continues commitment to our values, principles, standards from the previous strategy. The action plan sets out that Looked After children and care leavers have the right to expect that we will provide them with everything a good parent would provide in order to ensure they reach their full potential and includes actions around: educational attainment for Looked After children and young people, further reduction of the time taken for placing children in alternative life-long permanent or adoptive families, further development of suitable provisions for children and young people who require to be accommodated and further support for care leavers to provide a range of suitable options including supported accommodation when they are ready to leave care.

We are progressing well towards full implementation of the new **Universal Health Visiting Pathway in Scotland: Pre Birth to Pre School**, which will be fully operational by March 2018. We have invested within the Health Visiting team and as a result each child in East Ayrshire will receive 12 home visits by a Health Visitor beginning with a visit in the antenatal period to identify any health concerns and promote bonding and attachment with parents.

The Family Nurse Partnership is in place across NHS Ayrshire and Arran and provides an evidence-based model of engagement between family nurses and vulnerable families which is being adapted to the Scottish context to better target vulnerable families, offer personalised support according to individual strengths and risks and plan to be more flexibly delivered across age ranges up to 24.

The 27-30 month review is part of the universal health programme delivered in Scotland, offered to children reaching the appropriate age. The aim is to ensure high uptake of the review to promote early identification and action to improve outcomes, to maximise, as expressed in guidance, the 'promotion of strong early child development'. For East Ayrshire in 2014/15, 68.5 per cent of reviews recorded identified no concerns about any aspect of the child's development. However, Speech, language & communication was the developmental domain where most concerns were identified. In this domain 15.5 per cent of children reviewed had a newly identified concern about their speech, language and communication and an additional 4 per cent had a known concern in this domain prior to their review.

In response to this, Communication Champions are in place in Early Childhood Centres to develop closer working relationships between Early Years practitioners and speech and language practitioners to better meet the needs of children and families with communication needs. Our innovative and successful service, Snappy Chats, provides early identification of speech and language support needs and parental strategies to facilitate language skills.

Snappy Chats is a group supported by Speech and Language Therapy which informally screens children who may require additional support. Snappy Chats was developed in recognition of speech, language and communication concerns found at the 27-30 month assessment. Health visitors invite parents of children with concerns to attend an informal session. Parents are supported to develop early language strategies to facilitate their child's speech, language and communication skills. Snappy Chats provides early access to specialist advice in an informal setting. The aim is to prevent later formal referral and self-management but also to develop early identification of children who may require more in-depth assessment and support.

Balanceability, Kay Park

13 Community safety and public protection, reduction of re-offending, social inclusion to support desistance from offending

Performance Measures

Indicator/s	Baseline	Progress	Status
Percentage of Social Enquiry Reports submitted to Court by due date (SPI32)	98.5% (2015/16)	98.5 (2016/17)	95%
Community Payback Orders with a requirement of unpaid work starting within one week (SOA Wellbeing LO3.4-2)	90% (2015/16)	89.9% (2015/16)	80%
Reconviction rate of offenders: Ayrshire (SOA Safer Communities)	28.7% (2013/14)	30.7% (2014/15)	Reduce

Performance Assessment

The measures reported here continue to show positive performance for criminal justice social work services within the Health and Social Care Partnership in relation to the submission of reports to Court to timescale with a performance of 98.5 per cent for 2016/17.

Performance also shows a slight dip in performance in relation to Community Payback Orders with a requirement of unpaid work starting within one week. This has been examined and compliance is often impacted by an individual's inability to attend within required timescales which is often influenced by external factors, for example imposition of custody, ill health, employment or an order being transferred into the authority out with the required dates for compliance.

Reconviction rates have increased slightly at 30.7 per cent. We continue to be engaged in pan-Ayrshire activity to support the local implementation of the national Community Justice Outcome, Performance and Improvement (OPI) Framework to improve how measures are reported against this outcome.

IJB Decisions

In March 2017, the IJB directed the Director to implement the Review of the Public Protection support arrangements within East Ayrshire and to report back at the IJB meeting on 31 August 2017. The review will include the Adult Protection Committee, Child Protection Committee, Alcohol and Drugs Partnership and Violence Against Women Partnership support arrangements.

Practice Examples

The Community Justice (Scotland) Act received Royal Assent on 21 March 2016 to implement the national re-design of community justice and locally, a pan-Ayrshire approach has been adopted.

In 2016/17, to inform the development of a pan-Ayrshire Community Justice Outcomes Improvement Plan ("CJOIP"), two Creative Justice events were held in partnership with Centrestage Communities at HMP Kilmarnock and Ardeer Community Centre on 19 and 20 October 2016. These events brought together 100 people involved in the justice system, including people in custody, service users and practitioners. These events sought to engage with people who had a history of offending to seek to better understand their experiences, challenges and hopes for the future. Both events were heavily driven by the assets of the people involved in the criminal justice system. Thereafter, an East Ayrshire Community Justice Planning meeting was held, involving a broad range of partners, to consider local arrangements for managing community justice priorities/ actions for East Ayrshire.

Beginnings, Belonging, Belief – A Community Justice Plan for Ayrshire 2017-18 was developed as a result and was published on 31 March 2017. A Community Justice Collaborative Network has been established in East Ayrshire to drive and support our contributions to the pan-Ayrshire plan.

During the reporting period, the East Ayrshire Violence Against Women Partnership ("EAVAWP"), agreed their Position Statement on Prostitution. The statement advocates a challenge demand approach, in line with that of the national Equally Safe strategy, and seeks endorsement from members' organisations to promote the position statement to all staff, making it clear that support for prostitution, in any form, is unacceptable. It has been recognised at national level by both Scottish Women's Aid and the national Violence Against Women Network.

The EAVAWP will now commission research to engage with local women who are involved in prostitution to gain an improved understanding of what is happening in their lives. It is expected this research will explore individual experiences of women and support us to develop clear responses to better support their safety and wellbeing. It is hoped this research will be progressed on a pan-Ayrshire basis and a final report prepared by the end of the year.

Violence Against Women Conference

14 Integration Joint Board- Governance and Decision Making

Table of Key Integration Joint Board Decisions 2016-17

Key Decisions	Date of Integration Joint Board
Integrated Care Fund (ICF) £2.470m ICF funding has been fully utilised in 2015/16. This includes expenditure against the **48 distinct projects** identified through the locality engagement process. To direct the Director of Health and Social Care, to arrange for the utilisation of slippage, including the Winter Plan Investments.	2 June 2016
The Integrated Joint Board approved the arrangements for providing **equipment and adaptations to support independent living** within East Ayrshire and directed the Chief Officer as follows. I. Direct the Chief Officer to arrange the extension of the Medequip Assistive Technology Contract for servicing and repair until a Pan Ayrshire framework is in operation; II. Direct the Chief Officer to test out the provision of adaptations through Self-Directed Support arrangements subject to audit and legal approval; III. Direct the Chief Officer to the transfer of £0.030m to Care & Repair to enable a single tenure approach to the provision of handrails across council stock and owner occupiers subject to a Service Level Agreement; IV. Direct the Chief Officer to further progress to further discussions with respect to provision of adaptations through a procured framework alongside Registered Social Landlords; V. Direct the Chief Officer to exploration of further engagement with Care & Repair with respect to their role as a Broker to facilitate provision of adaptations;	18 August 2016
Annual Performance Report for the Health and Social Care Partnership for the 2015/16 period was approved by IJB members and to Direct the Chief Officer to ensure that the final version of the Annual Performance Report is published online; Direct the Chief Officer to ensure that the final version of the Annual Performance Report is distributed to relevant stakeholders, including East Ayrshire Council, East Ayrshire Community Planning Partnership and NHS Ayrshire& Arran a detailed in paragraph 17; and; to Direct the Chief Officer to ensure that accessible versions of the Annual Performance Report are publicly disseminated.	18 August 2016
Following the approval of the IJB the audited Annual Accounts for 2015/16, Direct the Chief Finance Officer and Chief Auditor of the IJB to respond to actions 1 and 2 as outlined in Appendix IV Action Plan of the External Auditor's ISA 260 report.	18 August 2016

