south ayrshire
health & social care
partnership

Community Health and Care

Adult and Older People

Service Improvement Plan 2022-25

July 2022

NHS Ayrshire & Arran

South Ayrshire Council
Comhairle Siorrachd Àir a Deas

Community Health and Care
Adult and Older People
Service Improvement Plan 2022-25

Document Governance Arrangements

Date	Version	Action
13/05/22	Community Health and Care SIP 04/05/22	Initial Draft Submitted to DMT for Comment
12/09/22	Community Health and Care SIP 06/09/22	Approved by DMT
13/09/22	CHC Adults and Older People SIP Final Draft 13/09/22	Document Governance Arrangements Table Added Participatory Budget updated to priority status
19/09/22	CHC Adults and Older People SIP Final Draft 19/09/22	Updates made to Service Improvement Plan Table
TBC	CHC Adults and Older People SIP Final Draft 13/09/22	Approved by Performance and Audit Committee

Service Description

Areas Covered

Services provided by Community Health and Care are wide ranging and include the following services to adults and older people in South Ayrshire:

Locality Services

- Social Work
- Continence Service
- Community Equipment Store
- Hospital Social Work
- District Nursing
- Occupational Therapy
- Care Home Reviews

Intermediate Care and Reablement Services

- Community Hospitals
- Reablement
- Enhanced Intermediate Care

Maintenance Care Services

- Care at Home
- Care Homes

Mental Health Services

- Primary Care Mental Health
- Network Services
- Social Work Mental Health
- Community Mental Health
- Community Addictions

Learning Disability Services

- Learning Disability Health Service
- Day Services
- Transport
- Learning Disability Social Work
- Respite Services

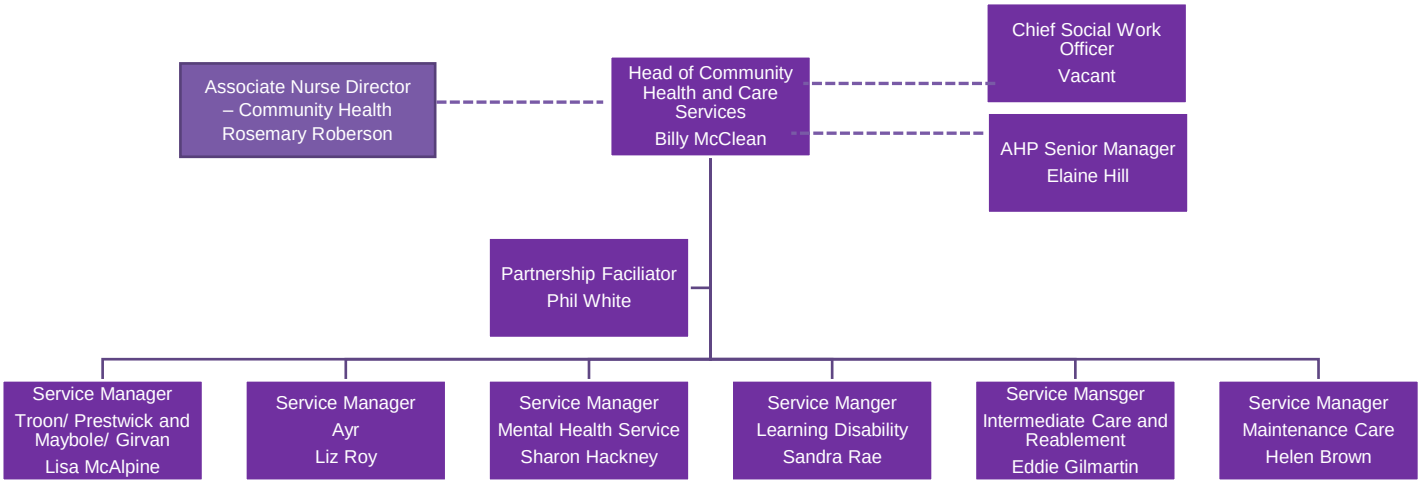
Sensory Impairment Services

Dementia Services

Budget

The total budget for South Ayrshire Health and Social Care Partnership'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.

Structure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Head of Community Health and Care Services
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Partnership Faciliator
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Service Manager
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Learning Disability
Sandra Rae
Service Mansger
Intermediate Care and Reablement
Eddie Gilmartin
Service Manager
Maintenance Care
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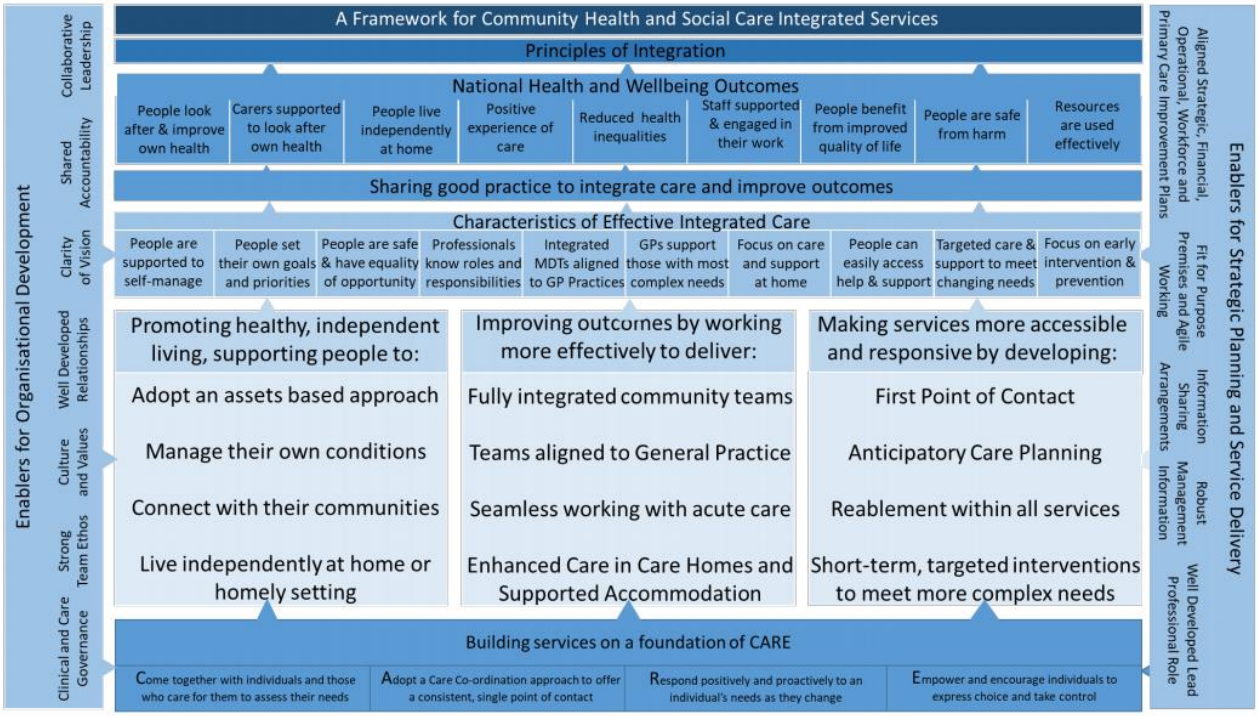
Context

National Context

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
- Coronavirus (Scotland) Act 2020

