

EAST AYRSHIRE COUNCIL

SOCIAL WORK COMMITTEE : 9 SEPTEMBER 2004

JOINT FUTURE

Report by the Executive Director of Educational and Social Services

1. PURPOSE OF REPORT

- 1.1 To advise Social Work Committee of progress in implementing the Joint Future Agenda Policy Initiative.
- 1.2 To seek Committee endorsement of East Ayrshire Extended Joint Future Partnership Agreement 2004.
- 1.3 To seek Committee endorsement of Local Improvement Targets for The Joint Future Agenda.

2. BACKGROUND

- 2.1 In November 2000 The Scottish Executive published its Joint Future Report. Since this time they have progressed the initiative through a range of guidance and a legislative framework contained in the Community Care and Health (Scotland) Act 2003.
- 2.2 The aims of the policy are:
 - quicker and better decision-making, through delegated decision-making and financial responsibility;
 - more flexible and better quality home care services, including a shift in the balance of care towards these services; and
 - agencies working in partnership in localities, through better operational and strategic planning, joint budgets, joint services and joint systems.
- 2.3 Progress in East Ayrshire in implementing Joint Future has been reported to Committee previously on 22 May 2003 and 9 April 2002

3. EAST AYRSHIRE EXTENDED PARTNERSHIP AGREEMENT

- 3.1 In April 2003 local partnerships, based around local authority geographic boundaries were required to submit Joint Future Local Partnership Agreements for Older People to the Scottish Executive.
- 3.2 By May 2004 Local partnerships were required to submit Extended Joint Future Partnership Agreements. These would not only cover services to older people but also, mental health, learning disability, physical disability, carers and addiction services. Following consideration at the East Ayrshire Joint Future Partnership Group a draft version of the report was submitted at the due time. (Appendix 1)

- 3.3 In East Ayrshire this Extended Local Partnership Agreement was developed in close consultation with service users, carers, frontline staff and partner agencies in the respective service areas.
- 3.4 The report focuses on explicit outcomes for service users in each service area, and clear plans on how we will work towards achieving these outcomes. This is a development from previous reports where the Scottish Executive had led partnerships to focus more on process
- 3.5 Initial feedback from the Scottish Executive Joint Future Unit on the draft report is very positive about our work with staff in developing this agenda. Our work in implementing Single Shared Assessment is also received positively. Most importantly we are recognised as demonstrating good practice in effective communication with older people and their families.
- 3.6 These outcomes have been achieved through positive relationships with service user groups particularly the elderly forum through the Better Government for Older People initiatives, and also frontline staff through the staff forums.
- 3.7 In 2003 after consultation with frontline staff and service user groups about the impact of Joint Future, three temporary support assistant posts were established to support joint working. These posts are targeted directly at engaging in practical tasks with service users and carers, issues such as form filling and advocacy. This also ensures qualified staff such as social workers, occupational therapists and nursing staff can be used to best effect for assessment and intervention.
- 3.8 To support the development of locality teams we require to ensure that all staff are fully supported, including our personal carers. The Home Care Assistant role introduced following the Home Care Review in 2002 is an essential link in this process. In the new arrangements we require to recruit an additional Home Care Assistant (AP1), to provide this support to all our locality teams.
- 3.9 The feedback from the Joint Future Unit also suggests that at this time we have insufficiently progressed areas of Joint Management and Joint Resourcing of Services. The Joint future Unit recommend:
- we review our management arrangements for specific client groups (e.g. older people, mental health or learning disability) and consider the introduction of joint managers across agencies;
 - we move towards closer, pooled or aligned financial arrangements particularly between the Local Authority and Health.
- 3.10 We are progressing these areas in conjunction with partners, but are doing so cautiously to ensure the aims and duties of the Council in serving our local population are central to any service development. We also require to ensure that within any new arrangements there are clear lines of accountability for public finances.

4. LOCAL IMPROVEMENT TARGETS FOR THE JOINT FUTURE AGENDA

- 4.1 The Scottish Executive requires that Local Partnerships set Local Improvement Targets for the Joint Future Agenda aimed at working towards set National Outcomes. (Appendix 2)

4.2 In this context Outcome is defined as a benefit or change for an individual or group of individuals delivered through joint better working. It is again a move to more measurable improvements for service users rather than developments in process and infrastructure.

4.3 The National Outcomes are:

- supporting more people at home as an alternative to residential and nursing care.
- assisting people to lead independent lives through reducing inappropriate admission to hospital, reducing time spent inappropriately in hospital and enabling supported and faster discharge from hospital.
- ensuring people receive an improved quality of care through faster access to services and better quality services.
- better involvement and support of carers

4.4 Our Local East Ayrshire Improvement Targets include:

- an increase of 10% by 31 March 2005 of people receiving intensive care packages at home
- an increase of 20% by 31 March 2005 of people receiving support through SMART technology (e.g. all detectors linked to community alarms).
- a reduction of 20% by April 2005 of people experiencing delayed hospital discharge
- an increase of 5% in the number of assessments completed within 6 weeks from time of referral by 31 March 2005
- an increase in the number of carers assessments by 10% by 31 March 2005
- an increase of 10% in the total hours of home based respite available by 31 March 2005

4.5 The Local Improvement Targets are to be reported to the Scottish Executive in September 2004 in shadow form until March 2005, with substantive targets introduced in April 2005.

5. FINANCIAL IMPLICATIONS

5.1 Development proposals within this report can be achieved within existing resources this financial year. The continuous improvement agenda from the Scottish Executive will require to be resourced if targets are to be achieved. Funding can be identified in part from redesign of services (e.g. resource transfer from Health following closure of hospital beds) but it is nationally acknowledged this will also require significant additional public funding.

5.2 Staffing proposals for Support Assistants within this report are already included in social work resources.

5.3 Staffing proposal for additional Home Care Assistant post can be funded from additional resources provided by the Scottish Executive for free personal care and the supports required to implement this policy.

6. POLICY/LEGAL IMPLICATIONS

6.1 Proposals within the Extended Local Partnership agreement and Local Improvement Targets contribute towards the Council meeting its duties in relation to Community Care legislation and policy.

7. PERSONNEL IMPLICATIONS

7.1 It is proposed that the 3 temporary Support Assistant posts as detailed in paragraph 3.7 are now established as substantive posts.

7.2 It is proposed that a Home Care Assistant post as detailed in paragraph 3.8 is established to support locality working.

7.3 Employee representatives are fully involved within the Joint Future Agenda through local and Ayrshire wide staff forums.

7.4 Trade Union agreement has been achieved with the proposed personnel implications.

8. RECOMMENDATIONS

8.1 It is recommended that Social Work Committee:

- (i) endorse the East Ayrshire Extended Partnership Agreement;
- (ii) endorse the Local Improvement Targets for The Joint Future Agenda;
- (iii) refer the staffing implications to Corporate Governance Committee; and
- (iv) otherwise note the content of this report.

John Mulgrew
Executive Director of Educational and Social Services
23 August 2004
Enc (2)

LIST OF BACKGROUND PAPERS

Nil

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IMPLEMENTATION OFFICER: JACKIE DONNELLY

FINAL DRAFT

**Joint Future
Extended Partnership
Agreement**

Community Care Services

April 2004

East Ayrshire Council

NHS Ayrshire and Arran



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1 NAMES OF THE LOCAL PARTNER AGENCIES

(And of the representatives of each partner agency, together with space for the individuals to sign.)

- **East Ayrshire Council**

.....Cllr. E Jackson,
Chair of Social Work Committee

.....Cllr. J Kelly,
Chair of Housing Committee

.....John Mulgrew,
Director of Educational and Social Services

.....Bill Stafford,
Director of Neighbourhood Services

- **NHS Ayrshire and Arran**

.....Wai-Yin Hatton,
Chief Executive

- **Ayrshire and Arran – Community Health Division**

.....Allan Gunning,
Chief Executive

- **Ayrshire and Arran – General Hospitals Division**

.....Jim Currie,
Chief Executive

- **Date of Agreement**

2 NAME OF THE PARTNERSHIP ARRANGEMENT/BODY

- 2.1 The partnership will be known as the East Ayrshire Community Care Partnership.

3. DATE AND SCOPE OF THE AGREEMENT

- 3.1 This agreement encompasses the Local Partnership Agreement (Older Peoples Services), which was implemented between the service partners indicated at Section 1 from April 2003.

- 3.2 This agreement represents the organisation of all partnership activity in the area of community care namely:

- Older people's services These include health and care services for frail elderly, those with dementia, older people with mental health problems and older people with learning disabilities;
- Services for people with mental ill health. These include health and care services for people with severe and enduring mental illness and mild to moderate mental health problems;
- Services for people with learning disabilities. These include health and care services for people with severe learning disabilities and those with moderate disabilities who have additional needs;
- Services and opportunities for people with physical disabilities, acquired brain injury, progressive ill-health and/or sensory impairments causing substantial and long term adverse effect on their ability to carry out normal day to day activities;
- Addiction services for adults and older people. These include health and care services for adults with alcohol, drug or other substance dependency issues. Addiction services addressing the needs of children and young people will be addressed through children's service planning;
- Carers of people receiving the services outlined above.

- 3.3 The partnership will also refer to advocacy services and supporting service users and carers to be fully involved in the planning development and evaluation of services.

- 3.4 The partnership agreement also cross refers to partnership arrangements regarding the Supporting People programme and specifically the East Ayrshire Supporting People Strategic Plan 2003-2008.

- 3.5 The Full Partnership will commence in April 2004 and will continue to be reviewed on an annual basis.

4. STATEMENT ON SHARED VISION, PRINCIPLES AND VALUES

4.1 The vision, values and principles of this partnership agreement have been agreed by all partners through the East Ayrshire Community Planning Partnership and are consistent with both Local and National policies.

Our Vision

4.2 “East Ayrshire will be a place with strong, vibrant communities where everyone has a good quality of life, access to opportunities, choices and high-quality services that are sustainable, accessible and meet people’s needs.”

Our Guiding Principles

4.3 Joint Future planning brings together health, housing and social care agencies, organisations and communities to identify and prioritise what needs to be done, and to plan, co-ordinate and deliver action to meet these identified priorities.

