Public Document Pack

**ADDITIONAL CIRCULATION**

ABERDEEN
CITY COUNCIL

To: Councillor Kiddie, Convener; Councillor Leslie, Vice-Convener; and Councillors Allan, Cormack, Donnelly, Ironside, Laing, Malone, McDonald, Penny, Jennifer Stewart, Kevin Stewart, Wendy Stuart, Kirsty West and Young.

Town House,
ABERDEEN 23 February 2010

# SOCIAL CARE AND WELLBEING COMMITTEE

The undernoted items are circulated in connection with the meeting of the **SOCIAL CARE AND WELLBEING COMMITTEE** to be held here in the Town House on **THURSDAY, 25 FEBRUARY 2010 at 2.00 pm**.

JANE MACEACHRAN
HEAD OF LEGAL AND DEMOCRATIC SERVICES

## B U S I N E S S

**4 SOCIAL CARE AND WELLBEING**

4.1 Response to the Consultation on the Draft Social Care and Wellbeing Commissioning Strategy for Adults (Proposed revisions are highlighted by track changes in the attached document) (Pages 1 - 82)

4.3 Annual Grant Making Programme (Pages 83 - 104)

Should you require any further information about this agenda, please contact Mark Masson, tel. (52)2989 or e-mail mmasson@aberdeencity.gov.uk

This page is intentionally left blank

# Aberdeen City Council

## Social Care and Wellbeing Commissioning Strategy for Adults

## 2010 – 2013

ABERDEEN
CITY COUNCIL

# CONTENTS


| Contents | Page |
|---|---|
| **1. Introduction:** | |
| 1.1 Commissioning Focus: personalisation and client outcomes | **3** |
| 1.2 Commissioning Principles | **5** |
| 1.3 Consultation and Engagement | **5** |
| 1.4 A Partnership Approach | **6** |
| 1.5 Wellbeing | **6** |
| .1.6 Budgetary Information | **7** |
| **2. How We Commission Services:** | |
| 2.1 Legislation, Policy and Regulation | **8** |
| 2.2 Commissioning Activities | **8** |
| 2.3 Making it Happen | **9** |
| 2.4 Agreeing on our Commissioning Priorities | **12** |
| 2.5 Joint Strategic Needs Assessment | **12** |
| 2.6 Social Care and Wellbeing Vision Statement | **14** |
| 2.7 Strengths, Weaknesses, Opportunities, Threats | **15** |
| **3. Commissioning Plans for 2010-13:** | |
| 3.1 Overall Priorities | **16** |
| 3.2 Older People | **18** |
| 3.3 Physical/Sensory Impairments & Long Term Conditions | **26** |
| 3.4 Mental Health | **34** |
| 3.5 Substance Misuse | **40** |
| 3.6 Learning Disabilities | **45** |
| 3.7 Carers | **50** |
| **4. Prevention, Adult Protection, Wellbeing and Rehabilitation** | **53** |
| **Appendices:** | |
| Appendix 1: References to Linked Plans and Strategies | **56** |
| Appendix 2: Local Performance Targets | **57** |
| Appendix 3: Social care and Wellbeing Vision Statement | **58** |
| Appendix 4: Aberdeen City Council Outcomes Framework For Social Care provision | **74** |

# 1 Introduction

This document summarises the commissioning plans for adults in Aberdeen City Council for the coming three years (2010 to 2013). It builds on the Social Care and Wellbeing Vision statement and indicates how Adult Services, in partnership with others, will be working towards achieving this vision over the coming years.

Within Aberdeen we regard commissioning as the strategic activity of determining the range of services to be purchased or provided to meet local social care need.

We use this commissioning strategy in order to:

- guide the work of the Social Care and Wellbeing service who will be overseeing the implementation of these plans;
- give clarity to our staff, councillors, people who are using or who may want to use our services and carers about the way services will develop;
- guide current and potential providers of services so they can provide what we wish to purchase;
- provide a mechanism through which we can monitor the progress we are making towards achieving our vision.

More detailed commissioning plans are being developed for particular services as necessary.

The commissioning process is a continuing cycle with information regularly feeding into the planning and procurement of services. We will continue to update these plans on an ongoing basis.

## 1.1 Commissioning Focus: personalisation and client outcomes

The term personalisation is one that is often used and has become an accepted part of the terminology that we use in Social Care. However as with many familiar terms, the meaning can at times become lost. For clarity, the definition used within the "personalisation papers[1]" is as follows

*"Personalisation enables the individual alone, or in groups, to find the right solutions for them and to participate in the delivery of a service. From being a recipient of services, citizens can become actively involved in selecting and shaping the services they receive." It was recognised that Changing Lives[2] "would only be achieved by social work services working with their partners locally to re-design the delivery of services."*

The concept of outcome focused commissioning is one that originated separately from the personalisation agenda, but the concepts appear to be converging and a focus on outcomes is

[1] The "personalisation papers" is a combination of three papers from the Changing Lives Service Development Group as follows "Personalisation : A Shared Understanding", "Commissioning for Personalisation" and "A Personalised Commissioning Approach to Support and Care Services.

[2] Changing Lives: Report of the 21st Century Social Work Review http://www.scotland.gov.uk/Publications/2006/02/02094408/0

now an integral part of the personalisation agenda. This is illustrated with a further quote from the personalisation papers.

*"The current way in which services are often delivered, and the emphasis on inputs and processes rather than outcomes for the individual, family or community, is too inflexible for the scale and nature of future demand"*

Too often there has been a disconnect between the outcomes of individual assessments of need and the narrow range of stock service responses in the resultant care plan. This has come about, in large measure, because commissioning has become overly centralised and overly focussed on standardised processes with too little scope for individual variation, often dealing with too few providers as a matter of bureaucratic convenience to the detriment of user choice.

In order to address this disconnection between care management and commissioning, it is the our intention that, at the individual level, service users and carers themselves should increasingly assume the lead role in commissioning services to meet their own individual needs and aspirations. These users and carers may be assisted, as necessary, by advocates and brokers, using the resources allocated to them by professional assessors/care managers.

**Policy Drivers**

One of the key messages of Changing Lives is the need for systemic change in the way that we provide services;

*"Doing more of the same won't work. Increasing demand, greater complexity and rising expectations mean that the current situation is not sustainable: Tomorrow's solutions will need to engage people as active participants, delivering accessible, responsive services of the highest quality and promoting wellbeing."*

*"Increasing personalisation of services is both an unavoidable and desirable direction of travel for social work services. Unavoidable in the sense that both the population and policy expect it; desirable in the extent to which it builds upon capacity of individuals and communities to find their own solutions to self care, rather than creating dependence on services. "*

Deleted: .

A key theme is that of *"Building capacity to deliver personalised services"* which is within chapter 5 of the report.

This chapter begins with a quote from the Changing Lives Users and Carers panel

*"We expect services to make a positive difference to our lives. We are people first. The outcomes we want include having power and control, being able to take risks and contribute to society. This means that there needs to be a shift in power away from people who commission and provide services to service users and carers."*

A detailed paper on our approach to Outcomes in shown at appendix 4

**National Outcomes for Community Care**

The National Outcomes for Community Care is a package of national measures and targets aimed at improving services for users and carers with a focus on feeling safe, satisfaction with care packages and opportunities for social interaction. The outcomes seek to:

- Change the balance of care with a focus on increased personal care at home and intensive Care at Home when required as opposed to inappropriate care in a care home
- Provide support for carers and thus increase the number who feel supported and able to continue in their caring role
- Reduce the number of unplanned hospital admissions and Delayed Discharges over 6 weeks

**Commissioning has a key role to play in supporting the modernisation agenda. It seeks to:**

- Achieve improvement in the quality of services at a sustainable cost
- Develop commissioning strategies in conjunction with all stakeholders
- Through these strategies to influence the local market in the provision of social care
- Develop overarching service specifications in accordance with strategy
- Support operational services in their individual commissioning of services
- Support the contract team in contract monitoring activity. Deleted: .
- Participate in the review and evaluation of services
- Undertake capacity planning in order to identify areas for service development. Deleted: .
- Liaise with contracting ensuring procurement process is in accordance with strategy. Deleted: .
- Liaise with contracting in relation to the decommissioning of services

## 1.2 Commissioning Principles

As a commissioning authority we will:

- Ensure that the process of commissioning is understandable, transparent, accountable, inclusive and engaging. Deleted: .
- Promote and support the delivery of personalised services which focus on improved outcomes
- Take regard of best practice and available evidence. Deleted: .
- Place continuous improvement and the views of users at the heart of what we do. Deleted: .
- Link the planning for universal and targeted services to promote positive outcomes and life choices for individuals. Deleted: .
- Meet statutory duties with regard to Best Value. Deleted: .

We believe this will enable us to:

- Provide service users and their carers with the outcomes that they want and services they need at the times, and in the places, they want. Deleted: .
- Promote an effective and vibrant local economy of care
- Ensure all legislative and regulatory duties are complied with. Deleted: .

## 1.3 Consultation and Engagement

Aberdeen City Council is committed to ensuring that services are person centred and personalised wherever possible. To achieve this we will ensure that we establish and maintain meaningful engagement with our service users, their carers, providers and other stakeholders. We will utilise a range of approaches to ensure the voices of all stakeholders are heard. Deleted: .

With partners we will continue to pursue innovative ways to engage all interested parties to incorporate their views in the ongoing commissioning and service improvement processes.

## 1.4 A Partnership Approach

This Strategy summarises the commissioning plans for Adult Services and those areas where joint work is needed to achieve the required outcomes for service users and their carers. It does not include all the commissioning priorities of partners, but it aims to reflect the increasing number of areas where close joint working is needed. The commissioning plans summarised in this document will continue to be developed to better reflect joint strategic intent will be monitored through the Social Care and Wellbeing service.

Deleted: .

Deleted: T

The commissioning team will work in partnership with a range of key stakeholder to develop services better tailored to the needs of individuals and to the changing environment of social care provision.

Key potential partners include:

- Community Planning
- Corporate Services
- Neighbourhood Services
- NHS/CHP
- Housing
- Independent Services Providers
- Users
- Carers

Commissioning seeks to strengthen the social care market by encouraging diversity and enterprise in social care service provision and by promoting innovative approaches which shift care closer to home and towards a greater emphasis on self-directed support, prevention and early intervention.

The purpose of community care (Joint Future) is to maximise the quality of life and independence of all Aberdeen's citizens. The main focus to achieve this is by implementing and improving the set of 16 community care outcomes for people set by the Scottish Government in Aberdeen. A performance report on how this is being done in Aberdeen is published on an annual basis.

## 1.5 Wellbeing

The responsibilities of the Director of Social Care and Wellbeing and the new committee goes beyond the purchase and provision of care. They have a clear responsibility for the wellbeing of people, particularly those who are vulnerable. This includes leading the Council's contribution to public health promotion and preventative services.

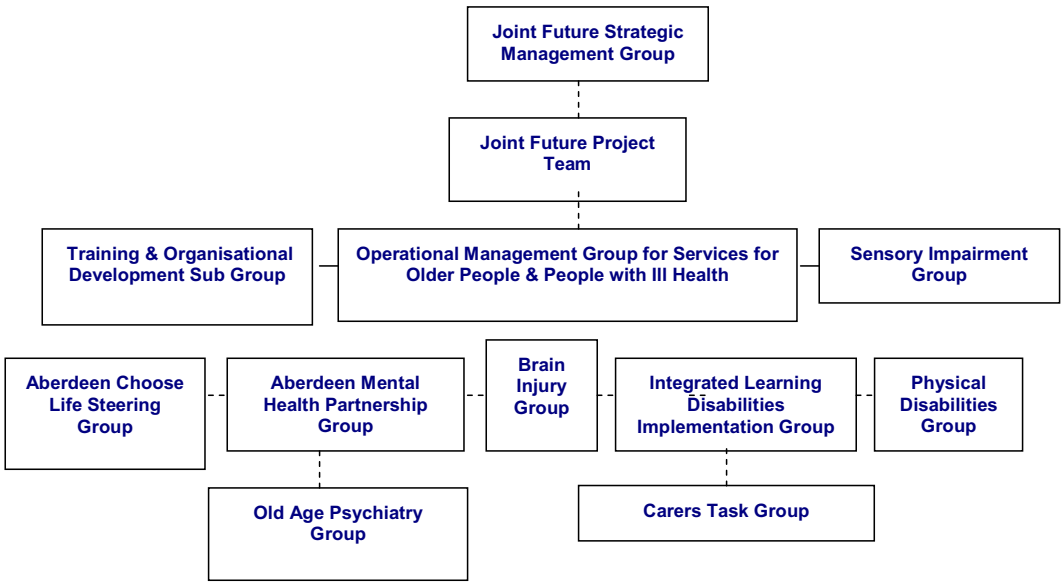
It is also important to ensure that the whole independence and well-being agenda actually is addressed.

If there is not a clear strategy in place with a responsible officer then there is a danger that the intention to prioritise a personalised and independent focussed service will become a secondary priority to the imperatives of the service. This area also ought to work closely with the NHS on Health promotion/ public health.

Deleted: .

Deleted:

**Diagram 1 below shows the joint planning arrangements we have in Aberdeen for the main community care client groups.**




These are the main strategic planning groups. Linked to each of these areas there are implementation groups that ensure that the visions and strategies are put into place.

## 1.6 Budgetary Information

The total social work budget amounts to £103.6m. The key areas of spending relating to this strategy are as follows

| | |
|---|---|
| Older People | 37.1m |
| Learning Disability | 16.6m |
| Physical/Sensory Impairments and Long-Term Conditions | 6.7m |
| Mental Health | 4.6m |
| Drugs and Alcohol | 1.7m |
| Carers | 0.9m |

# 2 How We Commission Services

## 2.1 Legislation, Policy and Regulation

The statutory duties of Social Work and partner agencies are governed by a wide range of legislation across children's services; justice services; and community care.

Principal legislation includes:

- Social Work (Scotland) Act (1968)
- Children (Scotland) Act (1985)
- NHS & Community Care Act (1990)
- Mental Health (Care and Treatment) (Scotland) Act (2003)
- Management of Offenders etc (Scotland) Act (2005)
- Adult Support and Protection (Scotland) Act (2007)
- European Procurement Legislation

Most services described in this strategy, both directly provided and commissioned, are regulated by the Scottish Commission for the Regulation of Care. The social care workforce is regulated by the Scottish Social Services Council. There are also a number of different inspectorate and audit bodies who scrutinise performance on a single or partnership agency basis.

National policy is focussed on effective partnership working between agencies. This applies to all areas of activity - community care, children's services and justice. Key policy initiatives in this respect include:

• For Scotland's Children (2000)
• Getting it Right for Every Child (2005)
• A Joint Future (2000)
• Multi-Agency Public Protection Arrangements (2007)

In October 2006 the (then) Scottish Executive published Changing Lives – Report of the 21st Century Social Work Review". Amongst the conclusions was that:

***• Social Work services don't have all the answers. They need to work closely with other universal providers in all sectors to find new ways to design and deliver services across the public sector….building new capacity in individuals, families and communities and focusing on preventing problems before they damage people's life chances."***

## 2.2 Commissioning Activities

Diagram 2 (overleaf) summarises the activities needed in order to deliver effective commissioning. These activities can be divided into four key areas of work:

Collection and Analysis

Planning

Doing

Reviewing

(Following the guidance published on the CSIP Commissioning E Book and prepared by the IPC (Oxford Brookes University).

All of these activities need to be undertaken to make sure that we are effectively planning and delivering health and social care services.

## 2.3 Making it Happen

In order to deliver the actions outlined in this commissioning strategy we have a number of working groups whose responsibility it is to ensure that we are moving closer towards our visions for services.

Diagram 3 shows how these various groups link together and highlights the roles each of them play in delivering this strategy.

Alongside these partnership arrangements each partner agency has its own business planning systems. Our aim is to ensure that the commissioning priorities we have agreed as partners are reflected in the internal planning arrangements of each separate agency.

