south ayrshire
health & social care
partnership

South Ayrshire HSCP
Winter 2021-22 Investment Plan

NHS Ayrshire & Arran

south AYRSHIRE COUNCIL

Introduction

This briefing sets out the Health and Social Care Partnership's investment plan for adult and older people community health and care services over the winter 2021-22 and into the financial year 2022-23. The report **focuses on the proposed use of the additional Scottish Government 'winter pressures' funding** but also describes ongoing, budgeted-for investment contained within existing HSCP plans and how this activity contributes to the achievement of both the Scottish Government key performance indicators (KPIs) for winter pressures funding *and* the HSCP's own Strategic Objectives.

This report is published to inform our IJB and other groups within the HSCP. Work continues to develop our overarching Commissioning Plan for Adult and Older People (and associated refresh of Service Plans) linked to the IJB Strategic Plan.

South Ayrshire IJB Strategic Plan

The South Ayrshire IJB Strategic Plan was published in 2021, setting out our strategic objectives (below) and the models of care we will deploy to achieve these objectives, including a focus on prevention, locality planning and tackling inequalities.

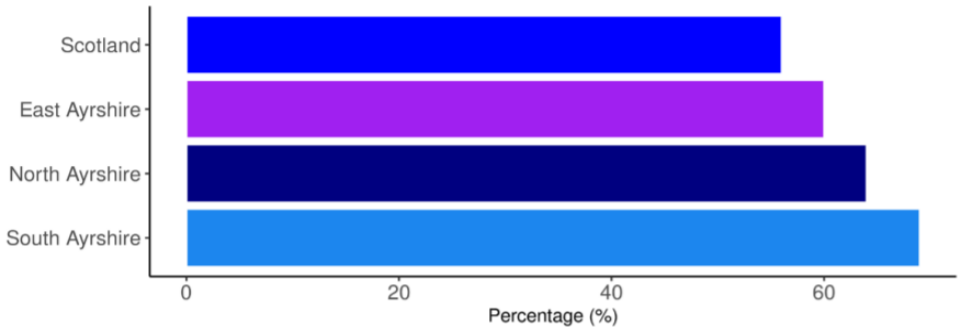
Our Strategic Plan is ambitious and aims to promote wellbeing in its broadest sense while keeping a sharp focus on improving health and social care outcomes. For adult and older people's services our model of care revolves around a 'team around the practice' approach (MDTs), described in further detail below.

Specific challenges in South Ayrshire

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.**

Dependency Ratio

The chart below shows the number of people aged 0-15 and 65+ as a percentage of those aged 16-65. For South Ayrshire HSCP, the figure was 70% for the most recent year.



Inequalities

Each locality has its own unique strengths and assets, as well as its own challenges.

Severe deprivation continues to be concentrated around the Wallacetown, Ayr North, Lochside, Whitletts and Dalmilling areas with Girvan, Barassie, Craigie, Kincaidston, Ayr Town Centre and Maybole also suffering deprivation.

By reducing inequalities, deprivation and the impact of poverty, we can make a long-term improvement to the health of local people.

6.7%

In March 2020, **6.7%** of the over 16 population in Ayr North were unemployed compared to only **1.7%** in Prestwick.

17.1%

17.1% (19,257 people) of South Ayrshire's population live in the **20%** most overall deprived datazones.

23%

23% of South Ayrshire's children live in poverty. (after housing costs)

73.6

The average life expectancy for males in Ayr North is **73.6 years** compared to **80 years** for males who live in Troon.

17%

17% of South Ayrshire's mothers exclusively breastfeed compared to **31%** in Scotland as a whole. The figure in Troon locality was **27%** compared to **12%** in Ayr North.

Ageing Population

Older people are valued members of our community and contribute so much to the care of our children and families. South Ayrshire has a significantly higher proportion of older people than East and North Ayrshire.

We need to ensure that we are supporting people as they grow older to live as independently and as full a life as they can.

The HSCP needs to consider the population change to ensure health and care services are equipped and able to support our ageing citizens to achieve their personal outcomes as well as supporting our unpaid carers.

The dependency ratio in South Ayrshire (the ratio of people aged 0-15 and 65+ compared to those aged 16-65) was **70%** in 2019, which is higher than both East and North Ayrshire (61% and 65%).

In 2019, **11.7%** (13,179) of South Ayrshire's population were aged 75 and over. This is a higher proportion than both East and North Ayrshire (8.8% and 9.9% respectively)

Life expectancy is expected to increase from **80.4** years in 2018 to **81.2** years in 2030.

At the Scotland Census 2011, **11,709** people in South Ayrshire identified themselves as a carer. This number includes both adult and young carers.

In the 2016 South Ayrshire 1000 Quality of Life Survey, **28%** of respondents said that they provided unpaid care in the last 12 months.

Balance of Care

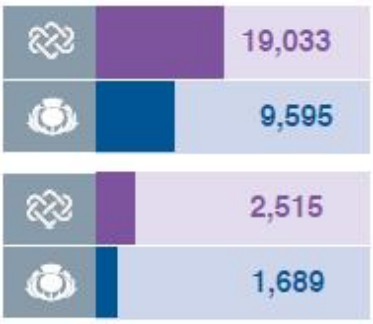
"Shifting the balance of care" is an objective for all of our services and for everyone we support: from childhood to old age.

For older people's services, a key priority that received concerted effort is bringing down delayed discharges. A delayed discharge is defined by NHS Services Scotland as "a hospital inpatient who is clinically ready for discharge from inpatient hospital care and who continues to occupy a hospital bed beyond the ready for discharge date". [1]

Reducing delays in discharge from hospital matters for many reasons, but most importantly it is almost never an appropriate place for someone to be if they no longer need hospital care. Time spent in hospital when medically fit is an unnecessary risk to health and welfare, involving risks such as hospital acquired infection and loss of mobility.

In children's services "shifting the balance of care" is about our ambition to keep South Ayrshire's children in South Ayrshire and within families where ever possible.

This includes increasing the number of children and young people living within their own communities in South Ayrshire.



In 2018/19, the rate of delayed discharges in South Ayrshire (19,033 per 100,000) was more than double that of Scotland (9,595 per 100,000) as a whole.

In 2018/19, the rate of potentially preventable admissions to hospital was higher in South Ayrshire (2,515 per 100,000) than Scotland (1,689 per 100,000)

There has been no young people in secure accomodation since May 2019.

