EAST AYRSHIRE
Health & Social Care
Partnership

STRATEGIC PLAN SUMMARY 2018 -21

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

Welcome

Welcome to the summary version of our second Strategic Plan for East Ayrshire Integration Joint Board. The Plan covers our ambitions and shared priorities for health and social care over the 2018-21 period.

We want to celebrate the progress we have made over the last three years and continue to deliver our vision of:

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

We will continue to deliver on this vision with all partners as part of taking forward the Wellbeing theme of East Ayrshire Community Plan 2015-30.

Our second Strategic Plan must be transformational if we are to realise our ambitions for the people of East Ayrshire. We face significant challenges as our full Plan shows. Our Medium Term Financial Plan projects a financial gap of £37.8 million if we do not make major changes.

A consistent message from our engagement with partners is that prevention and early intervention is important. We have listened to this and included this as a key plank in our Strategic Plan. The Strategic Plan also focuses on the 'triple aim' of better care, better health and better value in line with the national Health and Social Care Delivery Plan.

The core themes of the Strategic Plan 2018-21 are:

- Scaling up our work on ***Prevention and Early Intervention*** across all ages;
- Supporting ***New Models of Care***;
- ***Building capacity in Primary and Community Care***, and;
- ***Transformation and sustainability*** - to tackle the financial gap.

Over the course of the Plan we will continue to work with Acute Services to plan together to support people at home, to prevent unnecessary hospital admission and make best use of resources.

This includes joint planning on the 'set aside' budget associated with unscheduled care.

As always we will work with all our partners and the whole workforce involved in health and social care to deliver the Strategic Plan 2018-21. We want the ideas, creativity and commitment of our workforce and partners to continue to drive change and I look forward to working with you on this.

Eddie Fraser, *Chief Officer*

Our achievements

Over the course of our 2015-18 Strategic Plan we have made a great deal of progress. Detail of this is included in our full Strategic Plan [link].

Some highlights include:

- Establishing East Ayrshire Health and Social Care Partnership in April 2015, taking on the full range of delegated services and developing as an organisation.
- Progress in equalities including contributing to Ayrshire-wide Shared Equality Outcomes, Disability Inclusive Confident Employers (DICE), endorsing Stonewall Scotland - No Bystanders campaign and approval of a Position Statement on Prostitution which challenges demand.
- For children and young people we have equalised Kinship Care allowances with Foster Carers, developed the role of the Children and Young People's Strategic Partnership and supported accommodation for care leavers.
- With partners we have developed a range of new ways of supporting people through multi-disciplinary working in Localities, redesigning services such as the health and community care 'front door', through Self Directed Support and Technology Enabled Care (SmartSupports), increases in provision of equipment and adaptations, and care home-based support for people at end of life.
- Innovative programmes have been taken forward by our providers such as the 'My Home Life' leadership development programme and Care About Physical Activity (CAPA) in care homes. We have engaged with a stakeholder group in the re-design and re-provisioning of Rowallan Ward at Kirklandside Community Hospital. We have engaged with carer peer mentors in preparing for implementation of the Carers (Scotland) Act 2016.

- In Primary Care we have taken forward our 'Ambitious for Ayrshire' approach, developing cluster and quality arrangements, creating an integrated Ayrshire Urgent Care Service, promoting the 'Know Who to Turn too…' and 'Eyecare Ayrshire' signposting campaigns.
- Partners in Housing and the Third Sector have made major contributions through developments in supported accommodation such as Lilyhill Gardens, and in the digital community hub located in the social enterprise and community resource WG13.
- We have engaged with partners, individuals and communities developing Locality Planning arrangements with Community Planning Partners, holding annual 'Big Plan Days' and 'Local Conversation' events.
- We have implemented the Scottish Living Wage for care workers delivering direct care and support for adults in care homes, care at home and housing support. We have developed workforce planning position statements across a range of service areas.

