



Summary

Joint Commissioning Strategy Older People Services

2010-2013

Draft for Consultation

Consultation Period:
01/01/10 – 28/02/10

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SECTION 1: INTRODUCTION

This joint strategy has been prepared by North Somerset Council and NHS North Somerset to identify how the needs of older people will be met within the available resources.

The term “we” is used throughout this strategy to reflect the joint intentions of both organisations; even where one organisation (NHS North Somerset or North Somerset Council) may hold the responsibility for providing the service in question and therefore will undertake a certain function or action but that this is done with the full knowledge, agreement and sign up from the other partner.

Services for older people with mental health needs and the acute, hospital services are not specifically covered within this strategy but are covered in more targeted documents. However, clear pathways for accessing acute hospital care, and managing safe and timely hospital discharge are covered.

This commissioning strategy relies heavily on North Somerset Council's Older People Strategy and the Adult Social Care Review and NHS North Somerset's Strategic Framework and Transforming Community Services in North Somerset.

The key aim of this strategy is to achieve the transformation of services which deliver real control, meaningful choices and better outcomes for older people. In particular, NHS North Somerset and North Somerset Council are keen to develop a range of joint services which actively work to promote independence and reduce our use of institutional care options, be they hospital-based or in care home settings.

How will the strategy be agreed?

This strategy has been developed in consultation with the Older People Strategy Group and has been developed taking into account the latest national guidance, the views of local people, their families and their carers and a detailed analysis of local need and supply. The Joint Transformation and Commissioning Board (TCB) have approved this strategy for consultation; we want to make sure that people living in North Somerset help us to make these decisions by asking for views on the content of the strategy during the consultation period. The final strategy will be ratified through each organisation's internal mechanisms.

Detailed annual action plans will be drawn up each year to deliver the stated objectives. Some objectives will be cost neutral, whilst others may require different levels of investment. Both the PCT and Local Authority are in an increasingly stringent financial position; any investment in new services will need to come from funding released, either from elsewhere within older people services or elsewhere in the health and social care system.

As part of the action planning arising from this strategy, we will be investigating the impact on all parts of the health and social care system and ensuring a joint approach to delivery.

What is a Commissioning Strategy?

Commissioning means finding out what services people need and then deciding how

to best jointly commission those services, ensuring quality and the range of services that we can afford within the resources available. We have to decide which services are the most important and then plan to deliver them in a strategy.

Commissioning in North Somerset

We are committed to establishing clear commissioning arrangements in North Somerset that will best meet people's greatest needs as cost effectively as possible. Our aim is to establish lead commissioning responsibilities (where one agency, either the Local Authority or the PCT, takes on the function of commissioning the service(s) that have been jointly agreed as needed). As part of the arrangement, we must decide which functions will be delegated to the lead commissioner, what will remain a joint responsibility and what should be an individual agency's responsibility.

SECTION 2: STRATEGIC CONTEXT

2.1 National Drivers

Summary of the National Strategic Context

There will be a greater focus on prevention, on promoting well-being and on delivering services in settings that are more convenient to the people that use them.

Services will be tailored to the needs and preferences of individuals, they will maintain independence and dignity and individuals will be well informed of what is available.

Citizens will be empowered to shape their own lives and the services they receive.

Service Development is expected to be achieved at the same time as delivering major financial efficiencies and savings.

2.2 Local Strategic Direction

Summary of the Local Strategic Context

Agencies will work together to make available, better integrated health and social care services for older people.

Community based services will be available that will enable older people to lead full, active and healthy lives for as long as possible and to live independently in their own homes for as long as possible.

Services will be rated as high quality, innovative and meet identified needs

The health and social care system will be more efficient and effective than ever before. There will be increasing emphasis on patients and service users being supported to manage their own care and in ensuring they access the right level of care in the right setting when required.

The focus will be on enabling older people in North Somerset to make a positive contribution to their own quality of life and to their community.

2.3 Linked Strategies

National	Local
End of Life Strategy	Older People Strategy
Stroke Strategy	Older People Mental Health Joint Commissioning Strategy
A new ambition for old age: Next Steps in implementing the NSF for Older People	Carers Strategy
NSF for Long Term Conditions	Learning Disability Joint Commissioning Strategy
Use of Resources in Adult Social Care	Learning Disability Self Assessment Action Plan
	Housing Market Assessment for Older People
	Safeguarding Adults Policy
	Joint Engagement Strategy
	Go4Life - Active Lifestyles
	Putting People First Milestones Framework
	Draft Physical and Sensory Impairment Strategy
	Transforming Community Services (Summary)
	Older People Housing Strategy
	North Somerset LINK Health & Adult Social Care Priorities Survey Report

SECTION 3 Current Commissioning Arrangements

NHS North Somerset and North Somerset Council are increasingly working jointly to manage the commissioning and contracting arrangements in North Somerset in order to achieve increased efficiencies and improved outcomes across community health and social care.

The following Tables shows the amounts spent by The Council and NHS North Somerset in the areas listed:

Jointly Commissioned Services	Local Authority	Health	Total
3rd Sector low level support services	£197,000	£75,000	£272,000
Equipment & Adaptations	£546,690	£820,000	£1,366,690
Rapid Response & Rehabilitation	£466,030	£1,624,413	£2,090,443
Single Point of Access (SPA)	£290,550	£171,982	£462,532
Carers Service	£184,667	£84,203	£268,870
	£1,684,937	£2,775,598	£4,460,535

Local Authority Funding on Services for Older People	2009-2010
Prevention and Self Care	£ 1,889,055
Early Intervention	£ 11,872,660
Access to Services	£ 695,200
Community Based Managed Care	£ 19,824,100
Total	£ 34,281,015

NHS North Somerset analyses spend according to morbidity, rather than age, as such it is not possible to analyse fully the amount spent on older people services. The following table shows the amounts spent by NHS North Somerset in the areas that are in the main but not specifically for older people:

NHS North Somerset	2009-10 Budget
Community Matrons	£505,575
District Nurses	£2,763,270
Occupational Therapy	£477,811
Community Physiotherapy	£432,509
Podiatry	£563,718
Continence	£357,246
Specialist nurses TVN	£67,621
Clevedon hospital	£1,637,389
Falls	£97,291
Funded Nursing Care	£4,915,000
Continuing Health Care ^{note 1}	£4,415,000
Total	£16,232,430

Note 1 – The CHC budget excludes those with Learning Disabilities as a significant majority are under 65 years of age, but does include people with physical disabilities and mental ill health as very few people are under 65.

