Context
The national policy directive Reshaping Care for Older People: A Programme for Change (2011) was developed after significant public consultation. The key objective is to shift the balance of care to community settings. A financial arrangement known as the Change Fund was established to provide bridging finance to allow community supports to be piloted.

Another requirement of Reshaping Care is that the NHS, Local Authorities, the Independent sector (both care homes and care at home) and the Third Sector Interface (the Partnership) work together to develop plans to inform how future support services will look, be delivered jointly, and improve the outcomes for older people

Within Ayrshire there was agreement to undertake this work on a pan Ayrshire basis and the resultant Draft Ten Year Vision for Joint Services- Reshaping Care for Older People is attached.

Comments and views are sought on this document; details of how these can be submitted are given overleaf. The finalised version is to be completed by 28 February 2012.
Responses by letter to:
FREEPOST RRRZ-TYRA-LGCT
Older people’s services
Patient and Community Relations
Eglinton House, Ailsa Hospital
Dalmellington Road
AYR KA6 6AB
Email: Reshapingcare@aapct.scot.nhs.uk
Telephone free: 0800 169 1441
You can also find out more information from the following websites:
www.nhsaaa.net
www.east-ayrshire.gov.uk
www.north-ayrshire.gov.uk
www.south-ayrshire.gov.uk
www.cvoea.co.uk
www.tsinorthayrshire.org.uk
www.voluntaryactionsouthayrshire.org.uk
www.scottishcare.org
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Engagement Draft 26.11.12
Executive Summary
As part of the Scottish Government's policy directive ‘Reshaping Care for Older People a Programme for Change’, every Community Health Partnership (CHP) across Scotland is required to develop plans to jointly commission services for older people covering a ten year period.

At the heart of this agenda is a new philosophy of care that promotes ‘enablement’ and supports people to maximise their independence and quality of life. Achieving this will require a ‘shift the balance of care’ away from hospital based services to the community.

Ayrshire Wide Approach
Building on the strong and positive partnership working already in place between NHS Ayrshire & Arran, North, South and East Ayrshire Councils as well as Third and Independent Sector organisations across Ayrshire, it was agreed to take this work forward on a Pan Ayrshire basis.

To this end, a Programme Board comprising representatives of the above organisations and agencies was established to progress this work. This is referred to throughout the document as ‘the Partnership’.

Ayrshire Older People’s Needs Assessment
A joint Older People’s Needs Assessment was carried out to provide a comprehensive overview of the issues relating to the demographic change and issues associated with the Ayrshire & Arran’s ageing population.

Ten Year Vision for Joint Services - Reshaping Care for Older People
In support of the Reshaping Care policy directive and drawing on the Ayrshire Older People’s Needs Assessment, the Partnership has agreed a Ten Year Vision for Joint Services – Reshaping Care for Older People:

**Older people in Ayrshire enjoy full and positive lives within their own communities**

Two key components will be important in realising this Vision: local communities, and services for older people.

- **Local Communities**
  There is a need for a shift in the way ageing and older people are perceived by society, as well as careful consideration of where responsibility for care and support lies. This includes recognising that ‘solutions’ are not always ‘service-based’, but rather, local communities are well-placed to support and care for older people.

- **Services for Older People**
  A strategic look at what and how services are provided is required, with a view to changing or stopping less effective services and introducing better ways of working together.

Underpinning this view is recognition that good health and healthy behaviours are essential at all ages to prevent or delay the development of chronic disease. ‘Good health adds life to years’ (WHO 2012). Good health, prevention and health improvement must therefore be at the core of any successful response to ageing.
Future models of care
Drawing on this Vision, future models of care will place increased emphasis on making use of the ‘assets’ and community capacity that already exist within local communities.

An ‘asset based approach’ is a way of working that promotes and strengthens existing assets within the community. Assets can be social, financial, physical and environmental and are more than just the things you can put a price on.

Areas of Change
In order to progress the Ten Year Vision for Joint Services – Reshaping Care for Older People, work has been prioritised in the following areas:

- Preventative and Anticipatory Care
- Sustaining Independence
- Effective Care at Times of Transition
- Care Homes
- Hospitals

Some services will have to be reconfigured or stopped and replaced by new services. It is expected that further suggestions will be brought forward as a result of engagement, and these will be incorporated into the Vision as it progresses.

Service Principles
A set of principles have been developed which will be used by Partners when redesigning or commissioning services for Older People:

- Person Centred
- Outcome Focused
- Proactive
- Flexible, Responsive and Forward Looking
- Joined Up
- Accessible
- Resilience Building

Next Three Years
The work progressed over the next three years will be critical to moving services towards the Ten Year Vision for Joint Services - Reshaping Care for Older People. There will be some new areas of work. However, most of the changes and improvements have already started and will involve working closely with local groups and communities to build on the good progress to date.

Alongside specific actions addressing individuals’ needs, ranging from anticipatory care to hospital care, actions to work with communities to raise and maintain health will contribute to reducing the burden of ill-health amongst the older population. Such actions will address the wider determinants of health such as income maximisation including benefits advice, cooking skills especially for those newly on their own, social activities to reduce isolation and walking groups to promote physical activity.

Engagement
All feedback received through the current engagement period will be used to further inform the Ten Year Vision for Joint Services – Reshaping Care for Older People. A wide and far reaching continuous engagement plan is in place for the further development of the draft plans and will run
until February 2013. It is important that everyone in Ayrshire is offered a range of opportunities to express their views using a variety of methods and approaches.

Social media, a DVD, presentations to groups and organisations, Focus Groups, engagement materials (including booklets) will be widely disseminated by all partners, while partnership pan-Ayrshire events will promote the Ten Year Vision for Joint Services – Reshaping Care for Older People.

Comments and views will be used to inform the Ten Year Vision for Joint Services - Reshaping Care for older people and associated implementation and investment plans.

Please forward any comments you may have to:

FREEPOST RRRZ-TYRA-LGCT
Older People’s Services
Patient and Community Relations
Eglinton House
Ailsa Hospital
Dalmellington Road
Ayr
KA6 6AB

reshapingcare@aapct.scot.nhs.uk

08001691441

In order for comments to be included in the final version, please return any remarks as soon as possible, but no later than Friday 15th February 2013.
Ten Year Vision for Joint Services – Reshaping Care for Older People

1 Introduction

1.1 Background

As part of the Scottish Government’s policy agenda to ‘Reshape Care for Older People’, guidance was issued to Community Health Partnerships (CHPs) across Scotland, outlining the requirement to develop plans to jointly commission services for older people covering a ten year period.

NHS Ayrshire & Arran, North, South and East Ayrshire Councils as well as Third and Independent Sector organisations across Ayrshire & Arran have a positive history of joint working. Reflecting the strong partnership working already in place, it was agreed to develop a Ten Year Vision for Joint Services – Reshaping Care for Older People on a Pan Ayrshire basis, supported by three year implementation and one year investment plans reflecting the needs within each Community Health Partnership (CHP), shown in Figure 1 below.

Figure 1 Hierarchy of Documents for the Development of Joint Services

To take forward this work, a Programme Board led by two senior officers, one from Health and one representing the Local Authorities, was established in March 2012. The Programme Board comprises representatives from Health, Local Authorities, the Third Sector and the Independent Sector. This is referred to throughout the document as ‘the Partnership’.

This Ten Year Vision for Joint Services – Reshaping Care for Older People sets out a high level vision, future direction of travel, as well as specific areas for action, to show how the Partnership will work to develop new models of care and support to reshape services and improve outcomes for older people, their families and carers.

1 Please refer to Appendix 1 for details.

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2 Integration of Health and Social Care
The development of a Ten Year Vision for Joint Services – Reshaping Care for Older People has been widely recognised as the first step on the path to the Integration of Adult Health and Social Care.

A consultation on the Integration of Health and Social Care was undertaken over the summer of 2012. Each of the Ayrshire CHPs were fully involved in the Integration of Adult Health and Social Care consultation process, and submitted a response to the Scottish Government\(^2\).

Key elements of the proposed new system include:

- Community Health Partnerships to be replaced by Health and Social Care Partnerships, which will be the joint responsibility of the NHS and local authority, and will work in partnership with the Third and Independent Sectors;

- partnerships will be accountable to Ministers, leaders of local authorities and the public for delivering new nationally agreed outcomes. These will initially focus on improving older people’s care and are set to include measures such as reducing delayed discharges;

- NHS Boards and local authorities will be required to produce integrated budgets for older people’s services to bring an end to ‘cost-shunting’;

- the role of clinicians and social care professionals in the planning of services for older people will be strengthened; and

- a smaller proportion of resources – money and staff will be directed towards institutional care and more resources will be invested in community provision.

The outcome of this consultation is awaited at a national level. However, many of the proposed elements for integrating health and social care services will start to be addressed through the development of the Ten Year Vision for Joint Services – Reshaping Care for Older People. The outcome of the consultation on the Integration of Adult Health and Social Care will be reflected by the Partnership in how it works together to provide integrated services for older people.

\(^2\) Please refer to link to response in Appendix 2.
3 Vision for Joint Services – Reshaping Care for Older People

The Reshaping Care for Older People guidance describes a new philosophy of care that promotes an ‘enabling’ approach, and supports people to maximise their independence and quality of life. At the heart of the Reshaping Care for Older People agenda there is recognition that people aspire to stay in their own home as they get older. To support this aspiration, the Partnership has agreed an overall Vision for Joint Services for older people:

*Older people in Ayrshire & Arran enjoy full and positive lives within their own communities*

Two key components will be important in realising this Vision: local communities, and services for older people.

- **Local Communities**
  
  There is a need for a shift in the way ageing and older people are perceived by society, as well as careful consideration of where responsibility for care and support lies. This includes recognising that ‘solutions’ are not always ‘service-based’, but rather, local communities are well-placed to support and care for older people. To achieve this, local communities must:
  
  - respect and include older people;
  - take responsibility for their welfare and well-being;
  - welcome the skills and experiences that older people contribute; and
  - contain strong support networks offering a variety of activities and opportunities.

  Community capacity building will be required to support local communities.

- **Services for Older People**
  
  A strategic look at what and how services are provided is required, with a view to changing or stopping less effective services and introducing better ways of working together.

  When services are required they need to be:
  
  - developed with and for older people, taking into account their carers, family, friends and social networks;
  - meeting needs and aspirations;
  - timely, integrated and co-ordinated;
  - preventative and anticipatory; and
  - working in partnership with older people.

  Good health and healthy behaviours is essential at all ages to prevent or delay the development of chronic disease. ‘Good health adds life to years’ (WHO 2012). Good health, prevention and health improvement must therefore be at the core of any successful response to ageing.
4 Future Models of Care

It is widely recognised that Reshaping Care for Older People will be highly complex and challenging. It may take several years to achieve; however, this process of change is not one which can be put off any longer because of the difficult financial position and the demographic change.

Some of the differences between the ‘old’ and the ‘new’ models of care are illustrated in Table 1 below.

Table 1 Old Model vs. New Model

<table>
<thead>
<tr>
<th>Old Model</th>
<th>New Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reactive care – only being given once you have</td>
<td>Proactive care – helping people to stay healthy and plan for conditions</td>
</tr>
<tr>
<td>become sick or have a crisis in your health</td>
<td></td>
</tr>
<tr>
<td>Hospital Centred Care</td>
<td>Community based in people’s own homes, if possible, as well as acute and</td>
</tr>
<tr>
<td></td>
<td>community hospitals, and other local facilities</td>
</tr>
<tr>
<td>Disjointed care</td>
<td>Integrated, continuous care</td>
</tr>
<tr>
<td>Patients and carers as passive recipients</td>
<td>Patients and carers fully involved in their care</td>
</tr>
<tr>
<td>Carers undervalued</td>
<td>Carers supported as partners</td>
</tr>
<tr>
<td>Self care infrequent</td>
<td>Self care encouraged and facilitated</td>
</tr>
<tr>
<td>Low tech</td>
<td>High tech</td>
</tr>
<tr>
<td>Episodic Care</td>
<td>Team based</td>
</tr>
<tr>
<td>Geared towards acute conditions</td>
<td>Geared towards long-term conditions</td>
</tr>
</tbody>
</table>

4.1 Moving to an Asset Based Approach

As part of the change to new models of care outlined above, there will be increasing emphasis on making use of the ‘assets’ and community capacity that already exist within local communities.

