

# Ageing Well Service Plan

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## Foreword

I am pleased to present the Ageing Well Service Plan for South Ayrshire.

This plan is important as it sets out our vision and ambitions for how we will work to take steps to improve the health and wellbeing of adults in South Ayrshire over the next 3 years. It also outlines the significant challenges that we will face as we strive to deliver services that address both inequalities and the impact of our ageing population.

Aligned to our landmark Ageing Well Strategy published in 2024, our services are increasingly preventative to enhance the resilience of our population and our ageing communities, resulting in improved opportunities and outcomes.

The development of the plan has been informed by listening to people who live in our communities and through engagement with our stakeholders who are providing valuable services and supports. We will continue to work together to involve people in their care and ensure that the right support is in place to enable our communities to lead their best lives.

**Councillor Julie Dettbarn**

**Chair of the Integration Joint Board (IJB)**



## Introduction

I am delighted to deliver an Ageing Well Service Plan for South Ayrshire. We are ambitious to enable people in our communities to feel supported and be able to live at home and as independently as possible for as long as possible.

We want to improve the quality and experience of care and utilise advancing technology to help people. To do this in the face of the financial, workforce and demographic challenges ahead, we must shape our services for the future in order to meet the needs of our ageing population.

In South Ayrshire we believe in providing support and services that allow our citizens to live independently. This Service Plan will act as a tool to allow us to work to this common goal across our organisation. In South Ayrshire we have one of the oldest populations in Scotland and we know we need to do things differently in the years to come.

This plan goes alongside our previously published Ageing Well Strategy for South Ayrshire which is embedded within Community Planning and sets our arrangements as a Health and Social Care Partnership (HSCP) for when formal services are required.

The Public Bodies (Joint Working) (Scotland) Act 2014 requires arrangements to be put in place for the delivery of integrated health and social care. As a result of this we have published the South Ayrshire Integration Joint Board Strategic Plan 2021-31 setting out both our aims and strategic

objectives to achieve this ambitious goal. This Plan was refreshed in 2025 to ensure it is both current and reflective of the needs of our population.

Our vision in South Ayrshire is to: *Empower our communities to Start Well, Live Well and Age Well.*

This plan looks ahead over the next three years and our approach to delivering services for adults and older people in South Ayrshire. The plan is accompanied by a delivery plan which sets out how we will achieve this work.

**Stewart Marshall**  
**Head of Community  
Health and Care  
Services**



## Setting the Scene for Ageing Well in South Ayrshire

This Ageing Well Service Plan for Adult and Older People's services in South Ayrshire follows on from our previous plan from 2022-25.

The timeframe of the previous plan included the Covid 19 Pandemic period, during which time there were different arrangements for a number of our services.

This plan not only builds from previous work but incorporates the learning that took place during the challenges presented by the pandemic. It is evident that relationships and trust were much improved during this challenging period.

Over the last few years, services have matured and our work is now in the context of positive arrangements for Community Planning. Our partnerships are productive with a whole range of agencies and colleagues working towards a shared vision for Ageing Well in South Ayrshire.

We now work closely with the University of the West of Scotland as a formal partner. It is hoped that this will support us to develop a skilled and sustainable workforce for the further through joint training programmes and career pathways, we are looking to create opportunities for local people in the care sector.

We have developed a population-based Ageing Well Strategy which has been driven by the Community Planning Partnership. A key driver in developing this has been more robust arrangements for engagement particularly with older people. In 2023 South Ayrshire joined the UK and international network of Age Friendly Communities.

We have also learned significantly from our participation in wider national and Ayrshire programmes and this learning is incorporated into this local plan.

We have invested in creating better clinical and care leadership and the development of more localised management structures across South Ayrshire.

This plan is the next iteration of our improvement journey and recognises this new context in which we are operating.

## Our Journey to 2025

In order to develop this plan, we have reflected on the previous planning period. We know that the projected demographic challenges had previously suggested services being pushed to the limit. Whilst services have been and are significantly challenged we have managed to meet demand through service transformation and improvement across the HSCP. There is much good work to be recognised and celebrated.

There is a separate associated document that more comprehensively sets out some of this positive work but it includes initiatives such as:

- Increased investment in multi-disciplinary staff in and aligned to GP Practices
- Arrangements for Step Up and Step Down Care
- More coordinated approach to reablement and community rehabilitation
- Promotion of early intervention services such as the Ahead of the Curve and Focus on Frailty Collaborative
- Better front-door Social Work
- Improved Mental Health Officer supports in and around acute settings
- Better stroke rehabilitation pathway
- New GP Practiced based arrangements for respiratory care
- The Connect model
- Emergent Micro-enterprises
- System wide Quality Improvement training and support

This new plan builds upon this existing work which is already underway and considers what we need to implement in the coming years to support our communities to access services to support them to live independently.

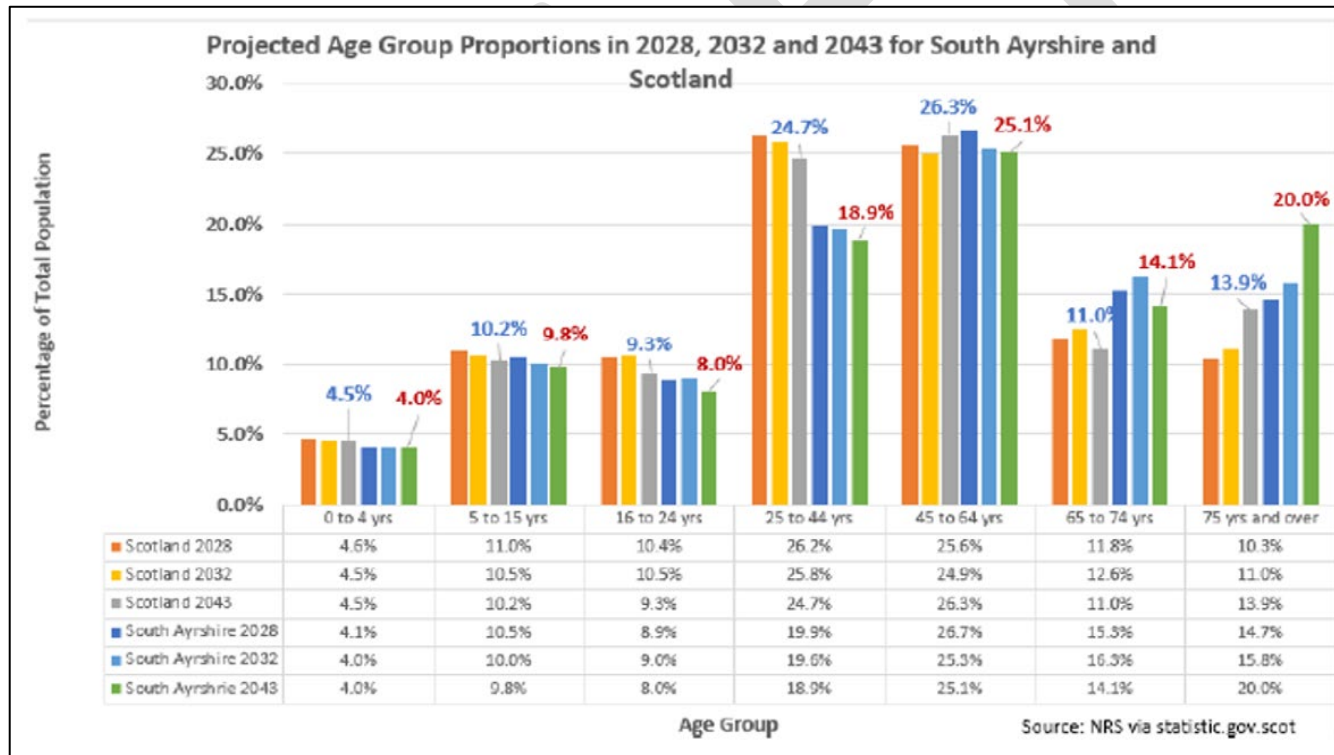


# South Ayrshire Demographics

## What does the data tell us about Ageing in South Ayrshire?

We know that people in South Ayrshire are living longer so it is important that we all play our part in supporting older people to enjoy healthier, longer lives.

In South Ayrshire we have an ageing demographic which is above the national average for Scotland. Currently, **26.6%** of the population is over the age of 65 and it is expected that this will increase by a further **6.7% by 2028**. It is important to look at the projected figures to understand what an increase in the older adult population will mean for our communities and services. By understanding the figures, this will help us to prepare and support all people in South Ayrshire to live well for longer.



We know that the population in South Ayrshire is increasing and will continue to do so each year. In 2043, it is projected that 20% of the population in South Ayrshire will be over the age of 75. Each locality area within South Ayrshire has had a steady increase in older people over the last 20 years and our overall 65+ population remains higher than the national average.

As the older population increases, we are projected to see an increase in the dependency ration in South Ayrshire.

