THIS PAPER RELATES TO ITEM 8

ON THE AGENDA

CLACKMANNANSHIRE COUNCIL

Report to Council Meeting of 12th March 2009

Subject: Forth Valley Joint Commissioning Framework : Services for Older People

Prepared by: Clare Hebbert Policy Officer Adult Care

1.0 Purpose

1.1. The Forth Valley Joint Commissioning Framework (attached as **Appendix 1**) has been compiled by the three Forth Valley local authority partners (Clackmannanshire, Falkirk and Stirling Councils) with Forth Valley NHS.

1.2. The purpose of the joint commissioning framework is to improve the joint planning and delivery of services for older people across Forth Valley.

1.3. The framework provides national and local contexts, definitions of strategic priorities and commissioning objectives in health and local authority services for older people.

1.4. The need for the development of a shared approach to joint commissioning arose from the multi- agency inspection of services for older people conducted across Forth Valley in 2007-2008 (MAISOP).

1.5. The framework embraces the Scottish Government's local public services modernisation agenda, maximising efficiencies and ensuring 'best fit' across different agency and professional agendas.

1.6. The principles that are set out in the framework, including collaboration and joint commissioning to meet identified needs, can potentially be applied across other care groups.

2.0 Recommendations

It is recommended that :

2.1. Council endorses the proposed framework for joint commissioning of services for older people and adopts it as a process for joint commissioning health and social care services across Forth Valley

and

2.2. Council approves the extension of the framework to other adult care groups where applicable

3.0 Considerations

3.1. The Joint Commissioning Framework document has been prepared in response to the recommendations from the Multi-Agency Inspection of Services for Older People in Forth Valley (MAISOP) 2008

3.2. In terms of commitment, it is acknowledged by all local health, housing and community care partners that working together is the most effective approach, using current and wide-ranging national and local partnership agendas, for achieving good outcomes for older people and their carers.

3.3. The Forth Valley Adult Care Strategic Planning Group takes the strategic lead and is representative of the three Councils and Forth Valley NHS. With a strategic overview of planning and development initiatives in Forth Valley, the group will ensure that actions taken forward on further integration and joint commissioning will dovetail with other relevant strategies and plans.

3.4. Joint commissioning of services for older people should achieve a good balance of care and a range of services with the following elements :

- ◊ User and carer participation : continuing investment will be made in the involvement of service users and carers in the planning and delivery of community based health and social care services.
- ◊ Enhanced care pathways : a more focussed joint approach to the management of acute and ongoing health and social care pathways that enhance access to appropriate services.
- ◊ Personalisation and enhanced service user control : people will have greater control over determining their care needs, deciding what services they need, which ones they will use and the arrangements for purchasing them.
- ◊ Enhanced support for carers : to enable carers to continue in their caring role. When it becomes necessary for the person that they have cared for to move into a formal care setting, they will be supported to continue to provide such care and support as they and the person concerned wish them to do.
- ◊ Preventative and anticipatory care : more people will be supported in their own homes, with a network of low level support services. Anticipatory care initiatives, falls prevention and rehabilitation will be more widely available.
- ◊ Care and support in the community : improved availability of services will help prevent unnecessary admissions to acute care and there will be more joint outreach support for people with dementia and functional mental illness.
- ◊ Intermediate Care : Jointly resourced intermediate care services will deliver joint assessment, rehabilitation and support at home whilst placements in care homes and specialist housing settings will help to maintain delayed discharge performance.
- ◊ Housing Options : access to good quality, affordable housing for all residents of Forth Valley, including older people, will be reflected in each Council's housing investment plans. Opportunities to develop mixed housing and care home models, including retirement communities could also be explored.

◊ Care Homes : Care homes will continue to play an important role in meeting the needs of older people who can no longer live independently in the community. Overall, the proportion of older people in care homes and NHS continuing care could reduce as additional community services enable more to remain in their own homes.

3.5 The Joint Adult Care Strategic Planning Group will oversee an action plan to take forward the development of joint commissioning approaches across Forth Valley, and through the three Community Health Partnerships, in response to identified need. Across Forth Valley, and with some local variation, there will be consultation and engagement with private and voluntary sector providers.

3.6 The process of joint commissioning includes

- Alignment between all partners, working within legal and political frameworks, to plan, prioritise, commission and deliver services to meet identified needs
- Understanding, mapping and forecasting supply and demand
- Adjusting provisions to meet ever-changing needs by reviewing and evaluating models of care
- Developing new approaches which enable more personalised solutions to be delivered by jointly commissioned services
- Ensuring that financial and workforce resources across the system are applied to best effect

3.7 The Joint Commissioning Framework offers an agreed direction of travel. It will be used in a variety of ways to ensure a greater consistency of approach to planning and delivering services to older people. The same principles will be applied to other adult care groups.

4.0 Sustainability Implications

4.1. The joint commissioning framework promotes the continuing health and well being of older people in their communities through effective joint working.

5.0 Resource Implications

Financial Details

5.1. A Joint Financial Planning Framework (see Appendix 2 of the framework document) includes a statement of financial planning parameters, an indication of the scale of expenditure, current processes and proposed arrangements for further development.

5.2. There are processes in place to identify the resource consequences of proposed service developments by one partner on other partners and there are examples of resources being transferred to enable such developments.

For example, there is a proposal to close some mental health beds and transfer the associated direct costs to community services.

Staffing

5.3. Through joint workforce development, partners can work together to establish a workforce that is better able to respond to demand and has the right skills and competencies to meet changing need. This includes enhanced flexibility in how key skills can be made available for the implementation of more innovative models of joint provision.

For example : local authority home carers receiving health services training to acquire skills in rehabilitation and personal care including minor treatments, providing a more comprehensive services to people in their homes and promoting independence.

6.0. Declarations

The recommendations contained within this report support or implement our Corporate Priorities and Council Policies.

(1) **Our Priorities 2008 - 2011**(Please tick ☑)

The area has a positive image and attracts people and businesses	☐
Our communities are more cohesive and inclusive	☑
People are better skilled, trained and ready for learning and employment	☐
Our communities are safer	☐
Vulnerable people and families are supported	☑
Substance misuse and its effects are reduced	☐
Health is improving and health inequalities are reducing	☑
The environment is protected and enhanced for all	☐
The Council is effective, efficient and recognised for excellence	☐

(2) Council Policies (Please detail)

7.0 Equalities Impact

7.1 Have you undertaken the required equalities impact assessment to ensure that no groups are adversely affected by the recommendations?

Yes ☑ No ☐

8.0 Legality

8.1 In adopting the recommendations contained in this report, the Council is acting within its legal powers Yes ☑

APPROVAL/SIGNATURE	DATE
Head of Service: Deirdre Cilliers	26.02.09
Director*: *Delete as appropriate	

CLACKMANNANSHIRE
COUNCIL

REPORT TO COUNCIL

To: Head of Administration and Legal Services, Greenfield, Alloa FK10 2AD

Report author: Clare Hebbert - Policy Officer

Service: Services to People - Adult Care

Report title: Forth Valley Joint Commissioning Framework : Services for Older People

Date of meeting: 12th March 2009

It is recommended that the attached report be:

1. **Given unrestricted circulation** ☑
2. **Taken in private by virtue of paragraph __ of schedule 7A of the Local Government (Scotland) Act 1973** ☐

List any appendices attached to this report (if there are no appendices, please state 'none')

1. **Forth Valley Joint Commissioning Framework : Services for Older People (January 2009)**

List the background papers used in compiling this report . If you have completed a sustainability checklist please add this to your list (if there are no background papers please state 'none'

1. **MAISOP Report : Multi Agency Inspection of Services for Older People : January 2008**

Nb. All documents listed must be kept available by the author for public inspection for four years from the date of the meeting at which the report is considered

Falkirk Council

FORTH VALLEY
JOINT COMMISSIONING FRAMEWORK: SERVICES FOR OLDER PEOPLE

FINAL VERSION – 21 JANUARY 2009

FORTH VALLEY
JOINT COMMISSIONING FRAMEWORK:
SERVICES FOR OLDER PEOPLE

CONTENTS

Glossary

AHP	Allied Health Professionals
CHP(s)	Community Health Partnership(s)
HEAT Targets	Targets set for Health Boards relating to: Health Improvement Efficiency and Governance Improvements Access to Services Treatment Appropriate to Individuals
MAISOP	Multi-Agency Inspection of Services for Older People – An inspection of services for older people carried out jointly by the Social Work Inspection Agency, NHS Quality Improvement Scotland and the Care Commission
MRSA	Methicillin-resistant Staphylococcus aureus -A hospital "super bug"
SDS	Self Directed Support - Support that is purchased directly by clients using funds from a variety of public sources, including health and social care, which is sometimes brought together into a single pot
SOA(s)	Single Outcome Agreement(s) – Agreements between each local authority and the Scottish Government as to the outcomes the authority is aiming to achieve
UDSET	User Defined Service Evaluation Tool - The UDSET has been developed to improve practice through application of user and carer defined outcomes tools, and to enable health and social care partnerships to gather data to determine whether they are delivering good outcomes to service users and carers. This data can be used to include user and carer experiences in performance management, planning, commissioning and service improvement. The toolkit has been developed alongside the National Outcomes Framework and has been piloted for use in this context, but can also be used as a standalone toolkit by any organisation interested in the experiences of service users or carers in community care settings

Commissioning Framework

1 Introduction

1.1 Local health, housing and social care partners recognise that they have embarked on a period of major change. They are committed to developing a joint commissioning framework for older people because:

- The needs and aspirations of older people are many and varied and no one agency can meet them all in full without the active support and assistance of its partners;
- Local partners have to address a number of cross cutting national and local outcome targets that involve different policy agendas and several service areas. Working together is the most effective approach to delivering against such a complex agenda;
- Commissioning some services presents particular challenges such as high risk, high cost or fluctuating demand, which are most effectively addressed by joint arrangements across the whole Forth Valley area;
- Joint working offers potential efficiency gains that should assist in meeting public sector efficiency targets; and
- Evolving service models and professional roles facilitate integrated working across agencies and encourage more imaginative and joined up approaches.