In addition NHS North Somerset spends a significant amount of money on hospital care for older people, as well as primary care services and pharmacy. Again, this spend is not analysed by age group. Over time our intention is to identify ways to invest this money in alternatives to hospital care to deliver our strategic objectives of delivering more care nearer to home and in community settings.

In drawing together this strategy, we will dedicate resources to undertake further analysis to give a full picture of the amount of money being spent in this area.

SECTION 4 Summary Needs Assessment

Demographic change to the population through ageing is one of the greatest strategic challenges facing the UK today.

Nationally, the number of people with longer-term healthcare needs is estimated to rise by 75% for those aged 85 and over by 2025. In North Somerset there is a greater proportion of its population in the over 65 age range than the national average and it is estimated that there will be a 16% increase in the number of people aged 85 by 2015 and 62% increase by 2025.

The proportion of older people will continue to rise, and with the 75+ age group growing faster than any other; there will be, more people suffering dementia, more people with disabilities, more people living alone, more men and more people from black and ethnic minority backgrounds.

Older people living alone will put pressure on general housing supply; there will be increasing pensioner poverty and housing not meeting decency standards, on average across the district 80% of those over 65 are owner occupiers. In North Somerset, it is anticipated that between 2008 and 2025 the population of those living alone aged over 75 years will increase by 58% and by 80% for men, indicating a potential increasing demand on support and care services with the possible onset of frailties.

North Somerset has a very high number of care home places for older people proportional to the over 75 population and a consequent high number of people living in care homes; the majority of which fund their own care costs. There is evidence that older people in North Somerset are not aware of the options available that offer alternatives to a moving to a care home.

Three electoral wards stand out as having a population with the poorest health outcomes in North Somerset. These are also the areas of greatest social deprivation, and are all situated in Weston-super-Mare. Whereas some of the more rural areas of North Somerset fall in the bottom 10% nationally, for barriers to housing and services, leaving some people potentially isolated with poor access to services.

Overall life expectancy in North Somerset is higher than national rates and similar to rates across the South West. The four main causes of death at all ages and of those who died prematurely (before reaching their 75th birthday) were cancer, coronary heart disease, stroke and circulatory diseases other than CHD and stroke.

SECTION 5 Shared Vision for Older People

Health and Social Care services in North Somerset will be integrated, more efficient and effective than ever before; they will have a new prevention-focus that will help older people manage their own situation with the necessary support from personalised commissioned services.

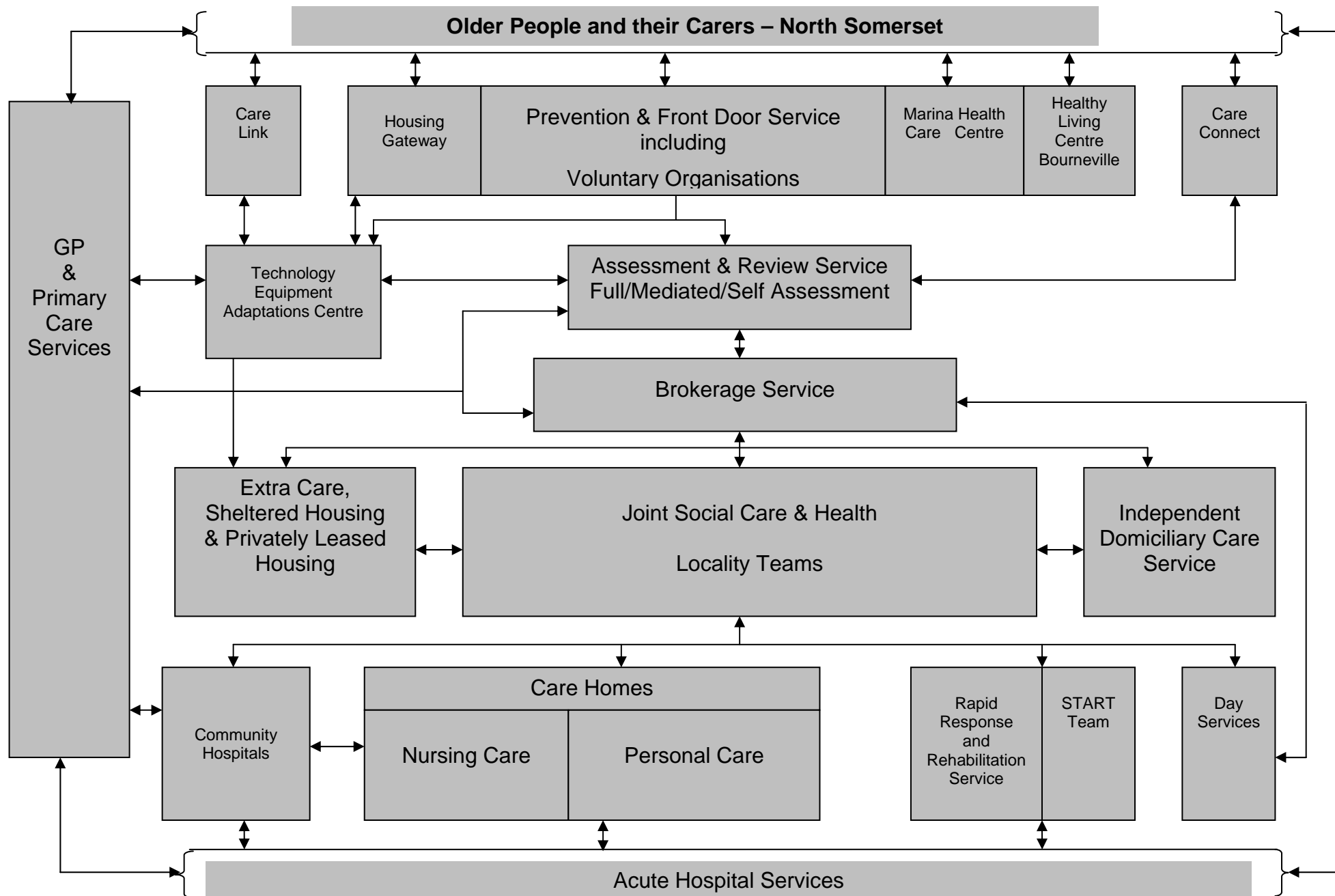
Where urgent care is needed following a crisis situation, this will be managed in the community, either in the patient's own home, a community hospital, an urgent care centre or minor injury unit. We will enable the patient to stay in their own home if possible, by providing community IV therapy, telecare and nursing and AHP input where needed.

