



West Dunbartonshire
Community Health & Care Partnership

**West Dunbartonshire
Community Health & Care Partnership
Commissioning Strategy For
Adult Mental Health Services**

2012 – 2021

August 2012

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An electronic version of this document can be downloaded from the
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1. OUR AMBITION

1.1 Vision

West Dunbartonshire Community Health and Care Partnership's (CHCP) vision for the provision of Adult Mental Health Services across the West Dunbartonshire Council area is to promote recovery and improve the quality of life for people affected by mental illness.

1.2 Scope

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

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

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

1.3 Values

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

- Quality
- Fairness
- Sustainability
- Openness

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

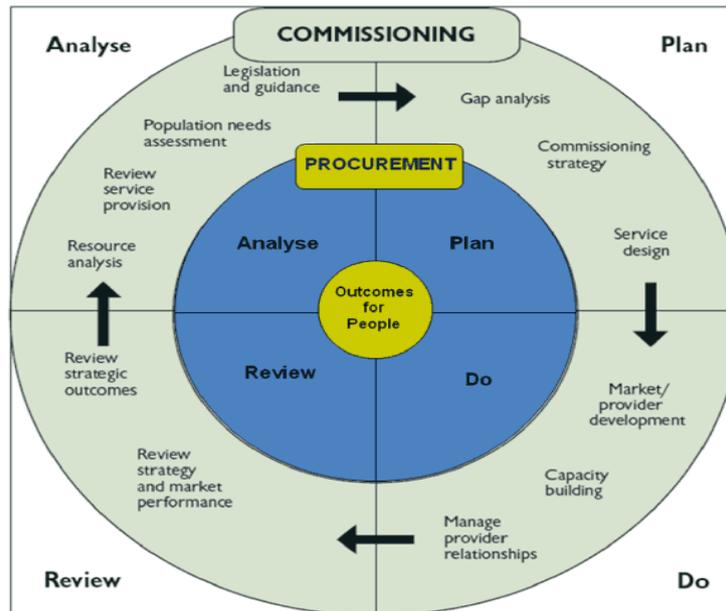
- Optimal outcomes for individual service users.
- A client-centred approach appropriate to individual needs through an emphasis on informed self-care, co-production and personalisation of services.
- Effective and safe services that draw upon the best available evidence and local feedback from service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

This document provides an important framework to ensure that these values and principles are explicitly reflected as part of the routine review of services and the development of new models of care.

1.4 Delivering Strategic and Outcome-based Commissioning

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

Diagram 1: Strategic Commissioning Cycle



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

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

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

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

2. LEGISLATIVE AND POLICY CONTEXT

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

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

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

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

2.1.1 Mental Health Strategy for Scotland: 2012-2015 (2012)

The Scottish Government’s mental health strategy to 2015 sets out a range of key commitments across the full spectrum of mental health improvement, services and recovery to ensure delivery of effective, quality care and treatment for people with a mental illness, their carers and families.

It identifies seven key themes for mental health action:

- Working more effectively with families and carers.
- Embedding more peer to peer work and support.
- Increasing the support for self management and self help approaches.
- Extending the anti-stigma agenda to include further work on discrimination.
- Focusing on the rights of those with mental illness.
- Developing the outcomes approach to include, personal, social and clinical outcomes.
- Ensuring that we use new technology effectively as a mechanism for providing information and delivering evidence based services.

2.1.2 National Dementia Strategy

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

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

appropriate, with a particular focus on reducing the inappropriate use of psychoactive medication.

- Continuing to support dementia research in Scotland.

It also highlights two key change areas:

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

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

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

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

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

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

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

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

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

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

2.1.6 National Targets

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

- Deliver faster access to mental health services by delivering 8 weeks referral to treatment for Psychological Therapies from December 2014.
- No people will wait more than 28 days to be discharged from hospital into a more appropriate care setting, once treatment is complete from April 2013, followed by a 14 day maximum wait from April 2015.
- Reduce suicide rate between 2002 and 2013 by 20%.

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

- Percentage of carers who feel supported and capable to continue in their role as carer.

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

- Improve support for people with care needs.

2.1.7 Health Improvement and Health Inequalities

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

The role of the CHCP in improving health and reducing health inequalities is set out in the WDCHCP 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'.