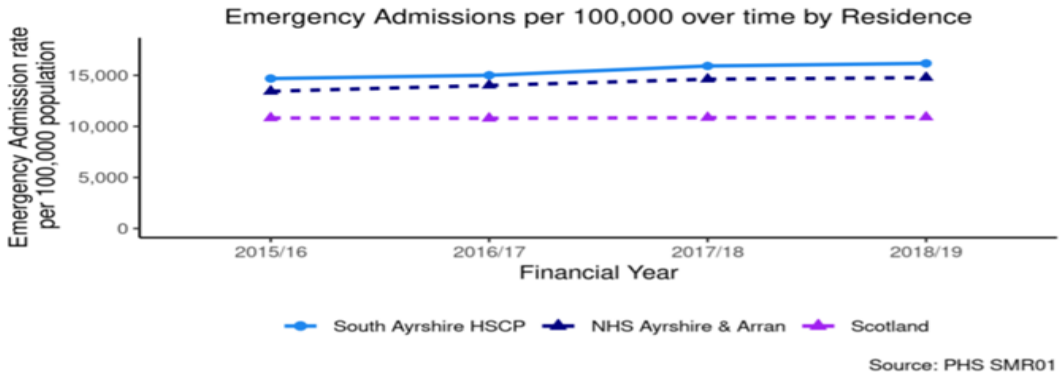
There were more emergency readmissions within 28 days per 1,000 discharges in South Ayrshire, particularly in the over 75 age group, than East and North Ayrshire in 2018/19.

In 2018/19, **90%** of people over 75 years spent **90%** of their last 6 months of life at home or in a community setting. This is slightly lower than the national figure of **92%** and varies across locality areas.

These contextual factors have an **impact on outcomes for our citizens** and create particular **challenges for our services** which is borne our in a range of indicators including South Ayrshire's significantly higher rates of hospital admissions than the rest of Scotland.

Hospital and Community Care

Emergency Admissions per 100,000 population



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. Our Strategic Plan sets out how we will achieve this and makes commitments to future work with a ten-year timeframe; but much of our success will depend on the resources available to the HSCP. The additional investment from Scottish Government is therefore welcome and will enable the HSCP to deliver on the criteria set out in alignment with our direction of travel.

At this moment in time (December 2021), South Ayrshire continues to have very high numbers of people who are experiencing a delayed transfer of care (DTOC) and faces challenges in creating capacity within Care at Home to meet demand. Everything the HSCP delivers and commissions – from primary prevention through building community capacity, to delivering direct care – has an impact on these key measures and national outcomes.

Our model of care: place-based and person-centred

To improve outcomes for people, the starting point for our model of care is **the person**: their needs, their home and their assets and strengths. People live in communities – neighbourhoods and villages – and our approach seeks to maximise the supportive assets that these communities contain to support their own people.

The closest universal services to most adults in communities are in primary care, not least GP Practices (but not forgetting the range of supports and services that Community Pharmacies provide). We are focused on building up Multi-Disciplinary Teams around our GP Practices to enable build better integrated and comprehensive supports for patients.

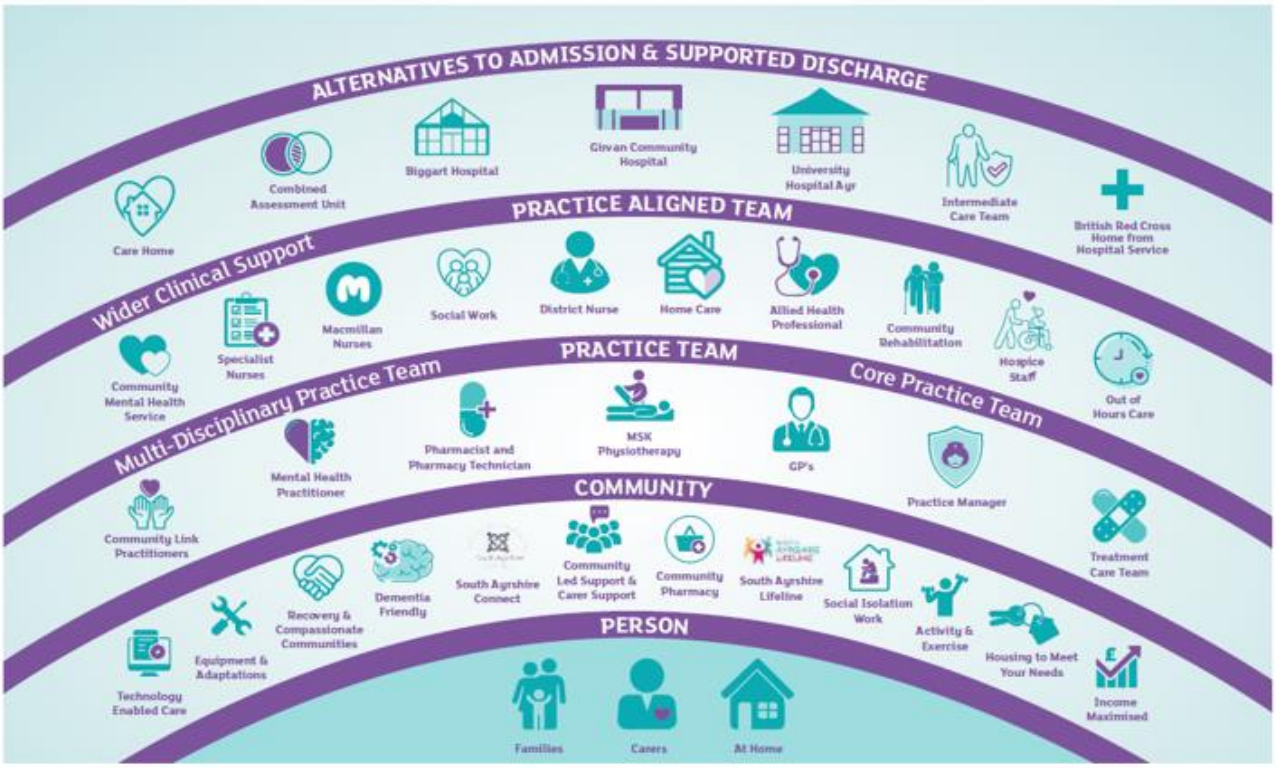
Where staff are not integral to GP Practices, we will align HSCP staff, as far as possible with GP Practices and/or localities.

Where people need more specialist services we will make them accessible as far as possible within our locality approach to services. Where this is not possible, we will ensure good articulation with services at local and specialist level.

In South Ayrshire we take seriously our six localities and in each area we aspire to:

- Local leadership attuned to the particular context of need and assets in their localities
- Comprehensive, preventative services that maintain health and independence
- Articulated services between and among levels of care and need
- Clear use of analytical information to pre-empt future demand and target need
- Partnerships with local statutory, third and independent services and with the wider public.

To deliver this, our 'team around the practice' multidisciplinary team approach is being rolled out across South Ayrshire, described in the model of care diagram below.



For each of the 'layers' of this model (i.e. **Home; Community; GP Practice; Aligned Team; Wider Specialist Support**) a logic model at Appendix 1 below describes how our services will be shaped to improve outcomes for our communities. This model has clear read-across to the Scottish Government's principles for winter preparations (**Maximising Capacity; Ensuring Staff Wellbeing; Ensuring System Flow; Improving Outcomes**) as well as the three high-level areas for investment of winter pressures funding i.e. **Multi-Disciplinary Working; Providing interim care; Expanding Care at Home capacity.**

Our model of care will also be increasingly supported by the **South Ayrshire Wellbeing Pledge** – our strategic approach for investing in and supporting community capacity and developing a new relationship with the community to promote self-care. This has been developed and is being implemented in partnership with our local third sector umbrella organisation VASA and other partners.

