West Dunbartonshire Council

NHS Greater Glasgow and Clyde

West Dunbartonshire
Community Health & Care Partnership

West Dunbartonshire Community Health & Care Partnership Commissioning Strategy For Older People's Services

2012 – 2021

March 2012

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An electronic version of this document can be downloaded from the
WD CHCP website: www.wdchcp.org.uk

1. OUR AMBITION

1.1 Vision

West *Dunbartonshire Community Health and Care Partnership's (CHCP) vision for the provision of Older People's Services across the West Dunbartonshire Council area is to enable independence and care in a homely setting.*

1.2 Scope

The Institute of Public Care (IPC) has defined a commissioning strategy as "a formal statement of plans, for specifying, securing and monitoring services to meet people's needs at a strategic level. This applies to all services, whether they are provided by the NHS, the Local Authority, other public agencies or by the voluntary and private sectors".

The focus of this commissioning strategy reflects the requirements of Scottish Government as they relate to the provision of community based older people's services. It forms part of a suite of commissioning strategies covering the breadth of operational responsibilities of West Dunbartonshire Community Health and Care Partnership (developed jointly on behalf of NHS Greater Glasgow and Clyde and West Dunbartonshire Council).

Its aim is to provide a strategic framework for on-going activity to project and address changes in demand for local community-based services over the course of the next decade (i.e. 2012 to 2021) within the context of policy/legislative requirements, emergent best-practice and available resources.

1.3 Values

There are four core values that underpin the CHCP's approach to strategic commissioning, namely:

- Quality
- Fairness
- Sustainability
- Openness

These values are manifested through a systematic concern for the following principles:

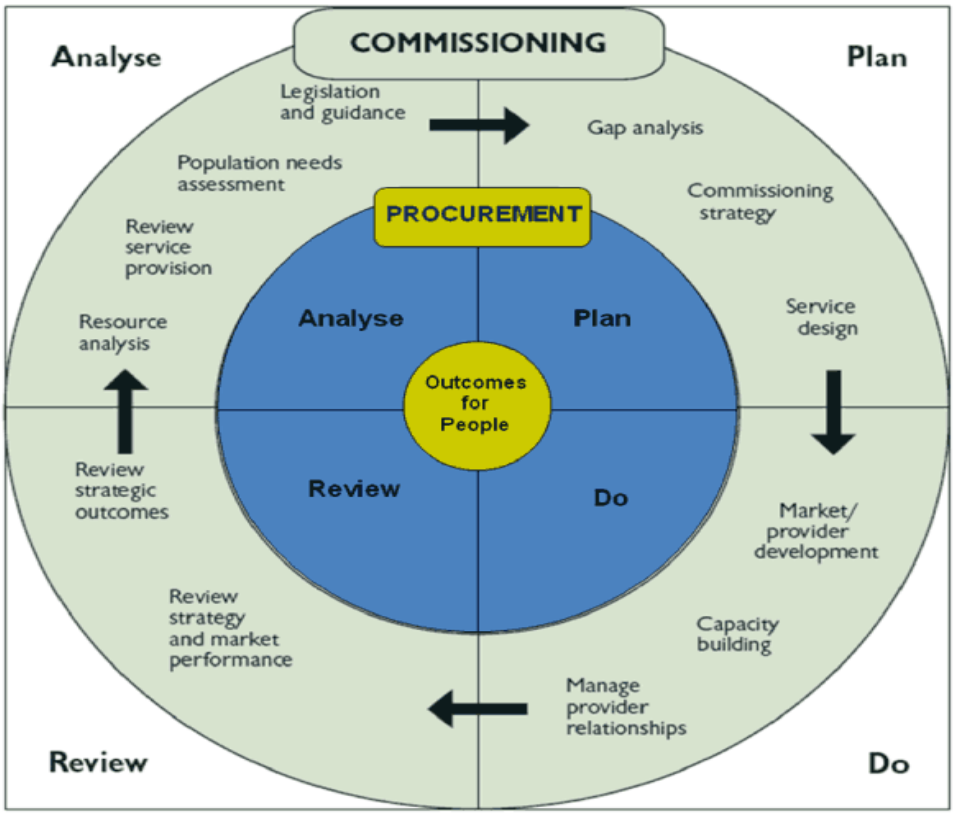
- Optimal outcomes for individual service users.
- A client-centred approach appropriate to individual needs through an emphasis on informed self-care, co-production and personalisation of services.
- Effective and safe services that draw upon the best available evidence and local feedback from service users.
- Equalities-sensitive practice.
- Acceptability of service provision informed through constructive engagement with local stakeholders – including staff, community groups and elected representatives.
- Affordable and efficient services that continue to be reflective of the relative demands across the West Dunbartonshire population as a whole.

This document provides an important framework to ensure that these values and principles are explicitly reflected as part of the routine review of services and the development of new models of care that incorporate (for example): better self management of conditions and co-production; improved use of technologies; earlier interventions; specific planning for those individuals at most risk; improved housing solutions; comprehensive support within communities; and better re-ablement packages.

1.4 Delivering Strategic and Outcome-based Commissioning

This document is a key element of an on-going process of commissioning as advocated by the IPC and illustrated below (Diagram 1) and further detailed in Appendix I.

Diagram 1: Strategic Commissioning Cycle



The Audit Commission (2003) has emphasised three particular strengths of this model:

- The cyclical nature of the activities involved, from understanding needs and analysing capacity to monitoring services.
- The importance of meeting needs at a strategic level for whole groups of service users.
- The importance of commissioning services to meet the needs of service users, no matter who provides them.

Audit Scotland has emphasised the challenging financial climate in which the public sector will be expected to deliver services over the coming years. Alongside the realities of a reduction in public sector budgets, CHCP services also have to manage the increasing complexity of demands for and capacity of services whilst being responsive to demographic changes within the population. Robust commissioning of community-based older people's services is essential to ensure that high quality and sustainable services are available to those who need them. This document will shape the substance of relevant operational service plans on an annual basis, within the wider context of the Community Planning Partnership's multi-agency Single Outcome Agreement (SOA) and the CHCP's wider set of development priorities as set within its annual CHCP Strategic Plan. It will provide a framework for a number of emerging local workstreams concerned with delivering key outcomes for service users and carers within a process to align relevant budgets within an integrated resource framework. These workstreams will be informed by guidance from the JIT and Audit Scotland (2012) to collate and utilise demand and capacity information to support increasingly detailed commissioning activities on an iterative basis (in keeping with the cycle above). This will require increasingly detailed analysis across a range of partners providing services; and will have implications for statutory, voluntary and private sector providers.

The CHCP will account for the delivery of the above approach primarily through its core governance arrangements to NHS Greater Glasgow and Clyde and West Dunbartonshire Council (as articulated within its Scheme of Establishment).

2. LEGISLATIVE AND POLICY CONTEXT

2.1 The Scottish Government has set a clear purpose for its policy and spending programmes, i.e. "to focus Government and public services on creating a more successful country with opportunities for all of Scotland to flourish, through increasing sustainable economic growth".

Within this overall purpose, the Scottish Government has established strategic objectives of making Scotland *wealthier and fairer, healthier, safer and stronger, smarter and greener*. At a local authority-level, the above are reflected within agreed Single Outcome Agreements (SOA) that bring together national outcomes with local priorities; and the delivery of which are overseen by Community Planning Partnerships (CPP). All health and social care services are expected to deliver outcomes in relation to:

- User satisfaction.
- Faster access to services.
- Support for carers.
- Quality of assessment and care planning.
- Identifying those most at risk.

Both the corporate priorities of NHS Greater Glasgow & Clyde and West Dunbartonshire Council reflect the above in general terms as well as the following key policy directives:

2.1.1 <u>Reshaping Care for Older People (2010)</u>

This national programme aims to optimise independence and well-being for older people in their own home or in a homely setting. It provides a framework - built on consensus across all sectors and interests - to address the challenges of supporting and caring for Scotland's growing older population into the next decade and beyond. It sits above, and supports the delivery of, other strategies for particular groups or issues including the Dementia Strategy (2010), Carers Strategy (2010), and Living & Dying Well (2008). Together these build a cohesive and comprehensive approach to meeting the care and support needs of older people.

The specific outcomes articulated by the programme to achieve by 2021 are:

- A philosophy of co-production (i.e. delivering public services in an equal and reciprocal relationship between professionals, people using services, their families and their neighbours) embedded as mainstream practice in both the development and the delivery of all services for older people.
- All care and support providing personalised care based on outcomes/goals agreed with the older person (and their unpaid carer) and on assessments which focus on personal outcomes.
- Services focused on prevention, maintenance of independence, recovery, rehabilitation and re-ablement, with a corresponding reduction in the need for emergency admission to hospital or a care home.
- More older people living in housing which suits their needs and helps maintain their independence.
- Community support for older people enlisted and mobilised, through volunteering, community enterprises and care co-operatives.
- A readily accessible, comprehensive information, advice and support resource available for all older people to help them make decisions about life choices, including adoption of personal budgets for care and matters relating to housing choice.
- Public sector resources from all sources (NHS, Councils, Benefits) available to jointly fund any agreed aspect of care.
- Clear and agreed care pathways for all older people, particularly those with complex care and support needs, to enable them to move smoothly through the care system, accessing timely and effective community and hospital care as necessary.
- Community based support for end of life care to increase the proportion of older people who are able to die at home or in their preferred place of care.
- An infrastructure designed to facilitate and sustain the changes and outcomes set above.

