

EAST AYRSHIRE COUNCIL

SOCIAL WORK COMMITTEE : 2 MAY 2000

COLLABORATIVE LINKS WITH AYRSHIRE AND ARRAN PRIMARY HEALTH CARE TRUST

Report by Director of Social Work

1. PURPOSE OF REPORT

- 1.1 To seek Committee approval to a Joint Strategy involving the Council and the Primary Care Trust to provide services to support those for whom these agencies have a joint responsibility; and to seek approval to refer to Policy and Resources Committee a joint commitment by both agencies to a collaborative effort across the wider range of responsibilities.

2. BACKGROUND - POLICY

- 2.1 A number of elements of national policy require “joined-up working” between agencies. The considerable overlap between the Government’s Social Inclusion Strategy and the Health White Paper “Towards a Healthier Scotland” has already been identified. Similarly, the requirements of the Government paper “Modernising Community Care” requires effective joint work between the Council’s Community Care services and Health services. East Ayrshire Council’s Children’s Service Plan, as required by the Children (Scotland) Act 1995, was developed in partnership with other Departments and services including health, with joint strategic aims being given specific attention in the planning of services for children and young people.
- 2.2 The Council has sought to provide access to services within local communities. This has led to the development of local offices providing an initial point of access to the range of Council services. These developments have been set within the context of a decentralisation strategy which has also included a commitment to engagement / consultation with local communities and for an organisational structure [local committees] which reflects the range of communities served by the Council.

3. BACKGROUND – DEVELOPMENTS

- 3.1 The Council has progressed a number of developments with the Primary Care Trust which can now be considered together within the context of the national and local strategic directions set out above.

(i) Joint Services

The Council operates an extensive range (see Appendix 1) of services on a joint basis with the Primary Care Trust.

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(ii) **Newmilns / Darvel Initiative – Evaluation**

The Social Work Department has for some time operated a pilot project within the Newmilns / Darvel area in conjunction with the Primary Care Trust and local Primary Care services. The project was visited by the Minister for Health in 1999 as it had already been identified as a leading edge project in the developing joint agenda between health and social care.

The project has now been formally evaluated and has the potential to serve as a “model” project for implementation throughout the Council area (subject to variation in respect of the service networks and service requirements of local areas). A summary of the Evaluation is attached to this report as Appendix 2.

(iii) **Joint Health and Social Care for People Requiring community Based Services in East Ayrshire : A Strategy for the Future**

It is considered appropriate that further developments involving Social Work and the Primary Care Trust should be set within a proper strategic context and relate to the new organisational arrangements within the NHS, particularly the introduction of Local Health Care Co-operatives [LHCC's]. This joint strategy [Appendix 3] has been developed to establish that strategic context and to provide a framework for further development (including the further implementation of local joint services as piloted in Newmilns / Darvel).

(iv) **Co-location**

On 28 March 2000 Policy and Resources Committee agreed to the development of premises shared by the Council and Primary Care Trust (and others) in Dalmellington [Item 18, Page 829] and Drongan [Item 19, Page 830]. It is anticipated that the Dalmellington development will provide one of the most comprehensive access points to public services in Scotland.

There is scope for further consideration of co-location of Council / Primary Care services in other parts of East Ayrshire.

(v) **Community Planning**

The Primary Care Trust has agreed to be a core partner for community planning with the Council.

4. FINANCIAL / PERSONNEL/LEGAL IMPLICATIONS

4.1 No new issues require to be identified as a consequence of this report.



5. POLICY IMPLICATIONS

- 5.1 This report builds on the existing policies of the Council across a range of areas and consolidates a partnership with a key agency.

6. CONCLUSIONS

- 6.1 The range of initiatives set out in Section 3 establishes the depth of engagement between the Council and the Primary Care Trust. This creates a fertile context for the establishment of a more explicit joint approach between the two agencies.