The South Ayrshire Wellbeing Pledge

Activity and investment to date

The overall budget for the HSCP's adult and older people's services (including community nursing, AHPs and intermediate care and rehabilitation) is **£66.850m**, with spend targeted according to need and in line with our Strategic Plan. To continue delivering high-quality services and move further towards the model of care set out above, there are a range of existing specific investments and improvement programmes in place, to complement and transform our routine business.

This existing investment programme is summarised below and is grouped according to the main locus of support as set out in our overall Older People and Adults with Complex Care approach:

- **Home**
- **Community**
- **GP Practice MDT Team**
- **Wider Practice Aligned Team**
- **Alternatives to Admission and Supported Discharge (+ wider specialist support)**

Locus	Intervention	Investment
Home	**Investment in purchased care at home,** to provide additional capacity in the community to reduce unnecessary delays in hospital. **Mobile Responder Service** to expand existing service to provide a timely response to alerts and provide capacity to enable transfer of care from hospital back to home Additional **mental health nurses** in the community to support elderly referrals to avoid unnecessary admissions to hospital, supporting care home residents and those at home to remain in the community. **Technology Enabled Care:** investment in home pods in the community to support health and care needs at home for specific service users.	**£1,049,957** **£100,000** (2020/21) **£80,000** (2020/21) **£60,000** (2020/21)
Community	**South Ayrshire Wellbeing Pledge funding** to local community groups to strengthen and build on significant Covid response, meet needs within localities and offer early intervention supports.	**£100,000** (2020/21)
GP Practice	**Additional Self Help Workers and Mental Health Practitioners to support GP practices** to meet needs of increasing referrals providing early intervention support	**£96,984** (2020/21)
Aligned Team	Additional capacity for AHPs to provide additional **Speech and Language therapy, Dietetic, Physio and OT** input to meet an increased demand and people with complex rehabilitation needs (inpatient and community). This additional capacity supports **Rehabilitation and Recovery** and positive outcomes for people through improved access to therapy, and early intervention and prevention. Additional **Occupational Therapists** to support increased frailty need in the community linked to GP Practices Investment in **district nursing capacity** following full review of the current structure and assessment of community need.	**£322,880** (2020/21) **£143,000** (2020/21) **£100,000** (2020/21)
Alternative to admission and discharge support	**Reablement Team**, growing the service by 66% to reduce acute and hospital pressure, supporting a “discharge to assess” model.	**£415,000** (2020/21) **£590,000** (2022/23) **£200,000** (2020/21)

	Temporary investment of **increase care home capacity** to support timely discharge until reablement team is at capacity. Investment to support **Adults with Incapacity**, expanding existing MHO capacity to increase support to adult concerns and AWI cases in relation to Delayed Discharges Additional capacity to **review community care packages** to ensure care needs are met and where appropriate reduce care allowing for release of care capacity to support reduction in delayed transfers. **Additional beds in Biggart Hospital** to remain open due to lack of capacity in the community to support rehabilitation and community care.	**£104,000** (2020/21) **£125,000** (2020/21) **£500,000**

This programme of investment has been fully endorsed by the IJB with the aim of furthering the objectives of the Strategic Plan. With oversight from the Directorate Management Team the Head of Community Health and Care leads on the delivery of the range of initiatives through the internal "Driving Change" group. The logic models below (**Appendix 1**) demonstrate how these programmes of work contribute to our overarching strategic objectives, *and* those Key Performance Indicators set out by the Scottish Government to be achieved through the additional winter funding.

In the context of the current recruitment and retention problems for care at home services it is important to note that the HSCP upgraded all front-line care at home staff in 2020. The investment of **£316,104** was made to reflect the increase in complexity in managing higher levels of need in the community. While anticipated outcomes included the recruitment and retention of staff the more recent experience is that it is proving extremely difficult to recruit to the service.

Primary Care

Some of the investment to further substantiate activity within and aligned to GP Practices is in addition to the significant investment that is in place from Primary Care Improvement Funding and other sources.

This includes the develop of a comprehensive **Practice based Pharmacotherapy** provision (over £1 million in South Ayrshire), new **Community Treatment and Care** services (over £1 million in South Ayrshire), **Physiotherapists for MSK issues** (over £100k) and **Mental Health and Wellbeing related services** including the provision of Mental Health Practitioners, Community Link Practitioners and Distress Brief Intervention.

Broader activity

In addition to these investments, there are a range of other activities underway across the HSCP that will drive improvement within our services and contribute to the objectives and desired improvements set out in the Scottish Government's winter plan e.g.

- Targeted work to **recruit and retain more staff in Care at Home**, including in our third and independent sector. A Short Life Working Group has been established with the aim of maximising recruitment opportunities and improving retention. Examples of work being progressed include improvements to the MyJobScotland Portal and plans for "Recruitment Fayres" in early 2022;
- Implementation of our **HSCP Digital Strategy**, including the move from Analogue to Digital, implementation of new information systems, further exploration of ;
- Implementation of our **Adult Social Work Learning Review**;
- Continuation of **enhanced support to care homes and care at home providers,** through strong links to Scottish Care local reps and the rollout of a QA Framework;
- **South Ayrshire Wellbeing Pledge** (above);
- Collaborative development of new strategies / commissioning plans for Learning Disability and Mental Health Services.

These key areas of work ultimately report into the South Ayrshire IJB but are supported by a range of internal governance groups such as Driving Change, the Frailty Commission, the Wellbeing Pledge Board and the Strategic Planning Advisory Group. The HSCP's Directorate Management Team (DMT) takes collective operational ownership of these programmes.

Scottish Government winter funding

On 5th October 2021, the Cabinet Secretary announced new recurring investment of £300m nationally to help protect health and social care services over the winter period and to provide longer term improvement in service capacity across health and social care systems. This announcement was followed up by a letter from NHS Scotland Chief Operating Officer and the Director of Mental Wellbeing and Social Care, detailing the winter planning investment for health and social care included in Appendix 2.

The criteria for use of this funding adhere to the four principles guiding the Scottish Government's winter preparations (Maximising Capacity; Ensuring Staff Wellbeing; Ensuring System Flow; Improving Outcomes) and is targeted at three high-level areas:

1. **Multi-Disciplinary Working (including the recruitment of 1,000 Health and Care Support Staff)**
2. **Providing interim care**
3. **Expanding Care at Home capacity**

These areas are supported by further national initiatives such as continued financial support to social care providers; funding for the social care pay uplift (to enable an uplift from £9.50 per hour to at least £10.02 per hour); targeted national/international recruitment campaigns; and, funding to support staff wellbeing.

South Ayrshire allocation

South Ayrshire's allocation of the funding (**£4.11m recurring** from 2022/23) is broken down below.