A **Financial Management Report** with the projected outturn position for East Ayrshire Health and Social Care Partnership for 2016/17 was agreed by IJB members and directed the Chief Officer as follows: I. Direct the Director of Health and Social Care to produce an overall recovery plan and associated analysis of risks to achieve financial balance in the current financial year; II. Direct the Director of Health and Social Care to produce a recovery plan and associated analysis of risks for the Lead Partnership Ayrshire Doctors on Call for consideration and approval by all three Ayrshire Integration Joint Boards.	28 September 2016
The IJB members proposed a future Development session on Telecare Strategy and e-health and directed the Director of Health and Social Care with developing a local action plan to implement the Strategy within an East Ayrshire context.	28 September 2016
The IJB noted and agreed the **Financial Recovery Plan** report directing the Chief Officer as follows: I. Direct the Director of Health and Social Care to continue discussions with East Ayrshire Council around the risks arising from mitigating actions to achieve financial balance in the Council delegated budget including the possibility of an additional non-recurring allocation of funding.	24 November 2016
The IJB approved **the projected outturn position for the East Ayrshire Health and Social Care Partnership for 2016/17**, including the Integrated Care Fund, based upon the current financial position as at 30 November 2016 (period 8) and directed the Director ensure progress continues towards the Recovery Plan , variances and cash releasing efficiencies.	25 January 2017
The IJB approved recommendations in relation to the **Scottish Living Wage** in respect of service users who commission services through Self Directed Services options 1 and 2 and directed the Director to implement the recommendations.	25 January 2017
The IJB approved and directed the Director to implement the plans for investment of the **Integrated Care Fund** (ICF) for 2017/18.	1st March 2017
Direct the Director of Health and Social Care to arrange for children and young people and social care contract **extensions to contracts with third sector providers,** and to remit to Cabinet for approval for the extension to contracts until 31 March 2018.	1st March 2017
The IJB directed the Director to implement the **Review of the Public Protection** support arrangements within East Ayrshire and to report back at the IJB meeting on 31 August 2017.	1st March 2017

The IJB approved the annual alterations to charges and contributions for **Social Care Services for the Financial Year 2017/18**;including the Health and Social Care Partnership Social Care Services Contributions and Charging Framework; and directed the Director to implement the approved rates paid for Social Care Services as detailed below; (i) the standard are at home rule to be paid from 1 May 2017 i (ii) the foster care payments; (iii) the fee increase in respect of the national foster and continuing care framework contract; (iv) the revised rates and fee award in respect of secure accommodation; (v) the fee negotiations continue to progress in respect of children's residential; (vi) the rates paid to Kinship Carer and Adoption Allowances; (vii) the payments made to Children and Young People.	1st March 2017

15 Financial Performance

IJBs are required to prepare financial statements in compliance with the Local Government (Scotland) Act 1973, Accounting Codes of Practice, Scottish Government Finance Circular 7/2014, and the Local Authority Accounts (Scotland) Regulations 2014, Integrated Resource Advisory Group (IRAG) guidance and Local Authority (Scotland) Accounts Advisory Committee (LASAAC) Additional Guidance for the Integration of Health and Social Care 2015/16.

Regulations and statutory provisions require the IJB or a relevant committee to consider unaudited accounts prior to the end of August following the close of the financial year. Subsequently, the independently audited accounts must be signed-off by the end of September and published by the end of October.

As part of our twice yearly reporting arrangement, Audited Accounts are presented to the Audit and Performance Committee in August each year for final approval and are then reported onwards to the IJB before submission to the Council and Health Board. The unaudited Annual Accounts were presented to the IJB on 14 June 2017 and to the IJB Audit and Performance Committee on 15 August 2017. The audited Annual Accounts were presented to and approved by the IJB on 31 August 2017.

The net cost of provision of services in 2016/17 was £210.765m. The net revenue expenditure represents the running costs of the IJB and indicates the significant size and complexity of the organisation.

The Approved Budget 2016/17 report presented to the IJB on 18 August 2016 outlined risks going forward into the 2016/17 financial year, particularly around the achievement of cash releasing efficiency savings against a backdrop of increasing demand for services. Demands highlighted in the report included demographic pressures and external factors such as increasing costs of medicines, as well as potential additional cost pressures from the introduction of the National Living Wage in respect of private and Third Sector service provision. Over the course of the 2016/17 financial year the Partnership mitigated these risks through ongoing monitoring and review, to manage the impact on resources in respect of increased demand and other unplanned activity.

A financial recovery plan was approved by the IJB on 24 November 2016. This recovery plan was required to mitigate the mid-year month 6 projected overspend of £2.643m and is a key requirement in terms of financial arrangements approved as part of the Integration Scheme. This £2.643m projected overspend comprised £0.880m on NHS managed services and £1.763m on Council managed services.

Financial Performance by Service

The following table highlights financial performance by Partnership service portfolio for 2016/17 (with corresponding figures for 2015/16):

Annual Estimate 2015/16 £m	Actual to 31/3/16 £m	Variance (Favourable) / Adverse £m	Service Division	Annual Estimate 2016/17 £m	Actual to 31/3/17 £m	Variance (Favourable) / Adverse £m
			Core Services			
15.813	16.396	0.583	Learning Disabilities	18.076	18.327	0.251
5.331	5.609	0.278	Mental Health	5.473	5.415	(0.058)
2.074	1.971	(0.103)	Addiction	1.867	1.839	(0.028)
0.406	0.406	0.000	Adult Support & Protection	0.375	0.375	0.000
36.041	36.152	0.111	Older People	37.477	38.113	0.636
2.380	2.324	(0.056)	Physical Disabilities	2.400	1.943	(0.457)
0.170	0.178	0.008	Sensory	0.179	0.163	(0.016)
4.846	4.958	0.112	Service Strategy	6.011	5.855	(0.156)
0.442	0.442	0.000	Transport	0.457	0.457	0.000
0.156	0.116	(0.040)	Health Improvement	0.222	0.222	0.000
4.072	4.161	0.089	Community Nursing	3.811	4.016	0.205
24.579	24.579	0.000	Prescribing	26.185	26.185	0.000
15.262	15.262	0.000	General Medical Services	15.440	15.115	(0.325)
2.470	2.470	0.000	Integrated Care Fund	2.470	2.470	0.000
114.041	**115.023**	**0.983**		**120.444**	**120.496**	**0.052**

Annual Estimate 2015/16 £m	Actual to 31/3/16 £m	Variance (Favourable) / Adverse £m	Service Division	Annual Estimate 2016/17 £m	Actual to 31/3/17 £m	Variance (Favourable) / Adverse £m
			Non District General Hospitals			
2.832	2.935	0.102	East Ayrshire Community Hospital	2.889	2.898	0.009
1.152	1.345	0.193	Kirklandside Hospital	1.189	1.194	0.005
3.984	**4.279**	**0.295**		**4.077**	**4.092**	**0.014**
			Lead Partnership Services			
0.256	0.256	0.000	Standby Services	0.243	0.243	0.000
64.406	64.223	(0.183)	Primary Care (incl. Dental)	65.054	65.054	0.000
2.986	2.930	(0.055)	Prison & Police Healthcare	2.827	2.806	(0.021)
1.224	1.224	0.000	War Pensioner	1.224	1.226	0.001
0.143	0.113	(0.031)	Other Lead Services	0.071	0.091	0.020
69.015	**68.746**	**(0.269)**		**69.419**	**69.419**	**0.000**

