Budget Scrutiny: Integration Authorities

The Committee has chosen to consider the integration of health and social care as part of its consideration of the Scottish Government’s budget. The following questions are designed to explore the budget setting process for 2016-17 and how budget allocation reflects the priorities set out in the performance framework.

1. Which integration authority are you responding on behalf of?

North Ayrshire Health and Social Care Partnership

2. Please provide details of your 2016-17 budget:

<table>
<thead>
<tr>
<th></th>
<th>£m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health board</td>
<td>130.996</td>
</tr>
<tr>
<td>Local authority</td>
<td>82.390</td>
</tr>
<tr>
<td>Set aside budget</td>
<td>20.825</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>234.211</strong></td>
</tr>
</tbody>
</table>

3. Please provide a broad breakdown of how your integration authority budget has been allocated across services, compared with the equivalent budgets for 2015-16.

<table>
<thead>
<tr>
<th>£m</th>
<th>2015-16</th>
<th>2016-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>56.347</td>
<td>56.483</td>
</tr>
<tr>
<td>Community healthcare</td>
<td>31.488</td>
<td>28.744</td>
</tr>
<tr>
<td>Family health services &amp; prescribing</td>
<td>47.393</td>
<td>47.876</td>
</tr>
<tr>
<td>Social care</td>
<td>98.523</td>
<td>101.108</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>233.751</strong></td>
<td><strong>234.211</strong></td>
</tr>
</tbody>
</table>

4. The 2016-17 budget allocated £250m for social care. Please provide details of the amount allocated to your integration authority and how this money has been utilised.

The allocation for North Ayrshire was £7.280m and was allocated as follows

<table>
<thead>
<tr>
<th>Allocation</th>
<th>£m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implementation of National Living Wage and Living Wage including Personal Assistants</td>
<td>2.948</td>
</tr>
<tr>
<td>Children with Disabilities – meeting existing demand pressures</td>
<td>1.095</td>
</tr>
<tr>
<td>Investments – reablement, out of hours, equipment and intermediate response team</td>
<td>1.015</td>
</tr>
<tr>
<td>Kinship Care – meeting existing demand and new demand</td>
<td>0.846</td>
</tr>
<tr>
<td>Learning Disabilities – increased demand</td>
<td>0.567</td>
</tr>
<tr>
<td>Mental Health – increased demand</td>
<td>0.366</td>
</tr>
<tr>
<td>Flexible Intervention Service – increased demand</td>
<td>0.175</td>
</tr>
<tr>
<td>Charging Thresholds</td>
<td>0.150</td>
</tr>
</tbody>
</table>
Budget setting process

5. Please describe any particular challenges you faced in agreeing your budget for 2016-17

There have been a number of challenges in setting the budget for 2016-17, the main areas being:

- uncertainty over funding with partner bodies operating to different timescales in relation to budget setting
- inability to finalise budgets until Health finalised their budget in August 2016 which makes it difficult to put strong financial management arrangements in place
- the initial uncertainty about how the £250m could be used for social care and the impact that this had on the relationship with the Council during the period of uncertainty and also restricted how these funds could be used to support increasing demand
- the level of savings set for the HSCP from both Health(5%) and the Council(4.7%) which required to be delivered against a climate of increasing demand and investment required to support a shift in the balance of care
- the budget process in itself represents a challenge. The IJB can make savings by shifting the balance of care, however this is likely to require investment in Council services to deliver savings within Health services. This could be done to the overall benefit of the public purse, however both partners continue to operate individually for budget setting purposes imposing savings separately which impacts on the investment which can take place. Direct funding of IJB’s by Scottish Government would remove these cross sector barriers.
- the savings within Health are against a backdrop of historic underinvestment, examples of which are within community nursing and mental health which means that the delivery of savings within Health are contingent on cutting frontline nursing care which runs counter to the national policy and local strategic direction of shifting the balance of care from acute
- the unbudgeted additional costs in relation to the national commitment to living wage continues to present operational issues for the service with some providers either threatening not to deliver living wage or threatening to withdraw from service provision completely

6. In respect of any challenges detailed above, can you describe the measures you have put in place to address these challenges in subsequent years?