Vision and values

Our shared vision for the Strategic Plan 2018-21 is:

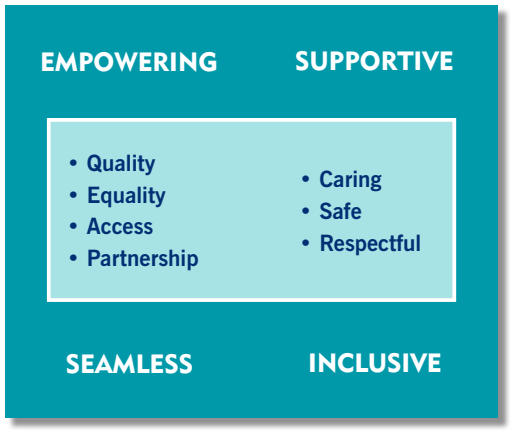
Working together with all of our communities to improve and sustain wellbeing, care and promote equity.

This reflects our contribution to delivering the Wellbeing theme of the East Ayrshire Community Plan 2015-30.

Health and Social Care Partnership values encompass partner values and some added elements linked to the National Health and Wellbeing Outcomes and the Integration Principles that we must work to.

The aim is to have a health and social care system that:

- 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.



Partnership Services

East Ayrshire Health and Social Care Partnership services cover the full range of community-based health and care services. You can find out the detail of this in the Integration Scheme that we are required to produce.

To efficiently deliver services across Ayrshire there is agreement that one HSCP will 'Lead' on some services on behalf of the other HSCPs. East Ayrshire HSCP has the 'Lead Partnership' role for Primary Care and Out of Hours Community Response. This refers to GPs, General Dental Services, General Ophthalmic Services and Community Pharmacy. The 'Lead Partnership' role also carries responsibility for Public Dental Services, Ayrshire Urgent Care Services and Contracting for GP services for settings such as Prison Services and Police Custody.

North Ayrshire HSCP has 'Lead Partnership' responsibility for Mental Health Services and certain other specialist services. South Ayrshire HSCP is the 'Lead Partnership' for Allied Health Professionals as well as certain other specialist provision. The detail of Lead Partnership responsibilities can be found in our Strategic Plan [Link].

Policy Context

National and local policy influences how we will deliver the Strategic Plan 2018-21. In developing our Plan we have reviewed current policies.

Major policies and plans at a national level that we need to consider include the **Health and Social Care Delivery Plan**, the **National Clinical Strategy**, and **Realistic Medicine**.

Legislation that we must implement covers the Children and Young People (Scotland) Act 2014 and the Carers (Scotland) Act 2016.