**Diagram 2: The Commissioning Framework**

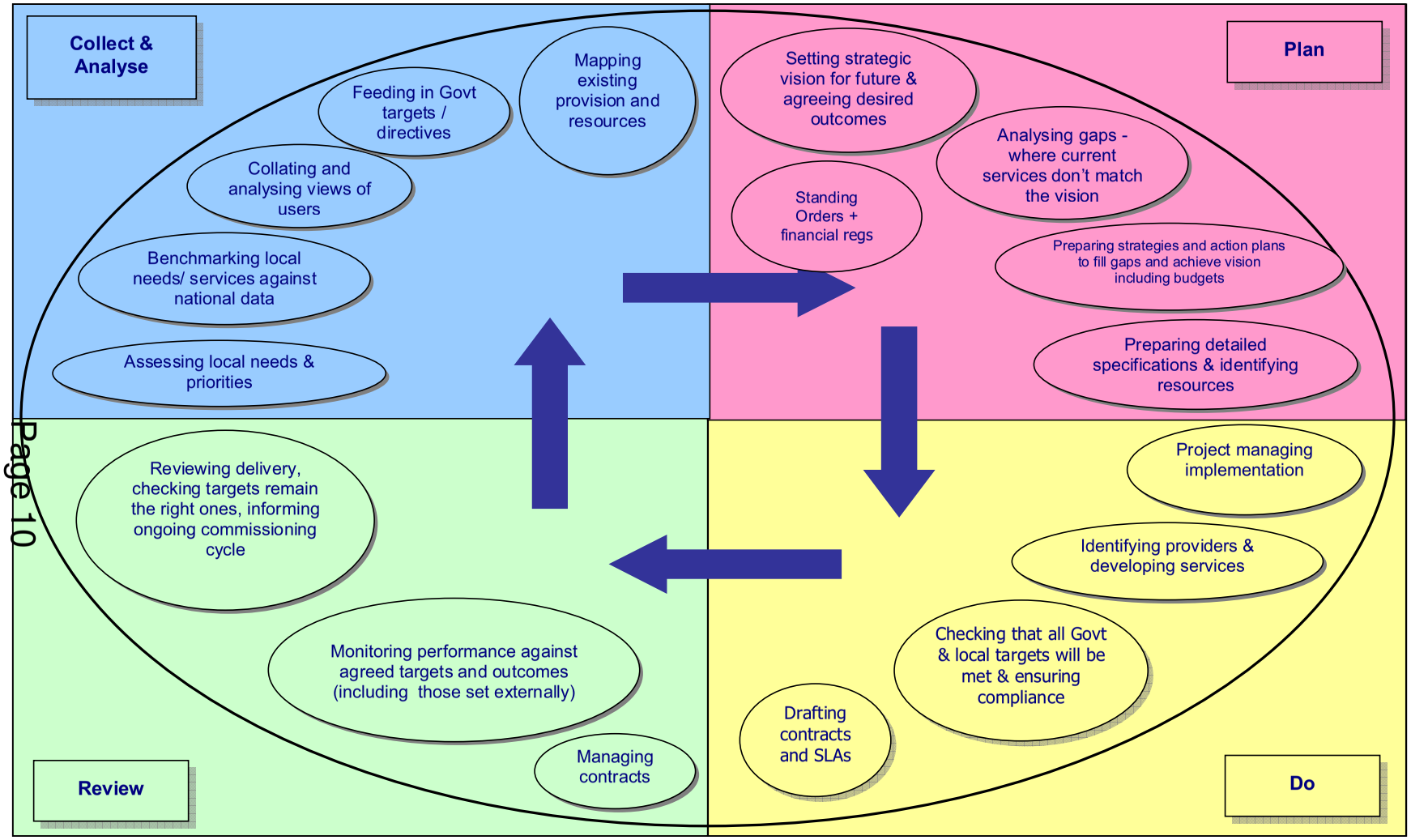
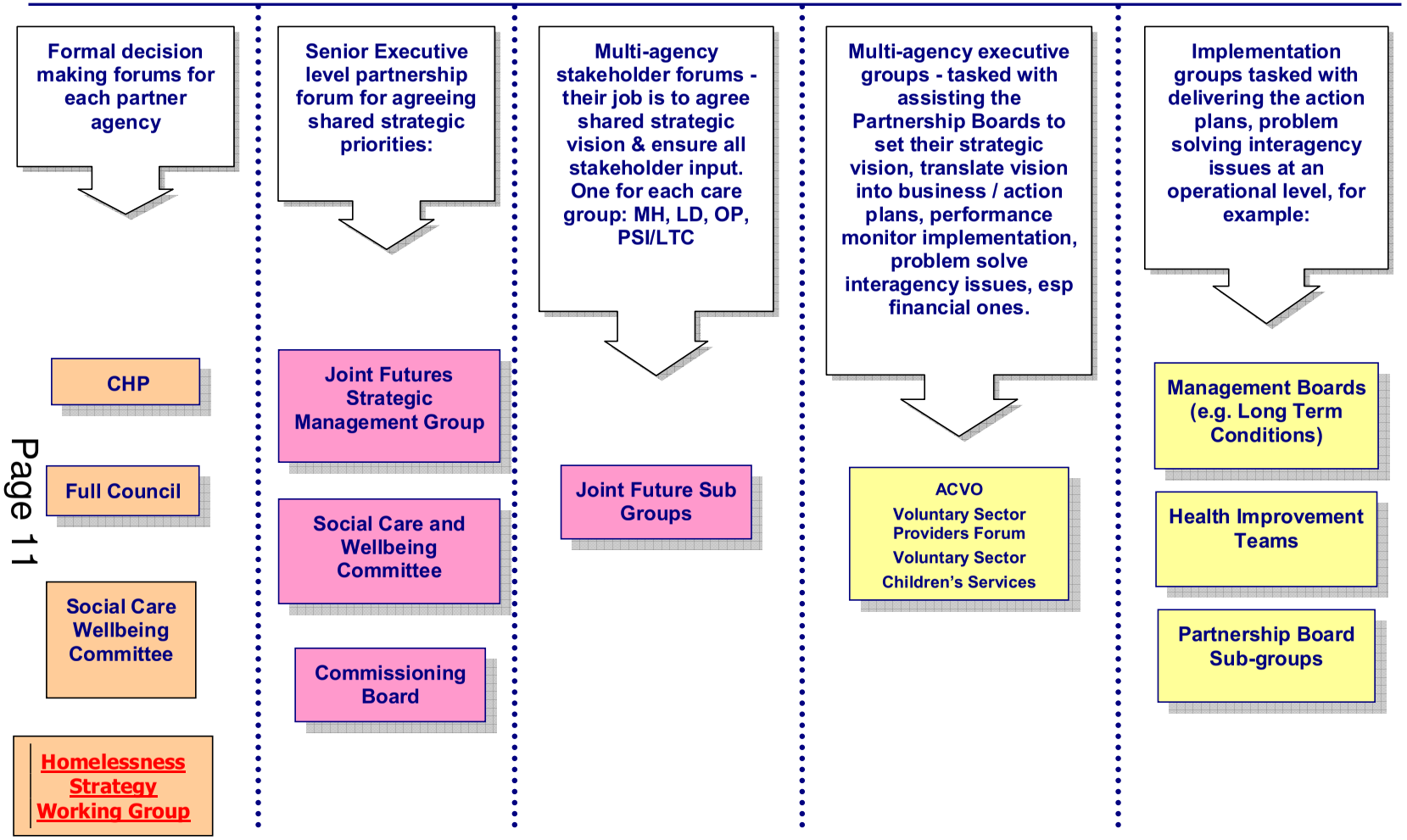
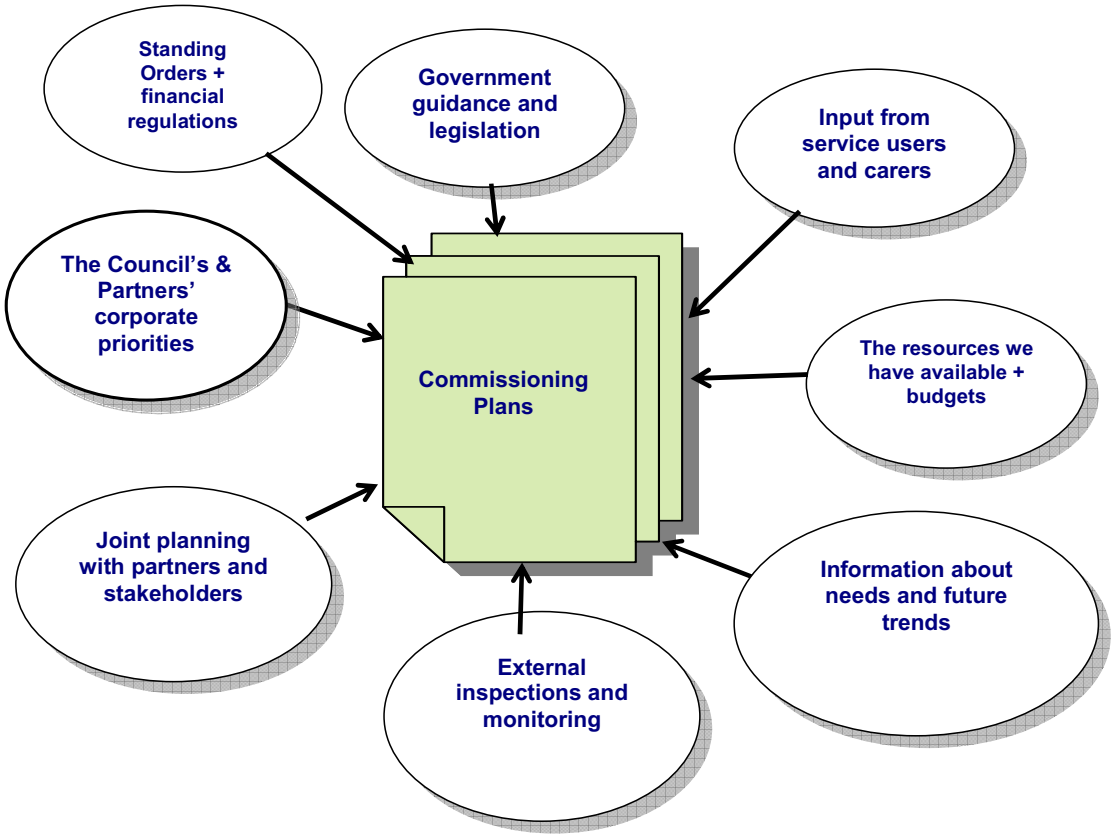


**Diagram 3: Making it Happen - responsibilities of the various interagency planning and working groups**



## 2.4 Agreeing on our Commissioning Priorities

Many things influence the way we develop services. The following diagram shows the range of factors that guide and influence our commissioning intentions here in Aberdeen:




## 2.5 Strategic Needs Assessment

In line with national trends, Aberdeen has a growing older population with physical and mental health problems - this inevitably will lead to increased demands for services and support.

More older people means more illnesses associated with old age:

For example:

- Isolation and a lack of social networks is a major issue for older people, for disabled people and for people with mental health issues.

- We need to improve support for people with social care needs to remain in or return to employment - as this will deliver better outcomes for individuals and for families.

- A broader range of housing options are needed for older and for disabled people, including extra care; supported living; different tenure choices; etc.

Deleted: better

- Access to and sustaining appropriate housing is a real problem for many groups across Aberdeen including young people; people on low incomes; disabled people; smaller households.

- Obesity and lack of physical activity are leading to major long term health problems for our population.

**Other health conditions that we need to focus on are:**

| | |
|---|---|
| **Mental ill health;** | **Pain** |
| **Heart disease and stroke** | **Diabetes** |

**Other behaviours that we need to address are:**

| | |
|---|---|
| **Smoking** | **Food/poor nutrition** |
| **Alcohol consumption** | **Drug misuse** |

As needs are increasing we need to change the way we respond to these needs, through:

- re-focusing on prevention/well being;
- supporting carers to enable people to be supported at home;
- encouraging and supporting people to self care;
- encouraging people to behave in ways which will improve their health outcomes;
- ensuring that mainstream services are much more accessible to disabled, ill and older people - to enable specialist services to support those people in greatest need.

Demographic and local needs based information guides our commissioning plans and work is continuing to refine and develop this commissioning intelligence and knowledge.

## 2.6 Social Care and Wellbeing Vision Statement

Extracts from the Social Care and Wellbeing statement are shown throughout this document and the document is shown in full at appendix 3

> Our Core Purpose is to identify and respond to the social care needs of people living in Aberdeen. Often working in partnership with others, we aim to respond with cost effective quality services which support safeguard and promote the well being and safety of people who are in greatest need. We will respect and promote people's rights, support their independence and their inclusion in their own community respecting their choice wherever it is possible.

**Our guiding principles are that we:**

- Give clear and easy to understand information to people about what we can and can not do.
- Help people to have as much choice and control as possible over their lives.
- Work with others to look at the problems some people have when using ordinary services, like health, housing, leisure and work.
- Make sure that the services we offer are the best they can be. If services need to be better we will work to make them better.
- Listen to what people say and are open to new ideas and are there when people need us.
- Listen to what carers say and finding out what they need. If they are satisfied and feel confident it will help them in their role.
- Deliver on our promises.

## 2.7 Strengths, Weaknesses, Opportunities, Threats

We are aware that there are a number of factors, both internal and external which impact on our ability to deliver this commissioning strategy. Some of these are summarised below.

| **Strengths** | **Weaknesses** |
|---|---|
| • Committed workforce within the council and provider organisations<br>• Policy guidance encourages partnership working and innovation<br>• Aberdeen City Council is committed to Improvement<br>• Supportive Government guidance e.g. Changing Lives, Personalisation Papers<br>• NHSG commitment to developing joint strategies<br>• Ability to support local organisations to develop projects and helping them attract funding<br>• Strong and diverse independent providers<br>• Examples of service provision/ social enterprise model developing | • Knowledge/ management of market trends<br>• Lack of baseline data and business plan<br>• Accountability for budget and performance<br>• Lack of overall Best Value approach to in-house, private and voluntary sector<br>• Lack of strategic vision in relation to in-house provision<br>• Assessments are resource focused, not inclusive<br>• Providers focused on statutory agency funding<br>• Lack of outcome focussed service specifications<br>• Market Analysis-what level of service to expect for what cost<br>• Governance of commissioning weak |
| **Opportunities** | **Threats** |
| • Build on successful Stakeholder events and recent consultation activity with stakeholders<br>• Consensus that processes need to be more inclusive<br>• Joint commissioning with NHSG, linked to more person-centred, outcome-focused & less risk-averse professional approach<br>• Joint procurement/commissioning with Aberdeenshire on specialist services<br>• Joint initiatives across public/independent sector<br>• Potential for local community organisations encourage local solutions<br>• Local service development increases opportunity for low cost support in neighbourhoods<br>• Use national support, best practice models –e.g. "*In Control", Fair costing of care, 'Talking Points' planning tool*<br>• Potential to harness Contracts and Commissioners to strengthen purchasing<br>• Opportunity to reshape social care and SP spend jointly | • Very serious financial threats, existing overspend, temptation to focus on savings rather than efficiency measures – are we buying the right things at the right price<br>• Support to individuals continues to be resource rather than community focussed<br>• Balance skewed to risk management rather than promotion of choice, independence and risk enabling.<br>• Short term decision making may compromise long term goals<br>• Revenue and capital commitments to existing services reduce scope for innovation<br>• Mistrust between users/carers and Council<br>• Traditional small providers fear loss of business, danger of replacement by institutional national players in absence of new services<br>• Demography – more complex needs, shrinking workforce<br>• Loss of skilled staff, attracted elsewhere |

# 3 Commissioning Plans for 2010 – 13

On the following pages we have summarised our commissioning intentions for Adults in Aberdeen for the coming three years. The plans are divided into the following areas:

Older People, including Older People with Dementia

Disabled Adults with Physical / Sensory Impairments and Long Term Conditions

Adults with Mental Health Needs

People with Substance Misuse problems

Adults with Learning Disabilities

Carers

The Social Care and Wellbeing service is responsible for ensuring that these commissioning plans are implemented.

Regular reports on progress will be delivered to the Director of Social Care and Wellbeing and any areas of difficulty or major changes will be discussed.

## 3.1 Overall Priorities

There are some cross cutting themes that emerge as a high priority for service development across all care groups. These include:

- need to continue focusing on the integration of health and social care services to deliver more seamless and effective services for people
- the need for a better range of living options to be available that range from care home with nursing, through various models of extra care and supported living to intensive support in people's homes, with a variety of tenure options
- supporting working age adults (including carers) into employment wherever possible
- increase choice and control for people through the development of Direct Payments and Individual Budgets and the personalisation agenda
- the need to ensure the protection of vulnerable adults in all our directly provided and contracted services
- ensuring that our services are culturally appropriate for people from a range of different community backgrounds
- continue to develop services that support carers as more people are cared for and supported in their own homes
- the need to refine our workforce strategy across the statutory, independent and voluntary sectors to ensure that there will be a sufficient supply of appropriately skilled staff to meet future needs
- developing an enabling culture within both in-house and contracted services, that supports people's independence and encourages people to self care
- Encourage the maintenance of a diverse range of third sector providers with which Aberdeen City Council may partner sustainably
- ensuring that we have a preventive / rehabilitative approach to services which enhances community health and general well-being and aims to prevent deterioration

Deleted: ;

Deleted: ;

Deleted: .

Formatted: Bullets and Numbering

Deleted: ¶

Formatted: Font: Arial, 12 pt, Not Bold

Deleted: .

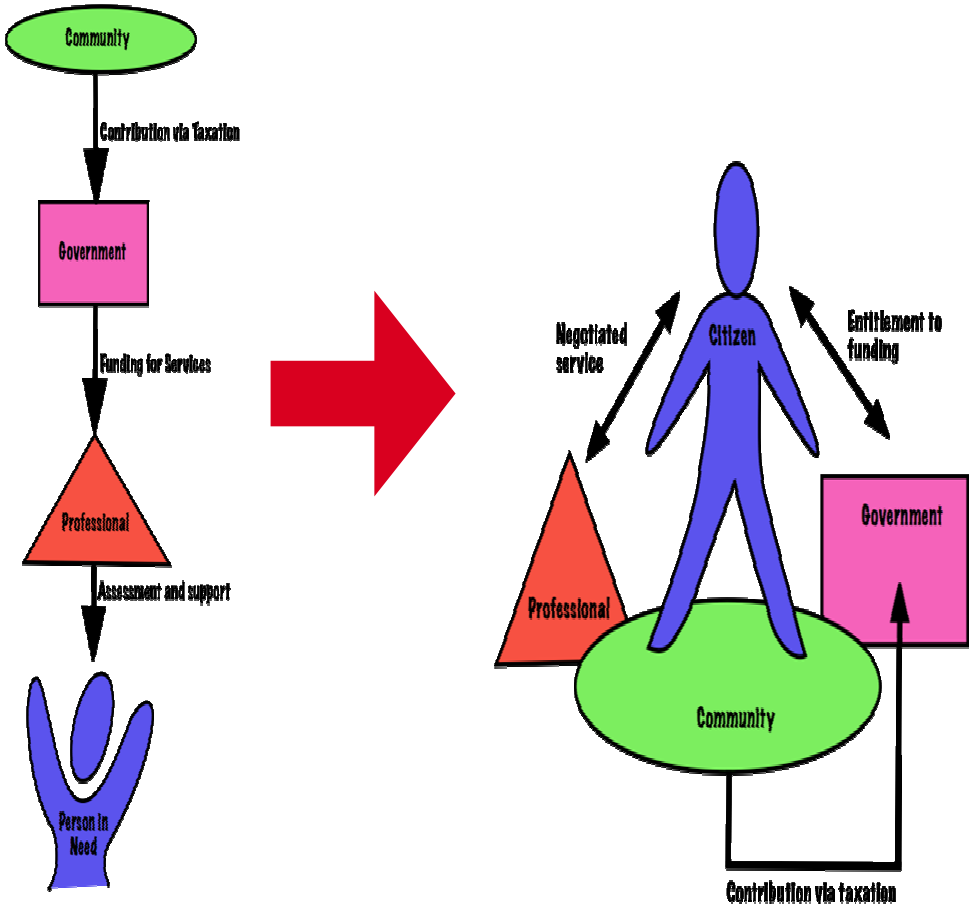
As noted, many commissioning priorities are common to different client groups. Where this is the case for the purposes of clarity, certain items may be repeated in different sections.

## Link to Community Planning Services and the Single Outcome Agreement

The Commissioning Strategy differs from existing strategy in that it seeks to achieve outcomes for the whole community not just those eligible for social care support. It seeks to influence and work with a wider range of partners in recognition they have a powerful influence over health & wellbeing of community.

Traditional role in providing services has viewed individuals as passive recipients of welfare emphasising the role of the professional.

Instead in a model which views individuals as citizens with full array of rights, choices and responsibilities, then we should see that the majority of needs can be met through ordinary every day services. The role of social care services should be focused; supporting complex needs and enable them to access mainstream service.




