# Aberdeen Health & Social Care Partnership

# Strategic Commissioning Implementation Plan 2018-2022

ABERDEEN CITY COUNCIL

NHS Grampian

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## Foreword

I am delighted to welcome the publication of this Strategic Commissioning Implementation Plan which sets out our commissioning priorities for the next few years. The plan also maps out, in the Market Facilitation Statement, how we intend to support our valued partners in the third and independent sectors to realise our ambitions together.

This plan supplements the partnership's Strategic Plan 2016-19 and is aligned to the Transformation Plan, both being central to our ongoing commitment to reshape significant areas of service delivery and introduce new, enhanced models of care.

The document is wholly consistent with our strategic ambitions and priorities and is integral to our aspiration to be a high-performing partnership that delivers improved experiences and outcomes for the people who use our services and their carers.

The plan should also be seen in its wider context – as one of a suite of strategic documents that we are producing to show how we will deliver good quality, person-centred services across all our areas of work. The others include a Carers Strategy, a Learning Disability Strategy, a Mental Health Strategy and our four Locality Plans. We are ensuring that there is a strong strategic coherence between all of these documents and we will co-ordinate their implementation smoothly.

The third and independent sectors are integral to our ambition to provide integrated services to the people who need them. I look forward to continuing to develop positive relationships with our many partner organisations as we seek to address common challenges and develop truly transformative supports and services that will be of value to the people who use them and their carers.

**Judith Proctor**

**Chief Officer**

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**If you require further information about any aspect of this Plan please contact:**


ACHSCPEnquiries@aberdeencity.gov.uk

Aberdeen City Health and Social Care Partnership
Community Health and Care Village
50 Frederick Street
Aberdeen
AB24 5HY

Website: https://aberdeencityhscp.scot

Twitter: https://twitter.com/HSCAberdeen

## 1.0 Executive Summary.

This Strategic Commissioning Implementation Plan reflects the many conversations we have had with valued partners and stakeholders over the past year or so about the partnership's commissioning intentions and market development activities.

Our Strategic Plan 2016-19 was published on 1st April 2016 ('Go Live' day) with the delegation of health and care functions and services to our Integration Joint Board. The ambitions that we set out to improve the health and wellbeing of the population of Aberdeen and reduce the health inequalities that we know impact poorly on people's lives were broadly well received. There has since been a continued interest in our chosen areas of focus and what we propose to do differently to deliver improved experiences and outcomes for the people who use our services.

This Strategic Commissioning Implementation Plan provides the required clarification and detail about the ongoing transformation of our health and care services and the continuing support and development of our market provision.

We recognise the value of developing effective and sustainable models of care but we also accept that most people remain healthy and active into old age without the need for services. Although health problems generally increase with age, ill health and disability should not be inevitable as we grow older. A strong aspiration of the partnership is for our personalised approach to be evident in all our activities and for individuals and their carers to truly believe that they have choice and control, as far as is reasonably practicable, over the care and treatment that is offered to them.

We are seeking a significant shift in how we commission services. We want to promote health and wellbeing and strengthen early intervention and prevention. We also want to make sure that people have access to the right treatment, care and support services when they need them, in ways which are effective, personalised and empowering. We need to enable people to be more in control of their health and wellbeing and managing any health problems they may have.

This Plan has a strong evidence base. It is important that we are able to show the difference that these intentions will make to people's lives. We accept that we will be judged on the difference that we make to the health and wellbeing of the people of Aberdeen and the effectiveness of the services that we have put in place.

The depth and resilience of the relationships that we have with our commissioned providers is important to us. Market fragility can cause uncertainty and unexpected change to the detriment of the people who are using services and those staff members who are providing them.

We strongly believe that a well-resourced and well supported market will be better placed to make a significant contribution towards the development of enhanced models of care and a more stable health and care environment.

These ambitions and activities will not be without their challenges. In the next few years it is likely that health and social care budgets will reduce in real terms while the demand for services will increase. We will need to be realistic and responsible in how we manage our resources to deliver the desired outcomes for those who use our services and their carers.

The integration of health and social care services has offered us many opportunities to reflect on what we currently do and to agree about what we could and should be doing to benefit the local population. We are very clear about the pivotal role that our communities and localities can play in shaping the health and care services of the future.

We are committed to improving the health and wellbeing of the local population, delivering quality services and becoming one of the highest performing partnerships in Scotland. This Strategic Commissioning Implementation Plan is an integral driver towards the fulfilment of these ambitions.

## 2.0 Introduction.

Following on from the publication of the Partnership's Strategic Plan[1], this Strategic Commissioning Implementation Plan seeks to outline our commissioning intentions over the next four to five years to help reshape our services in the face of anticipated demographic, financial and workforce challenges.

Our proposals have focussed on particular service areas which the partnership feels are ripe for change and development or have the potential for significant, positive impact on improving outcomes for the individuals who use our services and their families.

These areas include:

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

We recognise that our intentions will be of interest to many stakeholders including those from the independent, third and housing sectors that we presently commission particular services from or those who we may do so in the future.

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

With this in mind, a Market Facilitation Statement is incorporated into this plan. This offers additional information that will hopefully be of value by helping to enhance awareness and understanding of our local health and social care marketplace. We hope to sustain relationships and align our respective organisational aims and ambitions going forward.

### 2.1 Vision, values and priorities

Given the diversity and complexity of the partnership's delegated functions and the interdependency with its partner organisations (ACC and NHSG), it is crucial that all our developments and activities are strategically coherent and co-ordinated and that there is a strong, clear alignment with our vision, values and priorities.

Our Strategic Plan outlined our vision as a partnership and our defining purpose by stating explicitly that we are:

**"A caring partnership working together with our city communities, to enable people to achieve fulfilling, healthier lives and wellbeing".**

Our values are the pillars that shape our identity and help explain why we do the things we do; they underpin all our intentions and should be evident in all our activities. They are:

- caring
- person-centred
- enabling

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.

Our vision, values and priorities will be expressed in each and every one of our strategic policies or plans and we will seek to evidence these in all of our current activities and future developments.

## 2.2 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:

"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 will work towards embedding 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

We are very aware that an individual's needs may and will vary over the course of time and so we will not adopt a uniform, one-size-fits-all commissioning approach but instead strive to be sensitive to age, wellbeing and complexity of need.

## 2.3 Strategic coherence.

There is currently an ambitious and wide-ranging legislation and policy agenda for the provision of health and social care that varies from the choice and control we can

[2]Scottish Government, Health and Social Care Integration: Strategic Commissioning Plans Guidance 2015

[3] Strategic Commissioning Steering Group, Joint Strategic Commissioning: a definition, 2012

exercise at an individual level[4] through a broader population health and inequality perspective to the development and implementation of stronger collaborative approaches to strategic commissioning and service delivery.

