North Ayrshire Health and Social Care Partnership
Annual Performance Report 2016–17
Reflections from Stephen Brown

This is the North Ayrshire Health and Social Care Partnership’s second annual performance report. Contained within the following pages is the detail of how the Partnership is progressing and how we have performed in 2016/17 against a range of local and national indicators. Whilst there is still much to do, I think that overall we have performed well.

Crucially, we have woven through the report some real-life case studies. These are designed to highlight the direct impact of our services on the lives of individuals. We exist as a Partnership to improve the health and wellbeing of our service users, patients, carers and communities and simple percentages and numbers do not convey the difference we can make when we do things well.

In a challenging financial climate it can be difficult to balance the needs of our local population with the need to balance the books. The increasing demands on all of our services means we need to transform the way we deliver services to ensure they are sustainable into the future. This year, therefore, has seen a continued focus on prevention and earlier intervention. It has also seen us build on locality approaches to service design and working more closely with users of our services and the communities within which they live.

Just some of the highlights this year have included -

- Our Money Matters Team helped secure an additional £8.2 million pounds for the people of North Ayrshire in previously unclaimed benefits. This is an indication of the numbers of people reliant on benefits to survive but also an indictment of how complex the system is for people to claim what they are entitled to. With the impending impact of further Welfare Reform the introduction of Universal Credit in 2017/18 it will be vital to ensure we continue to support the most vulnerable in our communities to get their full benefit entitlement. The £8.2 million secured in 16/17 not only helps individuals and families but also brings much needed money to the local economy.

- Our initiative between the Scottish Ambulance Service and our Care at Home Community Alert Team in Irvine has produced significant results in reducing the number of older people being conveyed to hospital. Indeed in December 2016, when an ambulance was called, the initiative was able to support and assist 96% of callers to remain safely at home without the need for a trip to Crosshouse Hospital Emergency department.

- Alongside Community Planning Partners, we have reduced referrals to the Children’s Reporters by 46% through the setting up of a Multi-Agency Assessment and Screening Hub. We have seen a 21.7% reduction in domestic abuse incidents and a 12.9% reduction in crime across North Ayrshire.

- We held a Participatory Budgeting event for Mental Health and Wellbeing initiatives, attended by 250 people and disbursing £50,000 to community groups. We have extended the Community Connector role to 17 GP practices, extended Cafe Solace to three sites and launched a highly successful Carer’s Appreciation Card. We have seen a rise in the breast-feeding rates across North Ayrshire and a reduction in Childhood obesity rates.

- We launched our inaugural Staff Partnership Awards ceremony.

- In our Mental Health wards in the new Woodland View hospital we have witnessed reductions in the use of enhanced observations, a reduction in incidents of violence and aggression and an overall reduction in lengths of stay.

North Ayrshire Health and Social Care Partnership staff, our colleagues in the wider Community Planning Partnership and our communities have much to be proud of in what has been achieved to date. It is a privilege to work with such dedicated and passionate people who genuinely want to improve the delivery of health and care provision across North Ayrshire.

Stephen Brown
Interim Director, North Ayrshire Health and Social Care Partnership
People are able to look after and improve their own health and wellbeing and live in good health for longer.

Community Connectors in 17 GP Practices

Number of ORT referrals 2016: 67, 2017: 163

300+ People who took part in the Big Bike Revival

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.

80% of people who receive reablement service rate it as ‘Excellent’

Pilot project with Scottish Ambulance Service and Community Alarm

7,670 bed days saved

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

4745 people have attended Café Solace in 2016–17

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

Food Train

128 People with regular deliveries

26 Volunteers

Mental health participatory budgeting

42 projects awarded ££

Health and social care services contribute to reducing health inequalities.

Money Matters income generation for vulnerable people

45% businesses made changes to policy
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.

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

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

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.

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

Care at Home hours lost due to discharges being cancelled: 7,153hrs

98.5% of people referred to ICES are seen within 1 day.

Children’s Outcomes

94.7% 27–30 mth health reviews

In-house foster carers giving kids the best start in life: 100

Modern apprenticeships ring-fenced for care leavers: 5

Criminal Justice Unpaid Work sales raised £1000 for donation to good causes

Community Payback Orders level 1 93.3% completed within 3 months

12.9% reduction in crime in North Ayrshire

Launch of the first Carers Appreciation Card

Memory Cafés across North Ayrshire giving support to people with dementia and their carers

Using technology to keep people safe

Six Locality Planning Forum events took place

Breakfast for Champions Celebrating the hard work of staff and volunteers across the Partnership

North Ayrshire Health and Social Care Partnership Annual Report 2016-17
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Background

North Ayrshire Integration Joint Board (IJB) has been operational since April 2015; North Ayrshire Health and Social Care Partnership (NAHSCP/the Partnership) is working to progress the vision that:

“All people who live in North Ayrshire are able to have a safe, healthy and active life”

Our Partnership includes health and social care services within Health and Community Care, Mental Health and Learning Disability Services and Children, Families and Criminal Justice.

In this, our second annual performance report, we look back on the progress we have made, share some of our successes and reflect on some areas that have proved challenging.

To enable the Partnership to fulfil our vision, and after asking people who use our services, North Ayrshire residents and staff, North Ayrshire Health and Social Care Partnership will continue to focus on these five priorities:

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

People who use our services and North Ayrshire residents will experience our Partnership values in the way our staff and volunteers speak and how we behave:

Person centred, Respectful, Efficient, Caring, Inclusive, Honest, Innovative
Structure of this report

We have measured our performance in relation to:

- Scottish Government National Health and Wellbeing Outcomes
- Children’s and Criminal Justice Outcomes
- Local measures

North Ayrshire Health and Social Care Partnership has lead Partnership responsibilities for Mental Health Services, Learning Disability Assessment and Treatment Service as well as Child Health Services (including Immunisation, Infant Feeding and Family Nurse Partnership). We have included some of the highlights and a few of the challenges of leading services across Ayrshire’s three health and social care partnerships.

Our Locality Planning Forums continued to develop throughout 2016–17. We reflect on their progress so far and outline the areas they are going to focus on during 2017–18.

We will show that all of our services (those provided by our Partnership staff and those provided by other organisations on our behalf) are providing high quality care and support to the people of North Ayrshire.

Finally, 2016–17 has been another financially challenging year. We have detailed our financial position and shown how we have continued to provide best value for North Ayrshire health and social care services.
Our performance in relation to National Health and Wellbeing Outcomes

As we completed our second year, North Ayrshire Health and Social Care Partnership (NAHSCP/the Partnership) continued to focus our efforts on providing services that improve the lives of local people.

Our five strategic priorities link directly to the nine National Health and Wellbeing Outcomes. These outcomes provide a useful roadmap for us as we demonstrate our progress against them as outlined in this Annual Performance Report.

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

1.1 The Community Connectors pilot (started in 2015–16) was so successful that we expanded the service and now have Community Connectors in 17 out of 20 GP practices across North Ayrshire.

The Community Connectors continue to signpost people to a range of community and non-medical resources in their local area. In addition, a Macmillan Cancer Support Community Connector is now part of the team and works with people affected by cancer.

From the beginning of the pilot, GPs have referred significant numbers of people to the Community Connectors, and many of those referred have had repeat appointments with the Community Connectors. GPs are finding that having Community Connectors in their medical practice is having a positive impact and is enabling them more time to care for people with more complex conditions.

In addition, people attending GP practices can access CareNA (www.carena.org.uk), via touch-screen pods, for additional local information and resources.

Community Connectors

- **601 referrals**
- **1641 contacts**
1.2 We continue to develop our integrated addictions service. In 2016–17 we rolled out a new model of Opiate Replacement Therapy (ORT). Our new model works proactively with people, seeing them regularly to help them to reduce their methadone intake. We were able to offer 3,600 additional ORT appointments with over 3,000 being taken up by people who use our services.

‘It’s given me a lot of support and having me involved in decisions about my care is, I think, vital in my recovery.’

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<th>Year</th>
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<td>2013</td>
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Case Study

Sarah* is a young woman who was referred to the GP clinic for management of her ORT. She has long term health issues that were feeding her anxiety and low mood, both of which had proved to be triggers in her use of drugs.

Sarah’s health needs were assessed and dealt with appropriately at her GP practice. This allowed Sarah to focus on more deep rooted abuse and trauma problems that were making her physical complaints worse.

Perseverance, compassion and building of trust between herself, the addictions team and GP practice has led Sarah to transform her life. She is able to view her physical issues differently now.

Sarah is a changed person. She is able to leave the house, attend appointments on her own and takes care of her appearance. She has achieved this with the support of an addiction prescriber and her key worker. Sarah has stability and has transformed her life.
1.3 **On Yer Bike**

is a community project funded by our Integrated Care Fund (ICF) to encourage cycling as a way to promote fitness and wellbeing, changes in lifestyle and develop community cohesion. The project regularly runs cycling outings and offers cycle maintenance for families and young people.

The major cycling event of their year (October 2016) was as part of the Big Bike Revival. Over 300 people participated in various events including 10km bike ride, mountain bike events and health checks for people taking part.

1.4 **Healthy Active Rehabilitation Programme (HARP)** is an Integrated Care funded programme that provides health and wellbeing programmes for people with multiple conditions.

KA Leisure held regular sessions in local communities and during the first six months of 2016–17 they had 306 referrals (across Ayrshire). People benefited from the classes in various ways including finding their weight reducing, their blood pressure reducing and they had increased physical activity.
Outcome 2:

People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.

2.1 Care at Home has experienced a 30% increase in demand in 2016–17. This means waiting lists for Care at Home have increased and some people have been delayed in hospital longer than we would like. However, we have worked hard at continuing to provide a high quality service and our Care Inspection grades of 4s and 5s (maintained since 2015–16) reflect this (see page 53).

The total number of recorded visits by our Care at Home team, during 2016–17, was 1,514,166 – that’s an average of 4,148 home visits every day of the year.

2.2 Our Care at Home Reablement Service provides people with intensive support from occupational therapists and reablement care at home assistants for up to 12 weeks. This intensive support helps people to regain their skills and independence after an illness or a spell in hospital. Reablement is not suitable for everyone but for those that did receive this service, 45.5% either needed no further care support or had a greatly reduced care package. In 2016–17, 80% of people who received the reablement service rated it as ‘excellent’.

Case Study

Marie*, an 86 year old, was admitted to acute hospital in February 2017. She was very unwell with Chronic Obstructive Pulmonary Disease.

Prior to admission, Marie lived at home with her disabled husband and enjoyed relatively good health. Her recent illness left Marie extremely anxious and needing oxygen 24 hours a day. Marie was assessed as needing long term care and was transferred to Ward 2, Woodland View in March 2017.

While in Ward 2, Marie became able to spend short spells sitting up. She became less anxious and missed her husband. With support from Intermediate Care & Enablement Services (ICES), a plan was adopted to enable Marie’s discharge home. Her independence gradually increased and she started to do more for herself.

Community services put equipment into Marie’s home that enabled her to leave hospital. The respiratory nurse visited Marie while she was in Ward 2 and arranged for an oxygen concentrator to be delivered to Marie’s home. Marie was discharged home at the end of March 2017.

*Name changed
2.3 Our rehabilitation ward (Ward 1) in Woodland View Hospital continues to provide enablement and rehabilitation for people who are transferred in. Rehabilitation involves people receiving intensive sessions of physiotherapy, occupational therapy and specialist GP support. In 2016–17, Ward 1 rehabilitated 203 people back to their own homes or to a homely setting.

2.4 We started a pilot project in Irvine in 2015 where our Community Alarm team alongside Scottish Ambulance Service responded to 999 calls. From December 2015 to December 2016, 74.56% of people who called an ambulance via telecare remained in their own home with the support of Community Alarm carers. This pilot recorded 7,670 unrequired bed days in acute hospital.