7. RECOMMENDATIONS

- 7.1 It is recommended that Committee:
- (i) notes the evaluation of the Newmilns / Darvel Initiative;
 - (ii) approves “Joint Health and Social Care for People Requiring Community Based Services in East Ayrshire : A Strategy for the Future” [attached as Appendix 3 to this report];
 - (iii) recommends to Policy and Resources Committee the development of a statement of joint approach between the Council and the Primary Care Trust; and
 - (iv) optherwise notes the content of the report.

Douglas Bulloch
Director of Social Work
ENC (3)
12 April 2000
DB/AGW

LIST OF BACKGROUND PAPERS

1. Integrated Care Project Newmilns and Darvel Evaluation

A copy of which is available by contacting Douglas Bulloch, Director of Social Work. The Summary version is available in the Members Library.

Any person wishing to inspect the background papers listed above should contact Douglas Bulloch, Director of Social Work, Council Offices, John Dickie street, Kilmarnock. Tel: 01563 576725.

COLLABORATIVE LINKS WITH AYRSHIRE AND ARRAN

PRIMARY HEALTH CARE TRUST

Social Work Services and Health

Integrated Care Pilot
Joint Personal Record of Care
Co-location
Joint Training Initiatives
Joint Strategy for the Future
Community Mental Health Teams

Education Services and Health

Co-operation on the MENC vaccination programme for all children
Involvement of Primary Care staff in the Records of Needs processes
Speech and Language Therapy for services to children
Involvement in New community School projects
Partnership on anti-drugs initiatives
Involvement of a wide variety of staff in schools – school nurse, doctors, dentists, etc
Joint Strategy on head lice

Community Services and Health

Development of Health Living Centres
Exercise on Referral Scheme
Active Living Projects
Community Food Initiative
Book Start Programme

Corporate Services and Health

Ayrshire Electronic Community

Integrated Care Project Newmilns and Darvel

Evaluation Summary





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EXECUTIVE SUMMARY

In 1997 Ayrshire and Arran Community Health Care NHS Trust (and from 1st April 1999 Ayrshire and Arran Primary Care NHS Trust), in partnership with Dr Green and Partners (now Dr Kondol and Partners) of Newmilns and Darvel Surgeries, and East Ayrshire Council, were successful in their submission for Primary Care Development funds to pilot an innovative, inter-agency initiative across health and social work.

The initiative was to develop an integrated health and social work team, based in one site, which would be empowered to make and implement local decisions, on financial, clinical and social care support perspectives, for individuals with complex needs.

The results indicate that the integrated team has developed into a cohesive unit, which is able to question and challenge its own decisions. Similarly, increases in the teams' pooled collective knowledge, and their development of more effective formal and informal processes, have led to quicker, more effective interventions with the associated benefits for individuals receiving care. The team now has a greater understanding of respective roles, responsibilities and cultures across agencies.

Section one outlines the and the overall aims, objectives and anticipated outcomes from this integrated approach to delivering health and social care services for people with complex needs.

Section two details the costs and analysis of expenditure of the project and highlights the cost effective use of home care and occupational therapy budgets.

Section three discusses the conclusions arising from the evaluation setting out both the positive outcomes and the areas which were under developed.

Section four details the recommendations both in relation to the future delivery of services for people requiring health and social care services and lessons in relation to future joint agency evaluations, for action.

Overall this project has clearly demonstrated that there are many benefits to be gained for patients/service users through an integrated health/social care approach to the delivery of care; evidenced through the evaluation results. Perhaps most importantly, in speed of response to individuals who require care through re-designed referral, assessment, management and care delivery processes.

This project has also identified that high levels of funding are not required to provide integrated care for patients and service users and that many benefits can be achieved through integrated re-design of key processes at resource neutral cost.

Section five proposes the way ahead for East Ayrshire Council and the Primary Care Trust who are committed to rolling out integrated working.

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SECTION ONE - AIMS, OBJECTIVES AND ANTICIPATED BENEFITS

Aims and Objectives Of The Project

Aim

To provide co-ordinated seamless care across the boundaries of social and health services.

