EAST AYRSHIRE

Health & Social Care Partnership

Strategic Plan

2015 -18

Working together with all of our communities to improve and sustain well-being, care and promote equity

Foreword

NHS Ayrshire and Arran and East Ayrshire Council are working together in a new health and social care partnership. The purpose of the partnership is working together to deliver positive outcomes for our residents. Specifically, our focus is on ensuring that children and young people get the best start in life, that people live healthier, longer lives and are supported to be independent and have choice and control - no matter who they are or where they live. Much progress has been made, but significant challenges and opportunities lie ahead.

We know that many individuals and families live in circumstances of economic hardship, that our population is ageing, and that we are caring for more people with complex needs. We also know that there are significant inequalities within our communities.

Health and social care services are being brought together to address these challenges and bring about improvements to our services. East Ayrshire Health and Social Care Partnership will take responsibility for the delivery of health and social care services from 1 April 2015. The partnership will also work with acute services with a particular focus on unplanned or avoidable use of hospital beds by our residents.

This draft summary outlines our aims and vision and shows what success could look like.

We recognise that working with our partners in third and independent sectors, individuals and families will ensure that we develop services that are more personalised and meet people's needs.

The importance of making sure we engage with all individuals, families and carers at the earliest stage by adopting an early intervention and prevention approach has shown that in the longer term outcomes are much better.

We know that a number of our residents are living with a number of long term and complex health needs and we will support individuals to manage and be more in control of their health and care assisting them to live well for longer.

The tough economic climate also means we have to make the most efficient use of the available budget while at the same time delivering services that are more personalised.

In order to support this new partnership we have developed an initial three year strategy to help us plan and deliver services for both current need but also the needs of people in the future.

It is also an opportunity for you to comment and share your ideas on our proposals.

We want to hear as many views as possible and would encourage you to participate and help shape our plans for the future. The full draft plan is available for comment as outlined on the back of this summary.

Eddie Fraser
Director East Ayrshire Health and Social Care Partnership

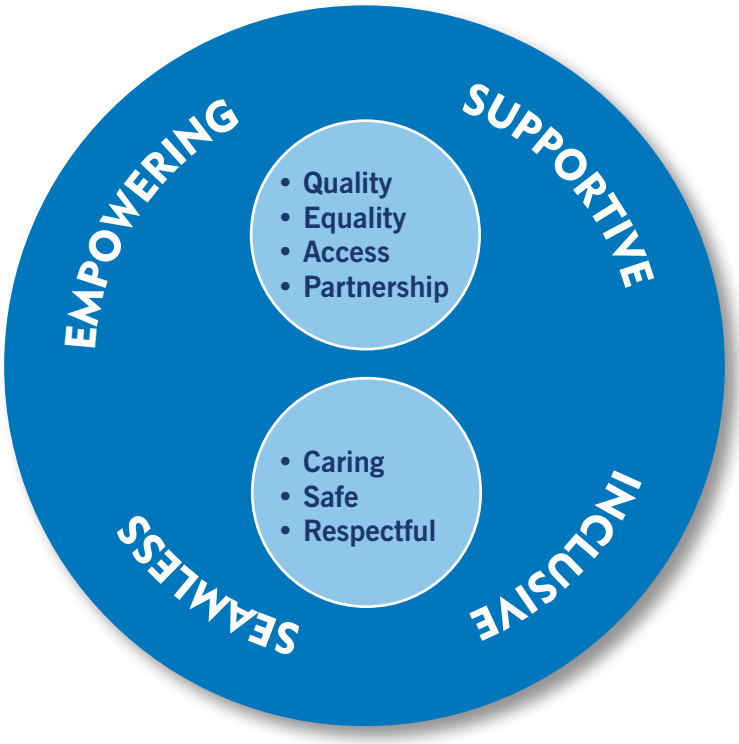
Vision

The vision developed for the partnership is:

Working together with all of our communities to improve and sustain well-being, care and promote equity

Values

Partners have aligned NHS and Council values with the policy intentions of health and social care integration to create a set of values for the partnership.
This is shown in the graphic below.



We will gauge successful integration by the extent to which:

- *People are involved in designing their own care.*
- *Services work together, are joined up and there is less duplication.*
- *There is easier access to services through a single point of contact.*
- *The benefits of new technology are realised and utilised*
- *People with multiple long term conditions are supported.*
- *There is a shift to early intervention and prevention for children and young people, families and carers.*
- *We make the most effective use of resources.*
- *Our workforce is motivated and skilled.*

Outcomes

Key outcomes for the partnership align with the Community Planning Partnership and are that:

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

National Childrens Outcomes and Health and Wellbeing Outcomes	
Outcome 1	Our children have the best start in life
Outcome 2	Our young people are successful learners, confident individuals, effective contributors and responsible citizens
Outcome 3	We have improved the life chances for children, young people and families at risk
Outcome 4	People are able to look after and improve their own health and wellbeing and live in good health for longer.
Outcome 5	People, including those with disabilities, long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.
Outcome 6	People who use health and social care services have positive experiences of those services, and have their dignity respected.
Outcome 7	Health and social care services are centred on helping to maintain or improve the quality of life of service users.
Outcome 8	Health and social care services contribute to reducing health inequalities.
Outcome 9	People who provide unpaid care are supported to reduce the potential impact of their caring role on their own health and well-being.
Outcome 10	People who use health and social care services are safe from harm.
Outcome 11	People who work in health and social care services are supported to continuously improve the information, support, care and treatment they provide and feel engaged with the work they do.
Outcome 12	Resources are used effectively in the provision of health and social care services, without waste.