If following a crisis situation, the patient cannot remain in their own home; they will receive a coordinated assessment of need, enabling the patient to return home with improved coordinated support networks as soon as possible.

Service Users, Carers and Family members will be at the core of any service developments and will be fully involved in planning and delivery processes.

To support this vision for North Somerset the following services will be available:

**North Somerset Council & NHS North Somerset
Social Care and Primary Care Service for Older People Service Configuration**



SECTION 6 Delivering the Vision

This section looks at how the local services will change or develop to the vision for older people in North Somerset.

6.1 Prevention and Self Care

6.1.1 “Front Door” Service

We will create of a new ‘front door’, problem solving service offering information, advice and help about the full range of older people’s facilities and services.

Community agents will be based in local neighbourhoods and will provide this first contact point for the host of services available to older people in their own homes and those being discharged from hospital. The service will target people who have historically funded their own care.

6.1.2 Health Shops

The vision for self care in North Somerset is to develop “Health Shops” throughout North Somerset where patients can for example:

- find the latest information about their condition
- book on line on to exercise classes or borrow exercise DVDs
- join expert patient programmes or support groups

These will be sited where they are most easily accessible and may also be established in locations such as supermarkets, libraries, GP surgeries or pharmacies. The first will be located at The Boulevard in the centre of Weston-super-Mare.

6.1.3 Low Level Support Services

The Community Development Workers offer low level prevention support and sign posting services to isolated, vulnerable older people, they support Community Cafes, and help develop local groups that promote inclusion, involvement and empowerment to take better care of oneself.

6.1.4 Prevention of social isolation

There are a range of services available for older people living in their own home that can help prevent social isolation. We have commissioned new services following feedback from older people and will keep under review the need for new developments in this area.

6.1.5 Self Care

Self Care plays a key role in supporting people to prevent disease, manage their condition when they become ill and care for relapses when they arise or prevent them from becoming ill. Self Care is one of the key building blocks for a patient centred service and in essence aims to support patients to self care.

We will develop resources to enable the maximum number of people be supported to self care. This will include:

- developing the skills of professionals to support self care,
- improving the provision of information about long term conditions through information prescriptions for example,
- introducing person-centred condition specific self-management plans that empower patients to recognise and manage problems thereby de-escalating a crisis,
- supporting people to access local services that help them maintain their physical and mental well-being, and
- Increasing the flexibility of service provision to fit in with patients' other commitments.

6.2 Early Intervention

6.2.1 Extra Care Housing

Ensuring an appropriate amount of Extra Care Housing according to need, is one of the key components to our vision. We are committed to continuing reductions in the use of institutional care, and will continue to ensure the provision of suitable housing and support for our older residents. For this we will need extra care housing in areas across North Somerset.

There has been a major expansion of extra care provision for older people in North Somerset, There are further plans for additional extra care in Worle with some specialist provision for people suffering from early onset of dementia.

There are further indications that some specialist extra care accommodation for younger people suffering from long term conditions including Multiple Sclerosis is needed.

Our biggest challenge with Extra Care housing is ensuring those that can benefit most from the services provided are aware of the schemes and are enabled to access them.

We also need to consider how the services that are provided within the schemes can be rolled out to benefit the local community

In addition we will establish a pilot extra care service that provides nursing care as a key component, referred to as extra, extra care.

6.2.2 Telecare and Telehealth

In line with national guidance, our aim is to make telecare integral to all community based packages of care and support. Telehealth and telecare will support the proactive case management of patients with long term conditions and will also enable patients to stay independent for longer.

We will increase the take up of telecare services in North Somerset to support independent living and create a Telecare and Equipment Centre for North Somerset to improve access and choice.

Plans are in place to develop a response services around the district to ensure that users of telecare services have round the clock access to care support as needed.

We will ensure any developments in Telecare and Telehealth are done in full consultation and cooperation between the PCT and the Council with a view to maximising benefits for people who may use the services.

Telehealth devices enable patients with a long term condition to self manage their condition in their own home, and any deterioration in condition can be detected early so that a hospital admission can be prevented.

NHS North Somerset are exploring ways to move forward in this arena, and are in discussions with NHS Bristol and NHS South Gloucestershire concerning proposals to create a new Telehealth service across the 3 primary care trusts. However, proposals will have to demonstrate that it relieves pressure elsewhere in the healthcare system (e.g. reducing hospital admissions) before they will be adopted.

6.2.3 *Respite Care and Short Stay Breaks*

We will ensure that carers are supported by the provision of good quality, reliable, flexible breaks recognising that carers can have a life beyond their caring role and to support carers maintain their own health and well being and prevent carer breakdown.

Services offering a break to carers will work in partnership with the carer and person being cared for to deliver flexible and reliable services.

We will ensure a range of options are available to meet individual need, including short stay placements in residential care homes, if necessary. We will continue to develop short-term home based emergency respite cover to provide support in crisis or emergency situations.

6.2.4 *Day Services*

We will develop day services that provide flexible, individually tailored services for people within their local communities; moving away from the traditional day care model.

All new contracts will include specific requirements in relation to delivering personalised services and we will work with providers to explore appropriate responses to meet the needs of people using personal budgets.