Assets are described as the collective resources that individuals and communities have – internally, externally and collectively – which help protect against poor health and also support the development and maintenance of good health\(^4\).

‘Asset based approaches’ are ways of working that promote and strengthen existing assets within the community. Assets can be social, financial, physical and environmental and are more than just the things you can put a price on\(^5\).

Central to asset approaches is the idea of people in control of their lives through development of their capacities and capabilities. The Partnership recognises and supports the value of an asset

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3 Adapted from Scottish Government *Overview of Evidence Relating to Shifting the Balance of Care* 2008 (p. 7)
4 McLean and McNeice (2012 p.6)
5 McLean and McNeice (2012 p.6)

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based approach to health and community care. This represents a radical departure from the ‘deficit’ approach that has been the main way health and social care has been approached in the past.

Deficit models focus on identifying problems and needs of populations which require professional resources to resolve them. This results in high levels of dependence on services which do not support the active involvement of individuals in their care,

The asset-based approach has also been closely associated with co-production – which means delivering public services in an equal and reciprocal relationship between professionals, people using services, their families and their neighbours. The differences in these approaches are shown in Table 2 below.

Table 2 Deficit vs Asset-Based Approach

<table>
<thead>
<tr>
<th>Deficit Approach</th>
<th>Asset-based Approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starts with deficiencies and needs of an individual or community</td>
<td>Starts with assets / resources in an individual or community</td>
</tr>
<tr>
<td>Responds / reacts to problems</td>
<td>Proactively identifies opportunities and strengths</td>
</tr>
<tr>
<td>Provides services to users</td>
<td>Invests in people as active participants</td>
</tr>
<tr>
<td>Emphasis on the role of services</td>
<td>Emphasises the role of civil society</td>
</tr>
<tr>
<td>Focuses on individuals in isolation</td>
<td>Focuses on individuals in communities / neighbourhoods and the common good</td>
</tr>
<tr>
<td>Sees people as clients and consumers receiving services</td>
<td>Sees people as participants and co-producers with something to contribute</td>
</tr>
<tr>
<td>Treats people as passive and ‘done-to’</td>
<td>Helps people take control of their lives</td>
</tr>
<tr>
<td>Tries to ‘fix’ people</td>
<td>Supports people to develop their potential</td>
</tr>
<tr>
<td>Implements programmes as the answer</td>
<td>Sees people as the answer</td>
</tr>
</tbody>
</table>

---

6 NESTA & NEF 2009
7 McLean and McNeice Assets in Action 2012 (p. 108)
5 National Policy Context
The imperative to transform services for older people has been set out in a number of policy and legislative documents in recent years. A full summary of these documents are outlined in Appendix 2. However, several documents have had particular importance in driving and the development of this Ten Year Vision for Joint Services – Reshaping Care for Older People, which are discussed below.

5.1 Reshaping Care for Older People (Scottish Government 2011)
‘Reshaping Care for Older People – an Programme for Change’, published by the Scottish Government in 2011, set out what change is to take place to ensure the right services and support are in place to meet the needs of older people across Scotland in the 21st century.

Critical to this agenda is the need to ‘shift the balance of care’ away from hospital based services to the community. This increases the need for:

1. prevention – so that people keep well and are helped to manage their conditions better so they do not require a hospital admission in the first place; and
2. community based services – if/when people do need more support, they are helped in their own community.

This requires a change in the way resources, both finance and staff, are deployed. This is illustrated by the model shown in Figure 2 below, which is the basis for this Vision and reflects the direction of travel adopted in this Ten Year Vision for Joint Services – Reshaping Care for older people.
Figure 2: Reshaping Care for Older People Model

Promoting Community Wellbeing

Staying independent and self management of health conditions

Integrated rehabilitation and enablement services

Intensive support

Hospital Based Services

Shifting the balance of care and resources
5.2 Commission on the Future of Public Services (Christie Commission 2011)

The Christie Commission identified the need to improve service delivery and redesign to obtain better value for money.

This report highlights that services must be redesigned as demographic change will mean there will not be enough people of working age to support current service provision, or the money available to pay for it.

The main recommendations made by Christie include:

- the need to empower individuals and communities by involving them in service design and delivery;
- all partners, including the Third and Independent Sectors need to work closely together to support people to have more years of healthy life;
- expenditure on prevention of negative outcomes should be prioritised; and
- the whole public service system, including the Third and Independent Sector must become more efficient by reducing duplication and sharing services wherever possible.

The recommendations made by Christie are reflected within this Ten Year Vision for Joint Services – Reshaping Care for Older People.

5.3 Review of Community Planning and Single Outcome Agreements (SOAs) - Statement of Ambition (2012)

Effective community planning arrangements will be at the core of public service reform outlined within the Christie Commission. These arrangements will drive the pace of service integration, increase the focus on prevention and secure continuous improvement in public service delivery, in order to achieve better outcomes for communities.

The review of Community Planning identified the need to work through how community planning feeds into and supports wider aspects of the reform agenda, particularly the integration of adult health and social care services and the establishment of single police and fire services. It focused on revising and strengthening the current approach in the face of financial and other challenges to ensure that community planning partnerships are a cornerstone of the outcomes focussed and partnership based approach to public service reform in Scotland.

Three core proposals were included:

1. Strengthening duties on individual partners through a new statutory duty on all relevant partners, (whether acting nationally, regionally or locally), to work together to improve outcomes for local communities through participation in community planning partnerships and the provision of resources to deliver the SOA.

2. Placing formal requirements on Community Planning Partnerships (CPPs) by augmenting the existing statutory framework to ensure that collaboration in the delivery of local priority outcomes via Community Planning and the SOA is not optional and is made as effective as possible.
3. Establishment of a joint group at national level to provide strategic leadership and guidance to CPPs.

To take this forward, revised guidance on the development of Single Outcome Agreements is expected, legislative change will be undertaken in support of the proposals, where necessary and arrangements will be put in place to support capacity building and scrutiny.

The Partnership is committed to monitoring the outcomes of this further work and will respond to these as required.

5.4 Achieving Sustainable Quality in Scotland’s Healthcare – A 20:20 Vision (Scottish Government 2011)

The 20:20 Vision outlined what is required to improve efficiency and achieve financial stability within the health and social care system. The 20:20 Vision applies to the health and care needs of the whole population, not just older people, who make more use of services as they grow older.

The 20:20 Vision highlighted that over the next 10 years the proportion of over 75s in Scotland’s population – who are the highest users of NHS services - will increase by over 25%. By 2033 the number of people over 75 is likely to have increased by almost 60%. There will be a continuing shift in the pattern of disease towards long-term conditions, particularly with growing numbers of older people with multiple conditions and complex needs such as dementia. Over the next 20 years demography alone could increase expenditure on health and social care by over 70%.

The key outcomes identified in the 20:20 Vision, that by 2020 everyone is able to live longer healthier lives at home, or in a homely setting, as well as the challenges in relation to person-based, staff-based and system based interventions are reflected in this Ten Year Vision for Joint Services – Reshaping Care for Older People.

5.5 Commissioning of Social Care (Audit Scotland 2012)

Audit Scotland identified the substantial gaps and uncoordinated way in which services have tended to be commissioned. The main recommendations made by the Audit Commission and adopted within this Ten Year Vision for Joint Services – Reshaping Care for Older People include:

- the need to develop commissioning strategies;
- the need to manage the risks of contracting services from voluntary and private providers;
- implement self-directed support in a way that service-users will get information, advice and support and processes are in place to monitor the outcomes of the support; and
- the need to work very closely together with all partners, including the Third and Independent Sectors.
5.6 Age, Home and Community: A Strategy for Housing (Scottish Government 2011)

The Age, Home and Community strategy document published by the Scottish Government set out the contribution housing services must make to Shift the Balance of Care. The main proposals outlined in this document and recognised within the Vision for Joint Services for older people include:

- The importance of advice and information for older people about the housing options and support available to them;
- Delivering adaptations in an efficient and effective way;
- Developing a national register of accessible housing;
- Establishing and promoting ‘Trusted Trader’ schemes;
- Encouraging ‘downsizing schemes’;
- New guidance for the redevelopment of sheltered and very sheltered housing;
- Making it easier for older people to access the equity in their home;
- Mainstreaming Telehealth and Telecare;
- Reviewing building and design standards to meet the needs of older people.

In addition to the proposals set out in Age, Home and Community, recent guidance has stipulated that a Housing Contribution Statement must be completed by the Partnership to outline the role housing will play in shifting the balance of care and achieving this Ten Year Vision for Joint Services – Reshaping Care for Older People. This will be completed and agreed by the Partnership when further guidance is issued.

5.7 Caring Together: The Carers Strategy for Scotland 2010 - 2015

Caring Together acknowledges the vital contribution unpaid carers make to the health and social care system and commits to working with carers as equal partners in the planning and delivery of care and support.

It is recognised both nationally and locally that Health and Social Care services depend on the significant amounts of caring provided by partners, family members and others to respond to the increasing challenges posed by an ageing population.

The economic contribution that unpaid carers make to the economy is significant. It is estimated that carers save statutory services £7.6 billion per year in Scotland.

The high social and economic value of unpaid carers is fundamental to society’s ability to cope with the increasing demand for older people’s services. The Partnership is fully committed to ensuring that unpaid carers are assisted in their role and that the services they provide are recognised and fully supported.
5.8 Scotland's National Dementia Strategy
Scotland’s National Dementia Strategy was published in June 2010 and sets out actions to improve services and support for people with dementia and their carers. The strategy focuses on two main areas of change:

- post diagnosis - ensuring that excellent support and information to people with dementia and their carers is offered following a dementia diagnosis; and
- hospital settings – improving the response to dementia, including through alternatives to admission and better planning for discharge.

In 2012, the Scottish Government made a commitment to guarantee that people receiving a diagnosis of dementia will be offered a minimum of one year of post-diagnostic support. This commitment will involve a link worker who will be assigned to work with the person, their family and carers in coordinating support and building a person-centred plan.

The Partnership recognises the importance of mental health in the overall health of older people and the impact that a dementia diagnosis can have on individuals and their families. The Partnership will work to implement the National Dementia Strategy as well as participate in the consultation on the second dementia strategy which is due to be published in 2013.

5.9 Equality Act 2010
The Equality Act 2010 places duties on bodies, including service providers in the statutory, Third and Independent Sectors not to discriminate on the basis of certain protected characteristics and make ‘reasonable adjustments’ in certain situations.

Whichever models of care are adopted in the future, the Partnership is fully committed to promoting equality and diversity within all future Joint Services.

This will be ensured through a robust process of Equality and Diversity Impact Assessment (EDIA), which is already embedded into practices across all public bodies, including NHS Ayrshire & Arran and each of the local authorities.

5.10 Welfare Reform Act 2012
The Welfare Reform Act received Royal Assent in March 2012. The reforms are mainly aimed at changing the benefits system for people of working age, but some of the changes will also affect older people. The Partnership is committed to exploring and understanding the implications of the reforms on older people, and will keep up to date with any future developments. The main changes are outlined in Appendix 4.

5.11 What does this mean for the Partnership?
The preceding discussion sets the scene for the considerable task that lies ahead to shift the balance of care for older people. A considerable amount of work and discussion has already taken place at a national level, and the implications for the Partnership in Ayrshire & Arran include:
Engagement Draft

- Services are under increasing pressure to meet the increasing demand for service with reduced budgets.
- The Partnership recognises that many services cannot maintain current ways of working into the future.
- There will be considerable change in what services are provided as well as the way in which they are provided.
- A transformational approach to commissioning is required to ensure the fullest use of all available resources across the Partnership, including the Third and Independent Sectors.

6 Strategic Commissioning

In the context of the policy guidance and to move towards ‘Joint Services’ for older people, the Partnership are committed to adopting ‘Strategic Commissioning’ practices. Strategic Commissioning describes a way of working that ensures the services available to the public are the best possible. It is the term used for all the activities involved in:

- assessing and forecasting needs;
- linking investment to desired outcomes;
- considering options, planning the nature, range and quality of future services; and
- working in partnership to put these in place.

