Integrated Care Fund Projects

1. Enhanced End of Life / Palliative Care Facility

Brief outline

Ayrshire is well served by Ayrshire Hospice in the field of palliative care which is being augmented by its 'hospice at home' outreach service. Its treatment facilities are single-sited which can be difficult for service users and their friends/family from outwith Ayr. A dedicated enhanced end of life care service facility in North Ayrshire which serves the neighbourhood and maintains individuals within their community is proposed. This is particularly important for families where transport is a problem.

Abbotsford holds a positive record for its end of life care and the Depute Manager has recently undergone the Generalist Nurse up-skilling programme funded by MacMillan. Another member of staff is currently undergoing training in Namaste. A strong focus and professional interest exists within Abbotsford in the field of end of life care. A dedicated room facility, supported by a skilled workforce, with specialist input from District Nursing / Hospice at Home staff, would offer a local alternative when a hospice-type setting is required.

Outcomes:

Enhanced end of life care brought locally to the people of North Ayrshire. Particularly favours those with family and friends with transport difficulties.

2. Health Promoting Care Home (HPCH) Framework

Brief Outline

Successfully trialled with 20 care homes in A&A in a collaborative initiative led by NHS A&A Public Health, HPCH is a project-based, inclusive (i.e. service users, staff, families & friends), change agent through which issues and improvements can be dealt with in a care home setting. It has a wide-ranging health promoting focus, which incorporates preventative measures. It includes a Resource Framework, Guidance Notes and a Resources Toolkit and is suitable for all age group care homes. This pack allows a service to use this process for any suitable issue or change requirement/enhancement which may be required – i.e. it can be used more than once, in a project-based way.
In order for this initiative to be fully rolled-out to all Ayrshire care homes, a
Coordinating / facilitating role is required – a sub-duty of the Independent Sector Development Office is thought to be ideal for this. It also requires each project to undergo validation – training of, say, 3rd Sector advocacy services or similar to undertake this function has been recommended.

Outcomes:

Service users in care homes benefit from improved health-related services.

3. Delivery of Talking Mats

Brief Outline

This is an outline proposal for delivering Talking Mats training to a range of staff across North Ayrshire Health and Social Care Partnership. Training can also be delivered to carers and family members. Undertaking this training will enable staff, carers and families to use a Talking Mats approach in their interactions with people with communication support needs.

Engaging individuals with a communication support need can be challenging for staff across health and social care and also for their carers, resulting in inequality for individuals. A communication support need is defined as any individual who needs help to:

- understand (written or verbal information)
- express themselves
- interact with others

All too frequently people with communication difficulties have decisions made for them, without being able to make their views known.

'Talking Mats' is a visual framework that uses picture symbols to help people with a communication difficulty communicate their views more effectively. It can be used with children and adults and is an approach that helps people think about issues and provides them with a structured way of organising and expressing their thoughts more easily.

'Talking Mats' is an evidence based, interactive resource that can be used by clinical practitioners, carers and support workers across health care, social work and in residential, education and early year's settings. Talking Mats has been used for a number of years with people with learning and or physical disability, stroke, neurological conditions, dementia, mental health issues and the elderly. It is now being used with individuals who do not have communication difficulties in goal setting, particularly with individuals with long term conditions.
Talking Mats training is delivered by attendance at 2 x 3 hours sessions (with a gap to undertake initial use of the approach). 8 – 10 delegates can be trained during each training session. The sessions allow participants time to reflect and develop their own communication skills with video feedback on their use of the approach a key part of the second training session.

Outcomes:

The use of a Talking Mats framework by staff can help us achieve the vision expressed in the National Health and Wellbeing outcomes.

It will contribute to individuals having positive experience of services and improved quality of life. By being able to share their views and feelings the individual is more likely to feel:

- safe
- cared for
- included
- empowered
- supported

Talking Mats supports staff in health and social care services who are trained in this approach to improve the information, support, care and treatment they provide by enabling the service user to communicate their views clearly.

4. Post Diagnostic Support

Brief Outline

Scotland's 2nd National Dementia Strategy 2013/16 states that everyone newly diagnosed with dementia from 1 April 2013 will be entitled to receive a minimum of a year's worth of post-diagnostic support (PDS), coordinated by a named and trained link worker. A HEAT target has now been developed to measure the implementation of this support.

Currently in NHS Ayrshire & Arran PDS is being delivered within the 3 Health & Social Care Partnerships (HSCP) by the Community Mental Health Teams (CMHT).

The intent of this new initiative is to provide a comprehensive co-ordinated approach across the three Partnerships. This would be accomplished by enhancing the current establishments in the CMHT's through the

employment of dedicated PDS Link workers to deliver on this HEAT target and ensure a needs led approach to this support is achieved.

This approach will maximise the opportunity for a small team in each Partnership to focus their skills, competencies and energies in providing a quality PDS service for people with dementia and their carers.

Outcomes:

Our vision is based on the 2020 Scottish Government for health and social care ambition to be "safe, effective and person-centred care which supports people to live as long as possible at home or in a homely setting".

The integration of health and social care provides significant opportunities to improve efficiency and effectiveness, reduce duplication, reinvest savings and ultimately enhance the experience of patients and users of services.

5. Early Intervention from Custody (Women)

Brief Outline

The Court Screening Service has been operational at Kilmarnock Sheriff Court since June 2014. The initiative is funded by the Scottish Government to March 2015. The service screens all women appearing at the Sheriff Court from custody, providing brief information to the Sheriff to aid decisions in terms of remand and bail.

The Court Screening Service has identified a major gap in provision for women who need support immediately on leaving Court e.g. emergency accommodation, addiction and health services and particularly in relation to mental health. The Court Screening Service currently highlights to the Court, women who are or can be, linked in with services to support them whilst bailed in the community, with an overall view of:

- reducing the number of women who are remanded in custody
- offering services immediately at a time when women are often highly motivated to engage
- encouraging this very vulnerable and marginalised group to access services to improve both their mental and physical health

The ability to offer support to access relevant services in the community through the Early Intervention From Custody (Women) project will clearly bolster this position.

