

**WEST LOTHIAN**

**STRATEGIC SERVICE  
STATEMENT**

**PHYSICAL DISABILITY**

**1 APRIL 2009 – 31 MARCH 2012**

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## EXECUTIVE SUMMARY

The West Lothian Strategic Service Statement for Physical Disability aims to set out how services will be developed and delivered over the next three to ten years to meet the current and potential needs of people living in West Lothian aged 18 to 65 experiencing physical and complex disability. Whilst definitions of physical disability can vary greatly due to the diversity of conditions and circumstances that can impact on people's ability to live their lives, we have chosen to include sensory impairment and acquired brain injury within this Strategic Statement.

The Strategic Statement has been developed within the context of national and local policy direction taking into account the key principles and values which underpin the planning, commissioning and provision of services to disabled people and has been informed by consultation with key partners, service users and carers.

West Lothian Council services for disabled people and their carers are delivered either directly by the Council or by commissioning from a range of partner agencies with access to services being determined by an assessment of need and eligibility criteria. The Strategic Statement outlines current service provision, which includes day support, care at home, short breaks from caring and care home services, as well as providing an Action Plan for future service initiatives and developments.

The future development of services for disabled people in West Lothian as described in this Strategic Statement has endeavoured to take into account a number of common themes that have been identified both from policy drivers and from service user and carer engagement.

There is a growing emphasis on personalised services and the promotion of self-directed support with an increasing number of service users and carers expected to seek control of their own care and support provision over the next ten years.

There is an increasing focus on the management of long term conditions within the local community and on shifting the balance of care towards home based services and support which will require a more integrated approach between service providers and the further development of joint and partnership working alongside a greater recognition of unpaid carers.

The Strategic Statement has been circulated for consultation to representatives from: disability support organisations; Disability West Lothian and other voluntary and independent sector organisations; West Lothian Physical Disability Forum; West Lothian Brain Injury Forum; Just Uz; ACSS Service User Forum; service users; carers; West Lothian Council managers and staff; West Lothian CHCP and NHS Lothian and others and has been largely welcomed by all those consulted.

The aim of service planning, development and delivery is to promote, enable and sustain independence, social inclusion and quality of life for service users and carers within a framework offering flexibility and choice. The on-going challenge is to provide services that are personalised, of high quality and which can most effectively meet needs from within finite resources.

The Strategic Statement seeks to set out how West Lothian Council proposes to meet this aim and challenge in the future.

## 1. INTRODUCTION

This Strategic Service Statement for Physical Disability services and support has been produced by West Lothian Council Social Policy – Adults Services and has been informed by partnership work undertaken with joint strategic working groups across physical disability services from West Lothian Council and NHS Lothian and by the Lothian Joint Physical and Complex Disability Strategy. This Service Statement has also been informed by key partners and stakeholders across Lothian and in the voluntary sector.

The Strategic Service Statement aims to address the current and potential needs of people from 18 to 65 years of age living in West Lothian who have physical and complex disability. People who experience disability due to physical impairment or who have complex problems due to both physical and cognitive impairment represent a significant proportion of the West Lothian population. Whilst it is not straightforward to estimate the number of people who have a physical or complex disability due to the different ways that disability can be defined, it is estimated that there are 10,000 people currently living in West Lothian who are experiencing some degree of physical disability.

Whilst this Service Statement focuses on physical disability, it should be noted that people may have a range of needs as a result of complex disability and that some of these may be covered in other Service Statements such as those for learning disability or mental health. In addition, disabled people reaching the age of 65 move on to older people's services where their disability needs require to be met and so reference to the older people's Service Statement is also appropriate.

There is a very wide range of conditions and problems which people can experience and which have the potential to impact on their ability to participate in almost every aspect of daily life. For the purposes of this Service Statement, these conditions will be considered to include sensory impairment and acquired brain injury (ABI). As a result of this wide range, services supporting disabled people require to meet the needs of people whose experience of disability and its impact on their daily lives varies greatly and is influenced by additional factors such as age, economic situation, environment and so on.

Whilst there is no national strategic statement of policy for people who experience physical disability, current policy development, both locally and nationally, does provide an effective opportunity to develop a West Lothian strategic approach to meeting the needs of disabled people. The 'personalisation of support services', 'service re-design', 're-enablement and self-management' and 'citizen leadership' are key themes of *Changing Lives*, the 21<sup>st</sup> century social work review and of the NHS *Kerr Report* and *Delivering for Health*. Joint Improvement, the development of Managed Clinical/Care Networks and the move towards self-directed support, are setting new structures and challenges for local service planning and delivery.

There is a great deal of evidence which demonstrates the needs of disabled people and the barriers and problems they face in their daily lives and this has been widely documented over recent years. Disabled people themselves have been extensively consulted about a range of issues, services and policy agendas and recurring themes have emerged from these consultations. These themes can be summed up as follows:

- Services should be person-centred, not 'one size to fit all'
- A person's journey through care, service and support systems should be enabling and empowering and not promote dependency
- Services should be aimed at maximising independence
- Assessments should be needs-led
- Services should be shaped to meet identified needs within a context of flexibility and choice that also promotes quality and safety
- Functional, rehabilitative and re-enablement needs should be addressed

This Service Statement aims to outline a blueprint for the provision and development of services and support for disabled people in West Lothian over the next three years to be delivered in partnership with service users, carers and key stakeholders.

## 2. BACKGROUND AND APPROACH

### a) Defining the Service User Group

Physical disability is a term which is used to describe disability arising from a wide range of physical causes which affects a person's ability to function in their daily life. Some people will have experienced disability from birth; others will develop disability in later life or as a result of some type of traumatic injury.

Disability has been variously defined as:

*'a physical or mental impairment which has substantial and long term adverse effect on his/her ability to carry out normal day to day activities'*

Disability Discrimination Act 1995

*'a condition affecting the body, perhaps, through sight or hearing loss, a mobility difficulty or a health condition'*

Disability Rights Commission

Long term in this context is understood to mean where the effect of the disability has lasted, or is likely to last, more than 12 months or for the rest of the person's life.

The World Health Organisation defines disability in terms of its effect on functioning and relates this to the environment in which a person lives. In this context, disability is an umbrella term for impairment, activity limitation and restriction of participation; function is an umbrella term for all body function and also activities and participation and environmental factors are the physical, social and attitudinal environment in which the person lives.

International Classification of Impairment, Function and Participation (ICF)

A person could be defined as having a physical disability, therefore, when they experience one or more of the following:

- Needs which stem from a physical impairment
- Needs which are complex, i.e. severe and likely to have a combination of impairments, including cognitive
- There is activity limitation which interferes with carrying out the normal tasks of daily living
- Their own environment restricts their participation preventing them from leading as full a life as they would wish

A person with a physical impairment could also experience disability as a result of:

- The inability of society and/or its structures to achieve inclusion

## b) Estimating the Number of People with Disability

Determining the number of people in West Lothian who have a physical and/or complex disability is challenging due to a lack of recent statistical data combined with the different ways in which disability can be defined. Some definitions of disability are so wide that they are likely to provide over-estimates whilst some are so restrictive that they are likely to provide underestimates of those people whose degree of impairment is such that it leads to difficulties in daily life.

This Service Statement draws on the approach taken by the Lothian Joint Physical and Complex Disability Strategy when calculating the number of physically disabled people in West Lothian. This approach used the concept of functioning combined with the estimates published by the Office of Population Census and Surveys (OPCS) in its surveys of adult disability conducted in the 1980's. These surveys provided a useful basis for estimating the number of disabled people as they included a definition of severity. For the purposes of the estimates provided here, the severity scores indicating moderate disability and above were used.

**Table 1: Disability Rates (per 1000 adults aged 16 to 64 years) with 95% confidence limits for West Lothian and Lothian as a whole**

Area	Estimated Numbers		
	Estimate	Lower Estimate	Higher Estimate
West Lothian	10,048	9,963	10,130
Lothian	50,940	50,521	51,370

An understanding of the relative proportion of each general type of disability can be gained from the Scottish Household Surveys (SHS) of 2001 and 2002.

**Table 2: Relative contribution of different types of impairment**

Type of Impairment (SHS 2001 & 02)	Percentage (SHS 2001 & 02)
Physical	81%
Visual	6%
Hearing	6%
Mental Health	5%
Speech	2%

Whilst this data cannot be over-interpreted due to the range of definitions that can be used when attempting to calculate the number of people with physical disability in a given population, it does provide an indication of the current situation within West Lothian. It is also worth noting that deaf and hard of hearing people would not necessarily consider themselves to be disabled but rather as people who use a different language when communicating.

It is recognised that there is a need for better information on the numbers of people who experience physical or complex disability and on the detail behind these numbers in order for us to better understand the diversity of disability and the factors that can impact on people's experience, including age, ethnic background and so on. This information, in turn, will help us to more accurately identify areas of unmet need and will inform future service planning, development and delivery.

West Lothian has a current population of around 170,000 but also faces future demographic changes which may well impact on the need for services and support for disabled people. West Lothian is predicted to have the fastest growing older population in Scotland and it has been forecast that by 2018 there will have been a 45% increase in the number of people aged 60 to 74 years and by 2014 one in three people in West Lothian will be aged over 50 years. In addition, the number of households in West Lothian is predicted to rise by an average of 1,020 per year between now and 2016, an increase of 12.7%, and West Lothian will continue to have a higher average household size than the Scottish average. This data supports the view that there is likely to be an increase in the number of disabled people within West Lothian who will require services and support to live as independently as possible within their local community.

### **c) Approach**

As outlined above, there is a wide diversity of people who experience physical and complex disability due to a wide range of conditions and events. This Service Statement aims to approach disability from the perspective of the impact which it can have on people's ability to participate in the activities of daily life and to live as full and as independent lives as they would wish. This approach will enable service providers across all sectors to understand the service and support needs of disabled people and will influence current service delivery and inform future service planning, developing and commissioning.

This Service Statement has been developed in partnership with key stakeholders within the context of national and local policy direction and aims to outline how these policies will be implemented in order to meet the needs of disabled people within West Lothian.

Finally, this Service Statement has been informed by consultation with service users and carers and will promote on-going engagement and dialogue with service users and carers in the process of service planning and development.

#### **d) Partnership Working**

West Lothian Council Social Policy Department provides and delivers a wide range of services for people with physical disability or sensory impairment via teams such as the domiciliary care team or Home Safety Service. Social Policy also works with other Council Departments to promote and meet the needs of disabled people. However, the Council also commissions an extensive range of services and support for people with physical disability or sensory impairment from both the private and voluntary sectors.

The Council aims to work in partnership with providers in the field of disability and in this way is able to both provide service users and carers with the range of specialist services they require and to support the ongoing existence and development of voluntary sector organisations.

A key partner of the Council in the delivery of services and support for disabled people is NHS Lothian and in West Lothian the establishment of a Community Health and Care Partnership organisation has helped to set the agenda for an ongoing partnership approach to service development.

#### **e) Capacity**

Capacity planning will be necessary in order to ensure the ongoing delivery of adequate services and support to disabled people. The anticipated future demographic changes in West Lothian, with one in three people predicted to be aged over 50 years by 2014, combined with the shifting of the balance of care and the management of long-term conditions agendas will require to be taken into account when looking at future service provision.

#### **f) Aims and Objectives**

This Service Statement aims to:

- Outline the strategic context within which services for disabled people within West Lothian will be delivered, planned and commissioned
- Outline the key principles and values which will underpin the planning and delivery of services and support for disabled people
- Outline the current service and support provision for disabled people within West Lothian
- Outline the future service and support needs of disabled people
- Outline the approach to future service commissioning and contracting
- Outline the approach to partnership working
- Outline the approach to service user and carer engagement
- Provide an Action and Implementation Plan for the on-going planning and delivery of services and support to disabled people within West Lothian

This Service Statement will provide the framework for the delivery, planning and commissioning of services and support for disabled people in West Lothian over the next 3 years within a context of partnership working, joint planning and the promotion of a person-centred approach to service delivery and support.

### **3. STRATEGIC CONTEXT**

#### **a) Legislation**

There has been a significant amount of legislation introduced in recent years which has been either directly related to disability or which has had an impact on disabled people. Much of this has been at a national Scottish level coming from the Scottish Parliament as well as coming from the UK Government.

A key theme has been the social justice agenda with a move to a rights based approach to service delivery for both service users and carers. Partnership working and a 'joined-up' approach to service planning have been promoted as part of the shifting the balance of care agenda which aims to support more people with long term conditions in their own communities. Multi-agency and multi-disciplinary team working is seen as an integral part of developing local services, care and support. There is a greater recognition of the essential role played by unpaid carers and of the need to engage with service users and carers as key partners. There is also an increasing emphasis on the personalisation of services with service users being more involved and having more control over their own care and support.

Relevant legislation is listed in Appendix A

#### **b) National Policy Context**

Several key national and strategic policy documents have been produced in the last ten years. Some have aimed to drive the agenda in the Health Service; others have been aimed at driving the agenda in social care and social work.

Relevant national policies are listed in Appendix B

#### **c) Local Context**

The legislative and policy drivers combined with the anticipated demographic changes in West Lothian will continue to have an impact on future service needs, levels and priorities. Advances in medicine and health care mean that people, including disabled people, are living longer and are remaining in their own homes in their local communities for longer. Increased awareness amongst disabled people of the rights based agenda for health and social care and the move towards individualised care and support as a response to individual need will require services and service providers to adapt and change and to work together to meet these needs.

The Community Health and Care Partnership (CHCP) model established in West Lothian provides a sound basis for partnership working and service planning and development across community health and social care services.

Relevant local strategies and initiatives are listed in Appendix C

#### **d) Common Themes**

The range of national and local policy drivers outlined indicates a high level of activity that recognises the current and future pace of change. There is a desire to focus on anticipating, planning and delivering services that are informed by service user and carer consultation and that will be accessible, fit for purpose and able to demonstrate best value.

Whilst the national and local policy drivers have come from a variety of sources and agencies, a number of common themes have emerged. These are:

- A greater emphasis on personalised or individualised services and a move to increased service user / carer responsibility and control over their care and support provision
- A focus on the management of long-term conditions within local communities – this would include offering anticipatory care, support for self-management and a robust risk management and enablement framework
- A focus on rehabilitation and re-enablement to be delivered as locally as possible
- The maximisation of independence and capacity – including improving employment and social opportunities and reducing attitudinal and environmental barriers
- A greater emphasis on service user engagement and choice
- A focus on shifting the balance of care more towards community and home-based care
- A recognition of carers as partners in care – including the need for carer training and support
- A greater emphasis on strategic planning and commissioning, joint and partnership working, integrated service delivery and robust performance monitoring, management and reporting
- A move towards outcomes focussed approaches and frameworks in service commissioning and delivery

These themes will be central to this Strategic Service Statement for Physical Disability.

## 4. KEY PRINCIPLES AND VALUES

### a) Values

The strategic vision and direction evidenced across the range of national and local policy developments is informed by a set of core values and principles. These key values underpin the planning, development and delivery of services and support to disabled people and include equality of opportunity; dignity; accountability and transparency; individuality and choice.

Key values informing this Strategic Statement are listed in Appendix D

### b) Service Activity based on Key Principles and Policy Drivers

There are key areas of activity that are focused on putting core values into practice when supporting and meeting the needs of disabled people. These activities reflect major policy drivers and what we are expected to deliver and also what we want our services to achieve.

