West Dunbartonshire Community Health & Care Partnership Commissioning Strategy For Rehabilitation Services

2012 – 2021

January 2012

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ACKNOWLEDGEMENTS

The CHCP gratefully acknowledges the comments and contributions from all those local stakeholders involved throughout the process of developing this commissioning strategy, particularly those staff planning and delivering our local services. The CHCP's local commissioning strategy approach has also benefited from considered feedback from colleagues at the former Social Care Social Work Improvement Scotland/now Care Inspectorate, the Joint Improvement Team (JIT), and the Scottish Government.

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An electronic version of this Commissioning Strategy 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 Rehabilitation Services across the West Dunbartonshire Council area is to enable independence and promote active living.*

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 adult rehabilitation 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).

The aim of this Commissioning Strategy is to project how the local provision of these community-based services will need to be developed over the course of the next decade (i.e. 2012 to 2021) so as to reflect changes in demand, development of policy, 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

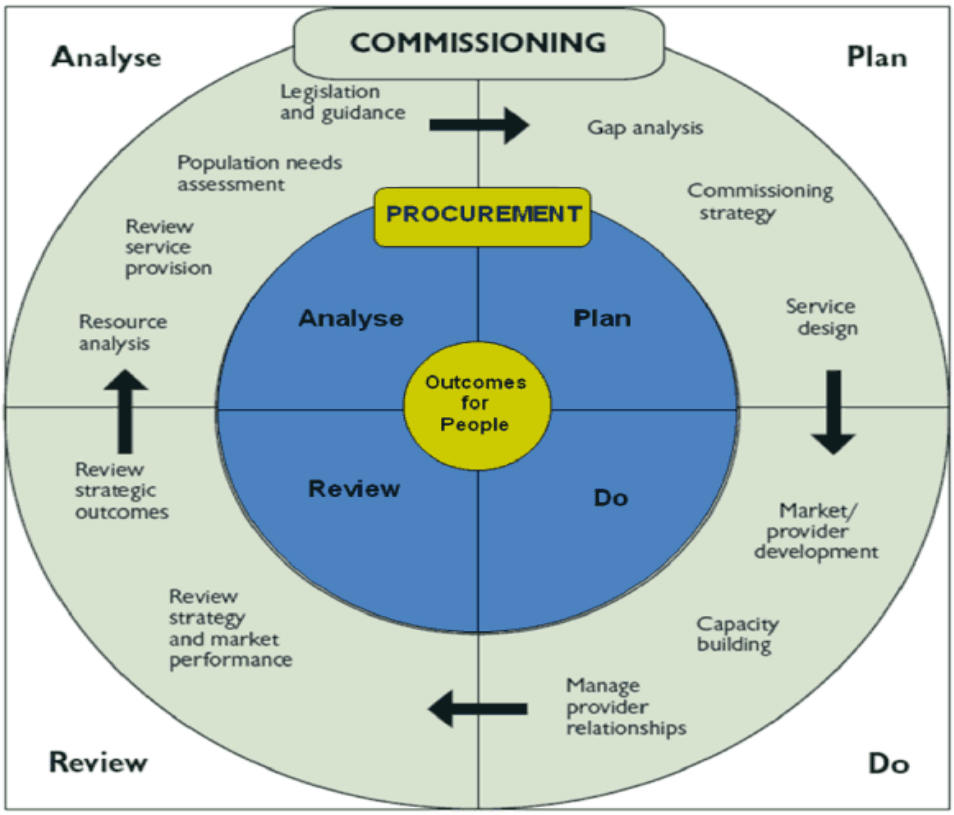
These values are manifested through a systematic concern for the following principles:

- 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.

1.4 Delivering Strategic and Outcome-based Commissioning

This commissioning strategy 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 rehabilitation and enablement services is essential to ensure that high quality and sustainable services are available to those who need them. This commissioning strategy will drive 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.

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 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*. This definition reflects the fact that the needs of individuals and carers are at the heart of rehabilitation.

The framework identified six themes to underpin the development of services:

- Rehabilitation services should be more accessible to those who use services, including direct access.
- Rehabilitation services need to be provided locally, with a strong community focus.
- A systematic approach to delivering rehabilitation to individuals is required, promoting independence, self management and productive activity.
- Rehabilitation services should be comprehensive and evidence based, should reflect individuals' needs at distinct phases of care, and should identify models to ensure seamless transitions.
- Practitioners and providers in health and social care services need to be better informed about current and evolving roles and expertise within rehabilitation teams.
- Health and social care professionals need to critically review staff resource deployment through service re-design and skill-mix review.