On average a person admitted to an acute hospital ward will spend five days in hospital. A frail elderly adult is likely to spend 11.3 days in hospital.

This successful project is now going to be rolled out to other North Ayrshire localities with the aim of replicating the success achieved with the Irvine pilot.

2.5 The sale of the Red Cross House site, Irvine provided an unexpected opportunity to accelerate the plan for transforming community services for people with learning disabilities or mental ill-health. The footprint of the building lends itself to many uses and is being redesigned to provide:

- Learning disability day facility
- Tenancies (20 of) for people with complex learning disabilities who need planned and responsive 24/7 support
- Houses (6 of) for people with learning disabilities who face particular challenges
- Nine houses for community mental health rehabilitation for people who no longer require care in a hospital, however will benefit from extra support as they continue their recovery journey to regain skills and confidence to live independently.

The purchase and plans for the development of the site is a partnership venture between North Ayrshire Council, North Ayrshire Housing and NHS Ayrshire & Arran. Refurbishment will take place through 2018; the full site will be complete by March 2019.
Outcome 3:

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

3.1 ‘My Home Life’ is a UK wide initiative that promotes quality of life and delivers positive change in care settings for older people, and is supported by the University of the West of Scotland, Age Scotland and Scottish Care.

In 2016–17, the Partnership funded ‘My Home Life’ course in North Ayrshire. The course was attended by independent care home staff and NHS Ayrshire & Arran nurses. The course evaluated well, enhanced staff knowledge and skills and, most importantly, participants reported revised practices in their workplace that improved people’s care.

3.2 The Partnership funding of Recovery at Work’s (RaW) Café Solace continued in our second year. This enabled Café Solace to expand to a second venue in Irvine, opening on Tuesday evenings from September 2016. More people are making connections in their local communities with the opportunity to eat a nutritious meal for less than £3.

Café Solace is a community café run by volunteers as part of their recovery journey from drug and alcohol misuse.

This year 4,745 people have attended the cafés and RaW continues to have a dedicated pool of volunteers.

A further development into outside catering was successful and a third Café Solace opened in Kilbirnie in June 2017.

3.3 Staff at our Dirrans Centre started a group, Healthy U, to help people lead healthier, more active lives. People who attend Dirrans centre have long-term health conditions and found that support groups were not always easily accessible.

The Healthy U group runs exercise classes specially designed for people with physical disabilities and delivered by experienced staff trained in fitness. Healthy eating is encouraged with regular cooking sessions taking place in the centre. People feel encouraged and supported and the results and feedback speak for themselves.
A Palliative and End of Life Partnership Education sub group is being established. Members are from health, social work, local care homes and hospice, and Scottish Care. We are developing and providing modular training across North Ayrshire where people require palliative and end of life care. This work is in line with the Strategic Framework for Action on Palliative and End of Life Care.

The training aims are to:

- Better identify those who would benefit from Palliative Care
- Enhance the contribution of a wider range of staff, across sectors, who can provide Palliative Care
- Increase openness about death, dying and bereavement
- Increase recognition of wider sources of support within communities
- Ensure Palliative and End of Life Care is included in strategic plans, research activities and improvement support programmes
- Enable more people to die in their place of choosing

Abbotsford’s Enhanced End of Life (EEOL) Care facility, funded through the Integrated Care Fund, is now in its third year and continues to successfully provide a local setting for supporting people, and their circle of family and friends, who are at advanced end of life stages.

To date, this has focussed on people from the Three Towns and West Kilbride areas due to clinical support availability. Considerations are currently underway with regard to an arrangement that will provide clinical support to people from North Coast and Garnock Valley localities. Without this Enhanced End of Life service, people would otherwise have to be admitted to hospital or to hospice - both of these options are not local to North Ayrshire people.

The staff were very helpful and friendly

We would like to thank everyone for all their care and kindness you gave to my Dad, it was very much appreciated

Thank you for all your help and support - it went above and beyond
Outcome 4:
Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.

4.1 Our new multi-disciplinary Health and Therapy Team was set up in Brooksby Medical and Resource Centre, Largs in May 2016. The new way of working replaced the previous Day Hospital model. Changes included removing the age restriction of over 65, introducing of home visits and holistic assessments.

From July 2016 to October 2016, the Health and Therapy Team experienced a 40% increase in referrals, with 8% of referrals being signposted onto other services. There was a 50% increase in the number of people being assessed compared to the same period last year. More people are being seen at home rather than at Brooksby.

4.2 Songbook Group works with people involved with addiction services who are stable in their recovery and interested in creative song writing. The group has written and produced several original songs and have had their music showcased on WestSound Radio. Being part of this group has helped people by boosting their self-confidence and making them proud of their achievements.

4.3 KA Leisure runs the Invigor8 Falls Prevention Programme for older people. There are 12 classes offered each week across North Ayrshire and attendance is high.

During 2016–17, 212 people were referred to the programme and are benefiting from postural stability (PSI), strength and balance classes and strength and balance circuit based classes. Although referrals were very slightly lower than last year, the number of attendees at the classes increased to 5,583.
4.4 Food Train, funded by our Integrated Care Fund, provides grocery shopping and home delivery service to local people aged 65 and over across North Ayrshire. The Food Train volunteers help older adults by providing social contact and unpacking and putting away their shopping. Food Train volunteers also discretely monitor their vulnerable clients.

97 year old twins, Lottie* and Elsie*, were overjoyed when we delivered a bouquet of flowers to each of them to celebrate their birthday. We printed off photos and framed them; they were both so happy.

Lottie said to her twin, ‘Look at us Elsie, we’ll definitely make it to 100!’

Source: Food Train * Names changed

4.5 In February 2017, with match funding from Scottish Government, we held our first Participatory Budgeting (PB) event with a total of £50,000 for local projects to support mental health and wellbeing in North Ayrshire. We worked with partners across the Community Planning Partnership (CPP), as well as local volunteers with lived experience of mental ill-health to design and deliver, ‘Your Mental Health and Wellbeing: Your Money, You Decide’.

We received applications from local people and groups, with project proposals (up to £1250 maximum per project) ranging from drama to gardening to jogging, aimed at reducing social isolation, stress and anxiety and/or improving young people’s mental health. Over 80 applications were received and after screening, 48 projects were invited to present their proposals to the local community on Decision Day.

Over 250 local people attended Decision Day and voted on all the projects presented. 42 different projects were awarded sums of money and are now embarking on supporting people’s mental health and wellbeing. This was a very positive, community engagement event and was a great way of allowing small, impactful projects to make a difference and empowering communities to make decisions about their own services.
4.6 Funky Films was established by North Ayrshire Alcohol and Drug Partnership (NAADP) and is a group of people in recovery learning the skills of filmmaking and creating short films in their local community.

The group has completed a short filmmaking course and engaged in sessions, including setting up and operating film equipment, developing a storyline, shooting on location and an introduction to film editing.

Their first film *The Journey* highlights the participants own personal journeys from experiencing addiction to celebrating their recovery and everything that has brought to their lives. They have since worked on a second film, *Up to You*, which explores how people can prevent becoming involved with alcohol, drugs and knife crime.

Funky Films was the overall winner of North Ayrshire Provost’s Award 2016-17.
Outcome 5:

Health and social care services contribute to reducing health inequalities.

5.1 In our Strategic Plan 2015–18, we promised that we would work to help people deal with their financial difficulties and our Money Matters team has advised and supported the most vulnerable people in our communities to access more of the benefits they are entitled to.

We increased income in households across North Ayrshire by over £8 million during 2016–17.

5.2 In a first for Scotland, we worked closely with public bodies across Ayrshire to develop a set of shared Equality Outcomes. By working towards these outcomes, we will ensure that no one in Ayrshire will be limited in their opportunity on the basis of any protected characteristic they may possess: no one should face discrimination on the basis of their: age; gender; disability; sexual orientation; race; religion; or if they are a trans-person or pregnant.

Following extensive public engagement, four shared outcomes were identified:

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

Developing outcomes in partnership means we will have a more joined up approach to improving services for all and make Ayrshire a fairer and more equal place to live.

Following the development work and consultation, nine of the ten partners agreed to adopt the proposed equality outcomes. South Ayrshire Council has in place a 10-year equality outcome plan and are unable to officially adopt the shared outcomes. However, the aims identified in their 10-year plan are broadly similar to the collective shared outcomes.
5.3 In our previous Annual Performance Report we reported that we had been a key partner in developing the Community Planning Partnership (CPP) inequalities strategy, *Fair for All*.

We have continued to play a crucial role in developing this, including representation on the Fair for All Steering Group, as well as the Fair for All Expert Advisory Panel (which draws on expertise on inequalities from across the country). The Partnership has been able to influence and shape pledges across four thematic areas of; Health, Economy, Children and Environment. A fifth theme, Food, is being co-developed by the Partnership and the Council and involves a cross-sector group to consider food policy in North Ayrshire. We look forward to updating you on this work in our next Annual Report.

5.4 Our Sensory Impairment Team is a small, specialist team offering supports to people of all ages, including very young children who live with the loss of sight, hearing or both.

In 2016–17, the team had 522 referrals from many different sources including parents and neighbours as well as people with a sensory impairment themselves. The team helps people in many ways, including supply of specialist equipment, e.g. flashing doorbells, talking watch, canes and providing sign language support to people who need a translator. The team has two rehabilitation officers who support people who have recently developed a sensory impairment and works with them to find ways to regain their independence and have as full a life as possible with their impairment.

**Case Study**

*My name is Bill* and I have been working with a member of your team since approx March 2015.

I was registered blind on March 4 2015 after a period of ill-health. I was retired from work on medical retirement grounds, from a job that I loved, at the age of 59. I was always very active (cycling, scuba diving, motor cycle, swimming) and my whole world just came to an abrupt halt. Depression set in and I could not even think about going outdoors.

Unknown to me, a referral was made to your department and a home visit was scheduled for an assessment by Lynne*. This was the last thing I needed in my life. How very wrong I was.

Quite simply, Lynne has gave me my life back again and I can’t find the words to thank her enough. Her patience and professionalism has gave me the confidence to grab on to life again. I dread to think where I would be at this moment in time if Lynne hadn’t helped me to find a way ahead.

My wife and I were recently on holiday on a cruise ship and I had the confidence to move around the ship on my own, swim (something I thought would be impossible), I even learned to waltz, and I think that this was all down to Lynne and her help and support.

I am a serving member of the Childrens Hearing System in North Ayrshire, and even now, Lynne is working with them to acquire a reading aid to enable me to carry on with something that has kept me going these past months.

*Name changed*
5.5 Transforming Care After Treatment (TCAT) is a national partnership, between the Scottish Government, Macmillan Cancer Support, NHS Scotland, the Regional Cancer Networks, Social Work Scotland, COSLA, Local Authorities and the Third Sector, to support a redesign of care following active treatment of cancer. The aim of the programme is to support and enable people recovering from cancer to live as healthy a life as possible for as long as possible.

An Ayrshire-wide Employability TCAT Project, supporting people recovering from cancer to get back into work, was launched by North Ayrshire Health and Social Care Partnership and Macmillan Cancer Support, working with partners in the private, public and third sectors. The project provides positive assistance to support individuals to return to work and helps to develop a greater awareness amongst local businesses to provide supportive relationships with people affected by cancer, for mutual benefit.

There have been 15 seminars across Ayrshire in 2016–17, with 325 businesses engaging in the seminars. 70% of the businesses/organisations followed through and communicated the key messages with their staff, 45% made changes to policy and practices as a direct result of the seminar.