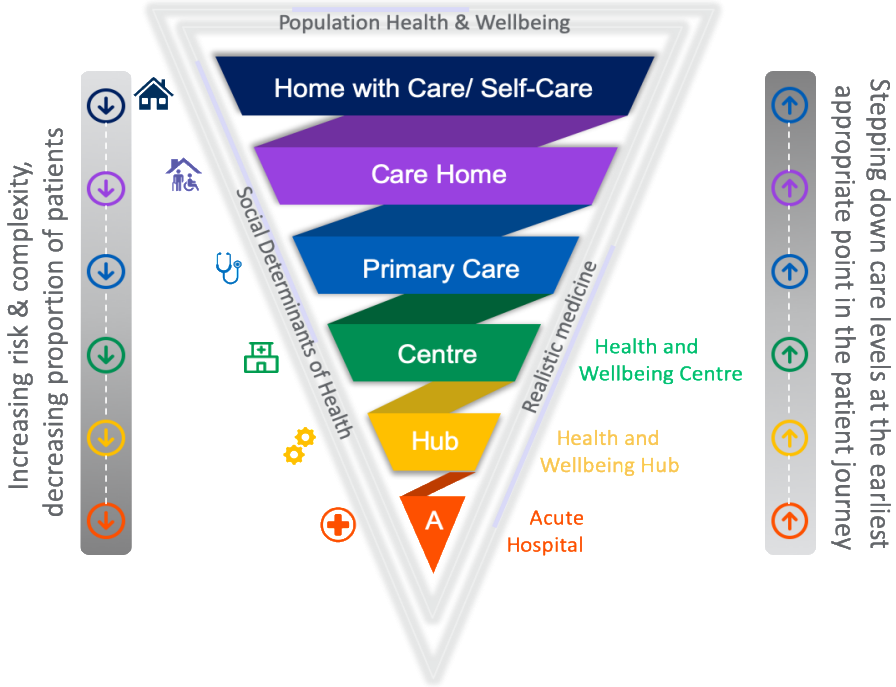
The Scottish Government Framework for Community Health and Social Care Integrated Services will inform our approach to service delivery implicitly and more explicitly (for example integrated community teams and teams aligned to GP practices).



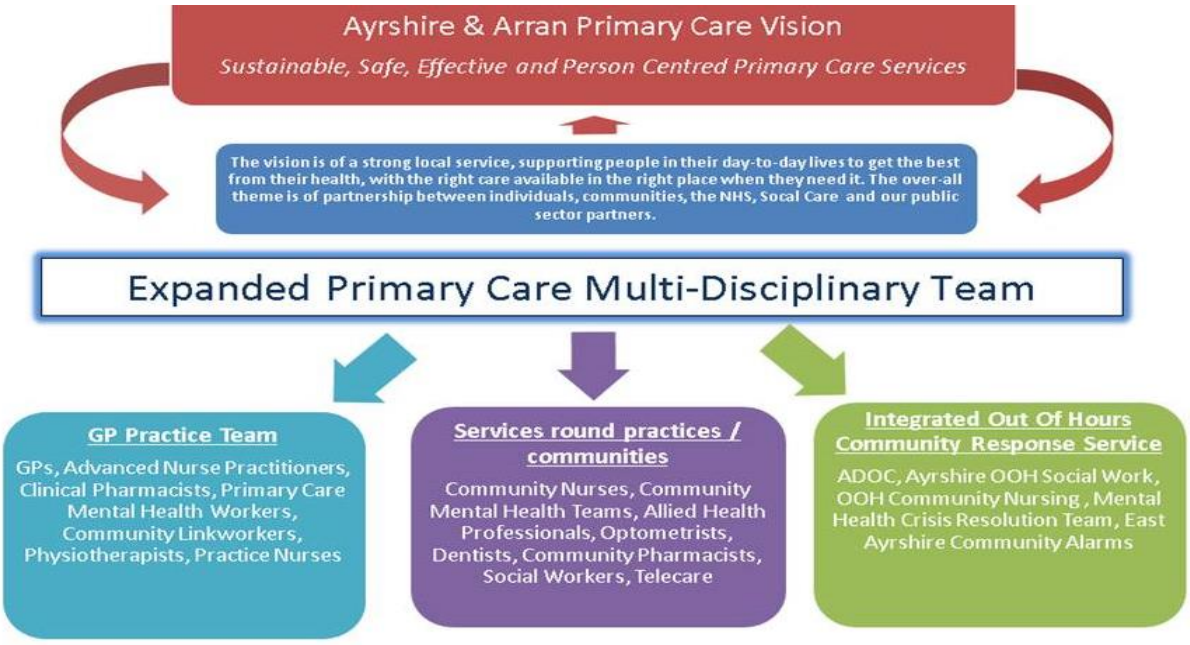
The Scottish Government have recently set out plans to develop a new integrated health and social care strategy for older people. This strategy will build on the work which has already been undertaken across Scotland to deliver integrated, person centred health and social care for older people, address gaps, and develop any new priorities from emerging areas of work from, for example, the impact of COVID-19.

Local Context – Pan Ayrshire

NHS Ayrshire & Arran and the three Ayrshire HSCP's have agreed on the key principles that should underpin the planning of all our services. Caring for Ayrshire is an exciting and ambitious programme to transform health and care services across Ayrshire and Arran.



The Caring for Ayrshire programme embraces much greater focus on primary care service delivery as set out in the NHS A&A Primary Care vision.



Local Context – Community Planning

We are increasingly working with colleagues across the range of Community Planning Partners to not only support our own working aims but to support and be supported by much wider Community Planning work such as:

- Addressing Scotland's public health priorities
- Tackling Inequalities with focused work in Wallacetown
- Supporting Place planning
- Developing environments that support positive wellbeing outcomes
- Supporting wider economic development including the Ayrshire Growth Deal and local Community Wealth Building
- Community Safety
- Building on, and supporting, local sustainability and 'carbon reduction' work
- Addressing poverty through a range of partnership based initiatives
- In addition, the Community Planning Partnership has a small number of Local Outcome Improvement Plan (LOIP) priorities and these include ones relating to adults and older people including social isolation and dementia friendly communities.

Local Context – HSCP

The South Ayrshire Integration Join Board Strategic Plan was published in 2021, and sets out the Partnership's strategic objectives (below) and the models of care deployed to achieve these objectives, including a focus on prevention, locality planning and tackling inequalities.

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. The Partnership's Integration Joint Board Strategic Plan 2021-2031 provides full detail on the challenges.

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.

Wellbeing Pledge

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

Primary Care

For many of our Adult and Older People services, there is a move towards the 'Team around the GP Practice' – either services in situ or aligned to GP Practices. There are some key services that have been established in order to support GPs to deal with more complex patients as 'Expert Medical Generalists'.

Ayrshire in general is much further ahead than other areas in delivering the demands in the GMS contract for GPs and is in a reasonable place fulfil the contractual needs of the contractual responsibility shifting in the next year for some services. These include:

- Pharmacotherapy Teams: a mixture of qualified pharmacists, pharmacy technicians, support workers, pre-qualification technicians and managers
- Mental Health Practitioners: there are now Mental Health Practitioners working from almost all South GP Practices, supporting people earlier with assessment and linking them into the appropriate level of care.
- Physiotherapists dealing with MSK issues: working in and from the majority of GP Practices and meeting the needs of patients with Musculo-skeletal issues such as joint pain.
- Occupational Therapists: pilot work in 4 GP Practices where OTs are attached to GP Practices where they are well placed to support patients where there is both physical and mental health needs.
- Community Treatment and Care: includes tasks formerly associated with health care assistants, practice nurses, treatment room nurses such as Phlebotomy, Wound dressing, suture removal, etc, and now includes ECG, B12 Injections, Other Injectable, Inhaler Technique, DMARDs and Breath Tests.
- Other teams aligned to GP Practices include: District Nursing, Social Work, Allied Health Professionals and Enhanced Intermediate Care.

This alignment and link to Multi-Disciplinary working allows much better relationships and working practice to be developed with the 'Team around the Practice'.

Covid

The Covid-19 Pandemic and subsequent 'lockdown' measures introduced in March 2020 significantly disrupted the normal delivery of Health and Social Care Services and in particular the way in which the Partnership delivered supports and interventions to its service users across South Ayrshire.

The Partnership had to adapt quickly to these new circumstances, in partnership with South Ayrshire Council, NHS Ayrshire & Arran, independent and third sector providers and organisations, carers and service users, to consider the manner in which we deliver on our statutory responsibilities and deliver services at this time of crisis.