This will have an impact on how and where we deliver our services in the future.

### Consultation and Engagement: What have people told us?

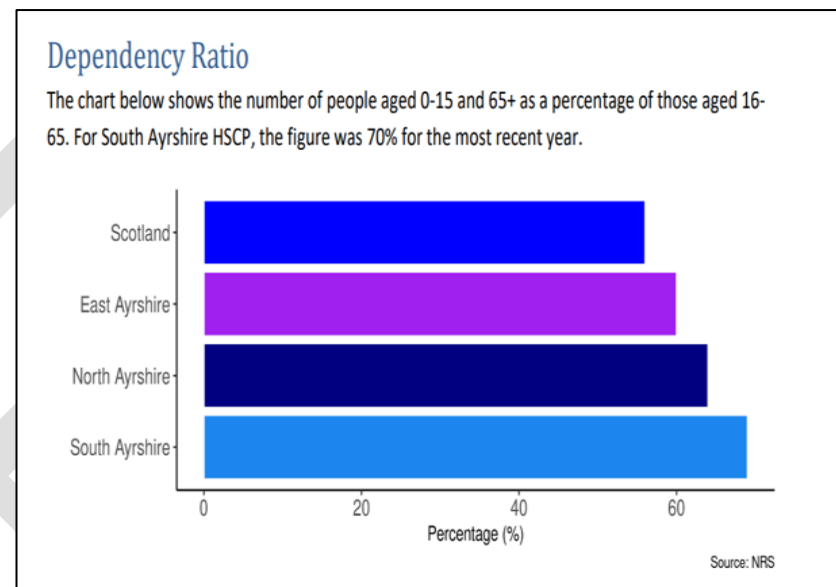
At the heart of our Ageing Well ethos has always been the voices of the older people within our communities across South Ayrshire. We are confident that the direction of our Ageing Well Strategy has been firmly set by the influence and input from our communities. It is a true example of co-production.

The development of this work is a catalyst to support healthy ageing and to develop a long-term movement of change that supports us all as we grow older. At the heart of our approach has always been the voices of the older people within our communities across South Ayrshire and the direction of the strategy has been firmly set by the influence and input from our communities.

This service plan is an extension of the Ageing Well Strategy and sets out our approach when people need to access formal services.

In 2023, an Ageing Well Champions Board was formed of people from across South Ayrshire over the age of 50 who came together to help shape this work. There are now multiple Boards across the area with over 150 members who continue to make contributions.

A full engagement report for our work for our approach to developing the Ageing Well Strategy can be found [here](#).



Through this valuable engagement with our Champion's Boards we have two separate but linked visions that set out what older people consider good.

One is a broader vision that underpins our Ageing Well strategy in Community Planning and the other is what they want to see from health and care services namely 'Getting it Right for Me'.

We have set out our Ageing Well vision to highlight what it will take to make this vision possible:

**Ageing Well in South Ayrshire**

South Ayrshire  
**COMMUNITY  
PLANNING**  
Partnership

We are committed to building a grassroots movement to create opportunities for healthy ageing in South Ayrshire that is owned and supported by all sectors and players being led by our local Community Planning Partnership. We want communities where:

- People are enabled to live actively, purposefully and independently and to contribute within their communities.
- Older people are respected, listened to and celebrated with maximum choice and control about how they live their lives.
- Barriers to healthy and active living are removed and older people are enabled to flourish.
- Older people are integral to the whole lives of communities and where there is good connection with older people from all generations.
- We support people as early in their health and care journeys as possible to help prevent poor health as they age.
- Information, advice and support is made available in different ways, to allow everyone to feel informed and equipped to live lives as they wish.
- The voice of older people informs the way services are provided and where the health and care services that support our older people are formed around their needs and their perspectives.
- We foster a culture of partnership rather than dependency.
- Age is not seen as a barrier to living vital and productive lives.
- Older people have access to supportive social friendship networks and groups as much as they wish to or require.
- We utilise technology of all sorts to enable a ageing well community.
- We proactively support older people's wellbeing, both physical, mental, emotional, social and spiritual.
- Places and spaces are inclusive, safe and accessible.

**Working together to make South Ayrshire the best place in Scotland to live and age well.**

On 29<sup>th</sup> April 2025 a Service Plan Development Day was held. This was attended by a range of stakeholders including staff, partners from across the system, third sector and Champions Board, and generating key insights, some of these are set out below.

- Think local
- Relationships are key
- Knowledge of local community and its assets
- Start from home and community – hospital is last resort
- Do the right thing first time
- Take Control of the Curve
- Sharing information effectively is vital
- Capacity building and joint training
- Plan ahead and enable patients to plan ahead
- Needs to articulate and work across and between levels
- Think local
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The learning from the engagement session, combined with previous engagement activity, has helped us to form this plan for services.

Further engagement with stakeholders and staff teams will inform the accompanying action plan which sets out how we will deliver supports over the next three years.

## Research and Evidence

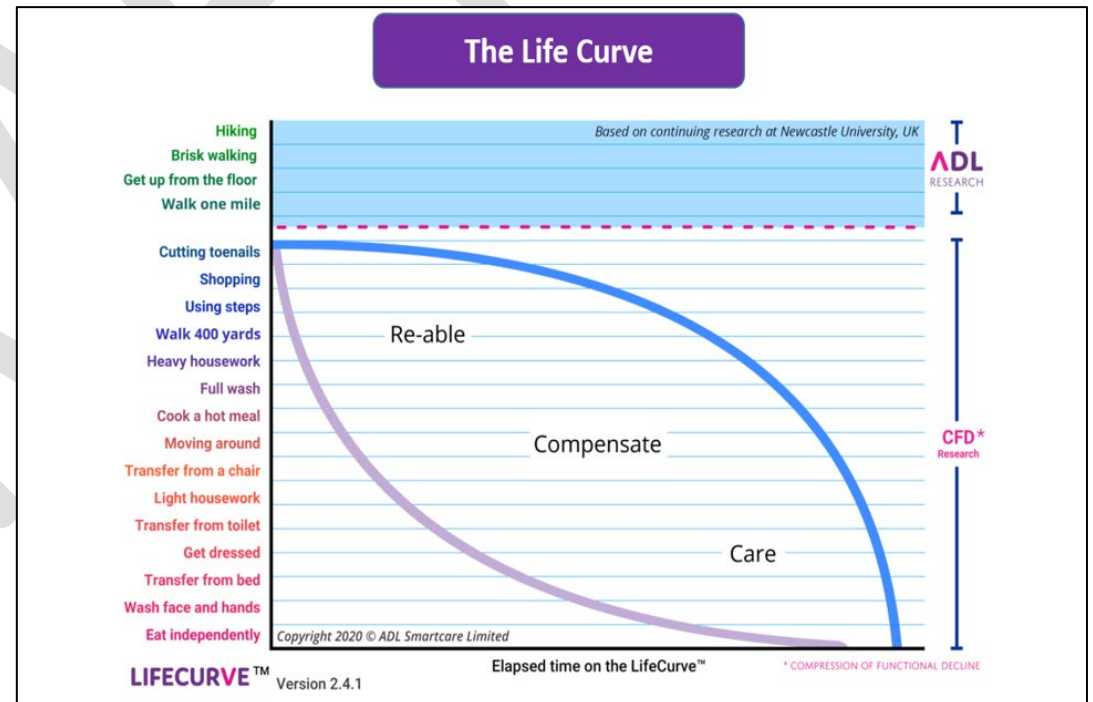
In developing this work, we have taken into account the evidence of what constitutes good practice and approaches to support older people and in particular frailty. This includes evidence from International, UK and Scottish contexts and underpins our local approach.

