EAST AYRSHIRE

Health & Social Care Partnership

STRATEGIC PLAN 2018 - 21






Contents

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

Foreword

Welcome to the Strategic Plan for East Ayrshire Integration Joint Board. This is our second Strategic Plan and it will set out our shared ambitions and priorities for health and social care in East Ayrshire for 2018-21.

We have much be proud of during the course of our last plan and the progress review section of this draft highlights many of those things. Moving into our second Strategic Plan we have strong ambitions. We will deliver on our vision of:

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

We will make a central contribution to the Wellbeing priority of East Ayrshire Community Plan 2015-30. We will focus on the National Outcomes and our aspiration that:

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

We must continue to be driven by ambition for the people of East Ayrshire. To do so our Strategic Plan 2018-21 must be truly ***transformational***. The needs assessment and finance sections of this draft Plan illustrate the challenges we face. Demand is increasing and resources are severely constrained. Our Partnership activity must therefore centre on the ***'triple aim'*** of better care, better health and better value.

At 'local conversations' and 'Big Plan' days people have told us that prevention and early intervention are critical. This will be key in our approach to managing demand and making best use of available resources. During 2018-21 our plan is to focus on a number of core themes. These are:

- Scaling up our work on ***prevention and early intervention*** across all ages;
- Supporting ***New Models of Care*** and ***building capacity in Primary and Community Care***;
- Ongoing ***partnership engagement*** about meeting challenges and creating opportunities, and;
- Transformation to ensure ***sustainability*** – to ***tackle the financial gap*** which, if we continue as we are, is projected to be over ***£37.8M*** by 2021/22.

This will be supported by joint planning focused on the 'set aside' budget to develop support for people at home and prevent unnecessary hospital admission and make best use of Acute Services.

Our work over 2018-21 will be taken forward with the involvement of the workforce across all partners. The ideas, creativity and commitment of our workforce will be core to how we develop as a partnership.

I would urge all those with an interest in health, social care and the wellbeing of the residents of East Ayrshire to contribute to the delivery of our Plan and look forward to working with partners in this.

Eddie Fraser, *Chief Officer*

Section 1: Review of 2015-18

Organisational development

- The Integration Scheme establishing the HSCP was approved by Scottish Ministers and Parliament for 1st April 2015.
- East Ayrshire Integration Joint Board first met on 2nd April 2015 taking on the full range of delegated services.
- Governance arrangements were put in place covering Chief Officer, Clinical and Professional leadership, Partnership Management, Audit and Performance, Health and Care Governance, Health, Safety and Wellbeing, Risk and Resilience, and Staff Partnership roles.
- Lead Partnership arrangements were established with East Health and Social Care Partnership taking the lead role in Primary Care and health services in HMP Kilmarnock.

Tackling inequality

- Contributed to the development of a set of Shared Equality Outcomes with a range of public bodies across Ayrshire and Arran.
- Participated in a local Disability Inclusive: Confident Employers (DICE) encouraging employers to make the most of the opportunities provided by employing disabled people.
- Endorsed the Stonewall Scotland –No Bystanders campaign and pledge.
- Approved a Position Statement on Prostitution which seeks to challenge demand.
- Further developed the 'Know Who to Turn To...' campaign signposting people to the right services.

Children & young people

- Implemented Kinship Carer parity equalising eligible allowances with Foster Carers.
- Continued to develop the role of the Children and Young People's Strategic Partnership.
- Launched supported accommodation provision for care leavers.
- Increased recruitment of foster carers.

Preventing illness

- Reviewed the level of investment in early intervention and prevention across the partnership.
- Considered the implications for East Ayrshire of the Annual Report of the Director of Public Health in relation to challenges of alcohol, tobacco, obesity and mental health (ATOM).
- Developed a new approach to eye care through 'Eyecare Ayrshire' to promote local optometrists as the first point of contact.

Care for older people

- Worked with partners in Housing and Vibrant Communities to increase the number of people receiving minor equipment and adaptations, new housing units for varying need and the range of activities in supporting older people to live independently in the community.

Supporting people with long-term conditions

- Contributed to reviews of pathways of care for people with long-term conditions as part of the Unscheduled Care Programme.

End of life care

- Incorporated end of life care into the development of future Models of Care and Service Change and Transformation Programmes and to test local care home provision.

Community justice services

- Contributed to partnership working in the transition year from the South West of Scotland Community Justice Authority to the Community Justice Ayrshire and to the production of the 'Beginnings, Belonging and Belief' plan.

Community engagement

- Further developed locality arrangements and engagement with Community Planning Partners in Northern, Southern and Kilmarnock Localities.
- Engaged with a stakeholder group including the Scottish Health Council, to support re-design and re-provision of Rowallan Ward at Kirklandside Hospital.

- Held locality engagement events, including our Strategic Planning Group 'Big Plan Day' and our annual 'Local Conversation' events involving people in shaping our plans.
- Co-produced our Carers Strategy, Local Eligibility Criteria and Carers Support Plans.
- Prioritised tackling social isolation across the life course through Locality Planning process.

Choice & control

- Redesigned our self-directed support and technology enabled care support teams into an integrated 'Thinking Differently' team.
- Participated in Power of Attorney campaigns with local publicity, social media presence and a national television campaign.

Redesign of services

- Developed Lillyhill Gardens supported accommodation.
- Through the IJB, contributed to testing Participatory Budgeting in our communities.

Care close to home

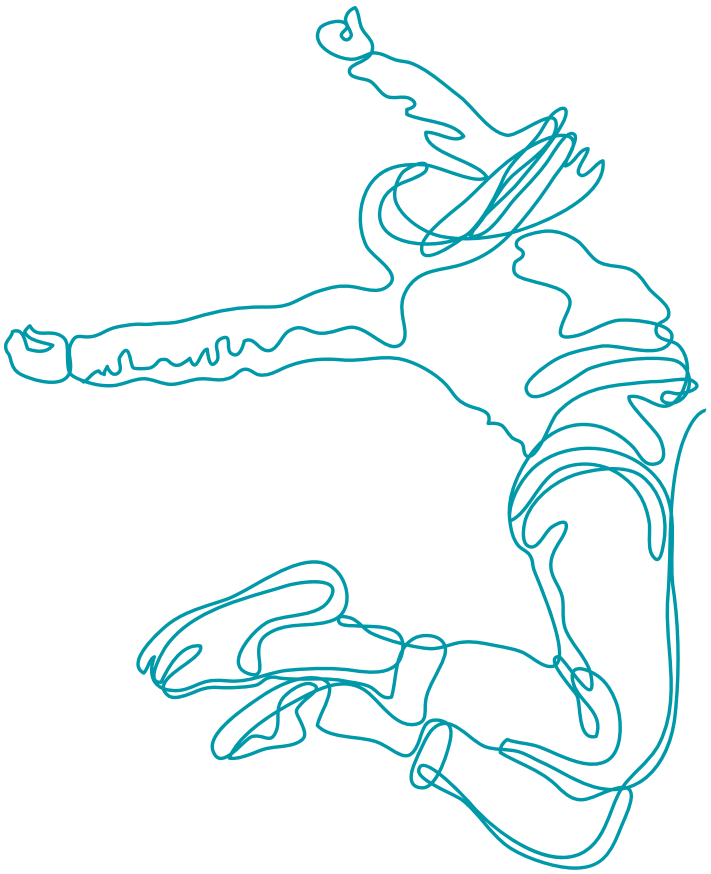
- Held 'Ambitious for Ayrshire' events setting out our vision for Primary and Community services and developing 'cluster' arrangements.
- Taken forward the integration of Out of Hours Primary Care and Community Response services across Social Work, Primary Care and Community Nursing in a Ayrshire Urgent Care Service.

Technology enabled care

- Established the WG13 community digital hub.
- Published our plans for taking forward Technology Enabled Care (SmartSupports) over the next two years.

Workforce

- In our first year organisational development work was taken forward to support integrated working within multi-disciplinary teams and safe and effective delivery of services continued.
- Undertaken baseline assessments of our nursing, GP, care home, personal carer, social work, corporate parenting and community hospital workforce to inform workforce planning for the future.
- Worked collaboratively to develop a General Practice Workforce and Contingency Plan which sets out the sustainability challenges and areas for development.
- Successfully taken forward the 'My Home Life' leadership development programme in care homes, and other areas of service, with significant benefits in relation to collaborative working and quality of life
- Implemented the Scottish Living Wage for care workers delivering direct care and support for adults in care homes, care at home and housing support.



Section 2: Engagement

Our Plan is being developed by engaging with our workforce, partners and the communities we serve. Through them, we will understand the ways in which the Partnership can transform.

The programme of stakeholder engagement used to gather and understand local perspectives is shown in the table below. A summary report of engagement was presented to IJB. We will continue to build on this to improve communication and raise awareness across partners. Ongoing engagement will be core to developing and delivering consistent, targeted and accessible communications across all partners.

PROGRAMME			
Date/time	**Event**	**Audience**	**Location**
31 August 2017	Strategic Planning Group Workshop	Stakeholder , IJB and SPG	CVO Belford Mill, Kilmarnock
14 September 2017	Integration Joint Board Development Day	IJB members and officers	WG13, West George Street Kilmarnock
26th October 2017	Locality Planning – Southern area	Joint stakeholders, employees, communities	Dalmellington Area Centre
8th November 2017 – Care Home. **23rd November 2017 – Care at Home.**	Providers Fora	Independent Sector	Auchinleck Resource Centre
7th Nov to 5th December 2017	Professional bodies- GP, Dental Optometry and Pharmacy		various
9 November 2017	Partnership Forum	Employee representatives	Kilmarnock
Dec 2017- 18 Jan 2018	EAC Budget	Joint stakeholders, employees, communities	Align where possible. various
7th November 2017	Locality Planning – Northern area	Joint stakeholders, employees, communities	various
2nd November 2017 and 18th January 2018	Locality Planning – Kilmarnock area	Stakeholders, employees, communities	various
23rd November 2017	Stakeholder Forum	People who use services and carers	
24 November 2017	Local Conversation	Employee , third sector and local communities event	Grand Hall, Kilmarnock
1st December 2017	Consultative Draft	All	Online
18th January 2018	Third Sector Providers	Third Sector/PN/Providers	WG13
22nd February/ 16th March 2018	Pre-publication Launch	Employees and Senior Leaders	Localities

Section 3: Vision and Values

Vision and Values

We developed a vision for how we would operate as a partnership in consultation with stakeholders prior to the establishment of the Integration Joint Board and the Health and Social Care Partnership.

This has driven our activity over the last three years and will continue to do so. Our vision is of:

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

We contribute to the **Wellbeing** objectives of **Community Plan 2015-30**:

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

Specific Health and Social Care Partnership **values** encompass partner values:

The long-term aim for health and social care in Scotland is for people to live longer, healthier lives at home or in a homely setting. The National Health and Wellbeing Outcomes, Children and Young People and Justice Outcomes guide our work. The aim is to have a health and social care system that meets with the Integration Principles:

- is integrated;
- focuses on prevention, anticipation and supported self-management;
- will make day-case treatment the norm, where hospital treatment is required and cannot be provided in a community setting;
- focuses on care being provided to the highest standards of quality and safety, whatever the setting, with the person at the centre of all decisions; and
- ensures people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission.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Section 4: Strategic Priorities

The health and care system has been continually changing as new treatments, technology and service developments have emerged. Our health and social care system will always evolve to deal with society's health challenges and to provide excellent care.

Scottish solutions have been found to the challenges faced which provide a solid foundation from which to build. There is a strategic focus on **prevention, early intervention** and developing better, **more integrated care** organised around the individual needs of people. Partners are working at a national, regional and local level to collectively plan to improve health and wellbeing, reduce inequalities and improve health outcomes. The extent of **preventable illness** is recognised as is the **depth of health inequalities** experienced in our communities.

Our Strategic Priorities are summarised below. More detail on activity to deliver these over the course of the Strategic Plan 2018-21 is set out in Section 9-12. These will provide greater focus to our work in recognition of feedback that we have been trying to change too many things at once in the context of pressure on services.