Commissioning is commonly described as a cycle of strategic activities outlined in Figure 3.

6.1 The Commissioning Cycle

In this model, the Commissioning Cycle (the outer circle in Figure 3) drives purchasing and contracting activities (the inner circle), and these in turn inform the ongoing development of Strategic Commissioning.

This applies to all services and supports provided and delivered through statutory services, procured services (from the Third and Independent Sectors) and unpaid carers. The activities outlined in this Vision relates to the ‘Analyse’ and ‘Plan’ parts of the Commissioning Cycle. The Partnership is committed to working towards the ‘Do’ and ‘Review’ parts of the Commissioning Cycle.

6.2 Joint Commissioning

‘Joint Commissioning’ is when two or more agencies, such as those in the Partnership, work through the Strategic Commissioning process outlined in Figure 3 using an agreed pool of resources.
Joint Commissioning allows a ‘Whole Systems Approach’ to be adopted so that the full implications of a change in one part of the system can be anticipated and considered. This is important as without careful consideration, changes in one part of the system may simply displace or defer problems to another part of the system.

Committing to a pooled budget is challenging for all partners in the current uncertain financial climate. The financial inputs required for this Ten Year Vision for Joint Services – Reshaping Care for Older People are an extension of the work carried out jointly by the Local Authorities and Health as part of the Integrated Resource Framework (IRF). Within the IRF process there was agreement on the financial protocols and mechanisms to manage resources across partners. As part of the IRF, the costs for Health were disclosed by Local Authority area, as far as was practical, and reported with the Local Authority Social Services costs. This was later developed to identify the costs of older people services and formed part of the submissions for the Change Fund. This work will be further developed to support the identification of the resources for the ten year vision.

6.3 Commissioning for Outcomes

‘Commissioning for outcomes’ is a commissioning approach which involves specifying what is required from a service. The buyer, which could be a local authority or the NHS, on behalf of the Partnership, stipulates the outcomes to be achieved rather than the level of input that is required, for instance, rather than asking an organisation to provide a certain number of home care hours, potential providers are asked to explain or demonstrate how their service could improve the quality of life for people who would use the service.

Moving forward, and in keeping with the nationally-led directive to provide greater focus on quality, the Partnership will evaluate and commission services with a specific emphasis on the outcomes those services achieve. This will include the views of patients and how clients rate their experiences of services, what they have received and the quality of outcomes delivered.

7 Workforce Planning and Development

Given the range of changes proposed as part of the Reshaping Care agenda, it is acknowledged that these will have significant implications for care providers across the Partnership, and the wider workforce.

Workforce planning and development will be crucial to ensure that workforce capacity and capabilities meet the future care and support requirements of older people. To create the workforce required to deliver the outcomes expected of this Ten Year Vision for Joint Services – Reshaping Care for Older People, the Partnership will need to work together.
The Scottish Government has funded the Institute of Public Care (IPC) to develop a National Learning Framework, which will help to cultivate a Joint Commissioning culture and develop Joint Commissioning Skills.

One of the outputs from this work will include a Joint Commissioning Workforce Development Framework, which will be published in due course. The Partnership will review and implement the recommendations contained within the Framework when these become available, and will be reflected in the final ‘Vision’ document in February 2013.

As progress is made in relation to Workforce Planning and Development, the Partnership will reflect the arrangements outlined in frameworks such as the NHS Ayrshire & Arran Partnership Agreement and the National Staff Governance Standard.

8 Local Drivers of Change

8.1 Ayrshire Older People Needs Assessment

A key component in developing this Ten Year Vision for Joint Services – Reshaping Care for Older People has been the Ayrshire Older People Needs Assessment (OPNA), which was undertaken between March and September 2012. The OPNA reported on the important trends in relation to population change, lifestyle and health factors. The results of this study support the issues raised at the national level and reaffirms the need to Reshape Care for Older People and Shift the Balance of Care.

Two important findings to come out of the needs assessment in relation to Reshaping Care for Older People and a move towards Joint Services for older people include:

- The vast majority of older people live full lives in their own homes and are able to self-manage their conditions with limited or no support from statutory agencies.
- The lifestyle choices and health-related behaviours adopted by people currently of working age will have an impact on their lifestyles and health status as older people in the future – meaning prevention work could make a real difference to the health of the future cohort of older people.

The key points from each of the Needs Assessment sections for this Ten Year Vision for Joint Services – Reshaping Care for Older People are outlined below.

8.1.1 Demographic Change

For the purposes of this document, there are two groups of older people: those aged between 65 and 84; those aged 85+ (very old).

Those aged between 65 and 84 often require little care or
support from statutory agencies. On the contrary, people in this age group quite often provide care for others.

The 85+ age group tends to require the highest level of support and care. As there is a growing number of people aged 85+, future services must focus on this age group.

Life expectancy of people in the over 85 age group is estimated to be six years with a further estimate of four of these years being non-healthy. This indicates that the potential input of health and social care services is highly likely to increase for people aged over 85.

8.1.2 Life Circumstances

Services and activities focusing on overcoming social isolation and developing personal support mechanisms will become increasingly important for older people, especially given the increase in 'solo living'.

Maximising income and support for energy efficiency and home improvements will also be fundamental to make sure that older people can afford to stay in a warm, dry, energy efficient home.

As there is a growing proportion of people aged over 85+, there will be a growing number of people eligible to receive free personal nursing care.

8.1.3 Lifestyle Factors

Health-related lifestyle factors - such as tobacco and alcohol consumption, and physical activity and obesity - are known to be worse in the West of Scotland than the rest of the country.

The health behaviours of the current working population - such as alcohol use and sedentary lifestyles - will have a bearing on service demands in the future when they become older.

Lifestyle factors are a major contributing factor to health inequalities in Scotland, with people from most deprived areas being known to adopt less healthy lifestyles.
The implications of poorer lifestyle choices in younger generations are that in future, people may experience poorer health compared to the current older generation, as they age.

### 8.1.4 Health Status

Mortality, life expectancy and healthy life expectancy are all improving but there are significant variations in health status across Ayrshire & Arran as there are in Scotland, and the key determining factor is deprivation.

People living in more deprived areas live proportionately more years in “poor” health than people in less deprived areas.

Men and those from more deprived areas are consistently observed to have higher rates of both Coronary Heart Disease (CHD) and Cardiovascular Disease (CVD).

As in the general population, mortality rates for both CHD and CVD have reduced in Ayrshire & Arran over the last decade for older people but remain higher than the Scottish average.

As the diagnosis of dementia has improved, it is estimated that 9% of the current 65+ population have dementia. Although the proportion of people with dementia is not expected to rise, the expected increase in the 65+ population will mean a greater number of people will have dementia and may require some form of care and/or support to live at home as long as possible.

### 8.1.5 Use of Health and Social Services

Ayrshire & Arran faces similar issues to those being addressed nationally through the Shifting the Balance of care agenda.

Based on trends from the last 10 years, demography alone could increase demand for 65+ people receiving 10+ hours of home care by 27% between 2011 and 2020 and 44% between 2011 and 2030.

Furthermore, the number of Care Home Long Stay Residents could increase by around 24% between 2011 and 2020 and 47% between 2011 and 2030.
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Tackling health inequalities in early life may reduce some of the disparities in later life and go some way towards relieving future pressure on the system

In order to address the impact of the increased population on service uptake, services will have to be reconfigured to address the changing health and social needs of the older population

8.1.6 Equity and Healthy Ageing

To make the most of the resources available and tackle inequalities, policies need to target those with most need.

It is never too early and never too late to improve lifestyle behaviours as this can make a real difference to health. Keeping people well across the life course will therefore be imperative.

Interventions appropriate to the older population need to be researched and developed to ensure this is achieved to a greater rather than lesser degree.

8.2 What does this mean for the Partnership?

8.2.1 Demographic Change

- Based on the findings of the OPNA outlined above, the biggest challenge facing the partnership will be the provision of care for people aged over 85. This can be planned for to some extent, given that those aged 75 today will be 85 in 2022 and mortality rates are known;

  - The predicted increase in numbers of those aged 85+ between 2012 and 2022 is:
    - East Ayrshire – 2,483 to 3,593 (31% increase);
    - North Ayrshire – 2,873 to 4,255 (32% increase);
    - South Ayrshire – 3,317 to 4,495 (26% increase); and
    - Ayrshire & Arran – 8,637 – 12,343 (30% increase);

- Although South Ayrshire has the highest estimated proportion of those aged over 85 years the increase in rate is lowest and is highest in North Ayrshire followed by East Ayrshire;

- There will be fewer people of working age and an increased older population so services will need to be reconfigured to maximise use of technology and new ways of working in light of the diminishing working age population;
Volunteers of all ages, but particularly recently retired, will be able to contribute to their own wellbeing and the care of older people.

8.2.2 Life Circumstances

- Given the growing number of people living on their own, it will be essential that community capacity and resilience are strengthened to support older people and their unpaid carers in the community.

- To support the aspiration that people prefer to stay at home, all care plans and assessments must consider how best to meet housing needs including:
  - housing choice;
  - housing support;
  - equipment and adaptations; and
  - new build standards

- As the risk of low income rises with age, and deprivation has a particularly negative impact on health status, it will continue to be important for all partners to look for ways to maximise income for older households in order to help tackle health inequalities associated with deprivation and social and financial exclusion and fuel poverty

8.2.3 Lifestyle Factors

- Rising alcohol consumption will have social and health implications for people and the kind of care they may need. Programmes tackling the impact and prevention of alcohol misuse will be required to support the ageing population across Ayrshire & Arran.

- Rising levels of obesity will have health implications as well as challenges that are often associated with caring for obese people. Programmes tackling the impact and prevention of obesity will be required to support the ageing population across Ayrshire & Arran.

8.2.4 Health Status

- As the number of people living longer with long term conditions is expected to grow, helping people to self-manage the challenges associated with long term conditions and multiple medications (polypharmacy) will be increasingly important.

- Recognition of and support to overcome loneliness and isolation and promote well being will help contribute to better health outcomes for older people who will be increasingly likely to live alone.

- As the number of older people is expected to grow, so will the number of people with dementia – even if the proportion of people with dementia remains the same. Cultivating dementia friendly communities which are well-informed and well-designed will be increasingly important to help keep people with dementia in their own homes and independent for as long as possible.

8.2.5 Use of Health and Social Services

- In view of the demographic changes and financial challenges, services will need to be reconfigured to meet need.
8.2.6 Equity and Ageing

- Adopting an Asset Based approach which draws on resources from across the community will be important in overcoming health and social inequalities and support people as they get older.

9 Current Services in Ayrshire & Arran

In order to review the current provision of services and activity available for older people across Ayrshire & Arran, a service mapping exercise was undertaken between May and July 2012.

The Reshaping Care Model shown in Figure 2 above was used to categorise the services and activity captured by the service mapping exercise, which provides a snapshot of what is currently available, shown in Figure 10 below.

![Figure 10 Services and Activity across Ayrshire & Arran compared to Reshaping Care Model](image)

Based on the above set of examples, it is clear that there is a range of services available to older people. Furthermore, in terms of the ‘number’ of services and activity, the profile fits the Reshaping Care model reasonably well.

However the majority of financial and staff resources are focused on clinical interventions in institutional settings.

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9 Please refer to the Service Mapping 2012 for full details
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illustrated by Figure 11 below which highlights the indicative spend in each of the care categories.

It is recognised that there will always be people who require hospital based care when they are ill. However, given the challenges outlined in the OPNA above and the aspiration to keep people at home so that they can enjoy full and positive lives in their own community, there is a real need for change in the services provided and the way we provide them in accordance with the Reshaping Care agenda.