Some key aspects of this research are:

- The Life Curve approach developed by Professor Peter Gore at Newcastle University
- The British Geriatric Society 'Joining the Dots' vision
- The Healthcare Improvement Scotland 'Model of Community Frailty'

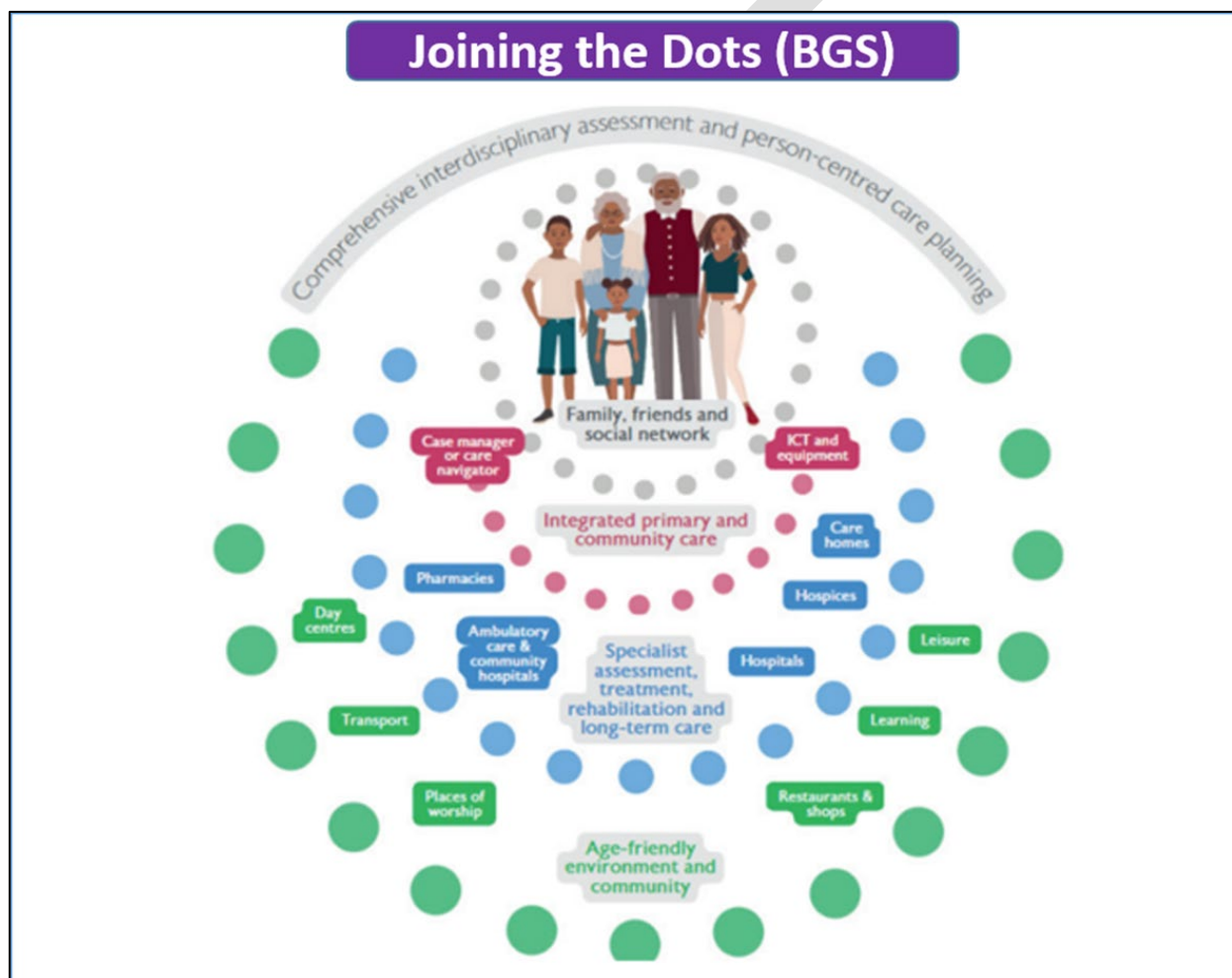
## The Life Curve

The Life Curve shown below sets out the trajectory in relation to frailty and functional ability and illustrates the need to 'bend the curve' in a positive way to enable people to live longer healthily and with more independence for longer before requiring significant service interventions.



## Joining the Dots

The vision below was part of the British Geriatrics Society approach to supporting ageing and frailty in their [Joining the Dots](#) document:



The graphic above shows how clinical and care services (community and hospital based) need to be seen within the context of the wider place of Family, Friends and Social Networks and also with Age Friendly Environments and communities.

This illustrates how our Ageing Well Strategy within Community Planning needs to underpin our approach to service provision.

### **Model of Community Frailty**

Informed by evidence and established good practice, Healthcare Improvement Scotland has developed a framework for effective approaches to supporting people with frailty, alongside Ageing and Frailty Standards that will be central to our local delivery.

#### **Core features of a community frailty service**

- Multidisciplinary and multiagency integrated frailty team.
- Clearly defined care pathways for older people living with frailty.
- Processes in place for care coordination and shared decision-making.
- Focus on proactive and preventative care as well as urgent response.

#### **Frailty Identification**

- System in place to identify older people living with frailty using a recommended or validated tool.
- Staff are trained and knowledgeable about clinical frailty scores.

#### **Frailty Assessment**

- Access to comprehensive geriatric or comparable assessment.
- Clear information of the outcome of an assessment and what to expect in future.
- Proactive reassessment and follow up where required.

## **Integrated Care Coordination**

- Multidisciplinary team responsible for delivery and coordination of frailty services.
- Clear referral pathways and key point of contact.
- Access to person led care, future care planning and polypharmacy review.

## **Urgent community response to deterioration in health**

- Urgent assessment and access to appropriate community-based support including Hospital at Home.
- Rapid response from emergency services where needed.

## **Frailty Standards**

**Standard 1:** Organisations have systems in place to identify older people living with frailty at the earliest opportunity.

**Standard 2:** Older people living with frailty experience have coordinated multidisciplinary support that is responsive to changes in their life, health and care.

**Standard 3:** Unpaid carers and care partners are valued, supported and trained to continue providing care.

**Standard 4:** Older people living with frailty are supported to keep active to maintain and improve mobility, independence and function.

**Standard 5:** Older people living with frailty are supported to eat and drink and receive specialist input if required.

**Standard 6:** Older people living with frailty receive early assessment and proactive management of bladder and bowel issues.

**Standard 7:** Older people living with frailty are prescribed medicines which are safe, effective and person centred.

**Standard 8:** Older people living with frailty are empowered to live well throughout their life, maximise enjoyment and die comfortably.

**Standard 9:** Older people living with frailty have their mental health needs addressed.

**Standard 10:** Older people living with frailty who experience a sudden change in their health can access timely, coordinated and consistent support.

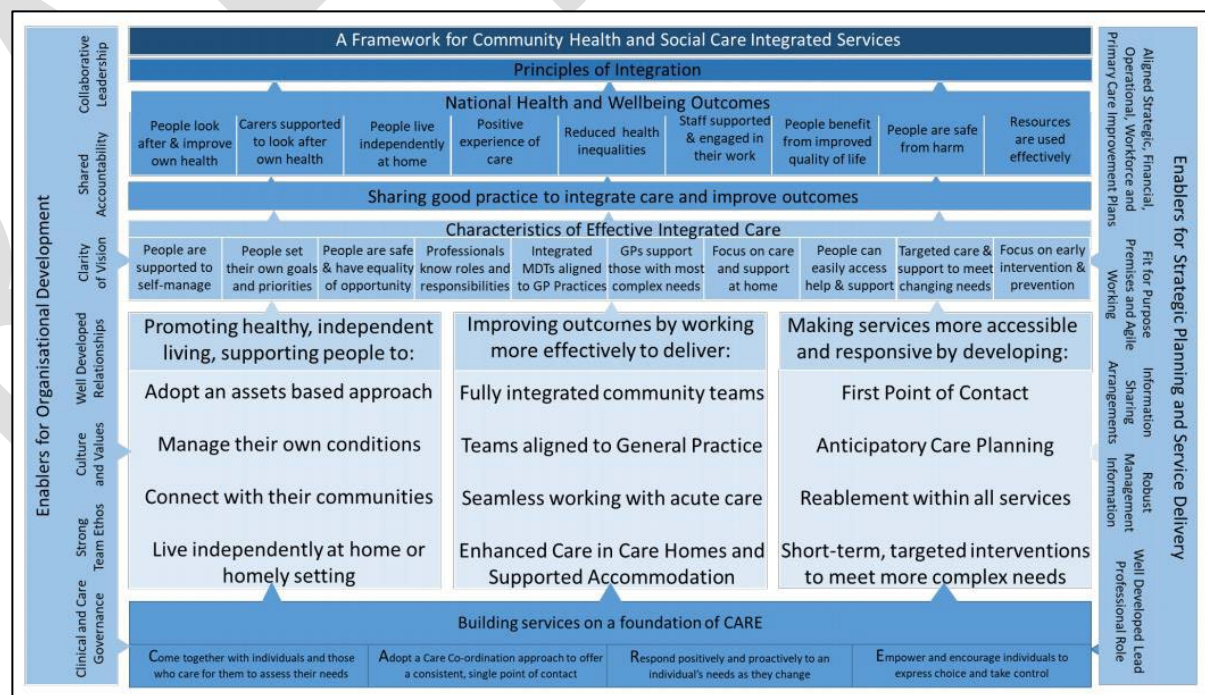
**Standard 11:** When in hospital, people living with frailty receive safe, effective and person-centred care.

## National Policy and Strategic Direction

A range of key national legislation informs the delivery of adult and older people services, including:

- Public Bodies (Joint Working) (Scotland) Act 2014
- Social Care (Self-directed Support) (Scotland) Act 2013
- Carers (Scotland) Act 2016
- Adult Support and Protection (Scotland) Act 2007
- Adults with Incapacity (Scotland) Act 2000
- Patients' Rights (Scotland) Act 2011
- Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017
- Health and Care (Staffing) (Scotland) Act 2019

The Scottish Government Framework for Community Health and Social Care Integrated Services will inform our approach to service delivery implicitly and more explicitly (for example integrated community teams and teams aligned to GP practices).