Early Intervention and Prevention

There is a broad consensus across partners in in East Ayrshire that significant **improvements in wellbeing result from tackling (undoing) the causes of ill-health rather than rather than treating the consequences (mitigation)**. The IJB commissioned a review of prevention and early intervention in 2016/17. Building on this, the intention is to make **prevention a core focus** of activity at the heart of health, social care and wellbeing during the course of 2018-21. We **will scale-up prevention and early intervention** across all Partnership work. There will be a focus on fairness, kindness and connectedness. This aligns with our prioritisation of **social isolation** across the life course.

New Models of Care

Considerable work has been taken forward in designing and implementing **new approaches** to our provision of health and social care services for older people and those with complex conditions, which is aimed at **supporting people in more homely and community-based** settings and contributing to the management of unscheduled care in acute hospitals.

During the course of this Strategic Plan **new models of care** will be fully embedded across East Ayrshire. This involves implementation of **multi-disciplinary** partnership working in Localities where a range of professionals and partner agencies work together to ensure that people get the 'Right Support, Right Place, First Time'. This includes developing models of care to support increasingly complex needs across partners.

Building Capacity in Primary and Community Care

Within Primary Care we are **widening the concept of the Practice Team** to ensure that patients benefit from wider range of available support. Practices will typically consist of c**omplementary teams of professionals** lead by a GP but supported by highly-trained **nurses, physiotherapists, pharmacists, mental health workers** and **social workers**.

Transformation and Sustainability

As a Partnership we have undertaken significant work to **understand our challenges** and how we can best meet these within **a new financial context** while continuing to strive towards our ambitions. We need to **close the financial gap** and **transform** how we work to achieve **sustainability**.

Ongoing **engagement** will be core. We will continue to improve communication and raise awareness across partners.

Section 5: Partnership Services

Partnership services include the full range of community-based health and care services. These are fully detailed in the Partnership's Integration Scheme.

Lead Partnership Primary Care and Out of Hours Community Response

Lead Partnership arrangements continue to be in place across Ayrshire & Arran. The East Ayrshire H&SCP will continue to manage and deliver the following services on behalf of the North and South Partnerships.

- Primary Care (General Medical Services, General Dental Services, General Ophthalmic Services, Community Pharmacy)
- Public Dental Services
- Ayrshire Urgent Care Services
- Contracting for GP services for settings such as Prison Service and Police Custody Services

The agreed vision for primary care services across Ayrshire and Arran is to achieve:

A strong local primary care service, supporting people in their day-to-day lives to get the best from their health, with the right care available in the right place when they need it. The overall theme is of partnership between individuals, communities, the health and social care and with partners.

The Ayrshire and Arran vision aligns to the Scottish Government's vision for the future of primary care services, which is for multi-disciplinary teams, made up of a variety of health professionals, to work together to support people in the community.

In its Lead Partnership role, East Ayrshire is responsible for the development and implementation of the **'Ambitious for Ayrshire'** programme of transformational change for Primary Care services. Good progress has been made in advancing the key priorities outlined in the this programme, which includes the development of **GP clusters** and supporting the development **of multidisciplinary team working** in and with GP Practices, increasing capacity to provide community-based services, improving workforce sustainability, improving **primary care infrastructure** and establishing an **integrated Out Of Hours** service.

Going forward our work will be informed by key Scottish Government policies including the new **GP Contract 2018**, *'Achieving Excellence in Pharmaceutical Care – A Strategy for Scotland'*, 'Community Eyecare Review', 'Oral Health Improvement Plan' and *'Realising Realistic Medicine'* as well as addressing health inequalities.

This work is being delivered in partnership between communities, Primary Care, the three Ayrshire Health and Social Care Partnerships, Acute and Third Sector. These partners are committed to working collaboratively and positively to deliver real change in local health and care systems that support people to receive the right care at the right time.

General Medical Services

General practice provides continuing, comprehensive, coordinated and person-centred healthcare to the communities of Ayrshire and Arran. A **strong and thriving general practice** is critical to sustaining high quality healthcare, which is available to all and which can realise Scotland's ambition to improve our population's health and reduce health inequalities.

A **new General Medical Services (GMS) contract** has been agreed with GPs and will be implemented across Ayrshire and Arran from April 2018. The way in which General Practice will work in the future will change in line with the new contract, the guiding principles of which are to support:

- **accessible** contact for individuals and communities
- **comprehensive care** of people - physical and mental health
- long term **continuity of care** enabling an effective **therapeutic relationship**
- **co-ordinating care** from a range of service providers

The benefits of the proposals is to develop **partnerships** between patients, their families and those delivering healthcare services work to provide care which is appropriate and based on an assessment of individual needs and values and improves wellbeing, demonstrates continuity of care, clear communication and **shared decision-making**.

What this will mean for local residents is that GPs will focus more on seeing patients who are unwell where a GP's skills are required for diagnosis and developing a treatment plan as well as caring for those who have complex care needs. Other professionals such as Advanced Nurse Practitioners, Pharmacists and Community Link Workers or Connectors, Physiotherapists and Mental Health workers will work alongside GPs to assess and treat individuals in line with their own expertise. People often know what care they need and in future more people will be able to seek this directly, so that for example a person with shoulder pain may choose to see a Physiotherapist as a first point of contact, while individuals with minor ailments will increasingly find that Community Pharmacists can provide a range of treatment.

These new changes will be brought in over the next 3 years as part of a Primary Care Improvement Plan. East Ayrshire Integration Joint Board will have the responsibility to ensure the Plan is in place and delivered across Ayrshire.

Some of the first areas for change will be the way local people receive services such as vaccinations, repeat prescribing and medication reviews, community treatment and care services (e.g. minor injuries and dressings, phlebotomy, ear syringing, suture removal, chronic disease monitoring), urgent care and out of hours being supported by advanced practitioners (nurses and paramedics) including for home visits; physiotherapy, mental health services and more use of Community Connectors and Link Workers attached to GP practices.

The Plan will outline how these changes will be delivered before the end of the transition period at March 2021.

Community Pharmacy

The publication of ***'Achieving Excellence in Pharmaceutical Care – A Strategy for Scotland'*** in 2017 by the Chief Pharmaceutical Officer for Scotland, provides an opportunity to review and align community pharmacy services with the Ambitious for Ayrshire vision for multi-disciplinary team (MDT) working in Primary Care. The Strategy makes a commitment to increase access to community pharmacy as the first port of call for self-limiting illnesses and supporting self-management of stable long term conditions, in and out of hours.

Through the Minor Ailment Service (MAS) community pharmacies are increasingly becoming the first port of call for eligible patients for a range of common clinical conditions and NHS Ayrshire & Arran has added to the range of common clinical conditions treatable by community pharmacists under the Pharmacy First Ayrshire service. Women between 16 and 65 can now be treated for uncomplicated urinary tract infections and patients aged 2 years and over, can also be treated for impetigo. Both conditions previously required prescriptions through GP practices or OOH services.

We are also expanding the range of common clinical conditions that can be treated by community pharmacists for other skin infections and shingles, and intend to further expand the range of conditions that can be treated. Expanding the range of common clinical conditions treated will improve outcomes for patients and reduce the workload for GPs and other health and social care professionals.

A number of community pharmacists are qualified as Independent Pharmacist Prescribers (IPPs), providing clinics from their community pharmacy, in conjunction with local GP practices. These clinics include respiratory clinics, as well as hypertension and sexual health clinics. Further training and development of this workforce will unlock a further resource that can play a role in the MDT. Supporting patient self-management of long term conditions will improve outcomes for patients whilst reducing the workload of GPs and other health and social care professionals.

The recent changes to the GP contract and development of the pharmacotherapy service over the next 3 years provides us with an opportunity to introduce a serial prescription service to reduce the time spent in GP practices dealing with repeat prescriptions and to streamline the process at community pharmacies. If more patients have serial prescriptions in place this will allow a greater range of activities identified within the pharmacotherapy service to be carried out by the practice based pharmacists.

The development of GP practice based pharmacists also provides an opportunity for better joint working between GP practices and local community pharmacists. Their mutual understanding of one other's issues will provide opportunities to provide better patient care and medicines management.

Optometry

Community optometrists provide a comprehensive eye examination service model to care for an aging population. The eye examination is universally funded and therefore free of charge to all eligible patients. Geographical access to eye care at optometrist practices across all HSCPs in NHS Ayrshire and Arran is good.

The 'Modern Outpatient Programme' (2016) outlines the further need for a collaborative approach to health care. In Ayrshire and Arran accredited optometrists provide locally enhanced eye care services reducing the burden on secondary care. These include: Low Visual Aids (Visual Impairment); Bridge to Vision (Learning Disability); Post-Operative Cataract Surgery Assessment; Medical Contact Lenses and Diabetic Retinopathy Screening.

Launched in February 2017, the 'Eyecare Ayrshire' re-direction initiative aims to shift the balance of care for eye problems from GP practices and EDs to local optometry practices and promotes the use of the optometrist as first point of contact for eye problems, advising people that eye drops will be available free of charge dispensed from community pharmacists.

Where needed electronic referrals are made directly from optometrists to the hospital eye service. These referrals allow for images to be attached which further enhance the effectiveness of the triage/vetting process and patient care as a consequence. NHS Ayrshire and Arran attain approximately 80% referrals electronically which compares favourably to other Health Boards.

The Scottish Government Community Eyecare Review was published April 2017. The review considered care currently provided within community optometry and identified examples of good practice across Scotland that could be replicated. NHS Ayrshire and Arran was commended in the report for the locally developed initiatives and examples of care already developed within community optometry.

General Dental Services

The Scottish Government published the Oral Health Improvement Plan (OHIP) in January 2018. The plan sets the direction of travel for oral health improvement for the next generation and has a strong focus on reducing oral health inequalities, moving to a preventive based approach for NHS dentistry and meeting the needs of the ageing population.

The aims of the new plan are to focus on prevention, encouraging a more preventive approach to oral health care for patients of all ages to ensure that everyone can have the best oral health possible and that education and information sharing is specifically targeted at individuals and groups most at risk such as those who do not attend regularly for check-ups, communities in low income areas and particularly those people who either smoked or drink heavily. New approaches will also be introduced to make it easier for dentists to treat older people who live in a care home or are cared for in their own home and to enable those dentists with enhanced skills to provide services that would otherwise be provided in a Hospital Dental Service i.e. oral surgery, treatment under intravenous sedation and complex restorative services.

The aim of the ***NHS Ayrshire and Arran Oral Health Strategy 2013-2023***, closely aligns with the new national Plan with the aim of ensuring the 'best oral health possible for the people of Ayrshire and Arran'. The strategy covers stages of life (children and adults) and targets oral health promotion work for priority groups, such as the homeless and prisoners, people in care homes and those with specific care needs. We are currently progressing the ***NHS Ayrshire and Arran Oral Health Action Plan 2016-2019*** and have completed the second year of the 3 year Plan and will continue to deliver oral health improvement activity over the remaining year of the Plan.

Ayrshire Urgent Care Services

NHS Ayrshire & Arran and East Ayrshire Health and Social Care Partnership has launched a new out-of-hours service which will bring together the skills, expertise and capacity of existing out of hours services to enable the citizens of Ayrshire to access the right person, with the right skills at the right time.

Launched in November 2017, the **'Ayrshire Urgent Care Service'** (AUCS) brings together Primary Care and Social Work services into an 'urgent care hub', operating from the Lister Centre at University Hospital Crosshouse .This will be supported by local urgent care centres and the home visiting service as required. In partnership with NHS24 there will be continued promotion of self-care and redirection to the most appropriate service, for example local pharmacist. Ayrshire Urgent Care Service includes:

- Doctors and Advanced Nurse Practitioners
- Out-of-hours district nursing service
- Crisis Resolution Team
- Out-of-hours social work
- East Ayrshire overnight emergency response personal carers
- Service support staff

This redesign is in-line with national policy for urgent care services as set out in the report ***'Pulling Together: transforming urgent care for the people of Scotland, 2016',*** which recognised the difficulty in sustaining GP

involvement in out-of-hours services. The service will continue to test new ways of working to ensure a safe, high quality, effective and efficient out of hours service is delivered to the communities of Ayrshire

Ayrshire and Arran will continue to have an out-of-hours primary care service which will include Doctors and Advanced Nurse Practitioners working a part of a wider team to ensure that members of the public will see the most appropriate healthcare professional

Lead Partnership Mental Health

The **North Ayrshire H&SCP** will continue to manage and deliver the following services on behalf of the East and South Partnerships.