6.3 *Urgent and Emergency Care*

Our aim for urgent and emergency care is to ensure older people are assessed and treated in the right place by the most appropriate person and that service resources are used to maximum effect. Current services are relatively independent of each other and we will move to an integrated pathway with the different components delivered by a partnership that includes stakeholders from all relevant services including GP services, the assessment and treatment centre, the emergency

department, community and social care, NHS Direct, Ambulance trusts and independent providers.

We will proactively manage demand to allow the Emergency Department to focus on life threatening and traumatic situations where the time taken is critical. The other less complex cases will be dealt with by primary care through the GP Health Centre or community services where appropriate.

6.3.1 Out of Hours

The Council's out of hours social work services are provided by the Emergency Duty Team (EDT) based in South Gloucestershire. Carelink (community alarm service) provides a 24/7 service and works closely with EDT, manages out of hours home care services and is the first point of contact for carers who have joined the Carers Emergency Response Scheme. It also provides out of hours logistical support to the District Nursing Service.

NHS North Somerset's Integrated Community Response Team forms part of the present integrated adult services programme and provides a 24/7 short term nursing response to crises in the community to prevent care home and hospital admissions.

We are investigating options to provide an out of hours response linked to the telecare service as listed above.

6.3.2 Rapid Response & Rehabilitation Service

NHS North Somerset has recently expanded the resources to rapid response and rehabilitation. We now need to embed working practice to ensure the team works in a fully integrated way.

The focus of the service is to rapidly respond providing intensive nursing assessment and support including short term packages of care and rehabilitation in people's own homes thereby avoiding admission and supporting earlier discharge.

We will monitor the impact this investment is having and how the service outcomes affect the requirements of a future rehabilitation team.

Falls Service

The North Somerset Falls Prevention and Management service is run by a multi-disciplinary team within the Rapid Response and Rehabilitation Team.

The team work with people who have been identified as having a high risk of falls. Interventions include supervised exercise training for strength and balance and a validated exercise programme delivered to individuals or groups. Training is provided for Care Home staff and residents and multiple partners are involved in identifying and supporting those at risk of falling.

We will fully implement a falls and bone health pathway that spans primary and secondary prevention, and multi-factorial assessment and management, based on the "Do Once and Share Falls Pathway".

6.3.3 Direct Access Diagnostics

NHS North Somerset is committed to developing better direct access to diagnostic services for GPs, especially for MRI scans. Direct access by GPs allows them to manage patient's health more effectively, making a more informed diagnosis. It allows for the treatment of a greater number of patients in the primary care setting and at the same time a more appropriate referral to secondary care when it is needed. It will also have the effect of reducing referrals to secondary care for the purpose of obtaining a diagnostic test.

6.3.4 Emergency Care Practitioners (ECPs)

NHS North Somerset have invested in ECPs which are highly trained ambulance paramedics who can treat people appropriately at home rather than see them admitted to hospital which can be a highly distressing and potentially counterproductive experience (such as exposing patients to viruses in hospital).

At the moment there is some pressure to meet targets on ambulance response times (8 minute response time for urgent calls) and some ECPs have had to be diverted into meeting these important targets. However, the long term strategy is to deploy them in avoiding unnecessary hospital admissions.

6.4 Access to Services

6.4.1 Single Point of Access (SPA)

“Care Connect” is our single contact point for people needing to access health and social care community services for adults. Staff in Care Connect provide call handling, triage, signposting, information, assessment, service coordination and referral functions. Cases requiring professional input are passed onto a team of professionals (sometimes called the back office) for a more detailed assessment. This enables us to provide an immediate response to some referrals from the first point of access. The SPA is jointly commissioned by the PCT and Council to support the integration of community services. In future the SPA will support the coordination of end of life packages of care and be the point of contact through which patients coming to the end of their life can get hold of their key worker.

To support integrated working and the seamless flow of referrals and information within and between teams we have plans to improve the information technology infrastructure. The Council has commissioned a new social care database (AIS) and customer records management system, which will provide better connectivity between different parts of the care management service and a smooth interface with local NHS systems. The PCTs locally have commissioned a community services system RIO, which is being rolled out on a phased basis to health teams.

Drafting note - Paragraph needed on how they will interface.

Supporting People services are currently developing a single point of access including individualised self assessment options. This will be accessible for both potential service users and services providers and will link with Care Connect and the brokerage team.

6.4.2 Single Assessment Process (SAP)

Care Connect carries out initial screening assessments which are now being developed into FACE contact assessments.

We are currently developing a single assessment tool that can incorporate the requirements of the personalisation agenda including outcome based care planning and resource allocation. This will be used by all health and social care professionals in North Somerset. An electronic version of the assessment will be embedded within the AIS database, and will be supported by the Practitioner Portal tool, designed to support remote working.

Our overall aim of the SAP is to ensure that we only need to collect information once but can use it many times by introducing a process that allows for sharing of information between agencies.

6.4.3 Self Assessment and Mediated Self Assessment

As part of the single assessment developments outlined above, we are also planning to introduce the facility for individuals or people acting on their behalf to complete a self assessment, via the internet. The self assessment tool will be accessed through Care Connect pages on the council website and will allow individuals to directly and simply express their needs and requirements.

SPA staff will triage electronic referrals as a result of the self assessment.

Online self assessment will not be appropriate for everyone; SPA staff will also offer mediated self assessments over the phone, where appropriate.

6.4.4 Brokerage

We have introduced a 'Brokerage' service responsible for procuring domiciliary care packages, care home placements and day service resources in line with care management assessments, and continuing health care packages against assessed needs.

The brokerage team includes "care navigators" who specifically assist people responsible for funding their own care. This service is available irrespective of whether they wish to have a formal community care assessment (although they will be encouraged to have such an assessment or to self assess via the RAS).

We will develop the brokerage service over time to become one of the resources available to people who need assistance with the development of their personal support plan or who want our help in identifying particular care resources included in their support plan.

To support the brokerage team, we have recently introduced the "Domiciliary Care Allocation Website" (DCAW). This introduces a new way by which care providers can see what work we wish to commission through the use of the website. Providers can log on to find out what packages of care are unallocated, rather than wait for us to call them.