A key emphasis of our reform and transformation is the anticipated positive impact on individual experiences and outcomes. Through an appropriate and consistent focus on prevention and early intervention alongside an integral enablement approach, we will seek to support individuals to self-manage their health and wellbeing and independence as much as is possible.

Supporting our unpaid carers is a key thread that runs through all of our developmental and operational activities. We will publish our Carers Strategy early spring 2018 showing how we will fulfil the requirements of the Carers (Scotland) Act 2016[5] (Adult Carers Support Plans/Young Carers Statements, Information and Advice services, Short Breaks statement) and our wider ambitions to support carers to have a meaningful life alongside that caring role if they so choose.

It is difficult to say with certainty how many unpaid carers there are but they are an integral element of our wider workforce which works across the health, social care, third, independent and housing sectors. It is our intention to support and develop a skilled and valued workforce that makes a significant contribution to the wellbeing of others so that individuals are able to live longer, healthier lives at home, or in a homely setting.

Delivering a seamless experience to those who use our health and care services will require us to be as strategically coherent and co-ordinated in practice as possible. This will require the involvement of many different partner organisations and stakeholders as we wish to say with confidence that we have co-designed and co-produced the solutions to the challenges that we face now and that we will face in the future.

### 2.4 Our localities.

In line with the requirements of the Public Bodies (Joint Working) (Scotland) Act 2014[6] we have identified four localities (North, South, West, Central), roughly aligned with the existing four GP cluster areas.

We have said from the outset that the purpose of creating localities is not to draw lines on a map and run the risk of creating a postcode lottery in respect of service delivery but instead to provide an organisational mechanism for local leadership of service planning, to be fed upwards into our strategic commissioning intentions and activities.

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[4] Social Care (Self-Directed Support)(Scotland) Act 2013

[5] http://www.legislation.gov.uk/asp/2016/9/contents/enacted
[6] http://www.legislation.gov.uk/asp/2014/9/contents/enacted

The respective Locality Leadership Groups are all up and running and have a pivotal role in bringing together individuals and organisations to discuss the needs of the local population(s) and how these might be best served.

The Locality Plans will reflect the overarching ambition and direction previously detailed in the Strategic Plan and in addition show where they hope to develop other activities and supports that will minimise the isolation and loneliness experienced by a great many individuals, strengthen community bonds and improve the health and wellbeing of the local population.

All of our Locality Managers are now in post and we are progressing with our plans to develop locality based multi-disciplinary teams that will engage with the third and independent sectors to support vibrant community activities and seamless person-centred care across our areas of work.

### 2.6 Quality

The quality of the services that we commission and what this means for the personal experiences and outcomes of the individuals who use our services and their carers is very important to us.

It is important for the partnership to know and understand how well it is doing in relation to the nine national health and wellbeing outcomes but it is also crucial that we know and understand what positive difference we are making to people's health and wellbeing and their experiences of the services that we provide.

Our ambition is to be recognised as a high performing partnership and for that to happen, all our services across the health, social care, third and independent sectors must aspire to deliver effective, good quality services themselves.

Our own improvement activities and quality assurance processes as well as positive, supportive relationships with the Care Inspectorate, Health Improvement Scotland and other regulatory bodies will all help us to deliver safe, responsive and effective activities and services.

## 3.0 Our commissioning intentions.

### 3.1 Key intentions.

Consistent with our understanding and analysis of the existing provision and the outcomes we wish to achieve, we intend to shift the balance of care to enhanced, community based models. This will require us to reshape our overall provision across many different areas but our initial areas of focus will be as outlined in figure 3.1 below.

In doing this we continue with our ambition to encourage individuals to take increased control over their support by considering and using the options of Self-Directed Support. Reshaping our overall provision increases real opportunity for individuals to have an increased suite of options of which they can purchase or direct.

**Table 3.1 Commissioning Intentions**

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|---|
| **3.2 Care at Home – support provided in a person's own home and may include personal care.** |
| **3.3 Re-ablement model – this is a model that aims to increase confidence and ability of the individual to be able to undertake task independently again.** |
| **3.4 Residential care for older people and people with physical disabilities.**<br>• Standard care home provision for older adults and others with a range of conditions that are appropriately met within that form of setting.<br>• Advanced Dementia Care in a Care Home Setting.<br>• Care Home services for individuals with very complex physical presentations<br>• Brain Injury Care Home Provision.<br>• Palliative and End of life Care |
| **3.5 Residential care for people with a learning disability**<br>• Standard Care Home provision for Learning Disability clients (under 65)<br>• Learning Disability Specific Nursing Care Home Provision<br>• "Core and Cluster" 24/7 staffed service for individuals with particularly challenging behaviour.<br>• Intensive short-medium term residential provision. |
| **3.6 Residential care for people with mental health needs**<br>• Standard Care Home provision for Mental Health clients (under 65)<br>• Rehabilitation Residential Service<br>• Longer Stay Mental Health Residential Home provision<br>• Short Stay/Break Residential Service |
| **3.7 Intermediate care**<br>• Locality based Intermediate Care<br>• Centralised Comprehensive Intermediate Care – Care Home Model:<br>• Centralised comprehensive intermediate care for both 'step up' and 'step down' – via a ''housing' type model: |
| **3.8 Out of Hours & Responder Capability** |
| **3.9 Joint Equipment Service.** |

As we develop these services we will be mindful of people's likely experience of using them and how these relate to other health and care services that might require to be accessed.

Developing effective services and supports that will promote improved health and wellbeing and provide flexible and responsive care through periods of transition or times of crisis will be of significant value in preventing unscheduled admission to hospital and minimising discharge delays.

This will require a change in the way resources are deployed and in what services are developed and commissioned.

### 3.2 Care at home

Good and effective care at home helps people with eligible care needs to live in their own home when they might otherwise likely require residential care. It should support people with care needs to live independently in the community and to maintain greater independence for longer.

It also acts as a key support, in conjunction with other health and care services in supporting people where there needs change and in recognising when more intensive support or other forms of care might be appropriate. A key ambition is that we are able, in Aberdeen, to have care at home services as part of the wider team approach we are developing and be able to adapt it to people's changing needs. In doing so, we will have a positive impact on preventing unnecessary admissions to hospital and helping people home earlier after a period of hospital treatment.

An interim procurement of care at home services for older people and adults with physical disabilities and/or learning disabilities will be completed before the end of 2017/18 This will address some operating challenges experienced by providers pending a more thorough reshaping of our provision.