Figure 11 Indicative Spend on Services and Activity in Ayrshire & Arran compared to the Reshaping Care Model

- Promoting Community Wellbeing: c. 15% of overall spend
- Staying independent and self management of health conditions: c. 17% of overall spend
- Integrated rehabilitation and enablement services: c. 3% of overall spend
- Intensive supports: c. 20% of overall spend
- Hospital Care: c. 45% of overall spend
10 Moving Towards Joint Services for older people across Ayrshire & Arran

10.1 Change Fund

As highlighted throughout this document the move towards Joint Services for older people is a continuation of the process started by the Reshaping Care for Older People – a Programme for Change agenda which has been supported through the Change Fund. The Change Fund was established in response to concerns raised about the difficulty of investing in new community care and support services before being able to de-commission existing institutional care. The need for ‘bridging finance’ was identified as a priority which resulted in the creation of a £300 million Change Fund, of which Ayrshire & Arran is allocated over £20 million over the term of the fund.

The four years of the Change Fund has allowed partners from NHS, Council, Third and Independent Sectors to work together with this additional investment to allow new approaches and services to be established and to support longer change processes to take place.

To support and structure the work undertaken in relation to the Change Fund and the wider Reshaping Care programme, the National Joint Improvement Team developed a set of ‘pathways’ shown in Figure 12 below. A number of services and organisations span these five pathways and workstreams and guide the work required to develop Joint Services for older people in relation to the Three Year Implementation and One Year Investment Plans.

**Figure 12 Reshaping Care Pathway**

<table>
<thead>
<tr>
<th>Preventative and Anticipatory Care</th>
<th>Sustaining Independence</th>
<th>Effective Care at Times of Transition</th>
<th>Hospital and Care Home(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Build social networks and opportunities for participation</td>
<td>Responsive flexible self directed home care</td>
<td>Reablement and rehabilitation</td>
<td>Urgent triage to identify frail older people</td>
</tr>
<tr>
<td>Early diagnosis of dementia</td>
<td>Integrated case / care management</td>
<td>Specialist clinical advice for community teams</td>
<td>Early assessment and rehab in the appropriate specialist unit</td>
</tr>
<tr>
<td>Prevention of falls and fractures</td>
<td>Carer support</td>
<td>NHS24, Scottish Ambulance Service and Out of Hour access to Anticipatory Care Plans</td>
<td>Prevention and treatment of delirium</td>
</tr>
<tr>
<td>Information and support for self management and self directed support</td>
<td>Rapid access to equipment</td>
<td>Range of intermediate care alternatives to emergency admission</td>
<td>Effective and timely discharge home or transfer to intermediate care</td>
</tr>
<tr>
<td>Prediction of risk of recurrent admissions</td>
<td>Timely adaptations, including housing adaptations</td>
<td>Responsive and flexible palliative care</td>
<td>Medicine reconciliation and reviews</td>
</tr>
<tr>
<td>Anticipatory care planning</td>
<td>Telehealthcare</td>
<td>Medicines management</td>
<td>Specialist clinical support for care homes</td>
</tr>
<tr>
<td>Suitable and varied housing and housing support</td>
<td></td>
<td>Access to range of housing options</td>
<td>Carers as equal partners</td>
</tr>
<tr>
<td>Support for carers</td>
<td></td>
<td>Support for carers</td>
<td></td>
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</tbody>
</table>

**Enablers**

<table>
<thead>
<tr>
<th>Outcomes focussed assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Co-production</td>
</tr>
<tr>
<td>Technology / eHealth / Data Sharing</td>
</tr>
</tbody>
</table>

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10.2 Potential Changes to Services
Building on the work already started as part of the Change Fund, further changes will be required as part of the Reshaping Care programme. Some services will have to be reconfigured or stopped and replaced by new services. It is expected that further suggestions will be brought forward as a result of engagement, and these will be incorporated into the Ten Year Vision for Joint Services – Reshaping Care for Older People as it progresses. Several proposals for change are outlined below.

10.2.1 Preventative and Anticipatory Care
- aligning resources to community wellbeing and prevention services to improve health and wellbeing;
- developing anticipatory care planning approaches;
- supporting projects that build Community Capacity through the Third Sector Interfaces;
- developing older people networks;
- improving access to transport for older people;
- offering training to a wide range of multi-disciplinary teams, carers and service users in relation to dementia and falls; and
- improving awareness, diagnosis and treatment of older people mental health problems, including dementia.

What this might look like:

- Third Sector organisations play a significant role in building and supporting community capacity;
- an increasing proportion of older people with high level needs cared for at home in relation to the proportion in long stay hospitals or care homes;
- wide awareness of the main causes of falls as well as training a wide range of people to carry out screening and how to access services when they are needed;
- community groups are recognised and supported as an important part of staying active and healthy and as a place to share positive health advice and information through funding and training;
- co-located services which are accessible and well-publicised;
- a programme of Community Capacity building rolled out across Ayrshire & Arran; and
- Dementia Action Plans in place across Ayrshire & Arran based on the Scottish Government Dementia Strategy and Dementia 2 Strategy.

10.2.2 Sustaining Independence
- closer partnership working between health, community care and housing in relation to housing options and housing support;
- increasing support for unpaid carers;
- improving options for out of hours mobile teams;
- increasing provision of flexible respite options;
- support for acute teams, such as Allied Health Professionals and Community Pharmacy to work in partnership with communities, in co-located, integrated teams to deliver quality interventions in order to maximise the health and wellbeing of the people of Ayrshire & Arran;
• exploring the best way to make use of Telecare and Telehealth equipment.

What this might look like:

• increased numbers of older people receiving support from community based services, re-enablement, intermediate care, community nursing and community based therapy teams;
• full recognition and support is afforded to family and friends who care for a loved one through Carers groups, training and access to good quality respite; and
• best use is made of Telehealth and Telecare to support people within their homes.

10.2.3 Effective Care at Times of Transition

• progressing towards continuity of service and care over 24 hours a day, seven days a week;
• rolling out re-enablement training to all Care Home providers; and
• widening community geriatrician capacity to support community based work.

What this might look like:

• home care services have a ‘re-enablement’ focus which means encouraging confidence and independence for people who have been ill or injured; and
• organisations work together so that care is coordinated.

10.2.4 Care Homes

• scoping ‘Step Up Step Down’ models of care in Care Homes as alternatives to admission; and
• developing role of specialists such as clinical pharmacists and Allied Health Professionals within Care Homes

What this might look like:

• a change in the way that care home places are used, with a reduction in long stay care home places and an increase in the number of beds used for respite and step up/step down care; and
• clinicians are available to offer support to staff and residents in Care Homes.

10.2.5 Hospitals

• refocusing hospital rehabilitation services into the community;
• reviewing the current Day Hospital service model;
• reviewing the need for care of the elderly long stay beds; and
• developing Community Hospitals and Care Services in line with national strategies to have key roles in care, treatment and wellbeing of elderly population.

What this might look:

• reduced ‘automatic admission’ to hospital for older people who attend A&E as there are safe alternatives at home; and
• reduced length of stay and reduced delays in discharge for people in hospital due to increased capacity within community based services.
10.3 Ayrshire & Arran Principles for Joint Services

Taking into account the Strategic Context outlined in Section 1 and the OPNA and Service Mapping outlined in Section 2 above, and the proposed change outlined above, the Partnership have developed a set of principles to guide the development of Joint Services, illustrated in Figure 13 below.

**Figure 13 Ayrshire & Arran Principles for Joint Services**

<table>
<thead>
<tr>
<th><strong>Person Centred</strong></th>
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</thead>
<tbody>
<tr>
<td>• Assessments are centred on the individual and takes into account their wider family and carers’ needs</td>
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<tr>
<td>• Personal choices of individuals are taken account when determining their support needs and how they can be delivered</td>
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<table>
<thead>
<tr>
<th><strong>Outcome Focused</strong></th>
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<tbody>
<tr>
<td>• Re-enablement ethos is embraced by all partners</td>
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<tr>
<td>• Commitment to coordination and continuity of care</td>
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<table>
<thead>
<tr>
<th><strong>Proactive</strong></th>
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<tbody>
<tr>
<td>• Service contact is proactive rather than reactive where possible</td>
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<table>
<thead>
<tr>
<th><strong>Flexible, Responsive and Forward Looking</strong></th>
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</thead>
<tbody>
<tr>
<td>• A flexible service response is available at all times</td>
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<tr>
<td>• Service change is based on best practice</td>
</tr>
<tr>
<td>• Services in the community have the confidence of individuals, families and professionals</td>
</tr>
<tr>
<td>• Services are as close to local communities as possible, in accordance with agreed locality planning arrangements</td>
</tr>
<tr>
<td>• Technology such as telehealth and telecare is promoted</td>
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<tr>
<td>• We have a skilled, well trained workforce</td>
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<table>
<thead>
<tr>
<th><strong>Joined Up</strong></th>
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<tbody>
<tr>
<td>• Services are committed to appropriate sharing of information</td>
</tr>
<tr>
<td>• Seamless case-management for individuals</td>
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<tr>
<td>• Strong working relationships across all partners</td>
</tr>
<tr>
<td>• Housing options and housing support for older people, regardless of tenure - is integrated into the assessment process</td>
</tr>
<tr>
<td>• Services are supported by shared IT systems</td>
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<table>
<thead>
<tr>
<th><strong>Accessible</strong></th>
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<tbody>
<tr>
<td>• Information about services, prevention and self management of conditions and maintaining health and wellbeing will be easily accessible to the public and professionals</td>
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<table>
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<tr>
<th><strong>Resilience Building</strong></th>
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<tbody>
<tr>
<td>• Families are supported to have a role and responsibility for care</td>
</tr>
<tr>
<td>• Community capacity building and wider support mechanisms, including volunteering are promoted</td>
</tr>
</tbody>
</table>
11 What will be done in the Next Three Years

The work progressed over the next three years will be critical to moving services towards the Ten Year Vision for Joint Services – Reshaping Care for Older People. There will be some new areas of work. However, most of the changes and improvements have already started and will involve working closely with local groups and communities to build on the good progress to date.

In three years, health and social care services will be more integrated for people in need and at risk. The effective improvements to community based care funded by the Change Fund will have been embedded into normal practice and the positive impact of these changes on reduced emergency admissions and time spent in hospital should be apparent. There will be an extended range of services provided outside acute hospitals, and hospital consultants and specialist staff will be working more closely with local GP practices to care for people in their homes wherever possible. There will be greatly expanded the use of Telehealth and Telecare to support flexible and responsive care at home, with more support for carers.

Health and social care services will have improved the joint use of resources for the benefit of local people. In three years for example, the way information is shared electronically between services to support integrated care will have been improved.

More staff and voluntary services will be located together in local community settings to support these changes. Local community planning arrangements will have been reviewed and arrangements agreed to encourage a local focus on the natural communities and islands in which people live. Care homes will be more integrated and co-ordinated with other health and social care services within communities.

GPs will be routinely analysing their lists to identify patients most at risk of hospital admission and, increasingly, GPs and community teams will be working with elderly people and their families to discuss future care needs and to plan ahead including improved palliative and end of life care. Community staff will have developed additional skills to support a wider range of care and treatment at home and in the community. More individuals will be actively managing and monitoring their own condition using self management skills and reablement approaches, with a focus on maintaining health and wellbeing.

Increasingly, services will be provided seven days a week rather than five, and out of hours services – including A&E, NHS24, Ayrshire Doctors On Call (ADOC) service, Scottish Ambulance Service, community nursing, mental health, social care and home care services – will be working more closely in teams to provide urgent and emergency care out of hours to individuals to avoid emergency hospital admission where possible.

Community hospitals will have reviewed their services and will have agreed plans for local services to meet changing community needs and outpatient services will have been reviewed with the help of local people in order to improve services and reduce treatment delays.

In three to five years, older people will also be benefitting from a number of building projects currently underway including the new Montrose House on Arran, the new North Ayrshire Community Hospital the ‘new front’ door projects at Ayr and Crosshouse to support rapid assessment and treatment.
Alongside specific actions addressing individuals’ needs, ranging from anticipatory care to hospital care, actions to work with communities to raise and maintain health will contribute to reducing the burden of ill-health amongst the older population. Such actions will address the wider determinants of health such as income maximisation including benefits advice, cooking skills especially for those newly on their own, social activities to reduce isolation and walking groups to promote physical activity.

