MAY 21, 2019

COMMISSIONING PLAN 2018-21

STRATEGIC COMMISSIONING

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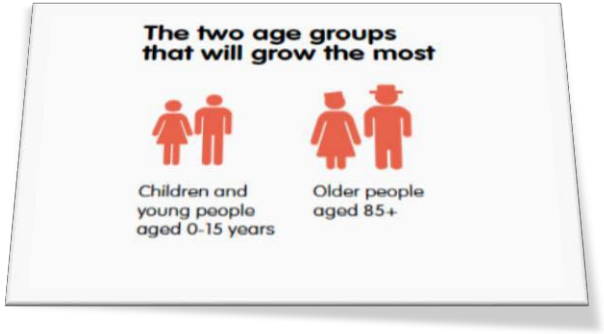
1 Introduction and Context

The 2018-21 Commissioning Plan (the Plan) has been written to compliment the Strategic Plan (the Strategy) of the HSCP. The Strategy is centred around 7 areas of strategic focus:

- Working together with children, young people and their families to improve mental wellbeing
- Working together with our community planning partners on new community justice pathways that support people to stop offending and rebuild lives
- Working together with our communities that experience short life expectancy and poorer health to improve their wellbeing
- Working together with people to maintain their independence at home and in their local community
- Working together with people who experience mental ill health to support them in their journey to recovery
- Working together with our colleagues in primary and acute care to care for people to reduce unplanned admissions to hospital
- Working together with people who care for someone ensuring they are able to exercise choice and control in relation to their caring activities

The Plan is designed to set out the financial and operational context that the HSCP is working within and to signal to stakeholders the direction of travel as we develop models of support and key operational structures and processes over the period of the plan.



The plan is focused on key areas of development within the HSCP. This includes the development of Community Led Support and Talking Points as our approach to the provision of services to adults within the local area. Across all service areas and ages there is a focus on early support and intervention to empower people to make good use of their own assets and the assets and resources within their communities.

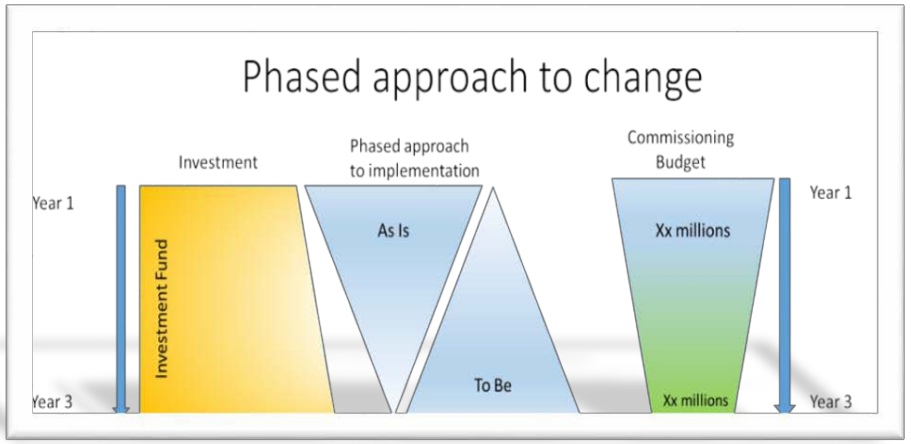
Through locality planning we will work to develop our market shaping plans to provide partners of today and tomorrow with clear information. This will help partners to see how best they can support the partnership to develop sufficiency within our local markets.

Through our Plan, including market shaping plans we intend to signal a reduction in our use of residential beds for the placement of older people. **'If not home why not?'**, will be our progressive approach to rebalancing provision locally. We will invest proportionately more in our approach to supporting people to remain at home whilst reducing our use of residential care across the authority.

> ***Shared Lives Birmingham,*** *Shared Lives are established alternatives to residential care homes or to carers popping in and out. It can tackle loneliness through offering independence, belonging and personal choice. Estimated savings in Birmingham of this approach have been £2 million. This can be for a short term or long term break and in the case of Birmingham is being offered to people with a learning disability.*

Over the term of the commissioning plan we will develop our focus on localities. Our structure now supports the development of our engagement and planning opportunities within our communities. We will work collaboratively to develop our models of care and to work to transform existing approaches.

We will be engaging with the NHS Board on our **Moving Forward Together** strategy to ensure that the opportunities around people-centred and realistic care can be realised.



We will complete our **Fit for the Future** redesign which has significant staffing savings attached. We hope by introducing further digital and process efficiencies we can make an additional saving of £0.25million in **2019/20**.

In summary, we will:

- Shift our focus to building capacity within our localities.
- Work to develop a realistic approach to primary and acute services.
- Rebalance our care arrangements towards care in the home, testing and developing new approaches to supporting people in the home.
- Engage and design new models and approaches and drive efficiencies through this approach.