1.2 This framework describes at a strategic level what services for older people will look like in the future and thus identifies the areas where changes are required. Once it has been finalised and signed off, it will provide the basis for a commissioning strategy which will set out in more detail how the strategic commissioning objectives laid out in the framework will be achieved.

1.3 Local partners are also committed to ensuring that services are planned and delivered with the maximum possible involvement of the community, including:

- Community Leaders, by which is meant Local Authority and Health Board members;
- Community Planning Partnerships and related stakeholders;
- Other relevant organisations, i.e. those with an interest in services for older people. This includes other public bodies in the Forth Valley area, and potentially wider, and providers of services in the independent sector;
- Participants, defined as service users, potential service users and those who care for service users, both formally and informally; and
- The wider public.

1.4 The framework has been prepared recognising the complex network of relationships which exists between all the partners and indeed between the partners and other agencies. This complexity is one of the reasons why a clear commissioning framework is so important.

2 Vision

2.1 Against a background of diminishing resources and an increasing population of older people, local health, housing and social care partners are committed to planning and working together in support of a shared vision. That vision is the achievement of their desired outcomes for older people, namely:

- Older people are able to live in their own homes and local communities for as long as they wish, whilst enjoying a lifestyle that gives them what they want out of life
- Universal public services are the principle means for supporting the wellbeing and healthy living options of older people and should enable many to live without recourse to formal health and social care services
- When an older person does need care and support their views and aspirations both as citizens and service recipients, as well as those of their carers, directly inform and influence the results that health and social care services strive to achieve
- Older people receive a personalised response to their particular individual needs and are increasingly able to make as many of their own decisions as possible including when, how and by whom their service is provided
- Services actively anticipate or prevent growing illness or infirmity and thereby support older people to remain active and healthy for as long as possible with the minimum necessary recourse to more intensive or intrusive care and support
- Older people are kept safe by high standards of practice in the services they receive
- The outcomes achieved for older people across Forth Valley are not dependent on where they live

2.2 Local partners are committed to engaging actively with local community planning partners and with generally available public services. This should ensure that the needs and aspirations of older people are fully recognised and that the benefits of directly accessible support are maximised.

2.3 Local partners recognise that the types and level of service for older people may vary from area to area in response to a variety of local considerations. They are committed to ensuring that these local differences will positively enable them to deliver the best solutions in each area and thereby maximise the benefits that people receive, whatever their needs might be.

2.4 Strategic commissioning by statutory partners faces significant challenges in ensuring that the design and delivery of each service is able to respond fully to the aspirations of users and carers for a personalised response to their particular needs. The mechanisms by which individuals fund, purchase and organise their own care and support are developing rapidly and this framework lays the foundations for an approach to commissioning which is capable of accommodating and indeed promoting, increasingly personalised services.

3 Context

National Context

3.1 The national policy agenda that provides the basis for this draft commissioning framework for older people is well documented. Detailed sources are set out in Appendix 1. The national policy agenda includes the following key aspects:

- Better public accountability by promoting shared ownership through public involvement in service planning
- An outcomes based approach which focuses on what services achieve, not on what they do
- Evidence based development
- Achieving a shift in resources to community based settings
- Greater focus on long term conditions
- More preventative and anticipatory care
- More personalised services and greater control for users
- More services located close to the user
- Ensuring services are sustainable and achieve good value for public money

3.2 Key pressure points in the health and social care system that are subject to national monitoring and/or specified targets and which also act as drivers to local commissioning arrangements include:

- Delayed Discharges from hospital
- Emergency / Multiple Admissions to hospital
- Commissioning of specialist services including the establishment of managed care networks

3.3 Housing services are key to delivering many of the changes envisaged in this framework. They are subject to a different set of policy priorities, such as improving the availability and affordability of housing and improving housing quality. However, addressing these priorities effectively requires close attention to the challenges presented by the growing number of older people who are living in the community with health and social care needs.

3.4 The national outcomes agenda that underpins the Concordat, and the related Single Outcome Agreements (SOAs) between the Scottish Government and Local Authorities, requires local partnerships to integrate Local Authority SOAs, the community care outcomes framework and NHS HEAT targets in order to deliver joint performance reporting.

3.5 Significant developments are emerging in support of this shift, in particular the development of more effective tools for consulting with users and carers, sponsored by the Scottish Government. These will assist local partnerships to understand better the outcomes that are being achieved for users, something that will help partnerships to monitor their progress against SOA and HEAT targets.

3.6 Work to assess the cost of specific services across health and social care is designed to give partners a better understanding of the resources which are committed to

different service elements. This will enable them to track how funds flow through the system and assess the financial impact of any change in service design.

Local Context

3.7 The specific purpose of this joint commissioning framework is to improve the joint planning and delivery of services for older people in Forth Valley. It sits within a complex network of other relationships:

- between the same partners in relation to other shared services, such as children's services;
- in relation to other localised planning structures, such as CHPs and Community Planning Partnerships; and
- partnerships over larger areas, e.g. partnerships between NHS Forth Valley and other Health Boards.

Whilst this added complexity is acknowledged, it is not explicitly addressed in this framework.

3.8 The framework reflects the strategic objectives contained in relevant plans of each of the 3 constituent Councils and in the Primary and Community Care Services Development Plan, which is part of NHS Forth Valley's Integrated Healthcare Strategy. Some policy areas have been identified as requiring further development in order to ensure maximum coherence, for example, Self Directed Support, eligibility criteria and charging policy.

3.9 The recent Multi-Agency Inspection of Services for Older People (MAISOP) report concluded that older people in Forth Valley are generally pleased with the services they receive and the way these services work together. It identified a very positive culture in Forth Valley between managers and staff at all levels in NHS Forth Valley, Clackmannanshire, Falkirk and Stirling Councils about working together in partnership to help older people and their carers lead as independent lives as possible. It concluded that significant successes have been achieved by the partners in relation to the way that older people are supported in the community and are admitted and discharged from hospital.

3.10 Following the MAISOP, the subsequent implementation plan identified a number of milestones which this framework seeks to address, including proposals that:

- map out the scope of the older people's framework and define the range of services to be included. The MAISOP implementation group has agreed that the framework will cover the full range of services, from healthy ageing to end of life care, but in terms of specific joint commissioning strategies it will focus on joint care/treatment services;
- within that agreed scope, identify the current base line of services and resources to be reviewed and benchmarked against national information;
- agree the balance of services to be commissioned at Forth Valley level and those to be commissioned through individual partnerships; and
- provide a first draft joint commissioning framework for discussion.

3.11 It should be noted that this framework concerns the processes which govern how decisions about joint commissioning will be made, including defining the strategic objectives and commissioning priorities which will steer those decisions. Existing

planning processes, commissioning strategies and service plans will inform the detail of what services and approaches will be jointly commissioned and their design.

3.12 In particular, other related work which is already in hand and which will be central to the ongoing development of local partners' joint strategic commissioning capability through the application of this framework includes:

- NHS Forth Valley's Primary and Community Care Services Development Plan
- Stirling University CHP Governance report
- Joint workforce planning
- Housing plans, including particular needs
- CHP reporting developments: SOA Outcomes / HEAT targets
- Continuing involvement of the Joint Improvement Team in Stirling

3.13 This work reflects an established commitment to a joint approach and will provide an important basis for further progress. However, to date only limited work has been undertaken to develop a strategic approach to jointly commissioning older people's services in Forth Valley. More generally, there are currently only a limited number of examples of joint commissioning of services between all Forth Valley partners - the Complex Care Beds working agreement for adults under 65 years is one example.

Present Services and Performance

3.14 Data on the range and scale of services currently available in Forth Valley is being updated by the commissioning sub-group of the Joint Adult Strategic Planning Group. Using existing data sets which provide compatible information across Forth Valley, the intention is to include a headline summary of current services in the final version of this framework.

