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INTRODUCTION

This is a summary of the East Ayrshire Joint Community Care Plan 2001 –2004. It has been developed jointly by social work, health and hosing providers working in partnership with service users, their carers and other service providers.

The aim is that the plan is a detailed strategy that fits into a wider planning context within East Ayrshire, including the overall Community Planning processes. It is also heavily influenced by National initiatives, legislation and guidance from the Scottish Executive.

In addition, information will be provided on performance in key areas of service provision to enable readers to see the progress that has been made by the various agencies contributing to community care services in East Ayrshire.

The plan is set out as follows;

- **This summary –** outlines the main areas for strategic development outlined in the plan.
- **Volume 1 –** sets out the aims and objectives of community care services in the next three years, what strategic position we are now working from and what actions we intend to take to meet our aims and objectives. The plan is set out by service user group as well as cross group issues.
- **Volume 2 –** Indicates the strategic and financial frameworks in which the plan operates, the current services provided, outlines our performance to date and details how each action outlined in volume 1 will be implemented.

We hope that you find the document easy to read and understand and are able to relate the plan to the wider issues affecting Community Care in East Ayrshire.

THE AIMS OF EAST AYRSHIRE JOINT COMMUNITY CARE PLAN

OVERALL AIMS

- To positively contribute to promoting a socially inclusive society and encourage an "ethos" of citizenship in the wider community through

  (a) Improving the quality of life for the people we work with, in particular service users and carers

  (b) Enabling the people we work with to realise their full potential

  (c) Enabling the people we work with to fully participate in the communities they live in as citizens

  (d) Promoting understanding of the needs and rights of the people we work with within the wider community

WHERE DO WE NEED TO BE BY 2004

- The balance of provision requires to continue to change from services provided in residential settings or in hospital to services delivered to people in their own home. This requires a re-focusing of existing and new resources;

- We require to improve on our ability to share with and gather from partner organisations, particularly Health staff, information which will assist in the process of providing support and care to people we work with;

- We require to improve the assessment of the individual needs of service users and carers, undertaken by Social Work, Health and Housing by working together locally to achieve better and quicker decision-making;

- We require to develop services and local planning which are co-ordinated between GP's, Community Health staff, hospital based staff, housing and social care staff and, which reflects the needs of local communities, facilitate early discharge from hospital and prevent unnecessary admissions to hospitals and residential and / or nursing homes.

- We require to adopt, along with partner agencies, a preventative approach, including participation in health promotion, social inclusion and early intervention.

- We require to effectively address the needs of carers

WHAT WILL WE DO WITH SERVICES

- A common assessment tool will be developed and implemented by all agencies to enable quicker and easier access to all health and social care services;

- Further devolution of authority and budget will take place within Social Work to enable Team Leaders to purchase services based on local need;

- Intensive Care Management will be introduced across Community Care;

- Staff in all agencies will be resourced to carry out integrated working;

- Staff in all agencies will be empowered to provide welfare rights advice and support to ensure that people who use services have a clear understanding of and access to their income entitlements;

- The Home Care service will be redesigned in order to provide cost effective and flexible support to service users who need it at assessed critical periods over 7 days and 24 hours a day. This will involve changes in current work practises, the provision of wide ranging skills training for staff and increase working partnerships with independent sector providers. A full needs appraisal will also be undertaken to evaluate the most appropriate means to provide an appropriate housework and shopping service within available resources.

- Access to respite will be improved, including a formal investigation of need for the provision of breaks directly provided to carers.

- Advocacy services will be expanded to provide support to the following identified priorities; children and young people with disabilities, people with acquired brain injuries, people with sensory impairment, Older People and people with dementia, people with learning disabilities being discharged from continuing care hospital beds

- A greater range of accommodation with support will be established, where housing and care provision are separate;

- The Council will review sheltered housing applications and allocations to better meet the needs of people. This will include joint assessment, by social work and housing services, of the need for sheltered housing to ensure that those in greatest need gain access;

- There will be improved joint working between housing providers to better meet the needs of individuals with community care housing needs.

- A Care & Repair project will be set up to assist older people and people with disabilities to live independently in their own home.

- The Council will secure improvements in bus and rail travel, interchange facilities, infrastructure provision, information and accessible public transport.

- The Council will review its Social Work charging policy based on National Guidance.

- Good Health practices will be promoted, through partnership working, with a particular focus on:-

  - diet and lifestyle
  - exercise
  - eyesight
  - hearing
  - dental health
  - sexual health

SERVICES TO CARERS

- Services to carers in the rural south of the authority will be enhanced by the development of an additional Carers Centre base in Cumnock.

- Longer term funding will be sought, where appropriate, for a range of initiatives (e.g. the Young Carers Group), which are currently supported through short term funding arrangements.

- Further training will be provided to improve professional awareness of the needs of carers.

- Local authority and health services will work together to identify hidden carers.

- an information pack for carers and professionals detailing services and access arrangement will be developed and disseminated.

- Relationships with specialist carers groups will be improved in conjunction with the Carers Strategy Monitoring Group.

SERVICES TO OLDER PEOPLE

- Develop an Ayrshire wide strategy for older people's services across Ayrshire will be developed in early 2001 and include the key actions in the final plan.

- The need for an intermediate care facility or comprehensive rehabilitation unit within the Council area will be explored.

- Day care provision will be increased across the Council area.

- 10 very sheltered housing units in Kilmarnock and 12 amenity houses in Newmilns will be developed.

- Residential and nursing home providers will be supported to deliver a full range of social and nursing care within a single home setting and East Ayrshire Council will make recommendations as to the future of its four residential homes for older people.

PEOPLE WITH DEMENTIA AND OLDER PEOPLE WITH MENTAL HEALTH DISABILITIES

- an early intervention service will be developed to screen people over 75 for dementia to enable early intervention ;

- Resources will be allocated to assist older people with mental health problems in partnership between the East Ayrshire Council, Ayrshire and Arran Health Board, Ayrshire and Arran Primary Health Care NHS Trust and other appropriate agencies;

- A comprehensive information and advice service to people with dementia and their families will be commissioned.

- The operation of the Care Programme Approach (a specialist assessment and care planning process) will be expanded.

SERVICES TO ADULTS WITH MENTAL HEALTH DIFFICULTIES

- Mental health awareness training will be developed, particularly for front line personnel.

- Mental health day supports will be evaluated.

- The intensive home support service will be extended throughout the whole Authority.
- Mental health discharge protocols will be evaluated.
- protocols for people in transition from Children/Adolescent Services to Adult services and from Adult services to services for older people will be agreed
- the need for a rehabilitation initiative within East Ayrshire will be determined.

SERVICES TO PEOPLE WITH LEARNING DISABILITIES

The Ayrshire wide Partnership in Practice Agreement will set out the broad context within which learning disability services in Ayrshire will develop. The East Ayrshire Partnership in Practice Agreement provides greater detail about local developments.

- the East Ayrshire Day Services Review will be Implemented to develop day support options for people with learning disabilities who wish to gain new skills by accessing leisure, recreation and educational opportunities in their local communities and improve centre-based day care to people with more complex learning disabilities and physical disabilities.
- A forum involving Council representatives, provider organisations and national organisations will be established to explore employment opportunities for people with learning disabilities.
- All service users leaving long stay hospital care to live in the community and other people in transition, will have a Personal Life Plan.
- Existing services will be redesigned to address the specific support needs of older people with learning disabilities including exploring options for developing supported living and day care for older people.
- Up to 10 people will be discharged from long stay hospital to supported living options in the community in 2001/2002. Detailed Assessment work will be completed on all people currently resident in Arrol Park and Strathlea and a clear discharge plan developed to identify discharges to 2005.
- Additional housing will be made available to people with learning disabilities through new-build, house purchase and re-letting.
- Opportunities for the joint commissioning of specialist services across Ayrshire e.g. for people with autistic spectrum disorders will be explored.
- Existing local authority residential provision will be restructured to achieve more individualised supported living options.

- A framework for transitional planning managing the transition between school and adult provision for young people with learning disabilities will be developed across all agencies and in partnership with young people and their families/carers. This will set out agreed inter-agency protocols and standards of practice.

SERVICES TO PEOPLE WITH PHYSICAL DISABILITIES

Brain Injury Service Improvements will include

- Systems will be implemented to improve information and communication between agencies.

- Work will be undertaken to establish a local Brain Injury service.

- Awareness raising initiatives of the needs of people with acquired brain injury will be undertaken amongst front line staff.

Sensory Impairment Service Improvements include

- Access to information at public access points will be improved.

- Rehabilitation services for people with visual impairment will be increased.

- Good practice adjustment in line with the “Programme for Government to improve disabled access to public buildings and promote barrier-free housing” will be continued.

- Specialist service delivery will be piloted in key areas – for example deaf / blind / interpreting, on an Ayrshire-wide basis.

- Sensory impairment awareness training to relevant service providers will be increased.

- planning of classes in Braille for parents, carers and service users;

- development of a Guide/Communicator service within the Personal Assistance Support Scheme;

- execution of an Ayrshire wide assessment of the level of need for services amongst people with dual sensory impairments

Physical Impairment Service Improvements include

- Specialist forms of provision for specific aspects of assessed need will be developed.

- Formal links and shared practice arrangements between Occupational Therapists working within Social Work and the Ayrshire and Arran Acute Health Care NHS Trust will be further developed.

- There will be substantial investment in equipment and adaptations to assist people to live in their own home.

- A register of council properties that have been adapted will be developed as information becomes available in order to allow the allocation process to be more effective in identifying a match between people who need adaptations with existing adapted properties.

- Disability Awareness training will be provided for the council and service providers in partnership with representative organisations to meet the requirements of the Disability Discrimination Act;

- All licensed vehicles will be suitable for carrying disabled people by 2004.

SERVICES FOR PEOPLE WITH ADDICTION PROBLEMS AND PEOPLE WITH BLOOD BORNE VIRUSES.

- The service improvement plan identified within the Review of the Bridge Project will be implemented along with the Review of Outreach Work. This will include;

  - The creation of Community drugs worker posts within Kilmarnock and Cumnock Bridge Projects. To focus on the needs of service users with chaotic lifestyles.

  - Strengthening the management and staffing structures to maximise effectiveness.

  - Developing capacity with in services to provide additional rehabilitation and support.

- There will be further development of a corporate approach to addiction related issues.

- There will be a full review of addiction services within East Ayrshire in the light of increased funding opportunities and develop appropriate service responses in accordance with the identified gaps in provision.

- There will be a full multi agency review of substitute prescribing provision and specific action developed.

- A multi agency working party will be convened to consider 'access to services issues' to ensure that individuals receive appropriate support on presenting to agencies. The conclusions of this working party will be developed and implemented

- The provision of services including needle exchanges, substitute prescribing, ante natal HIV screening, HIV testing and information and advice to travellers will be further developed in accordance with the HIV/Blood Borne Infection strategy;

- Ayrshire and Arran Health Board will continue to fund the Gay Men's Outreach Worker to provide information and advice on sexual health and well being to gay and bisexual men in Ayrshire.

FOR FURTHER INFORMATION OR COMMENTS ON THE PLAN

PLEASE CONTACT;

Stephen Sheach
Service Officer (Planning)
Educational and Social Services Department
Civic Centre
John Dickie St
Kilmarnock KA1 1BY
Phone: 01563 576 982
Fax: 01563 576 924
e-mail Stephen.Sheach@east-ayrshire.gov.uk

AIMS AND OBJECTIVES OF EAST AYRSHIRE JOINT COMMUNITY CARE PLAN

OVERALL AIMS

- To positively contribute to promoting a socially inclusive society and encourage an "ethos" of citizenship in the wider community through
  (e) Improving the quality of life for the people we work with, in particular service users and carers;

  (f) enabling the people we work with to realise their full potential;

  (g) enabling the people we work with to fully participate in the communities they live in as citizens;

  (h) promoting understanding of the needs and rights of the people we work with within the wider community.

OBJECTIVES

- To plan and deliver services and promote opportunities based on the principles of Quality, Equality, Access and Partnership;

- To provide people with high quality flexible, seamless and locally based health and social care services that enables them to live a fulfilling and meaningful life.

- To enable people to live at home with appropriate levels of support. Alternatively when they are no longer able to be supported at home, to ensure a homely environment that recognises and values their rights to choice and respect.

- To shift the balance of care from hospital and other institutionally based services to one that is primarily based within the person's own home or community;

- To ensure that service users have access to the full range health care via mainstream and or specialist provision, as appropriate to need and circumstances;

- To promote and enhance health and social care services to work together in the community for the benefit of individual service users;

- To routinely involve service users and carers in the planning, delivery and review of services and to promote opportunities for service users to express themselves and to be heard;

- To support staff, through appropriate supervision, training and development, to provide the best possible quality of care;

- To work in partnership to plan and deliver services within a Best Value Framework;

- To improve the health of the people of East Ayrshire through the promotion of well-being and tackling of inequality and social exclusion;

- To promote social inclusion by developing opportunities for service users and carers to access:

  - employment
  - leisure and recreation
  - education.

FRAMEWORK FOR ACTION

INTRODUCTION

In planning for Community Care, partners have been informed by internal values, aims and strategies as well as by National Initiatives. These will be described in more detail in Volume 2

However, central to the implementation of the plan is the core values adopted by East Ayrshire Council in 1995. These are;

- **Quality**
- **Equality**
- **Access and**
- **Partnership**

Key areas for attention for the development of strategies include the issues of **Best Value** and **Equal Opportunities.**

BEST VALUE

Best Value is a commitment to improve local government performance in the delivery of Local authority services to local communities. Best Value aims to ensure that the cost and quality of these services are of a level acceptable to local people by;

- increasing the role of local people in deciding the priorities for local government services
- improving the way authorities manage and review their business
- building on the experience and expertise of staff

The council already has a statutory duty to achieve economy, efficiency and effectiveness in the use of resources. Best Value builds on this duty and requires councils to;

- set service standards and targets based on what local people really want
- regularly and rigorously review services to deliver continuous improvement and
- look without preconceptions at how the public's needs can be met within available resources.

To do this, services require to look at the services delivered based on the following criteria:

- Are we doing the right thing?
- Are we doing it right?
- How do we plan to improve?
- How do we account for our performance?

Although the principles of Best Value are not currently in statute it is expected that the Scottish Parliament will pass legislation later in 2001ensuring that all public services adopt a Best Value approach.

A full Best Value Service Review was carried out within Social Work Home Care and the Housing and Technical services repair sections in 2000, with agreed changes in service delivery being implemented into 2002. Home Care also had a Performance Management and Planning audit carried out by Audit Scotland in 2000/2001. East Ayrshire Council has a planned programme of full Best Value service reviews for all its services based on a five-year rolling programme.

The European Foundation of Quality Management approach, to the measurement of service quality, acts as the cornerstone of the council's approach to Best Value. The council therefore undertakes formal three-year assessments of the quality of all its services using the EFQM model of assessment. A full EFQM assessment of Community Care and Housing services was undertaken in 2000 and a three-year improvement action plan implemented.

In addition to the full service reviews, a number of internal reviews of service have been carried out within East Ayrshire Council. These include a full review of the Equipment and Adaptation service for physically disabled people, a full review of day services for Older People's and adults with learning disabilities and a review of the Community Care field work service. Although rigorous and far reaching it is recognised that these reviews did not always adopt the framework of Best Value. It is recognised that this may require unnecessary duplication when carrying out a full Service Review.

Our Plans include to

All significant internal reviews of service in future will use the Best Value framework to ensure openness and rigour in planning services.

EQUAL OPPORTUNITIES

The Scotland Act 1998 interprets Equal Opportunities as meaning "the prevention, elimination or regulation of discrimination on grounds of sex or marital status, on racial grounds, or on grounds of disability, age, sexual orientation, language or social origin or of other personal attributes, including beliefs or opinions, such as religious beliefs or political opinions."

The “Equality Strategy: Working together for Equality” was produced by the Scottish Executive in November 2000 to put in practice the promotion of Equal Opportunities particularly for public bodies. This sets out a strategy that aims to;

- Work to foster respect and understanding.
- Encourage and enable everyone to live, work and take part in society to their full potential , free from prejudice and discrimination.
- Work to empower all our communities.

The strategy focuses on three strategic objectives:

- Making better policy and providing better services
- Promoting equal opportunities and tackling discrimination
- Being a good employer.

All public bodies, including community care providers will require to work in partnership to address the implementation of the strategy

In addition, the Race Relations (Amendment) Act 2000 was implemented from April 2001. This Act placed a duty on specified public authorities (including all the partners to the Community Care Plan) “to work towards the elimination of unlawful discrimination and promote equality of opportunity and good relations between persons of different racial groups.”

East Ayrshire Council and partners have had a longstanding commitment to the promotion of Equal Opportunities practice.

The Council has adopted a “mainstream” approach as recommended by the Equal Opportunities Commission, building in a positive Equal Opportunities approach into all major strategies.

The Council progresses Equal Opportunities policy through the Equal Opportunities Group, chaired by the Head of Personnel and staffed by representatives from each Department. The aim of the Group is to work together in support of the Council’s Corporate Strategy Group to recommend action to influence and progress towards mainstreaming equality, social inclusion and best practice in employment, service delivery and in the wider community.

The Council operates a set of Forums to engage with public representatives in three main fields:

1) People with Disabilities

2) People of Ethnic Origins

3) Women’s Issues

In addition, Social Work Services undertakes work with the local Elderly Forum.

The Forums for People with Disabilities and People of Ethnic Origin are managed and arranged by the Educational and Social Services Department.

The Council has also agreed to form a Multi-Agency Racial Incidents Monitoring Group in East Ayrshire to tackle racist incidents with representatives from the Police Service, Educational and Social Services, Scottish Homes and other organisations.