#### 3.2.1 What will we commission?

We are going to develop a locality based, outcomes focused care at home model that will be more responsive to the needs and circumstances of the individuals who receive this service and provide positive opportunities for providers who will have greater flexibility to decide how best to meet needs and fulfil outcomes.

Our care at home framework will continue to be city wide to ensure that there is equitable access and consistency of quality however within that we will be looking at ways in which we can be pragmatic and flexible about our delivery of service across the different localities. We will need a range of providers, some of them specialist to work across different client groups and complexity of need.

We will encourage 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. This approach will move away from "time and task" to a less prescriptive way of working that offers individuals greater choice in the way in which their allocated hours of care are used.

This approach will benefit from our INCA ("Buurtzorg") learning of how self-organising, integrated health and care teams can best provide seamless care by adopting a 'what needs to be done' approach rather than constant referral on or signposting elsewhere.

We also recognise the value of trusting our providers and offering them greater choice and control over the way that care is administered and delivered so that the fundamental agreement is between them and the individuals who are receiving the service. We envisage that this approach will result in packages of care that can flex easily to accommodate variations in demand and/or emergencies.

We will also examine our funding models to determine how we can best support the sustainability of our care at home provision and at the same time incentivise providers to be more responsive to our unmet need challenges and complex referrals.

We wish to develop 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 sector, faith organisations and ourselves as caring and compassionate citizens and neighbours to counter the detrimental effects of isolation and loneliness.

We will develop our care at home model in the two year time period 2018-2020 in time for the next procurement of this provision.

### 3.3 Reablement Model

Allied to our emerging care at home approach will be the development of a Reablement service to support individuals to learn or relearn skills necessary for daily living.

Reablement encourages individuals to develop the confidence and skills to carry out daily living activities such as personal care, and other practical tasks themselves so that they can continue to live at home. It tends to be provided to those individuals who have just been discharged from hospital or who are experiencing a change in their circumstances and needs.

'Reablement' is 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.

#### 3.3.1 What will we commission?

Our intention is to develop a time limited reablement programme (up to six weeks) that would essentially form an integral element of the care at home pathway with a view to enabling more people to remain safely at home.

The aims of this would be to assess an individual's functional ability within their own home or a homely setting. The programme will work with the individual and their

carers, and other staff where appropriate to maximise their independence with activities of daily living, and determining any on-going care at home requirements.

Other elements will include:

- Single access and referral point.
- Aligned staff comprising care management/coordinators, occupational therapists and support 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 connections – facilitating links to community/ third sector and other informal supports to counter isolation and loneliness.
- 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.

It is anticipated that having participated in the support that this service offers, two exit options will be available for individuals.

1 Where there are no on-going social care needs and the individual returns to pre-enablement level of functioning, signposting to informal community supports will be offered to maintain that functional status.

2 Alternatively, where there is a continued need for care at home support, the appropriate levels will be determined and arrangements put in place with the care provider. Integral to this process will be a smooth handover/ transition from the reablement service to the provider(s).

For both exit routes, communication with appropriate colleagues from primary and community care services will be a routine part of the discharge process.

The developmental timeline for this programme will mirror that of the care at home model above, 2018-2020.

### 3.4 Residential care for older people and people with physical disabilities.

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 suggested a growing older population coupled at the same time 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, our Older Adult and Physical Disability residential services will focus on supporting those individuals with a greater complexity of need and will continue to be a significant element of our wider service provision.

### 3.4.1 What will we commission?

Given that the partnership has set a clear strategic direction in 'shifting the balance of care' there is no envisaged increase in the overall volumes of standard care home places procured over the next four year period.

The partnership will instead, manage demand within the existing volume of beds, with a greater diversion of individuals to other available options such as reablement, care at home, intermediate care and the Acute Care at Home Service which will be available in the earlier part of 2018 .

In supporting our current provision, we are mindful of business sensitivity around occupancy rates but conscious that we need a level of capacity within the care home system to support client/patient 'flow' and appropriate management of any business continuity risks.

The continued development of our 'bed based' resource will include the following:

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

We will continue to require relatively large volumes of standard care home places which are equipped to manage the increasing complexity of needs/demands relating to older adult care and younger adults with physical disabilities.

The development of our locality model will offer our providers opportunities to link into a wider range of local resources and activities that may benefit the individuals that they care for. We are also keen to explore different intergenerational models and activities that may be appropriately and safely introduced.

We are open to discussions about the current residential care/nursing care distinction and its continuing relevance given the increasing complexity of individuals who are being cared for in all of these establishments. It may be that one categorisation with the consistent use of dependency tools to determine safe staffing levels is an option worth pursuing given the broad similarities that currently exist. We recognise that further discussions in respect of this development would involve our regulatory partners from the Care Inspectorate and the SSSC.

We have yet to determine what percentage of this standard provision should, if any, be block booked/funded. We are mindful that perhaps a better balance needs to be struck between the flexibility that comes with spot purchasing beds and the continuity and stability that block funding arrangements offers our providers. Whatever the

basis of the contracting, it will be done around a specification that is outcome based and consistent with the principles of personalisation.

**B) Advanced Dementia Care in a Care Home Setting:**

We envisage needing 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.

The increase in dementia prevalence (number of people, aged 65+ with dementia is projected to increase by 13% by 2022)[7] over the coming years leads us to believe that we will need to at least match our existing Elderly Mentally Infirm (EMI) bed base with the new type of service.

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

A key commissioning intention over the next five years will also be to trial different models of dementia care from the current 'care home' structures /staffing /delivery. This will be an opportunity for the partnership to look at national and international developments such as Hogeway Dementia Village[8] and Butterfly[9] models with a view to appraising their suitability for our purposes.

**C) Care Home services for individuals with very complex physical presentations**

We would wish to develop 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.

We would envisage funding of such residential services to be a mix between both block funding of some resource and 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.

It is hoped that the combination of placing 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.

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

[8] https://hogeweyk.dementiavillage.com/en/

[9] http://www.dementiacarematters.com/carehomedevelopment.html

**D) Acquired Brain Injury Care Home Provision.**

We envisage a small volume of care home beds to support individuals with brain injuries and other neurological conditions particularly those for whom more general services have already proven unable to meet their needs.

We are aware of the extent of current out of area placements for those with specialised brain injury residential provision and known unmet need within the City. 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. We envisage that there will be still be sufficient numbers remaining for us to develop our provision further.

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 recognise that individuals with an acquired brain Injury have differing complexities and needs from those with alcohol related brain damage and would therefore wish to develop a more detailed options appraisal in regards to the configuration of any new service(s).