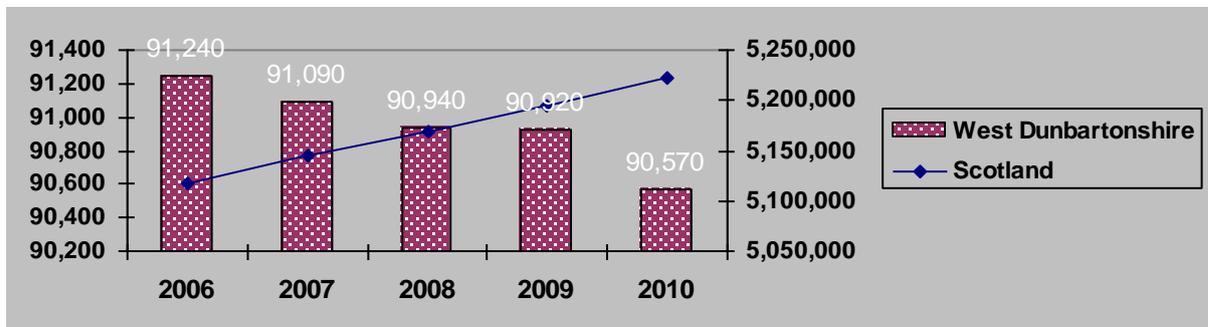
2.2 These, alongside other national guidance, have provided the core tenets for how the CHCP will increasingly discharge its responsibilities for mental health services in West Dunbartonshire over the decade, i.e.:

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

3. DEMOGRAPHIC PROFILE

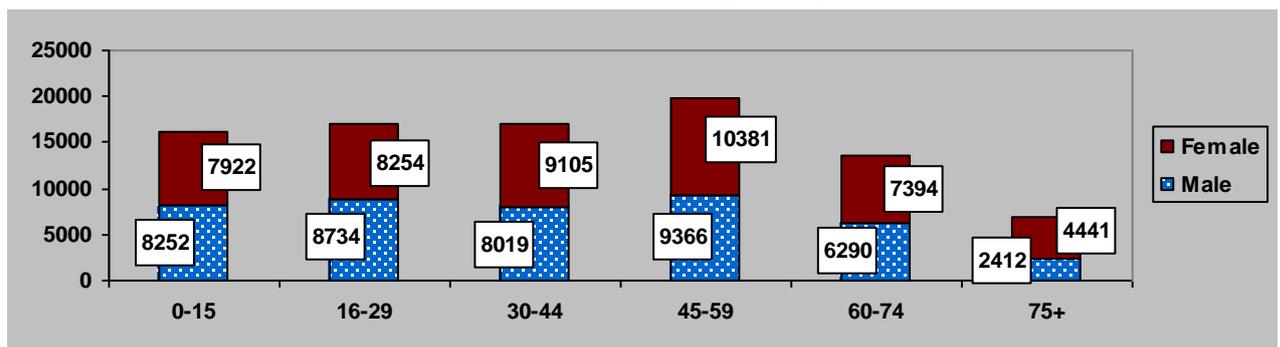
3.1 The population of West Dunbartonshire reported in the 2001 census was 93,388. By mid-2008 the population had reduced to 90,940, and in 2009 that figure dropped to 90,920 with a further reduction by mid-2010 to 90,570 (Chart 1 - General Registrar for Scotland).

