PAPER 2

EAST AYRSHIRE COMMUNITY HEALTH PARTNERSHIP

4th April 2011

RESHAPING CARE FOR OLDER PEOPLE

1. PURPOSE OF REPORT

1.1 The purpose of this report is to:

(i) to provide further information in respect of the Change Fund Guidance circulated by the Scottish Government on 23rd December 2010

(ii) to provide copy of the final approved submission for East Ayrshire Community Health Partnership to Scottish Government, and advise on the investment and implementation strategy to utilise the resources allocated through the Change Fund in support of further progressing the Reshaping Care agenda.

(iii) advise members of progress in the development of the Reshaping Care for Older People Programme, and the next steps towards implementation.

2. BACKGROUND

2.1 The budget statement by Scottish Government on 17 November 2010 included indication of a "Change Fund" to support the Reshaping Care for Older People programme with a national resource of £70million for 2011/2012. On 23 December 2010 Guidance on the Change Fund was issued and detailed for East Ayrshire an allocation of £1.648million.

2.2 Previous report to Community Planning Board on 16 December 2010, informed members of the Reshaping Care for Older People Programme and progress with East Ayrshire Older People Strategy.

2.3 The principal policy goal of the Reshaping Care for Older People programme is to:

"optimise independence and wellbeing for older people at home or in a homely setting"

2.4 Aspirations of older people and their families to live as independently as possible in the community have been clearly and repeatedly articulated. This was evident again locally at the East Ayrshire Reshaping Care for Older People event on 9 September 2010 and also the Older People Conference on 26 November 2010.

2.5 Older people play a critical role in keeping other older people out of the formal care system and living independently at home: they actually provide far more care than they receive. 9 out of 10 people over 65 utilise universal services and do not receive care in NHS continuing care, a care home or a home care service organised by social work. In the over 85yrs age group 60% continue to live without these formal supports.

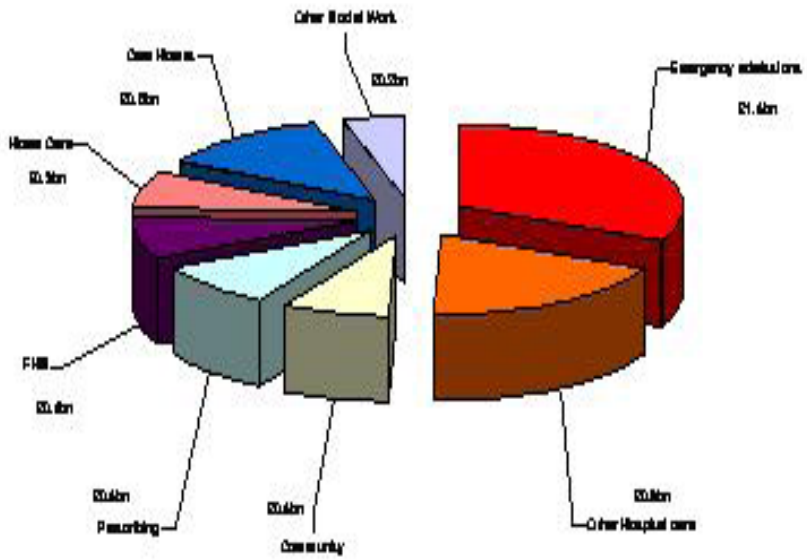
2.6 Demographic change in East Ayrshire over the next 20 years will see an increase of 85% in people aged over 75. This population change will provide a real opportunity for older people to utilize their skills, knowledge and capacity to contribute to local communities.

2.7 It is also anticipated that there will be resulting increases in resource demands and challenges for community social care and health services.

If service models remain the same, we will require an estimated annual increase in investment in health and social care services for older people of 24% by 2016 and 74% by 2031. This represents an average real increase in the NHS budget (total for all ages) of 1.2% per year, every year; and of 2.7% per year, every year to Local Authority older people's social work budgets. In reality the current financial environment will see a significant real terms reduction in public sector resources over the foreseeable future

2.8 The current spend profile across health and social care services sees almost two thirds of resources being invested in institutional based services including almost one third spent on unplanned admissions to hospital.

Health and social care expenditure
Scottish population aged 65+
(2007/08 total=£4.5bn)



2.9 For many older people an emergency admission to hospital is a safe and entirely appropriate intervention aimed to reduce escalation of dependency. However, for many others it may have been possible to anticipate and avoid the crisis that triggered the emergency admission; and for others, an alternative rapid community response, if available, may be a more effective option. For some older people, hospital admission can be associated with complications, a loss of confidence and functional ability and can lead to poor outcomes. This risk is exacerbated if there is a delay in their discharge once treatment is concluded.

2.10 As a consequence of the above factors the status quo is not an option to either meet the aspirations of older people or be sustainable within available resources. A key focus in reshaping care will be on reducing emergency admissions to hospital by older people, which nationally absorbs £1.4bn each year and is expected to grow unless we intervene. Models of care and support to deliver positive outcomes for older people require to be developed that take cognizance of the challenges we face.

