Aberdeen City Health & Social Care Partnership
A caring partnership

Draft Strategic Commissioning Implementation Plan

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1. INTRODUCTION.

Following on from the publication of the partnership's Strategic Plan[1], this Plan seeks to outline our commissioning intentions over the next over the next four to five years to reshape our services to improve individual experiences and outcomes in the face of future demographic and financial challenges.

The work to develop our commissioning intentions has focussed on particular service areas which the Partnership feels are ripe for change and have potential for significant impact on improving outcomes for service users and on improving efficiency.

These areas include:

- Care at home
- Residential care (older people & physical disability, learning disability, mental health)
- Intermediate care
- Re-ablement services
- Out of hours and responder services

Our intentions will be of interest to many stakeholders including those from the independent, third and housing sectors who we will commission particular services from. With this in mind, a Market Facilitation Statement is incorporated into this Plan giving guidance on our commissioning intentions, translating them into specific information to help providers prepare for forthcoming opportunities.

1.1 Vision, values and priorities

Our Strategic Plan outlines our vision, values and strategic priorities. Our vision is: "A caring partnership working together with our city communities to enable people to achieve fulfilling, healthier lives and wellbeing". Our values, which underpin everything we do, are to be caring, person-centred, empowering, enabling, and cooperative.

Our strategic priorities are to:

- Improve the health and wellbeing of our local population
- Contribute to a reduction in health inequalities and wider social inequalities that impact on health and wellbeing
- Strengthen existing community assets and resources
- Promote and support self-management and independence
- Develop personalised services
- Support those who are unpaid carers
- Work in partnership with our residents, communities and organisations
- Deliver high quality services that have a positive impact on personal experiences and outcomes.

[1] http://aberdeencityhscp.scot/en/progress/news/achscp-strategic-plan-2016-19/

1.2 Our approach to commissioning.

Our approach to commissioning is shaped by the Scottish Government's guidance on strategic commissioning plans[2] which defines strategic commissioning as: "the term used for all the activities involved in assessing and forecasting needs, linking investment to agreed outcomes, considering options, planning the nature, range and quality of future services and working in partnership to put these in place"[3].

We see commissioning as collaborative decision-making about how to achieve defined, agreed and jointly owned outcomes, generating a broader and more innovative range of options. To achieve our vision of effective strategic commissioning, we aim to embed the following principles into our practice:

- Commissioning is undertaken for outcomes (rather than for services)
- Commissioning decisions are based on evidence and insight and consider sustainability from the outset
- Commissioning adopts a whole systems approach
- Commissioning actively promotes solutions that enable prevention and early intervention
- Commissioning activities balance innovation and risk
- Commissioning decisions are based on a sound methodology and appraisal of options
- Commissioning practice includes solutions co-designed and co-produced with partners and communities
- Commissioning is evaluated on outcomes and social and economic return on investment

1.3 LEGISLATIVE and POLICY DRIVERS.

In Scotland there is currently an ambitious and wide-ranging policy agenda for health and social care. Key areas of reform and transformation include:

- Integration of adult health and social care introduced through the Public Bodies (Joint Working) (Scotland) Act 2014
- Greater personalisation of services and implementation of self-directed support, specifically through the Social Care (Self-Directed Support)(Scotland) Act 2013
- Reshaping Care of Older People is focussed on shifting care towards anticipatory care and prevention approaches in order to improve care of older people
- Carers' Act (Scotland) 2016
- Development and implementation of joint strategic commissioning and stronger partnership approaches to service delivery.

In line with the requirements of legislation, Aberdeen City Health and Social Care Partnership has identified four localities, roughly aligned with the existing four GP cluster areas. The purpose of creating localities is not to draw lines on a map, but to provide an organisational mechanism for local leadership of service planning, to be fed upwards into the Integration Authority's strategic commissioning plan. The intention is to develop single integrated community teams that will include staff that are employed by the NHS and Aberdeen City Council and working for the Aberdeen City

[2]Scottish Government, Health and Social Care Integration: Strategic Commissioning Plans Guidance 2015
[3] Strategic Commissioning Steering Group, Joint Strategic Commissioning: a definition, 2012

Health and Social Care Partnership. The team may also include staff employed by other agencies including the third and independent sector. Appropriate linkages will be developed with other providers within these communities to support seamless person centred care, including, where appropriate, effective community supports to enable self management of long term conditions and maintaining long term health and wellbeing.

We are also exploring opportunities for adopting “Buurtzorg” principles, especially those of self managing and self organising teams within an Aberdeen context. This is anticipated to include the development of local community teams initially in two communities in Aberdeen, with these principles embedded throughout the development and delivery of these teams. Public World is working with Aberdeen City to develop a shared understanding of Buurtzorg including co-designing a test and learn site.

3. OUR COMMISSIONING INTENTIONS.

3.1 Key intentions.

Consistent with the outcomes we wish to achieve, and our analysis of existing provision, we intend to shift the balance of care from institutional models to enhanced, community based models of care. This will increase the need for community based services providing support to stay at home and effective services at times of transition. It will require a change in the way resources are deployed and in what services are commissioned and facilitated.

In order to deliver this change, we will over the next four years re-shape services with the aim of ensuring flexible, personalised, and cost-effective support to stay at home.

3.2 Care at home

3.2.1 Purpose.

Good care at home helps people with care needs to live in their own home when otherwise they would need to be in residential care. It should:

- help people with care needs look after themselves in, and participate in all aspects of, the community
- encourage people with care needs to live independently in the community and to maintain greater independence for longer, while recognising that, for some older people in particular, there will be an inevitable deterioration in their condition
- prevent people with significant health or care needs from having to use emergency services or from being admitted to hospital inappropriately.

Where possible, assistance should include helping the supported person to become empowered and skilled to undertake tasks for themselves. Where this is not possible then the provision may include but will not be limited to the following activities:

- assisting with individuals' personal care
- recognising and assisting with health needs
- assisting with nutritional needs
- supporting a person to identify and attain personal goals and quality of life outcomes
- helping a person live with or manage having memory loss or dementia
- helping a person through end of life care
- supporting a carer who is helping any of the above.

