West Lothian Partnership

Reshaping Care for Older People

JOINT COMMISSIONING PLAN

OLDER PEOPLE 2013-2023

15 February 2013

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1. INTRODUCTION

The West Lothian Joint Commissioning Plan for Older People has been developed by the four main partners of the West Lothian Reshaping Care for Older People Programme, West Lothian Council, NHS Lothian, Scottish Care as representative of the independent sector, and Voluntary Sector Gateway as representative of the voluntary sector, in conjunction with a range of stakeholders including older people and their carers. The plan sets out the commissioning priorities for health and social care services over the next ten years (2013 to 2023).

The plan responds to national policy and demonstrates clear, joined-up commissioning priorities across health and social care to respond to local challenges and improve service delivery to an increasing older population. The plan identifies and details actions to address gaps and gives commitment to review resources to ensure fair access to services across West Lothian.

2. WHAT IS COMMISSIONING?

Commissioning is defined as the
'Strategic activity of assessing needs, resources and current services and developing a strategy of how to best make use of available resources to meet needs' (1)

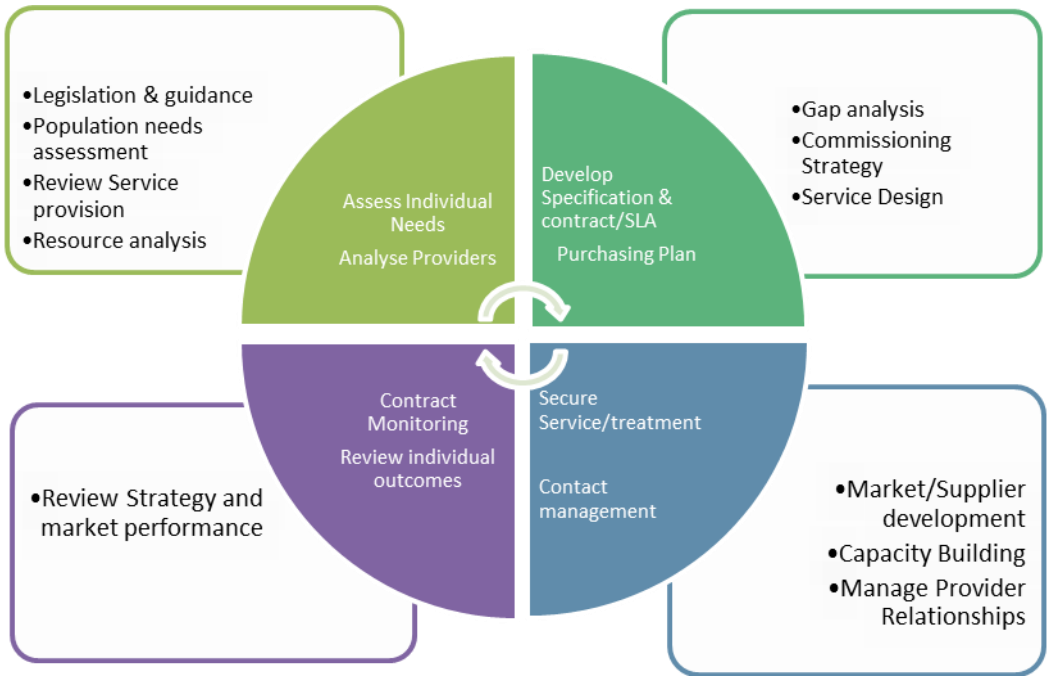

Figure 1 Commissioning Cycle (adapted from Institute of Public Care 2007(**2**)

Figure 1 demonstrates the commissioning process as a continuous cycle ensuring that the services commissioned continue to meet local needs, are of excellent quality and are valued by the people who use them.

1 DoH 1995 An introduction to Joint Commissioning
2 Key Activities in Commissioning Social Care - Lessons from the Care Services, Improvement Partnership Commissioning Exemplar Project, 2nd Edition, 2007.

3. VISION

Commissioning is the means to secure the best value for local citizens and is the process for translating aspirations and need, by specifying and procuring services for the local population.

West Lothian Community Health and Care Partnership's vision is

"To develop a partnership that will further enhance and develop the delivery of integrated health and social care services to the people of West Lothian"

The vision of this joint commissioning plan is

"To commission or facilitate the commissioning of a range of high quality health and social care services which are capable of delivering the outcomes sought for older people, their carers and the communities in which they live"

In order to achieve this vision there will be a focus on prevention and early intervention which enables older people and their carers to maximise their independence and remain within their own home where they chose to do so, whilst applying the principles of personalisation, in order to meet the needs and aspirations of individuals and their local communities.

Where services are required it is the intention via this strategic joint commissioning plan to ensure they are available, appropriate and fit for purpose.

4. SCOPE OF COMMISSIONING PLAN

The commissioning plan for older people will inform service users, carers, the wider public, commissioners, service providers and other stakeholders of the commissioning intentions for West Lothian's Older People during the period 2013-2023.

The plan focuses on establishing health and social care service priorities for older people, identifies the current provision and addresses the gaps and inequalities in service delivery and access.

The plan considers that older people are living and remaining active for longer and have increasing and changing expectations from the services they receive. This is coupled with a decreasing population of working age. A preventative approach to help people within this age group to retain their independence for the future is crucial in achieving long term well-being.

This plan incorporates services provided or commissioned by West Lothian Reshaping Care for Older People Partnership for those people aged 65 years and over. It is also important to acknowledge some groups of older people who may have specific needs including:

- Older carers whose numbers are expected to increase in line with the aging population and whose own health needs are also likely to increase as they themselves grow older
- Older people with dementia and mental health needs: A separate Joint Commissioning Plan has been developed for those with dementia and mental health needs which is inclusive of those with early onset dementia.

5. COMMISSIONING OUTCOME

The principle outcome of the joint commissioning plan for older people is

To enable older people live longer healthier and more independent and fulfilling lives within a safe and supportive community and continue to learn and develop.

Maintaining independence, promoting inclusion and well-being as well as giving people more choice and control are all central to achieving this outcome. Fundamental to this are the principles of:

- Improving health and well-being
- Improving quality of life
- Making a positive contribution to individuals and their communities
- Promoting and enabling more choice and control
- Supporting and promoting economic well-being
- Respecting the uniqueness of the individual

6. STRATEGIC CONTEXT

The national guidance is set within the context of continual improvement of health and social care services available for older people that delivers care closer to home, with a personalised approach and helps people maintain their independence.

The commissioning of older peoples services is shaped on a number of national and local policy drivers (detailed in Appendix 3). From these sources a number of common themes can be identified which require to be translated into both the range of provision to be made available as well as inform the way in which it is delivered, these are:

- Shifting the balance of care more towards community and home based care
- Personalisation and increased service user / carer choice and control over their care and support provision e.g. through Self Directed Support or Direct Payment.
- Management of long term conditions within local communities, this includes anticipatory care, support for self-management and a robust risk management and re-ablement framework
- Rehabilitation and re-ablement to be delivered as locally as possible
- Maximisation of independence and capacity – including improving social opportunities and reducing attitudinal and environmental barriers
- Service user engagement and choice
- Carers as equal partners in health and social care – including the need for carer training and support
- Strategic planning and joint commissioning, integrated service delivery and robust performance monitoring, management and reporting
- Outcomes focused approach and framework in service commissioning and delivery
- Prevention and upstream investment to avoid, delay or reduce the need for formal health and social care intervention, particularly hospital admission

7. RESHAPING CARE FOR OLDER PEOPLE

The National Reshaping Care for Older People programme has a primary goal of

"Optimising the independence and well being of older people at home or in a homely setting".