Since the start of the project on 23rd June 2014, 100 women from North Ayrshire have appeared from custody at Kilmarnock Sheriff Court (some appearing on multiple occasions). Data collated during this Court Screening Service provision supports the main areas of need presented by the women leaving custody (usually on Court appointed bail) are linked to those with chaotic alcohol/drug use in 56 % of cases and women presenting with mental health concerns in 25% of cases. Additionally, this data highlights that challenges in engaging with services is also a presenting problem and highlighted as problematic in 32% of cases. The women identified by the Court Screening Service can also frequently require support to access accommodation, general health and other specialist services.

The Court Screening Service is currently working to develop more efficient pathways to assist women in North Ayrshire to access these services immediately on release from the Court, or at least within twenty-four hours. The Early Intervention From Custody (Women) project would therefore be a service which provides short, intensive levels of support, to encourage access into existing services.

This new initiative would seek to support these women over a short period of time to engage with the relevant services, subsequently improving their health and reducing their risk of re-offending.

Outcomes:

The Scottish Government's strategic objective of "Healthier" highlights the need especially in disadvantaged communities for better, local and faster access to health care. The integration of health and social care aims to

provide seamless, joined up, high quality health and social care services. This Early Intervention From Custody (Women) project would intend to support and work towards these objectives.

Early Intervention From Custody (Women) would seek to:

- Engage with vulnerable and marginalised women in the criminal justice system at an early stage to avoid remand.
- Link these vulnerable and marginalised women into existing mainstream services available in North Ayrshire.
- Improve the pathways into health services for vulnerable service users.
- Develop closer working links between relevant social services, health and third sector organisations to improve the pathways into services.
- Improve vulnerable women's engagement with a range of health services.
- Increase health services ability to engage with this vulnerable and marginalised service user group.
- Increase the uptake of women accessing services by engaging them at their highest level of motivation.
- Reduce the number of women who are remanded by increasing the Court's confidence in the use of bail.
- Prevent the further marginalisation of women following a period spent on remand.
- Seek to support, stabilise and improve the mental health of those women supported to engage with mental health services.
- Provide robust, immediate and viable community based alternatives for sentences when they are considering the best course of action for individual women appearing in Court from custody.

6. Positive Connections

Brief Outline

The Positive Connections initiative would plan, develop and run creative therapy programmes for people who have mental health issues and for older people with disabilities within a supportive community setting. Programmes would include: crafting, arts, horticultural, reminiscence, focus and self-help support within our new support base.

Through this new initiative we want to explore the notion that every individual has a creative and imaginative capacity that is of central importance to mental and physical health and well-being.

As a third sector organisation, we are very proud of our achievements in providing
designated, personalised support to people with various disabilities and mental health issues. Over the years we have built up an excellent reputation and positive working relationship with the social work mental health team, community mental health team, primary care services and other third sector organisations. This integrated and partnership working ethos is essential for us to continue developing our services, to ensure that the people who receive
our support continue to be valued and play a full and meaningful role in directing their own support needs.

The people that we support are at various stages of their journeys to recovery and have to deal with health inequalities on a daily basis. They need to have support to be able to, not only live within their own home but also to avoid isolation and to play a part in their local community. In order that we support them efficiently, we ensure that our services are providing activities that they feel they could take ownership of and play an active role in the development of current and future services.

This community development and social inclusion approach would assist individuals to connect with their peers for support as well as positively increasing their social, emotional and physical well-being. This initiative would make a meaningful contribution to the mental health and well-being of communities through providing an opportunity for individuals who encounter social exclusion, to develop new skills, confidence and a new medium (creativity) through which to share their experiences of anxiety, depression and tackle discrimination.

Having run this initiative as a pilot project, we have noticed the benefits to participants and the difference it can make. Participants experienced significant improvement in their mental health and social function. There was improved self-esteem, communication skills and social interaction.

We believe these groups and activities, though the Positive Connections Initiative, will assist people to obtain better health prospects therefore avoiding multiple hospital admissions and more prone to living more independently in their home environment.

Outcomes:

Our Positive Connections Initiative will be out come led and will link into the integrated health and wellbeing outcomes for adult health and social care.

A number of outcomes will be achieved through this work, including:

- An approach to support which will aid recovery and development of well- being, valuing participants contribution at the level they are comfortable with.
- An environment where participants are listened to and supported to develop action plans to achieve their needs and wishes.
- A form of support which enhances the ability of participants with multi-morbidity conditions to cope with everyday life.
- Opportunities for participants to build confidence and self-esteem.
- Opportunities to develop a voice through their creative activities.
- An organised showcase event with partners to showcase the participants work and raise awareness of creativity to promote health and well-being.

7. Callcare 365

Brief Outline

Callcare 365 is a Care Telephone Support Service which can be delivered seven days a week, three hundred and sixty five days a year. It is designed to be responsive to the individual's needs.

The service calls daily to individuals at a mutually agreed time and a relationship is established. The service will also offer project and community news, promote local services, telephone numbers, information relating to issues which may arise for the client, medication prompts, appointment reminders, meal prompts, safety reminders etc.

Specifics of the service user are recorded e.g. medication, appointments, prompts etc. The person is telephoned. If no answer is obtained they go to the bottom of the queue system and come back up the list. They are telephoned a second time, if there is no answer again, a third time. In the event that no contact is obtained the named contact would be informed so that wellbeing could be ascertained. The escalation policy has proved very effective in preventing crisis situations occurring.

Calls are monitored and information recorded allowing continuity of service, even when different operatives are calling.

The service is delivered from two locations allowing high volume work to be distributed, enabling call times to be met.

By recording this information much more meaningful relationships can be established there by giving the older person a greater sense of security and wellbeing.

Staff and volunteers are skilled and adept at responding to the persons needs and provide security and information to help maintain independence.