In relation to the areas that are within our control, the following measures are currently being out in place:-
- Proposals to develop a medium term financial strategy to enable a longer term view of funding and funding reductions to be planned in a more pro-active way. The delivery of this is dependent on partner bodies being able to inform this process.
- Working with partners, we are developing a transformational programme, supported by business cases, which will identify the programmes for change which will secure the shift in the balance of care, deliver more effective and efficient models of care which will help the HSCP to manage services within the funding made available to it across the partner bodies.
- Working with partners we have proposals to agree a partnership approach to financial planning and budget setting to help to support the process across the different organisations, albeit different timeframes will continue to be an issue.
- Development of a longer term commissioning strategy which will enable us to lever the true shift in the balance of care

7. **When was your budget for 2016-17 finalised?**

   The social care budget element of the budget was approved on 16 June 2016. The Health element of the budget will not be finalised until the Health Board approves their budget on 11 August 2016.

8. **When would you anticipate finalising your budget for 2017-18?**

   It is estimated that funding from the Council should be known by February 2017 and Health by May 2017. Based on these timeframes the HSCP budget will be able to be finalised in June 2017.

**Integration outcomes**

9. Please provide up to three examples of how you would intend to shift resources as a result of integration over the period of your Strategic Plan:

   In the first year of the strategic plan, 2015/16, the IJB committed approximately £600k of NHS resource, made available through the Delayed Discharge Funding to enhance the capacity of the Care at Home Reablement Service with a view to discharging individuals without delay and to pilot an Immediate Response service through the Community Alarm Team to enable care staff to worth the SAS Teams to avoid unnecessary Hospital admissions. These initiatives were estimated, based on a conservative estimate of 5 day average length of stay, to have saved 4,710 acute bed days during the fourth month period to March 2016 and have now been mainstreamed through the new social care funding, as described in section 4 above.

   During 2016/17 North Ayrshire Health and Social Care Partnership, with the support of Scottish Government, NHS Ayrshire and Arran and North Ayrshire Council, are looking to purchase the facility currently owned by British Red Cross and operated as Options for Independence. This will enable the Partnership to consolidate plans to develop community based solutions, across Health and Social Care, within a single facility for the care support and
rehabilitation of individuals with complex and challenging behaviours by reason of mental disorder and/or learning disabilities. It is anticipated that this model of service delivery from a fully integrated Health and Social Care Hub will:

- Provide support at less cost than purchasing from private providers;
- Establish supported accommodation options as a safe alternative to long term care in a hospital setting;
- Establish a community mental rehabilitation resource to complement in-patient rehabilitation;
- Realise further developments in the use of in-patient beds at Woodland View;
- Enable a new Learning Disability Day Service to be created at less cost than that already agreed for a new build;
- Ensure our resources are aligned to changing needs and adapt to flexible usage;
- Provide models of care and support that are sustainable, and responsive to the changing needs of the mental health and learning disabled population;
- Promote community inclusion, independent living and active citizenship by enabling participation in community and employment opportunities.

Over the last year, we have been working to create a new type of Health Visiting Team in North Ayrshire. This work is aimed at building upon our prevention and early intervention agenda and, ultimately, improving outcomes for children across North Ayrshire. All of the teams now have a social worker as part of their establishment, with the aim of working at an earlier stage with parents and families who may be struggling. The new visiting pathway allows our Health Visitors to identify such families at an earlier stage and access to a social work resource within their teams allows for timely provision of low-level social work interventions.

In addition, we are working towards all parents of under fives having access to income maximisation and benefits advice via our Money Matters Team. Parents will be able to opt-out of this support but, otherwise, the support will form part of the overall universal provision. Finally, we have been successful in securing European Social Fund money to create a couple of Employability Workers who will also be based with the Health Visiting Teams. These workers will focus on helping parents of under-fives prepare for training or work and we have secured funds to ensure that some element of childcare costs can be covered to allow people to undertake training, work experience
and so on. All of this is aimed at embedding an Inclusive Growth approach into our universal health visiting provision.

The intended outcomes of this work are as follows -

- Fewer pre-school aged children subject to statutory orders via the Scottish Children's Reporter's Authority
- Fewer pre-school aged children subject to child protection processes
- Fewer pre-school aged children requiring to be Looked After and Accommodated
- Improved financial capability of parents of pre-school aged children
- Improved employment opportunities for parents of pre-school aged children
- Improved health and well being of pre-school aged children

Whilst this is an ambitious approach, we hope to see tangible progress within three years. This will allow, as per the aspiration of the Children's Services Plan, a shift of resource away from current levels of crisis spend.

