DORSET County Council

NHS

NHS Dorset
NHS Bournemouth and Poole

Health Community Strategy

The Community Strategy for Health and Social Care Services

1 May 2012

COMMUNITY STRATEGY FOR HEALTH AND SOCIAL CARE SERVICES

Table of Contents

1. Executive Summary

1.1. This is the Community Strategy for Health and Social Care Services that has been developed jointly by NHS Dorset and Dorset County Council with the involvement of a multi agency group including *voluntary agencies*, *carer*s and community representatives. It sets out a proposed vision for services that meet our local strategic goals:

- Helping you to live a longer and healthier life;
- Delivering care where and when you need it;
- Care delivered in a way that you would expect;
- Achieving the best value for money for you and your community.

1.2. Our vision for community services is summarised as:

"The provision of high quality, responsive, person centred support to maximise individual's independence and well-being."

1.3. Our proposal is to deliver this through locality based services in each of the six operational localities within Dorset, with access to a range of resources that meet the needs of each locality. This will bring together (integrate) health and social care to provide two distinct services:

- Planned care services;
- Intensive support services.

1.4. We have suggested the outcomes that we believe are important for people and the priority areas for development. We have carried out a wide engagement and listening exercise, to seek the views of patients and *carers*, formal partners, *voluntary* and *independent sector* organisations and community groups.

1.5. We have included a glossary of terms to explain some of the statements and words in the document; these appear in *italics* the first time they are used.

2. Background and context

2.1. This strategy is about the health and social care services which support the needs of the people of Dorset. It is primarily about the services people need to access when they become unwell, vulnerable or need support from health and social care. This strategy is not just about older people; however the number of older people does make a difference to the amount of services which need to be provided. This strategy talks about the number of older people in Dorset as a proxy for the level of services needed. Dorset already has a higher proportion of older people than the rest of England and this is set to increase.

2.2. The Marmot Review; Fair Society, Healthy Lives UCL Institute of Health Equity (February 2010) and other recent reviews states that the country can no longer afford to care for people in *acute general hospitals* in the same way and doing nothing will lead to the hospitals becoming overwhelmed. More importantly, it is usually better to provide care and support either in a person's own home or in a setting which is more residential than institutional. We want to help people to understand their illness enough to be able to manage both the physical and emotional impact of a long term condition or other illness.

2.3. We have listened and built on previous work to gain the views of people through a formal engagement process. This final strategy reflects the views we have heard. We have looked at how much we spend now and how much will be available in the future. This will help us to plan how we make any changes outlined in this strategy. We will also set out an implementation plan which will be very clear about who is leading and what the timescales are.

National context

2.4. There are links below to the key policy documents that have given direction to health and social care policy. The coalition government published the White Paper, Equity and Excellence; Liberating the NHS Department of Health (July 2010) and subsequently Liberating the NHS: Legislative Framework and next steps Department of Health (February 2011), The Health and Social Care Bill received Royal Assent on the 27th March 2012 to become the Health and Social Care Act (2012). This maintains the direction of travel of care closer to home, personalisation and people taking responsibility for both their own health and their own ill health.

2.5. Transforming Adult Social Care Department of Health (January 2008) and the Putting People First Concordat Department of Health (November 2009) announced a strategic shift towards personalisation, early intervention and prevention in adult social care. This means every person, whatever their need, should have choice and control over the shape of his or her support, to be delivered in the most appropriate setting. Central to this policy is the development of *self directed support* for social care clients. Providers of community health services need to adapt practices in order to respond positively to social care clients who choose to spend some of their budget on health care services. *Personal health budgets* will now roll out to those funded under *continuing healthcare* provision.

2.6. The key elements of national strategy remain to help people live at home for longer through solutions such as:

- Home adaptations;
- Community support programmes;
- Intermediate care;
- Support for long term conditions;
- Re-ablement;
- Providing much more control to individuals by extending the roll-out of *personal budgets* and *self directed support*, including *direct payments* to *carer*s;
- Greater involvement of independent and *voluntary* providers in providing services;
- Strengthening the *commissioning* role of GPs.

2.7. There are a number of other national policies that influence this strategy; these are listed in Appendix B.

Regional context

2.8. This strategy takes into account the ambitions set out in the Strategic Framework for Improving Health in the South West, 2008/09 to 2010/11 which supports delivery of national policy.

Local context

2.9. The Ageing Well (Dorset County Council) action plan in Dorset reflects what older people in Dorset say they would like to see to support them to enjoy a positive experience of old age. This is a plan for improving the health and well-being of older people.

2.10. The Strategic Plan for a Healthier Dorset 2010/2014 (NHS Dorset) sets out a clear vision for 'A healthier Dorset', with four strategic goals:

- Helping you to live a longer and healthier life;
- Delivering care where and when you need it;
- Care delivered in a way that you would expect;
- Achieving the best value for money for you and your community.

2.11. Health and social care community services are a range of services for adults that support people if they experience a detrimental change in their current level of well-being and require a short or longer term period of support to enable them to maximise their independence and well-being and to manage any long term changes as they happen and the transition of children to adult services.

2.12. To provide improvements, we will need increased support for health and social care community services. This will ensure that community services in Dorset provide support and care to people as close to home as possible, meeting the needs of the population. This increase will come mainly from re-shaping existing resources from building based provision to community based integrated health and social care services.

2.13. We need to plan for community services to meet the health and social care needs of the population of Dorset now and in the future, so understanding the characteristics of the population is a key factor in developing the right services. Dorset has a particularly high proportion of older people compared with the rest of England; this is projected to increase and the advancing age of our population is also expected to increase. These population changes are likely to require an increased need for both formal and informal care. The age groups of 20-39 are significantly under-represented across the county due to a period of low birth rates and the outward migration of this group. Dorset is therefore gaining an ageing population but losing its work force and those with the ability to deliver informal care. This means the requirement to deliver the required level of care, arising from the expected increase in the ageing population, will be challenging. Appendix C provides further detail.

2.14. Our strategy will move towards locality based services that meet the needs of the local population. As part of this work, locality commissioners and providers will need to gain a clear understanding of the characteristics of the population in their locality.

2.15. The *Localities* referred to in this document are operational localities that are aligned with health and social care. However as *Clinical Commissioning Groups* develop within Dorset it has been agreed there will be seven commissioning localities, the only difference being that West Dorset locality has divided in to two smaller localities. Together these localities remain co-terminus with the operational localities

3. What people say they want

3.1. We have heard the views of people in recent conversations and have summarised these in this section. As set out in the Engagement plan (Section 9) we have considered the responses we received to this strategy and produced the final version in May 2012.

3.2. The engagement process for this strategy took on the views and opinions from a wide variety of users including the 'hard to reach' groups (please see engagement plan and Equality Impact assessment). All views and opinions have been carefully considered and where appropriate included within this final document.

Ageing Well in Dorset

3.3. The Ageing Well action plan for improving the health and well-being of people in Dorset was based on what older people told us. Through extensive consultation, eight outcomes were agreed which older people in Dorset said were really important to them. It is worth noting the Ageing Well plan is about the whole community and not just health and social care services. We will be asking you for more specific responses to help us with this strategy.

Total Place

3.4. The views of older people were also taken into account in the consultation for *Total Place* for the Bournemouth, Poole and Dorset health and social care communities.

Messages from consultations

3.5. People stressed the importance of being socially integrated and how this supported ageing well. People who were involved in community activities said how much this helped their self esteem and confidence. Conversely, isolation was seen as a major barrier to ageing well. Isolation can be triggered by loss of health, being a *carer*, feeling unsafe, a loss of choice or control, bereavement, poor housing, transport problems, poverty, social barriers or being part of a minority group. Some older people suggested that being old was itself marginalising and described feeling invisible.

3.6. People had many ideas about improving their situations and how communities and services could assist. There was an increasingly articulate challenge from older people to services that did not measure up to expectations. The consultation provided an opportunity for older people to lead change in Dorset.

3.7. People supported the bringing together of services and the delivery of care closer to home with increased access to services and extended hours. The overall engagement process indicated public support for the drive to deliver services that can respond rapidly when required, along with the investment in services that can be pro-active and support people in maintaining their independence.

Desired outcomes

3.8. The proposed desired outcomes of this strategy have been developed following consultation and are summarised below:

- I want to be able to live the way I want to live. I want to wake up in the morning feeling positive. I want services to recognise the contribution I make to my family and friends and community;
- I want to live in decent, safe healthy housing which helps reduce risk of cardiovascular and respiratory disease, social isolation and falls;
- As I get older, I want services to recognise my fears of the unknown and give me good information and allow me to discuss those fears;
- I want services to work with me and do what's important for me;
- I want to be treated with dignity and respect. Do not make assumptions about what I can do simply because I have lived longer;
- I want information about choices and options to be easily available;
- I want all forms of communication to be clear and easily understood by all;
- I want to be supported to see if things can be done differently if I choose;
- I want people to be honest with me, when giving advice and support and I only want to tell my story once;
- I want to be confident that when I need health or social care I can get it effectively and efficiently, including specialist advice and support if required;
- I want to be supported to live independently;
- I want the staff who care for me to be well-trained and competent;
- I want to know that the money spent on my care is being spent wisely;
- I don't want to stay in hospital longer than I need to;
- I want my death to be a good death;
- As a *carer*, I want to know that the services recognise my contribution and will support me.