The service is backed up technically enabling it to be delivered even when telephone or power failure occurs.

The service can be tailored to the individuals needs and be flexible in its approach. It is an increasingly popular concept in Social Care Service that could be offered as a stand-alone support or additional to other care support. It can be introduced as short term support or long term contract.
It can be introduced daily or intermittently, over holiday periods or weekends (when perhaps other care support is not available). It provides a regular contract for people who may be experiencing isolation and loneliness thereby help to maintain emotional/physical wellbeing.

The Ayrshire Healthy Living Enterprise/Access Ability have a long history of one to one person centred approaches. We have seen the way Callcare 365 has benefited service users without compromising quality. Therefore we see this service as a very effective /support core mechanism which is much more cost effective and responsive than conventional befriending services.

Outcomes:

The aim of the service is to support people with care needs to live independently in their own homes and to promote their self – determination.

The Callcare 365 project will address the priorities through the following outcomes:

- reducing social isolation & loneliness
- provide companionship through continuity of contact daily
- help to improve self-confidence and self esteem
- overcome access to support due to rural isolation
- Improves feeling of being safe
- alert to potential health problems which could result in a reduction of hospital admissions
- optimises independence and well-being for people at home or in a homely setting
- connects people into their community
- Improve their knowledge of community services and local events
- gives peace of mind to relatives, friends and neighbours
- potential for reduction of burden on Social Work Services

8. On Yer Bike

Brief Outline

Based in the Auld Dirrans Centre Kilwinning.
CCC in partnership with North Ayrshire Council Dirrans Centre will provide 80 plus free use cycles and cycling events, focusing on the main target group low income families to encourage fitness, a healthy lifestyle and to provide safety training. Vocational training leading to a qualification in cycle maintenance and repair will also be available. The initiative will also promote the use of the national cycle track. Affordable refurbished cycles will be available for our target group.

Create a "Healthy Cafe" and repair shop for cyclists from the adjacent national cycle track and for the local community run by volunteers. A local food initiative will grow fresh produce in the grounds of the Auld Dirrans Centre and encourage volunteers in the local area to grow vegetables in their gardens. A local fresh food market will also be created. A healthy cooking initiative will be run We will work in partnership with North Ayrshire Council Dirrans Centre which provides rehabilitative support to adults with physical disability and long term conditions.

We will offer training and learning opportunities to support the service users by providing cycling activities including cycling for the disabled, cycle safety training, volunteering opportunities within both the cycle and cafe initiative and vocational training in cycle maintenance and repair.

Outcomes:

Community involvement; Encourage fitness and cycling; Improvement in health and wellbeing; Promote affordable healthy eating and positive lifestyles. Encourage positive family interaction; Training and learning opportunities for service users at the Dirrans Centre.

9. North Ayrshire Recovery Café

Brief Outline

This bid is to support the development of Café Solace as it consolidates its partnerships with NAADP, statutory and third sector partners and takes Café Solace into the community.

During a number of stakeholder events co-ordinated by NAADP throughout 2012, a key message was being communicated from North Ayrshires recovery community people in recovery want to "give something back". This message was emphatically expressed and has become a key part of North Ayrshire's working definition of addiction recovery. NAADP has since worked with a group of people in recovery to support the development of their ideas and their skills.

This work has focussed on parallel strands of development – people in recovery recognised that they had skills which were now unused and although they had ambition and enthusiasm many had been out of education, employment and training for some time. Over the last 18-24 months many people in recovery have been supported to gain new skills and develop existing skills with a view to volunteering in a local community café style provision, as well as undertake the management of same.

This has seen a range of training being undertaken and has supported people in recovery to form Recovery at Work (RaW) – the constituted community group responsible for managing and delivering the café. RaW has 8 members with an additional 2 co-opted onto the committee. These members take managerial decisions re: the café, as well as volunteer in the staffing of the café. The café has offered monthly café nights from Caley Court Resource Centre for approximately 18 months. Whilst these nights have been considered a success by all accounts, the venue is restrictive. This led RaW to approach a local church which has agreed to forge a partnership and provide a venue for Café Solace to hold more frequent recovery café nights.

RaW has undertaken market research which has gone on to inform what café nights at the church will involve. For brevity, Café Solace will be a recovery resource for people in recovery and those who support recovery in North Ayrshire, delivered by people in recovery and those who support recovery in North Ayrshire. RaW has begun to develop partnerships with a range of statutory and third sector partners to ensure the success of Café Solace and embed it as an essential resource to complement existing NAADP provision in support recovery in Ayrshire.

While RaW has delivered a number of café nights from Caley Court Resource Centre, there has been no fee taken for food served. This means the group's current balance sheet shows zero for profit/loss. This bid is to support the launch of Café Solace in the local community and address initial start-up costs including produce purchasing.

Outcomes:

There will be a range of outcomes and benefits for both the users of café solace and the volunteers involved in the delivery of the project.

The following are examples:

- Café Solace launched in the community
- improved partnerships between statutory and third sector providers
- improved opportunities for skill development
- improvement in physical and mental wellbeing of café solace users

- improvement in physical and mental wellbeing of café solace volunteers
- reduced alcohol and drug use
- reduced harm caused by alcohol and drug use
- unification of recovery community recovery allies in the community

10. Medication Management for paid/unpaid carers

Brief Outline

As patients with more complex co-morbidities are cared for in the community setting, demand for assistance in managing their medication will increase.

A change to the medication policy in North Ayrshire will ensure service users are supported to enable the promotion of independence in medicine taking and self-care where possible whilst receiving the most appropriate assistance with medication management required.
Training carers to administer medication will reduce the inappropriate demand for monitored dosage systems from community pharmacies. Ensuring service users receive their medication at the right time will reduce hospital admissions and wastage.

Trained and confident paid carers will better manage patient's medicines with the support of community pharmacists, thereby enabling patients to safely remain in own homes. Informed paid carers will be in a position to safely deal with any changes to a patient's medicines where patients move between areas of care.

