West Dunbartonshire Council

NHS Greater Glasgow and Clyde

West Dunbartonshire
Community Health & Care Partnership

West Dunbartonshire Community Health & Care Partnership

Strategic Plan 2013/14

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Acknowledgements:
The CHCP Senior Management Team would like to thank all those staff and colleagues who have worked so hard to deliver high quality services to the communities of West Dunbartonshire throughout the last year, and are committed to continuing to do so together over the coming year.

Please send any feedback on this Strategic Plan to: soumen.sengupta@ggc.scot.nhs.uk

1. INTRODUCTION

West Dunbartonshire Community Health and Care Partnership (CHCP) brings together both NHS Greater Glasgow and Clyde's (NHSGGC) and West Dunbartonshire Council's (WDC) separate responsibilities for community-based health and social care services within a single, integrated structure (while retaining clear individual agency accountability for statutory functions, resources and employment issues). The prescience of this commitment has been underlined by the announcement by the Scottish Government of its intention to bring forward legislation to further integrate health and social care services.

The CHCP's mission is to ensure high quality services that deliver safe, effective and efficient care to and with the communities of West Dunbartonshire; and to work in partnership to address inequalities and contribute to the regeneration of the West Dunbartonshire area. The core values that the CHCP is committed to across its sphere of responsibilities are:

- Quality.
- Fairness.
- Sustainability.
- Openness.

In addition to local children and adults services provided for and with the residents of West Dunbartonshire, the CHCP has formal responsibilities for a number of wider geographic functions:

- NHSGGC Community Eye Care Service.
- NHSGGC Musculoskeletal Physiotherapy Service.
- Management of Argyll, Bute and Dunbartonshire's Criminal Justice Social Work Partnership.

The CHCP also has a number of formal Service Level Agreements in place with the neighbouring Argyll and Bute Community Health Partnership in relation to services that have mutually agreed as being sensibly provided across the boundaries of our respective geographic boundaries (all of which are subject to regular review).

This third integrated Strategic Plan sets out the key actions prioritised for delivery over the course of 2013/14. Its focus reflects the requirements and expectations of the CHCP's "corporate parents": the West Dunbartonshire Council Strategic Plan 2012-17; and the NHSGGC Corporate Plan 2013-16. As in previous years, its structure is a blend of the distinct formats preferred by each organisations, including consideration of key issues from the Chief Social Work Annual Report 2011/12; and an overview of local Clinical Governance priorities. In a similar vein, it has also incorporated consideration of key strategic risks; and integrated workforce planning priorities.

In accordance with good practice and building on the success of the previous year, the Strategic Plan incorporates the CHCP Key Performance Indicators (KPIs) for 2013/12 which also include those indicators within the local Community Planning Partnership (CPP) Single Outcomes Agreement (SOA) that the CHCP has lead responsibility for as well as the relevant new SOLACE benchmark indicators for local authorities.

At the time of "printing", a number of indicators included still had targets to be confirmed: this is due to a combination of scheduling (e.g. NHSGGC corporately had not as yet confirmed local targets) and the developmental nature of some of the indicators (e.g. in relation to the national Early Years Collaborative and the new SOLACE benchmark indicators). The suite of indicators included relate to a combination of routine service activity and developmental/transformational initiatives; and delivery that is predominantly under the direct management of the CHCP as well as outcomes that are heavily influenced by the practice and contributions of other stakeholders (e.g. other council departments; other NHSGGC divisions; or NHS external contractors). It is also important to note that as in previous years, there is not a necessarily direct correlation between specific "actions for delivery" set out within the CHCP Strategic Plan and each of the indicators included, as the actions here deliberately represent high-level change commitments.

In keeping with the spirit of the participative approach that the CHCP is committed to, this Strategic Plan has been informed by an understanding of perspectives of key stakeholders (including the CHCP's Joint Staff Partnership Forum; the Professional Advisory Group; and the Public Partnership Forum) from on-going engagement through the year, reflecting the CHCP's cyclical commissioning process for the development of services. The specific local actions set out within reflect on-going self-evaluation processes within CHCP service areas; engagement within local Community Planning Partnership fora; and dialogue with both service user groups and the wider communities in West Dunbartonshire. It is underpinned by an appreciation of local health and social care needs (drawn from for example ScotPHO health and wellbeing profiles; and local Citizen's Panel survey findings); and other relevant sources of evidence - most notably the recent, highly positive Care Inspectorate external scrutiny assessment of the CHCP.

The Care Inspectorate scrutiny assessment report provided strong evidence to support the decision to formally establish the CHCP in the first place; amd provide welcomed reassurance to the CHCP Committee and other elected representatives; the NHSGGC Health Board; other local Community Planning Partners and the wider community. Importantly it evidenced that an integrated Health and Community Care Partnership model can provide a suitable structure to secure the delivery and support the continued development of social work services. That progressive approach to integration was also clear in the CHCP's formal submission to the Scottish Government's consultation on the new health and social care partnerships – which also highlighted the strong case for inclusion of children's health and social care services within the remits of the integrated partnerships (such as is already the case within West Dunbartonshire). While the Scottish Government's published formal response to their consultation indicates that the legislation will leave the decision to include these responsibilities and resources to local discretion between councils and health boards, it did accept the rationale and opportunities of doing so (not least within the context of the new Children & Young People's Bill). It is clear that West Dunbartonshire CHCP is well placed to already satisfy (if not exceed) the majority of the expectations from the new legislation without significant re-structuring; and where refinements are required (such as relates to CHCP Committee arrangements), that experience to-date would suggest these will be able to be addressed effectively and sensibly over the course of the coming year in a manner that is to the benefit of services and communities.