Area	Allocation	Scottish Government Allocation (£m)	Funding Status	South Ayrshire 21-22 (£m)	South Ayrshire 22-23 (£m)
Winter 21/22 Funding	Interim Care Beds	40.282	Non Recurring	1.002	0.501
	Care at Home Capacity	61.563	Recurring	1.554	3.108
	Multi-Disciplinary Teams	101.845	Recurring	0.501	1.002
			TOTAL	**3.057**	**4.611**

Developing our proposals

In order to make best use of this funding, ensure that it meets the criteria set by the Scottish Government and our local priorities based on local need, we have identified areas for investment through consultation with management, staff and our IJB members. The HSCP's Directorate Management Team (DMT) have led development of these proposals in consultation and collaboration with partners and existing partnership governance groups (e.g. South Ayrshire's Budget Working Group and Strategic Planning Advisory Group).

South Ayrshire HSCP 'winter pressures' funding allocations

Based on the data and intelligence above, our existing strategic direction and our commitment to meeting the Scottish Government's criteria for winter planning, South Ayrshire HSCP will invest the additional 'winter pressures' funding in the following areas:

Investment Area	Investment Proposal Description	Proposed Investment
Hospital at Home	Investment in practitioners and business support to support the Ayr Hospital 'hospital at home' model, manage interim care beds, linking with the community rehab and ICT team	£380,000
Discharge without Delay	Investment in additional social work capacity at hospital to support discharge without delay and co-ordinate services with ICT, Community rehab and care at home	£110,000
Interim Care	Commissioning interim care home beds across localities. Managed / monitored by the Hospital team for discharge without delay.	£500,000
Care at Home (capacity)	Investment in existing care at home services both internal and commissioned, increasing capacity to provide flow from hospital and reablement services, including resources allocated to Out Of Hours and Mobile attendants to provide round-the-clock access to support.	£1.15m

Care at Home (supervisory)	Additional supervisory capacity to manage systems and care at home services including business support, quality assurance and officers to monitor care and data systems essential to capture activity to continually improve standards	£690,000
Community AHP	Additional Physios, OTs, SLT and HSCW aligned to localities to provide a rehabilitation service, enabling discharge from hospital and recovery at home or in a homely setting. Working alongside hospital teams and Multi Disciplinary Teams to embed good practice and clear referral practices	£260,000
Community Nursing	Additional community nurses and a clinical nurse manager resource to build capacity in the community to provide services that would otherwise be delivered in hospital. Team will focus on anticipatory care.	£410,000
Enhanced Locality MDT Workforce (CTAC)	Community Treatment Assessment Centre nursing resource, to provide hospital services in the locality linked to GP service	£110,000
Enhanced Locality MDT Workforce (PC Dietetics)	Additional Primary Care Dietetics to provide capacity in supporting people in their locality and enhancing preventative approach to avoid care needs escalating	£110,000
Enhanced Locality MDT Workforce (OTs)	Additional Occupational Therapy support to provide early intervention and prevention to frailty to avoid and reduce care needs escalating.	£300,000
Enhance Community Supports	Commission services from third sector to provide supports to carers and alternative support to traditional services allowing greater choice and control to meet health and social care needs in the community	£250,000
Technology Enabled Care	Invest in technology enabled care to provide early intervention support and support people in their homes, this includes resources to understand the needs of the end user and how these can be met from the various technology options	£360,000
Total		**£4.61m**

Anticipated impact

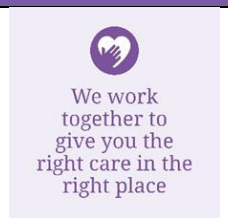
The additional activity outlined above, made possible by the winter pressures fund, will make a significant contribution to improving outcomes for the people we support and will support the achievement of the key performance indicators set out in the Scottish Government's letter of 4th November 2021 (Appendix 2).

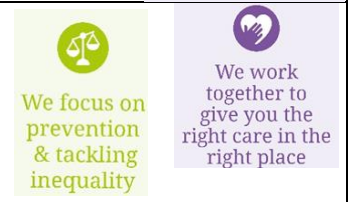
Further discussions are to be held with the Scottish Government around how these KPIs will be reported and in order to begin to benchmark the impact in South Ayrshire, we had captured the current status (below) on each indicator where the measures are already established.

No.	Key Performance Indicator	Current status (8/12/21)	Anticipated impact (by June 2022)
1	Number of people delayed in their discharge from hospital.	88	Reduced by 60-70%
2	Number of people who have been discharged to an interim care home.	**10** (cumulative)	Reach 40 by end December
3	Number of people who have moved on from the interim placement by the agreed date for the placement to end.	1	Aim for this to be standard.
4	Average length of interim care placements.	-	-
5	Significant reductions in delayed discharge and occupied bed days	2,454 Bed Days (Oct 21 source PHS)	See above – significant reduction
6	Number of NHS staff recruited at bands 3 and 4, to roles across community services and acute.	Data held by NHS.	Data held by NHS.
7	Increase in assessments carried out at home rather than hospital.	No data yet	Data to be tracked in 2022.
8	Evidence of a reduction in the number of people waiting for an assessment.	170	Reduce by 50-60%
9	Evidence of a reduction in the length of time people are waiting for an assessment.	Definition required	Reduction
10	Reduction in those waiting for care	8 (people waiting for Care Home who are delays in hospital)	
11	Reduction in those waiting for a care at home service.	1259community) 58(hospital)	Reduce by half
12	Reduction in unmet need	949 Hours (community) 771 Hours (hospital) (as at 6/12/21)	Tracked weekly
13	Evidence of the types of services and activity funded, and the number of people supported by these.	Contained within investment plan.	Reporting to SG to be agreed
14	% increase in the use of community equipment and technology to enable care, or other digital resources to support care provision.	2476 clients (Nov 2021)	Indicators to be confirmed
15	Evidence of resource to support the use of technology and digital resources.	Indicators to be confirmed	-

How these areas of investment contribute to the Scottish Government criteria and our broader objectives is shown in the diagram below. Progress (activity and impact/outcome) will be monitored within the HSCP and the spending decisions are subject to agreement by the IJB in December.