To achieve this partnerships are asked to demonstrate optimum use of all existing resources that fund care for older people and promote a philosophy of care centred on supporting independence through helping older people to remain safe and well and outside the formal care system for as long as possible.

The Scottish Government established a Change Fund to enable health and social care partners to implement local plans for making better use of their combined resources, facilitate shifts in the balance of care from institutional to primary and community settings, and influence decisions taken with respect to the totality of partnership spend on older people's services. The focus of this investment within West Lothian is to achieve progress within five thematic areas:

1. Development of re-ablement and crisis care
2. Integrated care pathways for long term conditions
3. Support to carers
4. Development of technology to support prevention and anticipatory care
5. Community capacity building

The partnership has established a Reshaping Care for Older People Programme Board with membership including all the main partnership agencies;

- West Lothian Council
- NHS Lothian
- Voluntary Sector Gateway West Lothian (representing the third sector overall)
- Scottish Care (representing the independent sector)
- Carers of West Lothian, the main local carers support agency
- Federation of Day-care providers, the local agency which represents all voluntary sector day-care providers.
- The acute sector:
- Joint Improvement Team

The board provides leadership and governance with regard to the projects, financial and other resources, strategic development, and performance

8. A JOINT APPROACH FOR OLDER PEOPLE

Our approach in developing this plan has been to review services provided or commissioned by West Lothian Council, NHS Lothian, Independent and third sectors and examine all available information which can be used for planning purposes and in doing so identify factors that will influence future demand or identify gaps in existing service provision.

The direction of the national guidance and local feedback has identified key themes, experiences and corporate responsibilities that are required to achieve the quality ambitions and desired outcomes for older people in West Lothian (Figure 2) which will form the basis of our strategic model for older people's services and action plan.

The themes encompass the principles of care that should be embedded in service development regardless of the type of service, level of need or how the service is procured or accessed.

The key experiences of service delivery pan across all services for all older people regardless of their level of need. All actions resulting from the strategy development are tabled in the 3 year Action Plan, Appendix 1, under these key headings.

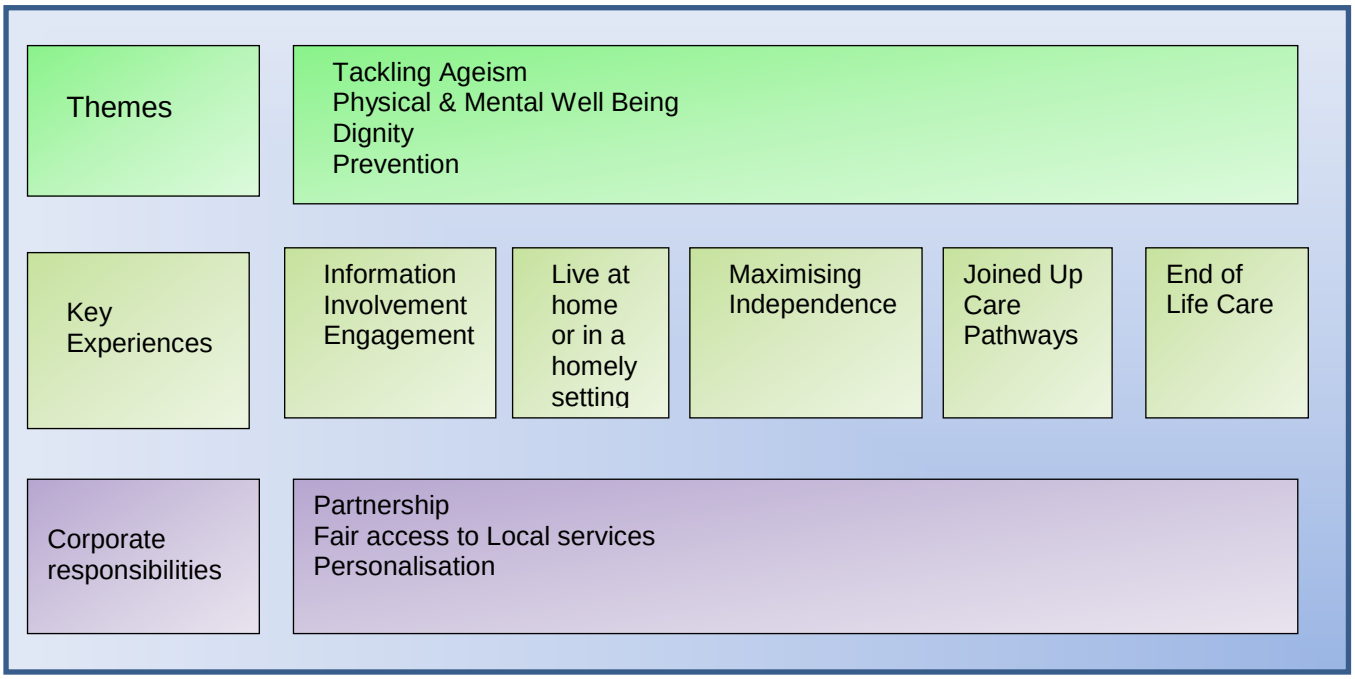

Figure 2: Strategic Model for Older People's Services (3)

The following key elements in our approach are fundamental to achieving the outcomes:

- Working in partnership to develop, fund and evaluate service delivery;
- Progress development of personalised service
- Ensuring equitable access to services enabling people to receive the right support, in the right place, at the right time.
- Ensuring commitment from all partners for the planning, development and delivery of sustainable, quality, cost effective services

The commissioning action plan has been developed in line with this model to deliver our commissioning objectives and takes account of the economic context, existing resources and local factors affecting quality, price and sustainability.

3 (Adapted from DCC Adults Well being and Health (2010) Joint Commissioning Strategy for Older People 2010-2013)

It is recognised that delivering quality care is reliant on a skilled, competent and confident workforce and that the risks attached to this require to be identified and mediated against. The West Lothian population demographic change estimates a significant reduction in the working age population making workforce development, recruitment and retention a key priority for the partners which will be supported through development of a local workforce development framework across the partnership. This will include a recognition that resources may need to be made available to all partners to successfully deliver on this goal.

There is a commitment from all partners to deliver better outcomes through sustainable, quality and cost effective services, achievement of this is supported through options appraisal and appropriate procurement processes to ensure Best Value.

It is recognised that to be successful in commissioning services for older people there is a need to support a mixed economy of care which allows all sectors to flourish. It is our intention via our commissioning priorities, partnership working and subsequent contractual arrangements to create a catalyst for this to happen, creating a climate in which existing and redesigned services can be sustained whilst allowing new opportunities to be realised.

The partnership has established a Reshaping Care for Older People Programme Board to provide leadership and governance. The Board, which includes representatives of the four main partners, NHS, West Lothian Council, independent sector and third sector, reviews progress of all projects/initiatives, monitors budget, considers strategic development, and monitors performance against outcome measures and indicators.

9. FUTURE DEMAND

West Lothian is facing an ageing population profile that presents a significant challenge. The projected overall growth in the numbers of older people in West Lothian over the period 2008 to 2033 is shown in figure 3.