Our ambition has been to continue to deliver high quality services to South Ayrshire's most vulnerable residents whilst adhering to Government directions on social distancing, ensuring that we continue to safeguard and protect the rights and interests of those who are in receipt of our services.

This crisis has resulted in some of the most innovative, creative and humanistic approaches to service delivery experienced within the Partnership to date.

Social Work Learning Review

The Adult Social Work Learning Review commenced in April 2021 and focused on 3 key projects covering: 'Locality Teams and Front Doors'; 'Support to Specific Groups'; and 'Social Work Principles and Models'. Alongside these groups, the Review also involved an element of practitioner research to ensure that the views and experiences of a wide range of practitioners and stakeholders were influential in the future design of services.

The Review concluded in March 2022, producing the following outcomes:

- Modernisation of **Locality Teams and Front Doors** has been a significant learning aspect of the Review. A draft model of a new Multi-Disciplinary Team (MDT) locality front door designed to improve both access and delivery of social work services has been developed and will require organisational change to implement.
- A training needs analysis has commenced to identify and support practice improvement to provide **support to specific groups**. Given the current working arrangements this will involve working with the Practice Development Team to look at creating an online database and designing a training plan/ schedule for implementation. There will be on-going engagement with staff through a staff reference group to continue to identify training needs going forward.
- Within **Social Work Principles and Models**, an Ethics of Care Framework for Social Work has been developed and in place since January 2022.
- **Research** work is ongoing and data from a combination of frontline staff and individuals and carers who access services is being analysed to inform a final research report. The research findings will require further consideration as the review moves into the implementation phase.

The final report includes a future proposal to be taken forward to implementation, underpinned by three key principles:

- Continue to engage and share the collective learning points from the review with a focus on improving the delivery of adult Social Work services in South Ayrshire
- Ongoing involvement of key stakeholders to refine any proposals following on from this review in line with relevant organisational change processes and to develop an adult Social Work system that is as prepared as it can be to respond to both the current and anticipated demand moving forward.
- Increase Social Work capacity as necessary to respond to the needs of the South Ayrshire community.

Local Strategies

While Mental Health, Learning Disability, Sensory Impairment and Dementia services sit within Community Health and Care and are referenced within this Service Improvement Plan, they each have their own strategy detailing their priorities; with specific actions for the HSCP outlined in the Community Health and Care Service Improvement Plans for Adults and Older People, Learning Disability and Mental Health.

- SAHSCP Adult Community Mental Health Strategy 2017-22
- SAHSCP Adult Learning Disability Strategy 2017-23
- Ayrshire & Arran Sensory Locality Plan 2014-24
- SAHSCP Dementia Strategy 2018-23
- SAHSCP Adult Carers Strategy 2019-24

Review of 2021/22

Activity

South Ayrshire Health and Social Care Partnership's Annual Report 2021-22 reflects the direct impact COVID-19 has had on services and some of the key indicators, e.g. emergency admissions to hospital were down significantly as a result of behaviour change within the population. There has also been volatility in delayed transfers of care. The Report also shows good progress against key national indicators as well as our own local strategic objectives.

Investment to Date

To continue delivering high-quality services and move further towards the model of care set out in this Plan, 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:

Locus	Intervention	Investment
Home	**Investment in purchased care at home,** to provide additional capacity in the community to reduce unnecessary delays in hospital.	**£1,049,957**
	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	**£100,000** (2020/21)
	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.	**£80,000** (2020/21)
	Technology Enabled Care: investment in home pods in the community to support health and care needs at home for specific service users.	**£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.	**£322,880** (2020/21)
	Additional **Occupational Therapists** to support increased frailty need in the community linked to GP Practices	**£143,000** (2020/21)

	Investment in **district nursing capacity** following full review of the current structure and assessment of community need.	**£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)
	Temporary investment of **increase care home capacity** to support timely discharge until reablement team is at capacity.	**£200,000** (2020/21)
	Investment to support **Adults with Incapacity**, expanding existing MHO capacity to increase support to adult concerns and AWI cases in relation to Delayed Discharges	**£104,000** (2020/21)
	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.	**£125,000** (2020/21)
	Additional beds in Biggart Hospital to remain open due to lack of capacity in the community to support rehabilitation and community care.	**£500,000**

Most of these initiatives are managed and led through our internal 'Driving Change' programme within the HSCP. The logic models below (Appendix 2) demonstrate how these programmes of work contribute to our overarching strategic objectives.

The HSCP also recently invested £316,104 to upgrade our in-house Care at Home staff to reflect the increase in complexity in managing higher levels of need in the community. This should also promote retention of staff and make the role more attractive for applicants.

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 development 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.

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.

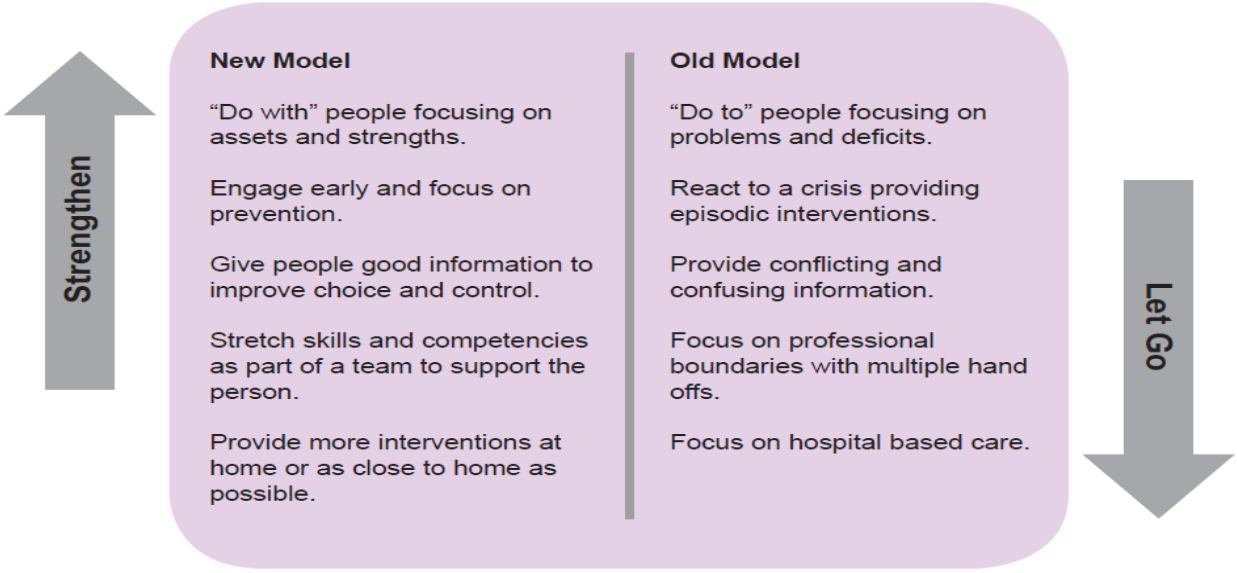
- Targeted work to **recruit and retain more staff in Care at Home**, including in our third and independent sector;
- Implementation of our **HSCP Digital Strategy**, including the move from Analogue to Digital, and implementation of new information systems;

- 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.