4.4 Our guiding principles will direct how we do this and make sure that the process is consistent. By planning together, working together and achieving together, we will:

- promote social justice and social inclusion;
- build sustainability;
- succeed in joint working by involving people;
- make sure our services are good quality and accessible; and
- deliver Continuous Improvement and Best Value.

4.5 Through the development of the partnership, it is anticipated that we should achieve the following outcomes:

- service users and carers will be actively involved both individually and collectively in the planning, delivery and review of services and services will promote opportunities for service users to express themselves and to be heard;
- services will be accessible to everybody who requires them, regardless of racial, physical, gender or sexual issues through the provision of accessible information and sensitive, flexible services that promote independence and choice;
- health and social care services will be delivered in a more integrated/less intrusive manner that enables people to live fulfilling and meaningful lives as part of the community and to promote social inclusion;

- the balance of care will be shifted from hospital and other institutionally based services to one that is primarily based within the person's own home or community;
- service users will have access to the full range of health care via mainstream and or specialist provision, as appropriate to need and circumstances;
- the health of service users and carers in East Ayrshire will be improved through the promotion of well-being and tackling of inequality and social exclusion;
- staff will be supported by equipping them with appropriate training, development opportunities and resources to provide the best possible quality of care for people in East Ayrshire.

5. OUTCOME OBJECTIVES FOR PEOPLE ADDRESSED WITHIN THIS AGREEMENT

5.1 Outcome objectives for 2004-2007 have been developed for each care group within individual care strategies as themes. Details of action being taken to implement these objectives are outlined in the strategies and are summarised in Section 20.

5.2 Older People's Strategy

- Implement the key recommendations contained in Ayrshire and Arran Strategy for Older People's Services, applied locally to reflect the needs of East Ayrshire.
- Deliver the benefits of the Single Shared Assessment process which has been implemented since April 2003, including reduced waiting times for assessment, better co-ordination between professional groups, reduced delays in service provision and improved communication with clients/patients and their families.
- Reduce inappropriate admissions to hospital and minimise delayed discharges through the implementation of local East Ayrshire initiatives as part of the Ayrshire and Arran Delayed Discharge Partnership, including Care and Repair.
- Improve the provision of equipment and adaptations for East Ayrshire clients by implementing the recommendation to establish a joint equipment service across Ayrshire.
- To deliver effective information about available services and how to access them for older people and their carers, including development of public information material on criteria for services and contact information on local services.

- Deliver a range of flexible community based health, housing and social care services which promote independence and real choices for older people and their carers in East Ayrshire.
- Continue to engage older people and carers in planning services and demonstrate by our actions that we are hearing the views expressed.
- Involve staff working with older people in East Ayrshire in the change process, through the joint staff forum; and through regular, multi-agency staff consultation and engagement. The planned outcome of this will be to ensure a well informed, well trained and appropriately resourced workforce.

5.3 Mental Health Strategy

- Address the Mental Health (Care and Treatment) Act 2003 through the development and implementation of a local plan for East Ayrshire.
- Ensure service users, carers and the public of East Ayrshire are engaged and actively involved in the planning, delivery and evaluation of Mental Health Services.
- Develop the capacity of services to implement the key aims of the National Programme for improving mental health across East Ayrshire: raising awareness and promoting mental health and wellbeing; reducing stigma; preventing suicide; promoting recovery.
- Ensure mental health education, training and development is delivered to the staff and public of East Ayrshire resulting in raised awareness, better understanding, reduced stigma and improved staff skills.
- Promote the further integration of services across East Ayrshire to improve the mental health care and treatment of services users, prioritising activity to improve access and accommodation and meet the needs of young people.

5.4 Learning Disability Strategy.

- Ensure that services are available, accessible, proactive, responsive and of a consistently high quality through people's lifetime including during periods of transition such as through childhood to adulthood and through the process of ageing.
- Through work within Community Planning partnerships, service development and the ongoing promotion of person centred practice, enable a shift in culture to promote social inclusion and independence.
- Ensure service users, carers and the public of East Ayrshire are engaged and actively involved in the planning, delivery and evaluation of Learning Disability Services.

- Promote the further integration of services across East Ayrshire to improve the care and treatment of services users.

5.5 **Physical Disability and Sensory Impairment**

- Ensure service users, carers and the public of East Ayrshire are engaged and actively involved in the planning, delivery and evaluation of services for people with physical or sensory impairments.
- Ensure education, training and development is available to enable Community Planning Partners address the needs of people with physical or sensory impairments enabling the promotion of equal opportunities and; to raise public awareness of the range of technologies and opportunities available to enable people affected by physical or sensory impairments lead full and valued lives.
- Work alongside all stakeholders within East Ayrshire to ensure equality of access to all services, leisure, housing and employment opportunities for people affected by physical disabilities and or sensory impairments.
- Ensure that standards for service development and operation, as outlined in the Scottish Executive “Sensory Impairment Action Plan”, “Social Justice a Scotland where everyone matters” are addressed in partnership.

5.6 **Ayrshire and Arran Alcohol and Drug Action Team Corporate Plan**

- To provide equitable, accessible and inclusive services to address the needs of those who experience problems with alcohol.
- Increase the proportion of drug misusers in contact with services through the development of good, accessible responsive and effective services.
- Reduce the number of drug misusers who have do not have timeous access to appropriate treatment.
- Reduce binge drinking.
- Holistic support to drug misusing parents, their carers and children.
- Increase the number of people recovering from alcohol problems entering training, further education and employment.
- Reduce alcohol related crime.
- Diversion from drug related crime.
- Develop constructive alternatives to prosecution, related to appropriate treatment for drug misusing individuals who offend.

5.7 **Carers Strategy**

- Ensuring more Carers are identified.

- Changing cultures within organisations to make sure that all staff recognise Carers as partners.
- Approaching Carers' assessments in a different way.
- Develop innovative services that meet Carers' needs flexibly.

5.8 **Advocacy Strategy**

- Awareness raising, information provision and communication of advocacy services will be promoted.
 - Services will be developed within the Best Value agenda, prioritising sustainability and independence.
 - Advocacy services will be developed to effectively address the expectations of the Mental Health (Care and Treatment) (Scotland) Act.
 - Identified gaps in services will be addressed.
 - Service user involvement in advocacy services will be promoted.
- 5.9 Objectives in other related strategically, (particularly the "East Ayrshire Supporting People Strategic Plan 2003-2008", but also the "East Ayrshire Children's Service Plan" and others) contains outcome objectives for Community Care client groups. Those objectives complement the outcome objectives outlined above.

<h3>6. JOINT MANAGEMENT ARRANGEMENTS</h3>
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- 6.1 Management arrangements for the strategic development and implementation of the Joint Future Agenda will operate at four levels:
- Elected Member and NHS Board Directorate level (Partnership Group);
 - Strategic Management level (JFIG);
 - Care group Strategy and Support group level (JFIG Working Arrangements);
 - Operational level (Delivery of Integrated Services including Housing Services).

East Ayrshire Partnership Group

- 6.2 The Partnership Group will ensure that there is political leadership at local level to deliver key local and national objectives in improving the delivery of frontline community care services within a framework of political accountability.
- 6.3 The membership of the Partnership Group includes:
- East Ayrshire Council Elected Members;

- NHS Ayrshire and Arran Directors/Local Health Care Co-operative Chairs;
 - 2 members of Health Council.
- 6.4 There is equal representation from East Ayrshire Council and the NHS Ayrshire and Arran.
- 6.5 The Partnership Group will be supported by senior officers from Local Authority and Health Services.

East Ayrshire Joint Future Implementation Group (JFIG)

- 6.6 This group has been reconfigured to reflect the extension of the Joint Future agenda from that of older people's services.
- 6.7 The group has senior management representation from East Ayrshire Council, NHS Ayrshire and Arran, including East Ayrshire Local Health Care Co-operative.
- 6.8 Each strategy group outlined in section 6.13 provides a representative to the JFIG to ensure effective communication between elements and also to ensure that care strategies are represented. It has been agreed that the representative from the carer's strategy will in future always be a carer.
- 6.9 There is also other representation from the four support groups outlined in 6.12 and 2 staff representatives from East Ayrshire Council and NHS Ayrshire and Arran.
- 6.10 The JFIG undertakes lead responsibility for:
- Producing relevant plans for the approval of the Partnership Group with financial frameworks and timescales;
 - Monitoring and reviewing the implementation of plans and making policy, strategy and resource recommendations to the Partnership Group;
 - Ensuring proper public consultation and accountability mechanisms are in place to support the work of the partnership;
 - Promoting the development of integrated services across all sectors.

East Ayrshire Joint Working Arrangements

- 6.11 There are a number of working groups whose roles are to address key issues and deliver on identified outcomes. They are as follows:
- 6.12 **Joint Support Groups** – there are four of these, each supporting the JFIG in different ways:
- **Joint Finance Group** – supports the JFIG in developing and managing a joint financial strategy, including the establishment of joint monitoring systems for aligned budgets;

- **Communication Group** - supports the JFIG in developing an appropriate ICT strategy, including developing the Modernising Government Fund 2 bid and looking at E Care options;
- **Joint Human Resource Group** - supports the JFIG in developing the Human Resource Strategy at a local level and provides the mechanism for a Joint Future Staff Forum;
- **Joint Planning and Performance Group** - supports the JFIG by leading on strategic planning within the community planning framework. The group also leads on the development and co-ordination of the Joint Performance, Information and Assessment Framework.

6.13 **Joint Care Strategy Groups** – there are six care strategy groups covering:

- Older People (including older people's mental health)
- Learning Disabilities
- Mental Health
- Physical Disability and Sensory Impairment
- Carers
- Advocacy
- They are accountable to the Joint Future Implementation Group and are supported by the Joint Planning and Performance Group.
- Will develop care strategies and will monitor the implementation of agreed actions.
- Will develop, implement and review joint services at a local level.

6.14 **Joint Initiatives (Pan Ayrshire)** – there are two of these, each with single management arrangements: Rapid Response and Joint Equipment Services. These services will be aligned with local structures.

Delivery of Integrated Services in East Ayrshire

6.15 In the previous year East Ayrshire Council has prioritised working in partnership with the two Local Health Care Co-operatives covering East Ayrshire. (see section 11 of this report for detail).