6.4.5 Personal Budgets & Health Budgets

Individual and Personal budgets are already being used in social care and the number of older people using direct payments is increasing. A significant proportion of those involved in the roll out of Personal Budgets are older people and there are some good examples of these users being supported to plan their own services in creative and very individual ways.

We are keen to increase the numbers in receipt of Personal Budgets and are analysing ways to support this aim. We are also following the developments being made nationally in Health Budgets with a view to introducing them in the future in North Somerset (subject to legislative changes to allow the NHS to make direct payments to individuals); this will in effect, create a multitude of “individual commissioners” who will purchase their own services

6.5 Community Based Managed Care

Currently self care in NHS North Somerset is mainly supported by community staff such as Community Matrons, practice nurses and specialist nurses who focus on patients with complex long term conditions rather than the patients with low level health needs.

We have expanded our Community Matrons in response to findings from our benchmarking exercise arising out of the JSNA. They have a target to deliver an additional 350 avoided admissions a year with this extra investment.

6.5.1 Locality Teams

Managers have been appointed to the new integrated Primary Care/Adult Social Services community teams. Business process planning is taking place in order to combine and streamline processes, wherever possible.

Through integration, we aim to ensure that service users receive a single unified response from health and social care services in North Somerset, that access to services is improved and duplication of information and effort is eradicated ensuring that service users are not confronted with multiple assessments or requests for information.

6.5.2 Rehabilitation

Rehabilitation is a process which starts with the assessment of impairment and leads the definition of specific, measurable rehabilitation goals which are reviewed and amended at key stages. This process is best carried out in an interdisciplinary team, with the person and their family at the centre of the goal planning process.

We will ensure the quality and availability of rehabilitation services in order to provide a coordinated pathway to enable people to live as independently and safely as possible. Our rehabilitation pathway will be well defined and will provide a seamless transfer of care between services that are timely, and ensure relevant treatment is provided by carrying out appropriate assessments and regular reviews.

Prior to discharge from hospital an appropriate package of care will be put into place. This work will start, as early as practically possible to ensure that community based rehabilitation can commence.

We will target rehabilitation services to support individuals who have achievable goals. For this reason where an individual is no longer making progress, we will discharge them from active rehabilitation and arrange an appropriate care package where required. Individuals may re-enter rehabilitation services if they are later assessed to have realisable goals.

We already invest in domiciliary support on discharge through our joint rapid response and rehabilitation service and also provide some residential based support at Clevedon Hospital and step down places. However, the rates of placement into care homes on discharge are very still high. We are therefore investigating ways to develop additional “step down” facilities that can be used to offer additional rehabilitation following a hospital stay or period of acute illness to enable people to return home. Consideration is being given to using vacant accommodation in existing Extra Care Housing and / or care homes.

6.5.4 Home Care

Home care is a key service that enables older people to continue to be supported in their own homes. The council's in-house START team provides an initial short term re-ablement services for new service users and service users whose needs have significantly changed, they work closely with the rapid response and rehabilitation team and initial data evidences high levels of success in promoting independence. In addition to START, the independent sector provide any long term home care packages for people moving on from START. We will introduce outcome based contracts for all providers to build on the work undertaken with service users by START.

Over recent years we have experienced a massive increase in the volumes of home care provided; this has lead from time to time, to some difficulties in sourcing sufficient home care to meet demand particularly in rural areas. Incentives have been put in place to increase levels of provision in these areas. In addition, we will work with providers to improve terms and conditions for care workers in North Somerset to improve retention and availability. We will review the effectiveness of these measures on an ongoing basis.

In order to address issues of availability, travel and to offer greater flexibility to work with more complex needs, providers will be guided to work in tighter geographical areas. We will divide the area into a number of zones and, using a framework agreement, will create smaller working partnerships between providers. The aim of this will be to positively impact recruitment and retention; providers will be able to target recruitment locally, offer work locally, reduce travelling time for care workers and encourage ‘greener’ ways of travelling i.e. walking and cycling.

Providers will be encouraged to work alongside local Voluntary and Community Organisations (3rd Sector) and the PCT. It is also hoped that relationships will form with local GP surgeries and pharmacies and care/residential homes.

A forum for each zone will be set up by the Providers with representation from Service Users, carers, local authority officers and members, the PCT and local 3rd Sector groups.

We will maximise the opportunities offered by the location of Extra Care Housing Schemes within the zones to secure both efficiencies and capacity to support vulnerable people 24/7.

6.5.5 Acute Hospital Services

The PCT commissions acute hospital inpatient, outpatient and diagnostic services from the 3 acute Trusts in Weston and Bristol. Older people consume a significant proportion of acute care services which may not be the most appropriate form of care them in all cases. This arises because our processes and lack of alternative services direct the flow of patients to acute hospitals. The Transforming Community Services Strategy will help redirect that flow as will the development of the urgent and emergency care model (section 6.3).

Elective stays in hospital will be as short as possible and will involve active rehabilitation focused on getting people back on their feet as soon as possible. Discharge planning will commence as soon as someone is admitted to hospital.

6.5.6 Community Hospital Services

The Bristol Health Services Plan is a major reconfiguration programme designed to transform, modernise and improve acute and community-based health services in Bristol, North Somerset and South Gloucestershire. It includes both new and redesigned healthcare facilities such as the new Clevedon Hospital and new primary care resource centres in Portishead and Weston.

Clevedon Hospital

We will undertake redevelopment work at Clevedon Hospital and will maximise the opportunities for rehabilitation. The development is being considered in two phases.

- Phase One - An interim arrangement to maximise the use of the existing facilities including MIU, outpatients and beds.
- Phase Two - A long term model that considers the reprovision of the hospital either on its existing site or an alternative site in Clevedon.

We consider Clevedon Hospital to be pivotal to the success of the newly proposed rehabilitation pathway for North Somerset.

Community Resource Centre

The Marina Health Care Centre at Portishead provides a new facility from which rehabilitation can be delivered in terms of group sessions, out patient facilities, gym facilities and as a base for staff.