3.15 A summary of the data on joint performance that was incorporated into the MAISOP report will also be included in the final version in order to provide a picture of the key national indicators that local partners are seeking to address through the implementation of this framework.

Population and Projections

3.16 In Forth Valley in 2006 there were 25,300 people aged 65-74 and 19,900 aged 75+ representing 8.9% and 7% of the total population of Forth Valley respectively [1]. It is generally agreed that deprivation adds to the challenge of providing health and social care services. In each of the three Council areas there are people living in the 15% 'most deprived' areas in Scotland as illustrated in the table overleaf, which also gives the proportion of people aged 60 or over who are claiming pension credit.[2]

[1] Source: GRO Scotland
[2] CHP profiles, produced by the Scottish Public Health Observatory (ScotPHO) in August 2008

	Clacks	Falkirk	Stirling	Scotland Average
60+ population claiming pension credit	18.5%	18.6%	14.9%	19.7%
People living in 15% most deprived areas in Scotland	23.6%	9.2%	5.7%	15.0%

3.17 Between 2006 and 2031, the population of Forth Valley is projected to increase by 9.5%. However, the projected increase in the number of older people is significantly higher. An increase of 68.5% in the number of people aged 65 or over is projected and the increase projected for those aged 75 or over is 94.3%. The projected increase across Scotland of the number of people aged 75 or over is 81%.[3]

Financial Context

3.18 The financial environment in which all four partner organisations are operating is currently one of uncertainty and pressure. Each has current budgetary pressures, notably those relating to increasing fuel costs and pay awards, and, under the terms of the spending review 2007, each is expected to achieve efficiency savings to enable it to maintain current service levels.

3.19 This uncertainty and pressure makes joint financial planning both increasingly important, in order to maximise what can be achieved with the totality of the resources involved, and more difficult to take forward than when there was more stability and less pressure on resources. A commitment has been made to develop joint financial planning and a joint financial planning framework is included as Appendix 2. The joint planning of other resources, such as workforce, assets and IT will also be developed.

3.20 The joint financial planning framework sets out the benefits to be gained by joint financial planning, acknowledges the difficulties involved and proposes a course of action which begins with work to identify expenditure on services for older people more accurately and which should lead to joint financial planning processes being in place from 2011/12 onwards.

[3] 2006 based population projections by GRO Scotland

4 The Commissioning Agenda

What is commissioning?

4.1 The commissioning of health, social care and housing provision in Forth Valley is concerned with a range of personalised and specialist services which are designed to meet the assessed needs of individual recipients. In addition however, it is also concerned with ensuring that a wider range of support concerning social inclusion and wellbeing is available to citizens. To achieve this, commissioners will engage with, and seek to influence, the wider community planning context.

4.2 Universal public services provide the primary source of support and assistance for people to lead healthy, active lives into old age. These are available to members of the public of all ages if and when they need or want the assistance or service on offer. The projected substantial growth in the population of older people over the next 20-30 years means that demands on commissioned services will grow. It also means that the importance of universal public services and community planning measures to support people to remain healthy into old age is paramount.

4.3 Commissioned services provide a personalised response to individual needs which is proportionate to people's requirements, sustainable and adds value to their lives by delivering better outcomes for them. Increasingly individual service users are taking control of managing their condition and of the arrangements by which they procure and organise their care and support. This framework recognises and positively supports this shift and is intended to provide the practical means by which local partners can develop more flexible commissioning arrangements that are better equipped to access and take account of the views of users and carers.

4.4 The process of commissioning includes:

a) Understanding, mapping and forecasting the supply and demand factors within the market to deliver the current and evolving outcomes required by service recipients;

b) Ensuring that expressed public needs and expectations and the views of service recipients are central to the development of plans and strategies;

c) Recognising that strategic commissioning goals must be achieved through delivering services that are capable of responding to the particular needs of individual recipients;

d) Ensuring that there is an alignment between all partners about planning aspirations and about what needs to be achieved to ensure demand is met, including working within the legal and political framework;

e) Ensuring the financial and workforce resources across the system are applied to best effect to maximise the attainment of strategic commissioning goals through the delivery of personalised services; and

f) Reviewing and evaluating models of care, and option appraisal of services with a view to any necessary re-provisioning of services to meet ever changing needs.

g) Developing new approaches which enable more personalised solutions to be delivered by larger scale commissioned services and which support individual

service users in purchasing and organising their, potentially small scale, support packages.

4.5 In addition commissioning necessarily involves the active management of markets, contracting and service reviews including:

- Community profiling
- Market mapping, including consideration of the potential for independent providers to respond
- Provider identification and development
- Tactical procurement and call off arrangements
- Quality monitoring and review
- Managing decommissioning and market failure

What do we mean by 'older people'

4.6 For many people, the move into old age can be characterised by three phases as illustrated in the table below. The goals of each partner organisation, individually and working together in partnerships, will have a different emphasis in each phase.

Phase	Typical description	Goals
Entering old age	People who are active and independent and who are around pensionable age with every prospect of remaining fit and well into later old age	To promote and extend a healthy active life and to compress morbidity (the period of life before death spent in frailty and dependency)
Transitional phase	People who are becoming less mobile, more frail and dependent upon family carers, usually as they move into their seventh or eighth decades	To identify emerging problems ahead of crisis, and ensure effective responses which will prevent crisis and reduce long term dependency
Frail older people	People who are significantly vulnerable as a result of health problems such as stroke or dementia, social care needs or a combination of both	To anticipate and respond to problems, recognising the complex interaction of physical, mental and social care factors, which can compromise independence and quality of life

4.7 Increasingly advances in medical science and prescribing mean that individuals who have had substantial and/or complex needs over their lifetime, particularly those with learning disabilities, are living into older age. The incidence of pre-existing particular needs across the full spectrum of older age is becoming more widespread and represents an important challenge in responding effectively to deliver better outcomes for all older people. As this feature of the older population grows, the typology illustrated above may become less widely applicable.

4.8 A number of conditions amongst younger adults present major challenges in providing suitably individualised service interventions, particularly long term and chronic conditions and acquired brain injury, which pose important questions about service design. Their needs may be similar to those of some older people and services for each may overlap, creating some crossover issues. As these service recipients

move into old age, they will follow different pathways to other older people whose needs are more closely age-related.

4.9 Different services often reflect different age-related admission criteria, yet most data concerning older people's services is collected in age bands from 65 years and upwards. In this commissioning framework 'older people' are therefore defined as meaning those aged at least 65 years old, whilst recognising that some of the services covered may specify a different entry age for eligibility.

What services are involved?

4.10 As citizens, older people benefit from the public services and infrastructure that are available to all. Lifelong learning, transport, environmental and community services all have an important bearing upon their lives. As the overarching planning body for public services, the Community Planning Partnership represents the key route by which the partners to this framework will seek to ensure that the needs and aspirations of older people are fully reflected across public services.

4.11 In addition, a wide range of services contribute more directly to meeting the health, social care and support needs of older people and new approaches or ideas are constantly shifting the boundaries of what is considered likely to assist recovery or wellbeing. This being the case, it is perhaps helpful to differentiate between services on the basis of some key characteristics that influence the extent to which they are focussed, or not, upon the particular priorities set out in this framework.

4.12 Some of the key differentiating characteristics are:

- the degree to which older people can choose to take up, or not, a particular service. For example universal public services, such as fitness centres and libraries, are generally available as and when someone wishes to use them, without prior notification or application. As such, they offer a response which is not particularly focussed on older people.
- the extent to which services are only or are principally available for use by older people, for example sheltered housing and lunch clubs. Such services may address age-related conditions or the particular wishes and aspirations of older people and thereby enhance their accessibility for older people.
- the extent to which access to services is formalised and subject to specific criteria or specified levels of need, for example day services and drop in centres. In some instances such services may operate an open door policy whilst others may be less able to respond to requests for immediate access.

4.13 The list of services in Appendix 3 contains examples of services that reflect each of these characteristics. Their relevance to this commissioning framework concerns the contribution that they make across the full spectrum of older people's needs from supporting healthy living to end of life care.

4.14 This framework focuses upon services which are commissioned primarily for older people, however, local partners recognise the potential of universal public services, such as evening classes and bus services, to enable recipients of all ages to achieve

better outcomes and they will seek to influence and enable these services to pay particular attention to the needs of their older service users.

4.15 Establishing the strong links to local community planning arrangements referred to above will be vital in developing suitably joined up public services where age-related considerations are properly addressed and service providers develop the means to stay informed about and responsive to changing needs.