6.16 In April 2003, fourteen of the seventeen GP Practices in East Ayrshire were operating on an integrated basis with social work locality teams based around patients in these practices. Links have now been established with the remaining three Practices, resulting in full integration.

- 6.17 Social Work Services structures have been realigned to facilitate the delivery of integrated services based around GP practices. Fieldwork and Home Care services have been integrated to create six locality teams managed by a Team Manager and comprising social workers, occupational therapists home care managers and support assistants. Staff from these locality teams are linked to individual GP practices and hold regular integrated team meetings for the purpose of discussing, allocating referrals and sharing information.
- 6.18 In addition, there are specialist authority-wide teams for: acute health, children with disability, learning disability and mental health managed by Team Managers. These teams have close formal links with their equivalent community based health teams. For example, there are Mental Health Officers, social work and housing staff aligned to the Community Mental Health and Community Learning Disability Teams and work together in an integrated way with staff attending meetings and working together to deliver efficient and effective health and social care to individuals.
- 6.19 Community Health Teams also prioritise linking with GPs with each GP practice having an aligned Community Psychiatric Nurse. Regular multi-disciplinary meetings are held at practice level.
- 6.20 Creating and sustaining stronger links between stakeholders remains one of the key priorities if we are to achieve joined up services which make a real difference to people's lives.
- 6.21 In some instances this is about creating pivotal posts such as:
- a Discharge Facilitator focusing on hospital discharges;
 - Housing Support Workers (via Supporting People funding) who are based within the CMHT's but managed by Housing Services;
 - The Home Care Manager role in Intermediate Care Project for older people in Kirklandside Hospital.
- 6.22 In other cases it means joint commissioning or funding of projects work such as:
- the Healthy Living Initiative for adults with learning disability funded by NHS Ayrshire and Arran but managed by East Ayrshire Council; or
 - Joint funding of independent sector initiatives such as the East Ayrshire Carers Centre or Advocacy Service
 - Integrated Out of Hours services encompassing medical, nursing and social care staff.
- 6.23 At other times it is simply close working between agencies in the development of strategic or operational planning, joint working to deliver services or close working to enable an effective Joint Performance Management framework.

- 6.24 The framework to encourage and facilitate integrated services is bedding in and will be enhanced by a commitment to work towards single referral points and informed and driven by an agreed set of outcomes determined by service users, carers and staff.

Community Health Partnerships

- 6.25 A key driver of this Partnership Agreement is that of developing a local planned response to the proposals outlined in the National Health Service Reform (Scotland) Bill and specifically the sections concerning the establishment of Community Health Partnerships.
- 6.26 East Ayrshire Local Health Care Co-operative is under development as a Community Health Partnership and will be in a shadow format as a CHP from April 04, with full implementation from April 2005.
- 6.27 East Ayrshire LHCC and East Ayrshire Council are working closely with other partners as part of an Ayrshire-wide Steering Group to ensure the development of an effective Community Health Partnership which will make a real difference for local communities in East Ayrshire.
- 6.28 The development of Community Health Partnerships requires the full involvement of key partners including local authorities. Therefore, partners to this agreement will view joint working arrangements set out in the agreement as a key element of the Community Health Partnership development.

7 JOINT RESOURCING

- 7.1 East Ayrshire Council Social Work Committee of 9 April 2002 agreed an aligned budgetary model as the way forward, which was subsequently endorsed by NHS Ayrshire and Arran.
- 7.2 The Financial Framework outlined in Appendix 4 was developed from the agreed model and based on the CIPFA guidance. This was developed jointly by the Joint Finance Group and reported to the JFIG.
- 7.3 The Framework has been developed by; agreeing financial arrangements; developing financial protocols; setting strategic and operational baselines and agreeing a medium term financial plan.
- 7.4 The figures supplied in the Financial Framework in 2003, predominantly related to Older Peoples Services. For this year, the framework covers all community care services and includes figures that are not aligned to specific care groups, such as Home Care.
- 7.5 The framework also specifically reports on Partnership initiatives involving joint resourcing, joint funding and support as outlined in the 2003 agreement as well as highlighting other financial initiatives related to all community care groups.
- 7.6 For example, progress in the last year includes:

- Further development of joint intermediate care service with 75% increase in service capacity.
- Development of flexible day services to include evening and weekend services through joint funding and linked to delayed discharge action plan.
- Development of Integrated out of hours service, with 100% increase in overnight social care services provided.
- Development of rapid response service to include pharmacy services and increased social care services.
- Through joint supporting people initiatives attachment of local authority housing staff to mental health services.
- Joint commissioning of integrated Locality Resource Centre in Kilmarnock North West. This will encompass, day services for older people, joint community mental health and learning disability services for both adults and older people, GP services including integrated social work services.

8 JOINT DEVELOPMENT PRIORITIES AND TARGETS

- 8.1 The development of a range of strategies, linked to the Joint Future Partnership with responsibility for development, implementation and monitoring is delegated to the Joint Care Strategy groups. This ensures that development is effectively co-ordinated and prioritised at an operational level and extended across all care groups.
- 8.2 All strategy action plans are working to the shared vision, principles, and values as outlined in section 4, with objectives as outlined in section 5.
- 8.3 In particular, development planning will emphasise action that enables the promotion of social justice and social inclusion; builds sustainability; involves service users and carers; ensures services are good quality and accessible; and delivers Continuous Improvement and Best Value.
- 8.4 All development priorities outlined in this framework and supporting strategies are also integrated within the wider East Ayrshire Community Planning framework to ensure a consistent and shared approach to strategic and operational development.
- 8.5 In addition to the specific care group priorities, the Partnership has identified a range of support priorities, cutting across care groups, with the aim to ensure that services operate at their most effective, continuously improve and within the overall ethos of Best Value.
- 8.6 These include:
- Ensuring all community care service planning is integrated at an early stage building on known good practice models properly evaluated;

- Build on the success of the Single Shared Assessment model to minimise delays, increase effectiveness and relevance of services for service users and carers and improve cross agency communication;
- Enabling a less fragmented funding process that promotes sustainability, minimises duplication and maximises equity across the authority;
- Improving Performance Management models to ensure that information is up to date and accurate, data collection relates directly to measuring stated outcome objectives and effective service evaluation systems are in place;
- Build on work to develop a “Joint Future” culture through joint training, joint working and building a common perspective through Community Planning;
- Build in mechanisms that can identify new technologies, ways of working and opportunities to promote flexible responsive approaches to meeting objectives.

9. JOINT GOVERNANCE AND ACCOUNTABILITY

- 9.1 ‘Governance is a structure, systems and policies in an organisation, designed and established to direct and control all operations and relationships on a continuing basis, in an honest and caring manner, taking into account the interests of all stakeholders and compliance with all applicable laws and regulatory requirements. Governance is based on the principles of openness, integrity and accountability.’ (CIPFA).
- 9.2 The Governance arrangements for the East Ayrshire Joint Partnership Agreement will be based on a system of aligned and joint funded services and will therefore take account of NHS Ayrshire and Arran and East Ayrshire Council’s requirements and intentions recognising that each has developed a system to meet the duties and functions of that organisation.
- 9.3 The Partnership is committed to developing and continuously reviewing governance and accountability arrangements to ensure that service users and carers have a full confidence in the services and the individuals who provide these services by keeping them involved and fully informed.
- 9.4 In addition, in the interests of efficiency and effectiveness, partners will continue to address the issue of streamlining governance arrangements to ensure good communication between partners; efficient use of available resources, including Performance Management, and effective Public Performance Reporting systems.

Political Accountability

- 9.5 The partnership has established political accountability and corporate governance arrangements through the East Ayrshire Joint Partnership Group. This group will meet quarterly and will receive information reports and presentations in respect of all strategic and operational aspects, relating to the Extended Partnership Agreement, as these are progressed.

Corporate and Financial Governance

- 9.6 Corporate Governance/Accountability will continue to lie with the organisation that has statutory financial responsibility, as it is intended at this stage to work with aligned budgets and current service delivery arrangements. Further work will take place to develop more detailed local arrangements for a joint resources framework.
- 9.7 Therefore financial governance remains through individual agencies who have: Standing Financial Orders; schemes of delegation and rigorous audit arrangements in place.
- 9.8 Partners will continue to work with performance information and financial regulation mechanisms with regard to resource transfer, delayed discharge, winter monies to ensure joint accountability. These mechanisms will be evaluated, reviewed and revised as required to ensure the most effective use of resources.
- 9.9 The East Ayrshire Community Planning Partnership has identified the issue of initiatives and projects receiving funding from a range of sources having to provide a range of monitoring information to the funding agencies. Therefore in 2004-05 the Partnership has committed to developing a single monitoring evaluation tool to enable projects to report a single set of performance information to a single source. This should facilitate a single monitoring system acceptable to all funding agencies. As key members of the Community Planning Partnership, partners to this agreement will be involved in this development with regard to joint funded initiatives

Clinical/Service Governance

- 9.10 Clinical Governance is defined as "A framework through which NHS organisations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish."
- 9.11 Both NHS and local authority services are subject to rigorous service governance arrangements, within NHS Ayrshire and Arran through clinical governance standards overviewed by NHS Quality Improvement Scotland and East Ayrshire through the Best Value audit managed through Audit Scotland, Social Work Services Inspectorate and Communities Scotland.
- 9.12 For aligned services, Clinical and Service Governance will continue to lie with the individual organisations. However, the Performance Management arrangements outlined in section 10 will ensure that a common approach will be implemented addressing the Quality Improvement and Best Value Standards, including ensuring a service user focus and safe and effective care.
- 9.13 The full range of top line Performance Information will be shared among partners and the Planning and Performance group will identify a common set of indicators, evaluation processes and reporting mechanisms for those services that are funded or managed jointly.

9.14 Those services managed or funded by partners that require to be registered under the provisions of the Regulation of Care (Scotland) Act 2001, will receive formal inspection by the Commission of Regulation of Care. All inspection reports to be made available to planning partners and the public. Action will be taken to address any identified improvements required.

Complaints Procedure

9.15 Complaints will continue to be handled by the respective organisations, informed by local and national guidance and statutory requirements as necessary. Reporting on complaints, outcomes and implications for service quality will be reported as part of the partners Performance Management and Public Performance Reporting mechanisms.