Chart 1: Population number 2006-2010



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

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

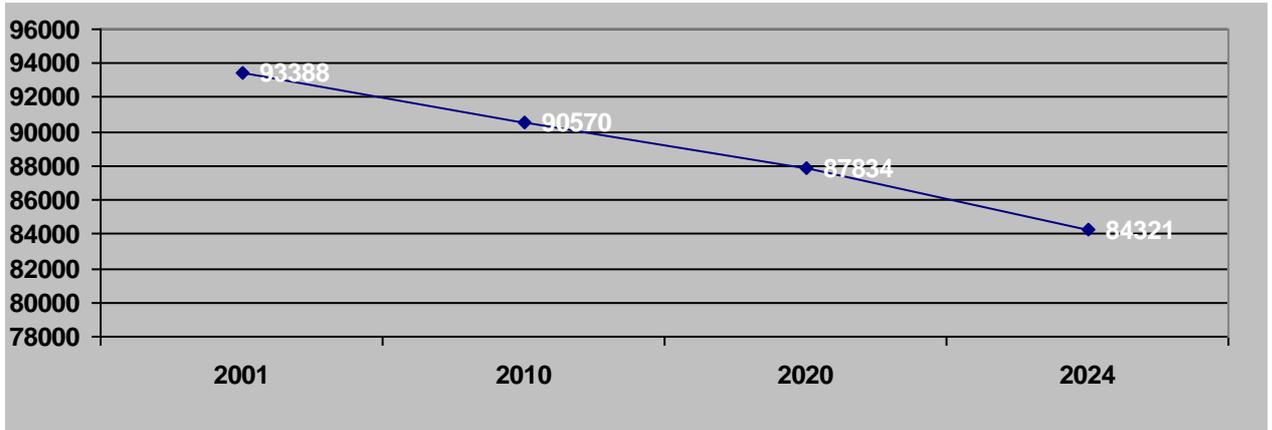


- One in five adults in Scotland is affected by mental ill health, with between 25% and 30% of all General Practitioner (GP) consultations involving depression, stress or anxiety. This suggests that upwards of 14,000 of the adult population in West Dunbartonshire are affected by mental health problems of some degree. According to the Glasgow Centre for Population Health Profile for Mental Health & Wellbeing (2012), mental health related drug deaths and suicides were markedly higher (80% and 59%, respectively) in West Dunbartonshire than in Scotland as a whole. West Dunbartonshire is also significantly worse than the Scottish average in relation to on rates of prescribed drugs for depression, anxiety and psychosis.
- It is estimated that 7.2% of people over 65 years in West Dunbartonshire have dementia – upwards of 1,400 people.
- The Scottish Index of Multiple Deprivation (SIMD) identifies small area concentrations (datazones) of multiple deprivation. In West Dunbartonshire, 47% of people being treated and supported by community mental health services live in the 20% most deprived datazones.

4. PROJECTED PROFILE OF FUTURE NEED

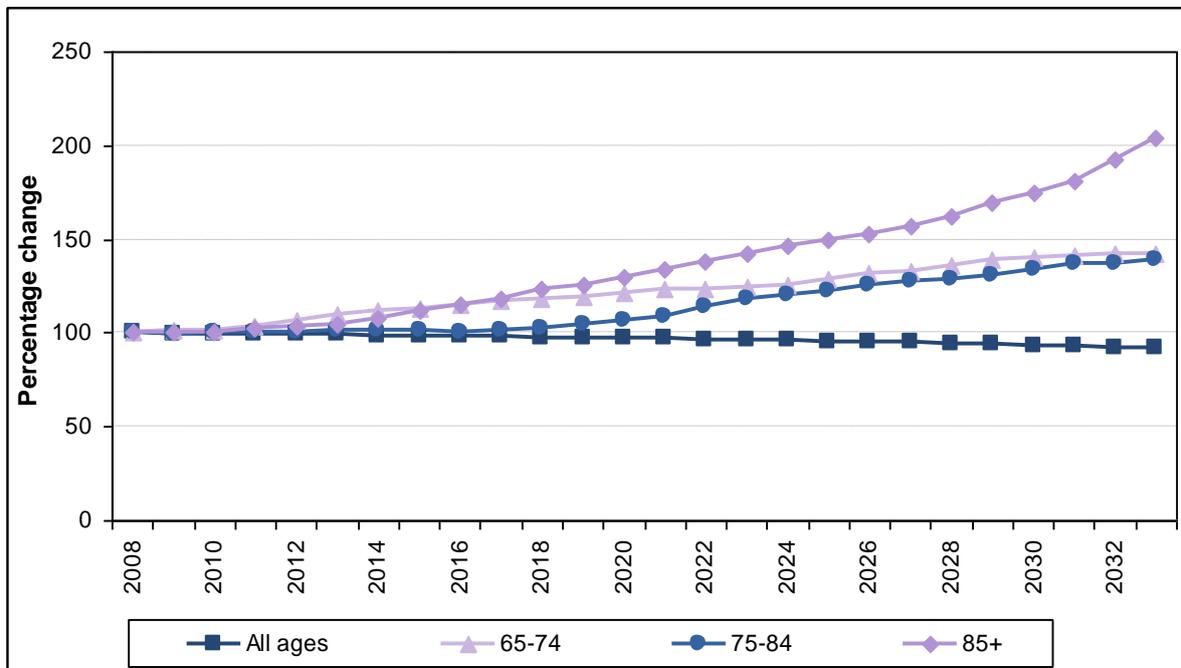
4.1 Analysis of the data taken from the General Registrar Office for Scotland and projecting likely trends in the population of West Dunbartonshire indicates a continued reduction in population size of approximately 3.2% over the next 10 years. Assuming this trend continues the population will continue 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



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

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



4.3 Whilst the population projections indicate a downward 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 Registrar’s Office for Scotland suggest that there will be more females than males. Specifically the number of males in the 0 – 15 years 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 five age ranges identified within Charts 5 and 6.