10. What efficiency savings do you plan to deliver in 2016-17?
   The HSCP have a total target for savings of £6.871m. These will not all be delivered through efficiency measures.

11. Do you anticipate any further delegation of functions to the integration authority? (If so, please provide details of which services and anticipated timescales)
   No
Performance framework

12. (a) Please provide details of the indicators that you will use to monitor performance and show how these link to the nine national outcomes

(b) If possible, also show how your budget links to these outcomes – it is not possible to link budgets to these outcomes. Although as an organisation we are committed to meet these outcomes, our budget management system is not set up to record budgets or spends against these national outcomes. If budgets and spend are to be monitored in this way moving forward further developments of our systems would be required to capture this data.

<table>
<thead>
<tr>
<th>National Outcome</th>
<th>Indicators</th>
<th>2016-17 budget</th>
</tr>
</thead>
</table>
| People are able to look after and improve their own health and wellbeing and live in good health for longer. | • MH Average length of stay  
• Referral to Treatment Times – Psychological Therapies  
• CAMHS – Percentage of patients seen within 18 weeks  
• Number of CAHMs referrals with presenting complaint of anxiety or depression  
• Addictions referrals to Treatment within 3 weeks Alcohol  
• Addictions referrals to Treatment within 3 weeks Drugs  
• Number of ABIs Delivered Priority Area  
• Number of ABIs Delivered Non Priority Area  
• Number of Naloxone Kits Supplied  
• Number waiting for PCMHT more than 18 weeks | |
<table>
<thead>
<tr>
<th>National Outcome</th>
<th>Indicators</th>
<th>2016-17 budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>People, including those with disabilities or long-term conditions, or who are</td>
<td>• Number of Adults accessing Direct Payments</td>
<td></td>
</tr>
<tr>
<td>frail, are able to live, as far as reasonably practicable, independently and at</td>
<td>• Number of MH/LD Adults accessing Direct Payments</td>
<td></td>
</tr>
<tr>
<td>home or in a homely setting in their community.</td>
<td>• Number of Service users receiving Care at Home</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Number of service users (65+) with a community alarm package.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Number of service users with an enhanced telecare package.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Number of LD service users in voluntary placements.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Number of referrals for equipment</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Average waiting time for referral for equipment from Stores</td>
<td></td>
</tr>
<tr>
<td>People who use health and social care services have positive experiences of</td>
<td>• Number of Café Solace Attendances</td>
<td></td>
</tr>
<tr>
<td>those services, and have their dignity respected.</td>
<td>• Number of Café Solace Volunteers</td>
<td></td>
</tr>
<tr>
<td>National Outcome</td>
<td>Indicators</td>
<td>2016-17 budget</td>
</tr>
<tr>
<td>------------------</td>
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</tr>
</tbody>
</table>
| Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services. | • Number of days people spend in hospital when they are ready to be discharged (Bed days lost).  
• Percentage of people aged 65 or over with intensive needs receiving care at home.  
• Number of bed days saved by ICES providing alternative to acute hospital admission  
• Number of people referred to Flexible Intervention service  
• Number of interventions completed by FIS  
• Number of Hospital Admissions to Pavilion 3 | |
| Health and social care services contribute to reducing health inequalities. | • Income generated by Money Matters Service  
• Percentage of Referrals to CMHT living in SIMD 15% most deprived areas. | |
| 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. | • Volume of respite care - adult 18-64 - overnight respite  
• Volume of respite care (adults 18-64) daytime  
• Volume of respite care - older people 65+ - overnight  
• Volume of respite care (older people 65+) daytime hours | |
<p>| People who use health and social care services are safe from harm. | • Percentage of ASP Referrals completed within 5 days | |</p>
<table>
<thead>
<tr>
<th>National Outcome</th>
<th>Indicators</th>
<th>2016-17 budget</th>
</tr>
</thead>
</table>
| 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. | • Average working days lost to sickness absence per employee (NAC)  
• Average working days lost to sickness absence per employee (NHS) |               |
| Resources are used effectively and efficiently in the provision of health and social care services. | • Percentage of ICES service users seen within 1 day of referral  
• Access to Services - Number of Adult/LD/CAMHS in out of area units  
• Care at Home capacity lost due to cancelled hospital discharges (Hrs)  
• CAH Capacity requested by patients in hospital (Hrs)  
• Average Number of patients waiting for CAH package  
• Number of Occupied bed days lost while waiting for Care at Home package  
• Number of Service Users delayed due to funding being confirmed (Care Homes)  
• Number of Service Users delayed in discharge to a care home after funding confirmed  
• Number of patients waiting for CAH package (Hospital and Community) |               |
Delayed Discharges

In relation to delayed discharge the Committee is interested in three areas. The extent to which the IJB is able to direct spending, how much money is available to tackle delayed discharge and how well it is being spent to eradicate the problem.

