EAST AYRSHIRE

Health & Social Care
Partnership

Strategic Plan
2015 -18

Working together with all of our communities to improve and sustain wellbeing, care and promote equity

Foreword

NHS Ayrshire and Arran and East Ayrshire Council are working together in a new health and social care partnership. The purpose of the partnership is to deliver positive outcomes for the wellbeing of our residents. Specifically, our focus is on ensuring that children and young people get the best start in life, that people live healthier, longer lives and are supported to be independent and included and have choice and control - no matter who they are or where they live. Much progress has been made over recent years but significant challenges and opportunities lie ahead.

We know that many individuals and families live in circumstances of economic hardship, that our population is ageing, and that we are caring for more people with complex needs. We also know that there are significant inequalities within our communities. We are committed to working alongside all Community Planning Partners to mitigate, prevent and undo inequalities.

Health and social care services are being brought together to address these challenges and bring about improvements to our services. East Ayrshire Health and Social Care Partnership will take responsibility for the delivery of health and social care services from April 2015. The partnership will also work with acute hospital services with a particular focus on creating a community health and care infrastructure for our residents that minimises the need for unplanned or avoidable use of hospital services.

This summary document outlines our aims and vision and shows what success could look like and sets out our priorities for the next three years. In doing so, it will take account of the priorities outlined in the 2020 Vision for Health and Social Care and the commitment within East Ayrshire Community Plan (2015/2030) to work together to tackle inequalities.

We recognise that working with individuals and families, our Primary Care and community services, our partners in third and independent sectors, will ensure that we develop services that are more personalised and meet people's needs and aspirations.

Engaging with all individuals, families and carers at the earliest stage to ensure early intervention and prevention promotes better outcomes in the longer term.

We know that many of our residents are living with a number of long term, complex health needs. We will support people to manage and be more in control of their health and care, assisting them to live well for longer. We will also work with Public Health to understand and mitigate the patterns of ill health in our communities.

The tough economic climate also means we have to make the most efficient use of the available budget while at the same time delivering services that are more personalised and effective.

In order to support this new partnership we have developed an initial three year strategy to help us plan and deliver services for both current need but also the needs of people in the future.

This is not a static document. It is a live strategic plan and as such we look forward to engaging with all those with an interest in health and social care to deliver on our plan between now and 2018.

Eddie Fraser
Director East Ayrshire Health and Social Care Partnership

April 2015

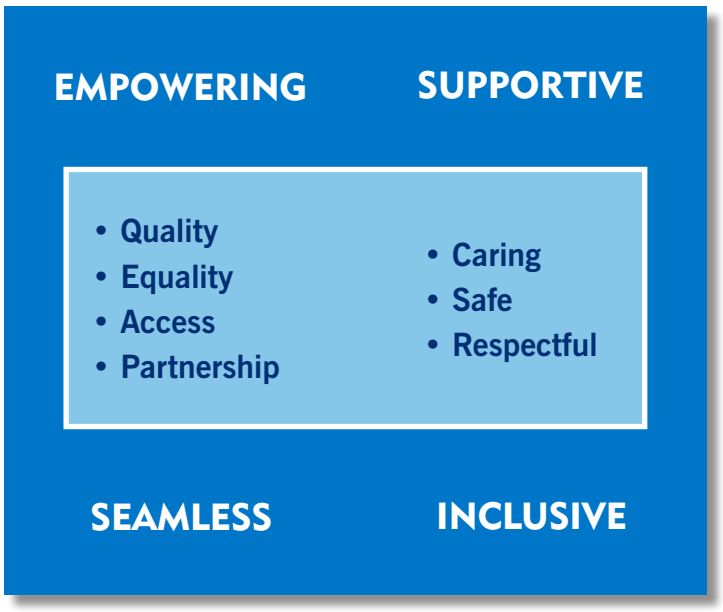
Vision

The vision for the partnership is:

Working together with all of our communities to improve and sustain wellbeing, care and promote equity

Values

Partners have aligned NHS and Council values with the policy intentions of health and social care integration to create a set of values for the partnership. This is displayed in the graphic below.



We will gauge successful integration by the extent to which:

- *We are focused on addressing the impact of inequalities in our communities.*
- *People are involved in designing their own care.*
- *Our workforce is motivated and skilled.*
- *There is a shift to early intervention and prevention for children and young people, families and carers.*
- *Services work together, are joined up and there is less duplication.*
- *People with multiple long term conditions are supported.*
- *There is easier access to services through a single point of contact.*
- *The benefits of new technology are realised.*
- *We make the most effective use of resources.*

Outcomes

Key outcomes for the partnership align with the Community Planning Partnership and are that:

- Children and Young People, including those in early years, and their parents / carers are supported to be active, healthy and to reach their potential at all life stages
- All residents are given the opportunity to improve their wellbeing ,to lead an active healthy life and to make positive lifestyle choices
- Older people and adults who require support and their families and carers are included and empowered to live the healthiest life possible
- Communities are supported to address the impact inequalities has on the health and wellbeing of our residents

National Outcomes for Children	
Outcome 1	Our children have the best start in life.
Outcome 2	Our young people are successful learners, confident individuals, effective contributors and responsible citizens.
Outcome 3	We have improved the life chances for children, young people and families at risk.
Health and Wellbeing Outcomes	
Outcome 4	People are able to look after and improve their own health and wellbeing and live in good health for longer.
Outcome 5	People, including those with disabilities, long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.
Outcome 6	People who use health and social care services have positive experiences of those services, and have their dignity respected.
Outcome 7	Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.
Outcome 8	Health and social care services contribute to reducing health inequalities.
Outcome 9	People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing.
Outcome 10	People who use health and social care services are safe from harm.
Outcome 11	People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.
Outcome 12	Resources are used effectively and efficiently in the provision of health and social care services.
National Outcomes Justice	
Outcome 13	Community safety and public protection.
Outcome 14	The reduction of reoffending.
Outcome 15	Social inclusion to support desistance from offending.

Governance

From 1 April 2015, the Integration Joint Board will be responsible for the management and delivery of health and social care services in East Ayrshire. The Integration Joint Board comprises a wide range of partners including four elected Councillors nominated by East Ayrshire Council and four Directors nominated by NHS Ayrshire and Arran Health Board. In addition, there are a number of representatives from health and social care professionals, including General Practitioners, employee, unpaid carers, people and patients who use services and the third and independent sector.