#### i. Promoting Inclusion

*'All disabled people having the same choice, control and freedom as any citizen at home, at work and as a member of the community'*

Disability Rights Commission

Disabled people have the same rights as everyone else to access facilities, opportunities and services and to receive quality services that are able to accommodate their needs and not disadvantage them further. Active citizenship should be promoted and is relevant to communities in their widest sense including Council activities and initiatives, health services, voluntary sector activity and local initiatives within communities themselves. Ensuring that disabled people have access to the specialist services and support they require should sit alongside ensuring that they have access to the universal health, social and community based services used by everyone else. Services and communities need to work towards achieving equality and the inclusion of disabled people in all aspects of their lives.

In order for mainstream services to be inclusive and accessible we need to ensure that staff attitudes and communication reflect an awareness of disability issues; that services can be both physically accessible and flexible about appointment times; that services have inclusive policies and procedures and can offer information using appropriate formats or technologies.

The Council now has a statutory duty to promote disability equality and the introduction of the Disability Equality Scheme and a more robust approach

to Equality Impact Assessment is helping to move the inclusion agenda forward. The creation of the Disability Equality Forum with disabled members working in partnership with council representatives has also ensured that there is effective monitoring of the implementation of the Disability Equality Scheme Action Plans with service areas being held accountable for making progress.

Promoting equality of opportunity and respecting diversity means that services should recognise and be sensitive to the needs of everyone irrespective of disability, ethnic origin, gender, sexual orientation, religion or belief. Service users and carers should be supported to enable them to become active participants in their care, daily life and communities and this support should include appropriate communication assistance where required.

Inclusiveness should be regarded as a key policy which should be built in to all service planning and delivery and should be a cornerstone of any corporate vision.

## **ii. Enabling and Sustaining Independence**

The aim of the planning, development and delivery of services and support both in-house and in partnership with health and other key partners and stakeholders should be to promote, enable and sustain independence for service users and carers. Disabled people have the right to remain living at home in their own communities for as long as possible and national and local policy direction increasingly reflects this. The emphasis on the development of rehabilitation, re-enablement and home based services and support ensures that adjustments can be made to meet the particular needs of individuals thereby reducing dependence on others and increasing choice and control over their lives.

## **iii. Shifting the Balance of Care**

The Shifting the Balance of Care workstream of **Delivering for Health** is aimed at improving the nation's health by moving the emphasis towards health improvement, preventive medicine and more continuous care in the community. This means the provision of faster, more personal care closer to home as well as improving services in order to deliver anticipatory care. In order to deliver more integrated care, integrated community teams equipped to deliver new models of care will be required and will involve partners from health, social care, the voluntary sector and others.

In addition, the aim is to shift the view of service users as passive recipients of care towards seeing people as full partners in the management of their conditions. Ensuring that people are well informed and supported enables them to become experts in their own health and care needs and to have a greater role in managing these. Services should include anticipatory planning for people with long-term conditions, supported self-care and the use of tele-health solutions.

#### **iv. Personalisation**

Personalisation, including a strategic shift towards early intervention and prevention, is the key driver for the shape of public service development and delivery. It enables people to live their own lives as they would want to and to be confident that services are of a high quality, safe and promote their own individual needs for independence and well being.

*‘Services should meet the needs of people. People shouldn’t have to fit services’*

Changing Lives: 21<sup>st</sup> Century Social Work Review

The personalisation of services puts the individual at the centre of care and support planning allowing them to work with their carers and professionals to manage risk and resources. This means that services need to be designed and delivered flexibly based on the needs of those who use them but that services also need to support the individual and their carers to develop the capacity to meet their own needs. Service providers need to work collaboratively focusing on prevention and on developing anticipatory care.

The personalisation agenda is central to many of the recent policy initiatives relating to social care service provision and a key aspect of this is person-centred planning. Person-centred planning is the term for a range of approaches that are aimed at enabling service users to decide how they would like to live their lives and what they wish for the future and to identify and plan their own services and support needs. Person-centred planning is based on the core principles of independence, choice, inclusion, equality and empowerment and these will underpin the process of care and support planning with disabled people in West Lothian.

#### **v. Assessment and Care Management**

Assessment and care management is the integrated process by which individual needs are identified and addressed within available resources. Assessment and care management is also a key part of the Joint Future agenda to improve outcomes for service users and carers. Robust assessment and care management policies, procedures and frameworks are essential to ensure a needs-led approach to assessment and a person-centred approach to care management, planning and support.

##### **i. Single Shared Assessment (SSA)**

The model of assessment delivered in West Lothian is a Single Shared Assessment (SSA) in line with the recommendations of the Scottish Government’s Joint Future Group. The aim of SSA is to provide an assessment framework that enables the implementation of shared arrangements for assessment in community care across social work, health and housing. The concept of SSA is to provide a more streamlined, person-centred approach, led by a single professional but

with other specialist involvement as appropriate. This model aims to eliminate duplication in assessment, ensure that information is shared effectively across agencies with the consent of the person being assessed and to speed up the delivery of appropriate services and support in order to improve outcomes for those who use community care services.

The e-Care system in West Lothian supports the SSA framework which is used by all social work assessment staff with specialist assessments being added as appropriate. Housing staff also use the SSA tool, as do some health staff.

## **vi. Risk Assessment**

The assessment of risk, including risk factors and the level of risk, is an integral component of both needs assessment and care management and helps to inform the development of both Care and Support and Personal Plans. Risk is considered in the context of capacity, the environment, health, cognitive impairment and vulnerability as well as whether there is a risk to or from oneself or others. There may be risks to carers and families as well as to service users.

In addition, there may be specific actions or activities in relation to the care and support of service users which require an individual risk assessment, for example in relation to moving and handling, and these are recorded separately.

Accurate risk assessment enables the implementation of effective risk management and this, in turn, means that the independence of individuals can be maximised through risk enablement, informed risk taking and appropriate decision making.

## **vii. Adult Protection**

Safeguarding adults who may be vulnerable as a result of disability, illness or age is a key role for health and social care services and their partners in the voluntary and private sectors and the wider community. The delivery of care and support to vulnerable people has become more individual and personalised with greater choice and flexibility being offered and services are increasingly designed to enable and support independent living at home. This dispersal of care into the community has been a welcome response to the needs and wishes of disabled people. However, there are some vulnerable people who may face the risk of abuse, exploitation or neglect and it is necessary for all staff working with disabled people to operate within a robust adult protection framework.

West Lothian was part of the multi-agency group which developed Protecting Vulnerable Adults – the Interagency Guidelines for People Working in Health and Social Care Settings and all staff operate within these guidelines.

West Lothian CHCP has, in addition, developed Enhanced Procedures and Guidance for Adult Protection to offer more detailed guidance to practice team staff who work in the area of adult protection.

#### **viii. Risk Enablement**

For the personalisation agenda to be implemented with on-going health and social care supporting people to live as independently as possible in their own communities, it will be necessary to ensure that people are well informed about the availability of services, the eligibility criteria and how to access them. In addition, consulting people about their situation and offering good quality information and support will enable them to develop expertise in managing their own needs and will enable them to be an active participant in the assessment of needs and care planning processes. Disabled people should be supported to manage their own needs even though this may involve taking risks.

Service providers must recognise the need to develop systems that support a framework of informed risk taking. This will require robust risk assessment protocols and procedures and must include an assessment of capacity. Service providers, however, must also be able to balance support for service user choice and risk enablement with the need to meet their duty to protect vulnerable people. Greater transparency of policies, procedures and frameworks in relation to risk will enable the development of a partnership approach to risk management with service users and carers.

#### **ix. Intermediate Care**

The delivery of intermediate care forms an important part of the 'Delivering for Health' and 'Shifting the Balance of Care' agendas. Intermediate care aims to provide integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admissions, support timely discharge and maximise independent living. The definition adopted by West Lothian CHCP is:

*'Intermediate care services can be delivered at home or in designated care settings to promote people's independence by providing enhanced services from the NHS and Councils to prevent unnecessary hospital admission and effective rehabilitation services to enable early discharge from hospital and to prevent premature admission to long-term residential care'*  
DOH Standard 3, Intermediate Care

In West Lothian, the development of a more targeted care at home service with an emphasis on personal care and support, the use of assistive technology and the establishment of teams such as the SDRT and HSS and other initiatives have all provided intermediate care options at levels which have helped to reduce the average length of stay in a Care Home from 36 months to 12.4 months and the number of delayed discharges from hospital from 67 in April 2000 to nil in March 2008.

## x. Rehabilitation / Re-enablement

Rehabilitation and re-enablement are key elements of the aim to improve the health and well being of service users and, in turn, this will have a positive impact on their carers. Many of the services provided by Health and Social Care agencies and professionals, including those listed within this Service Statement, make rehabilitation and re-enablement a focus of their service delivery.

Rehabilitation is an enabling, educational and problem-solving process that actively involves service users and their carers to achieve the best possible outcomes. A rehabilitation approach enables people to live their lives to their fullest potential by maximising abilities and independence and can be defined as:

*‘ A process aiming to restore personal autonomy to those aspects of daily living considered most relevant to patients / service users and their family and carers’*  
*King’s Fund*

The move towards planning and delivering care closer to people’s homes and within their own communities, rather than within a hospital setting, has enabled the development of rehabilitation services such as CRABIS within West Lothian.

In addition, preventing admission to hospital and intervention at an earlier stage in order to achieve this has been supported by occupational therapy services and the development of assistive technology which can be customised to individual need.

## xi. Promoting Choice and Quality of Life

For many service users and carers being able to exercise choice and control over their services and support has a direct bearing on their perception of their quality of life. The personalisation of services and the move towards **self-directed care** and support options such as **Direct Payments** has enabled disabled people to determine for themselves what works best for them and to organise their care around their lives rather than their lives around their care.

The challenge for service providers is to deliver services and support to meet assessed needs in a way that maximises the choices and preferences of individuals and their carers but within available resources. In order to achieve this it will be essential to seek the views of service users and carers and to involve them in influencing decision-making on policy development and the planning and delivery of services. Active engagement and participation should be promoted both at the individual care and support planning level and at the wider level of service development and change.

## **xii. Customer Engagement and Consultation**

A main feature of national and local policy development has been the inclusion of service users and carers in the process with disabled people being routinely invited to sit on project boards, steering groups and so on. In addition, the issuing of draft policies, strategies and procedures for wide consultation amongst service users and carers is now a required part of any planning and development process.

There is recognition of the importance of service user and carer feedback and in West Lothian there is a commitment to on-going engagement. The Customer Services Strategy 2006-2009 outlines the Council vision of better access to improved public services in West Lothian with listening to customers at the heart of the Strategy. The Council was awarded a corporate Charter Mark in 2007 and Social Policy services have incorporated service user consultation and feedback into their working practice.

Involving disabled people and their carers as partners in all areas of planning and service delivery is crucial to the success of those services. Disabled people currently sit on the Access Committee, the Disability Equality Forum and the Public Partnership Forum amongst others. Consultation is conducted in relation to new policies, strategies or service initiatives with feedback being taken into account at each stage. In addition, individual service users and carers are routinely asked for feedback about their experiences of services with a view to informing the process of continuous improvement.

It is important that we continue to build on and develop our customer engagement policies and practice to ensure that disabled people have the opportunity to meaningfully influence health and social care services and to support the achievement of more socially inclusive services in the wider community.

## **xiii. Implementing National Outcomes Frameworks and Locality Planning**

The Scottish Government set out fifteen National Outcomes in the 2007 Concordat with local authorities which are underpinned by 45 Measures and Indicators and together these have informed the development of West Lothian Council's Single Outcome Agreement. The Outcome Agreement identifies twelve priority issues for action within West Lothian and work on addressing these will be supported by community and locality planning processes. In adult services, this work will be informed by the National Outcomes for Community Care. The emphasis will be on working collaboratively with service users and carers and key partners and stakeholders to plan, develop and deliver services that meet local needs and to enable disabled people to live as safely and independently as possible in their own communities where they are included and able to participate and fully access all the opportunities, facilities and services available to everyone.

## 5. TEN YEAR OUTLOOK – PHYSICAL DISABILITY SERVICES

The common themes that have been identified across the range of national and local policy drivers are expected to continue to be developed and these will inform the development of services and support for disabled people over the next five to ten years.

The greater emphasis on personalised or individualised services combined with a move to increased service user choice and control over their care and support provision suggests that there will be a growth in the demand for self-directed care and support options from both service users and their carers. It is anticipated that one effect of this will be a steady increase in the numbers of disabled people deciding to pursue their entitlement to Direct Payments as an alternative to direct service provision. An increase in the number of disabled people seeking to choose, control and manage their own care is viewed as a positive development. However, this does present a challenge to future service delivery and provision, as there will be competing demands on the physical disability services budget to sustain existing direct services for those who want them whilst at the same time meeting the increased cost of individual Direct Payments.

With ever more advances in medical knowledge, treatment and medication being made, people, including those with disability, chronic conditions and illnesses, are expected to live longer. It is anticipated that the commitment to promoting the management and support of people with long-term conditions at home and in their local communities will continue. In addition, people are becoming increasingly empowered and aware and have an expectation that most of the medical and social care and support they need should be able to be delivered to them at home. There will be increased demands on existing services to be delivered in more flexible, responsive and individualised ways and services will have to manage these demands within a context of the loss of economies of scale.

There is likely to be a growing expectation that social care and other agencies should be able to provide 'on-demand' services which can respond at times of unplanned incident or need and existing services will require to adapt to meet these changing expectations. Council services will need to ensure that the process of joint working and partnership service planning already underway with initiatives such as Single Shared Assessment and Joint Care Management is continued and developed. There will be greater numbers of service users with increasingly complex health and care needs seeking to be supported at home and a joined up approach to individual care and support provision will be essential in order to maximise the use of available resources so that these increasing needs can be met.

The next ten years are likely to see the continued rapid development of the technology and technological solutions available to meet the needs and requirements of disabled people with health, care and daily living support needs. These developments in telehealth, telecare and other technologies will

be an essential factor in enabling disabled people to remain at home and to live more independent lives whilst also enabling service providers to maximise the use of other available resources. However, as the range of technology increases it is anticipated that so will the demand and, as the increased costs of such provision will have to be accommodated, clear and transparent eligibility criteria will be required.

With an increased number of people with complex conditions being supported in the community and new developments in technology, specialist training in the management of specific conditions and the use of specific technology will be necessary for staff with a robust programme of training delivery, monitoring and review of training needs being required.

Changes in the aspirations and wishes of disabled people have been, and are likely to continue to be, reflected in Government policy and legislation including the Disability Discrimination Act and the subsequent Disability Equality Duty. It is anticipated that there will be an ongoing move away from traditional models of day support and a greater demand for access to educational and employment training opportunities along with support to sustain employment. For those people who develop a chronic condition or disability, there will be an expectation that rehabilitation and support to re-enter employment will be available.

The balance of care and support is expected to continue to shift increasingly into the community and this will place greater demands on unpaid carers, the importance of whose role in being able to sustain this shift has been increasingly recognised. The development of carer information, training and support will be required as will the ability to work in partnership with unpaid carers and to deliver flexible services customised to individual service user and carer need.

The next ten years will see a range of competing needs and demands being placed on constrained budgetary, service and staffing resources and there will be a need to work collaboratively and flexibly in order to develop an approach to service delivery which will enable these needs to be met.

## **6. THREE YEAR SERVICE STATEMENT**

The following section details the range of services and support provision, both general and specific, available to disabled people in West Lothian and outlines the proposed local developments for these over the next three years. These developments are informed by the themes previously identified from across the range of national and local policy drivers.

With the implementation of the personalisation agenda and the expected increase in the numbers of people with long-term conditions being supported in the community, there is a recognition that the delivery of services and support to disabled people will require to become more individualised, flexible and responsive.