3. DEVELOPMENT OF OLDER PEOPLE SERVICES IN EAST AYRSHIRE

3.1 In East Ayrshire we have for a number of years recognised the challenges of demographic change and have implemented a strategic direction to develop a health and social care infrastructure to support older people in our communities. Progress has been made towards achieving a shift in the balance of care from institutions to community through:

1 Community Plan 2009/2011
2 Single Outcome Agreement 2008/2011
3 NHS Local Delivery Plan 2009/2010
4 East Ayrshire Strategic Direction for Older People 2006/2011
5 East Ayrshire Strategic Housing Investment Plan 2011/2012 – 2015/2016
6 Delayed Discharge Action Plan 2002

3.2 Our partnership work already extends beyond community health and social care services and includes acute and primary health, housing, leisure and other vital stakeholders including family carers, independent, voluntary and community sectors.

3.3 Notable successes have been:

- Meeting and often exceeding national balance of care targets for older people with intensive care needs.
- Consistent achievement of Delayed Discharge Target over a number of years
- Progression of the East Ayrshire Supported Accommodation Strategy for Older People including new Council House provision prioritised to older people
- Partnership arrangements with Independent Care Home Providers to deliver long term care for older people

3.4 Consistent challenges have been:

- A reduction in hospital bed days experienced by older people due to delayed discharges and emergency admissions
- To reduce the number of repeat emergency admissions to hospitals of older people.
- Meeting the aspirations of older people for social support to provide health improvement and address isolation
- Achieving substantial increases in the number of carer support plans implemented.

3.5 In working towards the policy aims, to further progress our success, and address our challenges workstreams that have been progressed include:

- Re-ablement, providing care supports to maximise independence rather than providing services that perpetuate dependence.
- Telehealth / Telecare, utilising technology to provide 24 hour access to services
- Integrated Resource Framework, working to bring public resources together to efficiently and effectively meet community need.
- Single Point of Contact, providing easy access and referral routes to services across agencies
- Long Term Conditions Plan, developing anticipatory care plans to support people manage their health needs in the community.
- Rehabilitation Framework, promoting recovery of independence
- Dementia strategy, providing information, care and support from diagnosis to end of life care.

4. CHANGE FUND

4.1 The challenges we face in East Ayrshire are reflected at a national level. In response a Ministerial Strategic Group has been established including representation from Scottish Government, Convention of Scottish Local Authorities, the National Health Service in Scotland, and strategic partners.

4.2 They have agreed that it is a priority to make progress in this agenda and recognised that to make the change required, particularly in shifting the balance of care – and subsequently resources - from acute care to community will require bridging finance to cover double running costs in the transformation period. The Reshaping Care Logic Model attached as appendix 1 describes how inputs to community infrastructure can deliver effective interventions, leading to positive personal and system outcomes.

4.3 At a national level it was agreed at an early stage that the fund would operate along the following principles:

- It was a partnership fund that would be hosted by NHS Boards. The resource could not be used without full partnership agreement;
- The fund should be used to unlock mainstream resources – it was not designed simply to augment revenue funding; and

- It was important that the partnership focus was not limited to NHS and social work spend but should also consider other council budget lines (such as housing and leisure) and private and voluntary sector expenditure;

4.4 Each of the 32 local Partnerships was required by end of February 2011, to submit to the Scottish Government a transformation plan that has been agreed by all partners. Plans will be approved by the Ministerial Strategic Group for Health and Community Care. It is advised that although the funding is only outlined for 1 year at this time, plans should anticipate a 4 year programme.

4.5 Responsibility for sign off of the Change Plan lies with Community Planning, Partnership. In anticipation of the guidance the Community Planning Partnership Board of 16 December remitted to the Community Health Partnership Committee to develop the East Ayrshire Local Transformation Plan. The guidance further indicates that plans will require to be agreed at partnership level by Local Authority, Health Board, Voluntary Sector and Independent Sector, or the funds available for a particular area will be frozen.

4.6 The Local Transformation Plans should have a focus on improving quality, value and outcomes through cohesive partnership working, across health and social care and between statutory and non-statutory bodies.

Improved outcomes would mean older people and their carers feeling safe and valued, receiving timely and responsive care and support leading to improved confidence and greater ability to self manage

4.7 Plans need to demonstrate that systems and relationships are in place locally to deliver against the following criteria:

- The Partnership is planning in terms of enabling significant changes in service planning and provision;
- The shared nature of the Fund is taken into account – its use is not to be planned in terms of an aligned budget, nor as a resource transfer from health to local government;
- Plans for 2011/12 should focus on work that will be undertaken during that year, and should show how actions taken in 2011/12 contribute to the Partnership's longer term strategy to shift the balance of care and be reflected in a joint commissioning strategy; and
- The Partnership is looking to strike a balance between managing reduction in NHS hospital capacity and providing reassurance to allow local government to underpin services.