Our Plans include to

Partners will;

- implement legislative requirements and guidance that ensues from the implementation of the Equality Strategy and work with our service providers to enable them also to do so

- to continue to consult with service users and carers on specific issues including aspects of their health and social care and to continue to seek more effective ways of doing so

- To continue to monitor both the workforce within agencies and with organisations we have a contractual relationship to ensure that equal opportunity policies are being applied

- To address the Commission for Racial Equality “Racial Equality Means Quality” standard in the following

    i. Policy and Planning
    ii. Service Delivery
    iii. Community development
    iv. Employment and
    v. Corporate image

- Specific actions to address this will include;

    i. Develop and maintain the Multi-Agency Racial Incidents Monitoring Group in East Ayrshire with other agencies.

    ii. Monitor the usage of community care services by people from ethnic minorities to ensure that their needs are being met in a non-discriminatory fashion.

ABOUT EAST AYRSHIRE COUNCIL

On 1 April 1996 East Ayrshire Council became one of thirty-two unitary authorities providing local government services in Scotland. As a result of the reorganisation of local government, The Council assumed responsibility for the areas formerly governed by Cumnock and Doon Valley and Kilmarnock and Loudoun District Councils as well as Strathclyde Regional Council. The Council has thirty elected members and approximately six thousand employees and has established seven local committees and nine departments to deliver essential local services.

GEORAPHICAL AND DEMOGRAPHICAL INFORMATION

East Ayrshire is situated in West Central Scotland, approximately thirty miles South of Glasgow. The authority covers an area of four hundred and ninety square miles and has a population of one hundred and twenty four thousand. There are thirty-five main communities and settlements in a diverse geographical area, embracing both rural and urban settlements. The main population centres are Kilmarnock, Stewarton and Galston in the North of the authority and Cumnock, New Cumnock and Auchinleck in the South.

Settlement	Population
Kilmarnock	44826
Cumnock	9099
Stewarton	6573
Galston	5259
Mauchline	4183
Hurlford	4135
Auchinleck	3879
New Cumnock	3829
Drongan	3044

DEPRIVATION AND SOCIAL EXCLUSION

Deprivation can exist in many forms such as rural, social or economic deprivation, and as such is complicated to measure. One of the more commonly used methods is the Jarman index which can give an estimation of the levels of deprivation in a particular area by the manipulation of a number of different census variables. Seven deprivation categories are calculated, one being the least deprived and seven the most deprived. In general, the level of deprivation within Ayrshire and Arran is higher than the Scottish average. Of the seven Jarman deprivation categories calculated, Ayrshire and Arran was significantly higher than the Scottish average for categories three, four, five and six[1] Within East Ayrshire, parts of Kilmarnock, Cumnock, Auchinleck, Gilfoot (Newmilns) and Hurlford *I* Crookedholm are amongst the worst ten percent in Scotland in terms of deprivation[2].

Employment in the traditional industries of whisky blending, mining, engineering and textiles in East Ayrshire has significantly declined. This has particularly affected the South of the authority, losing some seven and a half thousand jobs over a fifteen year period in coal mining and its associated industries alone. The level of unemployment in East Ayrshire stands 7.4%[3]. This compares to the Scottish rate of 5% and the British rate of 4%. In one area of East Ayrshire, the rate stands at 17.8%, the third highest recorded rate in Scotland.

In many of East Ayrshire's more deprived areas, the effects of social exclusion are particularly concentrated and compounded by its rural nature. Some of the remoter settlements have experienced a reduction in their population of over twenty- percent between 1981 and 1991. This has led to a cycle of gradual decline, which is increasingly leading settlements into stagnation. One post code area (comprising 10% of the population of East Ayrshire) is in the most deprived 10% in Scotland.

Other significant differences also exist when comparing the deprived areas of East Ayrshire with Scotland as a whole. For example, only fifteen percent of school leavers within East Ayrshire's deprived areas go onto further education, compared to nineteen percent for Scotland as a whole. Twenty six percent of all Scottish school leavers go into employment compared to only seventeen percent of those deprived East Ayrshire's communities.

[1] The 1999 report of the Director of Public Health -Ayrshire and Arran Health Board

[2] Ibid

[3] August 2000

In addition, of these communities, eighteen percent are dependent on income support, twenty five percent of pensioners receive income support and thirty seven percent of children in families are dependent on income support. These compare with eleven percent, twenty percent and twenty five percent respectively for Scotland as a whole.

There is also an imbalance in crime rates. From April 1997 to November 1998 the percentage rise in crime in the deprived areas of East Ayrshire (12.3%) was almost double that of the Strathclyde police force area (6.8%). Overall however the local crime rate is close to the national average.

In addition to the areas officially recognised as deprived, studies from other areas show that significant numbers (up to 40%) who can be categorised as deprived, live outwith areas of recognised deprivation.

Poverty is a major causal factor in issues of overall deprivation including poor health, lack of educational opportunities. and access to many of the activities and services which tend to be widely taken for granted by others.

POVERTY AND HEALTH

An established route to poverty is an extended period of illness or disability while, conversely, an established route to ill health is the experience of living in poverty.

The link between deprivation and health has been firmly established. Castairs and Morris (1991) have shown that for those people under the age of sixty five living in areas of high deprivation, their pattern of mortality greatly exceed their counterparts living in more affluent areas. In addition, certain causes of death, such as coronary heart disease and some forms of cancer for example have been shown to be greatly influenced by socio - economic factors.

The relationship between deprivation and health clearly holds for East Ayrshire. The standardised mortality rates (SMR's), when comparing those deprived areas of East Ayrshire to the Scottish average (SMR set at 100), shows that the rate for East Ayrshire is considerably higher (142) for all diagnoses. Despite improvements SMRs in Ayrshire and Arran for all causes of death in 75 year olds in the 10% most deprived communities was 6.2 per 1,000 compared to 3.5 per 1,000 in the 10% most affluent.

The Scottish Executive renewed the National Clinical Priorities for 2000/2001 including Mental Health, Coronary Heart Disease/Stroke and Cancer. (Most premature deaths for men are caused by coronary heart disease). In Ayrshire the rate for premature death from coronary heart disease is 9% higher than that for Scotland in 1998, 3% higher for cancer and 12% from stroke.

Individuals who suffer from chronic ill-health or are disabled may be entitled to access additional welfare benefits, the extra income from which can be a critical factor in sustaining quality of life. Failure however to access the appropriate

benefits, or withdrawal of an existing benefit can only serve to worsen an already difficult financial position which in turn will have an adverse impact on quality of life and general health and welfare.

It is important, therefore, that vulnerable individuals are encouraged and assisted to maximise their benefit entitlement, as despite the considerable publicity surrounding welfare benefits, many millions of pounds worth of benefits remain unclaimed each year.

The Social Security system is a complex maze of entitlement and many individuals who are vulnerable through ill- health or disability experience difficulty in identifying benefits to which they have entitlement. This may then contribute to further problems, which can arise from the day to day pressures associated with poverty.

A greater awareness of welfare benefits among health workers coupled with appropriate communication links to Social Work services would be of considerable help in increasing take up levels.

Increased disposable income can improve living standards and, subsequently, also contribute towards improved health.

POPULATION TRENDS

It is estimated that the overall population in East Ayrshire is likely to decline by 9% up to the year 2013. This will be an uneven decline with the decline of the population of people aged 20-39 years declining by as much as 26%. This will lead to an estimated growth in the relative percentage of People over 60 years by 6% to 27%. There will be also a decline in employment levels within the area by over 1% by the year 2007.

The particular projected decline in the younger, working age population, is likely to cause significant difficulties in the following ways;

- A reduction in income from council tax and spending in the local economy by the younger employed group

- It may create a vicious circle in that a lower working – age population would discourage business start-up by employers who require a skilled available workforce.[4]

[4] Ayrshire Economic Information Group “Ayrshire Labour Market and Skill Trends” 1999

	2001	%	2011	%
0-15	23,692	19.7%	20,759	18.0%
16-20	7,337	6.1%	7,272	6.3%
21-25	6,350	5.3%	7,005	6.1%
26-44	33,467	27.9%	26,601	23.1%
45-64	29,691	24.7%	32,760	28.4%
65+	19,511	16.3%	20,759	18.0%
Total	**120,048**	100.0%	**115,156**	100.0%

OLDER PEOPLE

Within East Ayrshire, it is estimated that currently 18% of the population are over 60 with 25% of these being over the age of 80. Within the council area the older population is unevenly dispersed with the over 65s ranging as follows;

Local committee area	**Over 65s as a percentage of the total population of the area**
Northern	12.7
Kilmarnock North	11.2
Kilmarnock Central	20.2
Kilmarnock South	16.7
Irvine Valley	14.6
Cumnock area	15.6
Doon Valley	14.0

It can be surmised that there are greater concentrations of Older People in more isolated areas and areas with higher deprivation and social exclusion.

As stated there is expected to be a significant increase in the numbers and proportion of older people between 2001 and 2013 with, in particular, a 25% rise in the number of people aged over 85

Estimated population for East Ayrshire Council area including gender distribution

	2001			2004			2013		
age band	male	female	persons	male	female	persons	male	female	persons
60-64	3046	3376	6422	3137	3463	6600	3479	3736	7215
65-69	2749	3194	5943	2857	3189	6046	3405	3715	7120
70-74	2351	2844	5195	2352	2888	5240	2545	2925	5470
75-79	1656	2311	3967	1763	2287	4050	1964	2441	4405
80-84	880	1658	2538	1026	1760	2786	1254	1818	3072
85-89	382	899	1281	361	832	1193	603	974	1577
90+	147	430	577	160	457	617	223	524	747
65+	**8165**	**11336**	**19501**	**8519**	**11413**	**19932**	**9994**	**12397**	**29606**

Projected Change in the Older Population

age band	2001-2004	2001-2013
60-64	3%	12%
65-69	2%	20%
70-74	1%	5%
75-79	2%	11%
80-84	10%	21%
85-89	-7%	23%
90+	7%	29%
65+	2%	52%

OLDER PEOPLE WITH DEMENTIA OR MENTAL ILL HEALTH PROBLEMS

It is estimated that the likely prevalence of dementia among older people will increase with age[5] with a third having dementia to the degree that social support will be required.

A survey in Tayside carried out by the Dementia Services Development Centre (Carr 1992) indicated that between 8-12.8% of the total over 75 population living in the community and 45% of people living in residential homes had some degree of dementia. In addition the study estimated that 10% of people over 75 with dementia (to the point that social support was required) were not known to any service provider other than the GP.

Therefore the increase in the number of older people in East Ayrshire over 75 is expected to result in a commensurate rise in the numbers of people with dementia in the are over the same period

[5] Hofman et al "The prevalence of dementia in Europe:a collaborative study" 1991

Prevalence of dementia in East Ayrshire 2001 - 2004- 2011 by gender and age bands over 60

	2001			2004			2011		
age band	**male**	**female**	**persons**	**male**	**female**	**persons**	**male**	**female**	**persons**
60-64	49	17	66	50	17	68	60	20	81
65-69	60	35	96	63	35	98	67	36	103
70-74	108	111	219	108	113	221	114	113	227
75-79	83	155	238	88	153	241	95	162	257
80-84	106	224	330	124	238	362	148	237	385
85-89	71	205	276	67	190	256	103	220	323
90+	47	147	193	51	156	207	64	173	237
65 +	**475**	**876**	**1352**	**501**	**884**	**1385**	**593**	**939**	**1532**

Estimated (%) rise in the population with dementia

age band	2001-2004	2001-2013
60-64	2.9%	18.6%
65-69	2.4%	7.6%
70-74	0.8%	3.6%
75-79	1.6%	7.5%
80-84	9.5%	14.2%
85-89	-7.0%	14.7%
90+	6.9%	18.3%
65+	2.5%	11.8%

PEOPLE WITH LEARNING DISABILITIES

Using the prevalence rates from the Health Needs Assessment report[6], the estimate of the adult population of East Ayrshire who have a significant learning disability in 2001 is as follows

Prevalence of Learning Disability Adults within East Ayrshire

	Males	Females	Total
16-20	15	13	28
21-25	12	12	24
26-44	62	63	126
45-64	34	37	71
65+	10	14	24
Total	**177**	**184**	**361**

[6] Felce D, Taylor D, Wright K Epidemiologically Based Needs Assessment report 12:People with Learning Disabilities (1992)

However, figures collected by staff within East Ayrshire Council Educational and Social Services Department indicate that the following numbers of people with significant learning disabilities known to service providers are as follows

Numbers of adults with learning disabilities known to agencies within East Ayrshire

	Males	Females	Total
16-20	16	13	29
21-25	29	17	46
26-44	115	92	207
45-64	60	63	123
65+	18	11	29
Total	238	196	434

The discrepancy in figures can be partly explained by the presence of three private residential homes that provide in total places for people with learning disabilities. Of the 56 places available within these homes, only 8 people originated from the East Ayrshire area.

PEOPLE WITH MENTAL HEALTH PROBLEMS

The following prevalence for people with mental health indicate that

Estimated Prevalence of people experiencing some mental distress (median estimate)[7]

	2001	2004	2011
the community	28265	27623	25906
total mental morbidity -attenders in primary care	23012	22490	21092
mental disorders identified by doctors	10155	9925	9308
total mental morbidity -identified by doctors	2081	2034	1907
Psychiatric in patients	340	332	312

However, these figures do not take account of the effects of within the council area, with mental illness likely to be as much as twice as high among people who were not economically active compared to those in full-time employment.

However, research has confirmed that there are significant links between poverty, unemployment and deprivation and the incidence of mental health problems including:

- Schizophrenia
- Suicide
- Depressive illness

[7] Goldberg D and Huxley P "Common Mental Disorders :A Bio - Social Model" 1992

- Anxiety

The study states that there is a link between first admission rates for specialist psychiatric care for schizophrenia by deprivation category. There are also links with suicide and deprivation especially affecting younger age groups.

There is a clear gradient for first admissions to hospital with increasing deprivation category for both men and women. However for depressive illness and anxiety the majority of contacts for these illnesses take place in the community through primary and community care services.

The impact of these findings reinforces the need to address the impact of deprivation on mental health services to ensure:

- Those with mental health difficulties do not become socially excluded.
- That health promotion is targeted on socially deprived communities/ groups, with the aim that people get maximum support to achieve and maintain good mental health.

PEOPLE WITH PHYSICAL AND SENSORY IMPAIRMENTS

PEOPLE WITH ACQUIRED BRAIN INJURY

Statistics provided by Ayrshire and Arran Health Board indicate that approximately 5,500 people in Ayrshire sustain an injury annually, with an equal split between North, South and East Ayrshire. The causative factors are mainly road traffic accidents, falls and medical conditions. Although Road Traffic Accidents are the cause of the highest incidence of brain injury, there has been an overall reduction with increased road safety measures such as the introduction of seat belts and air bags.

There has been an increase in head injuries associated with drugs / alcohol misuse.

The average age range of an individual sustaining an injury ranges from 31 – 40 years.

PEOPLE WITH SENSORY IMPAIRMENTS

In Ayrshire we know;

- **That 42,000 people have a hearing impairment and have received an audiology service the hearing impairment ranges from mild to profound and it was estimated that 40% have a profound hearing impairment,**
- 699 People are registered blind or partially sighted
- 118 People with a visual impairment who are not registered received a service.

PEOPLE WITH PHYSICAL DISABILITIES

The OPCS statistics indicate that 5680 people within East Ayrshire have a range of disabilities that, as a result, may require a limited or extensive level of service.

Of these, it is estimated that the following numbers of adults (under 65) will have a physical disability without associated mental health or learning disability.

Prevalence of adults with a physical disability alone

Age band	2001	2004	2011	2013
16-24	192	201	197	188
25-44	1012	947	806	771
45-54	1292	1253	1370	1385
55-64	2236	2422	2515	2436
16-65	4423	4483	4506	4404

1557 physically disabled adults received a community care assessment between April 1999 and March 2000.

PEOPLE WITH ADDICTION RELATED PROBLEMS

The Ayrshire & Arran Healthy Lifestyle Survey 1998 identified the following information:

- **34% of men and 16% of women claim to have drunk more than the recommended safe limit within the last week**
- **8% of men and 3% of women had been advised to cut down drinking**
- **51% of males and 43% of females 16-24 have tried drugs**
- **3% of males and 5% of females are current drug users**

The prevalence of drug dependence within East Ayrshire indicates the following.

prevalence of drug dependence by age band and gender East Ayrshire 2001- 2013[8]

	2001		2004		2011		2013	
	male	female	male	female	male	female	male	female
16-19	232	160	241	162	210	135	210	135
20-24	376	90	391	99	390	100	390	100
55-59	7	33	8	38	7	36	7	36
60-64	12	24	13	24	14	26	14	26
all	373	195	394	209	396	204	381	204

However, the Health Service and East Ayrshire Council provide services to a significant numbers of individuals with addiction problems. East Ayrshire Council Social Work has the second highest number of service users with drug/alcohol problems in Scotland (after Glasgow).

Within Social Work, referral analysis indicated that the number of assessments undertaken for people with drug/alcohol abuse problems is as follows.

Social Work assessments of people

1996/97	1997/98	1998/99	1999/2000	2000/2001
231	458	644	685	

Within this total, the Bridge Project and Ayrshire Council on Alcohol identified the following:

referrals to the Bridge projects

1997/98	1998/99	1999/2000	2000/2001
490	522	598	

57% of new referrals to Bridge during the period were in respect of heroin use.

25% of new referrals were in the 21-24 age bracket.

referrals to Ayrshire Council on Alcohol

1996/97	1997/98	1998/99	1999/2000	2000/2001
130	139	190	130	

[8] Strang J Health Care Needs Assessment No 18 Drug Abuse Department of Health 1994 population GRO (1998 baseyear)

CARERS

Statistical information[9] would suggest that some 15,550 people in East Ayrshire are carers.