It is intended that there will be greater promotion and delivery of Direct Payments and increased access to care at home, rehabilitation and technology services. Information, advice and advocacy services for disabled people will be supported. The role of unpaid carers is recognised as an essential factor in successfully supporting disabled people within their own communities and Carers' Assessments and support will continue to be promoted and delivered. Access to short breaks from caring in order to support both disabled people and their carers will be made available locally as well as a number of long term Care Home placements.

A collaborative approach to service development and delivery and partnership working across the public, private and independent sectors will continue to be promoted to maximise the delivery of streamlined, effective and user-focused services and support to disabled people and their carers.

### **6.1 CROSS SERVICE AREA PROVISION AND RESOURCES ACCESSED BY PEOPLE WITH PHYSICAL DISABILITY**

#### **a) Assessment and Care Management**

- **Service**

The Physical Disability Assessment and Care Management Team is responsible for carrying out needs-led assessments for people with physical and complex disability and for developing appropriate care and support plans as a response to identified need. The Team carries out the ongoing monitoring and review of care and support to disabled people providing a response to changing needs.

The Team also offers carers' assessments and care management services to carers of people with physical and complex disability.

The Palliative Care Social Worker, who offers assessment and care management services to people with life-threatening illnesses or

conditions or who are in need of end of life care, is also based within the Physical Disability Team.

- **Delivery**

The Physical Disability and Care Management Team is part of Adults and Older People's Services within Social Policy and is staffed by Social Workers and Community Care Assistants who work in partnership with other professionals and agencies and with service users and carers to ensure that the support and care services provided are as personalised and flexible as possible.

Under Single Shared Assessment (SSA) arrangements assessments are also completed by staff in the Council Housing Department and by Health staff.

- **Developments, Improvements and Initiatives**

- i. Single Shared Assessment (SSA)**

The SSA framework and assessment tool used in West Lothian is currently undergoing a complete review. The format for assessment is being redesigned in order to improve information gathering and to enable relevant electronic reporting from the e-Care system. The new format will also incorporate the information requirements from IoRN. The aim is to also increase the use of the SSA framework by partners in health and housing. (Funded by Social Policy)  
(Appendix references – B.1, B.23, C.5)

- ii. Information Provision at the point of Assessment**

The Adult Services Assessment and Care Management Teams are developing an Information Pack for service users and carers which will be given out at the point of assessment. This Pack will contain information on all relevant services and topics and will act as an initial resource pack for people with disability. (Funded by Social Policy)  
(Appendix references – A.1, B.6, B.10, B.12, B.19, B.23, C.1, C.3)

- b) Risk Assessment and Adult Protection**

- **Services and Delivery**

- i. Risk Assessment**

All areas of Adults and Older Peoples services deal with risk assessment and risk management but this is a core function of the Assessment and Care Management Teams. The Physical Disability Assessment and Care Management Team is responsible for carrying out risk assessments or, where appropriate, seeking specialist risk

assessments, e.g. from Health or independent sector staff, on behalf of adults with physical and/or complex disability or sensory impairment.

Whilst working with adults and risk, it is important to reach a position, and often an agreement with the individual themselves, about living with an “acceptable” level of risk. All policy drivers point towards “risk enablement” and inspection reports readily hone in on what is now referred to as “risk averse practices”. In reality it can often be a complex activity reaching and maintaining a level of “acceptable” risk.

The UK agenda that is moving both health and social care services towards personalisation emphasises an individual’s right of choice and independence. Across all services robust risk assessment and management practices must underpin these rights if vulnerable adults are to be helped to stay safe and be protected from harm.

A Risk Assessment and Management framework has recently been introduced across Adults and Older Peoples services which works alongside the mainstream assessment and care management tools and processes with an interface being created with the Single Shared Assessment process. It comprises a 4 level model as follows:

Level 1 – Screening. It is recognised practice that every referral received by the Adults and Older People’s Teams is screened and prioritised. The new framework has introduced a level of risk screening at this initial interface with the service.

Level 2 – Basic Risk Assessment. In all cases, a Basic Risk Assessment must be undertaken – risk may be related to carer stress / care arrangement breaking down; levels of independence; lifestyle choices and so on.

Level 3 – Specialised Risk Assessments. At present there are two specialist risk assessment tools and processes 1) Adult protection and 2) Capacity / Mental Health.

Level 4 – Enhanced Risk Assessment – usually undertaken by specialist health care staff, e.g. forensic psychiatry

This framework does not have to be applied in an incremental manner, e.g. following referral and screening a situation may require to go directly to Adult Protection. Team Managers are responsible for making these decisions.

## **ii. Adult Protection**

Social Policy Adults and Older People’s services, including the Physical Disability Assessment and Care Management Team, is responsible for identifying, assessing and managing adults at risk from harm/abuse, neglect and /or exploitation. Identifying those at risk from

harm is a responsibility of all employees of the council and all contracted services have a responsibility and a duty to report any incident or suspicion of harm to Social Policy staff.

West Lothian Council along with its multiagency partners in Lothian and Borders Police Public Protection Unit in Bathgate and NHS Lothian comply with the Edinburgh Lothians and Borders Interagency Guidelines 'Protecting Vulnerable Adults – ensuring rights and preventing abuse' (2003). In addition West Lothian Council implemented an 'Enhanced Adult Protection Guidance and Procedure' for social work practitioners and managers in 2006.

Adults and Older Peoples Assessment and Care Management staff undertake most of the Adult Protection risk assessment and adult support and protection planning activities with the Physical Disability Assessment and Care Management Team acting in cases involving adults with physical and/or complex disability or sensory impairment. A Service Development Officer and an Adult Protection Administrative Assistant support this work.

The Adult Support and Protection (Scotland) Act 2007 (ASPA) was introduced in October 2008 and in addition to creating a legislative framework for adult support and protection practice and procedures, it has also introduced a requirement for each council to establish a multiagency Adult Protection Committee to overview and scrutinise strategy and performance in each local council partnership area.

Each Assessment and Care Management Team is responsible for undertaking inquiries and investigations into all referrals / alerts to situations of actual or suspected harm. The ASPA requires that "council officers" undertake these tasks. West Lothian is developing a register of council officers' i.e. social workers in the Adults and Older People's Practice Teams who have been qualified for over one year with at least 12 months experience of identifying, assessing and managing adults at risk, and have attended the appropriate council officer training.

Comprehensive guidance and procedure on all activities and processes related to adult protection is included in the "Enhanced Adult Protection Guidance and Procedure" for social work practitioners and managers. A mandatory training programme is in place for all new staff.

Risk assessment and management is central to all adult protection activities. An overarching Adults and Older People's Risk Assessment Framework has recently been introduced and the protection of "adults at risk" from harm is highlighted throughout this framework with Level 3 introducing a specific adult protection risk assessment tool.

The Adult Protection Administrative Assistant coordinates minutes and tracks all activities related to professional concerns meetings, case conferences and case conference reviews.

An Adult Protection module has been set up on SWIFT where all service user related activities are recorded. A Sans Server file, with appropriate client information, has been developed for access by the Out of Hours Team (SCET).

- **Developments, Improvements and Initiatives**

- i. Risk Assessment**

The development and implementation of a robust Risk Assessment Framework, including Lifestyle Monitoring, was necessary to create a consistent and systematic method and approach to risk assessment. The Framework will enable risk to be considered both for individuals, taking into account capacity, and for the delivery of general or specific services. The assessment of risk will be part of a process of informed decision making and risk enablement undertaken with service users and carers and will form an integral part of assessment and care management. Further work is underway to streamline this Framework with Single Shared Assessment tools and processes.  
(Funded by Social Policy) (B.23, C.5)

- ii. Adult Protection**

A programme of implementation of the Adult Support and Protection Act has been developed and initiated and care management and review processes will be conducted within the framework outlined in the Adult Support and Protection Act. With the move towards more individual and personalised services and support to disabled people to enable them to live independently within their own communities, staff need to be aware of the potential for abuse, exploitation or neglect.

An Adult Protection Committee (APC) has been established. Two subcommittees have also been set up to take forward the multiagency development activities, i.e.

- Review of the Interagency Referral Discussion (IRD) with the possible adoption of the C me mechanism
- Development of a multiagency performance reporting and framework
- Development of a local multiagency Training Strategy
- Development of a local multiagency Training programme

There has been an appointment to a multiagency post to support the activities of the APC and multiagency operational supports and developments funded from ASPA Local Authority allocation for implementation.

There has been an appointment to an additional 0.5 admin. support funded from ASPA Local Authority allocation for implementation. (Funded by Social Policy) (A.7, B.1)

- **Performance Measures**

A suite of 13 measures has been proposed:

1. The number of AP referrals / inquiries received in a quarter
2. % of AP referrals /inquiries received in a quarter against the total number of Community Care referrals for the same period
3. % of AP referrals in a quarter that proceed to IRD
4. % of cases where a risk assessment has been completed
5. % of AP cases allocated to a Social Worker
6. Number of case conferences held
7. % of case conferences held against the number of AP referrals / inquiries undertaken
8. Number of service users or representative invited to attend case conferences
9. Number of carers invited to attend case conference
10. % of service users or representatives who did attend case conferences
11. % of carers who did attend case conferences
12. % of Adult Support and Protection Plans completed against the number of AP referrals received
13. % of AP case conference reviews carried out within the agreed timescale (6 months or earlier)

### c) **Self-Directed Support and Direct Payments**

- **Service**

Since the Community Care (Direct Payment) Act (1996), local authorities have been allowed to make payments directly to disabled people eligible for a community care service to employ their own personal assistants or buy care directly from an independent provider and in 1997, West Lothian Council was one of the first Scottish Councils to set up a Direct Payments Scheme. The range of people eligible to receive direct payments has grown since then and the West Lothian Scheme has been reviewed and amended to reflect these changes.

Recipients can use a direct payment to buy support for personal care, daytime activities, respite care and temporary adaptations and equipment. The only community care service that cannot be funded by a direct payment is permanent residential care.

Service users and carers are given the opportunity to consider whether they would wish to receive a direct payment instead of direct service provision at the point of assessment and developing the care and support plan.

- **Delivery**

The Social Policy Physical Disability Assessment and Care Management Team carries out assessments and arranges and monitors direct

payments for adults with physical and/or complex disability or sensory impairment.

West Lothian Council has recognised that becoming an employer can be a daunting prospect for people even if they are keen to have the flexibility and control over their own care delivery that direct payments can offer. Therefore, West Lothian Council commissions and funds support services from the Lothian Centre for Independent Living which include preparing and supporting people as they take on the role of an employer; supporting people as they recruit and hire personal assistants; offering a payroll service to direct payments recipients and ongoing information, advice and support in managing a direct payment.

There has been ongoing promotion of the availability of Direct Payments and a range of information leaflets have been produced and distributed to inform potential service users and carers of this service option.

- **Developments, Improvements and Initiatives**

The national policy agenda of shifting the balance of care and the management of long-term conditions within local communities will clearly require the increased personalisation of services and the recent Scottish Government revised guidance on self directed support endorses this.

Despite the availability of Direct Payments as an alternative to direct service provision, the take up in West Lothian has been limited. It is anticipated that this situation will change and that there will be a growing demand for Direct Payments and personalised care. There are no extra resources attached to the introduction of the new guidance with the government expecting that the move to a greater level of self-directed support will be funded from service re-design. However, many service users and carers are likely to opt for direct service provision and the challenge will be for the Council and key partners to manage these competing demands and the transition into alternative forms of service delivery.

Service users and carers who choose Direct Payments will require a range of supports to manage these including support and training on becoming an employer, recruitment issues, financial management and so on. The Council has commissioned additional services from a local support organisation in the voluntary sector to provide these services and we will continue to work with this organisation as we develop our self-directed support opportunities. This is in line with the new Guidance and government policy.

Service pressures and developments in the area of self-directed support include:

- Revision of the West Lothian Direct Payments policy, guidance and procedures in line with the new national guidance for Self-Directed Support published in 2007. (Funded by Social Policy)
- Staff training on the revised guidance and procedures

- Provision of service user and carer training and support to manage a Direct Payment
- Commissioning of services to deliver the training and support to service users and carers
- Information and promotion of self directed support services (Funding to be identified) (A.2, B.19)

#### **d) Occupational Therapy, Equipment and Adaptations Services**

##### **i. Community Occupational Therapy (OT)**

###### **• Service**

Central to the multidisciplinary care teams, Occupational Therapists offer specialist input to promote independence by:

- Assessment of everyday tasks and the environment through activity analyses to find the most suitable means of maintaining that person in the community.
- Offering advice and professional guidance on how to carry out particular tasks differently
- The provision of equipment to improve independence with day to day tasks
- Recommending alternations to make facilities more accessible
- Practice to promote confidence, ability and independence
- Getting support and advice from other agencies

OT Services are offered by both community and hospital based staff and are delivered to people who have a temporary or permanent physical, mental or learning disability. There is an established commitment from both health and council staff working in partnership to deliver OT and rehabilitation services. This has successfully seen a reduction in duplicated work, with processes in place allowing Council and NHS staff access to Community Equipment Store disability equipment. A recent survey evidenced a streamlined approach with appropriate use of each area's specialist skills. This multi-agency approach to service delivery is underpinned by the more recent development of joint service objectives and by joint staff training and development

Work with Housing Partners, WLC Grants Section and Care and Repair forms a significant part of community OT service delivery, supporting people by making their home more accessible.

###### **• Delivery**

Occupational Therapists provide a generic service and are based across two West Lothian Social Work offices. Key areas of priority for adults would be:

- Facilitating hospital discharge and contributing to zero delayed discharges
- Helping to prevent hospitalisation
- Supporting people with long term conditions to remain at home

- Reducing the risk of falls

For further information visit:

[http://www.westlothian.gov.uk/media/downloadaddoc/1799563/ot\\_services](http://www.westlothian.gov.uk/media/downloadaddoc/1799563/ot_services)

We aim to offer a seamless and responsive service and provide:

- A range of small equipment and adaptations without the need for an assessment (the Occupational Therapy Self Selection service). The service can be accessed directly by the public or by other professionals working with a service user. This simple, successful scheme has been in operation since 2000 and contributes significantly to reducing risk at home with everyday tasks. In a recent survey to users of this Service (December 2008), 24% of respondents requested a handrail following a fall and 66% requested a handrail to help prevent a fall.
- Occupational Therapists offer specialist professional advice on the selection, provision and use of a range of disability equipment. Specialist professional assessment is required to reduce risk either to the service user or to their carer. Examples would be equipment for getting in and out of bed and specialist shower chairs.
- Large equipment and adaptations can be recommended following assessment, such as showers, stair lifts or ramps. The Occupational Therapist can arrange the provision with the housing provider or with the house owner using Home Improvement Grant funding.
- **Performance Measures**
  - 63% carried out within seven days
  - 97% carried out within four weeks
- **National Targets**
  - The Occupational Therapy Service enables service users in West Lothian, promotes and supports the management of long term conditions, implements Shifting the Balance of Care, facilitates independent living for disabled people and contributes to zero hospital delayed discharge figures

## ii. The Community Equipment Store (CES)

- **Service**

The CES is a joint service provided by West Lothian Council Social Policy and NHS Lothian. The CES provides a wide range of equipment and specialist items which are issued, on loan for as long as they are required, to service users following an assessment of their needs and/or the needs of their carers. Equipment ranges from simple items such as dressing aids to specialist beds, seating and hoists. The aim of the equipment service is to enable people to remain living within their own home as independently as possible for as long as possible.

The CES has a highly sophisticated and effective cleaning and refurbishment facility for use with disability equipment based in nearby Fairbairn Road. The service also arranges the scheduled delivery of continence products across West Lothian.

Staff at the CES provide advice for equipment users by telephone and at the point of installation.