**Moving from the "professional gift model" to the "citizenship model"**

**17**

## 3.2 Commissioning Priorities for Older People (including older people with dementia)

### Vision

- Help people to be able to take a full and active role in their local community, as citizens of Aberdeen.
- Support people to live as independently as possible in their own home for as long as they are able and want to do so, through a wide range of personal and practical, home based services.
- Work with others so that people should have a choice of good quality housing resources which enables them to maintain their independence for as long as possible.
- Provide a broad range of affordable and accessible activities that should be available for all older people whether active or less mobile, including those with enduring mental health problems.
- Ensure that people have access to health and well being opportunities which are close to home, responsive, flexible, with no professional/organisational boundaries.
- Provide a range of affordable support services, both personal and technological, available to help older people in their day to day tasks and in their personal care.
- Ensure that people, including carers are able to get information about those services that are available quickly, easily, in a variety of ways and formats, and at a time convenient to them.
- Ensure that older people receive support / care from someone who is sensitive to their culture and needs.

### Needs and Trends

Projections suggest a significant and substantial increase in the numbers of older people between 2006 and 2031 in Aberdeen, reflecting national and regional trends. The number of over 65s is projected to rise by almost 65%. The largest growth of over 150% will be seen in potentially the most frail and dependent group of over 85s with key implications for planning future service provision for this group.

Dementia is most common in older people with prevalence rising sharply in people over 65 years. It is one of the main causes of disability in later life. As the numbers of older people rise, so will the numbers of people with dementia. There will be a steady increase in numbers of people with dementia over the next 3 years followed by a dramatic rise over the next 15 years. In Aberdeen there are an estimated 2700 people with dementia living in the community now and this is likely to rise to 4600 by 2031.

Early diagnosis of, and intervention for, dementia are the keys to delaying admission to long term care and to help people remain independent for longer. Promoting healthy ageing, for example keeping people active and tackling social isolation, is important in delaying the onset of dementia

**Isolation and social networks:** 1 in 5 adults aged over 65 live alone. As the older population grows in line with national population projections, the numbers living alone will therefore increase. Strong social networks are particularly important for vulnerable people. However a large proportion of older people, disabled people and carers find it difficult to access groups which provide support for people with specific health and social care needs.

### Pressures, Gaps and Business Issues

Alongside the population needs highlighted above additional pressures and issues facing services in Aberdeen include:

### Workforce issues

Aberdeen City has almost full employment, high cost of living, lack of affordable housing, limited social care market due to geographical location, an increasing proportion of the workforce do not have English as their first language, which can bring additional training needs, pay scales compared to the non social care are not favourable.

Deleted:

Deleted:

### Business issues

Providers can face High rent and capital expenditure costs along with a high cost of consumables and increasing transport costs.

### Shifting the balance of care

Shifting the balance of care is a term used to describe change at a number of levels, for example, shifting the location of care towards more community-based facilities, shifting the focus of care towards long term conditions and changing the roles and responsibilities of patients and professionals. The current pattern of social and learning provision in Aberdeen places reliance on models of traditional day care rather than supporting individuals to meet and participate in their local communities.

Deleted: ¶

### Services and accommodation for older people with alcohol problems

To date most services and initiatives to help and support people with alcohol related health and social issues have been directed at younger people. The numbers of older people with chronic health problems associated with alcohol abuse, who need appropriate accommodation, support and personal care, is growing.

### Joint workforce planning

We need to re-engage with our partners in health and the independent sector to achieve a balanced workforce thus ensuring that there is sufficient capacity of skilled and highly motivated social care and health staff to meet the current and future needs of our older people.

### Preventative services

We currently provide a range of intermediate care services that facilitate timely hospital discharge and support people to return home after hospital admissions and through our rapid response team prevent many hospital admissions. We need to continue to do that which we do well, but must address the need for the development of different types of low level support for people in their own homes.

**Promoting the well being agenda**

This is a multi-faceted agenda involving all 12 themes identified by older people as important in their daily lives. This will require significant consultation, engagement and planning with all our citizens. Older people are more likely to remain active and healthy if they have access to support to continue to lead their life in the community. One key area to focus efforts on is, the promotion of wellbeing through mobilising and sustaining local networks.

**This commissioning strategy is structured around 12 themes which older people have identified as important in their daily lives:**

| | |
|---|---|
| Citizenship and involvement | • A place to live |
| Money | • Getting around |
| Leisure and social activities | • Learning |
| Keeping safe | • Health and well being |
| Support in daily living | • Carers |
| Culture | • Information and access to services |

**This underpins the achievement of a number of key outcomes for older people**:

| | |
|---|---|
| Improved health and well being | • Improved quality of life |
| Making a positive contribution | • Exercise of choice and control |
| Freedom from discrimination | • Economic well being |
| Personal dignity | |

It is the aim of Aberdeen City Council to work jointly towards achieving these outcomes over the coming years. This commissioning strategy shows the actions that are needed over the next three years to implement this.

**Responding to an Ageing Population**

Older people are higher users of health services, and are at greater risk of being admitted as an emergency admission to hospital. Delayed discharge is a local, as well as a national, priority. Delayed discharge occurs when the patient who is ready for discharge cannot leave hospital (after 6 weeks) because the other necessary care, support or accommodation for them is not available. Aberdeen City Council and NHS Grampian have worked together to develop the full range of care packages needed to support hospital discharge. However, we need to make further sustained improvement. Through projects such as the Intermediate Care Programme NHS Grampian and partners are striving to retain people in their own home - independently or with support - while also having appropriate residential care capacity available for use as and when required.

**United Nations Principles for Older Persons**

Aberdeen City Council subscribes to the United Nations Principles for Older Persons.

**Issues for Services / Service Responses**

The "promoting wellbeing agenda" and 'Shifting the Balance of Care' touch on a wide range of services and means different things to every individual.

Failure in any part of the system often jeopardises outcomes in other areas. We have devised an initial work plan that looks across some key areas of in-house provision of social care and wellbeing for older people in Aberdeen.

To help older people have choice and control through:

- readily-available and accessible information
- services provided locally wherever possible

To ensure services develop in line with the experience and needs of older people:

- users, carers and the public will be involved at all levels of decision making
- services will have flexibility to allow older people to use less or more, depending on their changing needs
- services will increasingly be available at the times that users and carers want and need them

Deleted: .

To ensure that services are of good quality:

- improvements will be led by defined and better outcomes
- objectives and targets will be monitored to ensure continuous improvement
- fair and equitable access to resources within and across all age groups will be measured

Deleted: .

To ensure services promote independence:

- there will be a focus on prevention and early intervention, maximising opportunities to promote wellbeing, independence and choice, and enabling communities to develop their own solutions
- wellbeing will include improved economic wellbeing, the provision of appropriate housing and security

Deleted: .

To ensure effective use of resources:

- services will provide value for money and meet assessed needs
- we will improve partnership working to deliver integrated care for service users
- the capacity and flexibility of the workforce will be maximised through joint training and development with partners

Deleted: .

**Vision for Services**

Our vision for older people is to enable them to live the lives they want, achieving their potential to live independently, exercising choice over the services they use, importantly participating in community life. Improving their wellbeing and reducing inequalities are key elements of our vision.

For older people in our city services will be delivered in a way that:

- respects them
- values their contribution and their diversity
- ensures their dignity is maintained at all times
- takes account, when necessary, of their need for protection

Deleted: .

**'We need to see a fundamental shift if we are to meet the aspirations of older people. We need to stop thinking in terms of dependence…and start thinking about independence and wellbeing.**

**When they are asked, older people are clear about what independence means to them and what factors help them to maintain it. These factors...go far beyond care services to involve issues such as transport, housing, education, leisure and advice.'**

***'Older people - independence and wellbeing': Audit Commission and Better Government for Older People.***

**How will we make this happen?**

We will, through our commissioning activities:

- encourage the active citizenship and social inclusion of older people
- recognise that older people are a diverse group with different needs and aspirations
- put independence for older people at the centre of our plans and thinking
- work with our partners to achieve seamless services for older people
- value the contributions of the voluntary and independent sector, and other partner agencies, towards the promotion of health, social care and wellbeing for older people
- promote opportunities for older people to become actively involved in the design and delivery of services
- ensure a co-ordinated approach with other strategies and care pathways
- encourage the development of services which are able to respond to the increasingly ethnically diverse population in Aberdeen

Deleted: .

**Commissioning Priorities**

The following table highlights the commissioning priorities for older people for 2010-13.

| Key Outcome | Commissioning Priority |
|---|---|
| **Health and well-being** | A comprehensive review of older people's services.<br><br>Early intervention after diagnosis of dementia.<br><br>Review of specified tasks and standards within care contracts to ensure high quality support to those with complex needs.<br><br>In partnership with NHSG and care providers training will be developed as provided as required to secure improvements. E.g. medication management, adult protection. |
| **Safety and security** | Increase the use of Assistive Technology to allow people to feel secure in their own environment. |
| **Support in Daily Living** | The council wishes to consolidate the joint commissioning strategy with Health for the development of nursing and social care, whether provided in the community or in care home settings. |
| **Leisure & Social Activities** | In partnership with the other services, the council will develop more opportunities for older people to access activities and universal services, underpinned by an appropriate strategy on transport. |
| **A Place to Live** | People being supported in their own homes for as long as possible.<br>Support provided to maintain tenancies<br><br>Review and recommission extra care housing. |
| **Information & Access to Services** | A comprehensive and accessible advice service for older people. |
| **Relief Pool** | Develop Peripatetic Pool to replace the current relief pool and reduce reliance on agency staff. |
| **Information** | Complete work already commenced to rationalise and improve written Information.<br>Update website |
| **Care at Home** | Increase availability of care and support out of hours<br>Develop a joint and fully integrated training programme. |

Deleted: .

Deleted: .

Deleted:

| Key Outcome | Commissioning Priority |
|---|---|
| **Citizenship & Involvement** | The council will review its strategy for funding voluntary sector agencies either to provide or to advise on preventative services for people with low-level needs, with a view to ensuring more comprehensive coverage.<br><br>To give many more older people the opportunity to take charge of their own care and to influence wider service developments.<br><br>Develop a befriending scheme.<br><br>Build on existing volunteer bureau activity.<br><br>Encourage volunteering by Older People and opportunities for mutual support |
| **Money** | The Council will corporately consider how it can further reduce the non-take-up of welfare benefits and will enhance its promotion of Direct Payments, increasing the budget allocation as necessary.<br><br>Individual budgets to allow people to make their own choices about the nature of their care.<br><br>We will work with care at Home providers to agree new rates for the next 1-3 years when the current agreement ends in March 2010. |
| **Choice and Control** | Services to be personalised and focussed on individual's personal outcomes. |
| **Supporting Carers** | Support and value carers and involve carers in service development.<br><br>Recommissioning current carers services to ensure that they are in line with the Carers Strategy and priorities. |
| **Responding to an Ageing Population / Shifting the Balance of Care** | By 2010/11, reduce the emergency inpatient bed days for people aged 65 and over, by 10% compared with 2004/05. |
| **Making Change happen** | Develop infrastructure to support self directed support |

Deleted: activitiy

Deleted:

| Key Outcome | Commissioning Priority |
|---|---|
| **Sheltered and Very Sheltered Housing Services** | Review the Outcomes following the Integration of the Warden Service and Home Care Service<br><br>Collect, collate and analyse the views of service users, carers and staff<br><br>Assess local needs and priorities<br><br>Map existing resources and provision<br><br>Broaden the range of provision<br><br>Increase provision of Very Sheltered housing<br>Increase opportunities for tenants to engage with their local communities and support the development of activities that promote wellbeing<br><br>Scope the levels of housing support and care tasks<br><br>Consider the options for future charging of the range of housing support services<br><br>Establish performance indicators and monitoring systems<br><br>Develop joint information pack for prospective tenants |
| **Day Care Services/ Community Participation** | Review current and develop future local community based provision<br><br>Best Value Service Review of current provision<br><br>Engage with all stakeholders in the development of proposals for local services<br><br>Immediate review of staffing |
| **Care Homes** | Review staffing structure |
| **Rehabilitation/Respite Facilities** | Review and Support Development of systems that will make best use of these resources |

## 3.3 Commissioning Priorities for Disabled People with Physical / Sensory Impairments and Long Term Conditions

### Vision

- Help people to be able to take a full and active role in their local community, as citizens of Aberdeen.
- Ensure that people are in control of the support they receive through person centred planning and individualised services.
- Have a good range of local supported living options.
- Develop work and volunteering opportunities.
- Offer a range of leisure and day time opportunities for people who are unable to work, accessing local community venues.
- Increase the use of direct payments and self directed support.
- Ensure people are supported to develop friendships and relationships and are able to live in safe and secure environments.
- Help people have easy access to health services and be part of all mainstream health and screening services.

### Needs and Trends

The Scottish Government is firmly committed to equality for disabled people and is striving to create a Scotland that is fair and inclusive to all. Disabled people make up approximately one fifth of Scotland's population, yet often experience high levels of inequality compared to none disabled people.

### Pressures, Gaps and Business Issues

Improving the Life Chances of Disabled People

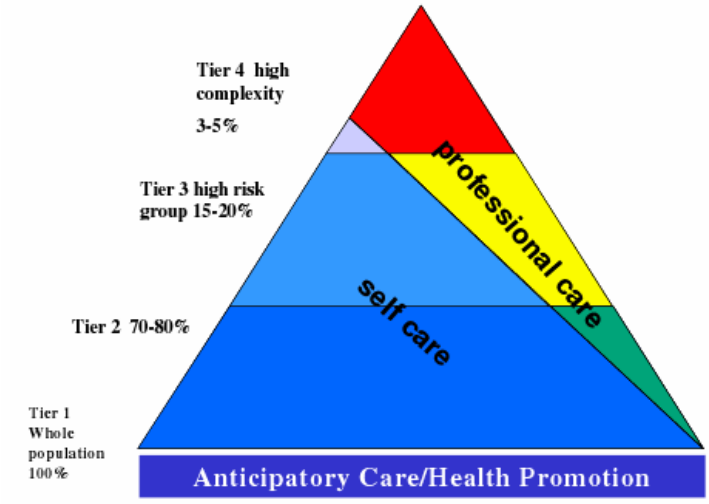
In 2005, the Prime Minister's Strategy Unit published this report which sets out a strategy for promoting and protecting disabled people's rights, improving choice and supporting disabled people in education, employment and other forms of participation.
The report recommends:

- individualised budgets which can be used to access support and services across a range of fragmented funding streams
- improving the availability of independent advocacy services
- improving the provision of accessible housing
- improving the availability of information
- increasing the number of disabled people in employment

**Health and Social Care Long Term Conditions Model**

Within the key Scottish Government document “Delivering for Health” one of the aims is to shift the balance of patient care into community and to anticipate and be proactive in the provision of care. This process will have an impact on the need for Social Care provision.

The diagram below helps to demonstrate a "level of need” model which will be used in this process.




Tier 1- Health Improvement involves a programme of education and awareness for the population to promote health, prevent disease and reduce inequalities by addressing lifestyles, in the context of peoples’ life circumstances. (100% of the population)

Tier 2- Supported Self Care involves collaboratively supporting individuals and their carers to develop their knowledge, skills and confidence, improving patient information and provide home monitoring equipment to help people effectively manage their long term conditions. (70-80% of people with long term conditions)

Tier 3- Disease Management involves multi-disciplinary teams providing high quality care according to disease-specific and evidence based protocols and pathways. Some people may have additional needs that are non- complex but stable and predictable and can be delivered through care co-ordination.
(15-20% of people with long term conditions)

Tier 4- Care Management, an integrated approach to anticipate, plan and provide targeted health and social care interventions to prevent deterioration and maintain sufficient health and wellbeing to function well in the community.

This is aimed at people with highly complex or unstable, multiple long term conditions. (3-5% of people with long term conditions).

Social Work support is most likely to be directed at people with needs described in Tier 4. Locality planning groups identify people in their areas with complex needs that are likely to require a multi-agency approach to support and treatment.

**Issues for Services / Service Responses:**

- Research has suggested that only 50% of people with complex impairments remain in their jobs.
- Supporting people with physical and sensory impairments to both enter and sustain employment is critical to enabling people to remain independent.
- There is a lack of accommodation options for people with more profound disabilities.
- Supported living and extra care housing options need to be better developed for people with more profound disabilities.
- Support for disabled parents could be improved and will avoid young people taking on too great a caring role.
- There is a need to improve access for disabled people to universal services to help increase people's independence and avoid reliance on specialist services.
- The range of physical and sensory disabilities is complex and diverse so services need to be tailored to individual needs.
- There is a need to help people with enduring health problems to regain control over improving their health through actively managing risks and reducing the number crises.
- A partnership approach is required locally to ensure sure that early support is provided to people to delay onset of acquired impairments, prevent worsening of conditions where appropriate and support people to remain independent and active for as long as possible.

Deleted: into

**Acquired Brain Injury**

*Brain Injury is defined as damage to the brain acquired at some point after birth but not due to any degenerative disease. It includes damage caused by traumatic injury, lack of oxygen or infection but not- for the purposes of this document - stroke.*

It has been acknowledged that there has been significant shortcomings across Grampian in the coordination of health and care services for those with acquired brain injury and in the range of specialist services for individuals and their families.

A Grampian Brain Injury Strategy Group was formed as a short life working group in 2004 which produced a draft strategy for this client group. This group included all 3 Councils plus key clinicians from NHS in addition to representation from a specialist voluntary service provider. The BIG group is a support group for carers of people with Brain Injury and this group enabled considerable consultation with service users and their carers throughout the development of the strategy.

A key proposal to emerge from this group was the establishment of a multi-agency specialist team which, in addition to providing specialist support to those with Brain Injury, would also provide training for informal carers and care workers to ensure improved quality of support.

This recommendation was not progressed due to a lack of resources across the agencies and an acknowledgment that reconfiguring existing resources to create such a team would not be achievable even if desirable.

As a result of this work however, Aberdeen City committed to work with NHS to improve the pathway for this client group by developing specialist rehabilitation opportunities through our Joint Service at Horizons and establishing a new rehabilitation service at Craig Court.

**Support at home**

Currently, the majority of individuals are supported to remain in their own homes with individually designed support packages provided by care providers across the sector. Some of these services are delivered entirely or partially through direct payments.

In addition, specialist support is provided by Momentum particularly in the area of supporting people to return to work/ re-engage in the community.