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

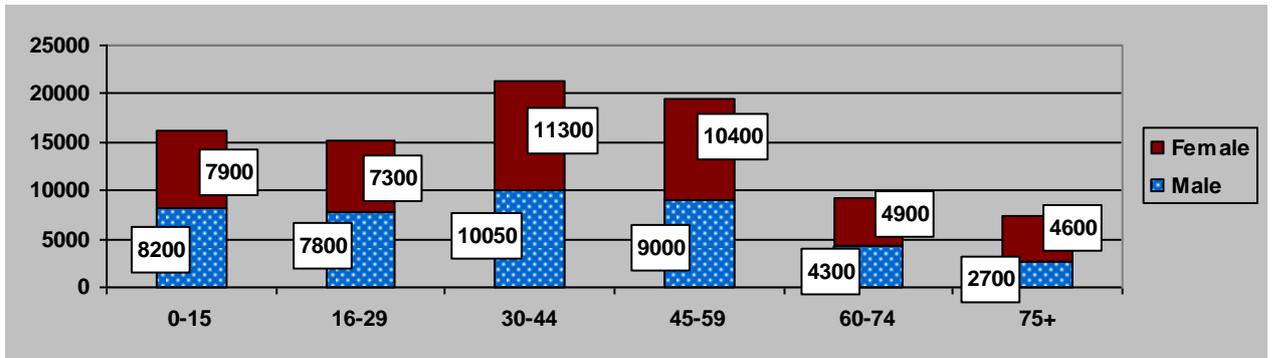
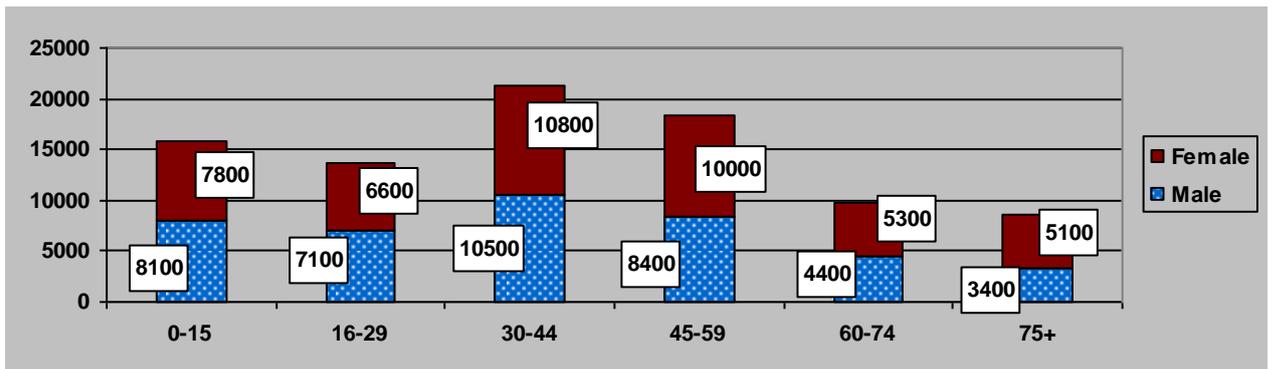


Chart 6: West Dunbartonshire - projected population (number) by gender and age (2023)



4.4 As the population profiles further “ages”, this proportion of people aged over 65 years with dementia in West Dunbartonshire is projected to increase by 75% by 2031 equating to approximately an additional 2,500 individuals.