2 Commissioning Intention: Transformation and Sustainability

Our approach to working with our local population is based upon our belief that communities can provide the right solution at the right time. We have motivated partners who want to develop their digital, networking and support capacity. Our work with the Greenhouse Community Café has confirmed our view that employability with appropriate support leads to the right outcomes for adults with additional support needs and family carers.

The HSCP will beginning planning at an earlier stage with younger adults in 'transition' from children's to adult services. This will ensure better decision making and resource matching that will result in the best outcomes for the person. Our approach will require difficult decisions to be taken about the continued provision of static models of day care as opposed to the development of resource centres that equip individuals with the skills of daily living that ensure their outcomes can be met.

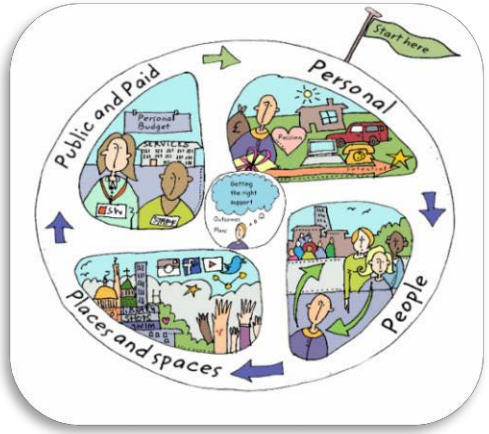
The HSCP acknowledges that different individual approaches are required to meet the particular needs of each person. That is why our workers promote person centred approaches and why we promote a model of risk-taking that encourages individuals to succeed within their abilities.

The HSCP has promoted the use of short breaks for individuals of any age with additional support needs and our Carer's Strategy and Short Breaks Statement supports this approach. Creative planning is supporting families to organise breaks from caring in a way that makes sense to them and their family. Self-directed support is supporting them to change how care and support is organised and provided.

The use of technology is similarly supporting people to organise and receive support in a different way. The Technology Enabled Care (TEC) team has set up 'Alexa' to remind people to do certain tasks at certain times. For example, to take medication or to remind them of appointments including time with friends.

Our approach to planning is designed to make the best use of individual, family and community resources. The development of short breaks has been a great example of how people with fresh ideas have been brought together with the right resources to deliver the right outcome.

We have undertaken truly inspirational work over the past three years to rethink our approach to providing support to people with additional support needs.



Approaches including Neighbourhood Networks provide truly community-based support from people who are located within the communities in which they work. The idea of social prescribing and the role of 'link working' is now embedded within our primary care setting and our wider community settings, including our Talking Points.

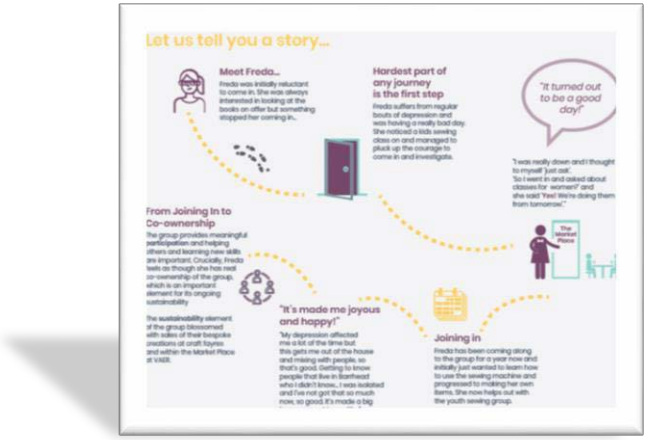
Our work with the Greenhouse Community Café has grown far beyond the Eastwood Health and Care Centre and is now an opportunity for training and employment across the authority.

In summary, we will:

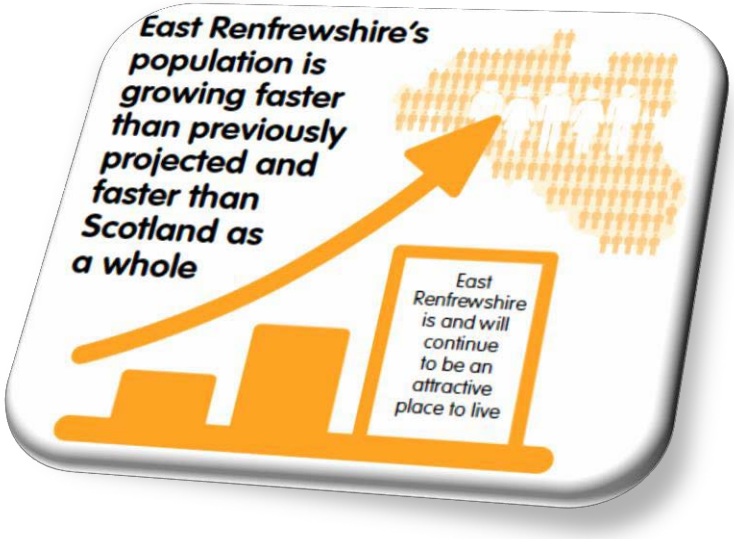
- Develop further social enterprise and community link working over the period of this plan.
- Introduce alternative models of creative breaks and breaks from caring as per our commitment to cares in our Short Breaks Statements.