Figure 1 on page 1 above, illustrates that this Ten Year Vision for Joint Services – Reshaping Care or Older People will be supported by a Three Year Implementation Plan and One Year Change Fund plans within each partnership.

As progress is made towards the development of integrated services and improving outcomes for older people across all five Reshaping Care pathways, the Partnership will adopt an Ayrshire & Arran approach to the delivery of services where it makes sense.

There are examples of services which are currently delivered on an Ayrshire & Arran basis, which include models where services are hosted within one local authority area. Examples include:

- The development of a Joint Equipment Service, which will include a central distribution centre for Ayrshire
- Out of Hours (OOHs) social work service, which is a Pan Ayrshire service, but is hosted by East Ayrshire

Examples of the workstreams being taken forward as part of the three year locality operational plans will be similar in each of the partnership areas, such as:

- **Unpaid Carers**
  Increasing the support provided to carers, through both direct and indirect support plans. Increasing support planning for carers to ensure that services continue to be responsive to local need.

- **Diagnosis, care and treatment of dementia**
  Building on the positive work delivered by the Elderly Mental Health Service by the addition of:
  - 2 Care Home Liaison nurses to provide information, support, advice and training within the care home sector;
  - 1 Training Officer designs and delivers training across Health, Local Authority, Third and Private Sectors in line with the Promoting Excellence Framework.
  - An Alzheimer Scotland Nurse Consultant has been appointed to work within Ayrshire & Arran. The post-holder will work with NHS and the University of the West of Scotland.

- **Community based Allied Health Professional (AHP) services**
  Enhancing capacity, changing the primary locus of work, ensuring full AHP support for the services focused around Community Hubs

- **Medicine Management Review**
  Providing specialist clinical pharmacist resources within the community setting to enhance pharmaceutical care and reduce avoidable hospital admissions due to medicines.
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- **Falls Prevention and Management**
  Providing rapid early intervention and training to older people, carers and partnership practitioners to reduce falls and ensure that community alert and Telecare solutions are available to increase confidence.

- **Support Community Capacity Building**
  Working with communities to build capacity and resilience to support older people in their own homes and communities.

Three Year Implementation Plans\(^{10}\) which outline the direction of travel and key actions have been developed by each of the Adult and Older People Sub Groups within the Adult Officer Locality Group (OLG). All the actions within the three year plans reflect the reshaping care pathways.

**11.1 East Ayrshire CHP**
PLEASE NOTE, THIS MAY BE SUBJECT TO CHANGE FOLLOWING OLG COMMENTS.

In East Ayrshire, some of the actions identified to support the Ayrshire Ten Year Vision for Joint Services for older people include:

- **Embed intermediate care and enablement services**
  Support older people by preventing admission and supporting early discharge from hospital through expansion of Intermediate Care and Enablement Services to ensure they continue to provide flexible and responsive rehabilitation and re-enablement services.

- **Improve access to equipment and adaptations**
  Build on the positive work that has taken place to date to improve and expand the delivery of minor aids and adaptations to older people’s homes.

- **Increase availability of Telecare / Telehealth Care**
  Continue to work in partnership with colleagues in Health and Fire and Rescue services to ensure the effective roll out of Telehealth support and the installation of linked smoke alarms.

- **Progress Anticipatory Care**
  Support anticipatory care planning for older people most at risk of admission to hospital by increasing the opportunity for multidisciplinary working between health and social care staff and GP practices.

- **Widen Volunteering Opportunities**
  Develop, provide and support volunteering opportunities and social networks for older people, which will allow them to become more active in their community.

**11.2 North Ayrshire CHP**
PLEASE NOTE, THIS MAY BE SUBJECT TO CHANGE FOLLOWING OLG COMMENTS.

In North Ayrshire, some of the actions identified to support the Ayrshire Ten Year Vision for Joint Services for older people include:

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\(^{10}\) The Three Year Implementation Plans are available upon request from reshapingcare@aatct.scot.nhs.uk
- **Reduce Hospital and Care Home Unplanned Admissions**
  Explore system wide integrated solutions to support older people to remain at home with anticipatory care plans and effective early intervention to prevent unplanned admissions.

- **Maximise recovery in the community**
  Support older people and their carers to feel confident about receiving care which meets their needs, is timely, integrated and coordinated, personalised and flexible delivered in their homes rather than a hospital or care home setting.

- **Neighbourhood Planning Approach to utilise community assets**
  Work with local communities to respect and include older people, take responsibility for their welfare and well-being, welcome the time, skills and experiences that older people contribute and that contain strong support networks offering a variety of activities and opportunities.

- **Develop care home resource as part of a neighbourhood planning approach**
  Recognise and use care homes as community based assets focussing their work on supporting Reablement and supporting recovery.

### 11.3 South Ayrshire CHP

PLEASE NOTE, THIS MAY BE SUBJECT TO CHANGE FOLLOWING OLG COMMENTS.

In South Ayrshire, some of the actions identified to support the Ten Year Vision for Joint Services for older people include:

- **Social Interaction and Networking**
  Expand older people’s informal opportunities for activity, advice, information and volunteering in order to enhance community capacity

- **Community Hubs**
  Improve access to services for older people by further developing the two service hubs based in Biggart and Girvan Community Hospital, through:
  - extending the hours and days that services operate;
  - co-locate services where practical;
  - establish better co-ordinated systems and processes (including shared assessment and better shared us of IT systems),
  - better utilise predictive data;
  - better utilise telehealth;
  - develop better anticipatory care planning;
  - establish easier and more accessible points of contact and referral;
  - ensure the availability of wide ranging clinical expertise, with strong links to key vulnerable groups and institutions (such as care homes), with strong independent health service involvement, and set within the context of existing voluntary and community based activities

- **Telehealth / Telecare**
  Support older people to feel safe and well at home by establishing comprehensive and strategic approach to Telehealth and Telecare provision.

- **Support older people within Care Homes**
  Recognise and support care homes as important contributors to the Reshaping Care and alternatives to hospital admission and/or discharge option.
• **Pilot Programme Post-Diagnostic – Dementia**

Pilot a programme in which people who are diagnosed with dementia are guaranteed post-diagnostic support. Findings from the pilot will be rolled out across Ayrshire to improve the care and support offered to older people who have been diagnosed with dementia.

### 12 Performance and Monitoring

#### 12.1 The Performance Context

There has been a great deal of investment and attention placed on shifting the balance of care over recent years, recognising that this ‘shift’ in service delivery will have a positive impact on outcomes for older people in our communities. There are some key delivery areas where significant improvement in performance has to be made in order to continue delivering on the outcomes, such as emergency admissions and subsequent lengths of stay.

A key national target relating to the Reshaping Care for Older People Programme is to reduce rates of emergency bed days used by those aged 75+ by a minimum of 20% by 2021 and at least 10% by 2014/15. Achieving this will go some way toward achieving the increases in the proportion of spend on care at home. It should also allow the impact of demographic growth to be absorbed, though may not support reduction in bed numbers within the acute sector. This target will need to be reviewed in the light of early experience to assess the scope for increasing the Partnership’s ambitions in bed day reductions.

The ability to de-commission capacity from institutional settings will be as crucial as investment in community capacity. To achieve this shift in activity and resources the local Change Plans will promote the development of a strong and responsive range of community based support and care services building on many of the current initiatives being developed. These will promote the Reshaping Care philosophy and approach to caring for older people as an integrated and comprehensive whole system framework\(^{11}\).

#### 12.2 Key Performance Indicators (KPIs)

In order to develop relevant Key Performance Indicators (KPIs) to monitor progress towards Joint Services for older people it is crucial that the Partnership knows what outcomes are to be achieved. This then allows an ‘Outcomes Focused Planning Approach’ to be used, which gives a clear framework of outcomes and the related performance indicators that will evidence progress towards these.

This approach allows clear and robust links to be shown between actions and overall outcomes and provides a performance framework which is consistent with the process used to develop local Reshaping Care for Older People Change Fund plans.

In line with this approach, an Outcomes Triangle for Joint Services for Older People has been developed and is detailed in Appendix 2.

Potential KPIs – outlined in Appendix 4 - have been identified for this Ten Year Vision for Joint Services – Reshaping Care for Older People and will include the Reshaping Care National

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\(^{11}\) Reshaping Care for Older People A Programme for change 2011-2021 – COSLA, The Scottish Government and NHS Scotland
Improvement Measures. These will be reported through the local Covalent performance management system.

As detailed in sections above, the Partnership already understands a great deal about both the demographic and societal context in which services are to be delivered in future. It is important that as progress is made toward Joint Services the totality of the outcomes that are to be delivered are kept in view. The suite of KPIs developed as part of this work and through the Change Fund plans will give an indication that outcomes are changing for the better through the interventions detailed in Section 10.

13 Engagement

This Ten Year Vision for Joint Services – Reshaping Care for Older People has been developed through initial engagement across key partners. All feedback received through the current engagement period will be used to further inform the Ten Year, as well as the three year implementation and one year investment plans, highlighted in Figure 1 on page 1.

A wide and far reaching continuous engagement plan is in place for the further development of the draft plans and will run until February 2013. It is important that everyone in Ayrshire & Arran is offered a range of opportunities to express their views using a variety of methods and approaches.

At the forefront of this process are the Community Health Partnerships. The Engagement and Communications Plans set out a variety of traditional and other methods to fully support engagement and a toolkit of engagement materials has been designed to take this forward. Methods include: social media, DVD, presentations to groups and organisations, Focus Groups, engagement materials (including booklets) to be widely disseminated by all partners, partnership pan-Ayrshire events to promote the Ten Year Vision for Joint Services – Reshaping Care for Older People.

A report will be produced at the end of the continuous engagement period reflecting all views and comments received during this period. These comments and views will then be used to inform the Ten Year Vision for Joint Services – Reshaping Care for Older People and associated implementation and investment plans.

In addition to involvement in the engagement process there is the opportunity to comment on this document.

Please forward any comments you may have to reshapingcare@aapct.scot.nhs.uk which is the email address hosted by NHS Ayrshire & Arran on behalf of the Partnership. In order for comments to be included in the final version, please return any remarks as soon as possible, but no later than Friday 15th February 2013.
Glossary of Terms

**Advocacy** The process of supporting someone to express their views and say how they feel about a specific issue that affects them or that they are concerned about. It may be about supporting someone in a meeting, helping someone express their rights, helping someone to access service and information or to explore different options.

**Care Package** A term used to describe all the different types of care that make up to total care received by an individual. For example, they may receive support from Community Alarms or a Mobile Warden, and have home care. All these services together make up the 'Care Package'.

**Care Pathway** The route followed by the service user into, through and out of NHS and social care services.

**Care Plan** A single, overarching plan that records the outcome of discussion between the individual and the professional. It could be electronically stored or written on paper. It should be accessible the individual in whatever form is suitable to them.

**Carer** Someone who spends a significant proportion of their time providing unpaid support to family or friends. This could be caring for a relative, partner or friend who is ill, frail, disabled or has mental health or substance misuse problems.

**Change Fund** A Scottish Government initiative that is aiming to improve services for older people by shifting care towards anticipatory care and preventative spend.

**Community Health Partnership** (CHP) CHPs are the key mechanism for providing integrated health and social care in primary and community settings.

**Community Planning Partnership** (CPP) Community Planning is a process which helps public agencies to work together with the community to plan and deliver better services which make a real difference to people's lives.

**Contribution Analysis** (CA) is a structured way of understanding all component parts required to reach a particular outcome.
Department for Work and Pensions (DWP) is responsible for welfare and pension policy and is a key player in tackling child poverty. It's the biggest public service department in the UK and serves over 20 million customers.

Equality and Diversity Impact Assessment (EQIA) EQIA is a strategic process to be considered when planning a new, or redesigning an existing, policy, function or service.

Holistic An approach to care that takes into account the whole persons needs, not just the presenting illness, injury or social circumstances.

Home Care Help provided directly to you in your own home.

Indicator of Relative Need (IoRN) – is a questionnaire containing carefully selected questions that are designed to inform an algorithm for determining the relative independence/dependence of individuals.