5. PROVISION AND DEMAND

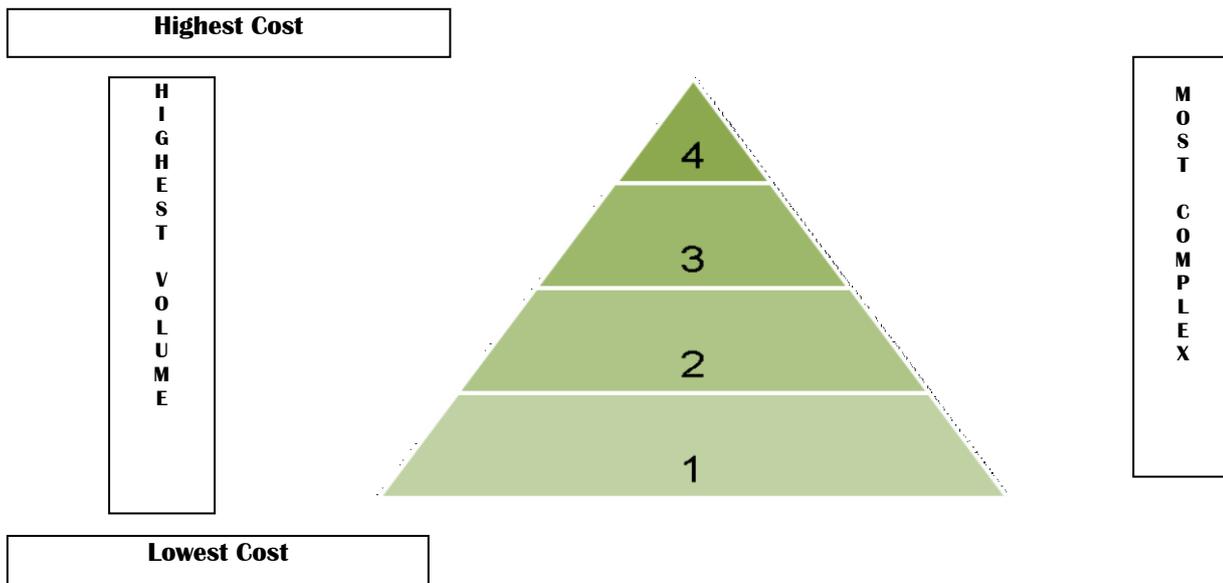
- 5.1 Promoting positive mental wellbeing is a key priority for the CHCP, particularly in relation to supporting people with a mental illness or mental health problem to:
- Live at home, whether that is with their family or carer, independently, or in accommodation with supports.
 - Realise full and enriching lives through access to education, training, employment, recreation and the achievement of personal goals and aspirations.
 - Enjoy supportive and fulfilling relationships.
 - Maintain good health and well-being.
 - Be in control of managing their lives and responsibilities.
 - See themselves and be seen as equal members of society and their community.
- 5.2 Shifting the Balance of Care is a key priority for the CHCP, in line with national policy, it is a means of supporting people to remain at home or in a homely setting for as long as possible. Together with the CHCP's Commissioning Strategy for Older People's Services, the CHCP's in-development Carer's Strategy and West Dunbartonshire Council's Local Housing Plan, this framework reinforces the critical activities to further support this shift in care. People with dementia and their carers need support early on to come to terms with the illness, to manage its symptoms and to put in place legal, financial and care arrangements for the future. Individuals with dementia need increasing help with everyday activities and personal care over time. Much of this care is provided by partners and family members, who themselves need support to enable them to continue to do so. With the prevalence of dementia set to rise within care homes settings and older people being discharged from acute settings, the case management of people with a diagnosis of dementia who have more complex needs will increase. West Dunbartonshire has made a commitment to review current services and to support investment in local services, including specific community mental health services and services for carers.
- 5.3 West Dunbartonshire CHCP provides a wide range of multi-disciplinary services that promote positive mental wellbeing (e.g. local mental health improvement Choose Life programme) and support adults with mental illness, with processes in place to ensure that each service can access a range of care and expertise for any given individual. Community mental health services have been enhanced with significant investment over recent years in additional services, adding capacity to enable and extend community treatment and support as an alternative to inpatient services. These exist and operate in tandem with services provided by other operational units of NHSGGC, other Council services, and NHS external contractors (e.g. general practice and community pharmacy). NHSGGC Acute Services are particularly important, in terms of service provision as well as management information.
- 5.4 The Primary Care Mental Health Service Team (PCMHT) offers a stepped model of service delivery for adults experiencing common mental health problems, which includes:
- Identification and management of common mental health problems.
 - Indirect clinical intervention through health promotion, education and training.
 - Direct clinical intervention through guided self-help, therapeutic groups, educational classes and individual psychological therapy.
 - Community bridge building and linking to social supports.
 - Shared care of individuals with more complex needs with the CMHT.
- 5.5 The Community Mental Health Teams (CMHT) encompass treatment and support services for adults with more complex mental disorders and provide:
- Access to specialist treatments and services including psychiatry, psychology, social work, community nursing, occupational therapy, employment support, and money advice.
 - Assessment, treatment and care for people with short term needs.
 - Assessment, treatment and care management for people with complex needs.

- Assertive outreach for people who are difficult to engage.
- 5.6 The Crisis Service works across the other mental health teams (including in-patient services) to support patients and their carers at times of acute mental health crisis and provide additional support as an alternative to admission to hospital; or where in-patient services are required. This includes:
- Intensive 24/7 care at home.
 - Expert support to CMHT regarding management of acute relapse.
 - Liaising with the hospital and facilitating early discharge.
 - Short term case management during period of acute relapse.
 - Provide a community link and post discharge support until crisis has abated.
- 5.7 Mental Health Officers (MHO) Services contribute to assessment, care planning and review of care plans. They have accountabilities to the Mental Health Tribunal for Scotland, the Mental Welfare Commission for Scotland and the Courts. Statutory interventions include:
- Assessment and consent to detention, applications for Compulsory Treatment Orders.
 - Social Circumstances Reports, plus inquiries and applications to Courts.
 - Reports for Court in relation to mentally disordered offenders.
 - Reports for applications for Welfare Guardianship.
 - Advice and consultation to clients, carers and colleagues.
- 5.8 The Acquired Brain Injury Team provides specialist assessment and care management for those where Acquired Brain Injury or Traumatic Brain Injury is the primary issue in their life, including:
- Neuropsychological testing and treatment.
 - Housing support helping individuals to cope with their day to day living.
 - Information, advice and training to individuals, carers and professionals,
- 5.9 Mental health inpatient and day services are provided locally in the Vale of Leven Hospital and the Dumbarton Joint Hospital. Admission and day services are being reviewed in line with Scottish Government policy on Reshaping Care for Older People.
- 5.10 A single Community Older Adults Mental Health Team has been established to provide services for older adults and their carers affected by the either functional or organic conditions. The team operates a person centred and recovery focused model aimed at individuals and their carers being at the centre of the assessment and care planning. The team provides:
- Advice, guidance and education to individuals, carers and professionals.
 - Access to a range of specialist services, including therapeutic and psychosocial interventions, memory clinics, service user and carer support groups.
 - Assessment, treatment and care for people with short term needs.
 - Assessment, treatment and care management for people with complex and enduring needs.
 - Assertive outreach for people who are difficult to engage.
- 5.11 As part of local Older People's Change Fund Plan related service improvements, a Primary Care Integrated Liaison Service has been established that provides specialist dementia support to staff, patients and residents in acute hospital wards and care homes, plus liaison with relatives.
- 5.12 Based on available data then the level of demand for services is consistent and increasing. 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. The CHCP has the benefit of a strong local track record for improvement that provides a solid foundation for the further developments necessary, especially in engaging and building relationships with existing forums, local and national service users' organisations and carers groups.