1. **As an Integrated Authority what responsibility do you have for tackling the issue of delayed discharges?**

   North Ayrshire Health and Social Care Partnership has full delegated responsibility for the design and delivery of community and community hospital based health and social care services aimed at supporting people to live a full, independent and active life within community settings and to ensure they are supported home following any stay in an acute hospital setting.

   A key element of service design is to ensure the configuration of assessment, support and care provision that can support an individual’s discharge from the acute hospital setting with no delay.

   There is a strong recent history of improved performance in relation to the numbers of individuals experiencing a delay in their discharge, as well as the length of those delays.

2. **What responsibility do you have for allocating expenditure including additional sums allocated by the Scottish Government to tackle delayed discharges?**

   The budgets for the community health and social care services are delegated to the Partnership, with additional funds, such as those for delayed discharge, directed to the Partnership as they are allocated centrally.

   All investment plans, including those for any additional allocations, are developed by the Partnership Senior Management Team before they are submitted to the Integration Joint Board for consideration and sign-off. This ensures funding allocation decisions are underpinned by sound governance and in line with stated strategic direction.

3. **How much was spent in 2015-16 on tackling delayed discharges? If necessary this answer can be based on your shadow budget for 2015-16.**

   61% of care home placements were from a hospital setting at a cost of £10.219m.

   15/16 total care at home spend is £12.625m and this includes referrals from hospital.

   67% of ICES (Intermediate Care and Enablement Services) were from a hospital setting at a cost of £0.383m

   Note that this excludes staff time for assessment and case management.

   Recognising that the best way to tackle delayed discharges is to reduce avoidable emergency admissions, North Ayrshire Health and Social Care Partnership invested in a pilot rapid response service in the Irvine area. This
pilot commenced in January 2016 and ensured that whenever a local community alarm service user requested a 999 Ambulance, a member of the Care Team would respond at the same time. The Care Team then worked with the responding team from Scottish Ambulance Service to assess the service user’s needs and identify, wherever appropriate, what support could be offered to ensure the person could safely stay at home. Early data from the pilot indicated a 50% reduction in emergency admissions for this client group. The pilot will continue during winter 2016/17 and will be extended to the Three Towns area subject to funding being made available.

4. What is the total funding (in 2016-17) you are directing to address the issue of delayed discharges? Please provide a breakdown of how much money has been received from each of the following for this purpose:
   a. NHS board
   b. Local authority
   c. Other (please specify)

Using the same % splits as question 3 the projected spend would be:

   Care Home Placements = £10.540m.
   Care at Home (total budget £12.626M) – this includes referrals from hospital.
   ICES = £0.417m.

The funding for this is traditionally Local Authority spend but some areas are now part of the additional £250M that was allocated nationally to the NHS to pass onto health and social care partnerships.

5. How was the additional funding allocated by the Scottish Government to tackle delayed discharges spent in 2015-16? How will the additional funding be spent in the current and next financial years?

<table>
<thead>
<tr>
<th>Area of Spend</th>
<th>2015/16 Spend £ 000's</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rehab and Reablement</td>
<td>152</td>
</tr>
<tr>
<td>Care at Home</td>
<td>177</td>
</tr>
<tr>
<td>Community Equipment</td>
<td>93</td>
</tr>
<tr>
<td>Winter Pressures</td>
<td>445</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>867</strong></td>
</tr>
</tbody>
</table>
For 2017/18 onwards the plan (subject to resources being available) would be to continue the expansion of community intermediate care and hospital at home with a view to making the service available seven days per week.

What impacts has the additional money had on reducing delayed discharges in your area?

Through various approaches including increasing care at home capacity, increasing occupancy at Pavilion 3 and a pilot project between community alarms and the Scottish Ambulance service the partnership has reduced the number of bed days. Between October 215 and January 2016 there was a reduction of 20,025 bed day (6,749 in unrequired bed days in acute hospital wards and 13,276 in frail elderly hospital wards). Our work is enabling more people who use our services to be effectively supported in their own home or homely setting.
6. **What do you identify as the main causes of delayed discharges in your area?**

   Capacity with the care sector is a major factor with independent Care Home capacity almost being fully utilised in North Ayrshire and significant limitations in the capacity offered by Care at Home providers, particularly in the North Coast and Garnock Valley areas.