Thank you for organising and presenting a sensitive topic in a very positive and forward thinking manner.
Outcome 6:

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

6.1 NAHSCP introduced the first ever Carer Appreciation Card in Ayrshire: a first step to helping and appreciating our unpaid carers in North Ayrshire.

The idea of the card was sparked from our young carers looking for something to help identify and support them in schools or in health and wellbeing situations. So the young carers asked, and we delivered ... but ... we did not want to stop there. We wanted the card to be for all carers, no matter their age, situation or impact of their caring role.

The Partnership is continuing to build a caring community across North Ayrshire and wants to ensure carers of all ages are welcomed and supported in their localities. The card entitles all unpaid carers to discounts, offers and concessions at a growing range of local shops and businesses. The Partnership will continue to ask what matters to carers and what they enjoy in their community. The card is encouraging unknown carers to come forward and identify themselves in their caring role.

In the months from January to March 2017, 310 carers (24% of all those registered) have applied to receive their card and enjoy the benefits from 24 supportive local businesses.

6.2 Memory Cafés are an invaluable support to people living with dementia and to their carers.

We now have three Memory Cafés running regularly in Largs, Kilbirnie and Irvine. They are well attended and offer a cup of tea, some baking and a reassuring chat with people in similar circumstances. Advice and support is readily available at every café.

6.3 Anam Cara respite service offers respite breaks to people living with dementia. It is a homely setting that helps people living with dementia to feel relaxed and safe for their respite period and supports their carers by giving them a much need break. Anam Cara staff members work hard to make people feel at home.

I love coming to Anam Cara as it gives my daughter peace of mind when she’s on holiday as she worries about me but I always tell her not to, as coming to Anam Cara is like being home.
Outcome 7:
People who use health and social care services are safe from harm.

7.1 The Multi Agency Assessment Screening Hub (MAASH), was established in August 2016. This screening team is responsible for ensuring that Police Concern Reports, relating to domestic abuse incidents, adult concerns, child concerns, youth justice concerns, are immediately and effectively routed to the appropriate service to ensure improved outcomes for the people involved.

Before MAASH was established, North Ayrshire had the highest number of children referred to the Children’s Reporter. The vast majority of those referrals were returned as requiring no further action by the Children’s Reporter. During the pilot phase (August 2016–January 2017) MAASH generated 485 Children’s Reporter referrals. The new screening process is producing results as we experienced a 46% reduction in completed Children’s Reports (August 2015–January 2016).

MAASH will continue to develop and will incorporate adults concern referrals in 2017–18.

7.2 This is the third year in a row that the number of domestic abuse incidents in North Ayrshire has reduced.

One domestic abuse incident is one too many however this continued reduction in incidents highlights that we are beginning to make inroads into an issue that sees many victims and children live their lives in fear and trepidation.

The Partnership, working within our Multi-Agency Domestic Abuse Response Team (MADART) (Police Scotland, Housing, social workers and third sector organisations Women’s Aid and Assist), has helped to better support victims of domestic abuse and their children more effectively and timeously.

This team, alongside Criminal Justice Services (notably the Caledonia Programme working with perpetrators of domestic violence), has been a major contributor to reducing levels of domestic abuse. MADART now sits within the MAASH (see 7.1, above).

7.3 As a result of innovative ongoing Adult Support and Protection training to staff and volunteers across North Ayrshire, the breadth of agencies who can now refer any adult they have concerns for has been considerably widened during 2016–7.

During 2016–17, there were referrals for 635 Adults at Risk of Harm, of these 49 progressed to a formal Adult Support and Protection Investigation (under Scottish legislation). During the 12 month period, there was 96 Adult Support and Protection Case Conferences, putting in place and updating robust and creative, multi-agency Protection Plans to ensure all adults who require support and protection, have appropriate plans in place to support this.
7.4 In early 2016–17, we established a pan-Ayrshire Community Mental Health Triage pilot to review the number of people contacting Police Scotland where mental health support would be more appropriate. The pilot is part of the work funded through the Scottish Government’s Mental Health Innovation Fund.

In the 6 months of the pilot, 401 referrals were received and of these 47% could have been directly referred to mental health services rather than require an intervention from Police Scotland or the local emergency department. In December 2016 we opened up a direct referral pathway between Police Scotland and mental health services in the out-of-hours period as a result of the pilot.

7.5 Community Alarm and Telecare is equipment that is used in people’s own homes to connect them, through their telephone system, to an emergency call centre. The equipment can be as simple as a pendant with a button that can be pressed or as complex as the buddi tracking system to monitor people who are prone to wandering and getting lost. When an alarm is triggered, contact is made to the call centre and help can be sent out very quickly to make sure people are safe and well.

In 2016–17 we continued to expand our Community Alarm service. More people have the equipment and this is making them feel safer and helping them to stay in their own homes for longer.
Outcome 8:

People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.

8.1 Our Locality Planning Forums have been active in their first year. The forums held successful ‘Local Connections, Better Outcomes’ events where staff and organisations based in each locality came together to hear about the locality planning forum role and the locally identified priorities. In total, 370 staff from across the Partnership attended.

See Reporting on Localities (pages 37–41) for more information.

8.2 Our Partnership Staff Awards celebrated partnership working – the input, working together and contribution people make to North Ayrshire Health and Social Care Partnership. The ethos and values of the Partnership were reinforced not only in the award categories and mechanism but in the design of the awards event.

Around 80 nominations were received for the work of NAC, NHS, Third and Independent Sector individuals and teams and around 90 people attended the ‘Breakfast for Champions’ awards event. A key aim was to ensure the inclusion of staff members and teams who might not normally receive recognition in traditional approaches or other awards mechanisms.
8.3 Staff sickness absence in the Partnership continues to be a cause for concern. Our three highest causes of absence are musculoskeletal issues, stress/anxiety and surgery. We actively offer supports as early as possible and work with people to find solutions to help them get back to fitness and work as quickly as possible.

One of our Challenge Fund projects for 2017–18 will be to reduce sickness absence levels in the Partnership. (See page 56 for more information on the Challenge Fund.)

Case Study

Diane*, an unpaid carer who is registered with North Ayrshire Carers Centre, re-engaged at the beginning of this 2017 as her personal circumstances had changed considerably and she needed more intensive support from the Centre.

Diane is a lone parent caring for her teenage son, who is diabetic and suffers from coeliac disease, her daughter and her mother. Diane felt isolated, lacked adult company and, due to the level and impact of her caring role, only received income benefits to support her family.

Diane began attending an Outreach Support Group and accessing the Therapy Service to help reduce stress and promote relaxation. Through engagement with staff members who facilitated this group, Diane was offered a programme of support, including a place on a Stress Relief Programme and a course of counselling.

Diane wants to meet other adults, re-enter the job market and regain personal fitness, health and wellbeing. KA Carers Leisure Discount card was offered to her but unfortunately she could not afford the costs. Alternatively, she completed an application for a Creative Break from the Carers Centre and was awarded two years gym/leisure membership with KA Leisure.

*Name changed

As a result of this input, Diane felt able and confident enough to apply for a Masters Course, on a part-time basis. This gave her the flexibility to study, while allowing her to continue in her caring and parenting role. Her future is looking brighter and she is able to get time to herself. Diane is hoping to enter the job market when her son is older and more capable of self-managing his medical conditions.
Outcome 9:

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

9.1 Demand for Care at Home hours has increased throughout 2016-17.

However, there are also many hospital discharges that require Care at Home support, which then do not take place (for various reasons). We have continued to work with our colleagues in acute hospitals to try to reduce the number of cancelled discharges. Together, we still have a great deal of work to do: the hours lost due to discharges being cancelled in 2016-17 was:

7,153hrs lost due to discharges being cancelled

9.2 Our Intermediate Care and Enablement Service (ICES) support people to regain their independence by supporting them when they are either discharged from hospital, or in their own homes, to prevent admission to hospital.

This early intervention and prevention approach has saved people having to spend the equivalent of 4730 days in hospital in 2016-17, a further improvement on 2015-16.

ICES bed days saved

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Bed Days Saved</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015-16</td>
<td>3,082</td>
</tr>
<tr>
<td>2016-17</td>
<td>4,730</td>
</tr>
</tbody>
</table>

ICES aim to see newly referred people within 1 day of receiving the referral. For 2016-17 they achieved this for 98.5% of all cases. However, this had an impact on the number of rehabilitation sessions that were carried out. 1607 sessions were rescheduled where we evaluated that the person would continue to be safe and able to continue their rehabilitation through a rescheduled visit.
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.

There are 23 indicators (four of these are under development) that the Scottish Government uses to measure the nine National Health and Wellbeing Outcomes (as noted on pages 9–27). Nine of the 23 indicators come from the biennial Health and Social Care Experience Survey and the additional 14 indicators, which evidence the operation of NAHSCP, come from NHS Information Services Division (ISD).

The data reported below is based on the information circulated in June 2017.

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Adults able to look after their health very well or quite well</td>
<td>93%</td>
<td>93%</td>
<td>94%</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Adults supported at home who agreed that they are supported to live as independently as possible</td>
<td>80%</td>
<td>82%</td>
<td>84%</td>
<td>8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Adults supported at home who agreed that they had a say in how their help, care, or support was provided</td>
<td>80%</td>
<td>77%</td>
<td>79%</td>
<td>7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Adults supported at home who agreed that their health and social care services seemed to be well co-ordinated</td>
<td>79%</td>
<td>78%</td>
<td>75%</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Adults receiving any care or support who rated it as excellent or good</td>
<td>79%</td>
<td>79%</td>
<td>81%</td>
<td>7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. People with positive experience of the care provided by their GP practice</td>
<td>85%</td>
<td>84%</td>
<td>87%</td>
<td>6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life</td>
<td>80%</td>
<td>82%</td>
<td>84%</td>
<td>8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Carers who feel supported to continue in their caring role</td>
<td>39%</td>
<td>43%</td>
<td>41%</td>
<td>6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Adults supported at home who agreed they felt safe</td>
<td>79%</td>
<td>79%</td>
<td>84%</td>
<td>8</td>
<td></td>
<td></td>
<td></td>
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<td>---------------------------</td>
<td></td>
</tr>
<tr>
<td>1. Premature mortality rate. (Under 75s age-standardised death rates for all causes per 100,000 popn).</td>
<td>448</td>
<td>459</td>
<td>484</td>
<td>441</td>
<td></td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>2. Rate of Emergency Hospital Admissions for adults (per 100,000 popn)</td>
<td>15,089</td>
<td>15,851</td>
<td>15,866</td>
<td>16,249</td>
<td>12,037</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>3. Rate of emergency bed days for adults.</td>
<td>139,451</td>
<td>141,260</td>
<td>141,398</td>
<td>139,750</td>
<td>119,649</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>4. Readmissions to hospital within 28 days of discharge.</td>
<td>100</td>
<td>105</td>
<td>107</td>
<td>105</td>
<td>95</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>5. Proportion of last 6 months of life spent at home or in community setting.</td>
<td>87%</td>
<td>87%</td>
<td>88%</td>
<td>87%</td>
<td>88%</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>6. Falls rate per 1,000 population aged 65+</td>
<td>24</td>
<td>21</td>
<td>23</td>
<td>20</td>
<td>21</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>7. Percentage of adults with intensive needs receiving care at home (all levels of CAH)</td>
<td>64%</td>
<td>67%</td>
<td>67%</td>
<td></td>
<td>62%</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>8. Number of days people aged 75+ spend in hospital when they are ready to be discharged per 1000 population)</td>
<td>576</td>
<td>663</td>
<td>443</td>
<td>624</td>
<td>842</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>9. Proportion of care services graded ‘good’ (4) or better in Care Inspectorate Inspections</td>
<td>73.3%</td>
<td>73%</td>
<td>79%</td>
<td></td>
<td>83%</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>10. Percentage of total health and care spend on hospital stays where the patient was admitted in an emergency</td>
<td>26%</td>
<td>26%</td>
<td>26%</td>
<td>26%</td>
<td>23%</td>
<td>7</td>
<td></td>
</tr>
</tbody>
</table>

*To support service improvement, the Scottish Government has identified benchmarking families. The family groups are made up of local authorities that share similar social, demographic and economic characteristics. North Ayrshire is partnered in its family group with East Ayrshire, Dundee, Western Isles, Glasgow, Inverclyde, North Lanarkshire and West Dunbartonshire.