3 Commissioning Intention: Community Led Support

Community Led Support is our mechanism for postponing and reducing long term demand for health and social care support. Through encouraging active and socially connected lifestyles, community led support will impact on the requirement for health care, preventing the development of long term conditions and supporting people with long term conditions to self-manage.



Benchmarking against areas across the UK we have identified that by linking earlier with people and supporting them to access the resources available in our local communities, we will reduce the demand on social care resources.



This ambition is only possible if we work with our community partners to design and shape the assets within the localities and shift our focus to prevention.

The 'Gateway to Care' is a joint service for health and social care in Calderdale that offers a single point of contact for the public and other professionals (particularly GPs) to address their social care concerns. 97% of people were assisted in Calderdale without requiring a full social care assessment.

During 2018 - 2021 we will:

- scale up our Talking Points, so that this becomes the first point of contact for adults seeking advice and support
- restructure our Initial Contact response (the Front Door) to signpost more appropriately to Talking Points investing in our 'Good Conversations' approach at the earliest point.
- review all our internal and external funding for community connector, link worker, local area coordinator and day opportunities and commission an effective and efficient community led support service.
- aim to retain some money each year for reinvestment in community supports through participatory community budgeting.

Talking Points
East Renfrewshire

Looking to the longer term (2020/21 and beyond) we need to support local organisations, social enterprises and community interest companies to develop innovative alternatives to statutory supports. We believe that this locality market development could lead to further savings. These activities will be supported by investment in locality market development.

In summary, we will:

- Work with our teams at the front door to demonstrate how they are: reducing demand; are providing good quality advice, information and signposting; and how their activities are contributing to the **£0.8million of savings** we anticipate through 2019/20.

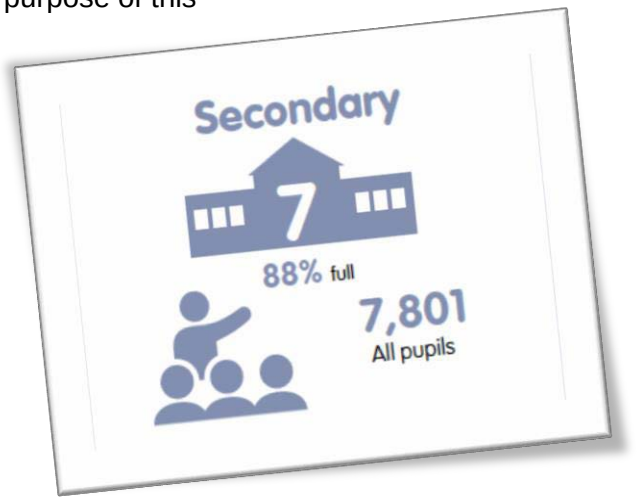
4 Commissioning intention: Prevention and Early Intervention

The **Children's Services Plan** is the primary planning document of the HSCP for children and young people's services. The purpose of this section is to reflect on required activity to:

- shape and respond to market pressures;
- shape and respond to demand;
- develop in response to individual choice.

Young Carers

The needs of young carers will be supported through the HSCPs Short Breaks Statement and Eligibility Framework. Work is already underway within our carers service to develop creative and short breaks as support for families with their caring role.



Our wider strategic commitment to development models including Shared Lives will support creative alternatives to more institutional forms of respite support.

A Shared Lives carer is someone who offers family support to a young person (and adults) to have time within a family home and to participate in activities and support as part of that family.

Young People – Transitions

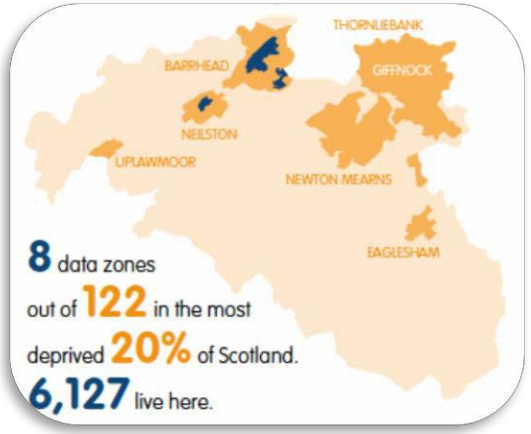
Our education services have developed exceptional support for individuals with additional support needs. Planning and resources need to be available for these individuals when they move into the adult world.