   In terms of Care at Home, this places a considerable strain on the directly provided service and while there has been significant increases in capacity over the last year, growing demand combined with the limited availability of independently provided services results in limitations.

   In addition to this, delays can occur when individuals have particularly complex needs and require multi-agency, multi-disciplinary engagement and / or longer-term assessments.

   Similarly, people awaiting the outcome of Guardianship can wait in hospital for a significant period of time.

7. **What do you identify as the main barriers to tackling delayed discharges in your area?**

   As stated above, North Ayrshire Health and Social Care Partnership has significantly improved local delayed discharge performance through strategic investment aligned with the reconfiguration of Care at Home services and the redesign of our long-term care assessment and funding approval processes.

   That said, the increasing demand for Care at Home services, combined with the limited capacity available is a major barrier to tackling delayed discharges.

   In addition with Care Homes operating towards the upper end of their capacity can result in slight delays in securing a planned transfer from hospital due to the time required to prepare the room for the individual due to be admitted follow a discharge from the home. Further, the current level of occupancy can restrict individual choice in terms of their preferred Care Home and this can result in delays to discharge.

   Finally, the lack of alternative facilities to support those who require longer-term, more complex assessments or who are awaiting the outcome of prolonged processes such as Guardianship impacts adversely on delays to discharge.

8. **How will these barriers to delayed discharges be tackled by you?**

   North Ayrshire Health and Social Care Partnership continues to redesign its Care at Home service to optimise the use of the available capacity and has developed further investment plans for its reablement service to ensure targeted growth of capacity as funding becomes available.

   At the same time, adopting a reablement approach through both Care at Home and within our in-patient and community-based rehabilitation services, will result in individuals living at home for longer, with a decreased demand for Care Home placements and an associated shorter length of stay over time. The resulting reduction in occupancy should enable Care Homes to
respond more quickly when a person is assessed as requiring long-term care and offer greater choice to the individual as to which Care Home they would prefer.

Finally, we will explore options for how individuals requiring complex, longer-term assessment and those subject to processes such as Guardianship, can be supported outwith the acute hospital in an environment more appropriate to their needs.

9. Does your area use interim care facilities for patients deemed ready for discharge?

No

10. If you answered yes to question 10, of those discharged from acute services to an interim care facility what is their average length of stay in an interim care facility?

n/a

11. Some categories of delayed discharges are not captured by the integration indicator for delayed discharges as they are classed as ‘complex’ reflecting the fact that there are legal processes which are either causing the delay (e.g. application for guardianship orders) or where there are no suitable facilities available in the NHS board area. Please provide the total cost for code 9 delayed discharges for 2015-16? What is your estimate of cost in this area in the current and next financial years?

There were 7 complex cases in 2015/16 with an average stay in hospital of 179 each (1,256 days in total). The cost is £502,400 assuming an average cost of £400 per day.

The current and next financial year are difficult to project as it depends on the circumstances of each admission but the above is a fair approximation.
Social and Community Care Workforce

In relation to the social and community care workforce the Committee is interested in the recruitment of suitable staff including commissioning from private providers and the quality of care provided.

1. **As an Integrated Joint Board what are your responsibilities to ensure there are adequate levels of social and community care staff working with older people?**

   NAHSCP has full delegated responsibility for NHS Ayrshire and Arran and North Ayrshire Council to determine the needs of older people locally, assess the capacity available to meet these needs across health, social care, third and independent sector provision and develop plans for the reconfiguration and/or growth of capacity to ensure adequate levels of staffing and services are available to meet that need.