By involving key stakeholders in raising awareness of the service, information on medicines should pass timeously at transition.

Outcomes:

Staff feel engaged & continuously improve the info, support, care & treatment. All categories of staff covered including private providers, community alarms, IC&ES, Local Authority care at home staff, day centre staff.

- Resources are used effectively & efficiently - Improved record keeping-audit trail available of medicine administration & assessment of service users need for assistance with medication management. Supported discharge-links made and awareness raised with the hospital teams to ensure service users have an assessment carried out of what assistance is required with regards to medicine administration and this is communicated to the community teams. Service users are now leaving hospital with a MAR chart when appropriate thus allowing 4 weeks for the GP and community pharmacist to take over this responsibility.
- People who use health and social care services are safe from harm. Improved patient safety-care staff trained to look out for possible side effects and alert GP to any changes in service user health as well as ensuring they are complying with their medication correctly.
- People live independently at home or homely setting in their community.
- Promotion of supported self-care and independence - updated medicine policy allows service users to remain as independent as possible by assessing the most appropriate assistance required with medication.

11. Clinical Pharmacist Working alongside ICES, the HUB and LOTS teams

Brief Outline

Clinical pharmacist input to the IC&ES team, Community Ward. Local Operating Teams (LOT's) fits in with the Scottish Government agenda of integrated care fund.
Ensuring pharmaceutical care to service users in the community will reduce hospital admissions from medicine related incidents, support discharges from secondary care and improve patient safety for those service users taking prescribed medicines within their own homes.
The Funding allows for testing of the model of provision of clinical pharmaceutical care to patients in the community setting, the results of which will be incorporated into a redesign of the pharmacy service. The

demand for better medicines management will rise as the number of patients with complex co-morbidities being cared for in the community setting increases. The clinical pharmacy resource will allow these patients to have access to expertise normally available in the hospital setting.

Pharmacist input to the health and social care teams will allow service users to access pharmaceutical care to ensure they are taking the right medicines at the right times. It allows other members of the multidisciplinary team a resource for any medication related issues.

Outcomes:

- People live independently at home or homely setting in their community - The demand for better medicines management will rise as the number of patients with complex co-morbidities being cared for in the community setting increases. The clinical pharmacist will also signpost service users to their local community pharmacist for ongoing pharmaceutical care as part of the Chronic Medication Service where appropriate.
- People look after and improve their own health and wellbeing - The clinical pharmacy resource will allow these patients to have access to expertise normally available in the hospital setting.
- Services help to maintain or improve the quality of life - Pharmacist input to the health and social care teams will allow service users to get access to pharmaceutical care to ensure they are taking the right medicines at the right times It allows other members of the multidisciplinary team a resource for any medication related issues.

12. "What's On" Service Directory

Brief Outline

The Ayrshire Community Trust (TACT) will work with the wider Third Sector, Ayrshire and Arran NHS and the Local Authority in order to create a "What's On", directory of services in order to prevent crises situations from happening. This will be similar to the "What's On" directory that was created as part of the Reshaping Care for Older people listing lunch clubs available across North Ayrshire.

This "What's On" directory of services will be targeted at people with complex and multiple health conditions though it will still be a valuable resource for the wider community.
This resource is aimed at early intervention and prevention. It will contain sections such as money, benefits, housing, food, fuel, advocacy, health, learning, community and emergency contact numbers. Under each section will be listed those organisations and services that offer tailored and intensive support interventions. This will assist individuals with complex and multiple health conditions to feel more in control of their lives, better manage their condition and prevent crises situations form occurring.

This "What's On" directory will also contain information on all the successfully funded projects through this particular integrated care fund, producing a valuable list of new and innovative services for people with long term conditions.

The proposal will pay for a part time member of staff to conduct a mapping exercise, working alongside partners in Third Sector, Health, Local Authority and CARENA. It will also pay for design, print, admin, launch and postage.

This directory will be given out to a number of Third Sector Organisations for dissemination throughout their client group. It will also be given out to primary health care as part of the hospital discharge process. It will support individuals to access support in order to have their benefits reinstated and maximised, as well as providing them with knowledge of other services in the community that will support them to better manage their health condition.

The "What's On" service directory will:

- support those who are most vulnerable and at risk of financial hardship, poverty and isolation

- be available through health care services including G.P's and medical practices, nursing staff, occupational and physiotherapists, dieticians and community mental health team
- support individuals to take part in community activities and to better informed of the range of community based services available to them within their local community

People with complex and multiple health conditions will benefit in a number of ways which include becoming more active within the community, knowing what is available, accessing a wider range of support services, improving their physical health and mental well-being, they will feel less isolated, better connected and involved.

Outcomes:

People with complex and multiple conditions will have:

- increased knowledge in the range of community based services designed to offer support
- the opportunity to access more services
- will be less likely to enter crises situations
- will be less likely to suffer from poverty and hardship
- will report and increase in confidence, self-worth and self-esteem
- will report improvement in their health and well-being
- will report an increase in motivation
- will report have the opportunity to meet new people, making friends and connections and feel less isolated
- will feel better able to manage their health conditions

13. Foodtrain

Brief Outline

Foodtrain is an established social enterprise currently operating in six local authority areas. Its basic offer is a shopping service to people who cannot manage the trip to the shops through age or infirmity or who are unable to carry shopping. It works in partnership with local authorities, local supermarkets, volunteers and the people who use the service. Typically a local manager and one other worker are employed to develop and manage the service.

Foodtrain's research has shown that people for whom shopping is a challenge tend to eat a less healthy diet than those who can shop or who have access to a shopping service. They may focus on items that are light and easy to carry, such as bread and cereals instead of healthier items such as fruit and vegetables and will often choose to carry food for pets rather than for themselves. By removing the challenge of food shopping people are able to eat better and to eat what they prefer rather than what is easy to obtain. The service also provides some social contact through the volunteers who take and deliver the orders. A shopping service may be the only support people need to enable them to stay in their own homes. The service can be seen as an early intervention and prevention service that helps to keep people safely in their own homes and delays the need for higher cost services such as care at home.