Within social care we also have some exceptional sources of support for young people and their families looking to plan ahead. Whether preparing for working life or moving away to university it is essential that this support is available.

The same emphasis on having a good plan in place as the basis for resource planning is outlined in the sections on Getting the Right Support and Talking Points.

Young people are already benefiting from a partnership between Isobel Mair and the Greenhouse Community Café. Young people have supported employment opportunities offered by the Greenhouse Community Café within Barrhead High School with plans to roll out to other schools in the area.

Within Children's Services an innovative partnership with Children 1st is supporting families on the 'edges of care' to use their assets and add resilience to their family circumstances.



In summary, we will:

- Develop our local contribution to creative and short breaks.
- Continue to develop our response to the needs of young carers with our partners in education and the carers centre.
- Continue to work with partners in housing to look at housing needs and provision for individuals with a range of complex needs.

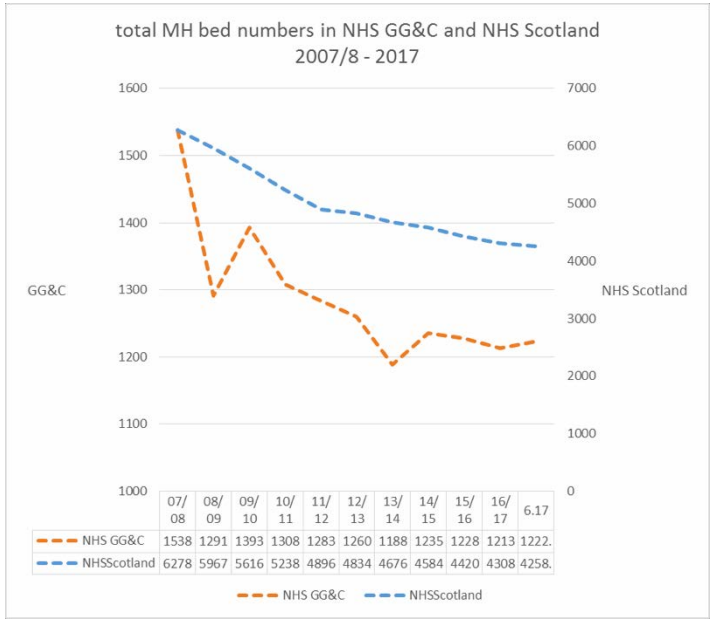
5 Mental Health and Recovery

Scotland' Mental Health Strategy for 2017–27 is framed around the following ways of working to improve how we support mental health:

- Prevention and early intervention;
- Access to treatment, and joined up accessible services;
- The physical wellbeing of people with mental health problems;
- Rights, information use, and planning.

In East Renfrewshire we currently direct resources towards supporting people through supported living and recovery services delivered in and across communities.

Within the strategy there is a clear focus on early support, intervention and education. We have a specific focus on our children and young people and the needs of adults living with mental illness.



The reduction in treatment beds across Glasgow is reflected elsewhere. As resources have focused on community provision, the need for such services has reduced.

There is a recognition that strengthening place-based approaches to employment, income maximisation and social prescribing can support a person's overall wellbeing and mental health recovery.

We aim to take a holistic strategic approach to mental health as reflected in our **Primary Care Improvement** work with better support to GP clinicians, and as part of the whole system programme outlined in **Moving Forward Together**.

Financial Context

The Scottish Government has provided funding for mental health over the lifetime of its plan that effectively protects this area from reducing resources elsewhere in local government and the NHS. The mental health **Action 15** funding is intended to support operational improvement across a wide range of mental health services.

The **Action 15** funding for East Renfrewshire will see the following funding allocation over three years:

- **2018-19: £0.172million**
- **2019-20: £0.265 million**
- **2020-21: £0.375 million**

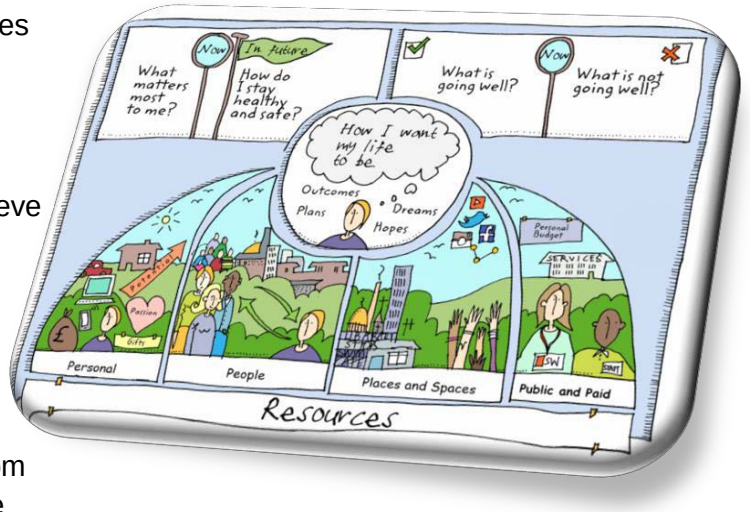
In summary, we will:

- Review with our partners our existing social care arrangements.
- Engage with users and carers to ensure that the NHS strategy and our Plan is communicated and reflects priorities within their communities.