6. MODEL OF SERVICE PROVISION – BUILDING ON STRONG FOUNDATIONS

- 6.1 West Dunbartonshire CHCP provides integrated health and social care services for people with mental illness. In delivering these services, CHCP staff take account of the physical, mental, emotional, social and economic needs of individuals.
- 6.2 Mental health services aim to develop and provide interventions which ensure that the individual (and their carers) is central to the development, implementation and management of their own care and recovery plan. This is reflected in the use of a tiered approach to service delivery (Diagram 2) which describes the type and intensity of services available in each tier.

Diagram 2: Tiered Model of Care



6.2.1 Tier 1 – Generic self care and health improvement – include:

- General health and mental health improvement information and activity.
- Access to education, training and employment.
- Access to recreation and positive affirming activities and relationships.

6.2.2 Tier 2 – Dedicated mental health primary health care and health improvement – include:

- General practice, occupational health and primary care mental health services,
- Mental health improvement and well-being activity.
- Self-help, advocacy and networks of support.
- Assessment and care management.

6.2.3 Tier 3 – Complex treatment and support – include:

- Psychiatry, Clinical Psychology, Community Psychiatric Nursing, and Supported Living services.

6.2.4 Tier 4 – Complex and intensive treatment and support – include:

- Inpatient services – admission and rehabilitation.
- Residential care and nursing care.

7. CARE PATHWAY

7.1 Audit Commission reports suggest that the drive to expand community services requires a well-planned “journey of care” with a package of support. The pathway below (Diagram 3) reflects the key stages in the CHCP’s commitment to personalisation in relation to mental health services.

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 services that are locally based within a community setting. While there will continue to be a need for specialist acute provision, the evidence suggests that better outcomes are achieved when individuals can access a range of care in their own communities.
- 7.3 CHCP adult mental health services are committed to deliver and demonstrate processes and outcomes that are:
- Person centred and personalised.
 - Responsive and inclusive.
 - Delivered through a partnership approach involving service users, carers and all key partners.
 - Promote opportunity and social inclusion.
 - Give recognition and support to carers.
- 7.4 The Single Shared Assessment (SSA) process is a cornerstone in harnessing the multidisciplinary team in a common and comprehensive assessment. Assessment, care management and review processes include service users and carers and aim to achieve personalised outcomes.
- 7.5 This model is compatible with an enablement approach across services. *Enablement* refers to the process of health and social care staff supporting people through promoting self-help and health improvement and by encouraging individuals 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).
- 7.6 The *Recovery Approach* is an enablement approach in mental health that has gained increasing momentum in recent years. It is promoted by service user organisations and the Scottish Government; and the CHCP monitors its implementation through application of the Scottish Recovery Indicator set.

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 on-going basis with an increasing emphasis in ensuring a clear relationship with and understanding of the service priorities that need to be met, both in-year and going forward. The financial framework is estimated and the figures provided are indicative. The composition (of the framework) is extremely complex and there are many strands of service provision connected to individual packages of care, which require to be financially evaluated on an on-going basis. Local authority expenditure on mental health services for older people (as contained in the Commissioning Strategy for Older People Services) are not disaggregated in terms of mental health spend and thus are not shown here, although NHS expenditure is – this reflects current accounting systems.

8.2 The total financial framework for CHCP mental health services in the 2011/2012 financial year was £8856.8million (see below):

WDC Budget Expenditure 2011/12	£000
Assessment & Care Management	922.8
Housing Support MH	818.4
Housing Support ABI	165
Adult Residential Care	304.8
Additional Support at Home	349.1
Employability	132
Independent Advocacy	30.9
Choose Life	75.7
Payments to other bodies	399.8
Sub-total WDC	3198.5
NHSGGC Budget Expenditure 2011/12	
MH Adult Community	3320.7
MH Older People Community	1045.7
MH Older People Inpatient	1291.7
Sub-total NHSGGC	5658.1
Total	8856.6

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

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

8.5 In addition to its directly managed services, the CHCP has also funded activity and service provision from third sector organisations. It is both appropriate and fair that the CHCP's external funding arrangements are robustly and routinely tested to ensure best value against the resources

available and the model of provision identified. In doing this, it is important to appreciate that local voluntary sector partners have often faced challenges of managing a range of short-term funding streams and appropriate weight should be attached to continuity of defined service provision for individuals. It is also important to understand that while matched funding arrangements between third sector organisations with the local authority and/or NHS has to-date enabled successful leveraging in of further external resources, the changed financial climate will likely diminish the scope for such arrangements and the capacity it supported going forward (not least because of the increased pressures on and reduced availability of such external funding).