Why Change?

Previous research on understanding needs within the partnership area shows that key services would need to increase by at least 25 per cent over the next 10 years to keep pace with population change. This work also highlights financial constraints and a considerable funding gap against rising demand.

This means that carrying on with 'business as usual' would not be sustainable and would not allow partners to deliver the positive outcomes linked to the shared vision.

The needs assessment underlines a number of key issues within our communities that should guide how we prioritise. Key information illustrating this is contained in the partnership profile below. In summary these are:

- Relatively high levels of deprivation, significant inequalities and the consequences of this for the whole community.
- An increase in people with more than one condition which affects their wellbeing (often referred to as 'multimorbidity').
- Changes within our population linked to life expectancy and healthy life expectancy which result in greater numbers of older people with support needs.
- That alcohol and drug misuse remain significant health and social care issues.
- Factors within communities that can increase vulnerabilities for children and young people.
- Reducing avoidable admissions.
- Reducing adverse events among children and young people.

Partnership services

By bringing our health and social care services together within the East Ayrshire Health and Social Care Partnership we have created the opportunity to improve outcomes through integrated working; better communication, improved efficiency, and reduced duplication of effort.

The total resource within the Partnership is £193 million (see partnership profile below). The partnership includes the full range of community health and social care services. Within East Ayrshire Health and Social Care Partnership there are 15 GP practices, 31 pharmacies, 18 opticians and two community hospitals providing 74 beds for care and rehabilitation for older people. Around 1,900 people use home care services and 745 older people are care home residents. At any one time around 54 children will have their names placed on the child protection register and 388 will be looked after with a further 117 with kinship carers.

The 628 bedded district general hospital, University Hospital Crosshouse, is also situated within the area. The partnership has a key relationship with acute services in relation to unplanned hospital admissions.

We will continue to work in partnership with Community Planning Partners, including those in the third and independent sectors enabling us to not only deliver flexible locally based services but also work alongside our communities.

People who live in East Ayrshire are also partners in change working with us. Services will be redesigned putting people first and in control of their health and care. We will work with individual using co-production approach- Co-production recognises that people have 'assets' such as knowledge, skills, characteristics, experience, friends, family, colleagues, and communities. These assets can be brought to bear to support their health and well-being.

By working in partnership we will be able to begin to address the issues highlighted in our needs assessment work. partnership working with people and communities recognises the assets available, making the most of opportunities for meaningful activity such as volunteering and lifelong learning, in addition to maximising opportunities to promote wellbeing.

Some of the services available

Health

- Unplanned inpatients (Medical care for the treatmentof urgent or emergency conditions that require an unplanned admission to hospital)
- Outpatient accident and emergency services (services provided within a hospital for the treatment of urgent or emergency conditions)
- Care of older people(medical care for older people when not covered by unplanned inpatients)
- District nursing
- Health visiting services
- Clinical psychology services
- Services provided by Community Mental Health Teams (services delivered in the community for those with mental health problems)
- Services provided by Community Learning Difficulties Teams (services delivered in the community for those with learning difficulties)
- Services for persons with addictions
- Women's health services(services providing the assessment, diagnosis care, planning and treatment of women's health, sexual health and contraception services)
- Services delivered by allied health professionals
- GP out-of-hours services
- Public Health Dental Service
- Continence services (Assessment, investigation, diagnosis and treatment of those with continence problems)
- Dialysis services delivered in the home
- Services designed to promote public health
- General Medical Services

- GP pharmaceutical services (prescribing and dispensing of medicine and therapeutic agents by GPs, nurse prescribers, and prescribing pharmacists working in GP practices.)

Local Addition

- Community Children's services (School Nursing, Health Visiting, Looked after Children's Service) [non medical]

Local authority services

- Social work services for adults and older people;
- Services and support for adults with physical disabilities, learning disabilities;
- Mental health services;
- Drug and alcohol services;
- Adult protection and domestic abuse
- Carers support services;
- Community care assessment teams;
- Support services;
- Care home services;
- Adult placement services;
- Health improvement services;
- Housing support services, aids and adaptions;
- Day services;
- Local area co-ordination;
- Respite provision;
- Occupational therapy services;
- Re-ablement services, equipment and telecare
- Children and families social work services
- Corporate Parenting
- Criminal justice social work services

What does this mean for service users?