6 Commissioning Intention: Getting the Right Support

Getting the right support at the right time is the ambition behind community led support. It recognizes that the HSCP, community, families and carers together with the person in the centre all have a role to play in getting support that is of the right type and quality.

Getting the Right Support reflects our aim to achieve the right balance between funding for paid support, and the resources and assets that individuals, families and communities bring.



Through the commissioning intentions described above we believe we can achieve efficiencies and shift the balance of care without significant impact on people's outcomes.

However this does not deliver our full potential savings requirement. Any additional saving would need to come from limiting access to care packages to those most at risk and reducing grant funding to external organisations that offer valued care and support to vulnerable people and their carers.

- Examples of this approach would include our partnership with SOL Connect to reduce the unnecessary and intrusive overnight arrangements that we have at the present time by using people and technology.

Each sleepover costs over **£95** pounds per night per person and costs the partnership in total approaching £1.5million.

Our partners are currently working with families to change their approach in the knowledge that to do so improves the financial opportunities for the partnership as a whole.

During the 2018-21 Plan:

- We will complete our review and redesign of sleepover arrangements replacing them with technology and responder or active overnight support as required.
- We will commence a review of all low hour home care packages looking for technology enabled care alternatives.
- We intend to review the remaining care at home packages with a view to seeing the potential for telecare and digital supports.

This will run alongside work to realign and rebalance our care at home provision.

Care at Home Rebalancing and Sustainability - we will:

- Align in-house reablement home care with our rehabilitation teams making more effective use of both health and care staff and resource.
- Work collaboratively with partners, to develop a stable provider market where providers are aligned to locality areas.
- At the end of their period of rehabilitation, if further support is required people will move to a partner provider.
- We will also move people from non-framework care at home providers to partner providers or to an individual budget.

We recognise that there is a need to ensure sufficient capacity within care at home which is underpinned by the correct contractual framework.

We further recognise the strategic importance of care at home and the need to develop a model that focuses more on outcomes for people and less on time and task.

This is reflected in the decision of the Board to invest **£1million** in 2019/20 into care at home.

We have developed and tested our individual budget calculator, which is linked to our community led support approach. We intend to roll this out on a phased basis during 2019/20.

In summary, we will:

- Reshape the way we provide overnight support to ensure the right response for individuals.
- Support the shift from residential care to care at home provision supported by an investment of £1million in 2019/20.
- Achieve an efficiency of £0.25 million through modernisation of our digital platforms.
- Further support our sustainability by deploying TEC at assessment and to providing support solutions.

7 Commissioning Intention: Transforming Models of Care

We continue to redesign and implement new approaches to our provision of health and social care services for older people and those with complex conditions, which is aimed at shifting the balance of care from hospitals to more homely and community-based settings.

As these New Models of Care progress and embed, we expect to improve multi-disciplinary working within localities further enhancing our integration of services. Partnership working between professions, communities and individuals should strengthen further.

These New Models of Care work streams include trajectories submitted to the **Ministerial Strategy Group** in relation to the indicators for 'Measuring Performance under Integration'. Expected impact over the course of the Strategic Plan includes:

- A five per cent reduction in unplanned bed days from baseline of 84,115 to 80,162.
- A ten per cent reduction in emergency admissions from 7,915 to 7,124.
- A reduction from 2,366 to 1,775 (20%) in occupied bed days where people spend longer in hospital than necessary and could be better supported in another setting due to incapacity law.
- An increase in the number of days in the last six months of life spent in the community rather than large hospital setting.

During the 2018-21 Strategic Plan we will:

- Embed our Hospital to Home team working in collaboration with our Acute colleagues to support early and safe discharge to home or a homely setting.
- Commission Adults with Incapacity intermediate care bed provision.
- Implement our 'new front door' to reduce demand for formal support at home through redirection and recognising early reablement opportunities.
- Restructure our Locality Rehabilitation and Enablement Service to meet the **demands** of our locality populations, **strengthening** our **locality** based multidisciplinary service delivery model.
- Develop and implement **Frailty and Falls pathways**, to support identification of our frail population and the supports available to them, with a focus on **prevention** and early intervention putting in place anticipatory care and support plans that reduce their need for hospital, residential and nursing care.
- Continue to work together to reduce the levels of delayed discharges, with a focus on early supported discharge.
- **Focus on avoiding preventable admissions.**
- Design and implement **intermediate care** at home services developing community-based rehabilitation.
- Develop and implement New Models of Care Programme for Palliative and **End of Life Care** working in collaboration with our local Hospices, to support people safely at home or in a community setting.