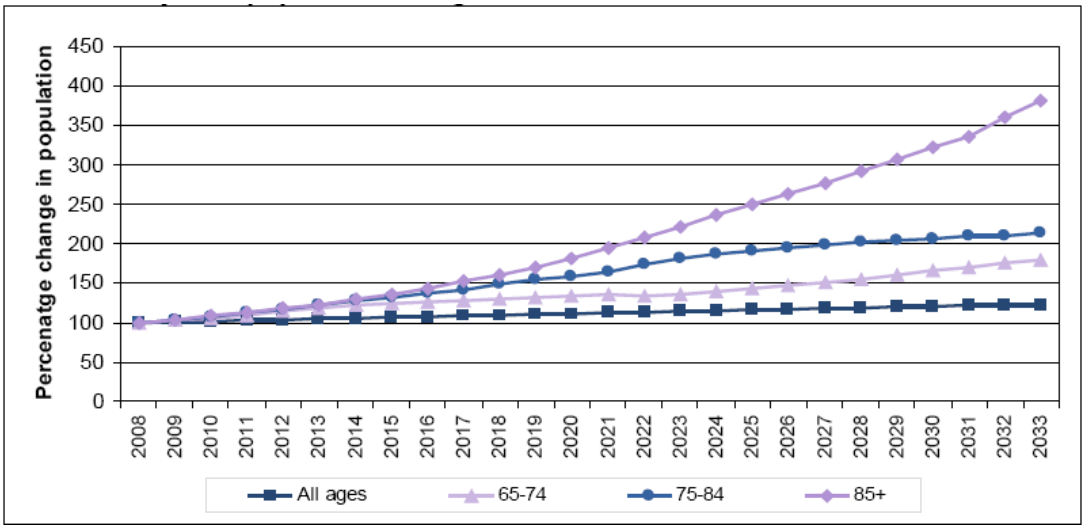

Figure 3: Projected population change: 2008-2033 *(4)*

The key features of this growth are:

- The number of 65-74 year olds will increase by 80%.

4 *General Register Office for Scotland - Population - Population Projections*

- The number of 75+ year olds will increase by 151%.
- The population of 85+ is projected to rise by nearly 300%.

In addition, a number of other factors have to be taken account of in assessing changes in demand for services:

Life Expectancy

In 2007-2009, average life expectancy at birth for West Lothian was 77.9 years, an increase of 4.4 per cent when compared to 1997-1999. Female life expectancy at birth (79.7 years) is greater than male life expectancy (76 years). The positive changes in life expectancy and population increase, particularly in the older population, point towards the need for local services to respond to demographic change by supporting people to lead more active and independent lives to ensure good health in later life.

Long Term Conditions

Long term illness has been identified as the 'Health Challenge of this Century' by the World Health Organisation. In West Lothian approximately 27,000 – 31,000 of the adult population live with one or more long term condition which potentially limits their ability to cope with day to day activities.

From Quality and Outcomes Framework (2011) information, West Lothian has a higher disease prevalence rate compared to Lothian for most long term conditions and a higher rate than the national and Lothian prevalence for certain conditions such as asthma, diabetes and depression (Figure 4)

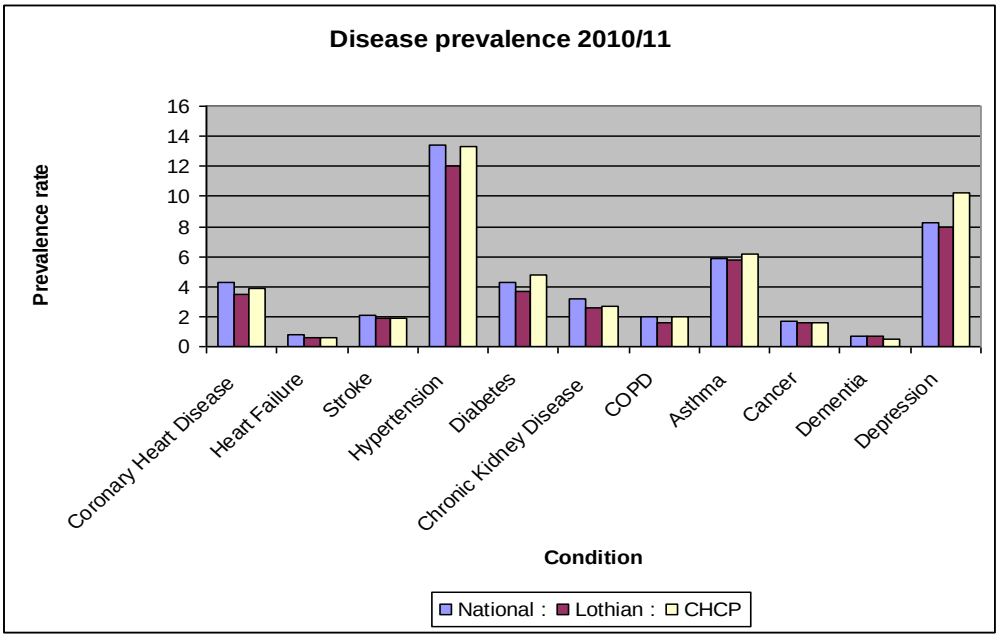

Figure 4: Disease Prevalence (5)

A number of long-term conditions have specific care pathways and it is acknowledged that the probability of having one or more long term condition increases with age. Given the evidence of multiple long-term conditions suffered by older people and the increased complex nature of the support and multiple care pathways required, a co-ordinated, personal approach is key to supporting older people and must include:

5 Quality Outcomes Framework 2011

- A preventative approach to help people sustain independence and live a healthy lifestyle.
- Development of 'self-care' to support independence wherever possible;
- The use of technology (telecare/telehealth) to support people at home.
- Increased support for carers of older people

This very significant growth in demand has to be seen in the context of reducing resource availability. The Joint Commissioning Plan will inform the remodelling of services and appropriate movement of resources to meet this challenge.

10. STRATEGIC NEEDS ASSESSMENT

The Community Planning Partnership completed a strategic assessment of West Lothian in 2012 to identify assess and prioritise what is important for West Lothian's communities which will inform the setting of achievable and demonstrable outcomes in the next Single Outcome Agreement.

Evidence demonstrated that inequalities and deprivation are at the heart of poor outcomes across health, community safety and education and employment for individuals and communities and "Tackling Inequality" is the core theme for the Community Planning Partnership and specific priorities have been agreed:

- Healthy Life Expectancy
- Mental Well Being
- Maternal and Child Health
- Older People

The main challenges in West Lothian are the aging population, persistent health inequalities, the continuing growth in number of people affected by long term conditions and those with multiple conditions and complex needs.

The 2012 Health & Well Being Profile (6) demonstrates the positive impact that our interventions are having on the West Lothian population and highlights the main challenges for the CHCP

<u>Impact</u>
There is improved life expectancy across the county although an inequality gap of 8-9 years persists from East to West
There are higher than average uptake rates of immunisations
There are improving levels of dental decay, smoking prevalence and teenage pregnancy
Long term conditions and lifestyle factors are having a significant impact.

<u>Challenges</u>

- To achieve reductions in emergency admissions to hospital
- Shifting the balance of care
- Tackling inequalities in health & well being

The commissioning plan directly links to the national priorities for older people and health inequalities and the following outcomes within the Single Outcome Agreement

- Our people are able to maintain their independence as they get older and are able to access appropriate support when they need it
- We live longer healthier lives and make healthy life choices

11. STRATEGIC LINKS TO HOUSING

There is a well-established principle of inextricable links between good health, availability of social networking and care, and enabling housing and environments to allow older people to maintain their dignity and independence in later life. One of the reasons people go into long term care results from a lack of appropriate housing in the community it is therefore important that the partners work closely with strategic housing colleagues in order to ensure that older people have access to appropriate housing options including accessible housing, repairs, adaptations, assistive technology and energy efficiency measures to help them remain in their own homes.

