Appendix 1

Better Outcome Actions

Key Action 1	Timescales / Milestone	West Dunbartonshire Position
Local partnerships should carry out an initial review of their existing joint services and the potential for developing more of them. This can be done as a one-off exercise or as part of existing service reviews and plans. It should cover all the services as set out in Part 2, Joint Services and the Journey of Care. Part 2 of the Framework promotes the inclusion within the review of: • Joint services for health promotion, prevention and early intervention • A range of joint services, such as augmented care at home, extra care housing, equipment and adaptations, to support older people better in their own homes. • Joint services for older people with complex or more intensive needs.	The initial review should be undertaken by 31 December 2005 and reported via the Joint Performance Information and Assessment Framework (JPIAF)	We have undertaken our initial review as part of our capacity planning work. A paper was presented to the Health Improvement & Social Justice Partnership in May 2005, with a follow-up paper submitted in February 2006. Key recommendations are covered the areas specified in Part 2 of the Framework, and were used to inform the development of Local Improvement Targets, which were reported via the JPIAF (2005/06). Our draft capacity planning framework is currently subject to an extensive consultation, and initial responses indicate strong support for health promotion, including prevention and early intervention. We propose to increase our provision of the range of joint services, as detailed, in our Local Improvement Targets, with a renewed effort to ensure that older people with complex or more intensive care needs are maintained in their own homes if at all possible.
Key Action 2	**Timescales / Milestone**	**West Dunbartonshire Position**
Local partnerships should continuously consider the benefits of joint services and ensure the development and expansion of joint services as set out in Part 2, Joint Services and the Journey of Care, whenever it is appropriate.	Progress should be reported via the JPIAF.	With the development of the West Dunbartonshire Community Health Partnership, we are now moving to a single NHS interface. This will mean that the process of redesign will be streamlined, as detailed in our capacity planning review. As the financial framework is developed, we anticipate identifying further opportunities to integrate services where appropriate. However, the continuing risk of the Clyde deficit remains a barrier to further development, as the single NHS interface cannot be fully realised until the issues around the Clyde deficit are resolved.

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Key Action 3	Timescales / Milestone	West Dunbartonshire Position
Local partnerships should have: • 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 partnerships should report on the evaluation of improved outcomes for people and their carers via the JPIAF Indicator 11 on Local Improvement Targets.	We have undertaken user surveys in respect of homecare provision and equipment and adaptations services. More recently, we hosted two major seminars to elicit the views of local older people within the context of the Scottish Executive Age and Experience consultation. Our Planning Structure has been redesigned to ensure that service users and carers are able to actively contribute to planning processes. For the past two years we have reported the main achievements and development priorities for all of our care sector planning groups through the Community Care Planning and Implementation Partnership, which is our key planning interface with service users and carers. Our performance management framework includes a number of streams of joint activity, including our Joint Delayed Discharge Action Plan (2006 – 08), and a range of Local Improvement Targets which have been developed collaboratively to capture the needs and wishes of service users and their carers, and also to respond to service pressure areas such as unplanned hospital discharges and a need to move from inpatient to daycase procedures wherever possible.

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Action 4	Timescales / Milestone	West Dunbartonshire Position
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	Our Guide to Accessing Services is available on the West Dunbartonshire Council website, which also has a direct link to the West Dunbartonshire Community Health Partnership (CHP) website. We plan to update the guide to reflect improvements made to streamline access. This work is scheduled to take place during 2006/07, and will be done in collaboration between the Council, NHS, Communities Scotland and the Community Care Planning and Implementation Partnership. We have also undertaken a number of customer surveys in areas such as homecare, welfare rights and user involvement, and the results of these have been or will be used to inform the Social Work Service Plan. Our partnership has also developed CHP and Social Work newsletters, both of which are widely available at public access points (such as libraries and health centres)