As well as the emerging approach from Healthcare Improvement Scotland we have considered a number of national drivers and ensured they have become integral to our approach.

These have included the Ageing and Frailty standards, the emerging Population Health Framework, the National Palliative Care Strategy, the emerging Long Term Conditions Framework and the Getting it Right for Everyone (GIRFE) approach.

The GIRFE principles are set out in the graphic to the right.

We have also considered a range of other related national strategies that need to be taken into account, for example those linked to Dementia, Adult Mental Health and Carers.

Alongside this we have taken into account national professional and ethical approaches including [Realistic Medicine](#) and Values Based Health and Social care.

The components of Realistic Medicine are:

- Personalised Care and Shared Decision Making
- Reducing waste, Harm and Variation and Managing Risk
- Innovation and Improvement



#### GIRFE principles

The ambition is that professionals working in health, social care, and beyond, can embed these principles into their work to start getting it right for everyone.

Our current draft GIRFE principles are:

- *I have the information I need to make decisions about my life, in a way that works for me, and I am supported to understand what options are available to me, and trusted to know what is right for me*
- *the people who support me take the time to listen and understand me as a person and we consider my whole life when making decisions about my life*
- *I know that I can be clear about what matters to me, and I trust that my choices will be respected and understood by the people who support me*
- *if I need to access services or support, I am treated with kindness, dignity and respect at all times.*
- *the people I am involved with work together with me and each other to share information, in a way that is accessible to me and develop a clear understanding of how to support my wellbeing*

A good example informed by the Realistic Medicine Principles is improvement in prescribing through GP Practice based Pharmacy staff who are improving prescribing efficacy and reducing unnecessary waste.

In June 2025 the Scottish Government published their [Population Health Framework](#) and [Health and Social Care Renewal Framework](#). These ambitious frameworks set out the national approach to health and care over the next 10 years. Underpinning the approach in both documents is the need to address demographic challenges with prevention being prioritised and people are enabled to live well for longer.

### [Pan-Ayrshire and Local Strategies](#)

In developing our approach, we have considered our local landscape and taken account of wider Ayrshire based approaches including the NHS Ayrshire and Arran Caring for Ayrshire vision.

Another key consideration is the local Primary Care Improvement plan as it moves through different iterations.

Within South Ayrshire, our services approach also takes cognisance of Council and Community Planning approaches and strategies such as the Council Plan, the Local Outcomes Improvement Plan, the local Housing strategy, Community Learning and Development strategy and others.

Other wider partner plans have also been considered such as those linked to transport and economic development.

In relation to Health and Social Care in South Ayrshire we have ensured that the Strategic Plan vision and approach is central to our planning and there is clear alignment with related strategies including Adult Mental Health, Dementia, Adult Carers, Digital and Advocacy.

One key HSCP approach that is core is the team Around the Locality.

### [South Ayrshire Strategic Plan](#)

On 12<sup>th</sup> March 2025 the South Ayrshire IJB agreed a refreshed [Strategic Plan 2021-31](#). This provided an update on the ten-year vision for integrated health and social care services which sets out objectives for the HSCP and how it will use its resources to integrate services in pursuit of national and local outcomes over the coming years.

# IJB Strategic Plan

2021-31



**Our Vision**  
Empowering our Communities to Start Well, Live Well and Age Well.

- HSCP Services**
- Children's Health
  - Children's Care
  - Justice
  - Allied Health Professionals (AHPs)
  - Adult Locality Health and Care Teams
  - Mental Health
  - Addictions
  - Learning Disabilities
  - Sensory Impairment
  - Reabling and Caring for Older People

- Enablers**
- Financial Resources and Commissioning
  - Property and Assets
  - Workforce
  - Digital Transformation and Data
  - Leadership and Culture of Continuous Improvement
  - Partnerships

The overarching aim of the SA HSCP remains that we will work together with the communities of South Ayrshire to improve health and wellbeing: to support, develop and encourage communities to be resourceful and supportive of family, friends and neighbours.

Our seven strategic objectives which are outlined below have remained the same for this period as has our *vision ‘empowering our communities to start well, live well and age well’* with a refreshed approach to delivery for the next stage:

- We focus on prevention and tackling inequality;
- We nurture and are part of communities that care for each other;
- We work together to give you the right care in the right place;
- We help build communities where people are safe;
- We are an ambitious and effective partnership;
- We make a positive impact beyond the services we deliver; and
- We are transparent and listen to you.

The Strategic Plan is ambitious and aims to promote wellbeing in its broadest sense while keeping a sharp focus on improving health and social care outcomes. For adult and older people’s services our model of care revolves around a ‘team around the practice’ approach (MDTs), which will be described in further detail throughout this document.

It is important to acknowledge the specific challenges to community health and care services within South Ayrshire as a result of our unique population and geography. In short, South Ayrshire has the highest dependency ratio in Scotland, an older-than-average population, pockets of substantial economic deprivation (including the poorest ward in Ayrshire) and areas of significant rurality. Our community and our public services are challenged by a combination of factors that mean there are less informal carers available, greater demand for care and a smaller working-age population from which to draw key workers.

These contextual factors have an impact on outcomes for our citizens and create particular challenges for our services which is borne out in a range of indicators including South Ayrshire’s significantly higher rates of hospital admissions than the rest of Scotland. With these challenges in mind, it is vital that our services remain focused on key objectives around prevention, investing in early intervention and tackling these inequalities.

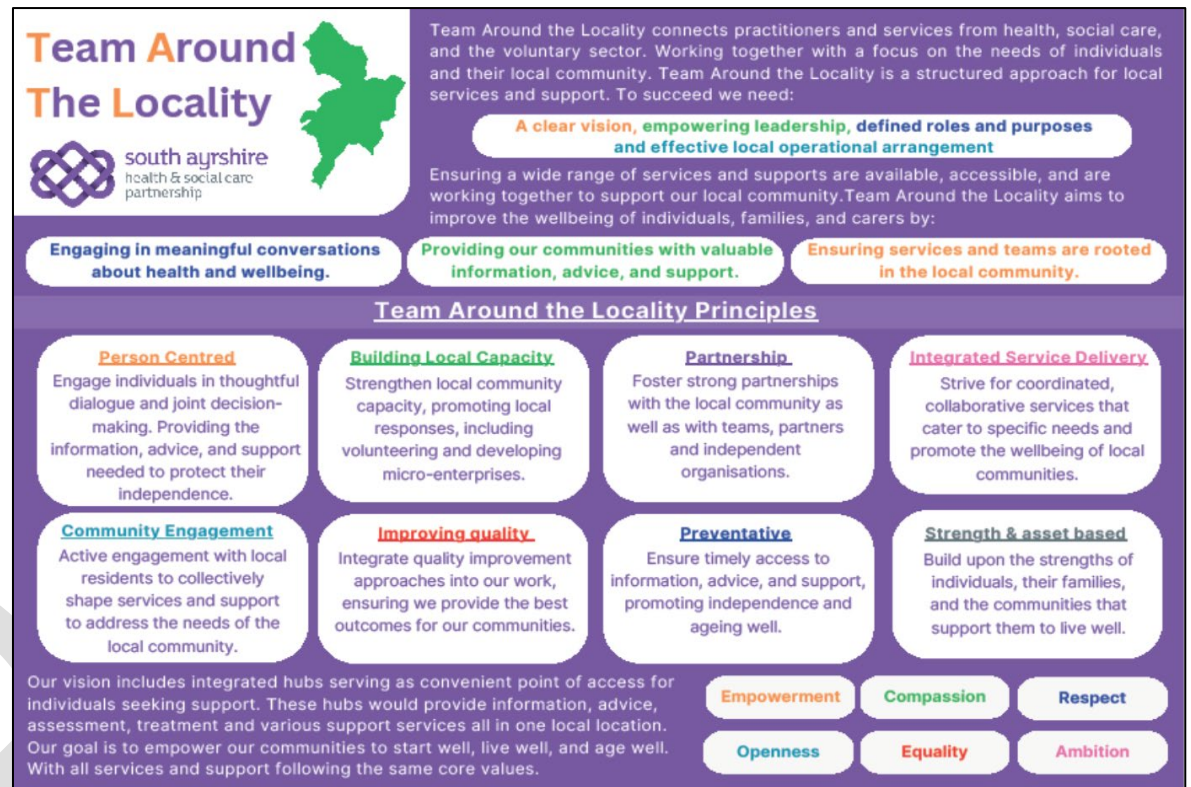
## Locality based priorities

In 2023 the IJB agreed investment in new locality teams including a Senior Locality Manager for each locality area – Central, North and South.