The framework also referenced a more detailed description of rehabilitation, as follows:

- Structure

A rehabilitation service consists of a multi-disciplinary team of people who:

- Work together towards common goals for each patient.
- Involve and educate the patient and family.
- Have relevant knowledge and skills.
- Can resolve most of the common problems faced by their patients.

- Process

Rehabilitation is a reiterative, active, educational, problem-solving process focused on a patient's behaviour (disability), with the following components:

- Assessment – the identification of the nature and extent of the patient's problems and the factors relevant to their resolution.
- Goal setting.
- Intervention, which may include either or both of (a) treatments, which affect the process of change, and (b) support, which maintains the patient's quality of life and his or her safety.
- Evaluation – to check on the effects of any intervention.

- Outcome

The rehabilitation process aims to:

- Maximise the participation of the patient in his or her social setting.
- Minimise the pain and distress experienced by the patient.
- Minimise the distress of, and stress on, the patient's family and 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.

The framework stressed four priorities for NHS Boards and local authorities:

- To transform their rehabilitation services to put rehabilitation at the heart of service delivery.
- To adopt a whole-systems approach to rehabilitation services.
- To give greater priority to rehabilitation services.
- To reflect evolving outcomes measures for community care (and any consequent targets) that impact on rehabilitation services.

2.1.2 Reshaping Care for Older People (2010)

This national programme aims to optimise independence and well-being for older people in their own home or in a homely setting. Its substance is being addressed within the West Dunbartonshire CHCP Older People's Service Commissioning Strategy (which is currently being prepared with reference to the *Older People's Change Fund*), with which this Commissioning Strategy has a complementary and reciprocal relationship.

2.1.3 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.
- 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 rehabilitation and enablement services in West Dunbartonshire over the decade, i.e.:

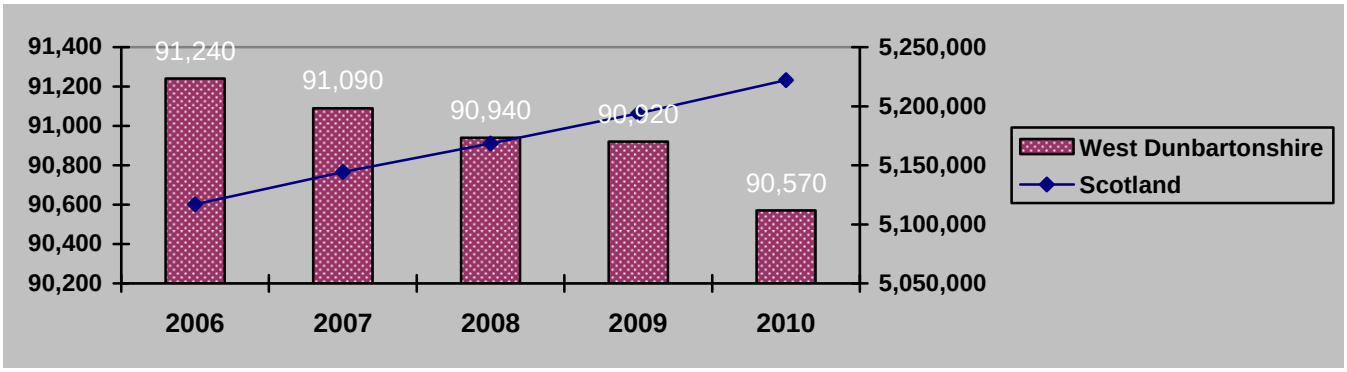
- A person-centred and outcome-based model of delivery that emphasises independence, self management and productive activity.
- Integrated care pathways and planning for each individual service user reinforced by co-ordinated assessment systems.
- An effective contribution to the early intervention agenda,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

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).