4.8 Key measures of success or outputs for use of the Change Fund will include:

- Reduction in unplanned acute bed-days in the over 65 population;
- Reduction in bed-days lost to delayed discharge;
- Remodelled care home placement use,
- increased levels of home care provision; and
- Improved support for unpaid carers.

4.9 Local Measures proposed locally in evidencing change are attached as appendix 2 and include:

- Emergency bed days for people over 75
- The percentage of people aged 65 and over with high levels of care needs who are cared for at home
- The number of People whose discharge from hospital is delayed
- Number of older people participating in Self Directed Support
- Number of Carer Support Plans in Place

5 EAST AYRSHIRE TRANSFORMATION PLAN

5.1 The Transformation Plan as outlined below is in respect of Reshaping Care for Older People. It includes how we engage with and where appropriate support older people and their carers through mainstream Local Authority and NHS services. The Change Fund is utilised in the plan as a mechanism for bridging finance to support service change rather than being the service change in its own right.

5.2 It is recognised that due to the very tight timescales and the need for inclusion of all stakeholders that initial plans submitted by end of February for 2011/2012 will describe a direction of travel with subsequent plans for future years being more detailed. This will include joint commissioning strategies to deliver the required service change.

5.3 Subsequent to the Change Fund consideration by the Community Planning Board on 16th December a number of partnership meetings have taken place in December followed by a well attended and very positive extended Officer Locality Stakeholder Event on the 19th January. This included representation from:

- East Ayrshire Council – (Educational and Social Services and Neighbourhood Services)
- NHS Ayrshire & Arran
- East Ayrshire CHP Carers Sub Group
- Scottish Care
- East Ayrshire Advocacy Services
- East Ayrshire Princess Royal Trust for Carers
- Alzheimer Scotland
- Citizens Advice Bureau

5.4 During this process initial proposals paper have been developed to reflect the partnership approach to the Reshaping Care for Older People, with a focus on the aspirations articulated by older people at engagement events during 2010. Key Changes to support service and culture change have been identified and will be delivered through 4 workstreams as outlined below and diagrammatically in appendix 3.

5.5 A report on the outcome of this engagement was presented and endorsed by the East Ayrshire Community Health Partnership Committee on 31 January 2011.

5.6 **Key Changes to Achieve Over Next Five Years**

- An integrated model of rehabilitation and enablement services established in East Ayrshire that includes, Local Authority, Health, Voluntary and Independent sectors.
- A shift from hospital based to community based intensive support services for older people. This will include development of Housing options that support independence for people with long term health conditions.
- Services developed which sustain independence and promote self management amongst older people
- Informal social networks developed which promote the health and wellbeing of older people
- A reduction in emergency admissions amongst people over 65 years
- A reduction in hospital bed days experienced by older people due to delayed discharges and emergency admissions

5.7 **WORKSTREAM ONE- Promotion of Community Wellbeing, including Universal Services**

In recognition that the majority of older people do not receive or require direct social care services we will seek to build community capacity that will see:

- Training and support for family carers
- Work with older people and communities to support self management of health conditions
- Capacity building, skills development and continuing professional development with employees, volunteers and other stakeholders and partners
- provision of a network community based active leisure/active lifestyle and wellbeing services addressing particular issues in relation to obesity.
- focus on Health improvement and population based approaches with older people.

5.8 **WORKSTREAM TWO-Sustaining Independence and Promoting Self Management (in homely settings)**

When older people require support we will further develop our services to make this available through models that are personalised to promote independence and are planned and delivered respecting the views of and with full participation of individuals. This will include

- Specific leisure and lifestyle work within the Supported Housing Complexes
- Increased investment in Care and Repair
- Further engagement with Housing providers including investment in equipment and adaptations to meet the needs of older people,
- Investment in telehealthcare (maximising 24 hour supports)
- Further development of Falls Prevention and Management pathway
- Implementation of community nursing strategy and new team focus.
- Advocacy support offered at locality level

- Maximise the expertise of the Independent Sector Providers through partnership work and support to Care Homes
- Enhancing capacity and building a culture of re-ablement in all care at home settings
- Community Pharmacy training to home care staff and family carers re medicine management
- Investment in self management support for older people and their carers.

5.9 **WORKSTREAM THREE – Integrated Rehabilitation and Enablement Services**

In order to deliver on the key policy goal of Reshaping Care to "optimise independence and wellbeing for older people at home or in a homely setting" it is essential that services work together in a co-ordinated way. To achieve this it is proposed to develop Community based integrated health and social Care service models with a focus on re-ablement/ alternatives to hospital admission/accelerated discharge teams.

Specifically this will see two locality Single Point of Contact Hubs (SPOC) established to ease access to services which serve the communities of East Ayrshire. This will require service redesign to bring together East Ayrshire Council employees with NHS colleagues in an integrated service with an aspiration for early movement towards joint management.