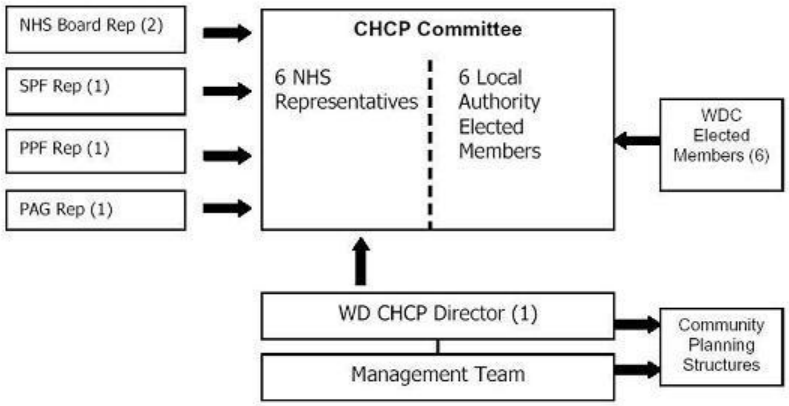
2. GOVERNANCE ARRANGEMENTS

CHCP Governance Structure

The governance arrangements of the CHCP reflect the fact that it is a full partnership between NHSGGC and WDC. There are five elements:

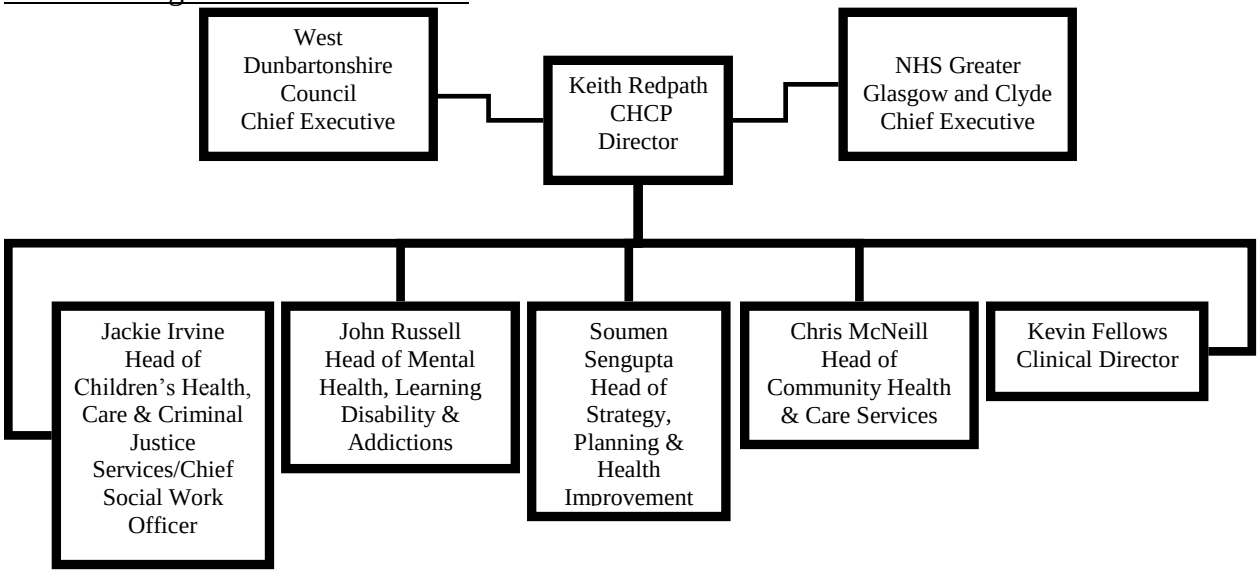
- The CHCP Committee.
- The Joint Staff Forum (JSF)
- The Public Partnership Forum (PPF)
- The Professional Advisory Group (PAG)
- The CHCP Senior Management Team (SMT)

The relationships of these five elements are as illustrated below:



The composition of the CHCP Committee reflects a partnership approach, with an Elected Member as chair and an NHS Board representative as vice chair. It should be noted that the governance of the Argyll, Bute and Dunbartonshires' Criminal Justice Partnership is not the responsibility of the CHCP Committee but rather rests with the Argyll, Bute and Dunbartonshires' Criminal Justice Partnership Committee (whose membership includes an Elected Member from WDC).

Senior Management Team Structure



Clinical Governance Overview

Clinical governance is how health services are held accountable for the safety, quality and effectiveness of clinical care delivered to patients. It is a statutory requirement of NHS Boards, achieved by coordinating three interlinking strands of work:

- Robust national and local systems and structures that help identify, implement and report on quality improvement.
- Quality improvement work involving health care staff, patients and the public.
- Establishing a supportive, inclusive learning culture for improvement.

The CHCP Director has overall accountability for clinical governance within the CHCP. This is primarily discharged through CHCP's Clinical Director (who is a practicing GP) and the CHCP's Heads of Service. The Clinical Governance Group is a sub-group of the SMT, composed of the Clinical Director (as Chair) and Heads of Service plus the CHCP Lead Pharmacist and the MSK Physiotherapy Service Manager. The Group is supported by the Clinical Risk Co-ordinator and Clinical Effectiveness Co-ordinator from the NHSGGC Clinical Governance Support Unit.

The CHCP's Clinical Governance Workplan explicitly reflects the three 'quality ambitions' as outlined in the NHS Quality Improvement Scotland paper on developing a 'quality strategy programme in primary care', i.e. person centred, safe and effective. Against the backdrop of the embedding integrated managerial arrangements across health and social care services, the CHCP's approach to clinical governance demonstrates the enthusiasm of all staff striving to deliver better quality clinical care. The cohesive manner in which all services come together to do this for patients is both reassuring and refreshing in these challenging times. It is also notable that priority continues to be attached to ensuring that the integrated management arrangements of the CHCP are fully used to both streamline and strengthen a number of clinical governance systems.

Looking to the year ahead, the coming year will see a greater emphasis on patient safety and appreciation of the importance of learning from previous significant incidents and near misses. The importance of this has been reinforced by the highly publicised findings and recommendations from the *Mid Staffordshire NHS Foundation Trust Public Inquiry (the Francis Inquiry)*. The Report makes for very sober reading, and provides food-for-thought for all staff who have responsibilities for the provision and quality of care - be they practitioners, clinical/professional leads or managers. Also, although the report is substantively around NHS health care services as provided in Mid Staffordshire, it does raise associated questions for local authorities in terms of the role and responsibilities of social work services. As an integrated health and social care partnership then, the CHCP is committed to all staff being encouraged and supported to reflect upon the learning from the Francis Inquiry as part of the quality improvement agenda being taken forward as part of the NHSGGC Facing the Future Together and WDC corporate transformation programmes.