A key commitment within this programme was to introduce a ring-fenced Older People's Change Fund for 2011/12 to 2014/15, to stimulate shifts in the totality of the budget from institutional care to home and community based care; and enable subsequent de-commissioning of acute sector provision. In 2011-12 the Scottish Government allocated £70 million to this Change Fund to enable NHS Boards and local authorities, together with voluntary agencies, to redesign services for our growing older population. For the year 2012 – 2013 a further allocation of £80 million has been made available for Partnerships, with an additional £80 million for 2013 – 2014 and £70 million for 2014 – 2015.

2.1.2 National Dementia Strategy

This Strategy articulates the commitment of the Scottish Government and its partners in local government to delivering world-class dementia services in Scotland, by:

- Developing and implementing standards of care for dementia, drawing on the Charter of Rights produced by the Scottish Parliament's Cross Party Group on Dementia.
- Improving staff skills and knowledge in both health and social care settings.
- Providing integrated support for local change, including through implementation of the dementia care pathway standards and through better information about the impact of services and the outcomes they achieve.
- Continuing to increase the number of people with dementia who have a diagnosis to enable them to have better access to information and support.
- Ensuring that people receiving care in all settings get access to treatment and support that is appropriate, with a particular focus on reducing the inappropriate use of psychoactive medication.
- Continuing to support dementia research in Scotland.

It also highlights two key change areas:

- Following diagnosis, to providing excellent support and information to people with dementia and their carers.
- In general hospital settings, to improve the response to dementia - including through alternatives to admission and better planning for discharge.

2.1.3 Caring Together: The Carers Strategy for Scotland 2010 – 2015

The vision set out within this national strategy is for a society in which:

- Carers are recognised and valued as equal partners in care.
- Carers are supported and empowered to manage their caring responsibilities with confidence and in good health and to have a life of their own outside of caring.
- Carers are fully engaged as participants in the planning and development of their own personalised, high-quality, flexible support and are not shoe-horned into unsuitable support. The same principle applies to carers' involvement in the services provided to the people they care for.
- Carers are not disadvantaged, or discriminated against, by virtue of being a carer.

The strategy sets out to achieve and sustain a number of key outcomes, i.e. that carers will:

- Have improved emotional and physical well-being.
- Have increased confidence in managing the caring role.
- Have the ability to combine caring responsibilities with work, social, leisure and learning opportunities and retain a life outside of caring.
- Not experience disadvantage or discrimination, including financial hardship, as a result of caring.
- Be involved in planning and shaping the services required for the service user and the support for themselves.

2.1.4 Living and Dying Well: A national action plan for palliative and end of life care in Scotland

Palliative and end of life care are integral aspects of the care delivered by any health or social care professional to those living with and dying from any advanced, progressive or incurable condition. Palliative care is not just about care in the last months, days and hours of a person's life, but about ensuring quality of life for both patients and families at every stage of the disease process from diagnosis onwards. Palliative care focuses on the person, not the disease, and applies a holistic approach to meeting the physical, practical, functional, social, emotional and spiritual needs of patients and carers facing progressive illness and bereavement.

The purpose of this action plan is to rather a plan to ensure that good palliative and end of life care is available for all patients and families who need it in a consistent, comprehensive, appropriate and equitable manner across all care settings in Scotland. It advocates an approach to care which is person centred and based on neither diagnosis nor prognosis but on patient and carer needs. It advocates an approach which recognises the diversity of life circumstances of people who will need palliative and end of life care and which is responsive to these circumstances, whether they relate to age, disability, gender, race, religion/belief or sexual orientation.

2.1.5 A delivery framework for adult rehabilitation in Scotland (2007).

The purpose of the national framework is to give strategic direction and support to health and social care services and practitioners who deliver rehabilitation services. Underpinning the framework is the vision of creating an effective, modern, multi-disciplinary, multi-agency approach that is flexible and responsive to needs. The framework acknowledged that there is no universally accepted definition or theoretical model to describe rehabilitation. It did subscribe though to a working definition produced by the King's Fund, which describes rehabilitation as: *a process aiming to restore personal autonomy to those aspects of daily life considered most relevant by patients or service users, and their family carers*. The framework emphasises an ethos of rehabilitation that is about enabling maximum physical, psychological, emotional, social and occupational potential of the individual and improving quality of life. The ability to perform basic activities should go hand-in-hand with the need to enable social engagement and purposeful occupation, which are key to encouraging self worth and well-being.

Its substance is addressed within the West Dunbartonshire CHCP Rehabilitation Services' Commissioning Strategy, with which this document has a complementary and reciprocal relationship.

2.1.6 Homes Fit for the 21st Century: The Scottish Government's Strategy and Action Plan for Housing in the Next Decade: 2011-2020 (2011)

This Strategy sets out a national vision for a housing system which provides an affordable home for all. It emphasises this we will need a strong recovery in the construction sector; and a substantial increase in the number of homes of all types, including (importantly) housing to meet the needs of disabled people and older people for independent living.

2.1.3 National Targets

For the period 2012/13, the Scottish Government has set out the following NHS HEAT (Health, Efficiency, Access & Treatment) targets that are particularly relevant to older people's services (and which will be reflected within the CHCP's local Key Performance Indicators) – most notably:

- Reduce the rate of emergency inpatient bed days for people aged 75 and over per 1,000 population, by at least 12% between 2009/10 and 2014/15.
- No people will wait more than 28 days to be discharged from hospital into a more appropriate care setting, once treatment is complete from April 2013; followed by a 14 day maximum wait from April 2015.

The Scottish Government's national Community Care Outcomes Framework (2008) includes a number of indicators particularly relevant for older people's services – most notably:

- Percentage of carers who feel supported and capable to continue in their role as carer.
- Number of people aged 65 years plus admitted as an emergency twice or more to acute specialties per 100,000 population.
- Percentage of people aged 65 years plus admitted twice or more as an emergency who have not had an assessment.
- Percentage of people aged 65 years plus with intensive care needs receiving care at home.
- Percentage of people aged 65 years plus receiving personal care at home.

The Scottish Government's over-arching suite of national indicators also include a number of particular relevance to older people's services, notably:

- Improve end of life care.
- Improve support for people with care needs.

2.1.8 Health Improvement and Health Inequalities

Health improvement *is "pursued both through wide ranging health promotion effort, aimed at promoting good health and preventing ill-health, and through maximising the population benefits of treatment of ill health"* (Scottish Executive, 2005). While the overall health of communities in Scotland is improving, it is clear that the most rapid improvements are within more affluent communities resulting in marked differences in health status, life expectancy, and premature mortality. The widening gap in health status between the most affluent communities and most deprived communities demonstrates that socio-economic factors impact on health and are determined by life circumstances and where people live. The Scottish Government has acknowledged that inequalities in health such as these are no longer acceptable, and have introduced three key social policy documents which together aim to address the ongoing cycle of poverty and inequalities which persist in deprived communities: Equally Well; the Early Years Framework; and Achieving Our Potential.
The role of the CHCP in improving health and reducing health inequalities is set out in the WD CHCP Scheme of Establishment in terms of its corporate responsibility for health improvement; and reinforced by the 2009 CEL 26 Health Improvement and Community Health Partnerships Advice Note, i.e.:

- To take action to reduce health inequalities.
- To prioritise health improvement.
- To plan for health improvement.
- To strengthen partnership working.
- To build capacity and resources for health improvement.
- To integrate improving health activity across all functions/services.

Current policy stipulates that the delivery for improving health and health inequalities should be tackled across all Community Planning Partners with the CHCP having a key leadership role in co-ordinating the health improvement activity specifying that this should be 'outcome focused'.

2.2 The above, alongside other national guidance, have provided the core tenets for how the CHCP will increasingly discharge its responsibilities for older people's services in West Dunbartonshire over the decade, i.e.:

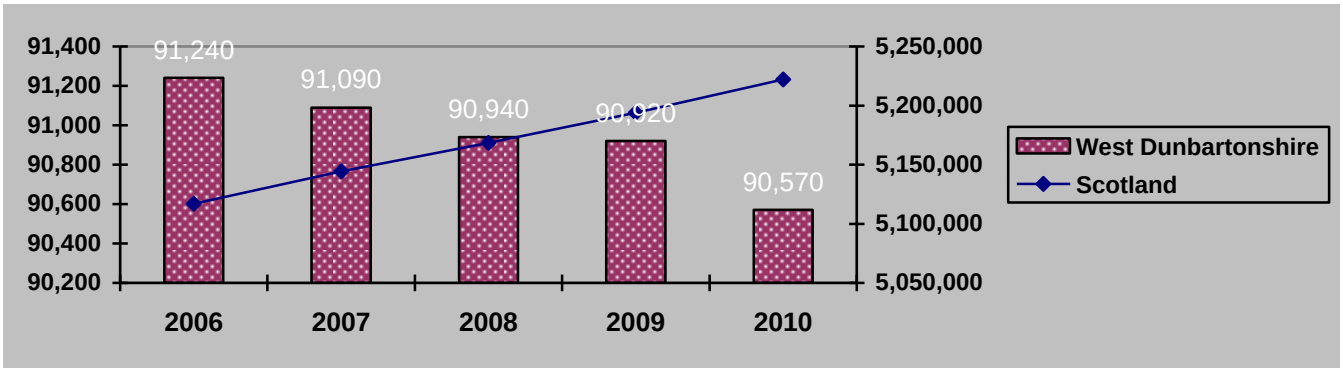
- A person-centred and outcome-based model of delivery that emphasises independence, self management and productive activity.
- Integrated care pathways and planning for each individual service user reinforced by co-ordinated assessment systems.
- An effective contribution to the early intervention agenda, both at individual and whole population level.