9.16 Further work will be carried out in relation to the handling of complaints which arise as a result of partnership working. As an interim measure any complaint which arises that crosses the boundaries between health and local authority, will be addressed by the organisations working together in line with each organisation's complaints procedure.

Statutory/Legal Accountability

9.17 The statutory and legal accountability will continue to lie with the individual organisation responsible for providing services, this will be reviewed as the partnership develops and matures, and new ways of working are implemented.

Professional Accountability

9.18 All practitioners working with the partnership are responsible for the quality of their practice and professional conduct. Direct accountability will be to agreed line and agency management structures within individual services and relevant professional staff will be accountable to their registration authority as relevant such as the Nursing and Midwifery Council and the Scottish Social Services Council.

10. JOINT PERFORMANCE MANAGEMENT FRAMEWORK

10.1 Partners to this Agreement recognise that as part of governance, a rigorous system of outcome monitoring and evaluation is required with a clear link to the broader range of policies and programmes intended to modernise public service provision, including the Community Planning, Modernising Government and Best Value agendas.

10.2 For local authority partners a legislative structure exists for this approach within the Local Government in Scotland Act 2003, which introduces a statutory duty of Best Value on public services. All publicly funded services may be subject to 'economy, efficiency and effectiveness examinations' by the Auditor General under the terms of the Public Finance and Accountability Act 2000.

- 10.3 Partners have developed, a Joint Performance Management Framework for older people's services. This will be formally implemented as the core Performance Management tool for services in 2004-05.
- 10.4 In addition, in this year the Framework will be further developed to address the performance for all community care groups encompassed within this Agreement.
- 10.5 The Frameworks will incorporate the Joint Performance, Information and Assessment Framework and existing performance systems to address performance at three levels;
- Local service and operational level linked to clinical and service governance;
 - Performance in relation to the development of the strategies allied to this agreement;
 - Strategic level, in particular how the outcomes of this strategy are addressed and how these link to the wider strategic expectations of community planning within East Ayrshire.
- 10.6 The Framework will link closely to the expectations of the Performance Assessment Framework, the EFQM excellence quality model and the Scottish Executive in relation to the duty of Best Value.
- 10.7 An annual report of performance will be published and linked to the Community Planning Public Performance Reporting mechanisms for older people's services in 2005 and thereafter for all services that are part of this agreement. The Joint Planning and Performance Sub Group will lead this process.
- 10.8 In the longer term, the Partnership will also look at additional tools for performance measurement such as Charter Mark, to investigate whether these will aid performance, particularly in relation to jointly managed services, where a consistent and rigorous approach will be required.
- 10.9 Examples of indicators that will be used include:
- Contract compliance information;
 - Information on the quality of services including quality standards developed by both the Scottish Commission for the Regulation of Care, NHS Quality Improvement Scotland, Audit Scotland and Communities Scotland;
 - Progress on each individual action agreed by partners and the sub groups;
 - Performance Indicators that provide evidence of the success of the overall roll out of the Joint Future Agenda, Delayed Discharge Action Plans and waiting times for assessments;

- Evaluation of outcomes for service users and carers;
- Other information as required, for example, by the Scottish Executive and or other national audit bodies;
- Information that evidences outcomes in relation to other strategic planning and particularly links to the objectives of the East Ayrshire Community Plan.

11. LOCAL PARTNERSHIP WORKING

- 11.1 East Ayrshire is currently served by two Local Health Care Co-operatives. East Ayrshire Local Health Care Co-operative represents the majority of practices in East Ayrshire. Practices in the Doon Valley area (Dalmellington, Patna and Drongan) are represented by the South Ayrshire Local Health Care Co-operative.
- 11.2 A review of NHS structures has been undertaken as stated in the Scottish Executive white paper "Partnerships for Care" and the resulting National Health Service Reform Bill. This has resulted in NHS Trusts being abolished as from 1st April 2004 with the creation of a single body – NHS Ayrshire and Arran. NHS Ayrshire and Arran now has two divisions – General Hospitals Division and Community Health Division, which manage the services previously provided by the Acute Hospitals NHS Trust and Primary Care NHS Trust respectively. Local Health Care Co-operatives will evolve into Community Health Partnerships during a shadow year 2004 – 2005. This new structure will devolve as far as possible responsibility to a local level and ensure that local needs are met.
- 11.3 Most of the practical joint activity will involve East Ayrshire Council and East Ayrshire Local Health Care Co-operative (Community Health Partnership), with the delegation of responsibility of Mental Health and Learning Disability services to Community Health Partnership level. However, close partnership arrangements will also be required with South Ayrshire Community Health Partnership with regard to the Carrick and Doon Valley area; services managed at other Community Health Partnerships, Community Health or General Hospitals Divisions; on issues such as Delayed Discharge or in terms of overall strategic development where an Ayrshire-wide approach is preferred.
- 11.4 The partnership working arrangements developed in response to the Joint Future Agenda reflect long standing arrangements that have been developed at both operational and strategic planning levels between Health and Local Authority professionals.
- 11.5 Practical implementation of these arrangements include:
- The alignment of social work teams with GP practices based on good practice identified in the pilot work with Newmilns Darvel project. This has also facilitated the smooth introduction of the Single Shared Assessment;

- building on the history of integrated multi-agency working to address the health and social care needs of adults with mental ill health and learning disabilities, such as the ongoing use of Single Shared Assessments by Community Health staff;
- the income maximisation project piloted in 2 GP practices in 2003, involving East Ayrshire Council and voluntary sector staff, which will be rolled out across the authority by 2007;
- the Social Work team based within East Ayrshire Community Hospital;
- joint staff recruitment and selection panels;
- joint resourcing of Joint Equipment Service with single manager;
- joint Single Shared Assessment training undertaken for fieldwork staff from health, housing and social work;
- the development of the Dalmellington Area Centre, enabling co-location of staff and a more holistic form of service provision to residents of the Dalmellington area. This was duplicated on a smaller scale in Drongan and funding has now been secured for a comprehensive project in North West Kilmarnock;
- the Care and Repair Project is piloted in Dalmellington, by Community Planning partners and also to be rolled out across the authority by 2005;
- joint work by Community Planning partners to address the Health Improvement Agenda;
- established partnership working arrangements exist at the strategic level in relation to a range of key areas including Community Care Planning, Joint Health Improvement Planning, Community Planning and Supporting People. As well as the development of strategies for the care groups addressed within this Agreement. The Partnership's strategic framework is detailed in Appendix 1;
- the inclusion of health service and service users and carers in the tendering for new support providers in the fields of learning disability, autistic spectrum disorder, mental health and physical disability.

12 HUMAN RESOURCES

- 12.1 The principles of partnership recognise that people within the existing service organisations will be crucial to the successful joint delivery of services to the communities within East Ayrshire.
- 12.2 In developing joint resourcing and joint management plans for Community Care, the partner organisations will ensure the inclusion of all interested parties to develop and resolve Human Resource issues that arise from that joint planning process.

12.3 This strategy is designed to support the Joint Future Agenda by developing shared aims and values and agreeing a joint approach to managing change. This will enable the development of an open, learning and development culture where people and their contribution are valued within an environment of good employment practice.

Joint Staff Forum

12.4 A staff forum is well established in East Ayrshire and will in future work in tandem with an area wide human resource group to be convened to review issues on a pan Ayrshire basis.

12.5 A Constitutional Agreement has been formally agreed with a remit to:

- develop a framework for implementing the best practice approach promoted by the Report of the Integrated Human Resource Working Group, identifying gaps and areas of work which require to be developed further to make Joint Future a success;
- create a culture that promotes partnership working and supports employees through the process of change;
- generate recommendations on key human resource issues to inform the process of service development and delivery; and
- promote communication between parties and an understanding of the change agenda.

12.6 Membership of the forum includes staff and trade union representatives (including full time officers) and management representatives from both East Ayrshire Council and NHS Ayrshire and Arran, as well as ex-officio members as required.

12.7 The forum meets a minimum of 5 times a year.

12.8 The staff forum will also keep up to date with issues within the East Ayrshire Partnership and across Ayrshire including participation in the other organisational meeting structures as required.

12.9 From April 2004 the staff forum will address issues relating to all care group staff addressed by this partnership agreement.

Statements of Intent

12.10 In addition to the staff forum, the Partnership will:

- Continue to establish effective communication systems between and across partner organisations in the joint delivery of services;

- Give due consideration to guidance on Human Resource matters, issued by the Scottish Executive and/or the National Integrated Human Resources Working Group, CoSLA and from within the partner organisations and their national negotiating bodies;
- Monitor links between the three Ayrshire local joint staff forums on common issues to facilitate opportunities for sharing, improvement and a co-ordinated approach where appropriate;
- Plan and develop appropriate frameworks and structures that facilitate the integration of each partner's employees into a joint working environment.

Joint Organisation Development and Training

12.11 The Partnership will continue to :

- Develop and manage effective structures in which roles, responsibilities and accountabilities of all employees in each partner organisation are agreed and specified, and within which the skills and experience required will be supported and developed by the partner organisations on a joint basis where appropriate;
- Agree a full joint Organisational Development Plan for all care groups in accordance with National Guidance, covering Values and Culture, Vision & Strategic Aims, Service Delivery Objectives, Leadership and Management, Competencies, Joint Training, Performance, Accountability and Governance and Communication;
- Manage and overview the Organisational Development plan as required;
- Design training and development programmes to improve and enhance the competence, aptitude and skills required to support the joint delivery of core services, focused on effective team-working;
- Design joint training, which will enable the differences between professions to be valued and potential opportunities for, shared roles/tasks to be identified.

12.12 There will be a continued commitment to ensuring that opportunities for professional development are continued and developed in accordance with the relevant professional and organisational requirements.

12.13 These aforementioned strategic objectives developed and supported by more detailed action plans in relation to training and development, secondment and joint post arrangements, when the partnerships progress further.

12.14 They are designed to support the joint resourcing and joint management of Community Care Services as outlined within the Partnership Agreements between the Local Authority and NHS Ayrshire and Arran. The Partnership's early work has realised the following achievements:

- establishing a local staff forum;
- establishing a Secondments and Attachments Protocol in partnership with employee representatives;
- establishing a final draft Organisational Development Framework;
- delivery of certified joint management training through Managing Health and Social Care;
- active participation of health staff to provide training in induction of social care staff.