Objectives

- To maintain individuals within the community, who might otherwise be admitted to residential nursing homes or hospitals, through a more co-ordinated approach to service delivery between primary health care and social work staff.
- To reduce the response time for an individual, who requires health, social care assessment, and/or treatment.
- To provide an increased support for carers through a seamless approach to service provision.
- To provide comprehensive pre admission planning
- To deliver high quality cost effective services by reducing duplication across services.
- To further develop a more co-ordinated approach to supporting individuals being discharged from hospital.

Anticipated Benefits of the Project

The anticipated benefits are directly linked to the objectives of the project and were detailed in the submission as follows.:

- Continuity of care across health and social work services
- A reduction in the number of professionals an individual requires to be in contact with during a period of ill health/increased frailty.
- A decrease in duplication of service delivery across health and social work and streamlining of documentation through the utilisation of a single multidisciplinary record within the individual's home.

Resources

The submission to the Health Board included a request for funding of £220,000 for:-

.5 wte Occupational Therapist and .5wte Occupational Therapy Assistant
1wte Social Worker,

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.5wte Counsellor

.3wte Podiatrist

Part time Co-ordinator

Dedicated budget for additional home support hours

Dedicated budget for Occupational Therapy equipment

Funding for associated supplies, travel etc.

The then Community Trust contributed in kind through the dedicated attachment of Community Nursing and Podiatry staff to the Practice. The Social Work department contributed in kind the services of the Home Help Organiser and Home Help staff.

SECTION TWO - FINANCIAL REPORT

Detailed below is the expenditure against budget from December 1997 to December 1999, expenditure against budget will continue until March 2000.

Dec'97 to Mar'98

Apr'98 to Mar'99

Apr'99 to Forecast

Outturn at Dec 99

Annual Budget	Annual Expenditure	YTD YTD Expenditure	Annual Budget	YTD YTD Expenditure	Budget
£	£	£	£	£	£
55,000*	43,529	105,235	220,000	103,885	
	177,000				

*Part year / start up costs

The projected full year costs of the initiative were £220,000.

Variances

There are three main areas which account for the substantial underspend year on year with this initiative, these are:-

1. Home Care Budget
2. Occupational Therapy Aids Budget
3. Co-ordinator Budget

The proposals in the original submission were based on the following assumptions :-

- High demand on home care services
- High demand on Occupational Therapy aids and adaptations
- Co-ordinator time
- Administration would be from within existing resources

Budget variances have subsequently arisen, in the main due to these assumptions not being realised, for example:-

- Home Care Budget
The Social Work Department provided a Home Help Organiser and Home Help staff in kind to the project. An additional allocation of £50,000 per annum was dedicated to the project.

In the final year of the project the anticipated outturn to December 1999 for the purchase of additional home care hours was £12,000.

The case studies presented as part of the evaluation would suggest that the additional monies have been effectively used for short-term periods of care, but have not necessarily been used over prolonged periods of time.

The project teams view is that this has been a cost-effective way of maintaining people at home and when used in conjunction with the increased co-ordination of services, this has resulted in less of the budget being used than originally anticipated.

- **Occupational therapy budget**
An additional allocation of £50,000 was made, for the purchase of additional occupational therapy equipment and adaptations. In the final year the expected outturn to December 1999 is £15,100. It would appear that the projected need for occupational therapy aids and adaptations has been fully met within this level of expenditure.
- **Co-ordinator time / administration**
Previous experience of self-directed teams would suggest that a co-ordinator would emerge naturally from within the group to take on a leadership role. This did not happen, therefore the funding allocated was not utilised. A need for a limited number of administration hours was identified and due to the underspend in the budget allocated for a co-ordinator the steering group agreed to support the creation of a 20 hour administration post.

SECTION THREE - CONCLUSIONS

The outcomes of the Integrated Care Team initiative have been influenced in three ways:

- planned benefits and outcomes arising from the initial submission
- developments taking place within a wider organisational context and piloted within the Integrated Care Team
- opportunistic developments, which had a strategic fit for all agencies

This has made the evaluation process complex and has influenced the final approach to the evaluation and in particular the conclusions which can be drawn from the initiative.