The housing sector already makes a significant contribution to outcomes on health and social well-being by:

- Providing information and advice on housing options
- Facilitating or directly providing “fit for purpose” housing that gives people choice and a suitable home environment
- Providing low level preventative services which can obviate the need for more expensive interventions at a later stage
- Building capacity in local communities
- Undertake effective strategic housing planning

The proposed integration of adult health and social care is recognised as bringing opportunities to strengthen connections between housing, health and social care, to improve alignment of strategic planning, to support the shift to prevention and to incorporate and review current arrangements for housing support and homelessness services.

The Housing Contribution Statement (Appendix 2) reflects the health and social care measures, including outcomes, that are considered most likely to be impacted by the housing contribution and describes the key service proposals and practical local measures which will maximise opportunities. The process of integration and synergy between housing health and social care will be developed and refined over the coming year.

Figure 5 Service Map: Overview of current service provision

Hospital Care		Accident & Emergency	Acute Wards			Assessment & Rehabilitation		Complex Care		Surgery
			Medicine	Stroke	Orthopaedic	Day Hospital	AHPs	St Michaels Hospital	Baillie Ward Tippethill	(SJH, WGH, RIE)
	£							938,000	1,772,000	
	Numbers	12,600	192	30	30	5000 per annum		24 beds	30 beds	
Intermediate Care		Crisis Care	Ambulance Paramedic Service	Step Down Residential Care	Discharge Liaison Service	Intensive Case Management Team				
	£	159,615			43,000	400,000				
	Numbers	ave 60/ month			3500 discharges per annum	1500 patients per annum approx				
Community & Primary Care		Social Work	Assessment and Care Management	Reablement Service	Care Line	Telecare		Social Care Emergency Team	Care at home	Day Care services
	£		1,558,293	2,124,951	409,259	502,662		529,622	5,523,382	892,223
	Numbers		2450	ave 30 new/ month		5,200				
		Carers Support (Carers of West Lothian)	Respite & Short breaks for Caring	Advocacy (through Lothian wide VOCAL Service)	Welfare benefits advice	Pensioner Income Maximisation Programme		Fuel Poverty and Energy Advisor		
	£	34,403	300,000	71,136	517,696	96,453		21,549		
	Numbers									
		General Practitioners (1)	Practice Nurses (2)	District Nurses	Health Visitors	Community Pharmacy		Psychology	Salaried Dental Services (3)	Adult Protection
	£	109,000	509,000	2,078,000	1,919,000	Pharmacy Contract		700,000	3,180,000	250,738
	Numbers	GMS provision to 182,000 practice population	127,000 contacts per annum	80,000 contacts per annum		30 community pharmacies		1500 per annum	not specifically for older people	

Community & Primary Care		Physiotherapy	Podiatry	Dietetics	Occupational Therapy	Speech & language therapy	Community Equipment	Falls & Bone Health	Blue Badge scheme
	£	2,022,000	3,217,000		1,190,000		1,015,000		
	Numbers	acute and community based provision- all ages	Lothian wide provision	acute and community provision- all ages	paediatric, mental health, adult and older people provision	acute and community provision all ages			
		Accommodation based provision	Housing with Care	Sheltered Housing	Care Homes	-	-	Accessible transport	Subsidised transport
	£		2,610,372	188,982	13,666,191				701,796
	Numbers		168 tenancies	110 tenancies	672				
		Pulmonary Rehabilitation	Cardiac Rehabilitation	Dementia Cafes		Reminiscence and Oral History	Dementia Early Onset Provision	-	Adult Learning
	£	37,000	25,000	50,000		27,914			332,149
	Numbers	300 per annum	200 per annum						
		Frozen Meals	Food Train & Food Train Extra	Food Coops	Lunch Clubs	-	Safe at Home	Befriending	-
	£	69,395	106,400	40,000	16,827		300,000	160,000	
	Numbers	110	110						
		Senior Peoples Forum	Intergenerational work	Community regeneration	Subsidised leisure options	Mobile library service	Gardening service	Older Peoples Music Programme	-
	£	Project funding shown		450,221	65,000	105,446	231,372	75,660	
		Health Improvement Team	-	Keep Well	-	-	Continence Service		
	£	157,467					68- specialist nursing service		

Notes:

Service numbers are based on full year actual or projected number of service users / patients.

This map does not detail the wide range of supports that often accompany the primary service e.g. Care Homes and other accommodation based provision often engage in a wide range of support activities.

1. Does not include budgets for GPs in GMS
2. Treatment Room Staff Budget
3. Does not include Salaried Dentists within GDS as no budgets attached
4. Budget for Lothian Wide Podiatry Service
5. Budgets for Dietetics and Speech Therapy now lie as hosted services within other areas
6. Only includes staff budget
7. Acute sector costs tbc

12. MARKET ANALYSIS

There are a wide range of health and social care services in West Lothian that are available to support the community as whole, as well as some that specifically support older people, or who have specialist aspects that are able to meet older people's individual needs. A map of currently available health & social care service provision is detailed in figure 5**.**

Analysis of the current provision and performance of the main service types has highlighted the following:

- Health improvement is an important aspect of early intervention. Taking measures to look after health and well being can prevent serious health conditions later on and can delay the progression of some diseases. Health improvement is seen as an integral part of a preventative approach to health and care, and as such, it is the intention that all people-focused services should incorporate health improvement into their service/team plan. Towards this aim, teams and services working with those most at risk of poor health can be supported by the West Lothian Health Improvement Team (HIT). The HIT is a well established resource funded by West Lothian Council and NHS Lothian whose primary remit is to build capacity in the West Lothian workforce to address health inequalities and targets support to teams and services working with those most at risk of poor health.

- Substantial increases in the numbers of older people needing to access social care services are being experienced and will continue to rise.

- People aged 85 and over have the highest level of need, with this age group having the most 'critical' level of social care need.

- The introduction of universal re-ablement service will require care at home providers working within West Lothian to change the focus of their service to sustain the benefits achieved for individuals during the re-ablement phase should they still require ongoing domiciliary support.

- Care at home services are largely provided by the independent sector (90%) the remaining 10% of packages of care are expected to transfer from in house provision to the independent sector in order to create sufficient capacity for the redesign and roll out of the re-ablement service.

- A dedicated crisis care service has recently been established and operates 24/7 with key purpose to
  - Respond to falls
  - Provide emergency short term personal care based on assessed need (up to 5 days) in order to avoid admission to hospital
  - Provide a response to telecare alerts

  The service has been launched and uptake will be carefully monitored to establish if the initial service design is appropriate to meet client needs

- The current assessment and rehabilitation provided through Templar Day Hospital and by Allied Health Professionals is based on a traditional model and requires to be more integrated with community based services and offer faster access to assessment if it is to provide a realistic alternative to admission.

Redesign of the service is planned to provide an integrated assessment and rehabilitation service which will encompass; Access to rapid assessment for older people with complex needs; Falls Management Programme; Increase AHP Capacity for Assessments and Rehabilitation

- An Intensive case management service has been piloted in the last 12 months. The service provides a pro-active, co-ordinated, multidisciplinary approach to those with long term conditions at greatest risk of hospital admission. The service will broaden its scope in phase two and three to enable a more comprehensive integrated service to be provided with direct links to crisis care, reablement and rehabilitation.

- Although there is provision for step down care there is currently no step up provision; this requires further exploration.