- **Delivery**

Based centrally at St John's Hospital, the store is ideally suited to delivering services across West Lothian and is an early example of single shared assessment in practice where a range of equipment can be accessed across service boundaries. A self-selection range of small equipment allows provision to be made without the need for assessment. Much of the equipment still requires the specialist input of a particular profession and this is well documented in joint agreements with Council and NHS staff.

Shared staffing and premises allow both the Council and Health to deliver services more cost effectively, for example, the scheduled delivery of continence and urology products across West Lothian, including to Care Homes in the independent sector, ensuring that all local partners can enjoy the same high standard of service delivery.

The recent introduction of the GPRS handheld device for delivery drivers, online ordering and e-mail notification of deliveries to requisitioners makes for a more efficient and user-friendly service.

Committed to efficiency and responsiveness the CES has a strong record of continuous improvement in relation to:

- Delivery and response times (86% of deliveries within 5 days)
- Cleaning and repair service allowing a higher percentage of reissue
- Using IT to ensure the best use of skilled people resources

- **Performance Measures**

- 86% equipment delivered within five days
- 42% equipment reissued through efficient cleaning and refurbishment

- **National Targets**

- Zero Delayed Discharge

- **Developments, Improvements and Initiatives – Occupational Therapy Service and the Community Equipment Store**

- The Equipment and Adaptations Guidance (consultation published by Scottish Government – 3 December 2008) recommends standards for how best to deliver occupational therapy services and equipment provision. Those areas in West Lothian not already of the required standard will be improved with partners in social policy, housing and NHS and will be implemented by staff

- The Housing Scotland Act 2007, with a Scheme of Assistance, is to be introduced in April 2009 and will replace the existing Home Improvement Grant scheme. Occupational therapy will work with partners in Housing to develop a West Lothian guidance to assist with the provision of disability adaptations for owner-occupier households
- Adoption of the new Single Shared Assessment framework for all Occupational Therapy assessments
- Occupational Therapy will work with Housing Allocations to make the best use of adapted Council housing stock and in assisting with allocating suitable housing to disabled applicants
- Improved stock control and re-cycling of equipment will help to meet increased demand. The range of occupational therapy equipment and eligibility is regularly reviewed, in consultation with service users – this has allowed us to continue to target those in greatest need without any increase in budgetary provision over the last four years
- A recent review of the equipment range provided for hearing impaired service users has been completed in consultation with Deaf Action, ensuring best value for service users.  
(B.4, B.5, B.18, C.10)

#### **e) Care at Home – General**

- **Service**

Care and support at home services are offered to assist with all aspects of personal care. The care at home service works closely with community health services to support people with care needs to remain living independently in their own homes and this service is targeted increasingly to people with complex health and care needs.

- **Delivery**

Services are provided by the Council's in-house service and by agencies from the private and independent sector contracted by the Council as well as some input from the community nursing service. Services are usually offered on a scheduled and planned basis but can also be implemented at times of crisis, illness or sudden change of circumstances.

Services are delivered seven days a week between the hours of 7.30 a.m. and 10.00 p.m. and are therefore capable of offering customer choice in terms of time and pattern of delivery. In response to an alarm call for assistance, support during the night can also be provided by the home safety service or by the evening nursing service. The development of shopping and frozen meals services have allowed care at home services to be developed with a focus on personal care and support.

Services will continue to be delivered by both the Council and the private and independent sectors with the in-house service continuing to develop in the areas of crisis intervention, hospital discharge and re-enablement. The promotion and support of self-directed support to maximise independence and choice is likely to impact on how care at home services are delivered in the future.

In order to target finite resources equitably and where most needed, eligibility criteria and service levels are, and will continue to be, applied.

- **Developments, Improvements and Initiatives**

The development of a personalised approach to services and support delivery with a view to enabling independent living within the community will mean an increase in the demand for care at home services for disabled people. Service levels and eligibility criteria will need to be managed robustly and may need to be reviewed. Service pressures include:

- The level of personal and domestic care support hours available
- The availability of care and support during the night and a demand for routine out of hours services
- The demand for service at times of crisis or emergency

West Lothian Council is committed to making a further significant impact on shifting the balance of care and, in the delivery of care at home services, aims to improve the following services:

- Support to Carers
- Crisis Response and Overnight Care
- Falls Prevention and Response
- Avoidance of Hospital Admission

The proposed development of an Assisted Care and Technology Service (ACTS) will be conducted in partnership with health. The service will be expected to respond to emergencies over a 24-hour period and will provide:

- Initial assessment of service user need for an emergency service (0-5 days)
- Risk assessment including the use of a housing with care flat as a means of keeping people safe temporarily
- Comprehensive multi-disciplinary assessment and fast track to appropriate specialist services including falls prevention, medical review, re-enablement and assistive technology
- Respite service to designated key holders at times of holiday and illness
- Check visits during the night

The team will be developed via service re-design of existing services supported with additional growth funding. The team will comprise a diverse range of staff including the Falls Co-Ordinator funded via the NHS Falls Prevention Programme.

(B.9, B.11, C.7)

## **f) SDRT (Supported Discharge and Re-enablement Team)**

- **Service**

The SDRT provides a 7-day, year round service to support early discharge or prevent admission to hospital. The Team specialises in re-enablement and is available to people of all ages who require specialist assistance in the short term within their own home to achieve a level of functioning where reduced or no ongoing formal care and support is needed.

The service aims to facilitate faster discharges, reduce the length of admission and to prevent admission or re-admission to hospital. The service can provide a flexible and rapid response to changing needs in order to support service users and their carers. The service is time limited and provides assessment information about ongoing needs in order to support the smooth transition to longer-term care and support plans if required.

- **Delivery**

The service is funded by Social Policy and is delivered by Social Policy staff.

- **Developments, Improvements and Initiatives**

There is a growing emphasis on the management of long-term conditions within the community, the need to reduce frequent re-admissions to hospital and the need to shorten average lengths of stay in hospital by facilitating faster discharges. The demands on the SDRT and similar services are likely to increase as a result of these policy initiatives and services such as SDRT and ACTS will need to work together to meet these changing needs.

(A.6, B.9, B.18, B.21, B.22, B.23, C.2)

## **g) HSS (Home Safety Service) – Technology and Telecare (and Future Telehealth)**

- **Service**

The HSS offers individual customised packages of technology and a back up service on an assessed needs basis to increase home and personal safety where there is actual or perceived risk to anyone resident in West Lothian. The HSS aims to promote independence, improve health and wellbeing and to ensure that people feel safe. Anyone in receipt of the service receives the core package and enhanced packages of technology are then developed on the basis of an assessment of individual need. The service aims to support service users in their own homes and their carers to avoid the need for a move into a Care Home setting or to prolong the time they can remain living at home.

- **Delivery**

The service is funded by Social Policy and delivered by Social Policy staff. West Lothian Council has made a major commitment to the development

and provision of innovative technology and telecare services and solutions for disabled people and aims to:

- Promote and sustain independence for people with low levels of need
  - Compliment personal care services by offering more effective personal and home safety monitoring mechanisms, including improved response to emergencies such as falls
  - Improve care management for people with chronic long term conditions
- West Lothian continues to promote the research and development of new equipment and systems to meet a range of changing and complex needs.

Home safety technology is currently installed in over 3,300 homes in West Lothian, with 4,600 individuals benefiting from this service, and the service is supported by a dedicated call centre with links to either unpaid carers or formal services ensuring a robust response system. The implementation of telecare has contributed to the maintenance of zero delayed discharges and to reducing the average response to falls time for those with Careline to 22 minutes compared to a Scottish average of 4 hours.

The provision of telecare has enabled services in West Lothian to promote and support the management of long term conditions within the community, to implement shifting the balance of care and to maximise independent living options for disabled people.

- **Developments, Improvements and Initiatives**

Developments in telecare and telehealth and the technology underpinning these are occurring at a rapid rate and the challenge for services is in keeping pace with these changes and ensuring that service users and carers have access to appropriate and personalised technology packages. These packages should have a focus on prevention as well as on the management of long term conditions. The national drive towards shifting the balance of care and individualised support within the community means that technology will have an increasing role to play in enabling health and social care agencies to support people with a range of complex needs to manage their conditions at home. Service pressures include:

- Meeting increased demand for telecare (and telehealth) customised packages
- Keeping up to date with new developments in telecare
- Providing the necessary level of support and adequate back up systems to service users and carers using technology to underpin their care
- Resourcing the Home Safety Service

The development of the ACT Service available over 24 hours will enable the fast track installation of Home Safety packages for people at risk of falling and the number of homes which have Careline installed is set to increase over the next three years. The use of assessment models which enable an increased range of staff to identify people who would benefit from telecare will help to target resources effectively.

(A.6, B.3, B.9, B.18, B.22)

## **h) Support to Carers**

### **• Services and Delivery**

Unpaid carers make up the largest group of care providers in Scotland, making an enormous contribution to society, and there is an ever increasing recognition of the role unpaid carers play and its economic implications. Supporting carers is central to the health and social care agenda.

The Future of Unpaid Care in Scotland Report made 22 recommendations creating a ten-year agenda for valuing and supporting carers. The Scottish (Executive) Government response, whilst accepting the recommendations as a whole, identified four priority areas for public service providers and their partners to focus on. These priorities are better support for young carers, improved provision of respite services and short breaks from caring, safeguarding the health of carers and carer training to develop the knowledge and skills to support them in their caring role.

Based on the 2001 census, there are 15,147 carers in West Lothian (9.5% of the population) with 3,794 carers providing 50 or more hours a week of unpaid care. It is clear that the development and delivery of services and support for carers will not only benefit those they are caring for by enabling them to remain living at home for longer but will also benefit service providers who would otherwise be attempting to meet people's care needs in their entirety.

Ensuring that unpaid carers are identified and supported to enable them to continue in their caring role for as long as they would wish to do so has been a key challenge. The growing awareness of the impact of caring on carers' health along with a recognition of the essential role unpaid carers play in reducing dependence on formal service provision and preventing admission to long term care has led to developments in carer services and support.

In West Lothian, carers are now seen as key partners in the planning and delivery of care and there have been a range of initiatives developed to support unpaid carers and to work collaboratively with them to develop and deliver the services and supports available to those they care for. In addition, work has been done with local medical practices to encourage the earlier identification and referral of patients who also have a caring role. The aim is to promote carers' health by enabling earlier intervention and support and thereby reducing or preventing situations reaching crisis point before support is accessed.

Services and support for carers includes:

#### **i. Carers' Assessments**

A Carers' Assessment Framework and assessment tool has been developed and implemented along with practice guidance for staff.

Staff and carer monitoring and evaluation forms have been introduced to ensure that staff are offering carers' assessments to carers and feedback is regularly analysed.

There has been an active promotional campaign to highlight entitlement to carers' assessments with almost 200,000 leaflets being developed and distributed across West Lothian in partnership with health and the independent sector.

There has been a steady increase in the numbers of assessments being completed and the aim is to show continued progress in this area.

## **ii. Carers of West Lothian**

The independent sector organisation, Carers of West Lothian, has been integrated into the CHCP Centre at Strathbrock. This organisation provides advice, information and support to adult and young carers. It aims to provide a voice for carers, to work in partnership with others to ensure that carers receive appropriate services and support and to promote a better quality of life for carers. West Lothian Council is a key funder of the organisation and remains committed to continuing to be so. There is an established relationship of co-operation and collaboration between the agencies that has created an ethos of partnership working when addressing carer issues and there is an ongoing commitment to continued joint working to support carers and take the carer agenda forward.

The range of services and support offered by Carers of West Lothian has expanded and includes:

- Information and advice
- Carer Support Groups
- Carer Training Programmes on a range of needs and topics
- Education and awareness training for professionals and other agencies
- Carer Support Workers
- Young Carer Support Worker
- Hospital Discharge Carer Support Worker
- Support to establish 'Carers' Voice', a carers' forum

## **iii. NHS Lothian Carer Information Strategy**

The requirement to develop NHS Carer Information Strategies was introduced in response to recommendation 6 of the Future of Unpaid Care in Scotland Report (2006) and these were required to be developed in partnership with local authority partners and the independent sector. West Lothian Council has been involved in the development of the NHS Lothian Carer Information Strategy.

### **• Developments, Improvements and Initiatives**

The essential role of unpaid carers in implementing national policy initiatives such as shifting the balance of care has been increasingly

recognised as has the need to support carers in their caring role and to ensure that their health is not put at risk as a result of their caring responsibilities. Discussion with key partners including the local carers' organisation, Carers of West Lothian, has identified that local priorities are broadly in line with the four early priorities identified by the Scottish Executive in their response to the Future of Unpaid Care in Scotland Report which were:

- Respite
- Carers' health
- Carer Training
- Young carers

A fifth priority was identified locally:

- Carer access to appropriate support

Carers want flexible and responsive services with transparent eligibility criteria.

Local service pressures and areas for development include:

- Respite and short breaks from caring within a service user's own home including sitter services and overnight care, particularly for people caring for someone with dementia

The further development of the SMU to act as a short breaks bureau may assist with this process

- Unplanned / crisis care / emergency respite / short break support
- Forward and contingency planning to be available to carers as part of the overall assessment and care management processes
- Carer Training Programmes, e.g., understanding long-term conditions, financial issues including Guardianship, safer moving and handling, etc
- Accessible and comprehensive information for carers and the implementation of the Carers Information Strategy in partnership with health – there should be an emphasis on promoting and sustaining carers' health
- Promotion of carers' assessments and working in partnership with GP's and other agencies and colleagues to facilitate the take up of these assessments. An updated Carers Assessment Tool is being developed as part of the review of SSA processes and protocols.
- Partnership working with other Council services and agencies to identify young carers and offer appropriate support and services
- Availability of day support and care at home services to enable carers to maintain employment if requested – services should be flexible, responsive and available
- Carer engagement and consultation should be a routine part of service planning and development  
(B.17, B.23, C.1, C.4, C.10)

## 6.2 SPECIFIC SERVICE AREA PROVISION AND RESOURCES ACCESSED BY PEOPLE WITH PHYSICAL DISABILITY

### 6.2.1 SENSORY IMPAIRMENT SERVICES

#### a) Sensory Resource Centre (SRC) Service

- **Services and Delivery**

The Sensory Resource Centre (SRC), based at St. John's Hospital, provides a range of services and support for people with sensory impairment. This specialist, multi-agency service is offered in partnership with colleagues from the voluntary sector, whose services have been commissioned by the Council, and with health.

#### i. Services for the Deaf, Deafened and Hard of Hearing

The Council commissions a specialist assessment and care management service from Deaf Action with a Social Worker for the Deaf providing these services and advice and information to adults across West Lothian.

Council staff within the SRC service also provide assessment and care management, advice and information services.

The Council commissions a specialist assessment, installation and maintenance of environmental equipment service from Deaf Action with a Technical Officer providing this service and advice and information to adults across West Lothian.

The Council provides and installs a range of environmental equipment free at the point of delivery to support deaf, deafened and hard of hearing people to remain living at home in their own communities as safely and independently as possible. Support is also offered to seek alternative sources of funding for other items.

**Deaf Action** is an organisation which provides advice, information and specialist services to people who are deaf, deafened or hard of hearing and aims to support people to overcome the barriers they may face in their daily lives. **Deaf Action** also offers education and communication training and communication support services, including BSL interpreters.

#### ii. Services for the Blind and People with Sight Loss

Council staff provide assessment and care management, advice and information services to people who are blind or experiencing sight loss.

The Council commissions a specialist rehabilitation service from RNIB with a Mobility and Rehabilitation Officer for the Blind and Visually Impaired providing services to adults across West Lothian.

The Council provides a range of environmental and support equipment free at the point of delivery to support people who are blind or experiencing sight loss to remain living at home in their own communities as safely and independently as possible. Support is also offered to seek alternative sources of funding for other items.