3. DEMOGRAPHIC PROFILE AND NEED

3.1 Population Size

The population of West Dunbartonshire reported in the 2001 census was 93,388. By mid-2008 the population had reduced to 90,940, and in 2009 that figure dropped to 90,920 with a further reduction by mid-2010 to 90,570 (Chart 1 - General Registrar for Scotland).

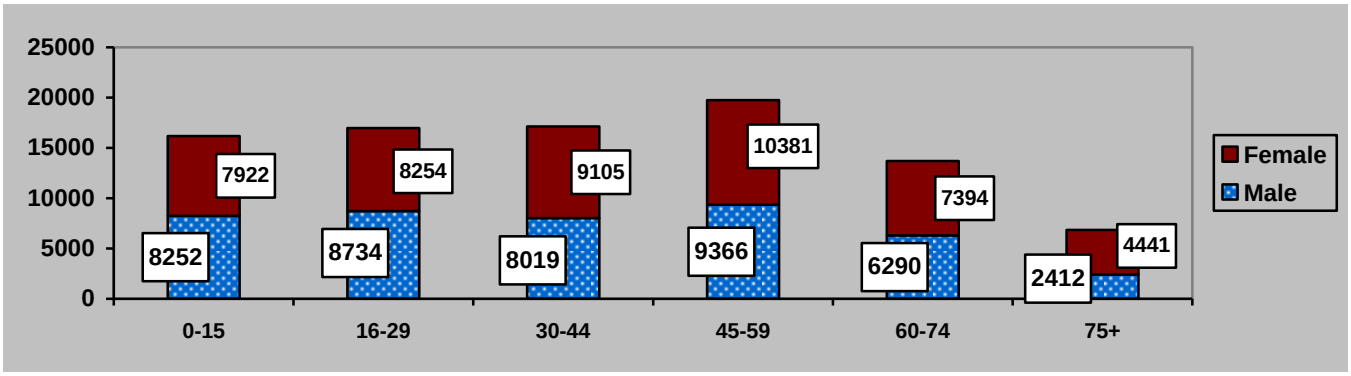
Chart 1: Population number 2006-2010



3.2 Age and Gender Profile

The population of West Dunbartonshire continues to age, and in 2011 the proportion of people over pension age (65) exceeds those of school age (under 16 years). There are more men than women in the population. Sixty seven percent of men and 59% of women are of working age (Chart 2).

Chart 2: West Dunbartonshire population (number) by age and gender (mid 2010)



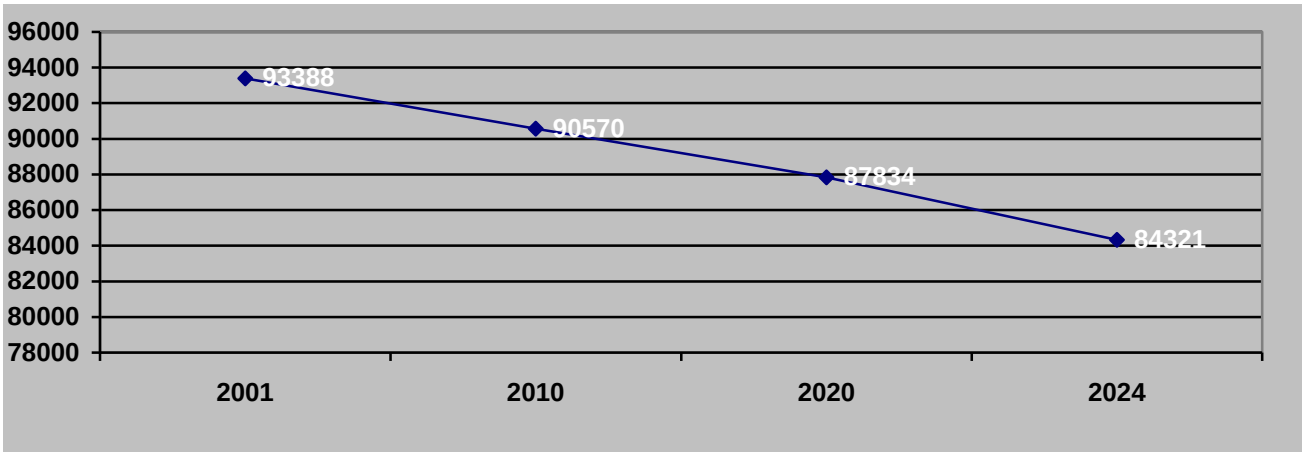
3.3 According to the General Register Office for Scotland's 2001 census, 20% of the adult population described themselves as having a long term limiting illness or disability, with over two thirds of them being over the age of 50 years.

4. PROJECTED PROFILE OF FUTURE NEED

4.1 Population Size and Profile

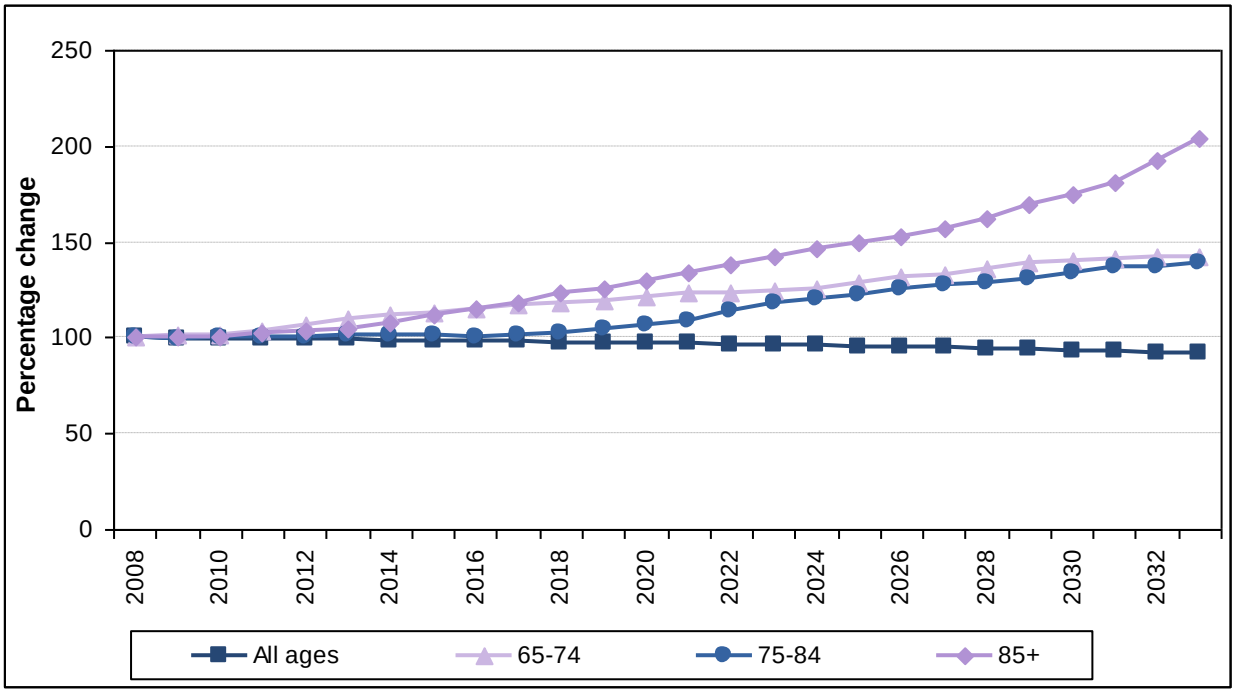
Analysis of the data taken from the General Registrar Office for Scotland and projecting likely trends in the population of West Dunbartonshire indicates a continued reduction in population size of approximately 3.2% over the next 10 years. Assuming this trend continues the population will continue to decrease at a rate of 3.2% over 10 years with a projected population of 87,834 in 2020 (Chart 3).

Chart 3: West Dunbartonshire – actual and projected population number



National and local evidence indicates that the population of West Dunbartonshire is ageing (Chart 4) due to a combination of factors: that the number of births within the area are dropping; the number of people migrating to other council areas within the 15 – 44 age group is increasing; and the number of deaths registered annually is falling. This mirrors the situation for Scotland as a whole.