The service operates an open referral system. People may use the service as frequently as they like and can opt in and out as they wish. The service involves the collection of a shopping list by phone or in person and delivery, in a liveried van, by uniformed volunteers. Volunteers will put away shopping and loosen jars, etc. if the person wishes. A £3 charge is made towards the cost of each delivery.

The service is delivered by volunteers who are recruited using whatever channels are available in a particular area: the Third Sector Interface, community and church groups and local authorities. Foodtrain is open to finding an appropriate volunteer role for those who wish to take part. This includes people who might use volunteering as a means of developing employability skills or as an alternative to traditional social care services

(e.g. learning disability day care). Volunteer roles include driving, delivery, taking orders and filling orders in the partner supermarket. Volunteers receive full training and support.

The service is supported by Scottish Government who are committed to contribute 50% of every new start-up (c £45,000). References have been taken from local authorities where the service currently operates and these, together with independent evaluations, have been very positive.

Outcomes:

The service directly supports many of the national health and wellbeing outcomes including:

- Healthier living & health inequality (people are able to eat a healthier diet as a result of not being restricted to foodstuffs that are light and easy to carry).
- Independent living (a shopping service may often be the only service that someone requires to enable them to continue to live safely at home),
- Positive experiences and outcomes (the service has been extremely positively evaluated by service users in areas where it currently operates).
- Quality of life (the service also provides some social contact when taking and delivering orders).
- Carer support (the service frees family and informal carers from the need to do shopping and can allow them to spend more social time with the person for who they care, to the benefit of both).
- People are safe (All volunteers are subject to PVG checks. The Foodtrain local manager will refer people who use its services to statutory services if volunteers notice that something appears to be wrong).
- Effective resource use (We do not currently have the resource to provide a shopping-only service. The use of a volunteer-based service allows more people to be supported and could prevent people from requiring higher cost services such as care at home

14. GP Establishment

Brief Outline

Establishment of a GP Surgery (outreach) by Eglinton Medical Practice providing healthcare locally and allow greater access to services. (Currently patients have two take two buses to get in the surgery). This would nest well within the Ayrshire Healthy Living Enterprise and would provide many opportunities for integration and joining up services, thereby, addressing the wider determinants of health. The Footcare Plus Service, The Help Me Help You project and a range of other support services could be co-located and provide much more positive outcomes for the patients and service users. It is seen a prelude to the potential new build Community/Health facility planned for the existing Community Centre.

Outcomes:

- Individuals will be able to access health services locally.
- A more appropriate approach will be offered.
- A one stop shop will be created for both health and social care needs.
- A much more integrated model of care would be established.

15. Ayrshire Home from Hospital Service (BRC)

Brief Outline

The British Red Cross have over 20 years' experience in delivering health and social care programmes. These include the provision of "home from hospital" services in several parts of the UK. The Glasgow Rapid Response and Resettlement Service (supporting four Glasgow hospitals) commenced in Jan 2013 and combines supported patient transport with follow up help to deliver assistance to older people (priority 60+) being discharged from Accident and Emergency and associated wards over 7 days. Within North Lanarkshire the Monklands Hospital supported transport from hospital service commenced in June 2013 and delivers a smaller scaled delivery over 7 days per week.

The evaluation and research from both of these projects has shown that:

- in Glasgow in the first year of delivery 737 people were supported home with 412 admissions avoided (reported by NHS staff)
- in Monklands in the first fifteen months of delivery 383 people were supported home with 305 admissions avoided (reported by NHS Lanarkshire)

Based on the aforementioned information, there was a discussion in November 2014, about an Ayrshire model which could be phased over two sites – Crosshouse Hospital and Ayr Hospital. After further discussions it was agreed that the implementation of this service would consist of 3 phases:

Phase 1: enable the British Red Cross to respond to the immediate need at Crosshouse Hospital
Phase 2: extend to a fuller model at Crosshouse
Phase 3: the establishment of the second site at Ayr Hospital

Phase 1: of the service commenced on Thursday 11/12/14 which consists of a two person crew and a wheelchair accessible vehicle based at Crosshouse Hospital A&E department.

The service is available over five days, Thu/Fri/Sat/Sun/Mon. Thursday/Friday/Monday operational hours are between 4pm to 10pm and Saturday / Sunday opening hours are 3pm to 9pm. It provides a home from hospital service to older people (aged 65+) who have presented at A+E and have been deemed medically fit to return home. The volunteers carry out a brief safety assessment for people who are returned to their own home to ensure that immediate needs can be met safely. Any onward referrals are made if there are any significant concerns highlighted/become apparent. There is a follow up phone call to the assisted person the next day and any onward referrals to relevant agencies are made on the person's behalf where appropriate. This can be seen as an early intervention prevention service that helps to keep people safe in their own and homes delaying the need for higher cost services such as care at home.

The service is delivered by volunteers who are recruited and managed by the British Red Cross.

It was agreed that this project would be initially funded via the three Ayrshire LA's as a test of change, December 2014 to March 2015. This will allow for an evaluation of the project moving forward into Phases 2 and 3.

Outcomes:

The service, over and above the aforementioned National and local objectives outlined, will also meet the following outcomes: directly supports many of the national health and wellbeing outcomes including:

- Avoid unnecessary hospital admission.
- Support individuals to return safely home.
- Positive experiences and outcomes (the service has been extremely positively evaluated by service users in areas where it currently operates)
- Reduced reliance on statutory care post discharge through improved access to community support ergo enhancing quality of life.

16. Hepatitis C Support & Peer Support Service

Brief Outline

The Scottish Governments Sexual Health and Blood Borne Virus Framework (2011-2015) aims to ensure that Health Boards and Local Authorities are providing the best care possible for those who are affected by a blood borne virus and that they are supported to lead a healthy and prosperous life.