Conclusions

1. The evaluation supports the assumption that ***'seamless health and social care can be more responsible and tailored to individuals' needs if health and social work personnel work together as an integrated team with the autonomy and budget to make and implement decisions locally***.
2. This project has demonstrated that integrated working, with devolved decision making and re-designed processes has **resulted in quicker more effective care for patients/service users**. Many of these refinements are cost neutral, others require a small devolved budget.
3. People with complex needs were supported within the community for longer periods of time than might otherwise have been the case and **acute admissions were prevented**.
4. The home care budget and occupational therapy aids budget have been cost effectively targeted to maintain people in their own home, **to prevent unplanned hospital or residential/nursing home admission** resulting in a lower cost against budget allocation.
5. The admission rate to residential or nursing home placement was not found to be different between the Integrated Care Team and neighbouring social work team.
6. **Home help personnel were critical in identifying key factors in a patient / service users situation** and communicating these to a team member, which if gone unchecked or unnoticed may have resulted in admission to care or hospital.
7. The length of time from referral to multi-disciplinary team meeting for urgent **complex cases was 1 working day** and within **7 working days for others**. Initial referrals were actioned by the appropriate staff within existing service standards.

8. The response times between referrals and start of community care assessment reduced considerably during the project. **The average waiting time for occupational therapy assessments reduced from 13 to 3 days.**
9. The reduction in the number of professionals requesting the same information from individual service users and the number of community care assessments carried out by other professionals should have influenced a reduction in response times for both assessment and support.
10. The understanding of team members roles and responsibilities has allowed team members to **access resources more quickly.**
11. Social Work staff have operated with a **greater degree of devolved financial and care management decision making.** This freedom has allowed the team to **operate effectively and speedily in providing flexible sensitive solutions tailored to individuals needs.**
12. **Carers have received increased support** from the counselling service and have been supported where services have been put in place to meet individual/service users needs.
13. There is no evidence to suggest that a greater number of carers received a separate community care assessment, **however over 85% of patients/service users felt that their carer was supported,** by the end of the project, compared with 75% at the start.
14. Service users and carers reported that by and large there was a reduction in the amount of times they were asked to provide the same information and that by the end of the project there was no overlap in visits by staff.
15. Over two thirds of patients/service users indicated that they had been involved in their own care planning. This is lower than expected.
16. The case study information identifies that **acute admissions to hospital were prevented,** they also highlight that, when required, **individuals were supported at home until appropriate admission could be planned.**
17. **Duplication** across services has been **effectively reduced.**
18. The **Integrated Care Team has developed to become a cohesive team** which has improved understanding of roles and responsibilities and effectively used this understanding to reduce response times for patient / service users, and duplication across services.
19. Accessibility, i.e. being based in the **same premises** has **positively influenced the development of the team.** However, equally important has been the team building and weekly meetings which have enabled critical and speedy decisions to be made about individual service users support.

20. A **number of key processes have been improved**, as a result of planned developments within the team including podiatry, occupational therapy, counselling, multi-disciplinary referral and assessment processes. Also planned agency developments such as the pilot revised assessment and care management procedures which enable occupational therapists and district nurses to carry out community care assessments (where appropriate) have been critical.

21. The role of home helps in maintaining people within the community should not be understated.

22. **The Personal Record of Care** has been used as an essential **means of communicating between disciplines**, but has not been used to the extent envisaged partially due to the perceived problems, as already discussed in cross boundary admission / discharge procedures. The use of the Personal Record of Care has however been used more routinely with home care staff than previously.

Cultural Aspects

It is important to highlight that health and social work operate in very different cultures and organisational structures. Though they both operated within a traditional 'top-down' hierarchical management structure, the decision making process within health care (i.e. general practice and the then Community Trust) appeared more devolved leading to speedier decision making. There were a number of occasions when differences proved challenging, however the commitment, trust and respect that each organisation has for one another meant that any differences were resolved through discussion and reason. Each agency has had to be flexible. Even closer working practices have had to be developed between health and Social Work Staff, the General Practitioners have required to renew their previously held assumptions in relation to ongoing care, and lastly, social work staff have had to operate within a greater degree of devolved decision making. This freedom has allowed the team to operate effectively and speedily in providing flexible sensitive solutions tailored to individuals needs.