Annual Estimate 2015/16 £m	Actual to 31/3/16 £m	Variance (Favourable) / Adverse £m	Service Division	Annual Estimate 2016/17 £m	Actual to 31/3/17 £m	Variance (Favourable) / Adverse £m
			Children's Services			
17.166	16.579	(0.587)	Children & Families / Women's Services	18.447	17.828	(0.619)
4.934	4.112	(0.822)	Secure Accommodation / Outwith Placements	4.120	4.957	0.837
1.748	1.755	0.007	Justice Services	2.018	2.105	0.087
2.150	2.080	(0.070)	Health Visiting	2.182	2.271	0.089
25.998	**24.526**	**(1.472)**		**26.767**	**27.161**	**0.394**
			Funded Elements			
(2.009)	(2.003)	0.006	Justice Services Grant	(2.292)	(2.413)	(0.121)
(2.009)	**(2.003)**	**0.006**		**(2.292)**	**(2.413)**	**(0.121)**
			Additional Funding			
0.000	0.000	0.000	Non-recurring allocation of funds – EAC	0.658	0.000	(0.658)
0.000	**0.000**	**0.000**		**0.658**	**0.000**	**(0.658)**
211.029	**210.571**	**(0.458)**	**NET EXPENDITURE**	**219.073**	**218.755**	**(0.318)**
0.000	0.442	0.442	Underspend relating to EAC – retained by IJB	0.000	0.318	0.318
0.000	0.016	0.016	Underspend returned to NHS A & A	0.000	0.000	0.000
211.029	**211.029**	**0.000**	**TOTAL**	**219.073**	**219.073**	**0.000**

The following table is the Comprehensive Income and Expenditure Statement from the Audited Annual Accounts 2016/17:

	Gross Expenditure 2016/17 £m	Gross Income 2016/17 £m	Net Expenditure 2016/17 £m
Core Services	142.274	(1.994)	140.280
Non District General Hospitals	4.092	0.000	4.092
Children's / Justice Services	24.754	(0.006)	24.748
Lead Partnership Services	22.379	0.000	22.379
Set Aside	19.266	0.000	19.266
Cost of Services	**212.765**	**(2.000)**	**210.765**
East Ayrshire Council funding	0.000	(74.605)	(74.605)
NHS Ayrshire & Arran funding	0.000	(136.323)	(136.323)
Total Income	**0.000**	**(210.928)**	**(210.928)**
(Surplus) / Deficit on provision of services	**212.765**	**(212.928)**	**(0.163)**

The net cost of services highlighted in the Comprehensive Income and Expenditure Statement £210.765m is £7.990m less than the net expenditure figure highlighted in the financial performance by Partnership service table £218.755m. The £7.990m variance is represented by the following:

- Lead Partnership managed income from North and South Ayrshire IJBs relating to their respective shares of Primary Care costs;
- Lead Partnership managed services contributions to North and South Ayrshire IJBs for East Ayrshire's share of Specialist Mental Health Services and Allied Health Professional Services costs respectively; and
- Large Hospital Set Aside expenditure attributable to East Ayrshire IJB.

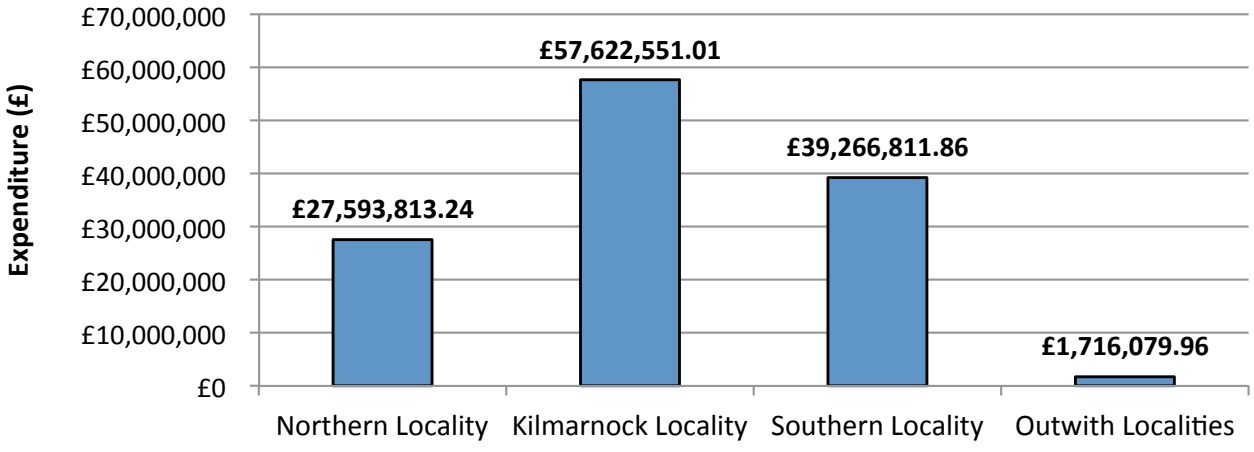
	Net Expenditure 2016/17 £m
Annual Accounts: cost of provision of services	210.765
Management Accounts: actual expenditure	218.755
Variance	**(7.990)**
Represented by:	
Lead Partnership income	(47.040)
Lead Partnership contributions	19.784
Large Hospital Set Aside	19.266
	(7.990)

Flu Jab for Council Employees

Financial Performance in Localities

The full details of locality arrangements are described in Section 20 of this report.

The table below highlights total expenditure by locality. This information is limited to those services where detailed activity data is available to accurately apportion costs by locality. Work is being undertaken to further refine activity data information to provide enhanced financial performance information at locality level in future years' Annual Performance Reports.



Please note: Out with Localities Expenditure represents expenditure in areas which are either; situated outside the geographical boundary of East Ayrshire or within East Ayrshire, post codes that are unrecognised by/misaligned with our localities data. General Medical Practices often provide primary care to populations across localities and expenditure has been apportioned by relative population size where this is the case.

[**KEY:** Expenditure by locality information refers to spend on service users aged 18+, comprising: Care at Home- total cost of all internal and commissioned, care at home hours delivered over 16/17 including the assistance of two. For commissioned services, account has been taken for the Scottish Living Wage rate change: April 16- Oct and Oct – Mar 17. Cost of overnight supports also included at the relevant rate. Care Homes: total cost of all weeks of care delivered over 16/17, net of personal contribution and accounting for stops and starts in service. Account has been taken for the Scottish Living Wage rate change: April 16- Oct, Oct- Mar 17, defined by person's home address prior to becoming resident. Day Opportunities- total cost for 16/17sessions/days, by person's home address, net of personal contribution. SDS Option 1- total cost for 16/17 of support packages delivered via Direct Payment, net of personal contribution. Account has been taken for the Scottish Living Wage rate change: April 16- Oct, Oct- Mar 17. SDS Option 2- total cost for 16/17 of support packages delivered via Option 2, net of personal contribution. Account has been taken for the Scottish Living Wage rate change: April 16- Oct, Oct- Mar 1. Community Alarms: total cost for 16/17 of community alarms, including provided in sheltered housing, by address, net of personal contribution. Community Meals: total cost for 16/17 for community meals, by address, net of personal contribution. GP Financial Activity- total 15/16 net spend per GP practice in East Ayrshire.]