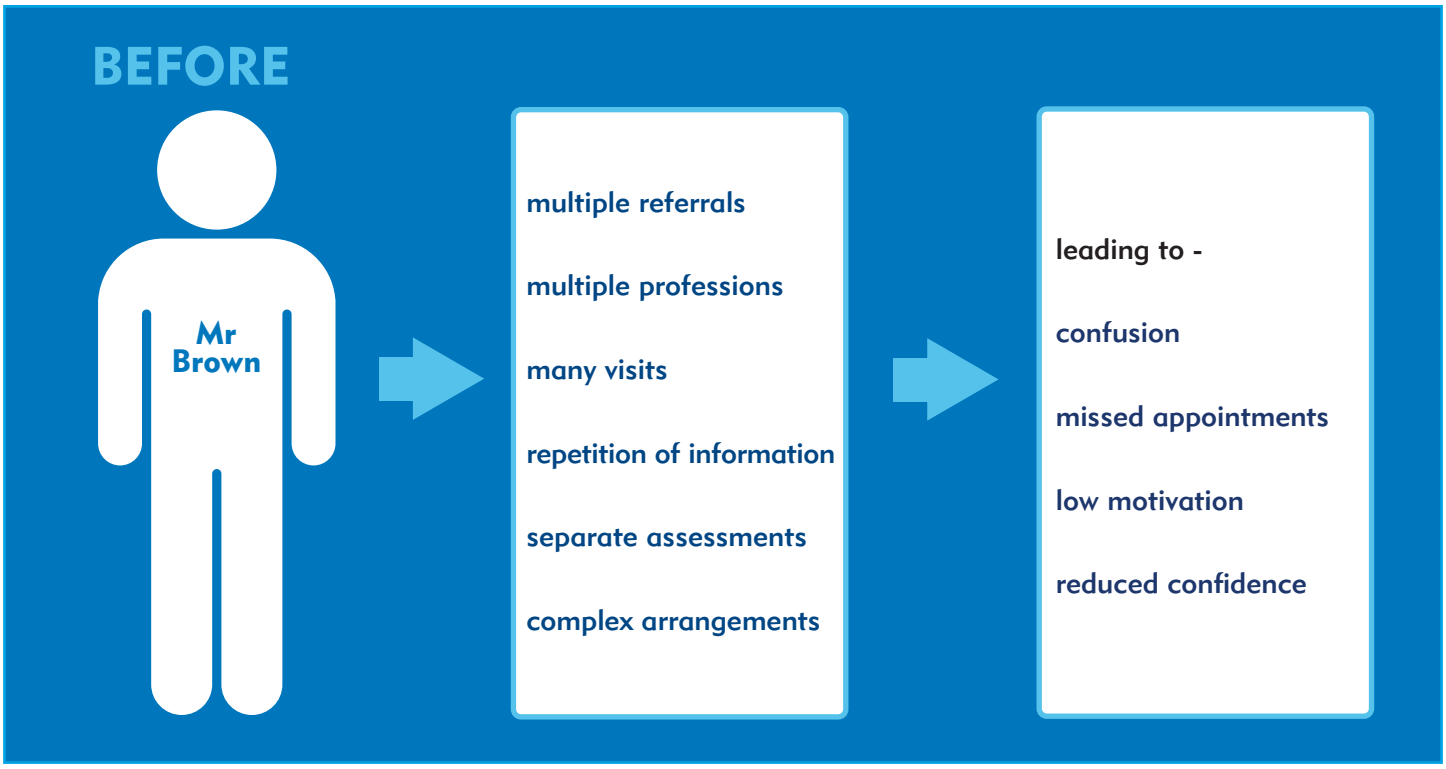
The overall aim of the health and social care service plan is to offer a better experience for individuals, families and their carers who receive a service and to make the provision more effective and efficient.