2. **Are there adequate levels of these social and community care staff in your area to ensure the Scottish Government’s vision of a shift from hospital based care to community based care for older people is achieved? If not, please indicate in what areas a shortage exists.**

   The key areas where we are experiencing shortages of staff are:
   
   - Care at Home – both directly provided and independent sector; and
   - Care Homes – where the stability of nurse staffing in particular is highly variable in the independent sector and recruitment to our own care home on Arran has been problematic; and

3. **Other than social and community care workforce levels, are there other barriers to moving to a more community based care?**

   **Other barriers include:**
   
   District Nursing – where the Nursing Workforce tool indicates a deficiency of approximately 15 WTEs in establishment to meet current demand;
   
   General Medical Practitioner Workforce – there are long-standing and increasing difficulties in recruiting GP Partners in North Ayrshire;
   
   The focus of specialist medical consultants within Acute Care rather than providing proactive care and consultancy advice in community settings;
   
   The availability of a suitably well staffed and configured AHP workforce capable of supporting rehabilitation and care at home;
   
   The availability of access to complex diagnostics, such as cross-sectional imaging, from home, resulting in unnecessary hospital stays.
4. **What are the main barriers to recruitment and retention of social and community care staff working with older people in your area?**

The key barriers reported are:

- Willingness to travel outwith the locality in which individuals are resident;
- Cost of travel outwith the locality in which the individuals are resident;
- Cost of childcare; and
- Interest in a career in care.

Attempts have been made to address these through the provision of affordable travel, dedicated transport and links with Ayrshire College and local Secondary Schools to provide opportunities for experience in the workplace.

5. **What mechanisms (in the commissioning process) are in place to ensure that plans for the living wage and career development for social care staff, are being progressed to ensure parity for those employed across local authority, independent and voluntary sectors?**

Through the commissioning process, bidders fair work practices are evaluated. Evaluation of fair work practices extends beyond payment of the Living Wage. In terms of fair work practices, bidders would be considered good employers if they have adopted policies which comply with relevant employment, equality and health and safety law, human rights standards and describe how they adopt fair work practices for all workers engaged in delivering contracts. This includes, fair and equal pay, respecting employee rights, providing stability of employment and avoiding exploitative employment practices such as inappropriate use of zero-hour contracts or applying unreasonable working hours, supporting progressive workforce engagement and encouraging staff to join a Trade Union, or suitable alternative.

For procurements which commence on or after 1 November 2015, NAC are required to consider how to address fair work practices in relevant public contract's where the estimated value of the contract is equal to or greater than £50,000 for goods and services and £2,000,000 for work contracts. NAC also considers whether assessing fair work practices is applicable where a lower value applies or the service being commissioned is exempt from contract.

Whilst developing Contract Strategies for any contracts whose values are equal to or greater than £50,000 for services, commissioning staff completes the following table and if the answer to any questions is “yes”, then fair work practices are likely to be a relevant consideration for the contract in question:

<table>
<thead>
<tr>
<th>Question</th>
<th>Y/N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is there any previous experience of poor work practices, including pay and conditions, impacting on the quality of the contract to be delivered?</td>
<td>Y/N</td>
</tr>
<tr>
<td>Is there any history of low pay or unequal pay in that sector?</td>
<td>Y/N</td>
</tr>
<tr>
<td>Is there a risk that staff working on the contract might be subject to exploitative practices, e.g. through the inappropriate use of zero-hours contracts, through unnecessary distancing of the employer worker relationship e.g. by use of an “umbrella company” and through pay and</td>
<td>Y/N</td>
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</tbody>
</table>
hours arrangements that deny workers stability of employment or hours of work, e.g. by failing to pay wages for travel time within the working day, such as in the care at home sector?

Is there evidence that working conditions are making recruitment and retention problematic?

Are contractors seeking to cut their costs through driving down staff terms and conditions, including pay?

Will workers be required to interact directly with the contracting authority’s employees and/or members of the public and whether they will spend any time on the contracting authority’s premises?

If the contract is for the supply of goods does the workforce that are engaged in the supply or manufacturing of the goods have an impact on their quality. i.e. where the goods to be supplied are created by processes involving manual labour does the terms of engagement impact on the quality of the goods.

For lower value procurements (£10K to £49,999), commissioning staff includes the following wording in quick quotes:

“The Public Sector in Scotland is committed to the delivery of high quality public services, and recognises that this is critically dependent on a workforce that is well rewarded, well-motivated, well-led, has access to appropriate opportunities for training and skills development, are diverse and is engaged in decision making. These factors are also important for workforce recruitment and retention, and thus continuity of service.