Chief Social Work Officer's Overview

Social Work and Social Care Services are delivered usually, but not exclusively, to the most vulnerable in our communities and therefore have a particular contribution to make to safeguarding individuals from harm and protecting the public. These are complex issues requiring a balance to be struck between needs, risks and rights. The assessment and management of risk posed to individual children, vulnerable adults and the wider community require both clear systems to be in place to govern those responsibilities and require close collaboration with partner agencies. The Local Government (Scotland) Act 1994 sets out the requirement that every local authority should have a professionally qualified Chief Social Work Officer (CSWO). The role of the CSWO is to provide professional governance, leadership and accountability for the delivery of Social Work and Social Care Services. Within West Dunbartonshire CHCP, the responsibilities of the CSWO are formally discharged by the Head of Children's Health, Care & Criminal Justice Services. The annual Chief Social Work Officer's Report was submitted to West Dunbartonshire Council at its December 2012 meeting. That report provided assurance that within the integrated CHCP, the governance of social work has been considered and appropriate mechanisms put in place to ensure that these functions are being dealt with properly and appropriately. Scottish Government Guidance emphasises the need for the CSWO to have access to the Council Chief Executive as required and within West Dunbartonshire this has never been a difficulty. Likewise, there is appropriate access to elected members. Within the CHCP, the role of the CSWO is clearly understood, with proper account taken of any need for specific involvement from the CSWO. The CSWO meets regularly with managers across the service to review and progress relevant areas of activity in a manner that clearly respects the CHCP's general management structure.

The Care Inspectorate's assessment of the CHCP's social work services published in December 2012 provided extremely positive feedback and reassurance regarding the quality of services and management arrangements locally. The report states that West Dunbartonshire CHCP's provision of social work services has been assigned to be **Level 1 - low risk, good performance and good improvement work**. This extremely positive assessment of local services very much reinforced the main themes of the CSWO Annual Report - and is to the credit of all CHCP staff.

From a wider multi-agency perspective, considerable development has and continues to be prioritised to support the local Public Protection Chief Officers Group (COG). The COG is chaired by the Council Chief Executive, and is responsible for setting the leadership direction; taking full account of performance; and instructing improvement action where this is required. Over the course of the year ahead, steps will be taken to make more visible what has been to-date an implicit community planning leadership contribution from the COG. The important role of the COG was underlined by the multi-agency review that it instructed the CHCP to lead in 2012 following the deaths of three residents from an Independent Housing Support Project in West Dunbartonshire. These deaths were as a result of suicide and we have acknowledged the individual and personal tragedies that each of these deaths represented and the impact that this had on their families, friends and the wider community. The CHCP and other community planning partners already engage in active suicide prevention programmes; and run extensive training and awareness programmes for staff in statutory and third sector organisations. This review will allow us to examine if there is any learning that can be applied from these very tragic deaths, reflecting our commitment to critical reflection and continuous improvement.

3. PLANNING CONTEXT

West Dunbartonshire Council

West Dunbartonshire Council's mission is *to lead and deliver high quality services which are responsive to the needs of local citizens, and realise the aspirations of our communities*. The Council's corporate values are to demonstrate: Ambition; Confidence; Honesty; Innovation; Efficiency; Vibrancy; and Excellence.

The Council's Strategic Plan 2012-17 identifies the following strategic priorities:

- Improve economic growth and employability.
- Improve life chances for children and young people.
- Improve care for and promote independence with older people.
- Improve local housing and environmentally sustainable infrastructure.
- Improve the wellbeing of communities and protect the welfare of vulnerable people.

The Council's Strategic Plan also stresses a commitment to assure success through:

- Strong financial governance and sustainable budget management.
- Fit-for-purpose estate and facilities.
- Innovative use of Information Technology.
- Committed and dynamic workforce.
- Constructive partnership working and joined-up service delivery.
- Positive dialogue with local citizens and communities.

The Council has devised a public value scorecard to structure the performance management of its Strategic Plan, with the following three dimensions:

- Social Mission
- Organisational Capabilities
- Legitimacy and Support.

NHS Greater Glasgow & Clyde

NHS Greater Glasgow and Clyde's purpose is to *deliver effective and high quality health services, to act to improve the health of our population and to do everything we can to address the wider social determinants of health which cause health inequalities*.

The NHSGGC Corporate Plan for 2013-16 sets out five strategic priorities:

- Early intervention and preventing ill-health.
- Shifting the balance of care.
- Reshaping care for older people.
- Improving quality, efficiency and effectiveness.
- Tackling inequalities.

NHSGGC's corporate approach to engaging and involving staff; and on how teams are managed and led across the whole organisation is articulated within its Facing the Future Together Programme sets out its with respect to following dimensions: Our Patients; Our People; Our Leaders; Our Resources; and Our Culture (The Way We Work Together).

West Dunbartonshire Community Planning Partnership

The aim of the West Dunbartonshire Community Planning Partnership (CPP) is to work in partnership to improve the economic, social, cultural and environmental well being of West Dunbartonshire for all who live, work, visit and do business here. The Single Outcome Agreements (SOA) are the means by which Community Planning Partnerships agree their strategic priorities for their local area, express those priorities as outcomes to be delivered by the partners, either individually or jointly, and show how those outcomes should contribute to the Scottish Government's relevant National Outcomes. The West Dunbartonshire SOA action for 2013/14 focus focuses on six following interconnected priorities:

- Stimulating Regeneration and Economic Growth
- Supporting Older People
- Supporting Children and Families
- Supporting Safe, Strong and Involved Communities
- Tackling Health Inequalities
- Promoting Physical Activity

The CHCP is committed to the four defining characteristics of the local Community Planning Partnership that have been fostered in recent years, and that partners are looking to further develop, i.e.:

- Ensuring that community planning takes a streamlined approach to delivering outcomes for communities – requiring action by all partners. This does not mean creating additional structures or increasing bureaucracy but instead should focus on building on and complimenting the core work of individual partners;
- A recognition that our priorities and outcomes do not exist in isolation nor can be delivered in silos from one another – they are fundamentally inter-connected;
- An emphasis on early intervention and prevention across all of our priorities, realigning resource and action to support this wherever possible;
- A commitment to pro-active and rigorous self-evaluation and scrutiny of activities across community planning partners as a driver for continuous improvement.