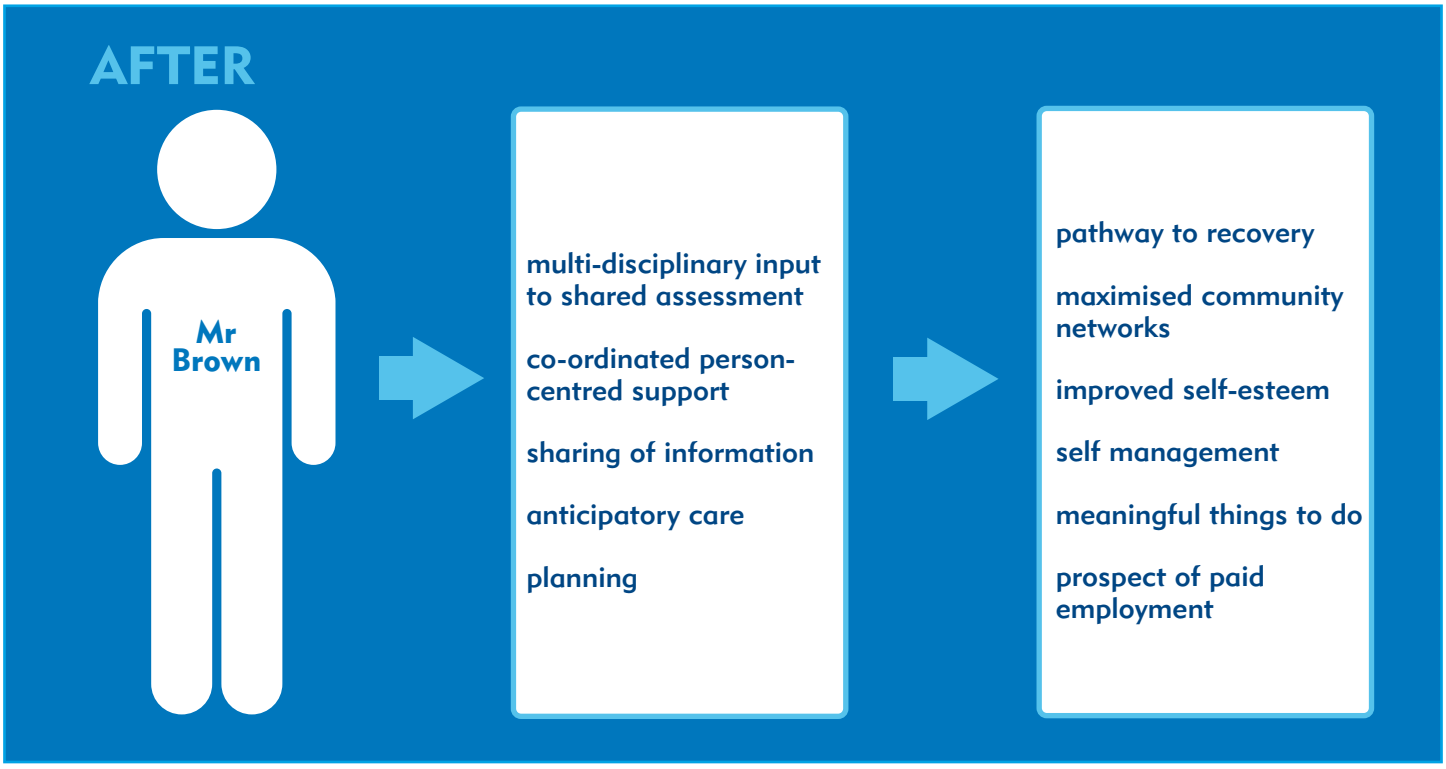
The following case study will illustrate what this will mean for people who use services.

Case Study

Benefits of Integrated Care

Mr Brown is a (fictitious) man in his 40s with a range of long-term health and social care problems for which he needs care and support. These include a diagnosis of Bipolar illness, obesity, lack of physical or social activity and diabetes. He is unemployed and lives alone. Mr Brown's elderly mother recently passed away which prompted his move to a new area to make a new start. Mr Brown is claiming benefits.

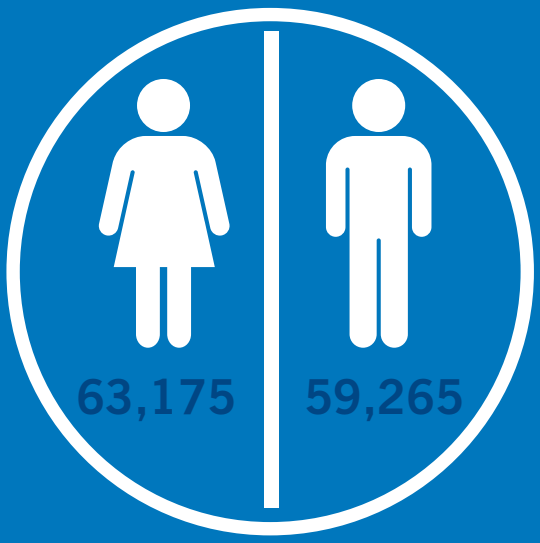




East Ayrshire Area Profile

POPULATION

All people
122,440

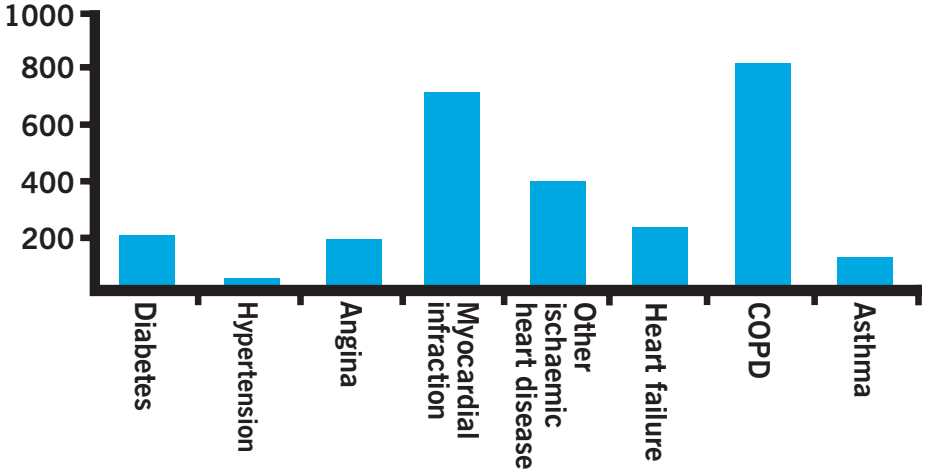


Age 0-15	21,375
Age 16-59	70,502
Age 60-74	20,747
Age 75+	9,816

WOMEN+CHILDREN

	East Ayrshire	*Scotland*
Teenage pregnancy rate	55	48
Mothers smoking during pregnancy %	27	21
Babies exclusively breastfed at 6-8 weeks %	17	26