Horizons continues to provide the full range of rehabilitation services including clinical input from psychology, speech and language therapy. 3 Care Managers provide a full care management service and link with Maidencraig, NHS in-patient rehabilitation service and now with Craig Court.

Craig Court, which will be fully operational from September 2009, has 10 places for people aged 16- 65 who need specialist rehabilitation as part of their planned discharge to home or supported accommodation. Currently, the main users will be those leaving hospital who require continuing rehabilitation to ensure safe return home but this facility will also be available for someone living at home who needs intensive therapy in order to remain independent.

A Managed Clinical Network has been established which involves all partners and agrees the management of complex cases across this client group. A review earlier this year concluded that this had been effective in improving coordination of care planning and identifying and resolving service gaps/ issues.

**Vision for Services**

This commissioning strategy follows the following themes:

Citizenship and involvement
Money
Leisure and daytime activities
Support in daily living
Communication
Culture/Religion
Access & Assessment

- A place to live
- Getting around / Mobility
- Employment, Education & Training
- Health & Well-being
- Carers
- Information

Work on delivering services to support people with enduring health problems has also highlighted a number of complementary themes to help people:

Self manage their own health
Increase their sense of control and reduce isolation
Return to the lowest level of care possible for them
Have a dignified end of life

**Joint Equipment Service**
Aberdeen City Council (ACC) and Aberdeen City Community Health Partnership (CHP) have been working together to establish a Joint Equipment Service for a number of years as the demand for equipment continues to grow. Both organizations have reached a point where the current service arrangements are no longer offering best value and are in need of modernization. It has been agreed that a Joint Equipment Service between the CHP and ACC is the best way forward to address the needs of the service so that staff can continue to provide an excellent service to the service users.

**Single Sensory Service**
Currently ACC has commissioned 2 external providers to provide social work and rehabilitation service for people with sensory impairments. Aberdeen North East Deaf Society (ANEDS) provides services to people who have hearing impairments or are Deaf. Grampian Society for the Blind (GSB) provide services to people who have visual impairments or are blind.

Aberdeen City Council is planning on commissioning a Single Sensory Service in the City. The benefits of a Single Sensory Service is that with reduced overheads and administration costs, the single service would be able to provide a full service to all people with sensory impairments and with dual sensory loss under one roof. This would mean integrated rehabilitation and technical services as well as assessment and registration.

With an increasing aging population, 50% of all people over 60 are affected by age related hearing loss. This number is set to rise due to other contributing health factors such as obesity, high blood pressure, smoking etc.

While normal aging can lead to some loss of sensory acuity and greater propensity for cataract formation – other changes are pathological and can increase the risk of additional health problems such as stroke, heart disease and mental health problems such as depression. Older people are the largest client group and are also at most risk of developing or acquiring sensory loss. It is particularly beneficial for this client group to have a single service where they would be able to get assessed, get information, advice and rehabilitation on all their sensory loss issues – visual and hearing.

Deleted:

People with dual sensory loss will particularly benefit from having a single sensory service.
ACC are currently working on development of such a service in consultation with service users and other stakeholders.

**Separate Sensory Impairment**
Patterns of physical and sensory impairment (PSI) prevalence are complex and diverse. A larger number of people with a range of long term conditions will come into contact with NHS services.

The conditions which affect a significant number of people aged 18 to 64 years old are hearing impairments including profound hearing impairments and visual impairment.

The conditions which affect small numbers of people aged 18 to 64 years old but have a huge impact on them and services are conditions such as Cerebral Palsy, Acquired Brain Injury, Multiple Sclerosis, Spinal Injury, Parkinson's Disease, Motor Neurone Disease, Huntington's Disease and Dual Sensory Loss.

There is no evidence to suggest dramatic increases in the numbers of people with physical and sensory impairments in future years for the 16-64 age group. However later onset conditions such as Parkinson's disease, sensory Impairment, arthritis and musculo-skeletal conditions will rise as the population aged 45 and over rises.

Disabilities linked to conditions such as diabetes and obesity are set to increase as levels of diabetes and obesity increase.

### Commissioning Priorities

The following table highlights the commissioning priorities for adults with physical / sensory impairments and long term conditions for 2010 - 13.

| Key Outcome | Commissioning Priority |
|---|---|
| **Health & Well-being** | Set up a Single Sensory Service for Aberdeen City<br>Assistance with access to leisure and recreation locations.<br><br>Establishment of effective adult and paediatric audiology groups.<br><br>Special arrangements for people in long-term care, including guide communicator service and appropriate staff training.<br><br>Redesign of in-patient and community rehab services. |
| **Support in Daily Living** | Single Sensory Service for Aberdeen City<br><br>Development and improvement of guide communicator service in Aberdeen for people who are deafblind.<br><br>Flexible respite options, skilled personal counselling for the individual and family, rehabilitation, interpreting service, HACs – Human Aids to Communication such as interpreters, notetakers etc.<br><br>TACs – Technical Aids to Communication – increase the number of public places with the loop system fitted (such as doctors surgeries, evening classes)<br><br>Integrated Transport Policy – to be adapted to best serve the needs of a person with sensory loss.<br><br>Consider a scheme to provide a support worker with BSL communication skills to work with vulnerable people in their own homes.<br><br>Easier physical access and cheaper access for disabled people.<br><br>Expand and develop use of telecare<br><br>Establish a Joint Equipment Service<br><br>Provision of appropriate respite care of all types, including day, overnight, and extended cover, both planned and emergency. |

Deleted: .

Deleted: .

Deleted: .

Deleted: .

Deleted: .

| Key Outcome | Commissioning Priority |
|---|---|
| **A Place to Live** | Single Sensory Service for Aberdeen City<br><br>Make full use of assistive technology in the home to enable independent living.<br><br>Care Homes – the provision of loop-systems and ensuring that people issued with hearing aids are bale to operate them effectively and that the hearing aids are properly maintained.<br><br>Consolidate and optimise the use of Craig Court<br><br>Consider the needs of those with Acquired Brain Injury as part of the review of sheltered housing |
| | From Exclusion to Inclusion -To enable service users to live in the most appropriate accommodation with the levels of support to remain as independent as possible. We will review the service we provide in our internally provided services to determine whether resources tied up in buildings could be used in different ways.<br><br>Adaptations to be installed and operational with minimal delays |
| **Access & Assessment** | Single Sensory Service for Aberdeen City<br>Access to specialist services such as hearing therapy and low-vision training, specific means of communication.<br><br>Thorough assessment of need of including carers, and regular review<br><br>Early diagnosis and identification of impairment.<br><br>Waiting times – continued reduction in waiting times for out-patient treatment for people with low visual impairment – in particular, for low visual aid appointment follow up. Reduction in waiting times for electric wheelchairs and orthotics.<br><br>Transition from children with sensory loss to adults.<br>Access to short-term intensive services. |

Deleted: .

Deleted: .

| Key Outcome | Commissioning Priority |
|---|---|
| **Carers** | Support for Carers Strategy<br><br>Single Sensory Service for Aberdeen City<br><br>Assessment of Carers Needs<br><br>Support and value carers and involve carers in service development<br><br>To involve carers in the development of our strategy and to increase the number of carers' breaks and direct support provided to carers. |
| **Citizenship & Involvement** | Involvement of service users and carers through Joint Futures Sensory Impairment Task Group, Joint Futures Physical Disability Group. Consultation and engagement of relevant stakeholders to set up the Single Sensory Service.<br><br>Social Inclusion – the eradication of stigma and achieve the same quality of life as other members of society.<br><br>Staff in public services to be trained to understand communication needs of people with sensory loss. |
| **Money** | Individual budgets to allow people to make their own choices about the nature of their care.<br><br>Maximising income through appropriate advice and support on benefits.<br><br>Assistance with access to education and employment. |
| **Choice and Control** | Services to be personalised and focussed on individuals personal outcomes |
| **Advocacy and Involvement** | To support and develop advocacy services to empower service users. We need to ensure services are available and accessible across the city. |
| **Developing Self Directed Support** | To continue to enable people to remain in their own homes with more flexible and responsive ways of meeting their needs. The expectation is that individual budgets will become the preferred way of providing and arranging services.<br><br>We need to work closely with Telecare providers and maximise support through Supporting People. |

Deleted: carers

## 3.4 Commissioning Priorities for People with Mental Health Needs

### Introduction

In 2007, the Scottish Government produced "With Inclusion in Mind"
This document lays out the local authority's role in promoting wellbeing and social development. We have reflected the demands of this document within the commissioning strategy.

#### Vision

- Help people to be able to take a full and active role in their local community, as citizens of Aberdeen
- Develop a mental health strategy based on well-being and implement Towards a Mentally Flourishing Scotland
- Develop services which support individuals to remain within their own community and to increase personal resilience enabling people to meet their full potential
- Ensure the provision of independent advocacy services
- Increase opportunity, choice and support and social networks that will enable access to mainstream experience
- Act with integrity in the spirit of openness and true partnership
- Encourage and empower individuals to exercise their rights to choice respect, dignity and independence through equality, opportunity and inclusion
- Embrace the diversity of our local population to facilitate their mental wellbeing
- Meaningfully involve and inform local people in planning and reviewing services to meet their needs
- Implement systematically improvements in service delivery, based on evidenced practice through effective & accountable leadership and management and value for money
- Ensure appropriate and timely access to services
- Value & accept feedback from individuals and service providers across Aberdeen City

Deleted: .
Deleted: .
Deleted: .
Deleted: .
Deleted: .

#### Needs and Trends

Nationally 1 in 6 adults report mental health problems at any one time with depression, anxiety and phobias being the most common and 1 in 4 adults are likely to experience a mental health problem during their lifetime.
1 in 8 adults and 1 in 5 older people will have depression or severe depression.
Less than 25% of people with mental health problems work.

The ISD website, Quality and Outcomes Framework, (QOF) for April 2007 to March 2008 local Aberdeen figures states there were approximately 1,804 people with severe mental illness such as Schizophrenia, Bipolar Affective Disorder and other psychoses registered with GPs in Aberdeen. The lifelong impact of these conditions on individuals and their families is substantial.

Carers are twice as likely to have mental health problems and mental health problems have a strong impact on families both financially and emotionally.

The impact of less serious mental health problems such as depression and anxiety, post-natal depression and bereavement is under recognised and we need to clarify the evidence base for what works and implement appropriate responses.

**Pressures, Gaps and Business Issues**

Alongside the population needs highlighted above additional pressures and issues facing services in Aberdeen include:

Recomissioning residential service using monies from the closure of Marchburn Hostel – there is considerable demand for residential beds within the City and there is a need to maintain capacity. Short term options being considered while in the longer term housing is being built.

Employment Services: presently evaluating services and present requirements for the future for supported employment where individuals can gain appropriate skills to re enter or enter the workforce.

Day services review - To commission one service that meet the demand for the citizens of Aberdeen and is fit for purpose and is sustainable for the foreseeable future.

**Issues for Services / Service Responses:**

Emotional well-being is a concern for all public services and we should be focusing on preserving emotional well being not just treating mental ill-health.

Promoting emotional well being is as critical to successfully supporting people who are physically ill as treating their physical symptoms.

People with mental health problems struggle to access a range of supported housing options and this impacts on their chances of recovery.

Supporting people to remain in or return to employment will pay dividends and we need to improve our performance in this area.

**Vision for Services**

Aberdeen City Council has a long term vision for services along with a set of values to direct the way services are offered and delivered. In summary this is:

Recovery not maintenance should be encouraged and optimal independence should be the goal. Deleted: .

To aim to develop services which support individuals to remain within their own community and to increase personal resilience and to meet their potential. Deleted: .

Ensure Carers receive the support they need to continue in their caring role

To measure customer satisfaction for all service in-house and in the independent sector

To regularly monitor contracts and service specifications ensuring that service specifications are regularly updated and reflect current demand. Deleted: .

Reduce the number of people on Incapacity benefit in Aberdeen City

Ensure that service users have an assessment of their needs, care plan and are reviewed in line with the care management standards. Deleted: .

Maximise the number of people with a mental health problem in employment or support them to maintain employment

Deleted: .

Reduce suicides

Reduce hospital admissions

To increase the use of direct payments and self directed support

Deleted: .

To increase opportunity, choice and support and social networks that will enable access to mainstream experience

Deleted: .

All partners are signed up to working towards achieving this vision over the coming months and years

Deleted: .

To implement Towards A Mentally Flourishing Scotland Action Plan

Deleted: .

We also know, from a range of evidence, that mental ill-health is closely linked with socio-economic disadvantage, for example unemployed people are twice as likely to have depression as those in work. The scale of mental ill-health is both a national and a local problem because of high prevalence rates, duration and the range of ways it can have an adverse impact on a person's life e.g. physical health, education, employment, income, personal relationships and social participation.

Mental ill-health accounts for 20% of the burden of disease in the UK, compared with 17.2% for cardiovascular diseases and 15.5% for cancer (World Health Organisation 2006). In Scotland only 14% of the population were classified as having good mental wellbeing (Braunhotlz S, Davidson S et al 2007).

Mental health improvement therefore is a corporate agenda, as much a concern of those responsible for economic, physical and environmental development as for specialist mental health services.

The national strategy for promoting mental health and wellbeing for 2008-2011 "Towards a Mentally Flourishing Scotland" describes three main areas:

- Promotion – wellbeing in the general population, both individually and Collectively
- Prevention – raise efforts around the prevention of mental health problems, mental ill-health, suicide

Formatted: Indent: Left: 0 cm, Hanging: 0.32 cm

- Support - improve the quality of life, social inclusion, health, equality and recovery of people who experience mental illness.

Formatted: Indent: Left: 0.32 cm

**The Recovery Model in Mental Health**

People can and do recover from even the most serious and long-term mental health problems. Recovery is a unique and individual experience and while there may be common themes and experiences, no two people's recovery journeys will be identical.

**The Scottish Recovery Network describes recovery as follows**

***"Recovery is being able to live a meaningful and satisfying life, as defined by each person, in the presence or absence of symptoms. It is about having control over and input into your own life. Each individual's recovery, like his or her experience of the mental health problems or illness, is a unique and deeply personal process."***

***"In talking about recovery we acknowledge that it is not necessarily easy or straightforward. Many people describe the need to persevere and to find ways to maintain hope through the most trying times."***

**Commissioning Priorities**

The following table highlights the commissioning priorities for mental health services for 2010-13

| Key Outcome / Strategic Objective | Commissioning Priority |
|---|---|
| **Improve flexibility and range of accommodation options** | Work with housing providers and other teams within the Council to address accommodation and support needs of people with Mental Health problems |
| **Employment, learning and education** | Continue to develop employment and training support available for people who use services and create real opportunities that lead to employment. Support people to maintain employment when the experience mental ill-health |
| **Social Inclusion** | Promote opportunities to become involved in different aspects of the community and promote social inclusion |
| **Advice** | Provide good quality information on components of mental well-being and their relationship with mental ill-health |
| **Money** | Individual budgets to allow people to make their own choices about the nature of their care.<br><br>Where it is not possible for a person to access paid employment, advise on fair access to specialist benefit advice and support to maximise income |
| **Choice and Control** | Promote recovery with outcomes defined by the individual using the service<br><br>Support personal growth |
| **Choose Life Services suicide prevention** | Continue to monitor impact of commissioned services<br>Raise awareness of the suicide prevention agenda<br>Continue training programmes in suicide prevention |
| **Choice / Individualisation** | Services to be personalised and focussed on individuals personal outcomes |
| **Housing** | Work with housing providers and other teams within the Council to address accommodation and support needs of vulnerable adults |
| **Community Leadership** | Challenge judgements and assumptions made about mental health within the organisation and the wider community |

Deleted: ¶

| Key Outcome / Strategic Objective | Commissioning Priority |
|---|---|
| **Making Change happen** | Develop infrastructure to support self directed support |
| **Involvement & Advocacy** | Work with the voluntary sector to develop peer support and befriending |
| **Carers** | Support and value carers and involve carers in service development |
| **Primary Health Care** | Delivery of physical health care checks for all people with a severe mental illness on practice based registers which are holistic, take account of known health inequalities. |
| **Psychological Therapies** | Work with the NHS to make psychological therapies more available |
| **Multi-disciplinary Mental Health Teams** | Continue to build on joint working arrangements |
| **Mental Health (Care and Treatment) (Scotland) Act (2003)** | Section 25<br>Ensure adequate care and support services to meet assessed needs<br><br>Section 26<br>Develop services to promote mental wellbeing<br><br>Section 32<br>Recruit a sufficient number of Mental Health Officers |

## 3.5 Commissioning Priorities for People with Substance Misuse problems

### Introduction

Services to support people with drug and /or alcohol dependencies in Aberdeen are commissioned jointly between Aberdeen City Council and NHS Grampian. The strategic direction for treating and rehabilitating people with drug and / or alcohol problems is established through the Alcohol and Drug Partnership. The strategic lead for the treatment and rehabilitation strategy in Aberdeen City is Simon Rayner.

### Vision

We aim to:

- Develop further an integrated commissioning strategy covering adults, offenders and young people's treatment.
- Develop more pathways into, and out of, treatment by promoting social inclusion and wellbeing.
- Improve the health of drug and alcohol users, including those in the criminal justice system.
- Ensure that commissioning is driven by quality standards, the evidence base and clinical governance.
- Ensure that parental drug and alcohol use and its impact on children are fully addressed.

### Needs and Trends
### Numbers - Adult Drug Use

Currently, in Aberdeen, it is estimated that there are an estimated 2800 opiate users in Aberdeen. The primary drug problem is related to opiates but many people will also be using other substances. Of the 2800 opiate users 1600 (57%) plus are in treatment with the NHS. Five hundred children currently have parents in NHS treatment for opiate dependence. Problems are city wide but are significantly prevalent in the areas of deprivation.

The proportion of the population hospitalised for drug related conditions is worse than the Scottish average, with 949 patients discharged from hospital over the last three years.

### Numbers - Adult Alcohol Use

The 2008 Health & Wellbeing Profiles for Community Health Partnerships, published by the Scottish Public Health Observatory, shows that the rate of discharge of patients with alcohol related disease in Aberdeen is higher than the Scottish rate.

There have been 206 alcohol related deaths in the last five years. The proportion of the population hospitalised for alcohol related and attributable causes is significantly worse than the Scottish average

NHS Grampian has been set a target of delivering 15,000 Alcohol Brief Interventions before April 2011 in primary care settings by GP's and Nurses. The target for Aberdeen City is 6,591.

Referral rates for the Aberdeen City Integrated Alcohol Service has shown a steady increase over the last year. An average referral rate is now 40 people per week.