Analysis of this range of Partnership services by locality shows the following per capita spend:

	Northern Locality	Kilmarnock Locality	Southern Locality
Total Spend (£)	£27,593,813.24	£57,622,551.01	£39,266,811.86
Adult Population	22,955	46,083	32,674
Spend per head (£)	£1,202.08	£1,250.41	£1,201.78

16 Best Value

A dynamic Transformation Strategy has been taken forward by East Ayrshire Council covering the period 2012-17. Work on Transformation Strategy 2 has commenced, informed by forecasts from the UK and Scottish Governments, the Office for Budget Responsibility and the Scottish Fiscal Commission. Transformation Strategy 2 will be taken forward in the context of continued austerity and the significant and tangible change factors shaping the next stage of the transformation journey over the coming five years. This was outlined in the Revenue Budget 2017/18 report to Cabinet on 22nd February 2017.

A programme of transformational redesign of services for older people and people with long term conditions commenced in 2016/17 across Ayrshire. Models of Care in East Ayrshire is a three year programme aiming to; avoid hospital admissions by developing multidisciplinary teams attached to GP practices and aligning practice and complex care to these arrangements and; reduce the time people spend in hospital by ensuring effective liaison between community based complex care teams and the acute Combined Assessment Unit(s) and delivering rehabilitation in a community setting.

A Review of East Ayrshire Intensive Support Service and Family Support Service was undertaken during 2016/17. This review found the Intensive Support Service and the Family Support Service to be highly valued supports with key strengths in building relationships and trust with vulnerable children, young people and families. The Intensive Support Service and Family Support Service were both found to be effective in supporting children, young people and families in the community, to be reunited or for young people to move toward independence as young adults. The services are viewed as providing critical intensive support at points of crisis and longer term support where required. The Review demonstrated high levels of satisfaction in relation to support from the services to improve outcomes across the SHANARRI indicators.

Children and young people value the strong relationships with team members and parents and carers report improvement in their parenting capacity as a result of engagement with the services. Individual feedback reported in the Review includes the following statement:

> "They made me the person I am. [ISS Worker] has always been there every time I need someone….I see them like my parents, I know I can go to them. They fill the gap"

In terms of the impact of the service, one participant in the Review stated:

> "they support me and help me feel I have a normal life"

The services were found to have a professional, skilled and experienced workforce with strong training and development opportunities. Improvement recommendations focused on contact for the Family Support Service, creative ways of engaging children and young people in progress reporting and review, considering the development of Service Standards, appraising options for efficiency through integration and business process improvement, further development of housing options, adding value through peer support, workforce development, and documenting and promoting the positive outcomes achieved through the work of the services.

In 2016/17 considerable progress has been made in taking forward the pan-Ayrshire Portfolio of Transformational Change. This programme reflects integrated services between Health and Social Care Partnerships and the NHS Acute Directorate and has been established in response to pressures on service configuration and delivery. The overall portfolio includes: older people and those with complex needs, mental health, unscheduled care, primary care - Ambitious for Ayrshire and planned care – Improving Access DoIT.

We established a Strategic Commissioning for Sustainable Outcomes Board to drive the delivery of transformational change at the required scale and pace and set the direction for our Strategic Plan 2018-21. Oversight is provided by the Audit and Performance Committee and the Strategic Planning Group will have a key role in engaging in and influencing the Strategic Commissioning for Sustainable Outcomes programme.

The approach to prioritisation will draw on good practice such as Cost Benefit Analysis (CBA), Social Return on Investment (SROI) and Programme Budgeting and Marginal Analysis (PBMA). This will inform investment and disinvestment decisions. National advice states that this approach will apply to the totality of delegated resources within Partnerships including 'set aside' hospital resources where there is a key planning role.

We have continued to implement the recommendations of the 2015/16 Best Value Service Review of Adaptations, to enhance the experience of East Ayrshire residents across housing tenures, when they need to access adaptations to their homes, to continue living as safely and independently as possible. There has been agreement to implement a single pan-Ayrshire Joint Equipment and Adaptations Service and accommodation has been identified as a base for the service's operation. Work continues to develop appropriate service delivery arrangements. Good progress is being made specifically in relation to integration of Occupational Therapy, which will bring staff together to provide effective multi-agency and multi-disciplinary team working and ensure that the number of contacts required by individuals who need to access an adaptation will be reduced. We have experienced delay with respect to our ability to effectively progress a number of the recommendations as a consequence of legislative, risk and VAT issues arising. Where this is the case, alternative solutions are being sought.

17 Inspection Findings

The Care Inspectorate undertook both scheduled and unscheduled inspections across a range of services during 2016/17. The overall quality of care is assessed as 'good' or better in 92.9% per cent of services for the reporting period.

A full list of Care Inspectorate inspection results for our registered services in2016/17 is shown in Appendix 1.

During 2016/17, we took part in the Care Inspectorate's programme of validated self-evaluation of Alcohol and Drug Partnerships (ADPs). The aim of the project was to provide an evidence-informed assessment of local implementation, measurement and quality assurance of ADP and service compliance with The Quality Principles: Standard Expectations of Care and Support in Drug & Alcohol Services. The evaluation report highlighted a number of strengths such as finding that the majority of individuals accessing services were made to feel welcome and valued from respectful and highly committed staff and identified areas for improvement including a need to improve recorded evidence of supervision and oversight to provide a clear picture of staff support and quality assurance activity.

18 Audit and Performance Committee

In 2016/17 the Audit and Performance Committee considered the Integration Joint Board audit reports from both East Ayrshire Council, Audit Scotland and PwC on behalf of NHS Ayrshire and Arran Board. The Committee considered and provided a view on the governance and assurance arrangements and performance reporting to the Integration Joint. The Committee received regular reports on Performance, Management and Financial arrangements including the Risk Register of the Integration Joint Board throughout the reporting period.

Matters considered by the Audit and Performance Committee during the reporting period included:

- Government advice on Strategic Commissioning Plans
- Government advice on Prioritisation Processes
- Performance Management
- Partnership Strategic Plan
- Partnership Service Improvement Plans
- Financial Recovery Plan

From March 2017, the Committee will receive reports from the Strategic Commissioning for Sustainable Outcomes Board to oversee the Financial Recovery Plan on behalf of the Integration Joint Board.

Aileen Campbell MSP visit to the
Alexander Fleming Centre

19 Audit and Performance Committee

The second Annual Review of the Strategic Plan 2015-18 has been completed, led by the Strategic Planning Group. The Review was undertaken, in line with the Partnership's Participation and Engagement Strategy, via a programme of stakeholder engagement shown in the table below:

EVENT PROGRAMME			
Date/time	**Event**	**Audience**	**Location**
24 August 2016	Locality Planning – Southern area	Stakeholders, employees, communities	Bellsbank Community Wing
31 August 2016	The BIG Plan Day	Stakeholder , IJB and SPG	Grand Hall Kilmarnock
22 September 2016	Joint Engagement Event EAC and CPP	Elected members and CPP Board	Council HQ
30 September 2016	Locality Planning – Southern area	Stakeholders, employees, communities	Cumnock Town Hall
6 October 2016	Third Sector Providers	Third Sector/PN/Providers	CVO - WG13, Kilmarnock
31 October 2016	Locality Planning – Kilmarnock area	Stakeholders, employees, communities	St Kentigerns Church , Kilmarnock
2 December 2016	Local Conversation	Joint Employee and third sector event	Grand Hall, Kilmarnock
6 December 2016	Locality Planning –Irvine Valley area	Stakeholders, employees, communities	Morton Hall, Newmilns

The Review found that the vision, values and priorities of the Partnership remain relevant and these were endorsed. People responding felt that outcomes should be kept 'at the top of the agenda' and that these are 'shared by all'. It was noted that there has been significant progress in delivery of integrated services while recognising an increasingly challenging operational context. Suggestions for doing things differently in this challenging financial context were sought. Two-thirds of respondents provided comment on this subject and these focused on having honest conversations about 'what can be provided with the resources available'. It was felt that the Partnership had been bold in this respect and that it is important that 'being open with communities about the challenges' continues.