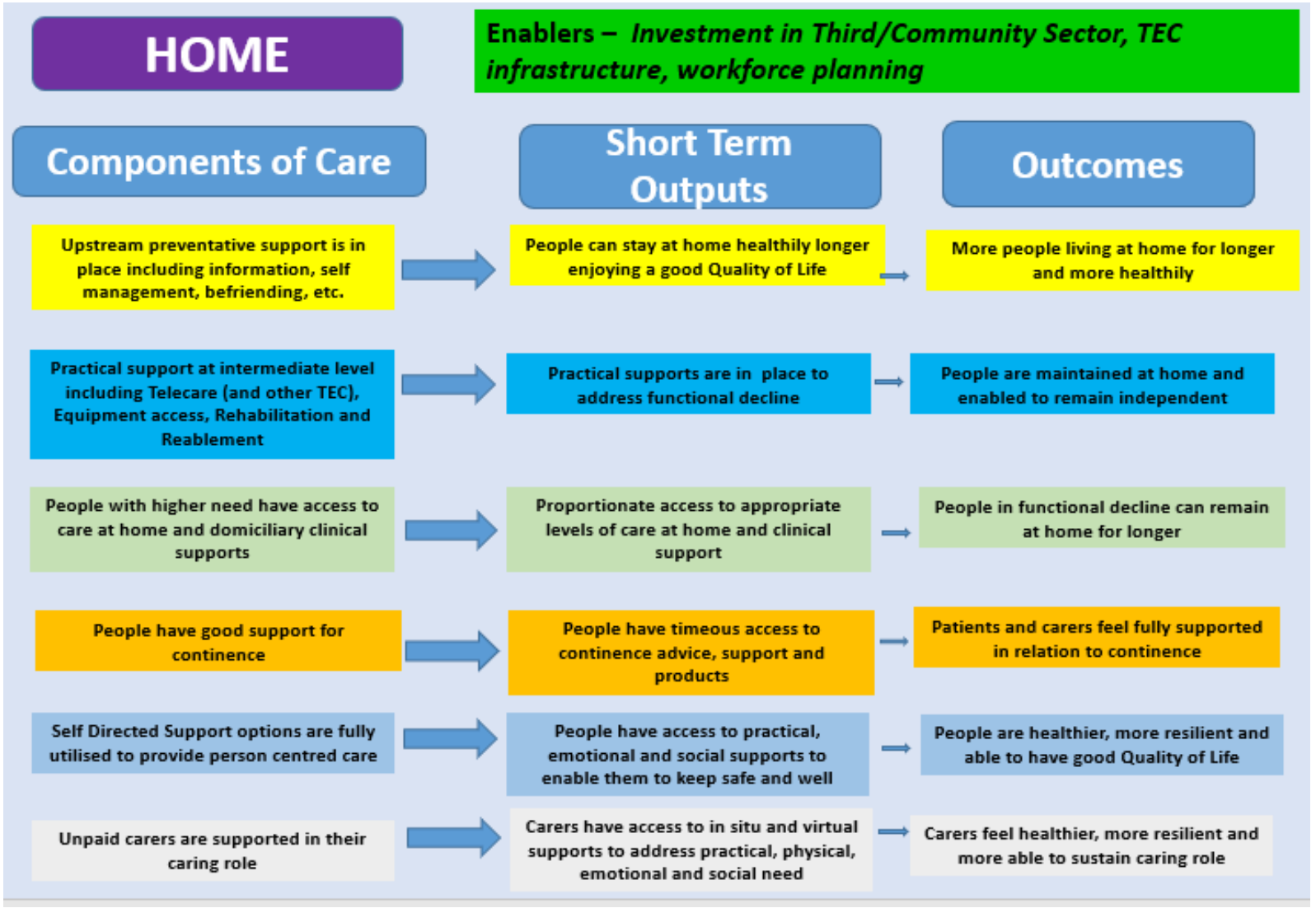
How it all fits together – winter pressures funding

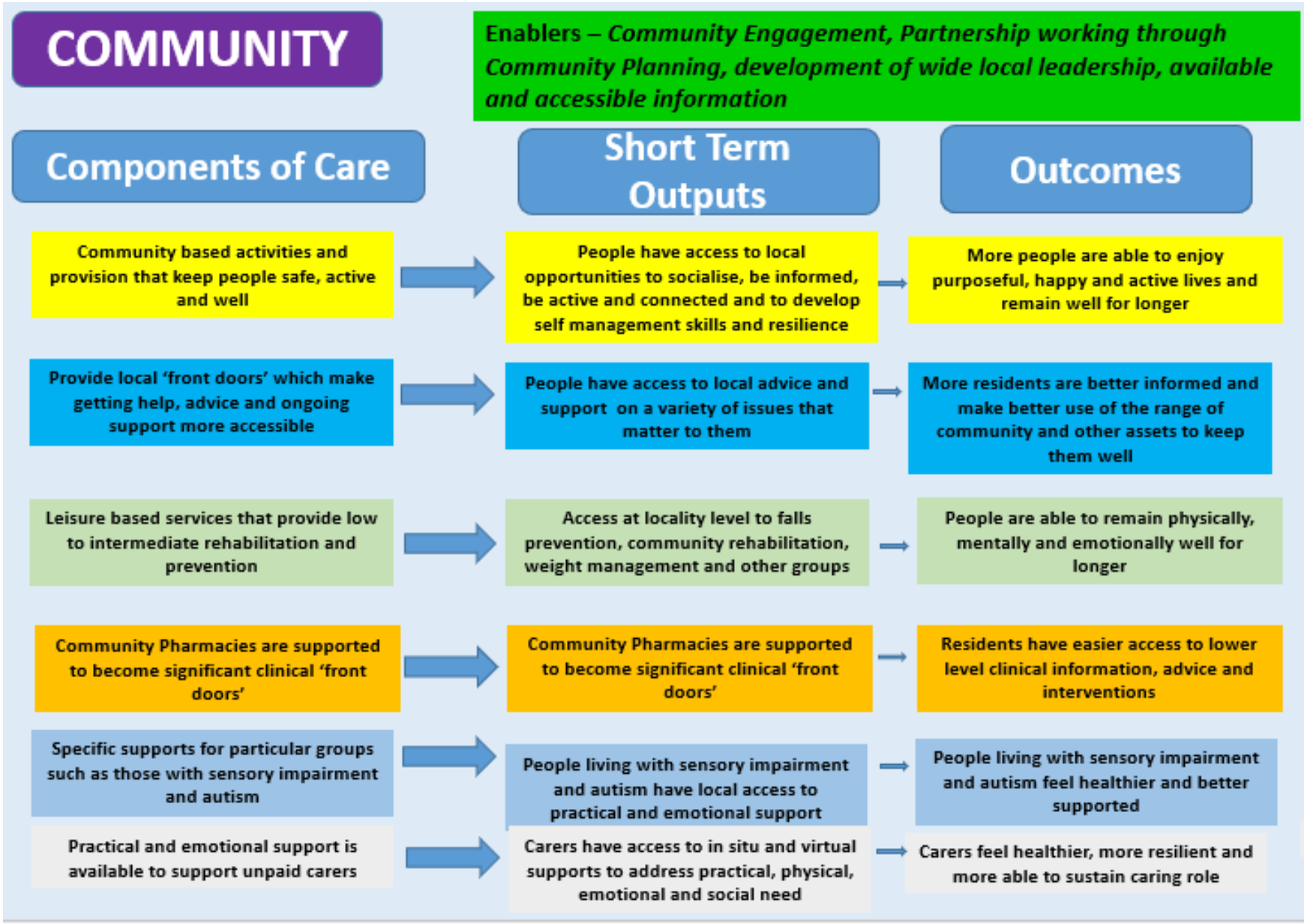
Investment Area	Investment Proposal Description	Amount	Impact (link to SG theme)	Scottish Government 'system pressure' themes			SG 2021-22 KPIs	Link to HSCP Strategic Objectives
				Multi-Disciplinary Working	Providing interim care	Expanding CAH capacity		
Hospital at Home	Investment in practitioners and business support to support the Ayr Hospital 'hospital at home' model, manage interim care beds, linking with the community rehab and ICT team	£380,000	***Multi Disciplinary Working*** - dedicated hospital to home teams, support social care assessments and augment hospital to home	X			1 to 4	
Discharge without Delay	Investment in additional social work capacity at hospital to support discharge without delay and co-ordinate services with ICT, Community rehab and care at home	£110,000	***Multi Disciplinary working*** - resources for social work to support complex care assessments and reviews	X	X		1 to 4, 5 to 9	
Interim Care	Commissioning interim care home beds (13+) across localities. Managed / monitored by the Hospital team for discharge without delay.	£500,000	***Interim Care*** - More appropriate care and support for people who are unnecessarily delayed in hospital.		X		5 to 9	
Care at Home	Investment in existing care at home services both internal and commissioned, increasing capacity to provide flow from hospital and reablement services, including resources allocated to Out Of Hours and Mobile	£1.15m	***Expand Care at home capacity*** - existing services should be expanded	X		X	1 to 4, 10 to 15	 