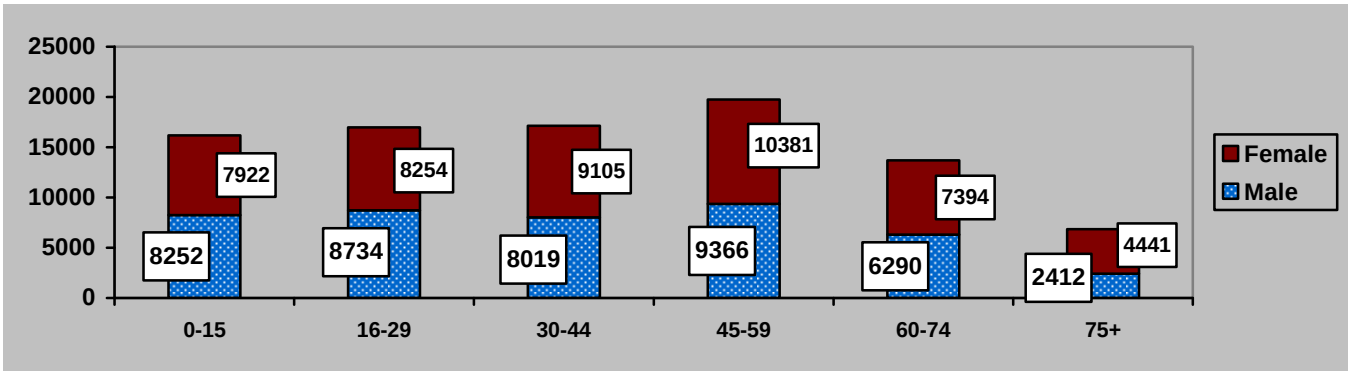
Chart 1: Population number 2006-2010



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. Of those over 65 14% are men and 25% are women. 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)



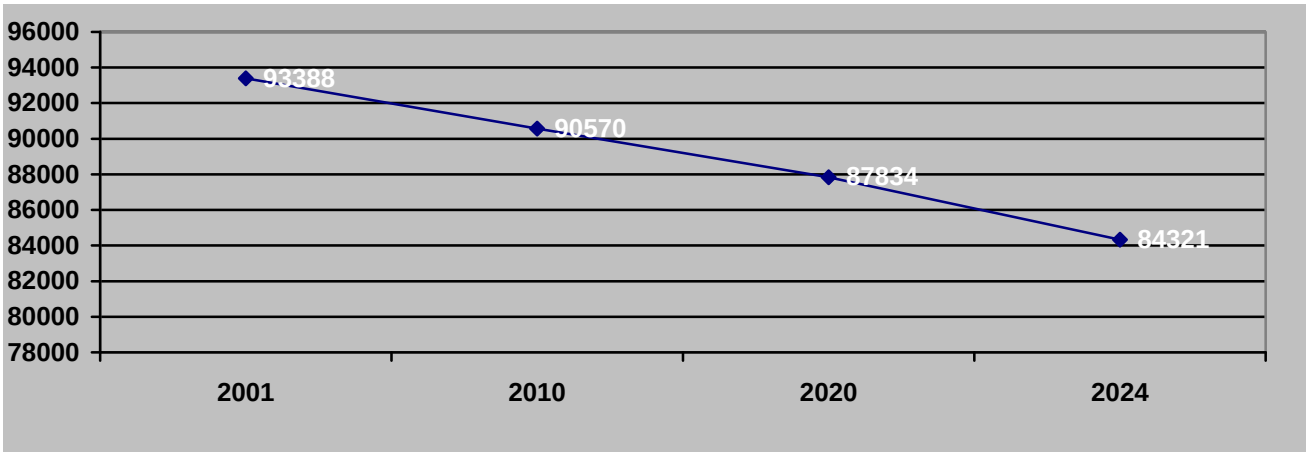
3.3 According to the General Register Office for Scotland's 2001 census, 20% of the adult population described themselves as having a long term limiting illness or disability was 20% of the population, with over two thirds of them being over the age of 50 years.

4. PROJECTED PROFILE OF FUTURE NEED

4.1 Population Size and Profile

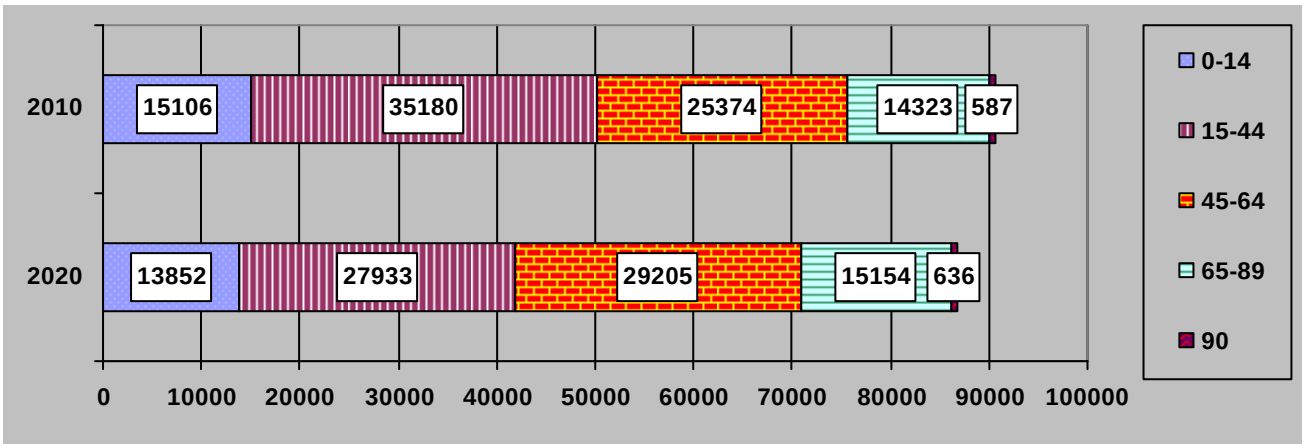
Analysis of the data taken from the General Registrar Office for Scotland and projecting likely trends in the population of West Dunbartonshire indicates a continued reduction in population size of approximately 3.2% over the next 10 years. Assuming this trend continues the population will continue to 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 - population (number) by age group at 2010 and projected for 2020