12.15 In addition, East Ayrshire Council has approved the transfer of employee rights for employees joining East Ayrshire Council from NHS Ayrshire and Arran including, recognition of NHS Ayrshire and Arran employment as continuous employment for service related entitlements.

13 COMMUNICATIONS AND INVOLVEMENT

13.1 Service user involvement and participation in the development of services is recognised by partners as being essential. The most important partnership is the one between our partners and the people living in our communities.

13.2 Partners have developed this agreement based on a policy of listening to people receiving services and using what they tell us to influence how we develop services.

13.3 Community Planning partners in East Ayrshire recognise that to bring about real and lasting change, the people and communities of East Ayrshire must be at the heart of the community planning process, and must be fully involved and represented. We have systems in place to tell people about what is happening and, more importantly, to make sure that they have an opportunity to play an active part in achieving our vision. These include:

- Supporting and listening to community organisations including residents groups and local interest groups;
- The East Ayrshire Council Local Committee structures were developed in 1996 to ensure that Council matters are discussed within local areas. These open Council meetings have the full authority of council committees but include local community organisations as non voting members. All key strategic documents are passed through the Local Committee structure for consultation;

- There is active community representation and extensive consultation systems in place within key priority areas in East Ayrshire, including the Social Inclusion Partnerships in both the Coalfield area and East Ayrshire North;
- Specific communities of interest have consultation arrangements within the Council structure. These include:
 - “Better Government for Older People”,
 - the Bi-Annual Forum on Disability,
 - the Ethnic Minorities Forum,
 - East Ayrshire Women's Forum, and
 - East Ayrshire Multi-Agency Domestic Abuse Forum.

13.4 A Patient Focus, Public Involvement strategy has been developed by NHS Ayrshire and Arran that aims to build on existing initiatives that involve patients and the public in the planning, development and evaluation of services. This includes the involvement of the Health Council in service planning, consultation with voluntary organisations and patients organisations and utilising the community organisations identified by local authorities in relation to strategic and service planning initiatives.

13.5 Service users and carers have been actively involved in the planning of services in East Ayrshire Council. Within Community Care, a range of service users and carers have been actively involved in the development of the strategies linked to this agreement, whether as members of the planning group; such as in the older people’s strategy and carers strategy, as part of focus groups identifying issues and solutions; such as the mental health and advocacy strategies or as part of wider consultation over the content of all strategies.

13.6 East Ayrshire Council has co-hosted conferences each year since 1999, for carers to ascertain their views and priorities and inform strategic development. The Council has also been committed to hosting an annual older people’s conference since 2000 and comments gathered at these conferences continue to influence strategic and operational planning. Feedback received from the Better Government Conference of 2003 has informed the further development of this Partnership Agreement.

13.7 A range of service users and carers groups have been supported by East Ayrshire Council. These include users committees within residential and day services. East Ayrshire Advocacy Services and East Ayrshire Carers Centre provide support to a range of individuals and groups.

- 13.8 Partners are further developing policy in relation to consultation processes. In particular, East Ayrshire Council has participated in the development of the NHS Ayrshire and Arran Patient Focus and Public Involvement strategy. East Ayrshire Council will in 2004-05 also develop a social work service user and carer involvement strategy that will audit and monitor consultation methods currently used and develop strategies for extending the effectiveness of involvement in the planning, implementation and review of services.
- 13.9 The implementation of the NHS Ayrshire and Arran Patient Focus, Public Involvement strategy aims also to support active citizenship, enable people to make informed choices and enable a cultural shift within the NHS towards a greater patient focused service and the adoption of a public engagement culture.
- 13.10 NHS Ayrshire and Arran and partners will, as part of the anticipated implementation of the NHS Reform Bill and in particular the Community Health Partnerships (Scotland) regulations, support the development of Public Partnership Forums to enable the development of the health agenda in East Ayrshire to be effectively informed by service user, carers and community views.
- 13.11 The views of individual service users and carers are also gathered through the assessment and care management process. Service users wishing additional support to express their needs and views can be supported to do so by East Ayrshire Advocacy Services. There is a commitment to extend direct and indirect methods of securing the views of our service users and communities.

14. INFORMATION SHARING

- 14.1 Information sharing within the Joint Future Agenda has two elements:
- Ensuring the provision of effective and accessible information to service users, carers and other key stakeholders about the range of services available and means of accessing these; and
 - ensuring that information about service users needs is effectively shared between agencies to ensure that duplication and misunderstandings are minimised.
- 14.2 There have already been some individual initiatives developing joint leaflets with information of services that have been jointly funded. In addition, all partners are members of the Ayrshire Electronic Community providing a central access point to services across Ayrshire. As a matter of priority the Information sub group will review additional opportunities for the joint provision of information to service users and family carers.
- 14.3 In relation to the sharing of information between agencies to support the implementation of the Single Shared Assessment, an information sharing protocol, and leaflets for members of the public have been developed between the three Ayrshire local authorities and NHS Ayrshire and Arran.

- 14.4 The Information Sharing protocol outlines the objectives, principles and parameters of sharing information between agencies. Systems are in place for ensuring that the written consent of service users and/or carers is obtained prior to any information being shared. In cases where the patient does not have the capacity to give consent to sharing information with others, information can be shared to the patient's benefit, under the principles of the Adults with Incapacity (Scotland) Act 2000. The protocol, developed for older people's services has now been extended to all care groups addressed within this agreement.
- 14.5 The three Ayrshire authorities and NHS Ayrshire & Arran received Modernising Government funding to develop a shared electronic information system for the purpose of improving the effectiveness and efficiency of sharing Single Shared Assessment information. This will permit a single point of entry to community care services across Ayrshire and provide a person-centred and needs-led process through which more effective outcomes can be achieved.
- 14.6 The project manager for the eCare Project has been in post since October 2003. Network links to enable secure sharing of information have been installed, and work is underway to define specific requirements for electronic Single Shared Assessment recording and subsequent sharing of information.

15. EXTENSION OF JOINT RESOURCING AND JOINT MANAGEMENT

- 15.1 There are a range of joint working arrangements already in place in respect of learning disability, mental health and physical disability. These include a single referral system and shared database in respect of learning disability, close working relations in respect of mental health work and direct access to equipment by health based occupational therapists.
- 15.2 The completed roll out of Single Shared Assessment has and will continue to strengthen existing partnerships.
- 15.3 At strategic level agreement was reached in relation to hospital retraction of learning disability beds. Resources were committed by both Health and Local Authority to facilitate this process. Joint work has also informed and supported the subsequent consultation and information sharing process as to the future location of resource centres.
- 15.4 A jointly resourced community living arrangement for people with very complex physical needs has been operational for four years. This arrangement is under review in light of the roll out of Direct Payments and all stakeholders are contributing towards the discussion.
- 15.5 The establishment of a jointly funded Arts Co-ordinator post has been explored, drawing on Arts Council funding. Supplemented by health and local authority resources.

- 15.6 The reconfiguration of the membership and remit of the Joint Future Implementation Group allows those managing the full range of services in this agreement to be involved in strategic development, implementation and evaluation of the Joint Future process.

16. SINGLE SHARED ASSESSMENT

- 16.1 A Pan Ayrshire Single Shared Assessment Steering Group, which was established to develop and implement Single Shared Assessment across the NHS Ayrshire and Arran area to:
- develop the assessment tool;
 - map and agree processes and use of tool; and
 - develop a training plan for staff:
- 16.2 The Group continues to operate and has widened its membership to include representation from all care group services and the e-care Project Manager (Ayrshire Consortium).
- 16.3 The Steering Group continues to oversee: progress in respect of the implementation of Single Shared Assessment across all care groups; and the development and implementation of care management arrangements across Ayrshire and Arran.
- 16.4 The group has recently reviewed the definition of Single Shared Assessment used in Ayrshire and Arran. The revised definition is out for consultation and will be implemented by 1st June 2004.
- 16.5 A review of the Single Shared Assessment documentation has also been undertaken by a group of practitioners from across the partners' agencies. This revised paperwork is currently out for consultation. Further work is envisaged following the consultation and in line with the ongoing development of the electronic version and the introduction of the Single Shared Assessment- Indicator of Relative Need.
- 16.6 Within East Ayrshire, the use of the Single Shared Assessment documentation has been implemented for all community care groups from June 2003.
- 16.7 Community based integrated teams can now access a range of social and health care services through this process, both during and outwith working hours. Further work is required in order that the full range of health and social care services can be accessed more easily.
- 16.8 Over 120 community-based health staff have been provided with financial assessment training during 2003 to assist in the Single Shared Assessment process. The local authority has also employed additional support assistants to assist qualified social work and health staff with the financial assessment process.

17 DELAYED DISCHARGES

17.1 55 people in East Ayrshire at the Census of January 2004 continued to experience a delay in discharge from hospital while assessment is undertaken and arrangements for their future needs are organised after diagnosed as clinically fit to be discharged.

17.2 However, this figure is down by almost 34% from 83 in the previous February due to work undertaken in partnership by NHS Ayrshire and Arran and the three Ayrshire Local Authorities.

17.3 A Delayed Discharge Action Plan has been agreed by the key Ayrshire partners, as well as the Scottish Ambulance Service and Ayrshire Doctors On Call, and is managed by the multi-agency Discharge and Capacity Group, with funding from the Scottish Executive. It contains a range of initiatives which are designed to deliver real reductions in the number of people waiting to be discharged from hospital and puts in place initiatives which would prevent people being admitted to hospital where this could be avoided.