### Children and Young People

Using the Scottish Schools Adolescent Lifestyle and Substance Abuse Survey (SALSUS) and Grampian Youth Lifestyle Survey (YLS) information we can build a picture of prevalence and trends in young people's drinking in Aberdeen City including some comparison to national statistics.

For example, between the SALSUS reports of 2002 and 2008 there has been a steady decline in the number of young people reporting they had ever had a drink and the number reporting drinking within the last week.

Although no locally specific data is available for Aberdeen City for 2008, the Grampian Youth Lifestyle Survey (YLS) of 2007 reinforces this picture by demonstrating that 14% less young people had drunk an alcoholic drink than in the 2001 survey, a decrease consistent with the SALSUS 2006 Grampian report.

However, a mixed picture was observed in terms of frequency of drinking, a 4% decrease was noted in those drinking on 1-2 days per week but the survey showed 6% more young people drinking at least once per month in comparison with the last YLS findings of 2001.

Overall the figures suggest young people are drinking with less frequency. However, of some concern is the fact that when they do drink, the average number of units consumed by young people has increased slightly since 2001 but very significantly since the first YLS in 1995 to 18.5 units per week.

Numbers of young people recorded to be drinking on 3 or more days per week have remained static since 1995.

Despite the figures reflecting reduced frequency, it is concerning that the average units consumed has increased, which is consistent with the increased 'binge' pattern of drinking among young people, although not consistent with SALSUS 2006 findings in relation to amount consumed.

### Context

Formatted: Font: (Default) Arial

Substance misuse is linked to other health and social problems, particularly mental health and poor life expectancy. Many substance misusers face significant barriers to recovering from their drug problem and require support with basic skills and literacy problems and limited work history is common. Significant numbers of sex workers, homeless people and offenders will have drug and alcohol problems.

### Pressures, Gaps, Business Issues

#### Adult Drug Services

Waiting times for access to drug treatment have been significant but this situation is improving. The Scottish Government is in the process of setting HEAT Targets for the access to treatment. Increasingly we are investing in the routes out of treatment towards long term recovery therefore there are pressures in assisting 1600 people out of NHS treatment which causes bottlenecks and waiting lists.

The current Integrated Drug Service Community Rehab Service is only partially citywide and requires to be expanded to be City wide.

Whilst the Integrated Drug Service has been established there is still considerable work to do in establishing links and strategies with mainstream support services and to build capacity, throughput and performance monitoring.

Adult Alcohol Services
Currently alcohol services in the voluntary and independent sectors are being redefined and re-commissioned.

Additional resources for alcohol are currently being invested within the Integrated Alcohol Service.

**Issues for Services / Service Responses**

**Substance Misuse: Outcome focus**
The achievement of sustainable outcomes should drive both the strategic direction of substance misuse commissioning and the operational delivery of the commissioned services. Consequently a significant theme throughout this strategy is the effectiveness of services. An outcome based analysis reflects the following classification:

***Prevention* – to prevent people misusing substances**

**Reduced dependence** - To enable those who are dependent on substances to access appropriate services and reduce their dependence

**Reduce harms** - To enable those who misuse substances to reduce harms to themselves and others

**Sustained quality of life** - To enable those who misuse substances to achieve and sustain a good quality of life

**Impact of substance misuse** –The prevalence of substance misuse in Aberdeen raises many issues for all communities, organisations and individuals. This is due to its varied and substantial impacts, including:

- **Physical health**: there is a significant link between alcohol and chronic illness and deaths, resulting in significant number of hospital admissions for alcohol related conditions.

- **Mental health**: substance misuse is usual rather than exceptional among people with severe mental health problems. 74.5% of users of drug services and 85.5% of users of alcohol services experience mental health problems

- **Accommodation and homelessness**: a lack of accommodation is the single biggest problem experienced by people with substance misuse problems, and it is accompanied by other inequalities including healthcare provision

- **Young People**: there have been sharp increases in alcohol and drugs consumption among young people, resulting in adverse health outcomes (physical, mental and **sexual).** Additionally a significant number of children in Aberdeen experience hidden harm through the substance misuse of their parents or guardians.

Formatted: Font: (Default) Arial

- **Crime and disorder:** In Aberdeen over 30% of all offences are alcohol related and nearly half of all violent offences are alcohol related

- **Employment and the workplace**: substance misuse impacts significantly on lost productivity, absenteeism and accidents in the workplace. Additionally it reduces the employability of individuals

- **Licensing and availability**: problems of violence in and around licensed premises; the sale of alcohol to underage young people and the availability of illegal drugs impact significantly on local communities.

**Vision for services**

The strategic priority for Aberdeen City is to establish an Integrated Drug Service and an Integrated alcohol Service.

Recent inspections have highlighted significant problems with drug and alcohol services which are being addressed.

The Government published an Outcomes toolkit for Alcohol and Drugs Partnerships in April 2009. This toolkit gives a menu of options for ADPs to consider in measuring local outcomes and for linking to their SOA. In addition to this, the Scottish Government has also indicated that they will, in due course, identify core outcome measures for alcohol and drugs which all ADPs will have to include within their performance monitoring.

**Commissioning Priorities**

The table below summarises the commissioning priorities for the Aberdeen ADP for 2010-13.

| **Commissioning Priority** |
|---|
| Establish an Integrated Drug Service |
| Establish an Integrated Alcohol Service |
| Link / embed / invest / redesign Family Staff in the Integrated Drug Service |
| Embed Criminal Justice Workers in the Integrated Drug Service |
| Integrate Community Learning, Adult Learning, Employability In The Integrated Drug Service |
| Expand IDS Community Rehab Provision |
| Establish Strategic Targets and Performance Management in community areas |
| Establish an operational management framework for recovery in community areas |
| Integrate delivery and co-ordination in community areas |
| Alcohol |
| Self Referred Counselling |
| Designated Place |
| Care Planned Counselling |
| Residential Rehab |
| Nursing Home / Respite Care |
| Community Support |
| In patient Detox |
| New central accommodation |
| Increase medical and nursing capacity |
| Increase social work capacity |
| Develop Integrated Pathways |

## 3.6 Commissioning Priorities for People with Learning Disabilities

### Vision

We aim to:

- Help people to be able to take a full and active role in their local community, as citizens of Aberdeen.
- Work in partnership to empower and enable individuals with learning disabilities to lead a full life as part of their own communities.
- Build modern person centred support for individuals to enable them to access opportunities for leisure, employment and support in daily living.
- Direct resources in a timely way, to those most in need and to support people to access mainstream activities within the community.
- Develop services that enable individuals to maintain their independence for as long as possible.
- Provide a range of high quality services for people with learning disabilities and their carers at times in their lives when they need support which also demonstrate best value.
- Ensure carers receive the support they need to continue in their caring role.
- Review our commissioning intentions and improve the quality of business transactions with our partners so that services provide the outcomes at a fair, but appropriate cost.

### Needs and Trends

The Scottish Government do not have specific figures for the number of people in Scotland who have learning disabilities. While there are some reported differences across the UK, studies suggest that, in Scotland:

- 20 people for every 1,000 have a mild or moderate learning disability; and
- 3 to 4 people for every 1,000 have a profound or multiple disability.

On this basis, there are around 4000 people in Aberdeen with learning disabilities and 600-800 with profound or multiple disabilities.

### Health

People with learning disabilities are living longer and are likely to have greater health and support needs as they get older. Increasing numbers of older people with learning disabilities have early onset dementia and heightened risk of developing age related frailties and illnesses. This has implications for older carers who may require additional support themselves. They may also have more health needs as a result of caring. Increased numbers of children with learning disabilities are surviving with severe and complex needs and moving into adulthood. Advances in medical and social care have led to a significant increase in the life expectancy of people with learning disabilities.

Research has also highlighted that people with a learning disability experience inequalities and inconsistencies in having their health needs met and accessing health care provision. People with learning disabilities are not always included in general screening and are not routinely identified in information systems that monitor public health, therefore we need to develop improvement plans.

**Employment**
Adults with learning disabilities are not well represented in the workforce. Reasons for this include: low expectations; Confidence and skill levels; Transport problems; Lack of knowledge/understanding of what support is available; Insufficient supported employment provision: Real and perceived benefit barriers to employment.

**Housing**
Younger people with learning disabilities are expressing an increasing desire to move out of the parental home and live in their own home, sharing with friends or living in ordinary homes which are private, comfortable and safe.

**Pressures, Gaps and Business Issues**
Learning disability accounts for a large proportion of the spend of the Social Care and Wellbeing service. Greater longevity of people with learning disabilities and greater survival rates for children with complex conditions indicates that this demand will continue to grow.

Considerable steps have and will be taken to contain this expenditure. Work will be carried out with external consultants on a Fair Cost Model for learning disability services.

**Issues for Services / Service Responses:**

Enabling people to have more choice and control. This means a greater emphasis on:

Self-directed support
This would include increasing the take up of direct payments and introducing individual budgets.

Advocacy.
Promoting the use of independent advocacy services and identify resources to support.

Person centred planning (PCP).
The design and delivery of services will be informed by PCPs. Person centred planning will be available to all adults with a learning disability and those in transition. Families and self-advocates will help lead planning.

Deleted: learning disabled adults

Respecting the role of carers
Carers often play a key role in an individual's life. A later chapter in this paper gives further information

**Provision of accessible information**
This will include all information provided by specialist learning disability services. Mainstream services, such as GPs and transport providers will be supported and encouraged to provide accessible information at every opportunity. This is a condition of the Disability Discrimination Act.

Provision of services that meet the needs of people from minority ethnic communities and diverse groups.
Our commissioning activity will seek to ensure future developments offer an equitable level of service to all the citizens of Aberdeen.

This means a greater emphasis on:

**Housing**

Continuing to offer the choice of where and how to live, this will include supported living. No one should live as an in-patient in NHS facilities where they do not require on-going treatment. The provision of residential homes will be reviewed. People should not be sent to live away from their local community. We will work with stakeholders to improve access to good quality housing resources which promote independence and reduce dependency.

**Employment and occupation**

Expanding opportunities for people to develop skills, undertake vocational training and obtain real jobs and recognised voluntary work. Accessing forms of work will be an opportunity for all people who express that wish regardless of their level of need.

**Providing high quality occupational activities and education**

This means continuing to modernise daytime services and respond to what people require. A close dialogue will be maintained between Adult Social Care and Wellbeing, Health and Adult Education. This should include access to mainstream universal services whenever possible.

Formatted: Font: Arial, 12 pt, Not Bold

**Supporting families**

This includes the provision of high quality, and flexible short break services. The needs of older carers will be a high priority.

We will improve our advisory support to families in their caring role.

**Protecting people from harm**

This includes all forms of abuse, exploitation and hate crimes, including bullying. Highest quality adult protection services will continue to be provided and specific anti-bullying programmes will be supported. The means by which services are regulated and performance is monitored will be made as consistent as possible and will pay close attention to the quality of life outcomes for people.

Improving the transition of young people into adult services.

Person centred approaches will be used to make sure young people, and their carers, are well equipped to move out of children's services into adult services**.**

**Improving health and well-being of people**

Preventable illness will be reduced and all learning disabled people will have access to comprehensive and regular health checks. Ensuring people with learning disabilities have fair and equal access to primary and secondary healthcare is a priority.

Providing affordable services that present 'Value for Money'. This means a greater emphasis on: contracting with providers that have a clear commitment to providing positive outcomes for those using services.

Ensuring support provided promotes people's independence, reducing dependence and enabling people to use ordinary community services open to any citizen.

Working in partnership with users, carers and providers to develop innovative services.

Improving the coordination between agencies to maximize the benefit of available resource.

Successful delivery of high quality services to learning disabled persons is dependent on maintaining sound partnership arrangements access social care, health care, housing, education and employment services. These partnerships will be sustained at strategic and operational level.

## Autistic Spectrum Disorder

It is our intention that a separate strategy will be prepared in relation to Autistic Spectrum Disorder

Deleted: Review of all transport services¶
¶
Respite and short breaks¶

Formatted: Font: Bold

### Vision for Services

The Learning Disabilities vision reflects the following themes:

- Where you live
- Improved Health
- Better choices and stronger voices.
- Flexible daytime and employment opportunities.
- To increase take up of Direct Payments and individual budgets.
- Inclusion and a full life
- Relationships
- Keeping Safe
- Transition
- Carers
- Making Change Happen

**This commissioning strategy shows the actions that are needed over the next three years to implement this.**

**People with learning disabilities should be able to lead normal lives. We want them to:**

- **be included, better understood and supported by the communities in which they live;**
- **have information about their needs and the services available, so that they can take part, more fully, in decisions about them;**
- **be at the centre of decision-making and have more control over their care;**
- **have the same opportunities as others to get a job, develop as individuals, spend time with family and friends, enjoy life and get the extra support they need to do this; and**
- **be able to use local services wherever possible and special services if they need them**

**Ministerial Foreword to "The same as you? A review of services for people with learning disabilities"**

**Commissioning Priorities**

The following table highlights the commissioning priorities for learning disability services for 2010-13. Detailed commissioning plans for particular services areas are also available and being developed, specifically in relation to accommodation and employment.

| Key Outcome | Commissioning Priority |
|---|---|
| **Daytime Opportunities** | To increase number of community based options to support people to have ordinary life experiences as other citizens. This should include access to mainstream universal services whenever possible. |
| **Community - Access & Inclusion** | Seek to develop inclusive community options<br>Promote opportunities to become involved in different aspects of the community and promote social inclusion |
| **Better Health** | Ensuring people with learning disabilities have fair and equitable access to primary and secondary healthcare |
| **Money** | Through development of a Resource Allocation System enable both the council and people who use services to have an improved understanding of what level of support to expect for what cost. |
| **Choice and Control** | Services to be personalised and focussed on individual's personal outcomes, enabling support to be outcome rather than service focussed. |
| **Personalisation** | Individual budgets will enable allow people to make their own choices about the nature of their care. Input to a self-assessment process will establish the level of budget that they have available.<br><br>Person centred planning will be available to all learning disabled adults and those in transition. |
| **Carers** | Carers to be offered assessment<br>Recognise carers and families as partners in the planning of support |
| **Relationships** | Every human being benefits from the sense of closeness and mutual support that comes from having a network of relationships developed through school, work, hobbies and community activities.<br><br>Experience of a variety of relationships helps us to develop the social skills, confidence and self esteem that underpin our ability to make, sustain and break more personal relationships and to express our sexuality. |
| **Autistic Spectrum Disorder** | A specific strategy in relation to support to people on the autistic spectrum is being developed |
| **Transition /Review** | A clear process for transitions and a robust review system |
| **Advocacy.** | Promoting the use of advocacy services and developing further self-advocacy. |
| **Making Change Happen** | Develop infrastructure to support self directed support |

Deleted: ¶

Deleted: equal

Deleted: ¶

Deleted: and what

Deleted:

Deleted: ¶

Deleted: ¶

## 3.7 Commissioning Priorities for Carers

### Vision

- Provide support which enables carers to remain healthy and provide support for work options. This will include an increase in the numbers of carers' assessments undertaken.
- Support carers with accurate, timely and good quality flexible services that meet the individual needs of the carers and the person they care for.
- Raise the profile of carers in the Aberdeen community and ensure all partners and council services recognise and understand the role of carers.
- Ensure carers are central to the development of social care.
- Involve carers in setting priorities for investment in carers support.

### Needs and Trends

Nationally Carers are increasingly providing a significant proportion of community care as services target provision on those with the highest need.

In the future most people's lives will include at least one episode of unpaid caring.

National research shows that 1 in 5 carers (20%) give up work as a direct result of caring

Nationally the peak age for caring is between 50 to 59. More than one in five of people aged 50 to 59 (1.5 million across the UK) are providing some unpaid care

Demographic change, coupled with the direction of community care policy, will see a 60% rise in the number of carers needed by 2037.

A high percentage of carers (53%) combine work and care which can cause stress and lead to carers giving up work. We need to provide more flexible, creative support to people being cared for to enable carers to return/remain in employment.

We need to work to combat carers' social exclusion and isolation.

Preventing ill-health amongst carers should be integral and explicit part of planning.

### Pressures, Gaps and Business Issues

- Housing adaptations
- Percentage of people who consider themselves able to continue in their caring role
- Respite care services
- Young carers support

### Issues for Services / Service Responses:

There are a number of acts, policies and strategies that have relevance to carers: -

- The national strategy for carers was published in 1999. Since then, greater recognition has been given to the contribution of carers.
- The Community Care and Health (Scotland) Act 2002 recognised carers as "key partners in the provision of care" and introduced the following rights for carers:-

1. Substantial and regular adults' carers, including parent and guardian carers of disabled children, are entitled to an assessment of their own support needs (carers' assessment) independent of any assessment of the person they care for.

2. Young carers are children who look after a family member who is sick, disabled or has mental health problems or misusing drugs or alcohol. Their day to day responsibilities can include cooking ,cleaning, shopping, providing nursing or personal care and giving emotional support. With so many adult responsibilities young carers can miss out on opportunities that other children have to learn and play. Young carers are children first but additionally have the same rights to support as carers.

Deleted:

Deleted: re

Deleted: Young carers under 18 have the same right to assessment.

3. Local authorities have a duty to inform eligible carers of their right of assessment.

4. Local authorities have a duty to take account of the care provided by a carer, and the views of the person in need and their carer before deciding what services to provide.

**Vision for Services**

- The Community Care and Health (Scotland) Act 2002 also included the requirement Health Boards to produce a Carer Information Strategy. NHS Grampian has produced this and copies are available.

- The Changing Lives - 21st Century Social Work review has set out a vision for the future development of social work services by emphasising the need to deliver more personalised services. A five-year plan was put in place in 2006.

- The Care 21 report: The future of unpaid care in Scotland, commissioned by the then Scottish Executive is a valuable tool for guiding the approach to supporting carers.

- In November 2007 the Scottish Government announced Scotland's budget 2008 - 2011, also setting out a new relationship between the government and local authorities. This Concordat contains specific areas of spending to benefit carers, including the requirement to progress towards an additional 10,000 weeks of respite care per annum in care homes or at home.