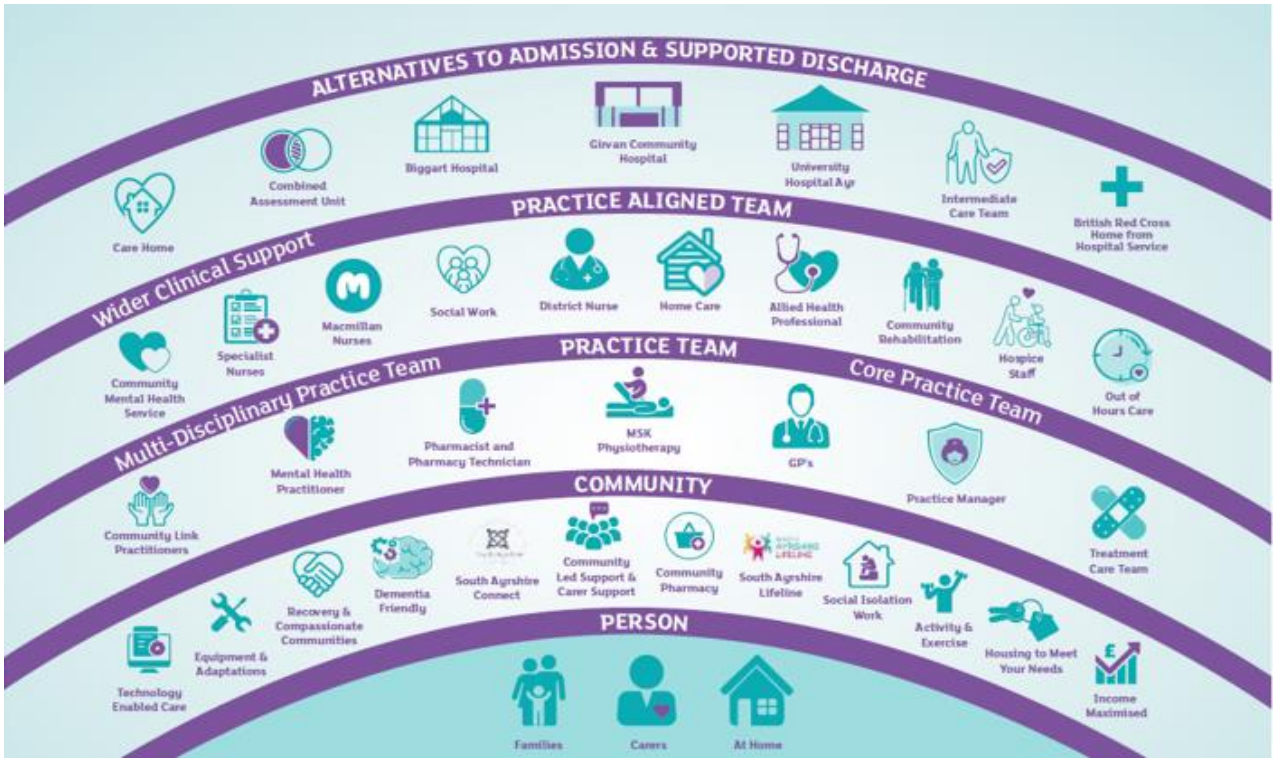
Strategic Approach

To develop our services in line with the ambitions set out in the Scottish Government Framework for Community Health and Social Care Integrated Services and our own Strategic Plan (above), we will fundamentally require to change our approach to delivering services for adults and older people.



Models of Care – Objectives

The Model of Care being adopted within South Ayrshire is aligned to the Scottish Government's framework for integrated community health and care and focusses on the provision of effective, integrated community-based assessment, treatment, care and support.



Within this, in South Ayrshire we are focused on tailoring services to suit the specific needs of each of 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.

Objective 1: 'Home' – improve our approach to prevention and early intervention to maximise and prolong independence.

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. We have consulted with our service users to inform our strategic approach and to ensure that we design and build our services to meet service need.

Objective 2: Community – provide alternatives to formal service to keep people active and engaged in their communities.

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.

So our approach will be rooted in people's own needs and strengths and assets but strongly located within real communities and localities and their associated networks.

Objective 3: Team around the locality – strengthen coordinated multi-service care to improve outcomes.

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 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.

For some teams this might mean co-location or very strong presence within GP Practices. For others this might mean very live relationships with the GP Practice and the associated MDT team expressed in virtual meetings. For some rural areas we will seek to ensure residents still have access wherever possible, to a full range of services.

We will increasingly utilise technology for the sharing of information, consultations, meetings and home monitoring.

Objective 4: Practice aligned team – provide specialist support in the community when extra support is needed.

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.

Objective 5: Alternatives to admission – deliver crisis support in the community to prevent hospital admission or support discharge.

Where people need building based care (care homes and hospitals, for example) we will create stronger pathways and links to and from the locality level to these institutions

We will also engage in Ayrshire-wide work to develop coherent and well-articulated Ayrshire wide responses to address need.

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**.**

Service Improvement Plan 2022-25

IMPROVEMENT ACTION	SPONSOR/ LEAD	TIMESCALE	FINANCIAL	PERFORMANCE/ IMPROVEMENT MEASURE AND/OR TARGET	LINK TO STRATEGIC PLAN OBJECTIVES (& BRIDGING OPERATIONAL PLAN ACTIONS)
Home/ Person					
1. Implement a whole systems approach to the delivery of Care at Home to people within the community. a. Implementation of the Care at Home Review b. Implementation of the Intermediate Care Unit at South Lodge (31/12/22) c. Maximise capacity within Care at Home ***Priority Area of Focus – PAC*****	**Billy McClean** Helen Brown	31st March 2023	FY22/23 £1.15m (Capacity) £18m (General Budget)	• Reduce Delayed Discharges attributable to Care at Home (Mainstream) • Reduce Delayed Discharges attributable to Care at Home (Mainstream) of more than 2 weeks • Reduce Care at Home hours commissioned from external providers • Increase Care at Home Hours provided by South Ayrshire Care at Home Service • Increase actual Care at Home hours provided as a percentage of planned hours • Number of Available Hours vs Actual Hours vs Planned Hours	SO3/ Action CHC2 & CHC3
Community					
2. Develop closer alignment with Community Pharmacies and linked GP Practices to support	**Roisin Kavanagh** Iain Fulton			(Emailed 04/05)	SO3/ Action CHC11

	Community Pharmacies as alternative clinical 'front door' in localities.				
3.	Establish local 'front doors' to provide information/advice/signposting and link to statutory Social Work functions (in line with Adult Social Work Review recommendations).	**Tim Eltringham** Steven Kelly	Commence March 2023	Under development	• Reduce response time for duty calls from new cases • Reduce number of duty calls from existing cases • Reduce number of unallocated cases on waiting list • Reduce number of high nominated caseloads • Increase number of service users reporting satisfaction with the ease of their initial contact with Social Work • Reduce wait time from initial enquiry to assessment • Reduce wait time from assessment to receipt of service • Reduce overall wait time from initial enquiry to receipt of service	SO3/ Action CHC11
4.	Re-design of day opportunities/ activities and support for informal carers to allow provision of more bespoke services	**Helen Brown** Phil White	Under development	Under development	• Increase uptake of SDS Options 1 and 2	SO3/ Action CHC9
5.	Establish virtual Community Wellbeing Teams/Networks to provide supportive information/advice/activities/training to promote empowered self – management including access to	**Billy McClean** Phil White	Under development	Under development	Under development	SO3/ Action CHC10

specialist support and support for carers. *****Priority Area of Focus – 6 Months*****					
6. Develop interventions for people in the early stages of frailty. *****Priority Area of Focus – PAC*****	**Phil White** Joanne Payne	31st March 2023		• Increase number of individuals accessing early frailty service • Increase number of individuals with a falls action plan in place • Increase number and types of signposting to supporting interventions • Increase number of people within project scope having annual frailty review sessions • Increase number of people utilising Life Curve app • Self-reported progress at annual review	SO1/ Action CHC8 & 11
7. Develop and reshape the AHP workforce within community hospitals and Community Rehabilitation to support the redesign of services to deliver earlier intervention for prevention, empowerment and high-quality effective rehabilitation for individuals.	**Elaine Hill**	Under Development	Under Development	• Reduce wait time for CRT • Increase training for registered and unregistered staff • Increase leadership capacity to support new models of service delivery	SO3/ Action NO5 & AHP4
8. Develop the Pan-Ayrshire Parkinson's service (and other clinical services) (by:	**Karen Wilson**	31st January 2023	Parkinson UK Budget	• Reduce overall waiting time from first referral • Reduce waiting time for face-to-face appointments	SO3/ Action 11