The Council provides a drop-in service at the Eye Clinic twice a month.

**RNIB** is an organisation which aims to challenge blindness by empowering people who are blind or partially sighted, removing the barriers they face and helping to prevent blindness. **RNIB** provide comprehensive information, assessment and support services to children and adults with sight problems, their families and carers within Edinburgh and the Lothians.

### **iii. Services for the Deafblind**

Council staff provide assessment and care management, advice and information services to people who are deafblind which entails the use of Guide/Communicators as required.

The Council provides a range of environmental and support equipment free at the point of delivery to support people who are deafblind to remain living at home in their own communities as safely and independently as possible.

The Council commissions care at home and support services from Deafblind Scotland via a Supporting People contract to enable deafblind people to conduct activities of daily life such as shopping and maintaining a home. From April 2009 the responsibility for contract monitoring and review will be incorporated into Social Policy Adults and Older People's Services.

**Deafblind Scotland** is an organisation which aims to support deafblind people to attain the permanent support and recognition necessary to be equal citizens and to receive the appropriate assistance to live independently in the community.

### **iv. Education and Awareness**

Regular Open Days are held across West Lothian in partnership with key stakeholders to raise awareness and to promote the services and support available to all those with sensory impairment.

There has been a sustained programme of sensory impairment awareness training with all Residential Care workers and Care at Home Workers being trained to recognise sensory impairment issues amongst service users. Workers in Assessment and Care Management and Specialist Teams have also received this training as well as front office staff such as receptionists. An annual rolling programme of awareness training ensures that new staff can access this locally. The Council commissions this training which is delivered in partnership by RNIB and Deaf Action.

The SRC service promotes the integration of a sensory impairment perspective into other training such as the Adult Protection Training which makes specific reference to potential communication issues that may need to be considered in the course of protection work.

#### **v. Communication Support**

The Council provides ongoing funding for Communication Support Services via the **Communication Support Unit at Deaf Action**, which can be accessed by people in West Lothian, and also funds interpreting services and support as required.

### **SENSORY IMPAIRMENT SERVICES**

#### **• Developments, Improvements and Initiatives**

There is a range of current issues related to offering services and support to people with sensory impairment and both statutory and independent sector partners acknowledge the need to work in partnership to maximise what can be achieved within existing resources.

The following are areas of ongoing work:

#### **i. Sensory Impairment Education and Awareness Training**

Education initiatives alerting other services and agencies and the wider community to the need to provide their staff with sensory awareness training should be promoted. (To be funded within existing resources) (A.1, B.6, B.16, B.24, C.3)

#### **ii. Technology and Communication**

Advances in technology and computer access can be utilised to benefit people with sensory loss. The Council and CHCP websites should be developed to include a Sensory Loss Webpage. An online information and advice service and referral process for people with sensory loss should also be considered. (Funding to be identified) (B.6, B.16, B.22, B.24, C.1)

#### **iii. Equipment**

The range of specialist equipment and technology for people with sensory loss should be regularly reviewed and updated with core

items continuing to be provided free of charge. (Funding to be identified) (B.4, B.5, B.6, B.16, C.1)

**iv. Identification and contacting hard to reach groups**

Systems for the identification and recording of people with sensory loss need to be improved – the review of the SSA framework will assist with this as will collaboration with key partners.

The needs of hard to reach groups including the BME communities and older people need to be taken into account in service development. Hearing and sight loss in older people is not always identified and dual sensory loss is more likely as people age. Staff should consider sensory loss as part of review processes both in the community and in care homes and care staff should be trained in the correct use of hearing aids and other equipment.

(To be funded within existing resources) (A.1, B.6, B.7, B.16, B.24)

**v. Information – Early Diagnosis**

Information packs in appropriate formats for people who have been newly diagnosed with sensory loss should be developed in partnership with key agencies and routinely given out. This will support people in considering whether or not to be registered blind or partially sighted and so on.

RNIB recently piloted Early Diagnosis Support Groups and the Middle Step Course and this work should be built upon.

(Funding to be identified) (B.6, B.9, B.16, B.24)

**vi. Consultation and Engagement**

The outcomes of the Focus Groups and Consultation commissioned from Disability West Lothian will be evaluated and used to inform future engagement with people with sensory loss. Greater partnership working with colleagues in the independent sector will promote more effective information sharing and help to reduce duplication and repeated consultation on similar issues. (Funded by Social Policy) (B.6, B.7, C.5, C.6)

**vii. Inclusion and Community Outreach**

Future and current services should be accessible and able to meet the needs of people with sensory loss and service planning should include the perspective of these service users. The SRC Service will support Strategy Outcome 3 of the Scottish Vision Strategy – Inclusion, participation and independence for people with sight loss.

The Sensory Resource Centre (SRC) is centrally located but is not always conveniently accessed by people with sensory loss. A rolling programme of community outreach surgeries / sessions across the county is being established in partnership with local agencies. (To be funded within existing resources) (A.1, B.6, B.16, B.24, C.5)

**viii. Standards**

Following the publication of the Sensory Impairment Action Plan (SIAP) in 2004, the Executive issued Community Care Services for People with a Sensory Impairment: Policy and Practice Guidance in 2007 which contained a set of proposed Service Standards for working with people with sensory loss that had been developed in line with the National Outcomes for Community Care Framework. These Guidance and Standards should be implemented locally collaboratively with our key partners. (To be funded within existing resources) (B.6, B.23, C.6)

**ix. Partnership working**

There are a number of specialist agencies in the independent sector working with people with sensory loss. Future service planning and development should be done in partnership with these agencies and health, as well as with service users and carers to promote an inclusive and coherent approach to service delivery that avoids duplication and maximises the use of available resources.

When contracting services, consideration should be given to joint commissioning with key partners and the implementation of joint Service Level Agreements (SLA's).  
(Funding to be identified) (B.1, B.6, B.16, B.24)

## **6.2.2 PHYSICAL DISABILITY SERVICES**

### **a) Day Support – Ability Centre Support Service (ACSS)**

• **Service**

The Ability Centre Support Service, which is based in the West Lothian Ability Centre, provides a hub for the delivery of day support services to people with physical disabilities with the focus being on promoting social inclusion, community based services and more responsive public services. A range of support services are delivered both from the Centre and from 13 community based buildings across West Lothian.

The service offers four levels of involvement:

- i. Extended Rehabilitation (4/5 places per day, Monday to Friday) – for service users who have experienced a change of life circumstance such as an accident or loss of ability and who require a time limited, focused period of rehabilitation
- ii. Personal Development (6/7 places per day, Monday to Friday) – for service users who require a supported environment for a time limited period to enable them to build self-esteem and confidence before moving on to involvement in community based activities and the use of community resources and facilities
- iii. Quality Maintenance (2/3 places per day, Monday to Friday) – for service users who are dependent on others for all their personal

- care and support but who wish to take part in a tailored programme of activities and opportunities
- iv. Community Outreach (8/10 people per group, two groups per day) – for service users who may have been socially isolated and vulnerable and who would benefit from a range of community based activities which they can develop the skills to access with the appropriate levels of initial support

The ACSS also offers a brokerage service enabling service users to access work experience, college courses and volunteering opportunities. The Centre also offers a community café, a library access point and a base for Disability West Lothian, a voluntary advice and information organisation.

- **Delivery**

The AC Support Service is funded by Social Policy and is delivered by Social Policy staff.

- **Developments, Improvements and Initiatives**

The range of services offered by the ACSS support the move towards personalisation and community based services and support for disabled people. The Ability Centre is a much-valued resource enabling people to access advice, information and direct service provision in one accessible place and the Community Outreach programme supports people to also look at the opportunities available within their own communities.

It is likely that in future, there will be more people seeking support to access independent living skills, education and employment opportunities as well as support at times of transition. The following are areas for ACSS development:

- i. **Brokerage Service**

To support the development of this service in order to increase the range of opportunities and activities that can be identified and accessed and the numbers of people who can be supported into these alternatives. A Resource Brokerage Worker would enable greater links to the private and independent sectors to be forged. (Funding to be identified) (A.1, B.13, C.1, C.11)

- ii. **Onto Work Service**

To make this service available full time and to offer pre-employment skills training; advocacy and support to seek employment; support at the point of taking up employment; support within the initial stages of employment and ongoing support if required to stabilise employment at risk of being terminated. (Funding to be identified) (A.1, C.1, C.11)

- iii. **Independent Living Skills**

To offer a range of skills training to enable people to live independently within their own homes. This service could be

developed in partnership with independent sector services. (To be funded within existing resources) (A.1, C.1, C.22)

**iv. Transition work**

The availability of services and support to disabled people at key times of change can be inconsistent. There is an opportunity to develop partnership working with other agencies and sections of the Council to deliver support at times of transition particularly for young disabled and profoundly disabled people and young people with acquired brain injury. (Funding to be identified) (A.1, B.13, C.1)

**v. Future planning work**

To develop the opportunities for service users and carers to be involved in long term planning for the future and in contingency planning – the Changing Times model could underpin work in this area. (To be funded within existing resources) (A.1, B.13, B.23, C.1)

**a) (i) Day Support – Other Services**

**Epilepsy West Lothian (EWL)** provide services to adults resident in West Lothian who have epilepsy and / or learning or physical disabilities. The services available are – the **Community Outreach Service** offering planned and personalised support to individuals assessed and referred by the Council, **Group Sessions** offering a range of activities and skills training, the **Outreach, Information and Advice Service** to people with epilepsy and their families and the delivery of **Education and Awareness Training** to a range of staff working in social care.

**Capability Scotland** provides services to people with physical and complex disability. The Council commissions day support services from the New Trinity Centre and employment support services via Café Mistura within the Strathbrock Partnership Centre.

**b) CRABIS (Community Rehabilitation and Brain Injury Service)**

**• Service and Delivery**

CRABIS offers an integrated, specialist, multi-disciplinary assessment and rehabilitation service to people aged over 16 in West Lothian who have either a physical disability and/or an acquired brain injury. The service is a joint partnership between NHS Lothian and West Lothian Council Social Policy with staffing from a range of professional disciplines, including physiotherapy, occupational therapy, speech and language therapy and psychology, aimed at providing a co-ordinated and holistic approach to rehabilitation. The service also offers a mild head injury service with links now established with key departments in St. John's Hospital.

The service accepts referrals from hospitals planning discharge, professionals, agencies, carers and service users themselves on a re-referral basis.

- **Developments, Improvements and Initiatives**

The National Rehabilitation Framework promotes the delivery of accessible, locally based services. CRABIS have continued to experience an increase in demand for their services and there is likely to be growing pressure on the vocational rehabilitation element of the service.

The service work plan has focused on a number of challenges and development areas aimed at supporting the provision of a responsive neuro-rehabilitation service:

- A single rehabilitation referral format and a single point of referral
- A self-referral format and process
- Promotion and development of the Mild Head Injury Service
- An audit of pathways and outcomes for return to work and vocational rehabilitation with a view to developing service delivery
- Development of the 'Bridging the Gap' service currently being piloted with the Stoke Unit. This service aims to reduce waiting times and avoid deterioration in a service user's condition by the OT from CRABIS engaging with the person whilst in hospital prior to discharge and then following up with a set number of sessions once the person is home
- Utilise, and contribute to, the information made available to families, carers, agencies and professionals on the ABI MCN website
- To link in with the SSA framework and processes and to streamline the service's screening process
- Develop a formal process for working with people with functional symptoms related to long term conditions in order to improve service delivery
- Identify an appropriate outcome measure framework for service users that incorporates quality of life issues. Develop relevant links with the National Outcomes for Community Care
- Develop systems for service user and carer engagement and links with partner organisations in the voluntary sector

(To be funded within existing resources / Funding to be identified) (A.1, B.1, B.4, B.9, B.18, B.23, C.1, C.2)

### **c) Respite and Short Breaks from Caring**

- **Service**

Respite and short breaks from caring are available and can vary in length from a few hours to several weeks. A sitter service can be provided within the service user's own home for a few hours to allow the carer to go out or the service user can arrange to go to the Ability Centre for a day if an urgent need arises. Service users can also access respite in residential and nursing Care Homes, including specialist Care Homes such as Leuckie for people with MS, for stays from a few days to several weeks.

Respite and short-term assessment provision is also available in housing with care for people aged over 60.

- **Delivery**

These services are provided by both the independent and private sectors with funding from the Council. In addition, people can access some respite support via the NHS either in a hospital ward or other facility providing that they need medical supervision or attention. Currently there are no specialist Care Homes for people with physical and complex disability to access for respite within West Lothian and people have to go outwith the county unless they are willing to go to a resource primarily for people with learning disability.

- **Developments, Improvements and Initiatives**

More people with long-term conditions or disability are living within their own homes for longer with the support of both formal and unpaid carers. This will mean a future increase in the demand for short breaks from caring both within and outwith the home. West Lothian does not currently have a designated respite care unit for people with physical disabilities although one is due to be commissioned within the next 12 months that it is anticipated will provide a response to future demand. There will be a need for:

- Locally available care home respite provision - a new purpose-built unit is currently being developed by Social Policy that will offer respite and short breaks from caring for people with physical and complex disability. The ongoing management and care service delivery will be put out to tender and commissioned from an alternative provider who will work in partnership with the Council. (Funded by Social Policy)
- Overnight respite support within a person's home
- Sitter services
- Unplanned or emergency respite or support which can be easily accessed
- Respite services within specialist facilities where requested  
(Funding to be identified) (B.17, C.1)

#### **d) Residential or Nursing Home Care – Care Homes**

- **Service and Delivery**

If an individual's assessed care and support needs cannot be safely and appropriately met within their own home, then a long-term residential placement may be appropriate. Care Homes currently used by physically disabled people from West Lothian are run by the private and independent sectors and placements are largely funded by the Council with a contribution from the service user. Most placements are currently made outwith West Lothian, as there are no specialist Care Homes for people with physical and complex disability within West Lothian, other than a small unit that is specifically for people with acquired brain injury.

- **Developments, Improvements and Initiatives**

Despite the move to more personalised, community-based service delivery, there will remain a need for care home placements for people whose needs can no longer be safely met in a less supported environment. Currently, the only designated long-term care home for people with physical disabilities in West Lothian is a small unit for people with ABI. However, the Council is funding the development of a purpose built unit for people with physical and complex needs which will be commissioned within the next 12 months and which it is anticipated will provide a response to future demand. The ongoing management and care service delivery will be put out to tender and commissioned from an alternative provider who will work in partnership with the Council. (Funded by Social Policy)

Consideration will also be given to seeking the possible provision of a Care Home service for people with physical and complex disability by an existing local Care Home provider within a local Care Home.

(B.17, B.13, C.1)

## **e) Care at Home – Independent Living, Specialist and Housing Support**

- **Service**

The move towards personalised services, independent living within the community and the shifting the balance of care agenda have led to a growth in the need for care and support at home services which can meet the care and support needs of people with increasingly complex conditions and disabilities as well as provide more individualised and personalised care arrangements.

The previous UK wide policy and funding framework known as ‘Supporting People’ was introduced to enable vulnerable people to maintain or improve their ability to live independently in the community by providing them with housing support services. Such services aim to a) sustain people in the community and avoid admission into some form of long term care b) assist homeless people to move on to managing their own home and resettle successfully in their community and c) to prevent crisis by intervening at an early stage to stabilise a person’s situation. In line with national objectives, the focus of service delivery was on prevention and promoting independence and inclusion and the level of support was determined on the basis of individual need.

- **Delivery**

Specialist care services are provided by agencies from the private and independent sector as well as by specialist input from the community nursing service. Services are usually offered on a scheduled and planned basis but can also be implemented at times of crisis, illness or sudden change of circumstances.