17.4 The initiatives include:

- **Medical, Nursing and Home Care Out of Hours Service**

This service incorporates a GP Revisiting Service (provided by Ayrshire Doctors on Call to assess response to treatment or ensure the clinical condition of patients is improving), increased District Nursing Evening service and increased Social care for Home Support. The aim of the service is to prevent avoidable admission to hospital and support discharge from hospital between 5.30 p.m. and 8.00 a.m.;

- **Additional social work staff based in Crosshouse Hospital and East Ayrshire Community Hospital**

Staff undertake assessment of need and process discharge arrangements to minimise time spent in hospital after medical need ceased;

- **Extended Day Care Access**

An extra 2900 places are being achieved per year by opening two centres on a Saturday for 8 people per centre and one centre 5 evenings per week for 8 people;

- **Intermediate Care**

Ensures that comprehensive and credible support packages are targeted at people with highest risk of hospital admissions to avoid inappropriate hospital admission.. This will also facilitate earlier hospital discharge and provide rehabilitation en route back to the community;

- **Accident and Emergency Assessment and Early Discharge**

To strengthen the existing Rapid Response Service by improving patient assessment within A & E. This will prevent unnecessary admissions, facilitate early discharge and help to prevent re-admissions;

- **Dedicated Discharge Vehicle**

A dedicated vehicle allows the discharge process to be completed on the same day if required and prevents a delay in discharge from 0.5 bed days to 1.5 bed days per patient. There is a potential to prevent 5 patients per day being delayed by 1 bed day = 25 bed days over 5 days = 1250 bed days saved per year;

- 17.5 A Discharge Co-ordinator within the General Hospitals Division regularly reviews patients, linking with social work and other partners to ensure that discharge is planned to meet people's needs and is not delayed any longer than necessary.
- 17.6 A Rapid Response Team is in place to prevent inappropriate admission to hospital and facilitate early discharge. This initiative has ensured that patients who can be cared for at home are maintained in their own homes while freeing up beds in Crosshouse and Ayr Hospitals for those who really need hospitalisation. A partnership approach has brought a number of different services together to provide a full service to the patient.
- 17.7 As stated, the initiatives have significantly reduced the number of people whose discharge from hospital is delayed, however partners within Ayrshire and Arran will continue to work together to ensure further reductions and to meet targets agreed with the Scottish Executive.

18 SUPPORTING PEOPLE

- 18.1 The Supporting People Programme is an integrated policy and funding framework for housing support services that became operational in April 2003.
- 18.2 The programme seeks to ensure that individuals requiring support to live independently in the community are enabled to do so through a complementary package of housing and care support.
- 18.3 The development of the Supporting People Programme is led by the East Ayrshire Supporting People Strategic Plan 2003-2008, which is managed by the joint team comprising managers from health and local authority services, housing providers and representatives of service users. The strategy also forms an integral part of the Council's Local Housing Strategy.
- 18.4 There is a close relationship between the work of the Joint Future and Supporting People agenda and therefore the development of the Supporting People Programme will complement the work that will be done through this Agreement.

19 ACHIEVEMENTS IN LAST YEAR

19.1 This section outlines the progress to date of the implementation of the actions specified in the 2003 Partnership Agreement to develop a co-ordinated and joint approach for older people's services.

AGREED ACTION	PROGRESS TO DATE	ACTION STILL REQUIRED
<p>Agree Key Recommendations from Ayrshire & Arran Strategy - East Ayrshire Older People Strategy Group to complete task and present paper to East Ayrshire Joint Future Implementation Group Report.</p>	<p>East Ayrshire Implementation group well established and co-chaired between local authority and health</p>	<p>Implementation strategy ongoing. Joint approach continuing in taking this forward</p>
<p>Delivery Benefits of Single Shared Assessment - Dedicated Social Work Team Leader to work closely with LHCC's to agree Action Plan. Complete gap analysis and report.</p>	<p>Widespread use of Single Shared Assessment. Single Shared Assessment Steering group well established. Team leader led review will report in 2004.</p>	<p>Finalisation of documentation. Review and implementation of same with any associated training addressed</p>
<p>Review Day Care Provision - Report recommendations.</p>	<p>Report prepared in 2003. Joint services commissioned.</p>	<p>Joint premises for day services in NW Kilmarnock due to be completed at the end of 2005.</p>
<p>Reduce Inappropriate Admissions to Hospital - Report to Joint Future Implementation Group on an ongoing basis to identify continuous improvement</p>	<p>Implementation of joint out-of-hours services, increased home care and joint working in localities</p>	<p>Address development of joint step-up intermediate care facility.</p>

AGREED ACTION	PROGRESS TO DATE	ACTION STILL REQUIRED
<p>Improve the Provision of Equipment and Adaptations - Service Unit Manager Adults) to participate in working group to develop model.</p> <p>Joint Future Implementation Group to further consider how to create single referral points ahead of new I.T. system.</p>	<p>Agreement reached to recruit a project manager to oversee the development of the joint equipment service.</p> <p>In East Ayrshire a new OT store has been commissioned that will allow the partnership area to fully contribute to the Ayrshire wide service.</p>	<p>Ongoing development of service between 3 Ayrshire local authorities and NHS Ayrshire and Arran</p>
<p>Provide effective information to older people and their families - Information working group to agree Action Plan.</p> <p>Operational Managers in all agencies to consider how to personalise information services.</p>	<p>Range of information-provision initiatives undertaken including Older People's conference, Care at Home leaflet, contact cards, funding for East Ayrshire Carers centre information pack. Web site being developed to enable access to more information. Joint Information Sharing protocol developed.</p>	<p>All partners require to evaluate effectiveness of current systems and to listen to service users and carers comments on our information strategies and adjust accordingly.</p>
<p>Develop and expand a range of flexible community based services - Care Strategy Groups and operational managers to identify gaps in the continuum of care and report to Joint Future Implementation Group.</p>	<p>Continuum of Care at Home services in place from low level household support to intense joint home based personal care. Development underway to improve range of accommodation from amenity housing to continuing hospital care.</p>	<p>Continue to monitor and develop service in line with needs of East Ayrshire population. Ongoing work in relation to accommodation services.</p>

AGREED ACTION	PROGRESS TO DATE	ACTION STILL REQUIRED
<p>Increasingly engage older people and carers in planning services - Care Strategy Groups to agree additional ways of taking participation forward in addition to existing arrangements.</p>	<p>Annual conference for Older People held. Carer representation on care strategy groups and equal membership with staff on carers' strategy group. Older people's representation on Older people's strategy group. Bi-annual elected members meetings held with Elderly forums. Service users surveyed in relation to Community meals service.</p>	<p>Identify unmet need through development of e-care system.</p> <p>Develop Service users and carers involvement strategy within Social Work Services and implement Patient / Public involvement strategy within development of Community Health Partnerships</p>
<p>Establish correct balance of care - Joint Planning Group to complete an analysis of need, provision and demographic changes with recommendations</p> <p>Older People Care Strategy Group to involve independent sector providers in capacity planning and agree appropriate balance of care.</p>	<p>Independent Care Home and Home Care services represented in Older people's strategy implementation group.</p> <p>Older people's strategy includes analysis of current and future demographics, assessed needs and current service provision.</p> <p>Older people's strategy Information on balance of care included in JPIAF10</p>	<p>Evaluation of capacity issues ongoing. It is anticipated that review of services will release resources for re-investment in appropriate community supports.</p>
<p>Involve staff working with older people in East Ayrshire in the Change Process – JFIG to meet frontline managers on an ongoing basis in April and key staff before summer recess to inform and involve on development.</p>	<p>Staff forum established at area-wide and local level. Series of joint presentations delivered to frontline staff. Further staff consultation / development sessions underway to review frontline experience of Joint Future.</p>	<p>Continue joint training initiatives and staff participation in liaison.</p>

20 IMPLEMENTATION PLANS FOR 2004-2007

- 20.1 This section summarises proposed implementation plans for all care groups affected by this partnership agreement with indications of anticipated year of implementation.
- 20.2 Strategies are due for completion for July 04, with the exception of the Partnership in Practice Agreement – which is due for completion in September. Therefore the action objectives outlined in this section may be subject to revision, based on development work undertaken by partners and consultation with key stakeholders.
- 20.3 The details of implementation including resource allocation, key agencies and detailed milestones and timescales will be included within the individual strategies.¹
- 20.4 In addition, a short overview of the strategic direction of joint services including information about the strategic implementation plans will be included within the East Ayrshire Joint Community Care Plan 2004-2007. The strategies will be reviewed and publicly reported upon on an annual basis as part of the review of the plan along with financial and performance overview of community care services including the Joint Performance, Information and Assessment Framework.
- 20.5 The key action objectives for each of the strategies are outlined as follows.
- 20.6 **Older People's Strategy**
1. **Implement the key recommendations contained in Ayrshire and Arran Strategy for Older People's Services, applied locally to reflect the needs of East Ayrshire.**
- The assessment and screening services for older people will be enhanced;
 - Develop and enhance direct payment schemes;
 - Introduce or enhance and evaluate 24-hour social care and social work services which link to the 24-hour health care services;
 - Consider the demographic impact on hospital and other services when reviewing capacity;
 - Address the unmet needs of acutely ill older people with multiple pathologies or rehabilitation needs who do not currently receive a geriatric assessment ;.

¹ Appendix 4

- Review out-patient services for older people to make them as accessible as possible;.
 - Develop an integrated cognitive assessment service (memory clinics);).
 - Enhance liaison arrangements between all older people services; .
 - Reduce the number of NHS continuing care beds once appropriate care packages are in place, to release resources for investment in other locally agreed and prioritised services;.
 - Develop a joint strategy to address issues of elder abuse;.
- 2. Deliver the benefits of the Single Shared Assessment process which has been implemented since April 2003, including reduced waiting times for assessment, better co-ordination between professional groups, reduced delays in service provision and improved communication with clients/patients and their families.**
- Develop outcome measures for the implementation of Single Shared Assessment.
 - Continue to roll out Single Shared Assessment to enable a range of agencies to undertake the assessment and develop effective care plans.
 - Further develop Information Sharing practices and tools.
- 3. Reduce inappropriate admissions to hospital and minimise delayed discharges through the implementation of local East Ayrshire initiatives as part of the Ayrshire and Arran Delayed Discharge Partnership, including Care and Repair.**
- Work with health and housing to ensure, where possible, unnecessary hospital admissions are avoided.
 - Further develop and implement the delayed discharge action plan and evaluate the outcomes through a multi-agency group.
- 4. Improve the provision of equipment and adaptations for East Ayrshire clients by implementing the recommendation to establish a joint equipment service across Ayrshire.**
- Develop the equipment and adaptation services.
- 5. To deliver effective information about available services and how to access them for older people and their carers.**
- Further development of public information material on criteria for services and contact information on local services.