The CHCP has been actively developed as a clear manifestation of community planning in practice. This allows the CHCP to drive key community planning programmes of work that reflect an emphasis on early intervention and prevention (notably in relation to the Older People's Change Fund; and Getting It Right for Every Child plus Early Years Collaborative); and lead a progressive determinants-based approach to addressing health inequalities with and across community planning partners.

4. DELIVERING OUR OUTCOMES

	EARLY INTERVENTION AND PREVENTING ILL-HEALTH		2011-12	2013-14 Target
	Key Actions for Delivery	**Indicators**		
SOCIAL MISSION	Complete relevant actions within CPP integrated children's services plan. Complete implementation of CPP parenting strategy. Undertaken agreed review and developmental work in support of CPP Early Year's Collaborative programme, notably in relation to: • Special Needs in Pregnancy • Smoking in pregnancy • Child protection • Childsmile Implement 30 month assessment for all children and establish Health Support Team. Implement Universal and Vulnerable pathways for all children 0-19 years. Ensure access to FNP for vulnerable women under 19 years with first pregnancy. Develop local implementation of GIRFEC National Practice Model. Fully implement the SLT framework. Redesign specialist community paediatrics. Complete local CAMHS redesign.	Total number of successful quits (at one month post quit) delivered by community-based universal smoking cessation service	163	TBC
		Total number of successful quits (at one month post quit) delivered by community-based universal smoking within specified SIMD areas of high socio-economic deprivation	66	TBC
		Percentage of patients who started Psychological Therapies treatments within 18 weeks of referral	N/A	85%
		Percentage of designated staff groups trained in suicide prevention	100%	50%
		5-year moving average suicide rate (per 100,000 population)	24	15
		Referral To Treatment for CAMHS (longest wait in weeks)	10	26
		Primary Care Mental Health Teams average waiting times from referral to first assessment appointment (Days)	34	TBC
		Percentage uptake of bowel screening	49.9%	60%
		Percentage of those invited attending for breast screening	N/A	70%
		Percentage uptake of cervical screening by 21-60 year olds (excluding women with no cervix)	77.8%	80%
		Completion rates for child healthy weight intervention programme	144	315
		Percentage of babies breast-feeding at 6-8 weeks	15%	16%
		Percentage smoking in pregnancy	21.0%	20%
		Percentage smoking in pregnancy - Most deprived quintile	29.6%	27.1%
		Percentage of five-year olds (P1) with no sign of dental disease	58.6%	60%
		Percentage of Measles, Mumps & Rubella (MMR) immunisation at 24 months	93.8%	95%
		Percentage of Measles, Mumps & Rubella (MMR) immunisation at 5 years	95.2%	97%
		Number of screenings using the setting-appropriate screening tool and appropriate alcohol brief intervention	1,068	838
		Number of drug-related deaths	16	14

SOCIAL MISSION	EARLY INTERVENTION AND PREVENTING ILL-HEALTH		2011-12	2013-14 Target
	Key Actions for Delivery	**Indicators**		
	Develop local implementation of GIRFEC National Practice Model. Implement EMIS Web across children's health services. Implement CPP Teenage Pregnancy Action Plan. Develop a Psychological Therapies Network. Further improve access to PCMHT. Lead implementation of CPP Alcohol & Drug Partnership Strategy. Lead CPP Choose Life suicide prevention programme. Implement CHCP Cancer Information Action Plan. Support Alcohol Brief Interventions within different settings. Implement local Smoking Cessation Service Action Plan. Ensure delivery of agreed child healthy weight intervention programmes with Leisure Trust. Ensure delivery of nutrition and physical activity programmes for adults. Ensure full compliance with outcome and requirements from the Scottish Governments Redesign of the Community Justice system for the delivery of adult criminal justice services.	Number of inequalities targeted cardiovascular Health Checks	1,812	1,067
		Percentage of children on the Child Protection Register who have a completed and up-to-date risk assessment	100%	100%
		Percentage of child protection referrals to case conference within 21 days	95.5%	95%
		Number of Child Protection investigations	147	N/A
		Percentage of 16 or 17 year olds in positive destinations (further/higher education, training, employment) at point of leaving care	69%	63%
		Number of children with or affected by disability participating in activities	172	TBC
		Rate per 1,000 of children/young people aged 8-18 who are referred to the Reporter on offence-related grounds	17.65	TBC
		Rate per 1,000 of children/young people aged 0-18 who are referred to the Reporter on non-offence grounds	42	TBC
		Number of children with mental health issues (looked after away from home) provided with support	23	TBC
		To ensure that women experience positive pregnancies which result in the birth of more healthy babies as evidenced by a reduction of 15% in the rates of stillbirths (from 4.9 per 1,000 births in 2010 to 4.3 per 1,000 births in 2015).	N/A	TBC
		To ensure that women experience positive pregnancies which result in the birth of more healthy babies as evidenced by a reduction of 15% in the rates of infant mortality (from 3.7 per 1,000 live births in 2010 to 3.1 per 1,000 live births in 2015).	N/A	TBC
		To ensure that 85% of all children within each Community Planning Partnership have reached all of the expected developmental milestones at the time of the child's 27-30 month child health review, by end-2016.	N/A	TBC
		To ensure that 90% of all children within each Community Planning Partnership have reached all of the expected developmental milestones at the time the child starts primary school, by end-2017.	N/A	TBC

