Inverclyde council

NHS Greater Glasgow and Clyde

AGENDA ITEM NO: 7

Report To	**Community Health and Care Partnership Sub- Committee**	**Date: 18th October 2012**
Report By:	**Brian Moore Corporate Director Inverclyde Community Health & Care Partnership**	**Report No: CHCP/48/2012/HW**
Contact Officer:	**Helen Watson Head of Planning, Health Improvement & Commissioning**	**Contact No: 01475 715369**
Subject:	**Inverclyde CHCP Commissioning Strategy 2012 - 2022**	

1.0 PURPOSE

1.1 The purpose of this report is to inform Members of the Inverclyde CHCP Commissioning Strategy 2012 – 2022 and to launch the consultation period for this. Appendix 1

2.0 SUMMARY

2.1 Inverclyde CHCP Commissioning Strategy is a draft joint statement of intent of Inverclyde Council and NHS Greater Glasgow and Clyde Health Board as parent organisations of the CHCP.

2.2 We have taken cognisance of the Joint Improvement Team Guidance in preparing this draft Commissioning Strategy, alongside the SWIA Guide to Strategic Commissioning.

2.3 The consultation period will conclude on 31st December 2012 and a final report will be submitted to the CHCP Sub Committee in April 2013.

2.4 A programme for stakeholder engagement will be developed, adopting a co-production approach of partnership working, including a series of workshops involving third sector partners and commissioners.

2.5 We have secured input from the Social Value Lab as part of the Scottish Government's Developing Markets for Third Sector Providers programme. Three intensive half-day workshop sessions are scheduled for October 2012 with the key aim of securing better local outcomes through more effective commissioning and collaboration with the Third Sector. The workshops will develop an action based Commissioning Improvement Plan for the Third Sector.

2.6 Services across the CHCP will complete a scoping exercise which will help in identifying priorities and commissioning intentions. These will inform service level Joint Commissioning Plans which will be developed throughout 2013 / 2014 starting with Older People's Services.

3.0 RECOMMENDATION

3.1 The Sub-Committee is asked to note the Draft Inverclyde CHCP Commissioning Strategy 2012 – 2022.

3.2 Members are requested also to approve the launch of the 3 month formal consultation period for this strategy.

Brian Moore
Corporate Director
Inverclyde Community Health & Care Partnership

4.0 BACKGROUND

4.1 Over the next ten years the social care landscape will change significantly. Key factors impacting on this include changing demographics, including an ageing population and an increase in demand for services while being in a period of considerable financial constraints and reduced budgets.

4.2 As a CHCP we embrace the principles of personalisation and the requirements of proposed Self Directed Support legislation. We are already making good progress in the substantial culture shift from delivering and measuring outputs to being outcome focused. There are also opportunities to consider collaborative commissioning across traditional service silos.

4.3 While we already commission services and have approximately 186 social care contracts with 120 different service provider organisations, we are in a new chapter of "shifting the balance of care", where it is no-longer about moving from large institutional based provision to more appropriate community or home based settings. The Commissioning Strategy will inform future discussion regarding the balance between in-house and external provision.

4.4 We are adopting the SWIA definition of strategic commissioning as *"the term used for all the activities involved in assessing and forecasting needs, agreeing desired outcomes, considering options, planning the nature, range and quality of future services and working in partnership to put these in place. Strategic commissioning is* ***not*** *just about purchasing services from external providers, although this is an important element of the commissioning process."*

4.5 Our CHCP arrangements provide an opportunity to have a broad strategic view of commissioning as we plan services for the long term. We recognise commissioning is not a short-term action, but rather, is a long-term vision of direction.

5.0 PROPOSALS

5.1 An extensive programme of stakeholder engagement will be developed for the 3 month period of formal consultation.

5.2 While this Joint Commissioning Strategy is a ten year, strategic statement of intent, services across the CHCP will be developing service level three year Commissioning Plans.

5.3 The Commissioning Strategy is a "live" document that will be reviewed on an annual basis.

5.4 It is a far-reaching strategy that will have close linkage as part of the CHCP planning architecture.

6.0 IMPLICATIONS

6.1 Legal: There are no implications for the Council's Legal Services.

6.2 Finance:

Cost Centre	Budget Heading	Budget Year	Proposed Spend this Report	Virement From	Other Comments

6.3 Personnel:

There are no implications for Human Resources.

6.4 Equalities:

The stakeholder engagement programme will seek views from a wide spectrum of partners, service users and carers. A comprehensive EQIA will be undertaken following the consultation period.

7.0 CONSULTATION

7.1 A programme of stakeholder engagement will be developed for the duration of the consultation period.

8.0 LIST OF BACKGROUND PAPERS

8.1 Guide to Strategic Commissioning, (2009), SWIA

8.2 Joint Strategic Commissioning – A Definition, (2012), JIT

8.3 Preparing Your Joint Strategic Commissioning Plan for Older People, (2012), JIT

8.4 Commissioning – A Guide to Structure and Content, (2012), JIT

8.5 Joint Commissioning – A Practical Guide to Get You Started, (2012), JIT

CHCP COMMISSIONING STRATEGY 2012 – 2022

A TEN YEAR PROGRAMME

Version	
Date	
Review Date	
Produced by	CHCP Planning and Performance Service (MH)

This document can be made available in large print, audio tape, computer disk and in a variety of Community Languages, on request.

Arabic

هذه الوثيقة متاحة أيضا بلغات أخرى والأحرف الطباعية الكبيرة وبطريقة سمعية عند الطلب.

Cantonese

本文件也可應要求，製作成其他語文或特大字體版本，也可製作成錄音帶。

Gaelic

Tha an sgrìobhainn seo cuideachd ri fhaotainn ann an cànanan eile, clò nas motha agus air teip ma tha sibh ga iarraidh.

Hindi

अनुरोध पर यह दस्तावेज़ अन्य भाषाओं में, बड़े अक्षरों की छपाई और सुनने वाले माध्यम पर भी उपलब्ध है

Mandarin

本文件也可应要求，制作成其它语文或特大字体版本，也可制作成录音带。

Polish

Dokument ten jest na życzenie udostępniany także w innych wersjach językowych, w dużym druku lub w formacie audio.