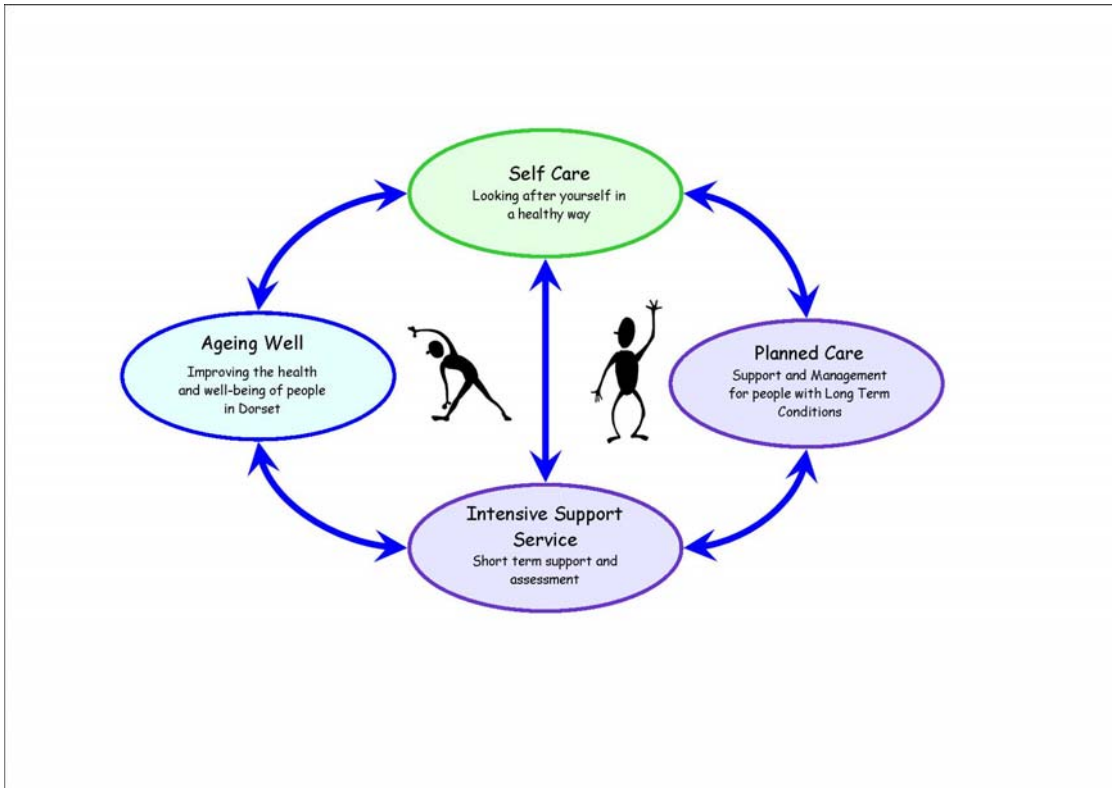
4. The vision for community services

4.1. Our vision for community services is summarised in the following statement:

"The provision of high quality, responsive, person centred support to maximise individual's independence and well-being."

4.2. This will provide support to meet your care needs at home following a period of illness, as a result of frailty, or after discharge from hospital. This support will help you to 'do things for yourself' which will include an in depth assessment of your ongoing care and support needs to enable you to be confident to remain at home. Diagram 1 represents the pathways which will help us to deliver our vision to improve the health and well-being of people in Dorset.

Diagram 1 – Pathways to deliver our vision



4.3. The services jointly commissioned in Dorset will:

- Build on the practice of care closer to home. Care will be delivered by competent health and social care services working together to offer maximum choice and control whilst effectively managing risk, optimising the person's outcomes and well-being;

- Develop services which recognise the whole person and treat mental well-being as well as physical well-being;

- Ensure that services offer prompt, effective and appropriate care, both planned and unplanned, that promote self care and personal responsibility and do not create dependency;

- Deliver integrated health and social care locality based community services that improve the length and quality of life by achieving a shift from a system based on treating illness to one focused on keeping people well and independent;

- Ensure that services support people to remain at home for as long as possible, and deliver safe and effective services. This will require a significant shift in care from hospital care to care closer to home; returning home is always the first choice;

- Develop services that enable patients, *carer*s and service users to make informed choices about care decisions which are personal to them and appropriately balance benefit and risk and can be provided by statutory organisations, the *voluntary* and independent sectors, to ensure wide choice;

- Ensure services are based on person centred assessment of need, undertaken in a timely manner in the most appropriate setting, that also inform *Continuing Healthcare*, *Funded Nursing Care* and *Social Care assessments*. If required.

5. The principles of health and social care community services

5.1. The main principle for this strategy is to increase the effectiveness of community services by moving from buildings based services to integrated locality teams delivering, wherever possible, services in people's homes.

5.2. There are further shared principles which underpin the desired outcomes and care pathway that this strategy aims to achieve. The care pathway:

- Offers choice and control;
- Is *person centred*;
- Ensures equitable access;
- Ensures patients and carers will be treated with dignity and respect;
- Promotes well-being, self care and access to information which is clear and easily understood;
- Delivers services that support individuals to do things rather than does things to individuals;
- Delivers high quality services in the most appropriate setting;
- Is a partnership between physical and mental health, social care, *primary care*, independent sector and *third sector* organisations which promotes good, effective communication.

6. The current services, resources available and who pays for what

6.1. The resources in place for health and social care community services in Dorset include not only those paid for or subsidised by the NHS or Local Authority, but also all the preventative activities, such as leisure or learning activities, that enrich people's lives.

6.2. The majority of services provided by a Local Authority are means tested according to their respective charging policies, there are however some support and prevention services provided by the Local Authority that are exempt from the charging policy. This is in contrast to NHS services which are, with a few exceptions, universal; available to all and free at the point of use. A summary of the current service provision is set out in Appendix D.

6.3. Health and social care community services are commissioned by NHS Dorset in partnership with Dorset County Council. However there is a wide range of complexities for both organisations which include the different statutory responsibilities and legal accountability that need to be considered within this partnership for *commissioning* and delivery of services.

6.4. Through this partnership NHS Dorset currently invests over £55m a year on the community based health services that are most relevant to this strategy. Please note that because of the way that we currently contract for services, we are only able to provide estimated costs for these services, as set out in Table 1.

Table 1 – Estimated spend on community services 2011/12

Community services 2011/12	**£'000s**
Intermediate care	2,891
Intermediate care orthopaedics	1,019
Community nursing	10,577
School nursing	879
Community hospitals	35,219
Elderly mental health services	2,927
Wheelchair services	2,114
Total	**55,626**

6.5 Dorset County Council expenditure for adult social care is set out in Table 2. Please note that this includes direct expenditure on care provided for all adults. Some individuals contribute to the services they receive and this expenditure is excluded.

Table 2 – Adult social care net expenditure 2010/11

Social care services 2011/12	**£'000s**
Residential care	45,778
Supported living	4,132
Direct payments	7,488
Day care	6,984
Homecare/re-ablement	11,946
Equipment and adaptations	1,191
*Commissioned support services	1,948
Total	**79,467**

* Pooled budget total

Last year the government announced two streams of funding that *Primary Care Trust*s and Local Authorities could invest in social care services to improve long term health gains, and in community re-ablement and rehabilitation services. Table 3 sets out Dorset's allocations.

Table 3 – Additional funding 2011/12 and 2012/13

Social care services 2011/12	**£'000s**	
	2011/12	**2012/13**
Re-ablement funding (community re-ablement and rehabilitation)	1,100	2,200
PCT social care funding (social care services that improve long term health gains)	5,200	4,900
Total	**6,300**	**7,100**

7. The model for community services

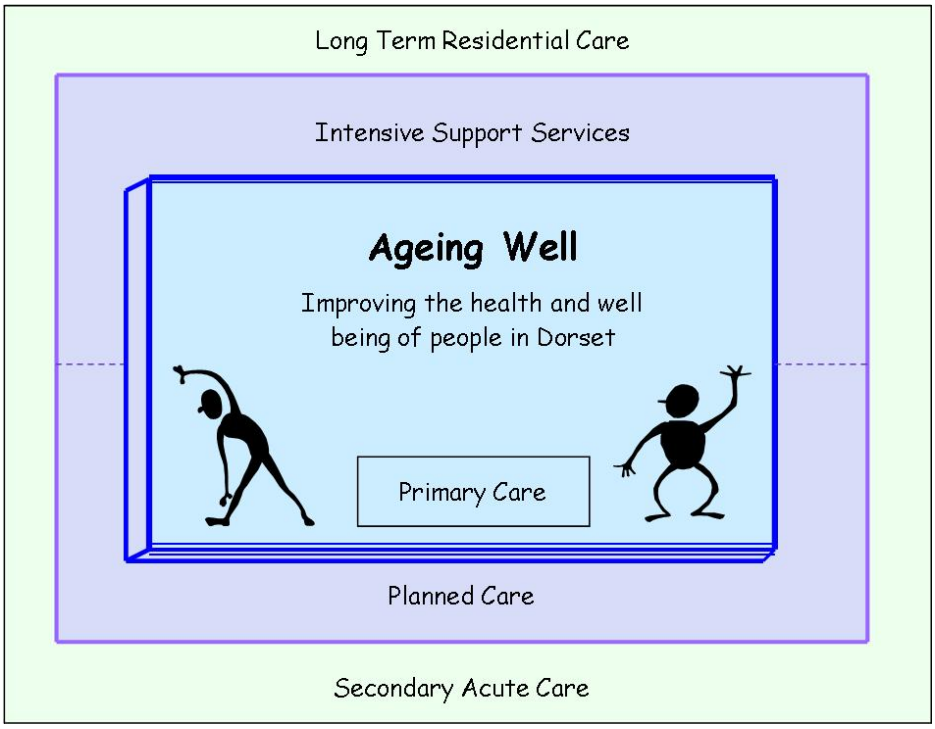
7.1. The following model has been agreed through the joint *commissioning* structure for NHS Dorset and Dorset County Council

7.2. It is an evolution from existing models rather than a completely new model; we would move to a *locality* based service taking into account the population needs and *rurality* in each of the six localities within Dorset, with access to a range of resources that meet the needs of each locality. We would see this provided by integrated services within each locality. This will bring together health and social care to provide two distinct services that work closely together.