a. Increasing nursing staffing levels; b. Introducing Physiotherapist to the team to enhance patient experience; c. Developing education days for clients and relatives; d. Increasing face to face clinics; e. Increasing neurologist clinic sessions.)				• Reduce number of clients waiting on appointments/ diagnosis/ treatments • Increase in number of education and support sessions/ days for patients and relatives • Increase in-house training undertaken by staff	
Team Around the Locality					
9. Develop Team Around The Locality model to deliver seamless coordinated integrated care . *****Priority Area of Focus – 6 Months*****	**Billy McClean** Phil White Simon Farrell Claire Muir	N/A	FY21/22 £4,161,895	Refer to the Ayrshire and Arran Primary Care Improvement Plan for agreed measures.	SO3/ Action 11
10. Enhance the Occupational Therapy Frailty Pathway to identify people in mild to moderate stages of frailty; and to work with these individuals proactively to maintain or improve levels of frailty. *****Priority Area of Focus – PAC*****	**Phil White** Joanne Payne	31st March 2023		• Increase the number and % of patients aged 65 and over with mild to moderate frailty, being identified proactively as benefiting from Occupational Therapy input. • Increase the number and % increase in referrals to community services • Reduce falls and fractures of patients supported • Increase number and % of poly pharmacy reviews carried out	SO1/ Action CHC8 & CHC11

				• Increase number of patients improving/maintaining their score on the electronic frailty index • Increase number of patients with a wellbeing plan in place • Increase number of patients reporting a positive experience • Impact demonstrated using standardised measurement of function • Impact on IoRNS 2 outcome measure	
11. Improve information sharing between MDT's (eKIS, ACP's etc). *****Priority Area of Focus – 6 Months*****	**Phil White** Claire Muir Simon Farrell	Under development		• Under development	SO3/ Action CHC11
Practice Aligned Team					
12. Implement recommendations from the District Nurse Review. *****Priority Area of Focus – 6 Months*****	**Rosemary Robertson** Val Burns	Under Development	Under Development	Outcome and process measures under development	SO3/ Action CHC11
13. Improve community rehabilitation services for people with complex recovery and rehabilitation needs.	**Elaine Hill** Aileen Fyfe	31st March 2023		• Reduce response time for requests for assistance for initial screening • Reduce response time between screening and initial contact • Reduce number of unallocated cases on CRT waiting list • Increase number of service users reporting satisfaction with CRT	SO1 & 3/ Action CHC8

				• Increase number of primary care colleagues reporting satisfaction with CRT • Increase numbers of referrals from GP Practices • Increase numbers of self-referrals	
Alternative to Admissions and Supported Discharges (Community Based Specialist Services)					
14. Re-design reablement, rehabilitation and community support services. *****Priority Area of Focus – PAC*****	**Billy McClean** Eddie Gilmartin	31st March 2023	£1.2m (2020)	• Reduce demand on care homes over a 10 year period. • Reduce demand on care at home over a 10 year period. • Reduce number of Delayed Discharges in Acute Hospital • Reduce percentage of people requiring ongoing care support	SO3/ Action CHC1
15. Invest in practitioners and business support to support the UHA 'Hospital at Home' model, manage interim care beds, linking with the Community Rehabilitation Team and ICT. *****Priority Area of Focus – 6 Months*****	**Billy McClean** Eddie Gilmartin	Under development	FY22/23 £380,000	Under development	SO3/ Action CHC6
16. Develop and support discharge without delay and co-ordinate services with ICT, Community rehab and care at home.	**Billy McClean** Eddie Gilmartin Lisa McAlpine Helen Brown	Under development	FY22/23 £110,000	Under development	SO3/ Action CHC7

*****Priority Area of Focus – 6 Months*****					
17. Undertake a service review of community equipment and minor adaptation service.	**Billy McClean** Lisa McAlpine	31st March 2023	N/A	Under development	SO3/ Action CHC7
18. Review of Biggart Community Hospital.	**Billy McClean** Eddie Gilmartin Rosemary Robertson Elaine Hill Phil White	Not currently available	Not currently available	Not currently available	SO3/ Action CHC11
19. Review of Girvan Community Hospital.	**Billy McClean** Phil White Eddie Gilmartin	Not currently available	Not currently available	Not currently available	SO3/ Action CHC11
Enablers and Cross Cutting Themes					
20. Support and strengthen flexible community care and health provision through microenterprise development. *****Priority Area of Focus – 6 Months*****	**Phil White** Helen Brown Eddie Gilmartin	31/03/22	FY22/23 £52,777 (TBC)	• Increased number of microenterprises in South Ayrshire • Increased number of microenterprises in Troon • Increased number of microenterprises in Rural Carrick • Increased number of microenterprises in Alloway	SO3/ Action NO4
21. Develop a strategy to consult, engage and communicate internally and externally on locality planning approach.	**Phil White**	Under development		Under development	SO6/ CHC11

22. Increase capacity and quality of TEC Service to provide early intervention support and support to people in their homes.	**Billy McClean** Eddie Gilmartin	March 2025	FY22/23 £360,000	Under development	SO1&3/ Action NO7
23. Implement TEC Service analogue to digital project work. *****Priority Area of Focus – 6 Months*****	**Eddie Gilmartin** Karen Lambert	Under development	Under development	Under development	SO1&3/ Action NO7
24. Review the implementation of SDS ensuring alignment with National Standards. *****Priority Area of Focus – 6 Months*****	**Gary Hoey** Meg Williams	Under development	Under development	• Increase uptake of Options 1, 2 and 4	SO3/ Action NO13&LD1
25. Develop out of hours support for the Emergency Response Team, Reablement and Care at Home services. *****Priority Area of Focus – 6 Months*****	**Billy McClean** Eddie Gilmartin	Under development	Under development	Under development	SO3/ Action CHC1&3
26. Implementation of the SAHCP Dementia Strategy 2018-23	**Phil White** Stephen McCutcheon	31st March 2023		• Increase percentage of referrals achieving the LDP standard of 12 months post-diagnostic support for people with dementia. • Increase number of South Ayrshire Health and Social Care Staff/ Third Sector and Partner organisations who have completed Dementia training. • Increase referral rates to the Memory Clinic.	SO1&3

				• Increase number of Dementia Friendly activities including awareness raising sessions which have taken place across the localities. • Increased proportion of people with dementia accessing Self-Directed Support (SDS) Options 1 and 2. • Increase take-up of Technology Enabled Care options. • Increase number of identified carers caring for someone with Dementia offered an Adult Carer Support Plan. • Increase number of local businesses signed up to the 'Keep Safe' programme	
27. Deliver the Ayrshire and Arran Sensory Impairment Locality Plan 2014-24.	**Sandra Rae** Karen Walker	31st December 2024		• Increase number of service users with sensory loss engaging with the pan-Ayrshire and Arran sensory service • Increase in number and percentage of service users with sensory loss reporting improvements in outcomes through 'Talking Points'	SO1&3
28. Review along with Children's Services how to deliver best outcomes for those with autism and how best to arrange services to enable an integrated, person centered approach.	**Billy McClean Mark Inglis**	Under Development	Under Development	Under Development	SO1&3
29. Reflect on new management arrangements once embedded (6month review) and consider how to deliver best outcomes for those	**Gary Hoey**	Under development	Under development	Under development	SO1&3

with complex physical disabilities and how best to arrange services to enable and integrate, person centred approach.					
30. Deliver the SAHSCP Adult Carers Strategy, taking cognizance of any changes require to align with planned new models of care.	**Phil White** Stephanie Cox	31st December 2024		• Increase in adults carers support plans completed • Increase in number of carers supported through Carers Centre • Increase in carers reporting satisfaction with the level of support received • Increase in carers identified/ supported through health (Primary Care, Community Pharmacy etc)	SO1&3/ Action NO11
31. Develop and implement a Workforce Plan for the Partnership for 2022-25.	**Billy McClean** James Andrew	30th June 2025		• Reduce vacancies/ turnover • Increase attendance levels • Increase efficiency rates • Reduce recruitment time-scales and on-boarding • Increase PDR completion rates • Increase in career path opportunities	SO5/ Action NO5
32. Refresh Mental Health Strategy and recommission the Mental Health Framework.	**Sharon Hackney**	Under development		Under development	
33. Implementation of the new Community Health and Care structure	**Billy McClean**	31st March 2023		Under development	

Key Performance Measures

National Health and Wellbeing Outcomes

The Scottish Government has set 15 National Health and Wellbeing Outcomes against which progress is measured towards the aspirations for Integration as set out in the 2014 Public Bodies (Joint Working) (Scotland) Act. These Outcomes guide the activity of the South Ayrshire Health and Social Care Partnership. They are supported by a core suite of 23 National Performance Indicators. 9 of the Outcomes relate to services for adults and older people, as provided by Community Health and Care.