Punjabi

ਇਹ ਦਸਤਾਵੇਜ਼ ਹੋਰ ਭਾਸ਼ਾਵਾਂ ਵਿਚ, ਵੱਡੇ ਅੱਖਰਾਂ ਵਿਚ ਅਤੇ ਆਡੀਓ ਟੇਪ 'ਤੇ ਰਿਕਰਾਡ ਹੋਇਆ ਵੀ ਮੰਗ ਕੇ ਲਿਆ ਜਾ ਸਕਦਾ ਹੈ।

Urdu

درخواست پر یہ دستاویز دیگر زبانوں میں، بڑے حروف کی چھپائی اور سننے والے ذرائع پر بھی میسر ہے۔

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1. INTRODUCTION BY THE CHCP DIRECTOR

Welcome to Inverclyde Community Health and Care Partnership
Commissioning Strategy 2012 - 2015

Over the next ten years the social care landscape will change significantly. This will take account of changing demographics, including an ageing population; an increase in demand for services; while being in a period of recovery from a financial recession that has resulted in considerable financial constraints on already strained budgets.

Notwithstanding these extensive challenges, there is an opportunity to strengthen an outcome focused approach that is centred on the individual and embraces the principles of personalisation and the requirements of proposed Self Directed Support legislation. As a CHCP we are already making good progress in this considerable culture shift from delivering and measuring outputs in terms of hours and services delivered to measuring what impact services are having and are they meeting the individual's outcomes? There is also opportunity to consider collaborative commissioning across traditional service silos.

The CHCP values the good partnership working in place locally between service providers in the voluntary, third and private sectors. We also place great importance in our partnership with service users and carers in ensuring services are meeting their outcomes.

This Joint Commissioning Strategy outlines the path we are taking alongside our partners in ensuring we are "Improving Lives" of the people of Inverclyde.

2. CONTEXT FOR COMMISSIONING

Vision, Objectives and Values

The overall vision of the CHCP is "**Improving Lives".** There are four strategic objectives underpinning the vision:

1. We put people first.
2. We work better together.
3. We will strive to do better.
4. We are accountable.

These strategic objectives also form the basis of our approach in Commissioning.

Planning Context

Inverclyde CHCP operates within a complex and wide ranging context in terms of the number and range of planning and performance arrangements in which we are engaged in to deliver on the planning requirements of both the Council and NHS Greater Glasgow and Clyde. We are streamlining the CHCP planning architecture in that our CHCP Directorate Improvement Plan will be our key planning vehicle, outlining our priorities.

The CHCP also leads or contributes to the following multi-agency plans:

- Learning Disability Strategy
- Carers Strategy, including a Young Carers Strategy
- Financial Inclusion Strategy
- Alcohol and Drugs Partnership Strategy
- Youth Justice Strategy
- Mental Health Strategy
- North Strathclyde Community Justice Authority Area Plan
- Integrated Children's Services Plan
- Housing Strategy including a Homelessness Strategy
- Reshaping Older People's Services – Change Plan
- Inverclyde Dementia Strategy
- Family Support Strategy
- Child and Maternal Health Strategy
- Inverclyde Child Protection Committee Business Plan

Our Vision for Commissioning

Inverclyde CHCP's vision for commissioning is to ensure that what we do and what we plan takes us to where we want to be.

As with Inverclyde Alliance SOA 2012 – 2017, Inverclyde CHCP have adapted the wellbeing outcomes from GIRFEC to fit the wider community. These principles underpin our Commissioning Strategy and are set out below:

We want all our citizens' to be:

- **Safe** Protected from abuse, neglect or harm and supported when at risk. Enabled to understand and take responsibility for actions and choices. Having access to a safe environment to live and learn in.
- **Healthy** Achieve high standards of physical and mental health and equality of access to suitable health care and protection, while being supported and encouraged to make healthy and safe choices.
- **Achieving** Being supported and guided in lifelong learning. Having opportunities for the development of skills and knowledge to gain the highest standards of achievement in educational establishments, work, leisure or the community.
- **Nurtured** Having a nurturing place to live and learn, and the opportunity to build positive relationships within a supporting and supported community.
- **Active** Having opportunities to take part in activities and experiences in educational establishments and the community, which contribute to a healthy life, growth and development.
- **Respected** Respected and share responsibilities. Citizens are involved in decision **and** making and play an active role in improving the community.
- **Responsible**
- **Included** Overcoming social, educational, health and economic inequalities and being valued as part of the community.

Our Commissioning Strategy is outcome focused. These include the following broad outcomes.

- Health and wellbeing is promoted.
- Services are centred on preventative and anticipatory care with a focus on recovery, rehabilitation and re-ablement, leading to greater independence.
- Service Users and Carers feel included and involved and are recognised as partners in the Commissioning process.

Where We Are as a CHCP

The establishing of the CHCP in October 2010 resulted in a merging of Social Work Services and the Community Health Partnership. Unlike other CHCP's, our model of service integration specifies each member of the management team having responsibility for managing both health and social work services staff within their respective service area supporting a genuinely integrated approach. This represents a real opportunity to take an overarching strategic approach, with a strong outcomes focus. It is our intention to reflect this model in our commissioning.

In the current climate of tightening resources, increasing and changing demand for our services and the drive for modernisation it is essential that we have a structured and coherent approach to how we resource our business, ensuring that we commission the right services for the right people, and at a time when they will have optimum effectiveness. It is also essential that we have confidence that what we commission provides value for money, is of high quality, meets the needs of the people who use our services and fulfils our legislative requirements.