- Collaborate with partners to **reduce attendance** at emergency departments, inappropriate referral to MAU, and admission to hospital.
- Further develop our local 'Know Who to Turn to' **signposting** to direct to the **most appropriate person** for particular treatments in a timely fashion.
- Focus on planned interventions rather than unplanned admissions to hospital that often lead to admissions to residential and nursing care. Locally, we will develop a small in-house intensive support team that can respond to changing health needs and end of life support requirements and begin to introduce tested ideas from other areas such as the Red Bag Scheme.
- Red Bags to be issued to all local Care Home estate to support safe and speedy transfer to and from acute sites. The Red Bag initiative was a Sutton pilot evidencing residential home residents stay in acute sites was reduced by 6.8%.

In summary:

- We believe that this will enable us to reduce the number of people we place in permanent care (nursing and residential).
- We are planning to invest an additional **£1million** in care at home through 2019/20.
- We will make good use of technology and people to manage demand in a smarter, person-centred way.

8 Commissioning Intention: Building Capacity in Primary and Community Care

The 2018 General Medical Services (GMS) Contract in Scotland envisages a new role for the GP as an 'expert medical generalist'. This means GPs focusing on complex care, quality and leadership.

The 2018 Scottish GMS contract is intended to allow GPs to deliver the four Cs in a sustainable and consistent manner in the future.

- Contact – accessible care for individuals and communities.
- Comprehensiveness – holistic care of people - physical and mental health.
- Continuity – long term continuity of care enabling an effective therapeutic relationship.
- Co-ordination – overseeing care from a range of service providers.

To achieve this the Primary Care Practice Team will extend to include a range of professionals led by the GP including advance practice nurses, physiotherapists, pharmacists, community health care support workers and link workers.

This extended Multi-Disciplinary Team (MDT) in Primary Care will cover a number of activities which are at present generally undertaken by GPs. This will include phlebotomy, community treatment and care.

At a national level the intention is to see **investment** in Primary and Community Care **rising to more than half of frontline spending in health services** and an increasing **shift of the budget** towards investment in mental health, primary, community and social care. There is a national commitment to increase investment in Primary and Community Care by £500million by the end of the Parliament.

The allocation for East Renfrewshire Health & Social Care Partnership in Year 1 is **£0.714million.** The funding increases **to £0.858million** in 2019/20 and to **£1.717million** in 2020/21.

There is also funding via Mental Health Strategy **Action 15**. These funds must be used for mental health related activities, but this may include the Community Link Workers.

During the 2018-21 Plan we expect to implement the aspirations outlined in the **Primary Care Improvement Plan** which will be put in place from **July 2018**.

Year 1 focus is on locally tested approaches and evidence where there has been a positive impact on GP workload. This includes:

- The Vaccination Transformation Programme.
- Pharmacotherapy services.
- Community Treatment and Care Services (Health Care Assistants and Treatment Room Nurses).
- Urgent Care (Advanced Nurse Practitioners).
- Additional Professional Roles (Advanced Physiotherapy Practitioners).
- Community Link Worker (CLW).

Years 2 and 3 will be used to continue to define models and approaches in areas where this is not yet fully developed and include:

- Community Treatment and Care Services (Community Treatment Rooms).
- Additional Professional Roles Community (Clinical Mental Health Professionals).

The extent and pace of change to deliver new ways of working over the three years (2018/21) will be determined largely by workforce availability, training, competency and capability and the availability of resources through the Primary Care Fund.

Governance arrangements (structures and reporting processes) will support a **programme approach** for working together across the six **HSCPs**, the **NHS Board**, the **GP Sub Committee to monitor the implementation and on-going development** of Primary Care Improvement Plans.

Prescribing cost pressures are a significant risk to the HSCP budget as a consequence of demographic changes, pharmaceutical innovation, and research and development. Our HSCP Prescribing Support Pharmacy team work with all 15 East Renfrewshire GP practices to promote safe and cost-effective use of medicines within East Renfrewshire.

During 2019/ 20 we will:

- Support GP Practices and HSCP prescribers to improve compliance with the NHS Greater Glasgow and Clyde Formulary.
- Deliver a programme of efficiency savings via an annual Prescribing Initiative, individual practice prescribing work plans and continuing to promote practice use of decision-support tools.
- Support GP practices and Care Homes to reduce excess supply costs and medicines waste via support with a Repeat Prescribing Local Enhanced Service and introduction of regular support to our care homes around their medication ordering processes.