The Partnership also regularly reports on local indicators to help us to evidence the National Health and Wellbeing Outcomes and also our Strategic Priorities. See Appendix 1 (page 61).

Our performance in relation to three Children’s Outcomes and three Criminal Justice Outcomes

Outcome 1:
Our children have the best start in life and are ready to succeed.

1.1 Our Universal Early Years team, including health visitors, assistant nurse practitioners in parenting and nutrition and infant feeding nurse, work in partnership to support all mums in North Ayrshire. From ante-natal through to pre-school (54–60 months) our staff support new mums and babies in their own homes at regular, planned key health, wellbeing and infant developmental times, with breast feeding, weaning, safety and nutrition and play. This early intervention holistic approach is supportive of families and mums and, as reflected in the falling obesity rates within North Ayrshire, is giving children a healthy start in life.

1.2 All children should receive a 27–30 month review to make sure they are healthy and thriving.

Our health visitors carry out these reviews and, in the most recently published data, we achieved 94.7% of all children having their review carried out when it should be. This is a positive achievement for the Partnership and was ranked highest in Scotland.

1.3 Breastfeeding uptake in North Ayrshire is amongst the lowest in Scotland. However we are working to improve this and we are progressing in the right direction.

During 2015–16, 15.6% of all mums in North Ayrshire were recorded as breastfeeding at 6–8 weeks. The number of mums breastfeeding their babies has increased to 20.22% during 2016–17. This is an upward trend and we are continuing to work to increase the breastfeeding uptake year on year.
1.4 We recognise that to make a real difference to the long term health and wellbeing of the people of North Ayrshire we need to give our young people a good start in life.

To improve services and outcomes for children in the early years (those aged 0–5), we have developed locality based early years leadership teams. The teams will be working towards the vision for children in their early years as set out in the Children’s Services Plan, Getting it Right for You. They support the Partnership and partners to deliver on all the promises that were made.

The teams are made up of early years ‘leaders’ in each locality, including: health visitors, primary school head teachers, nursery managers and third sector representatives. They will identify the priorities for supporting children in the early years in each of the six localities and positively influence the shaping of services to improve the outcomes for young people.

1.5 Some children and young people cannot stay in their family home because it is not safe or they are not thriving there. When this happens, the Partnership’s foster carers step in and give the vulnerable young people a safe, welcoming home. Young people can stay with foster carers for a short time or for years, depending on the circumstances.

Our foster carers do a fantastic job and we will always welcome new foster carers who can provide a homely, safe place for young people. During 2016–17, we ran various recruitment campaigns and we now have 100 foster carers in North Ayrshire.
Outcome 2:
Our young people are successful learners, confident individuals, effective contributors and responsible citizens.

2.1 The Kids Aren’t Alright is a film about four young girls from Ayrshire dealing with difficult pasts with their families who have addiction issues.

The girls were involved in all aspects of the film, from scripting to casting. The film shows how they have turned their lives around and how each of them now has hope for their own future. The Kids Aren’t Alright has already caused a stir on social media.

2.2 Throughcare / Aftercare services support young people who were looked after, or accommodated by North Ayrshire Council, in all areas of employment, training opportunities, work experience opportunities and educational aspects of their lives to achieve what they want to in life.

We have a dedicated employability co-ordinator who supports young people with opportunities through Activity Agreements and with external employers offering Modern Apprenticeships and mainstream employment.

In partnership with Ayrshire College (Kilwinning campus), we created the Care Experienced, Corporate Parent event (October 2016). This was attended by 37 care experienced young people, who received certificates of participation in various aspects of employment, training and education that Throughcare / Aftercare Services support. For example, we have a young person gaining her HND in Hospitality; this is an example of a young person achieving and being supported by Throughcare / Aftercare Services and Ayrshire College.

I have been supported by Throughcare for about eight years. They have helped me through some tough times with my family and to get a house. They have also supported me with all my paperwork as I have dyslexia and very recently they helped me get a job in a care home.

Ms K

Mainly, just being able to pick up the phone and talk to you, when I had no one else and you were there
Outcome 3:
We have improved the life chances for children, young people and families at risk.

3.1 Family Nurses work with young mums (19 and under) and their families from early pregnancy until their children are two years old.

In September 2016, Irvine’s Gailes Hotel was packed with young mums and dads (and some grans too!) and lots of happy, noisy children, at the graduation of the first cohort from Ayrshire and Arran’s Family Nurse Partnership. Over 30 young mums had commitment to this programme and have been supported by a dedicated team of nurses.

3.2 Young people who have lived experience of care are sometimes furthest from the employment market.

North Ayrshire Council, in conjunction with the Partnership and Community Planning Partnership, has agreed to ring fencing five Modern Apprenticeships for care experienced young people (2017-18). This opportunity will give five young people a great start to improve their life chances.
3.3 The CHARLIE project helps young people ages 8 to 11 years who are living with parents dealing with substance misuse. It is a 30-week programme and its impact can be transformational.

Case Study

Craig*, aged 10, was living with his mum (who was drinking daily). Craig attended the CHARLIE programme for the full 30 weeks.

At the initial assessment Craig scored himself as 10 (plus) on the anxiety scale, suggesting he had a great deal of anxiety. He described ‘feeling lonely and horrible’ but stated that ‘nothing’ was making him anxious and told staff that he didn’t want or need help.

At his 3-month review, Craig was still living with mum and her drinking had increased. He scored his anxiety as 10 again, but with comments stating that, ‘the group has helped him to understand what is going on with mum and belly breathing (a technique utilised in mindfulness - part of the CHARLIE programme) has helped a bit.’ Craig advised the CHARLIE team that his anxiety was at a level where he didn’t feel safe within his home. He explained the pressure of looking after his mother and her inability to tell the truth to services. Taking Craig’s wishes into account, we recommended he should live with his father.

At his 6-month review, Craig scored himself as 1 (no anxiety) on the anxiety scale. He described, ‘being able to keep calm on my own by doing belly breathing and body scans’. He advised that he feels secure and loved with his father and wants to remain there. He stated in his evaluation that the group, ‘really helped him with his situation at home’. In particular, he cited peer support as a positive as ‘before I felt alone’.

Craig is now teaching mindfulness to his class and his confidence and mental health has improved dramatically. School advise that he is thriving in all aspects of the curriculum.

At the final 12 month review, Craig is sustaining the positive outcomes and he is continuing to utilise mindfulness to manage his emotions, in particular his anxiety.

He scored himself 3 on the scale (a slight increase) however with his imminent move to secondary school and growing into a teenager this increase can be viewed as a normal response to life. He stated that he ‘could be a lot more calm’ and ‘I learned how to talk to adults’. He felt he had changed a great deal: he was more active, listened too and less angry, hurt, worried, scared and felt happier, important and calmer. In addition he had improved his relationship with his parents and had a better understanding of his situation. He continues to miss everything about the group, adding that he would recommend it to other young people ‘because it really helped with the situation at home’.

*Name changed
Outcome 1:
Community safety and public protection

1.1 Our Criminal Justice Service continues to have a positive impact on the local community through the Community Payback Order (CPO) scheme. For the fourth year we have achieved continuous improvement with CPO level 1 and level 2 performing well above their targets.

This is despite the fact that North Ayrshire has the highest number of CPOs per 10,000 in Scotland, standing at 86.

People completing unpaid work are paying their debt to society by completing a wide variety of tasks that are needed in our local communities. We currently have almost 300 people of all ages and abilities completing unpaid work by doing gardening for the vulnerable and the elderly, house painting and heavy lifting when people are moving house.

The biggest role for the people completing unpaid work is supporting North Ayrshire Foodbank. They collect the food donations from supermarkets and Council buildings and take them to the Foodbank at Church of Nazarene, Ardrossan. They then carry out deliveries of the allocated food across North Ayrshire.

The sale days held at Smithstone House in Kilwinning are always a great success. The hanging baskets, garden accessories and furniture sold so well that £1000 could be donated to NHS Ayrshire & Arran’s Neonatal Unit and SANDS during 2016–17.
Outcome 2:
The reduction of re-offending

In our Strategic Plan we gave a commitment that our Criminal Justice and Youth Justice would work closer together to reduce reoffending.

Our prevention and early intervention approach is seeing continued positive results and recorded crime in North Ayrshire has reduced by 12.9% in 2016–17. This has partly been achieved by our continued improvement in our community payback service which for both level 1 and level 2 Community Payback Orders performed well above our regional targets.

Outcome 3:
Social inclusion to support desistance from offending

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

The Caledonian Women’s Service offers emotional and practical support to women, advice on safety planning, risk assessment and advocacy. By working in partnership with women, we aim to reduce their vulnerability and work with other services, like health, education, housing, social work, the police and the voluntary sector, to better support them and their family.

The main role of the children’s worker is to ensure that the Caledonian System upholds the rights of the child and that the child’s needs are met. The children’s worker is not the only worker who supports children’s needs, welfare and protection. The Caledonian System is a systems approach involving team and multi-agency working. It is everyone’s job to support and protect children involved.

In 2016–17, the team worked with 123 women across Ayrshire, offering a variety of services and support, from safety planning sessions to longer term interventions and support. The team currently has ongoing work with 98 women from North Ayrshire.
In our last Annual Performance Report we told you about the development of our six locality planning forums. These forums are the key link between the people in our communities and the Health and Social Care Partnership. The six localities are:

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

During 2016–17, the forums have spent time growing their profile and promoting the priorities they identified for their localities.

Throughout the year, each forum hosted an engagement event, ‘Local Connections, Better Outcomes’. Inviting staff and organisations based within each locality to come along, the forums identified three broad goals of the connection events:

- Outline the locality planning forum’s role
- Enable staff to get to know each other, build relationships and learn about the range of services (assets) available in the area
- Present the locality priority needs, gather staff feedback and explore possible contributions

Each forum decided upon the format of their own locality event, including:

- Market stalls with teams displaying information about the service they provide
- Round table discussions about locality health and social care priorities
- A combination of both market stalls and discussions
Overall, the events attracted 370 staff members from health and social care, third and independent sector organisations across North Ayrshire.

Feedback from the Local Connections, Better Outcomes events was positive and Partnership people fully endorsed each locality’s identified priorities. Of those surveyed following the event …

93% reported having gained knowledge of the work of the locality planning forums

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**Year 1 achievements**

*A word or two from our locality planning forums*
The Garnock Valley locality planning forum has had an interesting and informative year. The group has grown in size and variety of members and has learned a lot about the challenges facing the locality.

The initial steps were to identify priorities through discussion with stakeholders and since then each meeting has discussed one of the priorities with speakers from the different service areas. Developments have included changes to local mental health service provision and a new Garnock Valley Café Solace (see page 14) has been established, with further discussion planned about services for children and young people. The challenge will be to embed change and to continue to identify the priorities that are vital to the local area.

Following on from the identification of the local priorities, the group has been speaking to a variety of stakeholders and held a successful engagement event Local Connections, Better Outcomes, to ensure that these priorities were shared. This engagement will continue with public events planned during 2017.