Integrated Resource Framework (IRF) Mechanism used to share data between organisations about the cost of care.

Key Performance Indicators (KPIs) help an organisation define and reach its goals.

Long Term Conditions (LTC) Conditions that cannot be cured at present, but can be controlled by medication and other therapies.

Multi-disciplinary Team (MDT)- A team made up of professionals across health, social care and third sector who work together to address the holistic needs of their patient service users/clients in order to improve delivery of care and reduce fragmentation.

Personalisation Care and support services received by a person that are individual and tailored to them

Preventative Services These services help people to do things for themselves as much as possible.
Primary Care  Services provided by GP practices, dental practices, community pharmacies and high street optometrists.

Programme Budgeting Marginal Analysis (PBMA) a structured way of looking at how money is spent on services.

Quality and Outcomes Framework (QOF) A system to remunerate general practices for providing good quality care to their patients, and to help fund work to further improve the quality of health care delivered.

Re-enablement A method of providing care that is focused on helping individual to develop or regain their ability to do things for themselves, thereby increasing their independence and reducing their reliance on statutory health and social care services.

Shifting the Balance of Care (SBC) Changes at different levels across health and care systems intended to bring about better health outcomes for people.

Secondary Care a service provided by medical specialists who generally do not have first contact with patients.

Service Model Term used to describe the key service elements and how they work together

Service Providers An organisation that provides health, social care or housing services

Service Users Anyone who uses, requests, applies for or benefits from a service

Scottish Patients at Risk of Readmission and Admission (SPARRA) data is a way of identifying those people at greatest risk of emergency admission to hospital over the next year.

Single Outcome Agreement Agreements between the Scottish Government and Community Planning Partnerships (CPPs) which set out how each will work towards improving outcomes for the local people in a way that reflects local circumstances and priorities, within the context of the Government’s National Outcomes and Purpose. There is an SOA for each of the three CPP partnerships.
Social Return on Investment (SROI) – an analytic tool for measuring and accounting for a much broader concept of value. It incorporates social, environmental and economic costs into decision making, providing a fuller picture of how value is created or destroyed.

Stakeholder An individual or group of people who have an interest in service organisation or development

List of Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>Arran CVS</td>
<td>Arran Community and Voluntary Service</td>
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<tr>
<td>CVD</td>
<td>Cardiovascular Disease</td>
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<tr>
<td>COPD</td>
<td>Chronic Obstructive Pulmonary Disease</td>
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<td>CHP</td>
<td>Community Health Partnership</td>
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<tr>
<td>CHD</td>
<td>Coronary Heart Disease</td>
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<tr>
<td>CVOEA</td>
<td>Council for Voluntary Organisations East Ayrshire</td>
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<td>EAC</td>
<td>East Ayrshire Council</td>
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<td>JIT</td>
<td>Joint Improvement Team</td>
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<td>NAC</td>
<td>North Ayrshire Council</td>
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<td>OLG</td>
<td>Officer Locality Group</td>
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<td>OPNA</td>
<td>Older People’s Needs Assessment</td>
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<td>SAC</td>
<td>South Ayrshire Council</td>
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<td>SHRUG</td>
<td>Scottish Health Resource Utilisation Group</td>
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<tr>
<td>SOA</td>
<td>Single Outcome Agreement</td>
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<tr>
<td>VASA</td>
<td>Voluntary Action South Ayrshire</td>
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</table>
Appendix 1 The Partnership

The Partnership comprises the following members:

- Senior Responsible Officers (SROs). One representing the NHS and one the three Ayrshire Local Authorities (Joint Chair)
- Joint Chair of North, South and East Ayrshire Officer Locality groups (OLGs) or nominated deputy.
- A representative from the North, South and East Ayrshire Third Sector Interface
- A representative from the North, South and East Ayrshire Independent sector to include both Care Homes and Care at Home
- Health Care Manager for Care of the Elderly
- Consultant in Public Health
- Assistant Director of Finance NHS Ayrshire & Arran, as point of contact for NHS/LA Finance group
- Chair of the Collaborative Commissioning Group
- CHP facilitators for North South and East Ayrshire
- Housing Managers for North, South and East Ayrshire
- Head of Primary Care Development
- Two staff side representatives. One representing health care staff and one Local Authority staff
- A carer representative in respect of North, South and East Ayrshire
- Programme Manager
- Planning Lead
- Performance Lead

Carers and service-user involvement has been through existing CHP arrangements and will be augmented through continuous engagement, the process for which is outlined in Section 12.

The governance structure for The Partnership makes use of existing CHP structures, which also link into the local Community Planning Partnerships.
## Legislative Framework

<table>
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<tr>
<th>Strategy / Policy Document</th>
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<tr>
<td><strong>Community Care: A Joint Future (2000) Scottish Government</strong></td>
<td>This report outlined recommendations to secure better outcomes for people through improved joint working between health and social care, including developing arrangements for managing and financing joint services.</td>
</tr>
<tr>
<td><strong>Joint Statement on the Relationship at Local Level between Government and the Third Sector (2009) Scottish Government; Solace Scotland; COSLA; SCVO</strong></td>
<td>This document sets out the commitment from the Scottish Government and Local Authorities to the third sector and the expectations of each of the partners in terms of operating, governance and commissioning processes and procedures.</td>
</tr>
<tr>
<td><strong>Caring Together: The Carers Strategy for Scotland (2010) Scottish Government</strong></td>
<td>The Carers strategy acknowledges the vital contribution carers make to the health and social care system.</td>
</tr>
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</table>
| **Scotland’s National Dementia (2010) Scottish Government** | Scotland’s National Dementia Strategy was published in June 2010 and sets out actions to improve services and support for people with dementia and their carers. The strategy focuses on two main areas of change:  
  - Following diagnosis, by providing excellent support and information to people with dementia and their carers; and  
  - In general hospital settings, by improving the response to dementia, including through alternatives to admission and better planning for discharge. |
| **Self Directed Support A National Strategy for Scotland (2010) Scottish Government** | Self-Directed Support aims to empower people to direct their own care and support and to make informed choices about how their support is provided. There are a range of mechanisms available to people to direct their support, including the use of direct payments and individual budgets.  
  
  In late 2010, the Scottish Government published a 10-year strategy to grow self-directed support and a Self-Directed Support Bill is progressing through Parliament. If enacted, this will place legislative duties on local authorities from late 2012. The Bill would require local authorities to offer four options when people are assessed as being eligible for support with their social care needs:  
  1. Direct payment – the local authority makes a direct payment to the supported person in order that the person can then use that payment to arrange their support;  
  2. Direct available resource – the supported person chooses their support and the local authority, or another organisation makes arrangements for the support on behalf of the supported person;  
  3. Local authority arranged support – the local authority selects the appropriate support and makes arrangements for its provision by the local authority; or  
  4. A mix of options 1,2 and 3 – recognising that some individuals may wish to take one of the options for particular aspects of their support needs, but to receive their remaining support under one of the other options. |
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<tr>
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<tr>
<td>Commission on the Future of Delivery of Public Services (2011) Christie</td>
<td>This report highlighted the role of voluntary organisations in service delivery. It also emphasised the role of prevention and personalisation for achieving better outcomes for service-users.</td>
</tr>
</tbody>
</table>
| Reshaping Care for Older People: A Programme for Change (2011) JIT | The ‘Programme for Change’, published in 2011 set out the reasons for change in the approach to care for older people and what has been seen as the key actions required to achieve this change. The Programme for Change outlined the main messages from stakeholders about the preferences of older people:  
- People want to stay in their own homes for as long as possible  
- People want a greater degree of personalisation and choice  
- People want more joined up working – less needless bureaucracy  
- People want to avoid prolonged hospital stays  
- People want greater support for unpaid carers  
- People want funding and support for pensioner networks of community groups  
- People want a consistency of paid workers  
- People want regular health and well being check ups  
- People want more specialist services for people with dementia  
- People want appropriate housing and timely installation of equipment and adaptations  
- People want information  
The Scottish Government’s Change Fund has acted as a catalyst for changing the way services for older people are delivered in line with the aims of “Reshaping Care for Older People”. Guidance from the Scottish Government has required local partnerships involving the local authority, NHS, Third and Independent Sectors representatives to work together to drive change. |
| NHS Scotland Quality Strategy (2010) Scottish Government         | The ultimate aim of the Quality Strategy is to deliver the highest quality healthcare services to people in Scotland and through this to ensure that NHS Scotland is recognised by the people of Scotland as amongst the best in the world. The strategy was built around these priorities:  
- Caring and compassionate staff and services;  
- Clear communication and explanation about conditions and treatment;  
- Effective collaboration between clinicians, patients and others;  
- A clean and safe care environment; |
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<th>Strategy / Policy Document</th>
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|  **Age, Home and Community: A Strategy for Housing (2011)**  
  Scottish Government                                                                 | The Age, Home and Community document published by the Scottish Government sets out the vision for housing services for older people in terms of the shifting the balance of care agenda.  

  The strategy highlights the importance of and support for:  
  - Advice and information for older people about the housing options and support available to them;  
  - Piloting a housing options approach for older people;  
  - Encouraging accreditation under the Scottish National Standards for Information and Advice Providers;  
  - Delivering adaptations in an efficient and effective way;  
  - Developing a national register of accessible housing;  
  - Establishing and promoting ‘Trusted Trader’ schemes;  
  - Encouraging ‘downsizing schemes’;  
  - New guidance for the redevelopment of sheltered and very sheltered housing  
  - Making it easier for older people to access equity in their home  
  - Mainstreaming telecare;  
  - Reviewing building and design standards to meet the needs of older people. |
|  **Commissioning Social Care (2012)**  
  Audit Scotland                                                                                                                                   | After a substantial review of how effectively the public sector commissions social care services,  

  Audit Scotland made several recommendations for Councils along with NHS boards and other relevant commissioning partners:  
  - The need to develop commissioning strategies;  
  - The need to manage the risks of contracting services from voluntary and private providers;  
  - Implement self-directed support in a way that service-users will get information, advice and support and processes are in place to monitor the outcomes of the support;  
  - The need to work very closely together. |
|  **Intermediate Care Framework (2012)**  
  Scottish Government                                                                                                                             | This document provides a framework for local health and social care partnerships to review and further develop Intermediate Care within their area.  

  Intermediate Care services provide a set of ‘bridges’ at key points of transition in a person’s life, in particular from hospital to home and from illness or injury to recovery and independence.  

  Intermediate Care services can play a vital role at a point of crisis, such as in the event of serious fall, providing timely care and support, and beginning the process of optimising a person’s recovery and restoring independence post fall. |
|  **Review of Community Planning and Single Outcome**                                                                                               | Background information and the Statement of Ambition can be found at [http://www.scotland.gov.uk/Topics/Government/local-](http://www.scotland.gov.uk/Topics/Government/local-) |
### NHS Documents

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<tr>
<td>Partnership for Care (2003) NHS Scotland</td>
<td>This white paper included proposals to increase patient-centred care and established the mandate to create the Community Health Partnerships to bridge the gap between primary and secondary healthcare and between health and social care.</td>
</tr>
<tr>
<td>NHS Scotland Partnership Agreement (2006) Scotland</td>
<td>The National Human Resources Strategy ‘Towards a New Way of Working’ had at its heart the concept of partnership and collaboration in providing a meaningful and practical framework which will support change and achieve the strategic agenda for NHS Scotland. The publication of the National Plan ‘Our National Health- A Plan for Action, A Plan for Change’ in December 2000 re-emphasised the need to work in partnership with staff to improve the services that the people of Scotland deserve. The SEHD (Scottish Government Health Department) indicated that each NHS Board area would have an Area Partnership Forum, which would involve all key partners involved in delivery of Health Care and Health Improvement in the design and operation of these services through the development of the Local Delivery Plan. The Partnership Agreement puts in place the mechanisms to allow this to take place.</td>
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</table>
| Carer Information Strategy (2008) NHS Ayrshire & Arran | A Carer Information Strategy was prepared by NHS Ayrshire and Arran in order to comply with legislative requirements set out in the Community Care and Health (Scotland) Act 2002. The purpose of the Carer Information Strategy was to ensure that:  
  - Carers are given the support and information they require to carry out their caring role  
  - Carers are given the opportunity to be actively involved in the development, implementation and evaluation of the Strategy and related services |
| Up and About Pathways for the prevention and management of falls and fragility fractures (2010) NHS Scotland | This programme supports partnerships to implement the co-ordinated, evidence-based and person-centred approach to falls and fracture prevention. |
| NHS Local Delivery Plan (2012) NHS Ayrshire & Arran | The performance of NHS Ayrshire & Arran is recorded annually within its local delivery plan. This plan focuses on the outcomes to be achieved for patients and clients through the services that NHS Ayrshire & Arran provides. The plan provides evidence to NHS Scotland on the |
Local Authority Frameworks and Policies

**East Ayrshire**

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<th>Strategy / Policy Document</th>
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| East Ayrshire Single Outcome Agreement (2011) East Ayrshire Community Planning Partnership | The Single Outcome Agreement (SOA) 2011 - 2014 in East Ayrshire is recognised by the local Community Planning Partnership (CPP) as a management tool to:  
  - Further improve the quality of life across our communities;  
  - Deliver better outcomes for local people;  
  - Secure opportunities for reducing bureaucracy;  
  - Make more efficient use of resources;  
  - Make a difference by removing barriers to improved service deliver  
  - Identify areas for improvement.  
Included in East Ayrshire’s Single Outcome Agreement is a commitment to shifting the balance of care, illustrated by the Local Outcome:  
‘Older people, vulnerable adults and their carers support, included and empowered to live the healthiest life' |

**Getting Better...Together - Care Counts (2012) NHS Ayrshire & Arran**

The Care Counts document explains NHS Ayrshire and Arran’s vision for the future of the local health service over a ten year period from 2012.  