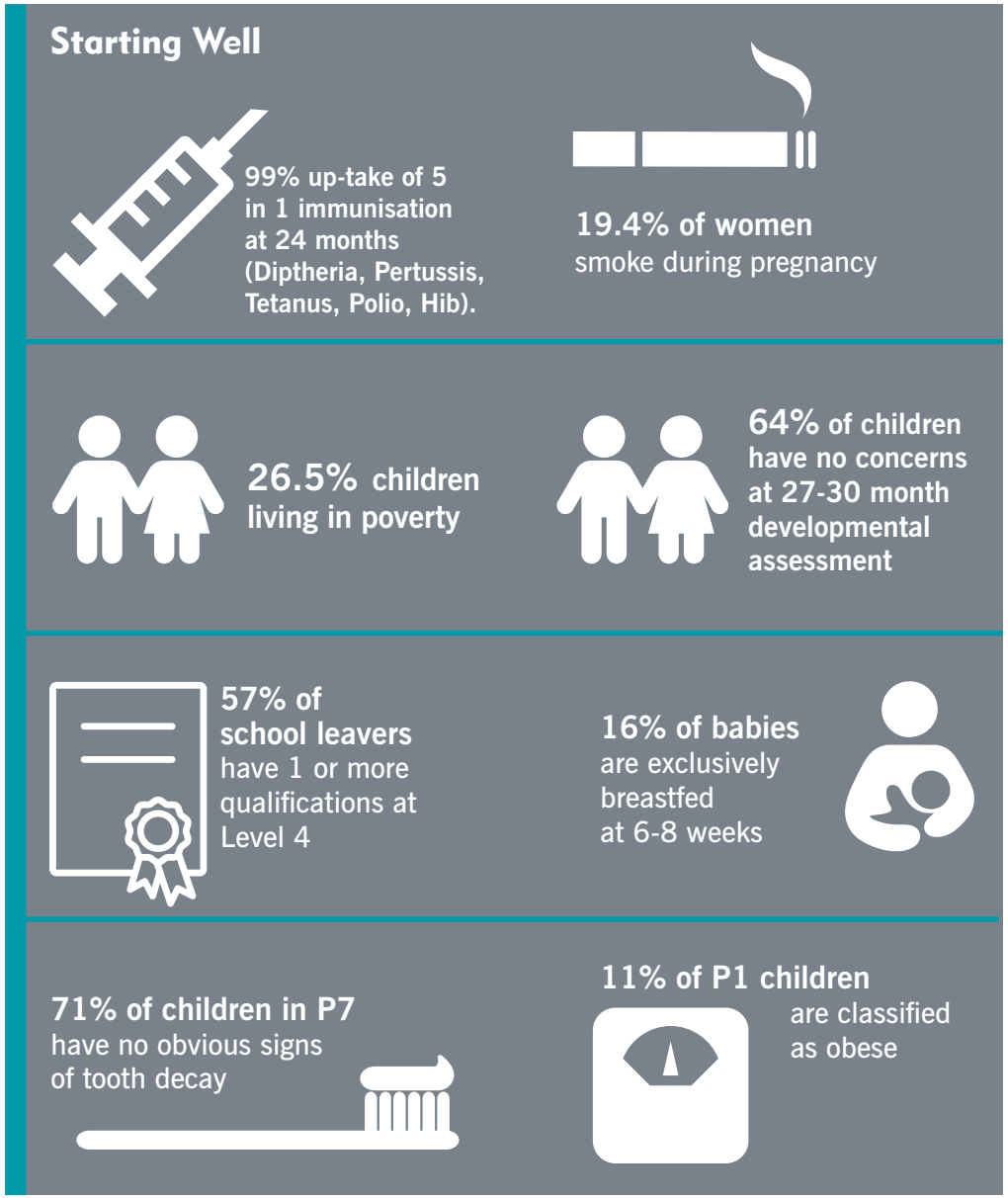
Partners in East Ayrshire Council and NHS Ayrshire and Arran have transformation plans that we will be part of and will shape the changes that we want to make.

We will also be involved in work on a West of Scotland Regional Delivery Plan for Health and Social Care.

Population Health and Wellbeing

The health and wellbeing needs of our population also shapes our plans. In preparing our Plan we have refreshed our assessment of population need. The diagram opposite shows some of the main trends. Partners have been mapping the assets within local communities that can contribute positively to wellbeing.

Joint Strategic Needs Assessment



Living Well

21.8 rate of falls per 1,000 population aged 65 and over

58% of adults meet physical activity guidelines

20% of adults are regular smokers

15% of adults consume the recommended daily portions of fruit and veg

97% of older people were living at home rather than in hospitals or care homes

87% of last 6 months spent in community

Alcohol related hospital stays decreased, from 819.7 to 737.0 per 100,000 population