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)

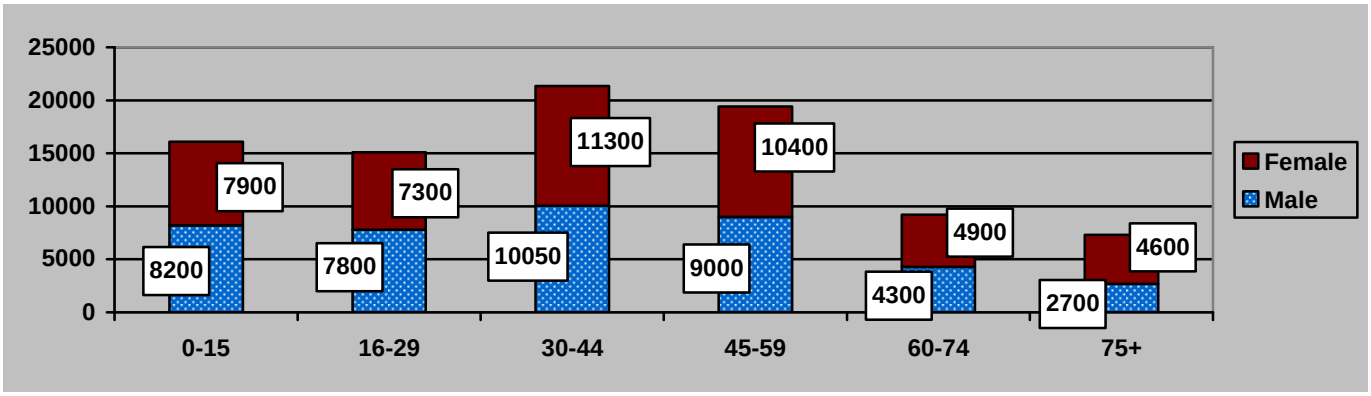
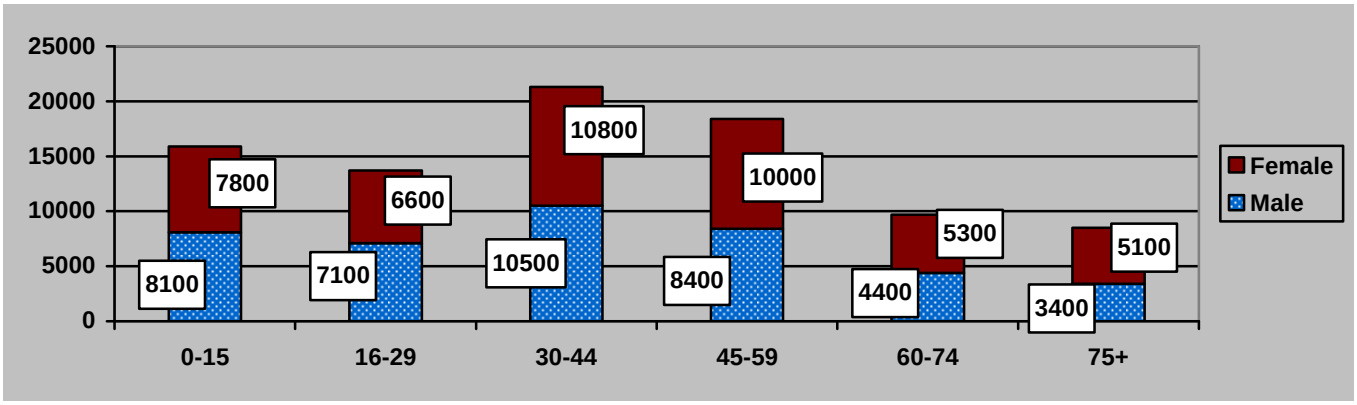