- Further develop a range of information provision formats including consultation meetings, e-based information and targeted information material.
- 6. Deliver a range of flexible community based health, housing and social care services that promotes independence and real choices for older people and their carers in East Ayrshire.**
- Develop an increasingly rights based approach to service delivery;
 - Develop services that can fully respond to crises;
 - Develop a full range of respite services.
 - Enhance the community alarm service.
 - Develop a “whole system” approach to Capacity Planning to ensure appropriate services from low level home maintenance to continuing hospital care are available in East Ayrshire to meet the needs of the population.
 - Progress the Supporting People agenda.
- 7. Continue to engage older people and carers in planning services and demonstrate by our actions that we are hearing the views expressed.**
- Ensure that information is available that makes clear organisational structures including roles and responsibilities and delegation of decision making authority.
 - Develop service users and carer involvement strategies by agencies in partnership and separately, which will quantify and anticipate resource needs and develop transparency around prioritisation, develop and extend involvement in service development implementation and evaluation.
- 8. Involve staff working with older people in East Ayrshire in the change process through the joint staff forum and through regular, multi-agency staff consultation and engagement to ensure a well informed, well trained and appropriately resourced workforce.**

20.7 Mental Health Strategy

- 1. Address the Mental Health (Care and Treatment) Act 2003 through the development and implementation of a local plan for East Ayrshire.**
- The level of current and future need will be identified and services developed that will meet these.
 - A series of awareness raising and skills development training will be provided jointly which will be targeted towards staff requiring additional or strengthened skills and knowledge.

- Operational plans will be put in place to ensure that the statutory duties and powers of the new Act are addressed and resourced by the appropriate agency.
- 2. Ensure service users, carers and the public of East Ayrshire are engaged and actively involved in the planning, delivery and evaluation of Mental Health Services.**
- Information will be available that makes clear organisational structures including roles and responsibilities and delegation of decision making authority.
 - Meaningful user involvement will be developed to enable participative service design, commissioning and monitoring.
 - Agencies will agree a common set of guiding principles, terms of reference and language which are also accessible to service users/carers.
- 3. Develop the capacity of services to implement the key aims of the National Programme for improving mental health across East Ayrshire: raising awareness and promoting mental health and wellbeing; reducing stigma; preventing suicide; promoting recovery.**
- An audit of stakeholders will be carried out to identify gaps in existing information and knowledge of issues relating to mental well being.
 - Implementation of the national programme will be coordinated on a multi agency basis to ensure it reflects local needs and links with other strategies such as the Community Plan.
- 4. Ensure mental health education, training and development is delivered to the staff and public of East Ayrshire resulting in raised awareness, better understanding, reduced stigma and improved staff skills.**
- Public information on mental ill health will be developed and monitored to ensure that it is accessible, targeted and addresses the intended purposes.
 - Awareness raising events and training will be developed and targeted at key areas, including schools and staff with public contact.
 - Feedback from service users and carers will be evaluated and used to inform skills training planning.
- 5. Promote the further integration of services across East Ayrshire to improve the mental health care and treatment of services users, prioritising activity to improve access and accommodation and meet the needs of young people.**

- Develop multidisciplinary services that are able to respond appropriately to the needs of service users and carers on 24/7 basis (housing/social work, health, voluntary organisations).
- To further integrate services to ensure that there is effective response to the holistic needs of service users including those with Post Natal Depression, substance misuse issue, children and young people and mentally disordered offenders.
- To ensure equal access to all services including leisure, housing and employment for people affected by mental ill health.

20.8 Learning Disability Strategy

1. **Ensure that services are available, accessible, proactive, responsive and of a consistently high quality though people's lifetime including during periods of transition such as through childhood to adulthood and through the process of ageing.**

- Ensure there is a robust information system in place to enable identification of people who will be approaching periods of transition.
- Ensure that all people with learning disability have a named link worker during periods of transition.
- Develop accessible information systems describing what services and supports are available and how to access them for service users, carers and the community in general.
- Engage with all stakeholders to ensure shared practice and vision in relation to service planning and delivery.

2. **Through work within Community Planning partnerships, service development and the ongoing promotion of person centred practice, enable a shift in culture to promote social inclusion and independence.**

- To further develop Personal Care Planning by all partners as a core culture for identifying the needs of service users and carers and planning service provision.
- Budgets, resources and services to be developed with a view to ensuring increased flexibility, accessibility and opportunities.
- Promote appropriate risk, risk management and informed choice taking to enable real inclusion in the community and a lifestyle which reflects the majority of people in East Ayrshire.
- Promote the take up of Direct Payments by people with learning disability and ensure support is available for them to use it effectively.

- To develop effective Performance Management systems to measure outcomes for service users of Person Centred Planning, etc, based on the values and principles of East Ayrshire Community Plan.
- Work with Enterprise Ayrshire, Further Education providers, private and voluntary sector and other Community Planning partners to promote greater access to employment.
- Further develop services with regard to those with complex needs including people with multiple disabilities, autistic spectrum disorders etc.

3. Ensure service users, carers and the public of East Ayrshire are engaged and actively involved in the planning, delivery and evaluation of Learning Disability Services.

- Information will be available that makes clear organisational structures including roles and responsibilities and delegation of decision making authority.
- Service users and carer involvement strategies will be developed by agencies in partnership and separately, which will quantify and anticipate resource needs and develop transparency around prioritisation, develop and extend involvement in service development implementation and evaluation.
- How to ensure meaningful and inclusive involvement in planning for service users will be further explored in conjunction with colleagues in mainstream and further education sites as well as advocacy services.

4. Promote the further integration of services across East Ayrshire to improve the care and treatment of services users.

- Strategic and operational planning for people with learning disability will involve all key stakeholders to ensure a holistic approach.
- A joined up approach to service development will be delivered through the Joint Future and Community Health Partnership agenda.
- Work with partners to ensure facilities are adapted and accessible to enable full community activities inclusion at every level.

20.9 Physical Disability and Sensory Impairment

1. Ensure service users, carers and the public of East Ayrshire are engaged and actively involved in the planning, delivery and evaluation of services for people with physical or sensory impairments.

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

- Information will be fully available and in suitable formats to people with physical and sensory impairments.
- Service users and carer involvement strategies will be developed by agencies in partnership and separately, which will quantify and anticipate resource needs and develop transparency around prioritisation, develop and extend involvement in service development implementation and evaluation.
- Support the increased effectiveness of disabled people in campaigning for equal opportunities, through supporting Disability Forums and other campaigning groups of disabled people.
- Personal Life Planning will be implemented for service users with complex needs involving them in developing their long term goals and the tools required to achievement.

2. Ensure education, training and development is available to enable Community Planning Partners to address the needs of people with physical or sensory impairments enabling the promotion of equal opportunities and; to raise public awareness of the range of technologies and opportunities available to enable people affected by physical or sensory impairments lead full and valued lives.

- Develop effective responses to, raise awareness of and promote the increased use of improved technologies that enable people to be more independent both within their homes and in the community.
- Disability Awareness training will be provided for staff and service providers in partnership with representative organisations to meet the requirements of the Disability Discrimination Act.
- Awareness raising initiatives of the needs of people with acquired brain injury and also those with progressive or degenerative impairments will be undertaken amongst front line staff to ensure that a flexible and swift response is available to meet changing need.
- Ongoing training and awareness raising for staff in relation to sensory impairments will be continued to improve quality of access.

3. Work alongside all stakeholders within East Ayrshire to ensure equality of access to all services, leisure, housing and employment opportunities for people affected by physical disabilities and or sensory impairments.

- A Pan Ayrshire Joint Equipment Service is being developed to improve the efficiency and cost effectiveness of procurement, storage and distribution of equipment and continence aids and enable improved and quicker access.
- Measures will be implemented to ensure equal access to health and social care services by people with physical disabilities, sensory impairment and long term illness.

- Services will address the improvement of health and well being for people with physical disabilities, sensory impairments and long term illness.
 - A framework for transitional planning will be developed across all agencies and in partnership with young people and their families/carers. This will set out agreed inter-agency protocols and standards of practice.
 - Social Work realignment of services will be implemented to ensure an improved early assessment of need and delivery of appropriate services for children with physical disabilities.
 - Awareness raising and training relating to issues for people with physical disabilities and or sensory impairments will be offered to all frontline services.
- 4. Ensure that standards for service development and operation, as outlined in the Scottish Executive “Sensory Impairment Action Plan”, “Social Justice a Scotland where everyone matters” are addressed in partnership.**
- Every health and social care facility will have staff that are able to meet the basic communication needs of a person with a sensory impairment by April 2006.
 - An appropriate response will be made to the report of the short-life working group, established by the Scottish Executive, which will identify changes required in community care services for people with a sensory impairment to address inconsistencies and addresses specialist needs.
 - Conclude the consultation exercise in relation to sensory impairments and implement the proposals agreed relating to equipment and future service provision.

20.10 Ayrshire and Arran Alcohol and Drug Action Team Corporate Plan

- 1. To provide equitable, accessible and inclusive services to address the needs of those who experience problems with alcohol.**
- Public information distribution and dissemination via public access information systems, addiction services, campaigns and the CHIP van addiction services.
 - Partnership working involving the local authority NHS Ayrshire and Arran and the voluntary sector, i.e. Ayrshire Council on Alcohol.
- 2. Increase the proportion of drug misusers in contact with services through the development of good, accessible, responsive and effective services.**
- Targeted public information promotion.