**E) Palliative and End of Life Care.**

Commissioning appropriate care and support arrangements for individuals with palliative and end of life care needs are in order to response to changes in their wellbeing or circumstances, typically at times of crisis.

It can be the case that in the absence of other available options, individuals are admitted to hospital at the end of their life, although this may not be their or their carers chosen place to die.

We will give further thought to the development of a suite of palliative and end of life options that have appropriate levels of trained staff and other resources to continue to be able to provide person centred care and support at this critical time. We will explore the possibility of these arrangements being available across each of our localities.

The complexities of all of these different establishment based models are such that we envisage the life span of this Implementation plan 2018-2022 being needed to support our providers and reshape our provision to support our aspirations set out on our Strategic and Transformation Plans.

### 3.4 Residential care for people with a learning disability (LD)

The current discussion about the provision and purpose of residential services for individuals with learning disabilities must be seen within the wider context of national legislation and policy.

The Mental Health (Care and Treatment) (Scotland) Act 2003[10] puts a legal duty on local authorities to ensure provision of appropriate care and support services. The Keys to Life (2013)[11] is the current 10 year National Learning Disability Strategy which states that residential models of care should be viewed as a relatively small but very important element of overall provision primarily for the most complex individuals with the greatest need within a wider portfolio of supports and services.

Locally, there has already been a significant drive to rebalance our LD provision by shifting resources away from a predominance of residential care settings to supported living arrangements where individuals receive housing support or care at home services. This was part of wider efforts to support individuals who have a LD to have greater opportunity to become more active and be seen as valued members within their communities across the city.

The partnership is currently in the early stages of developing a Learning Disability Strategy. This will be published in 2018/19 and its particular ambitions, priorities and developmental activities will dovetail with the commissioning principles and intentions set out in this plan.

#### 3.4.1 What will we commission?

The projected demographics for LD individuals suggest a future need for residential accommodation for those individuals that have significant needs, both in regards to their LD and other aspects of their of support, e.g. health, physical disability, communication and behaviour.

The residential models described in this section forms part of a much wider continuum of health and social care services that are intrinsically interrelated. We wish to develop our LD provision along the lines of the 'right support in the right place at the right time' that is, as their needs change, individuals can access different models of care in different services.

#### A) Care Home provision for Learning Disability clients (under 65)

Some adults with a Learning Disability will have care and support needs that relate to their physical health or increasing frailty/dementia with age. These individuals benefit not from specialist LD specific services but from the expertise and care in standard care home or EMI provision.

[10] http://www.legislation.gov.uk/asp/2003/13/contents
[11] http://www.gov.scot/resource/0042/00424389.pdf

The intention will be to negotiate on a partnership wide basis with our residential and nursing care home providers to ensure that they are able to register with the regulator to deliver services to such individuals. We recognise that this may necessitate support from the partnership to engage with the regulator as a Body Corporate. Thereafter, these beds would be accessed from within the general care home estate governed by the National Care Home Contract. Beds would likely be purchased on a spot purchase basis.

**B) Learning Disability Specific Nursing Care Home Provision**

There is a need for a small volume of Nursing Care Home provision that focuses specifically on, and is configured for, the specialist needs of individuals with LD who also have other health/disability presentations.

This service is not restricted to any one age group as it is the complexity of need and disability which is the defining referral criteria for this model of care.

We would like to explore different staffing models for these services. Staffing levels could, for example, be nurse led with a mixed nursing/social care staff team depending on the needs and dependencies of the individuals receiving the care and support.

It is envisaged that this model would be specifically commissioned in small units (4-6 individuals) from the third and independent sectors with funding likely to be on a block contract basis.

Further discussions with other stakeholders in respect of possible accommodation options for this model of care will be necessary in advance of any other dialogue and development.

**C) "Core and Cluster" 24/7 staffed service for individuals whose behaviour can challenge services.**

This service will deliver care and support to people with complex care and behavioural management needs over a close geographical area, with some individuals residing in the 'core' resource and others in the surrounding area.

This model of care is not new but we envisage further developments along these lines given the advantages of single occupancy, available peer support and accessible staff support offered in a community setting.

Services would need to be small in design to support individually delivered care and support, and yet support enough individuals within the wider service to give a staff team of sufficient size to deliver the required flexibility and continuity of support.

The availability of suitable accommodation in suitable areas is a significant consideration for the size and location of these services and their developmental timeline(s).

We would envisage that we would work with our third and independent sector partners to stimulate such services.

**D) Intensive short-medium term residential provision.**

This model of care will provide intermediate support to those individuals with the most complex and highest level needs/behaviours who are either in a crisis situation or transition.

More specifically, we envisage that such a resource will be helpful to those individuals who are experiencing deterioration in their health, wellbeing and behaviours and whose current support(s) are unable at this time to continue to meet their needs. It may also include those individuals who have recently been in hospital and this service is part of their 'step down' to other accommodation and support models.

The inherent advantages offered by such a service are primarily because it offers intensive support for a time limited period, the exact length of which will vary for different individuals. It is not a long stay solution to accommodation or provider issues.

We envisage that this service will be relatively small but with a high staff/individual ratio. Its specialised nature would necessitate that it be delivered by providers with long standing experience, knowledge, and proven capability in supporting individuals through such periods of heighten need. In addition, sourcing safe and appropriate accommodation will be a key factor in the development and implementation of this model of care.

We envisage that these service models that will support individuals with a LD will require the time period 2018-2022 to be fully developed and implemented.

### 3.5 Residential care for people with mental health needs

The current thinking 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[12] 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.

[12] http://www.legislation.gov.uk/asp/2003/13/contents

The new national strategy for mental health (Mental Health in Scotland - a 10 year vision) was published in 2017 and has a focus on early intervention, self-management and improving both access and efficiency of mental health services. There is also a local Strategy (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 individuals who experience mental illness.

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 who experience mental illness to have greater opportunity to become 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.

### 3.5.1 What will we commission?

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

It is important that these services are easily accessible and responsive to individual needs and that they genuinely deliver person centred and recovery focused provision to maximise improved outcomes.

**A) Standard Care Home provision for Individuals with Mental Health needs (under 65 years)**

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 deliver services to these individuals assessed as needing this type of support.

### B) Rehabilitation Residential Service

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

It is envisaged that this service would primarily be met through procuring the services of specialist providers within the third and independent sectors. It is likely that this service would be 'block funded' to support market stability and allow greater control in regards to placement flow.