As a result of this, the work over the past few years has moved towards a more localised and devolved working practice within our six localities each with their own emergent local priority themes set out within their Locality Plans. These are aligned to the IJB Strategic Plan.

The Team Around the Locality is a core HSCP approach to service delivery in localities.

In addition, the Ayr North locality is developing a new, innovative approach – Integrated Neighbourhood teams – that will particularly address health and wider inequality and target those most needing support.



## Connect South Ayrshire

The development of the Connect South Ayrshire model was a key ambition of the HSCP to deliver more locality based services across all our local communities. The plan for delivering Connect includes integrated and accessible physical locations in all localities, a dedicated website and a free telephone number all providing information, advice and support focussed on promoting wellbeing and access to social opportunities.

The Connect model was informed by a combination of public consultation, learning from other areas and our involvement as a pathfinder in the GIRFE national programme. In partnership with VASA, we launched the online and telephony aspects of Connect and opened our first hub in Ayr in November 2025.



### Bringing these elements together

In order to bring our learning together, we have developed a tiered approach for this Service Plan that clearly defines what approach and interventions are required based on different levels of need.

This tiered approach includes population level approaches, prevention and early intervention and primary care-based work, through to more intense supports including crisis response and specialist hospital-based care.

The core principles at each tier are:

- Ensuring we are having strength-based conversations.
- Consider services within this tiered model and ensure all preceding levels of care are in place and intervene as early as possible.
- Localise support where possible.
- Multi-disciplinary and multi-agency working is vital with strong local relationships.
- Create a culture of shared risk enablement.
- Ensure technology is integral to supporting people.

We have also contributed to an Ayrshire-wide Self-assessment process linked to the [National Ageing and Frailty Standards](#) (HIS 2024) and have incorporated the key, high level improvement priorities, identified in this, within the Service Plan.

## Approach

Our approach to health and care services are depicted in the triangle diagram to the right:

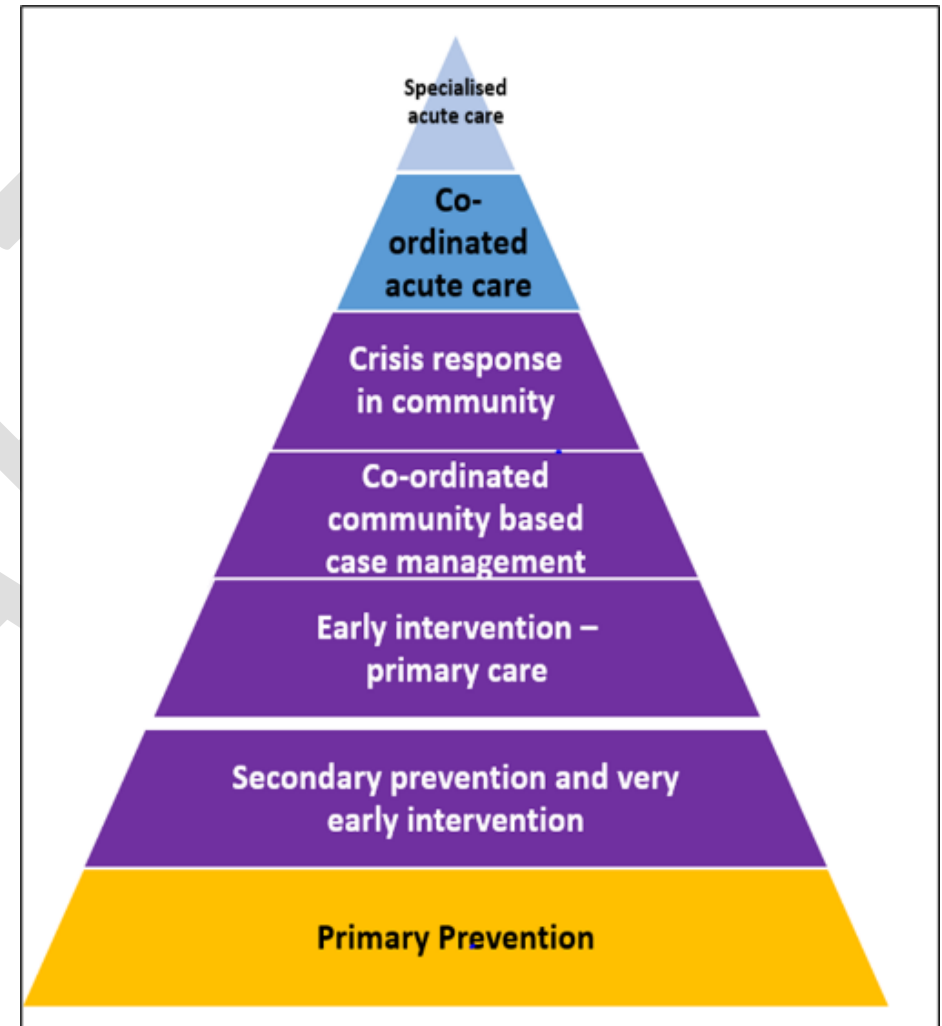
This approach attempts to reduce people's journey up the triangle of need and dependency where more services are needed or ultimately hospital based care is required.

At the bottom of the pyramid **Primary Prevention** interventions are aimed at the whole population. These interventions that keep people active, involved, contributing and informed. This is largely the content of our Ageing Well strategy that sits within a Community Planning context alongside some elements of health protection such as screening and vaccination.

The second tier **Secondary Prevention and Very Early Intervention** is focused on supporting those at the start of the journey where their functional abilities start to become affected but where they are still active and generally unknown to formal services.

The third tier **Early Intervention in Primary Care** focuses on those who are beginning to be noticed at GP Practice level and where functional ability is starting to decline. GP Practice staff and the wider health and care teams will start having more contact but there are still lots of activities that can slow down the functional decline and these should be promoted.

At the next tier **Community-based Co-ordinated Case Management** the level of functional decline is quite marked and at this level of need people might be the recipients of a range of health and care services. Although they will still be living at home more intense support is required to enable this to continue. The interventions at this level focus are on avoiding crisis episodes such as falls – that often lead to marked decline. This is often where palliative and end of life planning and support may be evident.



The fifth tier **Crisis Response in the Community** seeks to support those who are experiencing crisis such as falls and where a range of intense services might support the person to stay at home and not having to be hospitalised.

Even at the sixth tier **Co-ordinated Acute Care** there are many interventions within the hospital that might avoid long-term admission, speed up the initial assessment period, avoid losing functional ability during the stay and transferring their care to community settings as quickly as possible (either home or other alternatives).

The higher seventh Tier links to much more **Specialised Acute Care** and this is usually coordinated at a regional level.

Supporting all of these Tiers of activity are a set of cross-cutting **enablers**.

### Primary population-based prevention

At the bottom of the triangle the biggest focus is on Ageing Well at community or locality level. This means we need to focus on ensuring people live well independently at home for longer. To do this we need to promote how people can support themselves to live in their communities.

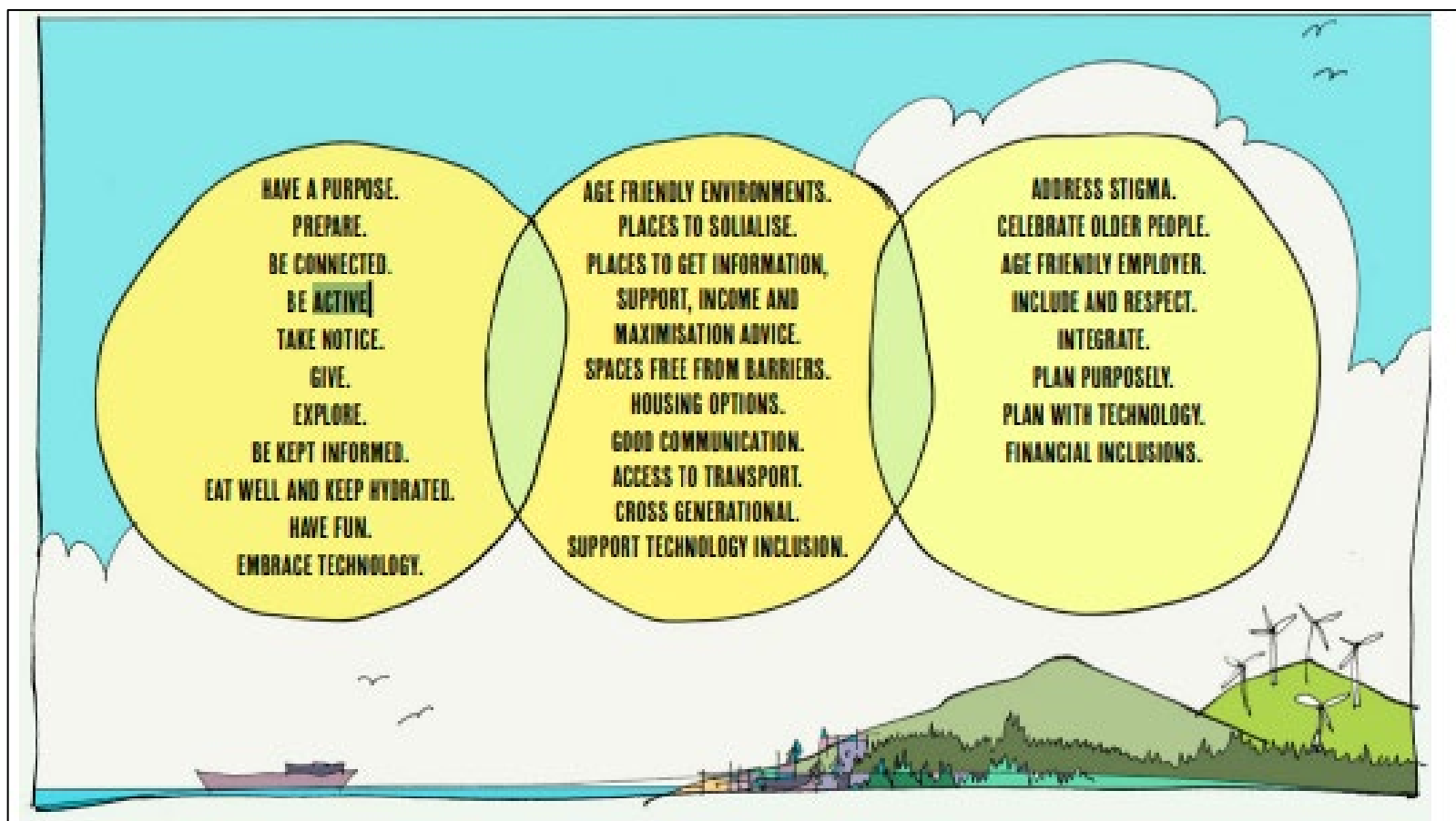
This thinking formed the basis of our [Ageing Well Strategy](#) developed during 2024.