The Review therefore makes specific reference to further necessary development of the Strategic Plan in 2017/18, strongly focussed on strategic commissioning for sustainable outcomes within constrained resources and working in partnership in Localities.

20 Localities

Over the course of 2016/17, localities have continued to be developed, building on the work of the previous year. Development of locality planning arrangements has been prioritised by the Community Planning Partnership as part of its approach to transformational change and the Partnership has worked as part of this broader agenda. At strategic level, localities mean a co-ordinated approach to multi-agency working on a geographical basis, aligned to aggregated Multi Member Wards.

The three East Ayrshire localities are:

- Northern Locality (Annick and Irvine Valley)
- Kilmarnock Locality
- Southern Locality (Ballochmyle, Cumnock and Doon Valley)

Operationally, localities will be the setting for partnership staff, primary care contractors, third and independent sector and community partners to make decisions and deliver service improvements. It is recognised that GPs are key contributors to achieving quality improvement and as such clusters of General Practices have been established and these align to localities.

The focus of recent months has been on engagement to identify and analyse needs, assets and priorities in these areas. Multi-agency implementation groups are operating in each locality to set up and progress work-plans to action the priorities identified and build local networks.

The local framework of Locality arrangements are illustrated in the diagram below

Northern Locality Annick (MMW1) Irvine Valley (MMW6)	**Kilmarnock Locality** Kilmarnock North (MMW2) Kilmarnock West & Crosshouse (MMW3) Kilmarnock East & Hurlford (MMW4) Kilmarnock South (MMW5)	**Southern Locality** Ballochmyle (MMW7) Cumnock & New Cumnock (MMW8) Doon Valley (MMW9)
GP Cluster 3 Stewarton Loudoun Galston	**GP Cluster 4** The Wards 31 Portland Road 34 Portland Road Glencairn Old Irvine Road London Road	**GP Cluster 1** Patna Dalmellington Drongan **GP Cluster 2** Auchinleck Ballochmyle Cumnock New Cumnock
Education Groups Stewarton Loudon	**Education Groups** James Hamilton Kilmarnock Grange St Josephs	**Education Groups** Auchinleck Cumnock Doon
Northern Planning Group	**Kilmarnock Planning Group**	**Southern Planning Group**

In addition to the findings of locality engagement, profiles of each locality's demography, health and wellbeing have been developed as the evidence base for decision making and service improvements.

"At a glance" infographic locality summaries are in place to supplement the information, which can be found in Appendix 2.

21 Lead Partnership Arrangements

Under the agreed Integration Scheme East Ayrshire Health and Social Care Partnership has Lead Partnership responsibility for Primary Care and Out of Hours Community Response. This lead responsibility relates to:

- Primary care;
- Medical practices;
- Community pharmacies;
- Optometry practices;
- Dental practices;
- Public Dental Service;
- Pan-Ayrshire Out of Hours (evening) nursing service;
- Ayrshire Doctors on Call (ADOC), and;
- Urgent Care Service (Formerly the Pan-Ayrshire Out of Hours Social Work Response Service).

'Primary Care' refers to the four independent contractors which provide the first point of contact for people with the NHS. These contractors are General Practitioners, Community Pharmacists, Optometrists and General Dental Practitioners. 'Out of Hours' refers to services provided beyond the common working pattern of 9.00 am to 5.00 pm and includes both Primary Care Health and Social Work out of hour's services.

As at April 2017, there are a total of 55 GP Practices across Ayrshire with a registered practice population of 385,007. There are 98 community pharmacy outlets and these provide 15 enhanced services to meet local needs. In addition, 64 dental practices offer general dental services (5 of which are orthodontic practices) and 57 optometry practices offer a range of optometry services across the area. Clinical Leadership arrangements are well-established across contractor groups.

The vision in Ayrshire and Arran is to have sustainable, safe, effective and person-centred Primary Care services. Multi-disciplinary team working is key to realising this vision, which will be delivered through a partnership between communities, Primary Care, Health and Social Care Partnerships and the Acute and Third Sectors. The main areas for change and development which were identified at the two "Ambition for Ayrshire" stakeholder events in 2015 were reviewed in light of the timescales and details outlined in a number of national and local strategic documents published in 2016/17. These documents include the Health and Social Care Delivery Plan 2016, the National Framework for Quality Improvement Clusters 2017 and also the Ayrshire and Arran Transformational Change Improvement Plan 2017. This review has resulted in a revision of the priorities for 2017/18 and a consolidation of the number of workstreams within the Primary Care Programme for 2017/18, reducing from 8 original workstreams to 6.

These workstreams, which are being taken forward through a pan Ayrshire and Arran Primary Care Programme include;

- Primary care at the heart of H&SCPs
- Increased capacity in community
- Investigate and address health inequalities

- Workforce and contingency planning
- Improve primary care infrastructure
- Integrated and sustainable out-of-hours services

Primary Care has continued to establish a strong focus on cluster-based and locality working during 2016-17. Each of the 4 East Ayrshire GP Clusters have implemented quality improvements in line with nationally defined areas as well as local priorities, including the co-ordination and standardisation of ACPs and a focus on identifying and intervening in at-risk diabetics.

As Lead Partnership for Out of Hours Community Response we have established a single business unit to see that Out of Hours Primary Care, Community Nursing and Social Work services are managed collectively. The model was developed by engaging with local communities to understand what out of hours services should be, using service redesign workshops, surveys and "What Matters to You" methods to understand local peoples' views.

Some of the improvement projects being taken forward through the Primary Care Transformation Fund are:

Pharmacy First

This initiative was introduced to further develop the pharmacy input to patient care both in and out of hours, decreasing the pressure on GP and other services both in and out of hours. This commenced with treatment for UTIs and impetigo which were conditions that were identified as using regular GP appointments.

Since February 2017, 79 of 98 pharmacies have at least one pharmacist trained to provide the service. Information on the service has been circulated to GP practices and pharmacies and GP practices are encouraged to discuss how best to utilise the service on a local basis. Plans are being put in place to publicise the service now that it is more widely available. The table below shows the number of prescriptions submitted to Practitioner Services for payment and indicates the level of use. This does not capture information on patients who may have been ineligible to access the medicine through the Patient Group Direction(s).

Service	Jan-17	Feb-17	Mar-17	Apr-17
Pharmacy First Trimethoprim	23	25	70	119
Pharmacy First Fusidic Acid	10	6	20	36

Eye Care Ayrshire

This project was taken forward to develop an improved patient care pathway for patients presenting with eye problems as well as to shift the balance of care from the GPs and local Emergency Department to the local Optometrist or Pharmacist to ensure the patient was seeing the most appropriate health professional.

Since March around 1700 eye drops and devices to support their administration were dispensed by Community Pharmacy under this service. Encouragingly the evaluation forms received so far have rated the service as excellent in most cases and very good in the others; no negative comments have been received. All community pharmacies have now signed up to participate in the scheme and only three optometry practices have not signed up as yet but work is ongoing to encourage them to do so. A full evaluation of the outcomes and benefits will commence in September 2017.

Pharmacists working directly in GP Practices

To date 16 practices have a General Practice Clinical Pharmacist working 5 half day sessions per week to assist GPs and utilise their skills fully. The remaining practices have a pharmacist working with them for at least one half day session per week. The majority of these pharmacists have qualified as independent prescribers or are currently undertaking this training.