The core of the Hub teams would be from existing services. The Hub will potentially include-

- out of hours mobile home care services,
- home from hospital services,
- the new community reablement service for older people agreed by Council in the 2011/2012 budget.
- Income maximisation
- Disaggregated Rapid Response Team
- Increase Home Care capacity
- Primary care services
- Community Nurses
- Social Work and home care staff
- Allied Health Professionals
- Community based Geriatrics service
- Community based elderly mental health liaison service Community based Geriatric Services
- Community based Elderly mental health liaison services
- Community pharmacy support for hubs, including medication reviews

Hubs will focus on the provision of –

- Integrated targeted support and services linked to condition, age, geography, falls or risk prediction such as SPARRA (Scottish Patients At Risk of Readmission and Admission), data

- Close working relationships established with individual GP practices to support integrated case/care management approaches, anticipatory care planning and multi-disciplinary team working
- Close liaison with GP practices to support delivery of reduced emergency hospital admissions
- Improved integration between in hour and out of hours health and social care services
- Clear links between out of hours services and ambulance services (unscheduled care)

5.10 **WORKSTREAM FOUR – Intensive Supports**

In achieving positive outcomes for older people through effectively delivering on workstreams 1 to 3 we require to utilise the full resources, skills and knowledge of Social Work and Health professionals. To support this we will develop arrangements that;

- Develop a virtual ward approach with dedicated clinical team to contribute to targeted reductions in acute admissions and acute bed days.
- Support end of life planning to older people including care homes
- Develop integrated palliative care at home services including links with palliative care specialists, and community pharmacy
- Provision of specialty services in the community (e.g. COPD)
- Promote Adult support and protection
- Provide support at times of crisis in an appropriate setting

6. FINANCIAL IMPLICATIONS

6.1 Detailed scoping across agencies in East Ayrshire has indicated that Direct Spend on Social Care, Housing and Health services equates to £121million. Appendix 4 provides a detail of this expenditure.

The Reshaping Care programme and investment from the Change fund gives an opportunity for whole system redesign to mitigate against these resource demands through Health Improvement and reinvestment of resources freed up from reduced dependency on institutional based services.

Change Fund Commissioning Strategy for Investment Priorities

6.2 **Voluntary Sector**

Independent Advocacy Services – Investment will be provided to increase capacity to ensure older people's voices, particularly the most vulnerable are fully considered in care planning.

Carer Support – Investment will be provided from the Change fund to support implementation of the carers' strategy through an increase in the number of carer support plans completed. This is supplementary to the investment programme from the additional 2011/2012 announced for carers.

Dementia Services – Resources will be directed through the voluntary sector in respect of implementation of the Dementia strategy to provide post diagnostic support, community capacity building and specific interventions.

Community Capacity / Social Enterprise – Resources will be made available to voluntary and community organisations to develop community capacity / volunteer recruitment to support older people and their carers.

6.3 **Independent Sector**

Care Homes – as part of existing strategies all long term care and residential respite for older people in East Ayrshire is already commissioned through Independent Care Homes. Further resources will be invested to expand this partnership working to include all care home facilitated rehabilitation and reablement.

Care Homes – Resources will be invested across the partnership to maximise the existing expertise in care homes in supporting older people with complex care needs including Dementia and end of Life Care.

Care at Home – To support the shift in balance of care from institutions to community, resources will be invested to increase both the capacity of commissioned care at home services and also the proportion of the total service delivered through these arrangements.

6.4 **Council Services**

Care at Home Services – Resources will be provided to both directly delivered services and commissioned services to increase capacity with an aim of:

1) Supporting early discharge of older people from hospital and a local target of 4 weeks maximum waiting time till discharge. (National Target is 6 weeks)
2) Supporting initiatives to prevent repeat hospital admissions of older people with long term health conditions.

Assessment and Care Management – Resources will be directed to increase capacity to deliver professional assessment and interventions to support older people achieve the outcomes articulated through Reshaping Care.

Telecare / Telehealth – Investment will be directed to:

1) Support the technical installation and maintenance of equipment
2) purchase peripheral equipment to meet the individual needs of older people.

Care and Repair – Investment will be provided to:

1) Support self referral
2) Reduce waiting times for installation of adaptations
3) Provide environmental risk assessments to reduce risk of falls

Leisure Services – Resources will be invested to:

1) Support and develop social activities and health improvement activities within supported housing services.
2) Build capacity of communities to sustain activities.
3) Support individual older people with lifestyle programmes

6.5 **NHS Services**

Primary Care Services – Support for reshaping Primary Care services, including further development of virtual ward models to support community based care, provide active GP leadership within locality hub services, support integrated health and social integrated working at local level and utilise Integrated Resource Framework data and approaches to explore issues of variation in order to deliver integrated, equitable, efficient services

Elderly Mental Health Services – Resources will be invested to support implementation of the Dementia strategy including liaison support to carers of older people accommodated in acute hospitals and independent care homes.

Frail Elderly Services – Resources will be invested as Bridging finance to support the expertise of consultant geriatricians and nursing staff to move from a hospital focus to increasingly support community services including development of the integrated health and social care hub.