National Health and Wellbeing Outcomes – Adults and Older People	
1.	People are able to look after and improve their own health and wellbeing and live in good health for longer.
2.	People, including those with disabilities or 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.
3.	People who use health and social care services have positive experiences of those services, and have their dignity respected.
4.	Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.
5.	Health and social care services contribute to reducing health inequalities.
6.	People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being.
7.	People using health and social care services are safe from harm.
8.	People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.
9.	Resources are used effectively and efficiently in the provision of health and social care services.

The Partnership's Annual Performance Report 2020-21 sets out local progress against these Outcomes. In addition, Appendix 1 of the Report details the 23 National Indicators and trends against time.

Ministerial Strategic Group (MSG) Measures

In addition to the Core Indicators noted against the National Outcomes above, the Ministerial Strategic Group for Health and Community Care (MSG) has proposed the following measures to track performance in Integration Authorities:

1. Unplanned Admissions (Emergency Admissions);
2. Accident and Emergency Performance (Emergency Department Attendances)
3. Unplanned Bed Days (Emergency Bed Days for Acute, Geriatric Long Stay and Mental Health)
4. Delayed Discharges (All Delayed Discharges and Code 9 Delayed Discharges)
5. End of life care; and
6. The balance of spend across institutional and community services.

The Partnership's performance against these measures can also be viewed in the Annual Performance Report 2020-21.

Local Performance Measures – Improvement Actions

Progress in implementing each of the improvement actions identified within the Service Continuous Improvement Plan is monitored by, and reported to, the Community Health and Care Driving Change group, which is held each month and chaired by the Head of Community Health and Care. Improvement actions may also be monitored by, and report to, other groups or boards – particularly those which are being progressed in conjunction with partner agencies. A Project Charter for each improvement action provides clarity on the aim of each improvement, as well as detailing expected performance improvement.

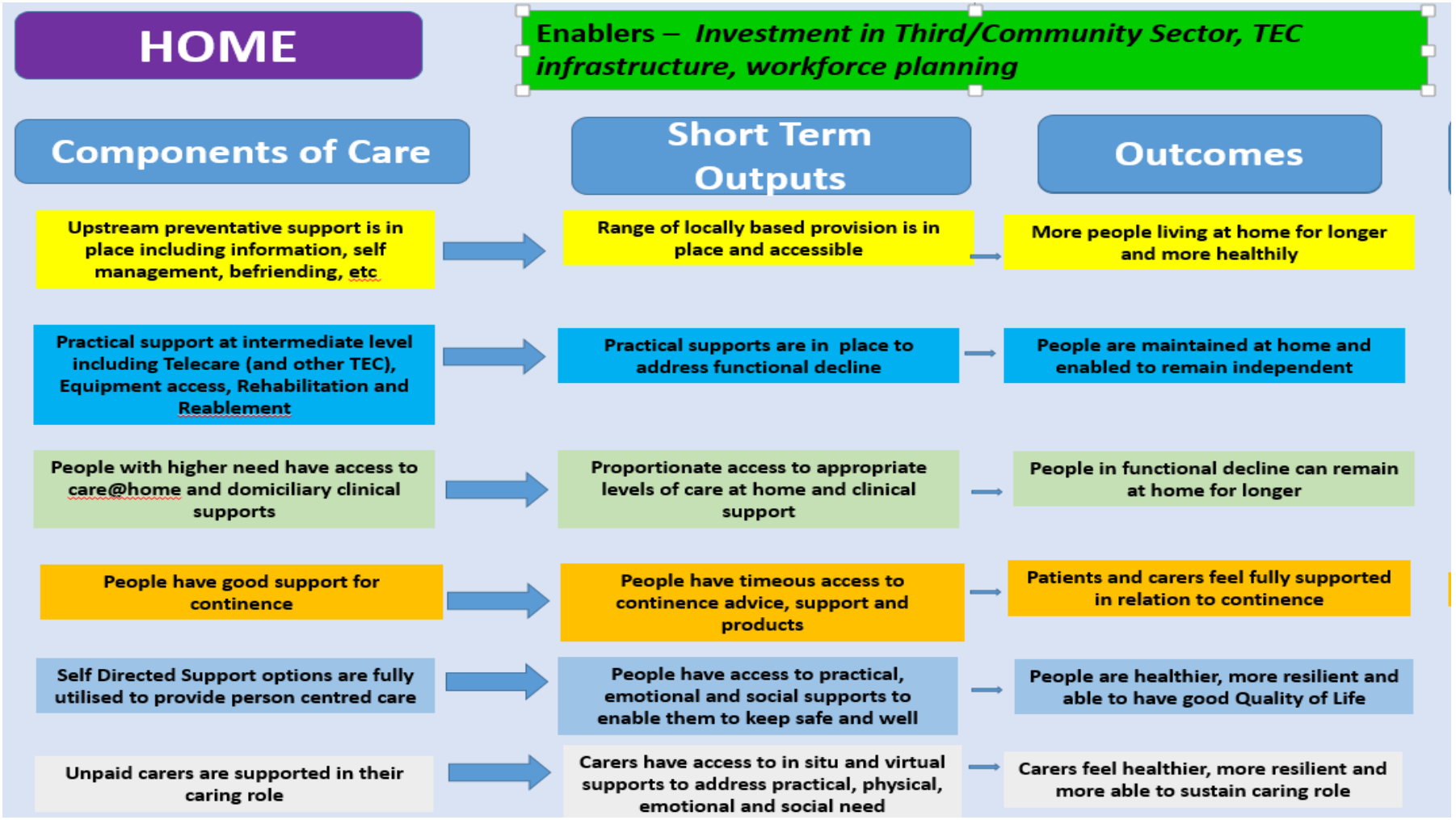
The Service Improvement Plan, above, provides details of agreed performance/ improvement measures and targets for each improvement action. A report on progress against all of the improvement actions identified within this Plan will be reported to the Partnership's Performance and Audit Committee on an annual basis. Progress against individual areas of work may be highlighted to the Performance and Audit Committee.