The roles vary according to the identified needs of the practice and include patient facing clinical reviews. Those operating on the half day per week in practice are focused on polypharmacy within care homes and patients in their own home (mainly patients on 10 or more BNF meds > 65 years of age) and CRES work.

Musculoskeletal ("MSK")

This test of change was introduced to model physiotherapists being the first point of contact for assessment, diagnosis and initial management of MSK conditions in a GP Practice setting. One physiotherapist has been placed in each Health and Social Care Partnership area, working across nine GP Practices in total. It is hoped that patients requiring early interventions in acute MSK conditions will access the right person at the right time and this model, reduce the overall patient journey, increase GP capacity, reduce GP referrals to MSK, reduce the need for longer courses of physiotherapy treatment and use Secondary Care services.

From February – June 2017 47.9% of patients seen have been first point of contact consultations which equates to over 860 GP appointments.

A total 1798 patients have been assessed across the 9 sites with 1176 (71.66%) having been given the required tools to self-manage their condition. Early data suggests that in the practices where there is a Physiotherapist working there is reduced onward referral to MSK services. More detailed reports will be available on this as the roles become more established.

Other Lead Partnership Arrangements in Ayrshire

North Ayrshire Health and Social Care Partnership is the lead Partnership for Ayrshire for specialist and in-patient Mental Health Services as well as some Early Years Services. 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 Service, Children's Immunisation Team, Infant Feeding Service and Family Nurse Partnership. North Ayrshire Health and Social Care Partnership's 2016/17 Annual Performance report can be found here.

South Ayrshire Health and Social Care Partnership is the lead Partnership for Ayrshire for Allied Health Professionals, Continence, Technology Enabled Care, Joint Equipment Store, Falls Prevention and Sensory Impairment. In respect of Allied Health Professionals and the Joint Equipment Store, this responsibility extends to the Acute Sector. South Ayrshire Health and Social Care Partnership's 2016/17 Annual Performance report can be found here.

EA Carers Consultation Event

22 Service Improvements

Service Improvement Plans were established and implemented over the course of 2016/17. The key achievements in each of the Partnerships' service portfolios are:

Children's Health, Care and Justice:

- Implementation of a Development Programme for the CHCJ senior management team.
- Development of a joint reflective practice model for social work and health visiting staff.
- Review undertaken of recording and reflective practice guidance (across social work).
- A significant range of work has taken place in relation to the implementation of the 80/20 Vision to support service improvement and efficiency. This has included:
    - Kinship and child protection process mapping;
    - Working towards a culture change across Children & Families which reduces bureaucracy;
    - Team leads for 80:20 have been agreed and key areas of work identified;
    - Rationalisation of taxi forms undertaken and testing impact;
    - New review case conference form currently being tested.
- Eleven foster carers were successfully recruited in the last year.
- Whatriggs Road (supported accommodation for care experienced young people) became operational on 22 August 2016.
- Revised recording format for child's assessment and plan has gone live on SWIFT and is implemented across children's services.
- A process mapping event was delivered within the prison healthcare setting resulting in the implementation of a new methadone kardex to reduce errors and improve efficiency.
- Implementation of a new staffing design to ensure effective delivery of an increased range of healthcare services in HMP Kilmarnock.
- Health Visitors are now visiting at every point in the Universal Pathway. Scottish Government guidance is anticipated to be launched which will confirm content of the assessment.
- Nationally, the new model for school nursing has not yet been ratified but part of the implementation has commenced. Two central hubs have been established in Cumnock and Kilmarnock.
- Testing arrangements for implementation of the named person arrangements within the health visiting service are progressing well with discussions underway to establish a formalised process between Health Visiting and Early Years.
- Successful implementation of the extension of the MAPPA arrangements to include serious harm.

- A review of the Ayrshire justice social work service was undertaken by North Ayrshire which highlighted a range of considerations including looking at locality models to better support women and people affected by problem drug and alcohol use.

Community Health and Care:

- A future model for supported accommodation for adults has been developed in collaboration with local communities. Building on the success of Lily Hill Gardens in Kilmarnock, three further future builds in Hurlford, New Cumnock and Mauchline have been secured and form part of the Council's Strategic Housing Investment Plan 2017-2022.
- Maintained performance of zero delayed discharges, supporting people in a more homely setting.
- The Red Cross Home from Hospital service has been operating across Ayrshire from University Hospitals Ayr and Crosshouse since April 2016. In the service's first year, it supported over 1,700 people to be discharged from hospital as early as possible, reducing their length of stay. The service provides people with supported transport to their home and re-settling, such as helping to prevent falls and reduce social isolation, which enables the person to regain their confidence at home and organising telecare, which supports families and carers to continue to care. In addition to the reduction in length of hospital stay, 125 hospital admissions have been avoided, saving hospital services costs equivalent to 2,020 bed days.
- Developed plans for a community based step- down bed model to provide a more homely environment for Adults With Incapacity.
- Maintained performance against three week target for access to recovery-focussed alcohol and drugs services.
- Redesigning the adult health and care "front door" service to change our relationship with the public and ensure fair and effective use of resources. The new service involves people across a range of disciplines including; health and social work professionals, community connectors and community- based groups. It is focussed on the assets and strengths people have in their lives, enabling them to use or regain their skills for independent living using the most appropriate community based support or service.
- Completed the process to re-provide in-patient services in Kirklandside Hospital via extensive stakeholder engagement and obtaining Scottish Health Council feedback.
- Developed sustainable, patient-centred models of care in East Ayrshire Community Hospital.
- Implemented a step-up palliative care bed in partnership with a local GP cluster.
- Tested and evaluated self-referral processes to the Primary Care Mental Health Team for three GP practices. PCMHT work with and signpost to Vibrant Communities Community Connectors to facilitate access to the right support at the right time. Pathways have been developed between PCMHT and the NHS telephone based self-help service, Living Life.
- Delivered recovery festival with 80 participants.
- Established independent chair arrangements for the Alcohol and Drug Partnership and Adult Support and Protection Committee
- Continued to support 2 trainees in Addiction Worker Training Programme.

- Developed three HSCP localities (Northern, Southern and Kilmarnock) and established a programme of engagement around locality planning. Locality social work teams are aligned to these localities. Rehabilitation and enablement services will be the next priority for locality alignment. Organisational Development is supporting process, resource and patient journey mapping to inform alignment on District Nursing going forward. Multi-agency Implementation Groups have been established and first meetings have taken place.

- Contributed to the Pan Ayrshire Models of Care Business Case for older people, submitting to the NHS Chief Executive for approval. The East Ayrshire Business Case has been drafted pending approval of above and the local work programme has been developed containing actions to be progressed in 2017/18.

- Developed and delivered 2016/17 Winter Plan on behalf of Ayrshire and Arran.

- Established a discharge hub at Crosshouse Hospital to facilitate early as possible discharge, reduce length of stay and shift the balance of care to the community.

- Established a community supports and GP liaison meeting that is showing very positive outcomes and feedback and with a focus on prevention, long term conditions and mitigating for those people who are at high risk of admission to Acute setting.

- Established governance arrangements to take forward the recommendations of the Best Value review of adaptations and electronic scheduling systems in Care at Home

- Secured governance arrangements to ensure delivery of the Unscheduled Care Programme.

Primary Care and Out of Hours Community Response:

- A total of 11 GP Clusters were established across the three Ayrshire and Arran H&SCPs, with each GP practice identifying a Practice Quality Lead (PQL) and all GP clusters also nominating a Cluster Quality Lead (CQL).