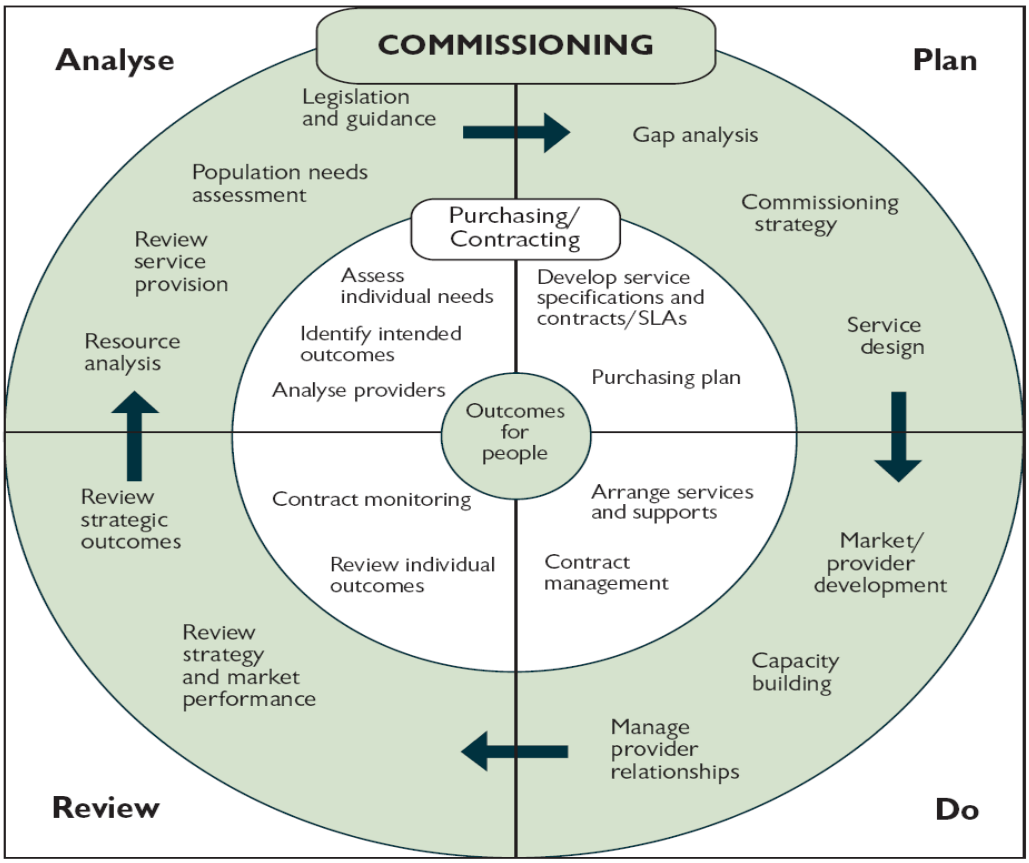
Our Approach to Commissioning

Our approach has been based on the SWIA definition of strategic commissioning:

"'Strategic commissioning' is the term used for all the activities involved in assessing and forecasting needs, agreeing desired outcomes, considering options, planning the nature, range and quality of future services and working in partnership to put these in place. Strategic commissioning is ***not*** *just about purchasing services from external providers, although this is an important element of the commissioning process."*

"We should see commissioning as a cross-cutting activity and not a sectional or specialist function. It links strategic and financial planning with assessment and care management. It involves making decisions about how to use resources most effectively to achieve desired outcomes for people." Guide to Strategic Commissioning, (2012), SWIA

Our starting point for our Commissioning Strategy, and our first guiding principle, is the SWIA Guide to Strategic Commissioning and in particular the *Commissioning Cycle Map* displayed below.

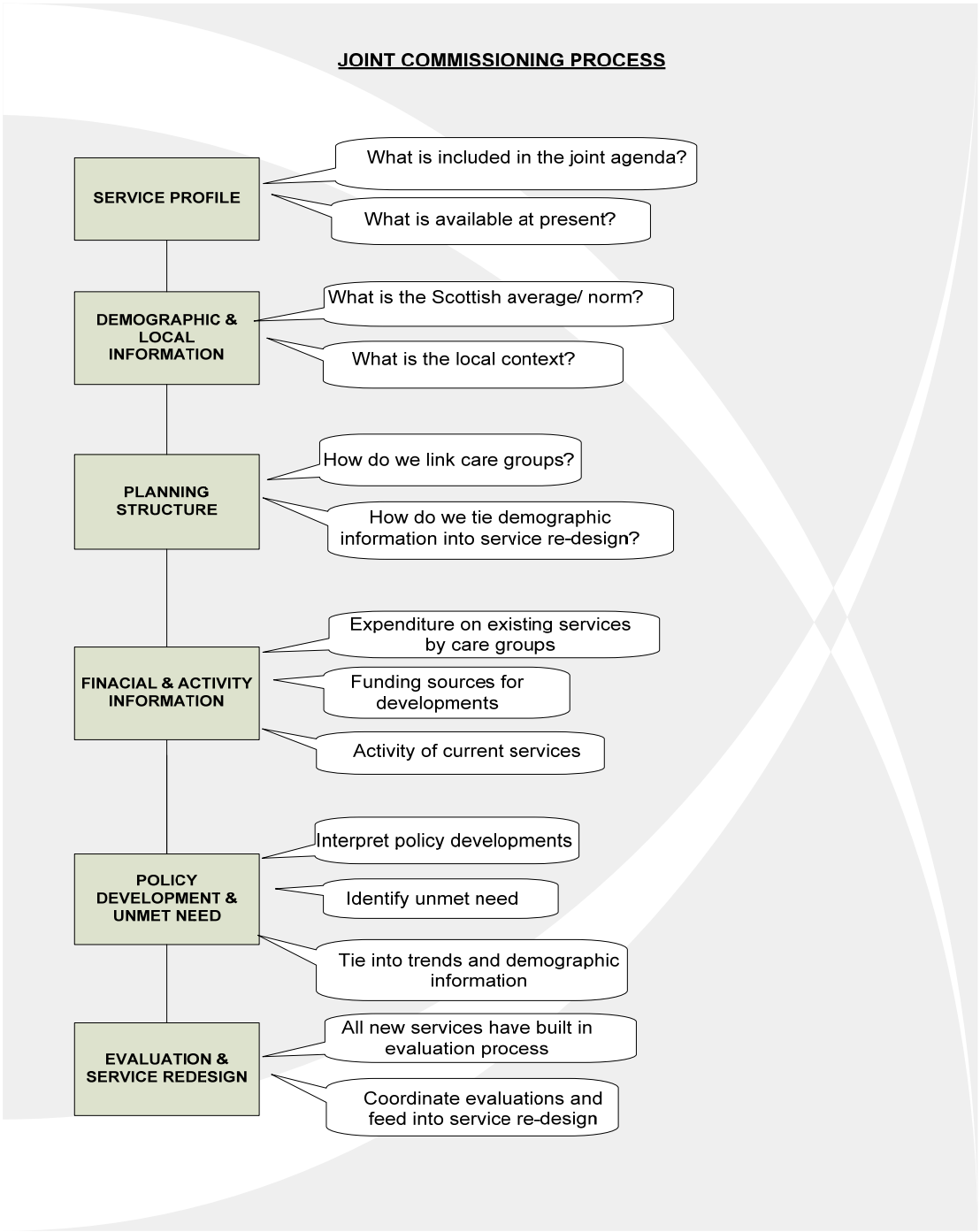


Joint Commissioning as a CHCP

Our CHCP arrangements provide an opportunity to have a broad strategic view of commissioning as we plan services for the long term. We recognise commissioning is not a short-term action, but rather, is a long-term vision of direction.