SOCIAL MISSION	SHIFTING THE BALANCE OF CARE		2011-12	2013-14 Target
	Key Actions for Delivery	**Indicators**		
	Develop Anticipatory Care as a model of prevention and work with GPs to develop self care models, and preventative interventions. Continue to develop care for patients with long term conditions inc. additional nursing support to patients, GP practices and care homes. Further develop Hospital Discharge team to increase early supported discharges. Further develop use of care planning and management to reduce hospital inpatient care. Introduce early referral for assessment by integrated health and social care teams. Introduce Practice Activity reports for primary care locality groups. Further develop CMS with local pharmacies through local community pharmacists group. Increase range of urgent access options to advice and appointments for GPs. Work with GP practices to monitor their provision of third available appointment, planned appointments and 24 hour access.	Number of adult mental health patients waiting more than 28 days to be discharged from hospital into a more appropriate setting, once treatment is complete	N/A	0
		Number of adult mental health patients waiting more than 14 days to be discharged from hospital into a more appropriate setting, once treatment is complete	N/A	20
		Number of bed days lost to delayed discharge for adults with mental health	N/A	530
		Number of bed days lost to delayed discharge for people with a disability	N/A	350
		Long Term Conditions - bed days per 100,000 population	10,603.1	10,000.1
		Long Term Conditions - bed days per 100,000 population Asthma	338.6	310
		Long Term Conditions - bed days per 100,000 population CHD	5,336.4	5,300
		Long Term Conditions - bed days per 100,000 population COPD	4,178.8	4,000
		Long Term Conditions - bed days per 100,000 population Diabetes	749.2	740
		Percentage of community pharmacies participating in medication service	N/A	50%
		Percentage of all Looked After Children supported within the local community	88.3%	88%
		Gross cost of Children Looked After in residential based services per child per week	£3,009	TBC
		Gross cost of Children Looked After in a community setting per child per week	£52.15	TBC
		Percentage of identified carers of all ages who express that they feel supported to continue in their caring role	81.5%	85%
		Self Directed Support (SDS) spend on adults 18+ as a percentage of total social work spend on adults 18+	1.6%	TBC
		Percentage of Care Plans reviewed within agreed timescale	72%	TBC

	SHIFTING THE BALANCE OF CARE		2011-12	2013-14 Target
	Key Actions for Delivery	**Indicators**		
SOCIAL MISSION	Expand Diabetic Retinal Screening service to cope with volume of patients and ensure quality. Deliver annual cycle for Retinal Screening appointments. Deliver quality assured NHSGGC-wide eye care service through audit and review. Contribute to reduction in Ophthalmology Out Patient by continuing OCT clinics. Expand the number of fixed sites for the delivery of local eye care clinics. MSK Physiotherapy Service: • Ensure equitable waiting times across sites. • Ensure equitable access to allow early intervention and prevent chronicity by introducing SCI Gateway referrals to MSK service and reviewing current self referral systems and results of NHS24 pilot. • Improve supported self management both pre referral and once referred by working with GP's and staff and by developing standardised resources and other methods to support self management. • Develop clinical pathways to ensure patients get the right treatment at the right time by the right person involving key stakeholders and developing an MSK steering group. • Outcome measures will be fully implemented and used to address physical activity, stress, anxiety & depression, employability, smoking, obesity and alcohol use.	Number of weeks for MSK physiotherapy treatment.	Various waits across GGC	9

SOCIAL MISSION	RESHAPING CARE FOR OLDER PEOPLE		2011-12	2013-14 Target
	Key Actions for Delivery	**Indicator**		
	Implementation of Year Three Older People's Change Fund Plan, including (1): • Lead local CPP Older People's Change Fund Plan Implementation Group. • Plan rapid response and alternative choices on behalf of at risk clients • Introduce ACP Nursing team, linked to Out of Hours services. • Introduce additional respite and rehabilitation options. • Further develop the LinkUp service to streamline referrals from and between the 3rd and Independent sectors. • Maintain a dedicated helpline number manned by volunteers. • Provide rapid multi-disciplinary geriatric assessment. • Increase appropriate use of Telecare and Step Up, Step Down provision. • Continue to develop appropriate medication-related education and training for CHCP (WDC) Home Care staff. Introduce Day Care Reablement and reablement in short term care home placements	Emergency inpatient bed days rate for people aged 75 and over (per 1,000 population)	6,547	6,400
		Number of people who wait more than 28 days to be discharged from hospital into a more appropriate care setting.	NA	0
		Number of acute bed days lost to delayed discharges	8,611	3,819
		Number of Acute bed days lost to delayed discharges for Adults with Incapacity	1,798	466
		Unplanned acute bed days 65+	55,176	55,000
		Unplanned acute bed days 65+ as a rate per 1,000 population	3,735	3,735
		Number of emergency admissions 65+	4,482	4,250
		Emergency admissions 65+ as a rate per 1,000 population	305	300
		Unplanned acute bed days (aged 75+)	41,615	38,600
		Emergency inpatient bed days rate for people aged 75 and over (per 1,000 population)	6,107	5,907
		Average length of stay for emergency admissions	3.1	3
		Number of patients on dementia register	530	672
		Percentage of at risk clients with anticipatory care plans	N/A	80%
		Percentage of identified patients dying in hospital for cancer deaths	N/A	30%
		Percentage of identified patients dying in hospital for non-cancer deaths	N/A	30%
		Number of bed days lost to delayed discharge elderly mental illness	1,363	530
		Average length of stay elderly mental illness delayed discharge	N/A	96
		Average length of stay adult mental health delayed discharge	N/A	35
		Total number of homecare hours provided as a rate per 1,000 population aged 65+	710.4	TBC
		Percentage of homecare clients aged 65+ receiving personal care	81.4%	TBC
		Percentage of adults with assessed Care at Home needs and a reablement package who have reached their agreed personal outcomes	N/A	50%