- The current provision of adult inpatient complex care is being reviewed in accordance with the revised eligibility criteria which potentially impacts on respite care and care home provision.

- A locally established care home education programme has been positively evaluated and is now being developed in conjunction with the development worker from the independent sector to establish a comprehensive development framework for staff working in care homes.

- The emphasis on investment in preventative services in order to reduce stress on carers cannot be overstated, especially in light of the demographic changes being faced. Implementation of the Carers Strategy "Caring Together" is expected to identify significantly more carers. Early identification, referral and assessment of carers is vital to promote carers' health and well being, enable earlier intervention and support to be introduced in order to support them in their caring role.

- Short breaks from caring are acknowledged as being a key element of integrated services which will support a shift in the balance of care from hospital and /or residential care to community based services. Short breaks from caring are currently made available in a number of ways with variations in the duration, location and type of short break made available, on a personalised basis. Demand for overnight short break provision within a residential setting is currently being met. The provision of short breaks at home or in the community and interest in accessing the flexible short break scheme and feedback from carers identifies this as an area of increasing demand.

- The implementation of Self Directed Support will have a significant impact on the next stages of promoting choice and personalising services. The Community Health & Care Partnership are wholly committed to ensuring that choice and control is at the heart of our commissioning processes and to facilitate this will require a review to ensure that larger block contracts don't undermine this vision.

- Day Care centres have historically functioned and modelled their services along a traditional approach, the review and redesign of day care services is being progressed through the Reshaping Care for Older People Programme, the findings of which will inform future commissioning.

- Although many people can be successfully supported in their own homes, the availability of alternative housing support options is critical for those whose existing home does not allow them to maintain independence. The challenge for the future will be to ensure a range of suitable housing and associated care options are available whilst maintaining sufficient flexibility to be able to respond to the changing environment.

- There are issues with regards to the sustainability of sheltered housing such as the physical condition and design of housing stock and the viability of some traditional staffing models. Providers of sheltered housing are reviewing their services and are actively looking for opportunities to remodel their services to meet future need.

- Service development utilising a co production approach has been very successful in providing an alternative shopping service which has provided access to a greater range of affordable healthy food. The resulting decreased demand for the traditional service and frozen meals provision suggests there is a need to consider planned disinvestments in this area and investment directed towards growing the volunteer shopping and household service.

- Equipment provision allows people to live longer healthier lives, in their own homes by improving independence and supporting carers. As a consequence of a growing number of older people living longer and with increasing frailty the volume of equipment and need for more specialist equipment is expected to increase.

- West Lothian CHCP has invested substantially in both the development and provision of innovative telecare solutions for people in their own homes and housing with care. Telecare also supports housing with care where people with complex needs live within their own tenancy in a supported housing complex with dedicated call service and support team. The demographic trends present a challenge in terms of maintaining the level of investment to meet need and investment will continue to be required in this area to support its growth in maximising independence and care support and link with telehealth technology.

- An advocacy service is available to older people within West Lothian in receipt of care at home or in a residential or hospital setting. This provision enables older people to access assistance to represent themselves or do so via an advocate. This service is provided on a one to one basis. Following referral once an understanding is reached the advocate will take forward or assist the individual to pursue issues until resolved or else all possibilities are exhausted.

- Palliative Care Is an integral part of routine care delivered by health and social care professionals to those living with a progressive incurable disease, regardless of the care setting. It is essential that older people and their family/carers have their specific needs taken into account and met within palliative integrated care pathways that support dignity, personal choice, and bereavement support around end of life care. Specialist Palliative Care Is based on the same principles of palliative care but can assist people with more complex needs. Specialist palliative care is provided through a tripartite partnership arrangement with NHS Lothian, Marie Curie and Macmillan and is delivered through specialist team based in the Macmillan Centre in St John's Hospital

The key areas of development identified from the analysis of current provision form the structure of the Action Plan (Appendix 1)

13. PROCUREMENT PROCESS

The partnership is committed to ensure that a range of health and social care services are available to meet the assessed needs of people who are ordinarily resident in West Lothian. Services commissioned have an emphasis on devolving choice and control as close as possible to service users and carers. This dimension means that there is a difference from the commissioning of other types of service, as there is generally a need to continue to work with providers where service user choice indicates the continuation of such services. In order to do this, services are either provided directly by the CHCP (on its own or with partners) or procured through third party providers.

A number of factors are relevant in the development of the procurement process for services including:

- Type of service to be purchased
- The range of appropriate and available service providers
- Cost
- Quality of services
- The volume of services to be procured
- The length of the contract

Decisions on the cost of services will be based on:

- Comparative data where available
- Experience of providing similar services
- Any other specifications set as required for a particular service
- Level of care needs and individual service requirements
- Meeting the principles of Best Value Options Appraisal

Decisions on the quality of services will be based on:

- Comparative data where available e.g. experience of providing similar services, Care Inspectorate Inspection Reports
- Ability to meet the quality requirements specified within the contract
- Any other specifications set as required for a particular service
- Level of care needs and individual service requirements.

The number of places and the level of turnover of service users will determine both the cost and the type of contract agreed. There is no single identifiable rule for service usage to enable a standardisation of costs due to:

- Some services providing for a high volume of people and also have a high turnover

- Some services having high overhead costs due to location or service user grouping.
- Some services having a low number moving through the service where the service users have lifelong conditions that require support.'

14. FUTURE PROVISION

Key to the success of effectively 'Shifting the Balance of Care' and helping to address some of the demographic pressures on services for older people in the future is the need to increasingly focus on maximising independence.

Existing services need to be reviewed to make sure they continue to be cost effective, maintain a clear focus on excellent quality and continuous improvement and are able to continue to meet older people's future health and social care needs. It is important to keep a focus on continuous improvement and drive up quality standards across all health and social care services.

- The introduction of universal re-ablement service will require care at home providers working within West Lothian to change the focus of their service to sustain the benefits achieved for individuals during the re-ablement phase should they still require ongoing domiciliary support.
- Care at home services are largely provided by the independent sector (90%) the remaining 10% of packages of care are expected to transfer from in house provision to the independent sector in order to create sufficient capacity for the redesign and roll out of the re-ablement service. Representation of the local independent sector providers' views and facilitate communication and engagement with local providers.
- Creation of an independent sector reference group to support good practice and to contribute to the governance process.
- Collaborative working with statutory and third sector colleagues and people who use services and their carers to improve service provision and support good practice
- Benchmarking local and national measures, outcomes, feasibility, local sector analysis

Helping older people to maintain their health and well being into later life is key to having lifelong quality of life and enabling health and social care resource to be targeted at those most in need.

It is also important to acknowledge the contribution of care homes and the range of variable services they may offer as a 'homely setting'. It is anticipated that these services will be further developed in future to support activities within the scope of this plan, for example, using care homes to support short breaks from caring, and contributing to intermediate and step up/step down care. Development of this provision is include within the Action Plan and it is expected that the process will be part of the ongoing partnership working between statutory agencies and the independent sector.

A focus on independence is vital to helping older people to:

- recover from illness quickly
- receive timely rehabilitation support to promote faster and more effective recovery
- receive 'seamless' joined up and personalised health and social care services, when they need them

This needs to be provided in line with the personalisation agenda, enabling older people and their carers to have choice and control over their health and social care service delivery.

Future service delivery will focus on:

- Prevention
- Fair access
- Cost effectiveness and efficient use of resources
- Quality
- Independence
- Positive outcomes for older people and their carers
- Personalisation

15. ONGOING GOVERNANCE AND REVIEW

The four main partnership agencies have been involved in the planning, development and delivery of the strategy to date and will be fully and equally involved in the governance of partnership commissioning and decision-making in the future.