Strong links have been created with the Community Planning Partnership (CPP) and an update was given to them on the various challenges facing people living in the Garnock Valley in relation to health and social care. We will work to build on our mechanisms for hearing the voices of our local residents.

Arran

The Arran Locality Planning Forum identified the following priorities:

- Reduce social isolation
- Develop transport solutions
- Improve support to those with complex care needs

It was agreed that these priorities had a strong link with the recently completed Arran Review of Service and any projects taken forward by the locality planning forum would tie in with the three priorities.

A befriending service is being set up to train befriender and provide support to those who identify as being socially isolated. The local lunch club is also hoping to extend their service.

A mapping exercise around transport was started. This will identify the current arrangements in place and describe the present situation.

There were further discussions around generic roles in relation to elderly people with co-morbidity issues. The story of an elderly island resident who has much experience with health and social care on Arran was given as an example. It was felt that multi-utilisation of staff across different service teams could be utilised to avoid duplication of visits.

The locality forum consulted with a wide range of health and social care partners at Local Connections, Better Outcomes. Partnership people were asked about each priority, about next steps and how they could contribute to priority success. There was a tremendous amount of interesting and useful feedback. This has been collated and will be used to contribute in taking work forward within the group and in collaboration with others.
The Kilwinning Locality Planning Forum has continued to develop its membership over the past year and now includes input from; a local pharmacist, a GP surgery practice manager, Education services, social work, Community Connectors, people who use our services and the third and independent sector.

Over the course of the year, we have made good progress against our identified priorities, we

- Have set up GP sessions in a local nursing home, proactively supporting elderly residents and reducing the need to attend surgeries and hospitals
- Are in the process of making Occupational Therapy advice available in a local pharmacy
- Have promoted early intervention through engagement with local parents in early years settings
- Held a successful staff engagement event, Local Connections, Better Outcomes

The forum has also engaged well with Housing services and now more clearly recognises the clear links between housing issues and their impact on health and wellbeing. A positive outcome from this engagement is improved links between Housing services, GP medical practice and Community Connectors.

The first year of the Irvine Locality Planning Forum was one of forming, storming and norming and we look forward to a year of performing.

Our Chair has taken the identified health and social care priorities to Irvine’s Community Planning Partnership (CPP) and these priorities are now reflected in Irvine’s CPP priorities.

A successful Local Connections, Better Outcomes event was held in November and attracted participation from staff members of local groups and organisations.

Perhaps our greatest challenge has been defining our purpose in relation to health and social care strategic planning and seeing how we can make a difference in the operational delivery of the priorities we have identified. We decided early on in the year that growing our forum membership was vital and that, alongside our feeding back to the Strategic Planning Group, the way we can start to address our priorities is through generating interest and participation from our communities in taking initiatives forward.
In our first year, we attracted a wide range of representatives from local organisations as members of the group. Members now include representatives from the Health and Social Care Partnership, the Third Sector Interface, the Ayrshire Community Trust and includes professions such as allied health professionals, psychiatrists, Community Connectors as well as people who use our services.

Using the wide range of knowledge and experience from the forum members – and available area profile information – we agreed the lead priorities we would focus on, namely:

- Social isolation
- Care at home for elderly residents
- Mental wellbeing of young men

The focus for our first year was to gain a better understanding of these issues and identify how services can be better shaped to address them. This work culminated in March 2017 with our Local Connections, Better Outcomes event, hosted in the heart of the Three Towns community. This was well attended by local health and care services. The participants widely endorsed the priorities of the forum and helped us prepare for the next stage of our work.
Change Programme

North Ayrshire’s Transformational Change Programme has had an exciting and challenging year in redesigning services, engaging with communities, improving mental health and developing new preventative approaches. The Transformational Change Programme uses the Integrated Care Fund developed by the Scottish Government to enable services, our key partners and stakeholders to be involved and change services to improve outcomes for the people of North Ayrshire.

In our communities we have:
- Designed and enabled a Participatory Budgeting session to enhance community support to improve mental health and wellbeing
- Provided funding to sustain third and independent projects such as Food Train, Café Solace, British Red Cross Home From Hospital
- Continued to provide funding to support TSI Development Workers who work in partnership to enhance Third Sector capacity

Children, Families and Criminal Justice Services have:
- Started work with the Tapestry Partnership to build effective teams around the child, including Education and other partners
- Worked to implement MAASH processes at Kilmarnock Police Station, which improve support and responses to children and adults who are identified as being at risk
- Implemented a prevention service to support women at risk of custody
- Worked with education colleagues to develop a business case for our new Additional Support Learning (ASL) school and our model for respite provision

Mental Health and Learning Disability Services have:
- Developed a business case, with a focus on prevention and early intervention, for an additional £800,000 recurrent funding. This was approved by Ayrshire & Arran Health Board
- Developed a business plan (approved by Ayrshire & Arran Health Board and North Ayrshire Council) for the refurbishment and redevelopment of Tarryholme Road building. This will provide housing tenancies, a supported accommodation model for people with mental health and learning disabilities. Community involvement will include access to the hydrotherapy pool for mothers and babies
- Opened Woodland View community mental health hospital which has enabled the development of a low secure forensic service, which provides support to Partnership areas across Scotland
Been identified as the preferred CAMHS National Forensic Centre – capital planning with Scottish Government has now commenced

Opened Veterans First Point service in Irvine to support our armed forces veterans

Undertaken stakeholder engagement with a wide range of stakeholders on the effectiveness of current Psychology Services as part of their wider service review

Begun a review of sleepover provision for people with learning disabilities to improve technical responses to allow people greater independence

Begun the review of Primary Care Mental Health Services, including the development and training of peer researchers

Health and Community Care have:

- Started to implement the Arran Services review findings including the co-location of staff and development of a single point of contact
- Rolled out the Community Connectors model and have undertaken an evaluation of its impact across the first six months
- Implemented a professional single point of contact for adults and older people to enable GPs and Allied Health Professionals (AHPs) to have speedier response for people at home
- Piloted a new HARP day services model that is being rolled out across North Ayrshire
- Developed an Ayrshire business case for older people and adults with complex needs
- Begun to explore the development of a See and Treat service for the Three Towns
- Begun a review of services on Cumbrae; findings will be available in September 2017

As we move ahead we will:

- Introduce mental health and wellbeing link workers to GP practices in the Irvine area from September 2017. This is a 12-month pilot
- Have Ayrshire business case for older people and adults with complex needs approved and implementation begin
- Begin building and refurbishment work on the building at Tarryholme Drive. Completion is scheduled for 2019
- Complete the review of Psychology Services and begin implementation of the findings
- Share the recommendations of the review of Primary Care Mental Health Services and begin implementation
- Develop a business case for Arran Services
- Full implementation of the CAMHS neurological pathway
- Deliver phase 3 of the Opiate Replacement Therapy (ORT)
- Develop a business case for Mental Health out of hours Psychiatric Liaison and Crisis Resolution Team that supports hospital emergency departments out of hours.
- Finalise the capital business case for the new CAMHs forensic unit for Scotland
Each Ayrshire Health and Social Care Partnership has lead responsibility for specific services across East, North and South Ayrshire.

North Ayrshire Health and Social Care Partnership has lead responsibility for Mental Health Services (including Psychology, CAMHS, Learning Disability Assessment and Treatment) and Child Health Services (including Child Immunisation, Infant Feeding and Family Nurse Partnership.)

East Ayrshire Health and Social Care Partnership has lead responsibility for Primary Care and Out of Hours Community Response, while South Ayrshire Health and Social Care Partnership has lead responsibility for Allied Health Professions (AHPs), Continence, Technology Enabled Care (TEC), Joint Equipment Store and Falls Prevention. Details of North Ayrshire’s performance in these services are available from East Ayrshire Health and Social Care Partnership (https://www.east-ayrshire.gov.uk/CouncilAndGovernment/About-the-Council/Information-and-statistics/CouncilPerformanceIndicators/Annualperformancereport.aspx) and South Ayrshire Health and Social Care Partnership http://www.south-ayrshire.gov.uk/performance/

Mental Health Services

In 2016–17 we saw the completion and successful transition of staff and patients to Woodland View, an award-winning state of the art community mental health hospital (including ECT treatment centre). Woodland View was positively reviewed by the Mental Welfare Commission during their review visits. People who experienced inpatient care in other hospitals have spoken of the benefits to their care experience at Woodland View as being ‘day and night’ (with regards to the standard of accommodation and access to outside space).

NHS Ayrshire & Arran was successful as the preferred bidder in their application to develop a new national Child and Adolescent Forensic Secure provision associated with Woodland View. The business case is ongoing and capital monies have been agreed for the new build accommodation.

A number of Community Mental Health services continue the process of aligning and joining together teams.

Primary Care Mental Health Teams (PCMHT) work with people who have mild to moderate mental health issues and offer up to a maximum of 12 sessions of treatment.

During 2016–17, Primary Care Mental Health teams across Ayrshire commenced 2,476 treatments.

<table>
<thead>
<tr>
<th></th>
<th>East</th>
<th>North</th>
<th>South</th>
</tr>
</thead>
<tbody>
<tr>
<td>CBT</td>
<td>57</td>
<td>67</td>
<td>120</td>
</tr>
<tr>
<td>Counselling</td>
<td>73</td>
<td>58</td>
<td>72</td>
</tr>
<tr>
<td>Nursing</td>
<td>218</td>
<td>380</td>
<td>402</td>
</tr>
<tr>
<td>Self Help Work</td>
<td>204</td>
<td>354</td>
<td>275</td>
</tr>
<tr>
<td>Group Therapy</td>
<td>86</td>
<td>42</td>
<td>68</td>
</tr>
<tr>
<td></td>
<td>638</td>
<td>901</td>
<td>937</td>
</tr>
</tbody>
</table>
Community Mental Health Teams (CMHT) work with people with more complex, lifelong conditions and treatment can be anywhere from 12 sessions and more.

These teams commenced 1927 treatments throughout 2016–17.

<table>
<thead>
<tr>
<th>Professional group</th>
<th>East</th>
<th>North</th>
<th>South</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPN</td>
<td>506</td>
<td>296</td>
<td>513</td>
</tr>
<tr>
<td>OT</td>
<td>116</td>
<td>73</td>
<td>118</td>
</tr>
<tr>
<td>Psychology</td>
<td>96</td>
<td>109</td>
<td>100</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>718</td>
<td>478</td>
<td>731</td>
</tr>
</tbody>
</table>

Child and Adolescent Mental Health Service (CAMHS) is a multidisciplinary service including psychiatry, psychology, nursing, speech and language therapy, occupational therapy and psychotherapy. Psychology and nursing work with young people with anxiety, depression, neurological presentations, eating disorders, psychosis, emotional instability, suicidal ideation and young people with high levels of risk. Young people with major mental health disorders are supported in conjunction with psychiatry. Occupational therapy focus mainly on functional assessment, intervention and risk management. Psychiatry will work with more complex presentations and higher risk cases along with medication reviews.

Within North, South and East Ayrshire there are dedicated CAMHS teams linking to local education, social work and health teams. CAMHS now meet the 18–week Referral to Treatment target but challenges still remain, including trying to develop alternative care models and achieving integration across agencies.

CAMHS commenced 92% of treatments within 2016–17, exceeding the service standard of 90%. At the end of March 2017, the pan-Ayrshire service had a waiting list of 348 children and young people. Of this, 20 (6%) had exceeded the desired 18–week maximum standard.

In 2016–17, the CAMHS teams have commenced 1,353 treatments.