The Healthy Living Centre at Bourneville in Weston Super Mare provides all forms of primary care. There is a team of doctors and nurses serving the community providing general practice medical services including: doctor surgeries; nurse led minor illness

clinics; treatment room clinics; clinics for diabetes, heart disease and respiratory disease; vaccination clinics; phlebotomy; antenatal clinic; health visitor clinic; counselling; support to stop smoking.

These facilities will link into the network of health shops identified above.

6.5.7 Nursing Care

In general people who choose to enter care homes have a wide choice of care homes of good quality. We have in the past however, had concerns as to whether levels of provision for older people with mental health problems were sufficient to meet demand in the medium term. We have increased this area of provision with the introduction of a new 'state of the art' care home for older people with dementia near Nailsea (the Granary), the development by the St Monica Trust of a new care home with nursing in Sandford.

6.5.3 End of Life Care

The phase "end of life" ends in death. Definition of its beginning is variable according to individual and professional perspectives. In all cases, subject to an individual's consent, the beginning is marked by a comprehensive assessment of supportive and palliative care needs.

We will ensure that "End of Life Care" helps all those with advanced, progressive, incurable illness to live as well as possible until they die and enable the supportive and palliative care needs of both the individual and family to be identified and met throughout the last phase of life and into bereavement. We will include management of pain and other symptoms and provision of psychological, social, spiritual and practical support.

The national End of Life Strategy, published in July 2008, describes end of life care as having had relatively low priority in health and social care services. The strategy's aim is to bring a step change in access to high quality care for all people approaching the end of life, whatever the patients preferred setting and irrespective of age, gender, ethnicity, disability, religious belief, sexual orientation and diagnosis.

We will ensure that we deliver quality services and maximise choice for individuals in North Somerset through a model of care that includes:

- End of life care facilitation in primary care and care homes by providing practical support to implement and build into everyday practice, the tools designed to identify people coming into their last 6 months of life.
- An end of life register that captures individual's preferred place of care.
- A palliative care framework that sets standards for staff by way of actions in response to managing care needs.
- Enhancing the single point of access to include coordination of services on behalf of clinical staff thereby releasing their time to hands on care.
- Improving the provision of information and advice to patients and their significant others through a dedicated web-site and literature as well as providing palliative advice to clinicians.

- Enhancing the skills of professionals supporting patients at the end of their lives through education opportunities, support from specialists.
- Development of an enhanced workforce to support more patients dying at home.
- Ensuring the local infrastructure is adequately resourced to support more people dying in the community e.g. community equipment.

SECTION 7 Infrastructure Issues

To support the implementation of this strategy, we will work jointly to ensure the necessary infrastructure issues are in place as follows:

7.1 Workforce Development

Our aim is to support the development of “a highly skilled, valued and accountable workforce drawn from all sections of the community. We need to ensure that there are sufficient numbers of people with the right skills in the right place at the right time.

We will:

- Commission training to support transformation for all agencies working in the social care.
- Develop opportunities to encourage recruitment of younger people into the workforce and to encourage older workers to return to work.
- Introduce initiatives to encourage staff retention and ensure knowledgeable, experienced and high quality staff

7.2 Safeguarding

We are committed to protecting vulnerable adults in North Somerset. We will continue to monitor access to our multi agency safeguarding training to ensure all statutory, private and third sector providers working in North Somerset have participated and understand the requirements.

Contracts with care providers specify requirements in relation to safeguarding policy and practice including whistle blowing and the Contracts team have dedicated staff who ensure contract compliance.

We will continue our strategy to increase awareness and recognition of safeguarding and adult abuse issues and have introduced a range of initiatives aimed at reducing instances of abuse taking place and improving the reporting of such incidents. We will ensure continual development of safeguarding.

7.3 Dignity in Care

In North Somerset our intention is to ensure dignity in care is extended to all adults receiving health and social care services irrespective of the setting and service provider.

Communication is a key component in fulfilling the Dignity Challenge. In order to maintain control and independence, people need information about what they are entitled to and what they can expect from services, and they need it at the right time, we will therefore ensure that expectations and standards are clearly set out in easy to read and understand publications.

7.4 Housing

We understand that in order to achieve our objective of supporting people to remain independent in their community, we need to ensure that there is sufficient and fit for purpose accommodation in the community. This means not only ensuring the right supply of high quality extra care housing and sheltered accommodation but also to ensure good standards in general housing stock both in the private sector, owner occupied and in social housing.

We will investigate the need for further developments of extra care housing and will earmark resources to support the increased demand for Disabled Facilities Grant.

We are also focusing work on trying to get information and advice right so that older people can make informed housing choices in later life.

7.5 Transport

We will work with our partners to focus on the transport needs and requirements of older people, particularly in relation to rural areas supporting subsidised schemes, community transport, dial-a-ride schemes and to improving facilities at identified bus stops by raising kerbs for low floor buses, additional bus information and provision of bus shelters.

In addition the Council will continue to issue new diamond concessionary travel card passes which is a free bus pass for older people and residents with disabilities.

We envisage that implementation of this strategy will reduce the need for patient and visitor transport across the district. We will continue to ensure that the limited patient transport service available is used appropriately and it is only used where there is a definite need for transport. We will be re-commissioning the Patient Transport Service in September 2010.

7.6 Data Systems / Data Sharing

We are committed to the procurement and implementation of the Northgate Adult Information System (AIS), which is critical to the delivery of the Personalisation Agenda. This will enable the on line self-assessment and calculation of an indicative Personal Budget. This will enable the individual to carry out their own Support Planning with family or professional assistance if required.

If professionals without access to AIS need input to the assessment then it can be passed into that person's operational system via the NHS Spine messaging service.

FACE has been adopted as the Single Assessment Process (SAP) tool to be used by the integrated teams and we have agreed information sharing protocols to facilitate data sharing in line with the Caldicott principles and with customer consent.

7.7 Estates

We are committed to maximising resources by achieving co-location of integrated teams as quickly as possible and are currently well advanced in securing property in Clevedon that will facilitate this aim.

7.8 Hospital Discharge Planning

A key outcome in delivering the vision for this strategy is to ensure that hospital discharge is timely and safe. A quality discharge process enables good patient care, ensuring that the right services are in place for the patient on discharge. This is good for patients and can help to minimise re-admissions to hospital.