Chart 6: West Dunbartonshire - projected population (number) by gender and age (2023)



5. PROVISION AND DEMAND

5.1 In 2005 a review was initiated of Rehabilitation Services within the then NHS Greater Glasgow Health Board area, that included primary care, secondary care and social care services – this was then expanded to cover the NHSGGC area. The purpose of the review was to determine in the context of the "whole system" whether or not the needs of older people and adults with a physical disability were being met in relation to rehabilitation and to highlight gaps in services. The headline finding of the review was that although all the key components of comprehensive rehabilitation services were present, there was evidence of duplication between teams which caused confusion for service users and referrers in terms of criteria for referral, access to services and intervention times. This led to a major re-organisation of Community Rehabilitation Services across NHSGGC, which concluded in May 2011 with restructuring of Older Peoples, Physical Disability and Hospital Discharge teams within CH(C)Ps.

5.2 West Dunbartonshire CHCP provides a wide range of teams which support rehabilitation and enablement, with processes in place to ensure that each service can access a range of care and expertise for any given individual. These include:

- Community Assessment and Rehabilitation Team
- District Nursing
- Homecare Service
- Community Occupational Therapy
- Acquired Brain Injury Service
- Sensory Impairment Team
- Community Alarm/Telecare Service
- Community Physical Disability Team

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. special needs housing) and NHS external contractors (i.e. general practice, dentistry, optometry and community pharmacy).

5.3 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.

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

5.5 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. Moreover, with better early healthcare and an emphasis on care at home, the number of children with a physical disability transitioning to adult services will increase.

5.6 Based on prevalence data, service usage and service fallout, it is likely that the current level of demand for services is likely to increase over the next 3 – 5 years. 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 When individuals face challenges to their physical or mental well-being, they experience an impact on their quality of life. Rehabilitation is fundamentally about enabling and supporting individuals to recover or adjust during this time, achieve their full potential and – where possible – to live full and active lives. 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 a sense of self worth and well-being (particularly prominent in rehabilitation offered within mental health services).

6.2 There are three levels of management in the rehabilitation process:

- For the majority of people, *self management* has been shown to be effective in improving quality of life and promoting appropriate use of services.

  Self management relates to individuals taking responsibility for their own physical and emotional health and well-being and includes staying fit and healthy, taking action to prevent illness and accidents, using medicines appropriately, seeking prompt treatment for minor physical and emotional ailments and self managing long-term conditions appropriately.

- People with less-complex needs and their carers are offered *condition management* support through multi-disciplinary primary care teams, with specialist rehabilitation as appropriate.

  Condition (sometimes referred to as 'disease') management has been defined as a system of co-ordinated health care interventions and communications for populations with conditions in which patient self-management efforts are significant.

- For the small number of people with the most complex needs (who are most are most likely to be at risk of admission to hospital and may become ill unless their needs are anticipated and addressed) and their carers, the aim is to offer *case management* (also often referred to as care management).

  Case management has been defined as: a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality cost-effective outcomes.