- Planned care services;
- Intensive support services.

7.3. Diagram 2 shows where these services sit within the whole of health and social care services.

Diagram 2 – The model for community health services



7.4. The provision of these integrated services, delivered in partnership between NHS Dorset and Dorset County Council, will contribute towards avoiding unnecessary hospital admissions, deliver effective rehabilitation services to enable early supported discharges from hospital and reduce the need for premature or unnecessary admission to long term residential care. An umbrella term for this is

'care closer to home'. These services will use telecare and telehealth as these services develop.

7.5. Through the '*Connecting Health and Social Care'* programme, the management structure for service provision is moving from a centralised structure to a locality based approach. We would like to see this extended and strengthened by integrating more closely with *primary care*, with GPs as an integral part of the locality management team. This will ensure the uniqueness of each locality is appreciated, understood and communicated effectively. Alongside this, NHS Dorset and Dorset County Council will be considering how to strengthen the joint *commissioning* arrangements to ensure that *commissioning* is sensitive to local need. This will include some detailed work to look at the current service provision and capacity and how it meets the needs of the local population in delivering care closer to home.

7.6. Whilst there is no one agreed definition or model of integrated care, the Royal College of General Practitioners (RCGP) preferred model for integrated care is '*primary care* led, *multi-professional teams*, where each profession retains their professional autonomy but works across professional boundaries, ideally with pooled budgets and ideally with a shared electronic record' (RCGP 2011). This is the model we aspire to achieve in each locality.

Planned care services

7.7. Planned care services will be delivered by 'integrated teams' including nurses, mental health nurses, therapists, social workers and generic support workers working with *primary care*, *domiciliary care services*, and the *voluntary* and independent care sector in each locality.

7.8. The planned care service will provide support and management for people with *long term conditions*, for example, chronic obstructive pulmonary disease (COPD), Parkinson's disease, chronic heart disease, diabetes, dementia. People with *long term conditions* experience periods of being well and in control of their condition but can also experience periods when their health or social care needs become problematic to them. The service will support people to live a healthy life, optimising their well-being and supporting them to make choices and be in control of their own health and social care needs.

7.9. Planned care services will work together with *primary care* to identify people that are at risk of hospital admission or deterioration in their health and/or social care needs, using approved risk assessment tools and their combined professional knowledge to plan and prevent wherever possible.

Intensive support services

7.10. Intensive support services will be delivered by 'integrated teams' of nurses, including mental health nurses, therapists, social workers, generic support workers and re-ablement workers (social care support workers) working with *primary care* and *voluntary* and independent care providers in each locality. Intensive support services provide a rapid response to unplanned episodes of illness and will include

assessments by the most appropriate health or social care professional within a two hour response time.

7.11. The service will manage acute events for people who would previously have been admitted to hospital. This may include the delivery of advanced nursing practice; social care or therapist interventions such as rehabilitation and/or re-ablement.

7.12. Some individuals may need this support when discharged from an acute hospital, or may be directly admitted from home for a short stay (up to a maximum of 6 weeks) in a residential based service for rehabilitation and/or intensive support and this will be managed by the Intensive support services in partnership with the individual and their family/*carer*s.

7.13. Services would be available for treatments such as intravenous therapies (antibiotics, blood transfusions) to support the individual to remain at home or as near to home as is possible.

Supporting services

7.14. Planned care and intensive support services will link closely and individuals who are supported by the planned care services may also require intensive support services. If referral between the two elements of the service is required, this will take place with no break in the delivery of service. The services will include the provision of specialist professionals, for example, Parkinson's disease nurses, continence services, heart failure nurses, community matrons, who will be based within a locality as part of a locality team, who may provide expert advice to individuals across one or more localities and/or advice and support to the treatment and delivery of specialist care.

7.15. Palliative care and end of life care may be provided by either the planned care service or the intermediate care service when general palliative nursing care is required for individuals approaching the end of their lives; ensuring individual choice is promoted and facilitated.

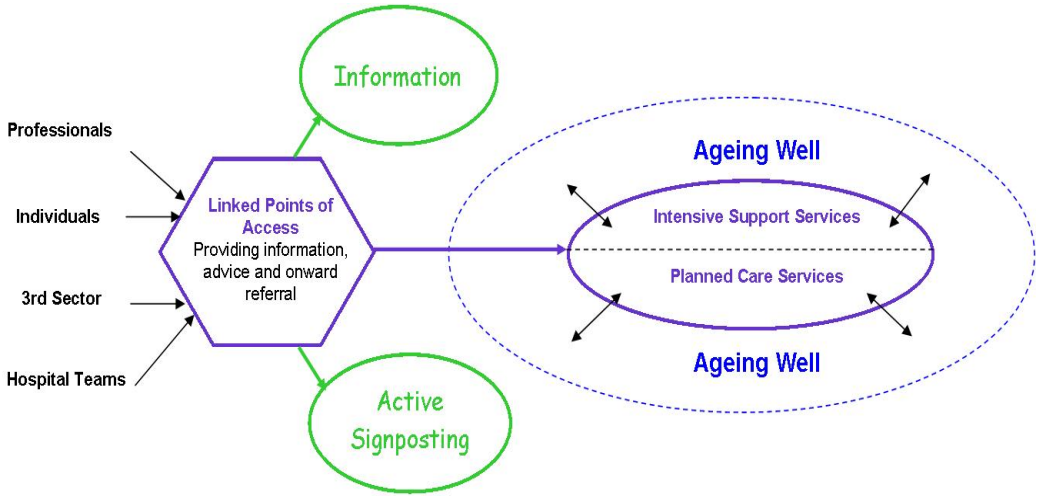
Access to services

7.16. Individuals, and other services wishing to refer an individual, will be able to access services through their usual referral route, or through a single point of access, which would require only one call to a centralised number.

7.17. In order to provide the service as described, core hours of service will be extended to deliver care from 08.00 to 20.00, with rapid response until 22.00, and an out of hours service will be available to meet the urgent, unplanned and end of life/palliative care needs of individuals from 22.00 to 08.00. This service will be available 365 days of the year.

7.18. Diagram 3 demonstrates the access route into the services.

Diagram 3 - Access into the services



Top priorities for transforming services

7.19. This section outlines the top priorities which will help us move forward:

- Ensure resources are deployed so the services are as efficient as possible;
- Increase in the number of people supported to remain at home;
- Increased expertise within competent locality teams;
- Health promotion and preventative care;
- Increased planned care and Intensive support;
- Integration of services;
- Increased personalisation;
- Increase the number of people receiving personal budgets and *direct payments*;
- Increased choice and control;
- Improved working with mental health services;
- Increased effectiveness in engaging with the *voluntary* and independent sectors.

7.20. As we move towards this model to achieve these priorities, we will create equitable service provision across Dorset.

8. Engagement plan

8.1. This strategy has been developed in partnership with key stakeholders, overseen by the Joint *Long Term Conditions* and Older Peoples Reference Group. The strategy is not considered to constitute a significant change in services but rather it enhances and streamlines service delivery.

8.2. The draft strategy was completed by 31 December 2011, followed by a comprehensive engagement process from January to March 2012, including identifying key priorities that could be incorporated into a *commissioning* implementation plan.

8.3. We were very keen to ensure that a wide range of individuals and organisations had the opportunity to engage with this process, including:

- Leagues of Friends;
- *Primary care*;
- People working in health and social care wherever the strategy will impact;
- Patient and public, including *carer*s;
- Local MPs and local councillors;
- Dorset Health Scrutiny Committee;
- Voluntary agencies, charities and forums.

8.4. Appendix E outlines the specific mechanisms for engaging with individuals and organisations to ensure their views, experiences and ideas are harnessed.

8.5. An Equality Impact Assessment has been undertaken as part of the strategy to identify what effect or likely effect will follow as a result of the implementation of the strategy for different groups within the community. It will also be used as a mechanism for analysing the impact of the service (Appendix F).

9. Commissioning plan

9.1. Table 4 shows the high level *commissioning* tasks that will be required in order to deliver this strategic plan. It should again be noted that this plan will need to be regularly reviewed.

Table 4 – High level commissioning tasks

Task	2011/12	2012/13	2013/14
Increased planned care			
Increased intensive support			
Increased Personal Budgets and Direct Payments			
Increased expertise within locality teams			
Increase in the number of people supported to remain at home			
Improved working with mental health services			
Increased effectiveness in engaging with the voluntary and independent sectors			
Health promotion and preventative care			

Key = Work underway

9.2. We anticipate that as a result of implementing this strategy, we will achieve:

- Increased personalisation;
- Increased choice and control for individuals;
- A shift of resources to deliver services as efficiently as possible.

9.3 Delivering and monitoring of this strategy will be undertaken by three routes:

- Contract and performance monitoring;

- Re-ablement projects;
- Re-ablement Board.