We will ensure that those services that support good discharge arrangements such as Rapid Response and Rehabilitation, Interim beds, District Nursing services and services provided from Clevedon Hospital are adequately resourced and managed to facilitate a smooth discharge care pathway.

We will invest in resources to ensure that service users have maximum access to information so they can make informed decisions about their options after leaving hospital.

We will investigate new models of post hospital support as an alternative to people going directly into residential care.

7.9 Charging

Health care such as nursing, physiotherapy and occupational therapy is "free to all" at the point of access and as such, are not subject to charging procedures, whereas social care is subject to a variety of charging arrangements depending upon services received. For example, those receiving domiciliary care, day care and/ or Supporting People are financially assessed and depending upon individual circumstances are charged up to the maximum cost of providing that service. Those living in care homes are allocated a fixed living expenses allowance (considerably lower than that allowed in community based services).

However the results of the current DH consultation "Personal Care at Home: A Consultation on Proposals for Regulations and Guidance" will impact on the charging arrangements detailed here. .

7.10 Risk Management

The Joint Commissioning Group has assessed risks associated with implementation of this joint commissioning strategy and will continue to monitor the impact of the identified and any new risks as they arise. Their aim is to identify strategies to minimise the impact of the issues and risks as they are identified.

7.11 Sustainability Issues

We have assessed that implementation of this strategy will have a positive impact on the environment. The driver is to deliver services closer to home allowing local employment and less travel requirements for those accessing services.

7.12 Equality Impact Assessment

Equality impact assessments have been carried out for the service areas covered in this strategy. It is noted that very few people from the BME population use our services. Proportionally more women use the services than men when compared to the wider population of North Somerset. The services are designed to meet the needs of disabled people. Information on sexual orientation is not routinely collected. The vast majority of service users are Christian (of various denominations), although there is a wide range of religions recorded.

The changes proposed are aimed at offering more options for people and are likely to make the service more accessible to individuals. Currently service users are generally required to move to a care home if they need daily support with living. The changes proposed should make service more accessible by offering a range of preventative services and more options to get better information and help through the maze of information of what is available.

7.13 Engagement and Consultation

We are developing a joint engagement strategy across all the partnership to improve the evidence-base for the development of policies. Engagement and consultation will be streamlined to avoid duplication and replication.

Through the Community Development Workers and the new Community Agents, we will develop opportunities for older people to be involved in shaping services and to help in meeting identified needs.

We will ensure the creation of a user led organisation (ULO) in North Somerset in line with Department of Health (DH) ambition as set out in 'Improving the Life Chances of Disabled People'. The service will be developed in line with DH design criteria and modelled on existing Centres for Independent Living.

7.14 Age Discrimination

The Equality Bill currently before Parliament includes age provisions and seeks to ban age discrimination against adults in the provision of services and exercise of public functions; and create a public sector duty to eliminate discrimination and to advance equality of opportunity.

The Equality Bill provides an unprecedented opportunity for the health and social care system to build on the progress already made, truly eliminate age discrimination and take further strides in ensuring care is personal and meets the needs of each individual and their carers regardless of age.

Ending age discrimination and promoting age equality are as much about changing the attitudes and behaviours of individuals and the culture and practices of organisations. Staff rarely set out to be ageist but for a range of reasons, their actions sometimes do not meet the needs of the patient or service user who is in front of them.

The health and social care partners in North Somerset will focus on ending age discrimination and promoting age equality through fairness in ensuring that services are provided on the basis of people's needs and personalised to them as individuals.

SECTION 8 Transforming the Provider Sector

8.1 Using competition

Competition, or competitive tension, is one way of improving services. However it is not the only lever to do this and we will ensure good performance and contract management is the first approach adopted with an existing provider.

Competition also increases patient and service user choice. We are undertaking a local healthcare market analysis in areas such as primary care services, the development of community services and public health commissioning.

As commissioners we need to be aware of the characteristics of our markets and develop strategies for mitigating instances of market failure and ensuring the competition is effective.

8.2 Building Capacity and Skills

In addition we are working with domiciliary care providers to introduce formal zoning arrangement whereby North Somerset is divided into a number of zones and, utilising a Framework agreement, the creation of smaller working partnerships between providers to enable more joint working.

Providers will be naturally guided to work in tighter geographical areas. This should have a positive impact on recruitment and retention. Providers will be able to target recruitment locally, offer work locally, reduce travelling time for care workers and encourage 'greener' ways of travelling i.e. walking and cycling.

Providers will be encouraged to work alongside local Voluntary and Community Organisations (3rd Sector) and the PCT. We are also aiming to build relationships between local providers and local GP surgeries, pharmacies and care/residential homes.

8.3 Developing the Third Sector

We are considering various options to help develop the third sector. Our aim is to make the provider sector as flexible as possible to be able to respond to individual needs in all locations within North Somerset. We will support the development of micro organisations to establish a network of support that can be accessed when needed.

We will develop a quality matrix that adequately measures key quality components and will ensure that we only commission services from service providers assessed as Excellent or Good quality providers.

8.4 Managing the Redesign of the Care Home Sector

Our commissioning policy has been to suspend the usage of homes that fall short of acceptable quality standards, whilst working vigorously with the provider, to improve the service. This initiative will continue.

We are aware that the changes encompassed within this strategy, when implemented, will see a reduction in the use of residential and nursing homes. We will therefore need to manage this surplus provision. We will communicate the likely impact of these changes to providers and will assist them in identifying opportunities to redesign services to meet the personalisation agenda. Providers will need to ensure their staff have the appropriate skills to embrace these changes.

We welcome approaches from providers who have proactively assessed their future development options and would like to work in partnership with us to transform their services.