LONG TERM CONDITIONS



People with two or more long term conditions

18,233

People with two or more conditions using 50% of resources

1,544

HEALTH BEHAVIOURS

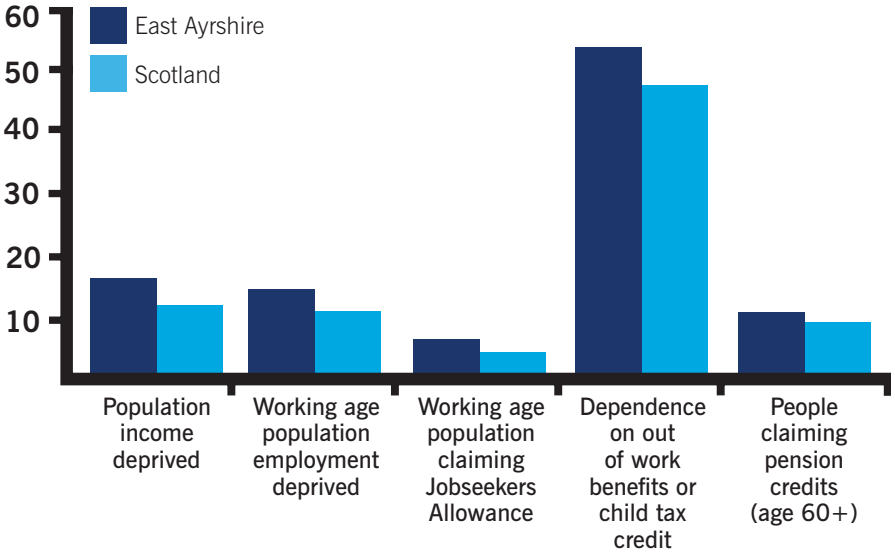
	East Ayrshire	Scotland
Smoking prevalence %	32.3	23
Alcohol-related hospital discharge rate	922.8	749
Drug related hospital discharge rate	284.4	118

ECONOMY

Population income deprived
20,060

Employment deprived
11,710

Claiming JSA
4,840



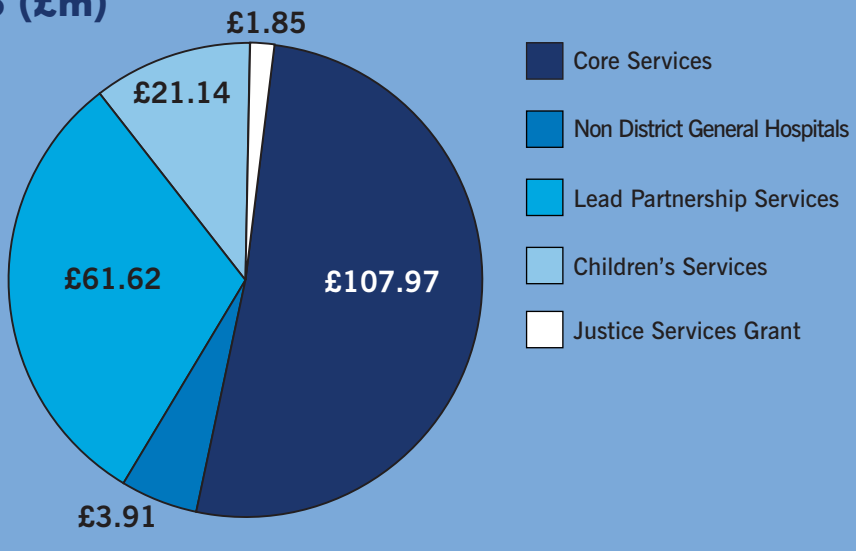
PARTNERSHIP RESOURCES (£m)

Partnership resource
£192.80

Lead partnership
£61.62

Non - elective acute use
£62.80

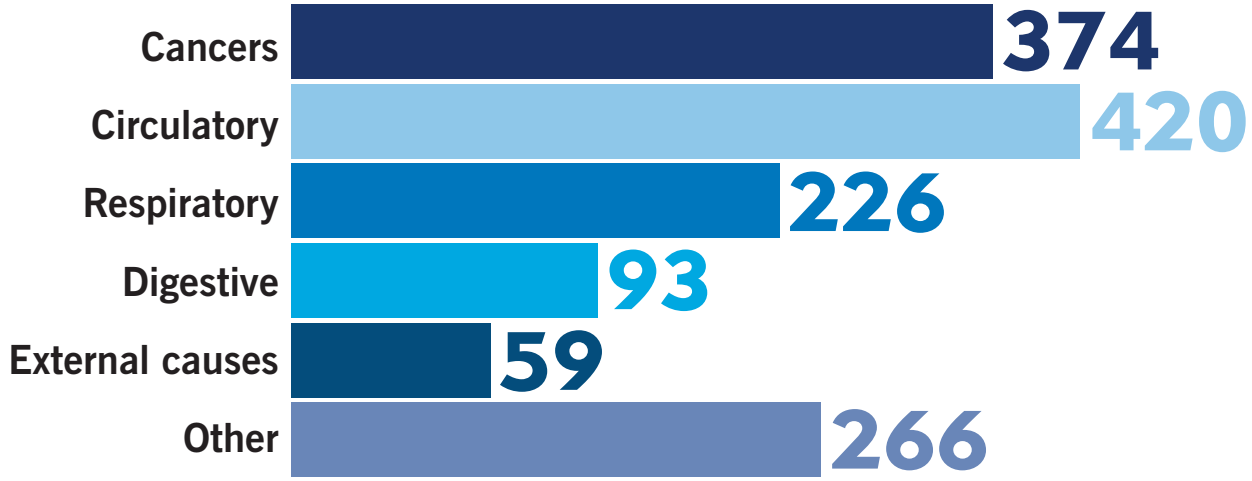
(IRF)