Mental Health Inpatient Services

NA HSCP leads on a wide range **Mental Health Inpatient services** across Ayrshire, including:

- Acute inpatient assessment for individuals experiencing functional and/or organic presentation
- Low Secure male inpatient services
- Intensive Psychiatric care provision
- Generic and forensic rehabilitation services
- Hospital Based Complex Continuing Care for individuals 65 and over on Ailsa site
- Inpatient addiction service, offering inpatient detoxification programme, residential and day attendance rehabilitation programme

Also included within the inpatient portfolio of services are -

- Community Forensic Team
- Elderly, Psychiatric and Alcohol Liaison Services
- Mental Health Advanced Nurse Practitioners
- Acorn – service based at Ailsa offering structured activity, sheltered employment opportunity and supporting individuals who have/are experiencing mental disorder to develop a range of skills

Inpatient services are split between Woodland View on Ayrshire Central Hospital site in Irvine and on Ailsa Hospital site in Ayr, the majority of adult services being based at the new bespoke provision within Woodland View.

Crisis Resolution Team

The Ayrshire Crisis Resolution Team offers a home based **alternative to in-patient care** for adults (aged 16-65) experiencing acute and severe mental health crisis. The service offers short term support up to 21 days, in line with the national standards for crisis services.

Learning Disability Assessment and Treatment Service

People with a learning disability have a significant, lifelong condition that affected their development and which means they need help to; understand information, learn skills, and cope independently. The **Learning Disability Assessment and Treatment Service** is a 16 bed inpatient admissions unit based at Arrol Park Resource Centre, Ayr. The unit provides access to specialist a range of specialist professionals and intensive multi-disciplinary services for all adults living in Ayrshire who have a learning disability.

The unit accepts both planned and unplanned admissions:

- A planned admission to Arrol Park provides short-term intensive assessment and treatment. Where a planned admission is deemed appropriate, a pre-admission meeting will take place with the individual and family members and a range of support staff including; Community Learning Disability Team, designated Social Worker, and Third sector representatives
- Emergency admissions to Arrol Park are facilitated by members of the Community Learning Disability Team. Admissions are agreed with a Responsible Medical Officer and members of the Community Learning Disability Team will be in contact with Arrol Park nursing staff to facilitate the admission process.

The following is a list of criteria for why an individual would be admitted to Arrol Park:

- The person requires a period of complex nursing and therapeutic care which cannot be met elsewhere.
- The person has severe emotional, behavioural or mental health difficulties which cannot be appropriately assessed or treated elsewhere.
- The person requires a period of sustained specialist led support and rehabilitation.
- Where risk evaluation indicates that hospital admission is most likely to reduce short and medium-term risks which are significant and likely to pose a hazard to the patient and/or others.

Psychology Services

Psychological Services are provided across Ayrshire and Arran and are embedded within various specialist teams. Specialities covered are:

- Child Psychology
- Adult Mental Health
- Older Adults, physical health and neuropsychology, and
- Learning disability services

The service deploys a range of staff within these specialist roles to undertake focused work, such as primary care mental health, community mental health and eating disorders.

Child and Adolescent Mental Health Service (CAMHS)

The CAMHS service is available to young people aged 5 to 18 years old and offers short term treatments for those with mild to moderate mental health problems; to more complex treatments for children and young people experiencing more severe and complex problems.

North Ayrshire shall deliver mental health services in line with the **10 year National Mental Health Strategy 2017-2027**. This strategy aims to ensure that mental health problems are treated with the same commitment and passion as physical health problems. We will work to improve: Prevention and early intervention; Access to treatment, and joined up accessible services; the physical wellbeing of people with mental health problems; Rights, information use, and planning.

In addition North Ayrshire has lead responsibility for the following Early Years Services:

Child Immunisation Team

In East and South Ayrshire, the HSCP Immunisation Team deliver all immunisation clinics, where in North clinics are delivered by both the Immunisation Team and many GP surgeries. The team is also responsible for the **pupil immunisation** programme in all Ayrshire schools.

Community Infant Feeding Service

The community **infant feeding nurse** works across Ayrshire to provide a specialist service to families experiencing complex challenges with infant feeding. The service supports health visiting staff with advice and provides direct support to families via telephone, face to face discussions or home visits.

Child Health Administration

Child Health Administration team co-ordinates, manages and supports the delivery of Ayrshire's **child immunisation programme** and development **screening programmes**. The team maintains all records and information in relation to its remit and provides information to the Information Statistics Division (ISD) via nationally established data systems.

Over the next three years, the early years teams will support the implementation of the 3 year Vaccination Transformation Programme and will prepare for the replacement of the current Child Health & Community Health Index (CHI) system, expected by 2020.

Lead Partnership Allied Health Professionals

The South Ayrshire H&SCP manages and delivers the following services on behalf of the East and North Partnerships.

Allied Health Professionals

South Ayrshire HSCP leads on **Allied Health Professional (AHP)** services across Ayrshire. Within this remit are the following services: **Dietetics, Orthotics, Occupational Therapy, Physiotherapy, Podiatry** and **Speech and Language Therapy**. AHPs are a distinct group of specialist and sub-specialist practitioners who apply their expertise to diagnose, treat and rehabilitate people of all ages within both mental and physical health, education and social care and across acute and community settings. They work with a range of technical and support staff to deliver direct care and provide rehabilitation, self-management, "enabling" and health improvement interventions. The Active and Independent Living Programme provides a National Strategic framework for development of AHP services. Locally, four key work streams have been identified to ensure that teams have the necessary support and infrastructure to contribute to the development of services: Workforce; Staff support and development; Data for improvement and research and Development and evaluation

Falls Prevention

A **Falls Strategy Position Statement** was developed in 2016 which outlined the local response to the national action framework for *The Prevention and Management of Falls in the Community* (Scottish Government, 2014). Key areas for future action by each of the Ayrshire Partnerships have been identified to both reduce the numbers of people who fall and improve the personal outcomes for those people who experience a fall.

Further development of multi-agency, **pan-Ayrshire falls pathways** is required as well as improved access to community services and local supports that will improve individual's ability to perform daily activity and reduce anxiety around falling.

Sensory Impairment

Key priority areas have been identified by the Sensory Impairment service. **A Pan-Ayrshire British Sign Language Plan** is being developed and requires to be published by October 2018. Other key areas that will be prioritised include the development and provision of **Sensory Impairment Awareness Training**; the development of mechanisms to share service user's confidential information across Council services; to improve access to service buildings; to provide a wider range of diagnostic procedures and specialist services in the community and to develop a structure where those with sensory loss are involved to improve services.

Continence

The **Integrated Continence Service** promotes continence by empowering patients to self-manage through behaviour and lifestyle interventions. The objectives of the service are to offer intermediate clinics across Ayrshire and to offer an advisory service to patients, carers and voluntary organisations and educational service to NHS clinicians.

Technology Enabled Care (TEC)

The Ayrshire and Arran strategy for **TEC and Innovation** outlines the need to harness the advances in technology and to develop the use of TEC across Ayrshire and Arran over the next three years. North, South and East Health and Social Care Partnerships and Acute Services are currently redesigning models of care and TEC will support and further enable services, the workforce and infrastructure transformational redesign.

Joint Equipment Store

Officers from across the three Ayrshire Council's and NHS Ayrshire & Arran have been in discussion about the feasibility of establishing a joint store for the provision of equipment to people living in the community. The equipment referred to is wide ranging and intended to enable people to live safely within their own homes.

Health Visiting (HV)

The HVs and their teams support the universal services that improve the health and wellbeing of children. This is part of an integrated approach to supporting children and families within the wider multidisciplinary teams, supporting development and engagement with specialist services. The HVs work in partnership with public health, social care, paediatrics, education and the wider public services to safeguard children and families. HVs are key in ensuring robust systems are in place to identifying families that require further support, assessing need and delivering interventions.

Family Nurse Partnership (FNP)

The **Family Nurse Partnership (FNP)** is a licensed programme where specially educated nurses work with first-time teenage mothers to develop their parenting capacity and support them to make positive choices for themselves and their children. The FNP aims to prevent damage a child's brain development, behaviour, learning, and long-term health by having a specially educated nurse visit the homes of first-time teenage mothers from early pregnancy (before 28 weeks) until their child is two years old. The programme has been shown to produce many benefits including improved early language development and academic achievement, reductions in children's injuries, neglect and abuse and fewer subsequent pregnancies and greater intervals between births.

School Health (SN)

The school nurse (SN) role is a significant part of the school health service, which is a universally accessible service provided to children and young people, aged 5-19 years and their families. The role focuses on delivering consistent and efficient services across Scotland in order to deliver safe, effective and person-centred care based on the principles of Getting It Right for Every Child (GIRFEC) national practice model. Based on available evidence, policy direction and priorities, the role focuses on priority areas which include mental health and wellbeing, substance misuse, domestic abuse, homeless children and young carers.

Looked After and Accommodated (LAAC)

Children who are looked after by local authorities can remain at home or be provided with accommodation away from their normal place of residence (i.e., kinship/ foster/residential placement, respite care). The lead professional from the Health Board, is a key worker who assesses the individual needs of the child and liaises with the wider multidisciplinary team over the delivery of healthcare. This role supports Looked after children's nurses links to school nurses, health visitors and paediatricians have the capacity to refer to other services, identify health records and request them from the NHS Board in whose care they are held, provide a comprehensive health assessment. The role is essential in connection between the child protection processes and wider structural processes to support and plan services for vulnerable people.

Section 6: Policy Context

Why is this important?

The wider policy context in relation to health and social care continues to evolve with developments being driven by wider economic, societal and technological changes.

Where are we now?

The key policy developments that continue to shape and influence the delivery of services include:

- The Palliative and End of Life Strategic Framework for Action;
- Report of the National Review of Primary Care Out of Hours Services;
- The Review of Public Health in Scotland
- A National Clinical Strategy for Scotland
- Social Services in Scotland: A shared vision and strategy 2015-2020.
- Healthier Scotland Conversation
- Health and Social Care Delivery Plan
- Realising Realistic Medicine (Report by Chief Medical Officer for Scotland)
- National Primary Care Vision
- Self-Management Strategy for Long Term Conditions in Scotland
- Children and Young People (Scotland) Act 2014
- Carers (Scotland) Act 2016

These policy and legal developments will shape our strategic and operational work during the planning period. Alongside this there have been developments at parent body, regional and UK level that need to be recognised in our activities:

NHS Ayrshire and Arran Transformational Change Improvement Plan 2017-2020: and associated Delivery Plan 2017-18. This is the local delivery plan for NHS services and includes delegated services. It describes how transformational change programmes will deliver improvements designed to meet the needs of the local population.

East Ayrshire Council Transformation Strategy 2: "Closing the Gap" sets out the Council's proposals for transformational change in local authority services between 2017-2022. The strategy is currently being developed via engagement and consultation with partners and communities and continues the message of a definitive shift in spending towards outcomes based services built around people and communities, towards prevention and early intervention and a fundamental, innovative redesign of services to achieve financial and organisational sustainability.

West of Scotland Regional Delivery Plan for Health and Social Care: Scottish Government has commissioned the development of plans to encompass the whole system of health and social care in three regions; North, East and West. In the West Region, this means planning for a population of 2.7 million people by 5 NHS Boards, 16 Local Authorities, 15 Health and Social Care Partnerships as well as the Golden Jubilee Foundation. Implementation Leads have been identified to take this work forward across the country.

Welfare Reform: The implications of the Government's Welfare Reform programme and the roll-out of Universal Credit in East Ayrshire will be significant. There are concerns that the reduction in welfare spending will impact negatively on income inequality, poverty and child poverty and on equality groups, including the impacts on women and people with disabilities.

It is projected that welfare spending in Scotland will be reduced by around £0.9 billion by 2020/21 as a direct result of these reforms, which equates to a loss per working age adult in East Ayrshire of £299 per annum. This reduction in incomes for individuals and families in receipt of benefits will likely exacerbate the already significant levels of poverty which exist across East Ayrshire and have a detrimental impact on the physical and mental health and wellbeing of those living in situations of poverty.

Addressing the impact of these reforms will be a further challenge for the Partnership over the life time of this Strategic Plan.