**Priority areas identified through consultation with carers**

- Increased and more effective Carers Support Plans/Carers Assessments
- Develop/Promote Training & raise awareness of carers and carers' issues
- Appropriate Respite provision
- Young Carers
- Improving Carers health

Formatted: Left

Formatted: Font: (Default) Arial, 12 pt

Formatted: Font: (Default) Arial, 12 pt

Formatted: Font: (Default) Arial, 12 pt, Not Bold

Formatted: Left, Bulleted + Level: 1 + Aligned at: 0.63 cm + Tab after: 1.27 cm + Indent at: 1.27 cm

## Carers Commissioning Priorities

The following table highlights the commissioning priorities for carers services for 2010-13.

| Key Outcome | Commissioning Priority |
|---|---|
| **Carers have the support, knowledge, skills and confidence to continue in their caring role** | Develop and implement a more effective system of assessing and supporting carers.<br><br>Ensure that carers have accessible and clear information about potential changes to service that may affect the person they care for as well as themselves.<br><br>Increase the availability of carers assessments and carers support plans |
| **Develop and implement plans in relation to specific needs of young carers** | Engage in consultation activity with Young carers as to what could be improved<br>Ensure links with children's services. |
| **Increased awareness of carers' issues amongst staff** | Roll out carer awareness training to all appropriate staff.<br><br>Further develop the joint carer awareness training currently led by NHS Grampian. |
| **More flexible respite provided for carers** | Provide more flexible and equitable respite provisions via the respite voucher scheme. |
| **Carers are fully involved in the development and implementation of strategy and services** | Further develop means and opportunities for carers to work with us to develop strategy and services. |
| **Making a positive contribution** | Building on the good involvement work with carers currently ongoing and create direct links to community engagement strategy. Increased involvement of young carers. |
| **Money** | Individual budgets to allow people to make their own choices about the nature of their care.<br><br>Develop infrastructure to support self directed support |
| **Increased choice and control** | Services to be personalised and focussed on individual's personal outcomes<br>Implement Scottish Government guidance on Self-Directed Support packages for carers. |
| **Economic well-being** | Individual budgets to allow people to make their own choices about the nature of their care. Flexible care arrangements will allow carers to continue in employment and remain economically active. |
| **Commissioning & Leadership** | Recommissioning current carers services to ensure that they are in line with the Carers Strategy and priorities. |
| **Carers Health** | Assist carers to monitor and improve their health |

Deleted: ¶

Deleted: ¶

Deleted: ¶

Deleted: ¶

Deleted: ¶

Deleted: Choice and Control

Deleted: Increased choice and control

Deleted: Ensure links with children's services.

Deleted: Making Change happen ... [1]

# 4 Prevention, Adult Protection, Well Being and Rehabilitation

## Background

Whilst in Aberdeen we have now focused our in-house and directly contracted services on those people who have urgent/emergency or high needs, we recognise the need to deliver preventive services in order to avoid people's conditions or circumstances deteriorating. The earlier chapters highlight the pressures that will be facing Social Work Services and NHS partners in the coming years and emphasises the need for us to encourage people to sustain their own health and well being as much as possible.

### Local Policy Context

The national policy is reflected in the local policy priorities (Vibrant Dynamic and Forward Looking) to shift the balance of care through the development of preventative measures which will support people to live independently in their own homes e.g.

1. Improved joint working with the NHS; Deleted: ;
2. Provision of appropriate respite and rehabilitation services; Deleted: ;
3. Adoption and implementation of strategies to involve and support service users and unpaid carers in developing appropriate service provision; Deleted: ;
4. Adoption and implementation of strategies to support independent living for people with special needs; Deleted: ;
5. Continued support and development of the Care and Repair Service; Deleted: ;
6. Supporting income maximisation measures to help disabled people and carers claim all the benefits to which they are entitled; Deleted: ;
7. Build on the Council's participation in "Scotland's Heath at Work" and in particular implement mental health and wellbeing policies within the Council and promote such policies within the wider community; Deleted: ;
8. Increasing the provision of sheltered housing for communities across the City, and
9. Improving the rate of provision of adaptations

**Well Being Vision**

The visions for services outlined in the previous care group chapters have included a focus on prevention and well being. In this chapter we have summarised the overall approach that we are taking for all care groups in relation to this agenda.

**Our Vision:**

It is our vision to ensure that everyone in Aberdeen is given the opportunity to flourish and to achieve their personal aspirations.

Well being is defined as being at ease with oneself, having a sense of purpose, meaning and fulfilment, experiencing positive emotions, having the resilience to deal with life's difficulties, and belonging to a respectful community.

We know that poor well being is both a cause and consequence of social exclusion. We also know there are health inequalities that need to be addressed.

**Our Commitment:**

We will build positive relationships between people from different backgrounds and cultures. We will also support the development of intergenerational work.

We will provide accessible information and support for people to help them take responsibility for their own well-being, make informed choices about how they live their lives and enjoy a life which is fulfilling and active.

We will promote well being, work to prevent risks for people and increase personal resilience. We will also target and support the most vulnerable and socially excluded groups to maximise their health, well being and independence.

We will continue to build and support a vibrant voluntary and community sector to extend the range and quality of choice of services and participation.

We will provide accessible services to reduce, delay or prevent people from becoming socially excluded and needing more intensive, costly support from social and health care agencies.

We will focus on providing a choice of preventative support and services through the wider well-being agenda and through better targeted early interventions to keep people independent, happy and healthy.

**Seven Aims of Commissioning**

1 Equal access to all services
2 Preventing dependence
3 More effective commissioning + procurement involvement, invest in innovation – without penalties
4 Right place to live
5 Commissioning for wellbeing – joint commissioning with NHS, 3rd sector + Aberdeenshire
6 Choice control – outcome focused contracts
7 Independent living: disinvest in traditional services. Build on smart technology

Deleted: .

**The Adult Support and Protection (Scotland) Act 2007**

The Adult Support and Protection (Scotland) Act 2007 introduced new powers and duties for local authorities in respect of adults at risk of harm. In response ACC has established an Adult Protection Unit to co-ordinate activities. In addition seven new posts have been created within operational teams to enhance the capacity and responsiveness of services. This has been achieved utilising specific additional funding agreed by COSLA and Scottish Government at national level.

ACC is a member of a Grampian partnership, comprising the three local authorities, Police, NHS, Care Commission and Voluntary Sector. The partnership has developed an interagency policy for the support and protection of adults at risk of harm, which is supported by a training programme. To date 60 members of ACC social work teams have undertaken Council Officer training, qualifying them to carry out specific adult support and protection related duties on the Council's behalf.

**Commissioning Priorities**

The following priority areas for the development of preventive services have been identified:

- continued development and support for the voluntary sector to enable them to deliver low level / preventive services;
- develop more information about the needs of the people who use the current prevention services, to inform new commissioning of these services;
- make projects more local by encouraging the use of many venues;
- develop an inclusion campaign, to increase the numbers and range of people enjoying these projects, and making them more vibrant
- prioritise voluntary sector services that help to tackle social isolation for disabled and older people and carers;
- continue to work with a range of other partners to ensure vulnerable people have access to support to become more physically active, to improve their diet, stop smoking and reduce their alcohol consumption;
- continue to develop carers' support services to ensure that caring situations are sustainable;
- continue to support employment initiatives to access /sustain / return people to employment wherever possible (including carers);
- continue to consider ways of supporting people with low and moderate levels of need, including the Gateway Worker / Health Trainer roles;
- ensure that people are supported to live as independently as possible;

**Budgets / Funding**

At present there is no discrete budget for preventative service. The spend is included within the current service budgets shown elsewhere in this strategy. However in future we will need to focus more on prevention by reducing spend elsewhere in the overall system and reinvest into the preventing the escalation of demand.

There is consideration to develop a 'Preventative Service Project which will link with the Social Care annual grants programme. The project would develop across the following themes:

- Local Area Coordination
- Capacity Building of small community Groups
- Training for staff in preventative care
- Transport
- Support arrangements for discharge from hospital
- Increased flexibility of out of office hours care
- Befriending and visiting services
- Volunteer opportunities
- Aids and adaptations in relation to fall prevention
- Luncheon Clubs

## Appendix 1: References to Linked Plans and Strategies

| Title: | Produced by: | Web Reference: |
|---|---|---|
| Changing Lives | Scottish Government | http://www.scotland.gov.uk/Publications/2006/02/02094408/0 |
| The Same as You | Scottish Government | http://www.scotland.gov.uk/ldsr/docs/tsay-00.asp |
| The Personalisation Papers | Scottish Government | http://www.socialworkscotland.org.uk/resources/pub/PersonalisationPapers.pdf |
| Towards a Mentally Flourishing Scotland | Scottish Government | http://www.scotland.gov.uk/Resource/Doc/201215/0053753.pdf |
| With Inclusion in Mind | Scottish Government | http://www.scotland.gov.uk/Resource/Doc/200490/0053601.pdf |
| Delivering for Health | Scottish Government | http://www.scotland.gov.uk/Resource/Doc/76169/0018996.pdf |
| United Nations Principles for Older Persons | United Nations | http://www.un.org/esa/socdev/ageing/un_principles.html |
| Single Outcome Agreement | Aberdeen City Alliance | http://www.communityplanningaberdeen.org.uk/web/FILES/SOA0910/SOA09-10FINAL.pdf |
| Vibrant Dynamic and Forward Looking | Aberdeen City Council Administration | http://tinyurl.com/lvkgap |
| Improving Outcomes by Shifting the Balance of care | Scottish Government<br>NHS Scotland<br>COSLA | http://www.shiftingthebalance.scot.nhs.uk/downloads/1249894242-Improvement%20Framework%20July%202009.pdf |
| Reshaping Care for Older People | Scottish Government<br>Joint Improvement Team | http://www.jitscotland.org.uk/action-areas/reshaping-care-for-older-people/ |
| Scottish Telecare Evaluation Report | Scottish Government<br>Joint Improvement Team | http://www.jitscotland.org.uk/downloads/1219664870-94-Telecare%20Strategy%202008%20-%202010.pdf |
| Older people: Independence and well-being | Audit Commission | http://www.audit-commission.gov.uk/nationalstudies/health/socialcare/Pages/olderpeople.aspx#downloads |

## Appendix 2 Local Performance Targets

**The Adults Commissioning Strategy will contribute directly to achieving the following targets:**

| Local Priority | Indicators | Baseline | Targets | | | Lead & other partners |
|---|---|---|---|---|---|---|
| | | | 09/10 | 10/11 | 11/12 | |

**This page will be completed after the consultation period for the draft strategy**

The Consultation period refers to the public consultation. This includes a detailed programme of events where council officers will meet to discuss and record comments from both individuals and groups. Both the full version of the Strategy and shortened accessible versions will be published on the city council website, and other local sites, with an address to make comment. To date there 19 events arranged with established groups of users of services, carers and organisations involved in the field of social care.

Deleted:

Following the consultation a revised strategy will be presented to Social Care and Wellbeing Committee on the 25th February 2010, including a range of quality measures linking to the Single Outcome Agreement, local priorities and targets.

# Social Care and Wellbeing Vision Statement

# Vision Statement

## Contents


| | Page |
|---|---|
| Introduction | 2 |
| Our Core Purpose | 3 |
| Our Focus | 5 |
| Our Vision for Social Work in Aberdeen | 6 |
| Services for Children and their Families | 6 |
| Services for People with Learning Disabilities | 7 |
| Services for People with Mental Health Problems | 8 |
| Services for People with Drug and Alcohol Problems | 8 |
| Services for People with Physical and Sensory Impairments/ Long Term Conditions | 9 |
| Services for Older People | 10 |
| Services for Carers | 11 |
| Criminal Justice Services | 12 |
| Organisational Support to Frontline Staff | 13 |


**The page numbering above refers to the document in it's original form and no longer applies within this document.**

# Introduction

This document is written at a time when Social Work services are changing very quickly in Aberdeen. We are building a new, city-wide service that aims to provide consistent, high performing services to the people of the city. This will in future be led by a Director of Social Care and Well-being who will be responsible for all Social Work Services.

Change is always unsettling for everyone, which is why it is important to remind ourselves and others of our underlying principles and intentions. We need to focus on what it is we aim to do.

Our primary aim is to support those people in our community who need support and assistance in their daily lives. We do not do this in isolation from other agencies & services.

We have statutory responsibilities for much of what we do. We realise that we are supporting people of all ages who have particular needs and services must be appropriate and responsive.

We do not forget that in providing services we are accountable to the local population too and we work within the governance of democracy. We therefore, have a responsibility to ensure we are good stewards of the resources made available to us and are accountable for its use.

## Our Core Purpose

Our Core Purpose is to identify and respond to the social care needs of people living in Aberdeen. Often working in partnership with others, we aim to respond with cost effective quality services which support safeguard and promote the well being and safety of people who are in greatest need. We will respect and promote people's rights, support their independence and their inclusion in their own community respecting their choice wherever it is possible.

Our guiding principles are that we:

- Give clear and easy to understand information to people about what we can and can not do.
- Help people to have as much choice and control as possible over their lives.
- Work with others to look at the problems some people have when using ordinary services, like health, housing, leisure and work.
- Make sure that the services we offer are the best they can be. If services need to be better we will work to make them better.
- Listen to what people say and are open to new ideas and are there when people need us.
- Listen to what carers say and finding out what they need. If they are satisfied and feel confident it will help them in their role.
- Deliver on our promises.

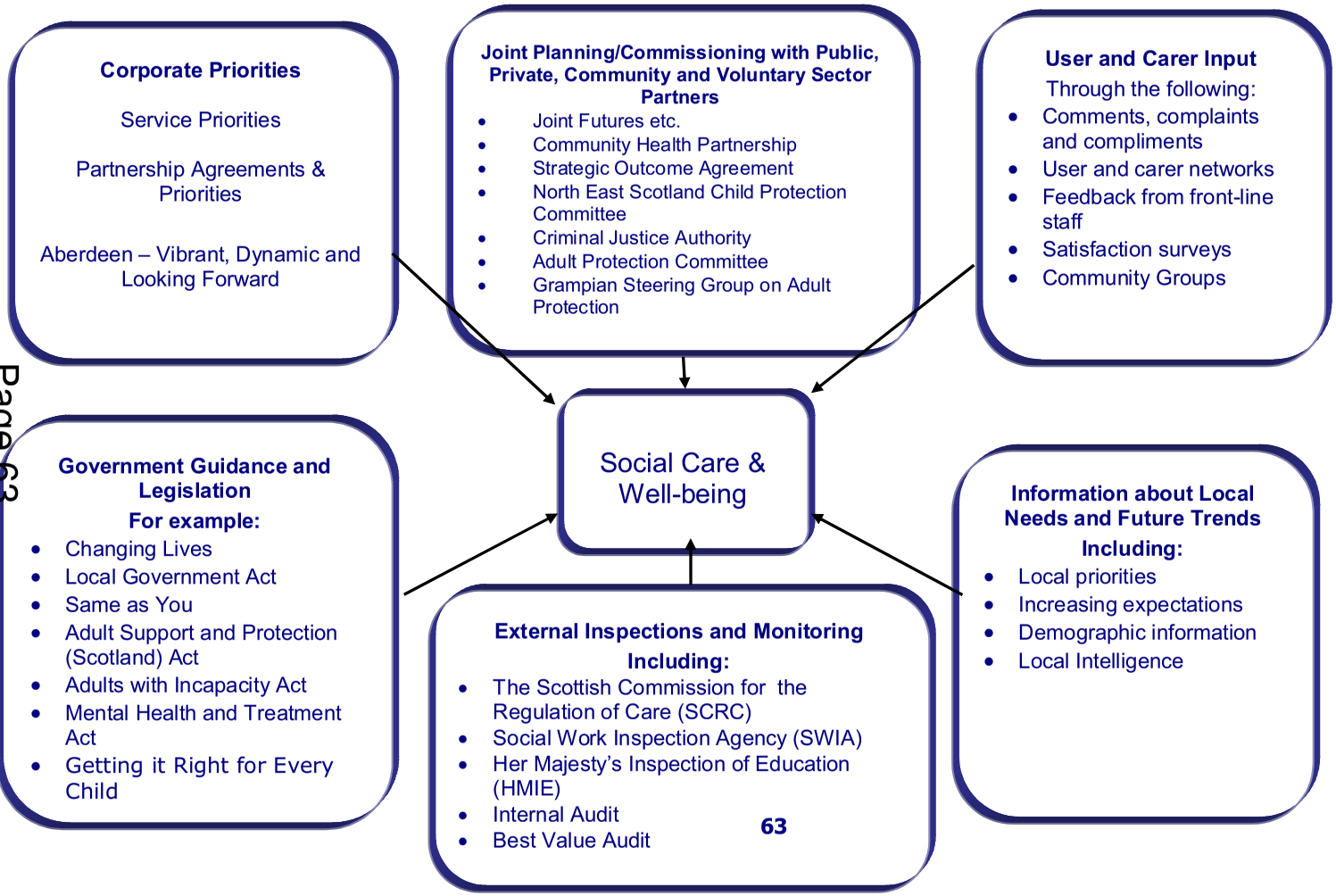
We believe that having staff who are well informed and appreciated is essential in ensuring that services are the best they can be. We want a Social Work service that:

- Helps staff to work in a person centred way with individuals.
- Treats everybody with respect.
- Listens and communicates with others in the organisation and values people's ideas.
- Supports staff to do their job and makes sure that they have the chance to build their skills and knowledge.
- Encourages new ideas and welcomes challenge.
- Gets value for money, works efficiently and challenges any rules that aren't needed.
- Is happy for feedback and listens to complaints and tries to make things better.
- Knows how important it is to check the quality of services and is always trying to improve services.
- Is getting better at communicating and listening to all people who we serve.

With these guiding principles and a newly emerging service we believe that we can deliver services that have real and lasting impact.

## Our Focus

The work of Social Care is directed by a number of different internal and external influences. The chart below gives examples of the issues that we must take account of and the organisations that we work alongside when services are planned and commissioned.



## Our Vision for Social Work in Aberdeen

It is important that at a time when we are reorganising the way we provide services and are also realigning our management structures, that we do not lose sight of the need to deliver quality services.

In each of the main areas in which we work we have developed the issues which we believe are important.

To achieve this we have to know what it is that we, and all our stakeholders, intend to use as our guide.

As we now embark on developing our services, we will build on these commitments by developing our services with our stakeholders.