The Board is supported by a Chief Officer who provides overall strategic and operational advice to the Integration Joint Board. The Chief Officer is accountable to both the Chief Executive of East Ayrshire Council and the Chief Executive of NHS Ayrshire and Arran. The Chief Officer will provide regular reports to both the Council and NHS Board.

The Partnership has a lead responsibility for the coordination and delivery of the Community Plan Wellbeing Delivery Plan. This allows the Partnership to work closely with Council, NHS, Community Planning Partners and our local communities.

An East Ayrshire Strategic Planning Group has been established with the purpose of developing this Strategic Plan on behalf of the Integration Joint Board. The membership of the Strategic Planning Group is wider than the Board and includes representation from clinical health professionals, social work services, housing services, care home and home care providers as well as voluntary and community services and people who use health and social care services.

Why Change?

Research on understanding needs within our partnership area shows that key services would need to increase by at least 25 per cent over the next 10 years to keep pace with population change. This work also highlights financial constraints and a considerable funding gap against rising demand. We know that there is a small number of our residents who have a range of long term conditions and as such create a high level of demand on our services. In fact, 2.5% of all of our residents use 50% of the resources and 72% of bed days in our hospitals.

There is a range of pressures on resources across the health and care system. These relate to the increasing complexity of needs, demographic change, cost pressures, legislation and working within the resources available. Over the next 3 years parent bodies will require to deliver year on year efficiencies to sustain priority services.

This means that carrying on with 'business as usual' is not sustainable and would not allow partners to deliver the positive outcomes linked to the shared vision.

Analysis of a wide range of data about our area informs our supporting needs assessment and underlines a number of key issues within our communities that should guide how we prioritise. Key information illustrating this is contained in the partnership profile below. In summary these are:

- Relatively high levels of deprivation, significant inequalities and the consequences of this for the whole community.
- An increase in people with more than one condition which affects their wellbeing (often referred to as 'multimorbidity').
- Changes within our population linked to life expectancy and healthy life expectancy which result in greater numbers of older people with support needs.
- That alcohol and drug misuse remain significant issues.
- Factors within communities that can increase vulnerabilities for children and young people.
- Reducing avoidable admissions to hospital and the wider care system.
- Reducing adverse events among children and young people.

Partnership services

By bringing our services together within the East Ayrshire Health and Social Care Partnership we have created the opportunity to improve outcomes through integrated working, better communication, improved efficiency, and reduced duplication of effort.

We serve a diverse geographical area with Kilmarnock as the largest urban area and a number of rural owns, villages and smaller settlements. We will continue to work in partnership with Community Planning Partners, including those in the third and independent sectors, enabling us to not only deliver flexible locally based services but to work alongside all of our communities.

Along with our Community Planning Partners we will work to mitigate the impact of inequalities, work to prevent individuals and communities experiencing inequalities and where possible take action and exert influence on the root causes of inequalities.

At its inception the total resource within the Partnership is £193 million (see partnership profile below). The partnership includes the full range of community health and social care services. Within East Ayrshire Health and Social Care Partnership there are 15 GP practices, 31 pharmacies, 18 opticians, 17 Public Dental Services, two community hospitals providing 74 beds for older people for care and rehabilitation. Around 1,900 people use home care services and 745 older people are care home residents. Over 3,000 people use Smart Supports (sometimes called technology enabled care or telecare). At any one time around 54 children will have their names placed on the child protection register and 388 will be looked after in the care system and a further 117 with kinship carers.

The 628 bedded district general hospital, University Hospital Crosshouse, is situated within the area and our residents are also served by University Hospital Ayr. The partnership has an integral relationship with acute services in relation to unplanned hospital admissions.

Our partnerships with the universal services of education, Housing, Vibrant Communities and leisure are integral to the delivery of positive mental and physical wellbeing within communities and in particular in relation to early intervention, prevention and recovery.

We have a proven track record in working with our third and independent sector partners to develop innovative and responsive new services. We know that these partners can often respond to the need for change more quickly than statutory services and at a more localised level. This can assist the partnership in engagement with ‘hard to reach’ groups and our smaller more rural areas.

People who live in East Ayrshire are working with us as partners in change. Services will be redesigned putting people first and in control of their health and care. We will work with individuals using a co-production approach. Co-production recognises that people have ‘assets’ such as knowledge, skills, characteristics, experience, friends, family, colleagues, and communities. These assets can be utilised to support their health and wellbeing.

By working in partnership we will, over the initial three period of the strategy, begin to address the issues highlighted in our needs assessment work. Partnership working will recognise the assets in people and communities, make the most of opportunities for meaningful activity such as volunteering and lifelong learning, and maximise opportunities to promote wellbeing.

Some of the services available

Detailed below are some of the services available through the partnership a full list of services are included within the East Ayrshire Integration Scheme which can be found at this link.

Health

- Community Hospitals - Kirklandside Hospital; East Ayrshire Community Hospital, Cumnock;
- Community Nursing (District Nursing);
- Allied Health Professionals;
- Community mental health services;
- Public Dental Services;
- Primary Care (General Medical Services; General Dental Services, General Ophthalmic Services, Community Pharmacy);
- NHS Ayrshire Doctors on Call (ADOC);
- Learning Disabilities Assessment and Treatment Services;
- Psychology Services;
- Community Children's Services (School Nursing, Health Visiting, Looked after Children's Service);
- Prison Health Service and Police Custody Health services.

Local authority services

Social work services for children, families, adults and older people and Justice services;

- Services and support for all our residents with physical disabilities, learning disabilities;
- Mental health services;
- Drug and alcohol services;
- Public protection services;
- Carers support services;
- Care home and care at home services;
- Health improvement services;
- Aids and adaptations;
- Day services;
- Respite provision;
- Occupational therapy services;
- Re-ablement services, equipment and technology enabled supports;
- Services for looked after children.