Where do we want to be?

Our activities are planned, designed and delivered to achieve the positive outcomes described in local and national policy. We ensure connectedness across our integrated teams and systems so that we are all working towards the same goals.

How will we get there?

- We will incorporate and align the key elements of these policy changes with our strategic and delivery plans.

- We will work across financial inclusion partners to offset the impact of welfare reform in our communities, including participation in the 'Menu for Change' programme aimed at tackling food insecurity.

Section 7:
Needs, Assets and Performance

Why is this important?

Understanding the needs of our communities and the assets that they have to improve their outcomes is key to our approach to transforming the way we design and deliver our services. Our ability to manage performance at a strategic and operational level helps us to measure our progress towards improvement.

Where are we now?

Demographic Influences

Our community is experiencing significant demographic change with extensive impact on current and future demand for services. Demographic change highlights why continuing to deliver health and care in the way we have done is no longer an option and why we need to focus on transformation.

- Demographic change is expected to result in an increase in the number of older people by over 30 per cent between now and 2026 and over 70 per cent by 2036.
- Over the 2016-36 period the number of people with dementia in East Ayrshire is expected to increase by 35%.
- The number of individuals aged 65 and over with one or more long term health condition is projected to increase from 14,411 to 17,360 in 2026 (an increase of 20%).
- The number of emergency attendances is projected to increase by 2.4% in 2026 and by 3.6% by 2036. The percentage of emergency attendances involving patients aged 65+ is projected to increase from 22.8% (2016) to 27.8% in 2026 and 33.8% in 2036.
- People living in the West of Scotland present to Emergency Departments at a rate which is 8 per cent above that expected from the population. Emergency admissions to hospital are 6 per cent higher than expected.
- Four groups of people, accounting for 19 per cent of hospital admissions, used 69 per cent of bed days and made up 61 per cent of costs (complex cases, adult major injuries, frailty and end of life).
- An expected rise in the number of children and young people living in low income families is expected to increase demand.

There has been significant focus on improving flow through hospitals with day-based care increasing and the length of stay in hospital reducing. However, there is a tendency for emergency admissions to hospital to increase.

This points to areas where effort must be concentrated to better support people in the community and to address unscheduled care.

Understanding the needs of our communities

We use research, data and intelligence from a variety of sources to understand need. The Local Intelligence Support Team (LIST) provide analysis and data.

- Public health analysis of the population in the West of Scotland suggests that multiple deprivation and ageing within our communities are major drivers of demand, particularly for unscheduled care.
- Life expectancy has a long-term tendency to increase, but indications are that this has slowed and that there is fall in life expectancy in some areas. This is a recent trend which seems to be the case for women and for older people in small towns and rural communities.
- The reasons for this emerging trend are complex and linked to the impact of the economic crisis, lifestyle related ill-health, e.g., alcohol-related harm, smoking, unhealthy weight and diabetes.
- There is unexplained variation in the use of unscheduled care within and between communities which needs to be better understood and addressed where this results in inequitable distribution of resources.
- Statistical modelling work has been completed to inform understanding of demand and capacity. Analysis shows that improvements have the potential to reduce occupied bed days in the unscheduled care system and to offset projected demographic pressures.
- There is a relatively high rate of emergency admission for conditions where effective community care and case management could prevent hospital admission.

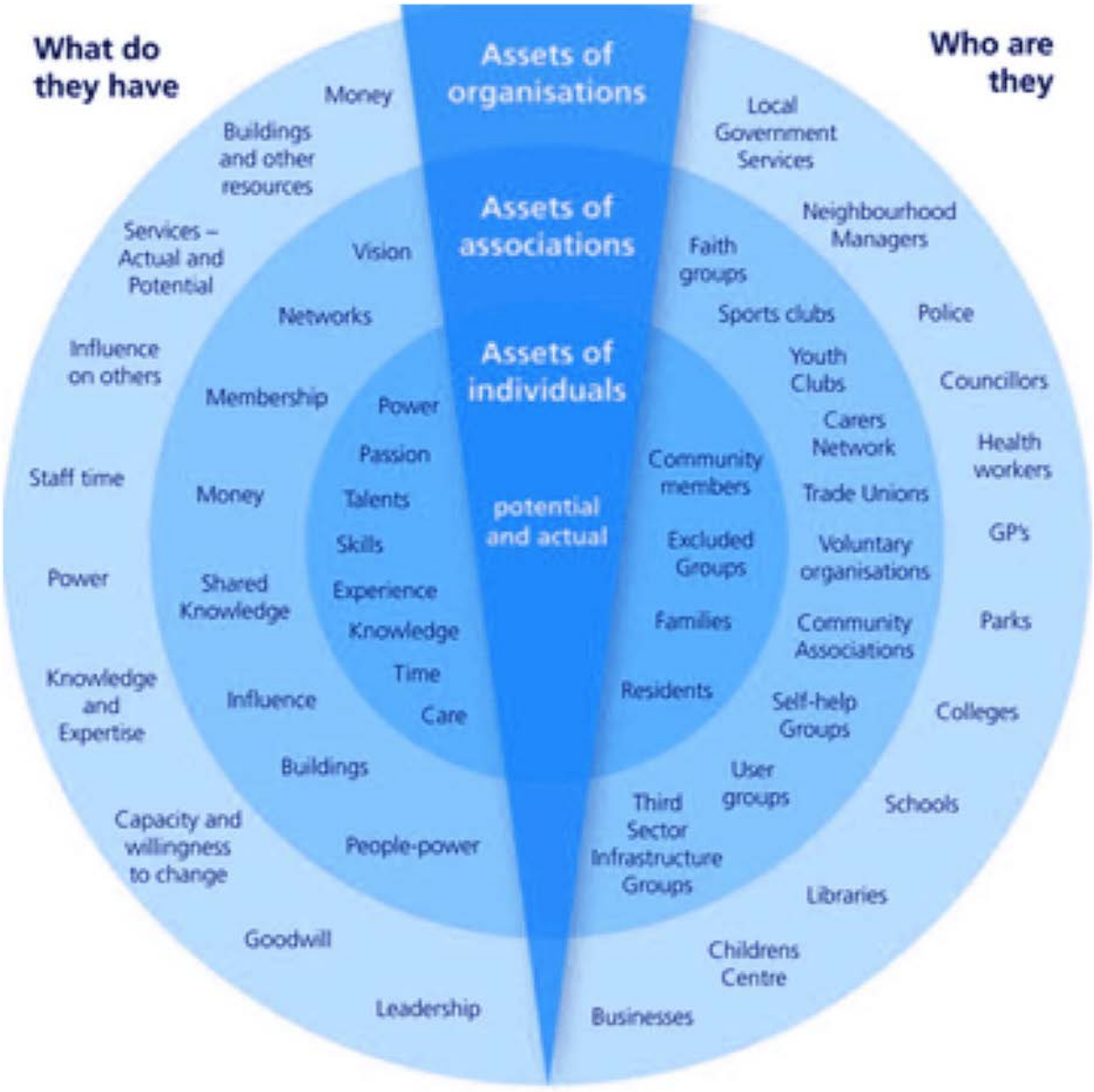
- Analysis of Ambulatory Care Sensitive conditions (ACS) shows that individuals with certain conditions are admitted to hospital where they may have experienced deterioration or where provision of care in a community (or outpatient) setting could have resulted in their condition being managed more effectively.
- Modelling indicates that there is potential to further increase the percentage of cases managed in this way.

A number of improvements with positive impact across the system are suggested including: improved access to senior decision-making at ED; rapid access clinics; improved ambulatory care pathways; work to reduce variability in length of stay; earlier discharge, and; high impact changes associated with community care capacity, intermediate care and multi-disciplinary working.

Asset Mapping

Community assets are a key resource in the delivery of transformational change and in the strategic shift to focus on prevention, self-management and more effective use of community based services.

In partnership with CVO East Ayrshire a range of asset mapping activity in our localities has taken place. This has added valuable information about resources in our communities, allowing us to build up an understanding of assets and activities within our communities that can contribute to wellbeing.



Through the ongoing development of the **MyEastAyrshire** online Community Directory and other digital resources, we will connect people in East Ayrshire with information and contact details for organisations, local groups, businesses and care providers who deliver a range of support.

The Independent Sector is also working closely with the Partnership to develop and provide services that meet the needs of East Ayrshire residents. This has involved the Independent Sector utilising community assets to provide services that support delivery of transformational change through provision of locally based step up/step down services, dementia friendly environments and specialist palliative care support.

Performance

We have developed a systematic approach to performance management, which links accountability to the National Health and Wellbeing Outcomes. Our approach provides information on our current levels of performance and helps identify shifts in performance trends over time. Through monitoring and analysis of our performance we can identify areas requiring improvement, which in turn informs strategic planning.

Our performance management focuses on the National Health and Wellbeing Outcome indicators. A combination of Statutory Performance Indicators, Wellbeing Delivery Plan local outcome indicators and local measures are included in Quality Assurance and Improvement Dashboards for Community, Health and Care Services, Primary Care and Out of Hours Community Response and Children's Health, Care and Justice Services.

The core set of indicators developed by the Ministerial Strategy Group is a further component of performance. These measures help provide a whole system overview and focus on six key areas: emergency admission; unscheduled hospital bed days; emergency department (ED) attendances; delayed discharge bed days; the percentage of the last six months of life spent at home or in community settings, and; the balance of care between community and institutional settings.

We produce an annual performance report covering the breadth of performance and have published two reports; our first in 2015/16 the second for 2016/17 Annual Performance Report 2016/17. We recognise the importance of benchmarking to identify improvement and understanding of local performance against peer areas.

Where do we want to be?

We have robust and agreed needs, assets and performance information about our communities, initiatives and services that is used across partners to drive our transformation decisions.

How will we get there?

- Continue to develop our approach to asset mapping with partners.
- Use local intelligence to direct improvement on an ongoing basis, e.g., identify and address unwarranted variation, or higher than expected emergency presentation at hospital.
- Ensure that the implementation of new Models of Care takes into account the findings of system modelling work.
- Promote on-line/digital resources that signpost community assets and sources of support in communities.
- Implement the findings of the Burns review of "Targets and Indicators in Health and Social Care in Scotland[1] ".

[1]*The review suggests that indicators and targets should be based upon the principles of purpose, co-production, review and whole system relevance. The current system requires to be refocused on impact, improvement and contribution to wellbeing across the life course.*

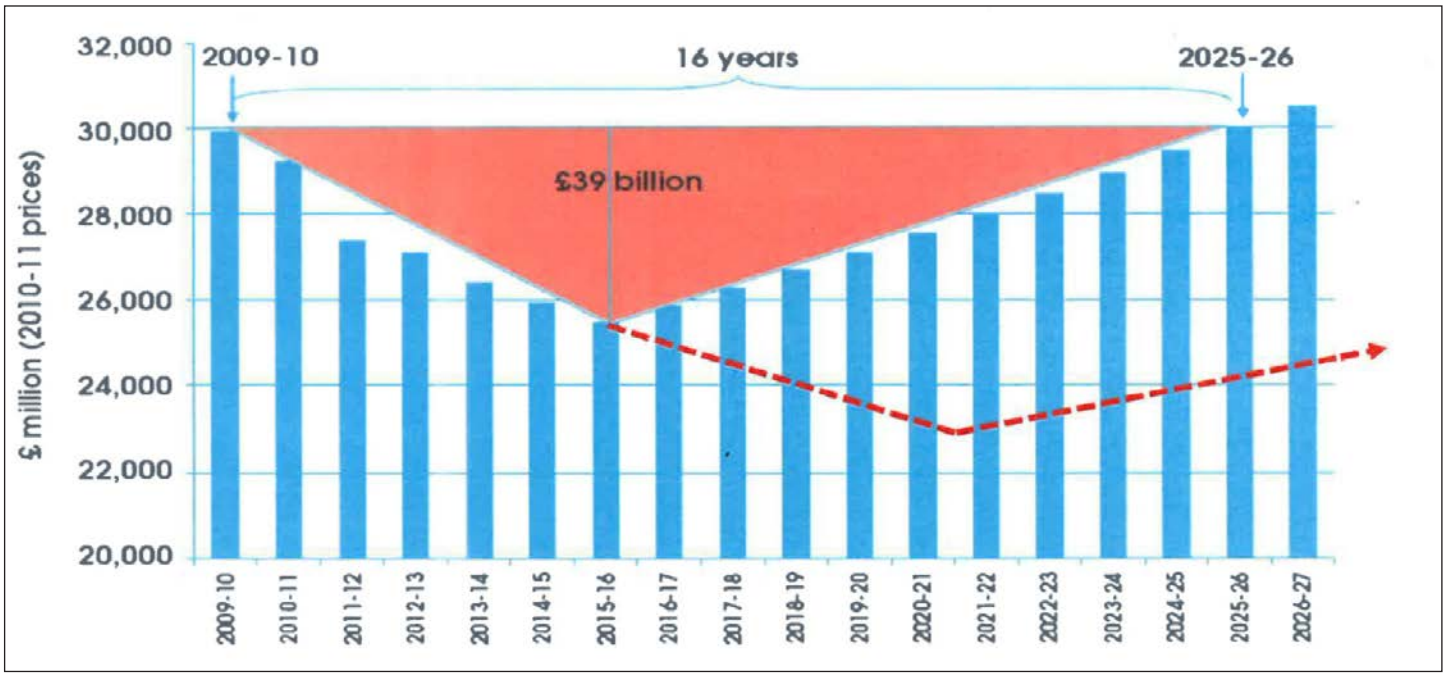
Section 8: Financial Framework

Why is this important?