- Undertake Polypharmacy Reviews of people who are on multiple medications both within care homes and patients residing at home.
- Support GP practices to utilise the revised Medicines Care and Review Service (previously Chronic Medication Service) within Community Pharmacy.

In summary, our focus is on:

- Freeing GP time to support complex patients including high resource use patients.
- Developing 'social prescribing' to provide other supports within a person's community e.g. community link workers.
- Developing community awareness through **Moving Forward Together** and engagement within our localities.

9 Commissioning Intention: Digital and Technology Enabled Care and Support

Developments in digital technologies and communication mediums present great opportunities to enhance how people are supported and how workforce systems and processes support working practices and communication.

Enterprise mobility enabled assessments – *deploying such solutions for front line case holding social workers has demonstrated efficiencies of 1.5 hours per day per worker. When the monetised savings are aggregated they can be in the region of circa £400k. This is a at the lower estimate end as through the application of such solutions other operational areas could be identified that would benefit from enterprise solutions.*

At a national level there is a concerted effort to **transform business systems** using modern digital delivery. The aim is to automate processes, promote self-service and improve access to a single source of information. Software systems will be increasingly integrated covering HR, payroll, finance and data under a 'Once for Scotland' approach. There are significant challenges to be overcome to achieve this aspiration.

East Renfrewshire – *The TEC team, working with GPs, is using a simple SMS text messaging service called 'Flo'. It is currently being used to help diagnose and medicate for the long-term self-management of hypertension. Patients are sent a text prompt from Flo asking them to check their blood pressure. They text Flo back with their readings. Their response is checked by a computer programme against their personal profile. Flo then texts the patient offering appropriate advice. The patient's practitioner can check the patient's readings as required and can send text messages to the patients offering advice or instruction. This approach reduces the number of GP appointments the patient requires, freeing up practitioner time to deal complex cases. Over 300 patients have been recruited to the hypertension protocol in East Renfrewshire and roughly 800 practitioner appointments have been saved.*

Within East Renfrewshire significant advances have been made through the adoption of Technology Enabled Care. This can provide **less intrusive and more efficient ways** of prompting and supporting people with health and social care tasks. Through use of monitors and sensors we no longer have to be in people's houses but can respond appropriately if required**.**

TEC is an essential component of our HSCP's aim of developing a 24-hour responsive service model. Service redesign is currently underway and will consider how, through the use of TEC, there is a further shift from planned care to support being delivered to individuals through a model of the right care at the right time.

Our new strategic plan commits us to a further period of transformational change with TEC being one of our key strategic commissioning enablers to support individuals to live safely and independently at home.

Key achievements from our TEC programme work have focused on the creation of a genuine technology enabled care service with 3 distinct elements – Telecare, Digital Health & Care and Telehealth.

Over the past three years in Scotland, Home and Mobile Health Monitoring (HMHM) has become firmly established through the Technology Enabled Care (TEC) Programme as a proven digital enabler in the pursuit of increased patient self-management, better service experiences and better clinical outcomes while supporting the optimal use of healthcare resources. This has focused on supporting people with Hypertension to self-manage with a view to prevention of further complications.

In summary:

- The use of TEC as an assessment aid will become the default position.
- Digital, TEC will become embedded within our ‘Front Door’ approach.
- Work to support our primary care colleagues to expand and explore the role of technology will continue.