Chart 4: West Dunbartonshire Percentage Population Changes 2008- 2033 (Projected)



Whilst the population projections indicate a down ward trend in the total population, and that the trend is of an older rather than young population, additional information using 5 yearly projections from the General Registrars Office for Scotland demonstrate that there will be more females than males. Specifically the number of males in the 0 – 15 age range is higher than the number of females. However, as we progress through each of the age ranges that is reversed with the number of females being greater than males in each of the remaining 5 age ranged identified within Charts 5 and 6.

Chart 5: West Dunbartonshire - projected population by gender and age (2018)

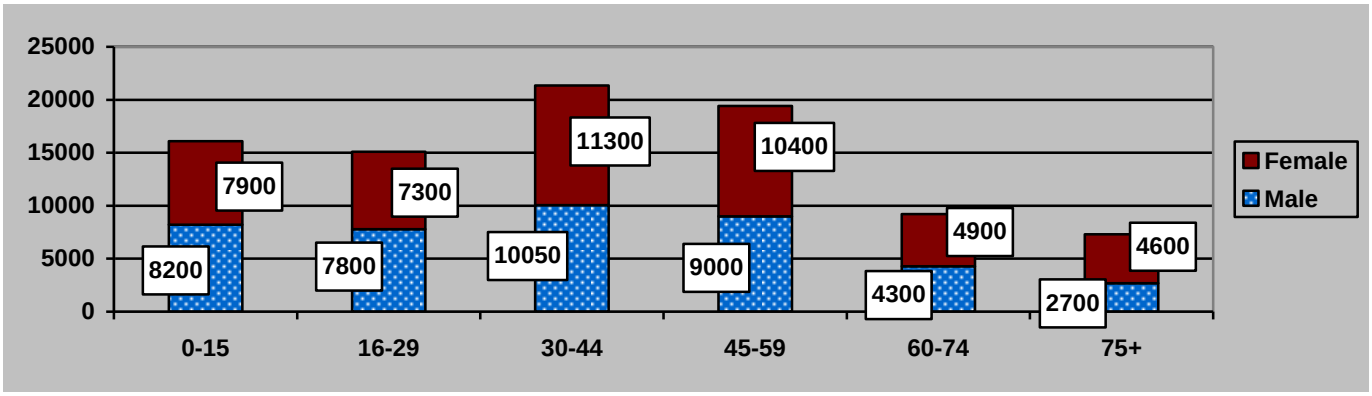
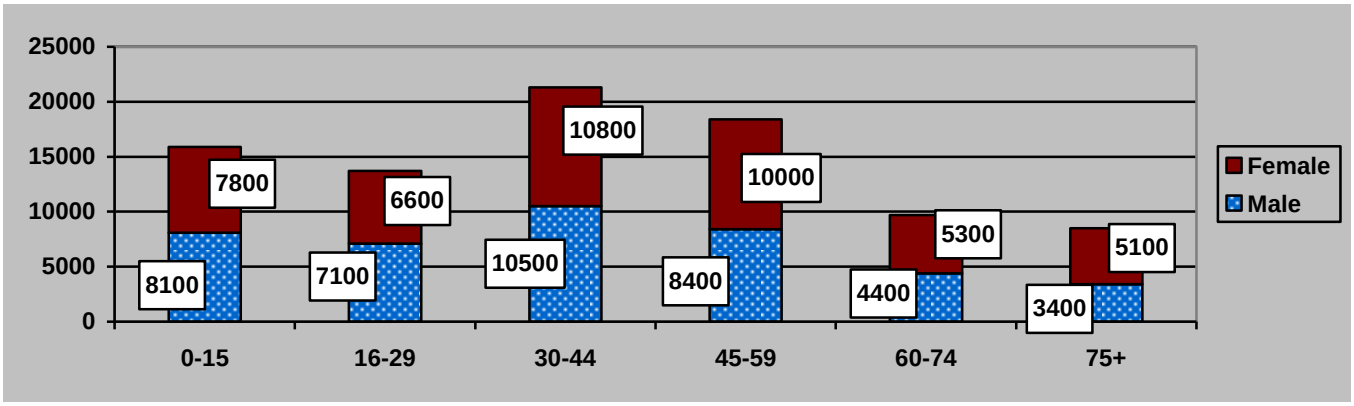


Chart 6: West Dunbartonshire - projected population (number) by gender and age (2023)



5. PROVISION AND DEMAND

5.1 Shifting the Balance of Care is a key priority for the CHCP, in line with national policy, it is a means of supporting people to remain at home or in a homely setting for as long as possible. Together with the CHCP's Commissioning Strategy for Rehabilitation Services, the CHCP's in-development Carer's Strategy and West Dunbartonshire Council's Local Housing Plan, this framework reinforces the critical components to support this shift in care, i.e.:

- Comprehensive assessment, rehabilitation and care management service delivery.
- A community-based service framework that delivers on an assessed need model across all care pathways.
- A service that responds to the needs of older people returning home following hospital admission, delivering assessment, discharge arrangements, community based rehabilitation and ongoing case management.
- A tiered model targeting specialist functions/resources at the highest and most complex needs.
- An emphasis on preventative and anticipatory care.

5.2 People with dementia and their carers need support early on to come to terms with the illness, to manage its symptoms and to put in place legal, financial and care arrangements for the future. As time goes on, people with dementia need increasing help with everyday activities and personal care. Much of this care is provided by partners and family members, who themselves need support to enable them to continue to do so. With the prevalence of dementia set to rise within care homes settings and older people being discharged from acute settings, the continued case management of people with a diagnosis of dementia who have more complex needs will increase. West Dunbartonshire has made a commitment to review current services and to support investment in local services, including specific community mental health services and services for carers.

5.3 Unlike the past, when many people died suddenly and at any age (largely from infectious diseases) the majority of deaths now are of people over the age of 65 and follow a period, possibly prolonged, of illness and/or frailty. This has wide-reaching implications for the type of care that will be required. Deaths are more likely to happen out with the family home than in the past, an individual is more likely to die in hospital and than at home. Evidence indicates that unnecessary and inappropriate admissions to hospital can be as a result of poor communication and planning of end of life care. Within West Dunbartonshire, palliative and end of life care have become an intrinsic part of care planning, with the need for local access to palliative care services and specialist community based support recognised. This is most notably reflected in a long-running and sustained commitment to the development and use of the Liverpool Care Pathway.

5.4 West Dunbartonshire CHCP provides a wide range of multi-disciplinary services which support older people, with processes in place to ensure that each service can access a range of care and expertise for any given individual. These exist and operate in tandem with services provided by other operational units of NHSGGC (e.g. acute/secondary care departments), other Council services (e.g. extra care housing) and NHS external contractors (i.e. general practice, dentistry, optometry and community pharmacy). NHSGGC Acute Services are particularly important, in terms of service provision as well as management information (notably in relation to activity and costs).

5.5 Equipment and adaptations are an important part of an integrated community care service, enabling some of the most vulnerable citizens to achieve their individual outcomes, helping them to live in their own homes for as long as possible, as independently as possible. EQUIPU is an innovative partnership of local authorities and NHS organisations in the West of Scotland which supports those who need assistance to live at home. The service provides a comprehensive range of equipment for children and adults of all ages across a number of authority areas including West Dunbartonshire.

5.6 Based on the most recent census data available, 715 people were living in communal residential establishments. There are currently 13 local care homes, six of which are WDC owned and CHCP operated (the latter providing 195 beds): Willox Park Care Home; Mount Pleasant Care Home; Dalreoch House and Day Care Centre; Boquhanran House Care Home; Frank Downie Care and Day Care Centre; Langcraigs Care Home and Day Care Centre.

5.7 While good collaborative/partnership working is a strong feature of local services, their organisational arrangements in many cases still reflect the historical and distinct responsibilities of West Dunbartonshire Council and NHSGGC. The implementation of this document within the context of an integrated CHCP provides the opportunity and the impetus to more appropriately amalgamate structure, processes and resources to further streamline access and delivery.

5.8 Changes in lifestyle, living conditions, health and social care have improved life expectancy and led to an ageing of our population. But, they also present challenges for services and society at large. For example, while many people lead active lives as they enter old age with little need for care and support (either in hospital or in the community), for many others increasing age is associated with long-term conditions and ill-health.

5.9 West Dunbartonshire CHCP has a strong track-record of engaging and building relationships with older people through existing forums, local and national service users' organisations and carers groups. Within the context of the national Reshaping Care for Older People agenda, the CHCP committed to build on those strong foundations by undertaking a dedicated and comprehensive consultation process throughout 2011. From all the initial pre-consultation preparation with existing stakeholders, the CHCP had an overwhelming endorsement of this particular community wide consultation process – which provides reassurance on the quality of its main messages, i.e.:

- Anxieties about getting older
  Respondents from all ages articulated fear and anxiety linked to getting older. These negative perceptions of increasing life-expectancy were primarily related to worries about frailty and illness with an attendant loss of independence. Older and younger respondents also made reference to negative messages about older people and ageing (often unintentionally reinforced by public agencies and other organisations) – e.g. older people as passive recipients of services and as a social burden draining future resources.