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Action 5	Timescales / Milestone	West Dunbartonshire Position
Local partnerships should develop joint services that: • support the person-centred approach; • focus on improving outcomes for older people; and • are based on the whole system approach.	Ongoing	We believe that the three key points of this action plan are very closely inter-connected. In response, our capacity planning and Local Improvement Targets development work has been undertaken in an inclusive way, to build in a person-centred approach. Given that our key underpinning principle of maintaining people in their own homes whenever possible is closely aligned to the stated wishes of our older population, we are committed to an approach that makes real differences to outcomes. The Joint Improvement Team will support us by running local workshops in September 2006 to look at how we develop our operational, communications and information systems to reduce unplanned or multiple unplanned hospital admissions, as these patients are the most vulnerable to ending up in care homes. Our work with the Joint Future Unit on helping to develop the care management training materials will be implemented across our partnership, and our E-Care Partnership Board continues to work to develop electronic solutions to information sharing.

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Action 6	Timescales / Milestone	West Dunbartonshire Position
Local partnerships should, when commissioning joint services: • 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; • improve information about stakeholders and existing services, and its use when commissioning and delivering joint services; • consider infrastructure development; • agree which aspects provide best value through local developments and those which are better served by national solutions; and • jointly and actively manage the changes, e.g. 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.	Action 6 should be continuously undertaken as joint services are commissioned.	We are committed to developing a comprehensive joint commissioning strategy, and a major component of this process has been the development of our capacity planning framework. The initial draft is currently the subject of a local consultation, and comments are due to be submitted by 31st July 2006. Once comments have been considered and incorporated where appropriate, the financial framework that will underpin joint commissioning of older people's services will be finalised. As this will set the parameters of a substantial local service redesign, it will form the basis of future joint commissioning for older people's services in West Dunbartonshire. The framework will also be informed by Best Value reviews currently underway, in relation to Equipment and Adaptations and to Older People's Residential Units and Sheltered accommodation. Our Service Plan is regularly updated and includes information on the progress of our Best Value Reviews. We also intend to use the joint commissioning process to establish more equitable access and provision of services. Current differences are a product of our previous structures, which included two Health Boards. Our approach will be fully inclusive of service users and carers, and voluntary / private sector providers. Our monthly providers meetings ensure full engagement with the private and voluntary sectors locally.

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Action 7	Timescales / Milestone	West Dunbartonshire Position
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	The establishment of the West Dunbartonshire Community Health Partnership has given renewed impetus to health promotion, preventative and early intervention services for older people, for both physical and mental health needs. Our new planning structure will ensure that these elements run through all aspects of planning for older people's services, and key responsibilities for driving health improvement forward will sit with the Older People's Strategy Group and the Health Improvement Strategy Group, which includes an Older People's subgroup. We have an agreed Joint Health Improvement Plan and the West Dunbartonshire CHP has recently issued its draft Annual Plan for comment. The draft fully recognised the need for health promotion, preventative and early intervention services for older people, for both physical and mental health needs. Additionally, the West Dunbartonshire Community Plan is currently under review, with full recognition of the need for health improvement, and the actions that need to be undertaken to tackle this issue. The Council Corporate Plan will be updated to reflect any new activity identified through the Community Planning process. We have a local authority health improvement officer (supported by COSLA and the Scottish Executive), who liaises closely with the CHP health improvement team, to ensure that staff across the whole council continue to recognise their health improvement roles and responsibilities.

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Action 8	Timescales / Milestone	West Dunbartonshire Position
Local partnerships should: • 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	West Dunbartonshire Council has provided higher levels of these key community care services than most other Scottish local authorities. However, our partnership continually reviews service levels against assessed need, and we have been improving the flexibility of our services to maximise the benefits that they can deliver. For example, home care clients who need frequent visits can now have their block of allocated time split to a pattern of shorter visits that addresses their needs more effectively. As part of our capacity planning work, we have identified a need to increase the number of sheltered housing units, and are working with housing providers to achieve this within the context of the Local Housing Strategy. We also have formal Partnership arrangements with Communities Scotland, and are working with 16 Housing Associations across West Dunbartonshire. All of this work continues to develop in the context of our Supporting People Strategy which is currently being reviewed to take into account our Departmental Service Planning, the setting of Local Improvement Targets, the monitoring and impact of the Supporting People Service Review Process and the Cost and Benefit and Services Outcomes Research being carried out on behalf of the Scottish Executive.