3.2.2 What will we commission?

- Encourage a move away from a range of services aiming to maintain somebody in the community into a single integrated health and social care community service for older Integrated framework for care at home across all types of service user
- Equitable access to and quality of provision across the city (no postcode lottery)
- Designed around a single point of entry

- Allow for planning and development of care on a locality basis
- Sufficient capacity in the system to accommodate variations in demand and/or emergencies
- A focus on developing collaborative relationships between providers eg in determining which geographical areas particular providers would cover, in shared recruitment and training
- An approach to commissioning based on developing long term relationships with trusted providers who have greater flexibility to decide how best to meet need and deliver outcomes.
- Give providers choice and control over time, people and process ie way that care is administered and delivered
- Providers are paid an appropriate and sustainable rate for what they do
- Providers to are incentivised to improve their efficiency (ie how they use time and resource; how they review their own use of care workers)
- Workers are paid the Scottish Living Wage and providers subscribe to Fairer Work Practices
- Easy to understand and manage contract payment mechanism and contract arrangements
- Simple to administer ie as few rates as possible
- Support and care delivered in users' own homes and that gives them choice in the way in which their allocated hours of care are used, including time for social and other activities. This may include as appropriate but is not not limited to:
- Personal Hygiene - Bathing, showering, hair washing, shaving, oral hygiene, nail care
- Continence Management - Toileting, catheter/stoma care, skin care, incontinence laundry, bed changing
- Food and Diet - Assistance with the preparation of food and assistance with the fulfilment of special dietary needs
- Problems with Immobility - Dealing with the consequences of being immobile or substantially immobile
- Simple Treatments - Assistance with medication (including eye drops), application of creams and lotions, simple dressings, oxygen therapy
- Personal Assistance - Assistance with dressing, surgical appliances, prostheses, mechanical and manual aids. Assistance to get up and go to bed. Transfers including the use of a hoist.
- Domestic tasks - support to deal with money, undertake shopping, and other domestic tasks
- Social life - enabling a full and rewarding social life and the opportunity to maintain or build personal relationships
- Employment and training - Providing support to access training, development and employment opportunities
- A move away from a range of services aiming to maintain somebody in the community into a single integrated health and social care community service for older people
- A 'what needs to be done' approach by lead care workers rather than constant referral on or signposting elsewhere
- ability to work across different budgets to create seamless services

- How, when and which services are provided to be agreed between the service user and the provider
- A whole-needs approach, where attention is paid to the needs of the whole person rather than treating them as a series of discrete problems, embedded in service delivery ie "Do we have the right help for this person and is it being delivered in a way that will maximise their opportunities for greater independence?"
- A move away from "time and task" to a less prescriptive way of working that offers service users greater choice in the way in which their allocated hours of care are used, including time for social and other activities;
- A more collaborative approach to addressing the needs of individuals that would see fewer workers engaging with any one service user but fulfilling a wider range of activities and tasks
- A more holistic approach to addressing needs that would bring in a much wider and innovative range of assets and supports, including those available through the voluntary and community sector, volunteers, and good neighbours
- Care packages that flex easily to meet changing needs (both escalating and reducing needs)
- Models that wrap around existing carers
- Models that allow individuals to have a relationship with their carer

3.3 Residential care for older people and people with physical disabilities.

3.3.1 Purpose

The current discussion about the purpose of residential services for older adults and adults with a physical disability comes at a time when 'bed based' care is subject to greater scrutiny across the health and social care continuum. Demographic projections have put forward a future in Scotland where there is a growing older population coupled with a shrinking working age population - so the national policy focus has been on either reducing the volume of bed based care, or at the very least constraining growth below the baseline that would be expected given the shift in demographics.

Locally, the Aberdeen City Health and Social Care Partnership's strategic plan indicates a more general desire to shift the balance of care away, for all adult social care client groups, from institutional settings. This is further developed in the Partnership's current overarching commissioning strategy for older people[4] which argues for further efforts to "…establish a trend towards care at home, particularly to reduce reliance on residential care".

Therefore, the role of Older Adult and Physical Disability residential services going forward should be seen as being a relatively small BUT very important element of the wider service provision offered. Residential care will focus on supporting the more complex individuals with the greatest need.

[4] Ageing wi' Opportunity in Aberdeen City: A Joint Commissioning Strategy for Older People 2013 – 2023: http://www.aberdeencity.gov.uk/nmsruntime/saveasdialog.asp?lID=50024&sID=23017

3.3.2 What will we commission?

It should be noted that demographic projections would indicate that, all other things being equal, a need for additional residential care home beds would be expected. Aberdeen City 'standard care homes' currently operate at an occupancy rate of approximately 83% (based on current contract information). NHS Grampian Health Intelligence have taken the current care home bed base and have extrapolated potential occupancy to 2020 based on future demographic projections. This indicates a shift upwards in occupancy rates for the care home estate to 89-91% by the year 2020.

Normally such a projected occupancy range (in excess of the current Scottish average of 86%) would trigger consideration of expansion of service provision. However, the Partnership has staked a clear strategic direction in 'shifting the balance of care' away from residential/institutional settings. As a result, it is planned that there will not be an increase in overall volumes of standard care home places procured over the next five year period.

Rather, the Partnership will manage demand within the existing volume of beds, with a greater 'diversion' of individuals from institutional care via the expansion of services such as enablement, intermediate care, hospital at home and care at home services. This should allow for the growth in residential bed based care to be curtailed and the remaining demand to be managed within current bed volumes. The Partnership is mindful that a balance needs to be struck between high occupancy rates (for the viability of providers) and reasonable 'spare' capacity remaining within the care home system to support client/patient 'flow' and appropriate management of any business continuity risks.

Particular aspects include:

1) Standard care home provision for older adults and others with a range of conditions that are appropriately met within that form of setting.

Relatively large volumes of standard care home places which are equipped to manage the broad range of needs/demands relating to older adult care alongside some younger adults with a physical disability. Small numbers of LD and Mental Health clients will also access this resource.

It is envisaged that this service would primarily be met through linking in with the local voluntary and independent care home sector. Beds would primarily be spot purchased. It is likely that this would be under the auspices of the National Care Home Contract(NCHC) as the client/patient cohort would not be expected to exceed the demands of what is currently considered standard care home provision – i.e. the current residential/nursing models.