- Local services highly valued – but uncertainty about the future
  While respondents provided a mixture of positive and negative comments about health and social care services, overall a high level of satisfaction with current satisfaction was expressed. Respondents did express the view that in order to make the best use of services on offer, it was important that up-to-date advice and information was widely available; and that people were encouraged to make use of them. This appreciation for current service provision was also accompanied by concerns about a lack of the "right" health and social care services being available in the future – although for some this was about maintaining what had been traditionally provided, and for others it was about making changes in anticipation of different challenges.

  A key insight that resonated across respondents was a recognition of the risks of focusing disproportionate attention on older people's specialist services as a "magic bullet" for addressing complex demands. A strong view was that many of the needs of older people should be addressed by "universal" community services – as these services should be responsive to the different requirements of all groups within local communities – rather than generating unrealistic and unsustainable demand for specialist provision.

- The importance of individual and community responsibility
  The majority of respondents - both older and younger - felt strongly that local communities had an important role in supporting older people to live more independently. A repeated point was made about the need for public bodies to identify and limit unnecessary barriers to residents/volunteers helping out in the community. However older respondents also felt that it was important for people to keep active and healthy to sustain a good quality of life – as fundamentally "living to a ripe old age" should be something that everyone would seek to achieve and enjoy.

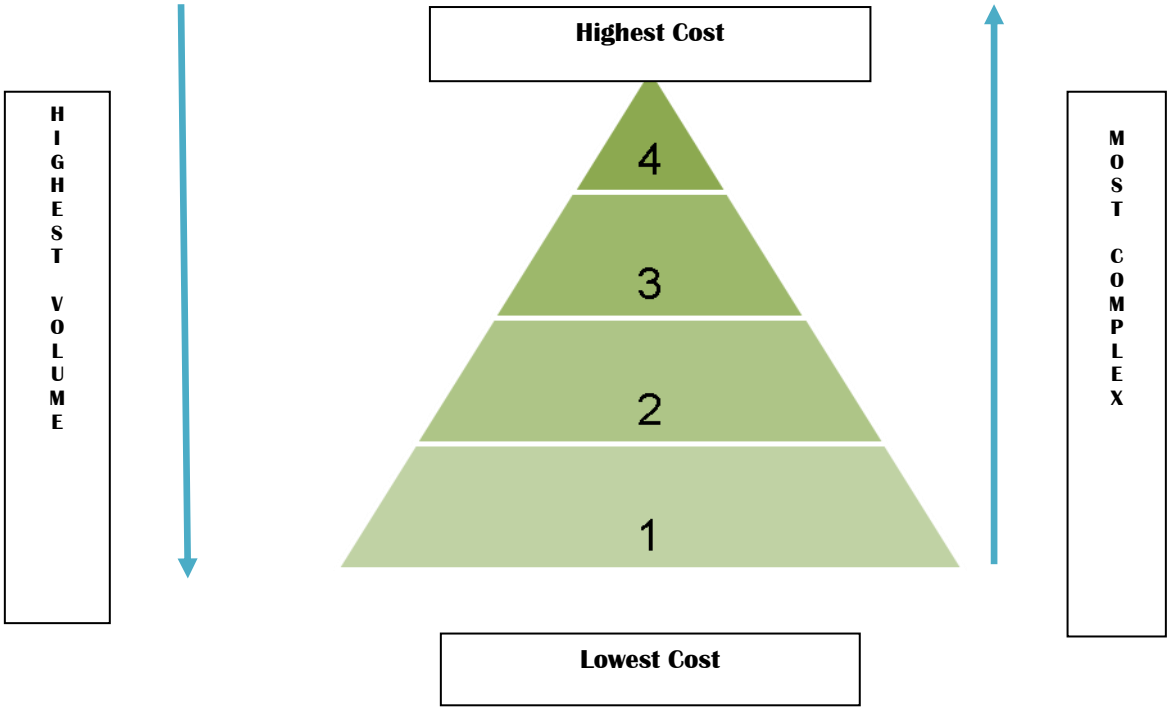
5.10 Based on prevalence data, service usage and service fallout, the level of demand for services has already begun to increase, and will continue to do so year-on-year. This is also going to be accompanied by further changes in the nature of the needs within the population, the types of demands that are expressed, the expectations concerning how best to meet them and the reduced finances available to resource them. Fortunately the CHCP has the benefit of a strong local track record for improvement that provides a solid foundation for the further developments necessary.

6. MODEL OF SERVICE PROVISION – BUILDING ON STRONG FOUNDATIONS

6.1 West Dunbartonshire CHCP provides integrated health and social care services for older people. In delivering these services, social and health care staff will consider the physical, medical and social needs of individuals. This, along with the use of Integrated Care Planning of services, will ensure that local services - and indeed the care plans of individuals - focus on addressing individual needs.

6.2 Increasingly, older people's services are driven to develop and provide interventions which ensure that the individual is central to the development, implementation and management of their own care package. This is reflected in the use of a tiered approach to service delivery (Diagram 2). This model of delivery enables providers to respond to, and support, individuals in accessing appropriate care which reflects their own needs.

Diagram 2: Tiered Model of Care



6.2.1 Tier 1 – Self care, health improvement and public health

Services at this level will be triggered by the common core assessment or dataset. Under this level, services are universal and often accessed by service users directly for example physiotherapy, GPs and smoking cessation services.

6.2.2 Tier 2 – Maintenance and support

Services, at this level, are triggered by a baseline assessment. Service users are identified as requiring a basic level f case/care management with monitoring and review. These services will focus on enablement and may be delivered by teams or by individual professions and require a less integrated approach but may also include Homecare and Community Alarm services.

6.2.3 Tier 3 – Complex needs

Services at this level are triggered by a comprehensive assessment and are managed by a case/care management process with a lower level of support. Services would be delivered by CHCP multi-disciplinary enablement teams as part of the integrated system.

6.2.4 Tier 4 – Inpatient/intensive support

At this level service users are identified as requiring intensive support services triggered by a comprehensive assessment specialist assessment. The model suggests that services within this tier

are being delivered by specialist teams, re-designed as multi-disciplinary teams with the CHCP, including residential and care home settings.

6.2 Reflecting best practice and national expectations, the key characteristics of the CHCP model are as follows:

- Promote early intervention.
- Direct access for the individual patient/client/service user.
- Single point of access for the individual.
- Single shared assessment of individuals by services.
- Co-production of care plan and package by individual and services/teams that emphasises early intervention through enablement.
- Provision of care in variety of settings (not just traditional health care facilities).
- Co-location of services/teams where feasible.

6.5 This framework also emphasises an enablement approach across services. *Enablement* refers to the process of health and social care staff supporting people through promoting self help and health improvement and by encouraging them to be as independent as possible. An enablement approach requires a shift from an intervention/episodic approach (where inappropriate) to a more continuous, systematic approach incorporating anticipatory care and self management (including lifestyle change and health improvement activities). The CHCP is strengthening a model of care which maximises the independence of older people to stay at home; and targeting care to older people living with complex care needs living home. Working in partnership with the third sector, wider community resources will "link up" and community capacity will be focused on supporting people at home. Joint workforce development alongside shared assessment and referral protocols will promote a village model within our communities that promote community participation for older people living at home and the likelihood of continued independence.

6.6 Moving forward, the CHCP is driving forward a number of key strands of activity in support of the above:

- <u>Preventative and Anticipatory Care</u>
  This relates directly to improve delayed discharge performance, reduced length of stay in acute hospital settings, joint discharge planning processes, homecare discharge team and step down provision.

- <u>Proactive Care and Support at Home to Hospital</u>
  This will be achieved by increasing telecare provision; identifying early development of "at risk" registers using predictive model as a prelude to the development of anticipatory care; development of "step up" provision; and having integrated care packages for long term conditions within general practice.

- <u>Effective Care at Times of Transitions</u>
  This will be achieved by making effective use of augmented homecare; increased respite capacity; establishing joint care management protocols; plus individuals having timeous access to domiciliary rehabilitation and appropriate housing.

- <u>Hospital and Care Homes</u>
  The focus here is on the CHCP further expanding the use of the Liverpool Care Pathway, and delivery of training for care home staff on end of life care.

- <u>Co-production, Education and Training</u>
  This covers a range of developments including increasing self directed care support and supported self care; development of social enterprise capacity (particularly in partnership with local older people's organisations and local housing providers); delivery of joint training with third sector and independent sector partners; and development of dementia support with Alzheimer Scotland.

6.7 This work is already being co-ordinated within and driven through the CHCP local Older People's Change Fund Plan implementation arrangements.

7. CARE PATHWAY

7.1 Audit Commission reports suggest that the drive to expand community services requires a well-planned "journey of care" with a package of support. The pathway below (Diagram 3) reflects the key thematic areas of activity set out in the previous page (Section 6.6).