A report on progress of the implementation of this strategy will be made available to all stakeholders annually.

Appendix A

COMMUNITY STRATEGY FOR HEALTH AND SOCIAL CARE SERVICES

Glossary of terms

- **Acute General Hospital:** refers to the same service that is usually delivered in a 'district general hospital' and is the specialised health care during which a patient is treated for severe illness or injury, trauma or during recovery from surgery in a hospital setting.

- **Assistive Technology: telecare, telehealth and telemedicine:** Assistive technology or adaptive technology (AT) is an umbrella term that includes assistive, adaptive, and rehabilitative devices for people with disabilities and also includes the process used in selecting, locating, and using them. AT promotes greater independence by enabling people to perform tasks that they were formerly unable to accomplish, or had great difficulty accomplishing, by providing enhancements to, or changing methods of interacting with, the technology needed to accomplish such tasks

- **Carer:** an individual who provides practical and long term emotional support to someone with a long term condition. They may or may not live with the person cared for. Carers may be relatives, partners, friends or neighbours.

- **Commissioning:** this means to secure the best care and best value for local people. It is the process of translating aspirations and needs, through the specifying and procuring of services for the local population which;
  - Deliver the best possible health and wellbeing outcomes, including promoting equality
  - Provide the best possible health and social care provision
  - Achieve this within the best use of available resources

- **Connecting Health and Social care:** The Connecting Health and Social Care (CH&SC) program is at the centre of delivering an integrated care service model for Adult Health and Social Care in Dorset and has made substantial progress in establishing teams of health and social care professionals with independent and voluntary sector input.

- **Contract and performance monitoring:** Contract monitoring can be summarized as the process of systematically and efficiently managing contract creation, execution, and analysis for the purpose of maximizing financial and operational performance and minimizing.

- **Continuing Healthcare (NHS funded):** NHS Funded *continuing healthcare* is a package of continuing care provided outside hospital, arranged and funded solely by the NHS, for people with complex ongoing healthcare needs.

- **Direct Payments:** Direct payments involve giving an agreed amount of money to someone who is eligible for publically funded social care, so that the individual can use it to arrange support that meets their needs in ways that best fit their circumstances.

- **Domiciliary care services:** services provided in peoples own homes usually by voluntary or commercial organisations.

- **Fair Access to Care Criteria:** is a system for deciding how much support people with social care needs can expect following their assessment. It aims to make fair and consistent decisions about the level of support needed and whether your local council should pay for this.

- **Equality Impact Assessment:** It is a process of systematically analysing an existing policy or strategy to identify what effect or likely effect will follow as a result of the implementation of a policy or strategy for different groups within the community. It can also be used as a mechanism for analysing the impact of a whole service or one aspect of the service.

- **Funded Nursing Care:** NHS-funded Nursing Care. The funding provided by the NHS to individuals in care homes with nursing to pay for the provision of nursing care to residents who have been assessed as eligible.

- **Independent Services/Independent Care Sector:** voluntary, charitable, not for profit and commercial organisations.

- **Locality:** For the purpose of this strategy a locality describes a place or neighbourhood where services are delivered. The defined localities for Community health services align with the Dorset County Council District boundaries.

- **Long term Conditions:** The Department of Health defined long term conditions as those conditions that cannot, at present, be cured, but can be controlled by medication and other therapies. Long term conditions include a wide range of health conditions, ranging from a single condition to multiple and complex conditions which can be physical, mental, behavioural or emotional.

- **Multiprofessional/Multidisciplinary Team:** A team made up of professionals across health, social care and the *third sector* who work together to address the holistic needs of patients/service users so as to improve delivery of care.

- **Person Centred:** non-directive approach to assist someone to make the right choices for him or herself.

- **Personalised:** describes care and services that are individualised and tailored to the person receiving them.

- **Personal Health Budgets:** Patients (families and *carer*s) with healthcare needs are helped by healthcare professionals to define what is important to them, develop a care plan and health resources are identified and allocated to them. They are supported in the purchase of services to meet their agreed needs.

- **Primary Care:** refers to services provided by GP practices, dental practices, community pharmacies and high street opticians.

- **Primary Care Trust (PCTs):** are local NHS organisations that work with local authorities and other agencies to provide health and social care locally.

- **Reablement:** Reablement is a service that provides practical and emotional assistance to people who are at risk of not being able to remain independently in their own homes because of frailty, disability or illness. The aim of reablement is to maximise independence, choice and quality of life, and reduce the need for support for the future. The service works with people, to enable them to do things for themselves, rather than having things done for them.

Reablement Board: A multiagency group with representation from all stakeholders including public/patient representatives that is led by Health and Social Care partners to: consider, approve and monitor delivery of projects as part of the section 256 agreement and reablement resources and to oversee the development of integrating health and social care.

- **Reablement Projects:** The reablement projects are projects that are funded through the section 256 agreement or the reablement funding and form a programme of projects that are approved and monitored by the reablement board.

- **Rurality:** There are multiple definitions of 'rurality' used in the public domain, encompassing a wide range of interpretations and descriptions. For the purposes of this report it is used to refer to non- urban areas.

- **Section 256 agreements:** Section 256 of the National Health Act allows Primary Care Trusts to enter into arrangements with local authorities to carry out activities with health benefits. Such arrangements are known as section 256 agreements.

- **Self Directed Support:** Self Directed Support puts people in control of their care arrangements and provides them with a Personal Budget to pay for the services.
- **Self Care/Self Management:** The individual is supported to take responsibility for their own health and well-being. This includes staying fit and healthy, both physically and mentally, taking action to prevent illness and accidents, the better use of medicines, treatment of minor ailments and better care of long term condition.

- **Social Care Assessments:** Social services carry out an assessment of an individual's needs of any community care services based on the *Fair Access to Care* criteria. An individual may need community care services because of a disability, health condition, or if they are frail or vulnerable.

- **Third Sector:** Non profit, health or social care service.

- **Total Place:** Total Place is a communities and local government pilot programme to test new approaches to best use of resources. The programme would explain ways of working together across a whole range of services both the voluntary and public sector.

- **Voluntary Service:** A service that is provided willingly and without pay.

Appendix B

COMMUNITY STRATEGY FOR HEALTH AND SOCIAL CARE SERVICES

Linked policies

High Quality Care for All, (June 2008), the final report of the NHS Next Stage Review, set out the strategic direction for driving improvements in the quality of care across the health service.

Our vision for primary and community care (July 2008), draws together the main conclusions of the Next Stage Review for community-based NHS services, including GP services, and sets out a strategy based around four key areas:

- Shaping services around people's needs and views;
- Promoting healthy lives and tackling health inequalities;
- Continuously improving quality;
- Ensuring that change is led locally.

Our Health Our Care Our Say: A New Direction for Community Services (January 2006), set out a vision to provide people with good quality social care and NHS services in communities where they live. The main goals are:

- Provision of care closer to home;
- Better prevention services with earlier intervention;
- Greater focus on tackling inequalities;
- More support for people with long term needs.

There are a number of other national policies that influence the community strategy for health and social care services, including:

- NHS Operating Framework 2012/2013;
- NHS Outcomes Framework (December 2011);
- National Stroke Strategy (December 2007);
- National Service Framework for long term conditions (March 2005);
- A Recipe for Care: not a single ingredient (January 2007);
- Supporting People with Long Term Conditions (February 2007);

- End of Life Strategy: Promoting high quality care for all adults at the end of life (July 2008);
- Improving Outcomes: A Strategy for Cancer (January 2011);
- No health without mental health a cross-government mental health outcomes strategy for people of all ages (February 2011);
- Living well with dementia: A national dementia strategy (September 2011);
- Carers at the heart of the 21st century families and communities: a caring system on your side, a life of your own (June 2008);
- Recognised, valued and supported: next steps for the *carer*s strategy (November 2010);
- Valuing People Now: a new three-year strategy for people with learning Disability (January 2009).

Appendix C

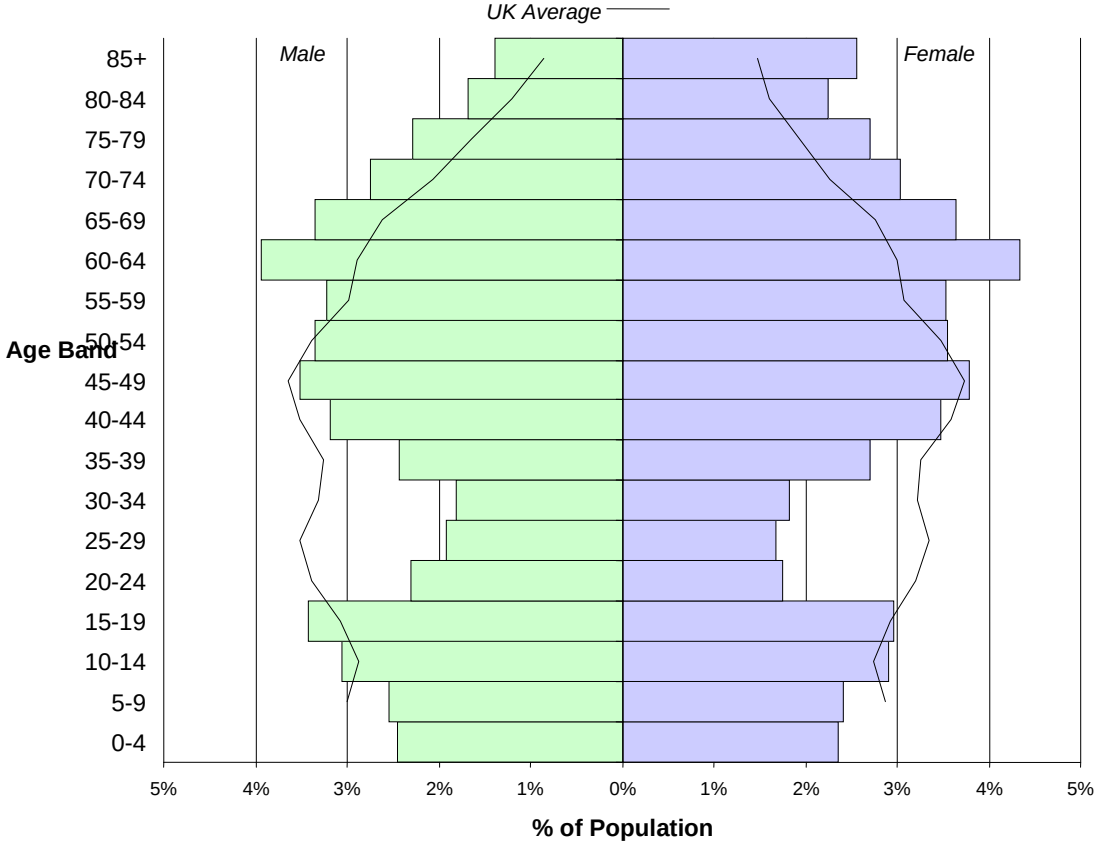
COMMUNITY STRATEGY FOR HEALTH AND SOCIAL CARE SERVICES