We have yet to decide our view on models of provision elsewhere where %'s of standard care home beds are block booked/funded on the basis of supporting the supplier market and providing greater control of placements. A commissioning aspiration over the next five years would be to trial/pilot such a model to examine/evaluate it on its merits.

An exception to our focus on spot purchasing in this area may be for a smaller dedicated cohort of beds that serve younger adults. [It would be hoped that the upcoming iteration of the NCHC may incorporate under-65's within it more explicitly, making the arranging of such a service less onerous.] There may also be some potential for block funding/booking a small cohort of standard care home beds to expedite discharge from hospital – however this will be evaluated in conjunction with developments in the Partnership's intermediate care bed base.

2) Advanced Dementia Care in a Care Home Setting:

A moderate volume of more specialised care home places that are specifically equipped to provide Advanced Dementia Care for particularly complex dementia related needs and presentations.

Again, it is envisaged that this service would primarily be met through linking in with the local voluntary and independent care sector.

Given the more specialised provision envisaged by this model of care, we are more convinced that at least a partial switch from the existing spot purchasing arrangement to block funding may yield dividends in regards to quality and continuity of such a service.

A commissioning intention over the next five years will also be to trial at least one very different model of acute dementia care which moves away from traditional 'care home' structures /staffing /delivery.

This will be an attempt for the Partnership to begin to consider its longer term model of delivery following the next round of commissioning. The Partnership will look both nationally and internationally at new developments in dementia care – ranging from Hogeway Dementia Village models through Butterfly models and ABLE methodologies – amongst others.

3) Specialised Care Home services for individuals with very complex physical presentations

Given the complex and specialised nature of this residential care delivery, we envisage these services only being provided via very particular, and specialist, independent and voluntary sector services.

We would envisage funding of such residential services to be a mix between both block funding of some resource + the ability to top up supply via spot purchase arrangements. This would strike a balance between the need to support and give security to relatively small volume suppliers whilst also allowing some flexibility in regards to numbers of beds purchased.

4) Advanced Dementia Care Home: Whilst we anticipate Advanced Dementia Care dealing with more complex presentations than the existing EMI places – the increase in dementia prevalence over the coming years leads us to believe that we will need to at least match our existing EMI bed base with the new type of service. (The number of people with dementia is projected to increase in those 65 years and over by 13% by 2022)[5]. The rising prevalence over time likely reflects the increase in the older age groups within the population and also potentially the increase in risk factors within the population[6]. Therefore, a reasonable estimate for volume of beds for this model would be in the range of **300-320 beds**.

[5] Aberdeen City's Partnership Statement of Intent and Action Plan in relation to People with Dementia 2013 - 2023

[6] Aberdeen City Joint Strategic Needs Assessment 2012: http://www.aberdeencity.gov.uk/nmsruntime/saveasdialog.asp?lID=50032&sID=23017

5) Specialised Care Home Services for individuals with very complex physical presentations.

A small volume of more specialised care home services that are equipped specifically to manage non-age related physical disabilities that are particularly complex or intensive, (e.g. high need neurological presentations etc)

It is hoped that the combination of cohorting some of our younger clients in more age appropriate standard care home settings; coupled with planned improvements in care at home provision and responder services, will allow us to meet complex demand within the existing bed base numbers.

Therefore, a reasonable estimate for volume of beds for this model would remain the existing **37 beds**. This takes account of potential Partnership progress with its various efforts to "shift the balance of care" alongside the general consistent level on unmet need within the system.

6) Specialised Brain Injury Care Home Provision.

A small volume of very specialised care home beds that work specifically to support individuals with brain injuries (of various aetiologies) – particularly individuals for whom more general services have already proven unable to meet their needs.

Given the complex and specialised nature of the proposed residential care delivery, we envisage these services only being provided via very particular, and specialist, independent and voluntary services.

We would envisage funding of such a residential service to be primarily a spot purchase arrangement. However, some guarantees of volumes could be provided to support supplier security and confidence. There would also be an option to link in and 'pool' a client cohort across a Grampian wide basis to increase the size and viability of any such service.

We requested information on all out of area placements for those with specialised brain injury residential provision + known unmet need within the City. This provided a gross figure of 30. We have to be mindful that a small number of those individuals will require such complex care that an out of area specialised provider would always have been the only viable option for their care.

Making a degree of adjustment, we could realistically expect the service to require at least 15 beds when commissioned. This would be based on Aberdeen City needs only. The service could be sized differently if negotiations were held with other Partnership areas to accommodate and provide services on a grouped basis.

These figures currently cohort together Alcohol Related Brain Damage clients and those adults with an Acquired Brain Injury. We recognise that these client cohorts have differing complexities and needs, and would therefore encourage a more detailed options appraisal in regards to configuration of any new service at the point of commissioning arrangements commencing.

3.4 Residential care for people with a learning disability

3.4.1 Purpose

The current discussion about residential services for individuals with learning disabilities (and their purpose) must be seen within the wider context of national and local policy. As a starting point, the Mental Health (Care and Treatment) (Scotland) Act 2003[7] puts a legal duty on local authorities to ensure provision of care and support services, including residential and support services. Therefore any commissioning intentions must ensure that this statutory duty continues to be met.

Additionally, The Keys to Life[8] (2013) which is the current 10 year National Learning Disability Strategy reinforces this point, stating that residential models of care should be viewed as a minority element of overall provision, working with the most complex individuals, whilst retaining as many elements of a homely environment as possible. This followed on from "The Same as You"[9] (2000). The direction of travel within national policy has been for the residential elements of LD services to be directed at those with the most significant and complex needs – with alternate models of support utilised for the majority of individuals with support needs.
Locally, the Aberdeen City Partnership's strategic plan indicates a more general desire to shift the balance of care away (for all adult social care client groups) from institutional settings. It should also be acknowledged that, locally, there has already been a significant drive to shift LD resources away from a residential model through the *reregistration process* where services historically recognised as residential care settings have shifted their focus to providing housing support and care at home services. This was part of a wider drive to support LD individuals to become more active and valued citizens within their communities.