Male life expectancy 76.5 years

Female life expectancy 79.8 years

Financial Framework

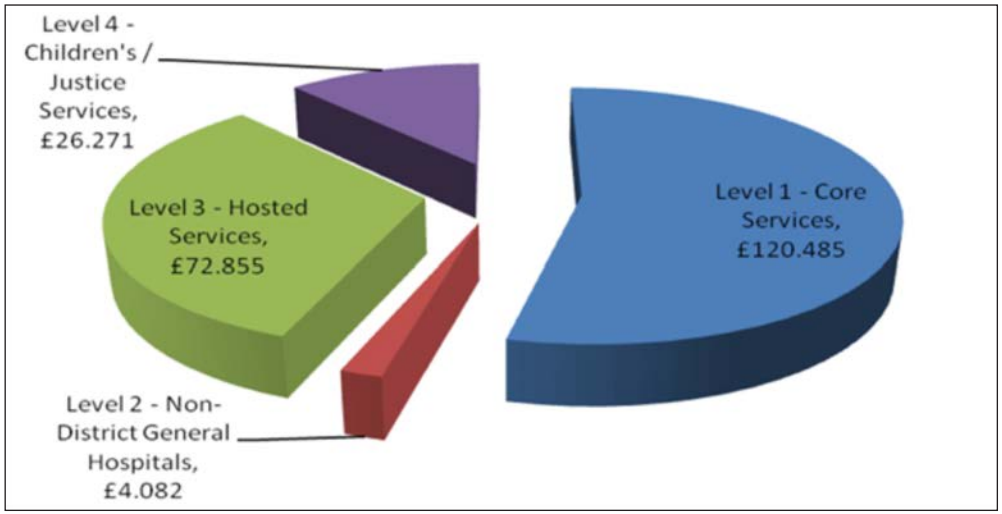
The Population and Wellbeing section shows that people are living longer. This is testament to improved living standards and advances in care, support and treatment. At the same time this results in more people living with long-term, complex conditions.

There are significant and persistent inequalities in wellbeing outcomes for our population compared to most partnership areas in Scotland. These must be tackled as they contribute to major social and economic costs as well as lost productivity.

These changes in our population are driving increased demand for formal support in health and social care.

At the same time public sector spending is severely constrained.

The Health and Social Care Partnership budget stood at almost £224 million in 2017/18. The breakdown of this is shown in detail in the full Strategic Plan [Link]. The 'set aside' budget which covers unscheduled care provided in large hospitals, and for which we are responsible for joint planning, is almost £20 million.



Our Medium Term Financial Plan estimates that demand, cost and efficiency challenges could result in a financial gap of £37.9 million.

The Strategic Plan 2018-21 priorities include areas of action and transformation to tackle the projected financial gap.

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. Joint planning in relation to the 'set aside' budget will be the key mechanism for achieving this.

Priorities

We have four main Strategic Priorities for 2018-21. These are:

- Scaling up our work on ***Prevention and Early Intervention*** across all ages;
- Supporting ***New Models of Care***;
- ***Building capacity in Primary and Community Care***, and;
- ***Transformation and sustainability*** – to tackle the financial gap.

The next four pages summarise what this means over the next three years as our Strategic Commissioning Intentions.

Prevention and Early Intervention

Where are we now?

There is consensus across partners 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).

It is recognised that the early years of a child's life are of crucial importance and can affect future health, wellbeing and life chances. The 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.

The IJB commissioned a review of prevention and early intervention in 2016/17.

A range of initiatives developed under the former Integrated Care Fund have been mainstreamed from 2018 onwards

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.

Triple Aim

Better Care - through targeting of effective interventions.

Better Health - focus on early years, prevention and self-management.

Better Value - investing in prevention and early intervention to manage demand.

Enablers: **Workforce** / ICT / Premises & Estates / Thinking Differently / Housing Contribution / **Leadership & Improvement**

Where do we want to be?

- We will scale-up universal prevention and early intervention work across Wellbeing, Alcohol, Tobacco, Obesity and Mental Health (WATOM).
- We will shift resources from crisis intervention to family and community support, which facilitates earliest possible identification of the need for additional support.
- We will put in place a programme of health literacy, self- management, supported self-management for people with long-term conditions.
- We will embed ethical care commitments/charters in partnership practices.
- We will advocate for and highlight the key opportunities that address inequalities.
- Reduce the number of women smoking in pregnancy from 300 to 226;
- Reduce alcohol use during pregnancy from 397 to 196;
- Increase the number of women exclusively breastfeeding at 6-8 weeks from 201 to 333;
- Reducing alcohol-related admissions from 970 to 910 per annum;
- Reducing the number of adults smoking from 20,188 to 17,665;
- Improve levels of physical activity to reduce overweight and obesity in the population from 69,600 to 65,600
- Reduce the number of unscheduled mental health bed days occupied in hospital from 20,545 to 18,901.
- An increase from 500 to 1,500 people engaged in health literacy programmes.
- 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.
- Annual costs avoided to health and social care of action to achieve these Strategic Commissioning Intentions of £1.3M in the first year, rising to £3.3M by year three.
- Potential resource release of £0.708M by year three with appropriate arrangements and invest to save agreement.