It sets down the notion that a ‘hospital’ based model of care is no longer sustainable or appropriate to meet the health needs of the population, and advocates the adoption of a community-focused health and social care service.  

This document explains that the public health priorities across Ayrshire and Arran are:  
Alcohol  
Tobacco  
Obesity  
Mental Health


The revised Staff Governance Standard provides sets out what employers are expected to do to develop and manage their staff to ensure that all staff have a positive employ experience.  

In addition it outlines the staff responsibilities in relation to their colleagues, managers staff for whom they have responsibility the organisation, patients, their carers and the public.
| **East Ayrshire Change Fund Plan (2012) East Ayrshire CHP** | The indicative Change Fund allocation for East Ayrshire in 2012/13 is £1.887M. East Ayrshire’s Change Plan for 2012/13 focused on the following areas: Falls prevention and management; Community based clinical pharmacy Voluntary sector Primary care Dementia Out of Hours Services |
| **Supported Accommodation Strategy for Older People in East Ayrshire (2006) East Ayrshire Council** | The Supported Accommodation East Ayrshire Council (2006) set out the way in which ‘supported accommodation’ is operated. Access to supported accommodation is based on an assessment of the level of dependency (low, medium and high) of the individual as well as how urgently they need the support (urgent, significant, moderate or aspirational). |
| **East Ayrshire CHP Response to Integration of Adult Health and Social Care Consultation (2012) East Ayrshire CHP** | Response to the consultation on the integration of Adult Health and Social Care |

### North Ayrshire

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<tr>
<th><strong>Strategy / Policy Document</strong></th>
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<tr>
<td><strong>North Ayrshire - A Better Life A Single Outcome Agreement for North Ayrshire (2009) North Ayrshire CPP</strong></td>
<td>The Single Outcome Agreement 2009 – 2012 replaced the Community Plan 2006 – 2016 and the North Ayrshire Community Plan 2008 – 11. Although the agreement slightly pre-dates the mainstreaming of the language of ‘shifting the balance of care’, there was a clear commitment to helping people to be supported in their own home: ‘North Ayrshire Outcome 6d – more vulnerable people are supported within their own community’ North Ayrshire’s SOA will be reviewed and updated this year and will include direct references to the rebalancing care agenda.</td>
</tr>
<tr>
<td><strong>North Ayrshire Change Fund Plan (2012) North Ayrshire CHP</strong></td>
<td>The indicative Change Fund allocation for North Ayrshire in 2012/13 is £2.24M North Ayrshire’s Change Plan for 2012/13 focused on the following areas: • Supporting people with dementia • Care Homes • Anticipatory Care and End of Life Training • Care at Home – including out of hours</td>
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<td>Strategy / Policy Document</td>
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| North Ayrshire Joint Commissioning Strategy for Older People 2009 - 2012 | The Joint Commissioning Strategy for Older People 2009 – 2012 was developed by the North Ayrshire Community Health Partnership. The main vision outlined in the strategy was to:  
‘Enable older people to remain at home for as long as it is practical and safe, give person centred care and provide a range of services and support appropriate to meeting their needs and achieving good outcomes’.  
Key proposals within the strategy included:  
- Need for joint needs assessment, and partnership working;  
- Refocus care in the community rather than relying on hospital beds or care home placements;  
- Agree level of in-patient care to be retained;  
- Consider number and use of assessment and rehabilitation beds;  
- Agree amount of resource release for investing in community health and care infrastructure;  
- Consider short to medium term purchase of care home places to reduce number of delayed discharges;  
- Agree joint investment strategies;  
- Link more closely with Rapid Response Team;  
- Develop respite facility for people with dementia;  
- Increase use of assistive technology;  
- Introduce closer liaison between community based social care and health and hospital to reduce numbers inappropriately admitted to hospital by accessing joint provision and out of hours services;  
- Increase range and type of community rehabilitation, anticipatory and preventative care. |

| North Ayrshire Local Housing Strategy 2011 - 2016 | The North Ayrshire Local Housing Strategy 2011 – 2016 provides a strategic vision for housing. In relation to meeting the needs of older people the strategy provides a commitment to:  
- Ensuring all new homes are built to a standard that allows households to remain living in them throughout their lives;  
- Working with local RSLs to ensure equality of opportunity in terms of accessing this equipment and adaptations as well as matching adapted empty rental properties to people with similar needs;  
- Ensuring there is housing support measures available that promote independent living through development of a Housing Support Strategy. |
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<th><strong>Strategy / Policy Document</strong></th>
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<tr>
<td>The North Ayrshire Local Housing Strategy 2011 – 2016 was approved through the Scottish Government Peer Review process in Winter 2011</td>
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**South Ayrshire**

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<th><strong>Policy Document</strong></th>
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| South Ayrshire Single Outcome Agreement (2009) South Ayrshire CHP | The Single Outcome Agreement 2009 – 2012 replaced the Community Plan ‘A Better Future Together 2006 – 2010’. As with North Ayrshire, although the SOA document predates the ‘re-balancing care’ rhetoric, there is a clear commitment to helping older people remain as independent as possible within their own homes: 

‘South Ayrshire Strategic Objective 9c’ – increase and maintain the independence of older people and people with long-term conditions and disabilities |

South Ayrshire’s SOA will be reviewed and updated this year and will include direct references to the rebalancing care agenda. |
| South Ayrshire Council Change Fund Plan (2012) South Ayrshire CHP | The indicative Change Fund allocation for South Ayrshire in 2012/13 is £2.21 M. |

South Ayrshire’s Change Plan focused on the following areas:  
- Community Capacity Building  
- Targeted Housing Adaptations  
- Dementia related activity  
- Telehealth and Telecare development and capital  
- Mobile attendants  
- Enablement  
- Community Ward |
| South Ayrshire Local Housing Strategy (2011) South Ayrshire Council | The South Ayrshire Local Housing Strategy 2011 – 2016 provides a strategic vision for housing. In relation to meeting the needs of older people the strategy provides a clear commitment to:  

A Strategy for Housing Options for Older People;  
Improve access to advice and information for older people;  
Agreeing a South Ayrshire amenity standard. |

The South Ayrshire Local Housing Strategy was approved through the Scottish Government Peer Review Process on the 1<sup>st</sup> September 2011. |
<p>| South Ayrshire Housing | The report outlined potential actions for the Council to widen the |</p>
<table>
<thead>
<tr>
<th>Policy Document</th>
<th>Summary</th>
</tr>
</thead>
</table>
| Options for Older People (2011) South Ayrshire Council | Housing options for older people including:  
- The development of a more integrated housing and support model for older people would help to reduce duplication of accommodation and support costs.  
- Using communal areas at sheltered housing complexes more flexibly for all people to attend day activities.  
- Increase support in sheltered housing and link allocation of sheltered housing with IORN scores  
- Install wet floor showers as standard to save on costs to install at a later point.  
- The allocations process should be developed further to reflect the differences between individual complexes and the extent to which they each meet applicant need.  
- Develop a process for assessing need and prioritising applications in the private sector for grant funding.  
- Ensure that new private houses are built to meet the needs of an ageing population  
- Owner occupiers should be encouraged to consider all their housing options.  
- To make best use of previous investment in aids and adaptations the Council should look at defining an amenity standard and designating individual properties as amenity. |

| South Ayrshire CHP Response to Integration of Adult Health and Social Care Consultation (2012) South Ayrshire CHP | Response to the consultation on the integration of Adult Health and Social Care                                                                                                                                  |
Appendix 3 JSOP Outcomes Triangle

As a result of these outcomes there will be effective whole system partnership working for the provision of services which fits the needs of older people (i.e those aged 65 years or more) and allows them to remain in their own communities wherever possible.

Reshaping Care for Older People

Joint Commissioning Strategy for Older People in Ayrshire and Arran 2012 - 2022

Production of Local Joint Commissioning service delivery and programmes of development - 10 years.

Services are more suited to the needs of individuals (personalisation)

A shift in the balance of care from institutional to community care

All stakeholders are appropriately involved in the development of the Strategy, communication on progress, implementation and enable feedback into this process

Agreed process for service developments and service decommissioning on a locality basis

There will be an improved focus on outcomes, flexibility and person centred approaches through procurement

Consultation and involvement arrangements are accessible to all older people

Decisions are based on a complete understand of local population needs and resource availability

All outcomes for older people will be measured against agreed performance targets/indicators

Effective whole system pathways for service provision

Transparency of resource allocation

Stakeholder involvement a wide range of views on current and future services

Robust process for communication of Commissioning process

Development of joint integrated service

Sound analysis of future population and health needs

Undertake needs assessment using available data sets

Consultation process confirmed and communication plan agreed which are accessible to all older people

Develop joint financial arrangements to support the commissioning process and outcomes

Performance indicators will be identified

Key stakeholders identified and process for engagement agreed

Development of joint workforce plan

Stakeholder engagement

Joint Commissioning Project team established

Communication Plan

Finance

IT Data Sharing

Needs Assessment

Commissioning Project Team

Equality and Diversity Impact Assessment

Workforce Plans

Performance Framework

Intermediate Outcomes

Short Term Outcomes

Outputs

Activities
### Appendix 4 Changes Related to Welfare Reform and Older People

<table>
<thead>
<tr>
<th>Change</th>
<th>When</th>
<th>Impact on Older People</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Introduction of Universal Credit</strong></td>
<td>October 2013</td>
<td></td>
</tr>
</tbody>
</table>
- Older people of Pension Credit age will no longer be able to claim Pension Credit if their partner is under Pension Credit age – rather their partner will need to claim Universal Credit instead  
- Older People who have dependent children living with them will no longer be able to claim Child Tax Credit – so financial help for children will be provided on Universal Credit or Pension Credit  
- Older People who are working in a low-paid job and over Pension Credit age will no longer be able to claim Working Tax Credit |
| **Abolition of Housing Benefit** |  
- New claimants October 2014  
- Existing claimants between 2014 and 2017 |  
- Pension credit will include a new housing credit to help towards rent |
| **Abolition of Child Tax Credit** | October 2013 |  
- Pension credit will include additional amounts if you have dependent children |
| **Abolition of Council Tax Benefit to be replaced by local schemes** | 2013-2014 |  
- This is still to be determined, although in England pensioners are expected to receive the same level of support under the new scheme as at present. |
| **Possible limit for Pension Credit** | October 2013 |  
- Older People will not be able to claim Pension Credit if they have over £16,000 in savings |
| **Introduction of Personal Independence Payment to replace Disability Living Allowance** | Autumn 2013 |  
- Older people receiving PIP when they reach Pension Age will be able to keep claiming it as long as they still meet the criteria for it |
Appendix 5 – Draft potential KPIs/evidence

The potential Key Performance Indicators (KPIs) include two HEAT targets and one HEAT Standard and the latest available data for these measures demonstrates that good progress is being made.