Most of the care and support at home is offered between the hours of 7-30 a.m. and 10-00 p.m. but support during the night can also be provided by

the evening nursing service or by the home safety service in response to an alarm call for assistance.

In order to target finite resources equitably and where they are most needed, eligibility criteria and service levels are applied.

The former West Lothian Supporting People Team identified and commissioned some housing support services for people with physical disability and /or sensory impairment and there are a small number of contracts in place with providers, including Deafblind Scotland, for this service user group that require monitoring and review.

Until 31<sup>st</sup> March 2008, the government funding allocation attached to Supporting People was ring-fenced but this ring fencing was removed from 1<sup>st</sup> April 2008. Following a period of transition, from 1<sup>st</sup> April 2009, all Supporting People ring fenced budget arrangements will cease and these budgetary and contractual arrangements will become part of the overall Social Policy delivery of service commissioning, contracting and provision.

• **Developments, Improvements and Initiatives**

With more disabled people being supported to live independently in the community, there will be an increase in the demand for more personalised and specialist care at home services. Service Pressures include:

- The demand for support with medical treatments, interventions and regimes
- The demand for support to acquire independent living skills and for carers to offer support to enable people to play a more active role in their care rather than in being passive recipients of care
- A demand for an increase in the range of tasks with which people can be supported

Supporting People funding is no longer ring fenced. All previous contracts for former Supporting People services will require to be reviewed. (To be funded within existing resources) (C.7, C.11)

The current Housing Support Services / Supporting People contracts for physical disability are:

- i. Commissioned for general access
  - Deaf Action – 19 hours per week
  - Deafblind Scotland – 12 hours per week
- ii. Commissioned for Named Individuals
  - Freespace – 59 hours per week
  - Richmond Fellowship (ABI) – 57 hours per week

**f) Information, Advice and Advocacy Services**

• **Services and Delivery**

In addition to the services offered via the Council's Advice Shop, including the Macmillan Advice Team, West Lothian provides ongoing funding and

support to a range of independent organisations offering information, advice and advocacy services to disabled people. West Lothian Council regards the independent sector as a key partner in the delivery of support and services and remains committed to collaborative working and to promoting and sustaining the work of the independent sector in this field.

Funding provision is available either through best value mechanisms or contracting and commissioning and there are robust monitoring and review processes in place.

#### **i. Information and Advice Services**

- Disability West Lothian (DWL)

DWL can be accessed by anyone resident in West Lothian with a disability. Services available include an information and advice service, a learning disability support service and a peer counselling service.

- Huntington's Association

The Scottish Huntington's Lothian service offers a support network to families affected by Huntington's Disease and provides – advice, information and education both to service users and families and to professionals and care providers; specialist assessment; support and counselling; advocacy and group work

- Lothian Centre for Inclusive Living (LCIL)

LCIL is a user-controlled organisation that supports disabled people to live independently. The services and support available include one to one advice to arrange and manage a self-directed support package; a payroll service; training opportunities for disabled people and 'Your Call' – a telephone counselling service.

#### **ii. Advocacy Services**

There is no designated independent advocacy service for people with physical and complex disability available within West Lothian and yet the need for such a service is likely to increase with the move to more personalised service delivery. Advocacy services for disabled people will need to be considered in future service commissioning. (Funding to be identified) (A.3, A.4, A.7, B.10, C.1)

#### **• Developments, Improvements and Initiatives**

A more robust funding and contractual framework is being implemented with organisations with service specifications and requirements being attached to funding arrangements. It is anticipated that partnership working with the independent sector will increase and there will be a growth in the service commissioning from this sector. Service developments in this area include:

- Continued development of a more robust commissioning framework and the implementation of contractual arrangements rather than funding agreements
- Increased joint commissioning and contracting arrangements
- Identification of service gaps and unmet needs, including independent advocacy for disabled people, and partnership working with the independent sector in order to deliver services to meet these needs (B.1, B.10, C.1, C.11)

**g) Additional Service Needs – Future Developments and Initiatives**

Current and future policy direction and the move to develop more community-based information, access, care and support for disabled people has generated service pressures and has led to the identification of gaps in service provision. This has enabled additional service developments and recommendations to be identified as detailed below:

**i. Befriending**

As more disabled people move into their own tenancies within the community there is a risk that some individuals may become socially excluded and isolated. The development of a Befriending Service which enables individual or family volunteers to be matched with someone in their area would help to promote social inclusion and to provide service users with an opportunity to access local activities and make links with local facilities. (Funding to be identified) (B.10, B.17, C.1)

**ii. Rehabilitation / Re-enablement**

Access to rehabilitation services in local communities with a view to promoting re-enablement and maximum independence is at the heart of the national policy agenda. A key aspect of this is vocational rehabilitation and the importance of getting people back to, or into, the workplace. Support to young disabled people to develop independence skills is also necessary. There will be increased demands being made on all hospital and community based rehabilitation services and partnership working and joined up approaches to service delivery will be essential in order to meet these demands. Service development priorities include:

- Rehabilitation training across agencies and an increased understanding of the roles of multi-disciplinary teams
- Enhanced community based rehabilitation to include beds in local settings; joint rehabilitation pathways across agencies to achieve flexibility and fluidity across services and capacity planning and service re-design aimed at reducing waiting times
- Self-management – staff training to promote self-management; the development of a self-management framework, perhaps in partnership with the independent sector, and working with voluntary groups to develop support mechanisms for people, for example, educational material, self-help groups and so on

- Ongoing support for the cardiac rehabilitation and pulmonary rehabilitation services which have been developed to support people to manage their own conditions
  - Development of a single point of access and self-referral and self-assessment options
  - Development of case management and a holistic, client-centred approach to rehabilitation goal setting based on service user lifestyle and choice
  - Development of service user and carer information and robust information management and sharing systems
- (Funding to be identified) (B.18, C.1, C.2)

### **iii. Information strategy**

A key priority regularly identified by service users and carers is access to good quality information. An Information Strategy should be developed and implemented in partnership with key stakeholders in the delivery of services and support to people with physical and complex disability.  
(Funding to be identified) (A.1, B.17, C.1, C.4, C.6, C.7)

## 7. ACTION PLAN – DEVELOPMENTS, IMPROVEMENTS AND INITIATIVES

SERVICE	CAPACITY	CURRENT SERVICE PRESSURES  DEVELOPMENTS AND IMPROVEMENTS
<b>Assessment and Care Management</b>		<p>The SSA framework and assessment tool used in West Lothian is currently undergoing a complete review. The format for assessment is being redesigned in order to improve information gathering, to enable relevant electronic reporting from the e-Care system and to incorporate the information requirements from IoRN.</p> <p>The aim is to also increase the use of the SSA framework by partners in health and housing.</p> <p>(Funded by Social Policy) (Appendix references – B.1, B.23, C.5)</p>

<b>SERVICE INITIATIVE</b>
<p>Single Shared Assessment (SSA)</p> <ul style="list-style-type: none"> <li>• Review of SSA framework and tool incorporating National Minimum Information Standards for Assessment and Care Management</li> <li>• The development of an Information Pack for service users and carers which will be given out at the point of assessment. This Pack will contain information on all relevant services and topics and will act as an initial resource pack for people with disability.</li> </ul>

SERVICE	CAPACITY	CURRENT SERVICE PRESSURES  DEVELOPMENTS AND IMPROVEMENTS
<b>Risk Assessment and Adult Protection</b>	Contained within Assessment and Care Management	<p>The Risk Assessment Framework is to be streamlined with the revised Single Shared Assessment tools and processes.</p> <p>Adult Protection Committee (APC) subcommittees will oversee multiagency developments including:</p> <ul style="list-style-type: none"> <li>- A review of the IRD process</li> <li>- Development of a multiagency performance reporting framework</li> <li>- Development of a multiagency Training Strategy and Programme</li> </ul>

<b>SERVICE INITIATIVE</b>
<p>Risk Assessment</p> <ul style="list-style-type: none"> <li>• To implement the Risk Assessment Framework across Adults and Older People’s Services</li> </ul> <p>Adult Protection</p> <ul style="list-style-type: none"> <li>• To develop a multi-agency Training Strategy and to deliver a multiagency Training Programme</li> </ul>

SERVICE	CAPACITY	CURRENT SERVICE PRESSURES  DEVELOPMENTS AND IMPROVEMENTS
<b>Self-Directed Support and Direct Payments</b>		<ul style="list-style-type: none"> <li>- Revision of the West Lothian Direct Payments policy, guidance and procedures in line with the new national guidance for Self-Directed Support published in 2007. (Funded by Social Policy)</li> <li>- Staff training on the revised guidance and procedures</li> <li>- Strategies for freeing up resources from within existing services</li> <li>- Provision of service user and carer training and support to manage a Direct Payment</li> <li>- Commissioning of services to deliver the training and support to service users / carers</li> <li>- Information and promotion of self directed support services (Funding to be identified)</li> </ul>

<b>SERVICE INITIATIVE</b>
<p>Self-Directed Support and Direct Payments</p> <ul style="list-style-type: none"> <li>• Review of Direct Payment Policies and Procedures in line with the Self-Directed Support: New National Guidance</li> </ul>

SERVICE	CAPACITY	CURRENT SERVICE PRESSURES  DEVELOPMENTS AND IMPROVEMENTS
<b>Occupational Therapy (OT) Services</b>		<ul style="list-style-type: none"> <li>- Adopt the new Single Shared Assessment framework for OT assessments incorporating National Minimum Standards</li> <li>- Work in partnership with Housing Allocations to maximise the use of adapted Council housing stock and to assist with the allocation of suitable housing to disabled applicants</li> <li>- Work with Housing Development and Care and Repair to develop West Lothian Guidance and implement the new Scheme of Assistance in relation to disability adaptations for home owners</li> <li>- Work with NHS OT to continue to minimise duplication and giving easier access to disability equipment provision</li> </ul>

<b>SERVICE INITIATIVE</b>
<p>Occupational Therapy (OT) Services</p> <ul style="list-style-type: none"> <li>• In preparation for the introduction of the Housing (Scotland) Act and Scheme of Assistance in April 2009, OT services will work in partnership with Housing to develop the West Lothian Guidance for the provision of adaptations to owner-occupier households (A.7, B.4, B.5, C.10)</li> <li>• Review the new Equipment and Adaptations Guidance (for publication Autumn 2009). The OT Service will work with partners across Social Policy, Housing and the NHS to improve service delivery in any areas not already of the required standard and to implement changes. (B.1, B.4, B.5, B.18, C.10)</li> </ul>

SERVICE	CAPACITY	CURRENT SERVICE PRESSURES  DEVELOPMENTS AND IMPROVEMENTS
<b>Community Equipment Store</b>		<ul style="list-style-type: none"> <li>- To improve stock control and the re-cycling of equipment to help to meet increased demand</li> <li>- To promote the use of GPRS hand held devices by equipment delivery drivers</li> <li>- To implement the revised arrangements for the supply of equipment to deaf, deafened and hard of hearing people</li> </ul>

<b>SERVICE INITIATIVE</b>
<p>Community Equipment Store</p> <ul style="list-style-type: none"> <li>• To implement any improvements required by the new Equipment and Adaptations Guidance (B.4, B.5, B.18, C.10)</li> </ul>

SERVICE	CAPACITY	CURRENT SERVICE PRESSURES  DEVELOPMENTS AND IMPROVEMENTS
<b>Care at Home – General</b>		<ul style="list-style-type: none"> <li>- Service levels and eligibility criteria will need to be managed robustly and may need to be reviewed</li> </ul> Service Pressures include: <ul style="list-style-type: none"> <li>- The level of personal and domestic care support hours available</li> <li>- The availability of care and support during the night and a demand for routine out of hours services</li> <li>- The demand for service at times of crisis or emergency</li> </ul>

<b>SERVICE INITIATIVE</b>
Care at Home – General <ul style="list-style-type: none"> <li>• The Development of an Assisted Care and Technology Service (ACTS) to address identified service pressures</li> </ul>

SERVICE	CAPACITY	CURRENT SERVICE PRESSURES DEVELOPMENTS AND IMPROVEMENTS
<b>Supported Discharge and Re-enablement Team (SDRT)</b>		Service pressures include: <ul style="list-style-type: none"> <li>- Increased service demands due to the shifting the balance of care and management of long term conditions agendas</li> </ul>

<b>SERVICE INITIATIVE</b>
Supported Discharge and Re-enablement Team (SDRT) <ul style="list-style-type: none"> <li>• The Development of an Assisted Care and Technology Service (ACTS) to address identified service pressures</li> </ul>

SERVICE	CAPACITY	CURRENT SERVICE PRESSURES  DEVELOPMENTS AND IMPROVEMENTS
<b>Home Safety Service (HSS)</b>		Service pressures include: <ul style="list-style-type: none"> <li>- Meeting increased demand for telecare customised packages</li> <li>- Keeping up to date with new developments in telecare</li> <li>- Providing the necessary level of support and adequate back up systems to service users and carers using technology to underpin their care</li> <li>- Resourcing the Home Safety Service (Funding to be identified) (A.6, B.3, B.9, B.18, B.22)</li> </ul>

<b>SERVICE INITIATIVE</b>
Home Safety Service (HSS) <ul style="list-style-type: none"> <li>• Fast track installations of Home Safety Packages via the new ACT Service</li> <li>• Increase in the number of homes with telecare installed</li> </ul>

SERVICE	CAPACITY	CURRENT SERVICE PRESSURES  DEVELOPMENTS AND IMPROVEMENTS
<b>Support for Carers</b>		<ul style="list-style-type: none"> <li>- Respite and short breaks from caring within a service user's own home, including sitter services and overnight care, particularly for people caring for someone with dementia (further development of the SMU may assist with this)</li> <li>- Unplanned / crisis care / emergency respite / short break support</li> <li>- Forward and contingency planning to be available to carers as part of the overall assessment and care management processes</li> <li>- Carer Training Programmes, e.g., in understanding long-term conditions, financial issues including Guardianship, safer moving and handling and so on</li> <li>- Accessible and comprehensive information for carers and the implementation of the Carers Information Strategy in partnership with health – there should be an emphasis on promoting and sustaining carers' health</li> <li>- Promotion of carers' assessments and working in partnership with GP's and other agencies / colleagues to facilitate the take up of these assessments.</li> <li>- Availability of day support and care at home services to enable carers to maintain employment if requested – services should be flexible, responsive and available</li> <li>- Carer engagement and consultation should be a routine part of service planning and development</li> </ul>

<b>SERVICE INITIATIVE</b>
Support for Carers <ul style="list-style-type: none"> <li>An updated Carers Assessment Tool to be developed as part of the review of SSA processes and protocols</li> </ul>

<b>SERVICE</b>	<b>CAPACITY</b>	<b>CURRENT SERVICE PRESSURES</b> <b>DEVELOPMENTS AND IMPROVEMENTS</b>
<b>Sensory Resource Centre (SRC) Service</b>		<ul style="list-style-type: none"> <li>- The promotion of sensory awareness and training for key staff – sensory loss issues to be included in assessment and review processes</li> <li>- Care Home staff training in hearing aid usage and care</li> <li>- The development of information on sensory impairment issues to be accessed via the internet or via information packs (including an early diagnosis pack)</li> <li>- Monitoring and review of service contracts and provision</li> </ul>

<b>SERVICE INITIATIVE</b>
<p>Sensory Resource Centre (SRC) Service</p> <ul style="list-style-type: none"> <li>• Implementation of a rolling programme of Community Outreach sessions</li> </ul>