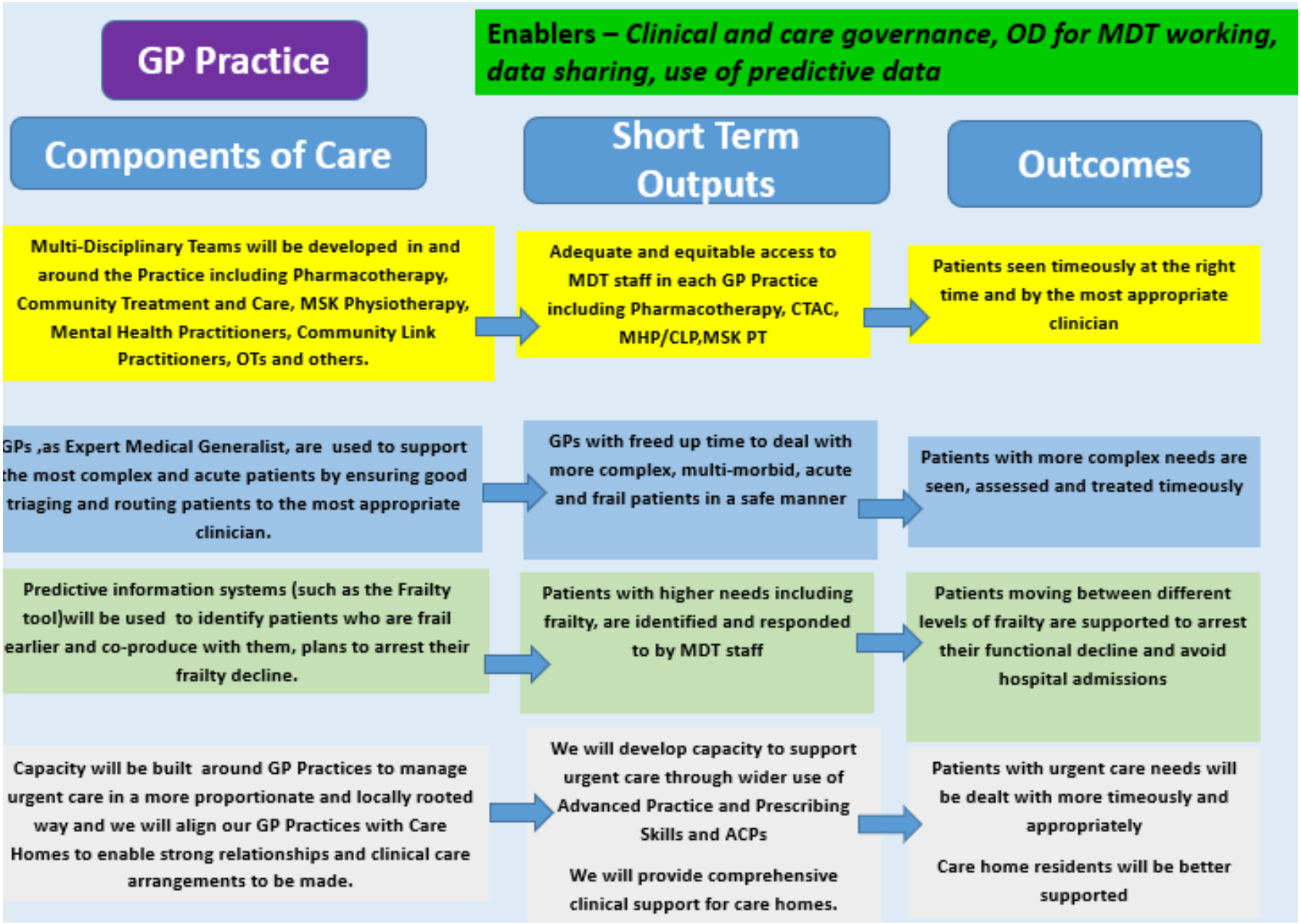
	attendants to provide round-the-clock access to support.							
Care at Home	Additional supervisory capacity to manage systems and care at home services including business support, quality assurance and officers to monitor care and data systems essential to capture activity to continually improve standards	£690,000	***Expand Care at home capacity*** - existing services should be expanded			X	10 to 15	
Community AHP	Additional Physios, OTs, SLT and HSCW aligned to localities to provide a rehabilitation service, enabling discharge from hospital and recovery at home or in a homely setting. Working alongside hospital teams and Multi Disciplinary Teams to embed good practice / clear referral practices	£260,000	***Expand Care at Home Capacity*** and ***Multi Disciplinary Working -*** support a range of preventative and proactive approaches rehabilitation	X		X	1 to 4, 10 to 15	
Community Nursing	Additional community nurses and a clinical nurse manager resource to build capacity in the community to provide services that would otherwise be delivered in hospital. Team will focus on anticipatory care.	£410,000	***Multi Disciplinary Working*** - dedicated hospital to home teams, support social care assessments and augment hospital to home	X		X	2 to 4, 10 to 15	
Enhanced Locality MDT Workforce	Community Treatment Assessment Centre nursing resource, to provide hospital services in the locality linked to GP service	£110,000	***Expand Care at Home Capacity*** and ***Multi Disciplinary Working*** - support a range of preventative and proactive approaches	X		X	3 to 4, 10 to 15	