Public Bodies in Scotland are adopting fair work practices, which include:

• a fair and equal pay policy that includes a commitment to supporting the Living Wage, including, for example being a Living Wage Accredited Employer
• clear managerial responsibility to nurture talent and help individuals fulfil their potential, including for example, a strong commitment to Modern Apprenticeships and the development of Scotland’s young workforce;
• promoting equality of opportunity and developing a workforce which reflects the population of Scotland in terms of characteristics such as age, gender, religion or belief, race, sexual orientation and disability;
• support for learning and development;
• stability of employment and hours of work, and avoiding exploitative employment practices, including for example no inappropriate use of zero hours contracts;
• flexible working (including for example practices such as flexi-time and career breaks) and support for family friendly working and wider work life balance;
• support progressive workforce engagement, for example Trade Union recognition and representation where possible, otherwise alternative arrangements to give staff an effective voice.

In order to ensure the highest standards of service quality in this contract North Ayrshire Council expects providers to take a similarly positive approach to fair work practices as part of a fair and equitable employment and reward package.”
NAC are unable to make payment of the Living Wage a mandatory requirement as part of a competitive procurement process where the Living Wage is greater than any minimum wage set by or in accordance with law. In the UK, this is the National Minimum Wage. It is, therefore, not possible to reserve any element of the overall tender score specifically to the payment of the Living Wage. However, it is possible where relevant to the delivery of a contract, to take account of a bidder’s approach to fair work practices. Fair work practices can and would normally be expected to include fair and equal pay, including the Living Wage as part of a package of positive fair work practices.

6. **What proportion of the care for older people is provided by externally contracted social and community care staff?**

Care at home is split as 64% in house staff and 36% purchased.

7. **How are contracts monitored by you to ensure quality of care and compliance with other terms including remuneration?**

**Contract Monitoring of Fair Work Practices:**

The recently reviewed contract monitoring templates takes into account Fair Work Practices (FWP) and the Ethical Work Charter (EWC). This to ensure that commissioned services take a positive approach to fair work practices as part of a fair and equitable employment that support the delivery high standards of care.

Every commissioned service receives a 6 monthly contract monitoring template in the form of a survey monkey. The template asks about the number of staff, their roles, staff vacancies and sickness rates and contingency plans to cover staff shortages. It also asks if the provider adheres to FWP and if they comply with the EWC.

As a starting point to promote FWP and EWC and as part of the contract management review a steering group including providers was established to look at all aspects of the contract monitoring process. This included discussions around fair work practices, copies of Unison’s ethical care charter was distributed to all attendees.

Moving forward fair work practices will be monitored by two methods; by the information submitted by providers via the contract monitoring survey monkey, and by regular site visits by the contract monitoring officer.

The table below illustrates the information that will be gathered from providers. The type of information may be added to as we move forward.

<table>
<thead>
<tr>
<th>Fair Employment Policy / Conditions</th>
<th>Evidenced at monitoring visit</th>
<th>Included in contract management return?</th>
</tr>
</thead>
<tbody>
<tr>
<td>A fair and equal pay policy that includes a commitment to supporting the Living Wage</td>
<td>Equal pay audits</td>
<td>NO</td>
</tr>
<tr>
<td>Living Wage Accredited Employer</td>
<td>Implementation of the living wage</td>
<td>YES</td>
</tr>
<tr>
<td>Clear managerial responsibility to nurture talent and help individuals fulfil their potential</td>
<td>Regular supervision and/or PPD sessions for staff when training wants and needs are identified.</td>
<td>YES</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Topic</th>
<th>Description</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff learning and development supported</td>
<td>Personal staff training and learning log books, with staff input clearly identified.</td>
<td>NO</td>
</tr>
<tr>
<td>Equality and opportunity promoted to develop a workforce which reflects the population of Scotland in terms of characteristics such as age, gender, religion or belief, race, sexual orientation and disability</td>
<td>Recruitment policies and procedures, which promote equality and diversity.</td>
<td>NO</td>
</tr>
<tr>
<td>Stability of employment (staff turnover)</td>
<td>Details of staff vacancies</td>
<td>YES</td>
</tr>
<tr>
<td>Avoidance of exploitative employment practices.</td>
<td>Detailed work rotas, no inappropriate use of zero hour contracts; no unreasonable shift patterns.</td>
<td>NO</td>
</tr>
<tr>
<td>Support workforce engagement</td>
<td>Trade Union recognition and representation where possible, otherwise alternative arrangements to give staff an effective voice.</td>
<td>NO</td>
</tr>
<tr>
<td>Involve staff in service improvement and innovation</td>
<td>Regular staff surveys / staff service improvement suggestions implemented</td>
<td>NO</td>
</tr>
</tbody>
</table>