HOSPITAL ADMISSION RATES

Emergency	8,944
Multiple (65+)	6,062
CHD	510
Asthma	988.6
COPD	370

MORTALITY

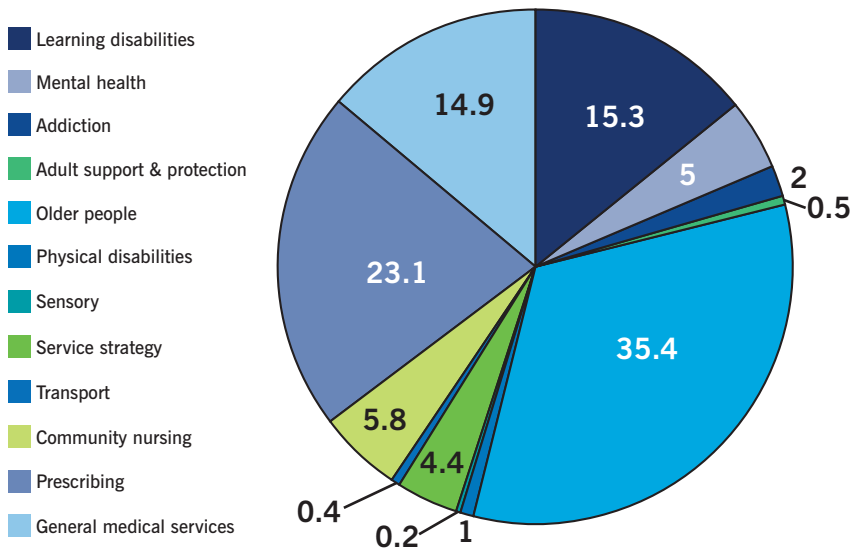


CORE SERVICES RESOURCES (£m)

Older People
£35.40

Prescribing
£23.10

Learning disability
£15.30



Strategic Priorities – Care at all life's stages

Children and young people: We aim to give our young people the best start in life and to support them through the transition to adulthood. We will do this by increasing support for families to help them avoid crisis and we will provide more flexible childcare available over longer hours. Children of all ages, particularly the most vulnerable, will be offered greater access to leisure opportunities and parents will be assisted to encourage them to adopt an active healthy lifestyle.

Preventing illness: Offering a greater range of community based health screening and health activities to support people to participate in smoking cessation, healthy weight and alcohol and drug programmes.

Health inequality: It is well known that the life expectancy for some of our residents can vary by as much as 10 years depending on where they live. We recognise that deprivation, long term illnesses and disability are common factors in ill health and we will work with our Community Planning Partners to improve access to and provision of services. We know that employment is a key route in supporting people to address the inequalities they face including health inequalities. Therefore ensuring that people are well connected to access employment opportunities is also important. Our staff will offer income maximisation assistance to families and access to specialist benefits and money advice.

Supporting people with long-term conditions: In line with 'Many Conditions, One Life: Living Well with Multiple Conditions' we will ensure that our approach is person-centred, anticipatory, and that people are supported to self manage multiple conditions.

Care for older people: We will continue to support as many people to live as independently at home as possible, providing the right kind of support to enable them to do so. We aim to reduce the number of admissions and readmissions to hospital and ensure that where people are admitted to hospital that they are timeously discharged from hospital and returned to their homes.

Technology Enabled Care: Extending the use of new technology such as telehealth/telecare services allows individuals to monitor their health and link closely with GP practices therefore reducing the frequency of travel to hospital appointments.

Contextual policy section: The publication of the Christie Commission on Public Sector Reform (2011) identified four pillars on how services should be reformed in Scotland, these are; a shift towards prevention, a focus on performance and workforce development and the need for a more localised partnership approach. For East Ayrshire our partners include the NHS, neighbouring Local Authorities and the Third and Independent Sector working together with patients, carers and the public.

More recent legislation and policy including the Quality Strategy (and the accompanying 2020 Vision) along with the Children and Young People's Act 2014, which seeks to ensure that young people's wellbeing is supported at all life's stages and transitions, underpin our approach to how services will be shaped and delivered in the future.

2020 Vision

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

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

Care close to home: We aim to deliver more care at home by increasing the number of integrated community teams in local communities around GP Practices. We will share information with other professionals and increase access to services through a single point of contact easing access to a range of services. We want to make it easier for individuals to get access to minor aids and adaptations and help families plan for the future when care at home may no longer be possible. We will work across partners to support and develop community-based services in local areas and to reduce the number of hospital visits by improving access to services in our communities.