<b>SERVICE</b>	<b>CAPACITY</b>	<b>CURRENT SERVICE PRESSURES</b> <b>DEVELOPMENTS AND IMPROVEMENTS</b>
<b>Ability centre Support Service (ACSS)</b>		<ul style="list-style-type: none"> <li>- To support the development of the Brokerage Service in order to increase the range of opportunities and activities that can be identified and accessed and the numbers of people who can be supported into these alternatives</li> <li>- To support the development of the Onto Work Service (e.g. pre-employment skills training; advocacy and support to seek employment; support at the point of taking up employment; support within the initial stages of employment and ongoing support if required to stabilise employment at risk of being terminated)</li> <li>- To consider how the ACSS may be involved in transition work</li> <li>- To develop opportunities for service users and carers to be involved in long-term planning for the future and contingency planning (e.g. using the Changing Times model)</li> </ul>

<b>SERVICE INITIATIVE</b>
<p>Ability centre Support Service (ACSS)</p> <ul style="list-style-type: none"> <li>• Development of a new day support service for people with complex disability and needs in partnership with the new Physical Disability Resource planned for Uphall</li> </ul>

<b>SERVICE</b>	<b>CAPACITY</b>	<b>CURRENT SERVICE PRESSURES</b>
		<b>DEVELOPMENTS AND IMPROVEMENTS</b>
<b>CRABIS (Community Rehabilitation and Brain Injury Service)</b>		<ul style="list-style-type: none"> <li>- A single rehabilitation referral format and consideration of a single point of referral in line with the National Rehabilitation Framework</li> <li>- A self-referral format and process</li> <li>- Promotion and development of the Mild Head Injury Service</li> <li>- An audit of pathways and outcomes for return to work and vocational rehabilitation with a view to developing service delivery</li> <li>- Development of the 'Bridging the Gap' service currently being piloted with the Stroke Unit.</li> </ul>

		<ul style="list-style-type: none"> <li>- Utilise, and contribute to, the information made available to families, carers, agencies and professionals on the ABI MCN website</li> <li>- To link in with the SSA framework and processes and to streamline the service's screening process</li> <li>- Develop a formal process for working with people with functional symptoms related to long term conditions in order to improve service delivery</li> <li>- Identify an appropriate outcome measure framework for service users that incorporates quality of life issues. Develop relevant links with the National Outcomes for Community Care</li> <li>- Develop systems for service user and carer engagement and links with partner organisations in the voluntary sector</li> </ul>
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<p><b>SERVICE INITIATIVE</b></p>
<p>CRABIS (Community Rehabilitation and Brain Injury Service)</p> <ul style="list-style-type: none"> <li>• To implement the service improvements detailed in the service annual work plan</li> </ul>

<b>SERVICE</b>	<b>CAPACITY</b>	<b>CURRENT SERVICE PRESSURES</b>  <b>DEVELOPMENTS AND IMPROVEMENTS</b>
<b>Respite and Short Breaks from Caring</b>		<ul style="list-style-type: none"> <li>- Locally available care home respite provision</li> <li>- Overnight respite support within a person's home</li> <li>- Sitter services</li> <li>- Unplanned or emergency respite or support which can be easily accessed</li> <li>- Respite services within specialist facilities where requested</li> </ul>

<b>SERVICE INITIATIVE</b>
<p>Respite and Short Breaks from Caring</p> <ul style="list-style-type: none"> <li>• To develop a local resource for people with physical and complex disability to offer short breaks from caring</li> </ul>

<b>SERVICE</b>	<b>CAPACITY</b>	<b>CURRENT SERVICE PRESSURES DEVELOPMENTS AND IMPROVEMENTS</b>
<b>Residential or Nursing Home Care – Care Homes</b>		<ul style="list-style-type: none"> <li>- To explore the development of a service for people with physical and complex disability by a local Care Home provider within an existing local Care Home</li> </ul>

<b>SERVICE INITIATIVE</b>
<p>Residential or Nursing Home Care – Care Homes</p> <ul style="list-style-type: none"> <li>• To develop a local resource for people with physical and complex disability to offer residential care provision</li> </ul>

<b>SERVICE</b>	<b>CAPACITY</b>	<b>CURRENT SERVICE PRESSURES DEVELOPMENTS AND IMPROVEMENTS</b>
<b>Care at Home – Independent Living, Specialist and Housing Support</b>		<p>Service pressures include:</p> <ul style="list-style-type: none"> <li>- The demand for support with medical treatments, interventions and regimes</li> <li>- The demand for support to acquire independent living skills and for carers to offer support to enable people to play a more active role in their care rather than in being passive recipients of care</li> <li>- A demand for an increase in the range of tasks with which people can be supported</li> </ul>

<b>SERVICE INITIATIVE</b>
<p>Care at Home – Independent Living, Specialist and Housing Support</p> <ul style="list-style-type: none"> <li>• To review all previous contracts for Supporting People services during 2009/10</li> </ul>

<b>SERVICE</b>	<b>CAPACITY</b>	<b>CURRENT SERVICE PRESSURES</b>  <b>DEVELOPMENTS AND IMPROVEMENTS</b>
<b>Information, Advice and Advocacy Services</b>		<ul style="list-style-type: none"> <li>- Development of independent advocacy services for people with physical and complex disability</li> </ul>

<b>SERVICE INITIATIVE</b>
<p>Information, Advice and Advocacy Services</p> <ul style="list-style-type: none"> <li>• To participate in the development of access to advocacy and independent and advice services within West Lothian</li> </ul>

SERVICE	CAPACITY	CURRENT SERVICE PRESSURES DEVELOPMENTS AND IMPROVEMENTS
<b>Additional Service Needs</b>		<ul style="list-style-type: none"> <li>- Befriending service</li> <li>- Rehabilitation / Re-enablement services</li> <li>- Development of an Information Strategy</li> </ul>

<b>SERVICE INITIATIVE</b>
<p>Additional Service Needs</p> <ul style="list-style-type: none"> <li>• To participate in any review and development of rehabilitation services conducted by key partners</li> </ul>

## 8. PERFORMANCE MEASURES

WEST LoTHIAN COUNCIL - ACTIVITY BUDGET 2009/10

SERVICE: CHCP AND SOCIAL POLICY

WLAM TEAM: PHYSICAL DISABILITY

Activity	Objective	Corporate Planning Priority	Performance Measure and Target 2009/10	Projected Output Narrative for 2009/10	Projected Output Unit for 2009/10
Assessment and Care Management Services	Provision of an assessment and care management service to adults with physical disabilities	Improving The Health And Wellbeing Of Communities	All assessments to be allocated within 13 weeks of date of referral	No of assessments and reviews completed	320
Assessment and Care Management Services	Provision of an assessment and care management service to adults with physical disabilities	Improving The Health And Wellbeing Of Communities	All assessments to be allocated within 13 weeks of date of referral	% of user assessments completed within target timescale	60% of user assessments completed within target timescale
Assessment and Care Management Services	Provision of an assessment and care management service to adults with physical disabilities	Improving The Health And Wellbeing Of Communities	All assessments to be allocated within 13 weeks of date of referral	% of care plans reviewed within target timescale	60% of care plans reviewed within target timescale
Assessment and Care Management Services	To offer support to informal Carers	Improving The Health And Wellbeing Of Communities	All assessments to be allocated within 13 weeks of referral	No. of carer stand alone assessments/reviews completed	25 carer assessments /reviews completed
Assessment and Care Management Services	To offer support to informal Carers	Improving The Health And Wellbeing Of Communities	All assessments to be allocated within 13 weeks of referral	% of carers' assessments completed within target timescale	60% of carers' assessments completed within target timescale

Activity	Objective	Corporate Planning Priority	Performance Measure and Target 2009/10	Projected Output Narrative for 2009/10	Projected Output Unit for 2009/10
Assessment and Care Management Services	To provide an assessment of need for people with a visual impairment	Improving The Health And Wellbeing Of Communities	All assessments to be allocated within 13 weeks of referral	Number of assessments / reviews completed for service users with a visual impairment	75
Assessment and Care Management Services	To purchase an assessment of need and advice service for people with a hearing impairment	Improving The Health And Wellbeing Of Communities	All assessments/ requests for service allocated within 13 weeks of referral	Number of people with a hearing impairment provided with an assessment or advice service	30
Assessment and Care Management Services – Adult Protection	To provide support and protection for adults with physical disability	Improving The Health And Wellbeing Of Communities	All adult protection cases to have an allocated worker	% of adult protection cases with an allocated worker	100% of adult protection cases have an allocated worker
Assessment and Care Management Services – Adult Protection	To provide support and protection for adults with physical disability	Improving The Health And Wellbeing Of Communities	All adult protection cases to result in an adult protection action plan	% of adult protection cases to result in an adult protection action plan	100% of adult protection cases have resulted in an adult protection action plan
Care Home Placement Service	Purchase of Care Home placements	Improving The Health And Wellbeing Of Communities	Placement is secured within 12 wks of Care Plan completion	Number of new placements per annum +28 days	6
Short Breaks from caring	Purchase of short breaks from caring in registered accommodation	Improving The Health And Wellbeing Of Communities	Short break is available within 12 wks of completion of Care Plan	Number of placements provided	35
Short Breaks from caring	Purchase of short breaks from caring in registered accommodation	Improving The Health And Wellbeing Of Communities	Short break is available within 12 wks of completion of Care Plan	Number of nights purchased within placements <28 days in registered accommodation	250 nights purchased

Activity	Objective	Corporate Planning Priority	Performance Measure and Target 2009/10	Projected Output Narrative for 2009/10	Projected Output Unit for 2009/10
Care at Home Services	Maintain and promote independence for individuals and provide support for carers	Improving The Health And Wellbeing Of Communities	In Older People Plan		
Care at Home Services	Maintain and promote independence for individuals and provide support for carers	Improving The Health And Wellbeing Of Communities	Service is commenced within 9 weeks of completion of care plan	Number of people for whom a care at home service was purchased	200 people received care at home (purchased)
Care at Home Services	Maintain and promote independence for individuals and provide support for carers	Improving The Health And Wellbeing Of Communities	Service is commenced within 9 weeks of completion of care plan	Number of hours care at home service purchased	69,500 hours purchased
Care at Home Services	Maintain and promote independence for individuals and provide support for carers	Improving The Health And Wellbeing Of Communities	Service is commenced within 9 weeks of completion of care plan	Number of people for whom a care at home service was provided	124 people received care at home (provided)
Care at Home Services	Maintain and promote independence for individuals and provide support for carers	Improving The Health And Wellbeing Of Communities	Service is commenced within 9 weeks of completion of care plan	Number of hours care at home service provided	40,500 hours provided
Day Care and Community Support Services	Promote volunteering and employment opportunities for people with Physical Disabilities	Improving The Health And Wellbeing Of Communities	To increase the no. of people supported into volunteering or employment	Average number of hours supported per week	41
Day Care and Community Support Services	<b>Provision of day support and activities outwith the home which promote independent living and supports carers</b>	Improving The Health And Wellbeing Of Communities	<b>Service is available within 12 weeks of completion of Care Plan</b>	<b>Number of people receiving a service per annum</b>	<b>150</b>
Day Care and Community Support Services	Provision of Community Rehabilitation Service	Improving The Health And Wellbeing Of Communities	Service is available within 12 weeks of referral	Number of people provided with this service	130
Day Care and Community Support Services	To purchase day support and activities outwith the home	Improving The Health And Wellbeing Of Communities	Service is available within 12weeks of referral	Number of people provided with a service	20

Activity	Objective	Corporate Planning Priority	Performance Measure and Target 2009/10	Projected Output Narrative for 2009/10	Projected Output Unit for 2009/10
Direct Payments	To provide Direct payments to adults with physical disabilities.	Improving The Health And Wellbeing Of Communities	Increase the number of people receiving direct payments per annum	Direct Payments provided	70
Sensory Imp Services	To purchase mobility or rehabilitation training for people with a visual impairment	Improving The Health And Wellbeing Of Communities	Service responds within 13 wks of referral	Number of people receiving a service per annum	130
Telecare	To provide telecare services to people with physical disability	Improving The Health And Wellbeing Of Communities	Service responds within 13 wks of referral	Number of people provided with telecare per annum	50 people provided with telecare per annum
Disability Info & Advice	To purchase disability information and advice services	Improving The Health And Wellbeing Of Communities	Service is available as contracted	Number of people receiving information and advice per annum	1700
Support at Home (including tenancy support) services	To purchase individual support services	Improving The Health And Wellbeing Of Communities	Service is available within 12 weeks of completion of Care Plan	Number of people provided with a service	30
	<b>Total: -</b>				

NB The measures highlighted in green are the additional measures to be gathered in future as part of the continuous development of outcomes focussed reporting

## APPENDIX – CONSULTATION

West Lothian has a strong commitment to engaging with key stakeholders, including service users and carers, as part of our service planning processes, as we believe that this improves the development of local services. There are established service user and carer groups and fora, as well as other interest groups, which regularly participate in consultation with the Council ensuring that the views of disabled people are given a voice. This approach to service user and carer engagement is underpinned via scrutiny by external bodies such as the Social Work Inspection Agency, the Care Commission and the Customer Service Excellence assessment body.

Following completion of the draft Strategic Service Statement for Physical Disability the document was circulated for consultation between January and February 2009. Feedback and comments were invited, particularly with regard to the prioritisation of the proposed initiatives, with a view to assisting with the completion of the final version. This consultation process ensured that key stakeholders had an opportunity to give their views on the proposed future delivery of services to disabled people in West Lothian.

The Strategic Statement was been generally well received with feedback offering positive and constructive comments which have been considered in developing the final document.

West Lothian Physical Disability Services appreciate the valuable contribution made by all those who took part in the consultation process and would like to take this opportunity to thank them for their participation.

The table below shows the range of people, including service users and carers, groups, organisations and agencies that were contacted as part of the consultation process.

	<b>AGENCY / GROUP / PERSON</b>	<b>NUMBER OF PEOPLE</b>
1.	Physical Disability Forum	c. 10
2.	Disability Equality Forum	c. 14
3.	Service User Forum – ACSS	c. 8
4.	Just Uz Group	c. 12
5.	Carers Voice	Sent to Chair for circulation to carers
6.	Vision Support Group	Sent to Chair for circulation to group members

7.	Carers of West Lothian	Sent to Chair and Manager for circulation to carers and members
8.	Disability West Lothian	Sent to Chair for wider circulation
9.	Access Committee	Sent to Chair for circulation
10.	West Lothian CHCP Patient and Public Involvement Officer	Sent for wider circulation
11.	Equalities Officer	Sent for consideration / circulation
12.	Moving Intowork	Sent for circulation
13.	RNIB	Sent to link officers for circulation
14.	Deaf Action	Sent to link officer for circulation
15.	Deafblind Scotland	Sent to link officer
16.	Epilepsy West Lothian	Sent to Manager for consideration / circulation
17.	Voluntary Action West Lothian	Sent for consideration
18.	Pinewood, Leonard Cheshire	Sent for consideration
19.	EARS Advocacy	Sent to Manager for consideration / circulation
20.	LCIL	Sent to Manager for consideration / circulation
21.	CRABIS	Sent to Manager for consideration / circulation
22.	Programme Manager – Disabilities, NHS Lothian	Sent for consideration / circulation
23.	Eye Department, St. John's, NHS Lothian	Sent for consideration / circulation
24.	Audiology, NHS Lothian	Sent for consideration / circulation

25.	AHP Manager, West Lothian CHCP	Sent for consideration / circulation
26.	Community Nurse Manager, West Lothian CHCP	Sent for consideration / circulation
27.	West Lothian College – Learning Support	Sent for consideration
28.	West Lothian Council – Senior Managers (Adults, Older People, Communities and Information)	Sent for consideration / circulation
29.	West Lothian Council – Group Managers (Planning, Housing with Care, OT, Domiciliary Care, HIT, Older People, Adults)	Sent for consideration / circulation
30.	Service Development Officers (Older People, Learning Disability)	Sent for consideration
31.	West Lothian Council – Team Managers (ACSS, Physical Disability / Mental Health / Child Disability Assessment and Care Management, HSS, Supporting People)	Sent for consideration / circulation
32.	West Lothian Council staff – Social Policy	Sent for consideration
33.	Joint Equipment Store	Sent for consideration / circulation

## APPENDIX A

### RELEVANT LEGISLATION

#### **A.1 Disability Discrimination Act (1995)**

This Act strengthens the rights of disabled people and addresses access in its widest sense. From December 2006, the Act has required that all public sector bodies promote equality of opportunity for disabled people by taking account of their needs as an integral part of all policies, procedures and practices. This is underpinned by the requirement for all public sector bodies to publish a **Disability Equality Scheme** and to provide annual progress reports on how they are meeting their disability equality duty.