Lessons Learned

1. Multi-agency staff developing this approach should ensure that a comprehensive training needs assessment and training programme is developed and delivered to all staff. Part of this programme should include management of change
2. It is essential that roles and responsibilities are clarified and defined at the outset of new developments.
3. IT training should be structured and tailored to develop in tandem with both individual learning and the implementation of IT within the project. Cognisance should be taken of the differing workloads and pressures on different members of the team e.g. General Practitioners required on-site training whereas other members of the team could travel to specialist training facilities.

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4. The evaluation of the project was unable to fully determine the impact of Value for Money – future evaluations comprising Value for Money elements must have specific modelling tools identified at the outset.
 5. For a project of this size a dedicated resource is required for evaluation purposes.

SECTION FOUR - RECOMMENDATIONS

Detailed below are the key recommendations resulting from the evaluation of this project.

1. East Ayrshire Council together with the Primary Care Trust should seriously consider rolling out the many cost neutral elements of the project, that has ensured integrated working, better co-ordinated, planned and speedier access to services for patients/service users, through re-design of key processes.
2. A detailed cost analysis should be carried out to identify the financial resources that would be required to provide teams with devolved home care and occupational aids/adaptations budgets. The outcome of the East Ayrshire Council Home Care Review may mean that the benefits from the devolved budget in the project can be effected in an organisational context without the use of a number of separate devolved budgets.
3. It is recommended that further discussions require to take place on more complex structural issues to allow this approach to be translated into an urban area.
4. The lessons learned from this joint approach of working across agencies should be considered by disciplines involved in providing services to children, young people and families.
5. The principles of devolving financial, human and care management decision making to integrated health and social work teams should be endorsed, for systematic application, area wide.
6. The electronic referral system (IPCIS), the use of GPASS by all team members and the sharing of information electronically between agencies should be further explored extended and developed.
7. The key processes, such as, electronic referrals should be assessed for replicability across the podiatry service.
8. The counselling input to the practice should be maintained at the current level.
9. It is recommended that appropriate health staff are trained to carry out community care assessments and assessments for care alarms.
10. Both agencies should review their arrangements for involving patients/service users in care planning to determine if patients/service users understand their involvement.
11. The critical role played by home care staff should be recognised in the current East Ayrshire Council Best Value Service Review of Home Care-Services.

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12. Lessons learned about the increased understanding of general practitioners in relation to the key role of Social Work staff should be part of a developmental programme for general practitioners.
 13. Discussion should take place between the Primary Care Trust, East Ayrshire Council, LHCCs and the Acute Trust to improve pre-admission and discharge planning.
 14. Lessons learned in relation to the sharing of information should be used to inform and re affirm the debate about information sharing across agencies.
 15. The wider role of the Community Occupational Therapist should be used to inform ongoing development of policy within the Council.
 16. The use of SCRUGS as a tool for describing peoples needs who live in the community would require further refinement if it was to be adopted by both agencies.

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SECTION FIVE - THE WAY AHEAD

At the start of the project all agencies recognised that resources were unlikely to be available to replicate the project in East Ayrshire. It was further recognised however, that an approach to working together which ensured better co-ordinated, planned and speedier access to services could be rolled out across the area, using the operational experience from the Integrated Care Project. To this end a Primary Care Strategy is currently being developed between East Ayrshire Council and the Primary Care Trust including Local Health Care Co-operatives, to set the strategic direction for the delivery of services where Health and Social Care Services input is required.

It is therefore recommended that the joint approach to delivering services for people with complex needs is implemented across East Ayrshire based on: -

- breaking down barriers through multi-agency team building, education and training.
- jointly agreeing some key processes which can be re-designed to make referral routes and decision making processes quicker and more effective.
- extending the use of personal Record of Care to be used routinely in complex cases by staff including general practitioners.
- establish Social Work presence routinely at regular Primary Care Team/GP Practice meetings.
- the Council and Primary Care Trust should consider sharing premises where this is maximising resources.