- 8.6 Reviews of all service provision, in house and externally purchased in line with best value competitiveness/benchmarking principles is required corporately and departmentally. This may result in a shift in both service provision and the associated financial framework. This new service design or reconfiguration will be carried out in accordance with the Procurement Guiding Principles set out in Appendix II and will be detailed as part of the procurement planning within the service's Operational Plan.
- 8.7 The Scottish Government has initiated some scoping on the Integrated Resource Framework (IRF): this is specifically to improve the quality of financial frameworks across Local Authorities and NHS organisations, including Primary Care and Acute Services. Contribution Analysis is similarly emerging concept at a very early stage of its practical development. This work will require to be undertaken by the CHCP as part of the improving and developing financial framework for the service.

9. DELIVERING OUR AMBITION – NEXT STEPS

- 9.1 At the heart of the CHCP's vision for improving adult mental health services is a focus on a person-centred approach that ensures that the person affected by mental illness is involved in decisions about their life, what they do and the services they receive. Robust commissioning of these services is essential to ensure that high quality and sustainable services are available to those who need them. This commissioning strategy provides a framework for the substance of relevant operational service plans on an annual basis within the wider context of the annual CHCP Strategic Plan.
- 9.2 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 document.

9.2.1 Quality Service Provision

National Quality Standards call for all areas across Scotland to offer a range of service routes, and for the quality of services to reflect a minimum standard. Service inspections and supported self-assessments for and by the Care Inspectorate aim to ensure that quality standards and personalised services achieving good service user outcomes are maintained. Whilst CHCP services have a good track record, there is no room for complacency. Fortunately there is clear commitment to quality and a commitment to sustain achievements. The CHCP will continue to identify ways of improving both choice and service quality. Using the Public Service Improvement Framework (PSIF) there will be an expectation on services, internal and externally purchased to set fresh, aspirational goals which continually drive further improvements. Regular, internal audits of the Single Shared Assessment (SSA) process and documentation will continue to provide an overview of service delivery and support a shared approach to Care Planning and Review.

9.2.2 Older People's Change Fund

The Scottish Government established the Older People's Change Fund to enable health and social care partners to implement local plans for making better use of their combined resources for older people's services. The Change Fund is intended to provide bridging finance to facilitate shifts in the balance of care from institutional to primary and community settings; and also influence decisions taken with respect to the totality of Partnership spend on older people's care. The CHCP successfully secured the year one funding against an approved local Change Fund Plan for 2011/12; and had completed all actions committed to within that time period. In tandem with discharging its year one commitments, the CHCP worked with local stakeholders to prepare its application to access its allocated year two Change Fund monies (which has now been secured), including the preparation of a Year Two (2012/13) Action Plan (which has now been approved). The routine and in-year implementation of the West Dunbartonshire Older People's Change Plan will continue to be driven and monitored through the local CHCP-led Change Plan Implementation Group (whose membership includes statutory, voluntary and private providers as well as community representatives).

9.2.3 Personalisation

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

payment can be used to purchase all defined community care services and support, except long term residential accommodation.

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

9.2.4 Early Intervention

The 2011 Report by the Commission on the Future Delivery of Public Services (the *Christie Commission*) made strong recommendations that Scotland's public services 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.

9.2.5 Carers

Carers play an increasingly important role in the support, care and treatment of people with long-term and/or multiple conditions, disabilities, illnesses, including dementia. With appropriate and timely support carers are able to care for longer, and enjoy better health and improved well-being. Carers do not usually 'down tools,' but unsupported they can experience real hardship financially, physically and emotionally. It is much more likely that a cared-for person will be admitted to hospital and the carer's own health deteriorates if the carer is unsupported. Carers can easily reach crisis point without appropriate and timely intervention. The CHCP is committed to identifying, assessing and supporting carers in a personalised and outcome-focused way and on a consistent and uniform basis (including the provision of short breaks or respite). The CHCP's local Carers Strategy is being refreshed and will be finalised later in 2012.