<table>
<thead>
<tr>
<th>Professional group</th>
<th>East</th>
<th>North</th>
<th>South</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Psychiatry</td>
<td>19</td>
<td>30</td>
<td>11</td>
</tr>
<tr>
<td>Child Psychology</td>
<td>70</td>
<td>73</td>
<td>37</td>
</tr>
<tr>
<td>Child Psychotherapy</td>
<td>3</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>Nursing</td>
<td>360</td>
<td>331</td>
<td>375</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>14</td>
<td>8</td>
<td>11</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>466</td>
<td>453</td>
<td>434</td>
</tr>
</tbody>
</table>

Throughout 2016–17, Psychological Services commenced 74% of treatments and interventions (aggregated total of twelve specialist teams). This was under the HEAT target of 90%. Additionally, at the end of March 2017, Psychological Services across Ayrshire had a waiting list of 2,730 people (all ages), with 785 (29%) having already exceeded the 18–week maximum standard.

The Partnership is undertaking a full review of Ayrshire-wide Psychological Services to better understand the challenges and constraints and to improve the service provided.
Acute inpatient activity in 2016–17 resulted in 605 adults being admitted to acute wards. This is a reduction on 2015–16 and was due to the opening of Woodland View in June 2016, which meant fewer people could be admitted at that time of transition.

During 2016–17, 17 people were placed in acute facilities outwith Ayrshire.

The Inpatient Census for 2017 is the second follow up to the Mental Health & Learning Disability Inpatient Bed Census (first carried out October 2014). Census date was midnight 30 March 2017.

- Woodland View – 102 out of 146 beds occupied (70% occupancy rate)
- Ailsa Hospital – 64 out of 88 beds occupied (73% occupancy rate)
- Arrol Park – 13 out of 19 beds occupied (68% occupancy rate)
- Marchburn Ward (each) – 12 out of 20 beds occupied (60% occupancy rate)

Specialist acute admission mental health wards that serve Ayrshire are Wards 9, 10, 11 at Woodland View. Bed occupancy is a measure to understand demand and how efficiently the beds are utilised. The national average is 80%.

N.B. Woodland View opened in May 2016. The rates displayed show the remainder of 2016–17.
Enhanced observations should be used for patients who have been clinically assessed as being particularly vulnerable posing a significant safety risk to themselves or others.

During 2016–17, the average number of enhanced observation hours reduced significantly. Reduction in enhanced observation levels have been achieved through a variety of routes – increased familiarity with the environment at Woodland View, reduced stimulus environment, ability to offer time in safe outside space as a de-escalation technique, earlier review by doctor, anticipatory care plans that allow reduction in observation level at the earliest opportunity, pro-active approach to risk management and Ward 8 model of care. This has moved focus from ‘safety’ to ‘therapeutic intervention’.

Enhanced observations

The Liaison Service responds to referrals and requests to assist in the management of people with psychological, psychiatric and/or alcohol problems. The role of this service is to provide psychosocial assessment, advice on management and to act as the referring agent for psychiatric follow up, where appropriate.

Liaison referrals in 2016–17

1,544
Acute nursing Liaison

1,122
Alcohol Liaison

1,286
Psych Liaison
Arrol Park Resource Centre is a pan-Ayrshire 16–bed learning disability assessment and treatment facility in Ayr. Adults are admitted for periods of assessment and treatment (as required).

The Crisis Resolution Team (CRT) is a pan Ayrshire service, operational 24 hours a day 365 days per year. It delivers community based mental health assessment, care and treatment to the population and works in partnership with all mental health services. In the out of hours period CRT also works in partnership with the Ayrshire Unscheduled Care Service, NHS 24, Police Scotland and the two emergency departments at Ayr and Crosshouse hospitals.

The service provides mental health assessment, care and treatment in a timeous and effective way in line with the Milan principals and delivered to the person at the right time in the right place. CRT provides an alternative to acute inpatient psychiatric treatment where this is determined to be the best option.

Below are the data for 2016/17

**Core CRT Database**

<table>
<thead>
<tr>
<th>Area</th>
<th>Number of assessments</th>
<th>Number of subsequent visits</th>
<th>Psychiatric Admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Totals</strong></td>
<td>1305</td>
<td>2812</td>
<td>138</td>
</tr>
<tr>
<td>East</td>
<td>427</td>
<td>886</td>
<td>50</td>
</tr>
<tr>
<td>North</td>
<td>439</td>
<td>812</td>
<td>46</td>
</tr>
<tr>
<td>South</td>
<td>399</td>
<td>1120</td>
<td>37</td>
</tr>
<tr>
<td>Out of Area</td>
<td>40</td>
<td>0</td>
<td>5</td>
</tr>
</tbody>
</table>

From December 2016, CRT opened up a direct mental health triage and referral route to Police Scotland in the overnight period (22:00 to 06:00). This was based on the recommendations from the Police Triage Scoping Exercise completed in September 2016. In the 7 months since the direct referral route commenced:

<table>
<thead>
<tr>
<th>Area</th>
<th>Number of assessments</th>
<th>Admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>155</td>
<td>6</td>
</tr>
<tr>
<td>East</td>
<td>42</td>
<td>2</td>
</tr>
<tr>
<td>North</td>
<td>73</td>
<td>3</td>
</tr>
<tr>
<td>South</td>
<td>40</td>
<td>1</td>
</tr>
</tbody>
</table>

Veterans 1st Point (VIP) opened its doors on 17 February 2017 and received 60 referrals within the first six weeks. VIP acts as a signposting service helping veterans to access appropriate mainstream services and/or to point them in the right direction for specialist organisations. There is also a small in-house provision to see veterans for psychological assessment and evidence based psychological treatments.
Child Health Service

The Child Health Service is responsible for the comprehensive immunisation/screening/health review programmes and fail-safe aspects provided to the eligible population across Ayrshire and Arran. The Child Health Service is governed by Scottish Government legislation and protocols.

Children’s Immunisation Service provides the Ayrshire school based immunisations programme. The immunisations delivered are Human Papilloma Virus, Diptheria Tetanus & Polio, Meningitis ACWY and Measles, Mumps & Rubella. This programme is offered to 20,533 pupils between the cohorts of S1 to S6. The annual influenza vaccine is offered to 25,900 pupils from Primary 1 to 7.

75.25% Child Flu (Schools) uptake
96.21% MMR uptake
95.53% Rotovirus uptake

The Infant Feeding Service health visitors continue to promote, protect and support breastfeeding, referring to the community infant feeding nurse for support with more complex issues. Audit with mothers shows that the care provided is of a high standard and well received.

Work is ongoing across Ayrshire to increase the number of premises signed up to the ‘Breastfeed Happily Here’ scheme as well as delivering learning sessions in local primary and secondary schools. This work in schools will continue to expand as we refine the learning sessions and increase the number of schools involved. Breastfeeding rates remain low but with a commitment from the team we hope to continue to make improvements. (See breastfeeding performance, page 30.)

The Family Nurse Partnership (FNP) is now into its 4th year in Ayrshire and Arran and has proved to be a successful programme. The programme held its graduation of first cohort of mums (see page 33) and has successfully enrolled a second group.

Most young women who are offered the support of family nurses take part in the programme (acceptance rate is 93%, well above the 75% target). The programme aims to ensure positive attitudes to breastfeeding, increase uptake in immunisations, increase the number of children born at a healthy weight, and reduction in smoking during pregnancy.

The programme has been extended (as a pilot) to a group of slightly older women who have lived care experience. They have more complex needs and their supports are tailored to meet these needs. The pilot shows signs of being as successful as the main FNP programme.
Inspection of services

Independent care providers who provide care services on our behalf

The Partnership works closely with our independent care providers to ensure that the care and support provided is being delivered in line with peoples’ outcomes, offers best value, meets regulatory requirements and keeps people healthy, safe and well.

Working together, we ensure that all required standards of quality and safety are met (as part of our contract management framework).

After successful registration, we ensure providers maintain and improve their standards of care and support on an on-going basis. We cross reference with a range of other sources of information, for instance:

- Compliments, complaints and feedback – things we’re told by staff, carers and people who use services
- Information that we collect, before visits, from the provider or from our records
- Local and national information, for example, Care Inspectorate reports
- Visits to providers, which includes observing care and support and looking at records and documents

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

At regular meetings with independent care providers, we discuss what has been found during our visits. This includes what is working well and where specific areas could be improved, including any action the service provider needs to take immediately. The care provider will develop an action plan outlining how they will improve their services (if applicable). We will work with the provider to ensure the actions identified improve care and support, until we are satisfied that the service has made the necessary improvements to ensure the care, safety and wellbeing of people. Where services continually do not improve or we feel services are unsafe, we will take action, including increased monitoring activity, and in extreme circumstances, termination of the contract.

All our work with independent care providers ensures the best outcomes for people who use our services, and promotes safety and wellbeing.

The table opposite shows average Care Inspectorate grades (as at 30 April 2017) for North Ayrshire independent care providers.
<table>
<thead>
<tr>
<th>REGISTRATION TYPE</th>
<th>Number of services</th>
<th>Average grade: Quality of care and support</th>
<th>Average grade: Quality of environment</th>
<th>Average grade: Quality of environment</th>
<th>Average grade: Quality of management</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADULT PLACEMENT SERVICE</td>
<td>1</td>
<td>6</td>
<td>N/A</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>CARE HOME SERVICE</td>
<td>4</td>
<td>5.2</td>
<td>5.5</td>
<td>5.5</td>
<td>5.5</td>
</tr>
<tr>
<td>• Children and young people</td>
<td>10</td>
<td>4.7</td>
<td>4.3</td>
<td>4.6</td>
<td>4.7</td>
</tr>
<tr>
<td>• Learning disability</td>
<td>1</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>• Mental health</td>
<td>20</td>
<td>4.1</td>
<td>4.4</td>
<td>4.1</td>
<td>4</td>
</tr>
<tr>
<td>• Older people</td>
<td>1</td>
<td>5</td>
<td>N/A</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>HOUSING SUPPORT SERVICE</td>
<td>20</td>
<td>4.9</td>
<td>N/A</td>
<td>4.8</td>
<td>4.5</td>
</tr>
<tr>
<td>NURSE AGENCY</td>
<td>1</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>SCHOOL CARE ACCOMODATION SERVICE</td>
<td>6</td>
<td>5.1</td>
<td>5.1</td>
<td>4.8</td>
<td>5.1</td>
</tr>
<tr>
<td>• Residential Special School Support</td>
<td>26</td>
<td>4.4</td>
<td>5.5</td>
<td>4.4</td>
<td>4.5</td>
</tr>
<tr>
<td>CARE AT HOME</td>
<td>5</td>
<td>4.8</td>
<td>4.8</td>
<td>4.8</td>
<td>4.8</td>
</tr>
<tr>
<td>OTHER THAN CARE AT HOME</td>
<td>20</td>
<td>4.9</td>
<td>N/A</td>
<td>4.8</td>
<td>4.5</td>
</tr>
<tr>
<td>Average grades (all services)</td>
<td>4.6</td>
<td>4.7</td>
<td>4.5</td>
<td>4.6</td>
<td></td>
</tr>
</tbody>
</table>
## Care services provided by Partnership teams

The services that the Partnership provides also undergo inspection from the Care Inspectorate. In 2016–17, 16 internal services were inspected and the table below shows the care grades awarded.