Scotland is in the midst of significant change in terms of the scale and composition of its public sector budget. This is the first time since the end of World War II that budgets have declined, in real terms, over an extended period. Reducing budgets are critical to our approach to transforming our activities and how we commission services.

Where are we now?

The graph below shows the original predicted gap in funding of £39bn for public services in Scotland with budgets recovering from 2015-16 returning to the levels experienced before the economic downturn by 2025-26. Current estimates, shown as the red dotted line in the graph, are for a further spread in the funding gap with signs of any recovery delayed until 2021-22.



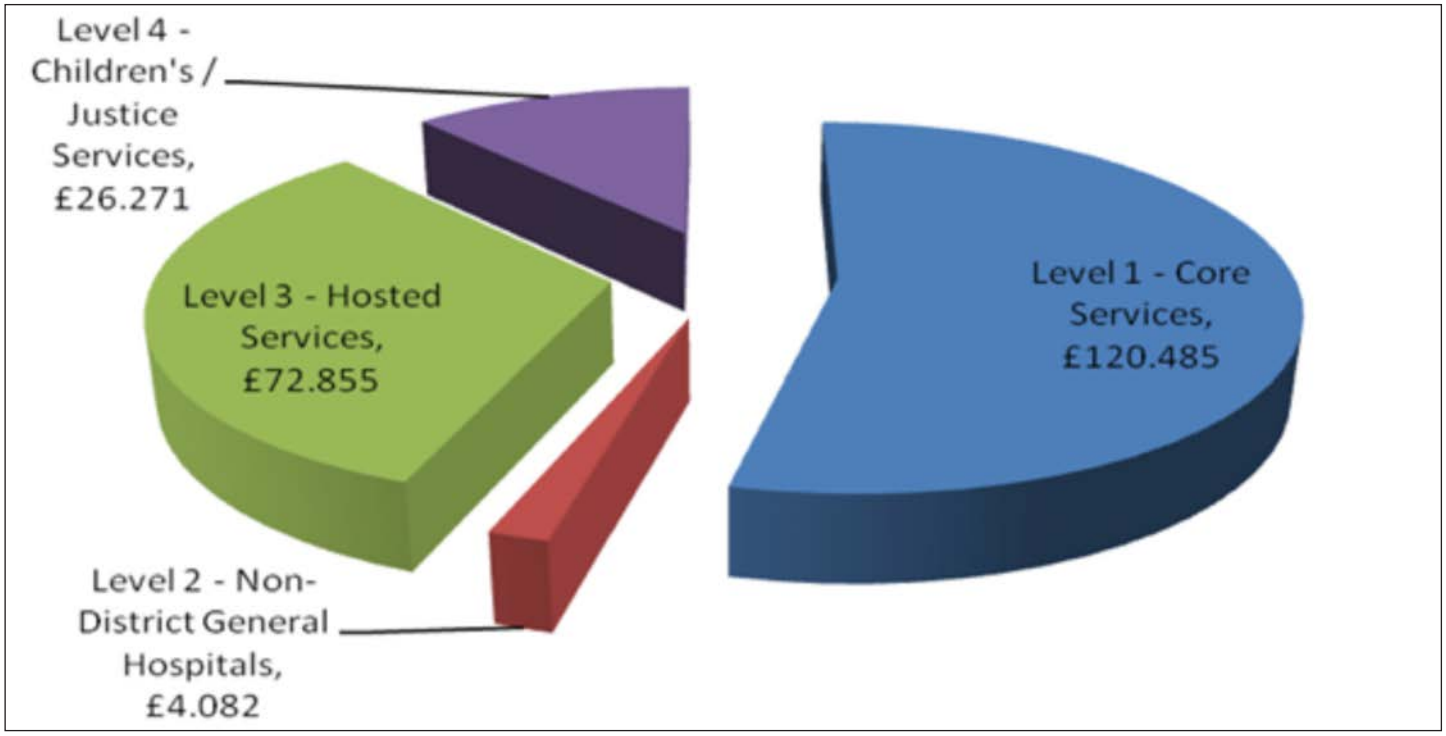
The Partnership's budget is delegated to it by the Council and NHS. As financial settlements to partners reduce, the financial challenges of the Partnership increase.

Analysis and projections of cost pressures have been undertaken and the IJB approved a Medium Term Financial Plan on 30 November 2017. In summary, the Medium Term Financial Plan sets out a £37.881m indicative funding gap for the Partnership until 2021-22.

We fully recognise the unprecedented levels of savings required and in order to meet this challenge alongside the demographic and societal challenges outlined earlier, we need to deliver transformational change in the way health and social care services are planned, delivered and accessed in East Ayrshire.

Should current practice continue, early modelling work has suggested that NHS Ayrshire and Arran would need an additional 398 beds by 2035 to meet this demand.

The 2017-18 budget for the Partnership is £223.693m in respect of Council and NHS managed services is illustrated in the chart on the following page.



The partnership has a responsibility, with our local hospital services at Crosshouse and Ayr, for planning services that are mostly used in an unscheduled way. The aim is to ensure that we work across the health and care system to deliver the best, most effective, care and support.

'Set aside' budgets relate to the strategic planning role of the Partnership. Key areas within this budget are: accident and emergency; inpatient services for general medicine, geriatric medicine, rehabilitation, respiratory and learning disability psychiatry, and palliative care services provided in hospital. The indicative 'set aside' budget for large hospital services which are used in a predominantly unscheduled way in 2018/18 is £19.3M for East Ayrshire.

This Financial Framework provides the context for our commissioning intentions over the course of the 2018-21 Strategic Plan. The commissioning implications of these priorities are set out in Section 9 – 12. This takes into account related system-wide change programmes.

As summarised in Section 4, our Strategic Priorities are:

- **Prevention and Early Intervention;**
- **New Models of Care;**
- **Building Capacity in Primary and Community Care, and;**
- **Transformation and Sustainability.**

Our commissioning intentions over the 2018-21 period will focus on the **'triple aim'** set out in the Health and Social Care Delivery Plan. The triple aim can be summarised as:

- 'Better Care' - improving the quality of care by targeting investment at improvement and delivering the best, most effective support;
- 'Better Health' - improving health and wellbeing through support for healthier lives through early years, reducing health inequalities and focusing on prevention and self-management, and;
- 'Better Value' – increasing value and sustainability of care by making best use of available resources, ensuring efficient and consistent delivery, investing in effectiveness, and focusing on prevention and early intervention.

Partnership working extends beyond our own services and includes close working with Education, Vibrant Communities, leisure and the Third and Independent sectors. The latter often support the delivery of **innovative responses to need within our localities**.

The indicative consolidated budget for 2018/19 is shown in the table below.

	2018/19 Draft Budget HSCP £m	2019/20 Indicative Budget HSCP £m	2020/21 Indicative Budget HSCP £m	2018/19 Draft Budget Health £m	2019/20 Indicative Budget Health £m	2020/21 Indicative Budget Health £m	2018/19 Approved Budget EAC £m	2019/20 Indicative Budget EAC £m	2020/21 Indicative Budget EAC £m
Level One Core									
Adult Support and Protection	0.190	0.190	0.190	0.000	0.000	0.000	0.190	0.190	0.190
Learning Disabilities	14.587	14.587	14.587	0.507	0.507	0.507	14.080	14.080	14.080
Mental Health	4.961	4.961	4.961	2.071	2.071	2.071	2.890	2.890	2.890
Physical Disabilities	2.320	2.320	2.320	0.000	0.000	0.000	2.320	2.320	2.320
Older People	34.882	34.882	34.882	0.000	0.000	0.000	34.882	34.882	34.882
Addiction	1.310	1.310	1.310	1.123	1.123	1.123	0.187	0.187	0.187
Sensory	0.187	0.187	0.187	0.000	0.000	0.000	0.187	0.187	0.187
Community Nursing	3.413	3.413	3.413	3.413	3.413	3.413	0.000	0.000	0.000
General Medical Services	15.558	15.558	15.558	15.558	15.558	15.558	0.000	0.000	0.000
Health Improvement	0.307	0.307	0.307	0.000	0.000	0.000	0.307	0.307	0.307
Prescribing	25.678	25.678	25.678	25.678	25.678	25.678	0.000	0.000	0.000
Service Strategy (HSCP Management)	7.039	7.039	7.039	0.815	0.815	0.815	6.224	6.224	6.224
Transport	0.470	0.470	0.470	0.000	0.000	0.000	0.470	0.470	0.470
Integrated Care Fund	2.470	2.470	2.470	1.264	1.264	1.264	1.206	1.206	1.206
Resource Transfer	10.473	10.473	10.473	10.473	10.473	10.473	0.000	0.000	0.000
Total Level One	123.845	123.845	123.845	60.902	60.902	60.902	62.943	62.943	62.943
Level Two - Non District General Hospitals									
East Ayrshire Community Hospital	2.960	2.960	2.960	2.960	2.960	2.960	0.000	0.000	0.000
Kirklandside Hospital	1.187	1.187	1.187	1.187	1.187	1.187	0.000	0.000	0.000
Total Level Two	4.147	4.147	4.147	4.147	4.147	4.147	0.000	0.000	0.000
Level Three - Hosted Services									
Primary Care (Including Dental)	68.930	68.930	68.930	68.930	68.930	68.930	0.000	0.000	0.000
Prison and Police Healthcare	3.007	3.007	3.007	3.007	3.007	3.007	0.000	0.000	0.000
War Pensioner	1.224	1.224	1.224	1.224	1.224	1.224	0.000	0.000	0.000
Other Lead Services	0.318	0.318	0.318	0.088	0.088	0.088	0.230	0.230	0.230
Total Level Three	73.479	73.479	73.479	73.249	73.249	73.249	0.230	0.230	0.230
Level Four - Children's / Justice Services									
Children & Families / Women's Services	17.694	17.694	17.694	0.000	0.000	0.000	17.694	17.694	17.694
Outwith / Secure Placements	4.791	4.791	4.791	0.000	0.000	0.000	4.791	4.791	4.791
Health Visiting	2.278	2.278	2.278	2.278	2.278	2.278	0.000	0.000	0.000
Justice Services	1.875	1.875	1.875	0.000	0.000	0.000	1.875	1.875	1.875
Total Level Four	26.638	26.638	26.638	2.278	2.278	2.278	24.360	24.360	24.360
Partnership Total	228.109	228.109	228.109	140.576	140.576	140.576	87.533	87.533	87.533

Section 9: Strategic Commissioning Intentions - Prevention and Early Intervention

We will scale-up universal prevention and early intervention work across Work, Alcohol, Tobacco, Obesity and Mental Health (WATOM). We will work with LIST analysts, public health and business intelligence to define where interventions can be most effectively targeted.

From initial analysis and self-evaluation our focus will be:

- Early years outcomes as a result of child poverty and deprivation;
- Potentially preventable ill-health;
- Higher levels of premature mortality (Cardiovascular and Respiratory disease);
- An ageing population and multiple long-term conditions.