Population characteristics of Dorset

1. Dorset is a largely rural community supported by mainly flourishing market towns; the population is relatively affluent with some pockets of deprivation and experiences some of the best health in England[1].In Dorset, there are over 66,000 children of school age (5 to 18 years). This represents 16.4% of the total population, similar to the national average (England & Wales). The proportion of the population that is of primary school age (5-10 year olds) has fallen slightly over the last ten years whilst 11-18 year olds have increased slightly.

2. There is an over representation of all 50+ age groups in Dorset, whilst the age groups 20-39 years are significantly under-represented. Dorset has, for several decades, had a relatively high proportion of older people. However, the low proportion of younger adults is a more recent change. This is partly due to the lack of a higher education establishment in the County and partly due a decline in birth rates, seen across the country. Dorset has a particularly high proportion of older people. Over 29% are over the retirement age (65+ males/60+ females) compared with just 19.5% across England & Wales. Diagram 1 below compares the percentage of populations in Dorset compared with the UK average by age band.

Diagram 1 - Population Pyramid: Dorset and UK Average



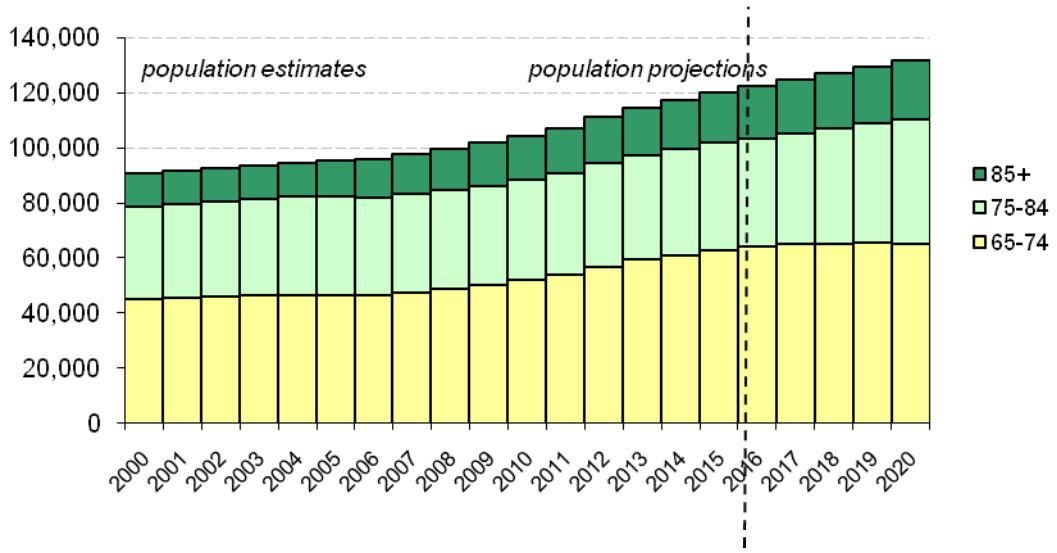
Source: ONS mid year estimates 2010.

[1] Dorset Research Bulletin: Rural Services 2010; Dorset Community Strategy 2010; Dorset Research Bulletin: Index of Deprivation 2010; Health Profile of Dorset 2011, APHO.

3. The number of older people living in Dorset is expected to increase, but particularly critical will be the growing number of people living to an advanced old age, largely due to continuing gains in life expectancy.

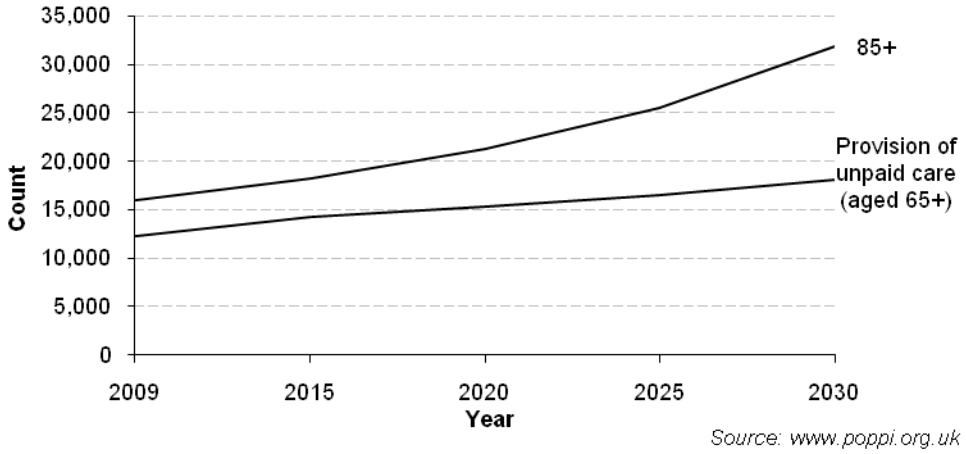
4. Diagram 2 below, which is based upon projections provided by the Office for National Statistics, shows that all three of the age bands of older people are expected to increase over the next 25 years. In 2033, it is projected that numbers of all adults aged over 85 years will have more than doubled since 2008. This will have a major impact on the future provision of care services in the County due to the increased vulnerability associated with this older age group (Office for National Statistics 2010e).

Diagram 2 - Estimated and Projected Numbers of Older People in Dorset, 2000 to 2020



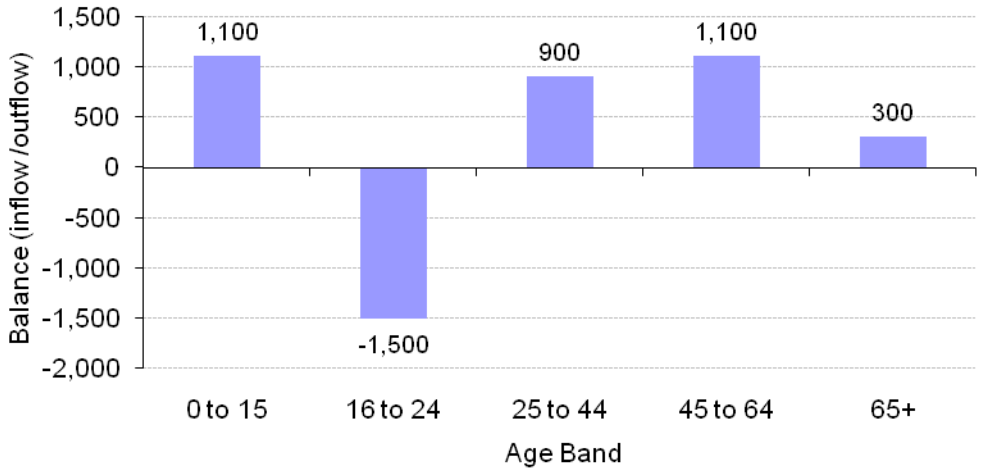
5. As the population ages, the growth in people who provide informal care is unlikely to keep pace. Diagram 3 below compares the growth in older people over the medium to long term with the growth in those providing unpaid care aged over 65. This gap will mean that there is an increased pressure in the need for formal care (funded largely by health and social care) to fill the gaps that had previously been filled by informal *carer*s.

Diagram 3 - Dorset's Ageing Population



6. We need to consider how more formal care can be given to this increasing ageing population and who will deliver this. In Dorset the estimates of internal migration, e.g. change of residence within national boundaries, show a net gain of around 1,800 people moving into the area. Within this figure Dorset has a net loss of younger people aged 16-24,the largest gains are in the 45-64 population, as highlighted in Diagram 4. This means that Dorset is gaining an ageing population but losing its workforce, making the requirement to deliver more formal care more challenging.

Diagram 4 - Internal Migration in Dorset



Source: Internal migration, mid 2008 to mid 2009, ONS

Appendix D

COMMUNITY STRATEGY FOR HEALTH AND SOCIAL CARE SERVICES

Current service provision

This appendix outlines some of the broad areas of community services to provide an understanding of the types of provision that are currently available.