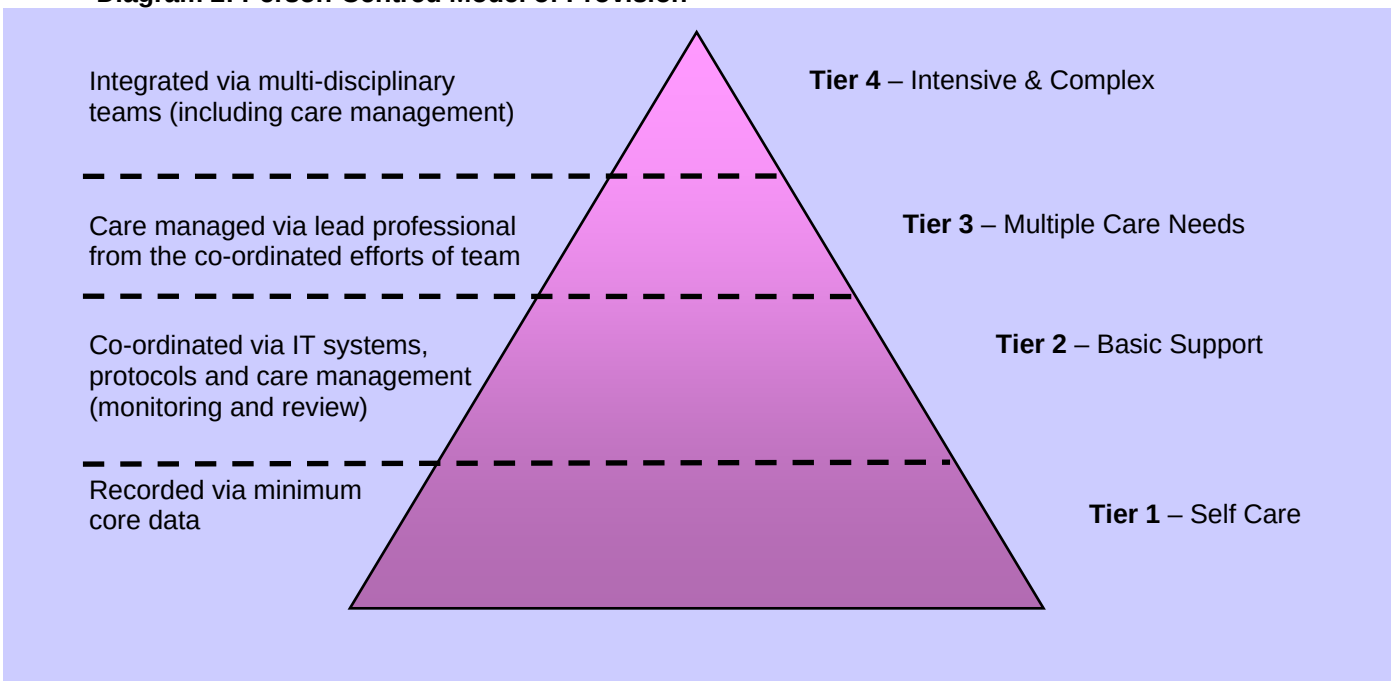
6.3 Rehabilitation services must further develop and provide joined-up interventions which ensure that the individual is explicitly central to the development, implementation and management of their own care package. *Enablement* refers to the process of health and social care staff supporting people 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).

6.4 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 individual 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 The following model (Diagram 2) emphasises an increased role for self-assessment, facilitates greater support for self-care and will also allow direct access to some services. The aim is to open up the health and social care system to support appropriate user directed care, and to better target specialist professional resources to people with the most complex needs.

Diagram 2: Person-Centred Model of Provision



6.6 To make sure there is a consistent way of providing people with the most appropriate care to meet their needs, the model sets out four tiers (or levels) of need. It is important to recognise that this is not necessarily a route followed by all people, rather a way of planning service responses for different levels of need.

6.6.1 Tier one: Self Care

People in this tier may be experiencing some loss of function and have a limited specific need for short term help but are able to carry out the activities of daily living without assistance. They need services that promote good health and wellbeing, prevent ill health, offer practical help and support, encourage independence and social inclusion, and prevent disability. The main service with which people in this group are likely to be in contact is primary care, particularly their general practice. People will require information on services available to them and how to access them at an early stage. This would include advice about benefits, safety, physical activity, and carer support. Access to screening for potential problems such as vision, hearing, mental health, oral health, continence and foot health. Preventive measures such as immunisation, dietary advice, smoking cessation, advice on addictions, and falls risk prevention will also be offered. Social care and housing supports include handy person's schemes, aids for daily living, day services, care and repair, and tenancy transfers to be closer to family and friends or to move to smaller accommodation.

6.6.2 Tier two: Basic Support

People in this tier will be experiencing some loss of function and require practical assistance with tasks inside and outside the home. This assistance may be provided as required by friends or family acting as carers, or by care services. People in this group may require housing, health, or social care services at times. This may be practical assistance such as shopping, housework, laundry, day centres, short breaks for carers, or meals at home. Health support may include medication or Allied Health Professional treatment, district nursing or health visiting. Housing support will include minor aids / adaptations such as grab rails, housing alarms and sheltered housing.

6.6.3 Tier three: Multiple Care Needs

People in this tier will be experiencing significant loss of function and probably need personal care as well as practical assistance. Friends and family acting as carers may provide some of this assistance but they are also likely to need multiple services from care agencies. They need access to more detailed assessment and rehabilitation / treatment and social care provision to maintain their level of

function and wellbeing for as long as possible. They may require housing, health, and social care services as part of a co-ordinated package of care. Practical assistance may be similar to that in tier two. Personal care can be provided by trained home carers. Health care support may be in the form of community or day hospital assessment and rehabilitation from community services. Social care may be in the form of enhanced home care and overnight services and care homes. Housing support could include major adaptations or very sheltered accommodation.