End of life care: We aim to provide better community-based palliative care to allow people who are near the end of their lives to be in the place they wish to be cared for and, when practical, to die where they choose.

Choice and control: We aim to support people with learning disabilities, mental health and autistic spectrum disorders, to be able to lead fulfilled lives and be in control of their support.

Workforce: Workforce development within the Partnership will focus on the five priorities of: healthy organisational culture; sustainable workforce; capable workforce; integrated workforce; and effective leadership and management. We will support our workforce to deliver high quality services.

Redesign of services: As people become more involved in deciding their own care, through the options available by Self Directed Support, we will consider if the way we currently offer services is still the best way. We will work with individuals, families and carers in local communities to inform this. We will look at where and how our services are delivered and consider if we can achieve this in a more efficient way.

Community Justice Services: We will work with our Community Planning Partners to support and encourage offenders to identify new skills whilst in prison to reduce re-offending when they leave. We are also working to ensure that our communities feel safe from incidents of harm.

Alcohol and Drugs Partnership: We know that a number of our communities have experienced the impact that the misuse of alcohol and drugs can have on individuals and families. We will work closely with the Alcohol and Drugs Partnership to implement the local strategy that focuses on supporting individuals on a rehabilitation and recovery route.

Performance Measures

Partnership performance will be measured on the basis of key indicators linked to the National Health and Wellbeing Outcomes and the local priorities outlined in this plan. The partnership will use existing measures that relate to these priorities and a Data Dictionary will be used to support this. It is recognised that further measures will need to be developed, e.g. in relation to experience. Performance reporting will dovetail with the requirements of key Health Improvement, Efficiency, Access and Treatment (HEAT), the Community Plan and Single Outcome Agreement.

Planning into the future

This strategy is only the beginning. It will be in place for three years and be reviewed on an annual basis. In the future we will focus on how to meet the needs of people who use services in local communities. We will develop services in localities and discuss with individuals, families and carers how best to achieve this.

Planning groups will be established in each locality with local people, staff and contractors working together. The role of the locality planning groups will be to identify what priorities are most important and use this information to develop the next strategy.

How can you help

Through this initial consultation we hope to get as many comments as possible and to reflect any changes to the draft based on what people are telling us.

We would like to hear views on all aspects of this plan. Between **December 2014 and February 2015** we will be creating opportunities for participation in the shaping of the strategic plan.

Opportunities will include staff engagement sessions, workshops and online consultation.

Written responses can also be sent to the contact at the end of this document or e-mailed to: **HealthandSocialCareIntegration@east-ayrshire.gov.uk**

Further Information

The full draft plan is available at the following website:

www.eac.eu/consultations

If you wish further information please contact:

Erik Sutherland

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East Ayrshire Health & Social Care Partnership

East Ayrshire Council

London Road

Kilmarnock

KA3 7BU

01563 576016

Consultation Response Form for East Ayrshire Health & Social Care Partnership Strategic Plan 2015-18

Please select the category below that best describes your role in responding to this consultation:

A member of staff of East Ayrshire Council who is not a health or social care professional		A commercial provider of health and/or social care	
A member of staff of NHS Ayrshire and Arran who is not a health or social care professional		A non-commercial provider of health and/or social care	
A health professional working in East Ayrshire		East Ayrshire Council	
A social care professional working in East Ayrshire		NHS Ayrshire & Arran	
A user of health and/or social care services living in East Ayrshire		North Ayrshire Integration Joint Board	
A third sector body carrying out activities in relation to health and/or social care in East Ayrshire		South Ayrshire Integration Joint Board	
An unpaid carer of someone using health and/or social care services in East Ayrshire		Prefer not to say	
A general practitioner		A non-commercial provider of social housing	
Other – please detail			

1 **Do you agree with the 'Vision' set out in the plan?** *(Please tick one option only)* **Yes** ☐ **No** ☐

If no, please explain why and / or let us know how you think these could be improved.

2 **Do the 'Values' fit with how we should be working as a partnership?** *(Please tick one option only)* **Yes** ☐ **No** ☐

If no, please explain why and suggest any changes that you think would improve this.

3 Are the 'Outcomes' described in the plan the right ones? *(Please tick one option only)* **Yes** ☐ **No** ☐

If no, please explain why and suggest any changes that you think would improve these.

4 Does the 'Why Change' section provide a good case for change? **Yes** ☐ **No** ☐

If no, please provide comment on how this section could be improved.

5 Is the 'Partnership Services' section helpful in setting out which services the partnership is responsible for? *(Please tick one option only)* **Yes** ☐ **No** ☐

If no, please suggest alternatives that would make this clearer.

6 Do you think that the 'Case Study – Benefits of Integrated Care' is a useful illustration? *(Please tick one option only)* **Yes** ☐ **No** ☐

Please note how you think this could provide a better illustration.

7 The draft Strategic Plan includes an 'Area Profile'. Is the content of the area profile helpful? *(Please tick one option only)* **Yes** ☐ **No** ☐

If no, please provide comment as to how you think this could be improved.