### Children and family services

<table>
<thead>
<tr>
<th>Care Inspectorate Number/Inspection Date</th>
<th>Quality Theme = Care Grades (Out of 6)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Abbey Croft, Kilwinning</strong></td>
<td>Support = 5</td>
</tr>
<tr>
<td></td>
<td>Environment = N/A</td>
</tr>
<tr>
<td></td>
<td>Staffing = 5</td>
</tr>
<tr>
<td></td>
<td>Management = N/A</td>
</tr>
<tr>
<td><strong>Achnamara, Saltcoats</strong></td>
<td>Support = 4</td>
</tr>
<tr>
<td></td>
<td>Environment = N/A</td>
</tr>
<tr>
<td></td>
<td>Staffing = N/A</td>
</tr>
<tr>
<td></td>
<td>Management = 4</td>
</tr>
<tr>
<td><strong>Canmore, Kilwinning</strong></td>
<td>Support = 4</td>
</tr>
<tr>
<td></td>
<td>Environment = 4</td>
</tr>
<tr>
<td></td>
<td>Staffing = 3</td>
</tr>
<tr>
<td></td>
<td>Management = 3</td>
</tr>
<tr>
<td><strong>The Meadows, Irvine</strong></td>
<td>Support = 5</td>
</tr>
<tr>
<td></td>
<td>Environment = N/A</td>
</tr>
<tr>
<td></td>
<td>Staffing = N/A</td>
</tr>
<tr>
<td></td>
<td>Management = 5</td>
</tr>
<tr>
<td><strong>Mount View, Dreghorn</strong></td>
<td>Support = 5</td>
</tr>
<tr>
<td></td>
<td>Environment = 4</td>
</tr>
<tr>
<td></td>
<td>Staffing = 5</td>
</tr>
<tr>
<td></td>
<td>Management = 3</td>
</tr>
<tr>
<td><strong>Adoption Service</strong></td>
<td>Support = 5</td>
</tr>
<tr>
<td></td>
<td>Environment = N/A</td>
</tr>
<tr>
<td></td>
<td>Staffing = 5</td>
</tr>
<tr>
<td></td>
<td>Management = N/A</td>
</tr>
<tr>
<td><strong>Fostering Service</strong></td>
<td>Support = 5</td>
</tr>
<tr>
<td></td>
<td>Environment = N/A</td>
</tr>
<tr>
<td></td>
<td>Staffing = 5</td>
</tr>
<tr>
<td></td>
<td>Management = N/A</td>
</tr>
</tbody>
</table>

### Adult services

<table>
<thead>
<tr>
<th>Care Inspectorate Number/Inspection Date</th>
<th>Quality Theme = Care Grades (Out of 6)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Supported Carers Scheme</strong></td>
<td>Support = 6</td>
</tr>
<tr>
<td></td>
<td>Environment = N/A</td>
</tr>
<tr>
<td></td>
<td>Staffing = 5</td>
</tr>
<tr>
<td></td>
<td>Management = N/A</td>
</tr>
</tbody>
</table>
### Older people services

<table>
<thead>
<tr>
<th>CARE INSPECTORATE NUMBER/ INSPECTION DATE</th>
<th>QUALITY THEME = CARE GRADES (OUT OF 6)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Anam Cara, Kilbirnie</strong>&lt;br&gt;CS2008177877&lt;br&gt;31 Oct 2016</td>
<td>Support = 4&lt;br&gt;Environment = 5&lt;br&gt;Staffing = 4&lt;br&gt;Management = 4</td>
</tr>
<tr>
<td><strong>Dementia Support Services</strong>&lt;br&gt;CS2012306108&lt;br&gt;28 Jul 2016</td>
<td>Support = 4&lt;br&gt;Environment = N/A&lt;br&gt;Staffing = 5&lt;br&gt;Management = N/A</td>
</tr>
<tr>
<td><strong>Irvine &amp; Garnock Valley Care at Home</strong>&lt;br&gt;CS2008192553&lt;br&gt;30 Mar 2016</td>
<td>Support = 4&lt;br&gt;Environment = N/A&lt;br&gt;Staffing = 4&lt;br&gt;Management = N/A</td>
</tr>
<tr>
<td><strong>Montrose House, Arran</strong>&lt;br&gt;CS2003001167&lt;br&gt;15 Sep 2016</td>
<td>Support = 3&lt;br&gt;Environment = 5&lt;br&gt;Staffing = 3&lt;br&gt;Management = 3</td>
</tr>
<tr>
<td><strong>Montrose House, Arran</strong>&lt;br&gt;CS2003001167&lt;br&gt;15 Feb 2017</td>
<td>Review Visit</td>
</tr>
<tr>
<td><strong>Stevenson Day Care, Largs</strong>&lt;br&gt;CS2003034611&lt;br&gt;28 Jun 2016</td>
<td>Support = 4&lt;br&gt;Environment = 5&lt;br&gt;Staffing = 5&lt;br&gt;Management = N/A</td>
</tr>
<tr>
<td><strong>Stronach Day Service, Arran</strong>&lt;br&gt;CS2003034609&lt;br&gt;14 Sep 2016</td>
<td>Support = 4&lt;br&gt;Environment = N/A&lt;br&gt;Staffing = 4&lt;br&gt;Management = N/A</td>
</tr>
<tr>
<td><strong>Three Towns &amp; Arran Care at Home</strong>&lt;br&gt;CS2008192560&lt;br&gt;16 Mar 2017</td>
<td>Support = 4&lt;br&gt;Environment = N/A&lt;br&gt;Staffing = 4&lt;br&gt;Management = N/A</td>
</tr>
</tbody>
</table>

One of the Scottish Government’s suite of National Indicators is the proportion of care services graded as “good” (4) or above in Care Inspection Grades. As at 31 March 2017, 84.2% of North Ayrshire HSCP inspected services were graded 4 or above.

No other inspections, by other agencies, were carried out during 2016–17.
Financial information is part of our performance management framework, with regular reporting of financial performance to the Integration Joint Board (IJB). This section summarises the main elements of our financial performance for 2016–17.

**Partnership revenue expenditure 2016–17**

During 2016–17 the Partnership was forecasting a projected overspend of £5.351m, across a range of services, reflecting high levels of demand, the cost impact of staff absence on provision of services and the non-delivery of savings.

The IJB approved a recovery plan (9 March 2017) that resulted in a reduction in this overspend to £3.245m. The plan put in place to reduce this overspend included:

- Tighter absence management arrangements
- Developing waiting lists for services
- Applying eligibility criteria
- Securing additional funding from partners

<table>
<thead>
<tr>
<th>2015–16 Budget £000</th>
<th>2015–16 Actual £000</th>
<th>Variance (Fav) / Adv £000</th>
<th>2016–17 Budget £000</th>
<th>2016–17 Actual £000</th>
<th>Variance (Fav) / Adv £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>57,797</td>
<td>57,633</td>
<td>(164)</td>
<td>Health &amp; Community Care</td>
<td>59,664</td>
<td>60,982</td>
</tr>
<tr>
<td>67,714</td>
<td>67,864</td>
<td>150</td>
<td>Mental Health &amp; Learning Disability Services</td>
<td>69,752</td>
<td>70,544</td>
</tr>
<tr>
<td>29,348</td>
<td>31,079</td>
<td>1,731</td>
<td>Children, Families &amp; Criminal Justice Services</td>
<td>31,027</td>
<td>32,289</td>
</tr>
<tr>
<td>47,393</td>
<td>47,862</td>
<td>469</td>
<td>Primary Care</td>
<td>48,095</td>
<td>47,929</td>
</tr>
<tr>
<td>5,003</td>
<td>5,031</td>
<td>28</td>
<td>Management and support costs</td>
<td>4,825</td>
<td>5,038</td>
</tr>
<tr>
<td>3,168</td>
<td>3,133</td>
<td>(35)</td>
<td>Change Programme</td>
<td>3,458</td>
<td>3,284</td>
</tr>
<tr>
<td>435</td>
<td>365</td>
<td>(70)</td>
<td>Lead Partnership and set aside</td>
<td>200</td>
<td>200</td>
</tr>
<tr>
<td><strong>210,858</strong></td>
<td><strong>212,967</strong></td>
<td><strong>2,109</strong></td>
<td><strong>TOTAL EXPENDITURE</strong></td>
<td><strong>217,021</strong></td>
<td><strong>220,266</strong></td>
</tr>
<tr>
<td><strong>210,858</strong></td>
<td><strong>212,967</strong></td>
<td><strong>2,109</strong></td>
<td><strong>TOTAL INCOME</strong></td>
<td><strong>217,021</strong></td>
<td><strong>217,021</strong></td>
</tr>
<tr>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>NET EXPENDITURE</strong></td>
<td><strong>0</strong></td>
<td><strong>3,245</strong></td>
</tr>
</tbody>
</table>
The deficit of £3.245m is required to be recovered by the Partnership in future years.

Partnership services experienced continued demand growth, particularly in Community Care services for older people and in Children and Families services. This led to in-year overspends on commissioned services against the original approved 2016–17 funding.

Unachieved savings also contributed to the overspend, particularly within Mental Health and Learning Disability Services.
Financial outlook, risks and plans for the future

In December 2016, the Scottish Government published the Health and Social Care Delivery Plan. This sets out the programme for further enhancing health and social care services. Critical to this is shifting the balance of where care and support is delivered, from hospital to community care settings, and to individual homes when that is the best thing to do.

In March 2017, the IJB approved a Medium Term Financial Plan, which sets out the financial challenges facing the Partnership. The Medium Term Financial Plan will:

- Provide the financial context for the Partnership
- Inform current and future decisions including shifting the balance of care
- Outline a high level plan to start to bridge the financial gaps that have been identified

North Ayrshire Council, working with the Partnership, has established a Challenge Fund of £4m that will enable the Partnership to undertake transformation projects. The Challenge Fund will be used to pilot new ways of working that will seek to provide innovative services for the local community, within a community setting, while also ensuring each service is financially sustainable moving forward.

Significant challenges remain moving forward. Some of the most significant risks over the medium to longer term are:

- Impact of budgetary pressures on people who use services - pressures on funding could lead to people’s assessed needs being unmet, resulting in the Partnership being unable to fulfil its statutory duty.
- Infrastructure - delays in the implementation of an ICT Strategy leading to non-robust and inefficient information recording and sharing resulting in inefficient business models and duplication of effort.
- Culture and practice - failure to embed the appropriate culture, standards and positive behaviours of staff across the Partnership leading to failure in transforming the way we work resulting in not achieving the required transformational changes to move services forward.
- Delivery of the Change Programme - failure to join services together efficiently will result in an inefficient use of resources, lack of sustainability, provision of poor quality services for local people and a failure to have teams meet our Partnership values.
- Governance - failure to comply with governance requirements such as Freedom of Information, Complaints and other regulations laid down within the Public Bodies (Scotland) Act. This could lead to a breach of specific regulations resulting in enforcement action from governing bodies, adverse public reaction and/or prosecution.
- Procurement - failure to adequately plan for the procurement of services leading to a breakdown in the procurement process resulting in non-adherence to partner organisation Standing Orders, potential legal challenge, negative experience and uncertainty about achieving value for money.
Demography and inequality pressures - failure to adequately plan for and respond to changes in our population profile and in the levels of poverty in North Ayrshire will result in more people experiencing higher levels of physical and mental ill health, resulting in increasing demand on services, and an inability of services to provide adequate care.

These risks mean that money is tighter than ever before. It is therefore crucial that we focus on early intervention, prevention and recovery if we are to work within the total annual Partnership budget of over £200m.

Moving into 2017-18, we are working to proactively address the funding challenges presented while, at the same time, providing services for the residents of North Ayrshire.

Strong financial leadership will be required to ensure that future spend is contained within the budget resources available. A number of areas have been implemented or are programmed for delivery in 2017-18.

We have well established plans for the future, and the Strategic Plan was updated during 2016-17. A new 3-year plan will be available in April 2018. The plan sets out our ambitions and priorities and how we will work with our local communities and partners to achieve them.