The Ageing Well approach aims to support the planning of our community-based supports as well as our health and social care services in the future. We know that if we can support people to live well for longer in their communities, there will be less need for input from formal services.

Whilst it is important that we can access services when they are required, we can also make use of a range of established community supports such as voluntary organisations and community groups as well as our family and friends.

The Ageing Well approach is more than just having formal services in place, it is based on a community wide approach to embedding age friendly communities across South Ayrshire. This means that if we all play our part in supporting older people in our communities, it will enable everyone to live a more fulfilled life for longer.

The diagram below illustrates the types of interventions that fall under the Ageing Well approach (and their differing locus):



One core initiative that supports Ageing Well throughout the level of need is the Connect initiative – providing local information, advice and support hubs, telephone and web-based support.

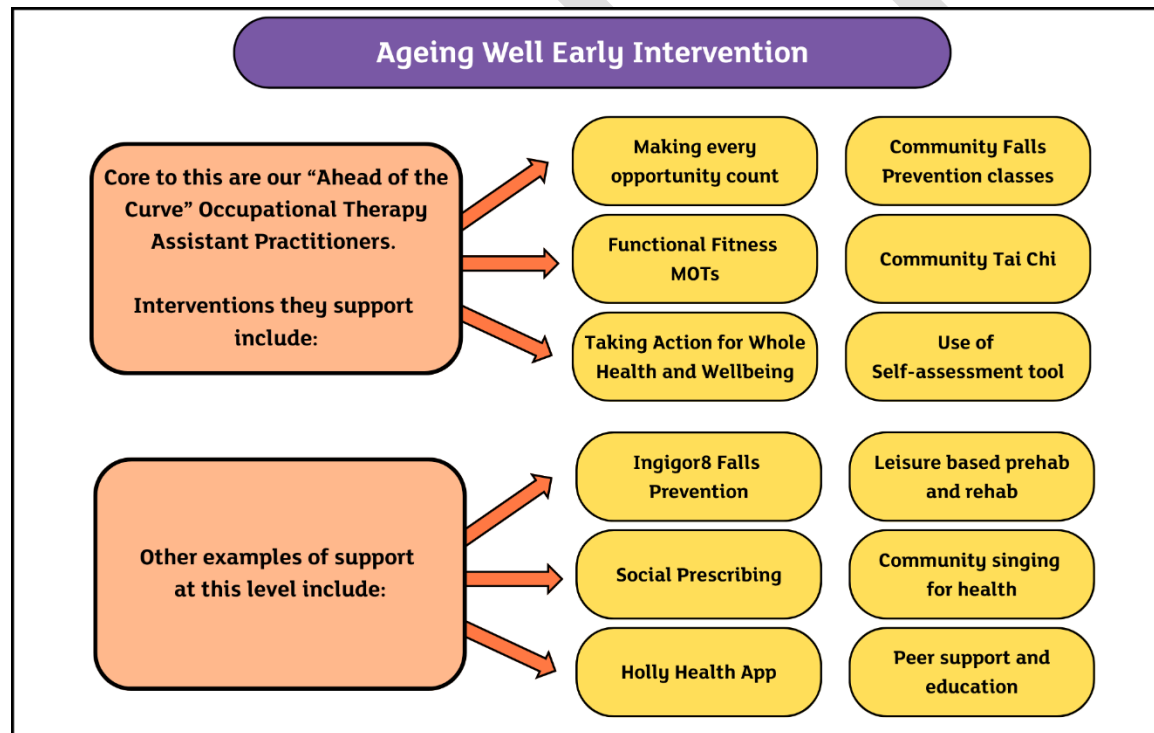
In addition, at this prevention level, it will be important to support ‘Health Protection’ interventions such as screening and immunisation.

## Secondary Prevention and 'Very' Early Intervention

At this level of the triangle the focus remains on prevention and a shift towards a very early intervention which is provided at community or locality level.

This means we continue to maintain our focus on ensuring people live well independently at home or in a home like setting for longer.

To do this we need to promote Ageing Well and how people can support themselves to live in their communities as set out in the diagram below:



## Early Intervention – Primary Care

At this tier the focus moves to those who are presenting via Primary Care routes. This could be where there is a marked change and functional ability is starting to decline.

Primary Care staff and the wider health and care teams will start having more contact and support is required but this should remain rooted in the locality wherever possible and people supported to live well at home.

One important ‘tool’ that is relevant in this and other (higher) levels is the use of the Electronic Frailty Index (EFI).

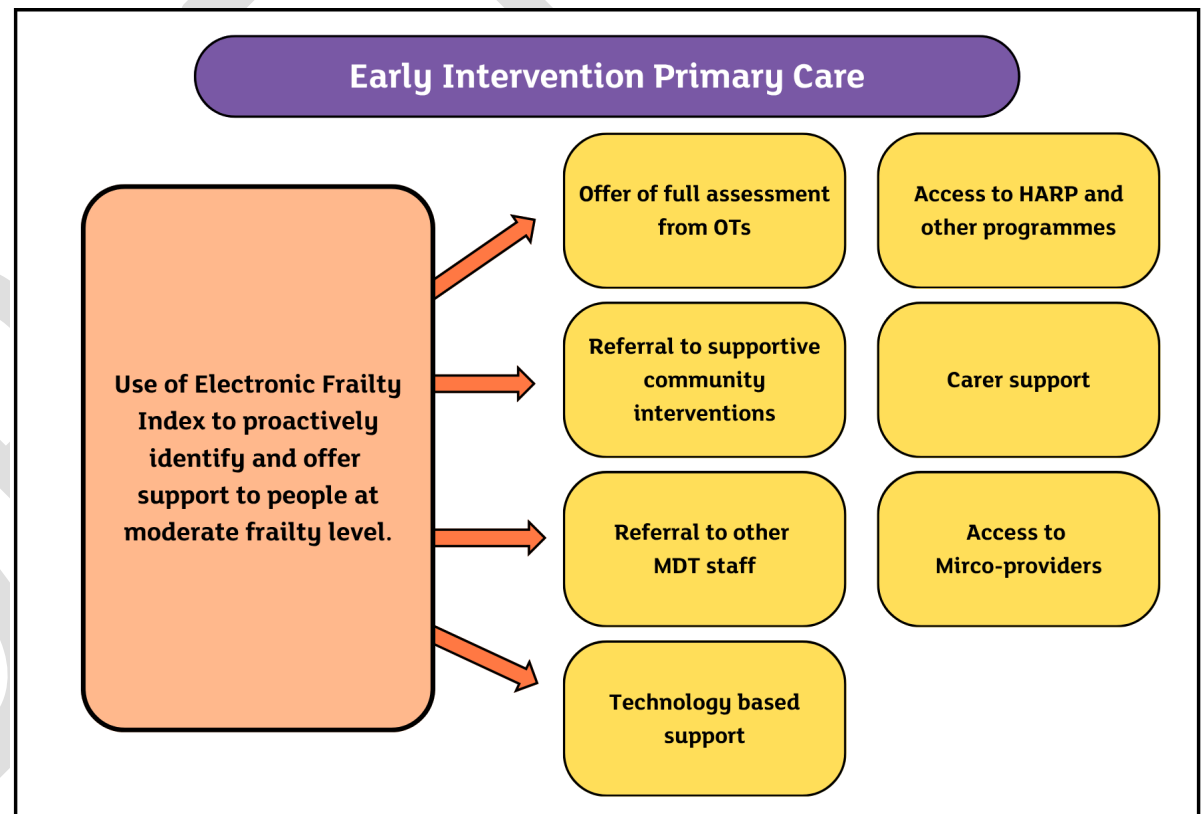
This can be used at GP Practice level to identify people at different levels of frailty so that the earliest intervention might be possible.