1. Community nursing

1.1. The community nursing service in Dorset currently operates 365 days a year, from 08.30 to 17.00. The services are provided to patients, in their homes, who have a physical care need. There are some services available out of hours but these vary between locations. Services are provided by teams including :

- District nursing sisters;
- Community staff nurses;
- Health care assistants.

1.2. Community matrons link to the teams with a focus on supporting individual patients with *long term conditions* to promote *self care* and to reduce emergency admissions.

2. Community hospitals

2.1. There are eleven community hospitals in Dorset:

- St Leonards;
- Swanage;
- Wareham;
- Victoria Hospital, Wimborne;
- Westminster Memorial Hospital Shaftesbury;
- Yeatman Hospital, Sherborne;
- Blandford Community Hospital;
- Weymouth Community Hospital;
- Portland Hospital;
- Westhaven Hospital;
- Bridport Community Hospital.

3. Other services

3.1. A number of other linked services operate across Dorset and include:

- Palliative care – acute, community and voluntary;
- Continence service;
- Stoma care advisory service;
- Diabetes nurses – acute, community and *primary care*;

- Parkinson's Disease nurse;
- Respiratory – acute, community and *primary care*;
- Anti-coagulation service;
- Dorset Orthopaedics Treatment Services;
- Tissue viability services;
- Resuscitation services;
- Stroke service;
- Heart failure nurses;
- Minor injuries units.

4. Intermediate care services

4.1. Intermediate care services in Dorset are provided by ten Integrated Therapy teams based at various locations across the county. These teams comprise of a mixture of therapy, nursing and generic support staff who provide support to maintain people at home in the community following a period of illness, frailty and hospital discharge

4.2. All teams offer a 'rapid response' service which aims to respond to referrals within two hours to prevent unavoidable admissions into acute or community hospitals. There are some differences in the current core working hours across the teams.

5. Re-ablement

5.1. Dorset County Council provides a re-ablement service that provides social care to those who require short term help to regain some everyday living skills and is delivered in the person's own home environment.

6. Adult Social Care

6.1. Adult social care provides social care for individuals over the age of 18 including older people, people with a disability and vulnerable adults. Social care staff will carry-out assessments of a person's care needs and if appropriate assist the individual to ensure their care needs are met either through local authority services or commissioned care and support.

Appendix E

Community Strategy for Health and Social Care Services Consultation Results

Consultation on the Community Strategy for Health and Social Care Services 2011 - 2012

Background

The Health Community Strategy (The Community Strategy for health and Social Care services) is about the health and social care services which support the needs of the people of Dorset. It is primarily about the services people need to access when they become unwell, vulnerable or need support from health and social care. Whilst this strategy is not just about older people, there is no doubt that the number of older people does make a difference to the amount of services which need to be provided.

This Strategy has been developed jointly by NHS Dorset and Dorset County Council with the involvement of a multi agency group including *voluntary agencies*, *carer*s and community representatives. It sets out a proposed vision for services that meet our local strategic goals:

- Helping you to live a longer and healthier life;
- Delivering care where and when you need it;
- Care delivered in a way that you would expect;
- Achieving the best value for money for you and your community.

The Vision for community services is;
“The provision of high quality, responsive, person centered support to maximise individuals independence and well being”.

The strategy does not exclude any groups in itself but the services described are for people over the age of 18 years

The main principle for this strategy is the need to increase the provision of community services and the shift in focus that is required to enable this transformation to take place. This transformation is supported by national and regional policy, and locally as set out in the NHS Dorset Strategic Plan for a Healthier Dorset 2010 – 2014 which was consulted on widely, and the Annual Operating Plan 2011/12.

It is not considered to constitute a significant change in services but rather it enhances and streamlines service delivery.

The engagement process - how did we engage?

A comprehensive engagement process was held from January to March 2012, with the delivery of presentations and workshops. The process included a wide

dissemination of the draft strategy requesting feedback from all interested groups, including service users, staff and residents of the County. All feedback has been carefully considered and the document has been amended accordingly

The table outlines the specific mechanisms for engaging with members of the public and people working in health and social care and related services and ensuring their views, experiences and ideas are harnessed.

Stakeholders	Key focus	Delivery Mechanisms
League of Friends	• impact on their specific community hospital/ services and local population	• Presentation at formal Friends' meetings with a workshop element to gain feedback
Primary care	• impact of strategy on their practices • ability to refer patients appropriately • potential impact on other community services	• Briefings from senior team at locality meetings • Uploaded to - *http://www.dorset.nhs.uk/getinvolved/community-strategy.htm*
People working in health and social care including across borders where the strategy will impact	• Impact of strategy on their practice • Opportunities • Service change implications for their service	• Briefings from senior team at locality meetings • Strategy with questionnaire to be available on Trust and Social care intranet
Patients and Public including carers	• how the changes will affect them or their friends and family • concern regarding safety and access to services • lack of understanding of potential changes • impact on jobs	• Survey monkey questionnaire to be launched to gain feedback on the strategy • Specific activity with hard to hear and visually impaired groups to be defined jointly with DCC • Two half day workshops with the public and patients: one in each locality in Wimborne and Dorchester – East Locality Half Day Engagement Event (Cobham Sports Centre 16th February 2012) West Locality Half Day Engagement Event - Dorchester (Dorford Centre, 23rd February 2012) • Presentation and discussion with Health Network members • Work with Dorset Community Action and LINks to promote activities and involvement opportunities • Questions submitted on patient panel to access c. 5k panel members' views • Uploaded to – *http://www.dorsetforyou.com*

		• 6 locality briefings – West Dorset Locality Meeting - Dorchester (Queens Avenue Surgery, 7th February 2012) West Dorset Locality Meeting – Rural (Puddletown, 8th February 2012) Purbeck Connecting Health and Social Care Locality (Wareham, 13th February 2012) East Dorset and Christchurch Locality Meeting (Ferndown 15th February 2012) East Dorset Connecting Health and Social Care Implementation Group (St Leonards Hospital, 23rd February 2012)
Local MPs and Local Councillors	• protecting the interests of their constituents and local health economy	• Face to face briefing session
Dorset Health Scrutiny Committee	• being informed of the process and how this is progressing • being able to brief local population if queried • ensuring appropriate involvement is undertaken	• Initial vision being presented on 29 November • Task and Finish Group
Voluntary Agencies/ Charities	• Impact and opportunities presented by the updated strategy • Understanding how potential service changes will affect their users	• Two central events to present draft strategy and gain feedback on the proposals.

The Strategy was shared with the following equality target groups

Equality Target Groups	**EVIDENCE OF CONSULTATION** **Name of Appropriate Body**
Sex	Dorset Community Action. LINks.
Gender Reassignment	Dorset Community Action. Chrysalis.
Race (BME communities)	Dorset Community Action. LINks.
Disability	Dorset HealthCare University NHS Foundation Trust – Older Peoples Mental Health Services. Dorset Community Action. Dorset Learning Disability Partnership Board.

	People First Dorset LINks. Help and Care. St John's Ambulance. Alderney Hospital – Older Peoples Mental Health Services. Dorset Advocacy. Occupational Therapy Richmond Fellowship. Weymouth and Portland Community Mental Health Centre.
Sexual orientation (lesbian, gay men or bisexual)	Dorset Community Action. LINks.
Age (older people, young people/children)	Dorset County Hospital. Cancer Network Patient Partnership Panel. Dorset HealthCare University NHS Foundation Trust – Older people Champion. Dorset HealthCare University NHS Foundation Trust – Older Peoples Mental Health Services. Dorset Community Action. POPP – Partnerships of Older Peoples Programmes. Over 50's Forum. LINks. Help and Care. Alzheimer's Society. Dorset Fifty Plus. Alderney Hospital – Older Peoples Mental Health Services. Shaftesbury and Villages 50+ forum. Dorset Advocacy. Age Concern. The Rowan Organisation. North Dorset Older Peoples forum. Weymouth Seniors Forum. Bridport Area Older Peoples Forum. British Legion. Dorset Gypsies & Traveller Group.
Religion or Belief	LINKs.
Pregnancy or maternity	LINKs.

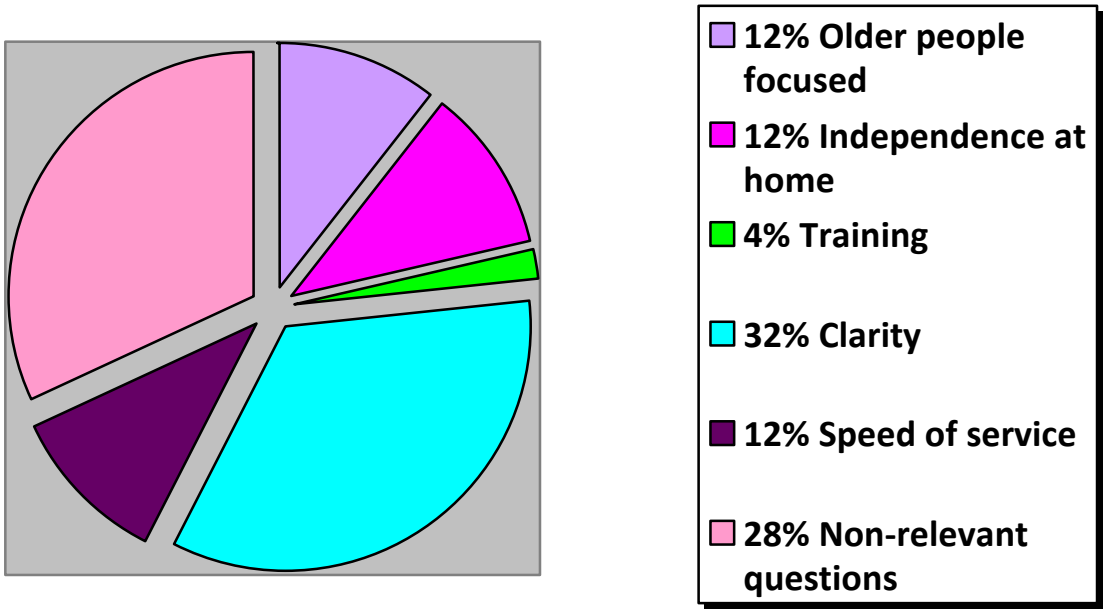
Health Community Strategy (The Community Strategy for Health and Social Care Services) Consultation Results

Stakeholders have been engaged in the draft proposals to obtain their views and opinions. Relevant feedback has been made the strategy has been amended.