	RESHAPING CARE FOR OLDER PEOPLE		2011-12	2013-14 Target
	Key Actions for Delivery	**Indicator**		
SOCIAL MISSION	Implementation of Year Three Older People's Change Fund Plan, including (2): • Use the Liverpool Care Pathway and the Gold Standards Framework to reduce the proportion of people within West Dunbartonshire dying in hospital. • Use Supportive and Palliative Action Register (SPAR) to aid the identification of cancer and non-cancer patients entering a palliative phase. • Ensure delivery of agreed active ageing programmes with Leisure Trust. • Deliver a Post Diagnostic Support Service for newly diagnosed patients and their carers, with Alzheimer Scotland. Develop respite provision to include respite at home. Deliver expanded reablement support as part of Care at Home Services. Work with WDC HEED to develop housing with care options to meet target of increasing the number of older people with complex needs living at home or in a homely setting.	Older Person's (Over 65) Home Care Costs per Hour	£15.67	TBC
		Percentage of people aged 65 and over who receive 20 or more interventions per week	47.69%	44%
		Percentage of people 65+ with intensive needs receiving care at home (Existing definition)	44.4%	49%
		Percentage of people 65+ admitted twice or more as an emergency who have not had an assessment	37.52%	33%
		Number of people aged 75+ in receipt of Telecare – Crude rate per 100,000 population	20,790	TBC
		The percentage of people receiving free personal or nursing care within 6 weeks of confirmation of 'Critical' or 'Substantial' need	98%	100%
		Number of weeks of respite provided for carers of Older People / Dementia 65+	3558	TBC
		Percentage of people aged 65 years and over assessed with complex needs living at home or in a homely setting	N/A	48%

LEGITIMACY AND SUPPORT	IMPROVING QUALITY, EFFICIENCY AND EFFECTIVENESS		2011-12	2013-14 Target
	Key Actions for Delivery	**Performance Measure**		
	Develop RTTC and Leading Better Care. Improve children's to adults' services transition Work with local GPs to introduce Productive General Practice model; and build on Quality and Productivity initiative. Implement SPSP in community care services. Maintain routine meetings with DOME and develop local services as a partnership. Complete scheduled development and review of service specifications for procured services. Deliver/open Vale Centre for Health & Care. Deliver plans for the design and location of two Older People's Residential Care Homes with Day Care facilities. Consolidate improvement in CI Gradings for Older People's Care Homes (older people), Day Care and Home Care. Consolidate improvement in CI Gradings for Children's Residential Care Homes. Implement findings of Blue Triangle review. Promote the principles of Facing the Future Together and WDC corporate transformation programmes in an integrated manner, with a focus on strengthening integrated arrangements; and learning from the *Francis Inquiry.*	Percentage of clients waiting no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery	95.6	91.5%
		Percentage of patients achieved 48 hour access to appropriate GP practice team	94.10	95%
		Percentage of patients advanced booking to an appropriate member of GP Practice Teams	74.6%	90%
		Percentage of SCI Gateway referrals	85%	100%
		Prescribing cost per weighted patient	£162.71	TBC
		The annual rate of increase of defined daily dose (DDD) per capita Citalopram/Fluoxotine/Sertraline anti-depressant prescribing for people aged 15 and over	N/A	>65%
		The annual rate of increase of defined daily dose (DDD) per capita Escitalopram anti-depressant prescribing for people aged 15 and over	N/A	<3%
		Percentage of Council-operated children's residential care homes which are graded 5 or above by 2017	0%	N/A
		Percentage of Council Home Care services which are graded 5 or above by 2017	100%	N/A
		Percentage of Council-operated older people's residential care homes which are graded 5 or above by 2017	0%	N/A
		Percentage of adults satisfied with social care or social work services	2010/11 = 67.7%	TBC

SOCIAL MISSION	TACKLING INEQUALITIES		2011-12	2013-14 Target
	Key Actions from Delivery	**Indicator**		
	Lead community planning approach to health inequalities. Work with CVS to establish social transport support scheme. Develop and progress proposals to embed identified violence against women projects within mainstream council services. Address impact of welfare reform addressed where possible, ensuring access to money advice services. Mainstream Work Connect employability programme. Assess whether access inequalities to carers support. Work with HEED and third sector providers to identify suitable housing to develop appropriate supported living accommodation for those with long-term mental health needs.	Percentage uptake of bowel screening SIMD1	42.3%	44.3%
		Percentage of those invited attending for breast screening SIMD1	N/A	70%
		Percentage uptake of cervical screening by 21-60 year olds (excluding women with no cervix) SIMD1	N/A	76.1%
		Proportionate access to psychological therapies (SIMD, Age and Gender)	N/A	TBC
		Percentage of babies breast-feeding at 6-8 weeks from the 15% most deprived areas	10.5%	13.50%
		Uptake of Hepatitis B vaccination	NA	TBC
		SIMD gradient for people with BBV	NA	TBC
		Number of unplanned admissions for people 65+ by SIMD Quintile 1	640	TBC

Action for Delivery as part of GGC-wide Approach

- Identify and address inequalities in access to cancer screening and services, specifically bowel screening for men in SIMD 1; and disabled people.
- Assess whether access inequalities to psychological therapies.
- Deliver relevant actions within NHSGGC Communication Support and Language Plan, ensuring access to advocacy.
- Assess current position regarding any discrimination faced by LGB, Trans people, sensory impaired people and people with learning disabilities and establish areas of exemplary practice in services most likely to be access by them.
- Assess current position, develop and implement actions to ensure no patient is treated unfairly because of their age and positive action is taken to counter age discrimination and ensure needs led access to treatment and support.
- Assess current position, develop and implement actions to address the health needs of homeless people; and Roma / Gypsy Traveller people.
- Assess current position, develop and implement actions to reduce DNA's by age, sex, ethnicity and SIMD.
- Assess current position, develop and implement actions to reduce inequalities gap for sexual health and BBV.
- .Identify barriers for disabled people in attending appointments and bring forward action to address these.
- Use of routine sensitive enquiry is extended to new settings; and support shared GBV approach with GPs.
- Deliver changes to address the issues identified by NHSGGC deprivation group.