All partners are committed to, and will continue to, work in partnership with other key stakeholders including service providers, the third sector, older people and their carers to implement the actions identified within this joint commissioning plan, review the plan to keep pace with changing local needs and work jointly to develop, design and deliver quality services throughout West Lothian.

An evidence based approach to monitoring and reviewing progress and making adjustments where necessary to ensure achievement of the agreed objectives and effectiveness of procurement arrangements will be supported through the Reshaping Care for Older People Programme Board.

Regular performance reports are provided to the Programme Board. Monthly reports include project output data. Quarterly reports are provided on the outcomes monitoring framework. A strategic dashboard has been created to facilitate this reporting. At present a number of the key indicators still lack data. In part this reflects the stage of development of the Integrated Resource Framework. It is anticipated that this work will be concluded by June 2013 enabling a full suite of outcome based indicators to be used both as part of regular governance but also as an important element of the joint commissioning plan review.

Although the plan envisages broadly a shift of resources from acute sector to community based provision, with a growing emphasis on prevention, it is not yet

considered possible to be specific about the detail of investment and disinvestment associated with this movement. This matter will be explicitly considered within the review process and updated versions of the plan will in due course provide this detail.

In addition to the ongoing monitoring of the plan by the Programme Board, the plan will be subject to a detailed annual review, including extensive consultation with all key stakeholders. This annual review will include consideration of the detailed investment and disinvestment decisions that will be required to achieve the strategic outcomes of the plan.

16. FINANCIAL PLAN

	2013-14 planned	Carers direct	Carers indirect	Preventative & Anticipatory Care	Proactive Care & Support at Home	Effective Care at Time of Transition	Hospital & Care Homes	2014-15 estimate
West Lothian Partnership Total	**£'000**							**£'000**
Previous year slippage	908							553
SG funds	1,712							1,500
WLC contribution	480							494
Total Partnership Funds	**3,100**			**808**	**619**	**300**	**820**	**2,547**
Under/over commitment	**553**							**0**
West Lothian Council led projects								
Develop integrated universal care at home re-ablement service	600				300	300		600
Crisis response and care management service	100		50		100			100
Daycare redesign	150		75	150				150
Small grants	30			30				30
Direct support to Carers								
Supporting Older People into Caring	70	70		35	35			70
Carers of West Lothian - Dementia project	34	34		17	17			34
Extension of respite	200	200		100	100			200
Befriending service (now Council mainstream revenue budget)	0							0
Development of tele-healthcare	100			100				100
Home Support Dementia (now Council mainstream revenue budget)	0							0
Home from Hospital Support (now Council mainstream revenue budget)	0							0
Mental Health service redesign	40			40				40
Alzheimer's Scotland	67				67			67
Independent sector development officer	36						36	36
West Lothian Council Total	**1,427**			**472**	**619**	**300**	**36**	**1,427**
NHS Lothian								
Intensive Case Management for Patients with Long Term Conditions	336			336				336
Mental health service redesign	230						230	230
Redesign of Day Hospital & rehabilitation Services	554						554	554
NHS Lothian Total	**1,120**			**336**	**0**	**0**	**784**	**1,120**

Carers direct	304	18%		
Carers indirect	125	7%		
Carers total	**429**	**25%**	**%age of Change Fund allocation**	

APPENDIX 1: ACTION PLAN 2013-16

This action plan will be reviewed on an annual basis during the life of the Joint Commissioning Plan. The timescales identified within this action plan are indicative and will also be reviewed annually in line with other developments that may impact on implementation. Note that revenue budgets are normally only agreed for a 1 year period though West Lothian Council has just agreed a 2 year budget. It follows that revenue budget commitments are contingent on the full budget setting process.

Actions Required	Resources	Target/Intended Outcome	Timescale
1.0 Information, Involvement and Engagement			
Development of monitoring and reporting systems. This will see the full implementation of the Integrated Resource Framework as well as the completion of the strategic score card to enable partners to monitor and report progress against the strategic outcomes.	Within CHCP 2013-14 revenue budget	To enable the partnership to monitor and report on progress. To enable the partnership to make informed decisions on investment/disinvestment as part of the review process of the plan.	December 2013
Develop a communications and involvement strategy for the implementation of this joint commissioning plan	Within CHCP 2013-14 revenue budget	To enable all stakeholders to receive information about progress on the joint commissioning plan implementation and enable stakeholders to feed into this process	April 2013
Establish consultation and involvement arrangements for older people with health and social care needs and their carers	Within CHCP 2013-14 revenue budget	To ensure older people and their carers have a range of opportunities to be fully involved and engaged in the planning design and delivery of local services and in meeting their individual needs	April 2013
Develop processes that make sure consultation feedback is considered through a robust process and duplication of consultation is prevented wherever possible	Within CHCP 2013-14 revenue budget	To ensure that older people's time and views are properly valued and that a robust process exists for using their input to shape service improvement and development	April 2013
Review the content, promotion and	Within CHCP	To ensure that marketing information is up to date	October

distribution of information in a variety of formats targeted for older people	2013-14 revenue budget	and appropriate	2013
To Review CHCP website content for older people in relation to health & social care advice and information	Within CHCP 2013-14 revenue budget	To provide up to date information in relation to health and well being including health improvement, advice and signpost to relevant support	October 2013

2.0 Live at Home or in a Homely Setting for Longer			
Transfer remaining 10% of care packages to independent providers	Within CHCP 2013-14 revenue budget	To release capacity for full roll out of Reablement	May 2013
Review contract arrangements for care at home (note current Framework Agreement runs until 31 December 2014)	Within CHCP 2013-14 revenue budget, to be reviewed for 2014 – 15.	Evaluate current performance of care at home provision Assess demand based on full Reablement provision Review market capacity, including supply of appropriately skilled workforce Develop procurement plan for future Framework Agreement	March 2014
Explore impact of universal reablement on service requirements of care at home providers	Within CHCP 2013-14 revenue budget	To ensure service model maximises independence gained from reablement	October 2013
Review the uptake and monitor the impact of the newly formed crisis care service	£100k Change Fund 2013-14, provisional 2014-15	Establish if service design and capacity is appropriate to meet client needs and demand	August 2013

Implementation of the Carers Strategy: *Caring Together*	£104k Change Fund 2013-14, provisional 2014-15	Ensure early identification, referral and assessment of carers to promote health and well being enable earlier intervention and support	December 2013
Explore and further develop the provision of short breaks at home or in the community	£200k Change Fund 2013-14, provisional 2014-15	To support carers through more flexibility in terms of the range and timing of respite made available, as well as more control over the actual process itself.	March 2014
Implement Self Directed Support and monitor uptake and impact on service provision and commissioning	£290k 2013-14 SG funding stream (not part of Change Fund)	SDS will be available to all service users and carers eligible for support via the four SDS options Service users and carers eligible for support will receive personalised and outcomes-focused assessment and support planning and will be as involved as they wish in these processes Service users and carers will receive the appropriate information, advice and assistance to make an informed choice of SDS option and, where appropriate, to direct their own support	March 2015 (detailed project plan)
To explore future commissioning options for day care service for older people	£150k Change Fund 2013-14, provisional 2014-15	Reshape Day Care services to support people as individuals with their own needs, preferences and choices. Improve and / or increase activities specifically linked to early intervention and prevention. Support current Day Care organisations through a period of cultural and organisational change.	Phase 1 report October 2013 (detailed project plan)
Explore step up and step down care provision in West Lothian and intermediate care pathways, including consideration of care homes as provider.	Within CHCP 2013-16 revenue budget		March 2014 (detailed project plan)