8.5 Joint Approach to commissioning

Details of the changes to the wider strategic framework that have been introduced to manage the joint commissioning arrangements within North Somerset are shown in Section 11 (below). We are committed to maximising opportunities for joint commissioning as a way to:

- Improve health and social care outcomes for people in North Somerset
- Ensure integrated thinking and practice
- Ensure the most effective use of resources

SECTION 9 Commissioning Intentions

**To be completed by JCG following consultation using
PCT OP plan and MTFF**

SECTION 10 Performance Indicators and Targets

To be set as part of the consultation exercise

SECTION 11 Governance Arrangements

11.1 Transformation and Commissioning Board (TCB)

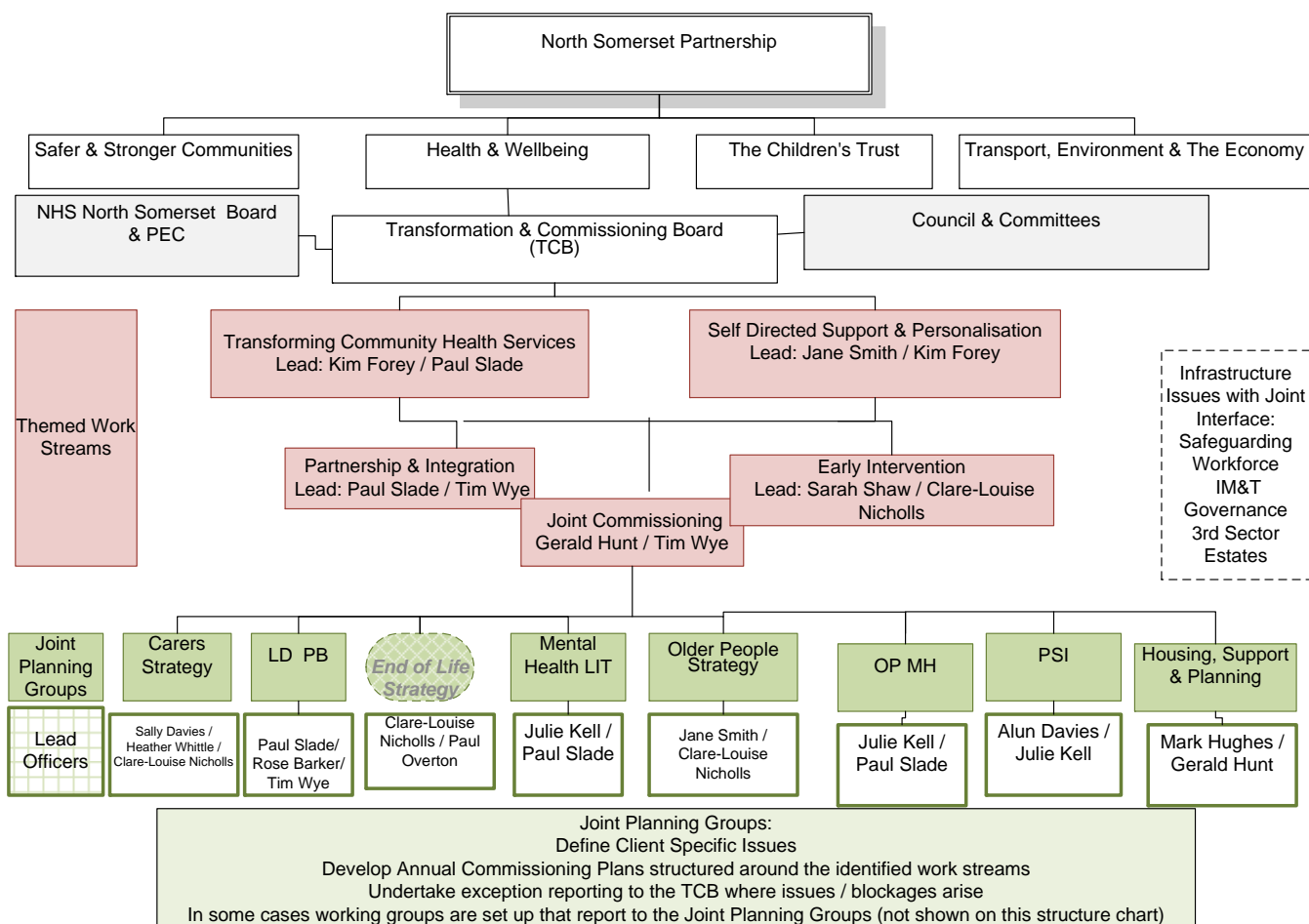
The 'Transformation and Commissioning Board (TCB) has been formed to agree and communicate a shared vision for the development and operation of social care and community health services in North Somerset, to develop and implement joint approaches to the commissioning and delivery of services that improve social care and community health outcomes for the area. The TCB reports to the Health and Wellbeing Strategic Partnership (HWSP) which is one of the thematic partnerships within the North Somerset Partnership.

The TCB has identified five key work streams emerging from the transformation agenda for health and social care, the 2 strategic agendas that drive the work of the TCB are Personalisation - lead by North Somerset Council and Transforming Community Services - lead by NHS North Somerset.

From these 2 agendas emerge the following important work streams:

- Partnership and Integration
- Early Intervention & Prevention
- Joint Commissioning

Joint leads, one each from the PCT and the Council, have been appointed to take forward the work for each work stream as shown in the following diagram:



11.2 Joint Planning Groups (JPG)

The JPGs assist the TCB to move forward the work-strands identified. The JPGs also contribute to and in the longer term will be responsible for development of joint commissioning strategies in their area of interest.

The JPG offer a forum for all key stakeholders to meet and work together, they are also an invaluable source for engagement, involvement and consultation.

Each group has been allocated a lead officer from health and one from social care to ensure that there is engagement, ownership and or a response from within their organisation for any decisions or recommendations made.

11.3 Joint Commissioning Group (JCG)

The JCG has been set up as a quality assurance group supporting the TCB in managing the commissioning and contracting arrangements, where interfaces exist.

The JCG is not a formal decision-making body, but has an important role in resolving interface issues, promoting partnership arrangements and in maximising joint working to reduce duplication and improve outcomes.

More specialist aspects of partner organisations (for example in health this would include NICE implementation of new drugs over which there is no local choice, very specialist interventions (e.g. ophthalmology, neuro-surgery, managing the GP contracts) are not included in the scope of the TCB or JCG.