Achieving this will require **collaboration** across Community Planning Partners and within Localities. This will involve leadership from the **workforce at every level**.

It is widely recognised that the **early years** of a child's life are of crucial importance and can affect future health, wellbeing and life chances. Our approach is to identify and respond to strengths, and to empower people, families/ cares and communities to be in control of their lives, with access to opportunities and services (where required).

This means **shifting resources** from **crisis intervention** to **family** and **community support**, which facilitates earliest possible identification of the need for additional support. Based on evidence of the challenges that our children and young people face in terms of poverty, safety, educational attainment and wellbeing, our priorities are:

- Youth Employment
- Tackling child poverty
- Alcohol and Drugs

In addition to these high level priorities, our **Children and Young People's Service Plan** has developed priorities for further improvements, with a key focus on: raising educational attainment, particularly in respect of looked after children; improving emotional wellbeing, and; improving opportunities for looked after children

Prevention and early intervention is a **positive choice** in the current resourcing context. With the embedding of prevention and earlier identification of need for support we can **offset the need** for more intensive or acute **involvement at a later date**. Prevention and early intervention assists with managing demand, releasing resources and **improving outcomes** in the longer term.

Part of this relates to **stretch aims** within the Children and Young People's Service Plan. Specifically this includes the aim to reduce smoking and alcohol consumption in pregnancy and to increase exclusive breastfeeding rates.

The expected effect of these stretch aim areas over the planning period would be to:

- Reduce the number of women smoking in pregnancy from 300 to 226;
- Reduce alcohol use during pregnancy from 397 to 196, and;
- Increase the number of women exclusively breastfeeding at 6-8 weeks from 201 to 333;

A range of prevention and early intervention programmes is in place with many developed from tests of change under the former Integrated Care Fund. There are proposals to extend this, for example, a diabetes prevention and early intervention programme focused on evidence-based activity to target Type 2 diabetes and gestational diabetes through unhealthy weight in pregnancy.

Working together to **reduce the impact of** the main public health and **wellbeing challenges** in East Ayrshire arising from higher levels of alcohol related harm, tobacco use and obesity is expected to have the following impact over the course of the Strategic Plan:

- Reducing alcohol-related admissions from 970 to 910 per annum;

- Reducing the number of adults smoking from 20,188 to 17,665;
- Improving levels of physical activity to reduce overweight and obesity in the population from 69,600 to 65,600, and;
- Reducing the number of unscheduled mental health bed days occupied in hospital from 20,545 to 18,901.

A programme of **health literacy**, **self-management**, supported self-management for people with long-term conditions is expected to result in:

- An increase from 500 to 1,500 people engaged in health literacy programmes, and;
- A reduction in the number of bed days used as a result of admissions related to the main long-term conditions from 9,500 to 7,600.

The estimated potential annual costs avoided to health and social care in East Ayrshire of action to achieve these Strategic Commissioning Intentions in Prevention and Early Intervention are £1.3M in the first year, rising to £3.3M by year three. While not all of these are cash releasing they do all represent **real cost avoidance** to the health and social care system and the public purse.

It is expected that planned interventions in alcohol, mental health and long-term conditions management could release resources of £0.708M by year three. Over the lifetime of the Strategic Plan 2018-21 it is expected that arrangements will be agreed to enable further release of these efficiencies across the system of health and social care through **invest to save** programmes. **Joint planning** in relation to the **'set aside'** budget will be a key mechanism for achieving this.

During the 2018-21 Strategic Plan we will:

- **Scale up** our joint approach to preventing and tackling ill-health in our communities linked to wellbeing, alcohol, tobacco, obesity and mental health.
- Ensure all staff working within the HSCP including independent and voluntary sector and are trained on inequalities, cultural competence, human rights, equality and diversity.
- Tackling inequality through addressing health literacy and raising awareness and capabilities of our workforce, spreading the use of **health literacy** tools, supporting accessible self-management tools and deploying new technology solutions.
- Ensure that ethical care commitments/charters are embedded in partnership practices.
- **Advocate** for and highlight the key opportunities that **address inequalities**.

Section 10: Strategic Commissioning Intentions - New Models of Care

We are designing and implementing new approaches to our provision of health and social care services for older people and those with complex conditions, which is aimed at shifting the balance of care from hospitals to more homely and community-based settings.

Taking forward the Strategic Commissioning Intentions – New Models of Care is expected to **increase the integration** of services, improve **multi-disciplinary working** within localities and further strengthen **partnership working** between professions, individuals and communities.

The effect of implementation of the New Models of Care workstreams includes trajectories submitted to the **Ministerial Strategy Group** in relation to the indicators for 'Measuring Performance Under Integration'. Expected impact over the course of the Strategic Plan includes:

- A four per cent reduction in unplanned bed days from baseline of 103,808 to 99,656;
- A nine per cent reduction in emergency department from 40,865 to 37,187;
- A reduction from 4,157 to 3,120 (25%) in occupied bed days where people spend longer in hospital than necessary and could be better supported in another setting due to incapacity law;
- An increase in the number of days in the last six months of life spent in the community rather than large hospital setting from 227,041 to 236,805;
- The delivery of a Care of the Elderly Physician, Advance Care of the Elderly practitioner model;
- Embedding multi-disciplinary Care Home Liaison;
- Commissioning Adults with Incapacity intermediate care bed provision;
- Development of pulmonary rehabilitation model;
- A reduction in the number of people placed in care homes from baseline of 725 to 700, and;
- An increase in reablement and redirection through the new 'front door' model resulting in reduced demand for formal support at home.

The estimated potential annual costs avoided to health and social care of action to achieve these Strategic Commissioning Intentions in New Models of Care are £5.1M in the first year, rising to £6.7M by year three. While not all of these are cash releasing they do all represent **real cost avoidance** to the health and social care system and the public purse.

It is expected that the implementation of New Models of Care Strategic Commissioning Intentions could release resources of £1.4M by year three. Over the lifetime of the Strategic Plan 2018-21 it is expected that arrangements will be agreed to enable further release of these efficiencies across the system of health and social care through **invest to save** programmes. **Joint planning** in relation to the **'set aside'** budget will be a key mechanism for achieving this.

During the 2018-21 Strategic Plan we expect:

- Implementing the East Ayrshire Models of Care Programme for **Rehabilitation and Reablement**.
- Continuing to redesign **intermediate care** at home services, modernising day hospitals and developing community based rehabilitation.
- Implementing the East Ayrshire Models of Care Programme **End of Life Care** workplan.
- Establishing and implementing **locality based multidisciplinary** service delivery models.
- Reducing inappropriate referral, attendance and admission to hospital, better signposting to ensure the right treatment in a timely fashion, and reducing unnecessary delay in individuals leaving hospital.
- Working together to reduce the levels of delayed discharges, ensure services are in place to facilitate **early discharge** and **avoid preventable admissions** in the first place.
- Maintaining upper quartile performance in delayed discharge bed days occupied.

Section 11: Strategic Commissioning Intentions - Building Capacity in Primary and Community Care

Within Primary Care we are widening the concept of the Practice Team to ensure that patients benefit from a wider range of available support. Practices will typically consist of complementary teams of professionals led by a GP but supported by highly-trained nurses, physiotherapists, pharmacists, mental health workers and social workers.

At a national level the intention is to see **investment** in Primary and Community Care **rising to more than half of frontline spending in health services** and an increasing **shift of the budget** towards investment in mental health, primary, community and social care. There is a national commitment to increase investment in Primary and Community Care by £500M by the end of the Parliament.

A new General Medical Services contract is in place, with a new funding formula, covering a transitional period of three years which aligns with the lifespan of this Strategic Plan. There is a longer-term plan for shifting responsibility for premises to NHS Boards alongside the new contract.

The **2018 General Medical Services Contract in Scotland** envisages a new role for the GP as an 'expert medical generalist'. This means GPs focusing on complex care, quality and leadership.

An extended Multi-Disciplinary Team (MDT) in Primary Care will cover a number of activities which are at present generally undertaken by GPs. This will include prescriptions, minor illnesses, and chronic disease management. Further developments relate to pharmacotherapy, and community treatment and care, e.g., phlebotomy, minor injury.

It is expected that investment across NHS Ayrshire and Arran will be around **£3.3M** for 2018/19 rising in line with the national commitment to increase investment in Primary and Community care described above on the basis of NRAC share.

During the 2018-21 Strategic Plan we expect:

- MDTs to expand to include pharmacy and prescribing support, physiotherapy, mental health support and community link workers.
- The specifics of these developments to be set out in a **Primary Care Improvement Plan** which will be put in place from **July 2018**.
- To work with National Boards to realise the benefits of developments, e.g., Scottish Ambulance Service and NHS24.
- There to be one coordinated Primary Care Improvement Plan for Ayrshire and Arran, with a focus on local priorities and delivery where services are commissioned within the HSCPs based on population need. Supporting this, there will be three distinct sections for each of the HSCPs to deliver the local needs of each IJB.
- Governance arrangements (structures and reporting processes) to provide a **programme approach** for working together across the three **HSCPs**, the **NHS Board**, the **GP Sub Committee** to jointly produce the Primary Care Improvement Plan and allow for ratification by the **IJBs** and **LMC**.
- The Primary Care Improvement Plan to be progressed through **Workstream Implementation Groups** established to design and implement the required changes to meet priorities. These include:
- Pharmacotherapy Service;
- Primary Care Nursing Services (will include two sub groups for the delivery of vaccinations and Community Treatment and Care services);
- Urgent Care, and;
- Practice Based Multi-disciplinary Team (includes Community Link Workers).

Section 12: Strategic Commissioning Intentions - Transformation and Sustainability

As a Partnership we have undertaken significant work to understand our challenges and how we can best meet these within a new financial context while continuing to strive towards our ambitions. We need to close the financial gap and transform how we work to achieve sustainability.

The **Medium Term Financial Plan** has identified a future **financial gap** of **£37.8M** by 2021/22 if we continue to deliver as we have. The financial gap is driven by **increasing demand**, **cost pressures** and a **constrained resource** envelope available for delegation to the IJB by partners.

If we are to deliver on our ambitions we need to **close the gap** and achieve **sustainability**. The Partnership has developed a range of actions to make **more efficient use** of our existing resource and is taking these forward through a Strategic Commissioning Board.

This is only part of the solution. Annual operational efficiencies within Partnership will not be sufficient. Scaling up prevention and early intervention, new models of care and building capacity in primary and community care – will be critical to **truly transform** how we work and **achieve sustainability**.

From engagement on this Plan feedback is that we need to transform what we do while continuing to deliver and this requires us to create **'space** and resources **to develop good ideas** and innovate' across **all partners**. We need to take a **'whole system'** approach across services to **avoid 'unintentional consequences'** where 'change in one area could have a negative impact in another'.

In transforming we will **build on strong relationships** and further developed this by **working with communities** linked to Community Led Action Plans to support capacity and self-care. Feedback tells us that we must continue to 'ask members of the community', to fully involve individuals, families and communities in co-design so that transformation is 'done at a pace set by those affected to ensure readiness'.

From engagement we recognise a need to **respond proportionately**, to avoid overprescribing support and creating dependency. We need to **value our preventative activity** – 'keep it simple but value it' is a key message in transformation. Also that some people just need 'a listening ear'. Throughout our transformation and sustainability work we will keep in mind that 'kindness is important. The small things make a difference…It's not about loads of money'.

Health and social care transformation will be an integral part of partner transformation programmes in **NHS Ayrshire and Arran** and **East Ayrshire Council**.