Lead Partnership Arrangements

Some of our services particularly but not exclusively in the NHS are managed and delivered across all of our communities in Ayrshire. These are generally services which are more specialist in nature or there may be good professional or clinical reasons not to split services. These services will be managed on a "lead partnership" agreement where one partnership manages and provides professional leadership for an Ayrshire wide service.

In East Ayrshire, the following services will be managed and delivered on behalf of the North and South Health and Social Care Partnerships:

Health:

- Primary Care (General Medical Services; General Dental Services, General Ophthalmic Services, Community Pharmacy)
- Public Dental Services
- NHS Ayrshire Doctors on Call (ADOC)
- Area Wide Evening Service (Nursing)
- Prison Service and Policy Custody services

Council: Out of Hours Social Work Services

Within North Ayrshire Health and Social Care Partnership, on behalf of the East and South Health and Social Care Partnerships:

Health:

- All Mental Health Inpatients Services (including Addictions) Psychiatric Medical
- Services, Eating Disorders, Forensic, Crisis Resolution and Home Treatment Team, Liaison (Adult, Elderly Learning Disabilities and Alcohol, Advanced Nurse Practitioner Services)
- Learning Disabilities Assessment and Treatment Services
- Child and Adolescent Mental Health Services
- Psychology Services
- Family Nurse Partnership
- Community Child Health, Immunisation and Infant Feeding Service

Within South Ayrshire Health and Social Care Partnership, on behalf of the East and North Health and Social Care Partnerships:

Health:

- Allied Health Professionals
- Community Continence Team
- Telehealth and United for Health and Smartcare European Programme and workstreams

Primary Care

East Ayrshire is the Lead Health and Social Care Partnership in Ayrshire & Arran for the leadership, management and development of Primary Care services and Out of Hours Community Response Services. This will require co-ordination across the Ayrshire Partnerships, Acute Services and Professional Governance arrangements for the services.

Primary Care Services are central to the achievement of local and national aspirations to deliver better health outcomes for individuals and communities and shift the balance of care. We will ensure that Primary Care services are consulted, engaged and integral to the design and delivery of future service models.

We need to build community services and third sector capacity to work alongside our General Practitioners and Pharmacists, and embrace their knowledge and understanding of the communities health needs, using this expertise to improve access and shift services to our local communities.

We will focus on early intervention and prevention. Our Dental services and Optometrists can increasingly provide more specialised services in local communities.The use of telehealthcare can improve access and reduce the requirement for travel to hospital for routine appointments.

Outwith normal working hours our communities across Ayrshire are served by the comprehensive services of Ayrshire Doctors on Call, Out of Hours Nursing Services and Out of Hours Social Work Services. These services all fall within the management scope of East Ayrshire Partnership and we shall explore the opportunities of Integration to seek service improvement and models of mutual support and sustainability.

Large Hospital Services

The partnership has a responsibility, with our local hospital services at, Crosshouse and Ayr, for planning services that are mostly used in an unscheduled way. The aim is to ensure that we work across the health and care system to deliver the best, most effective, care and support. Service areas most commonly associated with unplanned use are to be included in a 'set aside' budget. 'Set aside' budgets relate to strategic planning rather than day-to-day management. Key areas within this budget are: accident and emergency; inpatient services for general medicine, geriatric medicine, rehabilitation, respiratory and learning disability psychiatry, and; palliative care services provided in hospital.

The scale of this resource for the purposes of this Strategic Plan reflects the use of unplanned resources by East Ayrshire residents over the last three years. This would relate to at least 100,000 bed days, (that is approximately 275 residents from East Ayrshire in hospital at any time) and three-quarters of unplanned expenditure.

A key priority for us over the next three years is continuing to reduce instances where our residents remain in hospital when they would be better looked after at home or in a homely setting. Often described as 'delayed discharges', we will work to prevent unnecessary hospital attendance, admission and to ensure that people are discharged from hospital as quickly is possible. We will work towards discharging people within 72 hours from being clinically ready and on reducing the number of bed days occupied as a result of 'delayed discharge'. This fits with our focus on people's outcomes and also with improving the flow through hospital services.

The expectation is that we work together strategically to develop plans to transform care for our population. Changes in resource following the implementation of planned changes will be reflected in future Strategic Plans.

What does this mean for service users?

The overall aim of the Strategic Plan is to offer a better experience for people, families and their carers who receive a service and to make the provision more effective and efficient.

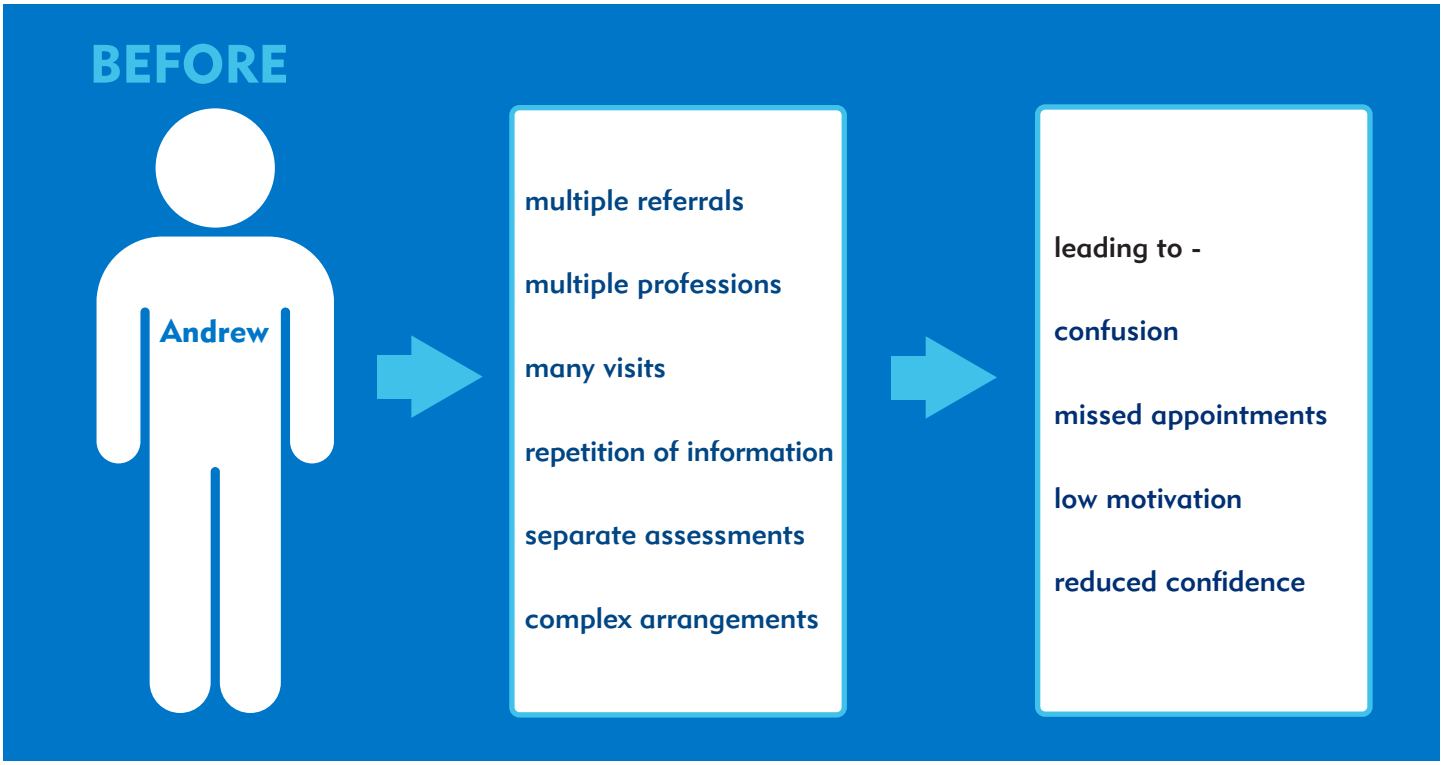
Through the implementation of Self Directed Support legislation for social care with an emphasis on promoting self management and co production in health services, there is a shift of power, choice and often responsibility from statutory services to individuals for their physical and mental wellbeing.

