

EAST AYRSHIRE COUNCIL

SOCIAL WORK COMMITTEE : 8 SEPTEMBER 2005

BETTER OUTCOMES FOR OLDER PEOPLE

Report by the Executive Director of Educational and Social Services

1. PURPOSE OF REPORT

- 1.1 The purpose of this report is to advise members of the joint publication by CoSLA, NHS Scotland and the Scottish Executive of "Better Outcomes for Older People – Framework for Joint Services."
- 1.2 To advise members of implications for East Ayrshire including key actions and timescales.

2. BACKGROUND

- 2.1 In November 2000 the Scottish Executive published the "Report of the Joint Future Group" which advised on joint measures which agencies required to have in place to plan, assess and provide services for people who required help from both social work and health services.
- 2.2 Through Local Partnership Agreements, initially for Older People in April 2003 and subsequently for all client groups in April 2004 we have required to demonstrate that structures and processes are in place for joint management and resourcing of community care services.
- 2.3 In 2004 the Scottish Executive indicated that the focus should shift from structures and processes to an outcome based approach demonstrating improvements in services to service users and carers.
- 2.4 In relation to services to older people throughout 2004 a National Joint Services Group, worked to:
 - Review existing good practice in joint service delivery.
 - Identify key features including barriers and solutions to implementation of joint services.
 - Formal consultation including stakeholder involvement.

The report is "Better Outcomes for Older People – Framework for Joint Services" emerged from this work and is intended to assist local partnerships to design and evaluate joint services. The full report is available at the Members Information Point.

3. KEY ACTIONS AND MILESTONES

- 3.1 The report details 3 key actions and milestones (and 13 supporting actions) for all Joint Future Partnerships.

Key Action 1 – Local partnerships should carry out an initial review of their existing joint services and the potential for developing more of them.

Milestone – The initial review should be undertaken by 31 December 2005.

Key Action 2 – Local partnerships should continuously consider the benefits of joint services.

Milestone – Progress should be reported via the Joint Performance Information and Assessment Framework (JPIAF) for 2006-07.

Key Action 3 – Local partnerships should have:

- Systematic arrangements for the collection of the views of service users and their satisfaction with joint services, as part of the public accountability agenda, and for continuous improvement.
- Sound performance management and evaluation frameworks for joint services, including appropriate measures of outcomes for service users and carers.

Milestone – All partnership should report on the evaluation of improved outcomes for people and their carers via the Joint Performance Information and Assessment Framework.

- 3.2 A full list of all actions and timescales are included as Appendix 1.

4. IMPLICATIONS FOR EAST AYRSHIRE

- 4.1 East Ayrshire Council through Joint Future arrangements has demonstrated a commitment to partnership working to deliver better outcomes for the most vulnerable in our communities.

- 4.2 The “Actions” of this framework document require that we review existing services and where appropriate develop these as joint services. Examples include care at home, equipment and adaptations or day care services.

- 4.3 The “Actions” of the framework also reflect work already initiated in East Ayrshire through for example, the Best Value Review of Sheltered Housing to ensure the involvement of housing providers in the Joint Future Agenda and work effectively with them in the design and delivery of joint services such as extra care housing.

5. THE NEXT STEPS

- 5.1 Joint Future partners will undertake an initial review of existing joint services, and scope the benefits for service users of development and expansion of joint services.
- 5.2 Following this review a set of proposals will be brought to a future committee.

6. PERSONNEL IMPLICATIONS

- 6.1 Trade Unions are involved in the Joint Future Agenda.

7. FINANCIAL IMPLICATIONS

- 7.1 The current partnership agreement involves the alignment of budgets and include community care services.

8. COMMUNITY PLANNING IMPLICATIONS

- 8.1 Developing effective joint services will contribute to the Improving Health, Improving Opportunities and Eliminating Poverty themes of the Community Plan.

9. LEGAL/POLICY IMPLICATIONS

- 9.1 East Ayrshire Joint Future Partnership are required to report to the Scottish Executive on progress against the actions detailed in Better Outcomes for Older People within an annual Joint Performance Information and Assessment Framework.

10. RECOMMENDATIONS

- 10.1 It is recommended that Committee:
 - (i) agree to the actions detailed in Section 5; and
 - (ii) otherwise note the contents of the report

John Mulgrew
Executive Director of Educational and Social Services
22 August 2005
Enc (1)

LIST OF BACKGROUND PAPERS

- 1. Report of the Joint Future Group - 2004
- 2. Joint Future Partnership Agreement – April 2004

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IMPLEMENTATION OFFICER: JACKIE DONNELLY