We have been utilising the EFI (1) tool for some years and our (GP Practice aligned) OTs actively use this to identify those moving up to higher levels of frailty.

In mid-2026, an updated version of EFI (EFI(2)) will become available. This is more accurate and nuanced, utilises more sources of data and can also be used to predict:

- Likelihood of falls
- Likelihood of needing Care at Home
- Likelihood of needing residential care

This will provide a very significant to our ability to detect need earlier and be able to respond more appropriately through our local MDT working.

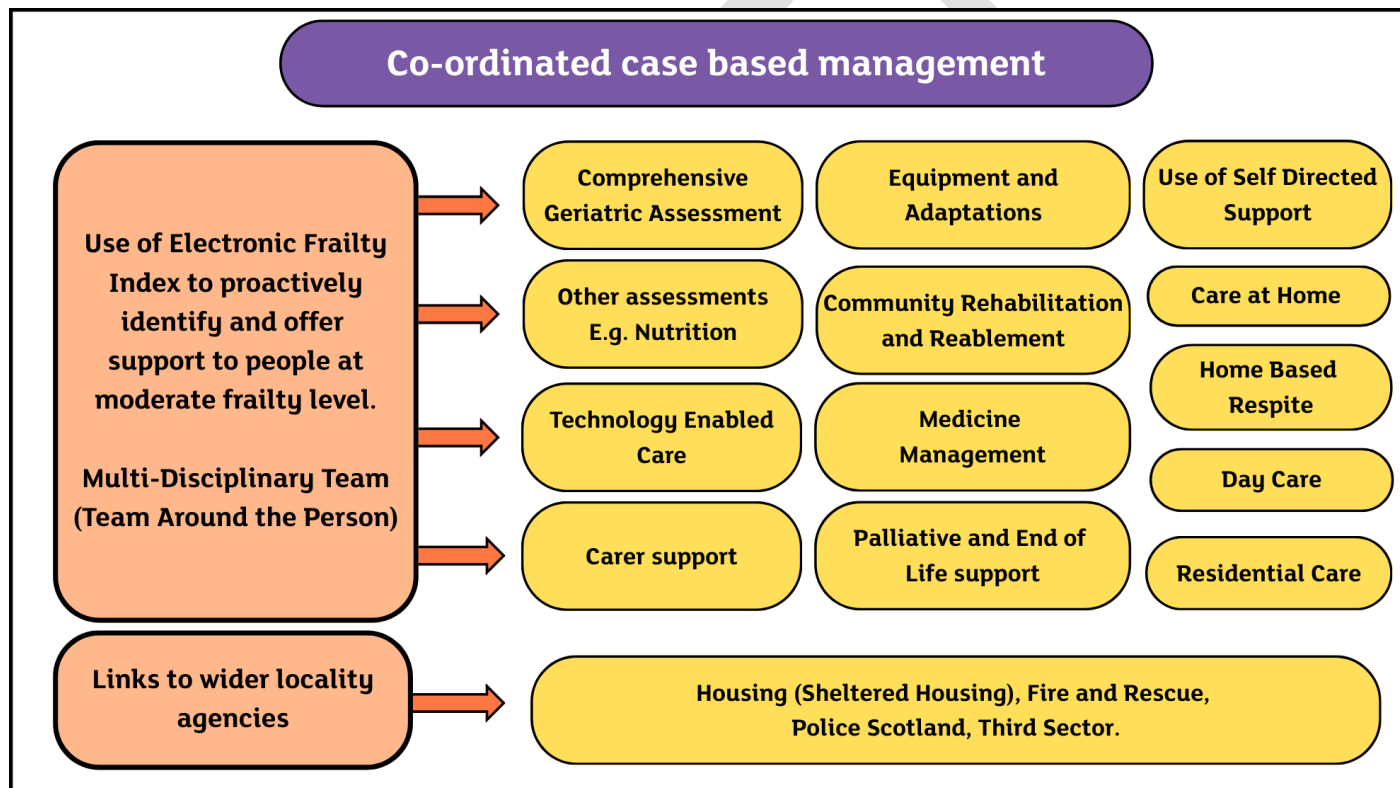


## Co-ordinated community-based case management

At this tier the level of need is greater and people might be the recipients of a range of health and care services.

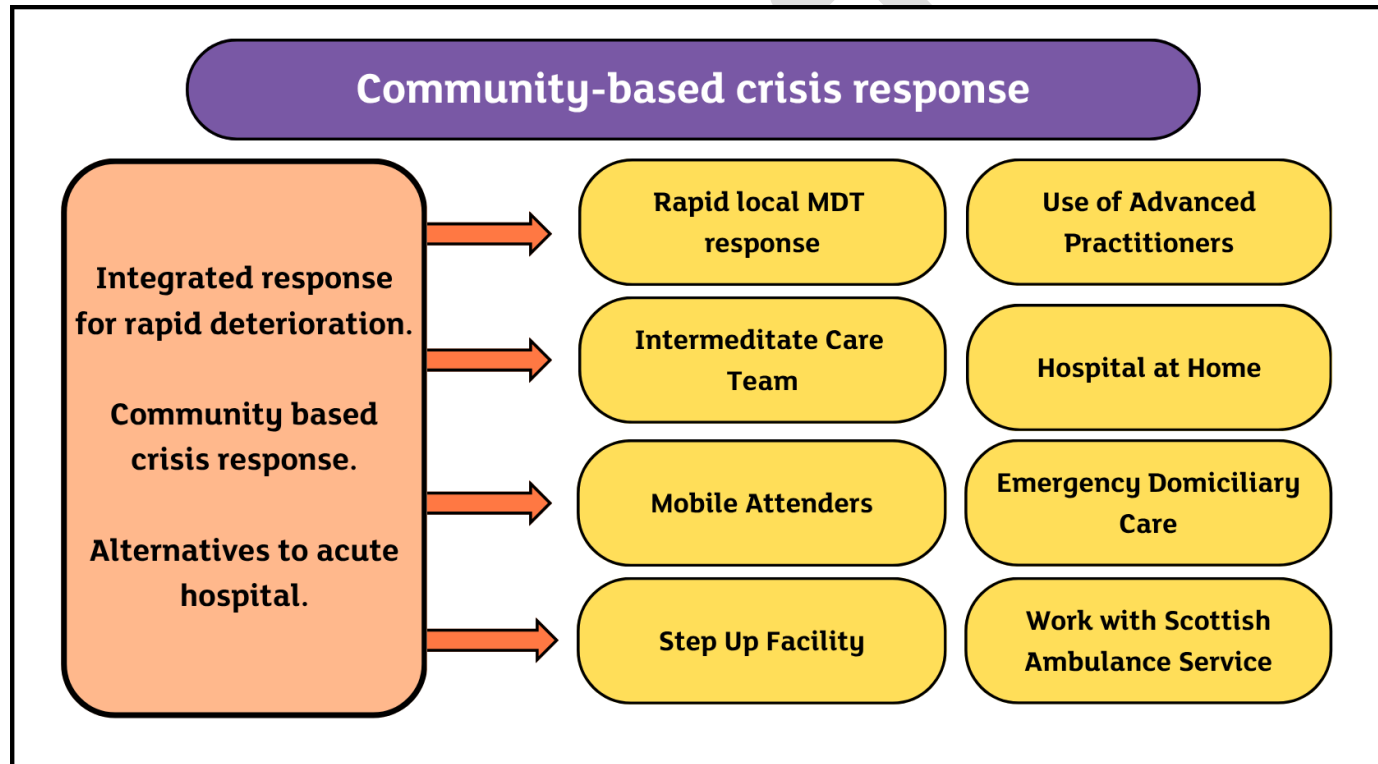
Although they will still be living at home more intense support is required to enable this to continue and this should take place in the community. The interventions at this level focus are on avoiding crisis episodes such as falls – that often lead to marked decline.