Diagram 3: The Person-Centred and Outcome-Focused Care Pathway

Preventative and Anticipatory Care	Proactive Care and Support at Home	Effective Care at Times of Transition	Hospital and Care Home (s)
Build social networks and opportunities for participation.	Responsive flexible, self-directed home care.	Reablement & Rehabilitation.	Urgent triage to identify frail older people.
Early diagnosis of dementia.	Integrated Case/Care Management.	Specialist clinical advice for community teams.	Early assessment and rehab in the appropriate specialist unit.
Prevention of Falls and Fractures.	Carer Support.	NHS 24, SAS and Out of Hours access ACP's	
Information & Support for Self Management & self directed support.	Rapid access to equipment.	Range of Intermediate Care alternatives to emergency admission.	Prevention and treatment of delirium.
Prediction of risk of recurrent admissions.	Timely adaptations, including housing adaptations.	Responsive and flexible palliative care.	Effective and timely discharge home of transfer to intermediate care.
Anticipatory Care Planning.		Medicines Management.	Medicine reconciliation and reviews.
Suitable, and varied, housing and housing support.	Tele-health care.	Access to range of housing options.	Specialist clinical support for care homes.
Support for carers.		Support for carers.	Carers as equal partners.

Enablers
Outcomes focussed assessment
Co-production
Technology/ eHealth/ Data Sharing
Workforce Development/ Skill Mix/ Integrated Working
Organisation Development and Improvement Support
Information and Evaluation
Commissioning and Integration Resource Framework

7.2 A key element of this person-centred and outcome-focused model is the provision of services that are locally based within a community setting. While there will continue to be a need for specialist acute/secondary care provision, the evidence suggests that better outcomes are achieved when individuals can access a range of care in their own communities. This will mean facilitating a change in emphasis from hospital provision to community based services, accompanied by the necessary reallocation of resources to support this shift in the balance of care to community settings.

8. FINANCIAL FRAMEWORK

8.1 The financial framework for West Dunbartonshire CHCP has been prepared on the basis of an aligned budget process that complies with and respects the integrity of the distinct financial governance and accountability arrangements of its parent organisations, i.e. West Dunbartonshire Council and NHS Greater Glasgow & Clyde. The corresponding financial framework for each and all CHCP service areas are rigorously reviewed on an ongoing basis with an increasing emphasis in ensuring a clear relationship with and understanding of the service priorities that need to be met, both in-year and going forward. As noted the financial framework is estimated and the figures provided are indicative. The composition (of the framework) is extremely complex and there are many strands of service provision, which require to be financially evaluated as part of an on-going process.

8.2 The total financial framework for Older People's Services in the 2011/2012 financial year is estimated at £65.7million. Details of the framework across both the Local Authority and the NHS service areas are noted below:

	WDC £M	**NHSGGC £M**	**Total £M**
Hospital Based Direct Expenditure			
Elderly Inpatient Services	-	1.9	1.9
Share of Rehabilitation & Assessment	-	4.7	4.7
TOTAL	-	6.6	6.6
Community Based Services			
Family Health Services Expenditure	-	13.2	13.2
GP Prescribing	-	9.8	9.8
District Nursing	-	1.6	1.6
Community Allied Health Professional Services	-	1.1	1.1
Community Mental Health Services	-	0.9	0.9
Older People's Rehabilitation	-	0.4	0.4
Other NHS Expenditure	-	1.5	1.5
TOTAL	-	28.5	28.5
Local Authority Services			
Residential Accommodation	14.6		14.6
Home Care	11.8		11.8
Day Care	1.2		1.2
Other Council expenditure	3.0		3.0
TOTAL	30.6		30.6
TOTAL DIRECT COST	**30.6**	**35.1**	**65.7**

8.3 All public sector services face budgetary restrictions. The rising gap between provision and potential need will be further challenged as local services manage further limitations on budgets. Increasing emphasis on efficiencies and effectiveness will become the norm, as will an increasing need to review the wider partnership demands to collaborate to reduce the impact on the individual and the community.

8.4 Local government and health boards have faced demanding budget reductions and the expectation is this will be the challenge over the next few years. Importantly any substantial dependence on such non-recurrent and time-limited funding streams poses risk in terms of sustainable service delivery, especially in the challenging financial climate that is anticipated to continue for some years ahead.

8.5 In addition to its directly managed services, the CHCP has also funded activity and service provision from third sector organisations. It is both appropriate and fair that the CHCP's external funding arrangements are robustly and routinely tested to ensure best value against the resources available and the model of provision identified. In doing this, it is important to appreciate that local voluntary sector partners have often faced challenges of managing a range of short-term funding streams and appropriate weight should be attached to continuity of defined service provision for individuals. It is also important to understand that while matched funding arrangements between third sector organisations with the local authority and/or NHS has to-date enabled successful levering in of further external resources, the changed financial climate will likely diminish the scope for such arrangements and the capacity it supported going forward (not least because of the increased pressures on and reduced availability of such external funding).

8.6 Reviews of all service provision, in house and externally purchased in line with best value competitiveness/benchmarking principles is required corporately and departmentally. This may result in a shift in both service provision and the associated financial framework. This new service design or reconfiguration will be carried out in accordance with the Procurement Guiding Principles set out in Appendix II and will be detailed as part of the procurement planning within the service's Operational Plan.

8.7 The Scottish Government has initiated some scoping on the Integrated Resource Framework (IRF): this is specifically to improve the quality of financial frameworks across Local Authorities and NHS organisations, including Primary Care and Acute Services. Contribution Analysis is similarly emerging concept at a very early stage of its practical development. This work will require to be undertaken by the CHCP as part of the improving and developing financial framework for the service.

9. DELIVERING OUR AMBITION – NEXT STEPS

9.1 At the heart of the CHCP's vision for improving older people's services is the prevention of dependency on 'care' and support services through the promotion of independent living. Robust commissioning of these services is essential to ensure that high quality and sustainable services are available to those who need them. This commissioning strategy provides a framework for the substance of relevant operational service plans on an annual basis within the wider context of the annual CHCP Strategic Plan.

9.3 The following provides a synopsis of the key issues for continued prioritisation in the short-term as per the vision and values set out at the start of this commissioning strategy.

9.3.1 Quality Service Provision

National Quality Standards call for all areas across Scotland to offer a range of service routes, and for the quality of services to reflect a minimum standard. Service inspections and supported self-assessments for and by the Care Inspectorate aim to ensure that quality standards and personalised services achieving good service user outcomes are maintained. Whilst CHCP services have a good track record, there is no room for complacency. Fortunately there is clear commitment to quality and a commitment to sustain achievements.

The CHCP will continue to identify ways of improving both choice and service quality. Using the Public Service Improvement Framework (PSIF) there will be an expectation on services, internal and externally purchased to set fresh, aspirational goals which continually drive further improvements. Regular, internal audits of the Single Shared Assessment (SSA) process and documentation will continue to provide an overview of service delivery and support a shared approach to Care Planning and Review.

9.3.2 Older People's Change Fund

The Scottish Government established the Older People's Change Fund to enable health and social care partners to implement local plans for making better use of their combined resources for older people's services. The Change Fund is intended to provide bridging finance to facilitate shifts in the balance of care from institutional to primary and community settings; and also influence decisions taken with respect to the totality of Partnership spend on older people's care. The CHCP successfully secured the year one funding against an approved local Change Fund Plan for 2011/12; and had completed at actions committed to within that time period. In tandem with discharging its year one commitments, the CHCP has worked with local stakeholders to prepare its application to access its allocated year two Change Fund monies, including the preparation of a Year Two (2012/13) Action Plan. As for all parts of Scotland, it is clear that Years Two and Three of the Change Fund will present a substantial challenge, not least given following the Scottish Government having now confirmed that its previous delayed discharge target (i.e. no more than 6 weeks delay) has now been superseded by the a new target that "no people will wait more than 28 days to be discharged from hospital into a more appropriate care setting, once treatment is complete from April 2013; followed by a 14 day maximum wait from April 2015". The routine and in-year implementation of the West Dunbartonshire Older People's Change Plan will continue to be driven and monitored through the local CHCP-led Change Plan Implementation Group (whose membership includes statutory, voluntary and private providers as well as community representatives).

9.3.3 Personalisation

The CHCP works with people using our services to offer more flexibility, choice and control over their support so that they can live at home more independently. It is important that our local services create arrangements which will facilitate more choice and control over service provision and promote the opportunities for co-production with service users. This will include ensuring built in flexibility by the introduction of framework agreements that enable individuals to access these services via Self-Directed Support (SDS) options. Direct payments for social care have enabled people who use them to achieve greater independence. West Dunbartonshire Council has a duty to offer a direct payment to eligible people assessed as needing community care services, this payment can be used to

purchase all defined community care services and support, except long term residential accommodation.

In line with the National Standard Eligibility Criteria and Waiting Times for the Personal and Nursing Care for Older People framework, West Dunbartonshire is amending relevant policies, procedures and assessment documentation. The existing criterion used in West Dunbartonshire CHCP is compatible with the current Scottish Government Guidance of Critical, Substantial, Moderate, Low or No risk. Work is progressing to update current recording systems to be able to report in line with the Guidance. The updated Guidance from the Scottish Government suggests that eligibility for services is recorded at the end of the assessment. The recording of Eligibility Criteria is a mandatory field on all Single Shared Assessments (SSA) and Specialist Assessment templates across client groups and service areas. West Dunbartonshire will be applying the criteria to all Community Care Client groups and services and will be able to report on this in the near future following the updated Scottish Government Guidance.