Relevant NHS Ayrshire and Arran Transformational Change Improvement Plan 2017-20 workstreams are:

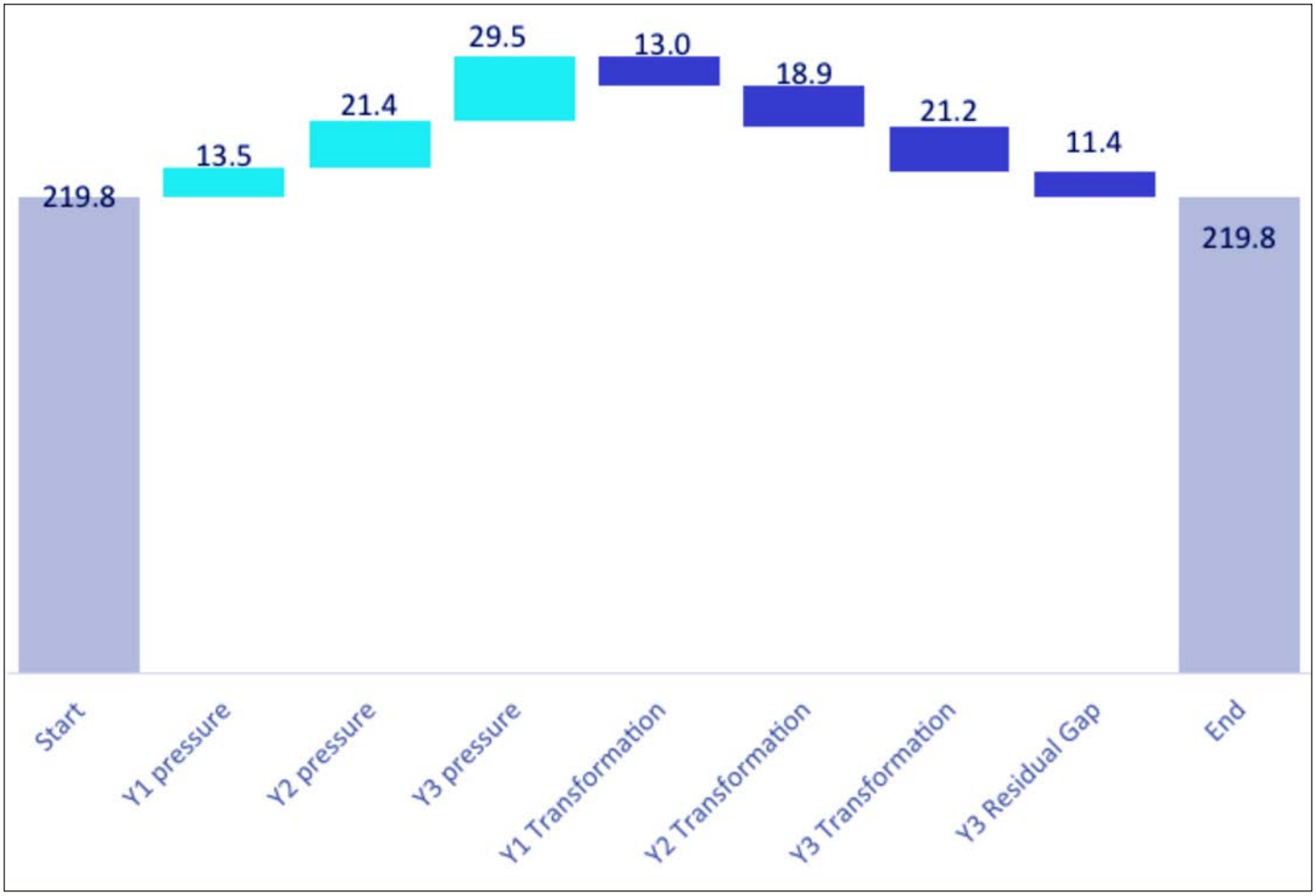
- Unscheduled Care including Older People and People with Complex Care Needs;
- Ambitious for Ayrshire;
- Mental Health, and;
- Planned Care: Improving Access – The Modern Out-Patient.

Relevant East Ayrshire Council workstreams are:

- A fairer, kinder and connected East Ayrshire;
- Workforce planning – culture change and service redesign;
- A digitally connected East Ayrshire;
- A vibrant and empowered East Ayrshire;
- Property and estates rationalisation, and;
- Income and commercialisation.

The chart below shows the potential impact of transformation and sustainability activity across the Strategic Commissioning priorities set out in the sections above. These are real cost-reduction actions which can contribute to demand management while also meeting the terms of the 'triple aim' of:

- **'Better Care'** - improving the quality of care by targeting investment at improvement and delivering the best, most effective support;
- **'Better Health'** - improving health and wellbeing through support for healthier lives through early years, reducing health inequalities and focusing on prevention and self-management, and;
- **'Better Value'** – increasing value and sustainability of care by making best use of available resources, ensuring efficient and consistent delivery, investing in effectiveness, and focusing on prevention and early intervention.



The chart illustrates the emerging gap set out in the Medium Term Financial Plan as a result of increasing demand and cost pressures. The potential impact from the Strategic Commissioning Intentions of prevention and early intervention, new models of care and building capacity in primary and community care are built in to this model. Scaling up prevention and early intervention across the main challenges to wellbeing, alongside a proportion of the additional investment committed to Primary and Community Care and plans taken through our Strategic Commissioning Board have significant potential to close the projected gap. This will require agreement on invest to save programmes and joint planning on the set aside budget over the course of the Strategic Plan period.

Section 13: Locality Planning

Why is this important?

We know that working in an integrated way at locality level is central to making these improvements.

Partnerships across Scotland are required to divide their areas into at least two localities and national guidance gives clear direction on the purpose of locality planning groups within these arrangements:

A group of people who play an active part in service planning for the local population, in order to improve outcomes... A mechanism for local leadership of service planning, to be fed upwards into the Partnership's strategic commissioning plan..Localities must have real influence on how resources are spent in their area.

Where are we now?

Community Planning Partners in East Ayrshire, has also been prioritised working in localities as one the ways to encourage involvement and engagement by local communities. The Partnership's locality arrangements work as part of this broader picture.

At strategic level, localities mean a co-ordinated approach to how we work across and with different organisations on a geographical basis, for planning purposes we have aligned these to aggregated Multi Member Wards.

Since the Partnership's inception, progress has been made through consultation and engagement to understand local priorities, improving data to better understand population needs and establishing defined locality areas within East Ayrshire. The three East Ayrshire localities established are:

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

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

Locality Planning Groups are operating in each of the three areas to map local assets and plan and implement proposals to deliver improvements for the identified local priorities.

The development of Locality Plans and working with all partners in an integrated way at locality level is allowing us to maximise the contribution of local assets including the third sector, volunteers and existing community networks. Our Community Connectors have forged links across sectors and are engaging with GP practices to access supports best suited to individual needs.

Locality Planning Groups regularly feed into the Partnership's **Strategic Planning Group** to inform the Partnership's strategic commissioning activities. In turn, the Strategic Planning Group reports to both the Partnership's governing body, the Integration Joint Board and to the Executive Officers Group of the Community Planning Partnership. Feedback is then built into Locality Planning Group business, which forms a **cycle of influence** for service planning and use of resources.

These arrangements are illustrated in the diagram below:

Locality Planning Groups have an agreed programme of meetings and events. Each locality will have a Plan in place by April 2018. Each Locality Plan will consider the needs and priorities of the area, understand the assets available to make improvements, identify any gaps that exist and put forward proposals.

One of the ways in which localities directly influence services and resources is in the use of participatory budgeting. For 2017/18, Council Vibrant Communities, together with the Partnership have secured £91k from the national Community Choices Fund to invest in a locality-focused participatory budgeting programme.

Where do we want to be?

Our outcome for locality planning is:

- Our communities, through Locality Planning Groups, are key participants in designing and delivering initiatives that achieve improvements for their health and wellbeing.

Section 14:
Enabling Delivery - Workforce

Why is this important?

Our workforce is our single most valuable resource and we are committed to ensuring we have the right people with the right skills in the right place at the right time.

To deliver our vision, our workforce will be required to do things differently and work in new ways. They will be flexible, appropriately trained and qualified, and motivated to drive change forward. The success of any transformational change relies on having an **experienced, skilled, innovative** and **adaptable workforce**.

We have and will continue to place our workforce and **workforce development** at the **core** of how we deliver **positive outcomes** for individuals and communities. We recognise that our workforce extends across all sectors and partners and value all contributions to the wellbeing of our population.

To ensure we are able to attract and retain the best workforce we need to be viewed as an employer of choice, where we invest in **training and development**, involve our workforce in the **shaping of our future** services and encourage challenge to the status quo to work in new innovative ways.

Given the current local and national workforce challenges and all the foregoing case for change, workforce planning is all the more important. Detail is available in our Workforce Plan 2018-21 [Link].

Where are we now?

- Our Initial Workforce Plan 2016-18 set out our workforce position, our workforce planning challenges and our action plan at that time.
- EAHSCP has employed a dedicated resource for workforce planning.
- Many areas across the partnership have benefited from workforce position statements being undertaken including the following services: GP Primary Care, Care at Home, Corporate Parenting, Care Homes, Social Work Services, Ayrshire Urgent Care Services and Intermediate Care and Enablement.
- These statements provide key workforce data highlighting any immediate and potential workforce challenges, such as turnover and ageing workforce, which will help inform future workforce plans.
- A number of areas of pressure have been identified, including recruitment and development within the third and independent sector.

Where do we want to be?

- An **employer of choice** attracting, retaining and development the right people.
- Have **skilled, motivated** and **flexible** workforce to deliver the transformational change programmes.
- Delivering new, efficient and creative ways of providing our future services, harnessing creativity across all partners.
- Develop **career pathways** by investing in our personal development review processes.
- Provide opportunities which enable people to move into a career with health and social care at any stage of their career, from school leavers to those looking for a career change.
- Develop our workforce skills, providing training and creating roles to **meet changing needs** in a person-centred way within an integrated context, e.g., frailty, dementia, self-management.
- **Prevention/early intervention** must be at the forefront of everything we do – signposting to appropriate services e.g. TEC
- Work collaboratively across the extended workforce to prepare for and deliver on new models of care, including with our third and independent sector partners.
- Engage with our **education providers** to ensure education pathways are robust and fit for purpose.
- Promote **health** and **wellbeing** and invest in **resilience** approaches for our workforce.
- Promote and **support integrated working** from senior level throughout the organisation across sectors as well as internally.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How will we get there?

Across all years it is imperative we continue to work collaboratively with our NHS Ayrshire and Arran, North Ayrshire HSCP, South Ayrshire HSCP, third party and independent sector partners. We will work within the direction of our local plans including our Strategic Plan, People Strategies and Transformational Change Programme.

- Implement the National Health & Social Care Workforce Plan.
- Develop EAHSCP Workforce Plan.
- Develop a training plan across partnership to include prevention/early intervention.
- Prepare and progress workforce plans for areas of transformational change e.g. Multi Disciplinary Team workforce in Primary Care setting to release GPs to deal with complex care, develop Ayrshire Urgent Care Service workforce plan.
- Review personal carer workforce.
- Engage with Education Providers to produce a robust pathway with generic focus to allow flexibility in the workforce and design and create opportunities in education for new roles.
- Deliver a health, wellbeing and resilience programme with and for our workforce, taking into consideration the impact of demographic change on the workforce.
- Optimise Recruitment and Retention.
- Explore expansion of Modern Apprenticeships, graduate programme and work experience opportunities.
- Conduct review of workforce with third and independent sector partners and develop flexible methods for developing the workforce.
- Prepare and progress workforce plans for next areas of transformational change.
- Prepare a holistic workforce plan inclusive of third and independent sector partners.
- Include third and independent sector partners in recruitment initiatives where appropriate.

Section 15:
Enabling Delivery - ICT

Why is this important?

Developments in Information Communication Technology and other digital technologies present great opportunities to enhance how people are supported and how the workforce communicates.

At a national level there is a concerted effort to **transform business systems** using modern digital delivery. The aim is to automate processes, promote self-service and improved access to a single source of information. New technology will be used to improve **personal experience**, **reduce processing**, **duplication**, and free-up t**ime to care**. Software systems will be increasingly integrated covering HR, payroll, finance and data under a 'Once for Scotland' approach.

Part of this relates to the procurement of a **Social Work Management Information System**. East Ayrshire Health and Social Care Partnership the Social Work Service utilises a computerised management information system for the creation, management and storage of personal records to ensure that all contact with individuals who are referred to and use services is recorded effectively and appropriately. The system records information across the social work functions of Community Care, Children and Families and Justice Services. The system is also integral to the production of performance monitoring and operational management information.

Where are we now?

A two year extension to the support and maintenance contract, for the Swift System was approved in August/ September 2016. This contract expires in March 2019. This was to allow time for a **specification** of requirements to be developed in collaboration with all services within the Partnership.