It is estimated that more than 3,100 individuals within East Ayrshire spend in excess of 20 hours per week on caring tasks.

Care can range from doing the weekly shopping to the provision of 24-hour continuous care.

While most carers (some 79%), look after older people there are also significant numbers of carers of people with a range of care needs including people with learning disabilities, mental health problems, physical disabilities and addiction problems.

There are over 1,000 carers registered with East Ayrshire Carers Centre including more than 100 young carers.

[9] General Household Survey 1991 applied to 1993 mid year estimates of population growth

SHIFTING THE BALANCE OF CARE

Since the introduction of the "National Health Service and Community Care Act 1990", reinforced by the publication of "Modernising Community Care - an Action Plan", national community care policy has emphasised the importance of maintaining people in their own home or in a homely setting. This has resulted in a National priority to shift resources from supporting people in long stay hospital settings or residential institutions to the provision of home and community based care provision

Within East Ayrshire, it is recognised that it will take time to develop this policy into practical results. Some identified difficulties include;

- Resources committed to institutional forms of care cannot be immediately released from existing services while new services are in the process of being developed. For instance Older People currently living in residential or nursing care will continue to require to be supported.

- The development of new services require to be undertaken in a manner that minimises disruption to existing service users, service providers, staff and the local economy as a whole.

- All stakeholders, including staff, service users, family carers and the community as a whole require to be reassured that community based services offer as high a degree of support and protection as the traditional services and that new services do not represent a cut in the overall quality or quantity of service delivery to individuals.

Notwithstanding the difficulties outlined above, both health and social care services in East Ayrshire have worked to begin to shift this balance. Evidence of a shift is currently less obvious in terms of outcomes to individual service users as the priority to date has been to lay the groundwork for the shift to occur.

Indicators have been identified as key areas where the pattern of shift can be evidenced;

- Expenditure between institutional and community based forms of care

- The pattern of care provision as between;
  - ⇒ Numbers of people living in long stay hospital care
  - ⇒ Numbers of people living in nursing homes
  - ⇒ Numbers of people living in residential homes
  - ⇒ Numbers of people living in sheltered or other specialist houses.
  - ⇒ Numbers of people receiving more than 10 hours home care services per week
  - ⇒ Numbers of people receiving housing adaptations and Occupational Therapy equipment
  - ⇒ The numbers of people receiving respite services
  - ⇒ The numbers of people receiving day care services

Information is included on the performance against these indicators, by each of the statutory planning partners, between 1997-2001.

There is clear evidence in some areas, such as financial prioritisation, that this shift is beginning to occur, although much more progress requires to be made.

FINANCIAL SHIFT

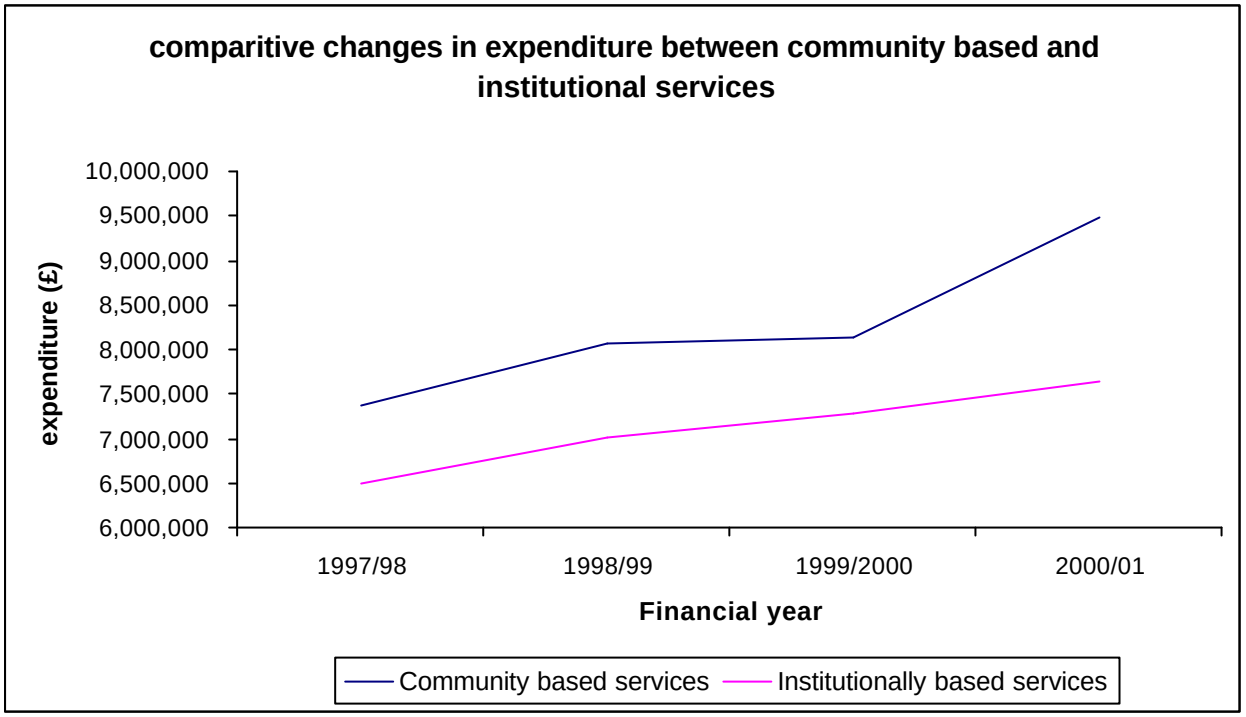
SOCIAL WORK EXPENDITURE (1997-2001)

Within Social Work the shift in expenditure towards community based services can be evidenced through examination of the community care budget between 1997/1998 and 2001/2002.

Gross expenditure in total (all client groups)

Service Type	1997/98	1998/99	1999/2000	2000/01
Community based services				
Community Alarms	415,661	480,797	504,204	584,137
Day Care	1,469,962	1,725,106	1,689,341	1,928,081
Home Care	4,270,325	4,501,677	4,849,035	5,582,383
Info / advice	331,644	382,382	471,115	560,211
Community Meals	454,609	370,738	393,633	432,469
Equipment	327,743	495,659	65,720	195,868
Respite	111,167	100,042	162,298	191,062
Sub Total	**7,381,111**	**8,056,401**	**8,135,346**	**9,474,211**
Institutionally based services				
Nursing Homes	2,071,134	2,050,449	2,129,517	2,390,317
Residential Homes	4,421,745	4,954,577	5,146,290	5,258,647
Sub Total	**6,492,879**	**7,005,026**	**7,275,807**	**7,648,964**
Services that cannot yet be categorised				
Staffing	-	2,178,270	3,022,110	3,354,179
Other CC Services	52,833	82,896	43,656	200,102
Sub Total	**52,833**	**2,261,166**	**3,065,766**	**3,554,281**
Total CC Expenditure	**13,926,823**	**17,322,593**	**18,476,919**	**20,677,456**

Graph Comparative changes in expenditure between Community care and Institutional care



It is accepted that the shift in the balance cannot yet be evidenced within East Ayrshire Council.

HEALTH EXPENDITURE (1997-2001)

One indication of Ayrshire and Arran Health Board' s commitment to shifting the balance of care is the amount of finance transferred to social care through Resource Transfer and also through Joint Finance

Income received from Ayrshire and Arran Health Board to East Ayrshire Council Social Work (£'000s)

	1997/1998	1998/1999	1999/2000	2000/2001
Resource transfer				
Joint Finance				
Bridging Finance				
Other Income from Health Board*				
Total				

*Includes non-recurring income such as winter monies.

Within health spending it is planned that an ongoing financial shift from hospital based services towards community based services will take place over the lifetime of this plan. The percentage of expenditure on community based services will therefore be as follows.

Percentage of total budget spent on community based services (£'000)

2000/01	2001/02	2002/03	2003/04
36.1%	37.9%	38.7%	39.5%

PATTERN OF CARE PROVISION (1997-2001)

INSTITUTIONAL CARE

Another indicator of the shift in the balance of care has been the reduction in the use of institutionally based care provision. These are defined as;

(a) Continuing care beds in hospital
(b) Nursing Home Care
(c) Residential care

Numbers of People living in institutional forms of care within East Ayrshire (Continuing care are for the whole of the Ayrshire and Arran Health Board area) East Ayrshire Council funded people only in residential and nursing care settings)

Older People including Older People with dementia and mental health difficulties

	April 1998	April 1999	April 2000	April 2001
Continuing care	**603**	**603**	**603**	**†**
Nursing homes	**206**	**204**	**193**	**246**
Residential care	**222**	**240**	**215**	**227**

People with enduring mental health difficulties

	April 1998	April 1999	April /2000	April 2001
Continuing care	**100**	**92**	**75**	**†**
Nursing homes	**0**	**0**	**0**	**0**
Residential care	**0**	**0**	**0**	**2**

People with learning disabilities

	April 1998	April 1999	April 2000	April 2001
Continuing care (East Ayrshire)	**132(49)**	**124(49)**	**113(48)**	**†**
Nursing homes	**10**	**11**	**16**	**24**
Residential care*	**79 (118)**	**79 (116)**	**81 (118)**	**82 (119)**

* Includes 7 individuals residing in Local Authority Older Peoples residential homes (Figures in brackets include people who do not originate from East Ayrshire Council)
† Figures not available

COMMUNITY CARE

A further indicator is the increase in the number of people receiving supports in a community setting, such as the number of people receiving support through the provision of day care. In addition, the provision of supported and other specialist housing allows service users to live in their own home but have the support needed to enable them to do so safely and in comfort.

Numbers of People living in institutional forms of care within East Ayrshire (Continuing care are for the whole of the Ayrshire and Arran Health Board area) East Ayrshire Council funded people only in residential and nursing care settings)

Older People including Older People with dementia and mental health difficulties

	April 1998	April 1999	April 2000	April 2001
Day supports	**280**	**300**	**345**	**387**

People with enduring mental health difficulties

	April 1998	April 1999	April /2000	April 2001
Supported Living	**10**	**10**	**14**	**19**
Day supports	**36**	**164**	**192**	**202**

People with learning disabilities

	April 1998	April 1999	April 2000	April 2001
Supported Living	**4**	**5**	**6**	**6**
Day supports	**288**	**254**	**243**	**244**

A key indicator for the shifting of the balance of care to community based services would be the level of Home Care provided to people.

Over time there has been an increase in the numbers of people receiving over 10 hours service as follows:

	April 97	April 98	April 99	April 2000	April 2001
Numbers receiving more than 10 hours per week	133	303	301	332	
Percentage of total case load	8.3	20.1	21.4	20.0	
Total Service Users	**1600**	**1505**	**1407**	**1658**	

Figures taken in April of each year apart from 2000 which was taken in September due to the introduction of a Management information tool in April

There has been some variation between single years partly due to improved data collection systems. Nevertheless it can be seen that, over the period of the 1998-2001 plan, that there has been a significant shift within Home Care to the provision of a higher level of care and more personal care to individuals.

The numbers of people receiving a respite service is also an indicator of Community based services being available to people as alternatives to long stay institutional care

Number of people receiving a respite service

	1996/7	1997/8	1998/9	1999/2000	2000/2001
a) Older People	215	258	261	255	
b)People with learning Disabilities	87	82	94	103	

East Ayrshire Council has increasingly prioritised the provision of occupational therapy equipment and adaptations to housing to enable disabled people remain independent, living in their own homes for as long as possible. The process of delivering these was also improved following a review in 1998.

The effects of these improvements can be seen in the increasing levels of provision over the years.

	1996/7	1997/8	1998/9	1999/2000	2000/2001
Number of adaptations made to individual property	718	1669	1907	1211	1579
Amount of pieces of equipment made available to people living in the community	593	2768	3411	3057	4056
East Ayrshire Council expenditure on equipment and adaptations ('000)	Figures not available	770	1000	1000	1000

FUTURE

The figures provided above indicate that although overall there has been some moderate progress made in shifting the balance of care there requires to be a significant amount of further work to be done to develop this in terms of improved levels of community care based provision for service users.

The main improvement over the last three years has been in the numbers of people receiving personal care from the home care service, the provision of equipment and housing adaptations and in the development of day services for older people.

Specific areas that require to be prioritised is in addressing the level of hospital based, nursing home and residential provision particularly for older people and people with learning disabilities. This plan will outline the work that will take place over the next three years. Key issues will include;

- The Ayrshire-wide working group on "Working with Older People" met over 2000/2001 and is developing a number of recommendations in relation to further shifting the balance of care from institutional to community based care.

- Similarly, the Ayrshire-wide working group on "The Same as You" (addressing the needs of people with learning disabilities) also met over 2000/2001 and provided a number of recommendations in relation to further shifting the balance of care from institutional to community based care. In addition a corporate group within East Ayrshire Council met to address the council's corporate response. Again the key recommendations of these groups address the shift of the balance of care are addressed in the section on the learning disability.

PLANNED ACTION

- The key recommendations from community care strategies will be published as part of our commitment to public information.

- Partners will prioritise the shifting the balance of care from institutional to community based services during the lifetime of this plan.

COMMUNITY BASED HEALTH AND SOCIAL CARE

INTRODUCTION

Key aims identified with the previous Community Care Plan highlighted the need to

- Develop services, which are co-ordinated between general practitioners, community health, hospital-based, housing and social care staff.

- Develop local planning with general practitioners, housing, community health staff, social care staff and hospital based staff which will reflect the needs of local communities.

Since the publication of the last plan, a number of documents have been published which reinforces this approach including:

- Designed to Care
- Modernising Community Care: An Action Plan
- The Way Forward for Care
- Towards a Healthier Scotland
- Report by the Joint Future Group.
- Our National Health – A plan for Action, a plan for change.

Partners to the plan have developed a range of joint strategies that underpin service developments in community care.

In particular, in April 2000, East Ayrshire Council, Ayrshire and Arran Primary Health Care NHS Trust and the two Local Health Care Co-operatives developed the strategy -"Joint Health And Social Care For People Requiring Community Based Services In East Ayrshire" The aim of this strategy was to;

"Improve the delivery of cost effective services to children, young people, adults and older people who require social and health care services based on the assessed needs of individuals living in East Ayrshire within the framework of Best Value and Clinical Governance"

Areas identified for joint action included;

- Developing a joint assessment approach and shared assessment procedures.

- Developing a Joint Training and Development Strategy.

- Maximising the use of premises to meet the needs of service users including developing the concept of co-location between Social Work , health and other agencies.
- Developing information sharing between agencies through rolling out the “Personal Record of Care” piloted in 1999/2000 as well as implementation of shared information systems.

- Improving the operational interface between health and social care services.

ANTI-POVERTY

The main focus of Anti-Poverty work, in the context of Community Care, lies in seeking to ensure that vulnerable individuals and carers have their incomes from benefit maximised.

AIMS

- To maximise the benefit entitlement of service users through extending and developing activities and procedures undertaken and followed by Social Work staff.

- To maximise take up of benefit among carers by improving and developing existing procedures.

WHERE WE ARE NOW

- Two Community Care teams, who were initially involved in a pilot exercise looking at potential for income maximisation, continue to undertake this work, recording claims made and subsequently linking with the Income Maximisation Co-ordinator to record outcomes as appropriate. A Welfare Rights Officer provides relevant technical back-up support for this activity.

- The Acute Team at Crosshouse Hospital continues to maximise benefit entitlement of patients and their carers where possible and staff receive support from Welfare Rights Officers in this context.

- The Community Health Team has now been linked with a Welfare Rights Officer who has a functional responsibility for supporting income maximisation work within the mental health setting. The team has also been provided with basic material for recording this work.

- Home Care staff continue to undertake income maximisation work on behalf of service users, although the volume of this work has decreased over the last eighteen months.

WHERE DO WE NEED TO BE

- We require to improve on ability to share with and gather from partner organisations, particularly Health staff, specific information which will assist in the process of maximising the benefit entitlement of service users and carers.

- We need to ensure that staff regularly appropriate training/briefings on a regular basis, to ensure that their ability and confidence to undertake basic income maximisation work is developed.

- We require to move to a position where all staff log and record the outcomes of the income maximisation work which they undertake.

GAPS IN SERVICE

- Lack of effective joint working with Health staff in the context of income maximisation.

- All staff not adequately trained in or comfortable with basic income maximisation activities.

- Only the income maximisation work currently undertaken by the two community care teams mentioned above is recorded.

- Briefing sessions and updates on relevant benefit issues or changes not provided on a regular basis.

HOW WILL WE GET THERE

- Training needs of staff in the context of income maximisation will be identified and met.

- Resource material designed to help staff to easily identify underlying entitlement to specific benefits will be accessed.

- Standardised recording material will be provided which will assist staff to progress and record their income maximisation work.

- Joint working, in particular with Health staff, regarding income maximisation, will be progressed by further development of existing protocols and training.

ASSESSMENT AND CARE MANAGEMENT

Assessment and Care Management is the process of defining an individuals needs and relating the provision of services to these needs.

AIMS

- To improve the assessment of the individual needs of service users and carers, undertaken by Social Work, Health and Housing by working together locally to achieve better and quicker decision-making.

- To secure better and faster results for individuals by focusing on them and their needs and on more effective and efficient joint working based on partnership.

WHERE ARE WE NOW

- Carers' assessment procedures are now fully operational with the production of a public information leaflet and self-assessment form.

- The Personal Record of Care is a communication tool for people with complex, multi-agency packages of care. This allows health and social care workers supporting a service user (as well as family carers) to keep each other informed about the services that are being provided and issues that have occurred in relation to the service users care. This was initially piloted within the North of the authority but is has now been extended across the authority area with training on the use of this joint documentation having been developed by the Local Authority and the Primary Care NHS Trust.

