Caring for Ayrshire

Summary of outputs re Respiratory, Diabetes, Frailty, Rehabilitation and Palliative/EOL

NB – Some of the work cuts cross the themes

Theme	High level actions identified	Narrative re present SA status	SA reps suggested	Potential investment needed	Scoring
Respiratory (COPD)	**Expand Community Respiratory Nurse Specialist service**	Funding through East. What are arrangements and proposals? Eddie to contact East and incorporate into H@H and ICT developments. New – OP plan	EG		
	Expand Rapid Respiratory Response service to provide consistency across Board area	Consider as part of H@H Development. New – OP plan	EG		
	Locality delivered Pulmonary Rehab	Part of rehabilitation action plan. In progress – rehab plan	LG		
	Spread TEC/Connect Me pathways – COPD newly diagnosed* & COPD review*	TEC Group overseeing work including Holly Health. In progress – OP plan	EG		
	Medicine in Reserve	Links with TEC pathways. Phil H to discuss with Ian Fulton. New – OP plan	IF/PH		
	Community Respiratory Clinics	Being delivered by Kenny in Girvan. New	PH		
	COPD Remote Group Consultations/Shared Medical Appointments (SMAs)	Consider using TEAMS/Skype for peer support and education. Incorporate into locality plans. New – locality plans	LM/SM/LR		
	Breatheasy/peer support groups	Links with support groups and remote support groups. Incorporate into locality plans. Locality managers to	LM/SM/LR		

		contact Alison Anderson and Hans Hartung. New – locality plans			
	Diagnostic spirometry	Scope current position and gap analysis to establish what kit and training is required. New	PH/PW		
Diabetes (Type 2) **To be developed and delivered on a pan-ayrshire basis.**	**Timely diagnosis, consistent information and pathway**	Pan ayrshire	SF		
	Optimising annual screening to support wider actions	Pan ayrshire	SF		
	Targeted expansion of Type 2 screening to high risk patient groups	Pan ayrshire	SF		
	Specialist services – injectable treatment options	Pan ayrshire	SF		
	Patient education including Control It Groups	Pan ayrshire	SF		
	Rybelsus tablet GLP-1	Pan ayrshire	SF		
Frailty	**Early Frailty Team (community / prevention)**	In place in South linked to 11 GP Practices and all localities Submission for HSCP to finance increased staffing complement to provide coverage at all GPs (and including Working Together OTs) Complete - FOF	JP		
	Digital Proactive Community Comprehensive Geriatric Assessment (CGA)	Testing in Troon and ICT have been trained. In Progress - FOF	VB/RC		
	Primary Care "MDT around person" assessment (including individuals at home and in care homes)	Currently work carried out at GP Practices using eFrailty + Community Nursing work in Troon on Respiratory/Frailty and Care Home	LM/SM/LR		

		Future Care Planning eKIS +RESPECT In progress - FOF			
	Direct access to step-up / step-down beds	Health - Girvan and Biggart beds Social – RRICU and Private Needs adding to FOF work. New - FOF	EG/SM HB/LM		
	Acute Frailty Assessment Unit	Being developed by acute team and reported through FOF. In Progress - FOF	JD		
	Improved specialty based hospital management	Being developed by acute team and reported through FOF. In Progress - FOF	JD		
Rehabilitation	**Expansion of Occupational Therapy in GP practices from 17/53 across Ayrshire**	(As per Frailty + Working Together) Complete - FOF	JP		
	Better health hub model expansion - earlier and across Ayrshire in communities	In South this would be the Connect Hubs, etc. In Progress – Locality Plans	LM/SM/LR		
	Targeted community-based assessment and interventions to promote independence and minimise demand on statutory services	In South this is RUNAT, reablement, ICT and RRICU. Complete	EG/HB		
	Enhanced and expanded 2-way exercise based rehab model supported by leisure and third sector services **Exercise on prescription**	HARP in place but likely to expand through rehabilitation plan and locality plans. Complete	LG		
	Healthy and Active Rehabilitation Programme	HARP in place but scope for expansion? Complete	LG		

	(HARP) principles expansion across Ayrshire in communities using all sectors				
	Community x-ray	No work in South – pilot work in East For Care Home access to portable x-ray machine. Scoping work explored for Girvan as part of Girvan locality plan. New – locality plan	SM		
	Care Home collaborative for falls prevention and management (close the ~50% gap)	Being developed as part of the rehabilitation plan and care home collaborative. In progress – rehab plan	LG		
	Understand "best in Ayrshire" from current Intermediate Care Team model elements supporting rehab and seek to spread (understand links / overlap with Hospital at Home).	H@H/ICT/CRT review – In progress – OP plan	EG/LG		
	Digital solutions to support seamless transitions between care settings - recognising the whole system challenge: information flow across transitions	Pan Ayrshire work	TG		
Palliative/EOL	**Palliative/EOL Care in Care Homes**	Future care plans, respite and step up for final few days including Biggart, Girvan and South Lodge/private CHs. New - FOF	VB		

	Access to step up/step down resources based in the community **Consider combining high impact changes 1 and 2 as they are similar.** **Step up resources in East is both Community Hospital and dedicated care home beds.** **Given the similarity between high impact changes 1 and 2, the differences in the impact and benefit should be explored**	Repeat of point under frailty. Health - Girvan and Biggart beds Social – RRICU and Private Needs adding to FOF work. New - FOF	EG/SM HB/LM		
	Palliative care equipment redesign	Rapid access to equipment to support EOL care. New – Community Equip Review/OP plan	LM/RW		
	Improved access to medication support in community settings inc 'just in case bags'/	Links to point in respiratory section. PH to work with IF. New - FOF	PH/IF		
	Embed future treatment/care plans into practice, including the anticipatory element of this e.g, ReSPECT	Links to point in Frailty section. Future care plans well progressed within care homes with training for staff and families in progress. In progress - FOF	VB		
	Education, training and supervision including the	Training in progress as above. In progress - FOF	VB		

	consistent use of the Scottish Palliative Care guidelines across the whole system				
	Develop an integrated EOL care team including DN, Marie Curie resource and Carers.	Review existing resources and develop and integrated approach. New - FOF	RC/HB		