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Action 9	Timescales / Milestone	West Dunbartonshire Position
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.	We await the outline national strategy from the Scottish Executive. However, we are making local progress through the Local Housing Strategy and Communities Scotland Development Programme for local Housing Associations.
Action 10	**Timescales / Milestone**	**West Dunbartonshire Position**
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	The principles of action 10 are central to capacity planning and service redesign in West Dunbartonshire. We are currently researching the key reasons that lead to older people being admitted to hospital or long term care, as well as identifying which models of care sustain older people in their own homes as long as possible. The Scottish Executive will be issuing its draft Rehabilitation Framework in July 2006, and we will use this, along with the national care management skills training toolkit, to improve care pathways for older people.
Action 11	**Timescales / Milestone**	**West Dunbartonshire Position**
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	Our Carer's Strategy Group regularly has at least 50% carer attendance at its meetings. We consider that carers lead this process in West Dunbartonshire.

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Action 12	Timescales / Milestone	West Dunbartonshire Position
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	The Carers Strategy is to be reviewed to take account of new NHS responsibilities to carers. We will use this opportunity to reconsider how different funding streams can be used to best effect. At present carers monies fund 2 Carers Centres, Carers participation in planning and development and a well established carer's forum. Our Local Improvement Targets also specify our commitment to improved outcomes for carers.
Action 13	**Timescales / Milestone**	**West Dunbartonshire Position**
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	Our new planning structure will facilitate the implementation of action 13. The West Dunbartonshire-wide Older People's Strategy Group will have inputs from all other adult care sector strategy groups in respect of older people, to ensure that our evolving joint commissioning strategy addresses the whole spectrum of needs relating to this population. Early successes from the implementation of this new structure include clear communication channels, which have highlighted sensory impairment issues for older people in a more holistic planning context, with expert inputs from organisations such as the RNID, Deaf Connections, FOCUS, Visibility, Guide Dogs and Deafblind Scotland. The role of Care and Repair Services takes cognisance of sensory impairment and physical disability issues in respect of older people, and dementia issues are being addressed through the Dementia Interest Group, which acts as a sub-group of the Older People's Strategy Group.

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Action 14	Timescales / Milestone	West Dunbartonshire Position
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	The Dementia Interest Group, which includes people with dementia and carers of people with dementia, has been working to complete the Scottish Executive/ Alzheimer's Scotland dementia planning template for West Dunbartonshire. The first draft has now been submitted to the Older People's Strategy Group, where the key actions will be incorporated into the wider workplan.
Action 15	**Timescales / Milestone**	**West Dunbartonshire Position**
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	In West Dunbartonshire we have a joint NHS/ local authority addictions service, with a single, jointly appointed manager. The Corporate Action Plan (CAP) for Alcohol and Drugs 2006/07 is the strategic planning document supported by AAT/DAT and ADAT. Within the CAP a number of prioritised actions will enable us to a) identify the number of "older" people living with alcohol problems b) the services currently available to them and c) develop a campaign which will ensure safe drinking messages are targeted at and accessible to "older" people. Work to explore the possibilities of expanding this work in a way that will see the development of an educational tool for health and social care staff is also underway. The actions noted here are not exhaustive in terms of the list associated with the CAP, however, they are specific to older people and link very closely to the recommendations contained within the Scottish Executives Report on Alcohol and Ageing.

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Action 16	Timescales / Milestone	West Dunbartonshire Position
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	The requirements of this action are also covered by our strategy to address Action 14.