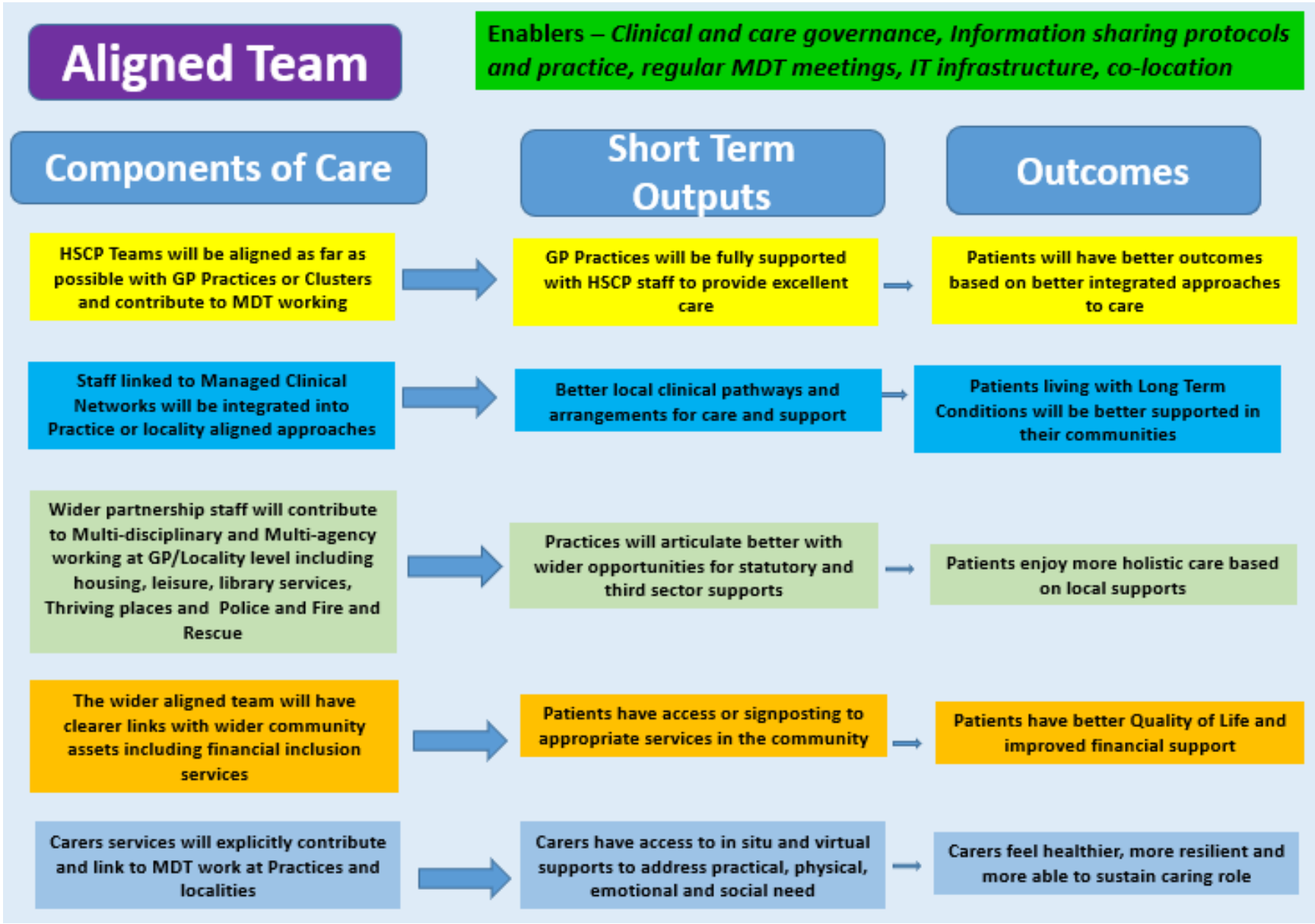
			(rehabilitation, reablement, community based support)					
Enhanced Locality MDT Workforce	Additional Primary Care Dietetics to provide capacity in supporting people in their locality and enhancing preventative approach to avoid care needs escalating	£110,000	***Expand Care at Home Capacity*** and ***Multi Disciplinary Working*** - support a range of preventative and proactive approaches	X		X	4 to 4, 10 to 15	
Enhanced Locality MDT Workforce	Additional Occupantional Therapy support to provide early intervention and prevention to frailty to avoid and reduce care needs escalating.	£300,000	***Expand Care at Home Capacity*** - support a range of preventative and proactive approaches	X		X	5 to 4, 10 to 15	
Enhance Community Supports	Commission services from third sector to provide supports to carers and alternative support to traditional services allowing greater choice and control to meet health and social care needs in the community	£250,000	***Expand Care at Home Capacity*** and ***Multi Disciplinary Working*** - enabling unpaid carers to have breaks and build community capacity	X			1 to 4	
Technology Enabled Care	Invest in techonology enabled care to provide early intervention support and support people in their homes, this includes resources to understand the needs of the end user and how these can be met from the various technology options	£360,000	***Expand Care at home capacity*** - Increase use of community equipment and Technology Enabled Care (TEC) where appropriate supporting prevention and early intervention	X			1 to 4	
Total		**£4.61m**						