Allied Health Professionals – To support development of the integrated health and social care hubs investment will be made to increase the capacity of allied health professionals including physiotherapists and occupational therapists working in a community setting.

Community Pharmacy - Specific investment to support pharmacies and care at home services to implement our medication policy.

Secondary Care Services – Resources will be invested to support reshaping services currently provided within secondary care, particularly to support outreach work in respect of Chronic Obstructive Pulmonary Disease, particularly co production / self management approaches.

6.6 **Pan Ayrshire Cross Agency Investment**

Resources will be invested to support the development of a business case and implementation plan for a pan Ayrshire equipment service.

Resources will be invested to further develop innovative work around falls. This work will be co-ordinated on an Ayrshire wide basis, with local investment in specific community based activity.

7. HUMAN RESOURCE IMPLICATIONS

7.1 Redesign of services to support independence and personalisation for older people and integration across agencies will require considerable workforce and organisational development. In East Ayrshire our positive partnership arrangements established over many years within Community Planning and

specifically through Joint Future and subsequently Community Health Partnerships will support this process.

A workforce development programme will be developed as part of the Change Fund investment.

7.2 The development of the Single Point of Contact Hubs will see service redesign to bring together East Ayrshire Council employees with NHS colleagues in an integrated service with an aspiration for early movement towards joint management. Any implications for terms and conditions of East Ayrshire will be reported to Cabinet as appropriate.

8. POLICY AND LEGAL IMPLICATIONS

8.1 The delivery of the Reshaping Care programme supports local and national policies including Shifting the Balance of Care, Carers Strategy, Long Term Conditions Plan and the Dementia Strategy.

8.2 In order to fully realise the potential of our High Needs Supported Accommodation facilities it will be necessary to review the allocations criteria to facilitate allocation to people with degenerative long term conditions at an earlier stage, with a view to providing easy access to health improvement activities.

9. COMMUNITY PLANNING IMPLICATIONS

9.1 The Reshaping Care programme is an integral part of the Health and Wellbeing Theme of the Community Plan and is a positive example of Community Planning partners working together.

9.2 The East Ayrshire Summary Change Plan Template is attached as Appendix 5.

10. RISK IMPLICATIONS

10.1 Delivery of effective social care, housing, health improvement and health services mitigates against risks to individuals against the impact of ill-health, lack of independence and inappropriate admission to institutional care.

10.2 Development of sustainable models of care mitigates against financial risk to the public sector.

11. EQUALITIES IMPLICATIONS

11.1 The delivery of the Reshaping Care programme is a positive contribution of inclusion of older people.

12. RECOMMENDATIONS

It is recommended that the Community Health Partnership Committee:

(i) Note the aspirations of older people in our community and the significant challenges posed by demography and diminishing resources.

(ii) Note the opportunity the "Change Fund" provided in progressing this agenda

(iii) Endorse the general principles and approach for an East Ayrshire Change Plan as outlined in section 5 of this report, and the Change Plan at Appendix 5.

(iv) Agree to receive further reports in respect of Reshaping Care as details of the programme including detailed funding proposals are developed.

(v) Otherwise note the content of this report.