#### **A.2 Community Care and Health (Scotland) Act 2002**

This Act introduced the duty to make Direct Payments available to all adults with physical disability who had community care needs and to disabled parents for children's services to meet their parenting needs.

#### **A.3 Adults with Incapacity Act (2002)**

This Act aims to help adults with incapacity exercise a greater degree of decision making over their lives, finances, personal welfare and medical treatment. The central principle of the Act is 'minimal intervention'.

#### **A.3 The Mental Health Care and Treatment Act (2003)**

This Act changes the criteria determining whether an individual's decision making is impaired in relation to compulsory treatment and introduces a mandate to provide independent advocacy services to people who are detained for treatment and applies to people with ABI.

#### **A.4 Education (Additional Support for Learning) (Scotland) Act (2004)**

This Act outlines duties for education authorities to achieve better planning and preparation for transition to post school life for children with special needs.

#### **A.5 NHS Reform (Scotland) Act (2004)**

**Building a Health Service Fit for the Future (2005)** (the Kerr Report) proposed that Health Services should be provided predominantly in local communities, should provide preventive and anticipatory care rather than reactive management and should have staff who are appropriately trained and skilled.

#### **A.6 Housing (Scotland) Act (2006)**

This Act came into effect on 1<sup>st</sup> April 2009 and gives local authorities new powers to provide advice and assistance to homeowners and targets funding towards adaptations that can allow people with disabilities to remain in their own homes.

**A.7 Adult Support and Protection (Scotland) Act (2007)**

This Act introduces legislation to better protect adults at risk of abuse/harm, neglect and/or exploitation. It prescribes new powers and duties to local authorities and other key partners and focuses on maximising vulnerable people's safety; balancing the right to be protected with the right to self-determination and information-sharing, inter-agency collaboration, responsibility and accountability.

## APPENDIX B

### RELEVANT NATIONAL POLICIES

- B.1 A Joint Future (2001), Scottish Executive**  
The lead policy on improving joint working between local authorities and the NHS in community care which aims to provide faster access to better and more 'joined-up' services. It promotes holistic decision-making by local partnerships on the joint management, financing, resourcing and delivery of community care services for all service user groups with a focus on single shared assessment (SSA) and joint performance management and reporting frameworks.
- B.2 Our National Health: An Agenda for Change (2001)**  
This outlines a modernising agenda to achieve a patient-centred approach to service delivery.
- B.3 Partnership for Care, Scotland's Health White Paper (2003)**  
This paper encourages greater integration between acute and primary care and with social care services and promotes the health improvement agenda.
- B.4 Equipped for Inclusion (2003)**  
This paper recognises the importance of equipment and adaptations in overcoming environmental barriers and sets out the strategic direction to improve provision in partnership with service users.
- B.5 Adapting to the Future: Management of Community Equipment and Adaptations (2004)**  
This report provided recommendations following a national review of equipment and adaptation services which included that people should receive faster and more targeted services to meet their needs.
- B.6 Community Care Services for People with Sensory Impairment – An Action Plan (2004)**  
This Plan refers to the national inspection of sensory impairment services, **Sensing Progress (1998)**, and makes recommendations relating to consultation, information, needs assessment, communication, research, service standards and training.
- B.7 Informing, Engaging and Consulting the Public in Developing Health and Community Care Policies and Services (2004)**  
A guidance on how health staff should involve their key stakeholder and partner organisations in all proposed policy or service developments, including service change.
- B.8 Moving Forward: Review of NHS Wheelchair and Seating Services in Scotland (2004)**  
This report recommended service redesign to create a national service to be delivered via an increased number of local access points and with

provision based on service user / carer needs with every individual having an agreed mobility and seating plan.

**B.9 Delivering For Health (2005)**

This response to the Kerr Report sets out an agenda for delivering more integrated services in local communities, for preventive rather than reactive services in the management of long term conditions and for patients and carers to be partners in their health care.

**B.10 Changing Lives: The Report of the 21<sup>st</sup> Century Social Work Review (2005)**

This vision for the future direction of social work services emphasises the importance of personalised services, the need to engage with service users as 'active participants', early intervention and prevention and collaborative working with other professionals. It promotes core values including respecting the right to self-determination, participation and taking a whole person approach.

**B.11 Transforming Public Services: The Next phase of Reform (2006)**

The promotion of social justice is an underpinning value of reform and there are five key elements detailed as fundamental to the approach to reform – public services need to be user-focussed and personalised to drive up quality and encourage innovation by improving efficiency and productivity, joining up services and minimising separation and strengthening accountability.

**B.12 The Future of Unpaid Care in Scotland (2006)**

This report sets out a 10-year agenda for carers encompassing 22 recommendations. It promotes the principles of greater recognition of, and respect for, unpaid carers as key partners and providers and the need to develop a rights based policy framework to support unpaid carers. Key priorities are carers' health and training and the provision of more short breaks from caring.

**B.13 A Scoping Study on the needs of, and Services to, Younger Disabled People, Including Those with Early Onset Dementia, in Scotland (2006)**

This study reviewed the research and related evidence about the needs of younger disabled people in Scotland.

**B.14 Improving Health by Providing Visible, Accessible, Consistent Care (2006 – draft)**

This review of nursing in the community in Scotland proposed a new service model for community nursing involving working directly with service users and carers, co-ordinating services, supporting self-care and anticipatory care, multi-disciplinary and multi-agency team working and meeting the health needs of communities.

- B.15 Fair for All: Disability (2006)**  
 Good practice guidance for all NHS staff on their responsibilities under part 3 of the Disability Discrimination Act. The guidance is about improving access and removing the barriers that disabled people experience when using NHS services.
- B.16 Review of Community Eyecare Services in Scotland (2006)**  
 A detailed review of community eyecare services in Scotland and recommendations for improved service delivery.
- B.17 Primary Care Modernisation Strategy 2007-2012**  
 A detailed briefing looking at the changes required of primary care in order to provide better care out in communities and including a focus on long term conditions.
- B.18 Co-ordinated, Integrated and Fit for Purpose: A Delivery Framework for Adult Rehabilitation in Scotland (2007)**  
 The key themes of this framework are that rehabilitation should be more accessible, including direct access, should be provided locally and that there should be a systematic approach to promoting independence, enablement and self-managed care. There should be sustainable professional teams and seamless transitions between phases of care.
- B.19 Self-Directed Support: New National Guidance (2007)**  
 This guidance is aimed at improving the take up of self-directed support as part of the range of solutions to promote disabled people's meaningful integration into mainstream society. It is part of the shifting the balance of care agenda aimed at sustaining and improving health and preventing longer term conditions through a focus on self-help and support that is continuous, integrated and individualised. Self-directed support also helps to equalise access to educational and employment opportunities.
- B.20 Concordat between National and Local Government (2007)**  
 Detailed both specific commitments and a National Performance Framework with National Outcomes which will influence the planning, development and delivery of public services. This in turn has led to the development of a National Outcomes for Community Care Framework.
- B.21 HEAT (Health Efficiency, Access and Treatment) Targets (2007&2008)**  
 These targets represent a core set of Ministerial objectives, targets and measures for the NHS which are set for three years and are measured through the Local Delivery Plan. This year the targets have been adjusted and improved in the light of Better Health, Better Care and the Spending Review. There are 30 targets in all:
- 7 Health Improvement targets
  - 7 Efficiency and Governance targets

- 7 Access to Services targets – these include waiting times for diagnosis, treatment and so on
- 9 Treatment targets – these include two new targets focused on the case management of people with long term conditions at risk of readmission to hospital and the early diagnosis of dementia.

#### **B.22 Seizing the Opportunity: Scottish Telecare Strategy 2008-2010**

This Strategy sets out the Scottish Government's expectations of further developments in telecare – that telecare will contribute significantly to the achievement of personalised health and social care outcomes for individuals; that telecare will contribute significantly to delivering wider national benefits in areas such as shifting the balance of care and the management of long term health conditions and that local partnerships will mainstream telecare within local service planning. Local partnerships have been set a number of challenges to expand telecare in Scotland – these include increasing the number of people in receipt of telecare services; raising awareness of telecare amongst service users, carers and the public; staff training; delivering telecare to recognised service standards and enhancing innovation.

#### **B.23 National Minimum Information Standards for Assessment and Care Planning for All Adults (2008)**

These standards are part of a drive to improve outcomes in Community Care and support professionals in social care, health and housing to carry out holistic, effective assessments, prepare appropriate care and support plans and review care plans efficiently – service user and carer participation is a key element. They support the reporting of some of the measures within the Community Care Performance Framework.

#### **B.24 Scottish Vision Strategy (2008)**

Following on from the Eyecare Review, the Scottish Vision Strategy outlines three Strategic Outcomes to be achieved in the delivery of services to people with sight loss.

#### **B.25 Living and Dying Well: A National Action Plan for Palliative and End of Life Care in Scotland (2008)**

This National Action Plan reflects the Scottish Government's aim of developing a single, comprehensive approach to the provision of palliative care that will be embedded across Scotland. The aim is to ensure that good palliative and end of life care is available for all patients and families who need it across all care settings.

## APPENDIX C

### RELEVANT LOCAL STRATEGIES AND INITIATIVES

#### **C.1 Our Lives, Our Way: Lothian Joint Physical and Complex Disability Strategy**

This Strategy was produced in partnership with the three other Lothian Councils, NHS Lothian, the voluntary and private sectors and service users and carers to address the needs of people between 16 and 65 years who have physical and complex disability.

#### **C.2 Improving Care, Investing in Change: NHS Lothian Strategic Planning Model**

This Plan focuses on four key areas:

Community based rehabilitation and health care – promotes the provision, via a single point of contact, of a range of integrated, accessible services staffed by a skilled workforce across a spectrum of community and hospital environments to support people to remain in the community within their own homes for as long as possible

Management of long-term conditions – aimed at minimising unnecessary visits to the GP and admissions to hospital through anticipating care and treatment and providing this in the least intensive setting and through supporting self-management, information provision and flexible service delivery

The role of medical day hospitals – aimed at preventing inappropriate admission to hospital and supporting recently discharged patients in order to avoid re-admission

NHS Continuing Care – this should be provided where an assessment of need has indicated that there is a need for on-going and regular specialist clinical supervision of a patient

#### **C.3 West Lothian Disability Equality Scheme 2006-2009**

Demonstrates West Lothian's commitment to fulfilling statutory duties under legislation and provides a road map for breaking down the attitudinal, environmental and professional barriers faced by disabled people and for improving outcomes for disabled people.

#### **C.4 NHS Lothian Carer Information Strategy (2007)**

This Strategy is aimed at delivering more effective partnership working between the NHS and family carers by recognising and supporting carers as key partners in the provision of care.

#### **C.5 Social Work Inspection Agency Inspection Process**

The inspection process aims to promote and encourage a focus on continuous improvement in all areas of service planning, development and delivery

#### **C.6 Customer Service Excellence Award**

This provides a tool for driving customer-focussed change within an organisation and operates on three distinct levels – as a driver of

continuous improvement; as a skills development tool and as an independent validation of achievement.

### **C.7 Supporting People Strategy**

This strategy outlines the Supporting People service objectives for disabled people and people with sensory impairment and ABI as enabling people to live as ordinary lives as possible; promoting rights and responsibilities and respecting individuality. The overall strategic aims for housing support services are to promote more flexible community-based services designed around individualised need; to invest in preventive approaches to enable independence, provide quality of life and avoid unnecessary use of costly crisis services; integrate housing support services with other local services and to provide a mixed economy of service provision to effectively manage risk, maximise service user choice and encourage innovation.

### **C.8 Social Policy Learning and Development Strategy 2008-2011**

This strategy provides an overview of the current national issues facing workforce development within the social services sector and outlines the learning and development needs and priorities within West Lothian. The strategy reflects a commitment to striving for excellence within the workforce and sets out plans for the continued development of the workforce over the next five years.

### **C.9 West Lothian Assessment Model (WLAM)**

The WLAM quality framework is an evidence-based self-assessment tool designed to drive quality and deliver excellence by helping services to gauge their performance and identify best practice and areas for improvement.

### **C.10 Single Outcome Agreement – 2008-2011 (SOA)**

The SOA sets out the key priorities for West Lothian over the next three years. The Council and its Community Planning partners have identified twelve joint challenges that have been developed into priority outcomes for people and communities. Those challenges which will impact on disabled people include community safety; unplanned admissions; health improvement and supporting people at home.

### **C.11 Locality Planning Process**

This process is linked to the SOA and aims to ensure that services are developed in response to community needs.

## APPENDIX D

### KEY VALUES

- **Equality of opportunity** – access to mainstream and specialist services and facilities when and where required and to the same opportunities open to everyone in society
- **Diversity** – services should recognise and be sensitive to the needs of everyone irrespective of disability, ethnic origin, gender, sexual orientation, religion or belief
- **Inclusion** – people should be valued and expect the same rights of social inclusion as everyone else. Inclusiveness should be key to any corporate vision and in order to achieve this, services need to examine staff attitudes, the way agencies provide services, how agencies tell individuals about their services and how services can be made more accessible. Services should promote inclusion and disabled people should be included as equal partners in planning and reviewing services
- **Dignity** – the uniqueness of each individual is recognised and respected regardless of disability or circumstances
- **Individuality** – individuality should be fully respected wherever people need assistance in managing their lives
- **Informed** – people should receive information in good time and in a format that is appropriate to their needs so that they can make informed choices and decisions
- **Risk enablement and management** – people should be assisted to make informed decisions about risk and to manage identified risks in order to live their lives in ways that best suit them
- **Empowerment** – a shift in the balance of decision-making and authority from professionals to the people who use services
- **Self-Management** – enables a person, with the assistance of an advocate if necessary, to have as much control as they want, or to have a major say, over their life and how their health and social care is assessed, provided and monitored
- **Equity** – services, facilities and opportunities should be available on an equitable basis according to need
- **Enabling and Sustaining Independence** – people should be assisted to minimise their disability, maximise their independence and to live independently in the community with a reduced need for institutional social or health care

- **Choice** – people should have choice about opportunities, alternatives and services. This enables people to have a say in decisions about their life, including their care and support, which may involve taking informed risks
- **Scrutiny** – people should be enabled to provide feedback about how they experience and perceive services. Monitoring and evaluation information should be acted upon and used to improve service development and provision and outcomes should be fed back to people
- **Justice** – disabled people are equal citizens and have the right to maximise their potential and aspirations. **Active Citizenship** means that all individuals have the same rights and responsibilities to fully contribute and participate in community life
- **Quality** – services should be of good quality and have the confidence and support of the people who use them
- **Effective services** – service delivery should be based on best practice, be effective from the service user's perspective and represent the best use of available resources
- **Priorities** – priorities should be based on needs and informed by service user and carer preference
- **Accountability and Transparency** – service delivery should be accountable and operate within transparent policies, procedures and resource allocation systems