- There has been an extensive review of current Social Work assessment and care management procedures with the following aims
    - To ensure that the service user and carer is at the centre of and involved in all arrangements,
    - To ensure that the approach is needs led with minimum intervention,
    - To ensure that responsibility is devolved as close to service users and carers as possible.

- Service standards and performance measures had been reviewed in order to ensure continuous and sustained improvement in all areas of service delivery.

- Discharge protocols have been developed and agreed between the Local Authority, Ayrshire and Arran Health Board, Acute and Primary Care NHS Trusts to ensure more robust arrangements and co-ordination of care packages. Joint training has been undertaken involving staff from the Acute and Primary care NHS Trusts and the Local Authority.

- Budgets have been devolved to first line managers to allow for quicker access to resources.

- Additional staffing resources have been identified for equipment and adaptation service and the enquiry support service was launched this year.

- A multi disciplinary working group, including representatives from the three authorities and Ayrshire and Arran Primary Health Care NHS Trust, was formed to address the issues raised in the report of the Joint Future Group. This group developed a holistic assessment tool that can be used in the development of services across social and health settings. Following consultation with the Chief Nursing Officers group, this tool was piloted in Newmilms/Darvel and Ballochmyle GP practises.

WHERE DO WE NEED TO BE

- We require to continue to shift the balance from institutional care to care in the community by ensuring that robust assessment and care management procedures are in place focusing on the individual and on early intervention.

- Need to refocus care management and address issues raised by the Scottish Executive in terms of professionals from all being equipped to carry out "Intensive Care Management."

- We require an agreed single shared assessment procedure between all the main health and social care agencies particularly Primary Care, Social Work and Housing services.

- We require a single shared assessment (including risk assessment) tool as a passport to all community care services.

- We require to expand delegated decision making budget decentralisation in all agencies.

HOW WILL WE GET THERE

- Intensive Care Management will be introduced across Community Care.

- An agreed holistic assessment tool will be implemented across the authority after the results of the pilot schemes have been evaluated and discussion has taken place nationally.

- A common risk assessment tool will be developed and implemented by all agencies.

- Self-assessment forms for single service provision, initially in the equipment and adaptation service will be developed.

- An inter-departmental case recording policy will be introduced to streamline information-gathering processes.

- Joint protocols will be introduced to secure local agreement on the systems for and ownership of assessments. The most appropriate member of staff, regardless of the agency they are employed by will carry out community care assessments.

- Joint training for health and social work staff in assessment practice will be developed.

- Further devolution of authority and budget will take place within Social Work to enable Team Leaders to purchase services based on local need.

- The Personal Record of Care will be used in all situations where two or more services are being provided to an individual within their own home. A core information form to be developed jointly for use by both health and social work staff.

- Carers' assessments will be promoted.

- The Joint Training and Development Strategy will be reassessed to meet identified needs of staff, in particular the need to train staff across agencies to enable them to carry out Intensive Care management.

INTEGRATED WORKING

AIMS

- To develop services and local planning which are co-ordinated between GP's, Community Health staff, hospital based staff, housing and social care staff which will reflect the needs of local communities.

- To maintain individuals in the community for as long as it is safe to do so, to facilitate early discharge from hospital and to prevent unnecessary admissions to hospitals and residential and / or nursing homes.

WHERE ARE WE NOW

- The Newmilns / Darvel Integrated Care Pilot was a project initiated to address best practice in terms of joint working arrangements between health and social care. This developed as a single integrated health and social work team based within the GP practise in the area. Evaluation of the pilot was completed in January 2000. The outcome supported the hypothesis that seamless health and social care can be more responsive and tailored to individuals needs if health and social work personnel work together as an integrated team with the autonomy and budget to make and implement decisions locally. As a result of this evaluation, East Ayrshire Council, Ayrshire and Arran Health Board, East Ayrshire Local Health Care Co-operative and the Primary Care NHS Trust worked together to extend identified Best Practise across the authority area. For instance;

    - The use of the personal record of care was extended across the authority area.

- Work commenced in 2000 to align social work teams with GP practices across East Ayrshire. Lead workers were identified to link with GP Practices to enable improved communication and shorten response times to requests for service.

- A rapid response service based in Crosshouse Hospital and serving the population of both East and North Ayrshire Councils became operational on 9th October 2000. The aim of this service is to facilitate early discharge and prevent inappropriate hospital admissions. The rapid response team is multi disciplinary team across both health and social care.

- Ayrshire and Arran Primary Health Care NHS Trust has also been addressing the issue of the co-location of community nursing teams in GP practices to assist with integrated working.

- Finance has been secured to modernise buildings in Drongan and Dalmellington to enable co-location of local authority and primary health staff, police and the ambulance service. The Dalmellington office opened in June 2001 and the Drongan office is due to open between December 2001 and March 2002.

WHERE DO WE NEED TO BE

- We require to further streamline services to improve communication and sharing of information between agencies and improve the overall decision making process.

- There requires to be a common shared agenda between care agencies which supports health and social care services to work side by side in the community and for individual service users.

GAPS IN SERVICE

- Lack of understanding of roles and responsibilities and structures between health and social work staff.

- Need for a single shared assessment process and tools to avoid duplication and speed up assessment and delivery of service.

- Need to further devolve budgets to enable speedier decision processes and enable decisions to be taken as close to the service users as possible.

- Require to improve information sharing between health and social work staff.

- Require to determine current staff's strengths and needs across agencies when determining roles and responsibilities with regard to intensive care management.

- Development of minimum standards and effective forms of performance measurement to ensure that standards are met.

HOW WILL WE GET THERE

- Staff in all agencies will be resourced to carry out integrated working through, for example extending joint training and job shadowing.

- Joint training will be specifically organised for health and social work staff in assessment practice and intensive care management in particular.

- Joint protocols will be developed between relevant agencies to address roles and responsibilities for care management.

- The local authority and Trusts will actively progress co-location of staff as part of the capital programme.

- An improved process of performance management will be introduced to reflect new priorities, including formalised benchmarking with other local authorities.

DIRECT SERVICE PROVISION

The issue of the development of primary health care and housing services have been addressed elsewhere in this plan.

Within Social Work, in addition to assessment and care management, there are two distinct areas where generic direct services are provided to service users and their carers. These are the provision of equipment and adaptations to promote independent living and home care services.

EQUIPMENT AND ADAPATIONS

AIM

To provide a responsive service which will promote / facilitate independence for service users or which will assist carers in their caring role.

WHERE ARE WE NOW

East Ayrshire Council undertook an extensive review of its equipment and adaptation service in 1998. This best value approach of reviewing the service included areas of quality, effectiveness and consumer satisfaction. The service was adequately resourced with significant budgets which were devolved to Team Leaders in line with key recommendations and modernising community care. These arrangements resulted in devolved decision making and more responsive approaches to delivering the service. The Local Authority and Trusts worked in partnership to develop joint funding initiatives. This was used to respond to the following other noted areas:

- Provision of adaptations to facilitate hospital discharge.
- To provision of specialist equipment or adaptations to prevent admission into care.

In addition, a range of service standards was developed to address the particular issues in relation to the working arrangements between agencies. These included:

- 24 hour response to referrals for terminally ill people.
- 24 hour response for provision of minor adaptations to facilitate hospital discharge.
- The prioritisation of referrals from people returning to the community after a hospital admission. The response time set at one week.
- Appointment of dedicated technician to key areas of responsibility to respond to hospital discharge referrals.
- Inter agency-funding arrangements to ensure resources are placed at point of need.

Other than resources one of the key areas in relation to this service is the professional development of Occupational Therapists. Occupational Therapists are deployed throughout the Trusts and Local Authorities and significant investment has been undertaken in increasing the number of qualified Occupational Therapists to deliver key areas of service. Joint training initiatives have been developed between staff to ensure that there is no duplication and that services are streamlined.

WHERE DO WE NEED TO BE

The identified gaps in service within the Occupational Therapy service are common with those of assessment and care management as outlined previously.

HOW WILL WE GET THERE

In addition to the actions identified within the Assessment and Care management section;

- To develop specialist links with specific areas of need where these have been identified

- To further develop formal links and shared practise arrangements between Occupational Therapist working within Social Work and the Ayrshire and Arran Acute Health Care NHS Trust.

- continue substantial investment in equipment and adaptations to assist people to live in their own home;

HOME CARE

WHERE ARE WE NOW

In the past three years East Ayrshire Council's Home Care service has been adapting in a number of ways to meet the changing needs of service users and carers. Examples include;

- To meet the needs of those in greatest need and shift the balance of care, the service has concentrated its effort on supporting those with personal care needs. For example, the percentage of service users who receive over 10 hours of home care a week has more than doubled from 8% in 1997 to over 19% in 2000. However, it is accepted that this emphasis has resulted in a reduction of those receiving under 4 hours of care from over 21% to 7% over the same period. This service was usually basic housework and shopping support to those more able (seen as preventative support).

- The Home Care service underwent a full Service Review in 1999 adopting the principles of Best Value. A report of the review gained council approval in February 2000 and the outlined options agreed.

- The rapid response team was initiated to meet the needs of service users who could leave hospital early with appropriate supports and also to prevent inappropriate admission to hospital.

- The Newmilns/ Darvel Integrated project outlined previously also enabled social and health care staff to access home care support rapidly as an alternative to hospital admission.

- £100,000 was provided by Ayrshire and Arran Health Board to provide intensive support to people with dementia in their homes, including home care and day care services.

- The service is committed to promoting a partnership approach with the independent sector. Home Care services are provided by a range of providers with service users' preferences also addressed.

WHERE DO WE NEED TO BE

Although, the home care service has increased its flexibility and changed in focus to meet the needs in the last three years, it is recognised that there will require to be a radical refocus of the service to meet the demands of the early 21st Century. Issues to address include;

- The need to address the needs of a population that is growing older with a lower number of younger people living in East Ayrshire in the next ten years.

- The need to continue and expand the shift in the balance of care from institutional care to providing supports to people in their home and community.

- The need to increasingly address the needs of care groups other than Older people who will wish to live in their own homes, including adults with learning disabilities and people with mental health problems. It is also recognised that parents of children with special needs require support in their home. This requires not only to refocus current service provision but also a values and skills shift among home care workers to provide an enabling role.

- The need to readdress the balance of care in order to continue to provide personal care to those require a high level of support but also to provide a complete continuum of care from the low level of support to those that need help to retain their independence at home. This includes helping with housework and or shopping or help in small tasks such as household maintenance. There is also an increased need to support carers to care for relatives in their home through the provision of home based respite when required.

- The need to ensure an appropriate mix of social care providers who are working to the same values and principles and are therefore able to provide a seamless service provision in the service users home. This would include close operational planning between staff from Social Work , Ayrshire and Arran Primary Health Care NHS Trust, Housing providers and the voluntary and private sector providers.

- The service will require to be ready for the introduction of the Scottish Commission for the Regulation of Care including the registration and inspection of all Home care services beginning in April 2002 and the introduction of national home care standards.

HOW WILL WE GET THERE

The Home Care service will be redesigned in order to provide cost effective and flexible support to service users at assessed critical periods over 7 days and 24 hours a day. This will involve;

- Changes to current home care workers contracts to reflect responsibilities and hours of working.

- Integration of staff from home care, community alarms and sheltered housing to provide a seamless home care service.

- Operating a formal partnership approach with providers from the independent sector.

- Best Practice from the Newmilns/Darvel Project will be rolled out throughout the authority including the development of home care teams aligned to GP practises where possible.

- An improved process of performance management will be introduced to reflect new priorities, including formalised benchmarking with other local authorities.

- Home carers will be trained according to their roles and responsibilities and the service will be geared to increasingly meet the needs of adults with learning disabilities etc, living in the community or discharged from hospital.

- A formal system of contract development and management will be developed with the independent sector emphasising common values and agreement to work to agree standards of care. East Ayrshire will adopt local common standards with partners prior to the implementation of National standards.

- A full needs and options appraisal will be carried out with partners including health and housing to address the most appropriate means to provide an appropriate housework, shopping and household maintenance service within available resources.

PRIORITY HEALTH ISSUES

INTRODUCTION

Within Ayrshire and Arran Health Board's Health Improvement Programme for 2000-2005, the key strategic aims were outlined as

- **Improving Health** – including health promotion, promotion of well being and health education.
- **Tacking Inequalities**
- **Reshaping Hospital services**
- **Developing Primary Care**
- **Developing Community Care**

The following clinical areas have been recognised nationally and locally as priorities for attention;

- **Mental Health** (this issue will be addressed separately within this plan)
- **Coronary Heart Disease and Strokes**
- **Cancer** – including further development of the palliative care service

Both East Ayrshire and Carrick and Doon Valley Local Health Care Co-operatives also identified **Respiratory Disease services** as local priorities.

Ayrshire and Arran Health Board convened a series Stakeholder conference in November 2000. The feedback from stakeholders was used in the planning processes.

The Arbuthnott report published in 2000 indicated both a need to shift resource allocation within health services in Ayrshire and Arran to areas where due to poverty and other factors there was identified higher need. In addition there was identified significant under-funding of hospital, community and primary care health services.

The publication of "Our National Health - A plan for action, a plan for change" has outlined a number of areas requiring wide ranging action in the development of services within health provision within East Ayrshire. Much of this will require an effective multi-agency approach with special emphasis of health promotion.

It is recognised that the development of action to address these aims will, in many cases, require an integrated approach from a number of agencies in addition to the health services. In particular the improvement of health will require to be addressed by all workers working in community care. This plan will address the priority health issues in relation to service users and carers of community care services.

HEALTH PROMOTION

The work of health promotion has now become a cornerstone of National policy and the core aims of the document “Our National Health - A plan for action, a plan for change” include to

- Build a national effort to improve public health and
- Reduce inequalities in health.

The role of social inequality in the relative health of the population is also formally recognised by Government and is seen as a priority for action among partner agencies.

The World Health Organisation has defined health promotion as “the process of enabling people to increase control over, and to improve their health. The overall goal of health promotion is therefore to enhance positive health- encapsulating physical, mental and social health – while preventing ill health.

The Health Promotion service located within Ayrshire and Arran Health Board has the lead responsibility for improving the public’s health within East Ayrshire. The Health Promotion service is closely involved in both strategic support and operational development across care sectors and across the health continuum from life circumstances to treatment and care. The aim of the service is to “improve and sustain health by working with individuals, communities and organisations to effect change on the determinants of health in order to ensure the equitable realisation of health potential.”

As well as its involvement in policy development, the service is also involved in staff training and development, project planning management, the provision of advice, information and resources. This encompasses supporting appropriate community based approaches to health promotion. The work of the service is targeted at three levels – Life circumstances, life styles and health topics.

The work of the service is prioritised in line with local and national health priorities and includes the promotion of healthy living, reducing ill health and promoting a multi-agency approach to public health.

RECENT DEVELOPMENTS

- The realignment of the health service in 1998 including the formation of the Local Health Care Co-operatives. This supported more localised planning to address health needs at a local level

- The development of the Social Inclusion Partnership in the Coalfield area and the transfer of best practice element throughout East Ayrshire provides a multi agency focus to address health issues at a local level linking poor health to other forms of deprivation.

- A number of pan –Ayrshire strategies have been developed in relation to health promotion, including the overall Health Promotion Strategy, the Mental Health Promotion Strategy, The Strategy To Reduce Smoking, Accident Prevention strategy,

Sex Education strategy Information for Health strategy, the Cancer prevention strategy, the Strategy on HIV and Blood Borne Infections and the Palliative care strategy.

- The Policy Advisory Committee on AIDS is a multi agency partnership comprising Health, Local Authority and voluntary sector representation was formed. This advises the Health Board in relation to formulation of policy in relation to HIV/AIDS and the expenditure of ring fenced HIV/AIDS monies allocated to the Board by the Scottish Executive.

- A training programme has been devised for professionals on HIV/AIDS.

- Hepatitis C has been identified as an issue likely to require both health and social care intervention over the next 20 years. Injecting drug users in particular have shown high levels of Hepatitis C infection. A joint health and social care strategy requires to be developed to address preventative action, assess future needs and plan future intervention. This has been included in the HIV/Blood Borne Virus strategy.

- The community hospital in Cumnock was opened in August 2000. The new community hospital provides 25 places for frail older people, 25 places for older people with mental impairments and 24 medium Acute GP led beds There is also a day hospital service 5 days a week for 12 people each day and out patient support.

- A MacMillan GP facilitator has been funded to work in 2001 within the Primary Care Trust as an educational facilitator.

- A salaried general dental practitioner is based in Kilmarnock to reflect local need for access to NHS dentistry for fee paying adult patients.

- Routine screening of people with enduring mental illness or learning disabilities has been introduced to ensure a more holistic approach to their health.

- A proposal to enable the early involvement of community pharmacy in discharge planning and appropriately target the pharmaceutical needs of older people was implemented in early 2001.

- A survey into dietary needs of older people in institutional care is now concluded and action implemented.

- Funding was allocated to East Ayrshire to implement a proposal for a “”Healthy Living Initiative”, which will target particular areas in East Ayrshire to stimulate community interest and provide a range of health related services. These include cancer awareness, income maximisation, healthy lifestyle awareness and community consultation.

- Ayrshire and Arran Primary Health Care NHS Trust has been awarded £10,000 to develop healthy food initiatives. Community Food workers have been employed to promote healthy eating.

- Ayrshire and Arran Primary Health Care NHS Trust have appointed a smoking cessation co-ordinator for a period of two years.

- A scheme was introduced to provide 24 hour access to palliative care medicines.

- East Ayrshire Carrick and Doon Valley Local Health Care Co-operatives both established nurse led secondary prevention clinics for Coronary Heart and respiratory diseases. Funding to continue these is being sought.