Work is currently in progress to set targets and trajectories for the other potential indicators and, in some cases, to develop indicators.

<table>
<thead>
<tr>
<th>Overarching strategic outcome</th>
<th>PIs/evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commissioning and delivery of improved integrated services to older people including supporting older people in their communities and shifting the balance of care</td>
<td>See below</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Long term outcomes</th>
<th>PIs/evidence</th>
</tr>
</thead>
</table>
| As a result of these outcomes there will be effective whole system partnership working for the provision of services which fits the needs of older people (i.e those aged 65 years or more) and allows them to remain in their own communities wherever possible | • Whole system partnership working processes and arrangements are operating effectively – confirmed by external assessment /evaluation  
“Councils along with NHS Boards and other relevant commissioning partners, should develop commissioning strategies for social care services which set out;:-  
➢ An analysis of needs and potential gaps in services  
➢ How users, carers and providers will be involved throughout the commissioning process  
➢ Consideration of quality and what impact services will make to the quality of peoples lives and how these will be measured  
➢ Consideration of who might be able to provide the services needed (capacity)  
➢ An analysis of costs and budgets for services (both in house and externally provided)  
➢ A summary of any planned improvements or different ways of working  
➢ *Timescales for implementing and reviewing the strategy*  
• Service users views on new system/impact on lives – use of *Talking Points*  
• People aged 65+ years remaining in their own home – advice to be sought on a suitable measure(s) |
<table>
<thead>
<tr>
<th>Medium term outcomes</th>
<th>PIs/evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reshaping Care for Older People</td>
<td>Reshaping Care Improvement Measures (JIT Scotland)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Code</th>
<th>Name</th>
<th>Comments</th>
</tr>
</thead>
</table>
| A1   | Emergency inpatient bed day rates for people aged 75+. *(HEAT Target)* | The Reshaping Care initiative from 2011/12 to 2014/15 and associated £300M Health and Social Care Change Fund are closely associated with this very significant area of partnership working. One of the primary purposes of the Reshaping Care programme is to release resources from acute hospitals and move them upstream to fund preventative and community based services and support. The Scottish Government asked NHS Boards to provide trajectories from the baseline year 2009/10 up to the end of the Change Fund in 2014/15 to demonstrate how NHS Boards and partners will reduce 75+ emergency bed day rates enough to release resources for investment inline with their Reshaping Care Change Plans. *(LDP 2012/13 Methods & Sources)*  
NHS Ayrshire & Arran is to achieve a 20% reduction in the rate of emergency inpatient bed days for people aged 75 and over by 2014/15. This equates to a target of 4,073 emergency bed days per 1,000 population by March 2015.  
As at April 2012, the performance was 4,637 against a target trajectory of 4,667 and the service predicts that the end of year target will be achieved.  
NHS Ayrshire & Arran were ranked 8th out of the 11 NHS Scotland Mainland Health Boards. The overall NHS Scotland performance was 4885. |
| A2a  | Patients whose discharge is from hospital is delayed more than 28 days *(HEAT Target)* | Patients should not have to wait unnecessarily for more appropriate care to be provided after treatment in hospital. Waiting unnecessarily in hospital is a poor outcome for the individual, is an ineffective use of scarce resource and potentially denies an NHS bed for someone who might need it. |
As at September 2012, 3 patients were waiting more than 4 weeks in to be discharged from an NHS Ayrshire & Arran hospital against a target trajectory of 12 patients. It is predicted that the end of year target of 4 patients waiting will be achieved.

**A2b** Accumulated bed-days for people delayed

**Measure under development**

**A3** Prevalence rates for diagnosis of Dementia

**Measure under development**

Maintain the proportion of people with a diagnosis of dementia on the Quality and Outcomes Framework (QOF) dementia register and other equivalent sources. *(HEAT Standard)*

The standard is to maintain the 2010/11 proportion of people with a diagnosis of dementia on the Quality and Outcomes Framework (QOF) dementia register and other equivalent sources.

Diagnosis of dementia is important as the diagnosis is the gateway to information, support, care and treatment for the person with dementia, their family and carers.

The performance measure used for this standard is the number of people with a diagnosis of dementia on the Quality and Outcomes Framework (QOF) dementia register and other equivalent sources.

The NHS Ayrshire & Arran target for 2011/12 was 3,091 registrations and 3,222 registrations were achieved.

As at March 2012, NHS Ayrshire & Arran were ranked 6th out of 11 NHS Scotland Mainland Health Boards.

**A4** Percentage of people aged 65+ who live in housing, rather than a care home or a hospital setting

**Measure under development**

**A5** Percentage of time in the last 6 months of life spent at home or in a community setting.

**Measure under development**

**A6a** % of community care users feeling safe

**Measure under development**

**A6b1** % of users satisfied with their involvement in the design of care package

**Measure under development**
<table>
<thead>
<tr>
<th></th>
<th>Measure under development</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A6b2</strong></td>
<td>% of carers satisfied with their involvement in the design of care package</td>
</tr>
<tr>
<td><strong>A6bc</strong></td>
<td>% users satisfied with opportunities for social interaction</td>
</tr>
<tr>
<td><strong>A6d</strong></td>
<td>% of carers who feel supported and able to continue in their role as a carer</td>
</tr>
<tr>
<td><strong>B1</strong></td>
<td>Proportion of people aged 75 and over living at home who have an Anticipatory Care Plan shared with Out-of-Hours staff</td>
</tr>
<tr>
<td><strong>B2</strong></td>
<td>Waiting times between request for a housing adaptation, assessment of need, and delivery of any required adaptation</td>
</tr>
<tr>
<td><strong>B3</strong></td>
<td>Proportion of people aged 75+ with a telecare package</td>
</tr>
<tr>
<td><strong>B4</strong></td>
<td>Measure of dependency: before and after re-ablement</td>
</tr>
<tr>
<td><strong>B5</strong></td>
<td>Respite care for older people per 1000 population</td>
</tr>
<tr>
<td><strong>B6</strong></td>
<td>Rates of 65+ conveyed to Accident &amp; Emergency with principal diagnosis of a fall</td>
</tr>
<tr>
<td><strong>B7</strong></td>
<td>Proportion of frail emergency admissions who access comprehensive geriatric assessment with 24 hours</td>
</tr>
<tr>
<td><strong>B8</strong></td>
<td>Use of long term care homes and continuing care</td>
</tr>
<tr>
<td><strong>C1</strong></td>
<td>Per capita weighted cost of accumulated bed days lost to delayed discharge</td>
</tr>
<tr>
<td><strong>C2</strong></td>
<td>Cost of emergency inpatient bed days for people over 75 per 1000 population over 75</td>
</tr>
<tr>
<td>Joint Commissioning Plans for Older People in Ayrshire and Arran 2012 - 2022</td>
<td>· Joint commissioning plans developed and agreed by all partners</td>
</tr>
<tr>
<td>Production of Local Joint Commissioning service delivery and programmes of development - 10 years. 3 years and 1 year ahead</td>
<td>· Local Joint Commissioning service delivery and programmes of development – developed and agreed by all partners</td>
</tr>
</tbody>
</table>
| Services are more suited to the needs of individuals (personalisation) | · % traditional service provision compared to % Self directed support (SDS)  
· Number of Direct Payment recipients  
· Number of people that received SDS packages  
· Service users and carers views on the service provided– obtained through Talking Points  
Discussion is required on suitable KPIs |
<p>| A shift in the balance of care from institutional to community care | · Change Fund PI C003 – A measure of the balance of care (split between spend on institutional and community based care) |</p>
<table>
<thead>
<tr>
<th>Short term outcomes</th>
<th>PIs/evidence</th>
</tr>
</thead>
</table>
| All stakeholders are appropriately involved in the development of the plans, communication on progress, implementation and enable feedback into this process | - Communications strategy/action plan developed in partnership and implemented  
- Stakeholders involved  
- Meeting/events held  
- Information issued  
- Feedback arrangements in place/used  
- The performance indicators in the *National Standards for Community Engagement*, (Communities Scotland, 2005)  
| Agreed process for service developments and service decommissioning on a locality basis | - Evidence that the process was developed and agreed by all partners |
| There will be an improved focus on outcomes, flexibility and person centred approaches through procurement | - *The recommendations from Commissioning Social Care* (Audit Scotland, 2012)  
| Consultation and involvement arrangements are accessible to all older people | - The performance indicators in the *National Standards for Community Engagement*, (Communities Scotland, 2005)  
| Decisions are based on a complete understanding of local population needs and resource availability | - Joint Needs Assessment document in place  
- Total Resource dedicated to care of elderly identified  
- Pooled budgets identified and management mechanisms in place  
- Costs of future services identified and are sustainable |
| All outcomes for older people will be measured against agreed performance targets/indicators | - Joint PIs identified and targets set  
- Joint performance management system in place, including reporting |
| Effective whole system pathways for service provision | - Points of contact in place, supported by whole system pathways for service provision |
| Transparency of resource allocation | - Appropriate financial mechanisms are in place to show how funding is being spent – to be discussed  
- Information/FAQs/Awareness raising |
<table>
<thead>
<tr>
<th>Outputs</th>
<th>PIs/evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Robust process for communication of Commissioning process</td>
<td>Joint Communication Plan in place</td>
</tr>
<tr>
<td>Development of joint integrated services</td>
<td>Joint integrated services established</td>
</tr>
<tr>
<td>Sound analysis of future population and health needs</td>
<td>Joint Needs Assessment document</td>
</tr>
<tr>
<td>Joint Workforce plans help to set out partners responsibilities and contributions'</td>
<td>Joint workforce plans in place – there has been an adjustment to the original scope of the programme. This is now included within integration</td>
</tr>
</tbody>
</table>
| Performance monitoring/scrutiny to inform future delivery of services identified in the Commissioning Strategy | ● Joint PIs identified and targets set  
● Joint performance management system in place, including reporting |
<p>| Project management provides direction and leadership to the process and final Strategy | Programme/project management documentation/processes/arrangements in place |</p>
<table>
<thead>
<tr>
<th>Actions</th>
<th>PIs/evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultation process confirmed and communication plan agreed which are</td>
<td>• The performance indicators in the *National Standards for Community</td>
</tr>
<tr>
<td>Develop joint financial arrangements to support the commissioning</td>
<td>• Total Resource dedicated to care of elderly identified</td>
</tr>
<tr>
<td>process and outcomes</td>
<td>• Pooled budgets identified and management mechanisms in place</td>
</tr>
<tr>
<td></td>
<td>• Costs of future services identified and are sustainable</td>
</tr>
<tr>
<td>Undertake needs assessment using available data sets</td>
<td>• Joint Needs Assessment document</td>
</tr>
<tr>
<td>Key stakeholders identified and process for engagement agreed</td>
<td>• Agreed process for engagement</td>
</tr>
<tr>
<td></td>
<td>• The performance indicators in the *National Standards for Community</td>
</tr>
<tr>
<td>Development of joint workforce plan</td>
<td>• Joint working plan</td>
</tr>
<tr>
<td>Performance indicators will be identified</td>
<td>• Joint review of available measures/indicators;</td>
</tr>
<tr>
<td></td>
<td>• JSOP specific PIs relating to the strategy and process</td>
</tr>
<tr>
<td></td>
<td>• Reshaping Care/Change Fund PIs</td>
</tr>
<tr>
<td></td>
<td>• Future suite of indicators and measures for integration of adult health</td>
</tr>
<tr>
<td></td>
<td>and social care)</td>
</tr>
<tr>
<td></td>
<td>• Joint PIs identified, agreed and targets set</td>
</tr>
<tr>
<td>Joint Commissioning Project team established</td>
<td>• Notes of meetings, ToR, governance arrangements</td>
</tr>
</tbody>
</table>