ORGANISATIONAL CAPABILITIES	**EFFECTIVE ORGANISATION**		**2011-12**	**2013/14 Target**
	Key Actions for Delivery	**Indicator**		
	Managers analyse and take action in relation sickness/absence performance in line with relevant HR policies. Staff will have annual PDP/KSF review. New staff will receive integrated induction. Introduce integrated induction programme for CHCP staff, as part of developing integrated training and development. Implement actions agreed in response to CHCP Staff Health Survey. Maintain Healthy Working Lives Gold Award. Maintain PFPI Participation Standards. Developing integrated Human Resource; Learning and Education; Complaints and Enquiries (including Freedom of Information) services; Asset and Resilience Management; and ICT development arrangements to further facilitate transformational change throughout and by the CHCP	Sickness/ absence rate amongst WD CHCP NHS employees (NHSGGC)	5.1%	4%
		Average number of working days lost per WD CHCP Council Employees through sickness absence	14.89	TBC
		Percentage of WD CHCP NHS staff who have an annual e-KSF review/PDP in place	66.23%	80%
		Percentage of WD CHCP Council staff who have an annual PDP in place	20%	TBC
		Percentage of complaints received and responded to within 20 working days (NHS policy)	91.6%	70%
		Percentage of complaints received which were responded to within 28 days (WDC policy)	60%	TBC
		NMC Registration compliance	N/A	100%
		Percentage staff with mandatory induction training completed within the deadline	N/A	100%

5. STRATEGIC RISK MANAGEMENT

The CHCP recognises that the management of strategic risk at CHCP-level will impact on both WDC's and NHSGGC's respective abilities to achieve their strategic aims and objectives. In view of this, the CHCP is committed to the role it has to play in supporting both parent organisations, and in managing the strategic risks identified at CHCP-level. The CHCP Senior Management Team has identified the actions necessary to mitigate relevant strategic risks; and, by undertaking these actions, the CHCP will assist WDC and NHSGGC in achieving their strategic aims and objectives as expressed earlier within this Strategic Plan.

To assist the CHCP to manage and monitoring such risks, it has developed an integrated and "live" CHCP Strategic Risk Register that both feeds the Corporate Risk Registers of its parent organisations; and is itself supported by operational service risk registers. At the time of writing, the following risks had been prioritised within the CHCP Strategic Risk Register (listed below in no particular order):

- Failure to meet legislative compliance in relation to child protection.
- Failure to meet legislative compliance in relation to adult support & protection.
- Failure to deliver Allied Health Professional (AHP) service national waiting time improvements.
- Failure to deliver efficiency savings targets and operate within allocated budgets.
- Failure to identify and/or then mitigate any significantly adverse effects to patients/clients – including protected equality groups – that may arise as an unintended consequence of delivering financial targets.
- Failure to promote patient safety measures (including infection control standards).
- Failure to implement recommendations/act upon learning from the Blue Triangle Review.
- Failure to implement action plan agreed in response to Care Inspectorate assessment of CHCP social work service provision (three actions).
- Failure to moderate and contingency plan for flood risk for sites of Dumbarton Health Centre and CHCP Bridge Street offices (SEPA flood map identifies a 1:200 risk for these locations).
- Failure to address health and safety requirements related to physical environment/overall building quality of Clydebank Health Centre.
- Failure to mitigate risks to NHSGGC-wide Diabetic Screening Service of heavy dependence on IT systems through on-going process of their being updated.
- Failure to ensure that services are delivered by appropriately qualified and/or professionally registered staff.
- Failure to monitor and ensure the wellbeing of people in independent or WDC residential care facilities[1].

The CHCP Risk Register has been developed and utilised as a "live" document, subject to regular review (and revision as necessary) by the Senior Management Team, both in terms of the concerns prioritised, the level of risk (in terms of likelihood and potential impact) assigned and the migrating actions implemented.

[1] The management of this risk element (as expressed through Care Inspectorate gradings) specifically contributes to the management of the following WDC strategic risk: failure to embrace opportunities which can be derived from constructive partnership working and joined-up service delivery.

6. WORKFORCE PLANNING AND DEVELOPMENT

The CHCP is responsible for a combined workforce of approximately 2400 staff (1763.34 Whole Time Equivalent/WTE):

- 652.20 (WTE) NHSGGC-employed staff.
- 1111.14 (WTE) WDC-employed staff.

The key principles that underpin the CHCP's approach to workforce planning and development are:

- A common approach consistently applied across all CHCP staff groups and services (as far as is possible and relevant).
- Where distinct uni-disciplinary/professional or service-specific actions are required, provide clarity of what and undertake in a manner that does not contradict integrity of integrated CHCP approach.
- An explicit focus on continual performance improvement in relation to quality service priorities and key targets.
- Approaches that are reflective and adaptive to organisational contexts and requirements of both NHSGGC and WDC.
- An emphasis on enabling team working and supporting greater skill-mix.
- That identifies and promotes opportunities for joint learning and collaborative development across staff.
- Actions that are affordable and realistic to achieve in a sustainable manner.
- A recognition, value and use of internal expertise within the CHCP workforce.
- A commitment to staff participation and partnership working with employee representatives.

Key cross-cutting organisational priorities for the year ahead are then:

- High quality service provision, particularly person-centred care and support.
- Staff and practice governance.
- Staff accreditation, disclosure and registration.
- Absence management.
- Staff personal and continuous professional development planning (PDP and CPD).
- The requirements of the Equalities Act 2010.
- Self-evaluation.
- Leadership development.
- Developing integrated Human Resource; Learning and Education; Complaints and Enquiries (including Freedom of Information) services; Asset and Resilience Management; and ICT development arrangements to further facilitate transformational change throughout and by the CHCP.

Consolidating the sound foundations of the CHCP and strengthening its integrated arrangements will require a continued focus on good quality organisational development. The CHCP will draw upon expertise and support from the organisation development functions of both WDC and NHSGGC to deliver as much joint activity as possible; ensure that the specific needs and legitimate distinctiveness of individual services, teams and staff groups (including primary care contractors) are recognised.

7. FINANCE

The CHCP's Scheme of Establishment is explicit that NHSGGC and WDC will remain legally responsible for services belonging to each of them and will set the budget for such services annually. Within the context of the CHCP, the NHSGGC and WDC have agreed to align budgets; and the CHCP has delegated authority to distribute the combined budgets allocated by each parent body. Importantly, the CHCP has to separately account to the both WDC and NHSGGC Chief Executives for financial probity and performance with regards their respective and distinct budgets.