It should, therefore, be recognised that the residential LD services and care models described in this report form part of a much wider continuum of health and social care services that are intrinsically interrelated. Readers must recognise that this document does not provide the "full picture" of support to individuals with an LD.

Also of note is that projected demographics for LD individuals suggest a future cohort for residential bed based care that have *proportionally greater needs* – both in regards to their LD and other aspects of their presentation. This is currently evidenced by the increased acceptance of referrals to the Transitions team.

In summary, the purpose of LD residential services going forward should be seen as a small BUT very important element of the wider LD service provision. Residential care will focus on supporting the most complex individuals with the greatest need. It is on this foundation that the Partnership's commissioning of services will be built.

[7] http://www.legislation.gov.uk/asp/2003/13/contents
[8] http://www.gov.scot/resource/0042/00424389.pdf
[9] http://www.gov.scot/resource/doc/1095/0001661.pdf

*NOTE: The Partnership is currently in the early stages of developing an overarching **Learning Disability Strategy** – it is anticipated that the commissioning intentions set out in this paper will dovetail with the priorities and aims/objectives of that document*

3.4.2 What will we commission?

1) Standard Care Home provision for LD clients (under 65)

This would be registered care home provision for individuals with a Learning Disability but who do not have care and support needs that are LD specific. Rather, the standard care home provision currently offered to older adults and adults with a physical disability would best meet their needs.

The intention will be to negotiate on a Partnership wide basis with our standard residential and nursing care home providers to ensure that they are able and willing to register with the regulator to deliver services to this client cohort. This may necessitate Partnership support to engage with the regulator as a body corporate. Thereafter, once achieved, beds would likely be purchased on a spot purchase basis. These beds would be accessed from within the general care home estate governed by the National Care Home Contract (independent/voluntary sector).

Negotiation on a global basis with City Residential/Nursing care home providers to agree under 65 registration and spot purchase access to standard care home services. [Will require liaison and support from the Care Inspectorate].

2) LD Specific Nursing Care Home Provision

Small volume of Nursing Care Home provision that focuses specifically on, (and is configured for), LD related needs. Potentially via external provider on a block contract (unless larger volumes can be established via Grampian wide 'pooling' of LD individuals and related service).

This would be dedicated nursing level care home provision that is configured specifically for the specialist needs of individuals with LD who may also have specific dementia or wider health/disability presentations.

It is envisaged that this would be specifically commissioned in small units (4-6 individuals). Given the clinical complexities of such care provision, it is anticipated that this would be sought from the specialist provider arms of the independent/voluntary sector.

3) 24/7 staffed "Small Cohort" Properties.

Continually staffed, small volume services which are generally mainstream housing 'type' accommodation. Primarily standard 'homely' properties but with full-time staff teams meeting both high physical and LD specific needs.

This would be 24/7 staffed care provision (but not at a clinical nursing level) that supports a small cohort of individuals within one setting/property. It is anticipated that each 'service' would support between 4-6 individuals of a roughly comparable need presentation.

We would intend to commission such services from the independent/voluntary sector. We are not yet decided in regards to whether services should be tendered individually or in bulk – this would be dependent on market conditions and appetite.

4) "Core and Cluster" 24/7 staffed service for individuals with particularly challenging behaviour.

Single Occupancy settings with consistent and relatively large staff teams delivering very complex care provision and behavioural management. [Some staff resource sharing across multiple individuals within a close geographic area – i.e. "core and cluster"].

It is envisaged that this service would be primarily delivered by specialised services within the independent and voluntary sector given the complex nature of the support needs of the individuals involved.

Services would need to be configured to be small enough to support individually delivered care and support, and yet 'pool' enough individuals within the wider service to ensure service continuity amongst the staff teams.

5) Intensive short-medium term residential provision.

Very high staff ratio service provision on a time limited basis to those individuals with the most complex and highest level needs/behaviours who are either in crisis or in transition.

It is envisaged that, much like core and cluster, the specialised nature of the service would necessitate that it be delivered by independent/voluntary providers with long standing experience, knowledge, and proven capability in this area.

3.5 Residential care for people with mental health needs

3.5.1 Purpose

The current discussion about the purpose of residential services for people with mental illness must be seen within the wider context of national and local legislation and policy. The Mental Health (Care and Treatment) (Scotland) Act 2003[10] puts a legal duty on local authorities to ensure provision of care and support services, including residential and support services. Therefore any commissioning intentions must ensure that this statutory duty continues to be met.

A new National Strategy for Mental Health is currently being finalised for publication this year (Mental Health in Scotland - a 10 year vision). The draft material[11] currently released relating to this

[10] http://www.legislation.gov.uk/asp/2003/13/contents
[11] https://consult.scotland.gov.uk/mental-health-unit/mental-health-in-scotland-a-10-year-vision/supporting_documents/mentalhealthstrategy.pdf

strategy indicates a desire to focus on early intervention, self-management and improving both access and efficiency of mental health services.

Locally, the Aberdeen City Partnership's strategic plan[12] indicates a more general desire to shift the balance of care away (for all adult social care client groups) from institutional settings. It should also be acknowledged that, locally, there has already been a significant drive to shift mental health resources away from a residential model through the *reregistration process* where services historically recognised as residential care settings have shifted their focus to providing housing support and care at home services. This was part of a wider drive to support people with mental illness to become more active and valued citizens within their communities.

It should, therefore, be recognised that the residential mental health services and care models described in this report form part of a much wider continuum of health and social care services that are intrinsically interrelated. Readers must recognise that this document does not provide the "full picture" of support to individuals with a mental health diagnosis.

Additionally, Aberdeen City has a Mental Health Strategy in place (The Joint Mental Health and Well-Being Strategy for Aberdeen City 2012–22), which places an emphasis on early intervention and the enhancing of existing services to best meet the needs of those with mental illness.

Therefore, our commissioning of residential services will, primarily, be focussed, on those individuals with severe and enduring mental illness with associated issues (such as physical health problems, behavioural or other such concerns). This ensures that mental health residential services are targeted efficiently, and on those with the greatest level of need. The mental health residential bed base will remain a small BUT very important element of the wider service provision made available.