Eddie Fraser
Co-Chair, Adult Officer Locality Group

Jean Hendry
Co, Chair, Adult Officer Locality Group

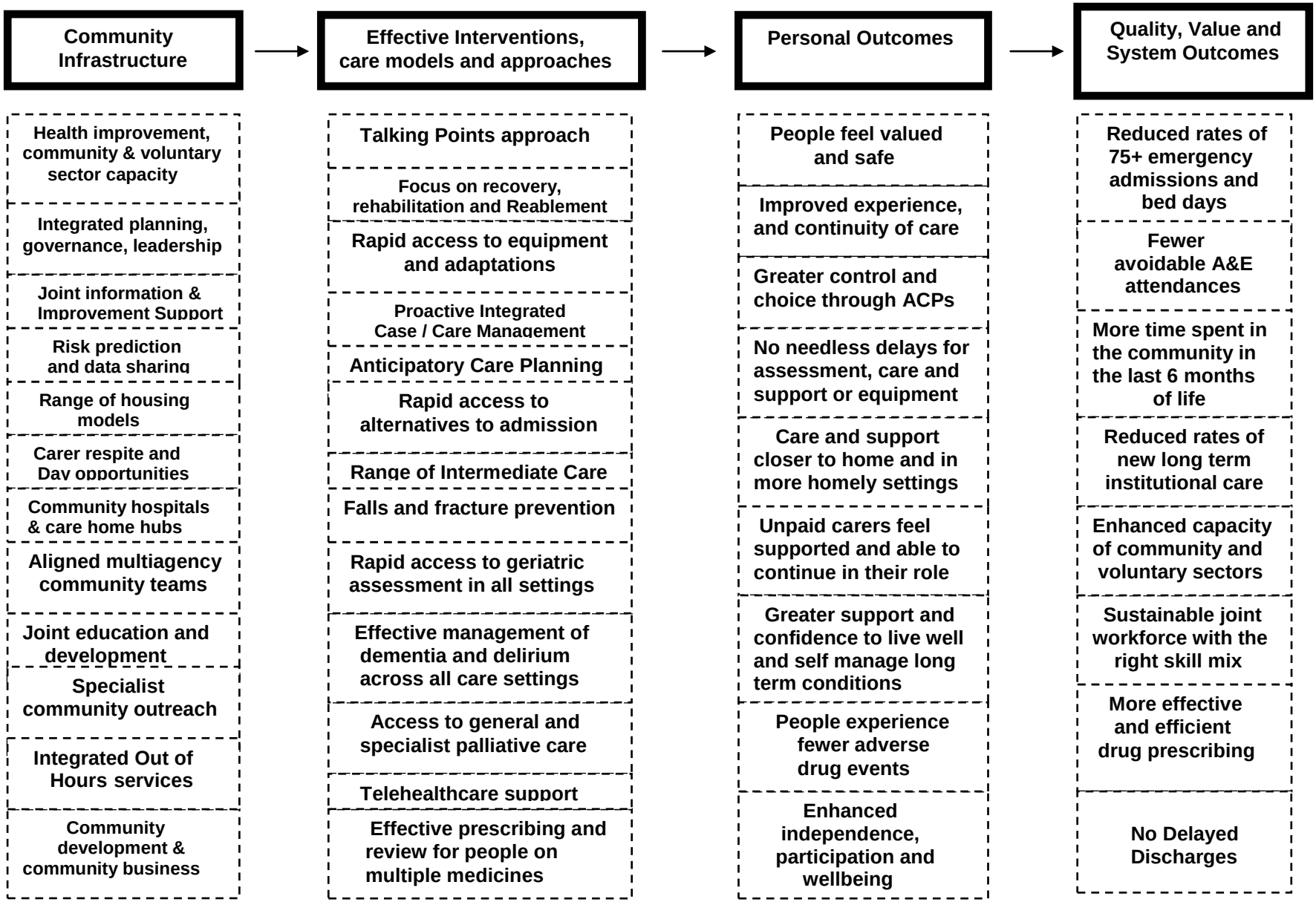
23rd March 2011

LIST OF BACKGROUND PAPERS

1 Community Plan 2009/2011
2 Single Outcome Agreement 2008/2011
3 NHS Local Delivery Plan 2009/2010
4 East Ayrshire Strategic Direction for Older People 2006/2011
5 East Ayrshire Strategic Housing Investment Plan 2011/2012 – 2015/2016
6 Delayed Discharge Action Plan 2002