- Carrick and Doon Valley Local Health Care Co-operative has also established two posts in the Doon Valley for oral health educators to promote good dental care. The project is funded over two years.

- East Ayrshire Council agreed in November 2000 to a request from the Primary Care NHS Trust that Needle Exchange provision be facilitated within the Bridge projects in Kilmarnock and Cumnock which are jointly funded by East Ayrshire Council and the Health Service.

- Joint working across agencies to provide up to date premises for the delivery of health and social care has resulted in two major schemes in Dalmellington and Drongan being taken forward.

- Ayrshire and Arran Health Board and East Ayrshire Council joint funded the establishment of 6 houses with support for people with complex care needs, including the provision of nursing support as required.

- Roll out of integrated care begun during 2000 and will continue over 2001.

WHERE DO WE NEED TO GO

- Both the health and social care sectors will require to address the structural and operational changes required to implement “Our National Health - A plan for action, a plan for change”.

- There requires to be improved information provision to people.
- The development of more flexible and innovative service delivery outwith traditional settings to better meet patients needs.

- Health promotion, education and other preventative actions require to be targeted at those people currently socially excluded through poverty, education or other factors.

- Further work requires to be carried out to ensure the dental, optical, podiatry and other associated health needs of people with community care needs are addressed.

- The diet of people currently living within residential or other institutional forms of living requires to be addressed to ensure that there is enough nutrition but that food is also palatable.

- Agencies should work together to provide suitable health education (including sexual health) for staff and people using home care, day care and other social and health care services.

- There requires to be a system to "fast track" people with palliative care needs for services to enable them to remain in their own homes where that is their wish. This includes addressing people's needs for benefits, housing, and social care provision, building on work already undertaken in the area of the provision of equipment and minor adaptations.

HOW WILL WE GET THERE

- Further priority will be given to ensuring equality of access of people with learning disabilities and/or enduring mental health problems to primary, community and specialist services.

- The promotion of health and well being of people receiving community care services will be addressed with a particular focus on:-

  - diet and lifestyle
  - exercise
  - eyesight
  - hearing
  - dental health
  - sexual health.

- A short-term multi-agency working group will be developed to produce an Ayrshire wide directory of information for people with cancer.

- Public awareness of services provided by community pharmacists will be increased.

- Simple nail cutting services will be made available to those patients assessed as requiring such as service.

- All health and social care staff to promote improved lifestyle behaviour with service users.

- The range of community/hospital services and facilities at East Ayrshire Community hospital will be further developed.

- The provision of services including needle exchanges, substitute prescribing, ante natal HIV screening, HIV testing and information and advice to travellers will be further developed in accordance with the HIV/Blood Borne Virus strategy.

- Ayrshire and Arran Health Board will continue to fund the Gay Men's Outreach Worker to provide information and advice on sexual health and well being to gay and bisexual men in Ayrshire.

- Both East Ayrshire and Carrick and Doon Valley Local Health Care Co-operatives will continue to seek opportunities to deliver services closer to the patients own home, including reviewing Diabetes care.

- Partners will jointly develop protocols to ensure that people dying in their own homes will receive the services they require quickly. Other key agencies will be asked to participate in this process.

- For every service development in primary health care, a workforce needs assessment will be undertaken to ensure the availability of staff who have the necessary knowledge, skills and experience to provide that service"

According to "Our National Health - A plan for action, a plan for change", the Scottish Executive is to publish details of a major programme of change which will include:

- changes in governance and accountability through the structure and remit of the new unified health boards
- increasing public and patient involvement in the NHS
- service change and modernisation

In the meantime, the development of primary care services will continue in line with the Local Health Plan and within the context of closer and more integrated partnership with local authorities.

HOUSING, HOMELESSNESS AND COMMUNITY CARE

INTRODUCTION

Enabling people to live in their own homes or in a 'homely setting' is a main objective of community care. Most people with community care needs require mainstream housing with appropriate levels of support. Some may need a specific housing design or adaptations. In addition, many homeless people require only a suitable place to live. Others have more complex needs.

The main planning partners have produced a Joint Accommodation Strategy that complements the Joint Community Care Plan. This chapter contains a summary of the Strategy.

The Strategy aims to:

- Employ a needs based approach to community care housing planning.
- Inform capital and revenue investment by local authority departments, Scottish Homes and other agencies.
- To agree common definitions and approaches to measuring housing need.
- To establish shortfalls and agree principles to meet assessed housing and related support needs of individuals, as identified in care plans.

RECENT DEVELOPMENTS

ALL CARE GROUPS

- Established joint working arrangements between housing, social work and health agencies to help individuals being discharged from hospital to access housing.
- The council has named staff to liaise with enquiries on the needs of council tenants and housing list applicants with community care needs.
- Adopted a new allocations policy for council housing that provides housing applicants with a needs based assessment of their housing requirements taking into account any specific community care needs that have been identified.
- Introduced a joint system, across all housing providers, to assess housing list medical priority.

- Developed joint training on dementia issues, for staff working in housing, health and social work agencies.

- Established a range of support and advice services, including short stay supported accommodation, for homeless people. This was achieved in partnership with North and South Ayrshire Councils through the Rough Sleepers Initiative.

OLDER PEOPLE

- Developed 29 sheltered housing units in Stewarton.

- Built 27 amenity units in total in Kilmaurs, Galston and Kilmarnock.

- Established a garden maintenance service for older Council tenants who need assistance to maintain their house.

PEOPLE WITH MENTAL HEALTH DIFFICULTIES

- Resettled 15 people with mental health problems from Ailsa Hospital to range of community settings.

- Developed an advice and information service for patients with mental health problems in Crosshouse Hospital. Housing Officers visit the hospital to discuss housing options and tenancy matters with patients.

PEOPLE WITH LEARNING DISABILITIES

- Resettled 4 individuals with a learning disability, from hospital and residential care, to a range of community settings

- Developed housing with support for 4 people with a learning disability in Kilmaurs.

PEOPLE WITH PHYSICAL DISABILITIES

- Built 2 wheelchair standard houses in Kilmarnock.

- Established 6 houses with support for people with complex physical disabilities in Kilmaurs.

- Invested substantially in equipment and adaptations to assist people to live in their own home.

WHERE DO WE NEED TO GO

In preparing the Accommodation Strategy, analyses of need estimates have been produced from a range of sources. These include the Office for National Statistics, East Ayrshire Council, Scottish Homes and Ayrshire and Arran Health Board. This has included information drawn from the Housing Plan, Local Housing Systems Analysis, Housing

Needs Survey 1998, Strategic Agreement, East Ayrshire Council housing waiting list review and Scottish Executive yardsticks. The most pressing needs include.

- Suitable housing to which support can be provided for the increasing numbers of frail older people.
- Shortfalls in very sheltered, sheltered and amenity housing.
- Housing with support for people with mental health problems or a learning disability who are returning to the community from hospital or residential care or who are presently inappropriately housed in the community.
- Shortfalls in housing suitable for people with a physical disability.
- A high demand for adaptations to existing housing to assist people to live independently in their own home.
- A range of temporary accommodation to meet the needs of homeless people with community care needs.

WHAT ARE THE GAPS IN SERVICES?

- A range of suitable housing for frail older people to which support can be provided.
- Shortfalls in numbers of very sheltered, sheltered and amenity housing.
- A range of housing with support for people with mental health problems or a learning disability who are returning to the community from hospital or residential care or who are presently inappropriately housed in the community.
- Shortfalls in housing suitable for people with a physical disability including wheelchair standard housing.
- Adaptations to existing housing, to assist all individuals who require them, and wish to live independently in their own home.
- A range of accommodation to meet the needs of homeless people with community care needs.
- Effective ways of consultation with people with community care housing needs on how current services can be improved.
- Awareness training for housing staff on community care services.
- Information and advice for service users on the range of services available.

- Improve information that is held on adapted council houses to ensure that appropriate waiting list applicants are matched with properties that have been adapted, to their needs, where possible.

HOW WILL WE GET THERE?

ALL CARE GROUPS

- Develop an Information and Advice Strategy including the provision of a Council tenant's handbook.

- Develop joint training programmes, on a locality basis, for staff working in housing, health and social work agencies.

- Improve joint working between housing providers to better meet the needs of individuals with community care housing needs.

- Progress the Rough Sleepers Initiative.

OLDER PEOPLE

- 10 very sheltered housing units will be developed in Kilmarnock.

- 12 amenity houses will be developed in Newmilns.

- A Care & Repair project will be set up to assist older people and people with disabilities to live independently in their own home.

- The Council will review sheltered housing applications and allocations to better meet the needs of older people. This will include joint assessment by social work and housing services of the need for sheltered housing to ensure that those in greatest need gain access.

PEOPLE WITH LEARNING DISABILITIES

- Housing with support will be developed for 4 people with a learning disability in Kilmarnock.

- 2 small-scale accommodation with support projects will be established for people with a learning disability.

PEOPLE WITH PHYSICAL DISABILITIES

- Housing partners will continue to invest substantially in equipment and adaptations to assist people to live in their own home.

- A register of adapted council house properties will be developed so that when an adapted property becomes available, applicants with particular needs can be better matched to a property let to them.

CARERS

INTRODUCTION

It is recognised that the estimated 15,500 informal carers in East Ayrshire, mainly members of the person's family, play a key role in supporting people in the community. For instance, it is further estimated that there are more than 3,100 carers in East Ayrshire providing in excess of 20 hours a week in personal and social care. This compares to 58 people who receive over 20 hours home care service commissioned or provided by East Ayrshire Council.

Many carers have their own distinct needs and a key aim of this plan is to provide adequate support for them. Within East Ayrshire, carers can expect to have their needs assessed and to be offered information, advice, practical assistance and support based on their assessed needs.

The development of the Ayrshire & Arran Carers Action Plan, the East Ayrshire Carers Strategy, and the East Ayrshire Respite Care Strategy in 1999 foreshadowed the production of the National Carers Strategy (1999) and the subsequent "Strategy for carers in Scotland" (2000). This Plan takes account of these and in particular addresses the three strategic elements of the National Strategy:

- Information
- Support
- Care for Carers

WHERE ARE WE NOW?

Services to carers within the East Ayrshire Council area have been prioritised over the last 5 years. Significant service developments have taken place.

- Carers conferences were held in East Ayrshire in Nov 1999 and March 2001. These enabled service providers to gather the views of carers, which were then used to inform the development of this plan.

- The Carers Monitoring Group has been established to monitor the implementation of the East Ayrshire Carers strategy.

- Arrangements for carers' assessments have been put in place.

- A range of training initiatives has taken place with staff from the council and the voluntary sector.

- Public information has been developed including the insertion of information into the wage slips of staff.

- A range of supports offered by the Carers Centre has been enhanced.

WHERE DO WE NEED TO BE?

- A more consistent multi-agency approach to identifying ‘hidden carers’ requires to be developed.

- Information on available services and promote services that are available to carers requires to be further consolidate.

- There is a need for a greater awareness of carers needs (including the needs of carers of different care groups) amongst Social Work and Health, including an awareness of the role of Carers Assessments.

- There is a need to improve and streamline access arrangements to services in particular respite care.

- Flexible services require to be developed that address the fact that the support needs of carers of individuals with different needs can vary considerably. For example the needs of a carer of an individual with mental health difficulties are significantly different to those of a carer of an older person.

- Existing initiatives require to be clear about financial support to enable them to plan services for the longer term.

- Support to carers in the rural areas of the authority requires to be further developed.

HOW ARE WE GOING TO GET THERE?

- Improved access to respite will be developed including a formal investigation of the need for the provision of breaks directly provided to carers.

- Services to carers in the rural south of the authority will be enhanced by the development of an additional Carers Centre base in Cumnock.

- Longer term funding will be sought where appropriate, for a range of initiatives (e.g. the Young Carers Group), which are currently supported through short term funding arrangements.

- Further training will be provided to improve professional awareness of the needs of carers.

- Local authority and health services will work together to identify hidden carers.

- An information pack for carers and professionals detailing services and access arrangements will be developed and disseminated.

- Relationships with specialist carers groups will be improved in conjunction with the Carers Strategy Monitoring Group.

- Work will be undertaken to identify the needs of carers who have specific responsibilities, e.g. the particular issues for the carers of people with mental health difficulties.

OLDER PEOPLE

INTRODUCTION

Since the last Community Care Plan and Strategy for Older People which covered the period 1998 – 2001 there have been increased demands placed upon services for older people both in health and social care.

The impact of the increase in the number of older people and the associated needs of these individuals has been recognised nationally. During the life of the last community care plan significant difficulties emerged over winter periods with the number of older people who were unable to be discharged from hospital due to difficulties in funding and the availability of appropriate resources. In 1999 representatives from the 3 Ayrshire Authorities, Ayrshire & Arran Health Board, Ayrshire & Arran Acute Hospital NHS Trust and Ayrshire & Arran Primary Care NHS Trust worked together on a document called Working Together to Provide Services for Older People in Ayrshire & Arran. This background document detailed the issues surrounding the provision of services for older people across Ayrshire & Arran and recognised that the difficulties being encountered were a shared responsibility. An Ayrshire wide strategy for older people across Ayrshire & Arran, is currently being developed, which will provide a framework for a fundamental review of services for older people across Ayrshire & Arran. This will focus upon shifting the balance from institutional and hospital based care to care in the community.

At the request of Elderly Forum members, the Council joined the Better Government for Older People network. Meetings are now held with older people and a range of Social Work, Health and other interested agencies quarterly to take forward the principles contained in the Better Government for Older People programme. This will develop an Action Plan that will identify the design of future services for older people.

The older people's section within this plan reflects the views of providers, carers and older people as to what they would wish to see within the new strategy. It aims to address how partners in older people's services can jointly meet the changing needs of individuals to deliver services in a flexible localised way to enable older people to remain in their own homes or, where this is not possible, to receive quality services in a care home.

RECENT DEVELOPMENTS

- A new day care service has been introduced for older people from Muirkirk and New Cumnock with resources transferred from Ayrshire and Arran Health Board. Ayrshire and Arran Primary Health Care NHS Trust and the support of the Social Inclusion Partnership. There are up to 12 day places for frail Older people provided from Monday to Friday each week.

- The community hospital in Cumnock was opened in August 2000 and the hospital at Ballochmyle was closed. The new community hospital provides 25 places for frail older people, 25 places for older people with mental impairments and 24 medium Acute GP led beds There is also a day hospital service 5 days a week for 12 people each day and out patient support.

- 29 sheltered housing units have been developed in Stewarton.

- 27 amenity houses have been built in total at locations in Galston, Kilmaurs and Kilmarnock.

- A rapid response team was introduced in East Ayrshire to assist individuals to avoid inappropriate hospital admissions and also to enable people to leave hospital at the earliest opportunity.

- The introduction of a personal record of care across East Ayrshire commenced following a pilot study in the Newmilns and Darvel Project and all individuals receiving complex home support will have a personal record of care within their own home.

- There are now 10 Nursing Homes which have become joint registered in the Council Boundary.

- East Ayrshire Council Social Work, Ayrshire and Arran Health Board and Alzheimer's Scotland - Action on Dementia have collaborated to develop a integrated day care service in Kilmarnock. This will provide 8 places for frail older people and 8 places for people with Dementia initially over 5 days extending eventually to 7 days a week.

- A wide range of locally based Community Education services are provided to Older People including leisure, education and health based as well as the promotion of Active citizenship among older people.

WHERE TO WE NEED TO GO?

The following service gaps have been identified by users of services and their carers and also by agencies delivering services.

- A multi–agency dependency tool that can assist all agencies to understand the dependency levels of individuals who are in different settings.

- Sufficient and accessible health and social care services that enable frail older people to remain within their own homes including;

    - Comprehensive rehabilitation services which support people following an illness, accident or acquired disability, including assisting them to return to their own home following a discharge from hospital.

    - A Home care service that can be tailored to ensure critical intervals of need are met for individuals over 24 hours, 7 days a week.

- Suitable provision, in Stewarton and Crosshouse and in other rural areas, to meet the social care needs for older people during the day.

- Sufficient integrated respite services across the Council area, which can meet both the health and social needs of older people.

- An advocacy service for people over pensionable age.

- A joint policy on elder abuse.

- A care & repair scheme for older people and people with a physical disability.

HOW WILL WE GET THERE?

- Common assessment and dependency tools will be developed and implemented to enable quicker and easier access to all health and social care services.

- The need for an intermediate care facility or comprehensive rehabilitation unit within the Council area will be explored. This would aim to provide an environment whereby professionals from all agencies could deliver intensive support to older people, within an agreed timescale, to enable them to regain their skills and abilities to enable them to return to their own homes.

- The lunch club service will be reviewed to ensure it provides an equitable service consistent with best value.

- Day care provision will be increased across the Council area.

- 10 very sheltered housing units and 12 amenity houses in Newmilns will be developed in Kilmarnock.

- A Care & Repair project will be set up to assist older people and people with disabilities to live independently in their own home.

- A joint assessment process of sheltered housing allocations will be implemented to better meet the needs of older people.

- Residential and nursing home providers will be supported to deliver a full range of social and nursing care within a single home setting.

- East Ayrshire Council will make recommendations as to the future of its four residential homes for older people.

- An advocacy service for older people will be commissioned.

PEOPLE WITH DEMENTIA AND OLDER PEOPLE WITH MENTAL HEALTH DISABILITIES

INTRODUCTION

In 1999 an Ayrshire Wide Strategy was developed for people with dementia and older people with mental health disabilities in partnership between the three Ayrshire Local Authorities, Ayrshire & Arran Primary NHS Trust, Ayrshire & Arran Acute NHS Trust and Ayrshire & Arran Health Board. This strategy arose from the framework from mental health services where it was identified that a new approach to local planning was required. The existing strategy covers the period 1999 – 2004.