As can be seen from the diagram, this Commissioning Strategy is but one step in the cycle. Each service will develop their own respective three year plan which will include service profiles. Across the CHCP, services are at different stages in this 'wheel' and this reflects the organic nature of commissioning as a process.

This diagram forms the basis of the process that all CHCP services will adopt in progressing their individual service commissioning plans.

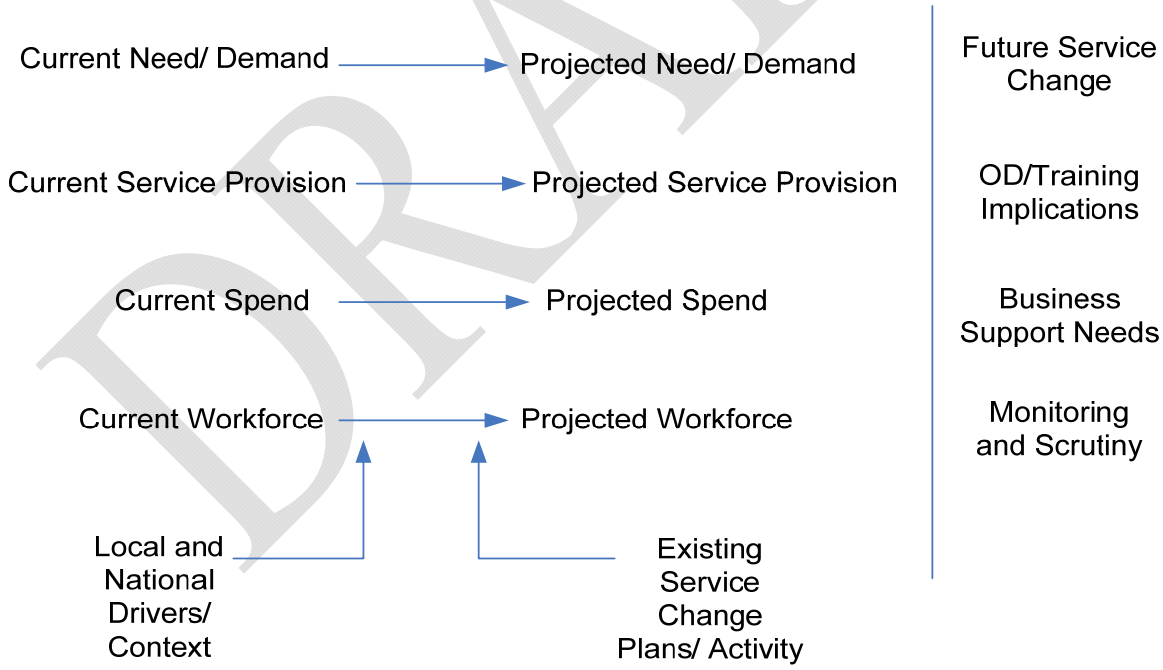


As outlined in the CHCP Directorate Plan and CHCP Development Plan; the service areas currently involved in scoping re-designs are:

- Older people services as detailed in the Change Plan.
- Mental health services as detailed in the Mental Health Strategy.
- We are currently developing a Learning Disability Strategy.

We expect all services to have completed the scoping of re-designs over the next two year period. As part of these exercises we have undertaken a current needs profile and service input profile. These profiles will provide a clear picture of our current service provision and we need to continue to the next stage of considering projected need and demand for these services and other key projected factors as demonstrated in the diagram below.

Commissioning Strategy Matrix



Each service area will also need to identify potential risks as part of the commissioning process. For example, Self Directed Support and existing contractual arrangements with service providers, and the potential implications for service users and carers as well as at a wider organisational and community level.

3. CORE POLICY DRIVERS

This Commissioning Strategy is written in the context of a detailed analysis of the socio-economic and Inverclyde demographic profile (Appendix 1), and has core policy drivers that underpin it. These core policy drivers are all inter-connected in changing the culture of service provision based on an outcomes focused and personalised model of care and support. They can be divided into drivers which focus on "*what we do and deliver*" as a service and those that demonstrate "*what we are*" as an organisation.

The Christie Commission on the Future Delivery of Public Services

The Commission was established by the Scottish Government in November 2010 to develop recommendations for the future delivery of public services. The recommendations are far-reaching and have set a direction of travel for the whole public sector in Scotland, particularly around preventative spending.

Service Policy Drivers

Commissioning for Outcomes

Historically, Social Work Services and to a similar extent health services, have been judged and compared, based on national indicators that measured levels of activity (for example, the number of assessments undertaken). There is now a growing realisation that we must gauge our performance based on the difference our services make to peoples lives, in other words, outcomes. The "outcomes" agenda has been a huge culture change in Health and Social Care and we are progressing this across all CHCP services as an approach. We recognise that our approach to commissioning needs to be based on the outcomes that need to be achieved. We hold the view that:

"Getting (this) right can transform people's lives giving more flexibility, independence and choice as well as quality and value for money". Commissioning for Personalisation (2009) Changing Lives Service Development Group

In essence, this approach encompasses all of the core policy drivers, but more than that, it ensures the service user and carer is at the centre of service design, commissioning and provision.

Shifting the Balance of Care

Shifting the balance of care has been a priority for many years in moving from large institutional based provision to more appropriate community or home based settings. However, it continues to have resonance in our Change Fund Plan where the focus is on recovery and re-ablement. This includes:

- Establishment of a single point of access for assessment and service delivery.
- Development of a re-ablement service.
- Increased early interventions to preventative services.
- Changes to the shape of long term care from inpatient services to care home provision, including use of housing with care.
- Improving end of life care.
- Development of capacity within the community to support independent living.

The term "*shifting the balance of care*" also refers to the shift we want to make in terms of using more external provision of services rather than in-house services supported by for example the increased use of modern technology like telecare. This will require significant redesign of services, looking at how we use resources like day centres and daycare; intermediate care (bridging between hospital care and transition back to independent living at home), and re-ablement services.