- Collaborative practice involving the local authority, NHS Ayrshire and Arran and voluntary sector, e.g. Bridge Addiction Services.
 - Implement the recommendations of the Addiction Services Review conducted by East Ayrshire Council in 2003/04. in liaison with NHS Ayrshire and Arran.
- 3. Reduce the number of drug misusers who do not have timeous access to appropriate treatment.**
- Reduction of addiction services waiting lists in accordance with the recommendations of the Addiction Services Review.
 - Reduction of waiting times following referral in accordance with the recommendations of the Addiction Services Review.
- 4. Reduce binge drinking.**
- Public information promotion, including early intervention through alcohol education in schools.
 - Address binge drinking through the core provision alcohol addiction services, care planning and review processes.
- 5. Holistic support to drug misusing parents, their carers and Children.**
- Local authority partnership with the Princess Royal Trust, East Ayrshire Carers Centre , including support for the Young Carers Project.
 - Department of Educational and Social Services employment of specialist drug workers to assist vulnerable children and families, young people who are accommodated away from home and promote drug education in schools.
- 6. Increase the number of people recovering from alcohol problems entering further education, training and employment.**
- Address issues raised by the Employment Issues sub-group of ADAT.
 - Development of appropriate throughcare services to enable service users successfully completing alcohol treatment and rehabilitation programmes to progress to further education, training and employment.
- 7. Reduce alcohol related crime.**
- Diversionary practice promoted by the All Ayrshire Criminal Justice Partnership Addiction Worker.
 - Updating and circulation of information to relevant professionals on services available.

- Criminal Justice Social Workers are provided with alcohol related information through training courses.

8. Diversion from drug related crime.

- Improve access to drug addiction services.
- Facilitate entry to further education and constructive leisure pursuits as alternatives to crime, through drug treatment and rehabilitation programmes.

9. Develop constructive alternatives to prosecution, related to appropriate treatment for drug misusing individuals who offend.

- Employment of an Addiction Worker by the All Ayrshire Criminal Justice Partnership to facilitate service users diversion from drug related offending.
- Build throughcare provision to promote entry to employment and / or further education , on successful completion of drug treatment and rehabilitation programmes as a means of combating recidivism.

20.11 Carers' Strategy

1. Ensuring more Carers are identified.

- Help people to recognise they are Carers by making the definition clear.
- Identify resources to ensure that information packs currently available are updated and appropriately targeted.
- Find out at an early stage if a Carer wants to be involved in different groups and or activities.

2. Changing Cultures within organisations to make sure that all staff recognise Carers as partners.

- Carers to be fully recognised as partners within the care process at a number of stages from assessment to reviews.
- To ensure that Carers are supported to be involved in the planning, development and review of services.

3. Approaching Carers assessments in a different way

- The current practices of undertaking Carers assessments will be reviewed to ensure that they are at their most effective in meeting Carers' needs.
- Carers will be supported to ensure that their incomes are maximised.
- The health consequences of caring will be addressed through health assessment and health improvement activity.

4. Develop innovative services that meet Carers' Needs flexibly.

- Develop training for carers, to assist in caring role, e.g. moving and handling or specific awareness training.
- Develop a service to support young carers caring for someone misusing drug or alcohol.
- Ensure that all Carers' services are operating in a Best Value culture.
- Further develop targeted support to carers of people with mental health problems.
- Provide input to and support the implementation of the NHS Ayrshire and Arran Carer Information Strategy.
- Develop support services that carers can call on an ad-hoc basis to allow them to attend appointments/be involved in social activity.

20.12 Advocacy Strategy

1. Awareness raising, information provision and communication of advocacy services will be promoted.

- Information provision and awareness raising developments will ensure that increased numbers of people across a range of services are aware of the availability of advocacy.
- Advocacy services will ensure that as many people as possible have access to the service.

2. Services will be developed within the Best Value agenda, prioritising sustainability and independence.

- Advocacy development will promote the flexibility, speedy response times and range of service delivery.
- Evidence will be available that indicates that service development is based on assessed local need.
- Inequalities of service provision will be audited and addressed, particularly ensuring that the needs of minority ethnic communities, homeless people, people from disadvantaged communities etc are addressed.
- Formal and informal networking and joint working will be promoted between service providers to enable mutual support and increased effectiveness of service provision.
- Monitoring and evaluation arrangements will be reviewed based on Best Value principles to ensure that they are consistent across agencies, coherent, holistic and meet the needs of all funding organisations without duplication or extensive measurement.

- A range of funding opportunities will be identified that ensure long term continuity, independence and enable service planning over a long period.

3. Advocacy services will be developed to effectively address the expectations of the Mental Health (Care and Treatment) (Scotland) Act.

- Service development in response to the requirements of the Act will be based on an analytical assessment of the level and location of need; the ability of existing services to meet need and a planned and rational response to addressing identified gaps.
- Effective capacity building will be built into service planning in relation to staff development, service user involvement and resource allocation
- The effects on other services of increased provision in relation to the Act will be analysed and where required contingency plans put in place to ensure no reduction in other services.

4. Identified gaps in services will be addressed.

- The need for young person's advocacy will be addressed, including children and young people with disabilities
- The needs for additional advocacy for adults with physical disabilities will be addressed.
- The level of need, available resources and sustainability of advocacy services to carers will be addressed.

5. Service user involvement in advocacy services will be promoted.

- Service users will be involved in the planning, development and evaluation of advocacy services.
- The number of service users and their peers involved in providing advocacy will be increased.

20.13 Each individual strategy is cross referenced to other key strategic plans in East Ayrshire such as the Community Plan, the Supporting People Strategy and the Local Housing Strategy. Therefore key actions identified in these strategies are included in the action objectives outlined above.

21. APPENDICES

21.1 The appendices listed below contain supporting information referred to in the Full Partnership Agreement and as required by the Joint Performance Information Assessment Framework (JPIAF). Where appropriate, appendices have been referred by footnote in the Agreement.

21.2 Appendices, which are located in volume 2, are outlined follows.

Appendix 1 Joint Management Arrangements for the Joint Future agenda in East Ayrshire

Appendix 2 Membership Lists and Remits of:

- (i) East Ayrshire Joint Partnership Group,
- (ii) Joint Future Implementation Group.
- (iii) Staff Forum including constitutional agreement

Appendix 3 Delivery of integrated Care Services in East Ayrshire including:

- (i) Locality management arrangements
- (ii) Joint Manager posts and remits

Appendix 4 Joint Resourcing including:

- (i) Framework and Protocols
- (ii) Joint Resourcing Financial Framework self assessment
- (iii) Strategic and operational baseline – financial envelopes
- (iv) Operational baseline / joint resourcing operational budget 2003-2004
- (v) Financial Plan 2004-2007

Appendix 5 East Ayrshire Joint Future Scheme of Delegation

Appendix 6 Performance Management Framework for Older people (JPIAF11)

Appendix 7 East Ayrshire Joint Future Partners input and comment on Whole System Indicator Relationships – Shifting the Balance of Care (JPIAF10)

Appendix 8 Organisational Development Framework for Joint Future Partnership

Appendix 9	Numbers Of People With Completed Single Shared Assessments (JPIAF6)
Appendix 10	Joint Training strategy update
Appendix 11	Joint Training for Single Shared Assessment (JPIAF7)
Appendix 12	Procedure to facilitate Joint Working Arrangements – secondment and attachment protocol
Appendix 13	Information Sharing Protocol
Appendix 14	Ayrshire and Arran Joint Equipment Service
Appendix 15	Joint Protocol for Accessing Joint Future resources (including JPIAF8)
Appendix 16	Assessment and Care Management policy
Appendix 17	Single Shared Assessment Self assessment Framework (JPIAF5)
Appendix 18	Information related to delayed discharge protocols etc.
Appendix 19	NHS Ayrshire and Arran Patient Focus & Public Involvement Strategy

DRAFT EAST AYRSHIRE LOCAL IMPROVEMENT TARGETS

National Outcome	Core areas for Local Improvement Targets	Examples of Local Improvement Targets outlined in Extended Local Partnership Agreements, 2004.
<p>1. <u>Supporting more people at home, as an alternative to residential and nursing care.</u></p>	<ul style="list-style-type: none"> • Intensive home care – increasing number of people receiving homecare over 10 hours per week. • Increase use of technology to support people at home. • Equipment and adaptation services – reduction of number on waiting lists and/or reductions in waiting times for equipment and adaptation services. 	<ul style="list-style-type: none"> • Increase by 10 % each year the number of intensive care packages of more than 10 hours with community health care involvement. • Increase of 20% by 31 March 2005 number of people receiving support through SMART technology. • To reduce the number of people on the waiting list for assessment by 31 March 2005.
<p>2. <u>Assisting people to lead independent lives through reducing inappropriate admission to hospital, reducing time spent inappropriately in hospital and enabling supported and faster discharge from hospital.</u></p>	<ul style="list-style-type: none"> • Reducing inappropriate emergency admissions of over 65+ to hospital. • Reducing delayed discharges over 6 weeks. <i>Please note that this is a national target agreed with the Scottish Executive.</i> • Rapid Response Service – increasing number of clients, number of admissions prevented and number of discharges speeded up. 	<ul style="list-style-type: none"> • To reduce the number of emergency admissions by 5 % by 31 march 2005. • Targets for April 2005 will be for each Partnership to achieve a 20% reduction in the: <ul style="list-style-type: none"> - overall number of delayed discharges; - number delayed over 6 weeks; and - number delayed in the acute sector. • Increase by 10% each year the number at home supported by the Rapid Response Services including Out of Hours integrated supports.

National Outcome	Core areas for Local Improvement Targets	Examples of Local Improvement Targets outlined in Extended Local Partnership Agreements
<p>3. <u>Ensuring people receive an improved quality of care through faster access to services and better quality services.</u></p>	<ol style="list-style-type: none"> 1. Improvements in waiting time for assessments to be started. 2. Improvements in time taken for assessments to be completed. 3. Improvements in time taken for the first part of a care package to be delivered. 4. Increasing number of carers' assessments. 5. User/carer satisfaction with Single Shared Assessment. 	<ul style="list-style-type: none"> • Increase the number of referrals for assessment started within 3 weeks by 5% by 2005. • Increase the number of assessments completed within 6 weeks of referral by 5% by 2005. • Increase the number of cases where people receive the first part of their care package by 5% by 2005. • Increase by 10 % each year the number of single shared assessments for carers. • To evaluate user and carer satisfaction with the aim of improving satisfaction with service provision by 5 % by 2006.
<p>4. <u>Better involvement and support of carers.</u></p>	<ul style="list-style-type: none"> • Increase in people receiving short breaks. • Increase in total hours of respite. 	<ul style="list-style-type: none"> • Increase by 10% each year the number of short breaks available. • Increase by 10% in total hours or home based respite. • By April 2005 provide all service users and carers with public information material on criteria for services and contact information on local services