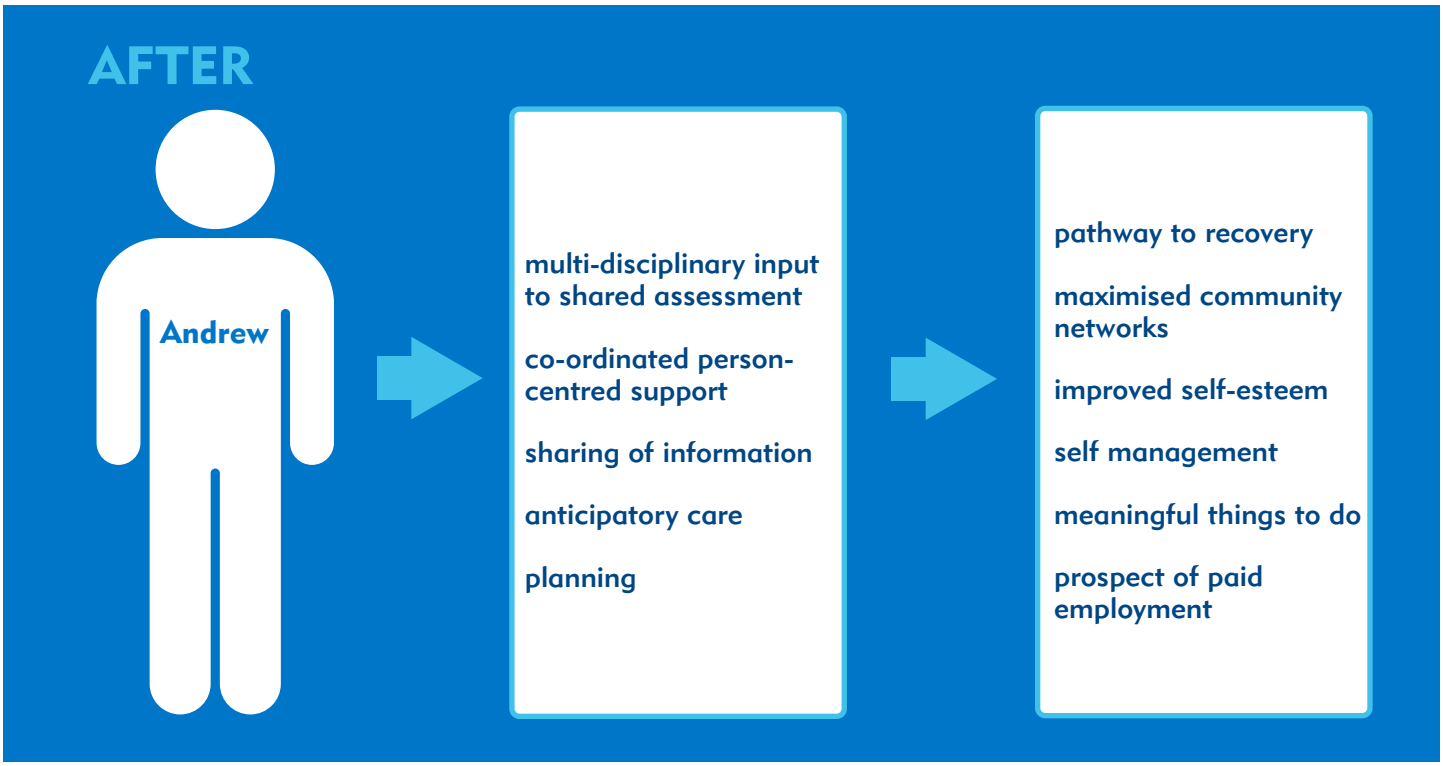
In east Ayrshire we have embraced this opportunity and will build on this value based partnership with people who access our services. There are already well established mechanisms in place to engage and hear from people who use our services on how we are doing and how we can improve. We will build on this to ensure that people feel included and are able to plan their care and shape services. We will continually challenge ourselves to 'think differently', to maximise choice and control and make sure people are at the centre of their care.

Case Study

Benefits of Integrated Care

Andrew is a (fictitious) man in his 40s with a range of long-term health and social care problems for which he needs care and support. These include a diagnosis of Bipolar illness, obesity, lack of physical or social activity and diabetes. He is unemployed and lives alone. Andrew's elderly mother recently passed away which prompted his move to a new area to make a new start. Andrew is claiming benefits.