WDC (Social Work) Budget

- Revenue Estimates

OUTTURN 2011/2012 £	SERVICE DESCRIPTION	REVISED EST. 2012/2013 £	PROBABLE 2012/2013 £	ESTIMATE 2013/2014 £
1,299,766	STRATEGY AND PLANNING	1,464,560	1,425,300	1,475,915
5,095,642	RESIDENTIAL ACCOMODATION - YOUNG PEOPLE	5,175,311	5,224,218	5,087,534
2,071,881	RESIDENTIAL SCHOOLS	2,002,577	2,381,923	1,979,000
3,114,565	CHILDCARE OPS	3,505,331	3,389,959	3,552,720
3,715,579	OTHER SERVICES - YOUNG PEOPLE	3,807,509	3,632,951	3,550,798
11,391,712	RESIDENTIAL ACCOMODATION FOR ELDERLY	11,550,702	11,400,269	11,096,895
1,321,447	SHELTERED HOUSING	1,325,436	1,319,061	1,339,808
1,061,963	DAY CENTRES – ELDERLY	1,111,449	1,054,420	714,879
112,515	MEALS ON WHEELS	112,509	113,243	75,961
253,872	COMMUNITY ALARMS	267,307	282,988	266,793
3,015,908	COMMUNITY CARE OPS	2,988,502	3,020,882	2,931,876
8,188,180	RESIDENTIAL CARE - LEARNING DISABILITY	8,561,021	8,638,585	9,280,586
1,118,319	PHYSICAL DISABILITY	1,026,321	1,088,843	1,061,952
1,532,270	DAY CENTRES - LEARNING DISABILITY	1,585,280	1,564,673	1,140,061
897,944	OTHER SERVICES – DISABILITY	862,786	929,050	930,042
433,009	CHCP HQ	227,977	182,464	230,375
1,736,572	MENTAL HEALTH	2,176,900	1,943,024	2,006,795
8,958,313	HOMECARE	9,123,339	8,973,818	8,815,600
375,166	OTHER SPECIFIC SERVICES	366,846	366,846	366,846
1,335,105	ADDICTION SERVICES	1,154,328	1,127,466	1,136,313
458,634	OTHER DISABILITY SERVICES	117,749	109,669	109,669
0	CPP - CHILDREN & FAMILIES	0	0	0
0	CHANGE FUND - OLDER PEOPLE	360,000	360,000	0
0	CPP – ADDICTIONS	0	0	0
		58,873,740	**58,529,652**	**57,150,418**

- Capital

DESCRIPTION	*ESTIMATE 2013/2014 £*
UPGRADES TO RESIDENTIAL HOMES/DAY CARE FACILITIES	66,560
REPROVISION OF LEARNING DISABILITY SERVICES	250,000
CARE HOME DEVELOPMENT 12/13	302,000
SLIPPAGE	**618,560**
SPECIAL NEEDS ADAPTATIONS	655,000
RECURRING: OPERATIONAL REQUIREMENTS	**655,000**
REPLACE ELDERLY CARE HOMES AND DAY CARE CENTRES	90,000
ONE OFF PROJECTS IN TOP 50 WDC PROJECTS	**90,000**
TOTAL	**1,363,560**

NHSGGC Budget

- Revenue Estimates

Key factors that affect financial planning for 2013/14 are:

- Efficiency challenge.
- Linking finance to planning.
- Focus on local/national.
- Equality issues. GP Prescribing.
- Older People's Change Fund – in 2012/13 the CHCP received a £1,381,000 allocation as the second year of a four year plan targeted at changing the balance of care for older people from an institutional setting to an at home or in a homely setting. It is anticipated that the allocation to the CHCP will be at the same level for 2013/14. As the Change Fund has been allocated to the Board on a non recurring basis this funding does not appear in the draft 2013/14 budget figure.

The revenue budget for the year 2013/14 has yet to be finalised. The table presents the budget based on the existing budget rolled forward to exclude non-recurring expenditure, including assumptions of changes based on best estimates available.

The draft opening 2013/14 budget by service area is as follows in the table of the below.

Service	**Annual Budget £000**
Accommodation and Administration	1,883.4
Addictions	1,790.8
Childrens' Services	2,978.4
Condition Management Programme	1.5
Executive	435.4
Family Health Services	22,260.4
Health and Community Care	8,982.2
Hosted Services	817.7
Learning Disabilities	260.3
Mental Health Adult Community Services	3,282.6
Mental Health Adult Inpatient Services	32.9
Mental Health Elderly Services	2,891.4
Planning and Health Improvement	896.6
Prescribing	16,788.9
Resource Transfer to Local Authority	7,371.1
TOTAL	**70,673.6**

2013/14 Draft Budget	
	£m
2012/13 Current Net Expenditure Budget	73.6
Less: Non Recurring	(3.7)
2012/13 Base Budget	69.9
Less total Indicative Savings Targets (see note 4)	-
Alexandria HC additional funding	0.8
Draft 2013/14 Opening Budget	**70.7**

Notes

1. Actual funding uplift for 2013/14 is subject to parliamentary approval of the 2013/14 budget. We expect that we will receive the indicative minimum uplift of 2.7%. The uplift includes additional income from SLAs with other Boards and NSD.

2. Pay provision: Current indications are that a provision of 1.0% for pay uplift in 2013/14 is reasonable. On top of the 1%, provision has been made for additional on-call payments.

3. Energy cost growth is forecast based on the estimated volumes of gas and electricity required in 2013/14, applying prevailing prices (based on contracted advance purchase prices) for both raw energy purchases and regulator charges. The increase in usage forecast for 2013/14 is minimal.

4. It is estimated that a 1.7% savings target will be applied to the total Partnership's budgets resulting in an indicative savings target of £2.4m. Work is underway to confirm West Dunbartonshire CHCP's share of the £2.4m indicative savings. The 1.7% has been applied to the recurring allocation excluding Family Health Services, RT and Prescribing as these will be included within their overall service area. Actual savings target allocations will be dependent upon the allocations from system-wide service redesign making up the £2.4m. Where services are hosted within a CHP, total Partnership savings will come from that CHP and so ultimately savings will differ within each CHP from this overall average. In the meantime, savings have not yet been deducted from the 13/14 budgets shown above.

- Capital

The main feature of the CHCP's NHS capital programme is the construction of the Vale Centre for Health and Care. Spend in 12/13 was budgeted at £16.9m; and spend in 2013/14 is budgeted to be £1.8m, with the scheme on track for completion on schedule and on-budget this year.