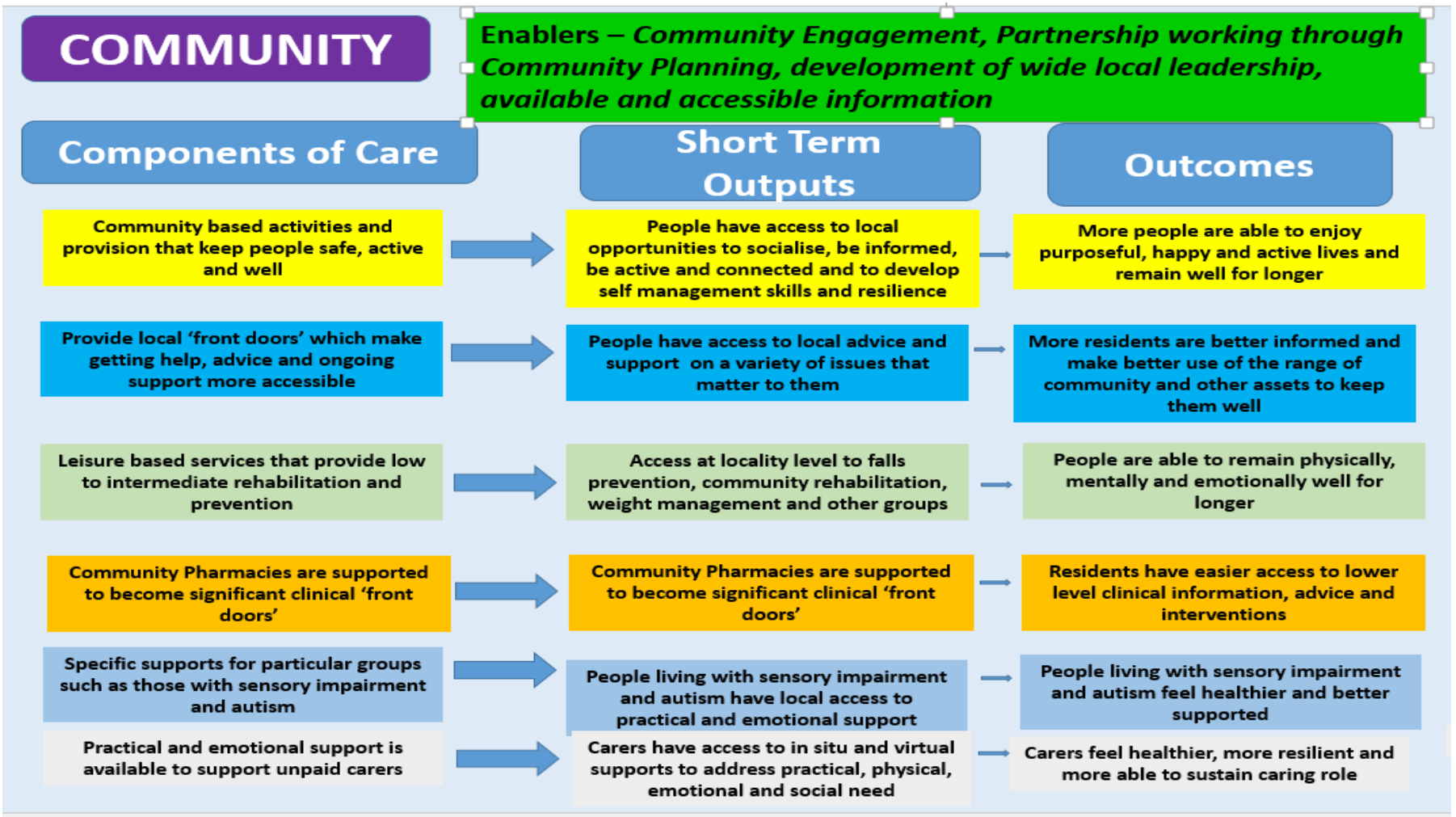
Operational Risk Management

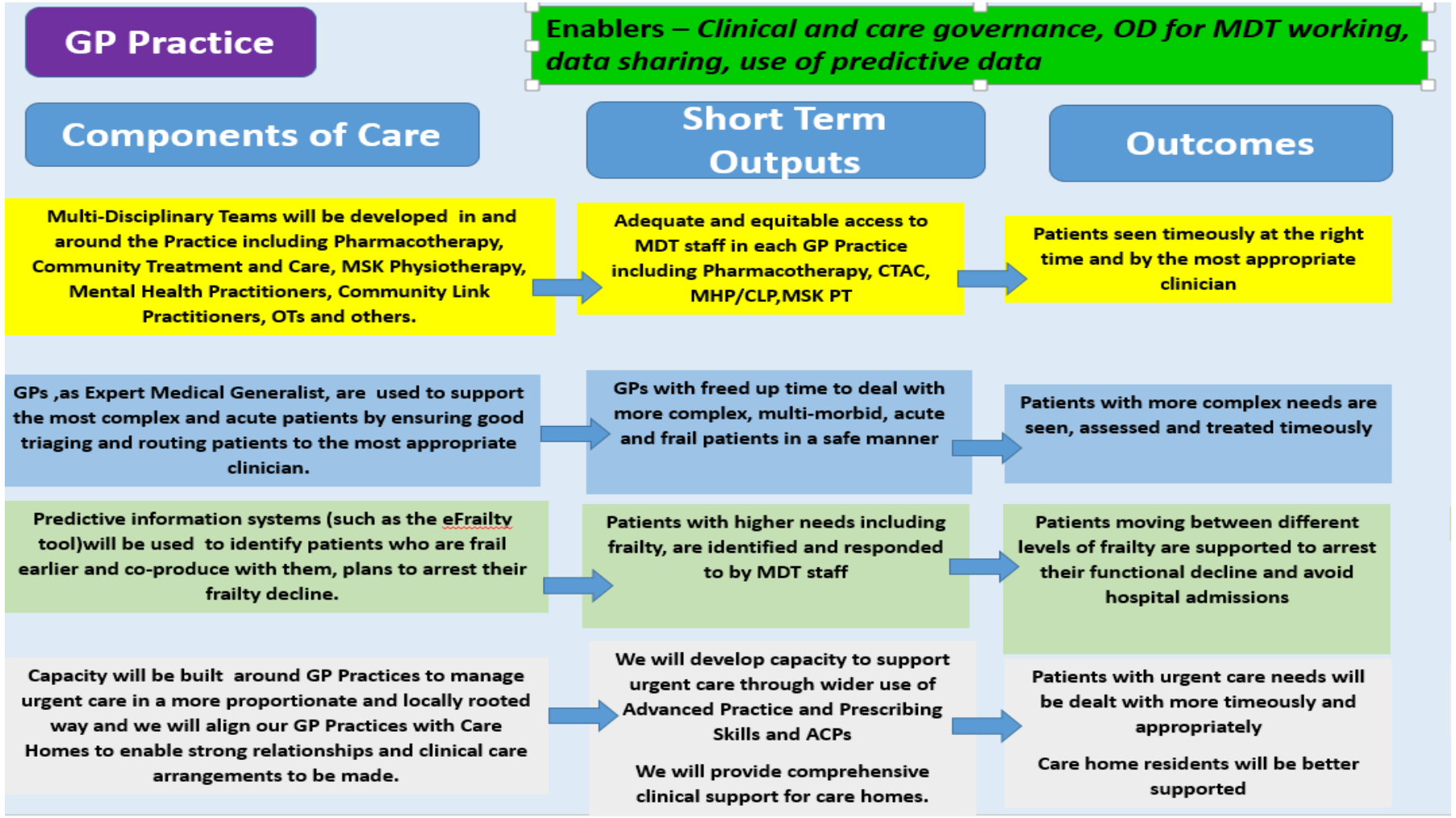
Service Improvement Plan Risk Assessment/ Management Register 2021/22