Beth is a (fictitious) young girl of primary school age who has additional support needs and lives at home with her family. Beth has a number of support needs including regular visits to a paediatric consultant to assist with maintaining her mobility and attending a speech therapy clinic to develop her communication skills. Beth attends her local primary school where she has access to a support worker and is keen to transfer to her local high school with her friends.

BEFORE

- Family recognise additional support needs
- Diagnosis - GP, Paediatrician, Consultant involvement
- Referrals - HV, Nursery, Specialist Nurse, SW, OT
- Services unclear of what each other provide - 'inappropriate referral'
- Integrated + Specialist assess
- Services arranged
- Service-specific info provided
- Eligibility for specialist services assessed

- Range of services in place - planned respite
- Some long waits
- Support service-led + complex
- Parents in negotiator role between services
- Ms Green likes her main support worker
- Move to primary 'pressure point', holidays 'very stressful'
- Specialist services seem narrow + require travel
- Family resilience stretched by focus on negatives
- Concern about transition - secondary school, adulthood

AFTER

- Family recognise additional support needs
- Community org signpost to service
- Single lead person
- Comprehensive info
- Early peer support
- Holistic joint assess, plan and review
- Lead shares info
- Focus on SHANARRI outcomes
- Family and child shape supports

- Support coordinated
- Natural supports maximised
- In control of support as needs change
- Family/lead person review child's plan to prepare for future
- Housing services involved + respond
- Inclusive leisure, play and sporting opportunities
- Circle of friends, confident and likes to 'give things a try'.
- Ms Green lives an 'ordinary life'

East Ayrshire Area Profile

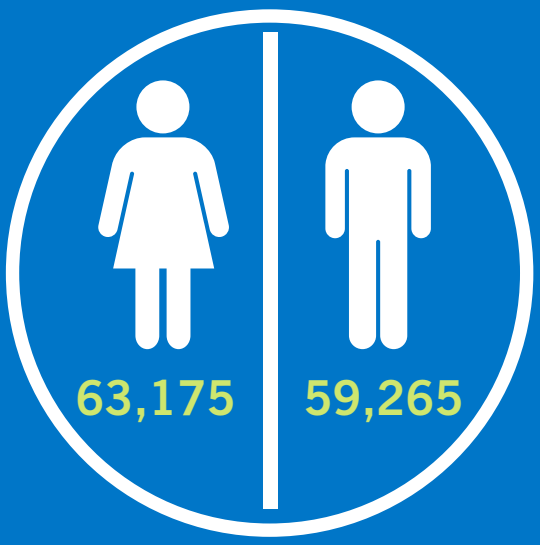
The pages that follow in this section illustrate some of the challenges that we have as a partnership in relation to health and wellbeing.

These show population changes, health behaviours and the use of hospital services. They also present information on indicators of wellbeing for women and children, long-term conditions within our population, and income and employment deprivation. Partnership resources are also shown. Indicators are taken from the most recent published (2014) community profiles from the Scottish Public Health Observatory (ScotPHO). Across a range of measures, East Ayrshire is significantly different from the rest of Scotland with health, wellbeing and economic outcome indicators tending to be poorer. This area profile informs the priorities for the partnership over the coming years.

The detail for data sources is provided on page 18.

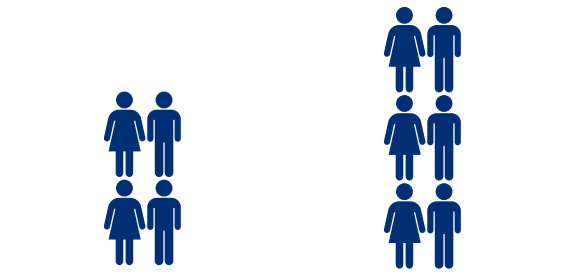
POPULATION

All people
122,440



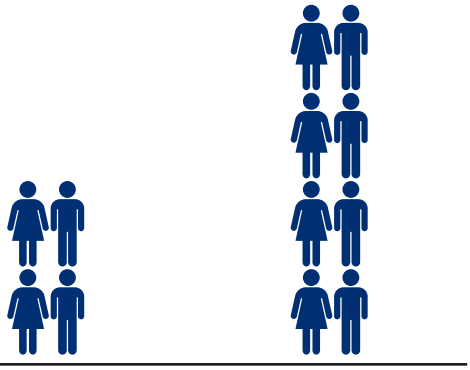
Age 0-15	21,375
Age 16-59	70,502
Age 60-74	20,747
Age 75+	9,816

People age 65 and over



2014	2030
23,356	31,896

People age 85 and over



2014	2030
2,501	4,853

(this is an increase of 86%)

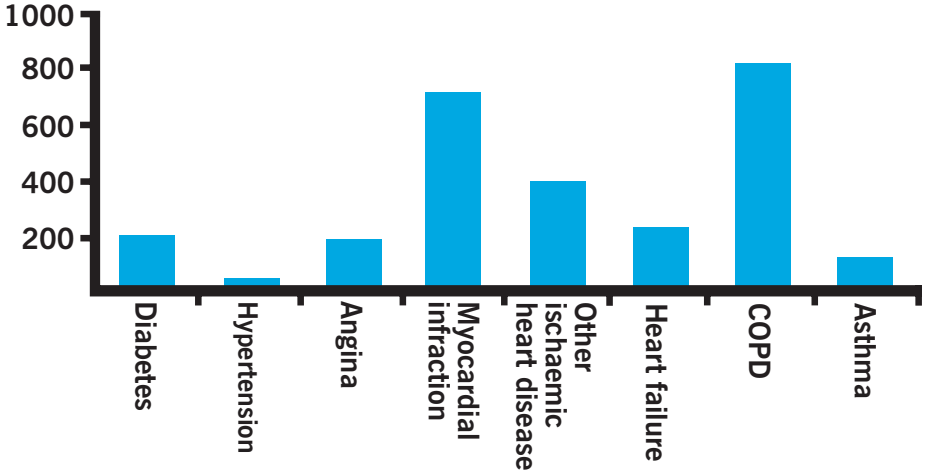
WOMEN+CHILDREN

	East Ayrshire	Scotland
Teenage pregnancy rate	56	41
Mothers smoking during pregnancy %	27	21
Babies exclusively breastfed at 6-8 weeks %	17	26