- The first year of the 3 year Ayrshire and Arran Oral Health Action Plan was completed successfully and a pilot initiative to provide an oral surgery service in primary care was implemented. We will continue to deliver oral health improvement activity over the remaining 2 years of the Plan

- We successfully implemented six tests of change with a focus on enhancing multidisciplinary team working that were initiated with monies secured from the Primary Care Transformation Fund. These included;

- The Primary Care Mental Health Team introduced brief screening assessment appointments and telephone triage appointments in GP practices with the aim of reducing the number of GP clinical appointments for people seeking advice about their mental health.

- The Eyecare Ayrshire campaign was launched at an event in Crosshouse Hospital in January 2017 and the initiative went live in February 2017. Clinical Management Guidelines were also finalised with necessary approvals and a significant number of Optometry Practices and Community Pharmacies signed up to participate in the scheme.

- The PCTF Pharmacy First initiative, aimed at fully utilising and further developing the pharmacy input to patient care re: UTI and Impetigo (both in and out of hours) made significant progress in 2016-17. As at 1st April 2017 fifty eight pharmacies (of ninety eight in NHS Ayrshire & Arran) had at least one pharmacist trained to provide treatment for uncomplicated UTIs or impetigo.

- The Advanced Nurse Practitioner (ANP) Academy was launched in February 2017 with eight practices identified and initial contact with nurses and clinical supervisors completed. The aim of the ANP Academy is to increase the number of nurses undergoing training in advanced practice.
- Publication of report providing analysis of deprivation and resources verse need across Ayrshire and Arran.
- The Integrated Ayrshire Urgent Care Service has been established at Crosshouse Hospital bringing together all out of hours GPs, ANPs, Social Work, community alarm, out of hours district nursing, pharmacy and optometry in a co-located single point of contact
- Review of the GP Workforce Plan was undertaken and actions identified to support General Practitioner workforce sustainability.
- Implementation of a range of short and medium term supports to secure sustainability of GP practices in Ayrshire and Arran.
- Introduction of a range of initiatives to attract and retain GPs and enhance GP career development in Ayrshire and Arran including the setting up of a twitter account to promote GP vacancies, expansion of the Golden Hello scheme to all practices and the appointment of a GPwSI development post support work on GP recruitment.
- The Report on the Review of Primary Care Infrastructure/Community Premises was published and further work was commissioned to identify by geography the premises development required.

23 Looking Ahead

Service Improvement Plans are in place for implementation in 2017/18.

For **Children's Health, Care and Justice**, key areas for improvement action over the 2017/18 relevant to performance are:

- To recruit foster carers who can care for larger sibling groups and older children (a more targeted approach).
- To increase children's placement choice and capacity.
- To develop and implement the HMIP Improvement Action Plan for HMP Kilmarnock healthcare planning and delivery arrangements.
- To continue implementation of Universal pathway for health visiting.
- To contribute to the national review of school nursing, and implement local model within East Ayrshire.
- To implement the named person arrangements within the health visiting service - to test arrangements for information sharing – and implement.
- To implement improved performance reporting arrangements for permanency planning.
- To design and implement a practice improvement programme in respect of national standards and outcomes for Justice Services.

For **Community Health and Care**, improvement activity driving performance for 2017/18 centres on:

- Implementing the East Ayrshire Models of Care Programme Rehabilitation and Reablement themed workplans: continuing to redesign intermediate care at home services, modernising day hospitals and developing community based rehabilitation,
- Implementing the East Ayrshire Models of Care Programme End of Life Care theme workplan: carrying out a national palliative and end of life care pilot and reporting on findings,
- Establishing and implementing locality based multidisciplinary service delivery models,
- Continuing to oversee delivery of the Unscheduled Care Programme across Ayrshire.

In **Primary Care and Out of Hours Community Response** improvement activity associated with performance for 2017/18 is as follows:

- Maximising the recruitment and retention of GPs in Ayrshire and Arran
- Enabling GP Clusters to participate effectively in the locality planning process
- Broadening the range of clinicians in general medical practice
- Moving activity from GP and GP practices to other independent contractors and community resources
- Increasing number of GPs utilising Telehealth pathways and integrating Technology Enabled Care within multidisciplinary teams
- Support for the development of Anticipatory Care Plans (ACPs)
- Expanding the range of services available in community pharmacies
- Delivery of oral health improvement activity with a focus on prevention

Appendix 1: Care Inspectorate Inspections

Children's Health Care and Justice Registered Services Inspections

Service Name Address	Last Inspection	Quality Theme	Grade (1-6)	No. of Reqs	No. of Recs
Benrig Children's House Kilmarnock KA3 7RL	30/01/2017	Care & Support	4	0	0
		Environment	5		
		Staffing	5		
		Management & Leadership	5		
East Ayrshire Council Fostering Service Kilmarnock KA1 1HU	19/01/2017	Care & Support	5	0	0
		Environment	N/A		
		Staffing	5		
		Management & Leadership	4		
Montgomery Place Kilmarnock KA3 1JB	30/01/2017	Care & Support	5	0	0
		Environment	4		
		Staffing	5		
		Management & Leadership	5		
East Ayrshire Council - Adoption Service Kilmarnock KA1 1HW	05/01/2017	Care & Support	5	0	0
		Environment	N/A		
		Staffing	4		
		Management & Leadership	4		
Sunnyside House Cumnock KA18 2HU	05/04/2017	Care & Support	4	0	8
		Environment	4		
		Staffing	3		
		Management & Leadership	4		

Community Health and Care Registered Services Inspections

Service Name Address	Last Inspection	Quality Theme	Grade (1-6)	No. of Reqs	No. of Recs
Stewarton Day Care Kilmarnock KA3 5AB	10/01/2017	Care & Support	5	0	0
		Environment	5		
		Staffing	5		
		Management & Leadership	5		
Ellisland Day Care Mauchline KA5 6EB	17/06/2016	Care & Support	4	1	3
		Environment	5		
		Staffing	5		
		Management & Leadership	5		
Patna Day Service Ayr KA6 7LX	03/10/2016	Care & Support	5	0	0
		Environment	5		
		Staffing	5		
		Management & Leadership	5		
Irvine Valley Dementia Day Care Galston KA4 8DF	17/06/2016	Care & Support	4	0	4
		Environment	5		
		Staffing	4		
		Management & Leadership	4		
Ross Court Day Care Galston KA4 8DF	10/01/2017	Care & Support	5	0	0
		Environment	5		
		Staffing	5		
		Management & Leadership	5		
East Ayrshire Adult Placement Kilmarnock KA3 1HL	09/02/2017	Care & Support	6	0	0
		Environment	N/A		
		Staffing	6		
		Management & Leadership	5		

East Ayrshire Health and Social Care Partnership Care at Home and Housing Support Service (North Locality) Kilmarnock KA1 1HU	26/07/2016	Care & Support	5	0	1
		Environment	N/A		
		Staffing	5		
		Management & Leadership	4		
East Ayrshire Supported Carers Scheme Kilmarnock KA1 1HU	07/11/2016	Care & Support	5	0	0
		Environment	N/A		
		Staffing	5		
		Management & Leadership	5		
Community Reablement and Support Team North Kilmarnock KA3 1NQ	12/04/2017	Care & Support	4	0	0
		Environment	N/A		
		Staffing	4		
		Management & Leadership	4		
Community Reablement and Support Team - West Kilmarnock KA3 1NQ	21/04/2017	Care & Support	5	0	1
		Environment	N/A		
		Staffing	5		
		Management & Leadership	5		
Moving On Service Galston KA4 8DF	05/04/2017	Care & Support	5	0	3
		Environment	N/A		
		Staffing	4		
		Management & Leadership	4		
Berryknowe Service Auchinleck KA18 2EU	23/03/2017	Care & Support	4	0	6
		Environment	N/A		
		Staffing	4		
		Management & Leadership	4		

Appendix 2: Summary Locality Profiles

NORTHERN LOCALITY

POPULATION

The population of East Ayrshire is expected to remain fairly stable between now and 2030. Over the same time, there will be a large increase in the number of older people. Many parts of East Ayrshire are prosperous and it is a vibrant area in which to live and work, and to visit; however, inequalities continue to exist within and between our communities.