## Services for Children and their Families

We aim to:

- Ensure that the protection, safety and wellbeing of children are our most important priorities.
- Provide clear eligibility criteria and thresholds for services, with all referrals receiving consistent, high quality responses based on thorough, evidence based assessments of need and leading to care plans that will be subject to monitoring and review.
- Link services organisationally so as to reflect service users' needs and to provide easy and quick access to resources in accordance with care plans.
- Take decisions about children as close to the frontline as organisationally possible, having listened to all points of view, balancing the responsibility for assessment of need with the ability to allocate resources to meet that need.
- Base services on identified needs, linking activities and costs and monitoring what happens to individuals and families as a result.
- Provide family support and other help to enable children and families to live normal lives at home, keeping children from unnecessarily entering the care system, without compromising their safety or protection.
- Work within a structure that enables and encourages 'joined up' Social Work where the child or young person is at the centre of our planning.
- Work closely with all partners implementing the Integrated Children's Services Agenda and ensure that we do "Get it Right for Every Child" (GIRFEC).

## Services for People with Learning Disabilities

We aim to:

- Help people to be able to take a full and active role in their local community, as citizens of Aberdeen.
- Work in partnership to empower and enable individuals with learning disabilities to lead a full life as part of their own communities.
- Build modern person centred support for individuals to enable them to access opportunities for leisure, employment and support in daily living.
- Direct resources in a timely way, to those most in need and to support people to access mainstream activities within the community.
- Develop services that enable individuals to maintain their independence for as long as possible.
- Provide a range of high quality services for people with learning disabilities and their carers at times in their lives when they need support which also demonstrate best value.
- Ensure carers receive the support they need to continue in their caring role.
- Review our commissioning intentions and improve the quality of business transactions with our partners so that services provide the outcomes at a fair, but appropriate cost.

## Services for People with Mental Health Problems

We aim to:

- Help people to be able to take a full and active role in their local community, as citizens of Aberdeen.
- Develop a mental health strategy based on well-being.
- Develop services which support individuals to remain within their own community and to increase personal resilience. This will include reviewing the provision of independent advocacy services.
- Increase opportunity, choice and natural support that will enable access to mainstream experience. Act with integrity in the spirit of openness and true partnership
- Encourage and empower individuals to exercise their rights to choice respect, dignity and independence through equality, opportunity and inclusion
- Embrace the diversity of our local population to facilitate their mental wellbeing
- Involve and inform local people in planning and reviewing services to meet their needs
- Implement rapidly and systematically improvements in service delivery, based on evidenced practice through effective & accountable leadership and management
- Ensure appropriate and timely access to services
- Value & accept feedback from individuals and service providers across Aberdeen City

## Services for People with Drug and Alcohol Problems

We aim to:

- Develop further an integrated commissioning strategy covering adults, offenders and young people's treatment.
- Develop more pathways into, and out of, treatment by promoting social inclusion and wellbeing.
- Improve the health of drug and alcohol users, including those in the criminal justice system.
- Ensure that commissioning is driven by quality standards, the evidence base and clinical governance.
- Ensure that parental drug and alcohol use and its impact on children is fully addressed.

## Services for People with Physical and Sensory Impairments/ Long Term Conditions

We aim to:

- Help people to be able to take a full and active role in their local community, as citizens of Aberdeen.
- Ensure that people are in control of the support they receive through person centred planning and individualised services.
- Have a good range of local supported living options.
- Develop work and volunteering opportunities.
- Offer a range of leisure and day time opportunities for people who are unable to work, accessing local community venues.
- Increase the use of direct payments and self directed support.
- Ensure people are supported to develop friendships and relationships and are able to live in safe and secure environments.
- Help people have easy access to health services and be part of all mainstream health and screening services.

## Services for Older People

We aim to:

- Help people to be able to take a full and active role in their local community, as citizens of Aberdeen.
- Support people to live as independently as possible in their own home for as long as they are able and want to do so, through a wide range of personal and practical, home based services.
- Work with others so that people should have a choice of good quality housing resources which enables them to maintain their independence for as long as possible.
- Provide a broad range of affordable and accessible activities that should be available for all older people whether active or less mobile, including those with enduring mental health problems.
- Ensure that people have access to health and well being opportunities which are close to home, responsive, flexible, with no professional/organisational boundaries.
- Provide a range of affordable support services, both personal and technological, available to help older people in their day to day tasks and in their personal care.
- Ensure that people, including carers are able to get information about those services that are available quickly, easily, in a variety of ways and formats, and at a time convenient to them.
- Ensure that older people receive support / care from someone who is sensitive to their culture and needs.

## Services for Carers

We aim to:

- Provide support which enables carers to remain healthy and provide support for work options. This will include an increase in the numbers of carers' assessments undertaken.
- Support carers with accurate, timely and good quality flexible services that meet the individual needs of the carers and the person they care for.
- Raise the profile of carers in the Aberdeen community and ensure all partners and council services recognise and understand the role of carers.
- Ensure carers are central to the development of social care.
- Involve carers in setting priorities for investment in carers support.

To a large extent our commissioning priorities for carers are included in the various care group sections above. In addition to carer involvement in planning for each care group, carers' issues are shared and brought together through to multi-agency Carers Strategy Group. This group focuses on wider issues affecting all carers and oversees the development of the Aberdeen Carers Strategy.

## Criminal Justice Services

We aim to:

- Increase public confidence in Criminal Justice Social Work services.
- Reduce re-offending.
- Increase public protection by providing effective supervision and management to offenders within the community.
- Provide a range of interventions for offenders based on:
  - Restrictions on opportunity to cause harm.
  - Rehabilitation through effective programmes.
  - Reparation for the harm they have caused.
  - Re-integration as contributing members of society.

To achieve this we need:

- Practitioners with the necessary discipline, knowledge and skills to engage and manage offenders.
- Strong partnerships with a range of services, both statutory and voluntary.
- Improved access to affordable housing and support.
- Earlier intervention in respect of drugs, alcohol and mental health services.

## Organisational Support to Frontline Staff

We aim to:

- Ensure that all Social Work support services are valued and fully integrated into the process of the service.
- Provide robust and accurate performance management information so that managers and elected members can make informed decisions.
- Prepare a detailed work force plan for social work so that long term employee planning can be effective.
- Review all administrative support so that it is appropriate and doesn't detract from front line service delivery.
- Challenge all processes that do not add value.
- Invest in the training and development of staff, targeted to the areas where greatest impact is required.
- Have staff within the service that can develop new and appropriate strategies and policies that can lead the service through the forces of change that impact on social work.

Appendix 4

# Aberdeen City Council Outcomes Framework For Social Care Provision

**What do we mean by 'outcome'?**

The working definition of outcome, used throughout this guidance is as follows:

'The impact, effect or consequence of help received'

## Part 1: Why focus on outcomes?

For social care, health and partner agencies faced with multiple change agendas, 'why?' is a significant question. Why should we focus on outcomes? Is this not just a passing fad, a passing trend? Who will benefit and what difference will it really make? Is it worth the investment of time, energy and resources?

In answer to this, the development of a more explicit focus on outcomes is fundamental to the core business of delivering effective, high quality, person centred services. It about:

- Best possible outcomes for clients and carers
- Best possible practice/services in pursuit of Best Value
- Developing management information to demonstrate effectiveness, and inform commissioning/contract monitoring

### Background

Recent policy initiatives clearly identify the role of social care, health and other relevant agencies, in working *together* towards specific outcomes. The historical approach of these various agencies is to work in isolation, with each agency 'dishing out' a standard range of their own traditional services. This can have a number of negative consequences for clients, carers and the agencies concerned, particularly in terms of:

- Important outcomes and needs being missed
- An inefficient use of resources
- Duplication of work
- Too many people getting involved
- An inability for staff from different agencies to work together

The NHS and Community Care Act 1990 was an attempt by government to address this issue, by getting agencies to work in a *seamless* fashion, with a focus on *needs led*, rather than *service led* assessment and care management.

Indeed, it was often quoted that **needs led** assessment and care management were to become **'the cornerstone of high quality care'.**

However, a research study across Wales (Parry Jones and Soulsby 2001), found that after ten years of the NHS and Community Care Act 1990 being implemented, practitioners…..

> ***' … were still rationing out a limited range of standard services'***

This study also identified the fact that many of these services were expensive, inflexible, often stigmatising, and not necessarily the sort of services that people wanted.

The reasons for the failure to break the traditional *service driven* approach appear to be complex, and include agency culture, the commissioning and allocation of budgets/resources, practitioner workloads and care management procedures, and performance management.

Our determination to break this pattern, is at the heart of why we are introducing an outcomes focussed approach to both commissioning and care management.

In Scotland, the National Outcomes Framework for Community Care is central to the drive to improve outcomes for service users. This is also a recurring theme in the development of social care services in Scotland

> "Doing more of the same won't work. Increasing demand, greater complexity and rising expectations mean that the current situation is not sustainable. Tomorrow's solutions will need to engage people as active participants, delivering accessible, responsive services of the highest quality and promoting well being
>
> **(Changing Lives-Report of the 21st Century Social Work Review)**

What we want to achieve: The call for a different approach?

In taking an outcomes based focus to care management and commissioning we are aiming to establish:

- A person centred approach
- A more integrated approach
- Best Value

## Towards a person centred approach

Ensuring a person centred approach is a fundamental aim, and a significant challenge for health and social care services. As one practitioner said:

*'Although we look at needs, we tend also to focus in on the set kinds of service delivery which may not fit into the outcomes that the person wanted'* (Practitioner quoted in Nicholas, 2003)

Whilst a focus on outcomes may not remove these dilemmas, research suggests that there are a number of benefits from practitioners taking an outcomes based approach to care management:

- The assessment process is more focussed
- A more positive orientation – attention to aspirations, not problems
- Enhanced understanding of the client's and carer's sense of priorities
- Greater recognition for carers
- More creative care planning
- Clearer guidance for providers about the purpose of help/support offered and individual preferences
- Clarification of any differences in perspectives which could assist negotiation
- Feedback about the impact of services which could help in fine-tuning care packages

## Towards an integrated approach

Fundamental to a person centred approach, are effective partnership working and the integration of services across agency boundaries. This is at the heart of the Unified Assessment process. Leaving aside paperwork and protocols, research by the Nuffield Institute for Health (Hardy et al, 2000) identifies some principles essential to effective partnership; clarity of purpose, underpinned by shared vision, values and service principles; and the ability to monitor, measure and learn from the partnership.

We believe that by taking an outcomes based approach across health and social care, which is focussed on the patient's/client's and carer's perspectives may assist partnership working through:

- Providing a common language and practice framework to assist communication
- Enabling clarity of purpose and shared responsibility, while avoiding some of the past tendencies towards professional defensiveness and protection of boundaries often associated with a focus on role and task
- Encouraging greater recognition of the interdependent contributions of social care and health in achieving particular outcomes
- Provide meaningful success criteria for evaluating partnership working

## Towards Best Value

Best Value, and the drive to push up standards, require both **creative thinking** and an ability to build **evaluation** into routine practice so that it becomes part of a cycle of continuous improvement.

In terms of **care management**, a focus on outcomes does not change the fact that resources are limited but may assist and enable limited resources to be targeted more effectively. (e.g. a client may ask for meals on wheels, but in subsequent outcomes based discussion, it becomes clear that the outcome she wants to achieve may be better social contacts or an ability to open jars and cans. In which case alternative services such as joining a local lunch club, or providing equipment to enhance independence may be more **cost effective** solutions).

In terms of the countywide commissioning of services, we also need to evaluate the ***impact*** of our services, rather than just ask whether people **like** them.

Historically, care managers in Aberdeen have not had particularly well developed links with staff involved in contract monitoring and commissioning. In taking an outcomes based approach to Personal Plans of Care and Reviews, it is our intention to strengthen these links.

We believe this can be achieved by using the Review process, to systematically gather a measure of outcomes being achieved, and also ensure a more effective evaluation of, and response to Service Deficits. Our hope is that this will enhance the contract monitoring of individual providers and also assist in the commissioning of new and more effective services.

# Part 2: Outcomes Framework

## Our aim

To develop a robust outcomes framework across care management, commissioning and quality assurance by developing:

- A high level set of outcomes linked to existing national policies
- A set of related core outcomes based upon research with service users and carers (UDSET)
- Outcomes based care management tools, linked to contract monitoring and commissioning
- Outcomes based contract monitoring tools, including outcome indicators and 'distance travelled' tools

## High Level Outcomes

In Scotland, a key driver for change in these areas has been the development of a new outcomes focussed joint performance framework, the National Outcomes Framework for Community Care. This framework centres around four high level outcomes that embrace the wider agendas of Public Service Reform, *Changing Lives*, *Delivering for Health* and *Supporting People*. These are:

- Improved health,
- Improved well-being,
- Improved social inclusion and
- Improved independence and responsibility.

## Core Outcomes

The High Level Outcomes need to be broken down into more easily measurable Core Outcomes. In selecting a set of Core Outcomes, we have used a framework initially researched and developed by the Social Policy Research Unit at York University (Nicholas et. al. 2003).

This framework suggests that there are broadly, three categories of outcome, which are:

**Process outcomes - with a focus on the way a service is delivered, and how it feels**

**Maintenance/quality of life outcomes - with a focus on maintaining a certain quality of life**

**Change outcomes - with a focus on improving certain aspects of life**

.

Whilst a purist approach to outcomes might suggest the need to start with a blank sheet of paper, large scale research with patients/clients across a wide range of service areas, including, mental health, learning disability, physical disability and sensory impairment, has identified the fact that a number of core outcomes come up time and again (Cook and Miller 2007). In this study, the researchers incorporated these commonly expressed outcomes into a framework known as the UDSET (User Defined Service Evaluation Tool)

We have adopted UDSET framework, for a number of reasons:

- It is based upon the views of patients/clients, rather than agencies
- It provides some consistency of guidance for practitioners who are unfamiliar with the outcomes based approach
- It provides a standardised framework for capturing information on outcomes achievement, which can be gathered systematically and used in county wide performance management and service planning
- The framework can be incorporated into service specification, and enhance the links between care management and contract monitoring
- The framework can be linked to high level national outcomes

**The core outcomes we have adopted, under the three categories of outcome identified by SPRU are:**

**Maintenance/quality of life outcomes**

- Feel safe
- Have things to do
- See other people
- Stay as well as you can be
- Live where you want to, in an environment comfortable to you
- Have control over your daily life and routines

**Change outcomes**

- Have improved health/reduced symptoms
- Improve your skills and/or learn new ones
- Be more able to get around your home and community
- Maximise your income and control of your money
- Have your carer(s) better supported in their caring role

**Process outcomes**

- Be listened to
- Feel valued and respected
- Have support that is flexible and gives you choice
- Have support that is reliable and timely
- Have support that is responsive to changing needs

## Relation between high level and core outcomes

Whilst the following table lists each Core Outcome only once, in relation to the High Level Outcomes, it should be noted that each of them may contribute to more than just one of the high level outcome

| High Level Outcome | Core Outcome |
|---|---|
| Have economic well being | Maximise your income and control of your money |
| Enjoy and achieve | Have satisfying things to do |
| | Have good social contacts |
| | Improve your skills and/or learn new ones |
| | Be more able to get around your home and community |
| Be healthy (both physically and mentally) | Live where you want to, in an environment comfortable to you |
| | Have your care needs met in an acceptable way |
| | Stay as healthy as you can be |
| | Have improved health/reduced symptoms |
| | Have support that is responsive to your changing needs |
| Stay safe | Feel safe and secure |
| | Feel valued and respected |
| | Have support that is reliable and timely |
| Make a positive contribution | Have control over your daily life and routines |
| | Have your carer(s) supported in their caring role |
| | Be listened to |
| | Have support that is flexible and puts you in control |

## Next steps

Having adopted an outcomes framework, we will need to develop a toolbox to support both care management and commissioning, including guidance on outcome indicators for each of the Core Outcomes, and some 'distance travelled' tools e.g. the Outcomes Star developed by St Mungo's available at:

**http://www.mungos.org/news/Briefings/Outcomes%20Star%20Briefing.pdf**

In order to develop these tools, three questions need to be asked for each of the Core Outcomes:

- What would individuals be doing differently, that would indicate this outcome was happening or has happened?
- What would individuals tell you?
- What would you see or hear that would encourage you that the individuals were making progress?

## Acknowledgements

**This guidance on outcomes, and the Outcomes Framework are taken and adapted from the following sources:**

Andrews, N. *Outcomes framework for Powys Adult Services*

Nicholas, E., Qureshi, H. and Bamford, C. (2003): *Outcomes into Practice Resource Pack*, York, SPRU/York University

Miller, E. and Cook, A., in association with Central England People First, Older People Researching Social Issues (OPRSI) and Service Users Research Enterprise (SURE) (2007): *Users and Carers Define Effective Partnerships in Health and Social Care*, Revised Report Submitted to Department of Health February 2007

Miller, E. and Cook, A. (2007) *Do health and social Care Partnerships deliver Good Outcomes to Service Users and carers. The User Defined Service Evaluation Toolkit. (UDSET)*

**References**

Hardy, B, Hudson, B. and Waddington, E. (2000): *What makes a good partnership? A partnership assessment tool*, Leeds, Nuffield Institute for Health

Parry-Jones, B. and Soulsby, J. 'Needs-led assessment: the challenges and the reality', *Health and Social Care in the Community*, 9(6), pp. 414-428

Scottish Executive (2006): *Changing Lives, Report of the 21st Century Social Work Review*

| Page 52: [1] Deleted | Jim Currie | 07/01/2010 16:33:00 |
|---|---|---|
| **Making Change happen** | Develop infrastructure to support self directed support | |

ABERDEEN CITY COUNCIL

COMMITTEE Social Care and Wellbeing DATE 25 February 2010

DIRECTOR Fred McBride

TITLE OF REPORT Update Report on Social Care and Wellbeing Annual Grant making programme

REPORT NUMBER: SCW/09/035

## 1. PURPOSE OF REPORT

The purpose of this report is to update members as to the current position in respect of voluntary sector grants from the Social Care and Wellbeing budget. The report identifies the impact of making savings across this budget following decisions made (Council Budget meeting on 11 February 2010). During 2009/10 the value of grants awarded in total was £300,359.57. Grants were made to twenty-one organisations. Last year, organisations were informed in November of the then new grant making framework and invited to make applications to the fund on this basis. Just over one hundred organisations made such applications. This year this process has been put on hold awaiting further decisions as to if and to what extent this programme may go ahead.

Mainstream funding grants which have already been agreed at Council Budget, are marked with an asterisk.

## 2. RECOMMENDATION(S)

1) Elected Members are asked to consider the grant awards not yet agreed and the recommendations of the officers in regard of these.

2) To note the funding already agreed (£131,700) and approve the mainstreaming of the amounts recommended (£71,463.57) and the subsequent savings (£97,196) from the grant fund.