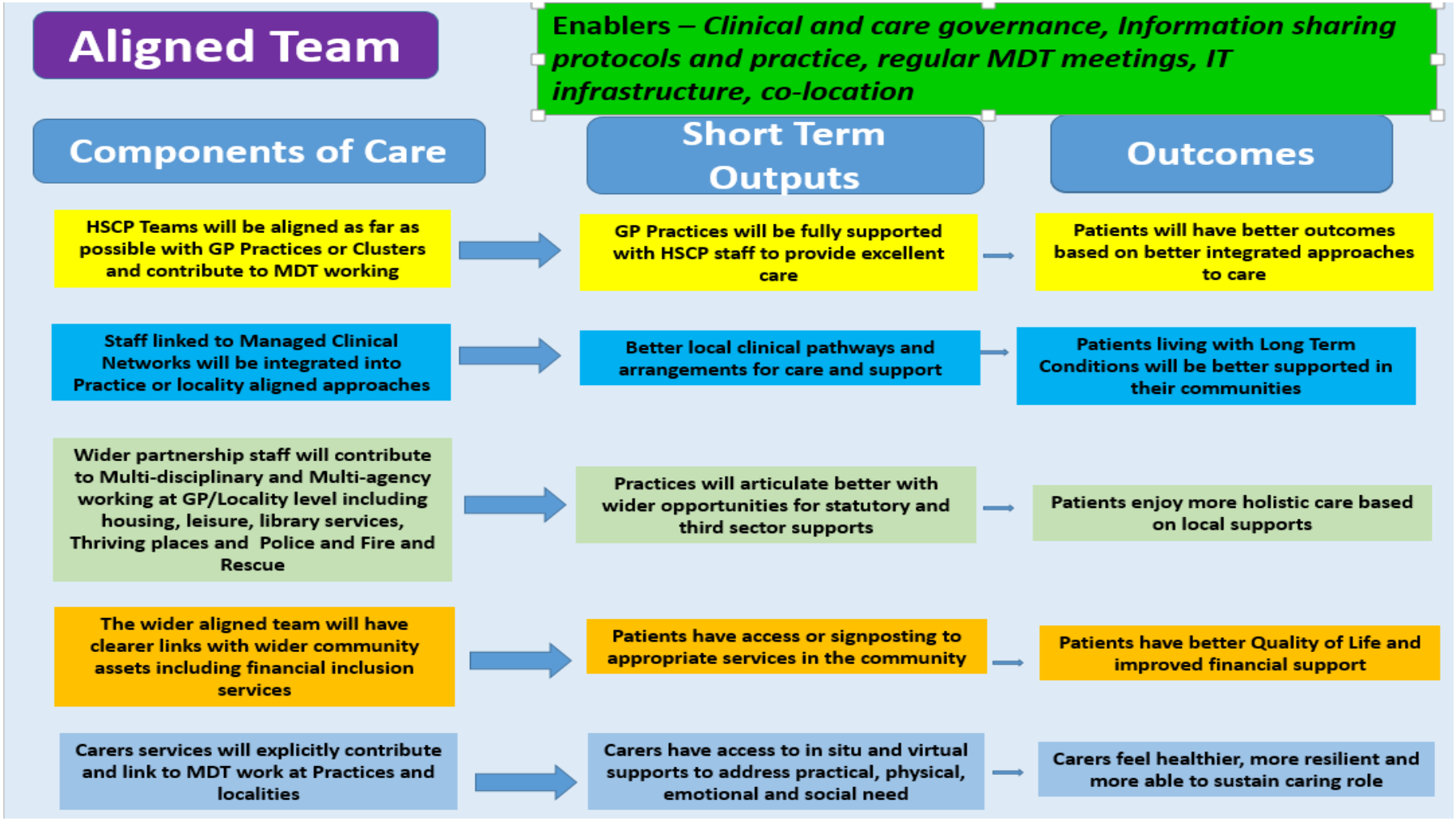
The Community Health and Care Operational Risk Register contains a record and assessment of all risks associated with the improvement activity identified within this Service Improvement Plan for Adult and Older People. It is monitored by the Community Health and Care Governance Group and forms part of its monthly agenda.

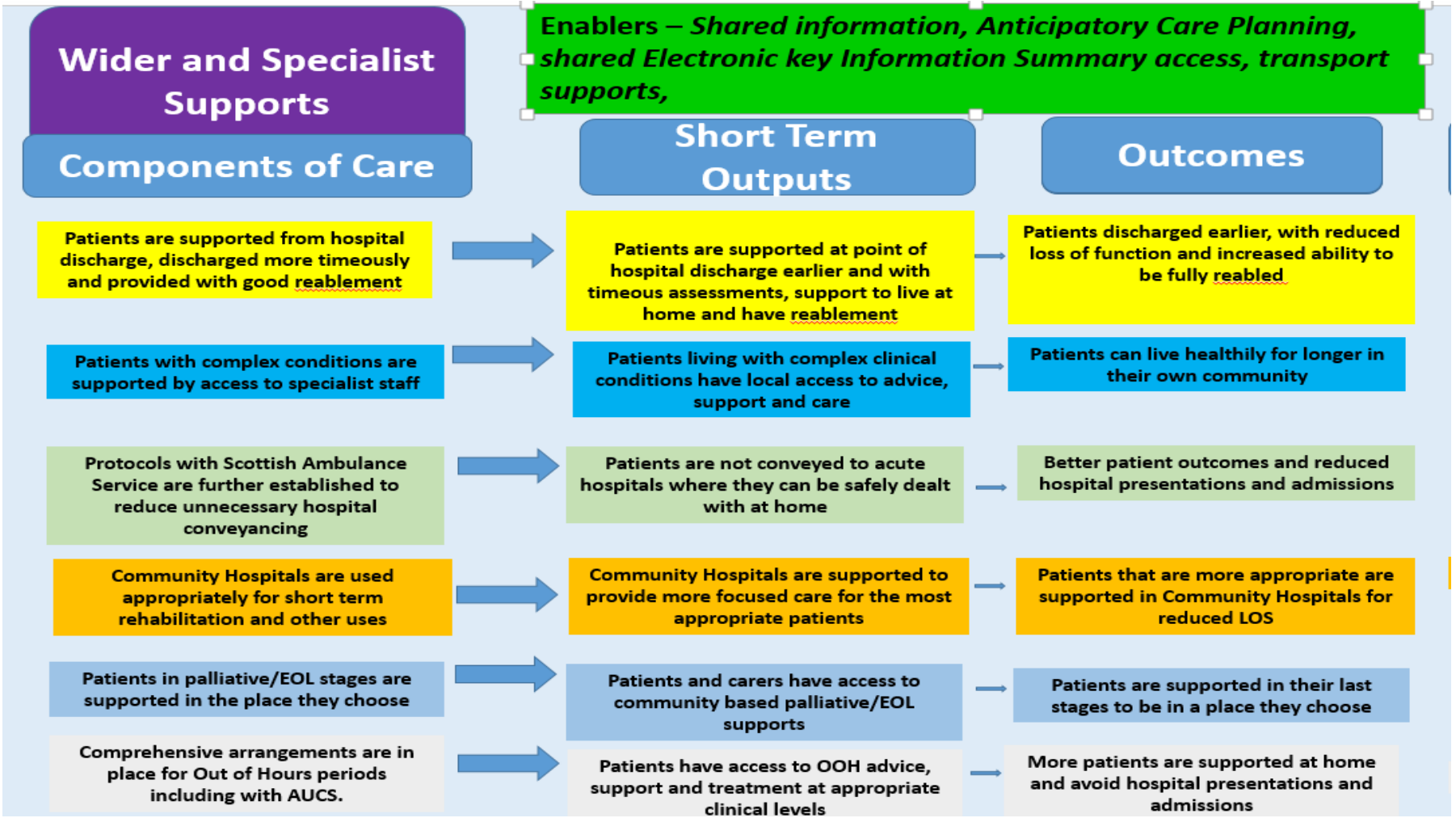
APPENDIX 1


HOME
Enablers – Investment in Third/Community Sector, TEC infrastructure, workforce planning
Components of Care
Short Term Outputs
Outcomes
Upstream preventative support is in place including information, self management, befriending, etc
Range of locally based provision is in place and accessible
More people living at home for longer and more healthily
Practical support at intermediate level including Telecare (and other TEC), Equipment access, Rehabilitation and Reablement
Practical supports are in place to address functional decline
People are maintained at home and enabled to remain independent
People with higher need have access to care@home and domiciliary clinical supports
Proportionate access to appropriate levels of care at home and clinical support
People in functional decline can remain at home for longer
People have good support for continence
People have timeous access to continence advice, support and products
Patients and carers feel fully supported in relation to continence
Self Directed Support options are fully utilised to provide person centred care
People have access to practical, emotional and social supports to enable them to keep safe and well
People are healthier, more resilient and able to have good Quality of Life
Unpaid carers are supported in their caring role
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


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 eFrailty 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 Electronic key 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