### C) Longer Stay Mental Health Residential Home provision

Longer Stay Mental Health Residential Home provision which primarily focuses on meeting ongoing complex mental health needs with the intention that a proportion of individuals 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 third and independent sectors with block funding arrangements.

### D) Short Stay/Break Residential Service

This service will offer Short Stay/Break residential type care support for individuals who are either in crisis or requiring planned support at a residential level for a relatively brief period.

It is likely that such a service would be block funded to ensure the sustainability of the provision and the availability of this resource as and when it is required by individuals.

These models of care will be developed and implemented in a similar timescale to those of the other client group residential models, 2018-2022.

### 3.6 Intermediate care

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

The primary client group to whom the partnership will be directing its bed based intermediate care resources will be older adults, although we envisage that younger adults with complex physical and neurological conditions would also benefit from the development of such models and services.

If the partnership wishes to achieve a reduction in hospital admissions and 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.

### 3.6.1 What will we commission?

"Maximising Recovery, Promoting Independence: An Intermediate Care Framework for Scotland"[13] identifies 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.

Similarly, there may also be some potential for block funding/booking a small cohort of standard care home beds to expedite discharge from hospital following on from the initial success of our interim beds however this taken forward as part of our will be evaluated in conjunction with developments in the partnership's intermediate care bed base.

**A) Locality Based Intermediate Care:**

It is envisaged that this service would primarily be met through linking in with the local third 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 individuals assessed as requiring this type of support. It is likely that this would be under the auspices of the National Care Home Contract as the needs of those individuals needing this support 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.

**B) 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 partnership directly, or a third/independent sector provider – however any potential provider would have to evidence significant robustness of service delivery given the critical nature of this model to partnership priorities.

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

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

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 partnership directly, or a third/independent sector provider – however any potential 'non-statutory' provider would have to evidence significant robustness of service delivery given the critical nature of this model to partnership priorities.

This provision will be developed over the two year period 2018-2020.

### 3.7 Out of Hours & Responder Capability

The purpose of out of hours (OoH) and community response services is to provide both scheduled and unscheduled 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 and support during unsocial hours and through the night. This involves caring for individuals who may be seriously unwell, often working in isolation from colleagues.

Some of the matters that OoH services can typically be required to respond to include:

- Medication management; 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; individuals present with a requirement for equipment due to a deterioration of their health and wellbeing or with equipment that is not functioning properly thereby posing potential risk to the individual and others.
- Acute ill health; individuals present with acute episodes of ill health or significant exacerbations of existing conditions either of which may be predictable or unpredictable.
- Palliative care; an exacerbation of condition(s) resulting in a deterioration in health and wellbeing or responding to the needs of carers and other family members who may feel unable or unsupported to deal with the developing circumstances.
- The frail elderly; may require support due to falls, confusion, deterioration of co morbidities, or UTI's.
- Mental health; interventions may be required to deal with distressed individuals who are needing additional supports until such time as other scheduled services are available for them to access.

Given the range and complexity of existing Out of Hours services it can be difficult for individuals, their carers and some staff from the many different organisations who are working in the evenings, nights and weekends to know what service best meets their immediate needs and how to access it.

Our ambition to deliver improved experiences and outcomes should apply across all of our scheduled and unscheduled activities and interventions. Providing an effective out of hours service that co-ordinates our responses to different individuals in different circumstances and communicates with other professionals, services and agencies as appropriate will be hugely valued by those individuals and their carers.

This will sit alongside planning already underway in relation to Acute Care at Home and End of Life Care.

### 3.7.1 What will we commission?

The Scottish Government's Review of Primary Care Out of Hours Services[14] recommends that partnerships should look for opportunities for integrated OoH service provision with clearly understood and delivered care pathways.

We recognise that there is a need to have a more integrated blended approach where services can work together to maintain the individual, where possible, in their own home or homely environment until other services can assist the next day.

We will seek to develop 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.

We will co-ordinate our responses to reduce the number of services who become involved by "default" so that our interventions are always by the appropriate professionals and agencies that can be of greatest value to the individuals who need our support.

We will develop a multi-disciplinary resource that has the capacity to respond to different situations some of which will be resolved shortly after intervening and some which will have a longer, more involved duration.

Development of this service will be undertaken during the period 2018-2021.

### 3.8 Joint Equipment Service.

The provision of required aids, adaptations and other OT equipment is currently managed and distributed separately by two different organisations depending on whether there is an assessed social care or health need for the equipment or aids.

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

These resources have developed separately from different origins and have different process strengths in terms of ease of ordering, timely delivery, stock control and equipment recall.

Increasingly, individuals with a complexity of needs require a combination of equipment and it is perhaps not as straightforward as it might be for them, their carers and other colleagues to navigate their way around the current service delivery models. This can lead to a less than seamless experience of health and social care services working together.

### 3.8.1 What will we commission?

The partnership intends to develop a single, integrated equipment service maximising available technology to enable individuals to live and function as independently as possible in their home or homely environment.

It is envisaged that this would be a 7 day, timely and responsive service from prescription through to delivery and installation with the anticipated benefit of releasing time and resource to care.

Some of the other expected benefits from developing such a service include;

- Unified stock – resulting in savings around procurement
- Improved procurement across all areas allowing improved value and standardisation of equipment.
- Reduced waiting times – better outcomes for individuals
- One unified IT system – resulting in a high standard of stock control.
- Direct access to equipment from a wider group of community based assessing staff
- Clear accountability for the repair, servicing and maintenance of all equipment.

We are open to the possibility that this service serves not just the city, but is developed on a pan Grampian basis to ensure a consistency of response and provision across the regions geography and population.

Development of this new service would be undertaken in 2018-2020.

## 4.0 Our Transformation Plan.

Whilst the Strategic Plan sets direction the Transformation and Change Plan describes the activities we will engage in to create sustainable health and social care

provision across Aberdeen City. The Transformation and Change Plan should be read in conjunction with this document as it clearly articulates how we have reached the decisions on our 6 ‘big ticket’ items.

Strategic commissioning is one of the partnership’s six ‘big ticket’ items that were approved by the IJB last year. The others were:

- acute care at home
- supporting self-management of long term conditions – building community capacity
- modernising primary and community care
- Transformation – supporting infrastructure
- IT, infrastructure and data sharing

Within these areas, a significant volume of transformational activity is being led and supported by colleagues to test new ideas and support sustainable change. There is a strong coherence between these activities and our overarching strategic narrative outlined in our Strategic Plan, the Transformation Plan and this Commissioning Implementation Plan.

Appendix 2 shows the current investment allocated to the six big ticket items listed above to date.