Commissioning Principles

4.16 Commissioning undertaken within the scope of this framework will follow a number of core principles. These are that commissioning should:

- ensure that users and carers are well informed and kept up-to-date regarding available services, care standards and service quality
- be based upon the expressed views of users and carers regarding the benefits they expect to receive and the indicators of quality that are most important to them
- be supported by a robust analysis of future needs and demands and of 'what works' in Forth Valley and beyond
- be outcome focused with service impacts being measured against the aspirations, goals and priorities identified by service recipients
- provide personalised services that respond to the needs of individual recipients whilst having regard to broader strategic considerations
- have regard to the sustainability of services as well as their cost and quality
- involve collaboration between partner agencies in order to maximise efficiencies and ensure 'best fit' across different agency and professional agendas
- seek to add value by ensuring that more service users and carers receive the benefits they want from services they receive
- aim to develop and promote a comprehensive range of services that are joined up and work effectively together
- recognise the strengths of the independent sector as providers of services and seek to maximise the benefit that is gained for service recipients from their involvement
- actively embrace the Scottish Government's local public services modernisation agenda and in so doing reflect a willingness to test established practice models, encourage innovation and exploit the potential of multi agency and multi disciplinary working

Joint Commissioning

4.17 The focus of this framework is upon joint commissioning and, whilst the description of commissioning activity, and the principles that underpin it, set out above, would also be applicable for commissioning undertaken by a single agency, adhering to the principles in practice can be more difficult in a joint commissioning environment and it is therefore important that they are explicitly stated. It is also important to establish a clear understanding of what 'joint' means, in the context of Forth Valley.

4.18 At the same time, it should be noted that the way in which commissioning is carried out may not be directly reflected in service delivery arrangements. In particular, local partners are clear that whatever the commissioning arrangements, services should be delivered locally where appropriate.

4.19 There are a considerable number of different actual or potential partnerships in Forth Valley and the degree of formality which does, or could, underpin them may also vary considerably. It is important therefore that the degree of commitment in any joint statement or joint operation is clear.

4.20 The level of commitment involved can be described as follows:

A. Shared intent - (baseline)
   - All partners share the same expressed commitment to taking forward a particular joint initiative
   - These arrangements are likely to apply during any period when the extent of final commitment is being actively discussed or the subject of agreement is not a present priority and instead forms part of a future agenda

B. Non binding - and possibly subject to amendment after discussion, impact assessment and negotiation
   - Relevant for service initiatives that involve and are funded by more than one partner but where the differently funded elements work in parallel with one another and could continue to do so if one partner withdrew
   - These arrangements are likely to apply where partners have complementary but different levels of interest or dependence on the subject of agreement and are able to commit resources for different periods of time

C. Binding - and formal, subject to due governance arrangements
   - Essential for service initiatives that involve and are funded by more than one partner and where the continuation of the service is dependant upon the continuing availability of all funding streams. In addition, if formal arrangements can to applied to service initiatives which are less interdependent (as in (B) above) this would give them greater security and stability
   - These arrangements are likely to apply where all partners share an equal interest or dependence on the subject of agreement and are able to commit resources for similar periods of time

Scope of commissioning activity

4.21 Joint commissioning may take place at a local level if:

- Priorities differ and lack of uniformity is considered appropriate, with due regard to considerations of equity
- Different models of service are necessary to respond to needs and demands in the different areas, for example to achieve equivalent outcomes for people living in remote rural areas compared with those living in an urban environment; or
- There is no identifiable benefit to commissioning over a larger area.

4.22 On the other hand, there is an expectation that joint commissioning is more likely to be on a Forth Valley wide basis if:

- Services are high risk, high cost and/or very specialist in nature;
- Services are considered to be strategically or tactically important;
- Services are at a scale which is relatively small and which fluctuates, where amalgamation across a wider area would reduce fluctuations; or
- The commissioning process requires particular expertise.

4.23 Regardless of the level at which joint commissioning appears to be appropriate, each local partner will scrutinise and consider the particular merits or issues associated with each commission, using their established governance arrangements. For joint commissioning to proceed, at whatever level, formal agreement by each partner agency will be necessary.

Commissioning Matrix

4.24 The decision making process associated with joint commissioning will be informed by the commissioning matrix which is described in Appendix 4. This can also be used to review and rationalise existing contracts and commissioning activity that is presently carried out both jointly and by individual agencies. It also provides a basis for establishing a more rigorous approach to the commissioning of new or re-modelled services across Forth Valley and within each discrete local authority area.

4.25 The matrix summarises how the different dimensions of joint commissioning, specifically the most appropriate level of commitment and the most suitable scope (pan Forth Valley or more local) interact depending upon the nature of the service that is under consideration. It also highlights the need to further develop the sorts of arrangements needed to underpin binding agreements.

5 Delivering Better Outcomes

5.1 Improving local partners' ability to deliver better outcomes for older people requires that the local balance of care and range of services address the policy objectives and strategic priorities set out elsewhere in the draft commissioning framework, as effectively and efficiently as possible. This paper describes the key elements required of the care pathways and services best designed to deliver the required outcomes.

Balance of Care and Care Pathways

5.2 The future balance of care will seek to support people in ways that they themselves choose, maximising their capacity for self care and reinforcing the flexibility and sensitivity of services to the changing needs of service recipients, to enhance the ability of services to deliver the personal outcomes people want. Delivering this approach will mean that more people receive the care and support they need in their own homes or local communities through better access and joint management of care pathways.

5.3 People will be assisted to remain in their own homes for longer by the enhanced provision of low level support that prevents or delays the need for more intensive support and enhances anticipatory care and responses to long term conditions. Better integrated services delivered by multi professional teams will improve service quality for users and service availability at all times, whilst support will be available to act as a bridge at key points of transition in the person's journey, for example between home and hospital and from illness to recovery.

Strategic Objectives

5.4 The strategic objectives for each local partner reflect the same direction of travel for health and social work whilst recognising the differences in emphasis that will be needed to achieve similar goals. In the case of housing, the health and social care needs of older people are important considerations in responding to broader housing concerns.

5.5 The priorities for health are:

- A clear focus on what needs to change – a shift towards health improvement and prevention, and from acute care to anticipatory and continuous care in the community
- The location of services – more appropriate community based support and more integrated care in joint premises locally
- Patients taking more responsibility for their care to both stay healthy and to manage their own long term conditions
- Moving to more joint working in community care teams and to a more accessible service

5.6 For social work the priorities are:

- More personalised care and opportunities for self directed support, including more opportunities for users to self assess
- Enhanced safety for service users from the risk of abuse or neglect and adequate safeguards to ensure high standards of practice
- A greater focus upon a whole system approach reflected in integrated multi agency services delivering a flexible network of enablement, care and support
- A re-balancing of care that maintains support for people with higher needs as well as providing preventative care at home to meet moderate level needs
- New housing based models of care and support that promote independence and are available to both home owners and all those who rent their homes.

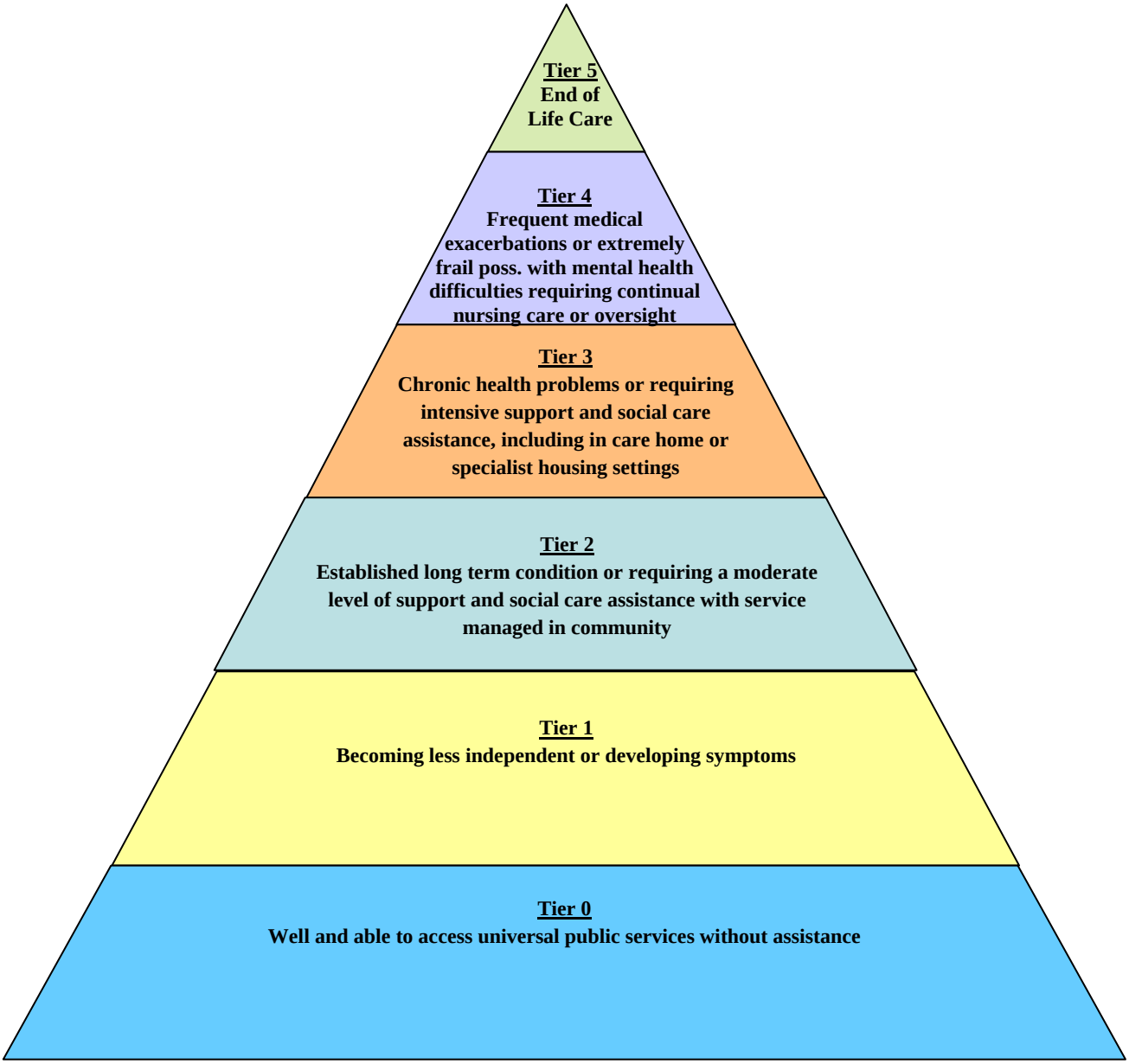
5.7 For housing the policy focus is upon enhancing affordability, increasing supply and improving housing quality. Important priorities relating to older people include:

- the challenge of investing wisely to meet the aspirations of people who wish to stay on in housing that may have a limited useful lifespan, regardless of whether they are home owners or rent their home
- the future focus of housing support services - whether they will be used to support intensive care packages or the delivery of preventative and anticipatory care
- the role of telecare and specialist housing in enabling a shift to community based care and the development of locality based integrated service models
- the challenge of developing relatively high cost, low volume specialist housing for older people at a time of restricted investment opportunities and pressure to demonstrate enhanced returns on investment

Commissioning Model

5.8 NHS Forth Valley, in conjunction with its local partners, has adopted, in its Primary and Community Care Services Development Plan, the following model for the integrated provision of primary and community services. The vision underpinning it is to provide sustainable, safe and effective integrated primary and community care services as close to people's homes as possible. Services will have to be flexible enough to meet changing demands in the future.

5.9 In order to achieve this vision, and to support its integration with that of all of the other partners to this framework, the Forth Valley Partnership has chosen to adopt an adapted form of the NHS Forth Valley model, to represent their shared objectives, approaches and priorities. The tiered model below, along with the explanatory tables in Appendix 5, is a framework which describes how people may move through the system. The model describes the needs within each tier as well as the possible organisational responses to these needs and will help us to identify gaps in existing service provision.



Commissioning Priorities

5.10 The joint commissioning priorities set out below reflect the strategic objectives of local partners and also confirm the range of services that are seen as being important to the lives of older people.

5.11 They are designed to complement the role of universal public services as the primary source of community engagement and support for most older people and to contribute, along with the independent sector and other community planning partners, to the wider task of creating sustainable communities that enable older people to remain in their own home for as long as they wish.

5.12 The following are intended to reflect the key aspects of service provision that will deliver the future balance of care consistent with the strategic objectives of local partners. A considerable amount of joint activity is already underway to develop joint

services for older people and the range of services and approaches set out in the work streams below incorporates the work that is currently underway.

User and carer participation

5.13 Strategic commissioning reflects a substantial willingness to listen and respond to the expressed views of users and carers and is increasingly able to determine and deliver the contracting arrangements that best meet the needs of individual clients. Continuing investment will be made in the involvement of service users and carers in the planning and delivery of community based health and social care services.

Enhanced care pathways

5.14 A more focused joint approach to the management of acute and ongoing health and social care pathways that enhances access to appropriate services.

Personalisation and enhanced service user control

5.15 Models of self care and self management based upon a collaborative partnership with service users will enable them to stay well, and will support them to manage their own symptoms. People will have greater control over determining their care needs, deciding what services they need, which ones they will use and the arrangements for purchasing them.

Enhanced support for carers

5.16 Carers will be recognised for the vital and irreplaceable contribution that they make to meeting the needs of older people in the community. They will have their needs as carers assessed. Suitable training, support and respite will be provided to enable them to continue in their caring role. When it becomes necessary for the person that they have cared for to move into a formal care setting, they will be supported to continue to provide such care and support as they and the person concerned wish them to do.

Preventative and anticipatory care

5.17 Members of the public have ready access to information and support to encourage healthy lifestyles. Informal community support networks, often involving independent sector agencies, will be recognised and supported in fulfilling a vital role in complementing the support provided by commissioned services. More people will be supported in their own homes, with a network of low level support services. Clustered support will be available for isolated people who may be at risk e.g. community day care and Good Neighbour schemes.

5.18 People with long term conditions will be encouraged to self manage their condition as far as possible. They will receive more effective support, at an earlier stage of their condition and in their own home or, if necessary, in an alternative community setting. Anticipatory care initiatives, falls prevention and rehabilitation will be more widely available, the benefits of telecare, telehealth and telemedicine will be given greater recognition and primary care services will be acknowledged as key players. Agencies will work to align their eligibility criteria with their strategic direction of travel.

Care and support in the community

5.19 Whilst all older people who need care and support in the community will receive support to manage their own care wherever appropriate, a higher rate of those needing a care at home service will benefit from improved service quality and commissioning

arrangements which deliver effectively and efficiently. Service delivery arrangements will enable home care, nursing and AHP services, practical support, equipment & adaptations, day hospital, day services and respite services to be provided in a co-ordinated and complementary manner. Improved availability of services will help prevent unnecessary admissions to acute care and there will be more joint outreach support for people with dementia and functional mental illness.

Intermediate Care

5.20 Jointly resourced intermediate care services will act as a bridge at key points of transition in the patient's journey from home to hospital and back home again and from illness to recovery. They will deliver joint assessment, rehabilitation and support at home whilst placements in care homes and specialist housing settings will help to maintain delayed discharge performance.

Housing Options

5.21 The importance of ensuring access to good quality, affordable housing for all residents of Forth Valley, including older people, will be reflected in each Council's housing investment plans. This will help to minimises the extent of fuel poverty, and in, addition the Councils will offer older people access to specialist housing that provides suitably adapted, accessible and spacious accommodation which meets their aspirations. Older people with needs arising from physical frailty, mental health conditions or a complex mix of care needs will benefit from access to extra care housing which offers flexible, person centred housing and care support which is available as required on a 24 hour basis. The support will be provided within an enabling culture which maximises each person's capacity for a better quality of life. Opportunities to develop mixed housing and care home models, including retirement communities may also be explored.

Care Homes

5.22 Care homes will continue to play an important role in meeting the needs of older people who can no longer live independently in the community. They will increasingly provide specialist care for particular groups and respond flexibly to requests for short term care placements. More support for people and staff in care homes will be available to ensure the quality of the service and to prevent unnecessary hospital admissions. Overall, the proportion of older people in care homes and NHS continuing care will reduce as additional community services enable more to remain in their own homes.

Enhanced workforce

5.23 Significant progress will be made through joint workforce development towards establishing a workforce which is better able to respond to demand, and which has the right skills and competencies to meet changing need. This includes enhanced flexibility in how key skills can be made available at any time, day or night, and to implementing more innovative models. Joint workforce development will also assist partners in addressing the particular challenges for remote and rural areas.

6 Implementation

6.1 Whilst this framework describes the strategic direction of travel as regards changing the overall balance of services and care for older people, achieving such change in practice will be the consequence of a number of smaller changes. Ongoing work to develop services and approaches reflects the work that is already in hand to take forward this agenda, central to which is the role of the Joint Adult Strategic Planning Group which provides joint leadership to the full range of planning and commissioning activities.

6.2 Achievement of the framework objectives will require proactive developments which the joint planning processes will initiate and steer. In particular, the resource planning processes which underpin service planning will be reviewed to ensure they are fit for this purpose. In addition some developments will be in response to the pressure of demand for an increase in particular services or in response to an opportunity to release resources to enable developments elsewhere. These opportunities may emerge within a particular locality, others may initially be identified at a pan Forth Valley level, but in each case the framework should provide the necessary underpinning to ensure consistency in approach and delivery.

Appraisal of service proposals

6.3 Each service redesign or reconfiguration, whether proactive or reactive, will require to be considered on its own merits and questions posed as to its implications for the wider planning context such as:

- Does it move the overall balance of services/care in the right direction?
- Will it lead to improved outcomes overall?
- What do service users and carers think about it?
- How much of a priority is it for each involved partner?
- Should other partners become involved in order to maximise efficiencies or beneficial outcomes?
- Is it affordable in overall terms?
- What are the implications for staff, other services etc.?

6.4 This will require a joint appraisal process, in the sense that all partners are involved in the appraisal to the extent that they need and want to be and each partner respects the views of the others, even if in some cases the final decision to proceed, or not, lies with just one partner. This process will be overseen by the existing Joint Adult Strategic Planning Group.