HEALTH BEHAVIOURS

	East Ayrshire	Scotland
Smoking prevalence %	32	23
Alcohol-related hospital discharge rate	796	686
Drug related hospital discharge rate	239	124

LONG TERM CONDITIONS



People with two or more long term conditions

18,233

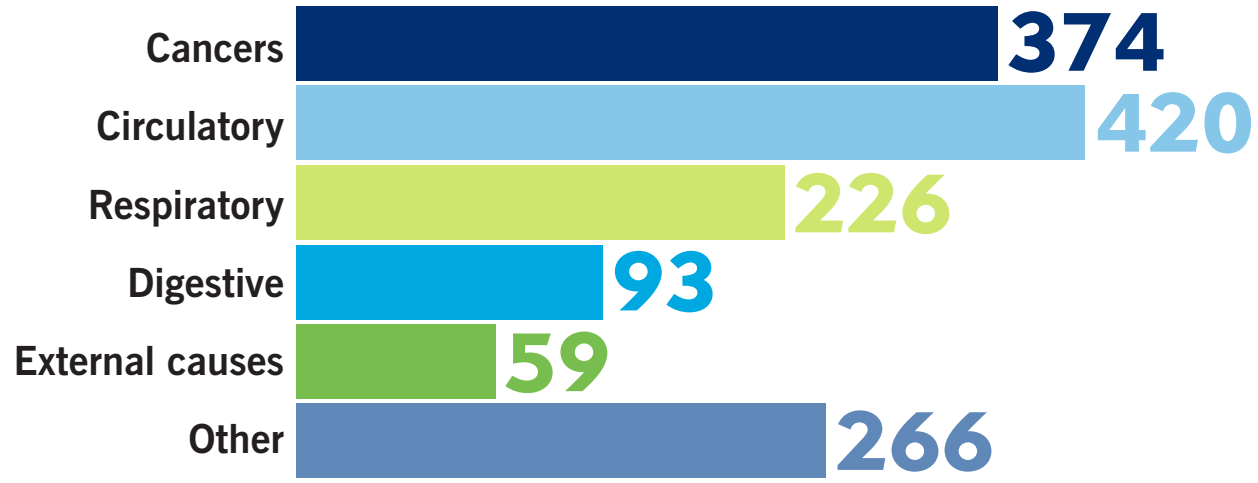
People with two or more conditions using 50% of resources

1,544

HOSPITAL ADMISSION RATES

Emergency	8,944
Multiple (65+)	6,062
CHD	510
Asthma	988
COPD	370

MORTALITY



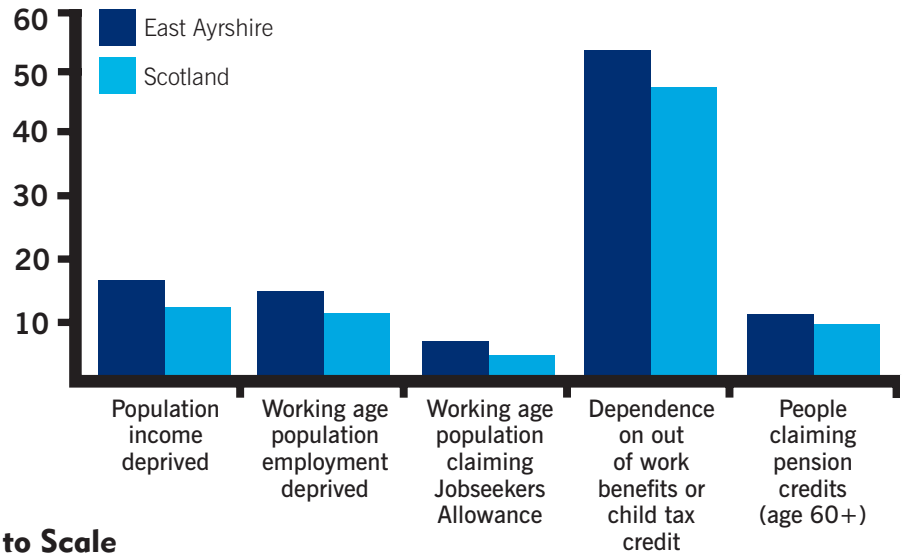
ECONOMY

Population income deprived
20,060

Employment deprived
11,710

Claiming JSA
4,840

Number of People



% to Scale

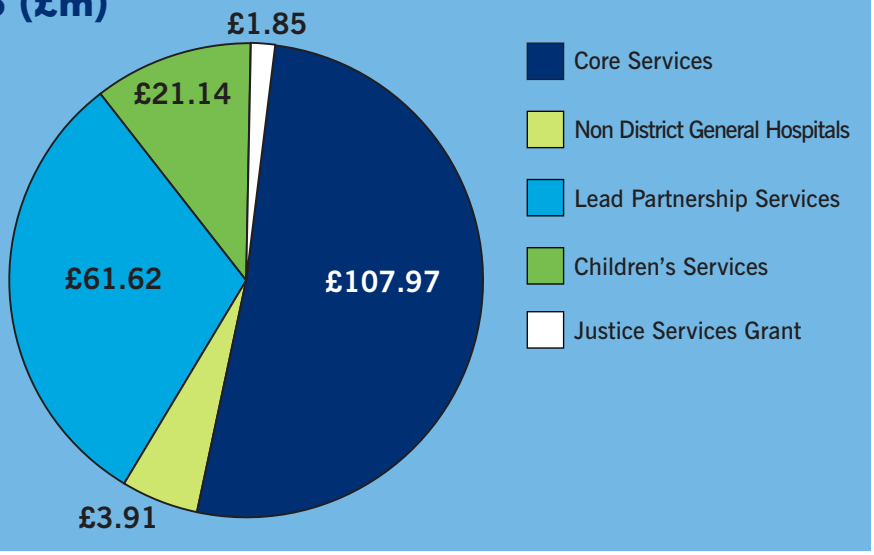
PARTNERSHIP RESOURCES (£m)