What is essential is that all residential services will be *'recovery focused'* – i.e. there is ongoing encouragement to meet particular outcomes and any residential placement remains under review with the aim to achieve greater independence and meet an individual's full potential.

Mental Health residential services are easily accessible and responsive to local needs and demands.

- Mental Health residential services genuinely deliver person centred and recovery focused provision with improved outcomes.
- Mental Health residential services are able to link in and cooperate fully with the full suite of health and social care services available to adults with a mental illness.

3.5.2 What will we commission?

1) Standard Care Home provision for Mental Health clients (under 65)

This would be registered care home provision for individuals with a mental health diagnosis but who do not have care and support needs that are mental health specific. Rather, the standard care home provision currently offered to older adults and adults with a physical disability would best meet their needs.

The intention will be to negotiate on a Partnership wide basis with our standard residential and nursing care home providers to ensure that they are able and willing to register with the regulator to

[12] http://ihub.scot/media/1110/aberdeen-city.pdf

deliver services to this client cohort. This may necessitate Partnership support to engage with the regulator as a body corporate. Thereafter, once achieved, beds would likely be purchased on a spot purchase basis. These beds would be accessed from within the general care home estate governed by the National Care Home Contract (independent/voluntary sector).

2) Rehabilitation Residential Service

Short stay (2-3 year) Rehabilitation Residential Service with a focus on building independent living skills for those adults with complex needs but identified potential to move to community based living.

It is envisaged that this service would primarily be met through procuring the services of specialist providers within the independent and voluntary sector. This service would primarily be 'block funded' to support market stability and allow greater control in regards to placement flow. There may be capability to allow a small proportion of spot-purchase beds on top of the main block funding arrangements.

As will be indicated below, (in the infrastructure section), there will be a need to ensure that the physical environments of such a service are setup to allow for both physical and mental health needs.

3) Longer Stay Mental Health Residential Home provision

Longer Stay Mental Health Residential Home provision which primarily focuses on meeting ongoing complex mental health needs. However, this model will still retain a 'recovery and outcomes' focused delivery of service – with an intention that a proportion of residents would move to other forms of less intensive supported living over time.

Again, it is envisaged that this service would primarily be met through engaging the services of specialist providers within the independent and voluntary sector. This service would primarily be 'block funded' to support market stability and allow greater control in regards to placement flow. There may be capability to allow a small proportion of spot-purchase beds on top of the main block funding arrangements.

As will be indicated below, (in the infrastructure section), there will be a need to ensure that the physical environment of such a service are setup to allow for both physical and mental health needs.

4) Short Stay/Break Residential Service

Short term (1 week) provision of Short Stay/Break residential type care support for individuals who are either in crisis or requiring planned support at a residential level for a short term period. [NOTE: this is not informal carer respite provision, rather short stay provision for the benefit of mental health service users themselves].

Again, it is envisaged that this service would primarily be met through engaging the services of specialist providers within the independent and voluntary sector. This service would primarily be 'block funded' to support market stability + allow greater control in regards to placement flow. There may be capability to allow a small proportion of spot-purchase beds on top of the main block funding arrangements.

As will be indicated below, (in the infrastructure section), there will be a need to ensure that the physical environments of such a service are setup to allow for both physical and mental health needs.

3.6 Intermediate care

3.6.1 Purpose

The purpose of Intermediate Care is to provide a short term intervention to preserve the independence of people who might otherwise face unnecessary, prolonged, hospital stays or inappropriate admission to hospital. The care is person centred, focused on rehabilitation and delivered by a combination of professional groups.

"Maximising Recovery, Promoting Independence: An Intermediate Care Framework for Scotland"[13] locates *bed based* intermediate care as part of a wider continuum of services both on a 'step up' basis during periods of acute need, and a 'step down' basis during recovery. Any intermediate bed base is therefore a constituent part of a much wider network of care and support to which the Partnership will be investing.

The primary client group to whom the Partnership will be directing its bed based intermediate care resources will be *older adults*, although *younger adults with a physical disability* and a small cohort of *adults with mental health issues* will also benefit from such a resource. The resources described should be configured in such a way that they can deliver intermediate care to individuals who, *as a secondary issue*, have drug and alcohol dependency alongside their main physical/mental health presentation.

The models of intermediate care the Partnership utilises will vary depending on patient/client cohort and the cost/benefit analysis of locality working vs economies of scale. It is clear that if the Partnership wishes to achieve a reduction in hospital admissions, delayed discharges, and a general shift in the balance of care away from institutional resources – high quality intermediate care will be a key driver of these objectives.

3.6.2 What will we commission?

1) Locality based Intermediate Care:

It is envisaged that this service would primarily be met through linking in with the local voluntary and independent care home sector. Beds would be reserved and 'block booked' with care homes in each locality to deliver 'care' and 'hotel' services to patients/clients. It is likely that this would be under the auspices of the National Care Home Contract as the client/patient cohort would not be expected to exceed the demands of standard nursing/residential care.

Assessment, care planning and rehabilitation delivery would be the responsibility of local integrated health and social care teams, who would 'outreach' to the beds within their locality area.

[13] Maximising Recovery, Promoting Independence: An Intermediate Care Framework for Scotland (2012): http://www.gov.scot/resource/0039/00396826.pdf

2) Centralised Comprehensive Intermediate Care – Care Home Model:

Larger volumes of centralised intermediate care that provides intensive step-up and step-down for individuals with a need profile at point of admission up to and including nursing home level care.

It is envisaged that the 'care' elements of the service would be met by one provider – to allow for economies of scale and ease of coordination. We are not yet decided as to whether this provider would be the Council/NHS directly, or a third/independent sector provider – however any potential 'non-state' provider would have to evidence significant robustness of service delivery given the critical nature of this model to Partnership priorities.

3) Centralised comprehensive intermediate care for both 'step up' and 'step down' – via a ''housing' type model:

It is envisaged that the 'care' elements of the service would be met by one provider – to allow for economies of scale and ease of coordination. Again, we are not yet decided as to whether this provider would be the Council/NHS directly, or a third/independent sector provider – however any potential 'non-state' provider would have to evidence significant robustness of service delivery given the critical nature of this model to Partnership priorities.