Of the three BBVs, Hepatitis C disproportionally affects the most vulnerable people in society, namely those who have ever injected drugs. Health Boards are empowered to diagnose and treat as many positive people as

possible in order to tackle this growing Public Health time bomb (Scottish Government target for NHS A&A 2014/15 is 82 individuals).

With vulnerability comes challenges and it can often be quite difficult to engage with those affected or to maintain them in services, much to the detriment of their own health.
The BBV MCN would like to create a support network which would create two different support strands.

The first strand would involve trained professionals providing a much needed intensive support service in a dedicated locality in order to assist those who require it the most. This could be to support them on their recovery journey from alcohol and drugs, attending various different appointments, lifestyle coaching, housing support, family support etc. The second strand would be to create a network of Hep C peers, using self-management principles, recruiting volunteers, education and prevention methodologies, employability etc.

Both strands together would encourage Hep C positive individuals to address their diagnosis and any other conditions they may have as many of them will have other conditions that may hinder their ability to tackle and treat their Hep C e.g. poor mental health, addiction, under or over weight etc.
Outcomes:

- increased numbers of Hep C tests being performed
- increased numbers of those being initiated onto Hep C treatment
- increased Sustained Virological Response (SVR) rate (e.g. curing Hep C)
- decreased DNA rates at clinical appointments
- improved support services available for Hep C positive individuals
- improved mental health outcomes for Hep C positive individuals
- improved knowledge and awareness within local communities regarding Hep C
- peers and volunteers recruited within each Partnership area
- people in recovery have fewer relapses and continue further on their journey

17. Self-Management Support Network

Brief Outline

Encouraging and enabling staff and service users to work together in a way that focuses on personal outcomes, enablement and supported self-management is a common aim across all sectors. Staff and service users embracing this approach have valuable knowledge and experience that others can learn from, and their inspiration can be the catalyst needed for others to follow suit.

This proposal will enable and support sharing and learning of skills, developments and experience in supporting people with long term conditions in North Ayrshire to better manage their condition and enhance their quality of life. The self-management support network will be inclusive across health, social care, third sector, service users and social enterprise.

Core activity
1. Hold 3 self-management network learning events; option to have 3 additional focused events following consultation with network members (from discussions below).
2. Explore alternative methods of supporting staff and service users to promote and adopt self-management approaches.
3. Engage with staff in health, social, third sector, service users and social enterprise (locally and nationally) to raise awareness of resources and services to support self-management.

Outcomes:

- 3-6 self-management support network learning events.
- Evaluation report from learning events and network users.
- Increased staff and service user knowledge of resources and services available support self-management.

18. Services to Redburn Caravan Park

Brief Outline

This initiative is targeted at the residents of Redburn Caravan Park. The residents of this site tend not to engage with services. They often have multiple health needs that are not being addressed. The initiative would tackle these needs by taking services onto the site. A combination of doctors and nurses would provide services, where possible/necessary, and refer onwards to other agencies as and when required. Furthermore, the practice would explore the opportunity to develop a lifelong Anticipatory Care Planning approach with these patients. The ACP would be a multiagency tool covering health and social need. Further, the practice would offer an early years MOT designed at finding chronic disease in this hard to reach group, initiating treatment plans as and when required.

Outcomes:

The outcomes are that a hard to reach disadvantaged community will receive services they previously wouldn't access. Furthermore, the initiative will seek to find previously undiagnosed illness and initiate treatment thereby improving health outcomes.

Rehabilitation, Health and wellbeing programme for Individuals with Multi-Morbidity

Brief Outline

It is suggested that we test the feasibility of a new model of rehabilitation care for those with multi-morbidities, to work in partnership with the disease specific programmes and all community partners. This project will develop a pathway which will ensure individuals with multi-morbidity are engaged and supported to manage their health and wellbeing and that they receive co-ordinated safe, person centred and effective care. The project would require a multi-professional, multi-agency approach. It is anticipated that pathways would be developed and piloting of this programme would occur in each partnership.

Number of patients:

- Tier 4 — 50 per partnership
- Tier 3 — 150 per partnership
- Tier 2 — 400 per partnership

Referral Criteria: Health, Social care, and Leisure professionals with be able to refer to all tiers of the programme. Individuals will be able to self-refer to Tiers 1 and 2. Following assessment individuals will be directed to the right level of care.

Inclusion criteria: individuals with more than one morbidity one of which is: Heart Disease, COPD, Cancer, Stroke, or those at risk of falls.

Core Activities: This will be a menu based generic rehabilitation programme. It will utilise a tiered approach. It will provide a Tier three programme supported by health professionals and a Tier two programme supported by leisure. It is anticipated that this will release some Tier four capacity to enable those most at risk to receive the specialist support they require. Individuals will be able to move both up and down the pathway according to their current needs.

The menu will include a range of options such as specialist assessment, group exercise classes, individual exercise programme, tele health programmes, self-management programmes, health and wellbeing support and development. This will initially be based on the current evidence based disease specific programmes and current provision protocols within local leisure services but will develop in line with the needs of this population. It is anticipated that there will be a need for up to three Tier three exercise programmes and assessment clinics within each partnership with linked local multi morbidity leisure classes and Invigor8 classes in Tier two. These will be placed in localities identified by the partnership as the areas of greatest need due to the incidence of disease and the level of deprivation.

Outcomes:

The new model will contribute to all 9 health and social care outcomes. It will enable people with complex long term conditions and multi-morbidities to set their own goals to improve their health and wellbeing and quality of life through self-management and rehabilitation, targeting areas of highest need.

This project will address four key objectives of the multi-morbidity action plan:

- Make every health and care contact an enabling experience and an opportunity to improve health and wellbeing.
- Support staff to learn from each other so that specialist staff have better general skills, and staff in community teams develop extended roles.
- Managed Clinical Networks work together to develop care and support pathways and guidelines that make sense for people who have multiple conditions. This will help individuals and staff to make the right decisions, and will ensure people with multiple conditions have the right care, support and rehabilitation, including support to remain in work.
- Identify people with multiple conditions so that they can access the right level and type of care and support as their needs change. This should include coordinated health and care services, along with support from peers, third sector and use of technology.