3.0 Maximising Independence			
Fully implement universal reablement service with expectation of service capacity of 1200 referrals per annum	£600k Change Fund 2013-14, provisional 2014-15	Provide universal access to reablement services enabling older people to retain their skills, maintain confidence and independence	March 2013
Undertake review of care & support in Sheltered housing	Within CHCP 2013-14 revenue budget	Identify developments and service changes required to meet future need	March 2014
Procure care and repair service to support small repairs and facilitate private sector grants process	Within CHCP 2013-14 revenue budget	Service to be tendered for October 2013	October 2013
Develop telecare and telehealth provision to support independence and capacity building.	Within CHCP 2013-16 revenue budget	Identify potential tele-healthcare development Linkage with DALLAS and other national/international programmes	March 2016
Review the existing arrangements and scope the future requirements for equipment provision	Within CHCP 2013-16 revenue budget	Provide comprehensive range of equipment to support independent living. Review current arrangements for storage and distribution.	March 2015
Promotion and take up of advocacy services through contractual arrangements for older people;	Within CHCP 2013-16 revenue budget	Ensure advocacy service is available and accessible to older people within West Lothian.	March 2014
Develop health improvement activities e.g. food and health, physical activity, mental well being, community development	Within CHCP 2013-16 revenue budget	Ensure that healthy aging activities are planned in partnership to avoid duplication and achieve a good geographical spread	March 2016

Small grants to develop community health activities (subject to criteria and selection processes)	£30k Change Fund 2013-14, provisional 2014-15	Grants to voluntary organisations to fund work which supports older people to live healthy independent lives in the community. Priority is given to applications which focuses on respite and short breaks, dementia or which are likely to result in financial savings by preventing or delaying institutional care or more expensive care packages.	March 2014
4.0 Joined Up Care pathways			
Develop integrated assessment and rehabilitation service to support provision of specialist multidisciplinary assessment for older people and timely access to rehabilitation	£400K Change Fund 2013-14, provisional 2014-15	Provide equitable access to team of older people specialist practitioners enabling rapid access to - specialist assessment for those with complex needs - comprehensive falls management programme - community based assessment and rehabilitation	March 2014 (detailed project plan)
Ensure appropriate links with stroke pathways to make sure needs are addressed	Within CHCP 2013-16 revenue budget	Ensure older people suffering stroke have their needs met appropriately	March 2014
Develop and implement phase two of the Intensive Case Management Team project	£336K Change Fund 2013-14, provisional 2014-15	Provide complex and intensive case management effectively at home and develop pathway with crisis care, reablement and rehabilitation. Reduce hospital admission and readmission	March 2014 (detailed project plan)

5.0 End of Life Care			
Ensure Implementation of Liverpool Care Pathway	Within CHCP 2013-16 revenue budget		March 2014
Review service level agreement with Marie Curie and Macmillan	Within CHCP 2013-16 revenue budget		March 2014
Monitor access to palliative care services for those with non malignant conditions	Within CHCP 2013-16 revenue budget		March 2014
6.0 Partnership			
Developing a workforce fit for purpose. This will involve close partnership working, particularly between statutory sector and independent sector partners. Change Fund resources agreed to support independent sector involvement.	£36K Change Fund 2013-14, provisional 2014-15 Within CHCP 2013-16 revenue budget	Sustainable capacity of suitably qualified health and care staff across all sectors. Where it is subsequently identified that additional resources are required, either for training or as a consequence of maintaining a skilled workforce, these will be factored into the revenue budgets of the statutory agencies.	March 2016
To develop and implement a Quality Assurance Framework for both regulated and non-regulated services for older people	Within CHCP 2013-16 revenue budget	Standard terms and conditions of contracts to include this requirement	April 2014
Ensure partnership approach to strategy development and service delivery. In addition to current RCOP partners, key partners will be the employers, volunteers' and carers' organisations, with the employees, volunteers and carers themselves, and with Trades Unions /	Within CHCP 2013-16 revenue budget	Engaging partners in development of shared goals	Ongoing

Professional Organisation representatives.			
Work jointly with housing to develop housing strategy reflecting the future housing and support needs of older people. This will include the contribution of Care Homes and the range of variable services they may offer as a 'homely setting'.	Within 2013-16 revenue and capital budgets	See Appendix 2	March 2016
7.0 Fair Access to Local services			
Undertake Equality Impact Assessments on service developments. This Joint Commissioning Plan has already been subject to Equality Impact Assessment.	Within CHCP 2013-16 revenue budget	To ensure full compliance with equalities legislation	Ongoing
Ensure that commissioning information on older people's services is readily available and kept up to date with a user friendly system.	Within CHCP 2013-14 revenue budget	Approach to include both high level market data and service specific data	April 2014
To review and ensure fair access to welfare benefit advice and support, financial and debt advice for older people	Within CHCP 2013-14 revenue budget	Action plan has been developed for council based services. Possible addition to future contract specifications.	April 2013
Ensure that equality and diversity information requested and collated by service providers includes information on gender, religion, belief and sexual orientation;	Within CHCP 2013-14 revenue budget	Standard terms and conditions of contracts to include this requirement	August 2013
8.0 Personalisation			
Implement Self Directed Support and monitor its uptake and impact on service provision	£290k 2013-14 SG funding stream (not part of Change Fund)	SDS will be available to all service users and carers eligible for support via the four SDS options Service users and carers eligible for support will receive personalised and outcomes-focused assessment and support planning and will be as	March 2015 (detailed project plan)

		involved as they wish in these processes Service users and carers will receive the appropriate information, advice and assistance to make an informed choice of SDS option and, where appropriate, to direct their own support	
Use existing service and contractual review processes to consider how older peoples services can move towards a more personalised approach	£290k 2013-14 SG funding stream (not part of Change Fund)	Revised standard contract terms and conditions to reflect SDS priority	March 2015 (detailed project plan)

APPENDIX 2

HOUSING CONTRIBUTION STATEMENT

Theme	Detail
Outcomes relevant to the housing contribution	To achieve the Older Peoples Joint Commissioning Plan's vision there will be a focus on prevention and early intervention which enables older people to maximise their independence and remain within their own homes where they chose to do so. In West Lothian, Housing will continue to play an important role in achieving this vision through the integration of housing and health and social care services which enable independent living and prevent institutional care. Therefore the Housing contribution in West Lothian will impact on the principle outcome of the Joint Commission Plan, '*to enable older people to love longer healthier and more independent and fulfilling lives within a safe and supportive community and continue to learn and develop*'. In particular Housing will contribute to 3 of the 5 key experiences required to achieve the desired outcomes for older people outlined in Figure 2, Strategic Model for Older People's Service of the Joint Commissioning Plan. These are • Information, involvement and engagement • Live at home or in a homely setting for longer • Maximising independence
Strategic direction of travel and proposed investment changes within the draft Joint Strategic Commissioning Plan for Older People	At both a national and local level demographics evidence that older people are living longer, remain active for longer and have increased and changing expectations from the service they received. Alongside this there is a decreasing population of working age. The primary goal of the National Re-shaping Care for Older People programme is '*optimising the independence and well being of older people at home or in a homely setting'*. To meet this goal partners are required to demonstrate the optimum use of existing resources which are aimed at supporting independence through helping older people to remain safe and well and outwith the formal care setting for as long as possible. The focus of investment within West Lothian's Change Fund is to achieve progress within five thematic areas; • Development of re-ablement • Integrated care pathways for long term conditions • Crisis care • Growth in safe at home technology • Community capacity building.