3.7 Out of Hours & Responder Service

3.7.1 Purpose

The purpose of out of hours and community response services is to provide both scheduled and unscheduled or emergency care to those in need. The current out of hours service provision appears to have areas of duplication and a large volume of responses tend to be handled in isolation by services and often in a way which can result in inappropriate and unnecessary admissions to the acute sector. Staff working in OOH services deal with many difficult pressures particularly delivering care during unsocial hours and through the night. This involves caring for patients who may be seriously unwell, often working in isolation from colleagues. OOH services and the pathway for the patient, is complex therefore it is difficult for the public and professionals to know where to refer their patient/client to. This can result in people finding it difficult to know where to seek advice or to go with their care requirements. There has previously been work done through NHSG and NHS 24, to inform the public, for example the know who to turn to campaign.

OOH services are required in response to a number of needs that present or are referred to:

- Medication management; typically, individuals have run out of medication, taken medication at the wrong time, taken the wrong amount of medication in error, are experiencing side effects of medication, have queries or anxiety about medication. These are often non-complex issues to resolve but time consuming for those involved.
- Equipment; users typically present with a requirement for equipment due to deterioration of condition or with equipment that is not functioning properly thereby posing potential risk to both patient and carer.

- Acute care; patients present with acute episodes or exacerbations of existing conditions either of which may be predictable or unpredictable.

- Palliative care; in general, this is the result of an exacerbation of condition resulting in call out of services. This is due to a number of factors eg fear of carer or family/relatives who feel unable or unsupported to deal with the situation, work/family demands, lack of care staff to support family and provide respite for family carers etc.

- The frail elderly; they may require an OOH service due to falls, confusion, deterioration of co morbidities, or UTI's.

- Mental health; OOH services may be required to deal with dementia, psychosis, emotional crisis, alcohol induced crisis, rescue medications or personality disorders

The Scottish Government's Review of Primary Care Out of Hours Services[14] recommended that:

- Health and social care partnerships should look for opportunities for integrated OOH service provision from Local Authorities and the NHS, including co-location opportunities
- Future models of care should meet local need and focus on early intervention and prevention
- A multidisciplinary OOH workforce be developed
- The use of video-conference technology, telehealth and telecare be enhanced including the use of mobile 'apps', to promote self care and to assist best use and access to urgent care services.
- Local care pathways need to be developed, clearly understood and delivered

3.7.1 What will we commission?

There is a need to have a more integrated blended approach where services can work together to maintain the patient, where possible, in their own home until contact with required services for assessment etc. can be undertaken the next day.

An integrated response service combining a single point of access for unscheduled support, capable of triaging the needs that are presented, supported by multi-disciplinary responders and enabled through the innovative use of assisted technology.

Pathway to reduce the number of services who become involved by "default" i.e. Police are called if there is no response to Community Alarms etc. they are often then expected to pick up patients who have fallen etc.

Care worker bank - access to "bank" of Care Provision so that short term support can be put in to avoid admission to the acute sector; able to be called on to provide support to the patient overnight until full assessment by the appropriate person can take place the following day. practically, this would not be feasible at this time due to the current fragility of the Care Worker market. There is a national Care Worker recruitment crisis and it was agreed that the role of the Care Worker needs to be enhanced with a clear career pathway to encourage people to take up this role.

[14] Pulling Together: transforming urgent care for the people of Scotland, November 2015

A more cohesive relationship with the Third Sector needs to be considered so that a full range of support services is available to support patients in Aberdeen City. Communication is pivotal across all services and there needs to be "good practice" in relation to data sharing i.e. promotion of multi disciplinary ACP's. Encourage Multi-Disciplinary ACP's so that all information including provision of specialist equipment and who to contact in the event of breakdown / malfunction etc.

3.8 Reablement service

3.8.1 Purpose

In this context, we see reablement as specific interventions provided to support people to learn or relearn skills necessary for daily living distinct from a wider concept approach to enablement which we endorse as a fundamental underpinning way of working across all of our health and social care services. Our intention is to develop a time limited reablement programme that would essentially form the gateway into continuing care with a view to enabling more people to remain safely at home and to reducing the costs of care. Providing personal care, help with daily living activities and other practical tasks, usually for up to six weeks, reablement encourages service users to develop the confidence and skills to carry out these activities themselves and to continue to live at home. It tends to be provided to people who have just been discharged from hospital or are otherwise entering the care system following a crisis.

Adults in Hospital or Community settings identified as having a new care need or a changed care need would be referred to the service. The requirement to be assessed for an identified care at home need is the primary reason for referral to this service.

3.8.2 What will we commission?

A service that is an integral part of the care at home pathway and that forms the gateway into care at home services, with the aims of:

- assessing service users' functional ability within their own homes (or homely setting), working with the service user and their family and/ or carers over a time-limited period to maximise their independence with activities of daily living, and determining any on-going care at home service requirements required
- supporting individuals to lead full and independent lives while ensuring most cost-effective use of available care at home resources.

A single-access point into assessment for care at home and a reablement programme for adults where a new care need or a change to their care support requirements has been identified

- Time limited reablement programme (up to 6 weeks)
- Care at home reablement Service comprising care management/coordinators, occupational therapy and aligned care workers/ health care support workers
- Clear pathways to other key services during the programme, such as physiotherapy, to ensure timely access
- A person-centred approach – focussing on personal goals/outcomes using an agreed approach e.g. Talking Points
- Client-held support plans
- Social connectedness – facilitating links to community/ third sector support would be a key feature. Link workers may have a role in supporting this.