6.5 The appraisal will need to draw on a number of contributions from each partner organisation to ensure that all proposals are subject to the appropriate level of challenge. Particularly if proposals involve the development of new service models, their appraisal will need to include a robust assessment of the workforce implications and of the financial consequences, both direct implications and any consequential impact on other services. The Joint Adult Strategic Planning Group needs to have the capacity to provide the necessary challenge in a timely fashion and, with this in mind, the mechanisms for providing support to the group will be reviewed.

6.6 Developments in service provision have always occurred and they will continue to be planned and implemented during the development of this framework and the commissioning strategy which will follow. The difference will be a clearer, jointly agreed direction of travel and processes in place to plan, assess and deliver those developments in closer partnership.

6.7 This framework will be used in a variety of ways to ensure greater consistency of approach in joint commissioning including; reviewing existing single agency and joint contracts, evaluating the most suitable commissioning arrangements for proposed new or re-modelled services and as a reference point for ongoing strategic planning work by the Joint Adult Strategic Planning Group and the Older People's Strategic Commissioning Sub Group.

Planning Processes

6.8 The high level system modelling which underpins the strategic planning processes concerned with the overall future shape of services does not address questions about the order of the constituent developments and how these may relate to each other. Once this future shape is clear and agreed, it is therefore necessary to have a plan for its achievement which identifies the individual developments and attributes to each a timescale which is achievable in both practical and financial terms. The principles underpinning this planning process should also inform the way in which partners deal with unforeseen opportunities for change and thereby provide greater rigour and consistency in all such planning matters.

6.9 If that implementation plan is to be any more than a statement of intent (as defined in paragraph 4.19), it will itself require robust underpinning processes, notably financial planning, workforce planning and asset management planning, so that each partner can be confident about what is achievable for them, and how quickly. The better developed joint resource planning processes are, the more likely it is that a binding implementation plan can be agreed, at least for an initial period. For this reason, more robust joint resource planning processes will be developed.

6.10 The planning process will also require to be informed by feedback arrangements so that the effectiveness of different service models is taken into account and also so that the learning from the change processes involved in each service redesign can be used to make future changes as effective as possible.

Evaluation Processes

6.11 Service evaluation processes already exist in all of the partner organisations. However, these will be further developed to ensure that:

- There are effective tools available with which to evaluate delivered outcomes for service users and carers, and provide the necessary material with which to inform decision making
- There are good communication channels to inform decision making on the basis of service review outcomes and more sharing of the results, in accessible language

- The extent to which the joint nature of the delivered service impacts upon the outcomes achieved for participants is explicitly considered
- There is conscious feedback into the joint planning process, including assessing whether the correct evidence is being collected to allow full evaluation of the service and its impact.

6.12 The possibility of rolling out a recently introduced model for evaluation within the CHPs will be considered as a way of achieving the developments required and the adoption of a single evaluation tool focusing upon outcomes that all partners can sign up to (e.g. UDSET) will also be considered.

6.13 Partners will also seek to ensure that there are suitable processes in place for universal services to develop a better understanding of the contribution that they can make to delivering better outcomes for older people and to "report back" on what they have done in support of achieving the desired outcomes for older people.

6.14 Processes will also be required to evaluate the framework itself and to ensure that it remains fit for purpose. That will include consideration of the impact it is having on relationships within the partnership, on the joint commissioning of services and on the services commissioned under the framework and related services. As a more detailed commissioning strategy is developed, this may highlight aspects of the framework which require refinement or particular scrutiny. The latest date for the first review of the framework is the review date which will be specified in the formal, signed version of this framework.

7 Next Steps

7.1 Throughout this framework various commitments have been made, e.g. to review and/or develop processes and to improve the quality of supporting information. This section summarises these and the actions identified will be incorporated within the work plans of the Joint Adult Strategic Planning Group (JASPG) and other groups noted below as appropriate.

Paragraph	Development need identified	Timescale	Responsibility
1.2 6.14	Achieve agreement and sign off for the commissioning framework and its review date	Jan 2009	JASPG
3.4	Integrate Local Authority Single Outcome Agreement and NHS HEAT targets	Mar 2009	Community Planning Partnerships
3.5	Ensure development of more effective consultation with users and carers	Ongoing, with progress checks at least annually	JASPG
3.6	Work to assess the cost of specific services across health and social care	Develop draft framework by Jan 2009	Joint Finance Group
3.14	Update headline information on the range and scale of services currently available	Dec 2008	Commissioning sub-group of the JASPG
3.19	Joint workforce planning – initial tasks to assemble baseline data and consider implications of this draft framework	Dec 2008	Heads of HR Group
3.19	Joint asset planning	[to be agreed]	Leads identified for Hub
3.19	Joint IT planning	[to be agreed]	eCare Project Board
3.20	Identify expenditure on services for older people more accurately	Mar 2009	Heads of Finance Group
3.20	Joint financial planning process	For 2011/12	Heads of Finance Group
4.14/4.15	Establish strong links to local community planning arrangements to influence and enable universal services to pay particular attention to the needs of their older service users.	For next Community Plan – Jan 2009	JASPG
4.22	Review and rationalise existing contracts and commissioning activity	Ongoing, with progress checks at least annually	Contracting Group
4.23	Further develop arrangements needed to underpin binding agreements	Ongoing, with progress checks at least annually	Contracting Group

6.5	The mechanisms for providing support to the Joint Adult Strategic Planning Group will be reviewed.	Jan 2009	JASPG
6.10	Service evaluation processes will be further developed	Ongoing, with progress checks at least annually	JASPG

Appendices

Appendix 1: The National Context

The framework must address the strategic challenges laid out in the most significant policy and guidance reports from the Scottish Government. The most recent include:

'Single Outcome Agreements – Guidance Scottish Local Government'[1] – an outline of the Single Outcome Agreement and its component parts and an explanation of the links between SOAs and the Scottish Government's Performance Framework

'Delivering for Health'[2] clearly emphasises the need to provide health services effectively in community settings, nearer to the point of delivery, to promote self-care and to support carers. This policy approach has also now been reinforced by the terms of the Kerr report, **'Building a Health Service Fit For The Future'**[3] – A National Framework for Service Change in the NHS in Scotland, which advocated a new direction in the way health care is provided with new ways of working, new skills, new thinking and a new culture.

Similar themes can be found in **'Changing Lives' Report of the 21st Century Social Work Review**[4], where there is an emphasis on developing personalised services and enabling people to remain at home and in control of their own lives.

'The Future Care of Older People in Scotland'[5] is a report advocating the need for capacity planning and a need for a whole systems approach that seeks to integrate all of the major reports into a series of principles and a vision for health and social care services for older people.

The key messages from '**Better Outcomes for Older People: A Framework for Joint Services'**[6] reinforces the need for continuity of strategic direction in putting forward the case for

- Proactively supporting older people living at home so they are not inappropriately admitted to a care home or hospital.
- Providing intensive rehabilitation prior to returning home from hospital.
- Ensuring a seamless transition from hospital or home.
- Actively supporting older people and their carers on returning home from hospital.
- Facilitating provision of appropriate rehabilitation support to people in care homes.

In particular, this report signposts the way that joint and integrated services should be provided – in partnership between individuals and their carers, health, housing and social care organisations, in the statutory and independent (voluntary and private) sectors.

[1] A Joint Audit Scotland, CoSLA, The Scottish Government, Improvement Service and SOLACE publication (2008) **Single Outcome Agreements; Guidance, Format and Indicators for Scottish Local Government**
[2] Scottish Executive (2005) **Delivering for Health**
[3] Scottish Executive (2005) **Building a Health Service Fit for the Future**- National Framework for Service Change in the NHS Scotland
[4] Scottish Executive (2006) **Changing Lives, Report of the 21st Century Social Work Review**
[5] Scottish Executive (2006) **The Future Care of Older People in Scotland**
[6] Scottish Executive (2005) **Better Outcomes for Older People**

'**All Our Futures ' – the Strategy for a Scotland with an Ageing Population'**[7] re-emphasised the continuing drive towards enabling people to live as normal a life as possible in their own homes.

The Scottish Government also commissioned work on the future of unpaid care in Scotland over the coming years to 2014. Its report **'The Future of Unpaid Care in Scotland'** [8] concludes with a number of core principles that include:

- The need to recognise carers as key individual care providers.
- Recognition that families and unpaid carers constitute Scotland's largest care force.
- The need to harness the contribution of unpaid carers for future care provision.
- The need to make caring a more positive life-choice and
- Strengthening independent living and self-care and improving quality of life and the quality of care.

[7] Scottish Executive (2007) **All our Futures- The Strategy for a Scotland with an Ageing Population**
[8] Scottish Executive (2005) **The Future of Unpaid Care in Scotland**

Appendix 2: Joint Financial Planning Framework

1 This joint financial planning framework is the first step on the path towards joint financial planning for services for older people across Forth Valley. It includes:

- A statement of the strategic financial planning parameters for older people's services, as at September 2008, of NHS Forth Valley, Clackmannanshire Council, Falkirk Council and Stirling Council;
- An indication of the scale of expenditure on services for older people by each of those organisations;
- An outline description of the current financial planning processes of each organisation; and
- Proposed arrangements for the further development of joint financial planning.