## 5.0 Evaluating impact.

The theme of improved personal experiences and outcomes for the individuals who use our services and their families runs through this plan however we would wish to say more about the particular benefits that will follow on from the implementation of our intentions.

For each project we have highlighted the expected benefits and impact, within the Transformation and Change Plan. Further work is being carried out to identify the necessary metrics that will help us fully evaluate the impact of these projects.

## 6.0 Next steps.

To fulfil the commissioning intentions outlined in this plan and to continue to dove tail this in entirety with our Transformation and Change Plan, we will establish a number of work streams that will develop more detailed specifications including project milestones and timelines and oversee their implementation. The Head of Strategy and Transformation will have overall responsibility to ensure this work is actioned and proper governance is followed.

| What Will We Commission? | When Will This Be Delivered? |
|---|---|
| Care at Home | 2018-2020 |
| Reablement | 2018-2020 |
| Residential Care for older People/Physical Disabilities | 2018-2022 |
| Residential Care for Learning Disabilities | 2018-2022 |
| Residential Care for Mental Health | 2018-2022 |
| Intermediate care | 2018-2020 |
| Out of Hours/Responder service. | 2018-2021 |
| Joint Equipment Store | 2018-2020 |

**Table 6.1 Commissioning Implementation Plan**

The financial resources that are to be aligned with these activities will also have to be worked through and agreed. In some areas, this will require exit strategies from how we currently commission particular models to be developed so that the monies can be realigned to our desirable future models. It may also be possible that accessing available transformation funding is appropriate for some aspects of this programme of activity.

Reports on our progress in respect of these developmental activities will be in the first instance to the Strategic Commissioning Board and from there to the Chief Officer and IJB as appropriate.

## 7.0. Market Facilitation Statement.

### 7.1 Introduction.

Our ethos to working in partnership with other stakeholders has been consistent from our integration 'Go Live' in that we believe that working closely across the health, social care, third, independent and housing sectors will help us realise our vision more fully and achieve all of our strategic ambitions and priorities in a coherent and co-ordinated timeline.

We are very aware that improving the personal experiences and outcomes of the individuals who use our services and their carers will require many varied contributions from many different individuals and organisations.

We are committed to developing and sustaining positive relationships across the third, independent and housing sectors and working together to develop and provide the high quality services that are wanted and needed by our citizens.

### 7.2 Why do we need a market facilitation statement?

This document is aimed at existing and potential providers of adult health and social care services and hopes to build on the work already done through the development and publication of our Strategic Plan 2016-19.

There is a rich diversity of organisations in Aberdeen committed to improving the lives of its citizens through better health and wellbeing, better relationships and/or better opportunities. Working in the health and social care sector provides great opportunities for personal and professional development but we recognise that there are different financial challenges that impact on the workforce and the wider sectors.

We wish to continue our dialogue with the individuals who use our services, their carers, providers and other stakeholders about the vision of the future of local health and social care markets in Aberdeen City, and how we can all work in partnership to develop a market that delivers improved experiences and outcomes for the citizens of our city who use our services now or who will do so in the future.

### 7.3 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 to enable us to understand the local market structure, key players, 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 we intend to influence the market through 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 we will make to deliver the required market structure, capacity and capability necessary to achieve desired outcomes.

The collection and analysis of data and the publication of a market facilitation 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 its practice in all three elements.

### 7.4 Current commissioned provision.

Most of our current provision is procured externally from many different partner organisations across the following areas

- Residential
- Care at Home
- Housing Support and Supported Living
- Employability/Training and Skills Development
- Day Care
- Advice, Advocacy, Counselling and Support
- Carer Support
- Substance Misuse
- Sensory Impairment

The majority of these contracts were established before integration 'Go Live'. All of our future commissioning will reflect the partnership's ambitions and priorities and at the same time, hopefully be sufficiently robust enough to withstand changing market circumstances.

### 7.5 Expectations and opportunities.

#### 7.5.1 Our ideal marketplace

We want our relationships with each and every organisation, agency or association to be characterised by the values of:

- ✓ Respect
- ✓ Trust
- ✓ Collaboration
- ✓ Transparency

We wish to develop a diverse, active, and sustainable market that is able to support individuals in their ability to manage their own long term health needs, and to enjoy living as independently as possible for as long as possible in their own homes. Our commissioned services will offer individuals 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.

To safeguard our commissioned service delivery from any future market upheaval we will commission a “service of last resort” 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 will 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 e.g. divestment or change of registration.

#### 7.5.2 What principles and behaviours can providers expect from the Partnership?

We have bold and ambitious plans to transform how we deliver our integrated health and social care services and are very mindful that positive relationships with our providers will be a necessary condition of our future successes together.

Our evident principles and behaviours will include

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

Should any provider believe that for some reason, the Partnership has fallen short of these standards that it has set itself then we would welcome a conversation about those circumstances and a dialogue about how we can best ensure that our practice always matches our rhetoric.

### 7.5.3 Our expectations of providers.

The providers we want to work with are those who want to help us realise the ambitions and priorities outlined in our Strategic Plan.

These providers:

- ✓ are committed to an enablement approach that is focussed on keeping individuals well, promoting independence and preventing the need for higher level care.
- ✓ 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.

We are keen to have meetings with different representatives from different organisations so they can tell us of the positive impacts they are having on the individuals who access their services and their own organisational development plans.

### 7.5.4 What providers can do to prepare

There are a number of different ways in which providers can begin to reshape their activities and priorities in order to align themselves with the partnership's own ambitions and priorities and future commissioning intentions.

The improved health and wellbeing of the individuals who use their services is of paramount importance.

- ✓ Develop models of care that focus on the holistic wellbeing of the person and on helping the individual to achieve personal and social outcomes.
- ✓ Consider how their services are, or can be made, preventative in their focus and how they support people to be as independent as possible

Providers are well placed to develop positive meaningful relationships with the individuals who use their services, their families and the communities in which they operate.

- ✓ Ensure they have mechanisms in place to engage, and, preferably, co-produce with service users and their families
- ✓ Consider how their services work within local communities and how they support the building of capacity within those communities
- ✓ Consider how their services and staff can form part of, or wrap around, the multi-disciplinary locality teams

The quality and effectiveness of the partnership's activities is based on the quality and effectiveness of individual services and organisations.

- ✓ 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

Collaboration and co-production across all activities is expected as a standard, not optional behaviour.

- ✓ Recognise that increasingly the purchasing partner will no longer be the Partnership but will be the service user or groups of service users via Self Directed Support
- ✓ Explore new forms of collaborative partnerships with other providers.

The Partnership is always keen to meet with different providers to discuss their ongoing development and what organisational supports can be put in place to facilitate this.