	The key intended service designs to enable this shift are outlined in The Joint Commissioning Plan's Action Plan 2012 – 15 in Appendix 1. Fundamental to this is a review of existing services to ensure that future service delivery focuses on prevention, fair access, fair access, cost effectiveness, quality, independence, positive outcomes and personalisation. Key service re-design proposals outlined in the Older People's Joint Commissioning Pan with clear links to Housing are • Under take a review of care and support in sheltered housing • Undertake a review of Care and Repair • Review and develop telecare and telehealth provision • Review existing arrangements and scope the future requirements for equipment provision
The housing contribution – investment already planned on the basis of the LHS (and if appropriate the LA Housing Business Plan for its own stock)	The West Lothian LHS is based on 6 themes with Housing Options and Independent Living Themes being off key importance in the delivery of the Joint Commissioning Plan for Older People. Both these themes focus on prevention, early intervention and enabling independent living. The Independent Living Theme within the LHS outlines the strategic commissioning process for care and support services and demonstrates a clear link with the Joint Older People's Commissioning Plan. Key LHS outcomes; • Homelessness is prevented for people in West Lothian as far as possible • People living in West Lothian can access the appropriate range of care and support services enabling them to live independently in their own homes. • Supporting people to live more independently and avoid institutional care where not needed. • Enabling people to develop lifeskills to increase independence. • Helping people to maintain their homes and to feel safe. The housing contribution investment already planned on the basis of the LHS is • 545 new build council homes to be completed over the next 2 years. This amounts to an investment of £45million. 34 of these homes are designed specifically for wheelchair users. All properties will be built to Housing for Varying Needs standard. Since 2012, 133 of the 545 have been handed over. • New Build Council Housing Programme – a further 1000 new build Council houses are

	proposed to be developed between 2012 – 2017. This amounts to an investment of £90million over the period of the programme. All properties will be built to Housing for Varying Needs standard. Some homes will be built specifically for wheelchair users. Some properties may have wet floor showers built in. Options are being considered to allocate some of the properties to vulnerable households, and some properties may be for amenity housing. There will be a focus on building smaller homes to meet the needs of single person households. • New Build Council Housing with Care Development, Bathgate. Provision of 30units at a capital cost of £6million offering medium/high care and support to enable people to continue living in within a safe and homely setting. • Strategic Local Programme: West Lothian has been allocated £10.7million between 2012 – 2015 to support Registered Social Landlord and Council Investment. To date £6million has been allocated to help fund 283 new build houses. • West Lothian Capital Programme: £1million pa on disabled adaptations which funds approximately 800 adaptations per year are for older people. • West Lothian Council General Services: £1million pa on disabled adaptations which funds approximately 1,800 adaptations per annum are for older people. • Housing Support Funding: £4.9miilion pa externally commissioned services. • West Lothian Care and Repair - £190,000 per annum
Likely future impact of plan upon housing resources	Impacts of Joint Commissioning Plan will have on housing resources • Further analysis is required on the impact of the Older People's Joint Commissioning Plan on the availability and suitability of housing stock (both mainstream and supported accommodation) its design, size and tenure mix. This will help inform future capital resource requirements. • Potential increase in the demand for aids and adaptations funded through the housing grant process may impact on both capital and revenue funding. • Increase in older people demographics along with the shift in balance of care will have an impact on housing resources required to provide older people with the advice and information on housing options to ensure maximisation of independence and enable

	people to live in a safe and homely setting where they choose to do so. This may require increased in-house revenue resources. • On-going need for appropriate housing support services which are person centred, based on individual need and enable older people to develop life skills, live safely in their own homes and avoid care homes or hospital admission. Impact on both in-house service provision and externally contracted services.
Process for integrating the housing contribution to the Joint Strategic Commissioning Plan for Older People in future	Develop a joint action plan for the Housing Contribution Statement which is agreed by West Lothian CHCP and West Lothian Housing, Construction and Building Services. Action plan to be based on SMART (specific, measurable, achievable, realistic, timescaled) objectives and reported to West Lothian CHCP Board.
Outline and understanding of shared data sources , and gaps to be addressed	<u>Shared data sources</u> Older people population profiles and projected overall growth in West Lothian. *Source General Register Office for Scotland* – Population Projections used in both the LHS and Older People's Commissioning Plan. • The number of 65-75 year olds will increase by 80% • The number of 75+ year olds will increase by 151% • The population of 85+ is projected to rise by nearly 300% Assessing Housing Need and Demand • Housing Demand – waiting lists for council and RSL properties in West Lothian. Highest need for 1 bedroom properties • Housing Supply – across all sectors identified with the LHS • Data on the provision of supported accommodation, floating housing support services, care at home, equipment and adaptations, telecare services and care and repair is collated by WL CHCP and outlined within the LHS and Older People's Commissioning Plan. <u>Gaps</u> • More information and analysis on housing need, (including support accommodation) and demand for older people across all tenures. • More information and analysis on housing supply for older people across all tenures.

	• Analyse the uptake of Housing Options Services by older people in West Lothian and identify any gaps in service provision. • Review information on SWIFT where people moving to care home settings and if this is due to lack of alternative housing options.
Key challenges going forward	Enabling older people to live independently in their own homes is a key outcome for the Council. The Council currently provides a range of housing that is suitable for older people and provides a range of support services that enable people to live independently in their own homes. It is clear that the numbers of older people living in West Lothian is projected to rise significantly over the coming years. This presents a particular challenge in terms of understanding the housing requirements of older people and ensuring that resources are available to allow people to live independently. The challenge will be to ensure that the types of provision and services available meet the needs and aspiration of older people at a time when resources are constrained.

APPENDIX 3: POLICY DOCUMENTS

National Policy
Social Care (Self Directed Support) (Scotland) Bill – included in programme of Gov 2011/12 Housing for Older People 2011 National Telecare Development Programme 2006 - 11 Self Directed Support A National Strategy for Scotland 2010 All Our Futures 2008 Shifting the Balance of Care 2008 Co-ordinated Integrated and Fit for Purpose 2007 The Adult Support and Protection (Scotland) Act 2007 Carers Strategy for Scotland 2010-2015, Caring Together Better Outcomes for Older People 2005 Changing Lives 2005 Partnership for Care 2003 The Mental Health (Care & Treatment) Scotland Act 2003 The Adults with Incapacity (Scotland) Act 2000
Local Policy
A Sense of Belonging – Joint Strategy for Improving Mental Health & Well-being of Lothian's Population 2011 West Lothian Joint Health and Social Care Commissioning Strategy 2011 - 21 Older Peoples Strategic Service Statement 2009 – 2012 Dementia Strategic Service Statement 2009-2012 West Lothian Council Housing Strategy 2011 Social Care & Social Work Improvement Scotland Scrutiny Report 2011 Social Policy Management Plan 2011 West Lothian Local Transformation Plan – Reshaping Care for Older People 2011 West Lothian Single Outcome Agreement Adult Support & Protection: Ensuring Rights Preventing Harm 2010 Improving Care Investing in Change 2006 West Lothian Capacity Plan 2005 West Lothian Carers Strategy 2012-2015 (Draft) West Lothian Community Planning Partnership Strategic Assessment 2012 Health & Well Being Profile 2012