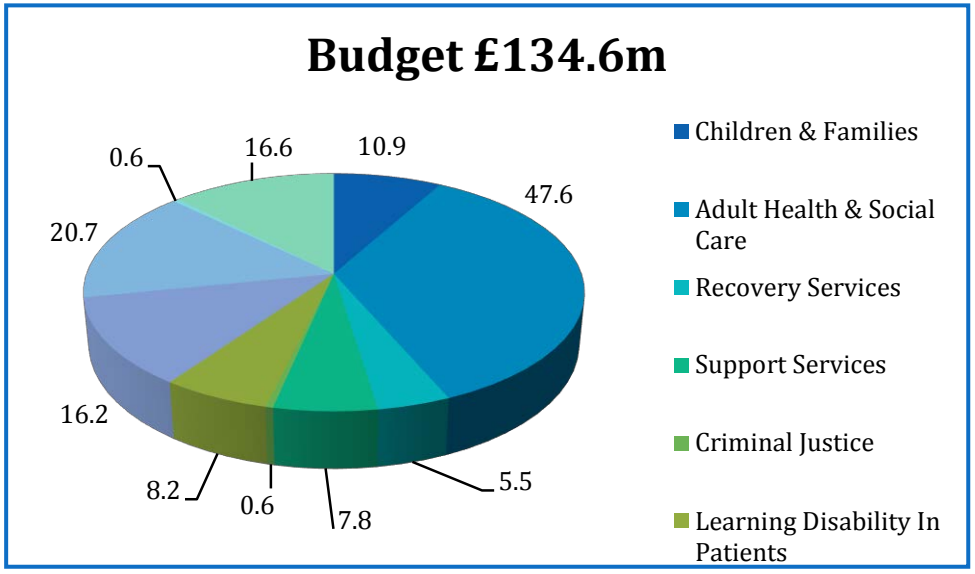
10 Financial Summary

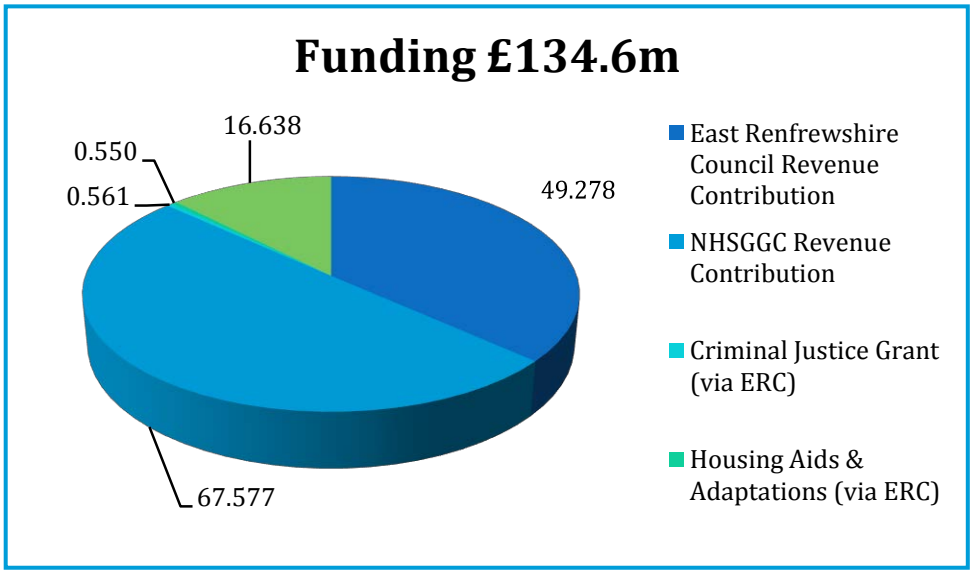
The 2018/19 budget was £132.9 million inclusive of £1million savings delivered in full. The Medium-Term Financial Plan 2019/20 to 2023/24 for the HSCP sets out the local and national context, medium term financial outlook, our response and the risk and sensitivity impacts over the five-year period.

The key messages for the remaining two years of this plan are:

- **2019/20**

The annual budget for 2019/20 is £134.6 million and this will be spent delivering a range of health and social care services to the citizens of East Renfrewshire.





Our budget broadly falls into two types of spending: revenue budget to deliver health and social care services and categories; and budgets for housing aids and adaptations and for large hospital services which come under the strategic direction of the IJB.

The revenue budgets for those “day to day” health and social care services delivered by the HSCP is £117.4million.

Our cost pressures in 2019/20 are £5.7million and after applying all available funding the savings we need to make to balance our budget are £3.1 million. We will achieve these savings by:

	£'000
Learning Disability Bed Model	125
Freeze uplift on Non-Pay – manage through efficiency	352
Fund Prescribing up to 3.5% uplift and manage through contingency supported by investment in technician resource	81
Release project flexibility and non-recurring allocations - maximise savings but removes flexibility	500
Release recurring funding – currently allocated on non-recurring basis	450
Fit For the Future – New Target Phase 2	250
Rationalisation of Community Resources – review duplication of functions	100
Digital Efficiencies – workforce and process	250
Increase income budget to current level of fees and charges received	200
Non-residential care packages: implement individual budgets, continued community led support, reviews, respite	800
Total Savings	3,108

- **2020/21**

The cost pressures for 2020/21 are estimated at just over £5m for the year and the funding gap to meet these pressures could range from £0 to £5 million depending on the UK and Scottish budget settlement.

Based on our partner's budget assumptions the funding gap for social care could be £3million to £3.5million. We will continue to explore new ways of working and service delivery models and will always try and maximise any savings opportunities that protect our front-line services. However, if we have a funding gap of this level then we would need to reduce care packages and retract services.

11 List of Key References

- East Renfrewshire Health and Social Care Partnerships Strategic Plan, Working Together 2018-21
- East Renfrewshire Council's Communities Together, Stronger and Fairer Communities - Community Plan 2018
- East Renfrewshire Council's Outcome Delivery Plan