JOINT HEALTH AND SOCIAL CARE FOR
PEOPLE REQUIRING COMMUNITY BASED
SERVICES IN EAST AYRSHIRE

A STRATEGY FOR THE FUTURE

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INTRODUCTION

This strategy has been jointly prepared by East Ayrshire Council, Ayrshire and Arran Primary Care Trust, East Ayrshire Local Health Care Co-operative and Carrick and Doon Local Health Care Co-operative.

It sets out the strategic direction over the next three years for the delivery of services for people in East Ayrshire who require both health and social care, within available resources.

AIMS

The overall aims of the strategy are to:

- Improve the delivery of cost effective services to children, young people, adults and older people who require social and health care services based on the assessed needs of individuals living in East Ayrshire within the framework of Best Value and Clinical Governance
- Work in partnership to promote a socially inclusive society
- Jointly plan for services at both a strategic and operational level with the routine involvement of representatives of service users, carers and the community
- Maximise and facilitate closer working across health and social care

SPECIFIC OBJECTIVES

The specific objectives are to:

- i) Provide and deliver joint health and social care services within agreed service standards;
- ii) Support adults or older people assessed as having social care and health care needs to live in their own home, residential, nursing home or hospital through co-ordinated, seamless delivery of services;
- iii) Prevent admission to hospital or other setting where it is inappropriate;
- iv) Support children, young people and their families who have social and health care needs at home or accommodated elsewhere;
- v) Provide co-ordinated planning prior to planned admissions to hospital for individuals who are likely to require joint health and social care when they are discharged;
- vi) Provide co-ordinated services to mentally disordered offenders;

- vii) Provide co-ordinated services for people who have alcohol or drug related problems;
- viii) Develop protocols for sharing information to enable effective assessment, care planning and communication;
- ix) Develop a locality planning process informed by the needs of users and /or carers and local people which maximises the effective use of resources and avoids duplication;
- x) Provide co-ordinated social and health care services within the criminal justice system, where appropriate;
- xi) Promote public awareness of services available for people who have both social and health care needs; and
- xii) Support staff through joint education, learning and development

STRATEGIC FRAMEWORK

The Strategy is developed within the context of the undernoted legislation and guidance.

The NHS and Community Care Act (1990) sets out a range of national objectives in relation to community care. Included in these are:

- Support to enable people to live at home
- Clarify the roles and responsibilities of agencies
- Prevention of admission
- Support to carers
- Assessment and care management as the cornerstone of good community care
- Quality and value for money
- Providing choice

The Act places responsibility on local authorities to take the lead in preparing joint Community Care Plans in partnership with Health Boards and other partners.

More recently, guidance was issued from the Scottish Executive setting out the requirement for local authorities to develop Modernising Community Care Action Plans. These require to address how local authorities, in partnership with health and housing (amongst others) will achieve:

- Better and quicker decision making
- Caring for people at home
- Working together locally

The overall aim of Action Plans is to evidence how community care services can be based on integrated working between agencies.

The Children (Scotland) Act 1995 places a duty on local authorities to prepare Children's Service Plans in partnership with other departments and services

including health. East Ayrshire Councils Children's Service Plan is based on the principles that

- The child's welfare is the paramount consideration
- The child's views should be listened to and taken into account
- Services should be provided timeously
- Planning and service provision should be undertaken in partnership with children, young people, parents and carers

Section 21 of the Act also requires Health Boards and NHS Trusts to comply with requests from local authorities to assist them by providing services to help local authorities carry out their statutory duties in relation to children.

The National Health Service White paper "Designed To Care" has as one of its key strategic aims a patient centred focus within primary care teams developed within the framework of a partnership approach between patients and the health service and the health service and its partners. In addition the other aims are:

- Improving health
- Developing primary care
- Developing care in the community
- Reshaping hospital services
- Tackling health inequalities

Specific attention is placed on developing services for children and young people across the range of strategic aims.

The reconfiguration of Trusts in Ayrshire has seen the establishment of a Primary Care Trust and within East Ayrshire two Local Health Care Co-operatives which are the locus within a primary care setting for planning and delivering local, patient centered health services. East Ayrshire LHCC covers the areas of Kilmarnock and surrounding areas and Cumnock area. The Carrick and Doon LHCC covers the Doon Valley area of East Ayrshire and part of South Ayrshire Council.