Appendix 1

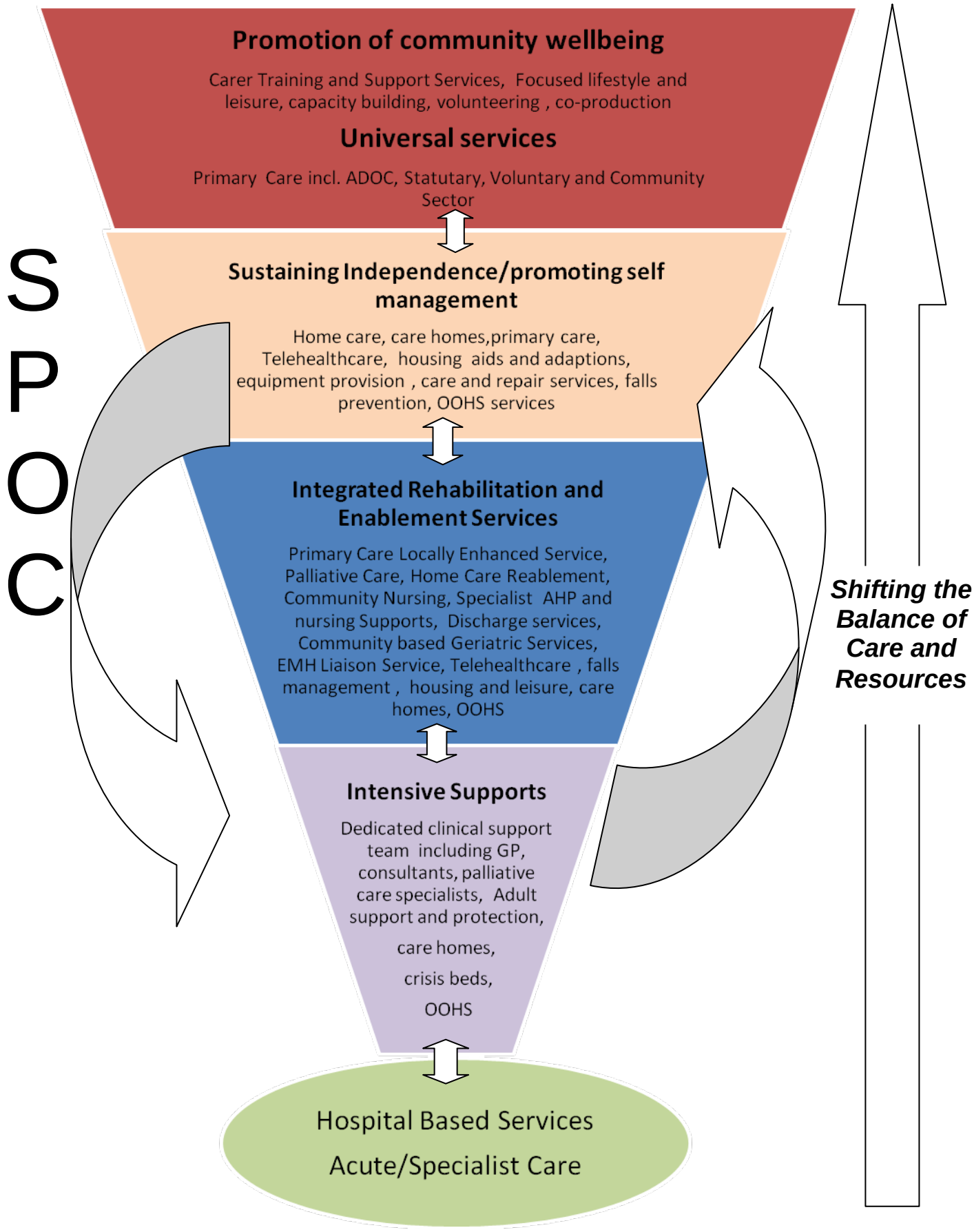
Reshaping Care Logic Model



Appendix 2

Metric	Levels of Measurement	Frequency
Reduction in number of emergency admissions of over 75 years population (key/prime indicator)	Board CHP Practice	Monthly
Reduction in length of stay for emergency admissions of over 75 years population	Board CHP Practice	Monthly
Reduction in number of emergency readmissions of over 75 years population (this should be shown by the number of admissions and over a certain threshold should be subject to a patient level review). We may also want to add separate categories of patient here (for example, dementia) as length of stay can be long due to complexity.	Board CHP Practice	Quarterly
Reduction in number of bed days utilised for over 75 years population (this would equate to number of bed days saved and eventual closure)	Board CHP Practice	Quarterly
Reduction in bed days lost to delayed discharge (new target of 4 weeks)	Board CHP	Monthly
Reduction in Assessment / Rehabilitation beds for over 65 years population	Board CHP	Quarterly
Bed days occupied by patients admitted from Care Homes	Board CHP Practice	Monthly
Reduction in Continuing Care Beds	Board CHP	Quarterly
Number of people over 65 years with telehealth / telecare support	CHP	Monthly
Number of people over 65 years with home care support of 10 hours+ and 20 hours+	CHP	Monthly
Number of older people participating in Self Directed support	CHP	Monthly
Number of carers' support plans in place	CHP	Quarterly

Appendix 3 ***Reshaping Care for Older People and their Carers living in East Ayrshire***



Information Infrastructure needed to underpin the model

Integrated IT systems, shared intelligence and information, including SPARRA, CHP profiles, identification of repeated fallers, referral patterns, admission and Out of Hours data, IRF data and modelling, Care home intelligence and hospital length of stay

Appendix 4

EAST AYRSHIRE COMMUNITY PLANNING PARTNERSHIP
RESHAPING CARE FOR OLDER PEOPLE CHANGE FUND
ANNEX C

	LA (£000's)	EAST CHP NHS (£000's)	Total (£000's)
HOSPITAL BASED			
Emergency Admissions		16,500	**16,500**
Elective Admissions and Day cases		31,223	**31,223**
Outpatients		5,974	**5,974**
Day Patients		1,599	**1,599**
Hospital AHP		1,739	**1,739**
Cross Boundary		4,097	**4,097**
COMMUNITY BASED			
GP Services		4,458	**4,458**
GP Prescribing		12,074	**12,074**
District Nursing		3,434	**3,434**
Community AHPs		1,431	**1,431**
Community Mental Health Services		743	**743**
LOCAL AUTHORITY SERVICES			**0**
Accommodation-based services	21,762		**21,762**
Homecare	12,543		**12,543**
Day Care	1,095		**1,095**
Equipment and adaptations	1,020		**1,020**
Assessment, Casework, Care Management, Occupational Therapy and Criminal Justice Field Work	2,482		**2,482**
Other services to support carers	50		**50**
Self Directed Support	434		**434**
Meals	126		**126**
Other social work services	127		**127**
Housing Welfare Services	785		**785**
Housing Support Services	225		**225**
TOTALS	40,649	83,270	**123,919**

Appendix 5

East Ayrshire Change Plan Template (Draft 17th Feb 2011)

1. Name of partnership

East Ayrshire Community Health Partnership
East Ayrshire Community Planning Partnership