9.2.6 Housing

Housing has a key role in supporting independent living for adults with mental illness, as recognised within the local Housing Strategy. Local authorities and housing associations have a long tradition of providing low – medium level, preventative support services (such as housing support), either as part of housing management services, provided under tenancy agreements, or through separately funded housing support services, such as the former Supporting People Programme. These services are particularly useful for people who just need a small amount of help to live independently and need to be available across all housing tenures. There is a growing

body of evidence that investments in services which support people to remain independent, avoid accidents in the home and reduce social isolation, make an enormous difference to quality of life and are cost-effective (reflecting the Christie Commission's emphasis on prevention). Housing services have committed to work with partners to identify the housing needs of different client groups. CHCP Mental Health Services are reviewing housing support needs for people with a mental illness within the Housing Support Group forum.

9.2.7 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) will be taken forward as an explicit element service planning processes.

9.2.8 Population Needs

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

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

All CHCP strategies, plans, performance reports and procurement activity are scrutinised to ensure that the requirements and duties laid out within Equalities legislation are being met. With constraints on budgets it is apparent that different approaches to service delivery are required to reflect the needs of different types of people and ensure equitable access to supports and services to other population groups.

9.2.9 Integrated Health and Care Arrangements

At the end of 2011, the Scottish Government announced its intention that (over the course of this current parliamentary session) legislation will be brought forward to further integrate health and adult social care services. Under the proposals currently being consulted upon by the Scottish Government, NHS Boards and Local Authorities will be required to set up a Health and Social Care Partnership that would replace/supersede existing current Community Health (and Care) Partnership arrangements. The NHS Board and the Local Authority will devolve their service budgets to the new partnership entities, that at the time of the initial announcement were suggested as including primary and community health (including NHS children's services), adult social care and an element of NHS acute sector expenditure. They will jointly appoint an accountable officer who will be responsible for the integrated budget and manage service delivery and development. All the new partnerships will be asked to deliver and report on seven national outcomes, underpinned by a number of performance indicators. The new partnerships will make decisions on service provision, redesign and the use of their 'pooled' budget. The jointly appointed

accountable officer will have a level of delegated autonomy that allows them to make decisions about the use of the budget to deliver the outcomes without on-going reference upwards to the individual statutory partners. These proposals reinforce the strength of the arrangement that WDC and NHSGGC put in place when establishing the CHCP in 2010.

9.2.10 Information Management

The commissioning task starts with improvements to data collection and analysis. Going forward there is a pressing need to refine data collection systems that provide clear, unambiguous, local data that informs the cyclical commissioning process that this document is a key part of. Data from the Scottish Government Statistics Group provides comprehensive health and social care data for the CHCP as well as benchmarked data from other partnerships in Scotland. This is particularly relevant for the CHCP given social and economic profiles for the area and supports the delivery of an improved health improvement agenda and outcomes. Realising the potential of outcome based commissioning as described requires improving information recording and sharing between and within the NHS and the local authority and across CHCP services (including the systematic application of Single Shared Assessment and recording of the Care First information system).

9.2.11 Performance Management

The National Performance Management Framework was introduced by the Scottish Government in December 2011 and builds on the outcomes based framework set out in 2007. It provides details of the 10 year vision clearly set out in terms of improving the measure of progress towards the National Outcome agenda. Locally a suite of key performance indicators (KPIs) has been identified across all key areas for development. There is a range of outputs which are reported which will allow for more detailed analysis of trends and performance linked to public investment. These outputs represent a combination of statutory national indicators and locally determined indicators which reflect current commitments and demographics. The KPIs capture the national HEAT targets (Health Improvement, Efficiency, Access and Treatment) targets that are pertinent to older people's services within the CHCP. They also represent the agreed requirements within the Council Assurance and Improvement Plan to focus on local health and well-being priorities. However, there is a need to ensure that internal and external systems are better able to produce data fit for a range of purposes including "live" data for reporting and more long term trend data to allow for planning and trend analysis.

9.2.12 Strengthening Links with Other Service Areas

- This Commissioning Strategy has an additional complementary and reciprocal relationship with the already approved Older People's Services Commissioning Strategy.
- Addictions Services
The *Alcohol and Ageing: Is Alcohol a Major Threat to the Baby Boomers?* Report (commissioned by Health Scotland) states that if the baby boomers (in 2010 this is the population aged 45 – 65 years) carry on with their current drinking patterns into old age they are likely to experience higher than anticipated levels of morbidity. Detailed analyses of these issues are laid out in the CHCP's Commissioning Strategy for Alcohol and Drug Services.
- Adult Support & Protection
The CHCP and its partners are committed to the support and protection of adults at risk of harm, who by virtue of disability or illness, are more vulnerable to being harmed. The West Dunbartonshire Adult Protection Committee brings together Council, Health, Police and Third Sector members to provide cooperation, guidance and oversight of policies and services that support and protect adults at risk. There is an extensive programme of knowledge and skills based training that equips staff in the public and independent sectors to intervene, support and protect adults at risk and this priority will continue.

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 who 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.