### 7.5.5 Getting the basics right

We are very aware that in order to create and support a more resilient environment where high quality of care is delivered and innovation flourishes we need to ensure firstly that we have got the basics right.

Better communication across all sectors and services is an essential element of a partnership that wants to improve its behaviours and activities. The need for timely and effective exchange of assessments and other up to date information becomes more crucial at times of transition or crisis.

We also recognise that what providers want is clear and unambiguous information about our expectations and future intentions. We will seek to keep providers up to date with significant changes in our organisational structure and workforce so that they know who to contact and how to escalate issues. We will then seek to respond to all queries and concerns as quickly as possible.

The prompt and accurate payment of invoices will always help ease any financial concerns that organisations may have. Delays can be frustrating especially when providers have already put in place the required levels of care and support for individuals.

Where spot purchasing is the agreed funding arrangement it would be beneficial for all partners if the parameters and criteria for agreeing any variation from the 'flat fee' were more widely known and understood especially if commissioning for complexity is going to become commonplace.

Consistent dialogue and support from all health and social care professionals to the providers will ultimately always be of value to the individuals who are receiving services. Increased interventions at times of transition or crisis and regular participation in other planned activities such as reviews are recognised as contributing to positive relationships and improved outcomes.

An integral element of all of our commissioning will be the involvement of providers to help frame our future solutions based on what we know is currently working and what are the challenges that are being experienced. We will use this intelligence to inform our procurement processes which will be flexible and proportionate to the scale and significance of the service(s) being commissioned.

We will design contract size around end need and purpose e.g. relevant to service being commissioned, the local market and its geography.

We will be consistent in our decisions regarding contract lengths recognising that longer contracts support greater stability in the marketplace but that shorter contracts can also be of value as an interim measure pending other discussions and decisions.

Similarly, we recognise the respective merits of block funding and spot purchase arrangements and will put in place appropriate funding mechanisms for each particular procurement exercise. We will operate on the principle of full cost recovery; we do not expect providers to subsidise the service that is being commissioned by the partnership.

### 7.5.6 Encouraging innovation

Innovation has been a key building block of our Transformation programme and we are keen to continue this exciting journey of exploration and discovery. We want to be recognised as a high performing partnership that supports innovation across all sectors to deliver improved experiences and outcomes.

Some of the things we may do to support greater innovation include:

- ✓ Directly fund innovation through seed or start-up funding; recognise that not every innovation will be successful.
- ✓ Design potential for innovation into contracts. 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.
- ✓ 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 other funding; signpost to alternative sources, assist with applications, endorse applications.
- ✓ Advocacy; speak on behalf of providers in discussions with Care Inspectorate, SSSC etc.

Contact us to discuss these and other ways of supporting your ambitions and innovations.

### 7.6 Participation and Engagement.

We recognise that creative, flexible and sustained participation and engagement across our localities and service delivery areas are essential elements in understanding the concerns and priorities of our citizens and communicating our ambitions and intentions.

The partnership, in association with other community planning partners has developed an Empowerment, Engagement and Participation strategy but we recognise that we need to be more consistent in how we engage with our stakeholders and maintain a meaningful dialogue with them.

We would welcome further comment and dialogue of where and how we could improve our approach to engagement and participation at an individual and broader organisational level.

### 7.6.1 Market Facilitation Steering Group.

The Market Facilitation Steering Group comprises representatives from the Partnership's Strategy and Transformation team, the Commissioning, Procurement & Contracts (Social Care) team, ACVO, CASPA (Care and Support Providers Aberdeen) and Scottish Care.

The group meets every two months and its primary role is to support the ongoing facilitation of our local health and social care market by asking the questions 'what is needed' and 'what will work'.

Sharing of information and developmental opportunities is recognised as being an important factor in strengthening the resilience and stability of individual organisations and the wider third and independent sectors. The group will also enable a strong providers' perspective to inform and influence proposed activities related to the roll out of this statement.

The credibility of this statement relies on the contribution of providers. The ongoing review and refresh must reflect their expertise and experiences.

### 7.6.2 Provider Forums.

These forums are an invaluable resource for strengthening our relationships with providers and facilitating discussions about the current challenges that the sectors are experiencing and the latest partnership developments that are to be communicated to a wider audience.

ACVO facilitates CASPA (Care And Support Providers Aberdeen) meetings and Scottish Care facilitates a Care Home forum and a Care at Home forum.

The partnership is committed to consistent attendance and active participation in these forums.

### 7.6.3 Locality Leadership Groups.

We have established Leadership Groups in our four localities to connect our operational service delivery with our communities and provide opportunities for the area's residents and other stakeholders to discuss and agree their respective challenges and priorities.

The membership of these groups reflects the diversity of the partnership's activities across the city. They have overseen the development of profiles showing the health and wellbeing of the local population, the evident health inequalities and the assets available for communities to use to their advantage. These profiles will in turn, inform the development of the Locality Plans which will outline our locality specific actions and developments.

### 7.6.4 Strategic Planning Group and Strategic Steering Groups

The integration legislation sets out the requirement to establish a Strategic Planning Group and also prescribes its core membership including representation from the third and independent sectors.

### 7.6.5 Communication and Engagement Group and Newsletter.

Our newsletter 'Partnership Matters', edited and produced by our Communications Lead is a great read and ideal for keeping up to date with our latest news and developments. With an increasing circulation, it is also an excellent opportunity to promote what is happening in your own service, organisation or sector.

### 7.6.6 ACHSCP Conference & Heart Awards.

The partnership is committed to holding an annual conference to showcase its achievements and developments and to enable participants to contribute

Similarly, the Hearts awards are an opportunity to celebrate our achievements and the commitment of our workforce in providing good quality services

> For further information about any of our engagement activities please email ACHSCPenquiries@aberdeencity.gov.uk in the first instance and we will forward your query to the appropriate colleague who will provide you with a timely and appropriate response.

### 7.7 Structure and Governance

The Public Bodies (Joint Working) (Scotland) Act 2014 has introduced significant change to the governance and operation of health and social care delivery.

### 7.7.1 The Integration Joint Board

The Integration Joint Board (IJB) is the key governance body with a responsibility for the planning and commissioning of the health and social care services which are delegated to it by its partner local authority and health board.

A Scheme of Integration[15] sets out what functions and services are delegated to the IJB.

The Chief Officer is accountable to the IJB and the Chief Executives of the local authority and the health board for the performance and quality of the Partnership's delegated functions. The Chief Officer is supported in this responsibility by her Executive team of:

- Head of Operations
- Head of Strategy and Transformation

[15] http://aberdeencityhscp.scot/contentassets/472f1da29a8f40729b99f404721f1658/aberdeen-city--ijb-integration-scheme.pdf

- Clinical Director
- Chief Finance Officer.