2. Partner organisations

Stakeholder events have been held within East Ayrshire to where all stakeholders participated in the formation of the Change Plan. The completed plan has been circulated for further consultation prior to submission and has undergone due process including consultation at CHP, Council and NHS structures and engagement with voluntary and independent sectors. Partnership agreement has been reached of the general principles and approach for an East Ayrshire Change Plan
Stakeholders have included:

- East Ayrshire Council – (Educational and Social Services and Neighbourhood Services)
- NHS Ayrshire & Arran
- East Ayrshire CHP Carers Sub Group
- Scottish Care
- East Ayrshire Advocacy Services
- East Ayrshire Princess Royal Trust for Carers
- Alzheimer Scotland
- Citizens Advice Bureau
- CVO

Finance – use of Change Fund and additional resources

From	Amount £
Initial central allocation	£1,684,000.00
Added by NHS Board	£227,000.00
Added by local authority	£785,000.00
Other	£0.00
TOTAL	£2,696,000.00

Summary of current partnership budget for older people

£123,919,000.00

Summary of key outcomes/outputs achieved through current resources

- Consistent achievement of zero patients waiting more that 6 weeks for discharge from hospital to appropriate setting
- Pilot work on Single Point Of Contact to integrated health and social care services
- Meeting and often exceeding national balance of care targets for older people with intensive care needs
- Progression of the East Ayrshire Supported Accommodation Strategy for Older People including new Council House provision prioritised to older people
- Partnership arrangements with Independent Care Home Providers to deliver all long term care home support for older people
- Engagement of family carers in planning and service redesign through development of carers sub group as part of CHP structure
- Reablement approach to home care provision to maximise independence
- Telemonitoring technology development to support responsive 24 hour services.
- Integrated Resource Framework pilots to identify efficient and effective use of public resource

Key changes to achieve over the next 5 years

The partnership has taken into account the JIT profiles for East Ayrshire in the development of our plan

- An integrated model of rehabilitation and enablement services established in East Ayrshire, that includes NHS, LA, voluntary orgs, and independent sector
- A shift from hospital based to community based intensive support services for older people. This will include development of Housing options that support independence for people with long term conditions
- Services developed which sustain independence and promote self management amongst older people
- Informal social networks developed which promote the health and wellbeing of older people
- A reduction in emergency admissions amongst over people over 65 years
- A reduction in hospital bed days experienced by older people due to delayed discharge and emergency hospital admission
- An increase in the number of older people living independently at home
- A reduction in the number of patients waiting 4 weeks for discharge from hospital to appropriate setting

Use of Change Fund and outcomes anticipated

Attached at Appendix One

Key performance measures to assess progress

Joint performance management framework being developed working with the Joint Improvement Team. The range of quantitative measures across the partnership are attached at Appendix 2. The partnership is continuing to work on qualitative measures e.g. talking points.

Summary of how Change Fund will enable shifts in core budgets and impact on the totality of spend by the partnership over the next 5 years

- Through strengthening community health and social care it is intended to reduce the dependency on hospital based services and as a consequence disinvest NHS core budgets from hospital care and shift to community provision - NHSA&A has closed, or plans to close 88 long stay care of the elderly beds and 31 elderly mental health beds over the next two years. This would generate resource release of over £3m to provide recurring revenue from NHSA&A for Change Fund initiatives which Ayrshire partnerships decide to support on a recurring basis. There is also support for reduction in acute and intermediate care beds to support the agreed shifting the balance of care objectives.
- Reduction of proportion of Local Authority funding to long stay care home placements and increased use of care homes for rehabilitation / reablement / respite
- Shift of NHS and Local Authority core budgets to joint commissioning of third Sector and Independent sector including a commitment to increase balance of care purchased from independent sector care at home services.
- Creation of joint budgets for the delivery of health and care services for older people.
- Use of community capacity resource through personalisation and co-production approaches.

Indicate the financial mechanism and governance framework

The Change Fund plan will be approved by the community health partnership, East Ayrshire Council and the Community Planning Partnership.
The change fund monies will be held by the Health Board and hosted in the Community health Partnership budget. The monies will held as a pooled budget for partners use using the Integrated Resource Framework 'financial driver' models which support the implementation of joint budgets and commissioning.

Support requirements to assist delivery

- On-going engagement with communities and stakeholders to support shift in expectations from institutional care to community care models
- On-going engagement with Third Sector and Independent sector
- National and local political support for possible future bed closures and NHS facility reductions
- National and local political support for possible future care home closures as Local Authority changes provider commissioning
- Joint improvement Team support to expand current older people joint commissioning strategy
- HR support for the transfer of staff from institutional care to community care roles

- HR support for the transfer of staff from institutional care to Independent providers roles
- Organisational Development support for NHS, Local Authority, Third Sector and Independent sector to support change agenda

This plan has been prepared and agreed by the NHS, Council, Third Sector and Independent Sector interests.

Drew Filson
Chair, East Ayrshire Community Health Partnership

Signed

Ian McMaster
Scottish Care for the independent Sector

Signed

Fiona Skilling
CVSO for the third sector interface

Signed