19. Talking About Diabetes (For Carers & Care Home Staff)

Brief Outline

Talking about Diabetes (TAD) is an educational programme aimed at people who are caring for and supporting individuals living with diabetes. The programme is developed around a pathway that moves from explaining diabetes to living with diabetes but is designed to allow the facilitator to take each topic individually as a stand-alone session.

The main objective of TAD is to promote better understanding and support for individuals living with diabetes through increasing knowledge and awareness for those providing care and support. The programme is centred on talking about diabetes and how to support individuals living with a long-term condition. 'Talking about Diabetes' should allow individuals to engage in conversations that are meaningful and based on everyday experiences that relate to living with a long-term condition. This interactive learning environment will ensure that the information that is shared will have a higher impact giving the learners the ability to recall important facts about living with diabetes.
The main aim of TAD is to allow the participants to develop a basic working knowledge of the physical, psychological and social challenges of individuals living with diabetes.
The learning outcomes are listed below for each of the four sections of the TAD pathway:

Explaining Diabetes

- Describe the basic functions of glucose and insulin
- Describe the main types of diabetes
- Define the possible long-term complications of diabetes

Treating Diabetes

- Discuss the treatment options for diabetes
- Describe the function of insulin and recall some of the devices used for insulin administration

Monitoring Diabetes
- Describe the reasons for self-testing of blood glucose and recall some of the devices available for this
- Describe the signs and symptoms of hypoglycaemia
- Describe the signs and symptoms of hyperglycaemia and Diabetic Ketoacidosis (DKA)
- Understanding of sick day rules for people with diabetes

Living with Diabetes

- Understand the healthcare review a person with diabetes should have on a regular basis
- Understand the effects lifestyle choices can have on diabetes
- Define the principles of self – management

Outcomes:

Key outcomes and outputs to be achieved over 2015/16
Launch TAD during 2015/16 and recruit to the programme.
The first step is for interested organisation to nominate their "Diabetes Champion" who will be provided with a licence (£25) to access the e-learning element of TAD.

They will be:

- given time to complete and pass this part of the programme
- asked to attend a ½ day workshop where they will be trained to facilitate the TAD Toolkit
- be passed competent to train within their host organisation

20. Weigh to go Ayrshire

Brief Outline

Weigh to go Ayrshire is a twelve week weight management programme that uses health behaviour change to facilitate clients to lead healthier lifestyles. A variety of models are being offered by NHS and local authorities.

The aim of this project is to generate a sustainable weight management pathway that can be managed within current resource from the Department of Nutrition & Dietetics.

To this end, the programme will be extended out to third sector / volunteers. A co-ordinator will have two main roles: train, mentor and support volunteers to manage their own programme, and develop protocols, resources and systems between partnerships to lead to a sustainable weight management process.

This is a pan Ayrshire bid and is expected to run across the three local authority areas concurrently.

Outcomes:

Healthier living

- Overweight and obesity is linked to multiple co-morbidities, deprivation and higher health care costs. A 5% weight loss reduces the risk of heart disease and stroke and improves wellbeing, thereby reducing the contributors to inequalities in life expectancy.
- Weigh to go Ayrshire motivates people to look after and improve their health and wellbeing through weight loss and weight loss maintenance.
- Local groups and volunteers within communities / neighbourhoods will be empowered to modify the programme delivery model according to local needs and priorities (including disabilities and long-term conditions). This will tackle health inequalities by providing services proportionate to need and developing inequalities sensitive practice.

Independent living

- Weigh to go Ayrshire provides opportunity to engage with weight management support. It uses health behaviour change to facilitate clients to lead healthier lifestyles. This approach allows service users, including those with disabilities and/or long-term conditions, to develop more control to care for their lifestyle related conditions e.g. diabetes, heart disease, depression.

- Local people will have opportunities to influence weight management provision in their area. They will be enabled to look after and improve their own health and wellbeing and live in good health longer.

Positive experiences and outcomes

- Positive discrimination will enable a strong focus on areas of need and “closer to home” service provision. The flexibility of the model will enable the programme to be relevant to service users. These approaches should contribute to positive experiences that meet their needs.

Carers are supported

- It is envisaged that carers will be invited to participate either in the events or contacted in a manner they prefer. Use of technology may provide solution for participation e.g. virtual weigh to go groups.

Services are safe and an engaged workforce

The Department of Nutrition & Dietetic will support the network of volunteers:

- to ensure that the values of the Health and Social Care Partnerships are followed
- to provide an equitable and high quality programme
- to ensure clinically consistent and up to date advice is delivered to service users
- to provide a safe environment to share learning and updates

Effective resource use

- Co-produced solutions to weight management will increase accessibility for service users.
- Dietetic expertise can be used in conjunction with local expertise around needs.

21. Community Connectors

Brief Outline

Community Connectors will play a fundamental role within health and social care integration by further identifying local need, developing greater community engagement, responsibility and ownership and assisting more third sector organisations to provide holistic services within communities. They will also have the key task to work to identify alternative resources and services in the wider community and assist patients, service users and carers to engage with them, particularly with hard to reach groups.

A clear area of focus will be on building information and intelligence relating to the Health and Wellbeing agenda. Significant work has already been undertaken to develop and promote information relating to Social Care and the Self-Directed Support agenda. This will continue with Community based solutions. Health and related support will be a priority to produce comprehensive and easily accessible information for patients. This focus has been supported by numerous local and national and health professionals such as Consultants, GP’s and Nurses including positive feedback from Transforming Care After Treatment events.

This proposal builds on the strengths of the successful models developed by TACT and North Ayrshire Council and will support a managed transition of function and responsibility to the third sector. It is intended that a team of Community Connectors is established with a managed transition and transfer of responsibility to TACT within one year to establish a single, coordinated and integrated function.