Financial Planning Context

2 The spending review 2007 set out funding levels for 2008-9 to 2010-11. The overall picture is one of diminishing resources and a requirement on all public sector organisations to achieve efficiency savings.

Strategic Financial Planning Parameters

3 NHS Forth Valley, Clackmannanshire Council, Falkirk Council and Stirling Council are all planning to achieve the 2% cash savings which are required of the public sector across Scotland. No decisions have yet been reached as to how this will affect funding for older people's services.

The Scale of Expenditure

4 For various reasons, relating to how financial records are kept and analysed, it is not possible to quantify the totality of resources devoted to services for older people in Forth Valley. However, the scale of existing expenditure can be illustrated by considering the three local authorities' budgeted net expenditure on social work services in 2008-09:

Clackmannanshire	£8.408m
Falkirk	£31.496m
Stirling	£17.901m

5 In addition, NHS Forth Valley spent about £29m in direct costs on geriatric services in hospitals in 2007-08. However, since only just over a quarter of the NHS FV total budget is spent on acute services, it is clear that this £29m represents only a small proportion of total expenditure on older people.

Financial Planning Processes

6 Financial planning in each of the three Councils follows a similar pattern:

- In February the Council agrees a revenue budget for coming year and high level indicative budgets for the two years after that.

- These are based on discussions which have been on-going since August/September, identifying service pressures, development plans etc.
- The latest date at which requests for alterations to the coming year's budget can be considered depends on the urgency and importance of the alteration concerned: Routine changes would be expected to be identified by October/November but changes are still possible if necessary up to early/mid January and, at least in principle, until the Council meeting itself.
- Service plans derive from 5 year Strategic Community Plans whose development involves a wide range of partner agencies. Falkirk's submission to the Audit of Best Value and Community Planning acknowledges that there is work to be done to strengthen the links between The Community Plan, the Council's Corporate Plan and individual Service Performance Plans to ensure that the allocation of finance and other resources is better aligned to the Council's strategic policy resources and they regard the MAISOP action plan as part of that process.
- A three year capital plan is also agreed at the February Council meeting.

7 The Health Board's financial plan is a rolling five year plan, covering both revenue and capital. It has to be signed off by the Scottish Government by the end of March. Discussions within the Board happen in outline in January and finally/formally in March, with detailed discussions at a Board seminar in February. As is the case in the Councils, revenue budgets are generally considered as incremental changes (up or down) on previous years' budgets and they should be, to an extent, predictable within the rolling five year plan.

8 The Health Board's financial plan is intended to achieve two main aims: Financial stability and delivery of the Healthcare Strategy and there is a Strategic Planning Group which considers all service developments and can ensure that the financial consequences of these are reflected in the financial plan.

9 There are processes in place to identify the resource consequences of proposed service developments by one partner on other partners and there are examples of resources being transferred to enable such developments. For example there is a proposal to close some mental health beds and transfer the associated direct costs to community services.

10 Both NHS Forth Valley and Councils receive funding from the Scottish Government for specific purposes, e.g. MRSA screening, more flexible access to Primary Care, telecare and free personal care, some of which impact on services for older people. However, this funding is often announced at relatively short notice and it is not always clear whether or not it will recur in future years. A joint financial planning process will improve the ability of all partners to respond to opportunities such as these as they arise.

Commentary

11 For quite understandable reasons, the current tight financial environment makes it difficult for any sub-set of an organisation's activities to be given clear strategic financial planning parameters which might be seen as giving them a more or less favoured status, in financial terms, than others. However, the consequence of having neither a comprehensive picture of current expenditure on older people's services nor

an explicit understanding of what this picture would look like in a "no change" scenario makes the assessment of the financial implications of change very difficult. It also makes it difficult for partners to commit to service developments if they cannot be sure of securing the necessary funding or of retaining any released resources.

12 The formal approval for the Health Board's financial plan is in March, compared with February for the Councils. However, there is a significant difference in the process which leads up to the approval and that is the fact that the Health Board's financial plan is a rolling five year plan. This means that there is a process to take on board changes as and when they become apparent, and accepted, rather than changes being concentrated around the turn of the financial year, as is the tendency in local authority revenue budgets where rolling multi-year budgets are very much the exception.

13 The existing financial planning processes in the four agencies are not incompatible with joint financial planning for older people's services, although they would be more robust if the Councils were to move towards multi-year revenue budgeting with more confidence attached to future years than is currently the case.

14 However, a more significant barrier to joint financial planning derives from the absence of a clearer financial envelope within which such planning should be taking place. This refers both to the need to identify and quantify the nature and scale of current expenditure and to the need for strategic financial planning parameters.

15 The obstacles here are clear:

- Councils are reluctant to budget over a longer time frame than they have been given funding commitments for;
- All organisations are reluctant to give future funding commitments to one aspect of their activities when they cannot predict the impact this might have on their other activities; and
- Many attempts at identifying and quantifying the nature and scale of expenditure on any type of activity have failed because of the complexity of public sector organisations and operations.

16 However, the benefits of joint financial planning are considerable, notably that it makes it possible to ensure that financial plans match the plans for service delivery and it provides opportunities for progressing those service delivery changes identified as being in the best interest of older people more quickly and effectively than can otherwise be the case. There is therefore a commitment to overcome the obstacles and move towards joint financial planning.

Next Steps

17 Work is already underway within NHS Forth Valley to identify expenditure on services it provides for older people. An important aspect of this is expenditure by CHPs. Currently these costs are identified by activity, e.g. District Nursing, rather than by client group and it is also not easy to identify expenditure by CHPs on the older people resident in each of the three Council areas since budgets are set according to managerial responsibilities, of which the locality aspect is but a part.

18 The intention is that, by the end of the current financial year, there will be an analysis which is accurate enough for planning purposes of CHP expenditure on services for older people. Another aspect identified for further research is the prescribing budget, although this may remain as "work in progress" for longer.

19 By 2009-10, therefore, core elements of expenditure on older people's services will be identifiable and work will continue to expand the scope of services which can be analysed in this way. This will provide some of the main building blocks which are required to underpin joint financial planning.

20 Also during 2009-10, there will be a focus on developing communication between the partners on strategic financial matters to gain a shared understanding of the extent to which future resourcing levels can be (a) indicated and (b) committed. This should allow some joint financial planning to take place during 2010-11 with the intention that, from 2011-12 onwards, joint financial planning will be the norm.

21 This joint financial planning process will include the development of discrete joint financial plans for specific areas of operation. These plans may each have quite a narrow scope but they will have been the product of a single, broader, planning process and will therefore have a degree of robustness which is not possible under the current arrangements.

Appendix 3: List of Services

The list below details the services that are assumed to fall under each definition.

Managed access for older people only or where older people receive a dedicated age-related service

- Assessment and care management
- Support for family carers and social support for service users (befriending)
- Advocacy
- Home care – including personal care, housing support and domestic assistance
- Day services for various particular needs groups
- Various forms of practical support in the home – e.g. Care & Repair and Handy Person schemes
- Aids, equipment and adaptations
- Telecare including community alarms, telehealth and telemedicine
- Short breaks – respite and emergency
- Community Mental Health Teams and services for Older People
- Intermediate care services
    - Rapid response and intensive home care
    - Rehabilitation and capability approaches
    - Community hospital, care home and housing based placements
- Community and Primary care services
    - Physiotherapy
    - Podiatry
    - Dietetics
    - Occupational Therapy
    - Speech & Language
    - Behavioural Psychotherapy
    - Specialist Nursing
    - District Nursing
    - Health Visiting Services
- Sensory impairment equipment and services
- Palliative care
- Care homes (long stay care or remodelling)
- Community Hospitals (remodelling)
- Extra care housing, very sheltered housing and traditional sheltered housing
- NHS inpatient continuing care, inpatient geriatric and long stay care
- NHS emergency admissions
- GMS
- Community Pharmacy
- Community Optometrists
- Community Dental Services

Public Access services for people of any age

- Libraries, lifelong learning and culture
- Leisure and fitness
- Transport
- Community support and capacity building
- Health improvement and well-being
- Family health services

Appendix 4: Commissioning Matrix

1 The table summarises how the different dimensions of joint commissioning interact depending upon the nature of the service that is under consideration.

Service Characteristics	Indicated Scope		Level of Commitment		
	Pan FV	Local	Statement of Intent	Non Binding	Binding
Similar service model	■				■
Different service models		■		■	
Similar priority	■				■
Different priority		■		■	
High cost	■				■
Low cost		■		■	
High risk	■				■
Low risk		■		■	
Small or fluctuating demand	■				■
Large scale		■			■
Self Directed Support		■	■		
Standard commissioning approach		■		■	
Specialised commissioning approach	■				■
NHS scope to deliver different local responses high		■		■	
NHS scope to deliver different local responses low	■				■

2 Any current or future services that are considered for a joint agreement may reflect conflicting indicators (e.g. high cost – pan FV; low risk – local) so it will be up to partners to analyse the indicated profile of the subject of each proposed joint agreement, alongside the potential benefits to be gained, in order to determine the most suitable agreement profile.