Personalisation

There are several definitions of personalisation; however, we have adopted the Changing Lives Service Development Group (2009) that has also been adopted by the Scottish Government:

"It enables the individual alone, or in groups, to find the right solutions for them and to participate in the delivery of a service. From being a recipient of services, citizens can become actively involved in selecting and shaping the services they receive."

Service users are very much at the centre of making decisions over the services they need.

Self Directed Support

Self Directed Support is a key enabler to Personalisation. The Social Care (Self-Directed Support) (Scotland) Bill enshrines self directed support into legislation and stipulates service users must be offered a choice of:

1. *Direct Payments (DPs)* - a payment in lieu of services provided directly to individuals, assessed as being in need of community care services, to arrange their own support. These have been available through legislation since 1996.
2. *Directing the available resource* - where the user selects the support that they wish, using the budget available to them, though where the local authority arranges matters on the individuals behalf but under their direction. This may include a service provider managing the resource on the service user's behalf. The principle here is that the resource should follow the individual and their wishes.
3. *Local Authority 'arranged' support* - where the authority arranges support on the user's behalf to meet their needs (this is the traditional method of service delivery).
4. *A mix* of the above options for distinct aspects of the user's support.

To underline the inter-connectedness of these policy drivers; every person will have unique outcomes and the mix of options outlined in self directed support will be different for each individual service user, just as their informal support network will also reflect that individual. Our challenge is to develop a strategic approach that captures and enshrines individual, personal outcomes.

Co-Production

Co-production is the process of partnership working with all stakeholder groups, including service users. A definition of co-production is:

"Co-production means delivering public services in an equal and reciprocal relationship between professionals, people using services, their families and their neighbours. Where activities are co-produced in this way, both services and neighbourhoods become far more effective agents of change."
The Challenge of Co-production, Boyle and Harris, 2009

As outlined in our People Involvement Framework (2012), at a strategic level we wish to demonstrate that users, patients, carers and the wider community have the opportunity to be involved in shaping the way services and resources are deployed in the area to produce better outcomes for local people. We recognise that services will have to consider their own specific commissioning requirements in the context of the outcomes that their service users want to achieve, therefore a co-produced approach will be required.

In line with legislation the CHCP has a Public Partnership Forum (PPF) which acts as the main formal vehicle for the involvement of patients, service users, carers and the general public in the work of the CHCP.

A CHCP / PPF Advisory Group is a forum of public partners and officers to direct and review the work of the CHCP in respect of people involvement. The Advisory Group support the initiation and review of people involvement work, with users, carers and members of the public at the heart of this, in line with the People Involvement Framework. The CHCP works closely with Your Voice (Inverclyde Community Care Forum) in running the PPF network and CHCP Advisory Group. The Chair of the Advisory Group has a seat on the CHCP Committee as a core part of the governance of the CHCP. The Advisory Group will be the main formal means although not the only means by which co-production will be achieved at a strategic level across the CHCP, nevertheless we will ensure that co-production principles are embedded at service level.

Preventative and Anticipatory Care

A core element of maximising independence is to support people in preventing the development of conditions that limit their abilities. Where such conditions already exist, we would aim to prevent them worsening. To that end, our commissioning approach needs to build in aspects of prevention, as well as anticipating the potential trajectory of such conditions with a view to developing supports that will work towards improvement, or where that is not possible, maintenance of existing levels.

We need to further improve delayed discharge performance, by focusing on reduced length of stay in acute hospital settings, joint discharge planning processes, re-enablement and homecare provision.

Effective Care at Times of Transitions

This will be achieved by making effective use of augmented homecare; increased respite capacity; establishing joint care management protocols; improving pathways and processes around end of life care, plus individuals having timeous access to domiciliary rehabilitation and appropriate housing.

Health and Social Care Integration

The Integration of Adult Health and Social Care in Scotland legislation and guidance are currently being progressed by the Scottish Government. The proposals include changes to how adult health and social care services are planned and delivered, aiming towards a seamless experience from the perspective of the patient, service user or carer. It would involve the development of Health and Social Care Partnerships that would be expected to produce joint commissioning strategies and delivery plans over the medium and long-term, which will be reviewed as part of the process of ongoing assurance. Inverclyde Community Health Care Partnership offers one integrated model that is already established and it is unclear what further changes would be required following the introduction of this proposed piece of legislation. However, we are already at the stage of producing this Joint Commissioning Strategy as a CHCP, benefiting from the integrated context within which we already operate.

Commissioning for Inequalities

The CHCP has a legal obligation to ensure that all our policies and practice meet the needs of all our staff and those who use our services regardless of their age, disability, ethnicity, gender, religion or belief or sexual orientation.

With regards to commissioning, we are adopting a strategy of “proportionate universalism”, whereby we would commission services that are ‘universal, but with a scale and intensity that is proportionate to the level of disadvantage’.

It is reasonable to expect that the more disadvantaged groups require a greater share of the overall budget to maintain or improve health compared to more affluent groups.

Proportionate universalism also involves commissioning a combination of universal and targeted services. Universal services are offered to all residents and address the whole social gradient. We will ensure that universal services do not inadvertently widen health inequalities. Physical access, staffing and budgets should be allocated in proportion to levels of need across Inverclyde.

Equitable commissioning may cost more. Funding should be based on need. This will involve accepting that it may cost more to provide the same service to certain groups due to increased cost of delivery and support.

Targeted services are offered to specific disadvantaged groups when they are unable to take full advantage of the universal service or have specific needs. When commissioning, a particular service provider may be the only service that is able to offer the specific requirements of an individual.

Organisational Policy Drivers

Getting It Right for Every Citizen and Community

The Scottish Government introduced "*Getting it right for every child (GIRFEC)"* as the vehicle for achieving their social policy framework. As outlined in Inverclyde Single Outcome Agreement 2012-2017, the Inverclyde Alliance has taken this approach a step further and has made a commitment to get it right for every citizen and community, focussing on making Inverclyde a place which nurtures all its citizens, ensuring that everyone has the opportunity to have a good quality of life and good mental and physical wellbeing.

Key to this is a move to prioritise early intervention and preventative approaches, as the many problems experienced by those citizens who live in the most deprived areas in Inverclyde will not be 'fixed' overnight.

Best Value

This Joint Commissioning Strategy is intended as a working document which identifies how purchased social care services will support our strategic objectives outlined in the CHCP Improvement Directorate Plan.