To adequately meet the needs for people with dementia in the community a transfer of resources will continue to be required from hospital based health services to community health and social services. To ensure that people with complex needs are appropriately supported in a co-ordinated fashion, the principle of the care programme approach has been adopted.

The challenge facing all agencies and organisations, who deliver services for older people with dementia and or mental health problems, is to provide a service that minimises the risks for the individual whilst allowing them to be supported within the community. Services require to be flexible (to meet changing needs), are localised, equitable and easily accessible.

The aim of this section is to develop a fully integrated approach to work with local service providers, voluntary agencies and representatives of local communities to promote the social inclusion of people with dementia and their carers within East Ayrshire.

RECENT DEVELOPMENTS

- The community hospital in Cumnock was opened in August 2000 and the hospital at Ballochmyle was closed. The new community hospital provides 25 places for frail older people, 25 places for older people with mental impairments and 24 medium Acute GP led beds There is also a day hospital service 5 days a week for 12 people each day and out patient support.

- The Community Health Teams for Older People were enhanced by the associate membership of Social Work staff.

- The Dementia Outreach Project was expanded now providing 68 places in total over 6 days a week.

- The Irvine Valley Dementia Day Care Centre was opened providing 5 places over 5 days a week.

- A crisis out of hours home based respite service for older people and their carers was opened.

- An additional £100,000 pa was invested to expand home care services to older people with dementia.

- An Ayrshire Wide co-ordinator on a temporary contract to assist with joint working between different agencies and services.

- 2 Consultants Psychiatrists in Older Age were appointed to join the 2 community mental health teams for older people.

- The time that the Community Psychiatric Nursing service is available for support was expanded.

- Joint training in dementia for front line staff from Social Work, Health and private and voluntary service providers was provided in 1999.

WHERE DO WE WANT TO GO

The following service gaps have been identified by users of services and their carers and also by agencies delivering services.

- An early intervention service that will provide over 75 screening and incorporate both memory clinics, health promotion service and access to the information and advice service.

- Specialist care home places that can deliver a service to older people who have complex mental health difficulties.

- Specialist health and social care services that enable older people with Dementia to remain within their own homes.

- Appropriate housing with support that meets the needs of people with dementia.

- Information and advice to older people and their carers about the services which are available and information about dementia.

- Sufficient respite service for people with Dementia and older people with Mental Health difficulties.

- An integrated working model, which will aid communication between Social Work, Housing and Health including shared information and joint assessment.

- Involvement of service users/ carers in the design, implementation and evaluation of services

HOW DO WE INTEND TO GET THERE

- An early intervention service will be developed to screen the over 75 group. This service should also be able to provide health promotion and promote primary care working and be expanded to screen individuals in the 65-75 age group.

- The level of need and the provision of specialist care home places for older people with mental health problems will be explored.

- Respite services for people with dementia will be expanded. In particular the possibility of a respite house jointly managed between the Ayrshire and Arran Primary Health Care NHS Trust and East Ayrshire Council Department of Educational and Social Services will be explored.

- Resources will be allocated to assist older people with mental health problems in partnership between the East Ayrshire Council, Ayrshire and Arran Health Board, Ayrshire and Arran Primary Health Care NHS Trust and other appropriate agencies.

- An advocacy service for will be commissioned for people with dementia and older people with a mental health problem.

- A comprehensive information and advice service to people with dementia and their families will be commissioned.

- The operation of the Care Programme Approach will be expanded.

- The attachment of social workers to each Community Mental Health Team for older people will be explored further to ensure what benefits there would be for service users.

- Funding of specific initiatives to the involvement of users/ carers in the development of services through focus groups, semi-structured interviews and questionnaires will be explored.

PEOPLE WITH MENTAL HEALTH DIFFICULTIES

The Joint Community Care Plan 1998 – 2001 and Strategy for people with mental health difficulties was produced following the Scottish Office publishing the Framework for Mental Health Services in Scotland in 1997. The Framework, provides a template for planning partners to agree priorities, which are related to outcomes, effectiveness and value for money. It also stresses mental health well being as fundamental for all people, requiring it to be considered in all service planning.

Within the Mental Health Framework, the Scottish Executive requires Health Boards to co-ordinate multi-agency mental health strategies across board areas over a five-year period. The developments set out in this Plan reflects the Ayrshire and Arran Mental Health (Adult) Strategy (1999-2004) and the assessed local need.

Both the Scottish Health Advisory Service report on mental health services in Ayrshire and Arran (1999) and the Accounts Commission report 'A Shared Approach (2000) have informed this Joint Community Care Plan.

Social care services for people with mental health difficulties are mainly funded from resource transfer and from the mental illness specific grant. There is however a need to address the on-going long-term funding for social care services, in particular to meet the needs of people with severe and enduring mental health problems in the community.

RECENT DEVELOPMENTS

- An agreement on the main components required for a local comprehensive service through the Framework for Mental Health Services was achieved through all partners agreeing the Ayrshire and Arran Joint (Adult) Mental Health Strategy (1999-2004).

- Resource Transfer discussions between the Council and Ayrshire and Arran Health Board have been concluded. Phase 1 of the Ailsa Hospital Discharge Programme has been completed with fifteen people previously in continuing care beds, now living in the community successfully supported by Richmond Fellowship Scotland. Additionally, people with severe and enduring mental health difficulties are being supported in their own homes, by Richmond Fellowship Scotland assisting discharge/ preventing readmission to acute beds.

- A Home Option Team has been developed. This team provides intensive support to people in their own homes, thus reducing the necessity for hospitalisation.

- An evaluation of the Care Programme Approach was concluded in 1999.

- Ayrshire and Arran Health Board have carried out an assessment of need for the population of East Ayrshire.

- East Ayrshire Joint Mental Health (Adult) Training Strategy has been agreed particularly focussing on the awareness raising needs of community based staff.

- An Ayrshire Appropriate Adult Scheme for people with mental health and/or learning disabilities commenced July 1999.

- Three additional Mental Health Officers have been trained and another three are undergoing training.

- Ayrshire and Arran Health Board have invested monies toward a Community Guide service to assist people to network their local facilities in the Kilmarnock area. Further Council investment has facilitated this service development to the Cumnock and Doon Valley area.

- A one-year part-time post has funded East Ayrshire Advocacy Services to help to facilitate and support service users in the planning and development of services.

- A Benefit surgery has been established in Crosshouse Hospital (acute wards). An easy access procedure has been agreed with the Council's Homes and Technical Services Department.

- Research undertaken with the Mental Health Helpline (now Copeline) clarified the high usage in the Kilmarnock and surrounding area.

- Resource transfer funding has facilitated the development of an intensive home support service for people with severe and enduring mental health difficulties.

WHERE DO WE NEED TO GO?

A range of stakeholders has been consulted/involved in the development of this section of the Community Care Plan. This has occurred through various meetings, interviews and events. The consultation arrangements highlighted the following:

- A comprehensive public transport service is required that gives people with mental health difficulties access to their support arrangements.

- Agreed consultation and involvement frameworks with users and carers and for external providers require to be implemented.

- information about statutory entitlements and services needs to be accessible.

- Information about the housing needs of people with mental health difficulties requires to be gathered to use to plan future service provision.

- Carers Assessments for carers with personal ongoing support needs requires to be promoted.

HOW WILL WE GET THERE?

- The transport issues that impact on people with mental health difficulties will be audited by service users of the Morven Centre.
- Mental health awareness training will be developed, particularly for front line personnel.
- The housing needs for people with mental health problems will be clarified.
- Mental health day supports will be evaluated.
- The intensive home support service will be extended throughout the whole of East Ayrshire.
- The mental health discharge protocols will be evaluated.
- Protocols for people in transition from Children/Adolescent Services to Adult services and from Adult Services for Older People Services will be agreed.
- The need for a respite service will be evaluated.
- The need for a rehabilitation initiative within East Ayrshire will be evaluated.
- A greater range of accommodation with support will be established.

PEOPLE WITH LEARNING DISABILITIES

In May 1999, the Scottish Executive published “The Same as You?: a review of services for people with learning disabilities”, This followed an eighteen month period of extensive consultation involving service users, carers, statutory agencies and independent sector providers. The document sets out a clear direction for the improvement of services and the development of opportunities for people with learning disabilities and their carers. It covers all aspects of peoples’ lives and indicates that progress will include:

- the closure of all long stay hospital beds;
- an increase in supported living arrangements;
- a shift away from centre based, traditional forms of day care to the development of day supports to facilitate access to mainstream education, leisure and employment opportunities;
- increased numbers of people with learning disabilities having real jobs;
- increased access to independent advocacy.

Previously, plans to discharge people with learning disabilities in hospitals across Ayrshire had not been carried out, because and application to the Scottish Office, for Bridging Finance to meet the costs, was unsuccessful.

In the absence of Bridging Finance, the Ayrshire planning agencies have worked together to plan the discharges of people living in the Royal Scottish National Hospital (RSNH) in Larbert, and other settings outwith Ayrshire hospitals. These national priorities have required to be balanced with the needs of people living in hospitals in Ayrshire and those people who are already living in the community. This continues to be a significant challenge for agencies in Ayrshire but local authority and health colleagues working together have achieved considerable progress. This includes the development of an Ayrshire wide Partnership in Practice Agreement.

The Scottish Health Advisory Service visited community and hospital services for children and adults with learning disabilities in Ayrshire and Arran in June and July 2000. The final report acknowledges the good practice that is in place in East Ayrshire, particularly in relation to joint assessment and care management arrangements between colleagues in the social and health care sectors. It outlines some areas for development including the development of a strategic plan for the resettlement of residents from Arrol Park and Strathlea and for people with a learning disability living in Ailsa Hospital.

The report also suggests that the direction of community learning disability teams requires to be reviewed.

RECENT DEVELOPMENTS

Following the implementation of the last Joint Community Care Plan 1998-2001, the following has been achieved:

- The creation of a Pan Ayrshire Strategy Learning Disability Group with responsibility for developing an Ayrshire wide Partnership in Practice Agreement. This group has had lead responsibility for negotiating a financial framework to meet the costs of community based living options following hospital discharge.

- The development of a new Service Officer (Learning Disability) post within East Ayrshire Council , with responsibility for improving and developing services.

- The appointment of a Social Worker (Learning Disability) funded by Ayrshire and Arran Health Board, with responsibility for the assessment and care planning tasks associated with hospital discharge arrangements.

- The creation of a joint assessment team working across Ayrshire in co-ordinating hospital discharge work.

- The discharge of 6 people with learning disabilities who do not require to be in long stay hospital provision.

- The development of housing with support for 4 people in Kilmaurs.

- The development of a framework which addresses how service users and carers will be appropriately informed, involved and/or consulted in improving and developing services in East Ayrshire.

- The completion of a review of local authority and independent sector day services.

- A range of practice improvements including:-

  - the involvement of people with learning disabilities in the recruitment of residential and day service staff;

- the funding of a partnership project between East Ayrshire Council and the Scottish Arts Council to promote access and participation for people with learning disabilities.

WHERE DO WE NEED TO BE?

A range of stakeholders has been consulted/involved in the development of this section of the Community Care Plan. This has occurred through various meetings, interviews and events. The consultation arrangements highlighted the following:

- Information about services requires to improve, particularly how to access services.
- Assessment arrangements can improve by further developing joint approaches between health, social work and housing providers.
- Service users and their carers should be involved in reviewing, planning and developing services.
- Protocols are required between health, education, social work and other agencies to manage the transition between children and adult services.
- Mainstream services require to offer greater opportunities for people with learning disabilities to get involved in their local community (currently services are mainly provided in segregated settings).
- Different types of day services are required for people who have different support needs. These require to be more flexible to individual need and should be available in evenings and at weekends.
- More leisure opportunities should be available and people need support to develop friendships.
- Real jobs with a proper pay are needed.
- Access to public transport requires to improve and specialist transport provision needs to be more flexible to individual need.

HOW ARE WE GOING TO GET THERE?

The Ayrshire wide Partnership in Practice Agreement will set out the broad context within which learning disability services in Ayrshire will develop. The East Ayrshire Partnership in Practice Agreement provides greater detail about local developments.

- The East Ayrshire Day Services Review will be implemented to develop day support options for people with learning disabilities who wish to gain new skills by accessing leisure, recreation and educational opportunities in their local communities. It will also

improve centre-based day care to people with more complex learning disabilities and physical disabilities;

- The need for alternative forms of short break services for carers will be examined, including family based care, intensive home care and day care.

- A forum, involving council representatives, provider organisations and national organisations, will be established to explore employment opportunities for people with learning disabilities.

- All service users leaving long stay hospital care to live in the community will have a Personal Life Plan. Priority will also be given to people at periods of transition e.g. leaving school.

- Existing services will be redesigned to address the specific support needs of older people with learning disabilities.

- Up to 20 people will be discharged from long stay hospital to supported living options in the community in 2001/2002. Detailed Assessment work will be completed on all people currently resident in Arrol Park and Strathlea and a clear discharge plan developed to identify discharges to 2005.

- Additional housing will be made available to people with learning disabilities through new-build, house purchase and re-letting.

- Existing local authority residential provision will be restructured to achieve more individualised supported living options.

- The current arrangements for the provision of community learning disability nursing services in East Ayrshire will be reviewed.

- Assessment and care management arrangements will be developed by creating lead roles in learning disability for social workers, and by extending arrangements whereby community nurses undertake care management functions.

- A framework for managing the transition between school and adult provision for young people with learning disabilities will be developed across all agencies and in partnership with young people and their families/carers. This will set out agreed inter-agency protocols and standards of practice.

- Opportunities for the joint commissioning of specialist services across Ayrshire e.g. for people with autistic spectrum disorders will be explored.

- The council will work across corporate departments to develop leisure, recreation and life-long learning opportunities for people with learning disabilities.

INDEPENDENT LIVING

This section addresses gaps in provision and develop proposals to improve services and opportunities for adults with physical disabilities, acquired brain injury and/or sensory impairment.

The aim of this section of the plan is to develop and provide a responsive service that will promote and facilitate independence.

The section is based on the social model of disability. This assumes that any individual with an impairment has the same rights as any other individual to be independent and to exercise choice and control over their lives. An individual becomes disabled only when society fails to put in place the necessary supports and assistance to allow him/her to function independently.

The planning partners provide services to promote independent living often in partnership with local and specialist voluntary organisations. These partnerships are particularly important when providing specialist services to people who have particular needs, for example, Multiple Sclerosis, or Huntington's Chorea.

The implementation of the Disability Discrimination Act provides an opportunity and an obligation for the planning partners to ensure these services are improved and access to goods and services is facilitated.

PEOPLE WITH ACQUIRED BRAIN INJURY

WHERE ARE WE NOW?

Preventative services include the health promotion work to reduce the incidence of acquired brain injury by following healthy eating /lifestyle plans and education on alcohol and drug misuse. In addition, improvements in road safety also have a positive preventative impact.

Services are organised around the initial stage following injury and thereafter community based services, which promote independence.

Initial stage

- An Ayrshire and Arran wide protocol for referral to the specialist rehabilitation consultant based at Douglas Grant Rehab Centre was established in 2000

- The Southern General Hospital has a continued expert role to play in the support for people with neurological disorder including brain injury.

- Patients gain access to specialist nursing, physiotherapy, occupational therapy, speech and language therapy and clinical psychology.

Community Services.

- Following discharge from hospital care (acute services), people with acquired brain injury may attend the Douglas Grant Rehab Centre at Ayrshire Central hospital to maximise independence.

- Headway Ayrshire (a local voluntary agency) provides information / advice and support to people with acquired brain injury and their carers. Currently they are working with East Ayrshire Council to provide group activities, which will promote socialisation and continued skill acquisition. Currently 16 people in East Ayrshire attend groups based in the North and the South of the Authority. East Ayrshire Council has attached an Occupational Therapist to this group and a standardised outcome measurement tool is being used to evaluate the benefits of the group for the individuals who attend.

- Kilmarnock College has established a course, aimed at people with acquired brain injury, which provides vocational and non-vocational learning opportunities. This aims to enable people to return to employment or to enter further education.

WHERE DO WE NEED TO BE

Consultation with individuals who have an acquired brain injury and their carers have indicated that:

- Information requires to be available at discharge and at the early stages.
- There requires to be improved access to counselling.
- There is a requirement for more clinical psychology to be available when required.
- Transport requires to more accessible and availability at a affordable price.
- There is a need for improved support from social care services and an improved range of services (such as respite) available when required.
- There is a need for improved opportunities to access social activities, including peer group opportunities.
- There is a need for specialised brain injury provision to be more locally based.
- Communication / information methods need to be improved.
- Lack of community services / respite.

HOW ARE WE GOING TO GET THERE

- Systems will be implemented to improve information and communication between agencies.

- Work will be undertaken to establish a local Brain Injury service

- Awareness raising initiatives of the needs of people with acquired brain injury will be undertaken amongst front line staff.

- Training will be provided to staff, carers and families of people with acquired brain injuries to develop their understanding.

- There will be further development of flexible support arrangements to people with acquired brain injury, including personal assistance, and groupwork.

- Work will be undertaken to identify employment opportunities for people with acquired brain injury.

PEOPLE WITH SENSORY IMPAIRMENT

This section covers visual impairment, hearing impairment and deafblindness.

WHERE ARE WE NOW

- East Ayrshire Council established a Sensory Impairment Service in 1998.

- The restructuring of the Council's Education and Social Work Departments into one Service Department has positively impacted on the provision of services from pre-school onwards.

- Rehabilitation / Mobility services are provided to children and adults who have a visual impairment. This ensures individuals retain or develop independent living skills following visual loss.