6.6.4 Tier four: Complex and Intensive care needs

People in this tier will be experiencing significant deterioration of function and need both personal care and practical assistance. Friends and family acting as carers may provide some assistance, but they are likely to need significant support. People in this tier need access to ongoing assessment and rehabilitation / treatment and social care provision. Some people may experience severe loss of function that has failed to respond to rehabilitation programmes, and so require assistance in most areas of their life. It may be difficult to maintain the person in their own home. People in this group will need a complex package of housing, health and social care services to support them, particularly when people are at risk of admission to hospital. Practical assistance may be similar to that in tier two, but with increased intensity. Home carers and enhanced care workers, supported by nursing staff, may provide personal care. Health and social care support will be more specialist or involve more complex assessment and rehabilitation, both at home and in care settings. Additional social support may be in the form of day care, respite and short breaks, again with increased intensity or specialist focus. A move to very sheltered or barrier free housing may be needed. Alternatively, people may need to move into a care home. Services should encourage people to live to as near as possible their potential in terms of physical, mental and social function. They should support people to do things for themselves, to live their lives the way they want to, being able to engage in meaningful activity. There should be a regular review of people's medical, cognitive, nutritional and care needs considering falls risk assessment and appropriate medical review and treatment.

6.7 The models aims to ensure that access to community services at all tiers will be needs led, simplified and that any contact with the health and social care system will be able to direct service users to the appropriate level of care as efficiently as possible. It is important to recognize that people's health and care needs may change gradually or unexpectedly and as a result they may move up or down the levels of care supported by assessment, care management and pathways.

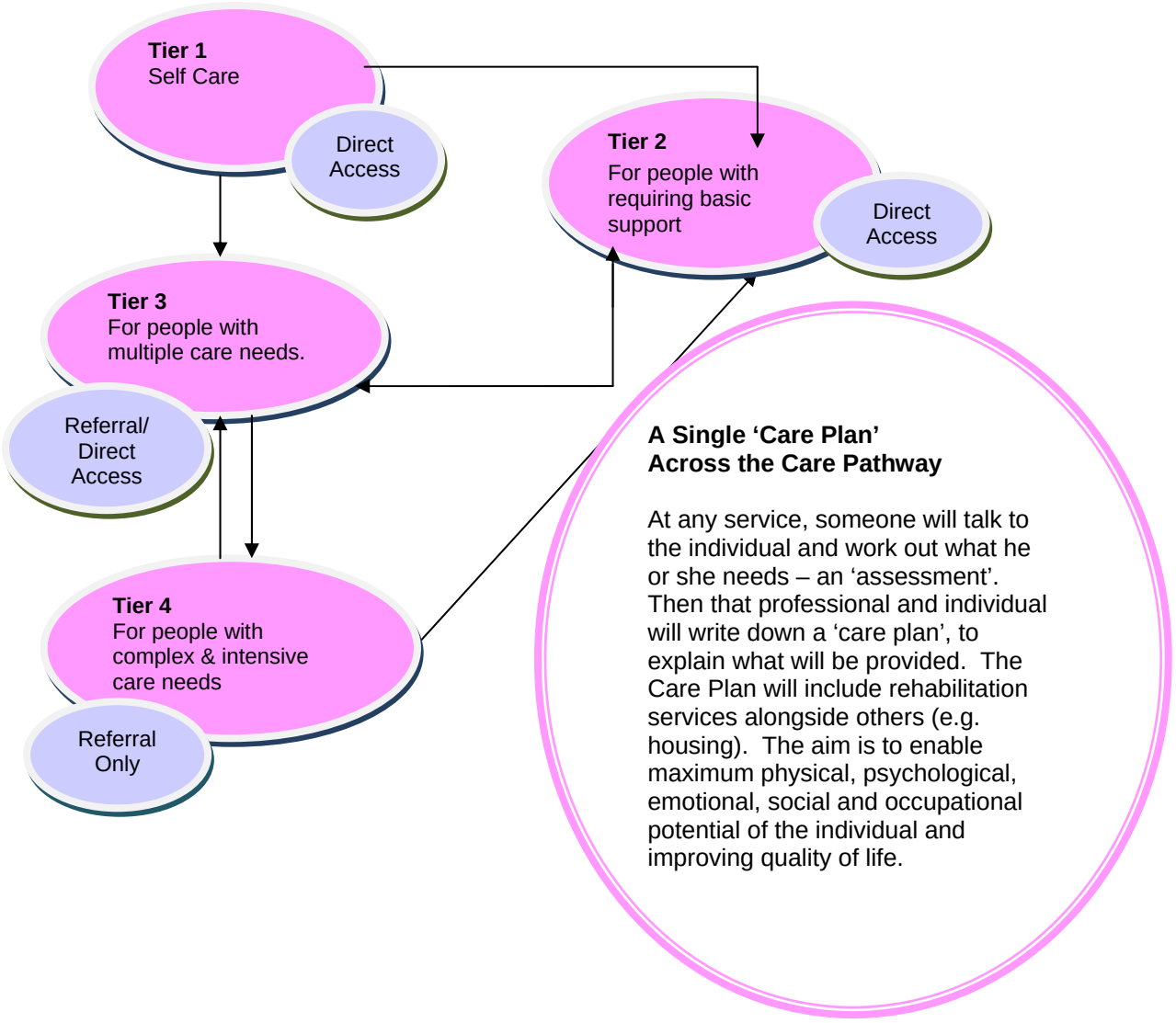
6.8 The tiered model above will be implemented and embedded through the development of community-based, multi-disciplinary health and social care teams which will be directly linked to hospital-based specialist services.