It also provides a framework for evaluating the quality of these services, the effectiveness of their contribution, and the extent to which they meet the needs of service users. This requires us to:

• Understand the needs of service users, their carers and their communities.
• Consult with all stakeholders to ensure commissioning goals are understood and agreed.
• Identify outcomes and develop ways to measure them.
• Ensure service user outcomes are at the centre of the strategic planning process.
• Ensure contracting processes are transparent and fair.
• Systematically monitor and evaluate the performance and effectiveness of purchased and in-house services and ensure that this influences on-going reviews of our commissioning strategy and plans.

The Strategy therefore aims to outline the current and anticipated future operating context for purchased and in-house services and the financial framework in which these priorities will be pursued.

This document acts as a catalyst to assist the provider market in identifying other possible service models that would meet the commissioning priorities and vision based on an outcomes approach. Other key stakeholders include: service users and carers, other areas of the Council and NHS Greater Glasgow and Clyde and CHCP staff. It should be noted that The Commissioning Strategy is a “living document” and as such will adjust to changes and will be subject to ongoing and regular review. In addition, Care Teams will develop action plans to drive forward their own services, again based on an outcomes approach.

CHCP Contract Management Framework

We are committed to developing a fit-for-purpose procurement / contract management framework for the CHCP. In liaison with Inverclyde Council's Corporate Procurement Department the CHCP's Contract Monitoring and Complaints Team are developing the following procedures:

- Updating the Council's Standing Orders for Procurement to include the Joint Improvement Team Guidance on the Procurement of Social Care Services within the Corporate Procurement Manual. (This will include guidance on the social care procurement journey prepared by Scotland Excel.)
- Liaising with NHS procurement colleagues to develop a joint commissioning/contracting process.
- Continuing to progress collaborative procurement opportunities with partner agencies.
- Reviewing the need for the Authorised Provider List of Providers – (this will eliminate duplication in the vetting process already performed by the Care Inspectorate.)
- Revising contract management procedures to establish joint working protocols with Corporate Procurement; commissioners; the Care Inspectorate; and streamlining contract monitoring procedures to effect a more focussed and expedient approach.
- Continuing to develop our partnership with providers, in particular our collaboration with the third sector.
- Continuing to work with Legal Services in developing model contracts that will be put in place with external providers for health and social care services.

Key developments include contractual requirements for Self Directed Support and services developed as part of the Personalisation agenda; outcome based specifications and contracts.

- Developing joint working arrangements within the CHCP with commissioning and finance teams.
- Continuing to work with COSLA on the National Care Home Contract and the Development Agenda for Older People's Services.
- Working with Scotland Excel and other national bodies where appropriate in support of the National Agenda on Public Procurement with particular focus on health and social care procurement.

Commissioning Options / Procurement Decisions

The strategy will identify future commissioning priorities which will inform any decisions regarding the procurement of health and social care services. A CHCP procurement plan will be derived from the strategy which will outline future tendering priorities.
In all CHCP procurement decisions the Joint Improvement Team Guidance will be applied to ensure consideration is given to the following to inform any decision to proceed to tender:

- Impact on service users and carers;
- Costs;
- Quality considerations;
- Availability of alternative services.

Working with the 3rd and Independent Sectors

With the emphasis on delivering more joined-up and efficient services, the CHCP is actively engaging with the third sector to achieve better outcomes. This will include developing learning and training opportunities. Further collaboration will take place on the use of Community Benefits in procurement; assistance in implementing Public Social Partnership projects and maxisimising social value in commissioning.

Corporate Social Responsibility

Sustainable procurement can be defined as:

“A process whereby organisations meet their needs for goods, services, works and utilities in a way that achieves value for money on a whole life basis and generates benefits not only to the organisation, but also to society, the economy and the environment.”

Inverclyde Council will continue to use all of its powers, wherever it can, to do anything it considers will promote or improve the well-being of the area. Steps to be taken include:

- Securing representation for black and ethnic minority communities in employment at all levels that is equivalent to their representation in the population;
- Developing a workforce that is highly skilled and well motivated and can truly meet the skill needs of the economy;

- Building a place where there are far fewer disparities in employment and everyone who wants to can participate in economic success;
- Providing residents with the skills to compete for the employment created by new investments in public services and private enterprise;
- Encouraging local residents to take up high quality, sustainable employment opportunities.

When commissioning services we will seek to implement Inverclyde Council's aims as stated in the Community Plan of securing skills and employability and equal opportunities in employment which resonates with the NHS GG&C Employability planning framework. This will be achieved by using procurement and development contracts specifications which include, where appropriate, broad regeneration activities which enable the use of both mainstream and additional funding to achieve objectives such as the enhancement of local skills within a broad value for money framework. To this end Inverclyde Council may require particular conditions concerning performance of the contract, provided that those conditions are compatible with European Community law and provided that they are stated in the contract notice or in the contract documents. Contract performance conditions may relate in particular to social and environmental considerations relating to the subject of the contract.

1. INVERCLYDE & INVERCLYDE CHCP PROFILE APPENDIX 1

Overview of CHCP

With the development of Inverclyde Community and Health Care Partnership in 2010, there has been a bringing together of Health and Social Work services to form a single integrated organisation. Each member of the management team has responsibility for managing both health and social work services within their respective service area and across the CHCP generally. In broad terms this incorporates:

- Children's Services
- Criminal Justice
- Mental Health Services
- Addiction Services
- Homelessness Services
- Older People's Services
- Rehabilitation and Enablement
- Assessment and Care Management
- Planning, Performance and Development
- Contract Monitoring and Complaints
- Health Improvement, Inequalities and Personalisation
- Administration and Business Support
- Money Advice Services

Staff Resources

Inverclyde CHCP has a total of 1,863 staff; which includes 1,241 staff employed by Inverclyde Council and 622 staff employed by NHS Greater Glasgow and Clyde.

Financial Resources

The net revenue budget for the CHCP for 2012 / 2013 is £118.782 million (m).

- The Inverclyde Council Social Work budget is £48.198m.
- The NHSGG&C Inverclyde budget is £70.584m.