Talking Points has been identified as the key vehicle for gathering service user/carer/patient outcomes from service interventions. These measures are part of SSA currently being used across services within the CHCP. The third and independent sectors - as service providers and through the co-production model - will also be part of the wider system changes to support the development of personalisation within West Dunbartonshire.

9.3.4 Early Intervention

The 2011 Report by the Commission on the Future Delivery of Public Services (the *Christie Commission*) made strong recommendations that public services across Scotland must do more to:

- Empower individuals and communities receiving public services by involving them in their design and delivery.
- Integrate service provision and improve outcomes by ensuring public services work in partnership.
- Prioritise preventative spending to reduce demand and inequalities.
- Improve efficiency to raise performance and reduce costs.

All of these elements have been and will continue to be characteristics of the CHCP's approach to the development of all of its services, including rehabilitation services. The emphasis on early intervention within the report (that COSLA have particularly highlighted) particularly resonates with the ethos of enablement described within this commissioning strategy - and it is crucial that its subsequent implementation reinforces that key requirement.

9.3.5 Housing

Housing has a key role in supporting the Shifting the Balance of Care agenda, as recognised within the local Housing Strategy. While the great majority of people live in established housing, as they enter old age increasing number of them require housing adaptations to enable them to continue living there. Specialised forms of housing with care or support can help older people to remain in their own homes for longer. However, there are issues of low demand in some areas, and some providers are seeking to remodel such developments. Many older people have considerable amounts of equity in their properties, but very low incomes. They could benefit from products or services, which would enable them to release money for adaptations or improvements.

Local authorities and housing associations have a long tradition of providing low level, preventative support services (such as housing support, handyperson, Care and Repair and community support), either as part of housing management services, provided under tenancy agreements, or through separately funded housing support services, such as the former Supporting People programme. Social landlords also play a key role in supporting wider activities in local communities, and services are also provided by Care and Repair and private and voluntary sector organisations.
These services are particularly useful for people who just need a small amount of help to live independently and need to be available across all housing tenures. If they can be provided at an early stage, their effectiveness can be enhanced. For some older people, these services are delivered alongside home care services provided by the CHCP.

There is a growing body of evidence that investments in services, which support older people to remain independent, avoid accidents in the home and social isolation, make an enormous difference to quality of life and are cost-effective (reflecting the the Christie Commission's emphasis on prevention). Such services bring peace of mind to older people and their families; whilst also contributing to health and social care objectives of reducing unplanned hospital admissions and delayed discharge. This recognition of the contribution and value of services which have a preventative focus – avoiding or delaying the need for more intensive services, or more importantly avoiding incidents which may lead to hospital admission – is shared with partners in health and social care. The whole Reshaping Care programme gives increasing priority to those services, which help prevent greater needs arising or 'anticipate' and plan for changing needs. Co-ordinated action across housing, health and social care in helping prevent unnecessary hospital and care home admission is a key theme of this strategy and the wider Reshaping Care programme.

Within West Dunbartonshire, the Council is preparing a remedial plan for submission to Communities Scotland under Section 74 of the Housing (Scotland) Act 2001. This plan will provide a clear strategic framework for housing policy development. Significant pieces of research are being undertaken to provide a robust analysis of housing supply and demand and to provide an asset management plan for the Council's Housing Revenue Account assets to underpin and complement its Business plan, and to set out priorities for the physical care and improvement of its housing stock.

Housing services have committed, as part of this process, to work with partners to identify the housing needs of different client groups, including the future housing needs of an older people's population. Housing Services, in partnership with the CHCP and service users, will review its sheltered housing service and will be making recommendations for the future of the service.

9.3.6 Care Homes

Over the past four years, COSLA, Scottish Care, the Care Inspectorate, the Scottish Government and other key stakeholders have made significant progress in advancing the quality agenda for the care home sector. The focus has been to enhance the quality and improve the standards of care being provided within care homes and to deliver consistency, efficiency, fairness and stability in the contractual relationship between commissioners and providers of care. Within West Dunbartonshire a key area of acknowledged concern is the level of Care Inspectorate quality grades that have recently been assigned to a number of local residential care homes: both independent sector and CHCP operated (the latter up until very recently having regularly experienced more positive gradings).

2011/12 was a very difficult year for the independent care home sector, with more than one high profile closure. It is fair to say then that in emerging from 2011/12, the independent sector is seeking to re-establish credibility and stability as a reliable source of quality care. With regards to local independent sector care homes, the CHCP will continue to work with them (individually, and increasingly collectively) to maintain and improve the quality of the care provided as per national standards (e.g. shared training for staff) and making full use of the levers within the National Care Home Contracts. It will also continue to constructively engage with any credible potential entrants to the care home provider market. This will be undertaken with a clear appreciation that independent sector care home providers are valuable partners and that the CHCP's primary responsibility is for the residents and communities for whom those providers are providing a service.

With regards to the six WDC owned residential care homes for older people, detailed analysis has generated the following conclusions:

- While the majority of residents (and families) express their essential satisfaction with the actual care they receive, the design, the layout and the fabric of the majority of existing homes are increasingly no longer suitable to meet the current and anticipated requirements of the various client groups, their families and care Inspectorate (particularly when compared to more modern, new build facilities within other Council areas).
- The increasing demand from the ageing population will put even more pressure on WDC's existing facilities (e.g. in relation to providing/supporting appropriate dementia care), but if they are not viewed as attractive compared to other facilities (either within the area or outwith, e.g.

due to lack of now standard en-suite bedrooms) then they may also suffer a reduction in fee income, thereby increasing the cost per head to the Council/CHCP.

Given the importance of the CHCP having access to sufficient numbers and high quality of residential care home places locally for those West Dunbartonshire residents who need them (including for respite), addressing the above represents a clear and present challenge that demands a confident and ambitious response to be formulated and agreed as a matter of urgency going forward.

9.3.7 Carers

Shifting the Balance of Care from residential and institutional settings to care at home and more people being cared for at home for longer has implications for carers. Carers play an increasingly important role in the support, care and treatment of people with long-term and/or multiple conditions, disabilities, illnesses, including dementia. With appropriate and timely support carers are able to care for longer, and enjoy better health and improved well-being. Carers do not usually 'down tools,' but unsupported they can experience real hardship financially, physically and emotionally. It is much more likely that a cared-for person will be admitted to hospital and the carer's own health deteriorates if the carer is unsupported. Carers can easily reach crisis point without appropriate and timely intervention.

The CHCP is committed to identifying, assessing and supporting carers in a personalised and outcome-focused way and on a consistent and uniform basis (including the provision of short breaks or respite). Key areas of change within older people's services including planned hospital discharges and with the right range of community services put in place, then there is a much greater likelihood of the cared-for person remaining at home with carer support. This means identifying the carer at an early stage when the person is admitted to hospital and ensuring that the carer is part of the care and discharge planning process, including having their own needs assessed through the Carers' Assessment process. The CHCP's local Carers Strategy is being refreshed and will be finalised later in 2012.

9.3.8 Best Value

The financial challenges facing the public sector are well documented. The scale of the reduction in finances brings immediate challenges for the CHCP to manage expenditure more efficiently and effectively but also to ensure long term sustainable services. Whilst there is scope to make further efficiency savings the funding gap currently faced is unlikely to be bridged by efficiency savings alone. The need to reduce costs provides the CHCP with an opportunity to reconfigure and streamline service delivery. However, in doing so we must focus on two things, long-term financial sustainability for services and the achievement of good outcomes for service users. This requires a clear understanding of service costs including how different activity levels affect costs, and a clear methodology for setting service specifications and budgets based on priorities and the outcomes to be achieved for the people who use those services. In keeping with the IPC's cyclical commissioning process, this necessary work stream (including the application of the Procurement Principles appended here) will be taken forward as an explicit element service planning processes.

9.3.9 Population Needs

The Equality Act 2010 imposes a general equality duty designed to integrate consideration of the advancement of equality into the day-to-day business of public authorities. Therefore the CHCP, in the exercise of its functions (e.g. as an employer, service planner and provider) must have due regard to the need to:

1. Eliminate unlawful discrimination, harassment and victimisation and other conduct that is prohibited by the Act.
2. Advance equality of opportunity between people who share a characteristic and those who don't.
3. Foster good relations between people who share a characteristic and those who don't.

All CHCP strategies, plans, performance reports and procurement activity are scrutinised to ensure that the requirements and duties laid out within Equalities legislation are being met. With constraints on budgets it is apparent that different approaches to service delivery are required to reflect the

needs of different types of people and ensure equitable access to supports and services to other population groups.