26,348
People live in the Northern Locality

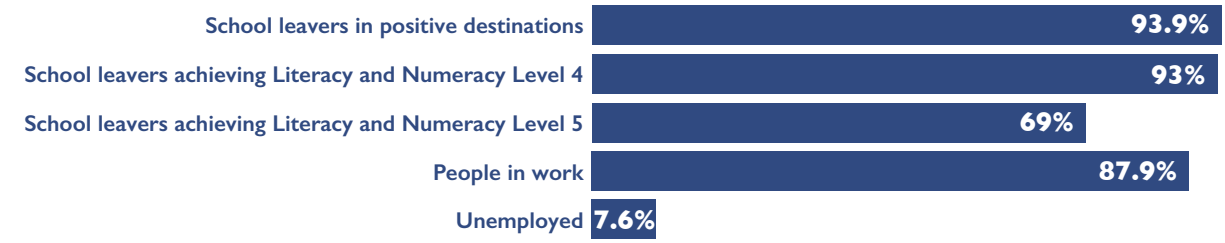
1 in 5 people are aged **65** or over

1 in 10 children live in povery

31%
There will be a significant increase in the number of older people by 2030

ECONOMY & SKILLS

A key driver underpinning future prosperity and the ability to realise the potential of our communities is a local economy which achieves sustainable growth. Delivering economic recovery and growth contributes to better outcomes for young and old, improved health, employment, inclusion, and safer and stronger communities.



SAFER COMMUNITIES

East Ayrshire is a safe place to live. Crimes of public disorder and violence have continued to reduce. We want to continue this downward trend and ensure that people feel safe in their homes and communities.

Fewer than 1 in 10 live in an area in the 0-15% most deprived areas in relation to crime

There were 10 fire casualties and fatalities in the Northern Locality in 2015/16

The rate of dwelling fires in the Northern Locality was notably lower than the rate recorded for East Ayrshire

Road traffic accident casualties are down from 27 to 20 over the last 10 years

WELLBEING

Positive health and wellbeing is at the heart of our Community Plan. We recognise the significant challenges in respect of the wellbeing of our communities and will work through our integrated health and social care arrangements to tackle these challenges.

1 in 5 mothers smoke during pregnancy

1 in 5 babies are breastfed at 6 - 8 weeks

1 in 10 P1 children are overweight or obese

1 in 6 people are prescribed drugs for anxiety or depression

Fewer people are admitted to hospital due to alcohol and drugs than in East Ayrshire

1 in 3 people have a long-term condition

KILMARNOCK LOCALITY

POPULATION

The population of East Ayrshire is expected to remain fairly stable between now and 2030. Over the same time, there will be a large increase in the number of older people. Many parts of East Ayrshire are prosperous and it is a vibrant area in which to live and work, and to visit; however, inequalities continue to exist within and between our communities.

56,033
People live in the Kilmarnock Locality

1 in 5 people are aged **65** or over

1 in 4 children live in povery

32%
There will be a significant increase in the number of older people by 2030

ECONOMY & SKILLS

A key driver underpinning future prosperity and the ability to realise the potential of our communities is a local economy which achieves sustainable growth. Delivering economic recovery and growth contributes to better outcomes for young and old, improved health, employment, inclusion, and safer and stronger communities.

SAFER COMMUNITIES

East Ayrshire is a safe place to live. Crimes of public disorder and violence have continued to reduce. We want to continue this downward trend and ensure that people feel safe in their homes and communities.

3 in 10 live in an area in the 0-15% most deprived areas in relation to crime

There were 15 fire casualties and fatalities in the Kilmarnock Locality in 2015/16

The rate of dwelling fires in the Kilmarnock Locality is considerably higher than the rate reported for East Ayrshire

Road traffic accident casualties are down from 67 to 27 over the last 10 years

WELLBEING

Positive health and wellbeing is at the heart of our Community Plan. We recognise the significant challenges in respect of the wellbeing of our communities and will work through our integrated health and social care arrangements to tackle these challenges.

1 in 4 mothers smoke during pregnancy

1 in 10 babies are breastfed at 6 - 8 weeks

1 in 10 P1 children are overweight or obese

1 in 5 people are prescribed drugs for anxiety or depression

More people are admitted to hospital due to alcohol and drugs than in East Ayrshire

1 in 3 people have a long-term condition

SOUTHERN LOCALITY

POPULATION

The population of East Ayrshire is expected to remain fairly stable between now and 2030. Over the same time, there will be a large increase in the number of older people. Many parts of East Ayrshire are prosperous and it is a vibrant area in which to live and work, and to visit; however, inequalities continue to exist within and between our communities.

39,679
People live in the Southern Locality

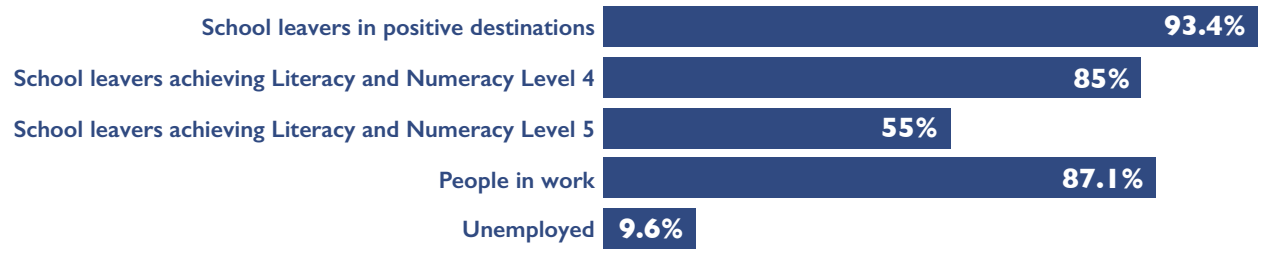
1 in 5 people are aged **65** or over

1 in 5 children live in povery

25%
There will be a significant increase in the number of older people by 2030

ECONOMY & SKILLS

A key driver underpinning future prosperity and the ability to realise the potential of our communities is a local economy which achieves sustainable growth. Delivering economic recovery and growth contributes to better outcomes for young and old, improved health, employment, inclusion, and safer and stronger communities.



SAFER COMMUNITIES

East Ayrshire is a safe place to live. Crimes of public disorder and violence have continued to reduce. We want to continue this downward trend and ensure that people feel safe in their homes and communities.

Fewer than 1 in 10 live in an area in the 0-15% most deprived areas in relation to crime

There were 8 fire casualties and fatalities in the Southern Locality in 2015/16

The rate of dwelling fires in the Southern Locality was notably lower than the rate reported for East Ayrshire

Road traffic accident casualties are down from 60 to 27 over the last 10 years

WELLBEING

Positive health and wellbeing is at the heart of our Community Plan. We recognise the significant challenges in respect of the wellbeing of our communities and will work through our integrated health and social care arrangements to tackle these challenges.

- **1 in 3** mothers smoke during pregnancy
- **1 in 5** people are prescribed drugs for anxiety or depression
- **1 in 10** babies are breastfed at 6 - 8 weeks
- More people are admitted to hospital due to alcohol and drugs than in East Ayrshire
- **1 in 10** P1 children are overweight or obese
- **1 in 3** people have a long-term condition