Budgeted Resources:	£'000
NHSGGC	70,584
Inverclyde Council	48,198
Total Partnership Budget 2012 / 2013	118,782
Corporate Director & Support Functions	3,903
Children & Families	13,155
Health and Community Care	37,840
Planning, Health Improvement & Commissioning	2,287
Mental Health & Addictions – Community	6,229
Mental Health – Inpatient Services	9,255
Family Health Services	21,165
Prescribing	16,258
Resource Transfer & Delayed Discharge	8,690
Total Partnership Budget 2012 / 2013	118,782

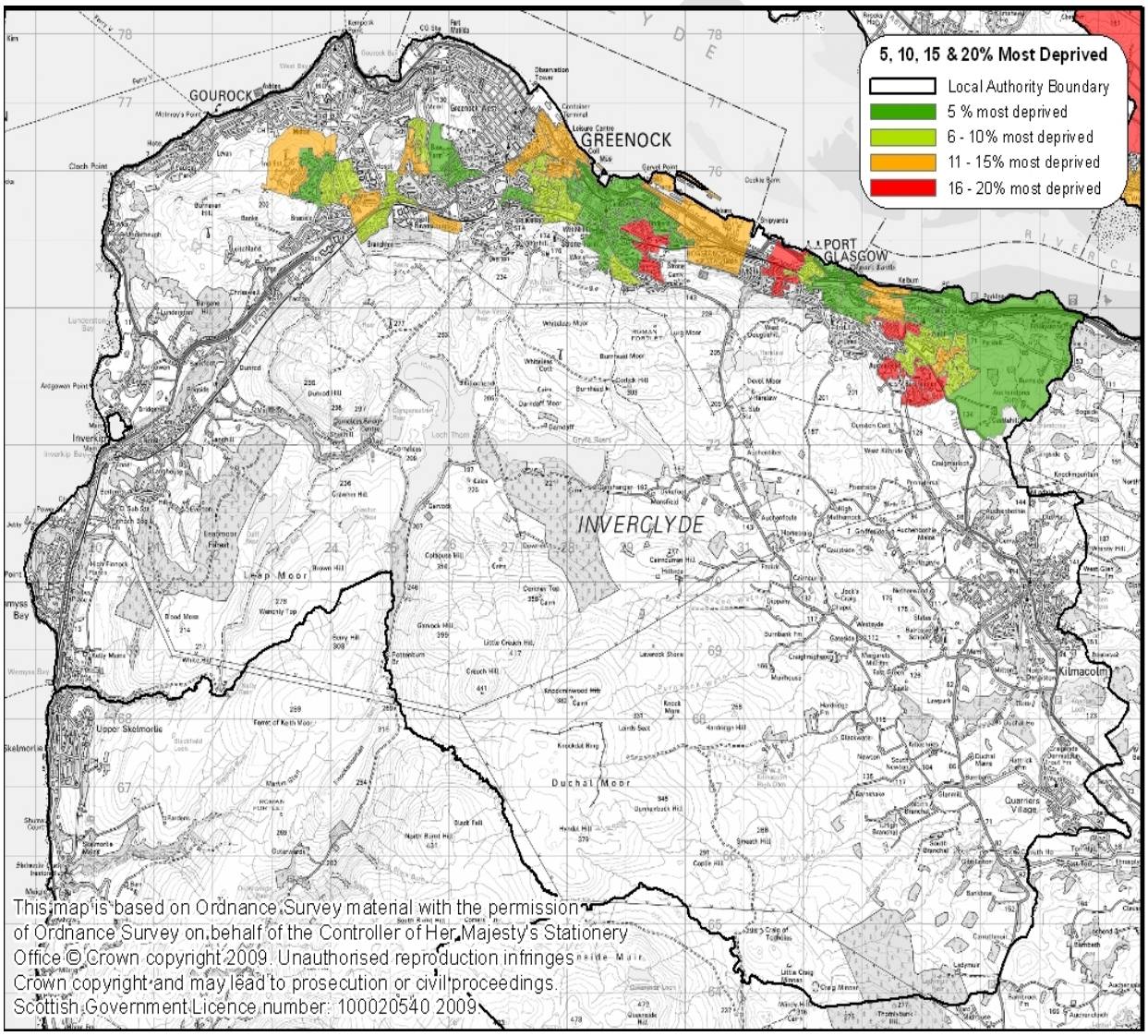
Social Care Contracts

During the period 2012 – 2013 the CHCP had 186 social care contracts in operation with 120 organisations. The total annual value of the contracts was approximately £28,000,000.

Overview of Inverclyde

Situated on the west coast of Scotland, Inverclyde is one of the smallest local authorities in Scotland, covering a land area of approximately 160 square kilometres with a population density of 497 persons per square kilometre. The map below outlines the geographical area, the levels of deprivation in certain areas (as recorded by the Scottish Index of Multiple Deprivation), as well as the mix of urban and rural nature of the locality.

Map 1: SIMD 5%,10%,15% and 20% most deprived datazones in Inverclyde



Scottish Index of Multiple Deprivation (SIMD)

As detailed in Map 1 above; statistics from the Scottish Index of Multiple Deprivation show that Inverclyde has particular problems in regard to deprivation and poverty. This includes:

- In SIMD 2009, 17 (5.2%) of the 325 datazones in the **5%** most deprived datazones in Scotland were found in Inverclyde, compared to 13 (4%) in 2006 and 6 (1.8%) in 2004.
- In SIMD 2009, 43 (4.4%) of the 976 datazones in the **15%** most deprived datazones in Scotland were found in Inverclyde, compared to 42 (4.3%) in 2006 and 36 (3.7%) in 2004.
- In SIMD 2009, 17 (15.5%) of Inverclyde's 110 datazones were found in the **5%** most deprived datazones in Scotland, compared to 13 (11.8%) in 2006 and 6 (5.5%) in 2004.
- In SIMD 2009, 43 (39.1%) of Inverclyde's 110 datazones were found in the **15%** most deprived datazones in Scotland, compared to 42 (38.2%) in 2006 and 36 (32.7%) in 2004.

Inverclyde has a high proportion of deprived areas with 43.7% of the Inverclyde population living in areas which are defined as the most deprived 20% across Scotland. In addition, it has the second highest local share with 39.1% of its data-zones in the 15% most deprived in Scotland. This is second only to Glasgow which has 43.1%.