At this tier more formal services are likely to be required and become involved:



## Crisis response in the community

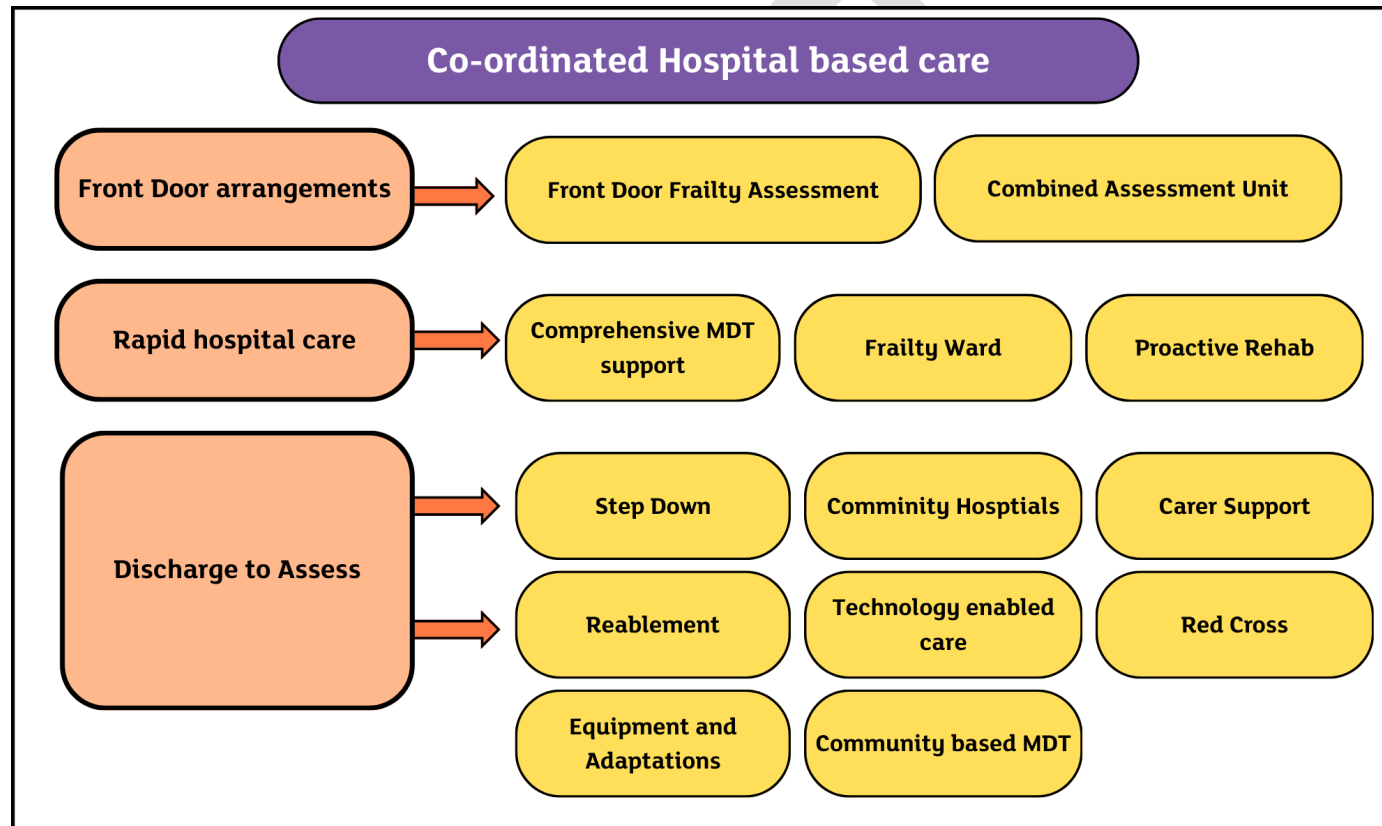
This tier seeks to support those who are experiencing crisis and where a range of more intensive services might be required to provide support for people stay at home and avoid hospitalisation.



## Co-ordinated Acute Care

This tier is specific hospital-led supports and there are many interventions within the hospital that might avoid long-term admission.

At this tier it is our aim to speed up the initial assessment period, avoid losing functional ability during the stay and transferring their care to community settings as quickly as possible.



## Enablers

Throughout the whole system we need to address 'Enablers' that will support all this working:

### Leadership and Culture of Continuous Improvement

South Ayrshire's health and social care workforce is critical to the effective delivery of health and social care. Even in the most challenging of circumstances, our staff demonstrate their skills, flexibility and commitment to continue to provide critical services for our communities.

We have a workforce of highly capable, committed and enthusiastic people, including skilled and dedicated leaders.

Our vision is for a culture which values leaders, regardless of hierarchy or experience or discipline. It is one in which people strive for continuous improvement, are enabled to be innovative. We want to see staff flourish and take pride and joy in their work.

Our partnership approach starts from an understanding that we are collaborating as a wider workforce bringing all of our combined assets to achieve shared goals.

In South Ayrshire we are committed to a culture of Quality Improvement (QI). The Partnership's Framework for Quality Improvement was approved by the Health and Care Governance Group in February 2023 and describes the Partnership's desire to embed a culture which empowers our workforce to deliver quality services through continuous improvement.

We have a number of staff who have undertaken national level training, and we continue to encourage and support participation where we can.

We know that despite challenges and budget pressures we must continue to ensure that our staff have the necessary training and support for them to undertake their roles.

### Digital

Transformation of services is key to shift the balance of care to community-based services this can be achieved by creating new ways of working that are more effective and efficient in enabling the citizens of South Ayrshire to live better lives.

Digital transformation will be a core focus going forward. The rate of change in digital technology is rapid and growth in the uptake of technologies such as mobile devices, social media, and high-speed broadband is changing the way we live, providing those living in our communities with greater choice and control than ever before.

This presents a huge opportunity for the HSCP to change the face of health and social care delivery and transform our services so that care can become more person-centred.

In June 2024, we launched our new [Digital Strategy 2024-29](#) which aligns closely with national and local strategies, including [Scotland's Digital Health and Care Strategy](#) and the digital strategies of both NHS Ayrshire and Arran and South Ayrshire Council.

Our Digital Strategy looks towards a future where technology and data are seamlessly integrated into our operations, service delivery, and decision-making processes. It outlines a vision to transform our HSCP into a digitally empowered, data-informed, and user-centric organisation.

### Workforce

People are at the heart of everything we do. The workforce of the HSCP is our greatest asset. Even in the most challenging of circumstances, our staff demonstrate their skills, flexibility and commitment to continue to provide critical services for our communities.

Effective workforce planning is essential to deliver on our strategic objectives and to ensure we are an ambitious and effective Partnership. We will continue to assess local and national workforce challenges and consider the changing landscape as we plan the delivery of our services, whilst continuing to work in innovative ways.

We will deliver on a new one year Workforce Plan during 2025 which will look ahead to enable delivery of our strategic objectives.

### Partnerships

Partnerships are important because they enable action on the determinants of health, which is vital in addressing health inequalities.

Our priorities are strongly connected to, and will help to build on our existing commitments, strengthen our contribution to local strategic planning and Community Planning Partnership activity, recognising that key partners will have a number of common priorities.

A number of key multi-agency priorities are being progressed through our Community Planning Partnership and Locality Planning Partnerships.

## Further areas for consideration

### Carers

The Adult Care Strategy sets out a range of improvement activity and this will be integral to the delivery of this Ageing Well Service Plan.

### Biggart and Girvan Community Hospitals

In relation to Biggart Hospital we are redesigning services to ensure patients receive the right treatment in the right area, ultimately helping them return home as safely and quickly as possible. Central to this initiative is the transition of stroke rehabilitation from acute care settings directly to the dedicated rehabilitation hub at the Biggart Hospital. Alongside this transition, the Integrated Care Team (ICT) is launching an innovative pilot program that introduces senior health care assistants to the team. This new role focuses intensely on encouraging patient independence with personal needs, a strategy designed to foster confidence and significantly release operational pressure on our essential reablement and care at home services. By focusing heavily on personal empowerment, this model ensures individuals regain their dignity, strength and daily living skills in a supportive environment. Patients will experience a much smoother, more coordinated journey from hospital to their own front door, surrounded by a team dedicated to their long-term health and autonomy.

Girvan Community Hospital was the subject of a recent review and has a related improvement plan that seeks to maximise the effective use of a significant local resource.

### Day Care/Day Opportunities

A range of options will be explored to ensure access to day breaks for carers and support for the 'cared for' is provided in flexible, localised, proportionate and effective ways.

### Community Equipment Store

Following the recent (April 2025) audit review of the Community Equipment Stores a range of improvement activity has been agreed. This will be germane in relation to the Ageing Well Service Plan.

### Continence services

South Ayrshire HSCP continues to provide lead partnership arrangements for the continence service across Ayrshire.

The Integrated Continence Service promotes continence by empowering patients to self-manage through behaviour and lifestyle interventions.

### Palliative and End of Life Care

We will seek to integrate the emerging work on Palliative and End of Life Care into our tiered service model and incorporate the demands of the new national strategy into our implementation plans. We will also support the Ayrshire-wide working and link this to our local approach.