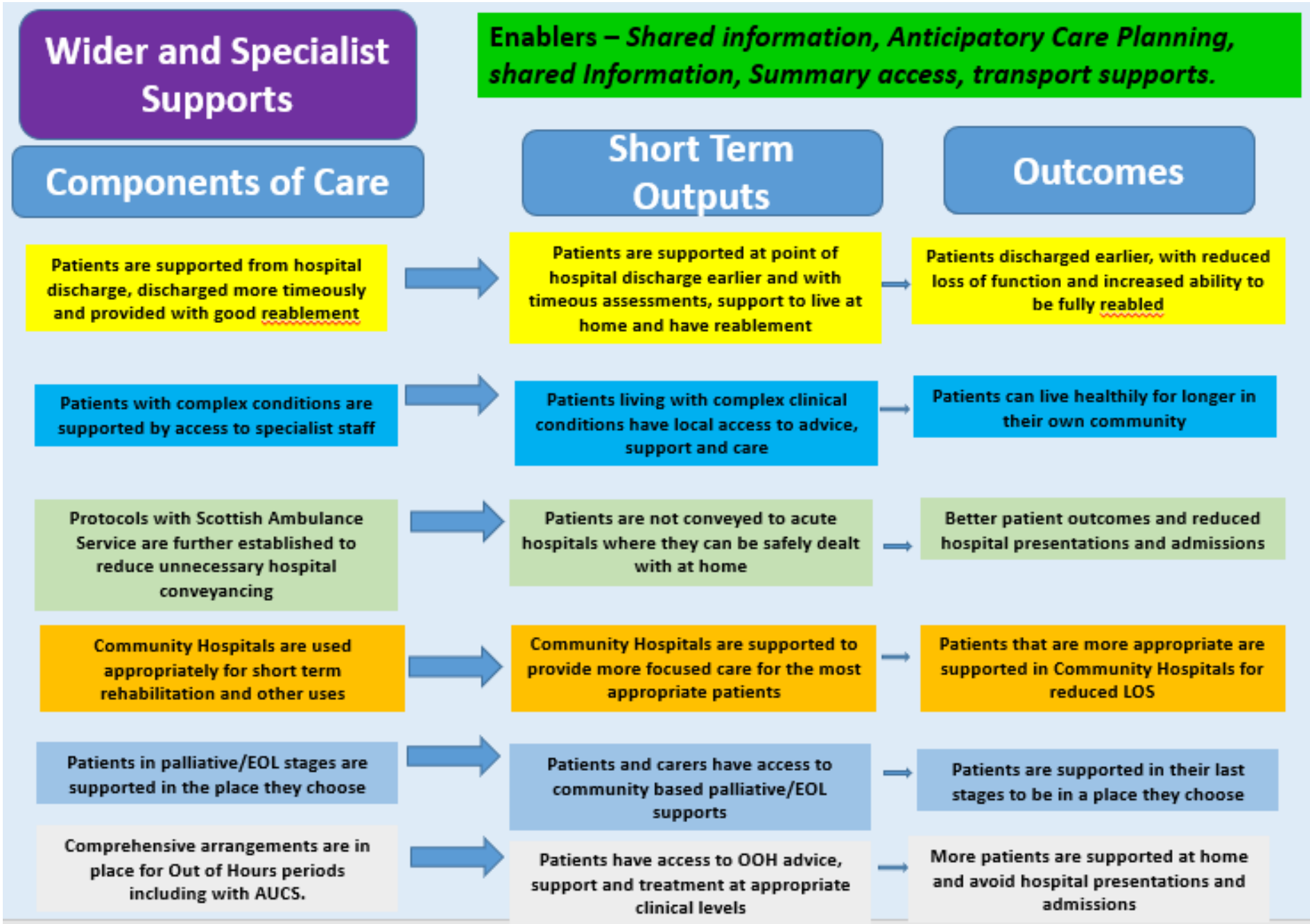
APPENDIX 1 – Logic Models




COMMUNITY
Enablers – Community Engagement, Partnership working through Community Planning, development of wide local leadership, available and accessible information
Components of Care
Short Term Outputs
Outcomes
Community based activities and provision that keep people safe, active and well
People have access to local opportunities to socialise, be informed, be active and connected and to develop self management skills and resilience
More people are able to enjoy purposeful, happy and active lives and remain well for longer
Provide local 'front doors' which make getting help, advice and ongoing support more accessible
People have access to local advice and support on a variety of issues that matter to them
More residents are better informed and make better use of the range of community and other assets to keep them well
Leisure based services that provide low to intermediate rehabilitation and prevention
Access at locality level to falls prevention, community rehabilitation, weight management and other groups
People are able to remain physically, mentally and emotionally well for longer
Community Pharmacies are supported to become significant clinical 'front doors'
Community Pharmacies are supported to become significant clinical 'front doors'
Residents have easier access to lower level clinical information, advice and interventions
Specific supports for particular groups such as those with sensory impairment and autism
People living with sensory impairment and autism have local access to practical and emotional support
People living with sensory impairment and autism feel healthier and better supported
Practical and emotional support is available to support unpaid carers
Carers have access to in situ and virtual supports to address practical, physical, emotional and social need
Carers feel healthier, more resilient and more able to sustain caring role


GP Practice
Enablers – Clinical and care governance, OD for MDT working, data sharing, use of predictive data
Components of Care
Short Term Outputs
Outcomes
Multi-Disciplinary Teams will be developed in and around the Practice including Pharmacotherapy, Community Treatment and Care, MSK Physiotherapy, Mental Health Practitioners, Community Link Practitioners, OTs and others.
Adequate and equitable access to MDT staff in each GP Practice including Pharmacotherapy, CTAC, MHP/CLP,MSK PT
Patients seen timeously at the right time and by the most appropriate clinician
GPs ,as Expert Medical Generalist, are used to support the most complex and acute patients by ensuring good triaging and routing patients to the most appropriate clinician.
GPs with freed up time to deal with more complex, multi-morbid, acute and frail patients in a safe manner
Patients with more complex needs are seen, assessed and treated timeously
Predictive information systems (such as the Frailty tool)will be used to identify patients who are frail earlier and co-produce with them, plans to arrest their frailty decline.
Patients with higher needs including frailty, are identified and responded to by MDT staff
Patients moving between different levels of frailty are supported to arrest their functional decline and avoid hospital admissions
Capacity will be built around GP Practices to manage urgent care in a more proportionate and locally rooted way and we will align our GP Practices with Care Homes to enable strong relationships and clinical care arrangements to be made.
We will develop capacity to support urgent care through wider use of Advanced Practice and Prescribing Skills and ACPs
We will provide comprehensive clinical support for care homes.
Patients with urgent care needs will be dealt with more timeously and appropriately
Care home residents will be better supported


Aligned Team
Enablers – Clinical and care governance, Information sharing protocols and practice, regular MDT meetings, IT infrastructure, co-location
Components of Care
Short Term Outputs
Outcomes
HSCP Teams will be aligned as far as possible with GP Practices or Clusters and contribute to MDT working
GP Practices will be fully supported with HSCP staff to provide excellent care
Patients will have better outcomes based on better integrated approaches to care
Staff linked to Managed Clinical Networks will be integrated into Practice or locality aligned approaches
Better local clinical pathways and arrangements for care and support
Patients living with Long Term Conditions will be better supported in their communities
Wider partnership staff will contribute to Multi-disciplinary and Multi-agency working at GP/Locality level including housing, leisure, library services, Thriving places and Police and Fire and Rescue
Practices will articulate better with wider opportunities for statutory and third sector supports
Patients enjoy more holistic care based on local supports
The wider aligned team will have clearer links with wider community assets including financial inclusion services
Patients have access or signposting to appropriate services in the community
Patients have better Quality of Life and improved financial support
Carers services will explicitly contribute and link to MDT work at Practices and localities
Carers have access to in situ and virtual supports to address practical, physical, emotional and social need
Carers feel healthier, more resilient and more able to sustain caring role


Wider and Specialist Supports
Enablers – Shared information, Anticipatory Care Planning, shared Information, Summary access, transport supports.
Components of Care
Short Term Outputs
Outcomes
Patients are supported from hospital discharge, discharged more timeously and provided with good reablement
Patients are supported at point of hospital discharge earlier and with timeous assessments, support to live at home and have reablement
Patients discharged earlier, with reduced loss of function and increased ability to be fully reabled
Patients with complex conditions are supported by access to specialist staff
Patients living with complex clinical conditions have local access to advice, support and care
Patients can live healthily for longer in their own community
Protocols with Scottish Ambulance Service are further established to reduce unnecessary hospital conveyancing
Patients are not conveyed to acute hospitals where they can be safely dealt with at home
Better patient outcomes and reduced hospital presentations and admissions
Community Hospitals are used appropriately for short term rehabilitation and other uses
Community Hospitals are supported to provide more focused care for the most appropriate patients
Patients that are more appropriate are supported in Community Hospitals for reduced LOS
Patients in palliative/EOL stages are supported in the place they choose
Patients and carers have access to community based palliative/EOL supports
Patients are supported in their last stages to be in a place they choose
Comprehensive arrangements are in place for Out of Hours periods including with AUCS.
Patients have access to OOH advice, support and treatment at appropriate clinical levels
More patients are supported at home and avoid hospital presentations and admissions

Appendix 2 – Scottish Government funding letters (winter 2021-22)

Appenix Two Care at home and interim

Appendix One SG Letter 5.10.21 £300m