There is a significant gap between our more affluent areas and those which experience high levels of poverty and deprivation. In our most deprived and disadvantaged areas, people face multiple problems such as ill-health; high levels of worklessness; poor educational achievement; low levels of confidence and low aspirations; low income; poor housing and an increased fear of crime. In addition, Inverclyde has particular issues relating to alcohol with significantly worse levels of alcohol and drug misuse compared to the rest of the UK. The levels of problematic drug misuse and alcohol-related death rates are among the highest in Europe and have markedly increased in the last 15 years. All of these are compounding factors leading to poorer than average

outcomes for the people of Inverclyde in terms of their overall health and wellbeing.

- Compared to Scotland over the period 2009 to 2011, Inverclyde had a higher death rate. The main cause of death in Inverclyde was cancer, followed by circulatory disease.
- Female life expectancy at birth (79.1 years) is greater than male life expectancy (73 years), but both were lower than the Scottish average.
- There is 20% above average incidence of heart disease in males in Inverclyde.
- There were 301 emergency admissions of people aged 65+ per 100,000 population.
- There were 268 hospital admissions for drugs misuse per 100,000 population.
- 10% of people in Inverclyde are prescribed drugs for anxiety, depression or psychosis.
- 31.8% of males smoke in Inverclyde, compared to 28.1% of Scottish males.
- 23% of women in Inverclyde smoke when they are pregnant compared to the Scottish average of 18.7%.
- 21% of people in Inverclyde are income deprived.
- 18% of adults in Inverclyde are employment deprived.
- 5.2% of adults aged 25-49 years claim Job Seekers Allowance in Inverclyde.
- 21.1% of adults aged 60+ claims the guaranteed pension credit in Inverclyde.
- 60.33% of households In Inverclyde are privately owned; with 34.06% being socially rented and 5.61% being privately rented.

The National Records of Scotland report *Mid-2010 Small Area Population Estimates Scotland* indicates that of the 110 datazones in Inverclyde; 9 of these have a population of under 500 people. In 4 datazones there has been a depopulation of between 51% and 56% since 2001. As outlined in Inverclyde Local Housing Strategy 2011 – 2016, there are significant regeneration plans underway. These changes will need consideration in both where and how services are delivered.

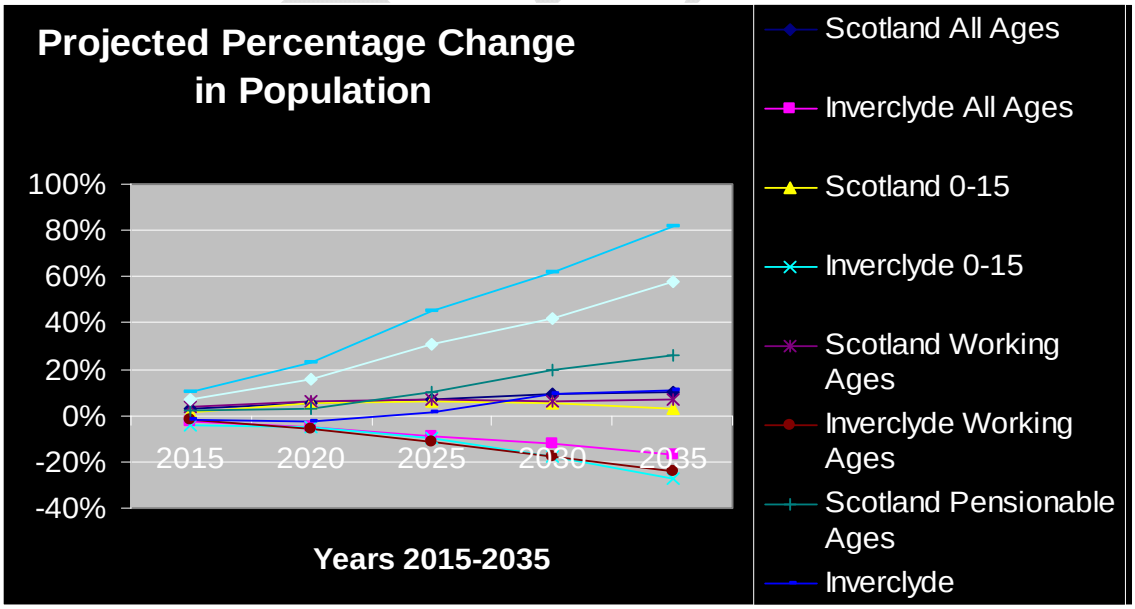
Projected Population Changes

The General Register Office for Scotland report that Inverclyde's population stood at 79,770 in 2010; 17.24% of whom were children; 61.34% were working age and 21.42% were pensionable age. Over the next twenty years there is projected to be a dramatic depopulation in Inverclyde. The table below outlines the projected population changes in Inverclyde by age band.

Table 1: Inverclyde Projected Population Changes

Category / Year	2015	2020	2025	2030	2035
Inverclyde All Ages	-3%	-5%	-9%	-12%	-17%
Inverclyde 0-15	-4%	-5%	-10%	-18%	-27%
Inverclyde Working Ages	-2%	-6%	-11%	-18%	-24%
Inverclyde Pensionable Ages	-2%	-3%	1%	9%	11%
Inverclyde 75+	7%	16%	31%	42%	58%

Graph 1: Projected Percentage Change in Population in Scotland and Inverclyde



The graph above illustrates the stark contrast of the projected population changes in Inverclyde compared to Scotland, particularly in the 0-15 and 16-64 age groups. However, there is more of a mirroring of the national projections with regards to age groups 65-74 and particularly the 75+ age group.

Notwithstanding, Inverclyde percentage projected population change from 2010 – 2035 is -16.7%, the highest level of depopulation in Scotland. This has implications both for the current and future profile of need, and for the provision of care and support to vulnerable members of the community.

This is explored further in a recent report, ***Inverclyde Depopulation Study, (July 2011),*** stating that:

- There will be a concentrated group of people with an increase in health issues related to poverty e.g.: substance abuse, mental health.
- Services will have to be redesigned to care for a population that will be comparatively older. This will include shifting the balance of care, whereby treatment of older people in communities is increased whilst treatments in hospitals is reduced.
- Increased focus will be placed on combining specialist stand-alone services.
- Outreach into communities will increase as will delivery of health services in communities.

The demographic changes will require considerable changes in the social care elements of CHCP service delivery. This includes a focus on re-enablement and personalisation. In addition, while there is a substantial percentage projection decrease of -27% of the 0-15 years age group, we are anticipating in view of the levels of deprivation and health needs in the adult population, that many of these children will have more complex needs.

All of these factors will inform future need and demand for services and require consideration when commissioning services.