Outcome measures

- Number of bed days per 1,000 population for long term conditions (asthma, COPD, heart failure, diabetes).
- Rate for alcohol related hospital stays per 100,000 population.
- Reduction in the percentage of pregnant women drinking 1+ units of alcohol.
- Reduction in the number of mothers smoking during pregnancy.
- Increase the percentage of babies exclusively breastfed at 6-8 week review.
- Reduced rate of exclusions per 1,000 pupils.

New Models of Care

Where are we now?

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.

We have tested aspects of our new models of care in a range of areas including multi-morbidity, long-term conditions and end of life.

We have developed Business Cases for a number of areas of work.

We have developed trajectories for the Ministerial Strategy Group indicators for 'Measuring Performance Under Integration'.

Programme Management arrangements are in place supporting New Models of Care and Unscheduled Care improvement programmes.

Triple Aim

Better Care - through improvement focus and effective integrated model of care.

Better Health - quality conversations at point of contact, maximising rehabilitation and enablement.

Better Value - ensuring partnership resources are used most effectively.

Enablers: **Workforce** / **ICT** / Premises & Estates / Thinking Differently / **Housing Contribution** / **Leadership & Improvement**

Where do we want to be?

- Implementation of the East Ayrshire Models of Care Programme for Rehabilitation and Reablement;
- Redesign of intermediate care at home services, modernisation of day hospital and developing community based rehabilitation.
- Implementation of East Ayrshire Models of Care Programme End of Life Care workplan;
- Implementation of locality based multidisciplinary service delivery models.
- 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 best performance in delayed discharge bed days occupied;
- Four per cent reduction in unplanned bed days from baseline of 103,808 to 99,656;
- Nine per cent reduction in emergency department from 40,865 to 37,187;
- Reduction from 4,157 to 3,120 (25%) in occupied bed days where people spend longer in hospital than clinically necessary and could be better supported in another setting for reasons of incapacity or mental health legislation;
- Increasing 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;
- 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.
- Annual costs avoided to health and social care of action to achieve these Strategic Commissioning Intentions of £5.1M in the first year, rising to £6.7M by year three.
- Potential resource release of £1.4M by year three with appropriate arrangements and invest to save agreement.

Outcome measures

- Rate of emergency bed days for adults
- Readmissions to hospital within 28 days of discharge
- Number of days people spend in hospital when they are ready to be discharged
- Proportion of last 6 months of life spent at home or in community setting

Building Capacity in Primary and Community Care

Where are we now?

We have taken forward our 'Ambitious for Ayrshire' Programme with a focus on Primary Care at the heart of health and social care.

Progressed key workstreams under the 'Ambitious for Ayrshire' Programme including.

GP Clusters arrangements to enable participation in locality planning .

Broadening the range of clinicians in general practice

Increasing number of GPs utilising Technology Enabled Care within multidisciplinary teams.

Delivery of oral health improvement activity with a focus on prevention.

Increased capacity in community – developing community phlebotomy; Advanced Practitioner roles, expansion of Pharmacy First and Eyecare Ayrshire initiatives.

Establishing an ANP (Advanced Nurse Practitioners) Academy.

Taken forward Ayrshire Urgent Care Services integration programme.

Triple Aim

Better Care - through improvement focus and effective integrated model of care.

Better Health - quality conversations at point of contact, maximising rehabilitation and enablement.