Local Authorities have been given the lead agency role in relation to community planning. This requires to be the foundation for planning and delivering services, which are sensitive to local needs. The most recent Priorities and Planning Guidance For The NHS in Scotland sets out the need for Health Improvement Programmes to "contribute to the development of community planning in association with local authorities"

HOW WILL WE GET THERE?

The undernoted sets out in broad terms how the relevant agencies will progress joint working to achieve the overall aims and specific objectives of the strategy.

Human Resources

The implementation of the Strategy will be dependent on the commitment and understanding by staff of the overall aims and objectives of the strategy.

The draft Community Care Joint Training Strategy should be developed into a Joint Training and Development Strategy between Social Work, the Primary Care Trust and the LHCC,s. It should encompass all the areas of joint interest and prioritised within an agreed set of criteria.

The Training and Development Strategy should include an agreed approach to:

- Prioritising training (including awareness raising; team building etc)
- Transferable qualifications / development of new qualifications
- secondments; mentoring; shadowing etc.
- evaluation of the effectiveness of joint training

Estates

A jointly agreed approach will be taken to maximising the use of premises where it is beneficial to individual service users and / or where it enhances understanding and co-ordination of seamless services.

Information Management And Technology

Organisations share the same objectives of improving services to individuals through sharing information, which is either individual service user/patient centred or aggregated for planning.

Within the overall umbrella of shared objectives an Action Plan should be developed aimed at implementing a number of practical steps:

- selected set of shared data which is retrievable through current systems
- phased implementation of electronic referral pathways
- maximise the potential of the Ayrshire Information Society and the Ayrshire Electronic Community

Needs Assessment

Organisations have a shared interest in jointly agreeing an approach to shared needs assessment. An approach to needs assessment should be developed based on:

- agreed planning process which has as its basis community planning led by the Council
- data collected on clinical and social care needs built around GP practices, recognising that these will not always be co-terminus with communities.

Accurate needs assessment should enable all agencies to plan for and submit funding bids on a more co-ordinated and planned basis.

Service Delivery

The successful implementation of the objectives of the Strategy are dependent on the operational interface between social work staff and General Medical Practitioners and other primary care staff.

Social work teams are not coterminous with general practices and the understanding of professional decision making processes and roles and responsibilities are variable.

In the past this has hindered integrated working. The undernoted sets out the main areas to be addressed over a period of time:

- The need to identify change agents to influence the understanding of roles and responsibilities, structures etc. along side a programme of seminars.
- The need to share information between staff about local issues; changes of staff; sharing of best practice. A different approach will be required in rural and urban areas
- In terms of best practice staff should routinely check for another agency or disciplines involvement at the point of referral.
- Case discussions should routinely take place based on a multi - disciplinary approach for service users requiring a care managed approach.
- Community care assessments should be carried out by the most appropriate member of staff
- Processes should be re-designed to further improve effectiveness.
- Decisions about who should undertake specific pieces of work should be based on the principle of “best fit” e.g. simple aids; delivery of incontinence pads
- Protocols should be introduced between criminal justice social work services and forensic services

Use Of Joint Investment Fund(Jif)

To date, opportunities arising from the JIF has been limited to the health service. Social work, the Trust and LHCCs need to jointly explore the wider use of JIF which incorporates service improvements across all sectors.

RESOURCE IMPLICATIONS

This strategy is set within the context of national and local policy which aims to:

- shift the balance from a hospital setting to care in the community for people requiring health and social care services
- within the community, shift the balance from residential or other care setting to care at home, and
- reduce the length of stay in acute hospital beds

Although a number of aspects of this strategy can be implemented on a cost neutral basis, some will be dependent on the shift in resources to meet the changing balance of care within the community. Following a future needs analysis a case may have to be made for new monies.



IMPLEMENTATION

This joint strategy will be subject to a detailed, costed implementation plan and will be reflected in respective agencies strategic planning documents and business plans.

AGENDA