Following approval in late 2017, East Ayrshire Health and Social Care Partnership will **tender** within the Crown Services Commercial Services Framework to obtain a contract for a Social Work Management information System. This will be taken forward in 2018.

Where do we want to be?

To support integration we will to ensure that the successful contractor's system has the ability to **integrate** with Partner Agency Systems i.e. the AYRshare System which is a Pan Ayrshire System which allows secure **sharing of information** between NHS Ayrshire & Arran; East Ayrshire Council Education Services and Partnership Social Care Services in relation to the GIRFEC Principles. The system will have the ability to integrate with Health and Social Care Systems e.g. FACE and EMIS.

How will we get there?

- Business Support Services will lead on the implementation of a new system with additional capacity invested in over the 2017 and 2018.
- This will include Project Management to ensure progress against timescales, testing, training and implementation together with business support to enable the migration of data.

Section 16: Enabling Delivery - Premises and Estates

Why this is important?

We need to ensure that our estates, the buildings used for delivering health and care in East Ayrshire, are used **efficiently** and are suitable for our **current** and f**uture needs**. Since the publication of CEL 35 (2010) it has been mandatory for all Health Boards in Scotland to have a **Property and Asset Management Strategy (PAMS)**. There is a requirement for this to be updated annually, either as a full PAMS document or a highlight report, and submitted to Scottish Government Health and Social Care Directorate.

Where are we now?

A PAMS Group has been created to collate data on behalf of NHS Ayrshire and Arran for inclusion in the Boards PAMS submission to Scottish Government. The PAMS Group are required to provide information as noted within the PAMS Guidance, issued by Health Facilities Scotland (2016). The East Ayrshire Health & Social Care Partnership is part of this group and the Partnership's High Level List of **Significant Projects** has been agreed by the Partnership Management Team.

Where do we want to be?

We want to have a **sustainable estate** that is **'fit for purpose'**, that Partnership services occupy efficiently. We want to deliver health and social care services from **premises** that **support integrated working** and the **wellbeing** of our workforce and communities. The aim is to complete the Partnership's Significant Projects within the timescales contained within the PAMS. This is set out in our PAMS [Link].

How will we get there?

East Ayrshire Health and Social Care Partnership will contribute to the delivery of the PAMS through a number of groups which are responsible for progressing the significant projects in line with timescales identified. These are:

- The Partnership Premises and Accommodation Group;
- the Bentick and North West Kilmarnock Area Centre Steering Group, and
- The Johnnie Walker Bond and Rothesay House Short Term Working Groups.

Section 17: Enabling Delivery - Thinking Differently

Why this is important?

The number of people who require support from health and social care services continues to grow. Alongside this, there are more people with more than one long term health condition living in East Ayrshire meaning that they often need support from health and/or social care services.

East Ayrshire Health & Social Care Partnership is passionate about helping people to have a **good life** and **reducing** health and social **inequalities**. We are keen to **think differently** and more creatively about how best to use our resources and work alongside people who use our services in order to empower them and increase their independence.

In East Ayrshire, there is a number of key areas we have identified as important:

- People who use services and their families having more **choice and control** in setting goals and in designing services/supports to best achieve them.
- Building **confidence in using technology** to support people to manage their own condition, become more independent and to make sure that people get the right support in the right way at the right time.
- **Recognising, empowering** and **supporting carers** and **young carers** to improve their health and wellbeing and have a life alongside their caring role.

Where are we now?

A Thinking Differently Programme Board is established to share learning and promote personalised and creative solutions. Dedicated **Peer Support** for Workforce to think differently and transform our services to meet future needs and outcomes. The number of people using technology to maximise their independence continues to grow. There is slow but steady increase in the numbers of children and young people using technology.

Where do we want to be?

- **Increased number of people using technology** to manage their health condition at home.
- Managing the transition from **analogue** to **digital**.
- Empowering individuals and families to **access mainstream technology** to maximise independence and reduce need for formal supports.

- More people will be getting the right support in the right way at the right time.
- **Dedicated** Thinking Differently **Resource** to work alongside **children, young people**, their families and the multi-agency **team around** each **child**.
- More individuals having choice and control
- Implementation of our **Carers Strategy**
- Increased confidence and permission to 'think differently' amongst the wider workforce

How will we get there?

- Develop and implement East Ayrshire Carers Strategy 2018-2020.
- Increase the number of people using be-spoke technology enabled care solutions.
- Assess the impact of technology enabled care on digital inclusion.
- Increase the number of people using SDS Option 1, 2 and 4.
- Invest in a dedicated Thinking Differently Resource for Children, Young People and their families.
- Roll-out a 'Think TEC first' campaign.
- Integrated health and social care risk management response across East Ayrshire.
- Embed the use of technology in the 'front door' point of contact for health and social care.
- Consider the implications of and plan for the transition from analogue to digital.
- Smart Technology Homes.

Section 18: Enabling Delivery - Housing Contribution

Why is this important?

Housing Services in East Ayrshire play an important role in contributing to the outcomes and priorities identified within this Strategic Plan.

Where are we now?

Housing Services work in partnership with health and social care services to support **planning for future housing solutions** and to deliver and enable services that support people to live independent lives and achieve their full potential. A Housing Contribution Statement has been produced and refreshed. The **Housing Contribution Statement** reinforces the strong linkages between housing, health and social care.

The contribution made by East Ayrshire Council Housing Department towards achieving the nine national 'Health and Wellbeing Outcomes' is evidenced by the wide range of housing services delivered to support the health and wellbeing of our residents.

These include an increase in the number of homes being built to **wheelchair standard** and for **varying needs** and the provision of bespoke housing solutions for people with learning and/or physical disabilities and for people with complex needs.

Where do we want to be?

The aim is for everyone in East Ayrshire to have **access to affordable quality homes** that meet their needs and aspirations. Housing services contribute to the wellbeing of people through affordable, energy-efficient homes and through supporting people to live independently in suitable accommodation or with appropriate support where required. Realising the **wider contribution** of housing, including Registered Social Landlords **(RSLs)**, to **wellbeing** in terms of the regeneration, re-provisioning of housing and the positive impact of this in creating strong, sustainable communities.

How will we get there?

In the period 2018-2021 a number of joint projects will be undertaken by the Partnership and Housing Services to support people in East Ayrshire to live independent lives and achieve their full potential. These include;

- Supported accommodation project in Hurlford that will promote independence for adults with additional support needs.
- Supported accommodation project in New Cumnock providing an assisted living model.
- Supported accommodation project in Kilmarnock where Registered Social Landlords will provide assisted living model for older people.
- Supported accommodation project in Mauchline will be developed for assisted living model

The full Housing Contribution Statement is available here: **East Ayrshire Housing Contribution Statement 2017**

Section 19: Enabling Delivery – Leadership and Improvement

The success of the strategic planning arrangements are underpinned by strong leadership across all sectors, working together within services, in hospital settings, with the third and independent sector and with partners in communities.

Our approach to leadership is based on **shared values** where individuals, families and carers are key partners in shaping and developing services focused on shifting the balance of power and creating equitable relationships.

The prevention and early intervention approach, working alongside residents in local communities to develop new community based activities, will support people to maintain their health and wellbeing and reduce reliance on services. This is the basis of transformation.

Transformation will require l**eadership from the whole workforce at all levels**. To support this we will:

- Build leadership capacity to deliver on the transformation agenda set out in this Strategic Plan;
- Develop leadership commitment to prevention and early intervention;
- Deliver a consistent, targeted and accessible set of messages across partners promoting our vision, priorities and progress;
- Create opportunities for creative and innovative ideas to be generated and harnessed;
- Develop learning and development opportunities across the workforce in relation to prevention, early intervention, promoting wellbeing and self-management;
- Support prevention and early intervention through case-finding/risk stratification methods to identify people at greater risk of experiencing reduced independence;
- Maintaining the current level of investment in prevention and early intervention within the Partnership while identifying opportunities to increase this.

There is a range of ways used to ensure we can report and measure how we are doing and ensure we continue to improve. We engage in dialogue with people who use our services, families, partners in communities, third and independent sector. These include annual public events 'Local Conversation', 'BIG Plan Day', the 'Connecting to Change Group, Quality Checkers and the Stakeholder Forum.

During the course of this Plan:

- We will engage with national improvement support agencies such as the Improvement Service and Health Improvement Scotland's Improvement Hub (iHub), Care Inspectorate, Scottish Social Services Council (SSSC) in relation to care delivery and system enabler programmes;
- We will work to ensure that a culture of evidence-based, continuous improvement is supported with business intelligence, analysis, performance reporting and programme management;
- We will collaborate with colleagues in North and South Partnerships and in Acute Hospital services to develop test quality improvements across the system and support new and sustainable models of care.

Locality Planning

If you would like to get involved in Locality Planning, or would like more information, please contact us on: **healthandsocialcareadmin@east-ayrshire.gov.uk**

or telephone: 01563 576000, asking for the Health and Social Care Partnership admin team

or by Textphone: 01563 576167

Our Voice

'Our Voice' is a national initiative with the purpose of engaging with people to improve health and social care. The HSCP will be building on locality engagement to develop the community network contribution to 'Our Voice'.

Address: Our Voice, Delta House, Level 4, 50 West Nile Street, Glasgow G1 2NP

Visit: http://www.ourvoice.scot/our-voice

Email: info@ourvoice.scot

Telephone: 0131 623 4503

Contact us...

Email healthandsocialcareadmin@east-ayrshire.gov.

Telephone 01563 576000
asking for Health and Social Care Partnership admin team

Textphone 01563 576167)

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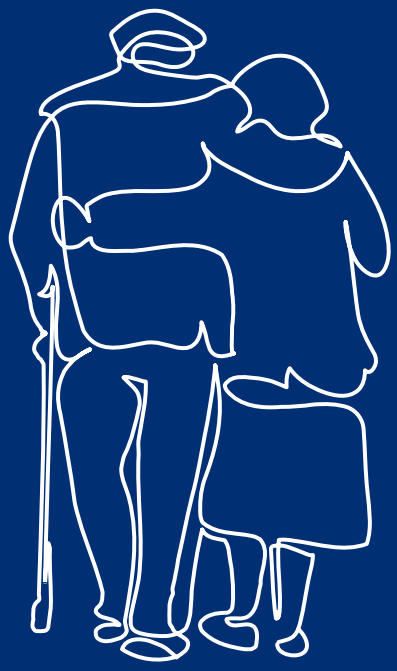

EAST AYRSHIRE

Health & Social Care
Partnership

This information can be made available, on request, in braille, large print or audio formats and can be translated into a range of languages. Contact details are provided below.

درخواست کرنے پر یہ معلومات نابینا افراد کے لئے اُبھرے حروف، بڑے حروف یا آڈیو میں مہیا کی جاسکتی ہے اور اسکا مختلف زبانوں میں ترجمہ بھی کیا جاسکتا ہے۔ رابطہ کی تفصیلات نیچے فراہم کی گئی ہیں۔

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ਇਹ ਜਾਣਕਾਰੀ ਮੰਗ ਕੇ ਬੋਲ, ਵੱਡੇ ਅੱਖਰਾਂ ਅਤੇ ਸੁਣਨ ਵਾਲੇ ਰਪ ਵਿਚ ਵੀ ਲਈ ਜਾ ਸਕਦੀ ਹੈ, ਅਤੇ ਇਹਦਾ ਤਰਜਮਾ ਹੋਰ ਬੋਲੀਆਂ ਵਿਚ ਵੀ ਕਰਵਾਇਆ ਜਾ ਸਕਦਾ ਹੈ। ਸੰਪਰਕ ਕਰਨ ਲਈ ਜਾਣਕਾਰੀ ਹੇਠਾਂ ਦਿੱਤੀ ਗਈ ਹੈ।

Niniejsze informacje mogą zostać udostępnione na życzenie, w alfabecie Braille'a, w druku powiększonym lub w formacie audio oraz mogą zostać przetłumaczone na wiele języków obcych. Dane kontaktowe znajdują się poniżej.

Faodar am fiosrachadh seo fhaighinn, le iarrtas, ann am braille, clò mòr no clàr fuaim agus tha e comasach eadar-theangachadh gu grunn chànanan. Tha fiosrachadh gu h-ìosal mu bhith a' cur fios a-steach.