Partnership resource
£192.8m

Lead partnership
£61.6m

Non - elective acute use
£62.8m

(IRF)

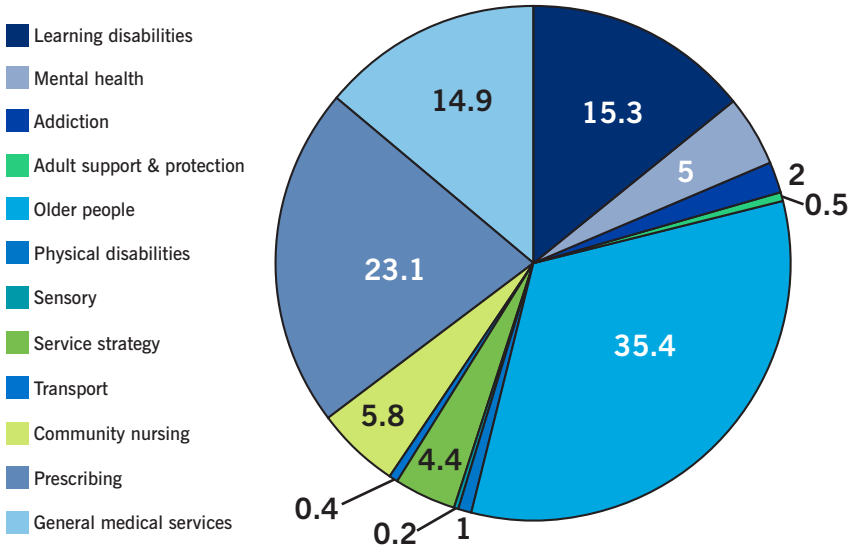


CORE SERVICES RESOURCES (£m)

Older People
£35.4m

Prescribing
£23.1m

Learning disability
£15.3m



HOUSING Properties in urgent disrepair

Key: rates and percentages in health behaviours, hospital admission, women and children, economy and long-term conditions, refer to crude rates per relevant population, percentages to observed number divided by relevant population expressed as a rate per 100. E.g., teenage pregnancy rate refers to pregnancies per 1,000 population aged 13-19; long-term conditions rates are bed days per 100,000; percentage exclusive breastfed refers to the number of babies exclusively breastfed divided by the number of babies reviewed at 6-8 weeks times 100. Population, mortality and resources refer to raw figures. **Abbreviations used - COPD = Chronic Obstructive Pulmonary Disease; CHD = Coronary Heart Disease**

Strategic Priorities – Care at all life's stages

The publication of the Christie Commission on Public Sector Reform (2011) identified four pillars on how services should be reformed in Scotland, these are; a shift towards prevention, a focus on performance and workforce development and the need for a more localised partnership approach. For East Ayrshire partnership our partners include, neighbouring Local Authorities and the Third and Independent Sectors working together with patients, carers and the public.

Community Planning is central to how partners come together to address the priorities for our communities. Mitigating the impact of alcohol and drug addiction and ensuring the best outcomes for our children and young people are paramount.

Recent legislation and policy including the 2020 Vision for Health and Social Care, along with the Children and Young People's Act 2014, which seeks to ensure that young people's wellbeing is supported at all life's stages and transitions, underpin our approach to how services will be shaped and delivered in the future.

2020 Vision

'By 2020 everyone is able to live longer healthier lives at home, or in a homely setting'.

We will have a healthcare system where we have integrated health and social care, a focus on prevention, anticipation and supported self management. When hospital treatment is required, and cannot be provided in a community setting, day case treatment will be the norm. Whatever the setting, care will be provided to the highest standards of quality and safety, with the person at the centre of all decisions. There will be a focus on ensuring that people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission.

Our commitments

Health inequality

It is well known that the life expectancy for our residents can vary by as much as 10 years depending on where they live. We recognise that deprivation, long term illnesses and disability are common factors in ill health and we will work with our Community Planning Partners to improve access to and provision of services. We know that employment is a key route in assisting people to address the inequalities they face including health inequalities. Therefore, ensuring that people are well connected to access employment opportunities is also important. Our staff will offer income maximisation assistance to families and access to specialist benefits and money advice.

Children and young people

We aim to give our young people the best start in life and to support them through the transition to adulthood. We will do this by increasing support for families to help them avoid crisis. We will provide more flexible childcare available over longer hours. Children of all ages, particularly the most vulnerable, will be offered greater access to leisure opportunities and parents will be assisted to encourage them to adopt an active healthy lifestyle.

Preventing illness

By offering a greater range of community based health screening and health activities to support people to participate in smoking cessation, healthy weight and alcohol and drug programmes.

Care for older people

We will continue to support as many people to live as independently at home, as possible, providing the right kind of care to enable them to do so. We aim to reduce the number of admissions and readmissions to hospital and ensure that where people are admitted to hospital that they are timeously discharged from hospital back to their homes.

Supporting people with long-term conditions

In line with 'Many Conditions, One Life: Living Well with Multiple Conditions' (National Action Plan) we will ensure that our approach is person-centred, anticipatory, and that people are supported in managing multiple conditions. We are working to support The National Dementia Strategy recognising that a number of people being cared for at home or in our homely settings in the community do so whilst living with the impact dementia has on their quality of life.

End of life care

We aim to provide better community-based palliative care to enable people who are near the end of their lives to be in the place they wish to be cared for and to die where they choose. For individuals and families, discussing and planning for the end of life care can be very difficult. A range of support is available to assist families to consider the care arrangements and to ensure that a plan is in place at the time that it is most needed.

Community Justice Services

We will work with our Community Planning Partners to support people to identify new skills whilst they are in prison and to reduce offending when they leave. We are also working to ensure that our communities feel safe from incidents of harm.

Community engagement

Encouraging people to take greater control over their own health and to become more active and involved in their local communities. Social isolation is a key factor in exacerbating ill health, being more involved and contributing to community life can create a greater sense of connectedness and reduce the feelings of isolation.

Choice and control

People with learning disabilities, mental health, autistic spectrum disorders, will continue to be supported to be able to lead fulfilled lives and be in control of their support.