6.9 It is important to appreciate the development of the CHCP of its local model for the provision of rehabilitation services does not occur in isolation, either from the development of other service agendas within the CHCP (e.g. older people's services more generally) or other developments within the related wider public sector system, particularly NHSGGC. A notable example of this are recent changes being implemented as a result of the NHSGGC Review of Allied Health Professionals (AHP), which has primarily resulted in a "hosted" approach to the management of AHP services as follows. Dietetics will be managed by the NHSGGC Acute Division, organised and delivered from four geographical quadrants: West, East, South Glasgow, South Clyde. Podiatry will be managed by Renfrewshire Community Health Partnership, organised and delivered from four geographical quadrants: West, East, South Glasgow and South Clyde. The Physiotherapy redesign has focussed only on the Muscular Skeletal Physiotherapy (MSK) service. MSK Physiotherapy services will be hosted by West Dunbartonshire CHCP as an integrated (partnership/acute) service, organised and delivered from four geographical quadrants: West, East, South Glasgow and South Clyde.

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 tiered level of service model which targets specialist functions and resources at the highest and most complex needs; is flexible and able to respond to the changing needs of individuals; and allows more direct access to resources at lower levels. Moreover, it reinforces the move from providing services on an episodic treatment approach to an approach with additional focus on rehabilitation and enablement with a stronger focus on supported self care and self management.

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



7.2 A key element of this person-centred and outcome-focused model is the provision of rehabilitation 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 rehabilitation, 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 annual basis, with an increasing emphasis on ensuring a clear relationship with and understanding of the service priorities that need to be met, both in-year and going forward.

8.2 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.

8.3 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.

8.4 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).

8.7 Reviews of all service provision, in house and externally purchased in line with best value competitiveness 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.

8.8 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. 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 Improving community-based rehabilitation services is integral to the rehabilitative approach, as 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 will drive 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.

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.

Whilst CHCP services have a good track record in achieving national targets, there is no room for complacency. Fortunately there is clear commitment to quality and a commitment to sustain achievements.

9.3.2 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.

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.

9.3.3 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.

9.3.4 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 of annual operational service plans for the CHCP's rehabilitation and enablement services.

9.3.5 Carers

Caring Together: The Carers Strategy for Scotland (2010) emphasises the valuable contribution of Scotland's carers to the health and social care system. 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).

9.3.6 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 i.e. women and older people.

9.3.7 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 commissioning the cyclical commissioning process that this document is a key part of.

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).

9.3.8 Strengthening Links with Other Service Areas

- This Commissioning Strategy has a complementary and reciprocal relationship with following local CHCP Commissioning Strategies (which are currently being prepared):
  - Learning Disability Services Commissioning Strategy.
  - Mental Health Services Commissioning Strategy.
  - Older People's Services Commissioning Strategy.
- Out of Hours Support Services

The CHCP is committed to developing a joint out of hour's service providing rapid response and interventions (including access to step up / step down facilities). Whilst continued funding and extension of operating hours remains a local priority, use of the service will be reviewed and modifications implemented as required.

- 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.

- Housing

The significant mismatch between the current stock profile and likely future demand is being considered within the recent local Housing Strategy published by West Dunbartonshire Council (including interventions relating to establishing an effective intermediate housing market, area regeneration and the effective asset management of the affordable housing supply).

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.