Better Value - ensuring partnership resources are used most effectively.

Enablers: Workforce / ICT / Premises & Estates / Thinking Differently / Housing Contribution / **Leadership & Improvement**

Where do we want to be?

- Realising the benefits of the new contract for residents in line with the Primary Care Vision and Outcomes in terms of access and a wider range of health and social care professionals to support GPs as 'expert medical generalists';
- Put in place a three year Primary Care Improvement Plan to identify how resources will be allocated and spent to are implement the Contract Framework and the MOU;
- Outline how changes to the delivery arrangements for these services will be introduced before the end of the transition period at March 2021;
- Establishing a multi-disciplinary team model at Practice and Cluster level;
- Develop plans with Health Boards in collaboration with local GPs and others, the GP Subcommittee (or representatives of by agreement locally) as the formally agreed advisors on general medical service matters;
- MDTs to expand to include pharmacy and prescribing support, physiotherapy, mental health support and community link workers;
- Specific developments to be set out in a Primary Care Improvement Plan by July 2018;
- A single 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.
- Three distinct sections for each of HSCPs to deliver the local needs of each IJB.
- Establishing governance arrangements 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).

Outcome measures

- Reduced GP workload through:
- Vaccination Services;
- Core and additional pharmacotherapy services;
- Community Treatment and Care Services;
- Additional Professional Roles, and;
- Improved personal experiences and outcomes

Transformation and Sustainability

Where are we now?

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 parent bodies.

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.

Triple Aim

Better Care - through effective leadership of quality and improvement.

Better Health - through prevention and early intervention, self-management and integrated models of care.

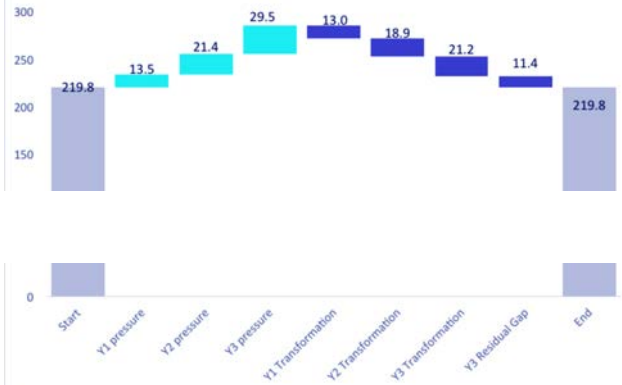
Better Value - transformational change programme to achieve sustainable future model of care.

Enablers: Workforce / ICT / Premises & Estates / Thinking Differently / Housing Contribution / Leadership & Improvement

Where do we want to be?

- Scale up prevention and early intervention, new models of care, and building capacity in primary and community care to truly transform and achieve sustainability;
- Transform what we do while continuing to deliver quality care and support;
- Create 'space and resources to develop good ideas and innovate' across all partners;
- Take a 'whole system' approach across services to avoid 'unintentional consequences' where 'change in one area could have a negative impact in another';
- Build on existing strong relationships and further develop this by working with communities linked to Community Led Action Plans to support capacity and self-care;
- Fully involve individuals, families and communities in co-design so that transformation is 'done at a pace set by those affected to ensure readiness';
- Responding proportionately, to avoid creating dependency;
- Valuing preventative activity – 'keep it simple but value it' is a key message in transformation. Also that some people just need 'a listening ear'.
- Health and social care transformation as an integral part of partner transformation programmes in NHS Ayrshire and Arran and East Ayrshire Council.
- NHS Ayrshire and Arran transformation programmes include unscheduled care, 'Ambitious for Ayrshire', mental health, and planned care.
- East Ayrshire Council transformation workstreams are a fairer, kinder and connected East Ayrshire, workforce planning, digital, vibrant and empowered, property and estates, and income and commercialisation.

Outcome measures



Key outcomes relate to impact on 'closing the gap'

Locality Planning

Locality Planning is a key part of how we want to work with communities.