Redesign of services

As people become more involved in deciding their own care through the options available by Self Directed Support, we will consider if the way we currently offer services is still the best way. We will work with individuals, families and carers in local communities and consider where and how our services are delivered and if we can achieve this in a more efficient way. Our partners in the third sector will assist in the delivery of new and innovative services, recognising the contribution to be made by voluntary and community organisations.

Care close to home

We aim to deliver more care at home by increasing the number of integrated community teams in local communities around GP Practices. We will share information with other professionals and increase access to services through a single point of contact easing access to a range of services. We want to make it easier for individuals to get access to minor aids and adaptations and help families plan for the future when care at home may no longer be possible. We will work alongside partners to support and develop community-based services in local areas and to reduce the number of hospital visits by improving access to services in our communities.

Technology Enabled Care

Extending the use of new technology such as telehealth/ telecare services allows individuals to remain independent, monitor their health and link closely with GP practices therefore reducing the frequency of travel to hospital appointments.

Workforce

Partnership work with employees is an effective and essential vehicle to support workforce and service delivery. We are committed to continuing to build and develop relationships with staffside colleagues in East Ayrshire to enable the partnership to deliver the best services and achieve the best outcomes for people that require our support. We will do this through programmes of engagement in the partnership, workforce planning and organisational development within the partnership and the Integration Joint Board.

Performance Measures

Partnership performance will be measured on the basis of key indicators linked to the National Health and Wellbeing Outcomes, local priorities identified in this plan and through our contribution to supporting the outcomes of the East Ayrshire Community Plan. The partnership will use existing measures that relate to these priorities. A Data Dictionary will support this. It is recognised that further measures will need to be developed, for example, in relation to experience. Performance reporting will dovetail with the requirements of key Health Improvement, Efficiency, Access and Treatment (HEAT), the Community Plan and Single Outcome Agreement.

The supporting Action Plan will provide the evidence on how well we are doing and whether we are achieving the national outcomes. The Action Plan will be set for a three period and will be reviewed annually.

Planning into the future

This strategy is only the beginning. It will be in place for three years and be reviewed on an annual basis. We will focus on how to meet the needs of people who use services in local communities. We will further develop services in localities (at a more local level) and discuss with individuals, families and carers how best to do this.

Planning arrangements will be established covering each locality with local people, employees and contractors working together. The role of locality planning is to identify what priorities are most important and use this information to inform and develop the next strategy.

We will evaluate how well we are doing through our Strategic Plan Action Plan which will provide greater detail on the actions we will take to achieve the best outcomes for our residents. The involvement and feedback from people who use our services will be key to how we measure success. We will continue to develop person-reported outcome measures to inform our assessment of performance and improvement.

Profile theme	Source
Population	National Records of Scotland, Mid Year Estimates 2013
People aged 65 and over People aged 85 and over	National Records of Scotland, Sub-National Population Projections 2012-based
Women and Children	Scottish Public Health Observatory, Health and Wellbeing Profiles 2014
Health Behaviours	Scottish Public Health Observatory, Health and Wellbeing Profiles 2014, Scottish Public Health Observatory, Alcohol Profiles 2014. Scottish Public Health Observatory, Drug Profiles 2014.
Long Term Conditions	ISD Scotland, Acute Hospital Activity and NHS Beds Information for Year Ending 31st March 2014
Hospital Admission Rates	ISD Scotland, Inpatient and Day Case Activity 2013/14
Mortality	National Records of Scotland, Vital Events Reference Tables 2013
Economy	Scottish Public Health Observatory, Health and Wellbeing Profiles 2014
Housing	Source: Scottish Government, Scottish House Conditions Survey 2011-13

Further Information

If you would like more information there are a number of documents produced to complement this summary plan;

- East Ayrshire Health and Social Care Plan - full document
- Strategic Plan Action Plan 2015-2018
- NHS Ayrshire and Arran Public Health Dept. Rapid Needs Assessment - Reducing Adverse Events in Children 2014
- NHS Ayrshire and Arran Public Health Dept. Rapid Needs Assessment Reducing Avoidable Emergency Admissions 2014

The full plan and supporting documents are available at the following website:

http://eac.eu/eastayrshirehealthandsocialcarepartnership

If you wish further information please contact:

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Or you can email us at

HealthandSocialCareIntegration@east-ayrshire.gov.uk

This information can be made available, on request, in braille, large print or audio formats and can be translated into a range of languages. Contact details are provided below.

درخواست کرنے پر یہ معلومات نابینا افراد کے لئے اُبھرے حروف، بڑے حروف یا آڈیو میں مہیا کی جاسکتی ہے اور اسکا مختلف زبانوں میں ترجمہ بھی کیا جاسکتا ہے۔ رابطہ کی تفصیلات نیچے فراہم کی گئی ہیں۔

本信息可应要求提供盲文，大字印刷或音频格式，以及可翻译成多种语言。以下是详细联系方式。

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ਇਹ ਜਾਣਕਾਰੀ ਮੰਗ ਕੇ ਬੇਲ, ਵੱਡੇ ਅੱਖਰਾਂ ਅਤੇ ਸਣਨ ਵਾਲੇ ਰਪ ਵਿਚ ਵੀ ਲਈ ਜਾ ਸਕਦੀ ਹੈ, ਅਤੇ ਇਹਦਾ ਤਰਜਮਾ ਹੋਰ ਬੋਲੀਆਂ ਵਿਚ ਵੀ ਕਰਵਾਇਆ ਜਾ ਸਕਦਾ ਹੈ। ਸੰਪਰਕ ਕਰਨ ਲਈ ਜਾਣਕਾਰੀ ਹੇਠਾਂ ਦਿੱਤੀ ਗਈ ਹੈ।

Niniejsze informacje mogą zostać udostępnione na życzenie, w alfabecie Braille'a, w druku powiększonym lub w formacie audio oraz mogą zostać przetłumaczone na wiele języków obcych. Dane kontaktowe znajdują się poniżej.

Faodar am fiosrachadh seo fhaighinn, le iarrtas, ann am braille, clò mòr no clàr fuaim agus tha e comasach eadar-theangachadh gu grunn chànanan. Tha fiosrachadh gu h-ìosal mu bhith a' cur fios a-steach.

East Ayrshire Council

Voluntary Action East Ayrshire

NHS Ayrshire & Arran

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