8 The strategy sets out a series of 'Strategic Priorities' that emerge from needs assessment and policy requirements. Do you agree with these Strategic Priorities? *(Please tick one option only)* **Yes** ☐ **No** ☐

Please provide any comment you have on these priorities.

9 Are the actions / proposals set out in this consultation document likely to have an adverse impact on any of the protected characteristics set out in the Equality Act 2010? *(Please tick one option only)*

For reference, the nine protected characteristics are: Age, Disability, Gender reassignment, Marriage and civil partnership, Pregnancy and maternity, Race, Religion and belief, Sex, Sexual orientation

Yes ☐ **No** ☐

If yes, please state the group or groups and provide comment on how these adverse impacts could be reduced or alleviated.

10 Are you aware of any indication or evidence – qualitative or quantitative - that the actions / proposals set out in this consultation may have an adverse impact on equality of opportunity or on good community relations? *(Please tick one option only)*

Yes ☐ **No** ☐

If yes, please give details and comment on what you think should be added or removed to alleviate the adverse impact.

11 Is there an opportunity to better promote equality of opportunity or good community relations? *(Please tick one option only)*

Yes ☐ **No** ☐

If yes, please give details as to how.

Please use the space below to provide any further comments on the draft Strategic Plan 2015-18

Equality Monitoring Information

As part of our commitment to equality we monitor our consultation processes. Your co-operation in completing this form to help us do this would be greatly appreciated. Any information you give will be confidential and no individual will be identifiable in any analysis of this information.

Sex

Male	
Female	
Prefer not to say	

Marriage/or Civil Partnership

	Yes	No	Prefer not to say
Are you married or in a civil partnership?			

Age

16-24 years		25-29 years	
30-34 years		35-39 years	
40-44 years		45-49 years	
50-54 years		55-59 years	
60-64 years		65 years or over	
Prefer not to say			

Ethnicity

What is you ethnicity?

Asian or Asian British - Bangladeshi		Mixed – White and Asian	
Asian or Asian British – Indian		Mixed – White and Black African	
Asian or Asian British – Pakistani		Mixed – White and Black Caribbean	
Asian or Asian British – any other Asian background		Mixed – any other Mixed background	
Black or Black British – African		White – British (English, Scottish or Welsh)	
Black or Black British – Caribbean		White – Irish	
Black or Black British – any other Black background		White – any other White background	
Chinese		Prefer not to answer	
Any other (please state)			

Disability
Do you consider yourself to have a disability?

I consider myself to have a disability	
I do not consider myself to have a disability	
Prefer not to answer	

Under Section 6(1) of the Equality Act 2010, a person has a disability if: (a) That person has a physical or mental impairment, and; (b) The impairment has a substantial and long-term adverse effect on that person's ability to carry out normal day-to-day activities.

Sexual orientation
What is you sexual orientation?

Heterosexual/straight	
Gay woman/lesbian	
Gay man	
Bisexual	
Other	
Prefer not to say	

Religion/ or belief
What is your religion or belief?

Agnostic		Muslim	
Atheist		Pagan	
Bahai		Rastafarian	
Buddhist		Scientologist	
Church of Scotland		Shinto	
Christian		Sikh	
Hindu		Roman Catholic	
Humanism		Zoroastrian	
Jain		No religion	
Jewish		Prefer not to say	
Any other religion/ belief			

Pregnancy and Maternity

	Yes	No	Prefer not to say
Are you pregnant, on maternity leave or returning from maternity leave?			

By completing this form you have helped us better understand how we ensure equality of opportunity for all.
Thank you for completing this form.
Please return to **HealthandSocialCareIntegration@east-ayrshire.gov.uk** by **23rd February 2015**

This document is also available, on request, in braille, large print or recorded on to tape, and can be translated into Chinese, Punjabi, Urdu, Gaelic and Polish.

閣下如需要這份資料的其他語言版本，請透過以下的地址與我們聯絡。

ਜੇਕਰ ਤੁਹਾਨੂੰ ਇਹ ਜਾਣਕਾਰੀ ਕਿਸੇ ਹੋਰ ਭਾਸ਼ਾ ਵਿਚ ਚਾਹੀਦੀ ਹੈ ਤਾਂ ਕਿਰਪਾ ਕਰ ਹੇਠ ਦਿੱਤੇ ਗਏ ਪਤੇ ਤੇ ਸੰਪਰਕ ਕਰੋ ।

اگر آپ یہ معلومات کسی اور زبان میں چاہتے ہیں تو برائے مہربانی نیچے دیے گئے پتے پر ہم سے رابطہ کریں۔

Ma tha sibh airson fiosrachadh fhaighinn ann an cànan sam bith eile, cuiribh brath thugainnaig an t-seòladh a leanas.

Dokument dost pny jest równie w alfabecie Braille'a, w wersji z powi kszonym drukiem lub w formie nagrania d wi kowego na kasecie. Na yczenie oferujemy tak e tłumaczenie dokumentu na wybrany j zyk.

East Ayrshire Council

Voluntary Action East Ayrshire

NHS Ayrshire & Arran

scottishcare
The voice of the independent care sector in Scotland

PPF

Designed by EAC Design Section 2014