9.3.10 Integrated Health and Care Arrangements

At the end of 2011, the Scottish Government announced its intention that (over the course of this current parliamentary session) legislation will be brought forward to further integrate health and adult social care services. Under the Scottish Government's proposals, NHS Boards and Local Authorities will be required to set up a Health and Social Care Partnership that would replace/supercede existing current Community Health (and Care) Partnership arrangements. The NHS Board and the Local Authority will devolve their service budgets to the new partnership entities, that at the time of the initial annoucement were suggested as including primary and community health (including NHS children's services), adult social care and an element of NHS acute sector expenditure. They will jointly appoint an accountable officer who will be responsible for the integrated budget and manage service delivery and development. All the new partnerships will be asked to deliver and report on seven national outcomes, underpinned by a number of performance indicators. The new partnerships will make decisions on service provision, redesign and the use of their 'pooled' budget. The jointly appointed accountable officer will have a level of delegated autonomy that allows them to make decisions about the use of the budget to deliver the outcomes without on-going reference upwards to the individual statutory partners. The initial annoucement explicitly stated that the initial common focus for all the new arrangementw would be integrating services for older people.

The Scottish Government's proposals reinforce the strength of the arrangement that the Council and the NHS Board had the foresight to put in place in 2010 in establishing West Dunbartonshire CHCP. The CHCP is also placed to meet the expectation to focus on older people, through its having developed well-rounded strategic frameworks for action, as expressed in the local Older People's Change Fund Plan and this CHCP Commissioning Strategy for Older People's Services

9.3.11 Information Management

The commissioning task starts with improvements to data collection and analysis. Current performance management systems are provided across a number of service areas and due to the complexity of information recording and gathering it is difficult to ascertain the definitive number of people using the services compared to the number of referrals currently recorded. Whilst some national data will be used appropriately there are many data fields that are collected at levels far greater than that covered by the West Dunbartonshire CHCP and will not provide local data. Going forward there is a pressing need to refine data collection systems that provide clear, unambiguous, local data that informs the cyclical commissioning process that this document is a key part of. Whilst the opportunity of increased investment has been provided via the Change Fund, estimates of the level of need are at an early stage of sophistication and will require detailed analysis as well as time to demonstrate real change across the system as a whole.

The ability to adequately utilise the data contained within both the Best Value Review of Older people's services and the Capacity Planning data, and convert it to viable options to achieve an effective challenge to the rise of the numbers of older people with complex needs will require staff commitment and time. Data from the Scottish Government Statistics Group provides comprehensive health and social care data for the CHCP as well as benchmarked data from other partnerships in Scotland. This is particularly relevant for the CHCP given social and economic profiles for the area and supports the delivery of an improved health improvement agenda and outcomes. Realising the potential of outcome based commissioning as described requires improving information recording and sharing between and within the NHS and the local authority and across CHCP services (including the systematic application of Single Shared Assessment and recording of the Care First information system).

9.3.12 Performance Management

The National Performance Management Framework was introduced by the Scottish Government in December 2011 and builds on the outcomes based framework set out in 2007. It provides details of the 10 year vision clearly set out in terms of improving the measure of progress towards the National

Outcome agenda. Locally a suite of key performance indicators (KPIs) has been identified across all key areas for development. There is a range of outputs which are reported which will allow for more detailed analysis if trends and performance linked to public investment. These outputs represent a combination of statutory national indicators and locally determined indicators which reflect current commitments and demographics. The KPIs capture the national HEAT targets (Health Improvement, Efficiency, Access and Treatment) targets that are pertinent to older people's services within the CHCP. They also represent the agreed requirements within the Council Assurance and Improvement Plan to focus on local health and well-being priorities. The local Change Plan has specific outputs relating to hospital admissions, care home admissions and waiting times and respite. While these are specific to older people's services, they do also contribute to the corporate indicators for both parent organisations (including national waiting times). However, there is a need to ensure that internal and external systems are better able to produce data fit for a range of purposes including "live" data for reporting and more long term trend data to allow for planning and trend analysis. Work on the development of local qualitative outcomes is already being developed to augment all of the above. As a result, a set of locally agreed outcomes will be established and will form the basis on which commissioning of services is delivered and monitored.

A key policy development has been the reduction in the current six week target for discharging someone from hospital when they no longer need hospital care. As described in Section 2.1.3., the new target is for a four-week maximum wait for discharge to be achieved by April 2013, followed by a two-week maximum wait by April 2015. In common with the rest of Scotland, meeting this new target will require the CHCP to continue to review, challenge and refresh its activities and processes; and to work with partners to do likewise (e.g. ensuring appropriate provision and quality of care home places).

9.3.13 Strengthening Links with Other Service Areas

- This Commissioning Strategy has an additional complementary and reciprocal relationship with Mental Health Services Commissioning Strategy (which is currently being prepared).

- Addictions Services

The *Alcohol and Ageing: Is Alcohol a Major Threat to the Baby Boomers?* Report (commissioned by Health Scotland) states that if the baby boomers (in 2010 this is the population aged 45 – 65 years) carry on with their current drinking patterns into old age they are likely to experience higher than anticipated levels of morbidity. A more detailed analysis of these issues are laid out in the CHCP's Commissioning Strategy for Alcohol and Drug Services.

- Adult Support & Protection

The CHCP and its partners are committed to the support and protection of adults at risk of harm, who by virtue of disability or illness, are more vulnerable to being harmed. The West Dunbartonshire Adult Protection Committee brings together Council, Health, Police and Third Sector members to provide cooperation, guidance and oversight of policies and services that support and protect adults at risk. There is an extensive programme of knowledge and skills based training that equips staff in the public and independent sectors to intervene, support and protect adults at risk and this priority will continue.

Appendix I

COMMISSIONING: DEFINING THE STAGES OF THE PROCESS

Analyse

- Identify the impact that you wish to have in relation to your strategic objective. This will take account of the mission and key policy drivers within your organisation and will mean focussing resources on the achievement of results for people w ho use our services. This "Outcome based' commissioning" is a strategic process of specifying, securing and monitoring outcomes to meet peoples' needs at a strategic level.

- Develop an understanding of the needs of service users and link this back to the outcomes desired for service delivery. This will involve consultation with service users and organisations that advocate on their behalf. You will be seeking to understand 'how' you will know that the outcomes and impact you are looking for have been achieved.

Plan

- Resources or a budget for the service should be agreed based on the outcomes sought and the assessed need. Initial targets will become clearer once the budget is agreed. The process is reiterative and may require that you take a step back if it is clear that your budget will not allow you to achieve the desired outcomes.

- The best service available within resources should be designed based on the outcomes sought and the assessed need. Effective outcome based commissioning minimises the attention on inputs and the micromanagement of services and focuses on the achievements made by service users at the end of any programme.

Do

- Options appraisal helps decide how the service should be delivered. Purchasing the service through a competitive process – procurement – is often the best option in terms of securing Best Value. At this point you will engage more fully with procurement professionals to follow established processes that will take account of Best Value, EU legislation and the strategic aims of the procurement strategy.

Review

- Once your service delivery organisation is in place you will have to monitor and evaluate the service delivery, involving key stakeholders (particularly service users) as appropriate. Monitoring and evaluation should be proportionate to the contract value and contract length to ensure value for money. Information gathered from the monitoring/evaluation process should help you redesign the service and make decisions regarding any future contracting processes.

PROCUREMENT GUIDING PRINCIPLES

The following guiding principles for the procurement of care and support services reflect the complexity of procuring care and support services and the complexity and the challenges associated with upholding values, delivering high standards and responding to individuals needs whilst complying with procurement rules and securing best value. Taken together, the principles govern all procurement activity and will be used as a framework for evaluating local practice.

1. **Outcomes** – achieve positive outcomes for service users and carers through the delivery of good quality, flexible and responsive services which meet individuals' needs and respect their rights.
2. **Strategic commissioning** – place the procurement of services within the wider context of strategic commissioning, reflecting strategic and service reviews.
3. **Personalisation** – secure personalised services which provide independence, choice and control for service users.
4. **Involvement** – involve service users and carers as active partners in defining their needs and the outcomes they require and in the design of their services.
5. **National Care Standards** – ensure services meet the National Care Standards and adhere to the principles underpinning the Standards (dignity, privacy, choice, safety, realising potential and equality and diversity).
6. **Codes of Practice (Scottish Social Services Council)** – ensure staff involved in procuring services promote the interests and independence of service users and carers, protect their rights and safety and gain their trust and confidence; ensure employers provide training and development opportunities which enable staff involved in procuring services to strengthen and develop their skills and knowledge.
7. **Best value**– secure best value by balancing quality and cost and having regard to efficiency, effectiveness, economy, equal opportunities and sustainable developments.
8. **Benefit and risk** – base strategic decisions concerning the procurement of services on benefit and risk analysis of the potential effects on: the safety and well-being of service users and carers; the quality and cost of services; and partnership working with service providers and workforce issues.
9. **Procurement rule** – ensure procurement exercises comply with the principles deriving from the Treaty on the Functioning of the European Union (equal treatments, non-discrimination and transparency), the requirements of the Public Contracts (Scotland) Regulations 2006, statutory guidance issued under section 52 of the Local Government in Scotland Act 2003 and Scottish public procurement policy.
10. **Leadership** – ensure senior managers give a high priority to the procurement of care and support services, setting clear strategic goals managing.
11. **Workforce** –ensure the procurement of services takes account of the importance of skilled and competent workforce in delivering positive outcomes for service users.
12. **Partnership** – promote collaboration between public bodies and partnership working across the public, private and voluntary sectors to make the best use of the mixed economy of care and bring about cultural change in all sectors.