3) To agree that the Director of Social Care and Wellbeing will write to the organisations, where funding is to cease, highlighting short term transitional support may be available

4) Approve the discontinuation of the Annual Grant making programme from this year.

## 3. FINANCIAL IMPLICATIONS

In previous years the total fund available has been up to £300,000. This figure has been suggested as a saving as part of the budget reduction measures.

## 4. SERVICE & COMMUNITY IMPACT

Links to Single Outcome Agreement:

**National Outcome**
2. We realise our full economic potential with more and better employment opportunities for our people.

**Local outcome:** Aberdeen will have high quality employment opportunities for citizens.

**National Outcome**
6. We live longer, healthier lives.

**Local outcome:** Sustain long term change by focusing on the prevention of, or reduction in, health inequalities (Joint Health Improvement Plan).

**National Outcome**
7. We have tackled the significant inequalities in Scottish society.

**Local outcome:** Improve the quality of life in our most deprived areas (Community Plan).

**National Outcome**
9. We live our lives safe from crime, disorder and danger.

**Local outcome:** Reduce anti-social behaviour, violence, domestic abuse, racist incidents and drug/ alcohol related incidents (Community Plan).

**National Outcome**
11. We have strong, resilient and supportive communities where people take responsibility for their own actions and how they affect others.

**Local outcome:** Every citizen is enabled to be more active in his or her community regardless of their age, gender, sexual orientation, ethnic origin, where they live or disability, to ensure everyone can contribute to 'active citizenship' (Strengthening Local Democracy Strategy).

## 5. OTHER IMPLICATIONS

Some of the organisations in receipt of funds from this grant are to receive the majority of their income from this source and are likely to close if they do not receive this grant.

## 6. REPORT

The Social Care Annual Grant funding in Aberdeen has tended to support long term service provision rather than provide start up, innovation and opportunity for new ways of working.

For the financial year 2009/10, a new Social Care Annual Grant making framework was introduced. Implementing a grant-making framework to manage the SCAG grant opened up this source of funding for new organisations to apply, thus creating a more competitive funding stream. This was welcome by the voluntary sector, introducing greater transparency to the process and with the same level of funding, saw several new organisations in receipt of grants.

The table below shows the organisations in receipt of a grant and the recommendations of officers in respect of those monies for 2010/2011.

Social Care Annual Grant

| Name of Organisation | Purpose/ Remit (inc National or Local) | Amount of Grant from ACC and purpose | Other Sources of Funding | Recommendations | Implication |
|---|---|---|---|---|---|
| Aberdeen Action on Disability | **Accessible & Social Inclusion**<br>• Aberdeen Action on Disability (AAD) will continue to support the proposed Independent Living Centre by representing the needs of people with physical and sensory disabilities.<br>• Promote community involvement through membership of the Civic Forum.<br>• AAD will be focal point where people can develop a greater sense of belonging.<br>• AAD to ensure the needs of Older People are being met and they too can access services.<br><br>**Promote Community Involvement and Social Capital**<br>• AAD will liaise with other disabled groups and aim to improve, maintain and | £20k | Various small grants and donations<br><br>£23,000 per annum agreed from the Disability Strategy Action Plan budget. | Cease | The funding has been replaced from the disability strategy action plan and the organisation can in its current form. |

| | | | | | |
|---|---|---|---|---|---|
| | introduce mutual support networks.<br>• Aim to provide a sustainable and effective neighbourhood network, which will ensure the needs of people with physical and sensory impairment are met.<br>• Provide an information and advice service to link disabled people with the correct organisation at both civic and voluntary level. Maintain a database and introduce quarterly checks on accuracy of information held.<br><br>**Inclusiveness**<br>• Examine feasibility of existing IT facilities to extend the availability of computer awareness for disabled people within AAD premises.<br>• To provide relevant information and support for disabled people in the city and to use AAD's considerable experience to influence decision-makers on the key challenges facing disabled people in Aberdeen.<br>• Maintain working relationships with Aberdeen City Council, | | | | |

| | | | | | |
|---|---|---|---|---|---|
| | NHS Grampian, Grampian Fire and Rescue Service and Grampian Police in order to develop Disability Equality Schemes.<br>• Continuation in the work of Aberdeen City Council Disability Advisory Group. | | | | |
| Aberdeen Council of Voluntary Organisations | • Support community-based services and activities linked to promoting independent living through development work. Provide capacity building support to community and voluntary sector organisations.<br>• Develop and support the emergence of networks to support people with specific conditions or difficulties they face.<br>• Bring people together for mutual support and joint networking through training, development support and work with community planning.<br>• Encourage local people to advocate on their own and on others behalf, through the provision of support, information, weekly bulletin and many ACVO web sites.<br>• Meet all targets in respect of | £22,837 | Largely grant funded (sources not detailed) but some trading income and member subscriptions | Allocate fund through Corporate Governance | ACVO provides support to 3rd sector organisations across the spectrum of service provision. Potential to develop Council wide service level agreement. |

| | | | | | |
|---|---|---|---|---|---|
| | Social Care Annual Grant Social Inclusion block.<br>• Provide group work support to all respective groups listed in the Social Care Annual Grant funding outcome framework by assisting groups to develop their projects effectively. Speak on behalf of the sector to ensure their voices are heard, and support people from all organisations to have a voice. | | | | |
| Age Concern Advisory Service | • ACASA offers help and advice to Older People, their Carers and relatives in Aberdeen and surrounding area. Grant goes towards expenses of advisors and salary for part-time coordinator and administrative worker. Advisors assist people in their own home and assist with any difficulties that maybe experiencing.<br>• Likelihood is the project will fold if the grant is discontinued. If it is agreed to award the grant then perhaps this should be the last grant awarded from SCAG and the organisation will need to look to identify funding from elsewhere. We could perhaps | £3k | National organisation with considerable other income. | Cease | Current funding is contribution toward local administration – likely impact reduced service – potential to be picked up by carers services, NHSG etc. |

| | | | | | |
|---|---|---|---|---|---|
| | link ACVO in to support this organisation | | | | |
| Age Concern Scotland | • This project is Aberdeen based. The funding is used to employ a Development Worker who is based within Aberdeen and is responsible for developing community based programmes for Older People as well as linking in with ACC Social User Involvement to undertake consultation programmes with Older People. One-to-one work also carried out with Older People. | £20k | National organisation with considerable other income. | Cease | National organisation who can reallocate funds.<br><br>This is the organisation's main source of funding to employ a Development Worker to deliver services to Older People in Aberdeen. The role of the worker includes: developing group activities, one to one support and working in partnership with local statutory and voluntary agencies to develop services within Aberdeen for Older People. |
| *Befriend A Child | **Making a Positive Contribution (community cohesion and intergenerational projects)** | £40k | Financial information not available | Allocate fund to mainstream funds and develop a service level | This is a critical service to support children and |

| | | | | | |
|---|---|---|---|---|---|
| | • The Befriending service ensures young people are engaged within the community and are encouraged to participate in positive activities, which benefit their own personal development and allow them to see more of the opportunities available in their own community.<br><br>**Promoting Healthier Lifestyles (promotion of active and healthier lives among primary school children)**<br>• Encourage and support young people to take part in fun and educational activities. These include; swimming, football, nature walks and cooking healthy recipes in our base unit kitchen.<br><br>**Build Respect in Communities / Reduce Anti-social Behaviour (address alarming behaviour within communities)**<br>• Volunteers pass on their experiences and values to young people, who subsequently develop an understanding of acceptable behaviour. This includes | | | agreement | young people and will be commissioned in an ongoing basis. |

| | | | | | |
|---|---|---|---|---|---|
| | encouraging politeness, good manners, discouraging swearing and spitting. | | | | |
| Counselling and Family Mediation | • Provide a range of services offered ultimately to support children and young people who are experiencing difficulties as a result of family transition and parental conflict.<br>• CFMG Counsellors and Children's Workers will continue to help children and teenagers to explore their feelings, voice their views and make more sense of what is happening in their lives.<br>• Promote community engagement and develop positive relationships across generations to strengthen self-confidence in the present and for the future. | £20k | Other small grants. ACC funding represents a large portion | Allocate fund to mainstream funds and develop a service level agreement | This organisation provide, amongst other things, a service to the Courts, e.g. in residence/ custody disputes. Local MSP and Sheriffs are keen to retain the service. |
| *James Tyrell Centre | • The work of the James Tyrell Day Centre relates to the Social Annual Grant *Social Inclusion* funding block. The overall aim of the organisation is to support and assist older People with physical disabilities and reduce social isolation. | £40k | Other small grants. ACC funding represents a large portion | Allocate fund to mainstream funds and develop a service level agreement | Essential part of day care services for older people |

| | | | | | |
|---|---|---|---|---|---|
| Quarriers | • Aim of the organisation is to provide support, training, and advice to children and adults who have a diagnosis of epilepsy. This includes working with health professionals, employers, school and relevant parties.<br>• The funding will be going towards a contribution of the Epilespy Fieldworker, management expenditure and expenses. The project maybe in jeopardy if the funding is withdrawn but perhaps cut backs could be made else where in the organisation to absorb the shortfall. Again, may wish to decide that this is the last year of funding from SCAG. | £5k | National organisation with considerable other funds | Cease | National organisation who can reallocate funds. |
| *Samaritans | • Service contributes to the reduction of social isolation by offering human contact and emotional support to many people who say they feel isolated, lonely and unsupported.<br>• Improve emotional well-being by undertaking outreach work to encourage people to talk about their feelings, rather than internalise all their anxieties, | £10k | National organisation wit considerable other funds, however ACC funding represents a large portion of local income | Allocate to mainstream funds and develop a service level agreement | Critical support for people with emotional problems in Aberdeen<br><br>SCAG + Choose Life funding = nearly 50% of the organisation's funding. |

| | | | | | |
|---|---|---|---|---|---|
| | which is the first step to improved mental health and wellbeing.<br>• Service continue to offer support to a number of Older People who suffer from depression and lack of human contact.<br>• Continue to undertake outreach work targeted at young people, who may be subjected to all sorts of pressures from parents, their peer group, teachers, and may feel unable to offload to anyone in their close family or social group.<br>• Maintain fundamental belief that by listening in confidence and being non-judgmental, helps people to explore their feelings and consider their options and straddle all aspects of the outcome framework by encouraging a positive approach to emotional health and well-being. | | | | |
| Scottish Motor Neurone Disease | • Local residents directly benefit from the work of Scottish Motor Neurone Disease through the use of specialised equipment. SMND have provided a list of | £1,196 | National organisation with considerable other funds. | Cease | National organisation who can reallocate funds. |

| | | | | | |
|---|---|---|---|---|---|
| | equipment that is leased out to sufferers of SCND within the city. | | | | |
| Shop Mobility Aberdeen | Shopmobility Aberdeen facilitates social and economic inclusion for people of all ages, regardless of race, creed or colour, who have impaired mobility.<br><br>Shopmobility contributes to the following funding themes:<br><br>**Older People Block**<br>• Enhance control, choice and participation.<br>• Improved health of older People.<br>• Improve economic well being.<br><br>**Social Inclusion Block**<br>• Accessible and Inclusiveness<br>• Promote community involvement.<br>• Inclusive city. | £22k | £22,000 per annum agreed from the Disability Strategy Action Plan budget. | Cease | The funding has been replaced from the Disability Strategy action plan and the organisation can in its current form. |
| Victim Support Scotland - Aberdeen Service | • Continue to provide a support service for all groups referred to in the Social Care Annual Grant outcome framework.<br>• Practical support is available to people of all ages including children and young people.<br>• Support victims of domestic | £15k | National organisation with considerable other funds. However ACC funding represents a large portion of local income | Allocate to mainstream funds and develop a service level agreement | This is the main source of funding to employ a Development Worker to work in Aberdeen. VSS make a small contribution to |

| | | | | | |
|---|---|---|---|---|---|
| | violence by being able to access relevant support.<br>• Continue to offer practical and emotional support to all people.<br>• Promote social inclusion and social capital by reducing social isolation and increase the sense of belonging by offering emotional support to victims of crime. | | | | salary and running costs. The role of worker is to support victims of domestic violence by being able to access relevant support. |
| Newhills Parish Church | • Aim of organisation is to enhance the lives of members, many of whom live alone, by providing companionship, lunch every Wednesday and bus outings and social events. Funding goes towards heating and lighting of hall, up-keep of mini-bus and subsidises activity programme. Should this grant be discontinued then the organisation can charge a membership fee to allow this group to continue.<br>• Provide a gentle exercise programme each day which benefits everyone, in particular those whose joints are stiffening through age and those who have limited ability in movement.<br>• Minds are stimulated by | £5k | Minimal other income. | Cease | Church organisation which has the potential to seek other funding services.<br><br>The SCAG is the main source of income to allow the fellowship to deliver activities for Older People. A small amount of income is generated through fundraising activities. |

| | | | | | |
|---|---|---|---|---|---|
| | quizzes, discussions, team games, outside entertainers giving talks and musical entertainment.<br>• Provide opportunity for those who live alone and possibly suffer from depression, to meet others in their community and develop new friendships. Referrals are made through direct agencies. | | | | |
| *Who Cares? Scotland | • This is a national organisation, however, the funding is used to specifically employ a Development Worker to provide advocacy support for children leaving care. WCS make a small contribution to the cost of providing this service within Aberdeen. | £15k | National organisation with considerable other funds, however ACC funding represents a large portion of local income | Allocate to mainstream funds and develop a service level agreement | This service supports and advocates for children and young people who are looked after or looked after and accommodated. |
| WEA Reachout Project | **<u>Community Arts Project</u>**<br>**Healthier / Safer Communities**<br>• Engagement with the arts improves mental health and the satisfaction of developing skills and producing work can benefit all. Art is an important tool in working with people with learning disabilities. Provide participants with the opportunity to discover new talents and increase their self- | £13,626.57 | National organisation with considerable other funds, however ACC funding represents a large portion of local income | Allocate to mainstream funds and develop a service level agreement | Look at number of classes currently provided. |

| | | | | | |
|---|---|---|---|---|---|
| | confidence and self-esteem.<br><br>**Social Inclusion**<br>• Currently engage some of the most socially isolated people, and adding a further dimension to the project will reach more people.<br>• Student-centred ethos of Reach Out and inclusion of all in the democratic process creates a strong sense of community. Skills gained can be transferred to participation in wider communities.<br>• Reach Out brings together people from all over the city with a wide range of issues. Emphasis on co-operative working allows skills sharing and develops appreciation of others strengths.<br><br>**<u>Older Peoples Project – Social and Education Provision</u>**<br><br>• Contribute to the following outcomes for Older People:<br>- Enhancing Choice, Control and Participation<br>- Improved Health of Older People | | | | |

| | | | | | |
|---|---|---|---|---|---|
| | • By setting up an independent group, WEA aims to promote principles of active engagement.<br>• Elderly participants will develop their own programme of activities, which will build confidence and encourage a co-operative response to working together.<br>• The group will provide a social and education forum where people would be encouraged to support each other. The social aspect of the group will help to address depression.<br>• Involvement of health practitioners and financial advisors from the Credit Union in the education programme will informally raise awareness and informed discussions after talks will provide the forum with more specific help if appropriate. | | | | |
| FARE (Food Action Reaching Elderly) DC | • Support the Growth of Community Food Outlets in Sheltered Housing Complexes | £4,500 | | Cease – was given to extend the areas covered | Organisation has option to seek other funding sources – would cover less areas |
| Alten's Over | • Facilitate 50s activities aimed at | £3k | Minimal other income. | Cease | Organisation has |

| | | | | | |
|---|---|---|---|---|---|
| 50's Project | encouraging positive outlooks and wellbeing | | | | option to seek other funding sources. Potential for reduction in the number of areas where the service operates. |
| *Inchgarth Community Centre | • Aim to develop a project that will deliver a programme of music, dance and movement, art and social events for people with both physical and learning difficulties. Based on an extremely successful pilot project and consultation with numerous service providers, proposals meets the needs of the client group and will compliment other planned projects by service providers who are also aiming to fill the gaps created by recent service cuts. | £5,400 | Has other income sources, however ACC funding relates to specific projects | Allocate to mainstream funds and develop a service level agreement | This project is part of learning day opportunities. Majority of the organisation's funding comes from ACC and fundraising activities. Their SCAG will be used to develop arts and social events for people with disabilities. Although this grant constitutes a very small percentage of their overall funding, the Council may consider commissioning ICC to deliver similar programmes in the future |

| | | | | | |
|---|---|---|---|---|---|
| Grampian Employment Opportunities | • A project based on supporting people with disabilities, establishing social enterprise in Grampian Employment Opportunities Initiatives | £4,500 | | Cease | Organisation has opportunities to seek other funding sources. |
| Cornerstone Aberdeen Employment Service | **Accessible and Inclusiveness**<br>• This project will help develop the skills and confidence of people with disabilities, to help them move into training and employment. This support will promote social inclusion and encourage individuals to become more independent as they are supported to make life choices.<br>• The project aims to give participants the confidence and skills to go out into their communities and work with others to achieve positive change. Cornerstone's links with the local business community will help to raise awareness of and help combat discriminatory attitudes towards employing people with a disability.<br><br>**Promote Community Involvement and Social Capital**<br>• Individuals will receive practical and emotional | £9k | National organisation with considerable other funds. | Cease | National organisation who can reallocated funds. |

| | | | | | |
|---|---|---|---|---|---|
| | support to help them in their daily lives and to integrate into their community. Project will provide an additional support network for people with a disability, who are often more isolated.<br>• Individuals will be encouraged to participate in a range of social activities to facilitate social interaction.<br>• Assist people to remain in their local communities, promoting local networking and opportunity. The project will encourage people to access community-based resources.<br>• Provide people with disabilities the opportunity to develop the skills and confidence to take part in local decision making processes. | | | | |
| *Bread Maker | • The Bread Maker encourages social inclusion as part of its daily routine with individuals, interacting with members of the public as part of their work experience. Individuals are trained in customer service, which aids in communication with others. It also assists members of the public to | £21,300 | | Allocate to mainstream funds and develop a service level agreement | Allow purchase of services on a spot purchase basis. |

| | | | | | |
|---|---|---|---|---|---|
| | interact with an individual with a learning disability, and promote a network in the local community. Being part of a local community increases the sense of belonging and the contribution of adults with a learning disability to the success of the Bread Maker and participation in working with the local community. | | | | |

## 7. REPORT AUTHOR DETAILS

Fred McBride
Director, Social Care and Wellbeing
frmcbride@aberdeencity.gov.uk
01224 523797

## 8. BACKGROUND PAPERS