Part I: Implementing and evaluating joint services	
Principles underpinning joint service design	
Action 1: Local partnerships should carry out an initial review of their existing joint services and the potential for developing more of them.	The initial review should be undertaken by 31 December 2005.
Action 2: Local partnerships should continuously consider the benefits of joint services.	Progress should be reported via the Joint Performance Information and Assessment Framework (JPIAF) for 2006-07.
Action 3 – Local partnerships should have: <ul style="list-style-type: none"> • Systematic arrangements for the collection of the views of people who use services, and their satisfaction with joint services, as part of the public accountability agenda, and for continuous improvement. • Sound performance management and evaluation frameworks for joint services including appropriate measures of outcomes for individuals and carers. 	All partnership should report on the evaluation of improved outcomes for people and their carers via the Joint Performance Information and Assessment Framework.
Action 4: Local partnerships should provide public information about their joint services, including the nature and availability of the joint services, and how they can be accessed, since the public may not be fully aware of them.	Ongoing
Action 5: Local partnerships should develop joint services that: <ul style="list-style-type: none"> • support the person-centred approach; • focus on improving outcomes for older people; and • are based on the whole system approach. 	Ongoing
Commissioning joint services	
Action 6: Local partnerships should, when commissioning joint services: <ul style="list-style-type: none"> • pro-actively develop and improve their processes to bring about a step change in joint commissioning; • seek to integrate pilot or joint service projects into mainstream services to ensure that benefits for people who use services and their carers are equitably accessible; • involve voluntary and private providers more effectively when commissioning joint services, especially at the start, so that service aims, objectives and design are right from the outset; 	Action 6 should be continuously undertaken as joint services are commissioned.

<ul style="list-style-type: none"> • improve information about stakeholders and existing services, and its use when commissioning and delivering joint services; • consider infrastructure development both at the outset of planning activities for joint services and throughout the commissioning process and ensure that appropriate infrastructure is put in place; • when considering their infrastructure needs, agree which aspects provide best value through local developments and those which are better served by national solutions; and • should jointly and actively manage the changes, for example by using effective communication strategies, and by implementing human resource strategies and the joint services governance frameworks that are required in developing and delivering joint services. 	
Part 2: Joint services and the journey of care	
An active and healthy life in old age	
Action 7: Local partnerships should review and develop joint services for health promotion, preventative and early intervention services for older people, for both physical and mental health needs.	As for Key Actions 1-3
Promoting independence at home for older people	
Action 8: Local partnerships should: <ul style="list-style-type: none"> • Develop more joint services such as care at home, equipment and adaptations, and day care services, in order to assist older people to live at home as independently as possible. • Review the current involvement of housing providers and, where appropriate, work more consistently and effectively with them in the design and delivery of joint services such as extra care housing. • Ensure that when developing Supporting People services, this is done in a way which promotes joint services as a more integrated option. Local partnerships should undertake this as part of their reviews of Supporting People strategies. 	As for Key Actions 1-3
Action 9: The Scottish Executive should take a lead in promoting a more integrated approach to housing services for older people, involving Communities Scotland, housing providers and local partnerships, by developing an outline national strategy.	Milestone This should be achieved by 31 December 2005.
Joint services for enhanced care	
Action 10: Local partnerships should develop joint enhanced (higher level) care services that are integrated and effectively meet older people’s spectrum of needs, as their needs increase. These services should assist in preventing inappropriate admission to hospital and long term settings, and in ensuring their speedy return to their own homes wherever possible. They should also assist older people to remain in their own homes for as long as possible.	As for Key Actions 1-3

Joint services for carers and older people	
Action 11: Local partnerships, when developing or reviewing their carers strategies or carers action plans, should involve carers effectively, and should develop more joint services for carers, where appropriate.	As for Key Actions 1-3
Action 12: Local partnerships should make more joint use of the funding received for carers services from the Strategy for Carers in Scotland, the “Same as You” and Local Outcome Agreements; and should consider funding services, including joint services, for carers on a longer term basis.	As for Key Actions 1-3
Joint services for older people with additional needs	
Action 13: Local partnerships should review the potential for joint services for older people with additional needs, such as learning disabilities, sensory impairment and physical disabilities and develop joint services in order to ensure that they can live as independently as possible.	As for Key Actions 1-3
Action 14: As part of the current developments in mental health services, local partnerships should incorporate joint arrangements and joint services for mental health promotion, early diagnosis and detection, assessment, care and treatment planning, and access to specialist services. This should be undertaken whether as part of the local older people’s plan, the mental health plan, the older people with mental health needs plan or a specific dementia services plan.	As for Key Actions 1-3
Action 15: In their next round of strategic and service plans for integrated care, DATS, AATS or DAATS should refer explicitly to the needs of older people with drug and alcohol problems and where appropriate develop joint services.	As for Key Actions 1-3
Joint services for older people with dementia and their carers	
Action 16: Local partnerships should incorporate joint services as part of the development or review of their joint strategic framework for dementia services. This should be undertaken whether as part of the local older people’s plan, the mental health plan, the older people with mental health plan or a specific dementia services plan.	As for Key Actions 1-3