- Ayrshire Council has funded the training of two British Sign Language (BSL) interpreters. These interpreters are now registered members of the Scottish Association of Sign Language Interpreters.

- Additional communication support is offered through the Talking Books Service and transcription service to Braille, large print or audio cassette.

- The Council has supported a local tape service to produce audio versions of local news.

- The Sensory Impairment Technician Service was established to assess and provide equipment to people with a hearing loss ranging from flashing door bells to text phones.

- The information / advice resource offers specialist information searches for service users, carers and professionals.

- Sensory impairment awareness training was a key recommendation in the Scottish Executive report on Sensory Impairment services 'Sensing Progress'. Awareness training has been delivered to a cross section of the Council's personnel.

WHERE DO WE NEED TO BE?

- Better and faster service delivery for people with a sensory impairment.

- Expanded access to information/advice for people with a sensory impairment.

- Establish robust interagency links to aid service delivery.

- Improve response times in the visual impairment registration process and in receiving specialist rehabilitation / mobility training.

- Address the requirements of the Disability Discrimination Act i.e. Text Phone Loop systems in public buildings.

- Address the limited audiology services in rural areas.

- To ensure comprehensive identification of the specific needs of deafblind people.

HOW ARE WE GOING TO GET THERE

- Access to information at public access points will be improved.

- Capital investment programmes will reflect the key priorities in implementing the Disability Discrimination Act.

- Rehabilitation services for people with visual impairment will be increased.

- Specialist service delivery will be piloted in key areas, for example deafblind guide/communicator service, on an Ayrshire-wide basis.

- Sensory impairment awareness training to relevant service providers will be increased.

- Classes in Braille for parents, carers and service users will be provided.

- An Ayrshire wide audit of the need for services to deafblind people will be implemented.

PEOPLE WITH PHYSICAL DISABILITIES

WHERE ARE WE NOW?

- East Ayrshire Council reviewed and increased investment in its Equipment and Adaptations service in 1998. A range of process improvements was established, which has resulted in a more streamlined, responsive and cost-effective service. In 2000/2001, 1517 adaptations were completed to local authority houses and 62 adaptations to owner occupied houses. Scottish Homes has also increased investment in equipment and adaptations.

- The section of this plan - "Housing, Homelessness And Community Care" - reflects the positive amendments to the housing allocation policy to ensure that adapted properties are allocated to people who will benefit from the adaptations. Work on a register of adapted stock has begun. In addition, 6 houses with support for people with

complex care needs have been built in Kilmaurs, 2 wheelchair standard houses have been built in Kilmarnock and 'Housing for Varying Needs' design guidance for new build housing has been developed.

- The council's Equipment and Adaptations Service enables people to return or stay at home and reduce stress on carers. Occupational Therapy staffing levels have been increased and specific operational management structures put in place.

- Service standards and performance indicators have been established and are closely monitored.

- The council has undertaken two joint working initiatives with the East Ayrshire Local Health Care Co-operative. The findings of this has influenced and shaped communication arrangements for example, named Occupational Therapists and Social Workers linked to GP Practices.

- East Ayrshire Council commissioned Kilmarnock Forum on Disability to manage a Personal Assistance Support Scheme. This is now fully operational with 19 people employing 44 personal assistants. This scheme has given service users choice and control to manage how their care is delivered.

- Ayrshire and Arran Primary Health Care NHS Trust , Ayrshire and Arran Health Board and East Ayrshire Council have a joint funding arrangement for the provision of specialist equipment and adaptations in order to prevent hospital admission or facilitate hospital discharge.

- Disability Discrimination Awareness training is a compulsory requirement of licensed taxi drivers wishing to renew their licence with East Ayrshire Council. This training is commissioned from Kilmarnock Forum on Disability.

WHERE DO WE NEED TO BE

- We require to work in partnership to provide people with disabilities real choice and control over their support arrangements.

- Effective and accessible transport is required to ensure that people with disabilities are socially included.

- To further improve the delivery of key services by working in partnership with other agencies.

HOW WILL WE GET THERE

- Formal links and shared practice arrangements between Occupational Therapists working within Social Work, the Ayrshire and Arran Primary Health Care NHS Trust and the Ayrshire and Arran Acute Health Care NHS Trust will be further developed.

- A register of council properties that have been adapted will be developed to more effectively in identify a match between people who need adaptations with existing adapted properties.

- Disability Awareness training will be provided for staff and service providers in partnership with representative organisations to meet the requirements of the Disability Discrimination Act;

- All licensed vehicles will be suitable for carrying people with disabilities by 2004.

- Access to the Personal Assistance Support scheme will be extended and a Direct Payments scheme will be established.

- Work will be undertaken to identify the needs of people living in the community with medical conditions that require specialist supports, such as Huntington's Chorea or multiple sclerosis.

ADDICTION

As part of the National initiative to tackle the complex problems of drug misuse, local areas were required by the Scottish Office in 1989 to establish Alcohol Misuse Co-ordinating Committees. The Drug Task Force Report of 1994 required local areas to set up Drug Action Teams based on Health Board boundaries.

In Ayrshire it was decided to combine both into the of Ayrshire & Arran Alcohol and Drug Action Team (ADAT) in recognition of the linkages between alcohol and drug misuse. Membership of this group now includes Ayrshire and Arran Health Board, Ayrshire and Arran Primary Health Care NHS Trust, Strathclyde Police and East, North and South Ayrshire Councils.

ADAT's overarching principle is:

- *the provision of an integrated approach to reducing alcohol drug related harm for people living within East Ayrshire.*

ADAT published its Action Plan in 2000, which sets out priorities and a framework for service development. This set out nine general areas for action to be implemented in 2000/2001

- Further develop the range of quality of services for young people
- Further development of support for families and carers
- Joint work with licensing boards, licence trade and enforcement agencies
- Development of service standards and performance indicators
- Ensure alcohol and drug misuse is addressed within the wider context of area regeneration, social inclusion and housing
- Further development of services for older people
- Further development of recording procedures and information systems across specialist and non specialist services
- Develop improved co-ordination and communication between generic and specialist services and across agencies
- Develop additional treatment services where need outstrips resources

RECENT DEVELOPMENTS

The following developments have been progressed in accord with the ADAT action Plan

- The Scottish Executive awarded East Ayrshire Council an additional £161,000pa until 2004 for the provision of services to address drug misuse in 2001/2002. This was part of £100m to be allocated Nationally over three years via a range of funding mechanisms. The council is currently planning the allocation of these additional resources in consultation with key stakeholders including service users and carers.

- A draft HIV/Blood Borne Infection strategy has been produced. A key aim of the strategy is to ensure high-risk groups (including drug misusers) are kept aware of the immediate risks they face. The final strategy is likely to be agreed in late 2001.

- Hepatitis C has been identified as an issue likely to require both health and social care intervention over the next 20 years. Injecting drug users in particular have shown high levels of Hepatitis C infection. A joint health and social care strategy is being developed to address preventative action, assess future needs and plan future intervention.

- The allocation, by the Scottish Executive, of Social Inclusion Partnership money for tackling drug misuse in 2000 has resulted, in a range of local initiatives. These include;

    - The development by the Bridge Project of a base within the Doon valley
    - The development of a diversion scheme for young people and
    - A needs assessment within the Social Inclusion Partnership area in tandem with partnerships based within South Ayrshire.

WHERE DO WE NEED TO BE

A decision was taken at the reorganisation of local government in 1996 that East Ayrshire would develop specialist services in partnership with the voluntary sector rather than make any direct specialist service provision. This decision was based on the assumption that people who misuse drugs and alcohol are less likely to approach services provided by statutory agencies. This approach to service provision, requires that there be effective communication between Social Work and Voluntary agency staff. Whilst existing links are good, a continued focus on joint working at an operational level is required.

Similarly, partnerships with health, police and other local authorities at a strategic level are well developed. However experience has shown that further progress could be made in joint working at an operational level. Services need to be able to respond in a flexible and co-ordinated manner to individuals as and when they present to services.

The increasing national focus on alcohol and drug related issues in conjunction with funding opportunities for service developments being made available through a range of mechanisms requires that the Council adopt a corporate approach to addiction.

The East Ayrshire Alcohol and Drug Forum is the formal vehicle for involving service users, carers and communities in dialogue and forms a constituent partner of ADAT. Some difficulties have however been experienced in engaging effectively with service users, carers and communities.

A need for more meaningful information relating to patterns of usage and the extent of addiction problems within East Ayrshire has been identified which will in part be addressed through the needs assessment in the SIPS area.

The need for greater information and public awareness of services available has been identified.

The need for an improvement in the types of information and services that are available has been identified.

A need for the further development of effective harm reduction strategies including needle exchange facilities has been identified.

Some initiatives such as those funded by Social Inclusion are subject to short term funding arrangements. Consideration requires to be given to linger term funding arrangements for such initiatives.

There is a need to develop more flexible service responses to take accounts of the 24hr nature of alcohol and drug misuse for instance.

- There is a need to develop aftercare and rehabilitation initiatives to complement existing counselling and treatment services.

- There is a need for improved support to families and carers.

- There is a need to improve service delivery arrangements for women who have addiction problems.

A review of Outreach Work was undertaken by ADAT in 2000, which identified that the role of Outreach Work was in transition and that there was a need for a greater focus on young people, chaotic users and rebuilding lives.

There is a perception that Social Work is engaging with significant numbers of children whose parents misuse alcohol, drugs or both. There is however, a need for improvement of this support.

Service users, carers and professional staff have identified some concerns about the operational protocols relative to the substitute-prescribing programme.

HOW WILL WE GET THERE

- The service improvement plan identified within the Review of the Bridge Project will be implemented along with the Review of Outreach Work. This will include;

  - The creation of Community drugs worker posts within Kilmarnock and Cumnock Bridge Projects. To focus on the needs of service users with chaotic lifestyles.

  - Strengthening the management and staffing structures to maximise effectiveness.

  - Developing capacity with in services to provide additional rehabilitation and support.

- There will be further development of a corporate approach to addiction related issues.

- There will be a full review of addiction services within East Ayrshire in the light of increased funding opportunities and develop appropriate service responses in accordance with the identified gaps in provision.

- There will be a full multi agency review of substitute prescribing provision and specific action developed.

- A multi agency working party will be convened to consider 'access to services issues' to ensure that individuals receive appropriate support on presenting to agencies. The conclusions of this working party will be developed and implemented

ADVOCACY

INTRODUCTION

In 1997 the Scottish Office produced the document; “Advocacy - A Guide to Good Practice" outlining the Governments commitment to the provision of service user advocacy in Scotland. In addition, guidance was issued in early 2001 through the publication of “Independent Advocacy: A Guide for Commissioners” that offers advice to Health Boards, NHS Trusts and local authorities on ensuring independent advocacy is available to those who need it.

Service user and carer advocacy has long been recognised as an essential to ensure that services are equipped to address the real needs of people, that provide real choices and enable service users and carers to remain in control of the service provision.

To address this need, the East Ayrshire Advocacy Project (formally an Urban Aid project) was re-established as a mainline service in 1998, funded jointly by East Ayrshire Council Department of Educational and Social Services and Ayrshire and Arran Health Board.

The remit of the service is to provide individual and group advocacy for adults between the ages of 16-65 years who either have a mental health related problem and/or a learning disability.

RECENT DEVELOPMENTS

In the period of the Community Care Plan 1998-2001, people with mental health problems and people with learning disabilities have been directly supported as follows

Year	Adults with mental health difficulties	Adults with learning disabilities
1998/1999	295	140
1999/2000	289	345

In addition, the service has been providing group advocacy for;

- People using the Morven Day service for people with mental health problems.
- People with learning disabilities in each of the local authority resource centres and residential units for, and
- Residents in private residential units for people with learning disabilities.
- Outreach advocacy support has also been provided to local groups of people with mental health difficulties in the Coalfield area.
- A regular surgery also takes place within the acute psychiatric wards in Crosshouse hospital.

- A one-year part-time post was funded to help to facilitate and support service users in the planning and development of mental health services.

- The organisation Advocacy 2000 was formally established with support from the Scottish Executive. This is a national project that supports existing and new advocacy developments through networking, training, promotion and support.

WHERE WE WANT TO GO

To date the Advocacy project has only supported people with mental health problems/learning disabilities. There is therefore a requirement to broaden the scope to make advocacy available to all other people receiving community care services. A decision needs to be made whether additional providers of Advocacy are required in the authority to meet current needs.

In particular, individual and group advocacy is needed on an ongoing basis for people with learning disabilities living in long stay hospital provision as part of the process of supporting their move into community based provision.

In addition advocacy services to older people, people with dementia, people with acquired brain injury and children and young people affected by disabilities have been locally identified as priorities.

HOW WE WILL GET THERE

- An advocacy forum, which involves service users and carers along with service providers, will be established. This forum will formulate the strategic direction, service planning and the dissemination of public information of advocacy services within East Ayrshire.

- A localised advocacy plan will be developed, which will set out the future direction of advocacy developments in East Ayrshire.

TRANSPORT

One of the key areas of concern raised by service users and carers regardless of the care group they represented was the issue of transport.

These concerns tended to focus on the availability and accessibility of public transport in the area, particularly in the rural areas and the service in the south of the authority.

It was stated that a lack of suitable public transport tended to exacerbate people's feeling of isolation and vulnerability and reduced their ability to participate fully as citizens. The cost of public transport was also raised as an issue for many.

It was also clear that service users and carers were keen to use public transport, with support when required, in preference to specialist transport for their needs. Nevertheless there was some agreement that the council's own transport service could be better utilised.

The views of service users and carers, although not quantified, do appear to be odds with the views of residents of East Ayrshire as a whole. A survey of householders undertaken in early 2000 indicated that only 43% of residents felt that investment should be used to increase bus and train usage (48% against).

However, there is also a statutory framework outlined in the Disability Discrimination Act that requires all forms of land based public transport to be accessible to disabled people. Despite this Nationally only 15% of Scotland's buses have low floors, many bus stations are inaccessible and less than 17% of Scotland rails stations are fully accessible to people in wheelchairs.

East Ayrshire Council produced a local transport strategy in December 2000. This has the following aims:

- To improve the strategic transport links to promote economic activity and regeneration in East Ayrshire.
- To increase the relative attractiveness of public transport, walking and cycling as a means of reducing car dependency.
- To improve personal safety and security.
- To protect the environment and enhance communities.
- To improve accessibility for vulnerable groups.

In September 2000 the Minister for Transport announced plans to provide free off peak bus transport for older people by 2003. This follows a similar scheme for registered blind people in 1999.

In addition, the Scottish Executive initiated the Scottish Rural Community Transport Initiative to fund community transport measures in rural areas. In East Ayrshire, the Coalfield Communities Federation, through the Social Inclusion Partnership made a successful bid in 2000 for two accessible community mini buses, to enable community organisations to access affordable transport and work in partnership with existing transport providers.

Within East Ayrshire Council Department of Educational and Social Services, there operates two distinct transport services:

1) An in-house service, operating Council owned and employee driven vehicles, mainly in Social Work and Community Supports.

2) An external provision, provided through SPT approved and Council approved contractors, servicing school and respite care provision in buses and taxis.

In addition, the Department uses volunteer drivers in some specialist areas (eg. meals-on-wheels, children and families).

East Ayrshire Council Social Work operate 30 vehicles and employs 15 specialised drivers who transport people to and from day care, and provide support for the community alarms and meals-on-wheels services, as well as supporting voluntary organisations. A transport improvement plan is currently being finalised for implementation in 2001/02.

WHERE DO WE WANT TO GO

- All partners to closely address issues of access transport by service users and carers when developing services.

- To increasingly promote the use of public transport and support services users to do so.

- To work with transport providers to improve accessibility of transport to vulnerable groups.

- To provide an internal transport system that better meet the needs of service users.

HOW ARE WE GOING TO GET THERE

- Partners will address transport within the East Ayrshire Community Plan.

- The Council will secure improvements in bus and rail travel, interchange facilities, infrastructure provision, information and accessible public transport.

- Road safety will improved for vulnerable users of the transport system.

- The Dial a bus and concessionary travel schemes will continue to be supported.

- To support community and special interest groups to access community transport where available and to promote the pilot the pilot initiative in the Coalfield area among service users and local service providers.

- Disability awareness training will be promoted amongst taxi drivers and private hire drivers to ensure that all drivers have completed this training by the end of 2002.

- We will ensure that all licensed vehicles are suitable for carrying disabled people by 2004.

- Care Planning will overtly address the needs of service users to successfully access public transport e.g. through the provision of befriending, volunteer support, training.

- The location of current and future centre based service provision and will be audited.

- Disabled people (including disabled older people, people with learning disabilities and people with mental health problems) should be consulted when developing transport policies in East Ayrshire for accessibility to suitable public transport.

- Upgrade transport provision within Educational and Social Services Department through the use of Council and SPT operated vehicles.

CHARGING POLICY

INTRODUCTION

Currently, direct health care provision whether delivered in the community or in hospital is free at the point of delivery and provided to everyone who requires it. The one exception is nursing care provided in nursing home, which is subject to a means tested charge. However, following the publication of the "Royal Commission on Long Term Care" the Scottish Executive has announced that, from October 2001 the nursing home element provided in nursing homes will also be free of charge.

Social care provision has always been subject to charge, whether provided in residential care or in the community. The charging system for residential services (including residential respite) is laid down in statute and people can expect to pay the same amount (dependant on their income) irrespective of where they live.

Councils have always been expected to make some form of charge for non-residential services and National guidance has outlined what services should be chargeable. However, local authorities have had considerable discretion with regard to assessment procedures, level of charges to be paid and identification of any services that should be exempt from charges. This has resulted in inconsistency and lack of uniformity among local authorities and confusion among service users and carers.