The Strategic Plan links to the vision of the North Ayrshire Community Planning Partnership (CPP) and the Single Outcome Agreement and is underpinned by an annual action plan and performance indicators. Regular progress reports on the delivery of the Strategic Plan are provided to the Performance and Audit Committee and the IJB.
Best value

North Ayrshire Health and Social Care Partnership is responsible for ensuring that its business is conducted in accordance with the law and proper standards, and that public money is safeguarded and properly accounted for and used economically, efficiently and effectively.

The governance framework comprises the systems and processes, and culture and values by which the Partnership is directed and controlled and the activities through which it accounts to, engages with and leads the community. It enables the Partnership to monitor the achievement of its strategic objectives and to consider whether those objectives have led to the delivery of appropriate, cost-effective services.

There is evidence of transformation taking place at strategic and operational level within the Partnership.

We have begun to see some of the benefits of integrated system working, for example, in supporting older people to remain at home or get home from hospital as soon as possible.

Reporting on localities

The Partnership has Locality Planning Forums to consult with and involve local people in health and social care services. Initial work with the forums has identified local priorities for investment and service redesign that will be reflected in the Partnership’s Strategic Plan.

As outlined in ‘Localities Guidance’ (The Scottish Government, July 2015) we are required to work towards reporting financial information by locality. This is a complex task and will improve over future years.

2016–17 is the first year that financial information is split into localities. For this year, this was done by allocating spend that could be directly identified to a locality and the remainder, which was not locality specific, was allocated on a population basis. Per the table below 61.2% of spend was allocated based on population, which means, at this stage, that the spend per locality can only be used as a guide and will not fully reflect actual locality usage of services. Locality financial information will continued to be developed.

<table>
<thead>
<tr>
<th>Age group</th>
<th>Irvine</th>
<th>Kilwinning</th>
<th>Three Towns</th>
<th>Garnock Valley</th>
<th>North Coast</th>
<th>Arran</th>
<th>TOTAL</th>
<th>% of spend allocated on this basis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children age 0–15 years</td>
<td>30.7%</td>
<td>11.7%</td>
<td>23.8%</td>
<td>14.9%</td>
<td>16.3%</td>
<td>2.6%</td>
<td>100%</td>
<td>11.9%</td>
</tr>
<tr>
<td>Adults age 16–64 years</td>
<td>29.9%</td>
<td>11.4%</td>
<td>23.9%</td>
<td>15.1%</td>
<td>16.7%</td>
<td>2.9%</td>
<td>100%</td>
<td>19.5%</td>
</tr>
<tr>
<td>Older people aged 65+ years</td>
<td>25.4%</td>
<td>9.7%</td>
<td>21.6%</td>
<td>13.9%</td>
<td>24.1%</td>
<td>5.3%</td>
<td>100%</td>
<td>17.9%</td>
</tr>
<tr>
<td>Share of total population</td>
<td>29.1%</td>
<td>11.1%</td>
<td>23.4%</td>
<td>14.8%</td>
<td>18.1%</td>
<td>3.4%</td>
<td>100%</td>
<td>11.9%</td>
</tr>
<tr>
<td><strong>Total allocated on population basis</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>61.2%</strong></td>
</tr>
<tr>
<td>By locality</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>38.8%</strong></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>
This resulted in the following spend per locality:

<table>
<thead>
<tr>
<th></th>
<th>Irvine £000’s</th>
<th>Kilwinning £000’s</th>
<th>Three Towns £000’s</th>
<th>Garnock Valley £000’s</th>
<th>North Coast £000’s</th>
<th>Arran £000’s</th>
<th>TOTAL £000’s</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016–17 expenditure</td>
<td>64,569</td>
<td>21,672</td>
<td>54,361</td>
<td>31,865</td>
<td>37,609</td>
<td>10,190</td>
<td>220,266</td>
</tr>
<tr>
<td>% share of spend</td>
<td>29.3%</td>
<td>9.8%</td>
<td>24.7%</td>
<td>14.5%</td>
<td>17.1%</td>
<td>4.6%</td>
<td>100.0%</td>
</tr>
<tr>
<td>% of total population</td>
<td>29.1%</td>
<td>11.1%</td>
<td>23.4%</td>
<td>14.8%</td>
<td>18.1%</td>
<td>3.4%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

**Where to find more information**

If you would like more information on North Ayrshire Health and Social Care Partnership strategies, plans and policies and our performance and spending, please refer to:

- Our new Partnership website ([www.nascp.org](http://www.nascp.org)) is currently under construction) will soon host our strategies, plans, policies, and performance information

Additional financial information for Ayrshire wide services can be found in:

- East Ayrshire Health and Social Care Partnership Annual Performance Report
- South Ayrshire Health and Social Care Partnership Annual Performance Report
Appendices
## Appendix 1: Local indicators

<table>
<thead>
<tr>
<th>Performance Indicator</th>
<th>2015–16 value</th>
<th>2015–16 value</th>
<th>Target</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>People subject to level 1 Community Payback Order (CPO) Unpaid Work completed within three months</td>
<td>90.32%</td>
<td>93.37%</td>
<td>57%</td>
<td>✔️</td>
</tr>
<tr>
<td>Number of Learning Disability service users in voluntary placements</td>
<td>78</td>
<td>71</td>
<td>43</td>
<td>✔️</td>
</tr>
<tr>
<td>Number of bed days saved by Intermediate Care Enablement Service (ICES) providing alternative to acute hospital admission</td>
<td>3,082</td>
<td>4,730</td>
<td>3,060</td>
<td>✔️</td>
</tr>
<tr>
<td>Number of people receiving Care at Home</td>
<td>1,839</td>
<td>1,715</td>
<td>1,703</td>
<td>✔️</td>
</tr>
<tr>
<td>People seen within 1 day of referral to ICES</td>
<td>82.1%</td>
<td>98.5%</td>
<td>90%</td>
<td>✔️</td>
</tr>
<tr>
<td>Number of secure remands for under 18s</td>
<td>5</td>
<td>1</td>
<td>5</td>
<td>✔️</td>
</tr>
<tr>
<td>Addictions referrals to treatment within 3 weeks (Alcohol)</td>
<td>96.5%</td>
<td>93.7%</td>
<td>90%</td>
<td>✔️</td>
</tr>
<tr>
<td>Addictions referrals to treatment within 3 weeks (Drugs)</td>
<td>96.0%</td>
<td>95.0%</td>
<td>90%</td>
<td>✔️</td>
</tr>
<tr>
<td>Children who have been through Stop Now and Plan (SNAP) who have been sustained within their local school</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>✔️</td>
</tr>
<tr>
<td>Preschool children protected from disease through % uptake of child immunisation programme (Rotavirus)</td>
<td>93%</td>
<td>95.53%</td>
<td>92.2%</td>
<td>✔️</td>
</tr>
<tr>
<td>Preschool children protected from disease through % uptake of child immunisation programme (MMR1)</td>
<td>97.8%</td>
<td>96.21%</td>
<td>98.2%</td>
<td>✔️</td>
</tr>
<tr>
<td>Care at Home capacity lost due to cancelled hospital discharges (shared target with acute hospital services) (number of hours)</td>
<td>3,657.94</td>
<td>7,153</td>
<td>4000</td>
<td>⊹️</td>
</tr>
<tr>
<td>Number of people attending Café Solace</td>
<td>3,621</td>
<td>4,745</td>
<td>4,000</td>
<td>⊹️</td>
</tr>
<tr>
<td>Number of volunteers working with Café Solace</td>
<td>27</td>
<td>22</td>
<td>30</td>
<td>⊹️</td>
</tr>
<tr>
<td>Uptake of Child Flu Programme in schools</td>
<td>75.4%</td>
<td>75.25%</td>
<td>72.1%</td>
<td>✔️</td>
</tr>
<tr>
<td>Number of unique individuals referred to MADART (under 16 years)</td>
<td>708</td>
<td>776</td>
<td>Data only</td>
<td>⊹️</td>
</tr>
<tr>
<td>Number of re-referrals to MADART</td>
<td>91</td>
<td>89</td>
<td>Data only</td>
<td>⊹️</td>
</tr>
<tr>
<td>Number of referrals to MADART</td>
<td>597</td>
<td>601</td>
<td>Data only</td>
<td>⊹️</td>
</tr>
<tr>
<td>People indicating an improvement in their holistic strengths-based recovery</td>
<td>61.22%</td>
<td>50%</td>
<td>Data only</td>
<td>⊹️</td>
</tr>
<tr>
<td>Individuals subject to level 2 Community Payback Order (CPO) Unpaid Work completed within six months</td>
<td>92.45%</td>
<td>95.63%</td>
<td>67%</td>
<td>✔️</td>
</tr>
</tbody>
</table>
## Appendix 2: Measuring performance under Integration

Please note: this table shows our performance using the most up to date published national data.

<table>
<thead>
<tr>
<th>Performance Indicator</th>
<th>Current performance</th>
<th>Long term trend</th>
<th>Performance data last update</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency admissions to acute hospitals</td>
<td>1,678</td>
<td></td>
<td>February 2017</td>
</tr>
<tr>
<td>Emergency admissions to acute hospitals (rate per 1000)</td>
<td>12.4</td>
<td></td>
<td>February 2017</td>
</tr>
<tr>
<td>Admissions from emergency department</td>
<td>1,036</td>
<td></td>
<td>February 2017</td>
</tr>
<tr>
<td>Admissions from emergency department (rate per 1000)</td>
<td>7.7</td>
<td></td>
<td>February 2017</td>
</tr>
<tr>
<td>% people at emergency department who go onto ward stay (conversion rate)</td>
<td>36</td>
<td></td>
<td>February 2017</td>
</tr>
<tr>
<td>Unscheduled ‘hospital bed days’ in acute hospital</td>
<td>8,165</td>
<td></td>
<td>February 2017</td>
</tr>
<tr>
<td>Unscheduled ‘hospital bed days’ in acute hospital (rate per 1000)</td>
<td>60.3</td>
<td></td>
<td>February 2017</td>
</tr>
<tr>
<td>Unscheduled ‘hospital bed days’ in long stay mental health hospital</td>
<td>6,676</td>
<td></td>
<td>Q3 2016/17</td>
</tr>
<tr>
<td>Unscheduled ‘hospital bed days’ in long stay mental health hospital (rate per 1000)</td>
<td>49</td>
<td></td>
<td>Q3 2016/17</td>
</tr>
<tr>
<td>Unscheduled ‘hospital bed days’ in geriatric long stay</td>
<td>1,082</td>
<td></td>
<td>Q3 2016/17</td>
</tr>
<tr>
<td>Unscheduled ‘hospital bed days’ in geriatric long stay (rate per 1000)</td>
<td>8</td>
<td></td>
<td>Q3 2016/17</td>
</tr>
<tr>
<td>Emergency department attendances</td>
<td>2,843</td>
<td></td>
<td>February 2017</td>
</tr>
<tr>
<td>Emergency department attendances (rate per 1000)</td>
<td>21</td>
<td></td>
<td>February 2017</td>
</tr>
<tr>
<td>% people seen within 4 hrs at emergency department</td>
<td>90.3%</td>
<td></td>
<td>February 2017</td>
</tr>
<tr>
<td>Delayed Discharges bed days (all reasons)</td>
<td>1,169</td>
<td></td>
<td>February 2017</td>
</tr>
<tr>
<td>Delayed Discharges bed days (all reasons) (rate per 1000)</td>
<td>10.7</td>
<td></td>
<td>February 2017</td>
</tr>
<tr>
<td>Delayed Discharges bed days (Code 9)</td>
<td>352</td>
<td></td>
<td>February 2017</td>
</tr>
<tr>
<td>Delayed Discharges bed days (Code 9) (rate per 1000)</td>
<td>3.2</td>
<td></td>
<td>February 2017</td>
</tr>
</tbody>
</table>