- A focus on ensuring support for unpaid/family carers to enable them to be able to continue in their caring role
- Optimising the use of telecare to support independence

1) Single access point and referral vetting process

- Referrals will come from a wide range of sources i.e. Medical, Nursing, AHP, Social Care, Care workers, self-referral and referrals from carers
- All referrals will be made through a Single Access Point
- An agreed referral format would be used e.g. Single Shared Assessment (SSA). For self-referral and referral from other non-statutory service routes, a suitable method of referral would need to be agreed
- All referrals would be vetted to ensure suitability for this pathway or redirected if inappropriate and a Key Worker identified

2) Assessment process

- An holistic assessment of the individual's physical, cognitive and functional abilities and social circumstances would be carried out by the care manager/coordinator or occupational therapist to assess reablement potential, including motivation to engage with this approach
- Baseline measures will be established and reassessed post-intervention
- Personal goals will be agreed with the client – SMART goals
- An intervention plan will be agreed with the client/family

3) Interventions

- 6 week programme- expected date for end of the programme agreed at the outset
- Reablement plan agreed with the client/patient
- Programme delivered by Care workers/OTs as appropriate
- Where there is a pre-existing care at home arrangement, the programme would be delivered in conjunction with the current care at home provider's care workers
- Continuous monitoring of improvement towards achieving personal goals
- Weekly review meetings of progress
- Links made to any other relevant services to support a successful outcome from the programme e.g. timely access to Physiotherapy
- TEC solutions considered as part of the reablement programme – short and long term solutions
- Links made to community solutions/groups that will help support transition from the programme/achievement of the agreed goals

4) Review

- Expected date of discharge from the programme identified at the outset
- Continuous monitoring of improvement towards achieving personal goals
- Weekly review meetings of progress against the personal goals with the assigned Care Manager/OT
- Close working with any pre-existing care at home provider

- By week 4, a formal assessment of progress towards goals by the Key Worker and determination of on-going care needs and plans made with care at home provider to support continuing care at home needs

5) Discharge/exit routes from the reablement service

- **No on-going social care needs** – return to pre-enablement level of functioning – exit route would include signposting to community support to maintain functional status and feedback to referrer
- **Continued need for care at home support** – level would have been determined and arrangements would be in place with care provider, including a robust handover/ transition from the reablement service to the longer-term provider.

For both exit routes, links to primary care and community services including updating Anticipatory Care Plans would be a routine part of the discharge process.

4. MARKET FACILITATION STATEMENT

4.1 OUR APPROACH TO MARKET FACILITATION

There are three commonly understood elements of market facilitation: market intelligence or analysis, market structuring, and market intervention, as described below.

Intelligence/analysis: the development of a common and shared perspective of supply and demand. Market intelligence should help the commissioner to understand the structure of market, key players, current market offerings, market drivers, the scope for innovation, market capacity and capability, and barriers to entry. It is critical to assessing market readiness, supporting provider resilience, and preventing or managing supplier and market failure.

Structuring: making explicit to providers how the commissioner intends to perform and behave in influencing the market. For example, this might include communications with providers and service users, ongoing planning, quality assurance or performance management arrangements designed to encourage desired services and discourage those that are not needed.

Intervention: the interventions commissioners make in order to deliver the kind of market believed to be necessary to achieve desired outcomes and impact. For example, this might include financial incentives, offering specialist training, support to providers with business planning, setting up not for profit ventures, grants, or other forms of support for providers to encourage the development of particular services.

The collection and analysis of data and the publication of a market facilitation plan, or market position statement, constitute the major part of market intelligence activity. Market structuring and market intervention have some overlap and involve a wide range of tasks and activities. For example, an activity that works with providers to change the shape of purchasing from cost and volume to outcomes would be market structuring activity: the actual contract would be a market intervention.

The partnership recognises that it is at an early stage in developing its capability in market facilitation and is committed to improving practice in all three elements.

4.2 Our ideal marketplace

Our ideal is a diverse, active, and sustainable market that matches people's individual needs and preferences to an appropriate range of high quality services and support, and offers them real choice and control over how their needs are met.

As well as a range of established independent and third sector providers, we wish to see small-scale providers and micro-enterprises able to form a vibrant and valuable part of the markets through the close local connections they often have and by their ability to provide very bespoke support in response to individual requirements.

Our view of the ideal market also encompasses social action initiatives such as time banking, befriending and meal sharing.

4.2.1 The providers we want to work with

The providers we want to work with are those who:

- have explicit quality standards and carry out independent monitoring
- are committed to active engagement with service users and communities and are willing to work towards a co-production approach
- are able to show the impact of their activities in terms of the outcomes they achieve rather than in terms of the number of people for whom they provide a service or the number of hours delivered
- wish to innovate and are willing to try new models of care, delivery and contracting
- have a collaborative approach to working with the Partnership and with other providers

4.3 Supply

Concerns about the stability of the UK care market, particularly given the growing dependence on the private sector market, are well documented. As we have seen, in Aberdeen all care at home and residential care is purchased externally with independent and third sector providers facing many of the same challenges as those faced nationally and across the UK. There have additionally been some high profile care home failures within the city in recent years. In recognition of the risks posed, we will commission a "service of last resort" in order to ensure continuity of care to service users of "failing" or "failed" services until such time as alternative arrangements for the running or delivery of the service are in place. This element of service provision should, in future, be clearly defined and understood as contingency for provider failure or serious service interruption brought about by financial or business failure such as insolvency; quality failure such as major safeguarding concerns or Care Inspectorate intervention; force majeure such as fire or flood; management or workforce failure such as inability to recruit a manager; and strategic exit eg divestment or change of registration.

4.2 What providers can do to prepare

- Develop models of care that focus on the holistic wellbeing of the person and on helping the individual to achieve personal and social outcomes as opposed to simply delivering personal care tasks

- Ensure they have in place means of evaluation that show the impact of their activities in terms of the outcomes they achieve rather than in terms of the number of people for whom they provide a service or the number of hours delivered
- Ensure they have mechanisms in place to engage, and, preferably, co-produce with service users and their families
- Consider how their services are, or can be made, preventative in their focus and how they support people to be as independent as possible
- Consider how their services work within local communities and how they support the building of capacity within those communities
- Recognise that increasingly the purchasing partner will no longer be the Partnership but will be the service user or groups of service users via SDS
- Consider how their services and staff can form part of, or wrap around, the multi-disciplinary locality teams
- Explore new forms of collaborative partnerships with other providers (eg alliancing, consortia, prime providers, joint ventures)

5 STRUCTURE AND GOVERNANCE

6.1 Commissioning Board

Whilst the ultimate body responsible for approving this Plan and its intentions is the IJB, the Commissioning Board, chaired by the Head of Strategy and Transformation, will be responsible for oversight and review of the strategy on an annual basis.