East Ayrshire Council currently charges for Home Care services (including community alarms and community supports for adults with learning disabilities), Day Care for Older People, and Lunch clubs. One off charges are also made for the provision of Occupational Therapy equipment or adaptations. Certain services are provided free of charge, regardless of the income of the service user. These include home care to people requiring short term support on leaving hospital (for up to three weeks), services to people with a mental illness who are also subject to a Community Care or Supervision order and day services to adults with learning disabilities provided within Adult Resource Centres.

The charges made by East Ayrshire Council are assessed on the basis of means testing with this process being underpinned by the principle of income maximisation in respect of the service user. Staff involved in this process will therefore take appropriate action to ensure that services users receive all benefits to which they may be entitled. Support and assistance is provided by staff in the context of making claims and subsequently for processing further claims or challenging unfavourable decisions as appropriate.

Service users whose chargeable incomes are below the specified Threshold level for their circumstances, receive services (apart from Equipment and Adaptations and meals taken at Lunch clubs) free of charge.

For those with incomes in excess of these levels, the charge to be paid is determined either by the level of chargeable income in excess of the appropriate threshold i.e. an income based charge, or by reference to an Indicative charge, which is based on the cost of the service(s) received.

A ***better off*** calculation in favour of the service user is always carried out to ensure that individuals with comparatively high incomes but less intensive service needs, are not financially disadvantaged through the charging process.

Under ***no*** circumstances will an individual be charged more than the Indicative cost of providing the services they receive.

All income derived from charges to service users, is returned to Social Work to provide community care services. In the financial year 1999/2000, £1,632,000 was derived from service user charges. This equates to more than the entire expenditure by East Ayrshire Council Social Work on specialist services for people with mental health problems and physically disabled adults. This money would not be available to the council other than through the charging policy.

Nevertheless, consultation with service users and carers during the period of this plans construction indicate that, although seldom the most important concern, the issue of charging for social care services was important to many people. Concerns were raised in two areas;

- Disagreement with the principle that people should be required to pay for social care services when health services were free.

- Concern about the differences in charging policies dependant on where the service user is located, for instance comparing the different charging policies of North, South and East Ayrshire Councils.

The Scottish Executive addressed these issues with the publication of the “Joint Future” group report in December 2000. The report concluded that providing free social care services would be unaffordable and would do nothing to improve community care services. However, they did recommend that two services should be free;

- Home Care services for Older People leaving hospital for up to four weeks (already implemented in East Ayrshire Council
- The additional costs of home care services provided to people who would otherwise require residential care.

The report also recommended that one system of charging be implemented for the whole of Scotland. This issue was addressed through CoSLA, and draft charging guidelines for non-residential services were issued to local authorities for consultation towards the end of

last year. This recommends a National Framework for charging through deployment of standard assessment procedures, but which at the same time allows for an element of local discretion and accountability with regard to charging levels.

ACTION TO BE TAKEN

- The Council will amend its Social Work charging policy to

  (a) Provide free services to Older People returning home from hospital for a period of four weeks.

  (b) Provide free services to people receiving “Extended Home Care”.

  (c) Implement the COSLA charging framework unless the current East Ayrshire Council practise is more favourable to service users.

INFORMATION MANAGEMENT

INTRODUCTION

Partners delivering community care services all recognise the key importance of having good quality information to enable effective management of those services. Accurate information is particularly required for the following purposes:

- To effectively match the needs of services users and carers to the range of services best able to meet those needs.
- To measure the quality and effectiveness of services.
- To measure partners performance against strategic objectives.

The increasing availability and access to Information and Communications Technology (ICT) particularly web based information has significantly improved the potential for the collection and interpretation of information effectively and quickly.

However, it is recognised, both nationally and locally, that a number of improvements are required to enhance the management and dissemination of information. These include:

- Improve the range and accessibility of information to enable service users and their carers to make informed choices about the delivery of care.

- The need to develop a common range of required information, (including definitions and data standards) particularly between local authorities in the first instance, but also between all service providers.

- To minimise the duplication of information gathering by the different agencies involved in service provision.

- The need to have effective information gathering to assess performance against set objectives for individual services and the strategic direction.

- The collection of information centrally to identify and disseminate good practise in innovation to other service providers.

- To improve the ability of individual service providers to make more effective use of the technology provided.

The Scottish Executive is currently progressing issues through the Modernising Government programme and the strategy for e-government. It has also established a Digital Scotland Task Force to promote the use of ICT in Scotland.

Within Health the Government has also made money available to expand the use of the GPASS data system and also has invested in NHS24 providing 24 hour access to health

and social care advice. Within Social Work, the Social Work Information Review Group has produced '"The Information Requirements Statement ", which sets out the core information set required within each local authority to plan and manage social work services provided or purchased by councils. The Information Requirements Statement is the first stage of a wider project to deliver Social Work data standards.

RECENT DEVELOPMENTS

- East Ayrshire Council's e-mail and standard software system has been significantly expanded.

- The Department of Educational and Social Services has recently engaged with a major software supplier to provide the software element of the revised Social Work Information Management System (SWIMS). This will provide an up-to-date, integrated information management system, gathering information from first contact to service provision and supplying high quality management information.

- The Homes and Technical Services Department has installed a new housing management system on a modular basis. The package allows for an integrated approach to housing management functions such as rent arrears, repairs and allocations but also provides accurate data to assess housing needs.

- Joint projects with the Health Board (such as the Newmilns/Darvel project) have been addressing the need for information sharing between agencies including the use of single assessments.

- Ayrshire and Arran Health Board and the two NHS Trusts have worked steadily toward linking GPs and NHS organisations to the secure communications network offered by the NHSnet and developing electronic links between GPs and hospitals and other health care providers.

- East Ayrshire Council, Ayrshire and Arran Health Board and Ayrshire and Arran Primary Health Care NHS Trust have been involved, with other Public sector agencies, businesses and community services, in supporting the development of the Ayrshire Electronic Community (www.e-ayrshire.co.uk). This aims to create electronic communities by providing open access to a range of public service information and direct on-line interaction with agencies.

WHERE WE WANT TO GO

- To promote a joint approach to information collection and data sharing.

- To pro-actively use Information and Communications Technology to provide services to vulnerable service users.

- To use information to more effectively measure the performance of services and publicise this information in a cost effective and effective manner.

- To continue to develop the provision of Public information to enable service users and their carers to make informed choices about the delivery of their services.

HOW WE WILL GET THERE

- SWIMS will be implemented into all Social Work operational sites. SWIMS will eventually operate across all departmental sites and will integrate with the wider Council's major Information and Communications Technology systems.

- Information and Communications Technology links with other relevant agencies will be increased and improved to promote joint working. In particular further development of effective data sharing and common data standards between health and social care providers at a local level will be promoted.

- An Information Portfolio will be developed within Social Work to enable the collection of effective Performance Indicators and disseminate this information as required. Key Performance Indicators to be publicised widely among stakeholders, in particular, service users and carers.

- Partners will become actively involved in national initiatives that disseminate examples of good practice.

- the availability of the NHSnet and GPASS will continue to be expanded to health professionals.

CONSULTATION PROCESS

In preparing Community Care plans, partners are required to consult with all key stakeholders before finalising the proposals. The consultation process for the Plan has been undertaken in two stages.

Initial Stage Consultation.

Initially a number of representative groups, who have a stake in the provision of community care services, were consulted on the specific parts of the draft Plan that directly affect them. This is done during the process of the initial drafting of proposals. These included service user groups, carers and service providers from the independent sector.

WORKING GROUPS

Representatives from key organisations were involved in working groups that drew up the initial draft for the following sections;

- Older people
- Older people with Dementia
- People with mental Health Difficulties
- People with learning Disabilities
- Independent Living Services
- People with Drug and Alcohol Problems
- Housing
- Finance

As well as representatives from the key partners to the plan representatives from other organisations were also involved including;

SERVICE USERS AND CARERS

A framework for service user and carer involvement was developed and a range of events/ meetings have taken place to gather the views of service users and carers. This has included:

1. Direct contact with the following organisations;

- Morven Day Services – Womens Group and Issues Group
- Men's Group - Cumnock
- Richmond Fellowship Scotland
- East Ayrshire Advocacy Services
- Trust a Carer Connection
- East Ayrshire Carers' Centre
- Carers Strategy Monitoring Group

- Compass Centre
- ADAT Stakeholder Conference.
- Bridge Project
- A range of other carers and carer support organisations

2. The outcomes of the Carers Conferences (Nov. 1999 and March 2001) have also been taken into consideration.

3. A range of consultation methods were used to gather views of the proposals for people with learning disabilities. These included:

- Four local area stakeholders meetings, involving service users, carers and staff of people using day services.

- Discussion with existing carers groups for each day centre and with carers of people using Hansel Community Supports service and fifteen other meetings for carers of people with learning disabilities.

- A series of service user "Choices Days".

- A comprehensive service user satisfaction survey facilitated by the East Ayrshire Advocacy service.

- A comprehensive carers satisfaction survey for carers of people using day services.

- Questionnaires were sent to 20 service users and 20 carers of Ayrshire and Arran Primary Health Care NHS Trust Community learning Disability service across Ayrshire.

- 20 carers were individually interviewed.

- An Ayrshire Learning Disability Conference was held on the 30th of March for stakeholders to discuss the proposed PIP. The views of stakeholders were then addressed within this document.

4. For Older People's services a range of consultation methods were also adopted .

- Members of the Elderly Forums in East Ayrshire were actively involved in the Older Person's working group and carers representatives on the dementia group.

- Workshops were held at the annual conference of the East Ayrshire Elderly forum in October 2000. Older people discussed their priorities before a draft of the section was prepared.

- A submission was made to the East Ayrshire Elderly Forum Liaison group meeting in October 2000, to draw together initial conclusions from the conference workshops.

STATUTORY AND NON STATUTORY AGENCIES INCLUDED -

Alzheimer's Scotland
Allies in Change
Social Work Personnel including meetings of social work Assessment and Care Management staff.
Community Mental Health Team Personnel
Richmond Fellowship Scotland
East Ayrshire Advocacy Services
Morven Day Services
East Ayrshire Council Personnel
Ayrshire and Arran Health Board
Ayrshire and Arran Primary Care NHS Trust Personnel
Scottish Care
Strathclyde Police
Ayrshire and Arran Alcohol and Drug Action Team.
East Ayrshire Learning Disability Group
Feedback from independent sector providers via the East Ayrshire Learning Disability Networking Group.

Public consultation

- Copies of the consultation draft of the plan were sent to a range of other stakeholders for comment and agreement on the direction of the plan. These included political representatives, community organisations, voluntary agencies and identified members of the community, in addition to representative organisations of service users and carers. In total over 230 stakeholders were consulted in this fashion.

- Copies of the consultation draft of the plan were also put on the East Ayrshire Council website.

- Copies of the draft plan were placed in libraries, council local offices and GP surgeries with a form asking for comments.

- Staff in all agencies were sent a draft of the plan.

- Copies were sent to the 700 members of the East Ayrshire People's panel representing a cross section of public opinion in East Ayrshire.

- Submissions were made to the seven Local Committees of East Ayrshire Council.

All comments submitted during the consultation process supported the strategic direction, objectives and proposed actions outlined in the plan. A number of additional helpful comments were incorporated into the final plan.

GLOSSARY OF TERMS

Acute services	Health services provided when the patient is in hospital for a planned period of time whilst their medical needs are being met. It does not include patients who are in Continuing Care basis.
Advocacy	Representing the cause of another, to secure services they may require, or rights they may be entitled to.
Amenity Housing	Housing commonly used by people with mobility impairments including older people that meets specified design standards for that group of people.
Assessment	Looking with a person at their needs to determine what help, if any, they require and how to provide it.
Ayrshire Drug Action Team	Planning group to develop a strategy on drugs, with representatives from the health board, social work, education, police, voluntary organisation and service users.
Best Value Review	A formal review of services overseen by the Scottish Executive that ensures that the best possible service is provided within available finance
Care Management	Co-ordinating the assessment of a service users needs and organising appropriate services.
Care Programme Approach	Scottish Executive Guidelines on co-ordinated packages of care for people with severe and enduring mental illness.
Care home	Generic term for service providing long term residentially based services to people with care needs. From 2002 care homes will be registered to provide both residential and residentially based nursing services.
Care Package	A combination of services put together to meet the assessed needs of a service user requiring care in the community.
Carers Monitoring group	Umbrella group supported by the carers centre, comprising of representatives of local carers groups and individual carers. The represent the collective views of carers in East Ayrshire
Carers centre	Agency joint funded by East Ayrshire Council and Ayrshire and Arran Health Board and supported by the Princess Royal Trust for Carers, that provides direct counselling, information and other supports to unpaid carers.
Clinical Governance	The approach within the health service towards achieving value for money through service standards, clinical outcomes and performance monitoring.
Commissioning	Developing a new project or service, specifying the service, identifying a provider and setting terms for a contract.
Community Alarms	An alarm system linked to a central control to provide on call support in a service users own home.

Community Learning Disability Teams (CLDTs)	Provide a community based health service to individuals aged 16—65 who have severe learning disabilities and complex care needs.
Community Mental Health Teams (CMHTs)	Provide a community based health service to individuals aged 16—65 who have severe and/or, enduring mental health problems and complex care needs.
Community Planning	A formal multi agency process, led by the local authority and involving the community that develops a common strategic vision and objectives for the local area
Compliance	Activity to ensure that service delivered meets agreed standards
Contracting	A formal legally binding agreement between the Council and an external provider on the service to be provided and the terms and conditions of supply and payment
C.O.S.L.A.	Convention of Scottish Local Authorities
Day Care	Services that provide care, rehabilitation and support outside a person's own home for a substantial part of the day
Direct Payments	Funding for care services made directly available for service users' choice and control
EFQM	European Foundation of Quality Management – an evidence based process of measuring the quality of a service based on inputs including leadership, people management, use of resources and outcomes based on customer and staff views of the service, impact on society and results
Headway	Support group for individuals with traumatic brain injuries and their carers.
Health Care	Medical and nursing care which is provided by the National Health Service and which is free at the point of access.
Health Improvement Programme (H.I.P)	A document produced by the Health Board which describes how they will improve the health of the population over the next *5* years.
Home Care	Services that provide care, rehabilitation and support within a person's own home
Housing with support	Housing where the tenant is provided with additional assistance to help them live independently - includes supported accommodation.
Independent Living Services	Funds for the assessment and funding of independent living services for disabled people.
Independent sector	A term used to describe all non-statutory services that provide care services
Joint Community Care Plan	A document produced by local authorities and partners which sets out how services will be developed over the next three years.
Joint Future Group	The report to the Scottish Executive by the Joint Future Group that sets out clear recommendations and timescales for community care services in Scotland.

Joint Planning Partners/ East Ayrshire Joint Community Care Planning Group	East Ayrshire Council, Ayrshire and Arran Health Board, Ayrshire and Arran Primary Health Care NHS Trust, Ayrshire and Arran Acute Health Care NHS Trust, East Ayrshire Local Health Care Co-operative, Carrick and Doon valley Local Health Care Co-operative, Scottish Homes
Local Health Care Co-operative	A voluntary collective of GP practises and other linked primary health care professionals including nursing, dental and pharmacists, etc. These were formed following the publication of "Designed to Care" to provide a primary health care structure at practise level
Locality Plan	The development of multi-agency local area plan that identifies local needs and priorities and develops local solutions to address these.
Mental Health Officers	Social workers who are specially trained and qualified to understand serious mental illness.
Mental Illness Specific Grant.	A ring fenced grant from the Scottish Executive that must be used by local authorities to develop agreed services for people with mental health difficulties
Modernising Government Programme	A development programme created by the Scottish Executive to assist the development of publicly funded services including electronic communications
Monitoring	Evaluating the quality of care being provided.
NHS Continuing Care	Long term in-patient care under the supervision of a consultant
Nursing Home	Accommodation, registered by the health board that includes a designated number of qualified nurse as part of the staff group over 24 hours. Will be
Partnership in Practice (P.I.P.) agreement	This multi agency strategy provides a clear focus for partners to work together to develop services for people with learning disabilities.
Primary Health Care	Health Care, usually GP surgery based, providing preventative, curative and rehabilitative services.
Private sector	A profit making organisation of varying sizes providing community care services.
Referral	Contact with, or advise or assistance from a service provider.
Residential Home	Accommodation, registered by Social Work, that provides intensive 24 hour social care to people with community care needs
Performance Indicator	Is a measurement of the quality of a service
Provider	Any person/persons, or organisation supplying a service.
Resource Transfer	The transfer of money to social services from health when responsibility for long term care changes.
Sheltered Housing	Housing, commonly used by older people, which meets specific design standards and has on-call warden support.

Short breaks/respite	Service designed to provide relief to the unpaid carer as well as the service user, by taking on the care tasks for a short period of time. This may take place in the person's own home, in residential care or in other settings
Social Care	Non medical care provided by designated agencies including personal care, domestic support and other services including housing support.
Social Inclusion Partnership (S.I.P.) Area	Area (Coalfield) designated by the Scottish Executive as deprived; suffering from a range of inter-related problems such as poor housing, lack of amenities, unemployment, ill health
Stakeholders	Individuals or groups who have an interest in using, providing or planning community care services
Standard	Defined level of service below which performance in not expected to fall
Statutory agency	Organisation or body that is required by law to arrange for or provide specific services.
Trust Implementation Plans (T.I.P.)	A document produced by Primary Care NHS Trusts which describes service development priorities and proposals over the next *5* years
Very Sheltered Housing	Accommodation similar to sheltered housing but with more intensive staff support.
Voluntary sector	Organisations that provide services in the community. They are organised predominately not for profit. They can both directly provide services or can have an advisory or campaigning role for service users and/or carers.

AGENDA