During the engagement events, a number of questions and issues were raised that did not relate to the proposed changes. Where the feedback is not relevant to this particular strategy the comments will be passed to relevant policy makers.

Topic/comment	Request	Response
Older people focused	Doesn't appear to reflect the voice of younger people with long term conditions or disability (older people centric). Could this be considered to ensure the needs of younger adults are addressed too?	Key issues included a perception that the strategy was predominantly focused on older people. The strategy is for all adults over the age of 18 years. However due to the demographics of the targeted population there was a predominance of feedback from the older persons (defined as over the age of 55 years)
Independence at home	Is the ambition for older people to remain independent?	The main principle for this strategy is to support people to remain independent for as long as possible. Services are to ensure that all individuals achieve their optimum level of wellbeing and/or recovery
Training needs (staff, localities, management)	Are health and social care workers to be empowered with the skills, resources and time to provide the care pathway according to the principles listed?	Services have been defined and specified with the providers of the services. The training, development and competence of all staff will be the responsibility of the provider and monitored against the agreed contracts. Significant investment into the services have been made by all commissioners of the services
Personal health budgets/ funding / costs	Clarity of personalisation, person centered care and personal health budgets required	All feedback has been carefully considered and the document has been amended accordingly
Clarity of wording	Request for clarity of Community Strategy wording	All feedback has been carefully considered and the document

	and glossary?	has been amended accordingly
Non-relevant questions	A number of views and opinions were made that were not relevant to the Community Services Commissioning Strategy.	Where the feedback is not relevant to this particular strategy the comments will be passed to relevant policy leads



Community Strategy for Health & Social Care Services
Figure 1

Conclusion

The Commissioning organisation recognises the need to undertake a programme of regular engagement and evaluation as services develop and evolve.

Appendix F

Dorset County Council and NHS Dorset

Equality Impact Assessment Form

Strategy or project title: Health Community Strategy (The Community Strategy for Health and Social care services)

What are the intended outcomes of this work? *Include outline of objectives and function aims*

This strategy outlines the drivers or change, the requirements, the proposed solutions and the commissioning approach for the development of community services across NHS Dorset and Dorset County Council. The strategy is about the health and social care services which support the needs of the people of Dorset and the services people need to access when they become unwell, vulnerable or need support from health and social care. Whilst this strategy is not just about older people, there is no doubt that the number of older people does make a difference to the amount of services which need to be provided. This Community Strategy for Health and Social Care Services has been developed jointly by NHS Dorset and Dorset County Council with the involvement of a multi agency group including General Practitioners, Community service providers' Local authority provider's *voluntary agencies*, *carer*s and community representatives. It sets out a proposed vision for services that meet our local strategic goals:

- Helping you to live a longer and healthier life;
- Delivering care where and when you need it;
- Care delivered in a way that you would expect;
- Achieving the best value for money for you and your community.

The Vision for community services is;
"The provision of high quality, responsive, person centred support to maximise individuals independence and well being".

The strategy does not exclude any groups in itself but the services described are for people over the age of 18 years

Delivering and monitoring of this strategy will be undertaken by three routes:

- Contract and performance monitoring;
- Re-ablement projects;
- Re-ablement Board.

A report on progress of the implementation of this strategy will be made available to all stakeholders annually.

Who will be affected? *e.g. staff, patients, service users etc*

Staff, patients/service users.

All protected characteristics under the Equality Act 2010.

Evidence

What evidence have you considered? *List the main sources of data, research and other sources of evidence (including full references) reviewed to determine impact on each equality group (protected characteristic). This can include national research, surveys, reports, research interviews, focus groups, pilot activity evaluations etc. If there are gaps in evidence, state what you will do to close them in the Action Plan on the last page of this template.*

This Commissioning Strategy has been developed in response to a number of National and Local policies the key drivers are discussed within the body of the strategy and the linked policies and strategies are referenced within Appendix B of the document. Key drivers Include:

The Marmot Review; Fair Society, Healthy Lives.
Equality and Excellence; Liberating the NHS
Liberating the NHS: Legislative Framework and next steps
Transforming Adult Social Care
Putting People First Concordat
The Ageing Well (Dorset County Council) action plan
The Strategic As above Plan for a healthier Dorset 2010/2014

The commissioning of community services (health and social care) has a direct and significant impact on the health and wellbeing of all communities. However evidence shows that not all population groups have equal access to these services or experience equality in health and social outcomes. It is therefore important that any strategy to improve the commissioning of these services is informed by an assessment of the possible effects on specific groups and communities that have experienced discrimination or disadvantage.

The Health Community Strategy (The Community Strategy for Health and Social Care Services) is informed by the *Joint Strategic Needs Assessment* (summarised at Appendix C).

Dorset has a current local population of approximately 405,000 with a particularly high **proportion of older people** 50 years of age and older as the general definition of an older person (World Health Organisation). Over 29% are over retirement age (65+ males/60+ females) compared with just 19.5% across England. There is a lack of transgender, black and ethnic minorities, travellers and gypsy community data and research for Dorset, a requirement of equality legislation.

Figures from the 2001 Census recorded that the County's population contains a 3.2% black and **minority ethnic minority** population compared to the figure of 13% for England. Information on **religious belief** in Dorset was collected for the first time in Dorset in 2001. The majority of Dorset residents (77.9%) identified themselves as Christians. 13.7% were recorded as having no religion and 7.4 % declined to answer the question. 1% declared a non-Christian faith.

Population figures for **Gypsy and Traveller** communities in Dorset are difficult to assess due in part to the mobile nature of these communities. A 2006 study (Homer et.al 2006) estimate a total population of between 2,400 and 3,000 across Bournemouth, Poole and

Dorset.

The 2001 Census asked all residents to state if they had a **long-term illness or disability** which limited their daily activities. 19% of Dorset population answered yes. The number of adults with learning difficulties registered with a Dorset GP = 1,454 (May 2012) However National statistics identify that 2% of the population have a learning disability and as such the likely true number of learning disabled (mild to severe) is approximated as 7,929.

Sexual orientation in Dorset 55% of all people aged over 16 were married (this excludes couples who are co-habiting. 0.13% of Dorset respondents said they lived as same sex couples. National statistics published in 2010 following a sample survey of a million adults 1% identified themselves as gay or lesbian, 0.5% identified themselves as bisexual and a further 0.55 as other. These results are not published at County level.

Deprivation There are many ways of measuring deprivation. The areas in Dorset with the greatest deprivation are located in Weymouth and Portland. However when compared to the national picture Dorset appears to be relatively free from the degree of deprivation found elsewhere in the country.

A wide engagement process has been undertaken with the delivery of presentations and workshops. Including wide dissemination of the draft strategy requesting feedback from all interested groups, including service users, staff and residents of the County.

All feedback has been carefully considered and the document has been amended accordingly.

Please see the engagement strategy and feedback report Appendix E.

Disability *Consider and detail (including the source of any evidence) on attitudinal, physical and social barriers.*

Access to premises is important The Disability Equality Duty states that public organisations must make 'reasonable adjustments' to ensure their services are equally accessible to disabled people as they are to other members of the public.

People with sensory impairments experience unique difficulties in accessing services that can easily be overcome through local adjustments such as the use of induction loops and other auxiliary aids.

People with learning disabilities and mental health are more predisposed to some long term conditions. Evidence suggests this group of people experience diagnostic overshadowing; that is reports of physical ill health being viewed as part of the mental health problem or learning disability and so not being investigated or treated.

Long term conditions; those conditions that cannot at present be cured but can be controlled by medications and other therapies. People with long term conditions use disproportionally more primary and secondary care services, nationally accounting for 52% of all GP appointments and 65% of all outpatient appointments.

This strategy supports the commissioning of and investment in new service models and equity of service along with the driving up of standards, quality and efficiency. As services are delivered closer to home by services that are integrated to the needs of the locality they

will have the opportunity to get to know their community and deliver person centred care in partnership with the individual.

It is likely that by implementing this strategy there will be a positive impact on people who have a disability as they will receive a more integrated and more efficient level of care.

Sex *Consider and detail (including the source of any evidence) on men and women (potential to link to carers below).*

Evidence suggests that men use hospital services less than women and tend to underutilize primary care services (The UK Men's health Forum 2002). The mental health charity MIND suggest that men tend to be more vulnerable to mental health problems and suicide for a number of reasons including access to services and cultural perceptions of health and social care.

The service development within this strategy such as increased use of proactive case finding and management using risk profiling tools that can identify vulnerable risk groups. Information technology and care closer to home will have a positive impact regardless of gender.