The purpose of Locality Planning is to actively involve people in planning for the wellbeing needs of the local population. Locality Planning is an opportunity for local leadership in planning and for connecting into and influencing wider strategic planning.

Three Locality Planning groups are in place:

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

The Locality Planning arrangements feed in to the Strategic Planning Group and align with Community Planning Partnership localities.

Locality Planning groups are involved in agreeing priorities, mapping assets and working together to improve outcomes, for example through the Participatory Budgeting process.

Anyone wishing to get involved in Locality Planning, or to find out more can contact:

healthandsocialcareadmin@east-ayrshire.gov.uk
or
Telephone: 01563 576000, asking for the Health and Social Care Partnership admin team (Textphone: 01563 576167).

Enablers

Workforce

We want to see a valued, skilled, motivated, flexible workforce to deliver change across the whole workforce.

- Develop career pathways into health and social care at any stage, working with education providers.
- Develop workforce skills through training programmes and new roles to meet population needs.
- Put in place detailed workforce plans for areas of transformational change.

ICT

We want to see the opportunities offered by digital technologies enhancing how people are supported and how the workforce communicates.

- Transform business processes using new technology enabling improved access to information, better personal experiences, reduce duplication and free-up time to care.
- Integrate information systems to facilitate secure sharing of information.
- Procure and implement an integrated social work information system.

Premises and Estates

We want to see a sustainable estate that is fit for purpose, that supports integrated working and wellbeing.

- Develop and implement East Ayrshire HSCP programmes as part of the Property and Asset Management Strategy.
- Take forward premises and estates work through the Partnership Premises and Accommodation Group and supporting working groups.

Enablers

Thinking Differently

We want to see innovative and creative ways of using resources to empower people to have choice and control over their support – to have the right support.

- Increasing use of self-directed support Options 1, 2 and 4.
- Implementation of East Ayrshire Carers Strategy to enable carers to have a life alongside caring.
- Building confidence in using new technology to support people to manage their own conditions, embedding 'Think TEC First' across the partnership.

Housing Contribution

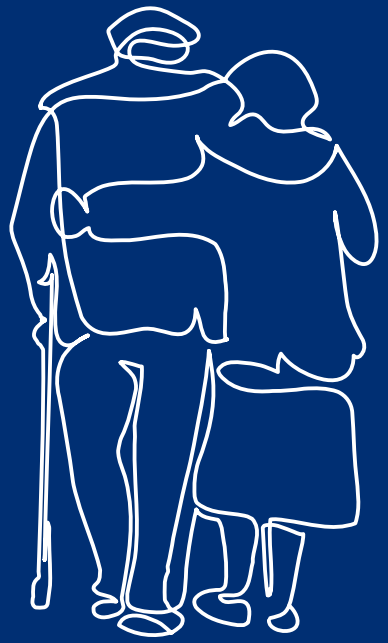
We want to continue working together in planning for housing solutions to enable people to live independently in suitable accommodation, with appropriate support where required.

- Realising the wider contribution of housing to wellbeing through regeneration, re-provisioning and the positive impact this has in creating strong, sustainable communities
- Delivering supported and assisted living housing models in Hurlford, New Cumnock, Kilmarnock and Mauchline.

Leadership and Improvement

We want to see strong leadership across all sectors, working together with all partners to deliver transformation.

- Create learning and development opportunities and programmes linked to priorities within the Strategic Plan.
- Build on good practice in engaging with people who use our services, families, partners in communities, third and independent sector and external scrutiny agencies, e.g., 'Local Conversations', Connecting to Change, Quality Checkers and Stakeholder Forum.
- Work with national improvement agencies such as the Improvement Service and Health Improvement Scotland's Improvement Hub (iHub) on our programmes.



EAST AYRSHIRE

Health & Social Care
Partnership

https://www.east-ayrshire.gov.uk/SocialCareAndHealth/East-Ayrshire-Health-and-Social-Care-Partnership/Health-and-Social-Care-Partnership.aspx