3 Deciding whether a joint agreement should be binding or non binding, regardless of whether it operates at a local or a pan FV level, is related not only to the characteristics of the subject of the agreement (service) but also the suitability in each case, of the arrangements that underpin a binding or non binding agreement.

4 As the sole pan Forth Valley partner agency, NHS Forth Valley may face particular challenges if joint commissioning is not conducted on a pan Forth Valley basis. For example, in order to accommodate service delivery arrangements, e.g. relating to hospital discharge arrangements or measures to deal with avoidable hospital admissions, which vary from area to area, NHS Forth Valley may also require to operate in different ways in different areas. Their ability to do this in some circumstance may be limited by resources or for practical reasons.

5 Below is a list of the arrangements that would normally be in place to underpin a binding agreement. Testing the suitability of these in each case may assist partners to determine the level of joint commitment that it is appropriate to adopt.

6 The arrangements underpinning a binding joint agreement should include:

- *Negotiation* – a structured process involving all relevant officers which ensures that the concerns of individual partners are recognised and discussed and that the final joint agreement reflects the fully developed, considered position of all partners, subject only to any explicit caveats, which have been recognised by all parties as being integral to the final agreement.
- *Sign off* – all parties ensure that the necessary officer, member or executive sign off to the final joint agreement is secured within a timescale which enables the agreement to be enacted as specified
- *Dispute resolution* – a formal process to resolve any dispute relating to the terms of any joint agreement is in place and has been agreed by all parties
- *Monitoring* – the nature of any monitoring of activity relating to any joint agreement is agreed, partners have put the resources in place to fulfil their particular commitment to monitor activity and any issues regarding data confidentiality and the sharing of information between partners have been identified, discussed and addressed to the satisfaction of all partners
- *Reviews/ reporting mechanisms* – the nature, practical arrangements and timing for undertaking formal reviews of joint agreements are agreed and all partners have put in place arrangements for review reports to be reported at an appropriate executive level within their organisation
- *Break clauses* – partners are able to negotiate specified periods within the joint agreement period when they may suspend their involvement (i.e. resource contribution and related activity), subject to the agreement of all partners and to a means being found to secure the continuing viability of the joint activity. Suspensions will be subject to a minimum period of prior notice and will continue for a specified period of time.
- *Termination* – a formal process is in place to handle the unlikely event that a partner is obliged to withdraw from a binding agreement. As a minimum this will include, formal notification, impact assessment, contingency planning and budget reconciliation between partners.
- *De-brief* – at the end of a binding joint agreement, either by virtue of the end date having been reached or a partner being obliged to withdraw, a formal de-brief will be undertaken jointly and severally by all partners to ensure that lessons are learned and applied.

Appendix 5: NHS Forth Valley Tiered Model – Explanatory Tables

Introduction: Overarching Themes

In compiling this commissioning model the partnership has identified two overarching considerations which inform every aspect of the model and will be central to its future development. These are:

User and carer participation
The Forth Valley Partnership is committed to listening and responding to the expressed views of users and carers and these views will increasingly determine the contracting arrangements that are put in place to best meet the needs of individual clients. More investment will be made in the involvement of service users and carers in the planning and delivery of community-based health and social care services.

Personalisation
Models of self care and self management based upon a collaborative partnership with service users will be developed to deliver more individualised services that enable them to stay well, and support them to manage their own symptoms. People will have greater control over determining their care needs, deciding what services they need and want and the arrangements for purchasing them.

Tier 0: Well and able to access universal public services without assistance	
Description	These are services provided to the general population who are well and who are not aware of having any social or physical needs or of exhibiting any symptoms of disease.
Aim	The aim of the services provided in this tier is to inform and educate the general population so that they can make choices to help maintain their healthy status. There will be services that bolster informal community support networks, particularly in rural and remote areas. Services will be available that predict or detect early signs of potential support, social care or health needs and other services will be aimed at prevention.
Where provided	Home and Community settings

Need	**Services Response**
Information and advice on health issues Robust community networks Help to make healthy choices Early detection of support and care needs and disease Health screening	Development of social policy Community planning initiatives Availability of a health promoting environment Provision of consistent information Education & Awareness Screening services

Tier 1: Becoming less independent or developing symptoms	
Description	These are services provided to help people who are less able to be independent and who are developing symptoms of illness or disease.
Aim	The aim of these services is to support self help strategies and informal family and community support networks. Also to provide speedy access to first point of contact, and to facilitate accurate and early assessment and diagnosis. They will provide low level support, aids to daily living within the home and accurate information to increase awareness of aspects of social need and a specific illness or disease.
Where provided	Home and Community settings Primary Care

Need	**Services Response**
As in Tier 0 Plus: Access to social support, befriending, housing support, domestic assistance, aids to daily living or Primary Care services Speedy assessment or diagnosis Self help information Understanding of social care needs and medical symptoms and their relationship to lifestyle Support and/or Treatment	As in Tier 0 Plus: Provision of service information Information about social care needs and medical conditions Self help management plan Prescription management plan Evidence based holistic management Multidisciplinary teams Direct access to assessment and diagnostic services Telecare e-Health support

Tier 2: Established long term condition or requiring a moderate level of support and social care assistance with service managed in community	
Description	These are services designed to help people who have an established long term condition or whose ability to live independently is diminishing but can be managed in a community setting. Some people may need adaptations or conversions to be made to their home or possibly to move home or to move into a supported living setting.
Aim	These services are aimed at maintaining the individual in a community setting, maintaining quality of life and maximising independence.
Where provided	Home and Community settings Primary Care

Need	**Services Response**
As in Tier 0 & 1 Plus: Access to additional support services Self help strategies Support for carers Supported living environment Medication	As in Tier 0 & 1 Plus: Coordinated services Day services Outreach Services Housing Adaptations/conversions Rehabilitation Services Sheltered housing Staged interventions plan 24/7 services Condition Management Programme – Job Centre Plus Tailoring the Self help management plan to meet increased need

Tier 3 Chronic health problems or requiring intensive support and social care assistance, including in care home or specialist housing settings - care mostly managed in community but requiring specialist input	
Description	Services provided for people with chronic problems or requiring high levels of care in the home, which can mostly be managed in community settings but may require specialist input from time to time.
Aim	Is to provide coordinated services which are aimed at maintaining the person's health so that they can continue to live in a community setting but also provide speedy access to specialist services when required.
Where provided	Home and Community settings, including extra care housing and care home providing residential care Primary Care Community Hospital

Need	**Services Response**
As in Tier 0, 1 & 2 Plus: Care co-ordination Extra care housing or care home providing residential care Specialist dementia care Support for carers	As in Tier 0, 1 & 2 Plus: Well developed inter-agency communication Integrated partnership approaches including intermediate care Multi-agency teams Single shared assessment Assessment of carers' needs Advanced care planning Dementia – friendly service models Multi-agency Care pathways Respite care Referral protocols in place Community based Teams Community Hospital Services

Tier 4: Frequent medical exacerbations or extremely frail possibly with mental health difficulties requiring continual nursing care or oversight. Health and social care requirements are more complex and exacerbations of condition more frequent and/or serious	
Description	Services provided for people with more complex problems, including those with more than one chronic condition, who have frequent exacerbations which can be serious and as a result whose capacity to sustain their independence is severely limited.
Aim	Is to provide coordinated services which are aimed at maintaining the person's health and social wellbeing so that they can be managed in a community setting but also provide speedy access to a broad range of specialist services when required.
Where provided	Home and Community settings including extra care housing and care home providing nursing care Primary Care Community Hospital Acute Hospital

Need	**Services Response**
As in Tier 0, 1, 2 & 3 Plus: Intensive support Care home providing nursing care	As in Tier 0, 1, 2 & 3 Plus: Complex care packages Telemedicine Simple access pathways for referral and/or admission to hospital Effective discharge planning arrangements Communication of person's needs to other involved services e.g. out-of-hours

Tier 5 – End of Life Care	
Description	Services provided to people who are nearing the end of their life and their families.
Aim	Provide coordinated palliative care services to people nearing the end of their life aimed at ensuring … comfortable, pain free facilitate choice of where the person wishes to die.
Where provided	Home and Community settings including extra care housing and care homes Primary Care Community Hospitals Residential Care Settings Hospice Care Acute Hospital

Need	**Services Response**
As in Tier 0, 1, 2, 3 & 4 Plus: Symptom control/management Recognition of needs and choices of the person and their family	As in Tier 0, 1, 2, 3 & 4 Plus: Gold Standards Framework Palliative care Pharmacy Network Liverpool Care Pathway