Race *Consider and detail (including the source of any evidence) on difference ethnic groups, nationalities, Roma gypsies, Irish travellers, language barriers.*

There is evidence of unequal access to services according to ethnic origin these include:

- Difficulties accessing existing services by those who speak little or no English;
- Low take up of GP registration amongst some groups such as Gypsies and travellers because of no permanent address.

The impact upon this group is recognised but considered low as a result of the implementation of this strategy.

Age *Consider and detail (including the source of any evidence) across age ranges on old and younger people. This can include safeguarding, consent and child welfare.*

Department of Health research highlighted that older people experienced difficulties accessing health and social care services. This may be due to poor transport networks, limited mobility or in some areas due to lack of local services.

This strategy will have a positive effect on the older people who are most likely to use the services defined within this strategy. The strategy will have no direct impact on younger age groups.

Gender reassignment (including transgender) *Consider and detail (including the source of any evidence) on transgender and transsexual people. This can include issues such as privacy of data and harassment.*

There is currently limited data available on the health and wellbeing of this user group however there is no evidence to suggest that any person of a particular gender will experience any negative impact as a result of the implementation of this strategy.

The impact upon this group is recognised but considered low as a result of the implementation of this strategy.

Sexual orientation *Consider and detail (including the source of any evidence) on heterosexual people as well as lesbian, gay and bi-sexual people.*

There is currently limited data available on the health and well being of lesbian, gay and bisexual (LGB) people. Research suggests there are specific health concerns that arise as a consequence of a person being LGB and it is useful for a person to feel comfortable about disclosing their sexual orientation.

The impact upon this group is recognised but considered low as a result of the implementation of this strategy.

Religion or belief *Consider and detail (including the source of any evidence) on people with different religions, beliefs or no belief.*

Healthcare services need to be sensitive and responsive to the cultural and religious needs of different communities, their attitudes and reactions to disease, types and modality of treatment, prognosis care giving and death.

The impact upon this group is recognised but considered low as a result of the implementation of this strategy.

Pregnancy and maternity *Consider and detail (including the source of any evidence) on working arrangements, part-time working, infant caring responsibilities.*

There is a separate area of work focusing on pregnancy and maternity.

The impact upon this group is recognised but considered low as a result of the implementation of this strategy.

Carers *Consider and detail (including the source of any evidence) on part-time working, shift-patterns, general caring responsibilities.*

An important aspect of health prevention is the strain that caring can place on people's health, particularly if they are already facing other disadvantages such as poverty, isolation and unsuitable accommodation.

The census data estimates that there are around 40,000 people with a caring responsibility in Dorset. A significant number of carers are young people under the age of 18. The Children's directorate within Dorset County Council supports young carers.

There is a Joint Commissioning Strategy for Carers; Recognising and Valuing Carers 2010-2013 that is available on the 'Dorset for you' web site. Within its key priorities is a commitment to joint commissioning arrangements and to increase the direct support and provision of services to carers.

The Health community strategy will have a positive effect on carers who are most likely to use the services defined. The strategy will have no direct impact on younger age groups as this will be addressed within a separate work stream within children's services.

Other identified groups *Consider and detail and include the source of any evidence on different socio-economic groups, area inequality, income, resident status (migrants) and*

other groups experiencing disadvantage and barriers to access.

No other groups identified.

Engagement and involvement

How have you engaged stakeholders in gathering evidence or testing the evidence available?

Please see the engagement plan attached as Appendix E.

How have you engaged stakeholders in testing the policy or programme proposals?

Stakeholders have been engaged in the draft proposals to obtain their views and opinion, where relevant feedback has been made the strategy has been amended. Where the feedback is not relevant to this particular strategy the comments will be passed to relevant policy makers.

For each engagement activity, please state who was involved, how and when they were engaged, and the key outputs:

Please see the engagement plan attached as Appendix E

Summary of Analysis

Considering the evidence and engagement activity you listed above, please summarise the impact of your work. Consider whether the evidence shows potential for differential impact, if so state whether adverse or positive and for which groups. How you will mitigate any negative impacts. How you will include certain protected groups in services or expand their participation in public life.

Engagement feedback identified a number of key issues as summarised in the engagement feedback statement Appendix E.

Key issues included:

Topic/comment	Request	Response
Older people focused	Doesn't appear to reflect the voice of younger people with long term conditions or disability (older people centric). Could this be considered to ensure the needs of younger adults are addressed too?	Key issues included a perception that the strategy was predominantly focused on older people: The strategy is for all adults over the age of 18 years. However due to the demographics of the targeted population there was a predominance of feedback from the older persons (defined as over the age of 55 years).
Independence at home	Is the ambition for older	The main principle for this strategy is

	people to remain independent?	to support people to remain independent for as long as possible. Services are to ensure that all individuals achieve their optimum level of wellbeing and/or recovery
Training needs (staff, localities, management)	Are health and social care workers to be empowered with the skills, resources and time to provide the care pathway according to the principles listed?	Services have been defined and specified with the providers of the services. The training, development and competence of all staff will be the responsibility of the provider and monitored against the agreed contracts. Significant investment into the services have been made by all commissioners of the services
Personal health budgets/ funding / costs	Clarity of personalisation, person centred care and personal health budgets required	All feedback has been carefully considered and the document has been amended accordingly
Clarity of wording	Request for clarity of Strategy Plan wording & glossary?	All feedback has been carefully considered and the document has been amended accordingly
Non-relevant questions	A number of views and opinions were made that were not relevant to the Community Services Commissioning Strategy.	Where the feedback is not relevant to this particular strategy the comments will be passed to relevant policy makers

Now consider and detail below how the proposals impact on elimination of discrimination, harassment and victimisation, advance the equality of opportunity and promote good relations between groups.

Eliminate discrimination, harassment and victimisation *Where there is evidence, address each protected characteristic (age, disability, gender, gender reassignment, pregnancy and maternity, race, religion or belief, sexual orientation).*

All areas of diversity have been carefully considered along with the feedback received from *the* engagement process.

Advance equality of opportunity *Where there is evidence, address each protected characteristic (age, disability, gender, gender reassignment, pregnancy and maternity, race, religion or belief, sexual orientation.*

The strategy sets out a vision for services that meet our local strategic goals:

- Helping you to live a longer and healthier life;
- Delivering care where and when you need it;
- Care delivered in a way that you would expect;
- Achieving the best value for money for you and your community.

-

This commissioning strategy will support the provider to develop services that meet the defined vision and as a result advance equality of opportunity for all individuals:

"The provision of high quality, responsive, person centred support to maximise individuals' independence and well being".

Promote good relations between groups *Where there is evidence, address each protected characteristic (age, disability, gender, gender reassignment, pregnancy and maternity, race, religion or belief, sexual orientation).*

Not applicable to this strategy.

What is the overall impact? *Consider whether there are different levels of access experienced, needs or experiences, whether there are barriers to engagement, are there regional variations and what is the combined impact?*

The Commissioners recognise the need to undertake a programme of regular engagement and evaluation as services develop and evolve.

Addressing the impact on equalities *Please give an outline of what broad action you or any other bodies are taking to address any inequalities identified through the evidence.*

- Closer monitoring of service user complaints and patient experiences;
- Evidence gathered should be used to correct areas where inequality of access is identified;
- Steps should be taken to monitor trends by 'Protected Characteristics' and any remedial action taken as soon as possible to mitigate any inequalities. This will include things like identifying correct language provision, producing 'Easy Read' documentation and patient centred care.

Action planning for improvement *Please give an outline of the key actions based on any gaps, challenges and opportunities you have identified. Actions to improve the policy/programmes need to be summarised (An action plan template is appended for specific action planning). Include here any general action to address specific equality issues and data gaps that need to be addressed through consultation or further research.*

Lessons Learned: Data received on the Equality Delivery System Monitoring Form was very limited. The majority of respondents did not complete this information. The monitoring form was sent out with the questionnaire and attached to the documents made available electronically. As stated earlier in this document the Community Strategy for Health and Social Care Services was disseminated widely and feedback from a diverse range of user groups has been received. However it is considered that completion of the monitoring form would have improved if correspondents had been able to return this form anonymously. This will be addressed in all future engagement activity.

Please give an outline of your next steps based on the challenges and opportunities you have identified;

- Arrangements for continued engagement of stakeholders;
- Arrangements for continued monitoring and evaluating the policy for its impact on different groups as the policy is implemented;
- Arrangements for embedding findings of the assessment within the wider system, other agencies, local service providers and regulatory bodies;
- The Health Community Strategy (The Community Strategy for Health and Social care Services) has been amended following the feedback from the of engagement process and will be shared with all relevant stakeholders;
- This publication will be made widely available on various electronic sites including;
  - NHS Dorset website;
  - NHS Bournemouth & Poole website ;
  - NHS Dorset intranet;
  - NHS Dorset Twitter;
  - NHS Dorset Health Networks;
  - NHS Bournemouth & Poole Health Networks NHS Primary Web;
  - Dorsetforyou;
  - Dorset County Council intranet;
  - DCC Twitter & Facebook.

Name of person who carried out this assessment:

Chris Parsons (Mrs), Service Improvement Manager, Joint Commissioning and Partnerships NHS Dorset, Bournemouth and Poole.

Date assessment completed: 1st May 2012

Name of responsible Director:

John Morton, Director of Joint Commissioning and Partnerships NHS Dorset, Bournemouth and Poole.

Date assessment was signed: 1st May 2012