This proposal requests support for six Community Connectors and one Team Leader (Full Time Equivalents).

Outcomes:

The proposal will bring together patients, service users, carers, providers and communities to facilitate the concept of choice and control in planning and identifying the support they need. It will enable people to quickly access support, guidance and advice appropriate to their circumstances.

Information and intelligence will be communicated to providers and potential providers in local neighbourhoods on a regular basis. As a result of more comprehensive information and intelligence and locally developed support, service providers will need to be truly demand and outcomes led. Services will reflect and lead demand in order to meet changing needs, improve outcomes and maximise associated benefits and impacts.

22. The Three Towns Growers Allotment & Community Garden

Brief Outline

The Three Towns Growers is a constituted community led organisation which was established in 2011 in response to local demand for community growing spaces to be made available in the Three Towns area of North Ayrshire. The group was offered a 1.5 hectare site at Parkhouse Road, Ardrossan by North Ayrshire Council in March 2013 and since then has obtained a successful contamination report and appointed an architect to draw up plans. They are presently negotiating terms of a fifteen year lease (with a five year rolling extension) with North Ayrshire Council.

We aim to restore this site (which was partially used for landfill purposes), which lies at the heart of a disadvantaged community and bring it into public use by creating a community garden and allotment site which will include 40 plots of various sizes to suit the needs of users, 12 raised beds, a community hub which will house two portacabins; one for workshops, meetings and activities and the other as a communal tool store to enable those without either tools or transport to walk to the site or use public transport.

The physical and therapeutic benefits of community gardening are well documented and we are already liaising with voluntary and third sector groups and organisations to ensure that people have the opportunity to get involved and are aware of the potential benefits that community gardening can bring to their lives.

Outcomes:

A local voluntary group is managing a community allotment garden for the benefit of local residents, families and groups.

- People are eating healthier as a result of growing their own fruit and vegetables.
- Peoples report that their mental and physical health has improved as a result of taking part in community garden activities.
- Levels of community cohesion have improved by working together to develop a community garden project.
- People report that they are feeling more independent and taking measures to improve their own health and well-being.
- People use community gardening as a preventative approach to maintaining and improving health and wellbeing.
- Environmental sustainability has increased.

23. Food Fluid and Nutrition for Care and Communities – the sustainability factor

Brief Outline

Further development and facilitation of nutrition work with Care homes, home carers and local communities across North Ayrshire. This would enhance awareness, skills and confidence in delivering and sustaining good nutrition and nutritional care messages and practice across partners and communities supporting future sustainability around nutritional health & well-being for all.

Outcomes:

- Development and facilitation of increased awareness, skills and confidence in supporting good nutritional care across partners and communities More people will have local access to more evidence based information on nutrition and food skills for their own, their communities' and their clients' benefit.

- More evidence based supported training and resources will support appropriate nutritional assessment and improvement and aid compliance with national nutritional standards and improved nutritional health and wellbeing.
- More people will be able to access support for improved nutrition via technology.
- Audit of practice on use of food first skills and MUST assessment tool.

24. Services to the Fullarton Community

Brief Outline

This initiative is targeted at the residents of the Fullarton area of Irvine. This community is amongst the most needy in Ayrshire and perhaps Scotland. There is currently no GP provision within the community with residents having to travel in some cases on two or three buses to their GP practice.

The initiative will seek to address the complex health issues that abound in these patients .The initiative will create the time and space to assess and address the currents needs of this community. Furthermore, the practice will engage with the wider community in initiatives designed to lessen the risk of future generations health following these patterns.

Outcomes:

The outcomes are that a hard to reach disadvantaged community will receive services they previously wouldn't access. Furthermore, the initiative will seek to find previously undiagnosed illness and initiate treatment thereby improving health outcomes.

25. Staying Connected- Good Neighbours-Home from Hospital-On Ward

Brief Outline

On ward
A support / befriending service for frail elderly patients who have no social support when admitted to Hospital- reducing the average length of stay. Placing a caring volunteer at the centre of an older person's recovery plan during their hospital stay dramatically improves their experience, their confidence and their well-being, and helps them to return to live independent fulfilling lives. It also drives important efficiencies in hospitals enabling well-managed discharge from wards. Support includes encouragement to eat (completion of menu cards), remaining hydrated (encouragement to drink water/fluids), reading, risk assessed support to other areas of the hospital and preparation of their home for their return.

Good Neighbours
A community support for older people needing assistance accessing shopping, receiving low level support at home or transport- decreasing frequency of contact with statutory services and therefore cost avoidance.
Our volunteer transport is currently replacing patient transport in many areas for those people who no longer meet the Scottish Ambulance Service criteria.

Home From Hospital
A community support service for those being discharged from hospital enabling a speedier discharge. Older people can be especially vulnerable and frail following a stint in hospital, and often require careful management of their health conditions. Across Britain, 13 per cent of older people are readmitted within three months of discharge, adding pressure to already stretched A&E services. A third (30%) of over-75s who were readmitted within three months said they needed more support at discharge than they received. Our service provides emotional and practical support to patients on their return from hospital and helps people settle back in their homes, rebuild confidence and independence, and reduce the effects of isolation and loneliness. With the right and often very simple and inexpensive support, readmissions can be dramatically reduced.

Outcomes:

On ward:

- Reduction in average length of stay on wards receiving volunteer input
- Patients have access to onward volunteers (reducing loneliness)
- Supporting people to retain or regain their maximum level of independence

Good Neighbours:

- Older people in project area have access to Good Neighbour service
- Service users benefit from a good level of service
- Creating a proactive approach to reducing the need to "react to crisis"
- Providing a service which is more responsive to the changing needs of the individual
- More options for living from home
- Removing barriers for people accessing care and support

Home From Hospital:

- Reduction achieved in short term readmission rate
- Patients and Hospital staff have more options facilitating quicker discharge