IJB meetings are public meetings. The schedule of dates and official reports (available one week in advance of the relevant meeting) can be found on our website. https://aberdeencityhscp.scot .

### 7.7.2 Strategic 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 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

### 7.7.3 How the partnership procures services.

Buying and contracting health and social care services is a complex activity that is clearly different from the procurement of other goods, works and services because of the considerable impact they will have on the health and wellbeing of individuals who will use these services.

The procurement and contract management of these services is undertaken by the **Social Care Commissioning, Procurement and Contracts Team (SCCPC)**. The SCCPC also undertakes this role for the Aberdeenshire Health and Social Care Partnership as well as Aberdeen City and Aberdeenshire Councils' Children's Services.

As a guiding principle, the SCCPC team place the procurement of services within the wider context of strategic commissioning, taking account of procurement and social work legislation and the Partnership's policy direction set out in its Strategic Plan, this Strategic Commissioning Implementation Plan and other relevant policies and plans.

The Scottish Government has, with other partner agencies, implemented **Public Contracts Scotland –Tender**, an online electronic platform, to help public sector organisations adopt standard procurement processes for goods, services and works for a wide variety of contracts. All our Partnership contracts are tendered via Public Contracts Scotland – Tender.

Collaboration and co-production are key behaviours that we endorse throughout the Partnership however we recognise that there is a commercial sensitivity and confidentiality to the procurement process that must be adhered to.

We will always seek to ensure that the procurement of services reflects the co-designed solutions that have been developed by our colleagues and partners.

### 7.11.4 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 the 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.

The relationship between the different elements of the Partnership is crucial to achieving the desired outcomes for the individuals who use our services. This will be so much more difficult where relationships are poor.

For further information about how the Partnership procures services from the third and independent sectors or how it manages existing contractual relationships please contact CommissioningandContracts@aberdeencity.gov.uk .

For help with **language / interpreting** and other formats of communication support, please contact 01224 522856/522047

ভাষা/ইন্টারপ্রেটিং এবং অন্যান্য ফরমেটের যোগাযোগ সাহায্যের জন্য দয়া করে :01224 523 542 নম্বরে যোগাযোগ করবেন।

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如果需要語言/傳譯及其他形式的傳訊支援服務，請聯絡:01224 523 542。

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Если требуется помощь при выборе языка /переводчика или других способов общения, звоните по телефону: 01224 523 542

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للحصول على مساعدة بخصوص اللغة/الترجمة و وسائط الاتصال الأخرى، الرجاء الاتصال بالرقم التالي:01224 523 542

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Lai saņemtu palīdzību sakarā ar valodu/tulkošanu un citiem iespējamiem komunikāciju atbalsta formātiem, lūdzu zvanīt 01224 523 542

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Jei jus turite sunkumu su kalba/ vertimu ar kitomis bendravimo formomis, skambinkite 01224 523 542.

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Jeśli potrzebujesz pomocy **językowej / tłumacza** lub innej pomocy w porozumiewaniu się, proszę zadzwonić pod numer: 01224 523 542

**Appendix 1 - CURRENT COMMISSIONED/PROCUREMENT ACTIVITY CURRENTLY (2017/18)**

| TYPE OF COMMISSIONED SERVICE | AMOUT OF PROJECTS/CONTRACTS | TOTAL COMMISSIONING SPEND |
|---|---|---|
| Employability | 6 | 547,385.37 |
| Adult Carers Support | | 231,883.90 |
| Day Care Services | 2 | 202,326.85 |
| Advocacy / Befriending | 13 | 728,337.05 |
| Sensory Impairment | | 465,899.00 |
| Housing Support (younger people) | 3 | 1,012,450.00 |
| OP/PD Care/Nursing Home | 26 | 28,969,589.74 |
| OP/PD Care at Home | 13 | 8,041,388.12 |
| OP/PD all residential | 8 | 3,411,924.96 |
| MH care Homes | 16 | 5,018,160.14 |
| LD Supported Living | 25 | 9,767,396.50 |
| | | |
| Other | | 26,289,000.00 |
| | | |
| TOTAL | | £84, 685, 741.63 |

**APPENDIX 2 – CURRENT AND PLANNED TRANSFORMATION ACTIVITY 2017 – 2019**

| STRATEGIC COMMISSIONING AREA | PROJECT | CURRENT YEAR | 2018/19 |
|---|---|---|---|
| Self-Management of Long Term conditions and Building Community Capacity | **Link Workers** | **£808,030.88** | **£1,561,445** |
| | **Connecting Communities** | | |
| | **Care Navigation** | | |
| | **Supporting Self-Management of Long Term Conditions.** | | |
| | **House of Care** | | |
| | **Golden Games** | | |
| | **Carers Support Services** | | |
| | **Locality Development** | | |
| Modernising Primary and Community Care | **GP Practices new Ways of Working** | **£1,796,872** | **£2,103,670** |
| | **Pharmacy and Prescribing** | | |
| | **INCA** | | |
| | **Nursing Succession Planning** | | |
| | **Community Falls Clinic and Pathway** | | |
| | **Develop GP led beds** | | |
| | **Advanced Nurse Practitioners** | | |
| | **Community Mental Health Hub** | | |
| | **Community Phlebotomy Service** | | |
| | **Clinical Guidance Intranet** | | |
| | **Transforming Urgent Care – early evening** | | |
| | **Alcohol Hub** | | |
| IT, Infrastructure & Data Sharing | **Planning for Capital Development** | **£814,464** | **£1,115,554** |
| | **Kingsmead** | | |
| | **Integrated Working** | | |
| | **ICT Systems and Equipment** | | |
| | **Technology Enabled Care** | | |
| | **DATA Sharing** | | |
| OD and Cultural Engagement | **Wider Leadership and Development Support** | | |

| | | | |
|---|---|---|---|
| | **Ensure a Fit and Healthy Workforce** | **£153,600** | **£95,600** |
| | **Implementation of the 'ideas Hub'** | | |
| | **Heart Awards** | | |
| | **Conference** | | |
| | **Develop Plan of Annual Engagement** | | |
| | **Board development, systems and governance testing** | | |
| Strategic Commissioning | **Implementation of Commissioning Strategy** | **£3,685** | **£750,000.00** |
| | **Supporting Resources** | | |
| Acute Care at Home | **Acute Care at Home** | **£245,804.00** | **£724,272.00** |