The role of the Board is to

- Ensure the partnership's approach to commissioning remains fit for purpose
- Maintain oversight of commissioning activity across the partnership, especially where this involves sourcing from third parties
- Ensure the effectiveness and efficiency of commissioning across the partnership

6.2 Market facilitation steering group

The primary role of the Market Facilitation Steering Group is to represent the perspective of providers in the ongoing development and monitoring of the Partnership's market facilitation plan and activity. It comprises representatives from the partnership, the Commercial and Procurement Service, and from provider groups ACVO, CASPA and Scottish Care.

In order to fulfil this role, the group has responsibility to ensure that:

- the plan meets the needs of providers in terms of giving them meaningful information that helps them to prepare for forthcoming business opportunities
- the views of providers inform the plan
- the plan is consistent with Scottish Government requirements and with best practice
- the plan benefits from the expertise and experience of providers
- the plan is reviewed and refreshed annually.

it is envisaged that this group would continue to operate and hopefully flourish as we endeavour to deliver our shared ambitions of improved experiences and outcomes for the individuals who use our services and their families.

6.3 HOW THE PARTNERSHIP PROCURES SERVICES

Buying health and social care services is a complex area which requires particular consideration within the overall approach to the procurement of goods, works and services. This is because these services have a considerable impact on the quality of life and health of service users. As a result of this complexity, procurement and contract management of these services is undertaken by a dedicated team – the Social Care Commissioning, Procurement and Contracts Team (SCCPC). The team also supports both the Aberdeen City and Aberdeenshire's Health and Social Care Partnerships and both Councils' Children's Services with strategic commissioning activity.

As a guiding principle, the team place the procurement of services within the wider context of strategic commissioning, taking account of procurement and social work legislation and policy direction, such as human rights, personalisation and the integration of health and social care.

Within that context, compliance with the following is required:

- Procurement Reform (Scotland) Act 2014, particularly Sections 12 and 13
- The Public Contracts (Scotland) Regulations 2015, particularly Chapter 3 Section 7
- The Procurement (Scotland) Regulations 2016.
- Aberdeen City Procurement Regulations and Aberdeenshire Financial Regulations including the values and thresholds set out in these documents and the specific sections on the exceptional procedure for Health or Social Care Services
- Statutory guidance on the procurement of care and support services
- Best Practice guidance on the procurement of care and support services
- guidance given in the Procurement Journey

All Partnership contracts are tendered via Public Contracts Scotland – Tender, an online electronic service commonly known to professional buyers as an e-Sourcing platform. The Scottish Government has implemented PCS-Tender along with various partners to help Scottish public sector organisations adopt standard processes for goods, services and works for a wide variety of contracts. PCS-Tender provides a more consistent tendering experience for suppliers, enabling them to store answers to standard questions. Registration is quick and easy to carry out on-line.

6.4 HOW CONTRACTS ARE MANAGED

Contract management is about active management of the relationship between the Partnership and the provider over the life of the contract for the delivery of services to the agreed standard. There are three aspects to effective contract management, all of which must be actively managed: performance management, relationship management and contract administration.

The Contract Management Framework sets out a proportionate approach to risk to determine frequency of monitoring activity. Contracts are monitored for compliance with terms and conditions, and for quality and value for money. The Framework also describes the process to be followed in non-compliance situations. Guidance is available for Providers on our Contract Management Framework, so that they know what to expect from the process.

Three key factors for successful provider relationship management are:

- Mutual trust and understanding
- Openness and excellent communications

- Dealing with problems early

All contract information is recorded and managed using an electronic database system developed specifically for use by the team (Capita Support). The system enables a range of reports to be produced, including team performance, monitoring reports on performance of contracts to assist with strategic commissioning decisions, and data to be uploaded to the Corporate Contracts Register.

6.5 SUPPORT FOR THE MARKET

6.5.1 Principles/behaviours – what providers can expect from the Partnership

- mutual honesty and respect
- acknowledge and value the contribution that each provider makes
- openness and transparency
- consult with and inform providers about our plans for the future
- open and fair in all aspects of our procurement and tendering
- proactive in identifying and supporting potential partnership working between providers

6.5.2 Getting the basics right

- ensure information is clear, consistent and timely
- respond to queries and concerns as quickly as possible
- flexible and proportionate procurement processes appropriate to size and scale of service being commissioned
- structure payment mechanisms in a way that helps providers manage cash flow
- 'simplest by default' payment mechanisms eg might a grant/funding agreement be more appropriate in some circumstances?
- Pay providers on time and accurately
- design contract size around end need and purpose eg smaller lots relevant to service being commissioned, market and geography
- allow sufficient time for bids to be developed and submitted, partnerships/consortia to be formed etc
- longer term contracts/funding arrangements
- make sure providers know how to escalate issues and to whom
- keep providers up to date with changes in personnel /structure etc
- full cost recovery - do not expect providers to subsidise the service
- Supplier Incentive Service (SIS). When suppliers sign up to the service they will become eligible for benefits including improved cash flow through early ayment; increased process efficiency via e-invoicing, dedicated processing and query resolution; enhanced channels of communication due to an improved P2P process; enhanced client satisfaction and visibility as a SIS member within the council.

6.5.3 Encouraging innovation

- Directly fund innovation through seed or start up 'innovation' funding. Recognise that not every innovation will be successful.
- Design potential for innovation into contracts eg ensure terms and conditions are flexible enough to allow for changes in technology or service approach during the life of the contract.

- Talk to providers about what is reasonable. Increased risk for the provider means an increased risk of provider failure.
- Create space for innovation eg innovation workshops with providers
- Support the development of community micro enterprises – invest in support, provide a point of contact and effective help for local people with a good idea who are keen to set up an enterprise
- Grants/funding agreements for small voluntary/community organisations
- Facilitate access to funding eg signpost to alternative sources, assist with applications, endorse applications
- Advocacy, speaking on behalf of providers eg in discussions with Care Inspectorate, SSSC
- Rewarding/recognising engagement in contracts and in contract prices